I CAN HELP!

Suicide Awareness & Prevention for Caregivers & Health Service Providers

The Samaritans

From the Executive Director...

Over 20 years ago, I responded to an advertisement in a New York City community newspaper that read: Good Listeners Needed! I didn't realize at the time how dramatically becoming a volunteer on the Samaritans of New York's 24-hour suicide prevention hotline would change my life.

Samaritans, an international volunteer network that is devoted to responding to people in crisis and preventing suicide, practices a way of thinking and of behaving that is what many of us aspire to in those quiet moments when we consider our life's potential. Focusing on empathetic listening and non-judgmental responses, Samaritans volunteers endeavor to take every person in crisis seriously and give every one they respond to the "benefit of the doubt," whether we understand what they are going through or not.

It has been my privilege to work with thousands of such caring and motivated people over the years and to come into contact with so many other like-minded and motivated "helping professionals" who believe that each one of us can make a difference when responding to people in need.

This small volume is Samaritans humble contribution to what is sometimes referred to as "caring community." It is our hope that it provides a little insight and some perspective in ways each of us can be more effective and responsive when providing support to our fellow man and woman.

Sincerely,

Alan Ross
Executive Director

Booklet Information

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Introduction To This Booklet

The information in this suicide prevention handbook is a result of the Samaritans of New York's experience training students, parents, teachers, social workers, guidance counselors, psychologists, police officers, firefighters, nurses, emergency service staff and others from the NYC Department of Education, NYPD, FDNY, St. Vincent's Hospital, Mt. Sinai Rape Crisis, Safe Horizon's, NYC AIDS Task Force, Gay Mens Health Crisis, LOISADA Corporation, Hunter College, NYU Graduate School of Nursing, Salvation Army, Girl Scouts of America and hundreds of other schools, non-profit and community-based agencies.

It is solely intended to provide the reader with insight and perspective into Samaritans approach to helping people who are depressed, in crisis or suicidal as practiced in 400 centers in 40 countries around the world--from Argentina, Bosnia, England and India to Singapore, Trinidad and Zimbabwe.

This booklet is born out of the basic need of those working on the front lines--whether as a family member or friend of someone in crisis or a lay or professional caregiver or service provider--to feel more comfortable and confident and better prepared when responding to or providing treatment to those who are in distress, depressed and/or "at risk" for suicide.

The information, guidelines, procedures and resource material in this booklet are derived from the 34-plus hour Samaritans Hotline Training Program that has prepared over 2,000 volunteers to respond to callers in crisis on New York City's 24-hour suicide prevention hotline since 1983.

Samaritans wishes to thank the American Red Cross for supporting this project as well as the NYC Department of Health and Mental Hygiene, the NYS Office of Mental Health and the NYC Department of Education, without whom this publication would not have been possible.

The Samaritans' Befriending Model

For over 20 years, the Samaritans of New York has been providing emotional support to people in crisis--from those experiencing everything from a bad day to a broken heart to some form of physical or mental illness or traumatic loss. If we have learned anything over that time, after responding to over half-a-million calls on our confidential 24-hour suicide prevention hotline and training over 25,000 lay and clinical caregivers and health professionals through our public education program, it is that trying to help people in crisis is a complex process that is often as challening for the person providing the help as it is for the one receiving it.

There are countless approaches people in the "helping professions" can follow and techniques they can practice when responding to someone who is in distress, experiencing a crisis or feeling suicidal. They range from simply holding someone's hand or providing a shoulder to lean on to those tied to religious or spiritual beliefs to the various schools of clinical thought and medical practice. The Samaritans approach, we believe, utilizes the best of all of them, something that may result from the fact that is was developed by an Episcopalian minister who was also a practicing clinician with a lifetime of experience providing people in crisis with emotional support and basic human empathy.

Many people note the Rogerian aspect of Samaritans' approach to helping, especially our emphasis on utilizing active listening skills in all of our communications; and still others recognize the techniques practiced in effective conflict resolution, such as our belief in separating the person from the problem. An analysis of the sources of Samaritans' approach could include eveything from the *Bible*, Aristotle's *Poetics*, Sartre's *Existential Psychoanalysis*, Kubler-Ross' *On Death and Dying*, Rogers' *On Becoming A Person* and Maslow's value theory to John Cage's works on silence and even Zen Buddhism; but this is probably more a product of cultural and historical assimilation than deliberate intent on anyone's part.

Disclaimers aside, Samaritans public education presenters are often chided by those in the mental health field for our disclaimer at the beginning of every one of our training sessions that, "We are not here as clinicians or practicing social workers!" Being told time and again, "the approach you take and the model you adhere to is proper practice in almost every counseling environment," most notably our reliance on keeping the focus on the person in crisis and not on ourselves.

The Samaritans Crisis Communications Model (page 13) is the centerpiece of all of our work and a variant of the model practiced in suicide prevention centers around the world. The model provides us with a guide for communicating with a person in crisis and a framework to help us organize our thoughts and responses. The engine that drives the model is described as "steering towards the pain," which is both an image that defines our approach in empathetic listening and a tool that we use in assisting the person in crisis to explore his or her thoughts and feelings.

Steering towards the pain reminds us to keep the focus on what *the person in crisis* is thinking and feeling and to not to get distracted by information and events, those issues that may be more comfortable to talk about. The helper's questions go to the heart of the matter, not in an adversarial or confrontational manner but through a gentle series of probing questions and follow-ups, using paraphrasing, say more and other active listening devices; the goal being to give the person in crisis the opportunity to talk about what he/she is thinking and feeling in a safe and supportive environment, no matter how scary or shameful it is.

The Samaritans Basics of Befriending

Every one of the close to 400 Samaritans centers around the world operate some form of non-religious, confidential crisis response hotline, support service and/or walk-in center and ascribe to "The Seven Practices and Principles" that outline the philosophy and approach we refer to as "befriending." The primary tenets of befriending are:

a) to be available to anyone at any time who is in crisis

b) to listen to someone without making judgments or expressing personal values

c) to maintain a confidential and safe environment when providing support

d) to explore the person's thoughts and feelings and steer towards the pain that he/she is experiencing at this time

e) to recognize that every person has the right to make his/her own decisions about their lives, including ending a contact and his/her right to commit suicide

f) to explore each person's situation focusing on him/her, not with a predetermined course of action or solution which the helper thinks would beneficial

g) to recognize that Samaritans is only one element of the "helping community" and to work with people in every field to promote awareness and prevent suicide.

Samaritans believe our approach utilizes many of the best elements of various disciplines and its strength is found in the fact that it can be practiced by anyone, in any situation, no matter what his or her education, training, background or previous experience.

Yet before we are able to follow the *model*, we have learned that we must first be aware of our own needs and agenda in this "helping relationship," the myths and misconceptions we have about suicide and the very real limitations of the caregiver/service provider role. The belief being you cannot be effective in helping people "deal" with their deep-seated feeling's until we have examined our own. Tied to this is our ability to listen, to really hear what the other person is saying, doing our best to minimize our own assumptions and preconceptions. Silencing that "voice within," and making the communication about the person we are responding to and not ourselves is possibly the greatest challenge that every "helper" faces.

This ability and willingness to discuss anything without expressing personal values or judgments has been found to be a great asset in encouraging people to make contact with Samaritans and discuss what they are thinking, feeling and going through. This rapport-builing being the first step to prevention.

To this end, this booklet contains guidelines to assist you in exploring your personal agenda, the myths and misconceptions people have about suicide and the keys to effective intervention and prevention responses. The guides to utilizing active listening tools and recognizing the obstacles to communications we all practice in some manner are designed to assist you in improving your skills and effectiveness. And, finally, the procedures and resource sheets provide an important initial step in expanding your individual and/or site prevention planning, including how to develop comprehensive resource and referral lists.

Why Talking About Suicide Scares Us

Let's be honest, suicide is something that almost everyone thinks about at some point in their lives but is something few of us feel comfortable talking about. Yet talking about suicide--its causes, prevalence and risk factors as well as what people in crisis are experiencing--provides us with the best opportunity we have to prevent it and many of the other problems that are tied to violence and self-destructive behavior.

People experience suicidal feelings for countless reasons, some of them understandable, others very difficult to comprehend. But for the person in crisis, the thoughts and feelings they are experiencing tied to their depression are very real and can seem perfectly logical.

There are as many profiles of the potentially suicidal as there are people who make up our society--from teenagers and elderly to the middle-aged, those who are creative and gifted to those who struggle with alcoholism or drug addiction, those from happy and supportive families to those who are victims of child abuse or are homeless. Most researchers agree that the majority of people who die from suicide are experiencing some form of mental illness, whether biological, environmental or situational in nature.

A Significant Public Health Problem

Once you gain perspective on the incidence and impact of suicide, you will see why it is imperative that every one of us--as friends, family members, colleagues and health professionals--learn more about it and what we can do to be more effective when responding to people in crisis. Some of the most recent suicide statistics from the federal government and other suicide research organizations include:

- Suicide is the 11th leading cause of death in the U.S.
- Someone dies from suicide every 17 minutes
- Suicide leads to over 30,000 fatalities a year
- Over 5,000,000 Americans have attempted suicide.

To put the scope of suicide as a public health problem in context, in 2003 twice as many Americans died from suicide as from AIDS and 40% more died by their own hands than were murdered by someone else. And though suicide is the 2nd leading cause of death of American college students, the 3rd of our teenagers and a leading cause of death of the elderly, it touches people of every age group, culture, social, sexual and religious identity.

For example, most health professionals are shocked when they learn that suicides amongst African American male children 10-to-14 are believed to have increased 400% over the last 10 years. Then there is the fact that more teenagers in this country die each year from suicide than all major illnesses combined. Many people are also surprised when they are told that white, middle-aged males--the population with the most status, power and highest earning potential in the U.S.--also commit the largest number of suicides.

Added to this is the underlying factor documented by experts ranging from the Surgeon General to researchers with the Institute of Medicine that as many as 95% of the people who complete suicide suffer from some form of diagnosable mental illness but the majority of them are never identified or diagnosed and, resultingly, never receive adequate care.

Suicide Can Be Prevented

The good news is that, in many cases, suicide can be prevented. For research tells us that up to 75% of the people who commit suicide do something to let us know their intentions *before they act*. Their behavior changes in a notable manner, they show warning signs and often say something that tells us they are in trouble and need help.

Most people who attempt suicide don't want to die! They feel lost and alone, isolated and overwhelmed by the pain they are experiencing and want it to stop. That is why it is so important to take every statement about suicide seriously. When someone talks about suicide, do not be afraid to get involved.

Suicide Myths And Misconceptions

Tied to the many stigmas and stereotypes people often associate with suicide--most prevalent among them being the belief that suicide is a "sin," it is a sign of weakness, the person must be "crazy" and he or she just wants attention--are the economic, religious and social biases that further victimize those who are experiencing severe distress or some form of mental illness.

Some of the most common myths and misconceptions people have about suicide include:

Talking to someone about suicide may give him or her the idea.

False. A person who is experiencing a traumatic loss, emotional crisis or mental illness is already depressed and may already be having self-destructive thoughts or practicing life-threatening behavior. Talking to them about these thoughts and feelings creates an immediate connection that *grounds* them and provides them with an outlet for their fears and other emotions.

People who talk about suicide don't usually do it, they just want attention.

False. According to research, 75% of the people who commit suicide do or say something to indicate their state of mind and intentions before they act. If a person has to go to the extreme of threatening to do his or herself bodily harm or commit suicide, it is not that he or she *wants* attention, they *need* it!

The majority of people who commit suicide are uneducated and impoverished.

False. In the United States the largest number of suicides are committed by white males, age 22 to 54, the race, age and class that has the highest level of education, the largest earning potential and who possess the greaest opportunity for advancement in our society.

If someone is determined to take his/her own life there is nothing you can do about it.

False. Suicide is an ambivalent act with between 50 and 100 attempts for every completion. Most people who attempt suicide do not want to die, they want their pain to stop and that can lead to self-destructive and life-threatening acts. The vast majority of people who call suicide hotlines having already taken a potentially lethal action, change their mind as their situation deteriorates, ultimately asking for help.

Exploring Our Personal Agenda and Preconceptions

It is not enough to examine the myths and misconceptions that others embrace, in order to encourage our volunteers to be as sensitive and self-aware as possible, we consistently challenge them to acknowledge their own preconceptions, their personal beliefs and values and to recognize how they can impact and shape the quality of the contacts and communication we have with another person. [For example: If I believe that every problem has a solution, I may focus all my energies on trying to discover the "cause" of that person's problems instead of spending valuable time providing him or her with the much-needed emotional support that they are lacking.]

Some of the questions Samaritans ask in both training and during practice include:

What personal need(s) am I possibly trying to deal with or satisfy as I do this work?

What am I expecting or hoping to accomplish by *helping people*, personally and professionally?

What possibly selfish agenda do I need to admit to myself so that it doesn't impact my work?

What is it going to take for me to do a better job of "keeping my ego in check" on a daily basis?

Which aspects of my personal and professional behavior do I need to be consistently aware of?

Befriending A Person In Crisis

The basic guidelines to follow when befriending a person who is in crisis and potentially suicidal are the same no matter what your role, lay or professional, or relationship. Samaritans suggests that you begin by following these six steps.

Take all talk of suicide seriously

People who are considering suicide frequently will tell someone, especially if they feel that person is trustworthy and respectful and will take them seriously. Being accessible is the key.

Get involved and use "Active Listening"

By listening to what the person in crisis has to say and by asking direct and open-ended questions, we show our willingness to talk about anything with that person, including his/her feelings about suicide.

Recognize the warning signs of depression

Since the majority of people who attempt suicide literally do or say something to let others know their intentions before they act, it is important to know the “warning signs.” They begin with noticeable or abrupt changes in that person’s “normal” behavior (whatever *normal* is for them) and include:

- Changes in sleeping patterns and eating habits
- Loss of interest in school, work, hobbies, etc.
- Alcohol and drug abuse, impulsive dangerous acts
- Feelings of helplessness, hopelessness, etc.
- Feelings of guilt, low self-esteem, shame
- Talking about and giving away prized possessions

Many depressions contain some element of grief and/or recent loss(es) tied to death, divorce, a job, a broken relationship, perceived status, etc. Watch for statements like "nobody cares," "everyone will be better off without me" and "I wish I was dead." Talking about suicide is a significant warning sign.

Don’t be afraid to ask: “Has it gotten to the point that you feel suicidal?”

If the answer is "Yes," take the person seriously and continue the "suicide risk" assessment questions:

- "Do you have a plan to take your own life?"
- "Do you have the means to act out your plan?"
- "Have you decided when you would do it?"

If the person has a plan, the means available and has set a specific time, consider the person "high risk." Also find out if the person or any member of their family has ever attempted suicide before.

Do not leave a person who is "High Risk" alone, for even a moment

Most people can get through their moment(s) of crisis, if they have someone who will spend time with them, listen, take them seriously and acknowledge their thoughts and feelings. Continue to befriend, maintain ongoing communication, utilize pre-screened resources and expand your own support network.

If the person has taken some form of life-threatening action, get help

If a person has taken any action that you believe could be considered life threatening, do not hesitate to get that person to a hospital yourself (if practical) or call an ambulance or emergency service.

Effective Active Listening

In NYC, Samaritans' advertisements for hotline volunteers asks: "**Can you shut up and listen?**" Throughout the world, Samaritans promotes active listening: whether it is being practiced by our hotline volunteers; taught to teachers, guidance counselors and other professional caregivers; or utilized by friends, family members and colleagues when responding to someone who is depressed or in crisis.

A learned skill that takes practice, active listening was brought to the public's attention through the writing of Carl Rogers in his book, *On Becoming A Person*. On a basic level, active listening takes the focus off of the helper and puts it on the person being helped (in our case, the person in crisis). In this way, active listening is not only a very effective form of communication, it also alleviates some of the isolation, loneliness, low self-esteem and feeling that *nobody cares* that often accompanies bouts of depression.

Active listening tells the person in crisis that what he/she is feeling is important and, by association, that he/she is deserving of our time and attention. For the person in crisis, being in communication with someone who is actively listening can be a calming and steadying influence. And most beneficial, it also assists that person in getting his/her feelings out in a safe and supportive environment, thereby acting as an all-important emotional pressure release valve which is a "protective factor" in preventing suicide.

On a basic conceptual level, active listening is a rejection of the traditional communications model developed in the early 1950's that focuses on the *sender of the message*, the person who is initiating the communication and deciding its content, focus and delivery, the common approach for market research, political polling, sales, interviews and all forms of argument (be they legal, academic or parental in nature). The diagram on the next page illustrates the difference between the two in terms of focus and purpose.

Silence

Silence is something that is meant to be shared not filled. Do not be afraid of silence. Used consistently in a balanced manner, silence demonstrates that you are paying attention and respect for the person with whom you are communicating in that it shows patience and the awareness that expressing ones emotions, thoughts and feelings can be a difficult process that takes time. Use silence when you are unsure of what to say or how to respond or to allow a pause or some time for quiet reflection.

Open-ended questions

Open-ended questions are structured in a way that allows the person with whom you are communicating to respond on his/her own level, without any restrictions or preconceptions. When you use an open-ended question properly, you meet the person you are talking to on his/her own level because the structure and design of the question provides him/her with the opportunity to respond within whatever framework or train of thought they are most comfortable. In this *whatever you want to say is acceptable* context, open-ended questions are ideal for establishing rapport and generating a non-threatening environment.

Examples: "How have you been dealing with your situation?" "What is it that you are finding to be most difficult?" "How is this affecting you now?"

Closed-ended questions

In contrast to open-ended questions, closed-ended questions are very restrictive in that they either confirm or deny a specific issue or point of view. As the name implies, closed-ended questions present a predetermined outcome and, therefore, force the person with whom you are communicating to take an absolute position. Though you may not realize it, when you use a closed-ended question, the thrust of your comment can become manipulative or coercive because it implies a sense of what is right and what is wrong. For instance the simple question "Can you talk to your father about that?" implies you should talk to your father. The seemingly innocent, "Have you thought about going to counseling?" also implies a "should." Yet, when used properly closed-ended questions clarify thoughts and feelings.

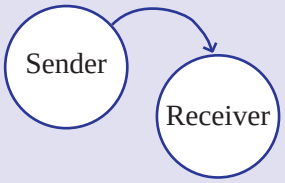
Examples: "Do you want to talk about what's going on?" "Would you like to speak again after you've gone to counseling and had a chance to think?" "Has it gotten to the point that you are feeling suicidal?"

Active Listening vs. Traditional Communications

You see who is in charge in traditional communications (diagram 1) and who is most important. The communication is only about the senders' thoughts and agenda. All feedback and input is analyzed with the goal of how it will best allow the delivery of the sender's predetermined message to his audience. The *receiver of the message* is merely the object of the action that the sender wants to take, not the focus.

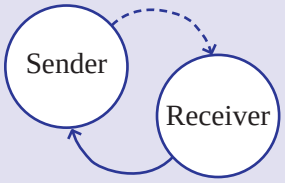
Message is sent with a focus that is predetermined

diagram 1



Message is sent only *after* input is received

diagram 2



When you look at the process from the perspective of someone practicing active listening (diagram 2), the sender (in our case, the helper) receives input and feedback *before* he or she shapes their message or determines the direction of the communication, resultingly, it is the person who is on the receiving end of the process who is most important and the focus of the communication.

Paraphrasing

Paraphrasing is the process of taking in what the person has said and, after uncovering its primary components and meaning, reworking it so that it comes out it in your own words while retaining the same content (and intent) as that originally stated. When practiced properly, paraphrasing proves that a person is paying attention because for the restatement to "ring true," the listener must have been attentive and focused on what was said. This tool is best used to clarify your understanding and to check for accuracy.

For example: The son says, "I don't know why so many people are upset with me, I didn't do anything." The listener responds, "You're saying that you don't understand why so many people are angry with you?"

"Say more" expressions

Say more expressions get the person with whom you are communicating to probe deeper into his/her thoughts and feelings. This tool is very effective when you are trying to learn more about what someone is thinking or feeling, when you are being asked to give advice or when the conversation seems to be stuck.

For example: The son says, "No one really understands all the things that I am going through." To which the listener responds, "Well, what is it that you want them to understand?"

Acknowledgement

Acknowledging what a person is feeling, thinking or saying is an important rapport-building tool in that it lets the person with whom you are communicating know that you are *taking in* whatever it is that he/she is feeling, can see its impact and recognize its significance to that person. Acknowledging what someone is saying does not mean you necessarily agree with, believe or condone it yourself.

For example: "From what you have said about how this has affected you, it sounds like you are going through a pretty tough time." (best followed by an open-ended question) "How are you handling all this?"

Validation

Validating what a person is feeling, thinking or saying is a stronger form of acknowledgement in that the listener takes a more formal role in the conversation by stating his/her personal understanding of the situation (though you should always be careful not to express your own beliefs or opinions). This tool is very effective in conveying empathy and sensitivity to someone's circumstance.

For example: "From what you have said about how this has affected you, no wonder you are feeling so upset. It sounds like you are dealing with a pretty difficult situation." (again, followed by an open-ended question) "So with all that is going on, how is this impacting your difficulties at school?"

A Befriender's Checklist

The following series of questions is derived from the Samaritans of New York's hotline volunteer training program and over 20 years of input and feedback from over 25,000 students, teachers, social workers, guidance counselors and other lay and professional mental health and crisis response staff who have participated in our public education suicide prevention and awareness training workshops.

It parallels the initial orientation and introduction to Samaritans hotline volunteer training (which devotes one entire day to these questions and issues) and is offered here as a "primer" and a preparation tool for anyone who is involved in helping people in crisis, whether as a family member or friend or in the role of a lay or professional caregiver or service provider.

To maximize the benefits of this process, read each of the questions and challenge yourself to answer them as honestly as possible, filling in the blanks and coming up with your own examples as you go.

What do I know about the problem?

Frequently, a lot less than we think. Even the most educated and experienced person cannot expect to be knowledgeable about everything. And often the knowledge we do have is based solely on our own experience and is not applicable to a third party. So we begin by acknowledging what we do and do not know, what is just our personal opinion, and go from there. What are my beliefs about this problem? What are they based on? What don't I know? What do I need to learn? Then fill in the gaps.

Example: At Samaritans, since we are responding to people who are potentially suicidal, we look at: suicide as a public health problem; the statistics and latest research; the causes, warning signs and individuals at greatest risk; the many myths tied to suicide (such as, if someone is determined to take his/her own life there is nothing you can do about it); what a person in crisis experiences;, etc.

How is this person experiencing this crisis?

No two people react to the same situation in the same way and, certainly, our experience with this or similar problems provides no basis for how we should respond to this person. What is the person we are responding to experiencing? What is he/she thinking and feeling? What warning signs/ risk factors is he/she revealing and to what degree? How is this impacting his/her daily life? How aware is this person concerning what he/she is going through? What fears, concerns, etc. might this person have?

Where am I coming from?

Before we approach any helping situation, we carefully examine our own agenda in this relationship, from our personal needs, goals and values to our expectations and preconceptions (e.g., the need to make someone "feel better" can be very problematic) so that we, to the best of our ability, can keep the focus on the person we are responding to and not our own issues and problems. What do we see as our role in this encounter? What are we trying to make happen? What judgements do we need to suspend?

What does this person need?

Tied to the necessity of trying to understand what the person in crisis is experiencing, we also want to be sensitive to their fears, concerns and expectations about the encounter. For even the best-intentioned and most knowledgeable caregivers and service providers can have trouble separating the person from the problem. We always remember to ask ourselves: "When we were in crisis, how well did we think our *helper* understood us?" We also keep an eye on the warning signs being revealed (i.e., isolation, low self-esteem, impulsive behavior) so that we focus on what the person is feeling and thinking. At Samaritans we always ask ourselves: "When I was in crisis and reached out for help, what *didn't work, turned me off, shut me down* or made me regret asking for help in the first place?"

How do I keep the focus on the person?

We are aware that in every helping situation we can easily become very invested in being *successful* and having a *positive* outcome and that, if we are not careful, our needs can overshadow and even sabotage the encounter. We remind ourselves of the nature of the problem (if it is depression, it is very complex and there are no simple answers), what the person is experiencing and the potential of our own needs, fears, intentions to become obstacles to helping. We rely on our rapport-building skills, active listening tools and our ability to pay attention to not only the information being expressed but the thoughts and feelings behind them. What is this bringing up for me or reminding me of that I have to be aware of?

How do I create a safe environment?

Research as well as common sense tells us that there is a direct connection between someone's comfort level and our ability to help them. The importance of establishing rapport and utilizing active listening tools cannot be overstated. The first impression we make, starting out and maintaining the focus on the person we are responding to, using open-ended questions and steering towards that person's thoughts and feelings--whatever they may be and wherever they may go--are all part of this process. The need for a safe, secure and confidential environment is also paramount, for the possibility of interruptions or being overheard takes away from the person's trust and confidence in us. "How can I make this environment more secure and conducive to the process taking place?" is a question that should always be addressed.

Am I remembering it's a process?

Tied to remembering to separate the person from the problem, comes the need to remind ourselves that people are not puzzles to be solved nor are they mysteries to be unraveled. Every person's situation and related problem(s), illness(es), etc. is going to take time as well as sensitivity, support and, possibly, even treatment before it will improve or alleviate. We do not try to tie everything up in a neat package, come up with options and plans and a logical course of action for every contingency. We provide a hand to hold, a shoulder to lean on, someone who can be trusted and relied upon as the person finds their way through their crisis, constantly expanding our resources and own supports as the process continues. Ask yourself: "What is it going to take for me to maintain a level of consistency and provide continuity for this person?"

What resources do I need to be aware of?

We recognize that each of us, no matter what our role or relationship with the person, is part of a larger *helping community* and that no one person, program or prescription is going to solve his/her problems or make his/her crisis go away. It is a tragedy that many of us develop contacts and resource lists *after* we need them instead of before. Knowing who and what is available--from crisis, information and referral hotlines to the local hospital triage nurse to the neighborhood police precinct public safety officer--assists us in providing ongoing support and expanding the person's coping tools and network as well as gives us, the caregiver, some additional options and resources when we need them. Ask yourself: "Which situations and/or circumstances do I feel ill-prepared to handle?" and work backwards in developing a plan.

Samaritans Sayings.....

Samaritans uses sayings, phrases and metaphors to remind us of the challenges we face when we try to help people in crisis. Some of the statements we rely on most strongly are:

Always have great respect for that which you do not know!

You don't solve other people's problems for them, it's hard enough to handle your own.

You don't save another person's life, you help him or her get through a moment!

Just because *you* don't understand someone, it doesn't make *them* confused.

If you are afraid of the dark, it is better to be sitting holding someone's hand than sitting by yourself, alone.

Sometimes it's best to just shut-up and listen!

Obstacles to Communication

Whether a friend, family member or mental health professional, when we try to help someone who is in crisis it is impossible to avoid all of our own needs, concerns and feelings. We would like to be able to help that person to feel better, to be able to explore different options and possibilities or, at the very least, be less self-destructive. But even the most sincere and educated amongst us can, inadvertently, express thoughts and values that create obstacles in establishing rapport or interfere with efforts to communicate with the person we are trying to help.

To communicate effectively we, first, have to acknowledge and try to correct those approaches and attitudes that, instead of engaging a person on an empathetic level, acknowledging and recognizing their perspective, only focuses on what we think and how we see a situation; thereby making the person we are responding to feel more isolated and misunderstood.

Review the list below and, being as self-aware and painstakingly honest as possible, identify the approaches and behaviors you practice that block effective communications, try to understand where they are coming from, the circumstances under which you practice them and try to avoid them in the future. [The most common obstacle almost everybody practices is talking in the “first person” (I, me, my, we, us) which takes the focus off of the person you are responding to and puts it on yourself.]

Talking too much

You cannot hear what someone else is saying or understand what he or she is feeling or thinking if you are doing most (if not all) of the talking.

Trapping

Asking questions or making statements that only have one possible outcome (“Don't you think you are being a bit over-sensitive?” or “Have you at least tried to talk to her about it?”). Closed-ended questions are the primary trapping tool.

Topic-changing

All manner of words, phrases and behaviors that convey the message that you would rather talk about anything other than the thoughts, feelings and issues that the person you are supposed to be providing support to, is trying to express.

Minimizing

Reducing a person’s thoughts, feelings and their own experience into a cliche, stereotype or trite phrase negates its importance and significance.

“I know how you feel”

When you tell someone *I know how you feel*, you deny them their individuality and the validity of their own experience and, instead, put the focus on yourself and how you react to situations.

Generalizing

Taking one behavior, situation, explanation or problem and applying it to explain everything the person is saying, feeling or going through.

Anticipating

When you complete people's statements before they complete them or try to fill-in what they are saying, you interfere with their thought process and need to express themselves and undermine the purpose of active listening in the first place.

Putting the focus on me

Analyzing another person’s feelings or a situation he/she is going through based on the lessons that you have learned in life, tells the person that their reaction or what they are experiencing does not matter or is not important.

Scoreboarding

Focusing on making a specific point or on being "right," instead of seeing the situation from the other person’s perspective and experience.

Mind Reading

When you act like you know what another person is thinking without letting *them tell you*, you reduce the other person's thoughts to your frame of reference and discourage him/her from trying to express themselves or going into greater detail.

Patronizing

Treating a person as a category of sociological phenomenon or societal problem that you are forced to "deal with" instead of as a real person.

Yeah-but-ing

Using statements and body language that imply agreement but are only utilized to undercut and contradict what the person is saying.

Crisis Communications Model

The volunteers in every Samaritans' crisis center throughout the world practice active listening techniques in some form of consistent framework that can be utilized when communicating with people of every age, culture, background, social or religious identity, whether face-to-face or on the telephone. What drives the model is our focus on steering towards the pain which, in Samaritans' language, means getting to the heart of the matter, what is bothering the person you are communicating with, what they are thinking and feeling.

In New York City, the Samaritans 24-hour suicide prevention hotline utilizes the following model:

MAKE FIRST CONTACT

Be aware of the importance of the first contact. When greeting the person, think about the attitude you want to convey and the words you choose. The first impression you make sets the tone for the entire communication.

ESTABLISH RAPPORT

Show interest and concern by using open-ended questions and giving the person the opportunity to open up and get it out. Keep the focus on the thoughts and feelings of the person you are talking with, not on yourself.

EXPLORE THE PRESENT SITUATION

Maintain the focus on what the person is thinking and feeling, not just facts and information. Use silence. Validate and acknowledge to find out what is going on in his/her life at this time. "Steer" towards their pain.

LOOK FOR WARNING SIGNS

Be aware of behaviors, thoughts and feelings that demonstrate potential for suicide risk. When examining warning signs, our focus is a series of "changes" in that person's normal behavior not one or two isolated signs.

ASSESS THE "DEGREE OF RISK"

Always assess a person's degree of risk and let him or her know that you are willing to talk about whatever he/she is feeling, including suicide. There are four questions in the assessment that determine degree of risk.

> "Are you to the point that you are thinking of suicide?"
>
> **--If he/she says "NO" - then you say:**
>
> "Well, even if you're not right now, I want you to know if you ever do feel that way, you can always tell me…"
>
> **--If he/she says, "YES" - then you ask:**
>
> "Do you have a plan/Have you thought how you'd do it?"
> "Do you have the means available to act out the plan?"
> "Have you set a time?"

The more *yes's* to the suicide assessment questions, the higher the person's degree of risk. If someone has suicidal thoughts, a plan, means and has set a time, do not leave them alone.

EXPLORE OPTIONS

Base your options on the person in crisis's need and your responsibilities. Look at the supports and/or services that are appropriate and available before determining what, if any, course of action you will take or suggest.

Determining The "Degree Of Risk"

In NYC, the Samaritans follow the Crisis Communications Model to make that first contact and establish trust and awareness of what that person is experiencing, and utilize what they say in the initial stages of the model to identify warning signs and assess their suicide ideation.

We then take what we have learned and apply it to our next procedure, Determining The Degree of Risk. This process assists us in deciding how much time to devote to that person, what other protocols or additional services--including providing an emergency response--are appropriate and necessary, etc:

Review What Caller Said

Review the entire conversation up to this point, including what the person has told you about the difficulties, problems or issues he/she is dealing with or experiencing, his/her present situation and what he/she is feeling now.

Thoughts and Feelings

What thoughts and feelings has the person expressed, how intense or extreme are they, how are they manifesting on a mental and physical level?

Warning Signs

Which warning signs and "at-risk" behaviors has the person presented? What are the number and severity of the signs and behaviors?

Suicide Risk Assessment

How did the person respond to the suicide risk assessment questions? What judgment did you make as to the person's suicide risk?

Determine Risk Category

Consider the thoughts and feelings the person expressed and his/her present situation, the number and severity of warning signs and your judgement as to the caller's degree of suicide risk.

No Risk

--minimum or no expression of depressive thoughts and feelings, few or no warning signs, *not suicidal* risk assessment.

Low

--some expression of depressive thoughts and feelings, some warning signs, *thoughts* and, possibly, *plan* risk assessment.

Medium

--clearly depressed state of mind, a series of somewhat severe warning signs, some at-risk behavior(s), *plan* and, possibly, *means* risk assessment.

High

--very depressed state of mind, serious warning signs and at-risk behaviors, *thoughts*, *means* and *time set* risk assessment.

Determine Time to be Allotted/Other Service Delivery

Based on the hotline's policies every degree of risk (no, low, medium and high) has a corresponding time range. There are other issues and procedures associated with this determination such as deciding when it is time to end a call, whether to give a specific referral or initiate an emergency response.

Continue To Befriend and Steer Towards the Pain

No matter the determination, continue to befriend, focusing on the thoughts and feelings the person has expressed, their concerns and fears, issues and problems being faced. Remember: It is not about procedures but providing emotional support and helping that person *get through a moment of crisis*.

Basic Suicide Prevention Planning

Every school, site and community-based organization should have some form of comprehensive suicide prevention plan in place. Suicide prevention planning also creates an *early warning* system and method of responding for every kind of problem and type of issue--from abuse, neglect, sexual assault and domestic violence to behaviors tied to alcohol and drugs, truancy, traumatic loss, and all forms of emotional problems and mental illnesses, etc. [See: Resources and General Information List, page 19, for groups and organizations that can provide more in-depth guidelines for suicide prevention planning.]

The following guidelines are based on the Samaritans of New York's experience working in the NYC-Metropolitan area over the past 20 years. They are intended as a preliminary step in developing a site-based plan and *are not intended to fulfill professional or legally mandated reporting requirements* nor are they meant to take the place of any school, program or site policy or protocol.

The effectiveness of any plan is dependent on the proper training of all lay, professional and administrative staff; and anyone working within the program who comes into contact with the general population, including custodians, food service workers, security guards, etc. But a plan will only be effective if it includes input from all the stakeholders involved in its implementation and is based on realistic expectations in terms of peoples' accountabilities, responsibilities and capabilities.

Samaritans suggests that your initial suicide prevention planning include the following:

A site awareness and education campaign

Basic information about suicide as a public health problem, its causes and relation to other health problems, the statistics, trends, populations most at risk, warning signs and risk factors, the myths and misconceptions people have about suicide as well as the keys to prevention must be disseminated and reviewed by every person served by or providing service. The better educated every member of the site's community, the more effective the planning and implementation will be.

A site crisis protocol to ensure a consistent quality response

Some form of user-friendly flowchart outlining the procedures that should be followed in every interaction with a student/client who may be in crisis, including how to assess suicide risk, the support staff and their roles and available resources. Issues addressed should include but not be limited to: what to do when a student/client is clearly demonstrating warning signs; what to do when he/she talks about suicide; what to do when a student/client tells you about another person who is suicidal; what to do when it is determined that the student/client is potentially suicidal and should not be left alone; etc.

A dedicated site for those in crisis who need someone to talk to

Specific rooms and staff as well as times available should be identified so students/clients know where to go and who to turn to when they are in need of confidential feedback, help and support. The plan should also include procedure(s) students/clients should follow to access that help (whether it is a slip to get out of class, which room to go to, the phone number to call, etc.), what the help will consist of and program-wide encouragement to access that help and support.

A pre-tested community referral and resource list

One of the more significant components of the plan--resources and referrals--are often overlooked until after an emergency has occurred for which the site's staff found itself ill-prepared. A resource list *should not* be taken from other sources but compiled by front-line staff who make direct contact with the site, police precinct, hotline, hospital, etc. The list should provide resources (if not responses) to any scenario that can be imagined. Once compiled, these lists should be distributed to every member of the staff. [A basic outline for creating this list appears on Page 16. Note that every city and state has its own unique division of community health support services. Make sure, when compiling your site's resource list, that you receive input and feedback from those most familiar with your locale.]

Community Resource & Referral List

It is suggested that your resource and referral list include agency/service, contact person's full name, direct phone number, beeper number, hours available, how to contact, backup, etc. Your list should be as specific as possible, covering 24 hours a day. This should include but not be limited to:

Local/county hospital (24-hour direct phone number)

For medical and psychological emergencies and support services, including ambulance service.

- Emergency room
- Head triage nurse
- Head ER resident
- Psychiatric resident
- Senior attending physician
- Clinical social worker

Local police precinct (24-hour direct phone number)

For crimes, including assault, child abuse, domestic violence, sexual abuse, and for emergencies and support services.

- Precinct captain
- Community affairs officer
- Public liaison officer
- Crisis/trauma team leader
- Special duty officer(s)
- Emergency medical services

Community health agencies and organizations

Agencies and non-profits that respond to those problems most frequently faced by students and clients, including but not limited to:

- Child abuse
- Teen alcoholism
- Child welfare
- Mental health information and referral
- Crime victims
- Domestic violence
- Incest
- Drug abuse and treatment
- Gay and lesbian issues
- AIDS information
- Sexual abuse
- Immigration services
- Social services
- Victim's services

Local fire department station (24-hour direct phone number)

For immediate response to emergencies and other potentially dangerous situations such as someone on a window ledge.

- Station captain
- Head of emergency services
- Head of crisis/trauma team
- Community affairs officer

Local 24-hour suicide prevention hotlines and support services

Those 24-hour hotlines that respond to those problems most frequently faced by students and clients, including but not limited to:

- AIDS hotline
- AA and Al-Anon
- Child abuse reporting
- Gay & Lesbian issues
- Runaways
- Sexual problems
- Suicide
- Teen and youth issues
- Teen shelters
- Victims services

Other names and numbers that may be helpful

- Community advocacy groups
- Community social groups
- Local community and district leaders
- Local religious leaders (every denomination)
- School and district union representative(s)
- City health and mental health dept.
- Department of Health (AIDS, women's health, domestic violence)
- Department of Mental Health (citywide mental health referrals)
- Department of Youth and Community Development (youth services)

Basic Suicide Awareness Class Outline

Samaritans centers throughout the world offer suicide prevention public education programs that provide awareness about suicide as well as training in the skills and philosophy practiced by Samaritans volunteers when befriending those in crisis. We believe every student, parent, educator, health professional, community leader, etc., should take part in some form of basic suicide awareness class discussion in a manner appropriate to their age, education, cultural and social background.

In the New York City branch, which has provided prevention training to over 25,000 people over the past 18 years, we attempt to infuse these discussions with a positive tone focusing on what we call *The Other Side of Suicide*, which we define as "life, living and exploring options." Our classes are not lecture-oriented but interactive, designed to get participants involved in discussing their own thoughts and feelings about the topic in as un-pressured and supportive an environment as possible.

We begin with the statement: "This topic can make some people feel uncomfortable and that's perfectly normal. But the issues we are talking about--suicide and depression--are very real and it is important that we understand what we should do if someone we know is talking about suicide."

The following outline is based on the Samaritans of New York's one-hour suicide awareness class:

An introduction to the topic of suicide. This usually begins by writing the key suicide statistics on the blackboard--11th leading cause of death in the U.S.; 30,000 people die a year; one suicide every 17 minutes; the 3rd leading cause of death of teenagers, 2nd of American college students--and then asking the participants why they think so many people experience suicidal feelings.

Why does suicide scare us? Open discussion about people's fears around death and dying. When someone mentions "suicide" what images does it bring up in their mind? Why are we afraid to respond to someone who says they are feeling suicidal? What do we think will happen? Focus is on myths and misconceptions about suicide as well as the stigmas and stereotypes.

Review of the causes of suicide. Getting as much of the information from participants as possible, then filling in the gaps. Short explanation of the difference between mental and emotional illness and those depressions caused by situations such as the loss of a parent, pressure to succeed, bad marks, etc. Relationship between suicide and other social/personal problems, including alcoholism, drug use, violence. Issues tied to people's ability to cope, isolation, self-esteem, etc. Review of warning signs.

How do you help? Ask participants in this order: 1) When they were in crisis at a time in the past, what did they *not want* from those they reached out to? 2) What made those responses unsatisfactory? 3) When they were in crisis, what *did* they want? Discuss what is and is not effective when someone is in crisis. Review the basics of befriending including: not being afraid to get involved; talking to some about their suicidal feelings; shutting up and listening; doing a basic suicide risk assessment.

What to do when someone you know talks about suicide. Emphasize the importance of being a friend, being respectful and the role of confidentiality, but that there are times when people need help whether they realize it or not. Explain that it is better to have a friend who is angry at you but alive than one who is dead because you kept what you thought should be a secret.

Review site's suicide prevention plan. Discuss the supports/programs available to participants to get help themselves or to report someone's suicidal feelings or behavior. Again, review the names and numbers of people, resources and organizations available.

Debriefing and support period. It is of utmost importance following this, and any other suicide prevention discussion, to leave time where you are available to those who have been touched by the topic, have something to say or report or just need a "cooling down" space to catch their breath.

Suicide Prevention Workshop Outline

Every teacher, guidance counselor, social worker and member of administrative and program staff should be required to take part in a suicide prevention workshop. The training can be provided by a local "expert" (social worker, psychologist or community suicide prevention center staff member) or your school, group or agency can designate a staff trainer who can study the topic him or herself and become the site "go-to" person. [The Samaritans are available to provide additional support, materials and, when necessary, "train the trainer" suicide awareness and prevention workshops.]

The workshop should be non-clinical in nature, be very interactive and utilize role-playing and team-building exercises. The emphasis should be on the fact that, in order for the site to implement effective suicide prevention planning, those people who are responsible for responding to students/clients in crisis must be able to talk about suicide, recognize their own issues, emotions and concerns about the topic and be confident that they know how to identify someone who is in crisis or potentially suicidal, what to do and how to do it. Examining worst-case scenarios is always helpful.

The following outline is based on the Samaritans of New York's three-hour suicide awareness and prevention public education training workshop for caregivers and service providers:

Introduction to the topic of suicide. This includes: why do so many people--especially young people, the elderly and middle-aged white men--attempt suicide; basic suicide statistics and trends; the many myths and misconceptions people have about suicide; the relationship between suicide and other health and social problems; highest risk groups; current suicide research about suicide, etc.

Recognizing our own difficulties in dealing with suicide. This includes: why does suicide scare us more than other health and social problems; coming to terms with our own fears and concerns about responding to people in crisis, especially the fear tied to talking about it and “saying the wrong thing”; the need to recognize our own personal agenda and how that impacts providing help; developing a very realistic and practical understanding of our personal limitations and strengths in responding to a crisis.

The philosophy of crisis intervention. This includes: a basic understanding of depression and mental illness; understanding what someone "in crisis" is going through; learning that when helping someone your own "attitude" and state of mind are of great importance; the basic precepts that "you never know" what is really going on, you should take nothing for granted and keep the focus on the person in crisis and not on yourself; providing support, a safety net, a pressure release valve.

The basics of befriending. This includes: crisis intervention as a process not a solution; don't be an expert, be a human being; don't focus on personal advice and judgements; respond to the person not the problem; deal with thoughts and feelings not facts; focus on acceptance and acknowledgement; "steer towards the pain"; take all talk of suicide seriously; never be positive, never be wrong.

Why listening is important. This includes: an overview of effective "active listening" and why it works; the importance of that "first impression"; the keys to establishing rapport; mastering the use of "open-ended" questions; using paraphrasing, restating and "say more" expressions; the importance of and the use of "silence" (which we say should be "shared" and not "filled"); etc.

Doing a suicide risk assessment. The Samaritans "Crisis Communications Model” provides a framework for all crisis intervention and emotional support work and incorporates all of the above.

Using your site's protocol and community resource list. This piece, designed in advance by those responsible for setting school or agency policies, should explain the process and procedures all staff are to follow when responding to different degrees of suicide risk, especially what to do when someone is "high risk" and cannot be left alone; outline available resources and referrals.

Resources and General Information List

The following agencies, phone numbers and websites are provided to assist you in doing further research and/or in finding additional resources and support services.

Center for Mental Health Services (CMHS)

(800) 789-CMHS (2647), Hours 8:30-5:00 M-F

Government agency under SAMHSA provides consumer and scientific information, including mental health agencies by state, treatment facilities, how to access "sliding scale" mental health services, etc.

www.mentalhealth.org

New York State Office of Mental Health (OMH)

(866) 270-9857

OMH provides a Suicide Prevention Education Awareness Kit (SPEAK) for free to the public, health care providers and educators to help them learn the issues tied to suicide and ways/methods to prevent it.

www.omh.state.ny.us/omhweb/speak

Suicide Prevention Resource Center (SPRC)

(877) GET-SPRC (438-7772) 9:00-5:00 M-F

Under SAMHSA, compiles and disseminates a broad specturm of research, state and local planning, evaluations, training, and other resource materials.

www.sprc.org

Suicide Prevention Advocacy Network (SPAN)

(770) 649-1366

National advocacy group for those who have lost loved ones to suicide provides information about legislation, state and community activities, etc.

www.spanusa.org

National Mental Health Association (NMHA)

(800) 969-NMHA (6642)

National non-profit agency provides information and referrals concerning mental illness and confidential depression screening test, support and advocacy.

www.nmh.org

National Alliance for the Mentally Ill (NAMI)

(800) 950-6264 10:00-5:00 M-F

Non-profit support and advocacy group with local chapters throughout the states with listing of support groups for the mentally ill and their families

www.nami.org

American Red Cross (ARC) September 11 Recovery Program

The 9/11 Service Guide provides a geographical list of programs that receive September 11 recovery grants from ARC including advocacy/case management; health screening and treatment; information and referral; mental health and wellness; etc.

www.redcross.org/september1l/help

1-800-LifeNet

(800) Lifenet (543-3638) 24 hours

Operated by MHA of NYC in partnership with the NYC Department of Health & Mental Hygiene, LifeNet has the City's largest health information and referral database and can direct you to key services in every borough, in many languages, sliding scale, etc. They also dispatch City mobile crisis units..

www.mhaofnyc.org

Columbia Teen Screen

A mental health and suicide risk screening program for youth to ensure that all parents are offered the opportunity for their teens to receive a voluntary mental health check-up.

www.teenscreen.org

Ulifeline

An anonymous, confidential, online resource center for college students and their parents, also includes Counseling Central, for college mental health and student affairs professionals.

www.Ulifeline.org

CornellCares

A geriatric psychosocial Web site offers innovative-yet-sensible practice tools, information, and resources to make assessments and interventions of older adults easy and effective.

www.CornellCARES.com

Samaritans 24-hour Suicide Prevention Hotline

(212) 673-3000 (English) 24 hours

(877) SUICIDE (784-2433) Prevention Infoline

www. samaritansnyc.org

Using Samaritans Hotline As a Referral....

The Samaritans of New York operates a 24-hour suicide prevention hotline that provides ongoing emotional support to those who are in distress, depressed, in crisis and suicidal. The service is completely confidential and offered by Samaritans volunteers who are trained in active listening and suicide risk assessments. Every caller to the 24-hour hotline is taken through the Samaritans Crisis Communications Model, no matter who they are, how they identify themselves or their stated reason for calling. You call the Samaritans hotline and we ask you how you are feeling and if you are suicidal. Often used to complement and bridge other services.

WE ALL NEED

SOMEBODY TO

LEAN ON.

BILL WITHERS
Spokesperson

If you or someone you know is having trouble coping with anything from a bad day to a broken heart to a sense of loss or longing tied to September 11 or any emotional problem, there is someone who cares.

Someone who will take you seriously and listen to what you are going through 24 hours a day. Talk to a friend at the Samaritans where our professionally trained and caring volunteers are dedicated to helping people in crisis.

As Bill Withers says, " We all need somebody to lean on..." When you do, Samaritans is there!

The Samaritans

CALL (212) 673-3000

NON-RELIGIOUS COMPLETELY CONFIDENTIAL

American Red Cross

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