CRISIS INTERVENTION 1970

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CRISIS TEAMS REACHING OUT TO AID PEOPLE IN TROUBLE[1]

Arthur Page

The chime-like telephone bell starts to ring: “Ping, pong.” Simultaneously, one of the lines on the white telephone console begins flashing.

A woman picks up the receiver and in a soft voice answers: “Suicide Prevention and Crisis Service. Can I help you?”

You hear only the woman’s voice.

“Yes. Would you like to talk to me?

“You know, if you don’t feel like talking I can hang on until you’re ready.

“Is it difficult for you to talk about it?

“All right.

“Do you feel like talking about it now?

“Do you think you’ll feel like talking about it later?

“You can talk to me.“

After her last statement, the woman slowly puts the receiver down. “He hung up,” she says flatly.

At the Suicide Prevention and Crisis Service, 560 Main St., there’s always someone to talk to – 24 hours a day and at four different telephone numbers. The volunteers and workers who man the telephones represent a wide cross section of the community – in terms of age, interests, occupation, education and socio-economic background. But they also share common qualities.

ALTHOUGH SHE SAYS their shared traits are hard to define, Mrs. George Schlenker nightwatch program supervisor, narrows them down to warmth, sensitivity, openness and “a nonjudgmental attitude.”

Describing their “humanness,” Dr. Gene W. Brockopp, executive director of SPCS, pictures the workers as “people who are able to feel for other people and their problems.”

A distinguishing trait of the SPCS workers is that all but about 10 percent can be classified as nonprofessionals having no extensive training in psychology, social work and related fields. The first suicide prevention center, established in 1949 in Los Angeles, was staffed by trained professionals. But as other centers sprouted across the country, they shifted their emphasis to the nonprofessional volunteer.

Centers have been tried which included only professionals while others using only nonprofessional volunteers also have seen their day. The best alternative, and the one centers will adopt in the 1970s, Dr. Brockopp says, is a “marriage” of nonprofessionals and professionals.

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[1] This article is reprinted from the Buffalo Evening News by permission of the publishers.

Suicide prevention centers also have broadened their crisis orientation since 1949. Dr. Brockopp explains that SPCS started out with one suicide-prevention line (854-1966) but that about 90 per cent of the calls were from people not suicidal who wanted to discuss "problems people have in living." So a problems-of-living number (854-5655) was added on Aug. 25, 1969.

HISTORY REPEATED and it was discovered that sometimes up to 50 per cent of the calls on the latter line were from persons under 22. "We felt that in a sense this was just the top layer of an iceberg," explains Dr. Allen Yasser, teenage problem service supervisor.

"We felt we could tap into an area where there was a substantial need." Once again SPCS expanded and a teenage problem line (856-1313) to serve what Dr. Yasser calls a "distinct culture" was established last October 1.

During 1969 a total of 10,564 calls were placed to the three numbers with almost 6000 of them from new clients. The first week in June the center received its 20,000th call for this year. Dr. Yasser estimates the teenage line alone now receives close to 500 calls a month and could get as many as 8000 calls in one year.

A contract agency of the Erie County Mental Health Department, SPCS receives half its operating budget from that department and the remainder from the state Mental Health Department. Dr. Brockopp boasts that SPCS is the largest of 138 similar centers in the U.S. and, "if not the busiest, one of the busiest."

SPCS now has more than 50 volunteers, ten part-time clinical associates (former volunteers now paid part-time salaries), ten teenage line volunteers, five nonprofessional mental health counselors, four professional staffers and a new group of nightwatch and teen-age volunteers in training.

VOLUNTEERS, about 75 per cent of them women, work shifts from 9 PM to 3 AM at least two nights a month as part of SPCS nightwatch programs. The clinical associates, four of them men, take 9 PM to 8 AM stints and day shifts on week-ends.

The ten volunteers on the teenage line, two at a time, work form 5 PM to 11 PM. Seeing clients in therapy is one job of the five women who work 40-hour weeks as mental health counselors.

After applicants have completed an extensive questionnaire about their views on life, suicide and mental health, they're screened through and interview and, if accepted, scheduled for a training session that formally runs up to 30 hours.

Volunteers, Mrs. Schlenker says, are trained to understand that "suicide is often seen as the only alternative to an intolerable life situation. "And that" "people who call the center are ambivalent. "That is," she emphasizes," they don't want to live and they don't want to die. The person who is suicidal is often "crying for help' to another human being and can't reach those people who are around him.

Mrs. Schlenker says "getting to know oneself" is an integral part of training Volunteers, she stresses, must become aware of their feelings and prejudices on various topics, how as a person they react to the word "suicide" and "what do you bring as a person that you can give someone over the phone."

"GUTS AND THE willingness to expose and/or to explore those guts" is one of the 14 criteria for mental health counselors listed by Nancy Bourne, former SPCS research director, in a report on training counselors.

The workers are real. They're sensitive to others. And after pondering their reasons for volunteering, they invariably confide they did it because helping other is a good, positive thing to do.

Typical is the response of Mrs. Antonio Pacheco, mental health counselor, who applied after "they said it would involve people. Helping people – that's my bag."

As a former worker in the Head Start program and at Planned Parenthood, Mrs. Pacheco was "always working with people." But the mother of six and resident of Lackawanna's 1st Ward adds that after working at SPCS, she's now "looking at people differently."

Like others, Philip J. Kinsler, 23-year-old graduate student working for his doctorate in psychology at the State University of Buffalo, volunteered because he discovered a need to help others. "I was kind of hung up on the fact that I ought to be doing something for the community," he admits.

Kelly W. Collier, teen-age-line volunteer works with youth programs at the Humboldt YMCA and Our Savior Lutheran Church. But he wanted "to do a little more-with people outside church – in the community, in the city."

The MOST important individual is the teenager," the 23-year-old Vietnam War veteran stresses. Most often he tells a caller: "I lived this life too. I know what you're talking about. I've had my own ups and downs and bumps and scrapes."

Nineteen-year-old Kathy Tosney, laboratory technician at Millard Fillmore Hospital, wanted to work on the teen-age line because "I felt I was on the same level with these kids and I'd just been through what they're going through. I can relate better to the teenagers because I think I'm closer to their problems.

Yet, in most cases, the decision to volunteer was on snap judgment. The SPCS workers admit that application was preceded by serious and sometimes lengthy self-examination and self-appraisal.

"You've got to know where you stand on a lot of things," explains Judy Dieterle clinical associate from Atlanta, Ga., and junior in social welfare at D'Youville College. "You have to know how you feel, and not let your feelings affect your relationship with the caller.

Bernard M. Engel, Town of Tonawanda businessman, and others first considered what traits SPCS volunteers should possess. Mr. Engel, nightwatch volunteer, says that "first of all you need an understanding nature. I figured that . . . if I am talking to a person in a crisis situation I should be able to give them understanding, sympathy perhaps and much more importantly, direction."

Volunteers also were concerned with whether they could communicate successfully over the telephone with persons in crisis. Richard Pariser, 24-year-old nightwatch volunteer and a first-year law student at UB, admits: "I guess the biggest question was 'Can I rap with people?' Can I do anything for them by simply talking?

SOME WORKERS also attempted to isolate and explore their attitudes toward suicide. For those who didn't, training is designed to make them focus on the subject both theoretically and pragmatically.

Miss Dieterle emphasizes: "I believe that life is basically better than death and that while you still have life there is a possibility for change."

Two nightwatchers, 25 –year-old Mrs. Hilda Drane, a telephone operator for the New York Telephone Co., and Mrs. Richard Pariser, 24-year-old social worker at West Seneca State School, agree that a person, inclined to suicide, wishes to kill a situation, not the self. “They want to kill the life they live or the crisis at that point – not themselves.” Mrs. Drane stresses, adding that “if they can get over it things will work out.”

The Rev. Robert H. Wilson Jr., 39-year-old pastor at Our Savior Lutheran Church and the father of five, says he doesn’t “like to see people commit suicide. I think if they had second thoughts about it and a chance, they’d change their minds.” Mr. Wilson, on the SPCS board of directors, adds, “I’d like to give them that chance.”

Suicide is “a waste of the good things of a person’s life,” adds Mrs. Doreen Klenke, a mental health counselor, “because he doesn’t know what his potential is unless he’s living it fully. You just have to try a little harder sometimes,” the mother of two and former family assistant for Head Start adds.

WHILE THE WORKERS all have opinions about suicide, they don’t try to force the sometimes anonymous callers around to their way of thinking. They attempt at all expense to be nonjudgmental. They “just give suggestions” as Miss Tosney puts it.

And the SPCS workers emphasize they’re there to listen and that in most cases time is not of the essence. “If a client keeps calling back, no one here is ever going to say ‘You just called five minutes ago,’ “Mrs. Drane stresses. “We’ll just start all over again.”

The workers are quick to point out that being real people, they also have real problems. But the minute they center the central “Telephone Room” at SPCS, they push their problems into the background.

It’s also a job which, for some of them, quickly lost the glamour they first saw in it. But with the glamour gone, they still work their shift and answer the telephones because, as Miss Dieterle says, “the rewards are there.”

BUT NOT EVERY CALL is rewarding. “Often it’s very frustrating work,” she adds. Some evenings the volunteers are plagued by nuisance calls – there were close to 8600 in the last 11 months of 1969. And there are those persons who call expecting magic formulas and hang up after a few minutes because they get not fast and easy solutions – just when the volunteer is beginning to establish some rapport between them.

There also are those completed calls, as Mr. Engel emphasizes, “where you simply don’t know and feel inadequate” when “you can’t get through the way you’d like to. And that’s tough.”

Satisfaction is a sign or response from a caller that he’s been motivated to “just try,” says Mrs. Drane. For Mr. Kinsler it’s the knowledge that “sometimes I can help a person take the first step in straightening things out.”

For him, says Mr. Collier, the satisfaction is realized “when I’ve completed a call with an individual who was in a true crisis and . . . they really want to go on, to work harder and have the feeling they can make it. And then they say ‘thank you.’”

The Night People: An Account Of One Evening[2]

Robert Wilson, Erie County SPCS

The first guy I ran into was Carlos. Everybody seems to know Carlos, but it's the first and only time I've ever seen him on the streets. He's Puerto Rican, with a heavy accent, no teeth, alcoholic, and pretty drunk at the time. His breath was like he'd just eaten a whole pound of garlic. He wanted some money but I couldn't afford it. So I got in conversation then with a cabby whose car had broken down.

Then I went to the Silver Dollar, and as I was coming in an Irishman, Joe, was just coming out, and he asked me for some money, and I said, well come on, and I'll buy you a drink. So Joe and I sat, drank a glass of beer, and he told me how he was an alcoholic. He really didn't want to be anything but an alcoholic. He was pretty miserable and unhappy and was particularly unhappy now because drinking beer was like drinking water and he wondered if I'd buy him a glass of wine. I said yes, I'll buy you a glass of wine. He said, well let's go over to the House of Quinn - the wine is better over there. So we went over there, and sat down at the bar, and he introduced me to Bill from Nashville, Tennessee, somewhere down there, who poured his heart to me while Joe went and drank his wine in a corner - he had to be alone.

Bill introduced me to another friend, a terribly insecure guy who tried to impress me with how smart he was, and how he didn't have any prejudices although they stuck out all over him. He asked for a drink, and he and Joe, Ernie and Bill discussed who owed who. Finally after they couldn't decide the other guy left, and Bill and I went on with our drinking and talking. We must have spent about an hour and a half together.

We also got into conversation once and a while with the bartender and with some working-class type standing next to me, loud, quite inebriated, insecure, unhappy home life apparently, and I had noticed Eulie sitting at the bar in his usual manner, staring down at the bar and drinking his beer. I didn't make any effort to recognize him or get his attention. But he must have noticed later on because all of a sudden, when I was sitting at this bar talking with Bill, I got from behind a big bear hug and lifted right off the bar and, as I tightened up, it felt like he broke a rib.

It was Eulie, an affectionate gesture, and I'm just now (two weeks later) getting over the soreness that he left from this affectionate bear hug. Well, the three of us (Bill, Eulie and I) got put out at closing time, went down to Texas Red Hots, and old friend Bill, the Black guy who's always looking for a ticket to Niagara Falls, was there with another black guy who was an acquaintance (at least for the night). Bill was again drunk as usual, loud. Eulie, loud, making all kinds of trouble for the short-order cook, and the busty waitress, who was nice looking with a nice bust. There was all kinds of interaction.

Some guy came in wearing a cross like he owned the world. For some reason or another he started putting down the three of us who were at the counter - four of us now - the Niagara Falls fellow was with us.

Carlos came in, and the short-order cook waiter charged at him with a pointing finger and told him to get the hell out of there, and the guy who owns the world pounces up and gives the short-order cook hell for treating Carlos that way and gave Carlos some money - a buck, a quarter or something - and told him to go somewhere and get himself something. He came back talking about how generous he was

[2] This program has been described by John Russell (1970).

and what a phony bastard he was in his patronizing way wearing his stupid cross, and we finally parted with him, leaving the place with the two of us shouting at each other.

Then Eulie and I left the place. Bill went his way, and Eulie and I went up to the Center where I was going to do my taping. I called Pat. She let me in and immediately asked me to get on the phone with some guy named Dave who wanted to talk to a man. It turns out he's homosexual and a patient of Dr. Yasser's. He was really uptight and suicidal. He was at the foot of Ferry Street by the river and needed somebody to talk to eyeball-to-eyeball. I said okay, I'd meet him and, after a lot of bickering and making sure I wouldn't call the police, we agreed to meet behind the Main Street Mall. Said I'd meet him there in 20 minutes. I sat and talked to Pat for a while. Eulie, by the way wanted to take some calls. He wanted to take over my call and thought I wasn't making any headway with the guy, and I said well, I've got to go now and meet Dave, and said let's go Eulie. And Eulie said, "Well, I think I'll just stay here till the rest of them come in the morning," and Pat about lost her britches at that, but I convinced him that Pat and I would both be fired if they found him there in the morning. So he agreed to leave and then decided he'd better go with me to meet David because David might do me some harm, I tried to talk him out of that. But he said, you drive to within a block of the place, and I'll just walk up there and kind of keep my eye on things.

Well, he did that. I met David inside the door of the Main Street Mall, and Eulie went by whistling, looking up at the stars or some dumb thing. After a lot of belligerent remarks, David finally decided we should go have a cup of coffee. We talked about his problem, and he got so damn nervous, shaking and quivering, trying to crawl under the table. We decided to leave there, go somewhere else. We went to a Your Host place on Main. We just sat in the parking lot, talked for a while, and then I convinced him that he should go home. So I took him home, and he was somewhat grateful and said he felt better. I left him over on the West side. Got home about 7:30 in the morning.

Reference

Russell, J. Using clergymen as night people counselors. *Crisis Intervention*, 1970, 2, in press.

A Night In The Life Of A Night-Watcher[3]

David Lester, Erie County SPCS

It hadn't been too good a day. I still had a cold and I was a bit depressed. Things improved a little during the day and by late afternoon I was more calm. I left the SPCS at 4:30 to get a combined lunch/dinner and was back by 5:00 p.m. when I was on.

For the first few minutes I tidied up the telephone room as I usually do. I hate just sitting there waiting for a call.

5:10 I got a call for Al (who wasn't around).

5:20 A call came in for Elsa but she was in with a patient.

5:32 A girl called on the teenage line. Ann was pregnant (checked to see whether a doctor had confirmed it – yes) and didn't know whether to tell her boyfriend or her parents first. There seemed to be no problems. She wanted to have the child, the boyfriend knew she might be pregnant, and her parents would probably act ok. She was just a little anxious. I told her to tell her boyfriend first and then see her parents together. I found it a little difficult to keep talking, but I felt I handled it ok. After I hung up I remembered to watch how I say "yes" and "mm-hmm."

5:49 Another call for Elsa but she was still in with a patient. I got talking to Fred and John who were also working about what to suggest for a girl whose father is making her act like a housewife and who is cruel.

5:59 A call from someone in the evening's training session who would be late. Then I talked to Mandi about her boat and about the possibility of going out for a night in a police car and to Marcia about the training group that evening.

6:16 A call on the teenage line from an anonymous girl (I didn't ask her name who was concerned with whether to go out with this boy since she had found out he laid the last girl he went out with. I told her if she felt she could handle him, why not. I felt uneasy about the call. First, I got another call in the middle of it and since John and Fred had disappeared I had to answer it. He wanted a girl to talk to but none were around so he hung up. I hate interrupting a call. If he had called when I was free I might have got him talking. (Fred had a call later from someone who wanted a particular counselor who wasn't around, and Fred had let the caller hang up without asking whether he could help. The same kind of situation. Maybe they would hang up anyway but it's easy to facilitate them hanging-up. I didn't say anything to Fred. I would have felt awkward doing so.)

Secondly, Marcia was walking in and out, and I felt inhibited. Which is dumb (after all she supervises me).

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[3] Details about patients have been changed to prevent identification. Al, Dave, Doran, Elsa, Mandi, and Marcia are staff members. Debbie, Fred, John, and Killian are volunteers. During this shift I was one of three volunteers taking calls.

6:22 A call on the teen line from a girl who hung-up after saying only a few words. I then went out and locked the outside door (it's supposed to be locked after 5 p.m.) and tidied up some more in the room.

6:32 A call from Elsa's daughter but Elsa was still busy. I went and locked the outside door again!

6:35 A hang-up on the teen line.

6:39 A call for Judy on the teen line. I was in toilet at the time and I knew Fred and John were on calls. So I ran back, breathless, answered the damn call with "suicide – er – teenage problem service". The girl didn't want to talk to me so we hung-up. Boy it hadn't been too good an evening so far.

6:40 Dorean called for Elsa and left a message.

6:49 A call on the teen line from Joyce whose boyfriend had broken up with her because she pestered him so much asking whether he liked her. It was difficult to get her to focus. She knew what she was doing wrong but kept drifting onto other topics. Felt it went ok.

7:03 A call for Killian. He wasn't in yet.

7:05 A call on the teen line from Carol. Carol calls up a lot and knows most of the male counselors. I like her. She's easy to talk to and is pleasant. If another call comes in or you are busy she understands. Tonight she told me that she had found out who I am. She knows I'm Dr. David Lester, a research psychologist and not just David. It seems Killian gave out the information to a friend of hers. (Remember to kill Killian.) We talked about she felt when she found out. Carol doesn't seem to have any problems. She just likes to talk. She likes having some friends down at the SPCS. After 45 minutes she said she has to hang-up since someone had arrived which was a pity since she said she had something important to tell me.

8:33 Picked up a call the same time as Killian but he took it.

8:33 Called home.

Lots of people left the center. The training group probable broke up. I went and locked the door again.

8:52 Went and locked the door again. There were still people around. I decided t give up locking the door. I reckoned the other door didn't have a lock so why bother. (I found out the next day that both doors have locks.)

8:55 A crank call on the teenline. They were laughing too much to talk.

8:56 Jane called for John. He was busy on a call. She said she'd call back.

8:57 A girl called on the teenline because her friend was pregnant. She hadn't had a test yet. So I recommended going to a doctor or Planned Parenthood for a test. After the call was over, I found Al's handout on referrals and realized I should have had the girl call him. But I did tell her to call back.

9:03 A call from Miguel who had just arrived in Buffalo from Chicago. He had had a job but had been fired. He had been thrown out by two aunts and now was living with an uncle and was expecting to get thrown out by him too. I referred him to the Youth Employment Program. Then we chatted some

more. He sounded nice. We talked about how lonely he must be. I tried to get him to talk about why he had been thrown out of two homes and fired but he wouldn't focus too well. Debbie, one of the trainees was listening in to the call.

Then Killian told me to listen in to Emma, one of our chronics who a lot of people don't like too well. Killian seemed to get on with her and liked her. They talked for over an hour on and off. I listened in to a few minutes and was glad Killian had the call.

9:33 Mary called on the teen line. She is the other regular caller that I like and get on with. She sounded fine. I remembered that Fred said she had called earlier and was upset. We talked awhile. I mentioned the letter she had sent me. She told me she had cut her wrists last Thursday and again on Friday. I remembered Fred had told me about that. She had been interviewed by Dave with everyone watching through the one-way mirror on Thursday. I asked her why she had cut her wrists but she couldn't answer. I think maybe I confronted her a little too much because she said she had to hang-up to go eat because she was anemic. Maybe she really did. She said she'll call back. Debbie listened in to that call and we talked about it afterwards. I hoped she would call back.

9:50 A social worker called on the teen line asking for the number of the drug line. I told him I would do. He wanted a place for the parent of a kid who had been busted for marijuana to call for advice. He asked about A.I.D. but I thought that was for hard drug users. I told him to call Al during the day.

10:00 I let Debbie out of the building.

10:01 A call from Vera on the teenline. She's 13 and wanted to know if glue-sniffing would cause brain-damage. I said yes. Talked a little bit, and she said she calls a lot. I tried to get her to call Al during the day. I told her he is talking with a lot of kids who sniff glue. I talked to her for about 7 minutes. I felt bad afterwards. Maybe it wasn't necessary to talk to her for more time but I realized that if it had been Carol or Mary I would have. It was as if she wasn't one of my regulars. I don't like acquiring regulars and the teen line regulars are more clinging than those on the suicide line. For example, Emma will talk to anyone and doesn't seem to get attached to one person. But it's more than that. In spite of the fact that maybe it's ok not to go on and on with callers, I felt bad because I do with some.

10:20 A wrong-number on the suicide line.

10:26 A call from a girl on the teen line (I didn't ask her name) who was worried because her friend was sleeping around. She wouldn't talk much which gets me uptight and so I gave her some advice but I hate giving advice when the person doesn't respond to it. Yet I also hate sitting there in silence. However, I do encourage every caller to call back to tell us how things went or if they need any further advice.

10:37 Jane called again for John. I put her on hold.

10:38 A hang-up on the teen line.

10:50 A call on the teenline from Helen who wanted this boy to ask her out. One of those two minute calls where anything you say seems to be satisfactory.

10:55 I went on home, hiding my wallet inside my trousers in case I got robbed on the way to the car. It was a standard 5 p.m. to 11 p.m. shift. All the patient calls were on the teen lines. I got calls from Carol and Mary. At least I felt good after two of them (Ann's and Miguel's). That doesn't always happen.

Steps Toward The Evaluation Of A Suicide Prevention Center: Part Two

David Lester, Erie County SPCS

In the first part of this series of articles, I presented some ideas for the evaluation of the lower level objectives of suicide prevention centers. The measures I looked at there were:

(1) Counselor-rated improvement of the patient as a result of the telephone contact,
(2) The extent of and success in referring patients both to the SPCS clinic and to other agencies,
(3) Interviews with high risk groups (attempted suicides to see whether they had heard of the SPCS and whether they had called the SPCS, and
(4) Looking up the death certificates of completed suicides in Erie County to see how many of them had called the SPCS as far as one could tell. (A large proportion of callers to the SPCS are anonymous.)

The aim of this series of articles is to suggest to other suicide prevention centers the kinds of measures that they can consider in evaluating their operation. In order to better illustrate the particular measures described, I presented old data from the SPCS of Erie County.

This paper suggests some more kinds of measures that can be utilized by suicide prevention centers in evaluating their operation, and again there are some illustrative data from earlier in the SPCS's operation.

In future articles in this series, I hope to suggest additional kinds of measures, present data on the evaluation of the higher level objectives of suicide prevention centers (such as the study of changes in the suicide rate of the community served), and to report on how, in one suicide prevention center, monitoring of the operations of the center have led to improvement in the service performed by the center.

How Long Does It Take to Get Through to a Counselor?

If you decide to call the SPCS, how long does it take for you to get your call answered? This question was studied by having an investigator call the Teenage Problem Service (856 1313) which can accommodate three calls at once. (This line was used so as not to hinder any suicidal caller calling on the Suicide Prevention Service from getting through.)[4]

During a four week period (5/11 to 6/4) one call was made to SPCS on the teenage line during each hour of the week from 9:00 am to 11:00 pm. The number of rings before the call was answered was noted and the response of the person who answered the phone.

[4] Almost all suicide calls received at the SPCS come in on the suicide prevention line.

number of rings heard	Evenings 5pm-11pm	weekdays 9am-5pm	weekend days 9am-5pm
1	21	17	5
2	5	20	4
3	4	2	1
4	4	0	1
5	2	1	0
6	0	0	1
7	0	0	0
8	0	0	0
9	0	0	3
10	0	0	0
11	0	0	0
12+	0	0	1
busy	6	0	0
total	42	40	16

The call was answered with an identification of the teenage problem service on all occasions but two. Once (5:30 pm) it was answered “Suicide Prevention Service” and once (also 5:30 pm) it was answered “Oh my gosh. Can I help you”.

Other similar measures can be taken.

(1) By day, when a receptionist answers the phone first, the time before a counselor answer could be noted.
(2) The amount of time during the day that all the lines of one service are in use could be noted. At these times no more incoming calls can be accommodated.
(3) The length of time for which callers are placed on hold can be noted.

These kinds of measures would serve to identify times of the day when callers were not receiving immediate therapeutic attention.

How Well are the Initial Contact Sheets Completed?

When a patient calls the SPCS, the counselor is required to complete an initial contact sheet. An analysis was undertaken to see how well these sheets were being filled out.

In a sample of 1,000 consecutive new patients calling between May 7th and June 4th 1970, the contact sheet of every tenth new patient was examined and the percentage of the forms with items not completed was computed.

In the sample of 100 sheets, 2 were missing. However, two numbers had been used twice and so the final sample consisted of 100 forms. The percentage of incompleted items is shown on the following reproduction of the initial contact sheet.

Percentage of forms with the item not complete.

INITIAL CONTACT SHEET

(Fill out EVERY item. Try to get some identifying information on callers, especially those referred to agencies)

Line: SPCS TPS PL JV 4%

Case Number: _____ COUNSELOR: 4%

Call began: 1% am pm 21%

Date: 2% Day: 11% Call ended. 4% am pm 28%

Taped: yes no

Caller: 39% Age: 16% Sex: 4% Marital Status: 31%

Address: 75% Telephone: 90%

(If patient will not give address get street, block, area, etc.) _____

Calling for: self 36% other If other, Who? _____

PROBLEM

check one primary problem as many secondary as appropriate

Check all appropriate items

	prim.	sec.
alcoholism:		
anxiety:	17%	
depression:		
drugs:		
employment:		
family:		
financial:		
homicidal:		
info:		
legal:		
lonely:		
mental dis:		
physical dis.:		
pregnancy:		
school:		
sexual:		
suicidal:		
other:		

CRISIS: acute: _____(change in past 2 days)

chronic: 42% (duration exceeds 6 mo.)

neither: _____

SEVERITY OF CRISIS: (counselor evaluation)

0 1 2 3 4 5 41%

none moderate severe

SUICIDAL HISTORY:

unknown: _____

none: _____

ideation: 42%

threats: _____

attempts: _____

CURRENT SUICIDAL BEHAVIOR:

none: _____

ideation: 37%

threats: _____

attempt: _____

SUICIDAL RISK: (counselor evaluation)

0 1 2 3 4 5

none moderate high 37%

CHECK THE FOLLOWING WHERE APPROPRIATE:

traced: _____ police: _____ rescue squad: _____

cab: _____ ambulance: _____ consultation: _____

COMPLETE INFORMATION ON OTHER SIDE

Background to problem: 0%

Disposition (Be specific. Which agencies did you refer caller to, if any? Did you suggest particular time?) 27%

Suggestion for future contacts: 83%

How did you feel about the call: 65%

The Care of Patients as Assessed from the Records of Telephone Contacts

It is possible to assess to some degree how adequately patients are being handled by examining the records of the telephone contacts. A study of these records provides some evaluation of the service and data on the kinds of people calling the service.

Ken Whittemore examined 100 consecutive new cases calling the suicide prevention and crisis service of the SPCS and compared the data with those from other suicide prevention centers. His report will be written up in full and published at a later date.

However, it is possible here to compare data from the SPCS with data from one other center. The comparison presented below is reproduced without modification from Ken Whittemore's summary of his study on the SPCS.

COMPARISON OF SPCS WITH ANOTHER CENTER:

	Other Center	Buffalo
A. Status of cases		
1. Open	6	-
2. Closed	88	-
3. Missing	6	0

NOTE: Buffalo does not have a system of reviewing and closing cases. Thus there is no valid comparison.

B. Information on clients		
1. Anonymous	15	27
2. Not enough information to allow for follow-up	17	36
3. Complete data	62	37
C. Suicide involvement		
1. In process	9	0
2. Threatening	18	9
3. Ideation	10	12
4. None	57	79
D. Disposition of call		
1. Telephone only	28	56
2. Referral made	66	44
E. Follow-up contact		
1. Took referral	26	-
2. Took other action	17	-
3. No action taken	13	-
4. No follow-up	38	-

NOTE: Buffalo does not have a routine call back to determine whether or not the patient took the referral. The other center checks with the client and confirms

with the agency. No valid comparison can be made. Buffalo did refer 11 of 100 cases to its own counseling services; 6 of 11 so referred kept the appointment.

F. Identity of caller

1. Self	50	77
2. Family member	22	14
3. Agency/professional	5	1
4. Friend/neighbor	13	8
5. Other	4	0
6. None given	0	0

G. Referral source

1. Agency or professional	6	1
2. Hospital	3	0
3. Radio/tv/phone book	7	0
4. Former client	1	0
5. Other	2	0
None given	75	99

NOTE: These data were not routinely elicited at either center and the validity of the comparisons are doubtful. The significance of the data is also problematic.

H. Alcohol involvement

1. Drunk at time of call	11	8
2. Alcoholic	9	7
3. Not "2" but a problem	3	6
4. None	71	79

I. Closed cases

1. Evidence of crisis resolution	22	-
2. Active involvement with agency or therapist	30	-
3. Neither (inc. anon. & nei)	36	-

NOTE: Buffalo does not have a system of review and closure. No comparison can be made. The other center says no case should be <u>closed</u> until a definite disposition has been made and confirmed. 32 or 26 cases not so handled were anonymous or not enough information to contact. Thus, of 56 cases where follow-up was possible, they did so in 52 instances. (6 cases were "missing" and 6 were still "open".)

The 100 consecutive incoming calls representing new cases covered a period of 19 days at the other center and 12 days at the Buffalo center. (In Buffalo only <u>Suicide line</u> calls were abstracted, not Teenage Line or Problems of

Living or Drug Line.

As a result of this comparison three recommendations were made:
(1) that a member of the SPCS review all cases as a matter of daily routine, and
(2) that there be a system of follow-up instituted for the more serious cases, which would require
(3) that more identifying information be obtained for the callers to the SPCS.

Steps Toward the Evaluation of a Suicide Prevention Center: Part Three

David Lester, Erie County SPCS

In the first two parts of this series of articles, I have suggested some kinds of measures that those involved in administrating suicide prevention centers can use to check upon the adequacy of their services. In this part four methods of evaluating suicide prevention centers that have been the focus for published studies will be reviewed.

These studies focus upon more general criteria for evaluating suicide prevention center, that is, rather than asking, for example, how long it takes for a caller to get through to a counselor from the time they dial the number of the center to the time when a counselor answers, they ask questions such as whether suicide prevention centers have any impact upon the suicide rate of the community that they serve. To use Suchman's terminology (Suchman, 1967) these studies focus upon idealized objectives rather than lower level administrative objectives.

Do Suicide Prevention Centers Prevent Suicide?

Clearly, one of the idealized objectives of suicide prevention centers is to prevent suicide. Thus, it has been important to demonstrate this. The frequent failure to find a reduction in the suicide rate of a community served by a center has led suicidologists to predict an initial rise in the suicide rate of a community when the suicide prevention center opens due to more accurate reporting of suicide statistics, which is believed to arise through the lessening of the societal taboo about suicide and through cooperation of suicide prevention centers with coroners in certifying deaths accurately.

Of the three studies related to this issue, that by Litman (1970), fails to meet acceptable criteria. He studied the suicide rate in Los Angeles over a period of years and tried to attribute the falls in the suicide rate to the Los Angeles suicide prevention center. Studies of a single center, however, are not able to provide adequate data since the fluctuations in the suicide rate of a community can have many causes, none of which can be controlled for in the study of the single case.

A study by Weiner (1969) compared the changes in the suicide rates of Los Angeles and San Francisco where there are suicide prevention centers to the changes in the rates of San Diego and San Bernardino where there are no centers. The suicide rate of Los Angeles County showed a significant increase during the period studied, while the suicide rates in the three other communities did not change significantly. Weiner also noted that the volume of calls received by the Los Angeles center was, if anything, negatively related to the suicide rate - the more calls the higher the suicide rate. Weiner concluded that there was no evidence that a suicide prevention center reduced the suicide rate of the community.

Bagley (1968) surveyed a large number of towns in England and compared 15 towns with suicide prevention centers with 15 whic had no center, matching the towns closely on economic, social and demographic variables. Bagley found that the suicide rate in towns with suicide prevention centers had declined whereas the rate in towns with no center had increased.

It is clear that the evidence is in conflict, and we must await the results of more research before deciding whether suicide prevention centers do prevent suicide.

Does the Suicide Individual Call the Suicide Prevention Center?

The answer to this appears to be in the negative. Although suicide prevention centers receive a large number of calls from people thinking about, threatening and attempting suicide, Weiner (1969) reports that research from the Los Angeles center indicates that 98% of those who completed suicide had not called the center.

Maris (1969) noted that the average person who calls a suicide prevention center is very different from the average person who kills himself. For example, females call suicide prevention centers more than males whereas males kill themselves more than females. Maris urged that suicide prevention centers find ways of reaching the lethal individuals in the community.

Do People Know about the Existence of Suicide Prevention Centers?

Motto (1970) studied a sample of people in the community who had a high likelihood that they would commit suicide and asked whether they had heard of the suicide prevention center in their community and whether they had used its services.

He studied a group of patients admitted to the in-patient services of mental health facilities with depression or recent suicidal behavior. He found that 6% of those studied had called the suicide prevention center. A further 20% had not heard of the center. Of those who called the center, 60% stated that the center had helped them.

Motto suggested that this kind of information can aid a suicide prevention center in assessing its service and is perhaps more useful than focusing on whether the suicide rate in the community has changed.

Standards for Suicide Prevention Centers

Ross and Motto (1970) have described some initial attempts to set up standards by which to judge the adequacy of suicide prevention centers. The criteria that they adopted covered organizational standards, staffing standards, service standards, consultation standards, program evaluation, and ethical standards. They examined six suicide prevention centers in one area and found that four of the six met an acceptable (arbitrarily determined) standard. The importance of the set of standards is that it gives centers and opportunity to compare their performance with that of other and so to evaluate their performance. The specific criteria adopted by Ross and Motto are described by Motto (1969).

Conclusions

It is too early in the history of evaluating suicide prevention centers to draw conclusions. At the moment we are devising ways of evaluating such centers rather than drawing final conclusions as to the worth of such centers. However, it seems that suicide prevention centers may require substantial

modifications if they are to reach the individual who is going to kill himself. Available evidence suggests that the presence of a passive telephone service which the suicidal individual must call does not have too great an influence on the suicide rate of the community.

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What To Do As The Volume Of Calls To A Suicide Prevention Center Increases

David Lester, Erie County SPCS

The SPCS has been operating since November, 1968 and the volume of calls received by the center has risen steadily since the center opened. This increasing volume of calls from patients has been accelerated by the addition of three new services to the agency. We have added a teenage problem service, a problems in living service, and a drug problem service. In May, 1970, the SPCS received

800 patient calls and 350 nuisance calls on the suicide prevention and crisis service
130 patient calls and 260 nuisance calls on the problems in living service
and 850 patient calls and 1700 nuisance calls on the teenage problem service

These calls are received by telephone counselors working at the center.[5] During the day, the calls are taken by a receptionist who then puts the patient calls through to a counselor. The nuisance calls are prevented from reaching the counselors by the receptionist. At night and on weekends there is no receptionist and all calls are answered by the counselor.

The feeling grew among the staff at this point that we were reaching a crisis point where we could no longer provide adequate counseling with the size of staff we had. Since the problems involved more than just the mere volume of calls received, it would be well first to review these.

The Problems

(1) The staff felt that handling such a large number of calls meant that they were no longer able to provide adequate counseling. More and more callers were being put on hold because there were not enough counselors to counsel them immediately. This problem was made worse by the high volume of nuisance calls which forced the counselor to interrupt a patient call only to answer a call where the caller hangs-up immediately.

This situation meant that sometimes a contact with one patient consisted of a large number of brief exchanges intermixed with periods when the patient was put on hold. Clearly, this was not good therapeutic practice.

(2) A second problem was that, by having calls on all lines come into the same room and to the same counselors, the counselors had to interrupt calls from patients in acute crises in order to deal with the more trivial problems on the teenage problem service. The staff felt that, one day, a patient in an acute crisis, put on hold, was going to kill himself. The staff felt that those counselors handling the calls on the suicide prevention service (which in general are more serious than calls to the other services) should not have to answer calls on the other services.

(3) A third problem was that the SPCS has had acquired a large number of chronic callers who called regularly – some every night and some several times a night. These people undoubtedly received support and comfort from the service and perhaps were enabled to live a more adequate life through the availability of this 24-hour counseling service.

However, the time spent in handling them increased the chances that a serious call would be interrupted. These interruptions could only lead to poorer handling of the serious calls.

Another problem associated with these chronic callers was those new counselors who were not well acquainted with these patients spent too long with them. In spite of the fact that the therapeutic plan for some of these chronic callers (a copy of which is placed in the caller's file and in a separate special

[5] The telephone room at the SPCS has positions for up to four counselors.

file in the telephone room) required their calls to be limited, some new counselors were spending several hours on occasions talking to them.

(4) A further problem was that the volunteers were sometimes arriving later than scheduled and occasionally not coming at all.

Solutions

(1) One solution is to increase the size of the staff – add more counselors. There is obvious and simple. However, it was felt that this was too simple and that there must be more inventive ways of handling the problem. To simply add more staff would probably inhibit thoughtful analysis of the underlying problems and issues.

(2) Brockopp (1970) has discussed ways in which the chronic caller could be handled by people outside of the center.

(3) A similar alternative that would make only a small dent in the volume involved recognizing that some of the callers to the SPCS would benefit from sustained long-term psychotherapy from a trained counselor. This could be done via the telephone. It might be possible to arrange for a staff therapist to accept some of the callers on a regular basis and conduct therapy via the telephone. Patients could be given regular times to call and could be talked to as in face-to-face therapy.

The advantage of this, using a trained therapist, is that there would be more likelihood that a patient could be aided and moved toward a healthier state in this setting than by talking for varying amounts of time to any one of some 50 counselors. Instead of perhaps at the best maintaining patients, we might be able to increase the chances of improving their psychological state.

(4) The problem of new counselors spending too long with chronic callers to the neglect of new callers can be handled by better and stricter supervision.

(5) For a center to have unreliable staff creates too many problems for the administrative staff. Centers probably need to impose certain standards on their volunteers and enforce them.

(6) One way of preventing the counselor from being bothered by nuisance calls or chronic callers while on serious calls is to use an interceptor. One staff member each shift can be used as a kind of receptionist to answer all calls and transfer the serious patient calls to the counseling staff. This interceptor could counsel those chronic callers and teenage callers whose were not serious (and who, therefore, would not be harmed too much by interruptions) if the volume of calls was larger than the counselors could handle. However, the interceptor would not handle a serious crisis call unless every one of the counselors was occupied with a serious crisis call also.

(7) Another solution would entail separating the services spatially. The callers to the suicide prevention service would be taken in a different room to those on the other services. Thus, the counselors handling calls on this service would not be interrupted by the less serious calls received on the other services.

It is probably necessary to separate the services spatially rather than by limiting the duties of particular staff members. If the counselors working on the suicide prevention service are in the same room as those on the teenage problem service, it would probably cause interpersonal friction if one service was busier than another. Counselors would tend to help each other out, and in no time we would be back where we started.

It would be possible perhaps to have a panic button in the suicide prevention room so that help could be summoned from the other room in emergencies.

Recommendation

At the Erie County SPCS, the solution adopted was to use an interceptor and to see how well this worked. If problems still existed, it was decided to investigate the possibility of placing the services in different rooms.

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Treating The Bad Trip By Telephone

Allen M. Yasser, Erie County SPCS

The SPCS has recently organized a Drug Hotline. This telephone program serves as a coordinating service for several clinical agencies interested in helping the drug abuser, an information line for individuals concerned about drug use and abuse, and a telephone counseling service for callers with a variety of drug related problems. This report will summarize a general approach which seems useful for helping callers who are experiencing the most frightening of all acute drug problems, the bad trip.

Any drug, but particularly the more potent hallucinogens, can facilitate a bad trip. Our immediate aim in "bummer" counseling is to help the caller turn his bad trip into a good one. In addition to the obvious humane reasons for this approach, there is a solid clinical reason. The phenomenon of flash backs (usually frightening psychedelic perceptions experienced days, weeks or months after the drug was actually ingested) appears to be positively related to unresolved bad trips. Theoretically, a reduction in the length or intensity of a bad trip may serve to reduce the likelihood of flashbacks or other drug induced decompensations.

Crisis counseling focusing upon the bad trip is a tricky procedure. It is best handled by counselors who, in addition to the general qualities one expects of a telephone crisis worker, have some basic knowledge of drugs and the local drug scene and who have worked through or at least confronted their own conflicts over chemically-induced experiences.

During the opening moments of our contact with the bad tripper we attempt to calmly explore with him the specific factors that are turning his trip into a bummer. These factors generally fall into a number of categories:

1. A feeling that the caller is going crazy.
2. A general paranoia manifested by feelings that the caller is in imminent danger.
3. A set of frightening hallucinations.
4. The breaking through into consciousness of long forgotten and disturbing memories.
5. A belief that the psychedelic experience will not terminate.
6. A feeling on the caller's part that he has taken some bad stuff. (In the illegal drug market the buyer can seldom be sure of the purity or potency of what he is getting. On the other hand, bad trips are frequently externalized to something bad in the drug). We feel that the best approach is to accept the caller's rationalizations about the purity of what he has taken.

Simply discussing these factors with the caller is often therapeutic. During this phase of intervention we try to reassure the caller that his feelings are mainly due to the drug he has taken. In a sense we help him recompensate by means of a temporary externalization which pulls him away from the notion that he has lost his mind. We repeatedly emphasize that once the drug has worn off, usually within 6 to 12 hours after ingestion, he will no longer feel the way he now does. Statements such as, "You are having a bad trip but it's going to pass," or "It's because of the drug you took and the bad feelings will end soon," are quite helpful.

Depending upon the intactness of the caller a number of additional approaches can be explored:

1. It's very good if a trusted friend can stay with the caller. If the caller agrees, the crisis worker will try to contact someone who can fulfill this function. Depending upon their relationship, the friend might try holding and reassuring the bad tripper.
2. We try to get the caller as physically comfortable as possible. If something in his immediate environment is upsetting him, we try to get either a friend or the caller to remove it.
3. People on bad trips often feel that they have in some sense lost control of themselves. The counselor can reduce his belief by emphasizing that the caller really has more control over

himself and his trip than he imagines. He can, for example, encourage the caller to turn his attention away from frightening thoughts and to concentrate on more pleasant notions. Music, especially if some is playing or available, is an excellent choice as are a number of other peaceful topics.

4. Some callers will improve after the counselor and caller explore the idea that even the more frightening elements of a bad trip might have some positive features. For example, the caller might speak of a confusing mixture of colors. The counselor could recognize the disconcerting quality of this perception but also inquire about the beauty of some of the caller's perceptions.

We stay on the telephone with the bad tripper until he begins to feel better. We then try to get him to call the SPCS back either on an as-needed basis or within a few hours. This stance contributes to a positive outlook for the remainder of this trip since the caller knows he can call us should things get bad again. We believe this also opens the door to future discussions aimed at exploring the nature of the caller's drug use, his feelings about subsequent chemical highs, and the more general problems he may be facing.

Hospitalization or emergency room treatment is sometimes a desirable alternative for the bad tripper. However, since drug-related problems are rarely handled sensitively in the typical hospital emergency room we consider this course of action only after all else has failed. Movement to the hospital is undertaken only with the consent of the caller. Depending upon the locale there is always the possibility that an individual taken to the hospital in a drug induced state will be searched or subsequently questioned by the police. Therefore, if hospital treatment is decided upon, we tell the tripper to dispose of any drugs he possesses.

Changes in Callers To The Erie County SPCS In The First Eighteen Months Of Operation

David Lester, Erie County SPCS

The Suicide Prevention and Crisis Service of Buffalo has been operating a suicide prevention telephone service for 18 months and this paper investigates how the characteristics of those using the service have changed since the opening of the service.

The suicide-prevention service began operation in November 1968. In October, 1969 the SPCS opened a teenage problem service and it was felt that the opening of these two alternative telephone counseling services might have changed the type of individual calling the suicide-prevention service.

Method

The data of the present paper come from an analysis of

(1) The first 626 new patients calling the suicide-prevention service from November 1, 1968 to February 13, 1969,
(2) The 74 new patients who called the suicide-prevention service from November 8, 1969 to November 14, 1969, and
(3) The 69 new patients who called the suicide-prevention service from April 1, 1970 to April 7, 1970.

Results

The results of the comparisons of the three groups of new patients are summarized in the following table

	SAMPLE		
	A 11/1/68 to 13/2/69	B 11/8/69 to 11/14/69	C 4/1/70 to 4/7/70
Sex:			
male	30%	28%	36%
female	70%	72%	64%
unknown	0%	0%	0%
Anonymous:			
anonymous	35%	57%	39%
first name)	65%	43%	38%
full name)			
Calling For:			
self	77%	77%	84%
other	23%	23%	14%
unknown	0%	0%	1%
	A	B	C
Marital Status:			
single	36%	36%	29%
married	28%	31%	35%
separated	7%)		6%
divorced	5%)	9%	1%

widowed	4%	1%	0%
common law	0%	0%	0%
unknown	19%	27%	26%
Age:			
0-9	0%	0%	0%
10-19	12%	27%	17%
20-24	11%	9%	22%
25-34	11%	15%	14%
35-44	12%	12%	6%
45-54	10%	5%	3%
55-64	3%	4%	0%
65+	2%	0%	4%
unknown	34%	27%	29%
Hour of Day:			
mid-3am	13%	9%	7%
3am-6am	6%	1%	6%
6am-9am	4%	4%	0%
9am-noon	15%	12%	7%
noon-3pm	18%	11%	23%
3pm-6pm	15%	12%	7%
6pm-9pm	12%	23%	20%
9pm-mid	14%	23%	28%
unknown	4%	4%	1%
Proportion of calls traced:			
traced	1%	1%	3%
Mean Length Of Calls:			
mean number of minutes	not measured	23.7	26.7
Suicidal History:			
history of attempts	15%	14%	10%
Current Suicidal Behavior			
threats	not used	15%	7%
attempting	not used	7%	7%
	A	B	C
Suicidal Risk:			
not rated	64%	72%	33%
0	not used	not used	29%
1	14%	9%	7%
2	5%	4%	6%
3	5%	7%	10%
4	5%	4%	7%
5	7%	4%	7%
Severity Of Problem:			
not rated	not used	72%	30%
0	not used	not used	12%

1	not used	9%	6%
2	not used	7%	16%
3	not used	7%	13&
4	not used	1%	16%
5	not used	4%	7%
Presenting Problem:			
suicidal	14%	15%	22%

Discussion:

Several changes are apparent in the characteristics of callers to the suicide-prevention service. There is some movement toward getting a higher proportion of males calling the service, a higher proportion of anonymous callers, and a higher proportion of people calling for themselves rather than another. There are fewer teenagers nowadays calling the suicide prevention service as compared to the early days of the center which is perhaps attributable to the opening of the teenage problem service.

The calls to the suicide-prevention service are getting more clustered in time and, at the time of the most recent analysis, 71% of the calls were received during 9 hours (from noon until 3 pm and from 6 pm until midnight).

The proportion of calls concerned with suicidal problems has also increased, again perhaps due to the fact that the other two services have handled some of the non-suicidal callers who might have called the suicide-prevention service. Of course, the volume of calls on these two new services is so great that it is quite clear that these new services have been used also by large numbers of individuals who would not have called the suicide-prevention service.

More notable is the fact that the suicide-prevention service has not been able to increase the proportion of calls from those divorced, widowed or separated and, similarly, has not been able to increase the proportion of calls from elderly individuals. These individuals might be thought to be more isolated than other members of the community and so in more need of a telephone counseling service. Either this notion is wrong or, alternatively (and this is more likely) the suicide-prevention service is not reaching these individuals.