Procedures Used in Crisis Intervention by Suicide Prevention Agencies

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THE large number of calls for help reaching suicide prevention agencies each year and the growing number of these agencies suggests that they fill urgent needs. They appear to offer a valuable service not only to the suicidal persons who call upon them, but also to the public service agencies of the community. Yet few sociological investigations have been conducted of suicide prevention agencies. Therefore, to obtain information on how they function, we undertook an exploratory study in 1966 of such agencies, all located in urban areas. Our purpose was to learn the specific activities of the agencies that were directed at crisis intervention, the relationship of these activities to the prevention of suicide, how the emergency telephone service operated, what initial procedures were used in crisis intervention, and the kinds of resources to which clients were referred.

Construction of Sample

In each of the 212 Standard Metropolitan Statistical Areas of the United States, the telephone information operator was asked to check the local directory for suicide prevention organizations. A questionnaire of 22 items was then mailed to the 31 organizations identified. A few suicide prevention agencies may have been missed; a directory of suicide prevention centers in the United States, published in March 1969 (*1*), lists 33 such centers in operation in 1966. Nevertheless our sample was constructed in such a way that it constitutes a substantial crosscut of the agencies in the United States which were providing emergency suicide prevention services in 1966.

Two months after the initial mailing to the 31 agencies, the post office had returned only three questionnaires (because the addresses of the agencies were unknown). By then, replies had been received from 17 of the remaining 28 agencies; (these 28 constituted the study sample). A followup letter and another copy of the questionnaire were sent to the other 11 agencies. By 2 months after this second mailing, replies had been received from seven more suicide prevention organizations. Thus, replies were eventually received from 24 (86 percent) of the 28 agencies in the sample; all 24 replies indicated that the purpose of the agency was emergency suicide prevention.

Methods

Since most of the questions in the questionnaire were of the checklist type, they could be handled quantitatively. In a few open-ended questions, however, the respondents were asked

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to give their opinions, for example, of the initial procedures their agencies used in helping an emergency patient. Replies to such questions required analysis to delineate the similarities and differences in the various agencies' programs.

In addition, we conducted in-depth interviews with personnel on the staffs of two suicide prevention agencies located in the New York metropolitan area (Harry M. Warren, Jr., president of the National Save-A-Life League in Manhattan, and a number of resident physicians of the Suicide Prevention Service of Kings County Hospital in Brooklyn).

When we reviewed the replies on the questionnaires and the information obtained in the interviews, certain key characteristics of the suicide prevention agencies were apparent which became the primary categories for our analysis—the emergency telephone service, the initial procedures used in crisis intervention, and the resources to which patients were sent.

Results

Eighteen of the 24 suicide prevention agencies constituting our sample indicated the approximate number of calls they received in 1966:

Agency and location	*Calls in 1966*
Emergency Mental Health Services of Maricopa County, Phoenix, Ariz	3,000
Suicide Prevention Center, Los Angeles, Calif	5,329
Mental Health Center, Pasadena, Calif	1,710
San Francisco Suicide Prevention, Inc., San Francisco, Calif	3,000
Suicide and Crisis Service of Santa Clara County, Santa Clara County Mental Health Health Services, San Jose, Calif	500
Contra Costa Suicide Prevention Service, Contra Costa County Mental Health Association, Walnut Creek, Calif	860
Suicide Prevention Clinic, Denver, Colo	240
F.R.I.E.N.D.S. Inc., of Dade County, Dade County, Fla	680
We Care, Inc., Mental Health Association of Orange County, Orlando, Fla	1,800
Fulton-DeKalb Emergency Mental Health Center, Atlanta, Ga	3,865
Wyandotte County Suicide Prevention Center, Wyandotte County Guidance Center, Inc., Kansas City, Kans	600
Rescue, Inc., Boston, Mass	2,000
Suicide Prevention Telephone Service, Ancora State Hospital, Hammonton, N.J	400
Suicide Prevention Center, Citizens for Mental Health, Buffalo, N.Y	11,000
National Save-A-Life League, Inc., New York, N.Y	3,000
Suicide Prevention Center, Dayton, Ohio	350
Crisis Clinic, Inc., Seattle, Wash	2,280
Suicide Prevention Center, Psychiatric Unit, Lutheran Hospital, Eau Claire, Wis	406
Total	**41,020**

The number of "cries for help" received by these 18 agencies (41,020) indicates the urgent need for specialized crisis intervention facilities aimed at preventing suicide. But not every caller is a potential suicide. For example, the Suicide Prevention Center in Buffalo, N.Y., reported that approximately 50 percent of the 11,000 calls they received in 1966 were from persons seeking information only, while the other 50 percent were from persons assessed to have suicide risk and serious emotional problems requiring immediate attention. The Suicide Prevention Center in Eau Claire, Wis., reported that approximately 50 percent of the calls they received came from persons seeking information, were prank calls, or were from callers who hung up. The Contra Costa County Suicide Prevention Service in Walnut Creek, Calif., reported that 40 percent of their callers were nonsuicidal and had alcoholic, marital, and other problems. This agency usually referred alcoholics to an Alcoholics Anonymous group or to an alcoholic rehabilitation clinic and referred persons with marital difficulties to a marital or family counseling agency.

If, however, even half of the 41,020 calls are considered to represent suicide risks, the importance of these emergency crisis intervention services are still vital, because they are concerned with saving the lives of a large number of people on the brink of self-destruction. Anyone who places a value on human life can see that crisis intervention services are needed when people threaten or attempt to take their own lives.

Emergency telephone service. All the agencies studied had 24-hour emergency telephone service 7 days a week to provide help quickly to persons at risk of suicide. The service was listed in the telephone book and with the police. Specially trained personnel handled all telephoned requests for help in which suicide was a danger, often backed by professional consultants—psychiatrists, physicians, psychologists, psychiatric social workers, public health nurses, and sociologists. A person calling in a crisis was never told: "It is now 5 o'clock, so will you call back tomorrow?" In contrast to some mental health associations, at least one trained suicide prevention worker was on duty at all times.

Although more than half of the agencies re-

ported they had no written plan for handling callers at risk of suicide, their workers did have operational principles to guide them. In responding to a caller in a crisis, the worker sought to show patience and provide a sympathetic ear. While none of the agencies followed exactly the same procedures in their initial contacts with a suicidal person, all of the replies indicated that the worker tried to abate the caller's stress and help him cope with the crisis.

Initial intervention in a crisis. When a worker at one of the agencies studied responded to a cry for help, his primary duty was to initiate crisis intervention services. The first step was to establish rapport with the person at risk and to communicate to him the worker's willingness to help. Listening to the client in a concerned and hopeful way, the worker would indicate that the person had done the right thing in calling. The caller was given an opportunity to relieve his stress by talking out his problem. An informal, personal, and noninstitutionalized interaction was sought.

As the worker listened to the client, he evaluated his suicidal potential. If the caller had the means for suicide, for example, a lethal weapon or a specific plan, then he would be considered at high risk. On the other hand, a caller would be evaluated as only lightly suicidal if he talked about ending his life but had not as yet planned the specific details.

The evaluation completed, the worker decided on an appropriate course of action for helping the caller help himself. In general, this course of action should help the caller understand his own needs better and how he might meet them. The worker tried to help the caller mobilize his individual capacities. When necessary, however, the client was also shown how to call upon appropriate resources in the community in order to achieve a better adjustment between himself and his total environment.

The specific initial procedures that suicide prevention agencies take to prevent a crisis caller from committing suicide were indicated in the response of the agencies to a request on the 22-item questionnaire to "Briefly explain the initial procedures used in helping to prevent the emergency caller from committing suicide." Sixteen agencies responded to this request and listed their initial procedures (see box). Every step was not noted by all 16 agencies, but a general pattern emerges, namely, establishment of rapport, evaluation of the caller's suicidal potential, and deciding on the course of action to be taken. The pattern of initial procedures reflected in the agencies' responses will probably continue, but certain modifications of the pattern will undoubtedly result when appropriate research has been carried out.

Resources used in referrals. When a person called one of the 24 agencies for help, he was usually referred to a professional treatment service, such as a general hospital, a psychiatrist in private practice, an outpatient clinic, a social service agency, a clergyman, or a physician. Sometimes the worker would recommend that the caller contact nonprofessionals, such as police, members of his family, or close friends. Often a combination of resources was used. The worker frequently made the first contact with the referred sources on behalf of the crisis caller. In any event, the worker made followup calls to see if the caller had contacted the resource.

The less serious callers—those whose potential for suicide seemed less—might be advised to see a physician or a vocational guidance counselor. Other callers might require only referral to an appropriate community resource. The large number of referral sources reported by the agencies reflects broad interagency cooperation.

As to professional resources, most of the agencies had a good working relationship with a local hospital. The hospital provided emergency treatment for the callers referred by the suicide prevention agency. Some hospitals, such as the Los Angeles County (Calif.) General Hospital and Jackson Memorial Hospital in Miami, Fla., provided medical care, ready access to hospital beds, and ambulance service for referred patients in serious condition.

The suicide prevention agencies often received calls from persons seeking psychiatric treatment. The worker might refer such a caller to a practicing psychiatrist if he knew of one. Of the caller might be asked to call the suicide prevention agency during its next regular nonemergency office hours (9 a.m.–5 p.m.) for a referral. The staff of the suicide prevention center in St. Louis, Mo., reported that they had a list of 31 psychiatrists and physicians who had

agreed to see persons who were referred by the center on a next-day basis.

When the danger of suicide did not seem high or perhaps was not even the caller's primary problem, he might be referred to a community agency. For example, if the underlying problem was marital discord, a family conflict, or chronic personal and social maladjustment, referral to a family service agency or a psychiatric clinic was considered. The staff of the Suicide Prevention Council at Ancora State Hospital, Hammonton, N.J., reported that they refer callers with marital problems to the local marital counseling agency. Callers with other problems were often sent by the suicide prevention agencies to an organization in the community dealing with the specific problem. Thus callers who were recognized as alcoholic were often referred to an Alcoholics Anonymous group. Drug addicts might be referred to a halfway house, mental patients to psychiatric hospitals, and unwed mothers to a home established for that group.

Warren stated that the National Save-A-Life League in New York referred mentally ill or psychotic callers to Bellevue Hospital. "It might be necessary," he added, "to have the family or a friend take the emergency caller to Bellevue Hospital if the patient himself is incapable of getting there." The staff of the suicide prevention center in Fort Worth, Tex., refers unwed mothers to a special home which provides care for them.

Initial Procedures Used in Preventing the Caller from Committing Suicide

Suicide Prevention Center, Los Angeles, Calif.

1. Establish contact and rapport.
2. Evaluate lethality by talking to patient about suicide (plan, specificity of time and method, prior attempts, etc.) and evaluating resources (intrapsychic and interpersonal).
3. Involve significant others.

Fulton-DeKalb Suicide Prevention Center, Atlanta, Ga.

Establishment of rapport, encouragement to discuss and delineate the precipitating events, urging to participate with the worker in finding alternatives, referring to treatment resources if available.

We Care, Inc., Orlando, Fla.

Crisis intervention worker tries to draw out the caller, to find out his problem; reassures caller that we do want to help, feel that we can if caller will tell worker what is bothering him; if caller is determined to go ahead with suicide, regardless of our help, we dispatch police or sheriff's department to intervene, take gun, etc., then we follow up.

Citizens for Mental Health, Buffalo, N.Y.

The caller is evaluated as to the seriousness or emergency nature. Depending on this, the caller would be:
1. Counseled over phone
2. Visited in person
3. Taken by police or rescue squad to hospital
4. Referred to clinic, hospital, social service agency, or clergyman.

Wyandotte County Guidance Center, Inc., Kansas City, Kans.

A quick assessment of the suicidal potentiality is the first approach to every call. What action is to be taken depends on the seriousness of the situation.

Emergency Mental Health Service, Phoenix, Ariz.

Keep them on the line and keep them involved. Find out if friends or relatives are close by. If no one is there, notify police, who will make a check. They (the police) are much more mobile than any other group or organization.

Santa Clara County Suicide Prevention Center, San Jose, Calif.

Obtain information, assess and evaluate information, and propose action.

Suicide Prevention Center, San Francisco, Calif.

Ours is a telephone "first aid" service for suicidal people. In emergency situations, our staff calls the necessary emergency facilities in the community to give the caller immediate aid. In all cases we win the caller's confidence in order to make the most appropriate referral for his particular problem.

Contra Costa County Suicide Prevention Center, Walnut Creek, Calif.

We ask, "May I help you?" and then play it by ear. Each caller responds somewhat differently depending on many variables.

Suicide Prevention Service, Eau Claire, Wis.

Personal attention, psychotherapeutically oriented.

Suicide Prevention, Inc., St. Louis, Mo.

Sympathy, attempt to understand, evaluation of risks, referral to appropriate resources, follow up to see they enter treatment.

Suicide Prevention Center, Denver, Colo.

When a call comes, we attempt to program a plan of action, whether it is to see the person in our program or to call on some other agency.

Mental Health Center, Suicide Prevention Service, Pasedena, Calif.

Name, telephone number. How do you plan to kill yourself? Why do you want to kill yourself? How will that help? Have you thought of something else to solve your problem other than killing yourself—death is forever.

Friends Organization, Miami, Fla.

We provide sympathetic listening, then evaluate the seriousness of the caller, and direct the caller to an agency or person where he can be helped.

National Save-A-Life League, New York, N.Y.

Your wish to help them; willingness to make possible contacts with relatives, friends, etc.; supportive help of all kinds; pastoral counseling, psychiatric, etc.

Suicide Prevention of Tarrant County, Fort Worth, Tex.

The question "Can I help you?" first; one requirement for prevention worker is a warm friendly voice; by skillful questioning and listening in particular, stress is reduced. If suicide is in progress—poison taken, etc.—trained police are called.

If the caller is near a church, the worker answering the emergency telephone in one of the suicide prevention agencies might encourage him to discuss his situation with a minister, priest, or rabbi. The Suicide Prevention Service of Dayton, Ohio, provides pastoral counseling. The caller is referred to the appropriate church or synagogue, where continued counseling can take place.

Among the nonprofessional resources the agencies used were the police. They used this source, however, only in case of a clear and immediate emergency, for example, if a suicide attempt was about to occur or had occurred. When the caller needed prompt medical attention, the police or someone else capable of assuming responsibility for bringing the caller to the hospital was notified. In general, the police were used if the caller was helpless and hurt. The staff of We Care, Inc., the suicide prevention agency in Orlando, Fla., will notify the police or the sheriff's department, asking that they intervene and take away the gun or other weapon if a caller is determined to go ahead with suicide.

Some of the agencies apparently neglect to use the family as a resource, but the staff of the Los Angeles Suicide Prevention Center indicated that they had found that the family was most valuable in times of crisis. This agency's workers encourage the suicidal caller to discuss his situation and problems with his family. Furthermore, they see to it that the family becomes involved both in accepting responsibility for the emergencies that arise and in seeing to it that the caller receives the help recommended by the agency.

Close friends were often used by the agencies in the same way as the family. In addition, the staffs of many agencies reported that they encouraged the caller to have a friend stay with him during a particularly bad night. The assumption is that the caller will often talk things over with a close friend.

Discussion

In less densely populated areas, crises such as suicide or suicide attempts are usually handled by the local mental health association, which provides this help along with its other emergency services (for persons who are alcoholic, mentally ill, in need of physical or mental rehabilitation, and so forth).

The agencies in our sample, however, were all located in urban areas and all provided only one service—emergency suicide prevention. The agencies operated in urban areas because of the somewhat higher incidence of suicides and suicide attempts there as compared with rural areas. Also, urban areas characteristically provide their residents with more formal services and are usually better equipped to handle crises routinely.

Roberts (*2*) has discussed the advantages of a separate organizational structure for suicide prevention agencies, including a separate board of directors and a separate advisory board. A suicide prevention service that is separate is easier to publicize than one which is only an element in a comprehensive community mental health organization. When the service is separate, the community can be made just as aware of the suicide prevention program as of other emergency services, such as the police and fire departments. Also, a separate organization facilitates the planning of research and training activities. Finally, the staff more readily acquires a highly developed sense of identity.

According to the replies from the suicide prevention agencies, they were able to provide immediate attention for the caller in a crisis by using diagnostic and referral services. Moreover, use of these services enabled each suicide prevention agency to attend to the needs of the many rather than to focus on the long-term treatment of only a few.

Although the suicide prevention movement began only 12 years ago, suicide prevention agencies now receive cooperation from most community agencies to which they refer callers. Almost all community agencies cooperate with the suicide prevention agency to help achieve effective community health services. Nevertheless, this cooperation needs to be increased. Suicide prevention agencies should use every appropriate community resource that furthers their aims. Sometimes when one agency seeks the cooperation of another, it fails at first to obtain a favorable response. The reason may be that the staff members of the initiating facility have failed to appreciate the other organization's goals and problems.

Our study revealed that the staffs of the suicide prevention agencies were instructed in referral methods and about the available community resources. Their knowledge about these resources, however, needs to be enlarged. The goals, functions, and problems of other organizations, including the restrictions under which they operate, should be made explicit. The reverse is also true. Other organizations in the community need to have the same kind of knowledge about the suicide prevention agency.

Thus, unilateral and reciprocal interorganizational relationships are needed to increase the accessibility and availability of the mental health services being exchanged from one community agency to another. In most cases, the organizational relationships established between the suicide prevention agencies and other community resources were unilateral, in that referral services were provided by the community resources and no service was given in return by the suicide prevention agency. Levine and White have explained the exchange system between 22 community health and welfare organizations in a New England community (*3*). Levine and associates (*4*) have also emphasized the need to direct the natural interplay among agencies to meet the health needs of the community.

Also, the public needs more information about suicide prevention agencies and mental illness. These agencies' efforts are still often restrained by prejudices, such as the belief that mental illness is disgraceful. Too frequently people regard those who commit, or try to commit, suicide as weak and useless. If the prevention agencies are to accomplish their aims, they will need not only increased financial support, but also the help of newspapermen, radio and television producers, publishers, and community leaders.

The approximately 41,000 calls for help that the suicide prevention agencies in the sample reported receiving in 1966 show how great the demand is. The research to date, however, has provided only limited evidence that the services provided by such agencies to suicidal persons actually prevent suicide in the long run.

Each suicidal caller, being an individual, responds differently. Therefore each of the different initial procedures the agencies in our sample used in crisis intervention may prove successful in the right setting. The staffs of all 24 agencies that returned questionnaires stated that they had helped prevent suicide in the past in the overwhelming majority of the persons who had called their agencies for help. Such estimations, however, must be evaluated by further research. The immediate suicide may have been deterred, but followup studies are needed to determine the extent of the caller's subsequent adjustment to life, for example, 3 to 5 years after the crisis call. The Center for Studies of Suicide Prevention, National Institute of Mental Health, along with suicide prevention agencies in St. Louis, Mo., Los Angeles, Calif., and Orlando, Fla., is conducting such followup studies. The results may provide some clearer indications of the effectiveness of the suicide prevention programs.

Conclusion

Since our research to date has provided only limited evidence that suicide prevention programs actually prevent suicide, the programs of all suicide prevention agencies must be evaluated to determine the effectiveness of their goals and methods. Followup studies also need to be planned and carried out at each agency in order to determine whether the emergency callers eventually commit suicide or make a satisfactory adjustment to life as of 3 to 5 years after their last contact with the agency. The results of followup studies now in progress should provide information on the part that suicide prevention agencies play in the prevention of suicide. Furthermore, we need to test the effects of an all-out publicity campaign on the number of calls a specific suicide prevention agency receives and on the suicide rate.

Summary

To determine how suicide prevention agencies function, an exploratory survey of such facilities in large urban areas of the United States was planned. A list of such agencies was obtained by checking the local telephone directories for each of the 212 Standard Metropolitan Statistical Areas. The 31 suicide prevention agencies thereby identified were mailed a 22-item questionnaire asking about the initial steps they took to avert threatened suicide.

Twenty-four agencies replied to the question-

naire. The questionnaires sent to three agencies were returned by the post office because the addresses were unknown. The staffs of two agencies in the New York metropolitan area, who were interviewed in person after their questionnaires were returned, supplied more detailed information.

A study of the replies of the agencies revealed that they handled 41,020 calls for help in 1966. Their initial procedures in dealing with persons at risk of suicide fell into a general pattern: When a suicidal person called, the suicide prevention worker of the agency would try to establish rapport, evaluate the client's potential for suicide, and decide upon a course of action.

A large proportion of the clients who called the suicide prevention agencies in a crisis were referred for treatment to general hospitals, physicians and psychiatrists in private practice, outpatient clinics, community agencies, clergymen, or other community resources. Sometimes the worker recommended that a client get in touch with nonprofessionals—the police, members of his family, or close friends. The worker would make several followup calls to see if the caller had contacted the designated community resource.

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Tearsheet Requests

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Medicaid Patients Can Choose Their Providers of Medical Services

Persons eligible for Medicaid may obtain the services covered by their State's Medicaid program from any qualified institution, agency, pharmacy, or practitioner participating in the program. Included are organizations offering medical services on a prepaid or membership basis.

Medicaid, now in operation in 52 U.S. jurisdictions, provides medical assistance for more than 12 million needy and low-income persons who are aged, blind, disabled, or members of families with at least one parent dead, absent, or incapacitated. Certain other needy families are included in many States. About half the total cost is borne by the Federal Government and the balance by State and local governments.

Puerto Rico, Guam, and the Virgin Islands, where most medical services are provided under Federal auspices, are not required to grant freedom of choice to Medicaid patients until 1972. The freedom of choice requirement, one of the 1967 amendments to the Medicaid law (title XIX of the Social Security Act) became effective elsewhere July 1, 1969, and was incorporated into the Code of Federal Regulations by publication in the *Federal Register on* June 5, 1970.

Treating Disturbed Children

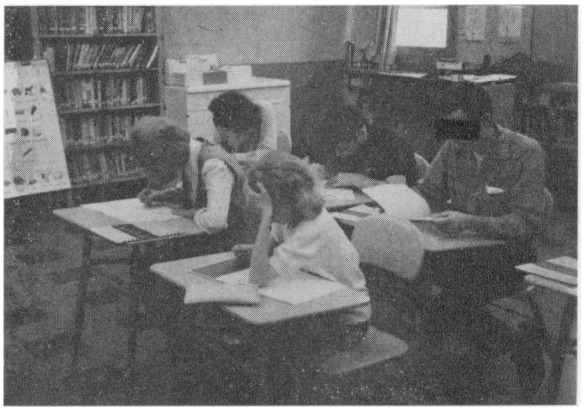
A special program at a State mental hospital in Ohio is treating disturbed youngsters so successfully that most of them can return to their homes and schools within a few months.

Hawthornden State Hospital in Northfield reports 80 discharges out of 88 juvenile admissions since October 1965, when it introduced an educational and behavior modification program for young psychotic patients. Mostly schizophrenics, the patients are 10 to 17 years old. The median length of stay is 10 months, an unusually short time for such severe illnesses. Only 10 percent of the patients who were discharged had to return for further treatment. The others are now living at home and attending school, or pursuing careers.

The education-oriented therapy program, started by Dr. George A. Golias, is based at Hawthorne Hills School, a State-accredited school located on the hospital grounds. It is staffed by four full-time teachers and one part-time teacher. One teacher also serves as the principal. In addition, psychiatrists, psychologists, social workers, activities therapists, and psychiatric aides from the hospital work with the children.

Boys and girls live in separate parts of an open ward which adjoins a large school area with a library, classrooms, and gymnasium. In this setting, the hospital tries to duplicate normal school days as much as possible for the young patients. The patients arise early in the morning, dress and eat breakfast, attend academic and vocational classes during the day with a break for lunch, and then have dinner. In addition, they have evening programs, including study halls, hygiene classes, and physical education.

Throughout the day, teachers employ behavior modification techniques to reinforce good behavior and discipline bad behavior. Those who behave acceptably earn wooden nickels which can be exchanged for special privileges. But those who behave poorly, or who lapse into psychotic episodes, get demerit slips which result in an extra assignment or an added chore. Students must follow their schedules closely, and all rules are strictly enforced. They know exactly what is expected of them at all times.



This highly structured program is the key to effective treatment. Not only does it condition the patients to behave normally, but it also provides them with the vital education that most children in mental hospitals miss. This education greatly facilitates their return to a regular school and life at home.

Neither drugs nor psychotherapy are given. Children receiving medication when they arrive are gradually removed from it. These forms of therapy, the staff believes, are not necessary if conditioning procedures are used effectively.

When youngsters go home for weekends, their parents apply the behavior modification techniques so there is no break in the conditioning procedure. The school's staff teaches parents how to apply these fairly simple techniques when their children first join the program. Parents also participate in a parent-teachers' association to keep up with happenings at the school.

Hawthorne Hills School is being aided by a hospital improvement grant from the National Institute of Mental Health, a component of the Health Services and Mental Health Administration, Public Health Service. The 5-year grant totals $452,097.