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U N I V E R S I T Y   O F   W I N D S O R

The School of Social Work

TELEPHONE CRISIS INTERVENTION

A comparative and exploratory  
study of TEL-A-FRIEND, Windsor  
and The Distress Centre, Toronto.

by

Russell A. Daniels

Audrey K. Wright

A research project presented to the School of Social Work  
of the University of Windsor in partial fulfillment of  
the requirements for the degree of Master of Social Work.

May 1971

Windsor, Ontario, Canada

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## ABSTRACT

This was an exploratory study of Tel-A-Friend, a telephone crisis intervention centre in the city of Windsor, Ontario. A comparison was made of this centre with the Distress Centre in Toronto, Ontario. The population of the study in the City of Windsor was defined as those people who called Tel-A-Friend during the month of August 1970 and November 1 - 5, and November 7, 1970. In Toronto the population was defined as those who called the Distress Centre during the month of August 1970 and November 1 - 6, and November 8, 1970. The sample size for Windsor was the total population, totalling 256 calls in August, and 39 calls for the period in November 1970. In Toronto, where the population was much larger, a random sample was made; selecting every fourth call. The Toronto sample was 255 calls for August 1970 and 64 calls for the period in November 1970.

In Windsor, the data was collected by the telephone volunteers, who completed a four page check-list (Appendix 4) for each of the sample calls. In Toronto, the researchers completed the four page check-list from the agency's report form (Appendix 5) for each of the sample calls.

The findings of this study partially answered the

questions posed in the research proposal:

1. Do the callers have social and psychological needs which the agency is prepared to handle?
2. Is the agency effective in helping the caller handle his feelings?
3. Is the agency effective in crisis intervention?
4. How does Tel-A-Friend, a new agency, in Windsor, compare in function and approach with the Distress Centre in Toronto, which has been in operation for three years?

The study revealed that:

1. The callers to Tel-A-Friend in Windsor and the Distress Centre in Toronto were generally considered to be depressed, lonely or distressed; and the volunteers in both centres felt they were effective in bringing about a change in these moods during the call.
2. The volunteers in both agencies in this study appear to have rendered a helpful service to their callers. However, the Windsor volunteers, who knew they were collecting data for a study, assessed themselves as more effective than the Toronto volunteers who had no knowledge of the study.
3. The two agencies are engaged in crisis intervention which effects a change in the reaction of their callers to hazardous situations, and the volunteers feel they are effective in this form of crisis intervention.
4. Tel-A-Friend in Windsor and the Distress Centre in Toronto do differ in their function and approach as follows:
  - a) Tel-A-Friend does not have any full-time paid staff; whereas the Distress Centre has a full-time paid Director.
  - b) Tel-A-Friend only operates from 8 p.m. to 1 a.m. on week days and 6 p.m. to 2 a.m. on weekends; whereas the Distress Centre operates 24 hours every day of the week.
  - c) Tel-A-Friend does not provide an ongoing continuous training programme for their volunteers; whereas the Distress Centre does provide such a programme.

- d) Tel-A-Friend does not record and classify the calls coming into their agency; whereas the Distress Centre does keep very fine records of each call received by their agency.

While there are differences in the structure and function of these two agencies; there appears to be great similarity in the manner in which their volunteers handle the callers.

Also the majority of callers to both agencies were female; and usually calling about personal difficulties; and appeared to be depressed, lonely or distressed.



## ACKNOWLEDGMENTS

The authors are grateful to their Research Committee; Dr. W. Y. Wassef, Chairman; and Professor H. M. Morrow and Associate Professor Stewart Moore, Members; for their guidance and encouragement in the writing of this thesis.

The study itself brought the researchers into close contact with staff and volunteers of Tel-A-Friend in Windsor, and The Distress Centre, in Toronto. This was an experience we will not soon forget, and for which we wish to thank Mr. Donald Effren, formerly of Tel-A-Friend, for the invitation to do the study and his help in getting it underway. Also the writers wish to acknowledge with thanks the co-operation they received from the telephone volunteers of Tel-A-Friend in collecting the data for their research in Windsor. In Toronto, the researchers received a warm welcome from Gordon Winch, Director of the Distress Centre, who patiently explained his agency's record keeping system, and then made these records available to us for our comparative study.

The writers are also grateful to Directors of other telephone crisis intervention centres who corresponded with them during the study providing them with current information on this movement throughout the world; Mr. John Harrison of Contact, London, Ontario; Mrs. Betty Tarrant

of Crisis Intervention and Suicide Prevention Centre, Vancouver, B.C.; Mr. Robert Louis of Federatie Van Telefonische Hulpdiensten in Nederland, Rotterdam, Holland; Miss P. Kamper of Federation on Mental Health in Amsterdam, Holland; and Mrs. Betty Webb of The Samaritans in Shropshire, Shrewsbury, England.

The authors also appreciate the help of Mrs. Kay Osborne, one of the early members of the Board of Tel-A-Friend, who provided us with a history of the agency. Special appreciation is due to Mrs. Diane Daniels (Russell's wife) for her patience with, and hospitality shown to the researchers throughout the preparation of the manuscript.

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## CHAPTER I

### INTRODUCTION

The deepest problems of modern life derive from the claim of the individual to preserve the autonomy and individuality of his existence in the face of overwhelming social forces, of historical heritage, of external culture, and of the technique of life.<sup>1</sup>

The significance of the study which follows on Tel-A-Friend of Windsor, Ontario, cannot be appreciated without some understanding of the socio-psychological framework out of which it has evolved. Telephone crisis intervention is a twentieth century approach to alienation and loneliness, produced by industrialization and urbanization. Through the creation of the telephone, man is able to maintain anonymity, while decreasing his sense of aloneness.

A historical, literary survey of telephone crisis intervention centres is included to show that this has become an accepted means of dealing with certain forms of crisis. In an attempt to ascertain similarity in function and approach of such centres we did a comparative study of Tel-A-Friend in Windsor and the Distress Centre in Toronto.

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<sup>1</sup>George Simmel, "The Metropolis and Mental Life", in Man Alone, ed. by Eric and Mary Josephson (New York: Dell Publishing Company, Inc., 1962), p. 151.

We will first explore the sociological and psychological theories from which the telephone crisis intervention method has evolved. This will be followed by a historical survey of telephone crisis intervention centres in general and the background of the Windsor project. The chapter will be concluded with a summary of some relevant research done on telephone crisis intervention centres.

### URBANISM AND CRISIS

Many sociologists see the city developing and changing the personality of its dwellers, and speak of the urbanite's interpersonal and intra-personal life as a privatization of activity, divorcement from mutual participation, withdrawal into self, personal anonymity, or a mere cog. This sense of aloneness can make coping with the pressures of daily life barely possible for some individuals and the encounter with unpredictable stress intolerable for others. In this study we focus on one medium which urban man has created to help him deal with this dilemma, i.e. the crisis telephone service.

When we try to establish the relationship between living in an urban environment and man's exposure to stress we find varied sociological viewpoints expressed. George Simmel, Louis Wirth and others<sup>2</sup> postulate that as urbanness increased we find a spread of secondary relations,

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<sup>2</sup>Paul K. Hatt and Albert J. Reiss, Jr., "The Nature of the City" in Cities and Society, ed. by Paul K. Hatt and Albert J. Reiss, Jr. (New York: The Free Press of Glencoe, 1957), p. 20.



high mobility with superficial contact, indifference, breakdown of primary group controls, mass organizations and voluntary association on one hand, and individuated persons with an atomized social life on the other. However, other urban sociologists such as Otis Dudley Duncan and Gideon Sjoberg<sup>3</sup> have challenged this approach to defining urbanism, and claim that it is very difficult to verify scientifically since the characteristics outlined above cannot be operationally defined in an adequate sense. Further there is not enough data available to generalize cross-culturally, or from one historical period to another. Urbanism cannot be measured by comparing rural-urban communities or size of place differences, because there is contact and communication between these places. Also many of these characteristics assumed to be causally connected with urbanness may in fact be a function of some other variable, which may have produced urbanness, i.e. industrialization. Finally while a characteristic such as anonymity may vary with the size of a city, this does not mean that anonymity occurs only in cities.

We cannot, therefore, conclude that disintegration of primary group ties, resulting in many individuals having to face crisis alone, is necessarily an outcome of urbanism. However, our exploratory study seems to indicate that the use of the telephone crisis centre is becoming an increasingly acceptable way for urban man to find the coping mechanisms needed when faced with personal crisis. This is

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<sup>3</sup>Ibid., pp. 20-21.

an attempt at permitting the individual to remain anonymous while accepting empathy in his time of need from an anonymous other.

### CRISIS THEORY

Crisis is the "emotional state, the reaction of the individual or family group to the hazardous situation, not the hazardous situation per se."<sup>4</sup> Working within the framework of the above definition we can see that the area of concern is the reaction to and not the precipitating event. Since we may assume that all people have a repertoire of behavioral patterns which they call upon in different situations, it follows that in a crisis these methods are no longer operational or valid. Thus the homeostatic mechanisms of the individual are overpowered.

While we are aware that crisis theorists differ as to whether crisis is the emotional state of the individual or the hazardous situation, we found that the practice of existing telephone crisis intervention centres was more in keeping with Selby's theory of crisis. The telephone volunteers are trained to provide emotional support to the caller to enable him to mobilize himself to deal with the hazardous event. Only under extreme circumstances does the crisis centre become involved in the situation itself.

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<sup>4</sup>L. G. Selby, "Social Work and Crisis Theory" in Perspectives on Social Welfare, ed. by Paul E. Weinberger (Toronto: Collier-Macmillan Canada, Ltd., 1969), p. 278.

Erich Lindemann and Gerald Caplan are considered the two initiators of crisis theory.<sup>5</sup> This resulted from E. Lindemann's study of bereavement surrounding the Boston Coconut Grove fire and the following studies in which he and G. Caplan teamed together. They forwarded the concepts that a crisis is a time limited event which follows a set pattern. The first phase of this pattern is a period in which the individual or group experiences a heightening of tension. This is followed by the person or people attempting to meet the situation within their range of coping behavior and meeting with failure. The next area is the intervention of a new approach, be it adaptive or nonadaptive. The final phase is the restoration of an equilibrium state of less intensity than that reached at the height of the crisis.

It appears that the crisis situation is a point at which the person is "more susceptible to influence . . . than at other times".<sup>6</sup> With this high susceptibility comes both a danger and an opportunity. It is possible, that with feelings at such a high level and the coping capacities seriously in question, the individual could select or be helped to select either an inappropriate or an appropriate response. Primary intervention of a positive nature which facilitates the individual in crisis, must at the same time include that individual as part of the problem-solving team. If this state of a team approach,

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<sup>5</sup>Ibid., p. 277.

<sup>6</sup>Ibid., p. 279.

between the individual or group which is intervening and the person or group who is being aided, is achieved, we have an excellent opportunity not only to provide for resolution of the existing crisis but also reinforce against future crises.

Crisis intervention is a time limited means of aiding the person. Because of this time limitation it cannot be expected to "solve all problems; long term, chronic problems".<sup>7</sup> These long term, chronic problems will require a more intensive form of treatment. While the crisis intervention cannot solve the long term, chronic problems, it can act as a first-aid treatment in order to maintain the person until they can be referred to an appropriate community service.

The structures of the majority of social service agencies which are designed for the treatment of chronic problems are not suitable for crisis intervention. The person who is experiencing a crisis situation requires immediate attention and a period of waiting in order to process the person through a traditional agency is unacceptable. At the same time the waiting list for treatment is self-defeating, as the optimum time for intervention would have passed by the time the person saw a professional worker.

Crisis intervention itself is based on a knowledge of

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<sup>7</sup>David M. Kaplan, "Observations on Crisis Theory and Practice," Social Casework, XLIX (March 1968), 155.

individual psychodynamics and on principles derived from traditional treatment methods. Therefore a differential approach must be taken which relates diagnosis and treatment to the individual. It must also concern itself with the relevant others in the person's life space.

As a summary we can now outline five areas of concern which D. M. Kaplan has capsulized.<sup>8</sup> Intervention must be readily available during crisis; crisis intervention is usually brief, lasting the period of the crisis, though it will fluctuate with regard to intensity from case to case; client's motivation for help is high because personal distress during the crisis is high, though the client may not be able to recognize his difficulties; crisis intervention is guided by knowledge of psychological tasks that must be accomplished to master each crisis; and crisis intervention may focus on client, family members, significant community caretaker or any combination of these people.

In order to meet the need of the individual and his family in crisis, (e.g. immediate attention) a special service has evolved. This emergency form of socio-psychological first-aid is usually offered by agencies classified as either crisis intervention or suicide prevention centres. These centres fall into approximately seven different categories, depending upon the philosophical orientation of their founder to crisis intervention.

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<sup>8</sup>Ibid.

CRISIS INTERVENTION CENTRES AND  
SUICIDE PREVENTION CENTRES

Historically, crisis intervention and suicide prevention centres were established to save the lives of potential suicide victims. Currently we have some agencies who continue to focus on the needs of the suicide victim, while others invite anyone facing crisis to contact them. Since the focus of our study is a newly formed service in Windsor, Ontario, i.e. Tel-A-Friend, we felt it would be helpful to try to place it into some historical framework. In order to accomplish this we found our search through the literature confronting us with such authors as Norman L. Farberow, Ph.D., Co-Director of the Suicide Prevention Center at Los Angeles and another Co-Director of the same Center, Edwin S. Shneidman, Ph.D. In their book The Cry for Help, they have a chapter entitled "A Survey of Agencies for the Prevention of Suicide";<sup>9</sup> we have summarized the information contained in this chapter in our accompanying Table I, and have expanded this to include descriptions of centres not described by these authors.

A survey of Table I reveals that most of these centres could be classified under the following categories:

- a) professionally staffed suicide prevention service
- b) professionally staffed suicide prevention service, using some volunteers

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<sup>9</sup>Norman L. Farberow and Edwin S. Shneidman, "A Survey of Agencies for the Prevention of Suicide", in The Cry for Help, ed. by Norman L. Farberow, Ph.D. and Edwin S. Shneidman, Ph.D. (New York: McGraw-Hill Book Company, 1961) pp. 136-149.

CRISIS INTERVENTION AND SUICIDE PREVENTION CENTERS  
TABLE 1

NAME	CODE (see p. 8)	LOCATION	YEAR ESTABLISH	PURPOSE	INITIATOR	STAFF	STAFF TRAINING	REFERRALS TO CRISIS CENTER	METHOD OF HANDLING CALLERS	VOLUME
Lemborg Volunteer Rescue Society	F		1893 to 1906	Volunteer emergency service for suicide, attempted suicide and problems in general						
Several agencies no longer operating	A	Vienna	1928	Prevention of Suicide				Welfare Dept. of the Vienna police	If possible, call home; if not, social worker sent to home.	
Anti-Suicide Dept. Salvation Army	D	London England now world-wide	1906	Prevention of suicide and attempted suicide				London Metro. Relief and Surrey Police		
National Save-A-Life League Inc.	C	New York now throughout the USA	1906	Help people in stress-full situations obtain help	Reverend H. M. Warren (Baptist)	4 full time counsellors in New York plus consultants.		24 hour telephone and letters	Non-religious counselling	
Rescue-Incorporated	A	Boston City Hospital	1959	Suicide Prevention	Reverend K. B. Murphy Roman Catholic	Professional Volunteers (70)		24 hour telephone local and state police Fire Department	Befriending, Group and Individual Therapy. Religious Guidance	800 in one year
Suicide Prevention Agency	A	Austria	1948	Suicide prevention	Catholic Welfare Organ. I. Ringle	Paid Social Workers and Professional Volunteers		Police Department Hospitals After Care University Clinic Advertising	Clinical Emphasized	1948 to 1950 2879 calls
Samaritans	F	England now throughout the world	1953	Suicide and Despair	Reverend Chad Varah	Lay Volunteers and Professional Consultants	Series of preparatory Classes	24 hour telephone	Befriending, Referrals to Professional Agencies. Flying Squads	1953 to 1969 164,289 calls
Branch of the Order of St. Luke	F	Berlin		Suicide prevention and other problems		Head is Doctor. 25 volunteers with professional assistance.		Police Dept. Hospitals	Psychotherapy Pastoral Help After Care is emphasized	800 patients in 1st year
Federatie Van Telefonische Hulpdiensten	F	Netherland	1958	Suicide prevention and other problems	Churches	Volunteers		Doctors Service Agencies	Befriending	
Suicide Prevention Centre	A	Los Angeles	1958	Save Lives Establish Agency Research	U.S. Public Health Grant	Full time paid Professionals		Doctors Friends Other Agencies 24-hour-telephone	Social history Family Contact Professional Conference	7,000 calls in 1967
Out Stretched Hand	D	Switzerland		Suicide prevention	Reverend R. Martin					

CRISIS INTERVENTION AND SUICIDE PREVENTION CENTERS

TABLE 1 continued

NAME	CODE (see p. 8)	LOCATION	YEAR ESTABLISH	PURPOSE	INITIATOR	STAFF	STAFF TRAINING	REFERRALS TO CRISIS CENTER	METHOD OF HANDLING CALLERS	VOLUME
Catastrophe Number	D	Sweden		Suicide prevention	Reverend E. Bernspang	Ministers and Volunteers		Telephone Letters Visits	Psychiatrists Mental Hosp.	
Deacon's Work	D	Germany				Professional and Non-professional Volunteers		Telephone		
People's Church Central Church "Emergency Call"	E	Chicago		Disturbed persons				24 hour telephone Referrals to Ministers and Psychiatrists	Refer to Social Agencies Religious and Psychotherapy	
Friends	C	Dade County Florida		Suicide		Volunteers		24 hour telephone	Refer to local Hospital	
Life Line International	G	Australia to World Wide	1963	To respond to human need.	Dr. A. Walker	Christian Volunteers	15 week training program	Telephone	Refer to Social Agencies	
Fish	G	World Wide		Lay ministry	Church of England	Volunteers	trained to refer	24 hour answer- ing service	Refer to Social Agencies	
Contact	F	London Canada	1969	People in distress	Local Churches	Volunteers with Professional Back-up	Series of Classes by Professionals	1pm to 7am Telephone	Befriending Visiting Emergency Squad Refer to Social Agencies	
Distress Centre 366-1121	F	Toronto Canada	1967	People in distress	Reverend Gordon Winch	Volunteers	Series of six classes by Professionals	24 hour telephone Social Agencies	Befriending Emergency Squad Refer to Hosp. and Soc. Agen.	January 1968 to February 1969 5,200 calls
Distress Centre	F	Ottawa Canada	1969	People in distress	Local Churches	Volunteers	six week training and screening by professionals	9am to 11pm Telephone	Befriending Refer to Soc. Agencies	
Crisis Now	B F	Vancouver Canada	1969 1970	Adults in Distress Teenagers in Distress	Community	Volunteers plus Paid Staff	six week training course by professionals	24 hour telephone	Befriending, Emergency visiting, Referral	July 1969 to August 1970 19,437 calls



- c) non-professionally staffed suicide prevention services with professional consultants.
- d) religiously oriented, non-professionally staffed suicide prevention services, with professional consultants.
- e) professionally staffed crisis intervention centres.
- f) non-professionally staffed crisis intervention centres, with professional consultants.
- g) religiously oriented, non-professionally staffed crisis intervention centres, with professional consultants.

#### PROFESSIONAL VERSUS NON-PROFESSIONAL CENTRES

At the first annual conference of the American Association of Suicidology held in Chicago, Illinois, U.S.A. in 1968,<sup>10</sup> Dr. Louis I. Dublin (retired vice-president and statistician of Metropolitan Life Insurance Company) and Dr. Erwin Stengel (professor emeritus of psychiatry, University of Sheffield, vice-president of International Association for Suicide Prevention, and past-president of Royal Medico-Psychological Association) discussed this controversy, and concluded that there was a distinct contrast in the administration of suicide prevention centres in the United States and Great Britain.

Dr. Dublin described how the Samaritans (lay volunteers) in Great Britain, under the guidance of Reverend Chad Varah, were not satisfied with only a telephone contact with a troubled person, but became a friend who reached out and established a living contact with the caller,

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<sup>10</sup>"Discussion: A Question for Research" in On the Nature of Suicide, ed. by Edwin S. Shneidman (San Francisco: Jossey-Bass Inc., Publishers, 1969) pp. 93-95.

which lasted until the volunteer was satisfied that his new friend was re-established. In the United States, Dr. Dublin felt that there seemed to be an over-cautious approach to becoming involved with the potential suicide victim, perceiving him as needing the skills of the professional. While he felt that the United States like Great Britain was full of capable people of good-will, the former seemed to view the use of the professional as a guarantee against erring in handling the individual threatening suicide.

Dr. Stengel's response to these remarks was to the effect that while the British approach appealed to many and seemed to mobilize a great deal of latent help, it might possibly not prove as effective in the long run. (See our report on Dr. I. W. Weiner's article "The Effectiveness of a Suicide Prevention Programme" contained under sub-section entitled Research on Crisis Intervention and Suicide Prevention Centres, at end of this chapter). Dr. Stengel did emphasize that the main objective of the Samaritans is befriending, not just emergency telephone service, and indicated that the volunteers received courses from doctors and sociologists to improve their knowledge and skill.

While Dr. Dublin felt that the United States was too over-awed by the authority of the professional, he did express pleasure with the fact that some of the professionally staffed centres were now choosing volunteers from the community, training them, and then placing them on

probation. However, he thought that the mental health community was missing out on a tremendous resource by not establishing a better working liaison with the public health nurse.

#### RELIGIOUSLY ORIENTED VERSUS NON-RELIGIOUSLY ORIENTED CENTRES

This controversy is probably best explained by Reverend Chad Varah, founder of the Samaritans in his Introduction to the book The Samaritans, which he also edited.<sup>11</sup> He emphasizes that while the name of their organization and the inspiration for their service comes from a parable in the Christian Gospel, they are not a church organization, nor even an exclusively Christian organization. The Samaritans, do not, therefore, feel that the potential suicide who seeks non-medical help is someone with a spiritual problem, and they object to this view, which is held by some church sponsored emergency telephone services, for the following reasons:

- a) It does not take into account
  - i) those in need of psychiatric help who are members of non-Christian faiths.
  - ii) members of churches with which the Church or churches offering the service have little in common.
  - iii) the nominal Christian who distrusts the church because he feels its representatives will seek to serve its own interests.
- b) It ignores the real problem of suicide which cannot be deterred by evangelization. If some callers are helped it is usually because of the kind interest

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<sup>11</sup>Chad Varah, "Introduction" in The Samaritans, ed. by Chad Varah (London: Constable and Company Ltd., 1965) pp. 79-80.

shown in them by the volunteer, despite their piety.

- c) It leads to the establishment of rival denominationally sponsored services within one community.
- d) It tends to become clerical, e.g. in Sweden the telephone is answered by a priest.
- e) It attracts volunteers whose main objective is proselytizing.
- f) It makes it very difficult to screen out unsuitable volunteers, e.g. the religiously devout who would make the clients feel guilty.

PROFESSIONAL CRISIS INTERVENTION AND  
SUICIDE PREVENTION CENTRES

SUICIDE PREVENTION CENTRE IN LOS ANGELES, U.S.A.<sup>12</sup> --

This is the chief medical centre for suicide prevention in the U.S.A. In 1958 under the purview of a five year United States Public Health Service project grant, administered through the University of Southern California, the Suicide Prevention Centre was established with the following goals:

- a) to save lives.
- b) to promote an integration and liaison of the Centre with such other agencies in the community as city health department, county health department, police department, Welfare Planning Council, coroner's office.
- c) to utilize psychiatric, psychological and social work data to test various hypotheses concerning suicidal phenomena.

CLIENTS - At its inception the Los Angeles Suicide Prevention Center focused on reaching out to individuals who were hospitalized at the Los Angeles County General

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<sup>12</sup>Edwin S. Shneidman, Norman L. Farberow, and Robert E. Litman, "The Suicide Prevention Center" in The Cry for Help ed. by Norman L. Farberow and Edwin S. Shneidman, (New York: McGraw Hill Book Company, 1965) pp. 6-18.

Hospital for medical or surgical treatment resulting from a suicide attempt. Initially they were interested in collecting data on presuicidal individuals, so after careful examination of the hospital records by the staff, i.e. a psychiatrist, psychologist and social worker; certain patients were interviewed and then processed as follows:

- a) Work-up -- two or three hours of interviewing by a psychiatrist; psychological testing; a written self-description of their personality accompanied by a duplicate of their suicide note, or a note they might have written.
- b) Contact with Collaterals -- social work interviews with significant others in the client's life focusing on the interpersonal dynamics and the potential psychological and financial resources of the family.
- c) Staffing -- focused on the meaning of suicidal behaviour for this particular individual, and the intrapsychic and interpersonal context within which the suicide attempt occurred.
- d) Referral -- hospitalization, individual or group psychotherapy in a clinic or the Suicide Prevention Centre, or some other agency.<sup>13</sup>

Later the Center designed an "Emergency Evaluation of Self-Destructive Potentiality"<sup>14</sup> and a more comprehensive "Schedule for Assessment of Self-Destructive Potentiality"<sup>15</sup> which was used when the interviewer was not pressured by a time limit.

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<sup>13</sup>Ibid., pp. 9-10

<sup>14</sup>Robert E. Litman and Norman L. Farberow, "Emergency Evaluation of Self-Destructive Potentiality", in Cry for Help, ed. by Farberow and Shneidman, pp. 49-59

<sup>15</sup>Norman T. Tabachnick and Norman L. Farberow, "The Assessment of Self-Destructive Potentiality", in Ibid., pp. 60-77.

TELEPHONE CRISIS INTERVENTION -- In 1961 the Los Angeles Suicide Prevention Center initiated a telephone service during clinic hours for those in crisis, and in 1963 extended this to a twenty-four hour service.

NONPROFESSIONAL VOLUNTEERS -- In 1968 an article entitled "The Role of Nonprofessional Volunteers in a Suicide Prevention Centre" by Hellig, Farberow, Litman and Shneidman<sup>16</sup> appeared in the Community Mental Health Journal, describing the Center's experience in training lay people to perform a psychotherapeutic function. This programme, the authors state, closely parallels a project described by Margaret Rioch and others in 1963 in the American Journal of Orthopsychiatry.<sup>17</sup>

The criteria used in selecting volunteers was -- maturity, responsibility, motivation, sensitivity, willingness to accept training and supervision, ability to get along well in a group. Those interested were interviewed by at least three professionals and had to be acceptable to all their interviewers. In addition they were given the Minnesota Multiphasic Personality Inventory and requested to write an autobiography.

Once accepted the volunteers were then involved in a

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<sup>16</sup>Sam M. Hellig, M.S.W., Norman D. Farberow, Ph.D., Robert E. Litman, M.D., and Edwin S. Shneidman, Ph.D., "The Role of Non-professional Volunteers in a Suicide Prevention Center", Community Mental Health, IV (4) (1968), pp. 287-295.

<sup>17</sup>Margaret Rioch, C. Elkes, A. A. Flint, B.S. Usdausky, R.G. Norman and E. Silber, "National institute of mental health pilot study in training mental health counselors", American Journal of Orthopsychiatry, XXX, (1963), pp. 678-689.

five week training programme including lectures on suicidal behaviour, methods and techniques for handling suicidal crisis, and case histories and clinical material. These were held twice a week, and followed by discussions in which the professional staff of the Center were involved. In addition they observed the staff handling suicide calls, and during the fifth week of training they began taking calls under supervision. At the end of the fifth week the volunteers began working one day per week, and one staff supervised two volunteers. During an apprenticeship period the volunteers met once a week for group discussion of cases, programme, and to share feelings and reactions to the work.

After several months these volunteers became very involved in the Center programme, and began doing some follow-up counselling in the office with their telephone clients. Out of sixteen people screened, ten were accepted. These were all women in their thirties or early forties, married with children and from the middle or upper classes. Six out of the ten accepted, had had a satisfactory psychotherapeutic experience. After eighteen months five of the original sixteen were still working as volunteers and were requested to take a repeat Minnesota Multiphasic Personality Inventory.

From the Los Angeles Suicide Prevention Center's point of view there are both pros and cons in the use of these nonprofessional volunteers. They did a fine job of obtaining information from the caller and in mobilizing the

client's resources during crisis. Frequently the non-professional was able to become more involved with the troubled individual in a direct, friendly manner than the professional. However, if not kept busy throughout their entire shift the volunteers frequently felt demoralized. The use of the volunteers at times created problems in keeping up-to-date on a client due to breakdown in communication between various volunteers and staff members involved in the case. Eventually the unpaid status began to lose appeal, and three of the original volunteers left to further their education. Throughout the experience the volunteers did feel accepted by the professional staff. The authors' evaluation of the programme was that the carefully selected, well trained volunteer had much to offer in crisis intervention and personal counselling in the field of mental health.

SUICIDE PREVENTION SERVICE OF WESTCHESTER COUNTY,  
WHITE PLAINS, NEW YORK<sup>18</sup> -- This is a co-operative venture of the Mental Health Association, the psychiatric division of the Westchester Division of New York Hospital -- Cornell Medical, and a private psychiatric hospital, High Point Hospital.

The personnel of this agency are the psychiatric residents and psychiatrists of the two hospitals whose services are co-ordinated by a psychiatric social worker

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<sup>18</sup> Elaine S. Fieden, M.S.W. "One Year's Experience with a Suicide Prevention Service, White Plains, New York", Social Work, XV (3) (July 1970), pp. 26-32.



employed by the Mental Health Association. From 9 a.m. until 5 p.m. on weekdays the Mental Health Association is responsible for service; and from 5 p.m. until 9 a.m., the phone is manually switched to New York Hospital on weekdays, where psychiatric residents handle the calls. On weekends and holidays the phone is switched to High Point Hospital where the calls are taken during nights, week-ends, or holidays are referred to the social worker who takes over, follows up and makes referrals. From their experience they claim the majority of the calls can be held over in this manner.

MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASS.<sup>19</sup> -- offers an around-the-clock emergency psychiatric service. The goal of this service is to encourage early referral of patients facing emotional or social breakdown by -- offering unrestricted intake; immediate availability; and comprehensive diagnosis and treatment through use of the entire hospital resources.

The author, a social worker, speaks out against the bias of the intake practices of the majority of professional agencies which make it impossible for a great many people to gain the help they need in the midst of a crisis. She stresses the need for a critical examination of policies and beliefs which support specialization of agency function, and urges that a greater use of reaching-out techniques be tried by the professional. We are reminded,

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<sup>19</sup>Eleanor Clark, "Round-the-Clock Emergency Psychiatric Services" in Crisis Intervention: Selected Readings, ed. by Howard J. Parád (New York: Family Service Association of America, 1965) pp. 261-273.

that as social workers we frequently cannot find the proper community resource for our clients, but expect them to be able to do this in the midst of an anxiety-ridden situation.

NONPROFESSIONAL CRISIS INTERVENTION AND SUICIDE  
PREVENTION CENTRES

THE SAMARITANS<sup>20</sup> were founded early in 1954 by Reverend Chad Varah in London, England. During the summer of 1953 the founder wrote an article giving what he believed to be an enlightened Christian philosophy of sex. For several weeks after the publication of this article he received a flood of letters requesting help with sexual problems. Out of a total of two hundred and thirty-five correspondents, two dozen appeared to be suicidal and three of these needed psychiatric help.

During that same summer, Chad Varah, read in the newspaper that there were three suicides a day in Greater London in spite of the professional help available. In November 1953 he publicized an invitation for anyone contemplating suicide to call him at Mansion House 9000, and before long he had a non-medical counselling service established, staffed by himself and a secretary with one telephone and one interview room. Before long it became apparent that the telephone was the most, and in some cases, the only convenient means of emergency contact, but that no operation of this size could meet the demand for

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<sup>20</sup>Varah, Samaritans, pp. 18-19.

service.

NONPROFESSIONAL VOLUNTEERS -- Soon other people became interested and began to offer their help. Among these were do-gooders, cranks, prestige seekers, some professionals and mature laymen. Soon a group of these volunteers began just sitting around the office, and got involved with the people waiting to see Chad Varah. Three things began to happen:

- a) Counselling went better because the clients were not exasperated by long waits, and had their confidence in Chad Varah reinforced by the volunteers.
- b) Some clients did not need to see Chad Varah, but gained whatever help they needed from the volunteers.
- c) Clients unable to use individual counselling sessions, and who might have left despondent, frequently responded to the friendly outreach of a volunteer as they left the counselling office.<sup>21</sup>

Early in 1954 this non-medical professional counselling service was replaced by a befriending service offered by volunteers under professional supervision. The name "Samaritans" was chosen by Chad Varah, not only because the parable of the Good Samaritan had inspired their work, but it conveyed the idea of a fellowship of concerned individuals who would not pass by on the other side. It was felt that any person in despair or contemplating suicide might find it difficult, if not impossible, to approach an organization labelled "Society for the Prevention of Suicide", for fear of being placed on a waiting list for several days or weeks.

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<sup>21</sup>Varah, Samaritans, pp. 23-24.

Since 1954 this movement which is not a church organization, nor even an exclusively Christian organization, has spread from London, England, throughout the world. In 1963 the twenty-one centres then in existence became incorporated as a Company, Limited by Guarantee, thus claiming control over the name and services offered under it. At present there are one hundred and one Samaritan centres, with around thirteen groups in a preparatory stage. The Continental services did not adopt the name "Samaritan" because few of them were akin to the Samaritan structure, principles, and methods; and the name does not evoke the same image as in the English-speaking world.

TRAINING OF VOLUNTEERS -- The Samaritans are chosen because of their obvious talent for friendship and unflinching concern. Then they attend Preparation Classes at which they learn how to befriend, and the difference between this and counselling. From these classes they go on Observation Duty, and enter their probation period as a Samaritan Helper prior to becoming Samaritan Members. Some branches also have a third category of volunteers known as Samaritan Companions (if members of a Company of Samaritans); or Samaritan Supervisors (if appointed by a committee). In other Branches (without committees) members of this third category are designated Samaritan Leaders. In Branches with committees the Samaritan Leaders are the Directors and Deputy Directors. Advisors to the Samaritans are known as Samaritan Consultants.

In addition to the volunteers manning the twenty-four hour telephone service there is a Flying Squad available to go out to someone needing emergency help immediately, or there is the Home Service offering more expert telephone counsel at any hour.

SAMARITANS INTERNATIONAL -- With the expansion of the programme to other countries, the Samaritans instituted international conferences every two years. In addition they affiliated with the "Centre International D'Information des Services de Secours par Telephone"<sup>22</sup> (a registry of telephone suicide prevention agencies), which was set up as a result of a Congress of these agencies held near Geneva in September 1960.

In the United States Fr. K. Murphy of Boston Mass.<sup>23</sup> after correspondence with Chad Varah launched "Rescue Inc.", and in Miami, Florida another agency invited people in distress to dial "F-R-I-E-N-D-S". The impact of this movement in Canada is described later under "Canadian Crisis Intervention and Suicide Prevention Centres".

FISH INTERNATIONAL<sup>24</sup> This movement began in England in 1961, under the leadership of Reverend Derek Eastman, pastor of an Anglican Church in Old Headington, and Dr. Donald Richards, layman. Their goal was "to get religion off its seat and onto its feet".<sup>25</sup> Volunteers were re-

<sup>22</sup>Varah, Samaritans, p. 85.

<sup>23</sup>Varah, Samaritans, p. 83.

<sup>24</sup>Clarence W. Hall, "A Friendly Neighbor Called Fish", condensed from Christian Herald for The Reader's Digest Association (Canada) Ltd. (Reprint February 1969).

<sup>25</sup>Ibid.

cruited from among parishioners and a card distributed to every home in the village bearing the fish emblem with the instruction, "if you need help of any kind, put me in your window."<sup>26</sup> Within each block a street warden was appointed, who was identified by a metal fish on his gate or door. Whenever a fish card appeared in a window and was noticed by a passerby, the latter was supposed to notify the warden.

Fish spread rapidly throughout Britain, and then to West Germany, Belgium, Netherlands, Switzerland, South Africa, Japan, Cameroons, and across the Atlantic. On the North American continent, Reverend Robert Lee Howell of the Church of the Good Shepherd of West Springfield, Mass. instituted a twenty-four hour telephone service, placing the caller in touch with a volunteer eager to help. From West Springfield, Mass. this movement spread throughout the United States and to Saskatoon, Saskatchewan. At time of printing of this story in Reader's Digest,<sup>27</sup> there were more than one hundred chapters in Canada and the United States.

FISH VOLUNTEERS -- There is a minimum of organization in Fish, where there are no officers other than a chairman and a steering committee. Expenses are so limited that they do not feel they are worth budgeting. Each volunteer sets aside one twenty-four hour period per month, during which he or she can either provide a telephone

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<sup>26</sup>Ibid.

<sup>27</sup>Ibid.

answering service, or be available to supply such services as -- emergency transportation, baby-sitting, companionship for elderly people, cooking and housework for the ill. Both males and females volunteer, and there are many couples who operate as a team on night calls.

While training varies for each local chapter, there is a strong emphasis on referral to professional agencies and providing auxilliary services which the professional has neither the time nor resources to offer. While geared to a "one-time only help"<sup>28</sup> some branches have established a daily phone check chain between shut-ins in groups of eight.

The foregoing survey of crisis intervention and suicide prevention centres throughout the world indicates that there is a variety of existing approaches. We would now like to examine what is taking place in Canada in crisis intervention.

#### RELIGIOUSLY ORIENTED CRISIS INTERVENTION AND SUICIDE PREVENTION CENTRES

LIFE LINE INTERNATIONAL<sup>29</sup> In 1963 under the direction of Dr. Alan Walker of the Central Methodist Mission a telephone ministry was started which has since spread to New Zealand, South Africa, United States and Canada. The centres in Canada and the United States are not able to

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<sup>28</sup>Ibid.

<sup>29</sup>"Telephone Ministries in Canada" published by National Committee for Life Line, Canada" (unnumbered handbook).

register the name Life Line for the entire country. However, while using different names, they will be able to identify themselves as members of the international organization through the use of a common mark or symbol.

In the United States the programme is sponsored by the United-Methodist Church under the name of Contact. In Canada an ecumenical committee known as the "National Committee for Life Line, Canada" was established in September 1968 to promote the establishment of this service throughout Canada. The first Life Line Centre in Canada was opened in Sudbury, Ontario in October 1965, and a second one came into being in Belleville in October 1967. The most recently established Life Line Centre in Canada to our knowledge, is that in Hamilton, Ontario. According to the Canadian Handbook, "Telephone Ministries in Canada"<sup>30</sup> this organization has received requests for information about the service from practically every province in the Dominion.

ACCREDITATION OF LIFE LINE WORKERS AND CENTRES -- The basic requirements for accreditation is a Life Line worker are:

- a) A Christian commitment expressed through active participation in a local church.
- b) Personal and emotional maturity and completion of a prescribed Life Line Training Programme.
- c) Respect for the confidentiality of the caller.

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<sup>30</sup>Ibid.



In order for a local unit to be certified as a Life Line Centre it must have a responsible governing board; be staffed by committed Christians; provide an adequate training programme for its volunteers, and have operated for at least ninety days.<sup>31</sup>

TRAINING PROGRAMMES FOR LIFE LINE WORKERS -- Volunteers are involved in weekly sessions for fifteen weeks of training under professionals. The training programme given in Sudbury, Ontario is followed by a written examination and an interview with the Director. Those accepted continue to attend monthly meetings to further their personal development.

Telephone counsellors are backed up by a staff of professional volunteers known as Backup Workers and Trouble Team. The telephone counsellors do not leave the office, and it is the Backup Workers or Trouble Team who go out on emergency calls when necessary. Depending on the size of the community there will be one or two workers on duty at a time (usually one); putting in four hours per week, but preferable four hours every two weeks.<sup>32</sup>

#### CANADIAN CRISIS INTERVENTION AND SUICIDE PREVENTION CENTRES

In Canada the telephone crisis centres have polarized around three models. The Salvation Army has developed a

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<sup>31</sup>Ibid.

<sup>32</sup>Ibid.

suicide prevention service which is equipped to handle only suicides. The other two models have been more of a generalized service dealing with any problem that the caller might have including suicide. One of these models is the Lifeline approach as developed in Australia, while the other is the Samaritan approach from England. The basic difference between these two approaches is that Lifeline has as a prerequisite that the person who mans the telephone be committed to the Christian faith, expressed by active association with a local church. The Samaritans on the other hand are interested in anybody who sincerely desires to help people, regardless of their religious or lack of religious affiliation.

DISTRESS CENTRE, 366-1121, TORONTO, ONTARIO<sup>33</sup>

On November the first, 1967, the Reverend Gordon Winch initiated a twenty-four hour service in Toronto. This service was based on the Samaritan operation. It is manned by volunteers who work a four hour telephone shift in pairs. The service is financed through private contributions and donations from the Addiction Research Foundation, Metropolitan Toronto Welfare, United Church of Canada and the Anglican Church.

The volunteer program is based on three areas. These are the telephone watch; contact befriending and emergency squad. The telephone watch is the initial contact with the

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<sup>33</sup>Distress Centre (Agency brochures)

person. The contact befriending is the person who goes outside the agency to develop a friendship in order to sustain a person in need through an extremely trying time in their life. The emergency squad is organized for immediate action in the extreme crisis situation where a caller might do harm to himself or others.

All the volunteers are trained under the supervision of a qualified full-time Director. At present this person is the Reverend G. Winch. Professional people from the local social service agencies volunteer time for the staff training period. Volunteers are screened for their ability to stand shock and abuse; high level of maturity; ability to be flexible and compassionate; empathetic nature.

The Distress Centre refers callers to community agencies but also accepts referrals from community agencies who feel they have a client who needs the type of support offered. In many ways the agency acts as a supportive role for people in the community who otherwise might have to be institutionalized.

The Distress Centre also offers as a service to other community settings, which are considering or setting up a similar service, their knowledge and help. They will act as an advisor to them and provide as much support as they can during the other agency's beginning pains. The Distress Centre has provided aid to such centres as St. Catharines, Oshawa, Ottawa and London.

DISTRESS CENTRE, OTTAWA, ONTARIO<sup>34</sup>

Distress Centre in Ottawa began as an outgrowth of a social action committee of the downtown churches. They considered the need for a telephone service for troubled people and decided to contact the Toronto Distress Centre. The Toronto Distress Centre was aware at the time of a recently arrived couple of England, in the Ottawa area, who had been Samaritans. They referred the social action committee to this couple.

What followed was the formation of a community service operated by volunteers in the form of an organization of friendly listeners. It is not a professional counselling service. Contact was made with existing social agencies such as the Social Planning Council, Family Service Agencies, and the Canadian Mental Health Association. It was here that the need for the service was established. A steering committee was then formed and a year was taken in the organization of the agency as well as the recruiting and training of volunteers. The Centre officially opened on March 17, 1969 with a staff of ninety trained volunteers ready to man the phones from 9 a.m. to 11 p.m.

The organization obtained fundings from local service clubs, a grant from the Addiction Research Foundation, a grant from the regional municipality, private donations and fund raising projects.

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<sup>34</sup>Dorothy S. Starr, B.A., M.N., "Distress Center—may I help you", The Canadian Nurse 66 (9) (September 1970), pp. 41-43.

The volunteers are given a two hour training session each week for six weeks. The screening and training process is carried out by professionals with backgrounds in counselling and community resources. Following the course the volunteers are placed in a schedule and are further screened in action.

The service itself is offered from 9 a.m. to 11 p.m. in two shifts. There are two volunteers a shift and an attempt is made to have a male and female on each shift. As of May 1970 the service had 150 volunteers. This centre has a high proportion of nurses in its volunteers.

CONTACT, LONDON, ONTARIO<sup>35</sup>

Contact in London appears to have commenced its service in 1969. It was seen as a service for core area citizens and was established by the congregations in an area identified as core by the City Planning Council. It was to be a nondenominational service, where a person would phone in for befriending. It would also have a visiting service. This visiting service could result from a telephone call or a referral by a local community agency.

Once the service was operational, the Inner City Committee of Churches which had established the agency, would relinquish control to the volunteers after five months. The actual service operated from 7 p.m. to 4 a.m. until it was extended to 1 p.m. to 7 a.m.

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<sup>35</sup>Contact Manual, compiled by John Harrison (1969).

The Volunteers are organized into six teams. Each team is composed of telephone and visiting personnel and a counsellor. Besides these areas there is a flying-squad to handle emergencies which cannot be managed over the phone. Each team elects a team co-ordinator who then sits on the executive council. Those volunteers who become involved in the administration of the agency, also elect one member to the council. The council elects one of their members to be treasurer and one to be the Executive Co-ordinator. The consultants, who advise from the various disciplines such as psychology, psychiatry and social work, advise the council.

Volunteers are required to submit to an evaluative process which includes two full evenings of written tests, and interviews. This is followed by an eight week course, two and a half hours a week. The final phase is a residential weekend which the whole training unit participates in.

Each one of the volunteers is required to give no less than four hours of work a week, in some capacity. They are all required to be a team member and over and above their service they must make themselves available for further training, dialogue and fellowship.

CRISIS INTERVENTION AND SUICIDE PREVENTION CENTRE IN  
VANCOUVER, BRITISH COLUMBIA<sup>36</sup> The Vancouver Crisis

Intervention and Suicide Prevention Centre began operation in July 1969. A steering committee of six people was first established to survey existing agencies in order to evaluate the need for such a service. It was found that Vancouver had the highest rate of suicide, a ratio of 18.9 per 100,000 population (Dominion Bureau of Statistics 1967) and a definite need was there. The agency was registered under the Societies Act in 1969 and a Board of Directors was appointed. Most of the Board members were professionals. An executive was hired, with a social worker on a sessional basis and a part-time secretary.

In order to provide funding for the agency a fund raising campaign was launched under the patronage of the Honourable T. D. Norris, Q.C., retired Chief Justice of British Columbia. This fund drive obtained \$26,000 in its first year. The local news media provided free publicity. The proposed budget for 1971 is approximately \$47,000. of which \$4,000 is to be spent on hiring a part-time research person.

VOLUNTEERS -- The volunteers come from a varied background which includes pharmacists, jail-guards, ministers, lawyers, teachers, priests, social workers, nurses, housewives, students and others. The agency looks for the qualities of maturity, emotional stability, warmth and the

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<sup>36</sup>Crisis Centre (Agency brochures)

desire to help in the applicants. The volunteers are given a series of lectures on drugs, youth, suicide and community resources. This is followed by the potential volunteers being divided into smaller sub groups for further training in techniques and some role playing. All the volunteers must observe on the phones at least twice before they go on a regular shift.

Once the volunteer is made a full-fledged member he must commit himself to one year of service. During this year he contracts to one night a week of either telephone work or public speaking, education, emergency visiting, fund raising, public relations, internal auditing, typing, filing, art work, face to face counselling or other related duties. An Inservice Educational session is held once a month which all volunteers must attend. There are professionals available to the volunteers at all times. Liaison with other community helping agencies is continued at all times.

In the area of call breakdowns for an average month they found that they had over six hundred calls. Of these six hundred calls 35% were family and/or marital in origin; 30% were personal and/or social; 20% were drugs and/or alcohol; 10% were suicide related, and 5% were legal concerns.

In February 1970 "Now" a specialized youth crisis service was started by this agency, with telephones handled by youth volunteers. Between February 15 and June 30,



1970, this service handled 3,076 calls.

The foregoing is by no means an exhaustive survey of crisis intervention and suicide prevention services available in Canada. However, it does provide examples of the basic models as shown in Table 2 below:

TABLE 2		
CLASSIFICATION OF CENTERS ACCORDING TO MODELS		
MODEL 1 (suicide only)	MODEL 2 (religious) (crisis intervention)	MODEL 3 (non-religious) (crisis intervention)
Salvation Army	Life-Line Sudbury	Contact London
		Distress Centre Toronto
		Distress Centre Ottawa
		Crisis Intervention and Suicide Prevention Centre Vancouver

It should be noted that the Vancouver Centre seems to have modelled its services after the Los Angeles Suicide Prevention Centre, but is a non-religiously oriented centre. Other than the Salvation Army Centres, all of the above services are prepared to deal with any form of crisis including suicide.

We can now look at the service currently being offered to the citizens of Windsor, Ontario by "Tel-A-Freind" which is of the Model 3 classification.

TEL-A-FRIEND HISTORY<sup>37</sup>

Tel-A-Friend, first referred to as Distress Line, had its birth out of The Windsor Committee of the Ecumenical Institute of Canada in the fall of 1968. The committee was formed from members of the various churches in the city. The committee was given a document on Living Ecumenism with the purpose of studying it. The committee members felt that they had spent enough time in discussion groups and now was the time to put ecumenism into action.

Out of much discussion evolved the idea of an emergency telephone service as an action oriented means of showing concern for people and their problems. A meeting was called, where representatives of the Mental Health Council, Ursuline Order, and United Community Services were present, and the need was established for the service. Programs such as Contact in London, Ontario; Samaritans in England; Distress Centre, Toronto; Fish, world wide; and Lifeline, Australia, were explored and their relevance to the Windsor area noted.

The next phase in development was the formation of a steering committee to do further research. Out of this committee came a proposal for the Windsor area. The final draft of the proposal put forward the idea of a befriending, listening service, designed to help alleviate loneliness, lower anxiety and help people to make their own decisions.

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<sup>37</sup>This information was obtained through an interview with Mrs. K. Osborne, one of the original members of the steering committee.

The proposal further stated that the service was not to counsel nor was it to duplicate any existing social service agency. It was to fill the void for people who were not at the point of agency contact or who were lonely.

The use of volunteers, who were to be well screened and trained, was also emphasized. It was felt that the volunteers should be maximally involved in policy and decision making. The emphasis on involvement here was seen as the most effective way of keeping a supportive and enthusiastic spirit in the agency.

The next phase was the contact with the University of Windsor's Psychology Department and School of Social Work. Also approached at this time were social agencies, service clubs, churches, unions and other community groups. This was an effort to draw expertise and financial and manpower commitments to the aid of the service.

A Co-Ordinator and two Committees were formed. The Selection Committee, which was composed of social workers, counsellors and educators, had as its task the formulation of the screening and training process for the volunteers. They were also responsible for assessing the number of volunteers required to make a start and to formulate some basic policy. The Organizational Committee explored the details of fund raising, financing, location, administration, need and use of consultants and other implementation problems.

The final phase was the location of a central location which would provide a rent free quarters. At the same time volunteers were located, screened and those who were successful started on a training program. In the middle of July 1970, the service went into operation on a 8 p.m. to 1 a.m. basis on week days and 6 p.m. to 2 a.m. on week-ends. Two befrienders were assigned to a shift and on the weekend the shift was split from 6 p.m. to 10 p.m. and 10 p.m. to 2 a.m. The split shift required four befrienders. The service has two telephone lines for befriending calls and one business telephone.

#### History of Research Proposal

In the spring of 1970, Dr. Don Effron, Co-Ordinator of Tel-A-Friend, approached Dr. W. Y. Wassef, Research Co-Ordinator for the School of Social Work, University of Windsor, requesting a research project. Dr. Wassef approached the writers and asked if we would be interested in doing the research for Tel-A-Friend. This research would partially fulfill the requirements required for our Masters' Degree in Social Work. When we indicated that we were interested, Dr. Wassef arranged a meeting with Mr. Effron, himself and us.

The meeting was held on March 12, 1970 at the University of Windsor. At the meeting the purpose of the research was outlined by Mr. Effron, as the agency saw it. A two part study was being proposed. The first part was to determine if the caller was meeting the agency's expect-

ations. This Mr. Efron saw as an attempt to establish the fact that the agency made sense. The factors to be considered here were alienation and loneliness, on which the agency based its purpose. The second area was to locate some indication of change in the person calling. Since this was a confidential service, this material would have to be based on the interpretation by the person answering the phone for the agency.

Also discussed in this meeting was the budget of the research, with Mr. Efron indicating that there would be some funds available. It was decided that we would draw up a letter containing the negotiations and include in it an estimated expense sheet. Mr. Efron would present this to the Board of Directors of Tel-A-Friend for approval.

Mr. Efron later advised us that the project had been authorized by the Board of Directors but that the expenses were out of line to what they could manage. We renegotiated the expenses with Tel-A-Friend and they agreed to provide a typist for the final draft, pay for the special paper and the duplicating of the required number of copies. They also agreed to pay for the transportation costs incurred.

In early April 1970, we submitted our research proposal. This proposal will be discussed in detail in chapter two. The purpose of the research, contained in this proposal was as follows:

1. Determine if caller<sup>38</sup> has type of social and psychological needs<sup>39</sup> which agency is prepared to handle.
2. Effectiveness of agency in aiding caller with his feelings.
3. Effectiveness of agency in crisis intervention.<sup>40</sup>
4. Comparison of the agency's function and approach with the function of an already established agency which is in the process of serving a similar population to Windsor.<sup>41</sup>

Data was collected for the month of August and the first week in November of 1970.

Prior to instituting the foregoing research process we acquainted ourselves with earlier studies on crisis intervention and suicide prevention centres. We are including brief summaries of a few of these projects which we felt were relevant to our proposed research.

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<sup>38</sup>Caller: those who telephone.

<sup>39</sup>Social and psychological needs: as to be announced in news media when agency commences service. At present defined as "alienated, lonely, confused or indecisive about problems they are having with life" in Policy Guideline of Tel-A-Friend.

<sup>40</sup>Crisis intervention: "a crisis is a period of disequilibrium overpowering the individuals homeostatic mechanisms" (H.J. Parad and G. Caplan, "A Framework for Studying Families in Crisis", Social Work, V, July 1960, p. 4) which implies "in a state of crisis the habitual problem-solving activities are not adequate for a rapid reestablishment of equilibrium" (Lydia Rapoport, "Working with Families in Crisis", Social Work, VII, July 1962, pp. 48-53) Examples of crisis situations are eviction, bereavement, sudden hospitalization of mother necessitating a babysitter, referral to a social agency, clergy, police and Tel-A-Friend counsellor.

<sup>41</sup>Similar population: a population similar in economic and social structure to Windsor, i.e. Toronto

RESEARCH ON CRISIS INTERVENTION  
AND SUICIDE PREVENTION CENTRES

Howard J. Parad, editor of "Crisis Intervention"<sup>42</sup> in discussing problems in the measurement of crisis phenomena in crisis intervention, states that there is a need for rigorous research to test and refine propositions of crisis theory. Questions which he feels need to be answered are:

- a) "How high a rate of agreement can we expect in assessing crisis as compared with non-crisis case situations?"
- b) How can we develop reliable criteria to select those who should be primary targets for our intervention?"
- c) Can we be certain that a mentally healthy adaptation to a crisis situation is attributable to our intervention rather than to some other source of help, whether planned or fortuitous?"<sup>43</sup>

Only as new crisis intervention programs incorporate research designs at the outset of their service will these and other important questions be answered.

Two research projects will now be presented. These are attempts at answering some questions concerning crisis intervention.

DISTRESS CENTRE STUDY 366-1121

This first one is an exploratory study currently still in process, on the Distress Centre in Toronto.

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<sup>42</sup>Howard J. Parad, "The Measurement of Crisis Phenomena in Crisis Intervention", ed H.J. Parad, Crisis Intervention: Selected Readings, (New York: Family Service Association of America, 1965) pp. 299-300.

<sup>43</sup>Ibid.

This study<sup>44</sup> is trying to establish a hierarchy of problems which motivate an individual in crisis to call a crisis centre. The researchers P. L. Mullins and F. McL. Gaviller took as their population the 5,200 calls received by the Distress Centre between January 1st 1968 and February 1969.

After reading several hundred of the volunteer's recordings of these calls they categorized the information contained in them for computer coding. This data was then transferred to a magnetic tape and from the tape to punch cards. They then tested the data obtained for statistical significance and found that the majority of the categories had a high enough completion rate to continue their study.

The results of this study are not available for publication as yet, but the study is continuing.

#### THE EFFECTIVENESS OF A SUICIDE PREVENTION PROGRAM

I. William Weiner, Ph.D.,<sup>45</sup> of Beverley Hills, California published a study on the effectiveness of a suicide prevention program.

The object of this project was to attempt to evaluate the effectiveness of the Los Angeles Suicide Prevention Centre.

In his report he makes reference to a study by C. Bagley<sup>46</sup> as one of a few that have attempted to deal

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<sup>44</sup>P. L. Mullins, F. McL. Gaviller, "Distress Centre Study, 366-1121" (unpublished research paper, 1968) No other information available.

<sup>45</sup>I. William Weiner, "The effectiveness of a suicide prevention program," Mental Hygiene, 55 (July 1969), pp. 357-363.

<sup>46</sup>Ibid., 358



with this problem. Utilizing as controls, towns similar in ecological variables, to towns having Samaritan programs, the researcher was able to demonstrate a significant difference in suicide rates in the latter. However, Dr. Weiner claims that this study is open to criticism on statistical grounds. "A non-parametric sign test of significance would have been more appropriate to his data. The null hypothesis would thus have been upheld."<sup>47</sup>

Suicide is defined as "a complex phenomenon, whose incidence seems related to many psychologic, ecologic and cultural factors . . . Yet, in the last analysis an effective prevention program should be mirrored in ratio reduction, irrespective of the above, if it is to be practical."<sup>48</sup>

Dr. Weiner then indicates that effectiveness in terms of reduction can be viewed in two different ways:

- a) does the program effect the suicide rate?
- b) is the program capable of reducing the rate despite the presence of other variables affecting the rate?

He indicates that Bagley's study was illustrative of the former while the majority of programs tend toward the latter model.

The Los Angeles Suicide Prevention Centre study focused on a comparison of suicide rates in Los Angeles County before and after introduction of the suicide prevention service. It was stated that if the service was

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<sup>47</sup>Ibid.

<sup>48</sup>Ibid.

effective you might expect to find:

- a) a significant reduction in the suicide rate, since inception of services in the county.
- b) an inverse relationship between the number of calls (or contacts) to the centre and the suicide rate.

In addition some comparisons were made with suicide rates in other California counties not having a suicide prevention centre.

Evaluation of the data showed that on comparing the suicide rates for the two periods there was a significant difference at the 0.004 level, using a one-tail Mann-Whitney U test. Data obtained from the three other California counties did not show a significant rise in suicide rates; in fact in one which did not have preventative services, there was a slight, though not significant, drop during the period of study. The number of telephone calls did not seem to be related to or effective in reducing the suicide rate. Little objective evidence was found to support the assumption that present services and techniques used by the Los Angeles Suicide Prevention Centre are effective in suicide prevention, if the rate is taken as criterion.

These negative results could be accounted by:

- a) the telephoning population not being suicidal.
- b) that people who are suicidal do not contact a suicide centre.
- c) the centre not being known to the community.

Upon looking into these factors, it was discovered

that while the callers were suicidal, almost half of the calls were from people who had had or were currently receiving psychotherapy and 98 percent of suicidal victims did not call a suicide centre.

It was then felt that a research priority was to ascertain why suicidal people do not contact a suicide centre. Further investigation revealed that the suicide rate for those sixty and over in Los Angeles was three times the average suicide rate. Dr. Weiner felt that possibly the approach-avoidance syndrome was operating here in that withdrawing from help and completing the suicidal act would be more in keeping <sup>with</sup> their motivational structures. This provided the age group with an escape from illness, loneliness, loss of friends, loss of loved ones, hopelessness, and failure.

The primary question raised by this study, which we feel is borne out by examining the analysis of calls, to multi-problem crisis centres, is whether or not it is realistic to expect the suicidal person to take the initiative in reaching out for help. It appears that the majority of calls coming to these centres are from people with problems other than suicide.

These studies brought to the fore two questions in the area of telephone crisis intervention which seemed relevant to the research we were about to embark upon. In the first study the researchers are trying to determine the hierarchy of problems which motivate an individual in

crisis to call a crisis centre. The second study indicated that there was an inverse relationship between the number of calls to the centre and the reported suicide rate. One of the conclusions of the researchers was that the majority of calls coming to these centres are from people with problems other than suicide.

While our study does not address itself specifically to these questions, it will attempt to provide a limited classification of the type of problem that motivates individuals to use a crisis service.

## CHAPTER II

### THE RESEARCH PROCEDURES

This is an exploratory study of a telephone crisis intervention centre in the City of Windsor, Ontario. This agency, Tel-A-Friend, was recently established. The exploratory study was instituted in order to

- a) determine if caller<sup>1</sup> has type of social and psychological needs<sup>2</sup> which the agency is prepared to handle.
- b) explore the effectiveness of agency in aiding caller with his feelings.
- c) explore the effectiveness of agency in crisis intervention.<sup>3</sup>

We have also attempted to include a comparative aspect to our study in order to provide a more meaningful study. This comparative study takes the form of

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<sup>1</sup>caller: those who telephone the agency.

<sup>2</sup>social and psychological needs: these are defined as "alienated, lonely, confused or indecisive about problems they are experiencing with life", as outlined in Policy Guideline of Tel-A-Friend.

<sup>3</sup>crisis intervention: "a crisis is a period of disequilibrium overpowering the individual's homeostatic mechanisms" (H.J. Parad and G. Caplan, A framework for studying families in crisis, Social Work V, July 1960, p. 4) which implies "in a state of crisis the habitual problem-solving activities are not adequate for a rapid re-establishment of equilibrium" (Lydia Rapoport, Working with Families in Crisis, Social Work, VII, July 1962, pp. 48-53). Examples of crisis situations are eviction; referral to a social agency, police, Tel-A-Friend counsellors, and other areas which the caller designates.

- d) comparison of the agency's function and approach with the function and approach of an already established agency which is in the process of serving a similar population to that of Windsor.<sup>4</sup>

Since this is a two phased study, exploratory and comparative, the hypothesis will be formulated at the conclusion of the study.

### Population

The population of the study in the City of Windsor was defined as those people who called Tel-A-Friend during the month of August 1970 and November 1 - 5 and November 7th, 1970. Since the agency operates between the hours of 8 p.m. to 1 a.m. on week days and 6 p.m. to 2 a.m. on weekends, the population was by necessity drawn from these time spans.

The population of the study in the City of Toronto was defined as who called The Distress Centre during the month of August 1970 and November 1 - 6 and November 8th, 1970. Since the Toronto agency operates on a twenty-four hour basis the population was drawn from this time span.

### Sample

The sample size for the Windsor study was the total population for the previously mentioned dates. This means that it was 256 calls for the month of August and 39 calls for November 1 - 5 and November 7th.

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<sup>4</sup>Similar population: a population similar in economic and social structure to Windsor, namely Toronto.

Since the Toronto Distress Centre draws on a much larger population than Windsor's agency, we have used random sampling to obtain a workable figure. We selected every fourth call which gave us a sample size of 255 calls for the month of August and 64 calls for November 1 - 6 and November 8th.

### Research Tools

In our original Research Design we planned to use four tools for collecting data:

F.R.E.S. Log (designed by Flint Regional Emergency Service) to summarize calls chronologically in a time sequence. (Appendix 1)

F.R.E.S. Initial Contact Guide - a detailed recording of each call giving relevant information about caller and reason for calling. (Appendix 2)

Assistance Report - similar to Appendix 2, but designed by "Contact" (a crisis telephone service in London, Ontario). (Appendix 3)

Befriender's Evaluation of Service Rendered - a four page check list designed by one of the researchers to gather data from the two agencies. It was based on what we saw as relevant information to help us evaluate service and carry out our research. (Appendix 4)

Since Tel-A-Friend did not record their calls it was not possible to use Appendices 1 - 3, and we enlisted the Befrienders help at Tel-A-Friend in completing Appendix 4. The Distress Centre in Toronto did record their calls and we have included a sample of their record sheet, designated Appendix 5, from which we (the researchers) completed Appendix 4.

### Method of Collecting Data

Tel-A-Friend, at the time data collection was done, had no system of record keeping. As a result we had the individual Befrienders<sup>5</sup> fill out the check list, Appendix 4, themselves for each call.

In order to provide consistency in the collection of data, one of the researchers was present at the beginning of each shift. The role of the researcher at this time was to explain the importance of completing the questionnaire for each call, and to answer any questions arising out of the questionnaire itself. It was also the responsibility of the researcher to establish rapport with the Befriender in order to further facilitate the completion of the questionnaire. On leaving the telephone centre, after having answered all questions and concerns, the researcher took the previous shift's completed questionnaires.

The time period for the collection of data was decided upon on the basis of allowing Tel-A-Friend a period of two weeks to establish their service. The first complete month of operation was August 1970. The period of November 1 - 7, was chosen on advice of Mr. Gordon Winch, Director of the Distress Centre in Toronto. From his experience he felt that this was a peak period for calls. We were forced to modify this to November 1 - 5 and November 7th

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<sup>5</sup>Befriender: is a telephone volunteer who gives all the love, support, encouragement and understanding one would give to one's personal friends in time of need.



because Tel-A-Friend experienced a major problem on November 6th of having no volunteers available.

Prior to collecting any data in Toronto, one of the researchers visited the Distress Centre on three occasions. During the first visit the researcher explained the Research Project to the Director, and gained his permission to use their Centre in the comparative study. The Director also gave the researcher copies of studies already done on the Distress Centre. He further explained the importance of confidentiality, and indicated that it would be necessary to notify him in advance each time we planned to visit the Centre. This would allow him to notify the counsellors on duty that we had his permission to take records from his files. On the succeeding two visits during the summer of 1970 the researcher did examine and record some data from their May 1970 records, which we later decided we could not use since Tel-A-Friend did not begin operation until mid-July 1970. However, these visits proved valuable in that the Director was present on all of them and shared considerable information about the operation of telephone crisis centres in general and some of the specific problems the Distress Centre had to resolve.

In October and November 1970 both of the researchers visited the Distress Centre, and using their record sheet (Appendix 5) completed their check list (Appendix 4), for the periods August 1970 and November 1 - 6 and November 8, 1970. We had been informed by Mr. Winch that their callers

were classified as: first calls, repeat calls and suicide calls. Since their monthly calls average around 900 we decided to select every fourth call from each of the three classifications in order to leave both samples of relatively equal sizes.

### CHAPTER III

#### RESEARCH DATA AND ANALYSIS

The data for this study was collected by using a four page check list, i.e. "Befriender's Evaluation of Service Rendered", (Appendix 4). This data has been illustrated on graphs and tables, and an analysis of these indicate that Tel-A-Friend in Windsor, and the Distress Centre in Toronto, are offering friendship, understanding, encouragement, and support to many troubled people in their respective cities.

It was not possible to determine how callers to the Distress Centre in Toronto learned of the service, since volunteers do not usually request this information from their callers. In Windsor where the callers were asked how they had learned about Tel-A-Friend, 158 out of 268 callers during August 1970 indicated they had read the agency's advertisement in the Windsor Star. During the week November 1 - 7, 1970, 20 callers out of a total of 39, reported learning about this Windsor agency through the newspaper.

While the Distress Centre in Toronto does not always ask their callers how they learned of the service, they do stress the importance of public relations. In May 1969 an article in Saturday Night<sup>1</sup> brought the service to the

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<sup>1</sup>Elizabeth Kilbourn, "Life and death on the telephone", Saturday Night, May 1969, pp. 21-23.

attention of people in distress, and others who wished to become volunteers. Social service groups and public-minded citizens have sponsored fund raising activities in support of this agency, at which the story of the Distress Centre is always told. The volunteers have also filled many requests for speakers in churches and other organizations.

The Samaritans in England, and Life-Line in Australia also emphasize the importance of publicity. A sociologist, C. R. Bagley, was employed by the Medical Research Council in England, to carry out a statistical study to examine the effect of Samaritan activities. While the suicide rate fell by 5.8% in the Samaritan towns, and rose by 19.8% in the control non-Samaritan towns, it was stressed that the smaller the Samaritan town, the more likely the existence of the agency was associated with a reduction in the suicide rate.<sup>2</sup> In other words, the greater the population of a community in which a telephone crisis intervention service is instituted, the more energy the staff, volunteers and interested citizens will have to expend in public relations to assure that the service is known and used.

The authors of this study wanted to know:

- 1) who calls a telephone crisis intervention centre?
- 2) do callers feel they are helped through contact with a telephone crisis intervention centre?
- 3) do the volunteers feel they were able to help the callers with whom they had contact?

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<sup>2</sup>The Samaritans, report and accounts 1968/69.

The above questions summarize and restate the research proposal in a manner which makes it possible to relate the collected data to the researchers' original purpose for the study. The following analysis of the illustrations of the research data attempts to answer each of the foregoing questions.

Prior to analysing the data the researchers wish to again define the sample of this study. In August 1970 the 256 calls recorded by Tel-A-Friend in Windsor were used, as were the 39 calls recorded during the period of November 1 - 5, and November 7, 1970. The Distress Centre in Toronto, reported receiving more than thirty calls a day during 1970. These calls were classified as either first calls, repeat calls, or suicide calls. In order to obtain a relatively equal number of calls for analysis from the Toronto agency, the researchers selected every fourth call from each of the foregoing mentioned categories. This gave us a Toronto sample of 255 calls for August 1970, and 64 calls for the period of November 1 - 6, and November 8, 1970. While the random sampling did give us a fairly equal quantitative sample from each centre for August, this was not the case in November where 39 calls in Windsor are compared with 64 calls in Toronto. This November discrepancy can be partially accounted for by the fact that data was only collected from the Windsor centre for six days, while in Toronto the researchers collected data for seven days. However, there must have also been a change in the daily volume of calls to each

of the centres during November, as compared with August. In August Tel-A-Friend received an average of eight calls per day, and this dropped to six calls per day in November. Tel-A-Friend volunteers selectively record calls, whereas all calls to the Distress Centre in Toronto are recorded. In Toronto the daily calls increased from an average of 30 in August, to 37 in November. This increase in the number of calls to the Distress Centre during this week in November, supports the prediction of the Director of this agency that their peak period of service is usually between mid-October and mid-November. However, in spite of the difficulties encountered in obtaining a truly equal number of calls for a comparative analysis of these two centres; the following illustrations of the research data seem to offer some answers to the three questions raised earlier.

1) Who calls a telephone crisis intervention centre?

Females used the services of Tel-A-Friend in Windsor, and the Distress Centre in Toronto, more than males during this study (Figs. 1, 1a, 2, 2a and Table 3).

TABLE 3

SEX RATIO

<u>LOCATION</u>	<u>DATE</u>	<u>FEMALE</u>	<u>MALE</u>
Windsor	August	62%	38%
Toronto	August	62%	38%
Windsor	November 1 to 8	77%	23%
Toronto	November 1 to 8	61%	39%

An examination of patient movement in mental health institutions in Ontario during 1967<sup>3</sup> reveals that 42% of first admissions to a Public Mental Hospital, i.e. an institution providing long-term psychiatric care, whereas 63% of first admissions to Public Psychiatric Units, i.e. a unit in a general hospital offering short-term intensive psychiatric treatment, were female. The majority of admissions to the latter units are usually for periods of less than four months, while admissions to the former would be for a much longer period, i.e. eight months to a year or more. These statistics seem to indicate that more males than females are admitted to Public Mental Hospitals in Ontario, which seems to point out that their illness is probably more severe than that of females requiring psychiatric treatment.

It would appear from a comparison of the data collected for this study with the above statistics that it might be safe to assume that women find it easier to talk about their problems, than males. In our society boys are expected to be more aggressive than girls, and are encouraged to be so with a goal of helping them develop the traits of independence, initiative and self-sufficiency. In other words, it is not considered manly to publicly express feelings of grief or loneliness. However, it is appropriate for the female to openly express feelings of hurt, especially to one upon whom she is dependent.

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<sup>3</sup>Institutional Admissions and Separations, 1967,  
Mental Health Statistics, Volume I, (Ottawa: The Queen's  
Printer, May 1970) pp. 14-24.

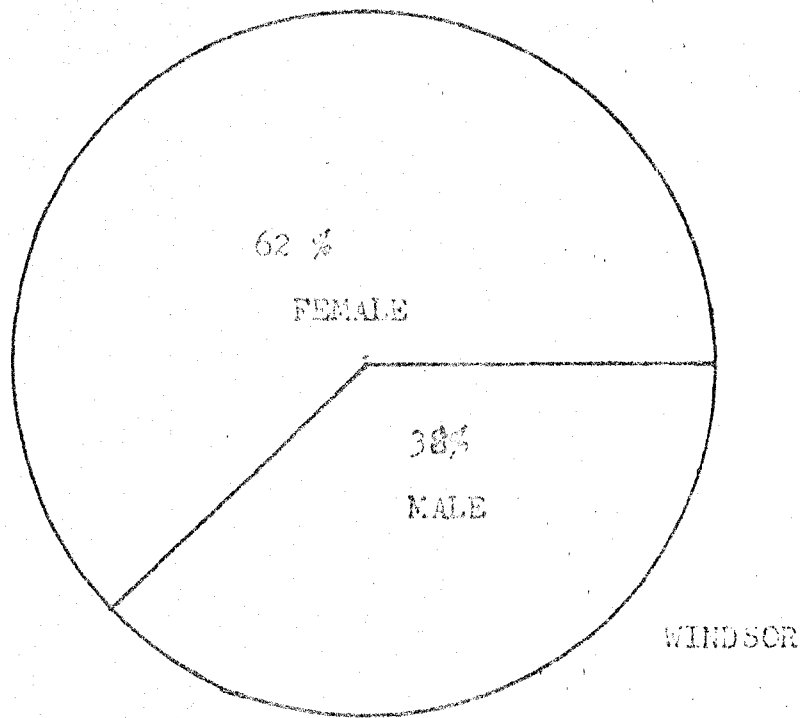
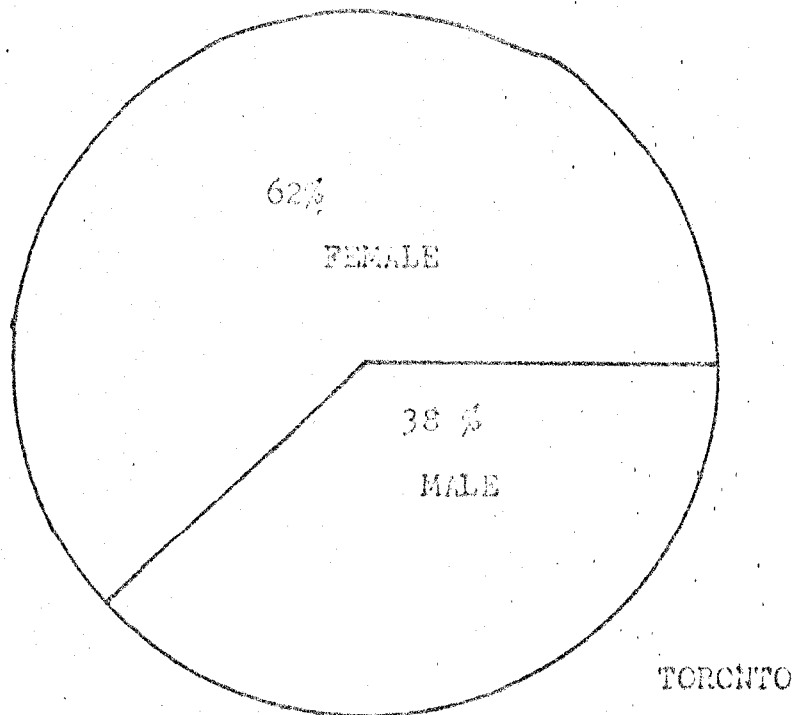


Figure 1



SEX RATIO OF CLIENTS

August 1 - 31, 1970

Figure 1a



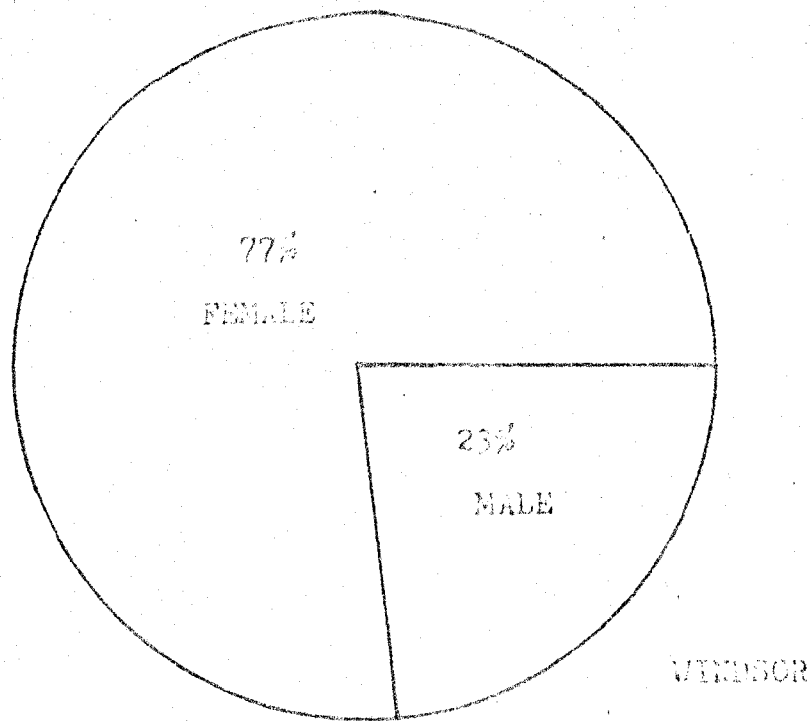
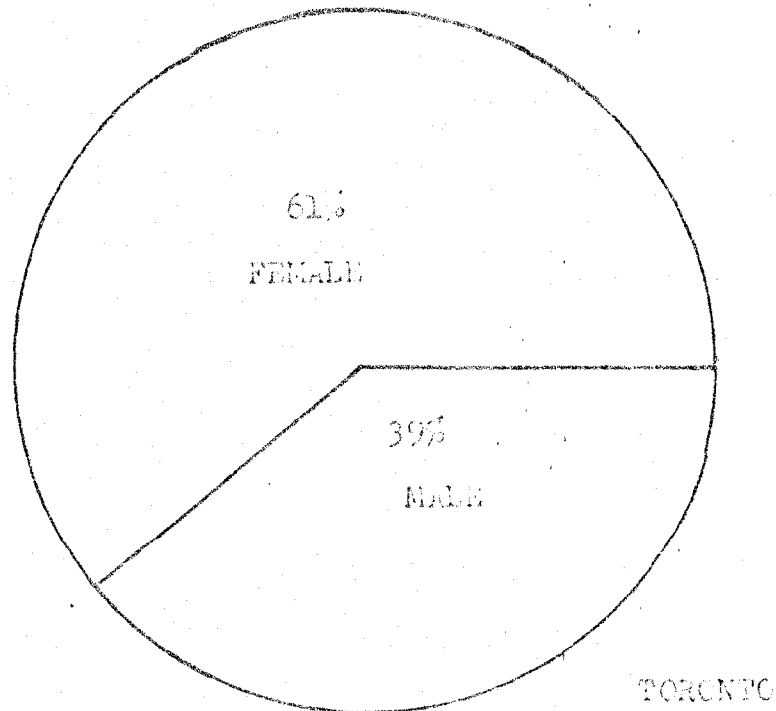


Figure 2



SEX RATIO OF CLIENTS

November 2 - 8, 1970.

Figure 2a

Bernice L. Neugarten and David L. Gutman in a study "Age-Sex Roles and Personality in Middle Age: A Thematic Apperception Study" used projective techniques to study age-sex roles in the family. They found that "the different images of all four figures presented by men and women at the two age levels, imply personality changes in the years from forty to seventy. For example, women, as they age, seem to become more tolerant of their own aggressive, egocentric impulses, whereas men as they age, of their nurturant and affiliative impulses. To take another example, with increasing age in both men and women, ego qualities in the personality seem to become more constricted -- more detached from the mastery of affairs and less in control of impulse life."<sup>4</sup>

In 1967 the typical first admission to mental health facilities in Ontario was the man aged 40-49 with a probable diagnosis of alcoholism or the female 30 - 39 with a diagnosis of psychoneurosis. These statistics seem to support the findings of the foregoing study of a change in personality with aging. Women having learned to express their feelings of hurt earlier in life, seem to require less intensive treatment than the male who has been trained to keep his problems to himself. Life-Line in Sydney, Australia reported that of the suicide calls to their agency during the third year of operation, 60%

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<sup>4</sup>Bernice L. Neugarten and David L. Gutman, "Age-Sex Roles and Personality in Middle Age: A Thematic Apperception Study", in Middle Age and Aging, by Bernice L. Neugarten (Chicago and London: The University of Chicago Press, 1968) p. 71.

came from males, with only 40% from females.<sup>5</sup>

Returning to our question of "who calls a telephone crisis intervention centre?", it has been established that more females than males use these services, but what do they call about? A further analysis of our data shows that the majority of the callers in our sample used the service of the telephone crisis intervention centre to seek help with personal conflicts, rather than to solicit help for a friend or relative. (Figs. 3 and 4, and Table 4).

TABLE 4

<u>PERSON ABOUT WHOM CALLER CONCERNED</u>				
<u>LOCATION</u>	<u>DATE</u>	<u>SELF</u>	<u>OTHERS</u>	<u>UNIDENTIFIED</u>
Windsor	August	185	62	9
Toronto	August	212	31	12
Windsor	November 1 to 8	32	6	1
Toronto	November 1 to 8	52	9	3

Life-Line in Sidney, Australia, insist that the individual in distress must call, unless they are unable to, i.e. unconscious. This policy is consistent with the social work principle of self-determination, i.e. "that the individual who is in economic, personal, or social need has the right to determine himself what his needs are and

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<sup>5</sup>Alan Walker, As Close as the Telephone, (New York: Abingdon Press, 1967), p. 122.

how they should be met."<sup>6</sup>

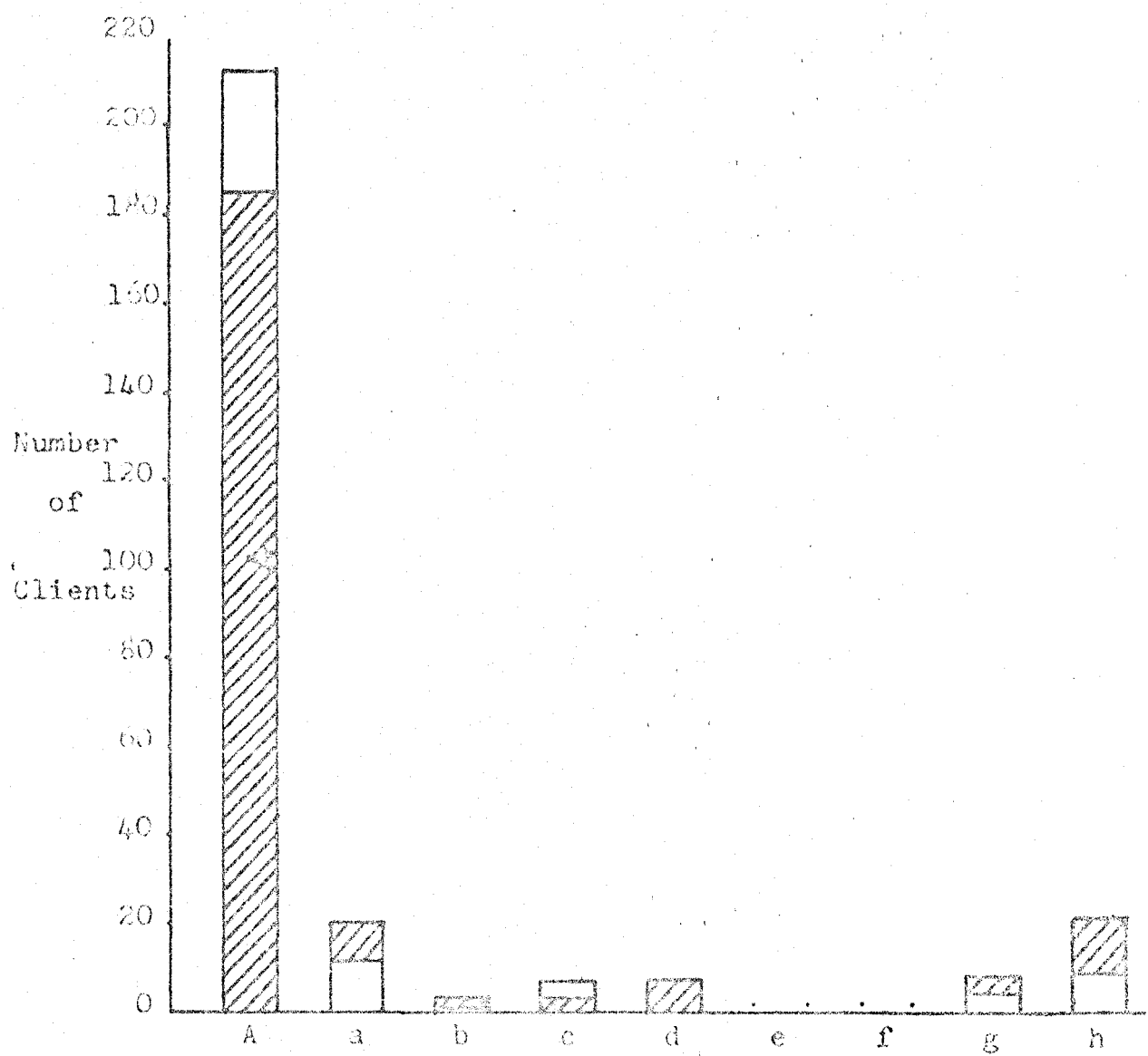
The "others" (Figs. 3 and 4) about whom the callers were usually concerned were spouses or relatives not residing with the family, but making certain demands on the caller. Calls in which the caller merely enquired about the function of the centre, without expressing any need for its services, were classified as "unidentified".

In comparing the data collected from the two centres, Toronto appears to deal more with the individual in distress, and become less involved in trying to assist callers in motivating significant others to reach out for help. However, possibly some callers use the presentation of someone else's difficulty to test how willing the volunteer is to help. Others may be describing their own problem as that of another. If it were possible to accurately assess who the caller was really concerned about, our research data would probably be dramatically altered. It is possibly safe to assume that a number of the "unidentified concerns" would become classified as "concerns about self", made by individuals who were trying to establish whether or not a telephone crisis intervention centre could help them with their problem.

Analysis of the data collected in this study indicates that the majority of calls received by Tel-A-Friend in Windsor, and The Distress Centre in Toronto, are from wo-

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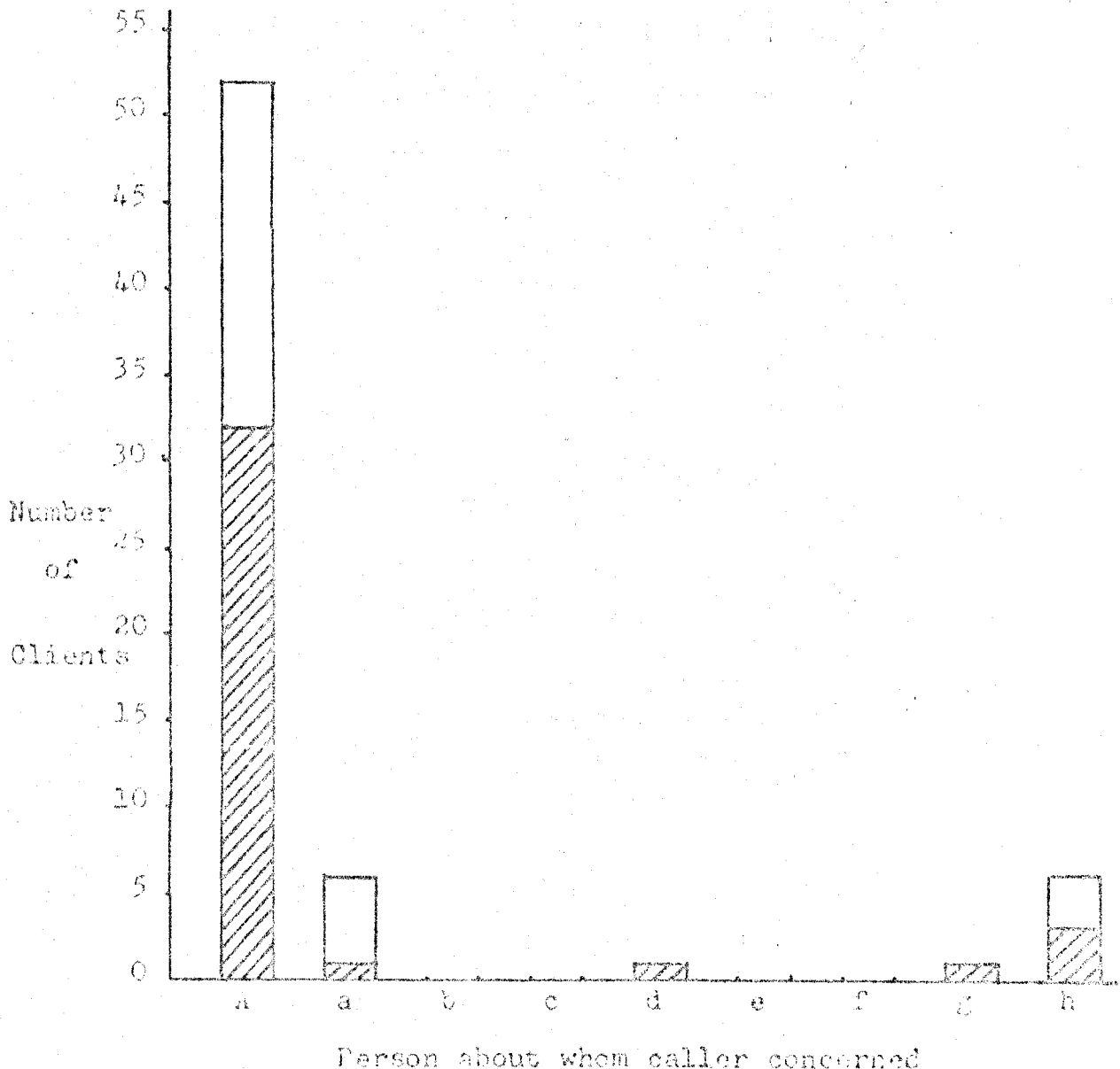
<sup>6</sup>Concepts and Methods of Social Work, ed. by Walter A. Friedlander, (Englewood Cliffs, N.J.: Prentice-Hall, Inc. 1958), p. 3.



Person about whom caller concerned

- A - self
  - a - wife or husband
  - b - son
  - c - daughter
  - d - relative (resides with family)
  - e - relative (temporarily residing with family)
  - f - boarder
  - g - friend
  - h - other (not felt significant enough to define on another graph.)
- Windsor Calls 
  
 Toronto Calls
- August 1 - 31, 1970

Figure 3



Person about whom caller concerned

- A - self
- a - wife or husband
- b - son
- c - daughter
- d - relative (resides with family)
- e - relative (temporarily residing with family)
- f - boarder
- g - friend
- h - other (not significant enough to warrant separate chart)

Windsor Calls Toronto Calls

November 1 - 8, 1970

Figure 4

men and individuals seeking help with personal conflict. Having established who uses these centres, the writers will now focus on whether or not the clientele of these agencies felt the telephone contact was helpful.

2) Do callers feel they are helped through contact with a telephone crisis intervention centre?

It is very difficult to assess whether a caller received the help he was looking for when he dialed the number of the telephone crisis intervention centre. The majority of these individuals are only heard from once, and the effect of this contact can never be known. However, The Distress Centre in Toronto report that some persons register appreciation during the call. The Director of this agency cites incidents<sup>7</sup> of individuals calling The Distress Centre long distance many days, weeks or months after their initial contact to express thanks for the help received and share how the call helped them effect certain changes in their life style. Similar stories are quoted by the Samaritans in England, and Life-Line in Australia.

In this study the authors were dependent upon the volunteer's assessment of whether or not the caller felt they received help. We have illustrated the data collected through this assessment on Figs. 5 - 9, and then summarized it in Table 5, ranging it on a continuum from "extremely helpful" to "not helpful".

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<sup>7</sup>Gordon Winch, A Mid-Year Report - June 1969, (Toronto: The Distress Centre, 1969), p. 2 (mimeographed).

During August 1970 the majority of calls to Tel-A-Friend in Windsor, fell in the middle of the continuum, i.e. "helpful", with very few calls being rated "not helpful". In Toronto, for the same period, while approximately seven-tenths of the calls were considered to be helpful to the caller, but three-tenths were rated "not helpful". According to Figs. 6 and 7 these latter calls were considered unhelpful because the caller was either confused, incoherent, resistant to the help offered, not seriously desiring help, or using the interaction as a means of sexual stimulation.

TABLE 5

DEGREE OF HELPFULNESS OF TELEPHONE CONTACTS

<u>LOCATION AND DATE</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
Windsor - August	8	27	116	63	10	32
Toronto - August	20	24	94	32	75	10
Windsor - November 1 to 8	2	6	21	9	1	0
Toronto - November 1 to 8	3	4	35	13	7	2

A-extremely helpful      C-helpful      E-not helpful  
 B-very helpful      D-slightly helpful      F-unidentified

Why did the Toronto volunteers feel they were less effective with more of their callers than the Windsor volunteers? The authors wish to point out that the research data was collected during the first month that the Windsor agency was in operation. Possibly the volunteers of Tel-A-Friend felt under pressure to prove themselves and their



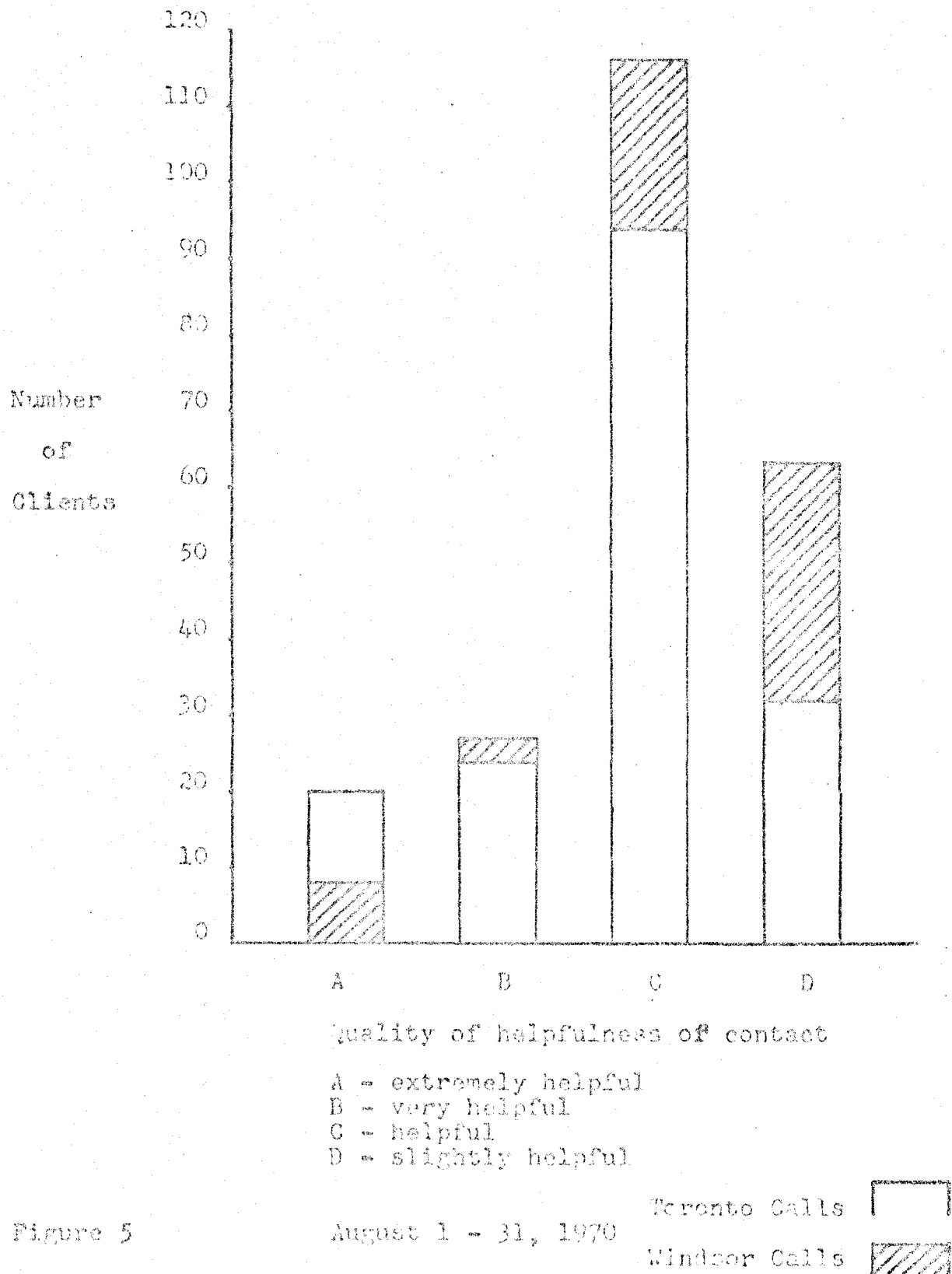
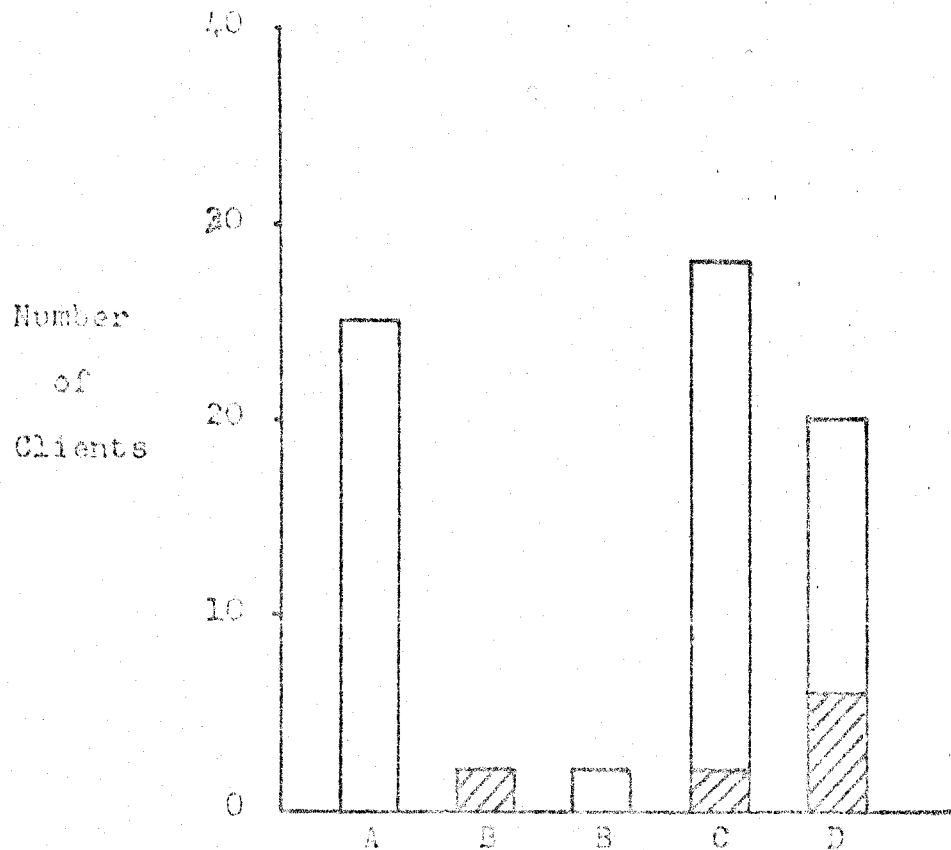


Figure 5

August 1 - 31, 1970


Toronto Calls


Windsor Calls



Telephone Contact was not helpful to caller because:

- A - confusion of caller prevented coherent conversation
- B - no available agency to refer caller to
- C - caller refused to accept help
- D - others (defined on Figure 7)

Toronto Calls 

Windsor Calls 

August 1 - 31, 1970

Figure 6

Telephone contact was not helpful to caller for reasons designated "other"

Figure No. 6

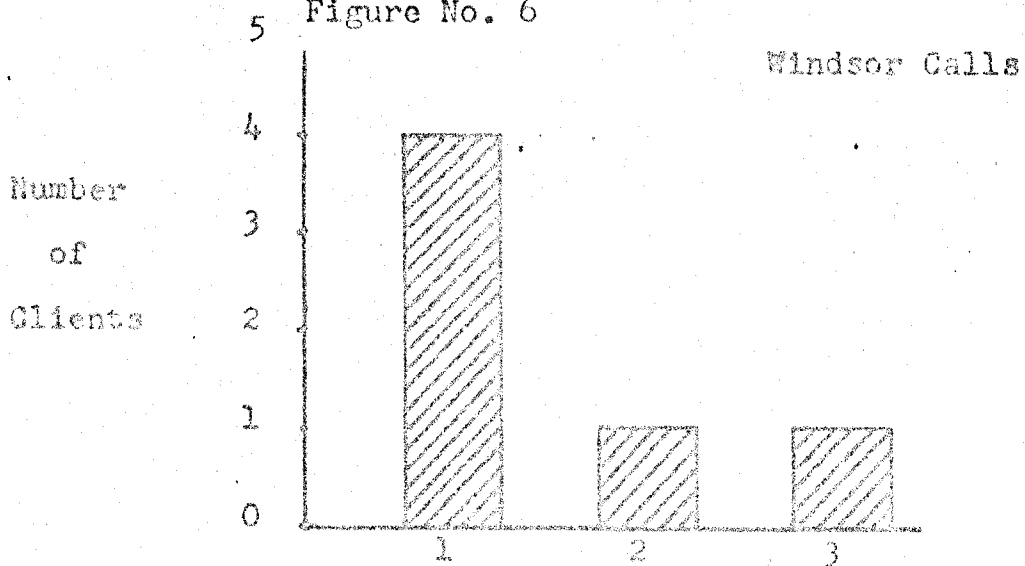


Figure 7

- 1 - hung up telephone
- 2 - obscene call
- 3 - antagonistic caller

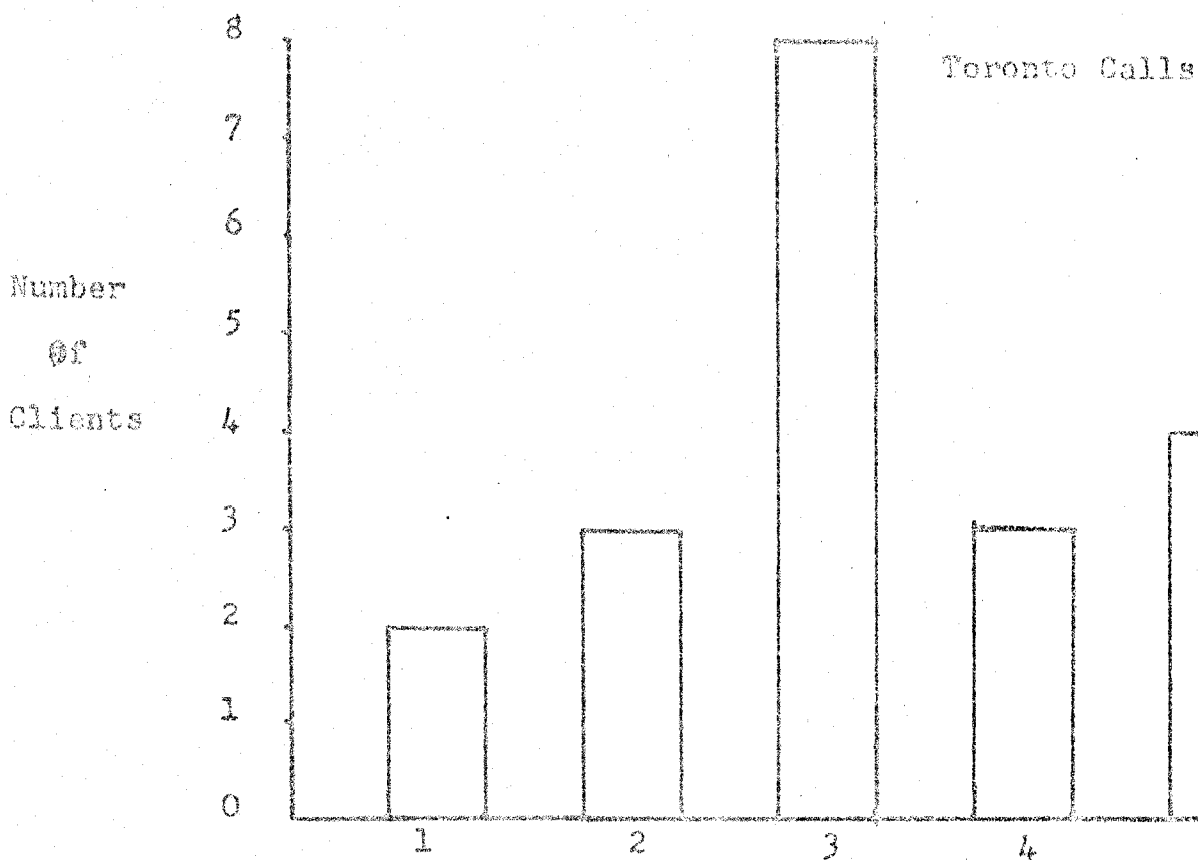


Figure 7a

- 1 - caller hung up phone
- 2 - resistant
- 3 - not meaningful for caller
- 4 - caller not serious
- 5 - sexual stimulation

August 1 - 31, 1970

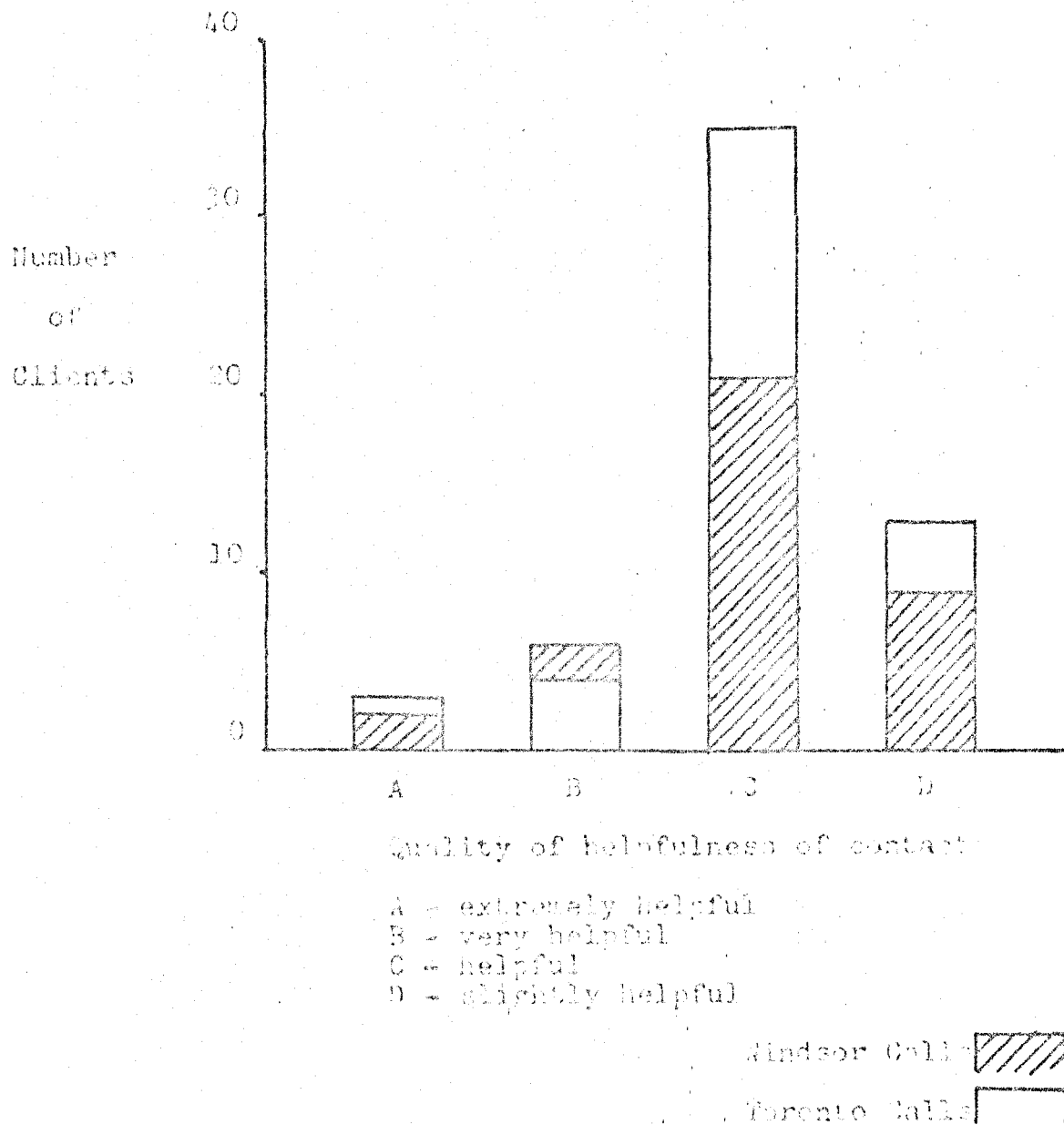
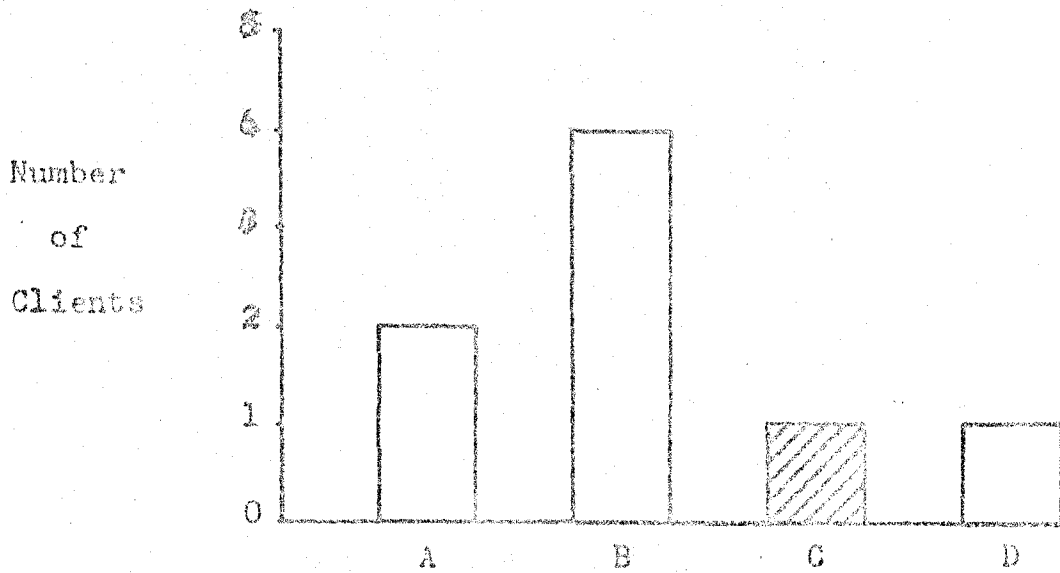


Figure 8

November 1 - 9, 1970



Telephone contact was not helpful to caller because:

- A - confusion of caller prevented coherent conversation
- B - no available agency to refer caller to
- C - caller refused to accept help
- D - others (not defined on separate graph)

November 1 - 8, 1970


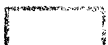
Windsor Calls   
 Toronto Calls 

Figure 9

service effective. Also, record keeping was not an integral part of the Windsor service, and was done only for this study, at the request of, and under the guidance of one of the researchers. In other words, the volunteers of Tel-A-Friend knew that their service during August was being evaluated and compared with that of The Distress Centre in Toronto, and that the data they collected would be used in a Masters of Social Work thesis. Further they were aware that copies of the study would be given to both their own agency and The Distress Centre in Toronto.

In Toronto, where the research check-list was completed by the researchers from the agency's record sheet, the volunteers did not know that their recording would become part of a study. Also the type of call, with which the Toronto volunteers judged themselves ineffective in aiding the caller, is the type of call which many Windsor volunteers did not record, labelling them as "crank calls" and therefore useless data for our study.

Again, if we could really know how the Toronto caller perceived the interaction, we might discover that having someone listen to them, in spite of their obnoxious presentation of self, seemed helpful. Rarely, if ever, does a Toronto volunteer hang up on a caller, but the caller has been known to hang up on the volunteer, especially if the caller is intoxicated or resistant to accepting suggestions offered by the telephone volunteer.

There were more "unidentified calls" in Windsor, than

in Toronto. In Windsor the volunteers neglected to assess these calls as being either "helpful" or "unhelpful". With the Toronto calls the researchers either missed evaluating the calls as "helpful" or "unhelpful", or placed in this category those calls requesting information about The Distress Centre. Probably these latter calls could have been considered as helpful calls.

Basil Higginson in writing about the Samaritans in Christian Comment states, "The Samaritans have always been cautious in claiming successes in statistics."<sup>8</sup> The authors survey of the literature on telephone crisis intervention centres, and our involvement with the two agencies in this study, indicates that telephone crisis intervention centres are not resistant to having social scientists study and evaluate the effectiveness of their service. However, the Directors of these agencies are as aware, as the researchers, of the many obstacles facing anyone who undertakes an evaluation of this form of intervention. The researchers mentioned earlier that the majority of callers only call once, remain anonymous, and unless they verbally express gratitude at the conclusion of the call, any assessment of its effectiveness must of necessity be a subjective evaluation made by the telephone volunteer.

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<sup>8</sup>Basil Higginson, "The Samaritans", Christian Comment, No. 92 (Lancashire: J. Andrew and Co. Ltd., 1968), p. 2

The researchers tried to allow for the identification of some specific help received by the caller, through inclusion of Question 6 in our check-list (see Appendix 4). However, this question fails to request that the volunteers differentiate between "needs" and "anxiety" of the caller, so the data illustrated in Figs. 10 and 11 is not considered to be relevant in establishing how the telephone contact was helpful to the caller.

Having established that it is very difficult, if not impossible, to establish whether or not a caller to a telephone crisis intervention perceives himself as receiving help; we will now examine the effectiveness of service given from the volunteers' viewpoint. We hope the examination of the research data, as it is depicted in the remaining illustrations and related to our final question, will prove profitable.

3) Do the volunteers feel they were able to help the callers with whom they had contact?

This final question will be answered by determining

- a) the number of callers who received help from the telephone volunteer without referral to either a counsellor within agency contacted, or another agency.
- b) Whether the volunteer noticed any change in the mood of the caller during the call.

According to Table 6 and Figs. 12 and 13, the telephone volunteers personally handled the majority of the calls to their telephone crisis intervention centres, referring relatively few to counsellors within their agency.



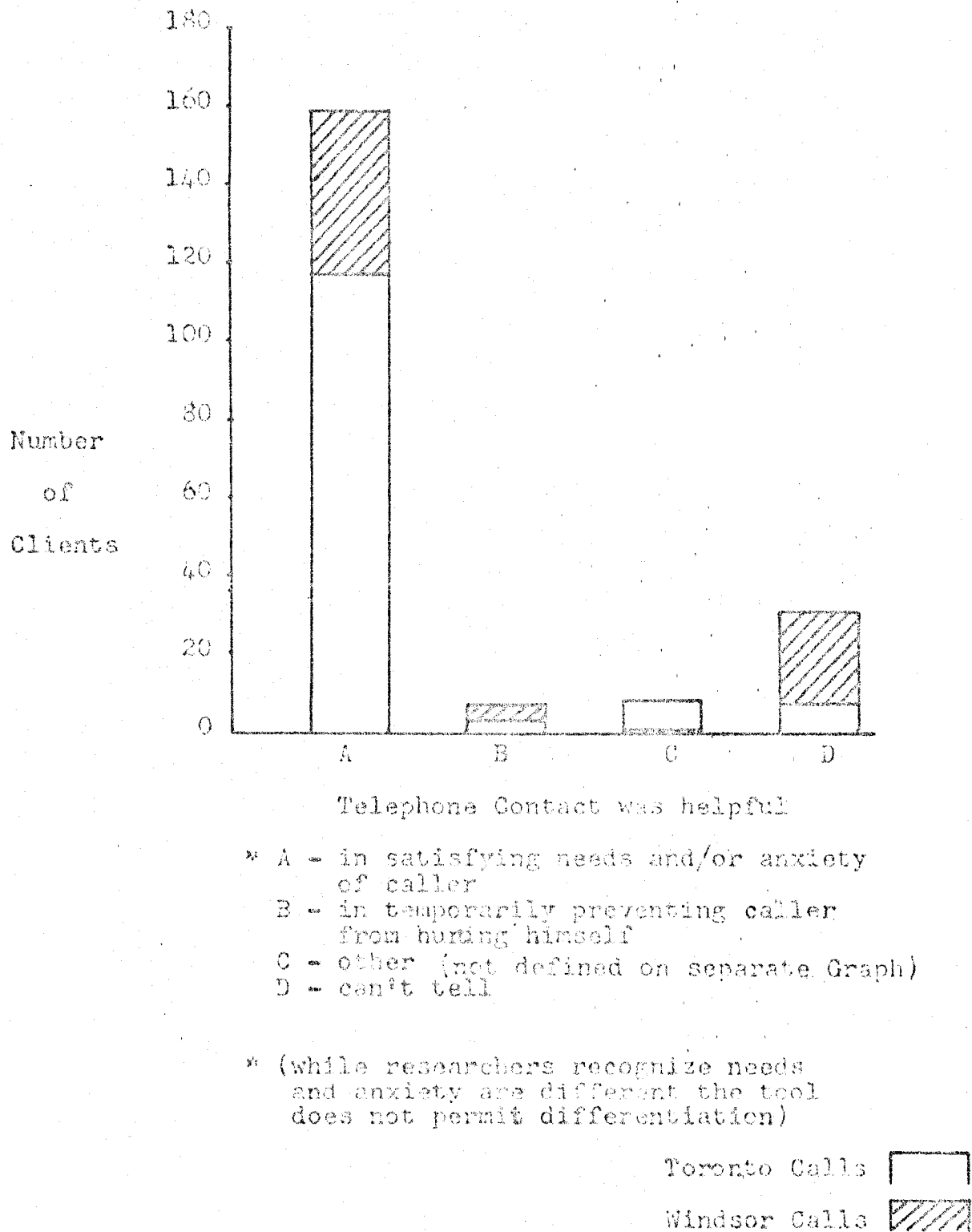


Figure 10

August 1 - 31, 1970

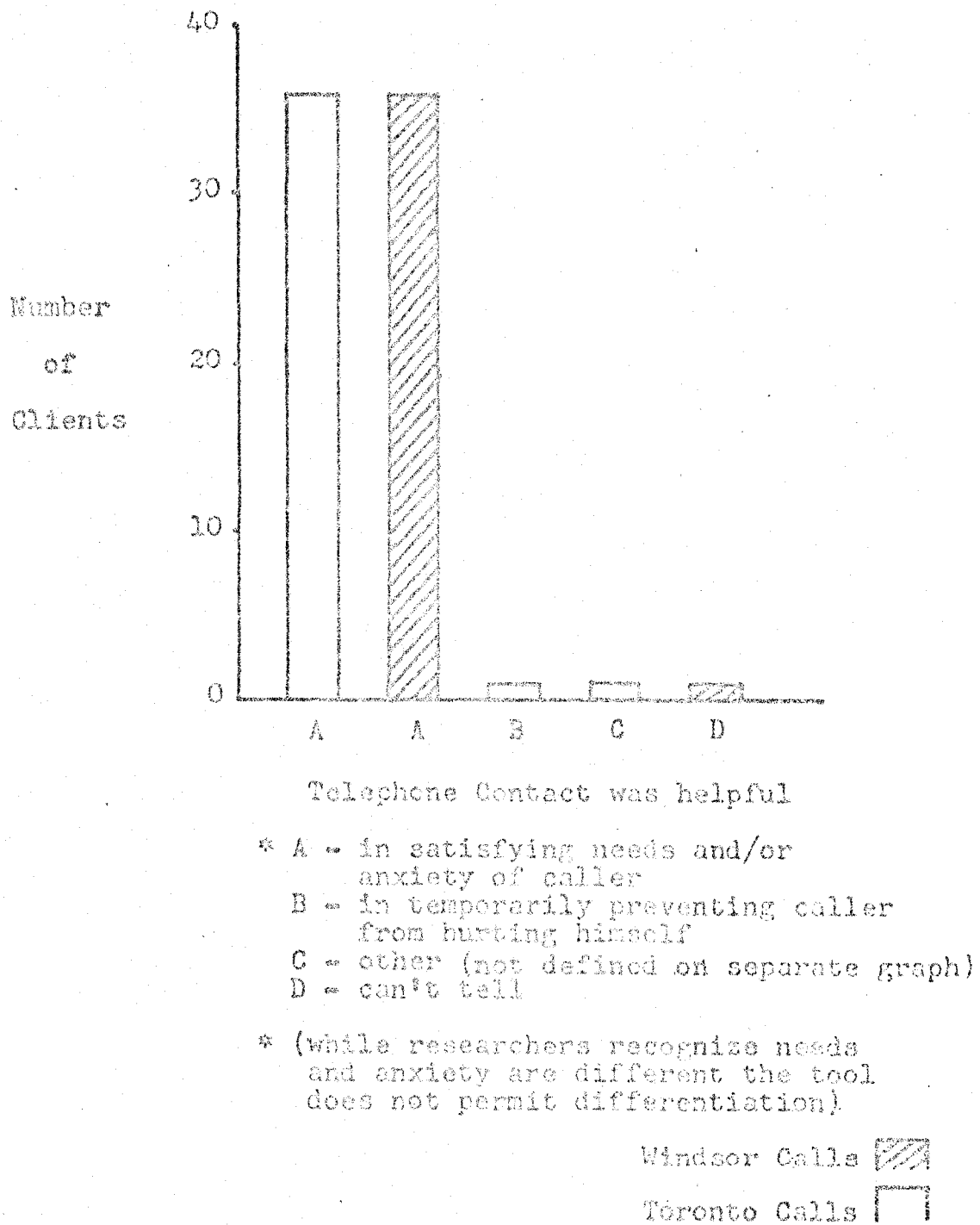


Figure 11

November 1 - 8, 1970

TABLE 6

AGENCY RESPONSE TO CALLERS' NEEDS

<u>LOCATION AND DATE</u>	<u>ON THE SPOT COUNSEL</u>	<u>AGENCY COUNSELLOR</u>	<u>OTHER</u>	<u>UNIDENTIFIED</u>
Windsor August	242	2	2	10
Toronto August	218	4	23	10
Windsor November 1 to 8	30	1	0	8
Toronto November 1 to 8	55	3	1	5

However, "on the spot counsel" includes those callers who the volunteer suggested that they contact another agency (see Table 7). The category "other" appears to have been checked off whenever "on the spot counsel" or "referred to counsellor" did not seem applicable. Under "unidentified", the authors placed all those check-lists for which the volunteers in Windsor and the researchers in Toronto neglected to answer Question 3 (Appendix 4).

Comparing the foregoing data with that illustrated in Figs. 14 - 17, and Table 7, the writers found that the agencies in this study, and more specifically the telephone volunteers, effectively met the needs of approximately two-thirds of the Windsor callers and half of the Toronto callers during August 1970. From November 1 - 8, 1970, more than two thirds of the callers to Tel-A-Friend were assisted by the telephone volunteers, as were half of the callers to the Distress Centre in Toronto.

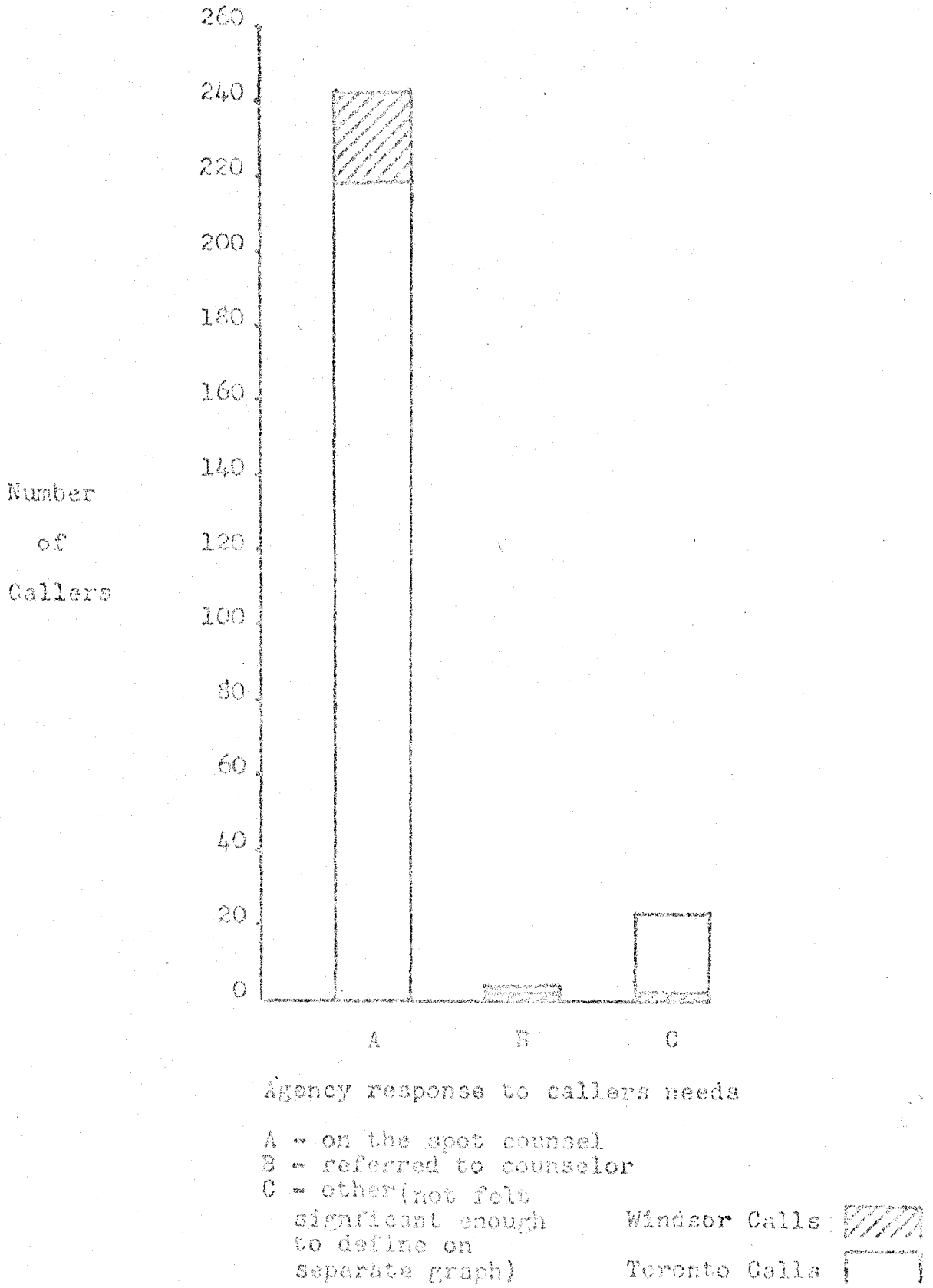


Figure 12

August 1 - 31, 1970

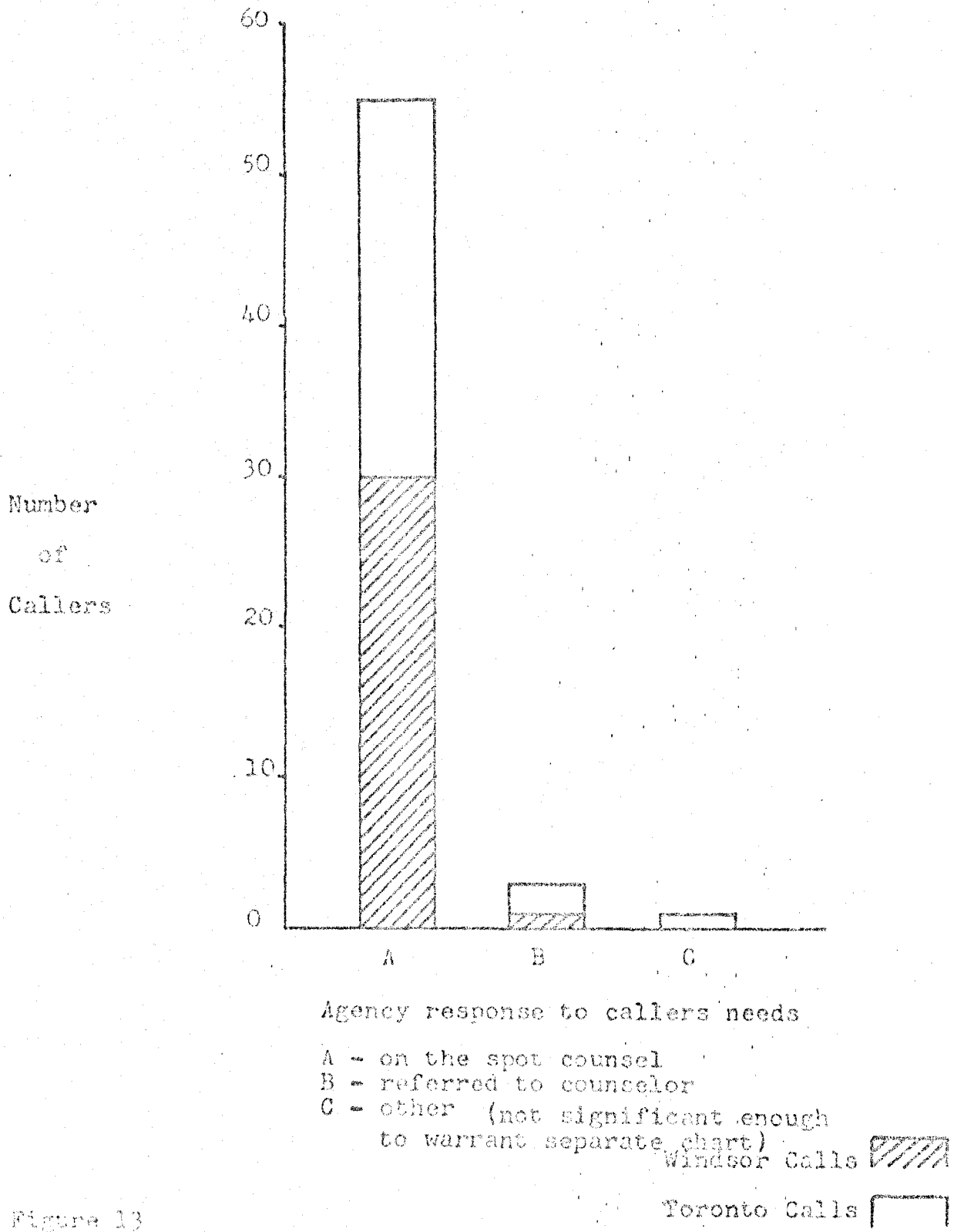


Figure 13

November 1 - 8, 1970

TABLE 7

TELEPHONE VOLUNTEERS DISPOSITION OF CALLS

<u>LOCATION AND DATE</u>	<u>NO REFERRAL</u>	<u>REFERRAL TO OTHER AGENCY</u>	<u>UNABLE TO HELP</u>	<u>UNIDENT- IFIED</u>
Windsor August	164	50	10	32
Toronto August	131	39	75	10
Windsor November 1 to 8	37	1	1	0
Toronto November 1 to 8	39	16	7	2

Examination of Tables 8 and 9, and Figs. 15 and 17 show that the volunteers in both the Toronto and Windsor agencies, suggested that the majority of the callers needing assistance not offered by their agency, contact social service agencies during August 1970.

During the week of November 1 - 8, 1970, callers to the Distress Centre were advised to contact a variety of community resources.

TABLE 8

CLASSIFICATION OF REFERRAL AGENCIESFOR AUGUST 1970

<u>CLASSIFICATION</u>	<u>WINDSOR</u>	<u>TORONTO</u>
Psychiatric	4	8
Medical	3	4
Social Service	30	22
Law and Legal	2	3
Religious	2	2
Not Identified	9	0

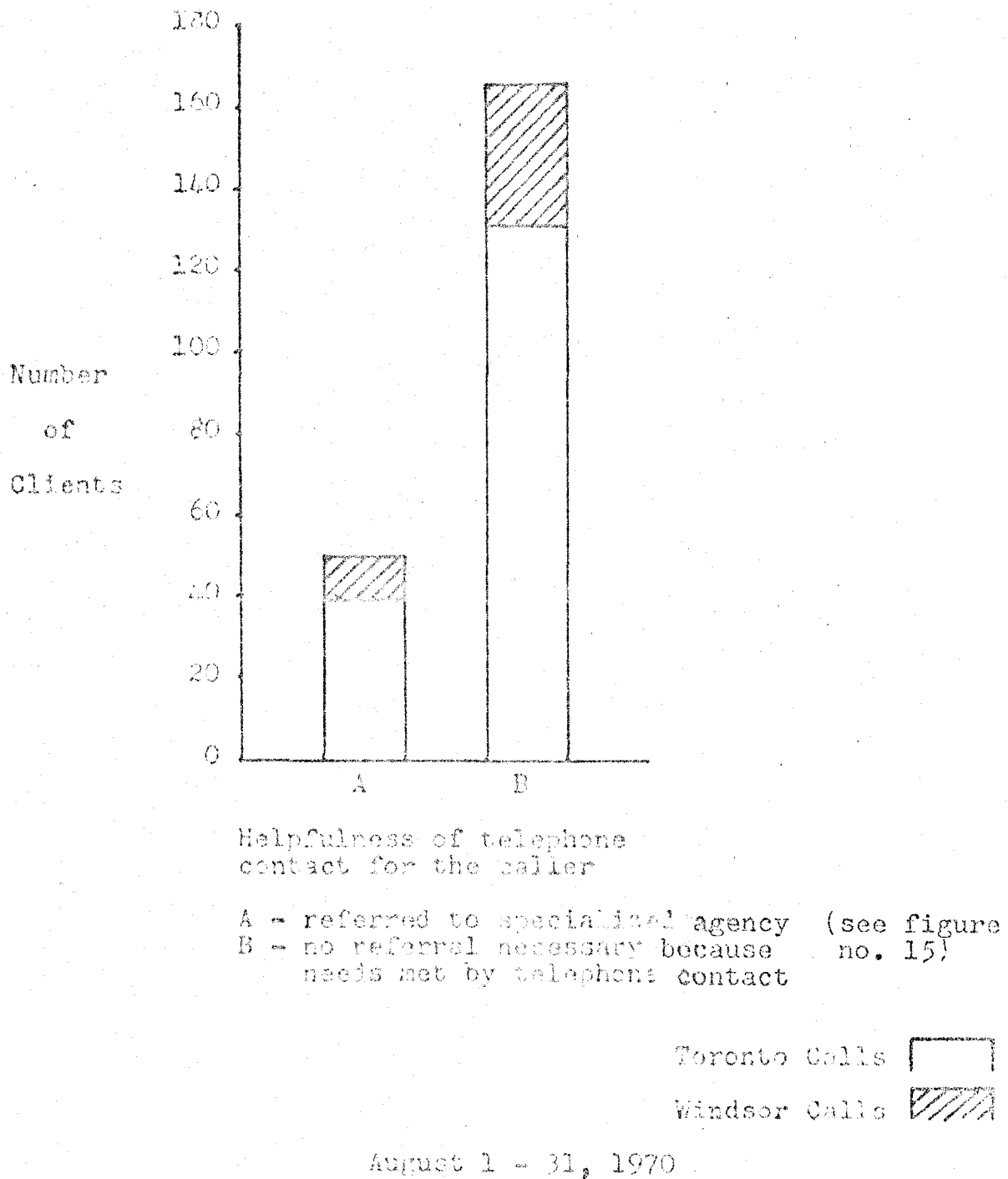


Figure 14

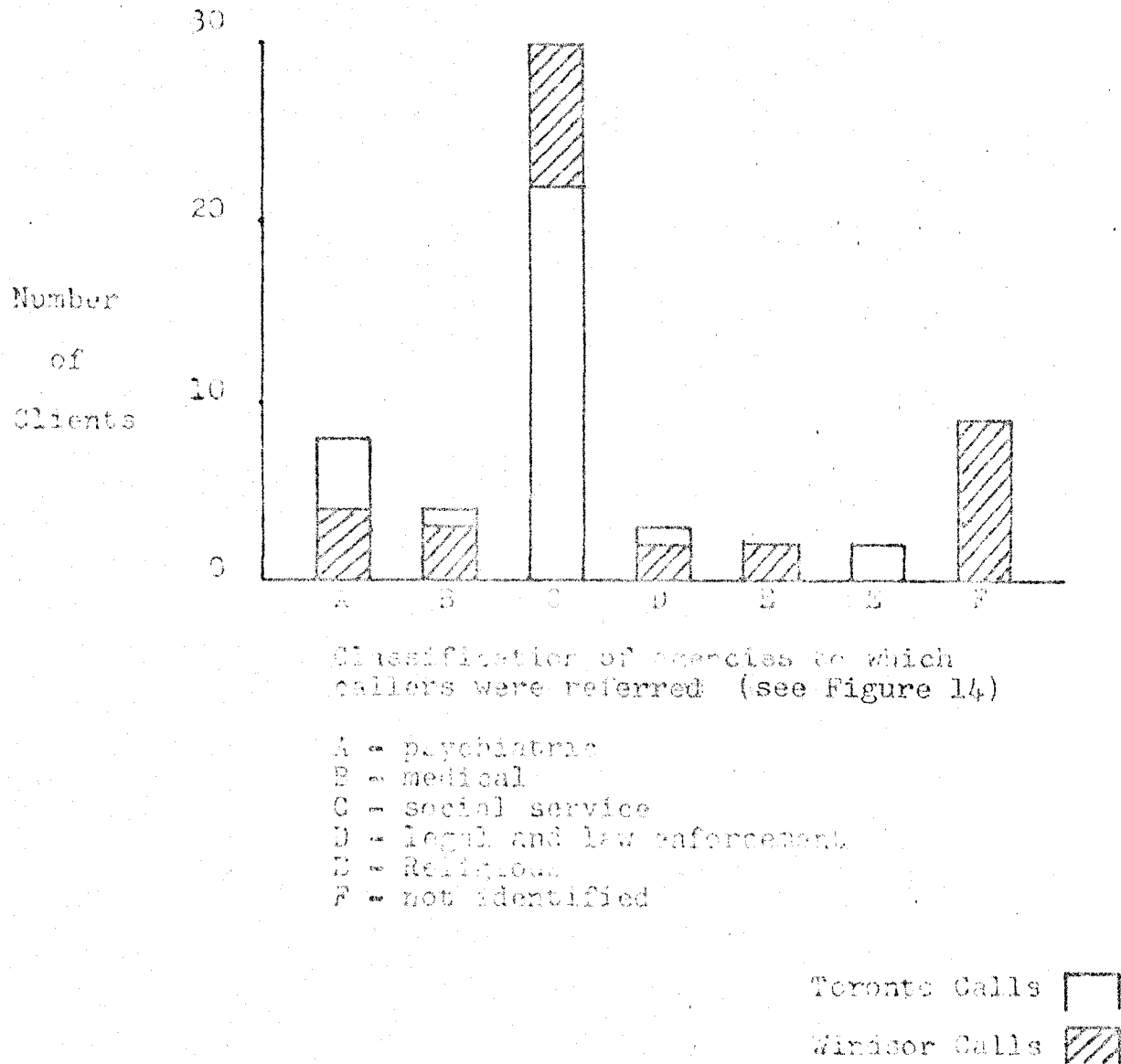


Figure 15

August 1 - 31, 1970



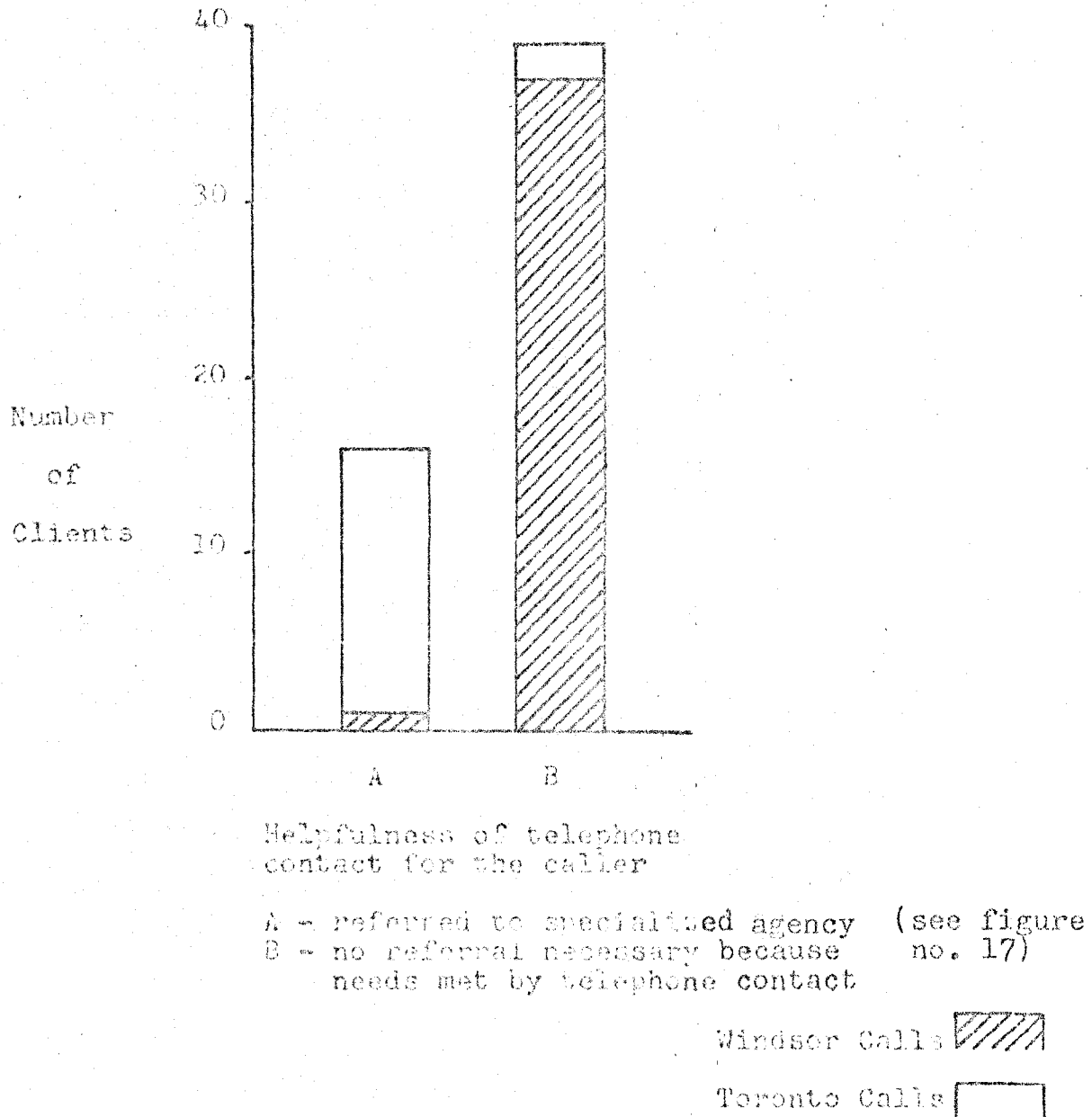
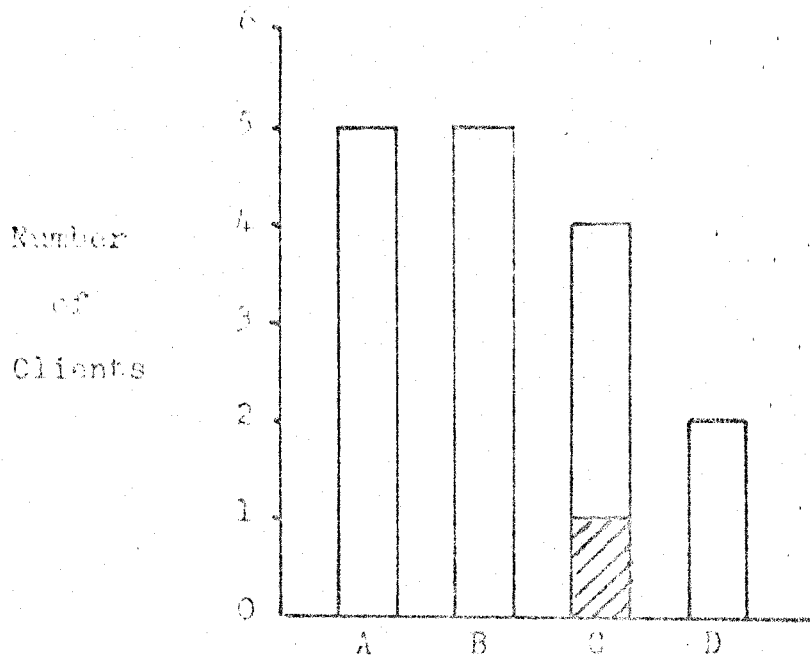


Figure 16

November 1 - 8, 1970



Classification of agencies  
to which callers referred:

- A - psychiatric
- B - medical
- C - social service
- D - legal and law enforcement

November 1 - 8, 1970



Windsor Calls   
Toronto Calls 

Figure 17

TABLE 9

CLASSIFICATION OF REFERRAL AGENCIESFOR NOVEMBER 1 - 8, 1970

<u>CLASSIFICATION</u>	<u>WINDSOR</u>	<u>TORONTO</u>
Psychiatric	0	5
Medical	0	5
Social Service	1	4
Law and Legal	0	2

If it can be assumed that the type of agencies to which callers were referred were suggested because of the specific problem presented by the caller, then it can probably be assumed that the volunteers in these two agencies can make appropriate referrals, and are aware of the referral resources available in each of their communities.

Since the authors have already explained at considerable length why they felt the Toronto volunteers probably assessed their service as less effective than the Windsor volunteers, this explanation will not be repeated again.

Having now established that the telephone volunteers in this study appeared to effectively handle the majority, or at least half of the calls coming to their agencies, we will now examine their impression of the effect of their intervention on the caller.

Through inclusion of Question 4 (A) and (B) in our check-list (Appendix 4), the researchers tried to establish whether any change occurred in the mood of the caller during the call (Tables 10 - 13, and Figs. 18 - 26a).

It should be noted that the total of the moods identified by the volunteers, does not coincide with the study sample, since each caller was described as exhibiting more than one mood during the call. Careful examination of Tables 10 - 13 indicates that the telephone volunteers were able to effect a positive change in the mood of the caller during the telephone contact. The only exception to this appears in Table 10 in the Windsor sample, where there seemed to be more people agitated at the end of the call than at the beginning; and there also appeared to be a decrease in the number of calls classified as coherent at the conclusion of the telephone contact. It should be emphasized that these records were made during the first full month of the agency's operation, when the volunteers would be inexperienced, and under a great deal of stress. Table 10 should be compared with Table 12 which gives a recording of data by volunteers in the same agency, after it had been in operation for four months. The data in Table 12 seems to parallel that recorded in Tables 11 and 13 from the Toronto agency which has been in operation for three years.

The researchers noted that the volunteers in both Windsor and Toronto felt they were dealing with individuals who were primarily depressed, lonely and distressed, and that they were effective in alleviating these moods in a number of their callers. A dramatic change is shown on Tables 10 and 11, which the authors find difficult to accept

TABLE 10

MOOD OF CALLER

Windsor - August 1970

<u>CLASSIFICATION OF MOOD</u>	<u>BEGINNING</u>	<u>END</u>
Depressed	53	18
Lonely	59	16
Angry	19	7
Distressed	46	18
Agitated	37	63
Coherent	52	17
Confused	42	4
Defensive	5	0
Helpless	18	0
Anxious	5	0
Drunk	2	0
Curious	6	0
Pleased	5	0
Bored	5	0
Improved	0	107
Not Improved	0	6
Can't tell	0	4
Sleepy	0	1

TABLE 11

MOOD OF CALLER

Toronto - August 1970

<u>CLASSIFICATION OF MOOD</u>	<u>BEGINNING</u>	<u>END</u>
Depressed	79	50
Lonely	96	60
Angry	19	3
Distressed	76	48
Agitated	37	1
Coherent	2	12
Confused	26	6
Defensive	7	7
Helpless	7	7
Anxious	2	0
Drug stone	4	3
Grateful	9	7
Drunk	13	9
Unable to sleep	1	0
Seeking information	3	1
Sex Urge	1	0
Felt better	0	77
Can't tell	0	8
Coma	0	1
Drug talk down	0	3
Extremely independent	0	1

TABLE 12

MOOD OF CALLER

Windsor - November 1 - 8, 1970

<u>CLASSIFICATION OF MOOD</u>	<u>BEGINNING</u>	<u>END</u>
Depressed	12	1
Lonely	12	4
Angry	1	0
Distressed	7	1
Agitated	3	2
Coherent	4	9
Confused	9	3
Normal	1	0
Unable to sleep	1	0
Anxious	1	0
Questioning	1	0
Drug stone	1	1
Information seeking	1	1
Improved	0	24

TABLE 13

MOOD OF CALLER

TORONTO - November 1 - 8, 1970

<u>CLASSIFICATION OF MOOD</u>	<u>BEGINNING</u>	<u>END</u>
Depressed	35	8
Lonely	11	8
Angry	5	5
Distressed	25	18
Agitated	10	4
Coherent	0	1
Confused	9	5
Defensive	6	5
Helpless	9	9
Unable to sleep	1	1
Drunk	3	3
Unable to eat	1	1
Information seeking	2	1
Suicidal	2	0
Physically ill	1	0
Senile	1	1
Improved	0	23
Grateful	0	1
Anxious	0	1



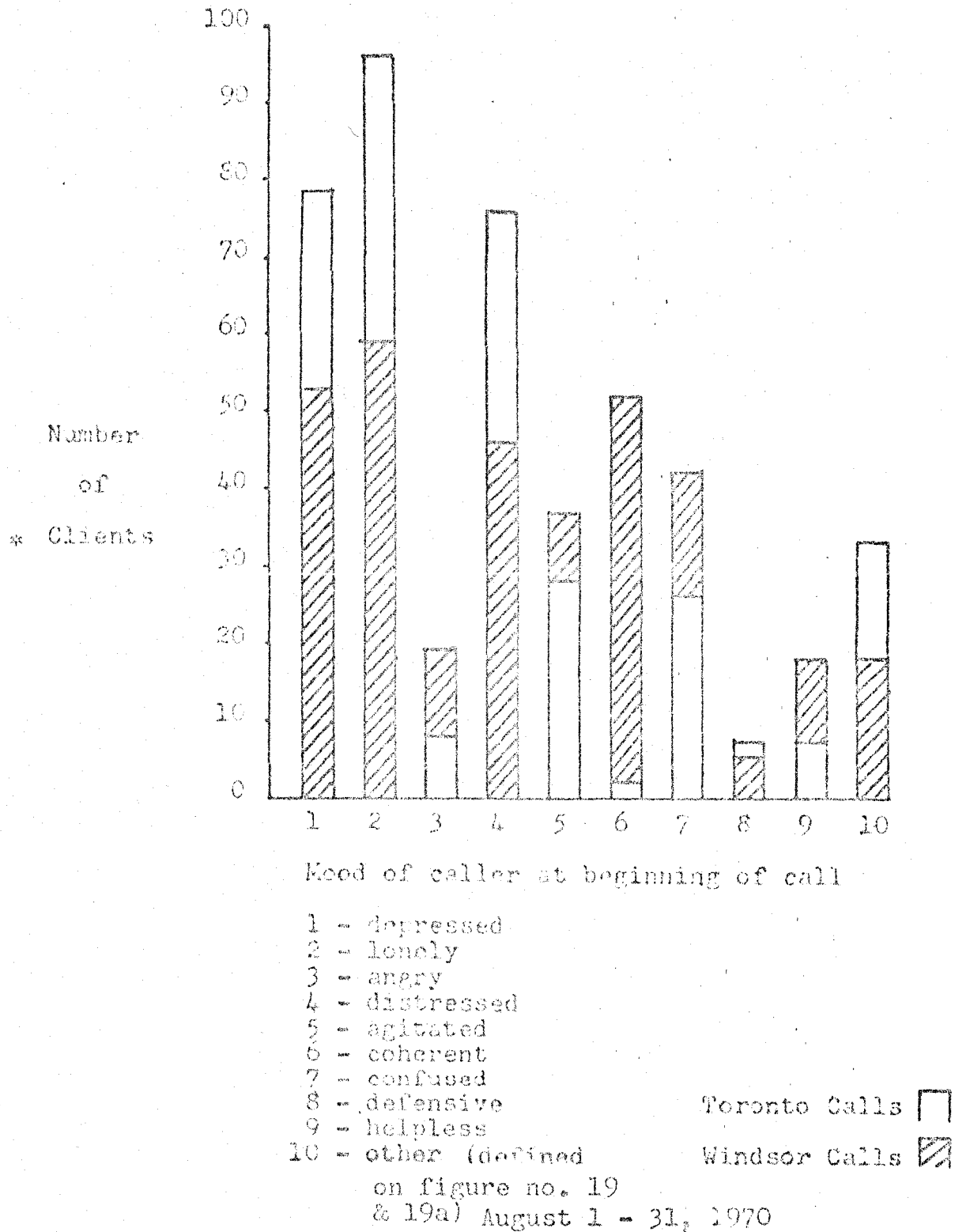


Figure 17 (some clients were classified under more than one mood)

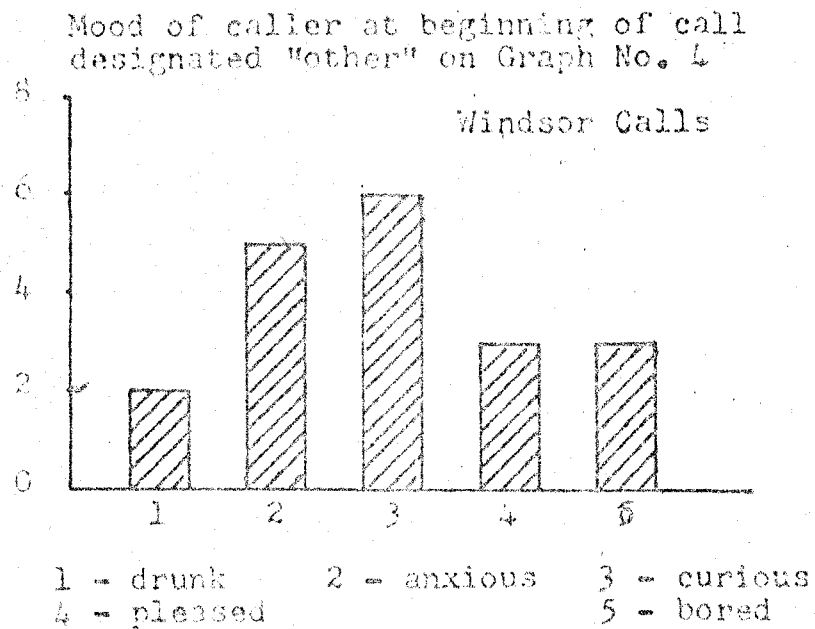


Figure 19

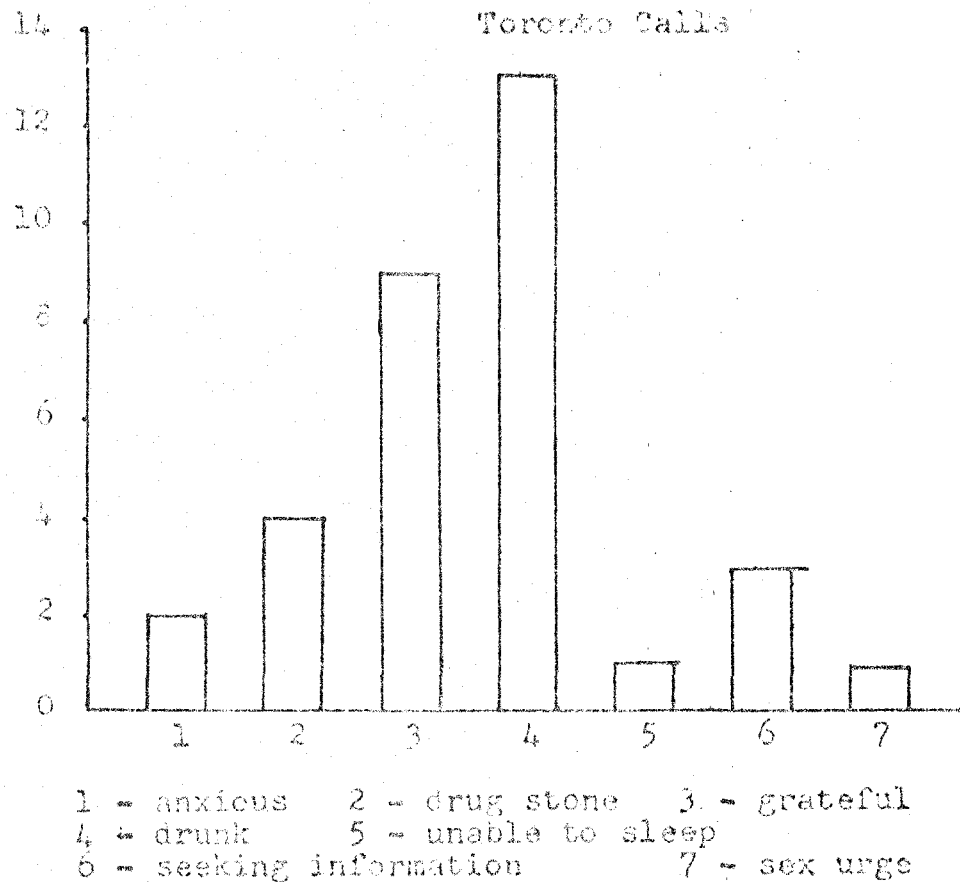
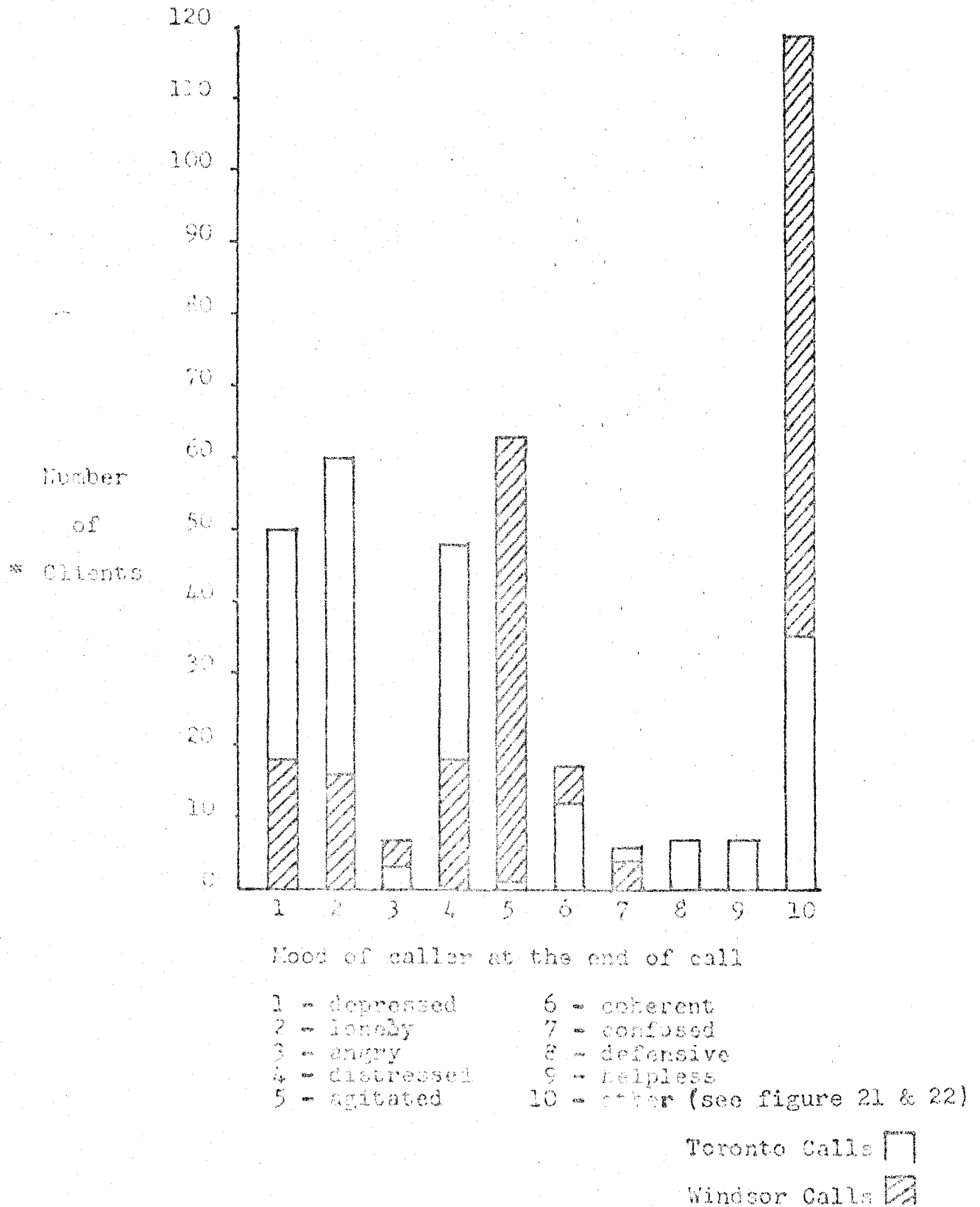


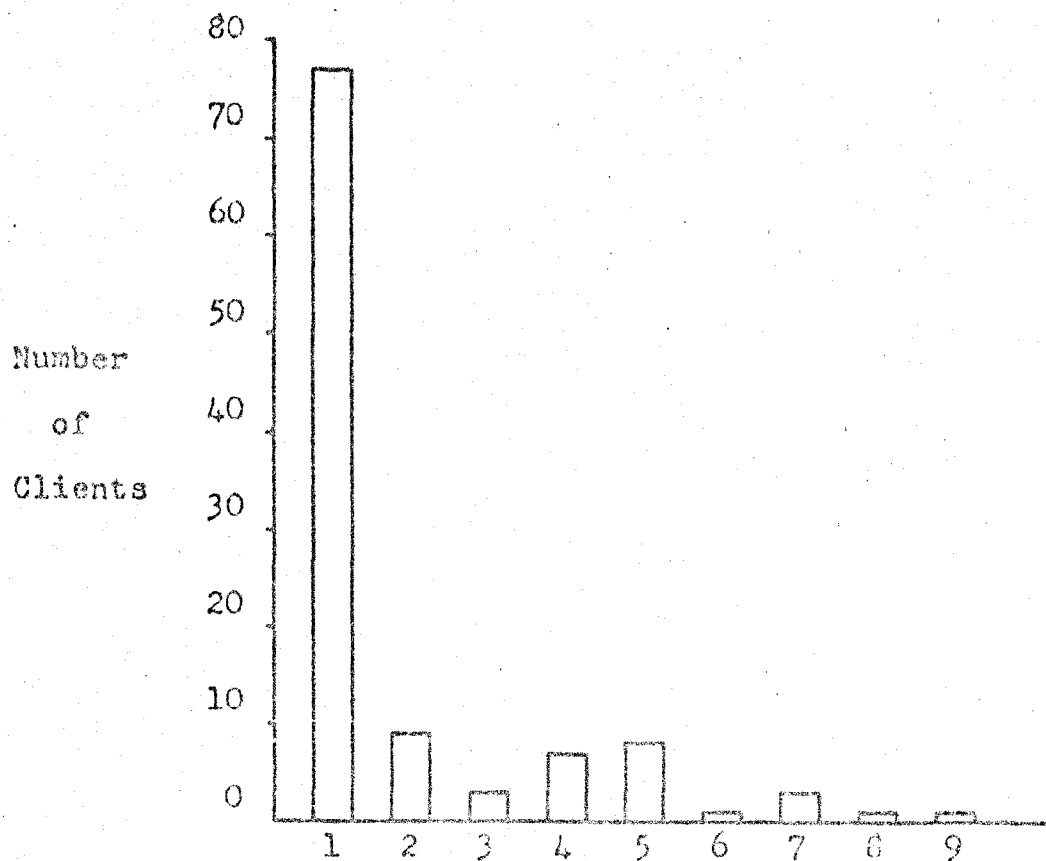
Figure 19a

August 1 - 31, 1970



August 1 - 31, 1970

Figure 20 \* (some clients were classified under more than mood)



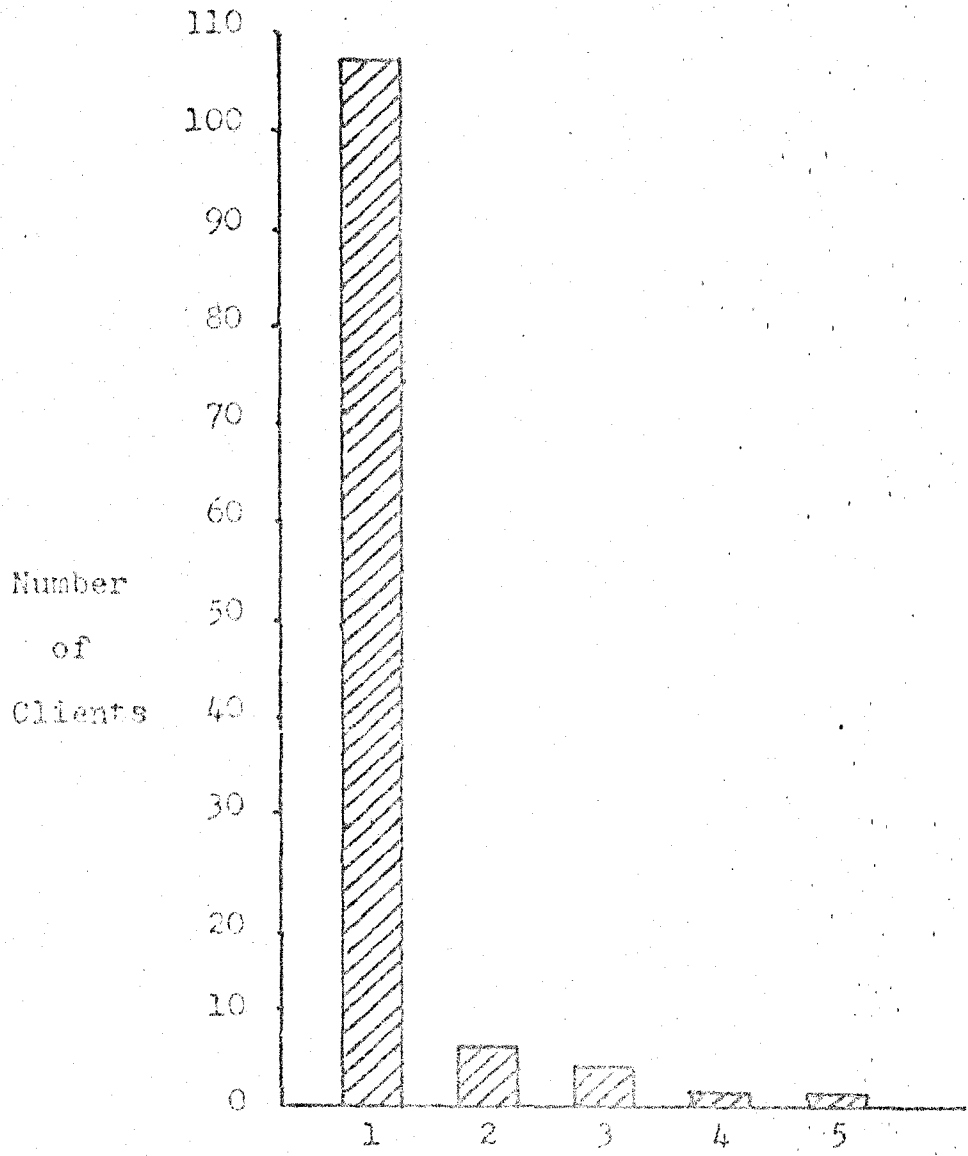
Mood of caller at end of call as defined under "other" Figure No. 20

1. felt better
2. drunk
3. drug stone
4. grateful
5. can't tell
6. coma
7. drug talk down
8. seeking information
9. extremely independent

Toronto Calls

Figure 21

August 1 - 31, 1970



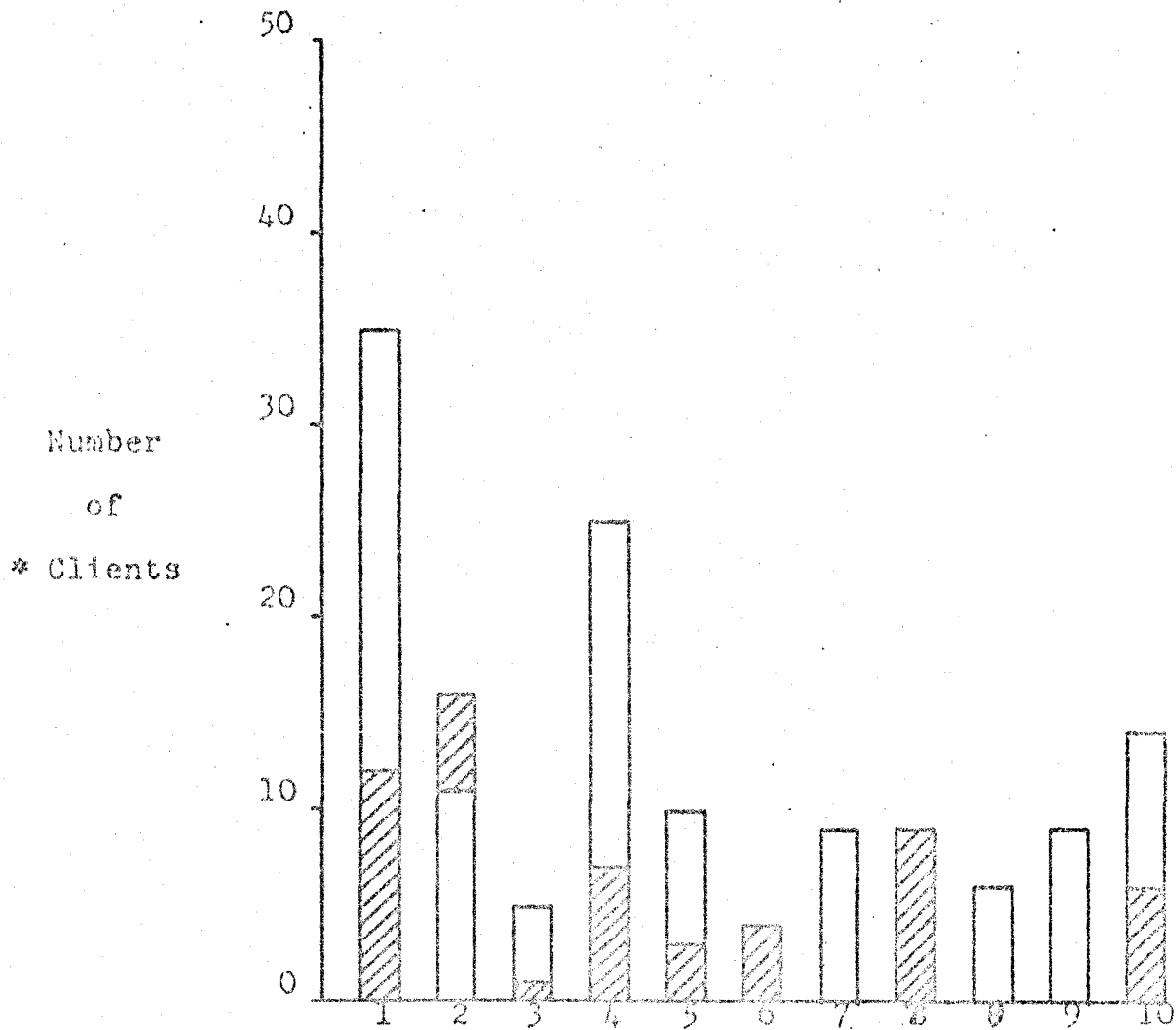
Mood of caller at end of call designated as "other" Figure No. 20

- 1 - improved
- 2 - not improved
- 3 - can't tell
- 4 - sleepy
- 5 - curious

Windsor Calls

Figure 22

August 1 - 31, 1970



Mood of caller at beginning of call

- 1 - depressed
- 2 - lonely
- 3 - angry
- 4 - distressed
- 5 - agitated
- 6 - coherent
- 7 - confused
- 8 - defensive
- 9 - helpless
- 10 - other

Windsor Calls

Toronto Calls

(see figure No. 24 & 24a)  
November 1 - 8, 1970

Figure 23

\*(some clients classified under more than one mood)

Mood of caller at beginning of call  
as designated "other" on Figure No. 23

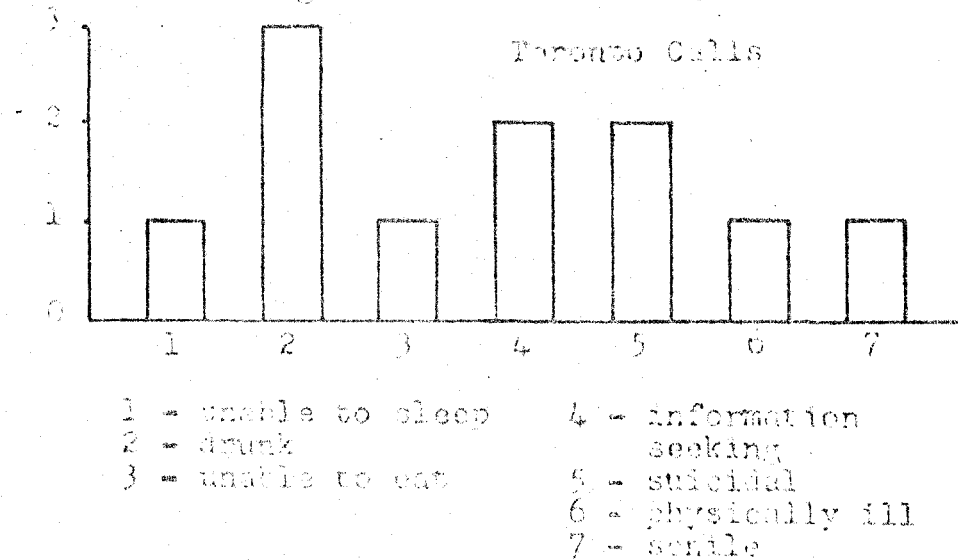
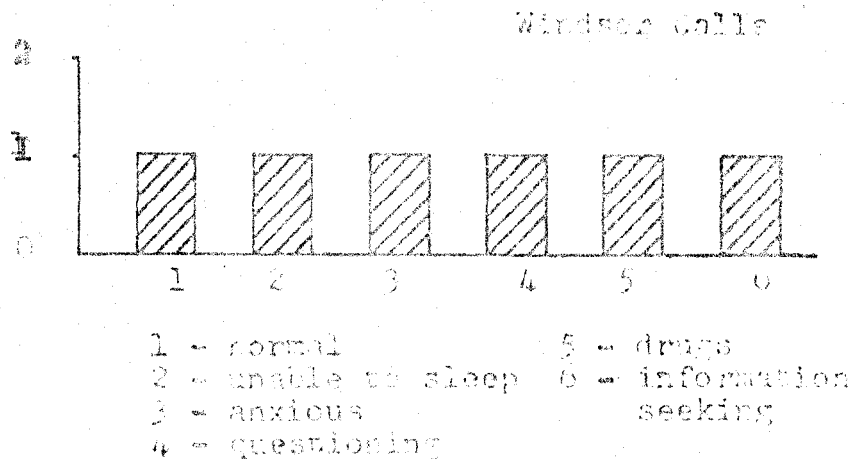
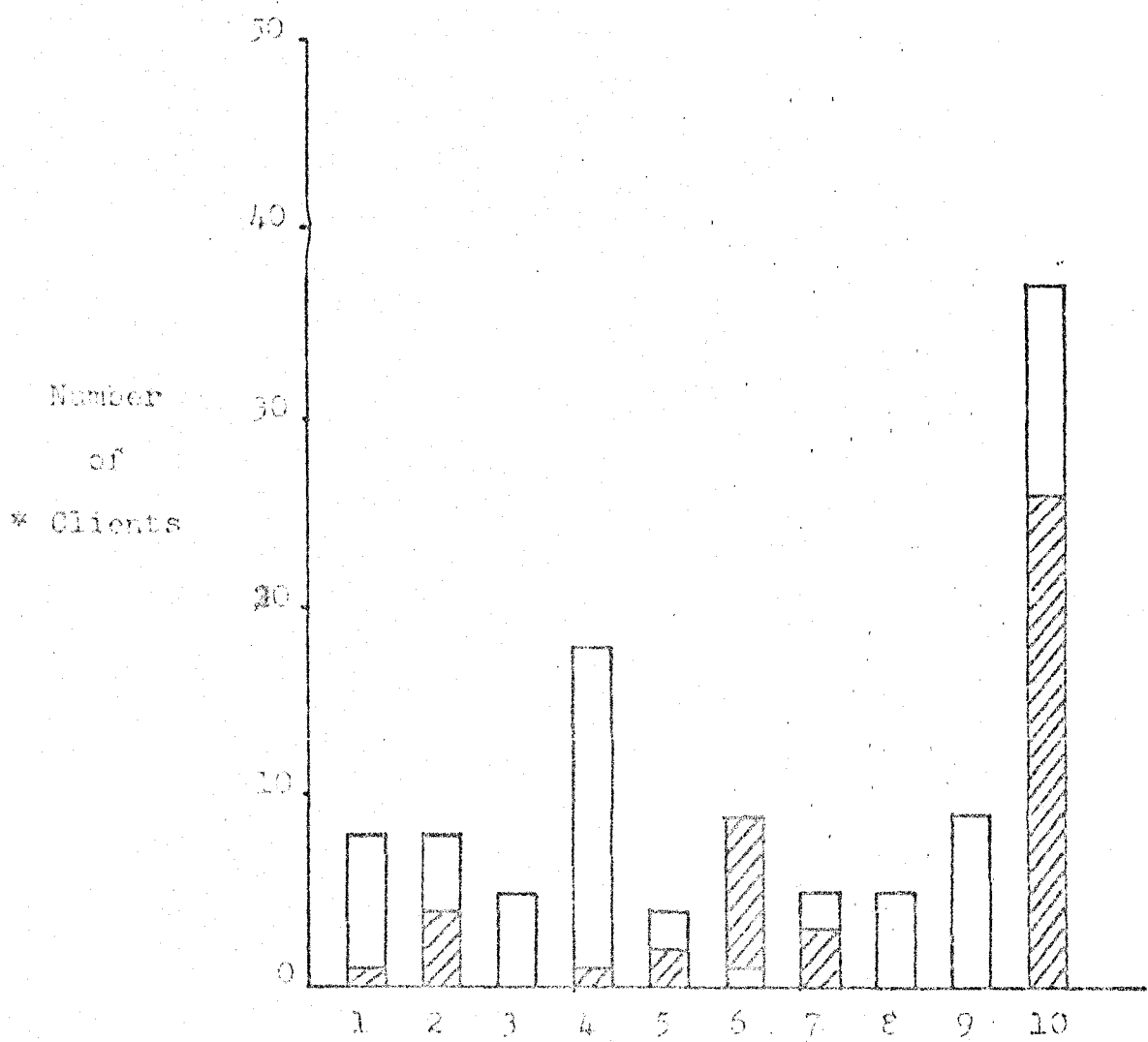


Figure 24



November 1 - 8, 1970

Figure 24a



Mood of caller at the end of call

- 1 - depressed
- 2 - lonely
- 3 - angry
- 4 - distressed
- 5 - agitated
- 6 - coherent
- 7 - confused
- 8 - defensive
- 9 - helpless
- 10 - other (see Figure 26 and 26a)

Windsor Calls [Hatched Box]  
 Toronto Calls [White Box]

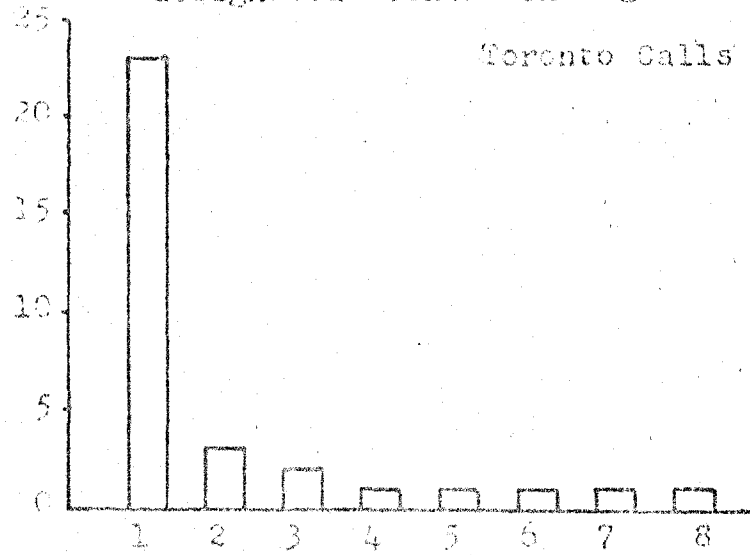
November 1 - 8, 1970

\*(some clients classified under more than one mood)

Figure 25

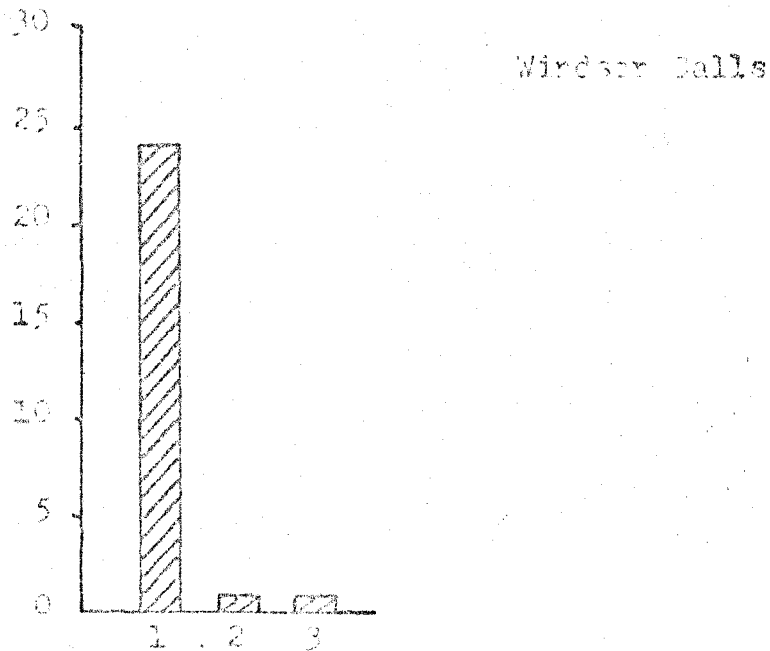


Need of caller at end of call designated "other" on Figure No 25



- 1 - improved
- 2 - drunk
- 3 - seeking information
- 4 - grateful
- 5 - unable to sleep
- 6 - unable to eat
- 7 - anxious
- 8 - senile

Figure 26



- 1 - improved
- 2 - information seeking
- 3 - drug abuse

Figure 26a

November 1 - 8, 1970

as authentic, i.e. the sobering of two drunks in Windsor, and four in Toronto.

Analysis of Figs. 10 - 26a, and Tables 6 - 13, reveal that the telephone volunteers of Tel-A-Friend, Windsor and the Distress Centre in Toronto, personally handled the majority of calls to these two centres. Very few callers were assessed by these volunteers as needing help from either their own agency counsellors, or other community resources. The volunteers also felt that they did effect some positive change in the mood of many of the callers during the call. The moods identified most frequently in callers to these two agencies were: depression, loneliness and distress.

It appears that until some method of evaluating the clientele's perception of the effectiveness of telephone crisis intervention, researchers will remain dependent on the agency volunteer's subjective evaluation of his effectiveness. The method used at present by the majority of these agencies to interpret the need for their service in a community is a monthly newsletter, reporting the total number of calls handled, and classifying these as specific social problems, e.g. personal - social; alcohol - drugs; family - marital; suicide; legal. The research tool for this study was not designed to identify the social problem of the caller, but the investigators did learn that the majority of the calls came from females, and individuals who were concerned about personal conflicts. These

personal conflicts, however, were not defined in terms of specific social problems.

This study, and the analysis of literature concerning telephone crisis intervention centres seems to indicate that most claims of effective service rendered are related to the number of calls received by the agency during a specified period of time, and whether or not the telephone volunteer felt his intervention effected a change in the caller's emotional state.

## CHAPTER IV

### CONCLUSIONS

#### FINDINGS:

The purpose of this research was stated in Chapter II, "The Research Procedures", on p. 44, and the foregoing analysis of the data collected in Chapter III does at least partially answer the questions posed in the research proposal:

1. If we accept the volunteers assessment of their effectiveness in bringing about a change in the mood of those callers considered to be depressed, lonely or distressed (see Tables 10 - 13), we can state that the callers to Tel-A-Friend in Windsor, and the Distress Centre in Toronto, have the type of social and psychological needs which the volunteers are prepared to handle.
2. If it is safe to assume that the telephone volunteers, in the two agencies from which data was collected, are capable of making an accurate and unbiased evaluation of the degree of helpfulness experienced by their clients through their intervention, then we would have to consider Tel-A-Friend in Windsor as giving a better quality of service than The Distress Centre in Toronto (Table 5) However, the authors feel the volunteers

in Windsor were under pressure to present themselves as exceptionally effective, whereas the Toronto volunteers may have under-estimated the value of their service to some of their more difficult clients. The authors did feel that both agencies seemed to be aware of when to refer clients to other resources, and the resources available within each of their communities. (Tables 8 and 9).

3. If it is accepted that crisis is the "emotional state, the reaction of the individual or family group to the hazardous situation, not the hazardous situation per se" (see p. 4, f.n. 4) as defined by L. G. Selby, then it appears that the two agencies in this study are engaged in crisis intervention. The authors also feel that if we are prepared to accept that the volunteers feel that the majority of their interventions effect a change in the caller's emotional state, then it follows that these agencies are engaged in offering an effective crisis intervention service to their communities. (see Tables 10-13).
4. The research tool was designed to evaluate the service rendered by Tel-A-Friend in Windsor and the Distress Centre in Toronto so a comparison could be made of the effectiveness of these two agencies in serving their clients. However, this tool did not provide for a comparison of the function and approach of these

two agencies. The researchers through survey of literature, i.e. agency brochures, policy guidelines, newsletters and other publicity about the agencies, became aware of certain similarities and differences in the approach of those two agencies.

Tel-A-Friend in Windsor does not have any full-time paid staff, it only operates from 8 p.m. to 1 a.m. on week days and 6 p.m. to 2 a.m. on weekends, and do not provide an ongoing training programme for their volunteers, nor do they keep any record of calls coming into their agency. The Distress Center in Toronto, has a full-time paid Director, operates 24 hours every day of the week, provides a continuous on-going training programme for their volunteers, and keep very good records on every call coming to their agency (see Appendix 5 Call Report). Further the Distress Centre in Toronto acts as a consultant to any new telephone crisis intervention service. Recently a conference was held at the Distress Centre to which eleven similar agencies were invited to send representatives. Tel-A-Friend in Windsor was one of four agencies invited who did not send a representative.

It appears that while there are differences in the structure and function of Tel-A-Friend in Windsor and The Distress Centre in Toronto; there appears to be a great similarity in the manner in which callers to each of these agencies are handled by the telephone volunteers. The majority of callers to both these centres seem to

reveal many common characteristics, in that most of them are female, and usually call about personal difficulties, and appear to be depressed, lonely or distressed. Now that we have identified both the differences and similarities between the two agencies compared in our study, we would like to look at the implications of these findings in relationship to the service of telephone crisis intervention centres in a community.

### IMPLICATIONS

Telephone crisis centres can and should be considered a valid method of crisis intervention, in that they provide the caller with readily available assistance at the peak of the felt crisis. The telephone provides an appropriate medium for callers to discuss deep, meaningful personal calls, while maintaining anonymity. This was borne out by the number of calls concerning sexual problems reported in the statistics of various agencies in the literature. Telephone crisis intervention centres do not limit their contact with the troubled individual to the telephone only, but also have trained personnel who are prepared to become involved at a personal level when a caller requests such involvement.

In order to establish and maintain an efficient ongoing service these agencies must meet certain requirements. During the establishment phase, it has been the experience of such international telephone crisis centres as the Samaritans of England and Life-Line of Australia,

that careful planning in the areas of policy, physical location, financial backing, record keeping and volunteer screening and training are necessary prior to commencing service. In Sydney, Australia, Dr. Allan Walker, Director of Life-Line, reports that the service did not open until five years of pre-planning had taken place. At the point of commencing service this agency had one hundred volunteers ready to man two telephones twenty-four hours a day. After inception of service these agencies report the need for continuous recruitment and training of volunteers, in-service training for active volunteers, regular periodic re-evaluation of service, records, etc. and research related to the effectiveness of the service.

Crisis intervention is a time limited means of aiding the person. Because of this limitation it cannot be expected to solve all problems: i.e. long term, chronic problems, will require traditional terms of treatment. Volunteers in the telephone crisis centres may require the assistance of auxiliary personnel in order to assess the appropriate agency to which callers requiring other than first-aid treatment should be referred. It is imperative that the volunteers be familiar with the resources available within their community.

In both on-the-spot counselling and referral the telephone volunteers should have direct contact with the person in conflict. Social science literature confirms that it is difficult, if not impossible to help any individual



who has not requested assistance. Since more females than males use this service, special consideration should be given to training the volunteers to help women deal with crisis situations.

An examination of the records of The Distress Centre in Toronto reveals that a number of their repeat callers, not only call every day, but during a particular period of crisis will call several times during one day. Usually the call is used to receive support to carry out a social function which the caller fears tackling. At times these callers will call the volunteer to report that the task has been successfully accomplished. Since few professionals are free to offer this form of support the authors assume that many of these repeat callers, without this form of assistance might have to be permanently institutionalized.

Our comparative exploratory study findings appear to support the impression gained through our survey of the literature, that where telephone crisis intervention services have been well established they easily acquire the support and respect of the overall professional community.

#### LIMITATIONS OF THE STUDY

Early in the carrying out of the research process we discovered that we were handicapped by our tool and data collection technique. We recognized that these handicaps would limit the implications that could be made from the findings of the study.

Limitations of the Tool:

Since we were unaware of any existing tool to collect data as defined in our research design we produced our own tool. Therefore, this tool has not been tested for validity or reliability.

Our tool did not permit us to measure the quality of help the caller received. This could only be assessed through a longitudinal follow-up study using an already established tool to measure effect of call on caller's subsequent functioning in daily life tasks.

We were unable to establish whether a suggested referral to another setting was ever carried through to its conclusion by the client. In order to confirm this it would be necessary to know who was referred, where they were referred to, and whether the agency to which they were referred was contacted by the client. This would require designing a tool to collect the above information and the co-operation of the client and agencies involved. It should be noted here that one of the distinguishing features of the service offered by telephone crisis centres is a guarantee of the anonymity of both the caller and volunteer, which inhibits this type of research.

The tool used in this study did not allow us to measure the type of social problem that telephone crisis intervention centres handle best. While the majority of the centres do compile monthly statistics of the categories of the problems of their callers, there has been no ext-

ended study of the overall population of these centres in relationship to problems handled. Though it has been assumed that a major task of these centres is suicide prevention, this is not borne out by the survey of literature<sup>1</sup> or the results of our study.

Limitations of our Data Collection Technique:

Since this study was undertaken in Windsor near the inception of Tel-A-Friend's service, when the volunteers and agency were undoubtedly under a great deal of strain, a number of problems were encountered. At this point in time this agency had not developed an adequate record keeping system. Consequently, the volunteers had no experience in this area, and the researchers had to teach them how to complete the check-list. Some of the telephone volunteers felt the completing of these records interfered with their being able to totally concentrate on the needs of the caller. A few of the volunteers saw any form of record keeping as being inconsistent with the agency's policy of anonymity.

While Toronto had a more than adequate system of record keeping this introduced another form of limitation. In this setting the researchers had to fill out the check-list from the agency's record sheet. This forced the researcher to interpret the telephone volunteer's assessment of the caller's problem, and permitted the possibility of researcher bias.

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<sup>1</sup>I. William Weiner, "Effectiveness of a Suicide Prevention Program", Mental Hygiene, No. 55, July 1969, pp. 357-363.

In order to provide a numerically comparable sample with Windsor, we decided to randomly select every fourth call to the Toronto agency. However, we discovered that this centre classifies each call, and then files the record of it under one of three categories: i.e. regular call, repeat call, suicide call. Therefore, instead of doing a numerically random selection, we chose every fourth call from each of the three categories.

We were limited in procuring a truly comparative sample during the period of November 1 - 8, 1970 because the Windsor centre was unable to operate on November 6th due to a lack of volunteers. They also recorded the calls received on November 7th, rather than November 6th, which we did not notice until it was too late to remedy. In Toronto the volunteers make a record of each call, no matter how insignificant they may judge it to be. However, in Windsor, some of the volunteers recorded only the calls they felt were significant, and as a result on August 29th only one call was recorded. Other volunteers in Windsor discussed this matter with the researcher and questioned the value of recording any calls concerning sexual problems, feeling these were all crank calls.

#### SUGGESTION FOR FURTHER RESEARCH

This study and our survey of the literature indicates that there are many unanswered questions concerning telephone crisis intervention. The authors feel there is probably a significant relationship between the sex ratio of

callers to these agencies and sex ratio of inmates in mental health facilities. In this relationship, it would be also interesting to compare the age of callers to a telephone crisis intervention centre, and the age of patients in mental health facilities.

As mentioned earlier our tool was not designed to assess the social problem of callers to the two agencies in our study, but it appears from many of the statistics reported by telephone crisis intervention centres that suicide calls do not constitute a high percentage of the total number of calls handled by these agencies, e.g. out of 27,000 calls received by the Distress Centre from 1968 until the end of January 1971, 6% to 10% were suicidal.<sup>2</sup> The authors would again refer you to their summary of Dr. I. William Weiner's study "The effectiveness of a suicide prevention program" (see pp. 42-46), and feel some further investigation should be done re whether or not it is realistic to expect the suicidal person to take the initiative in reaching out for help.

One of the unique features of the telephone crisis intervention centre is the preservation of anonymity of the caller and the volunteer. The researchers of this study wonder if there is any correlation between this preservation of anonymity, and the effectiveness of the service rendered, but realize this would be very difficult, if not impossible to measure.

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<sup>2</sup>Some Vital Statistics, mimeographed report from the Distress Centre, Toronto, January 1971.

The Distress Centre in Toronto, and others, do receive some follow-up calls from callers, and possibly these clients might be willing to become involved in a study to assess whether or not their initial contact with a telephone crisis intervention centre provided them with skills which they were able to use when faced with a future crisis.

The foregoing are probably only a few of many questions that could be explored in future studies concerning telephone crisis intervention. Carlo L. Lastrucci states that "the main purpose of an exploratory study is an examination of a given field in order to ascertain the most fruitful avenues of research."<sup>3</sup> He further expresses the opinion that it is not wise to suggest that major research be attempted until the findings of one or more exploratory studies indicate "the feasibility and probable fruitfulness of the final research design."<sup>4</sup> With the number of unanswered questions concerning this form of social service, the authors expect that there will have to be many exploratory studies done before any hypotheses can be formulated.

#### RECOMMENDATIONS FOR TEL-A-FRIEND OF WINDSOR, ONTARIO

The authors opened their concluding remarks of this study by examining the similarities and differences revealed between Tel-A-Friend in Windsor, who requested the study, and The Distress Centre, in Toronto, who agreed to

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<sup>3</sup>Carlo L. Lastrucci, *The Scientific Approach* (Cambridge, Massachusetts: Schenkman Publishing Company, Inc., 1963), p. 105

<sup>4</sup>Ibid. p. 106

allowing the researchers using their agency for comparative purposes (see Findings pp.102-104). In the Introduction to the total study, there is a description of programs of crisis intervention and suicide prevention offered by: Samaritans International, Fish International, Life Line International, The Distress Centre in Toronto, The Distress Centre in Ottawa, Contact in London, Ontario and The Crisis Intervention and Suicide Prevention Centre in Vancouver, British Columbia (see pp. 20 - 35). An examination of these sections of this study indicate that Tel-A-Friend in Windsor has adopted the basic theory and philosophy of telephone crisis intervention, but appears to be currently inhibited in delivering the quality of service offered by the above-mentioned centres due to certain weaknesses in their structure and function.

On the basis of our findings, the writers recommend that Tel-A-Friend, in Windsor would probably find the following suggestions helpful towards improving their service in Windsor:

A) Training of Volunteers: In the above-mentioned descriptions of other programs, there is an outline of the training programme used by each agency. The majority of these agencies not only have an on-going training program to insure that they always have sufficient volunteers to guarantee continuous service, but also offer in-service training programs. Most of these agencies also have a library for the volunteers including such books as:

- 1) The Samaritans, ed. by Chad Varah (London: Constable and Company Ltd., 1965).
- 2) The Cry for Help, ed. by Norman L. Farberow, Ph.D. and Edwin S. Shneidman, Ph.D. (New York: McGraw-Hill Book Company, 1961)
- 3) Contact Manual, compiled by John Harrison, London, Ontario, Canada, (1969).
- 4) As Close as The Telephone, by Alan Walker, (Abingdon Press; Nashville and New York, 1967).

The authors feel that in this whole area of training of volunteers, that Tel-A-Friend staff and board members should avail themselves of consultation from similar agencies who have had an extended effective service, i.e. The Distress Centre, Toronto and Contact, London. Literature from both of these agencies indicates that they have found the need to continually revise their volunteer training programmes to meet the needs of their callers, as well as the volunteers. The researchers were particularly concerned by the reluctance of some of the volunteers of Tel-A-Friend to accept calls concerning sexual problems as genuine calls. Possibly more emphasis in the training programme could be given to how to handle these needs with a caller.

B) Administration of the Agency: All of the Canadian telephone crisis intervention services, with exception of "Fish International", and the majority of the agencies on the European continent, described in this study have at least one full-time paid staff member to direct the programme. The authors recommend that Tel-A-Friend consider the hiring of a full-time director for their project a priority need of their agency.



C) Finances: The authors appreciate that probably Tel-A-Friend in Windsor, does not currently have the financial resources to pay the salary of a full-time staff member, and for this reason we would recommend that they use the consultation of such agencies as The Distress Centre, Toronto and Contact, London, to discover how these agencies have succeeded in obtaining the finances needed to provide service in their communities. In a recent newsletter The Distress Centre in Toronto indicates that the costs of their service has risen from \$16,000 in 1967 to \$26,000 in 1970 and that their budget goal for 1971 is \$36,000. If Tel-A-Friend has not yet obtained a charter as a nonprofit organization so individuals and groups making donations receive a receipt for income tax deductions, this might be worthy of consideration. A legal adviser might be helpful in this area, as well as in some of the difficult situations volunteers may encounter with callers to the agency.

D) Public Relations: The Distress Centre in Toronto sends out news sheets containing up-to-date information on their agency to hundreds of churches and groups, where they have been invited to tell the story of their programme. These are usually one page mimeographed circulars. Also the daily press and weeklies have done major articles on the Centre, and their Director and some of the volunteers have been interviewed on radio and T.V. The authors do not feel that Tel-A-Friend in Windsor has received sufficient publicity to gain the financial support needed

from their community. Possibly a Publicity Committee from the Board of Directors could visit The Distress Centre in Toronto and Contact in London, and discover how they obtained publicity for their programmes. The researchers have described the public relations programmes of some of the agencies within the description of the total programme of these agencies (see pp. 20 - 35).

Public Relations is also important in terms of making the service known to those in the community who need its help. Many of the European centers have been able to get their phone number listed in the telephone directory along with other emergency telephone numbers, e.g. police, ambulance, fire department, etc.

E) Research: The authors found themselves considerably hampered in the current research project because Tel-A-Friend did not have a record keeping system, and the volunteers were not accustomed to keeping records. It is suggested that Tel-A-Friend carefully evaluate three models of records used by similar agencies found in Appendices 1, 2 and 5, and then construct one in keeping with their needs. The researchers further recommend that the agency develop a coding and filing system which would make the information concerning their calls readily available for quantitative and qualitative analysis for future research projects.

## APPENDICES

APPENDIX 1

Reviewed \_\_\_\_\_  
 Date Initials

F.R.E.S. LOG

Date and Time	Contact with Whom	Identification of Caller	Callers Statement of Problem	Done and to be Done	Comment
Date _____ Time _____	Contact T W.I. Worker	Name Address Telephone			
Date _____ Time _____	Contact T W.I. Worker	Name Address Telephone			
Date _____ Time _____	Contact T W.I. Worker	Name Address Telephone			
Date _____ Time _____	Contact T W.I. Worker	Name Address Telephone			

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APPENDIX 2

ES-IV

FRES INITIAL CONTACT GUIDE

[Empty rectangular box]

Record Number

MH Worker \_\_\_\_\_

Caller's Name (if other than client): \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Time: \_\_\_\_\_ (begin) \_\_\_\_\_ (end)

Relationship of caller to client: \_\_\_\_\_ Walk in \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Client Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

How thought to call us: \_\_\_\_\_

Relevant information about client Religion: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Educ Level: \_\_\_\_\_ Income (head household): \_\_\_\_\_

Living Arrangements: \_\_\_\_\_

Other resources

Family? \_\_\_\_\_

Clergyman? \_\_\_\_\_

Mental Health Resources? \_\_\_\_\_

Other \_\_\_\_\_

Problem as stated: (Any recent change in life pattern?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

APPENDIX 3

ASSISTANCE REPORT

Telephone Call

NUMBER.....

Volunteer..... No.....

Date.....

Time..... to .....

AME..... Location.....

Age.....

Anxious about:

Counsellor notified

Accommodation

Health:

Law Suit

.....

Home:

Drugs

Loneliness

Husband/Wife

Drinking

Children

Disability

Parents

Sleep

Other relatives

Sex

Money:

Interview appointment for:

Debt

.....

Education:

Job:

Bankruptcy

Exams

Change of work

Gambling

Data:

Retirement

Fear of:

Man/woman/child

Unemployment

EMERGENCY.....

Client wants us to:

HOME CALL.....

Phoned from:

Home.....

Pay phone.....

Work.....

Previous Calls:

Suggested personal evaluation:

Why did I deal with this caller in this manner?

APPENDIX 4

RECORD NUMBER

BENEFICIARY'S EVALUATION OF SERVICE RENDERED

1. How did caller find out about agency (Please check one only)

- (a) Newspaper Advertisement
- (b) Radio
- (c) Television
- (d) Relative
- (e) Friend
- (f) Other (Please Specify)
- 
- 

2. Did caller call for (Please check one only)

- (A) Personal Problems
- (B) Family Problems  
(Please check one of the following to indicate relationship)
- (a) wife or husband
- (b) son
- (c) daughter
- (d) relative who resides with family
- (e) relative who temporarily resides with family
- (f) boarder
- (g) friend
- (h) others (Please Specify)
- 
-

## 3. Type of response to callers needs (check one or more)

- (a) on the spot counsel  
 (b) referred to counselor  
 (c) other (Please Specify)
- 
- 

4. The mental situation of the caller at:  
(check one or more of the following)

## (A) Beginning of telephone call

- (1) depressed  
 (2) lonely  
 (3) angry  
 (4) distressed  
 (5) agitated  
 (6) coherent  
 (7) confused  
 (8) defensive  
 (9) helpless  
 (10) other (Please Specify)
- 
- 

## (B) End of telephone call

- (1) depressed  
 (2) lonely  
 (3) angry  
 (4) distressed  
 (5) agitated



(question 4 continued)

- \_\_\_ (6) coherent
  - \_\_\_ (7) confused
  - \_\_\_ (8) defensive
  - \_\_\_ (9) helpless
  - \_\_\_ (10) other (Please Specify)
- 
- 

5. I feel that the telephone contact in this case was  
(check one only)

- \_\_\_ (A) Helpful to get the caller to accept  
referral to a specialized agency.  
(if so please name agency)
- 

- \_\_\_ (B) Helpful to the caller without need for  
referral to specialized agency.

If your answer to previous question was (B), please  
answer following question.

6. In which way was contact helpful

- \_\_\_ (a) Helpful in satisfying needs and / or  
anxiety of caller
  - \_\_\_ (b) Temporarily helpful in preventing  
caller from hurting himself
  - \_\_\_ (c) others (Please Specify)
- 
- 

- \_\_\_ (d) can't tell

7. If contact was not helpful please check one of the following

- (a) Caller in such a state that no coherent conversation took place
  - (b) No available agency to make referral to
  - (c) Refusal of caller to accept help
  - (d) Others (Please Specify)
- 
- 

8. If contact was helpful, how do you categorize this help (check one only)

- (a) extremely helpful
- (b) very helpful
- (c) helpful
- (d) slightly helpful

## APPENDIX 5

## CALL REPORT

VOLUNTEER.....	NO .....	NUMBER.....	(calls are numbered consecutively from beginning to end of year)
DATE .....			
TIME .....	to.....		
NAME .....	LOCATION.....	PHONE.....	(location and phone are only requested in cases of suspected suicide)
Age .....	Caller wants		
EMERGENCY....	(requiring sending ambulance, flying squad, etc.)		
HOME CALL....	(needing a call from one of the agency's counsellors)		
F/SQUAD.....	(volunteers available to go to client)		
Man/woman/child			
Point of Contact			
Repeat Caller	(if recognized as a repeat caller then volunteer would write "yes")		
Standing Order	(prescribed method of handling repeat caller)		
Needed?	(should caller be allowed to phone frequently for help)		
Feedback	(filled in if volunteer wants feedback regarding the handling of the call from the Director who reads every record)		

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## VITAE

Russell Arthur Daniels was born on May 28th, 1941 in the city of Toronto, Ontario, Canada. He attended Brock Avenue Public School from 1946 to 1949, at which time he transferred to Islington Public School until the spring of 1955. After elementary school he attended Royal York Collegiate Institute until the end of grade 12. He completed his grade 13 at Burnhamthorpe Collegiate Institute in the academic year 1961-62.

Mr. Daniels then worked for two years at National Cash Register in Toronto as a cash register systems analyst. In the fall of 1964 he entered the Child Care Workers Course at Thistletown Hospital, from which he graduated in 1966 as a Certified Child Care Worker. He then entered the University of Windsor in 1966 and graduated in the spring of 1969 with a Bachelor of Arts degree in Psychology and Sociology. In the fall of 1969, Mr. Daniels entered the graduate program in Social Work at the University of Windsor, from which he expects to graduate in May, 1971 with a Masters Degree in Social Work.

Audrey Wright was born in Toronto, Ontario in 1923 and attended Winchester Street Public School and Eastern High School of Commerce. She then worked for eight years at office work in Toronto, first in a printing machinery sales office, and later as a medical secretary for the Department of Veterans' Affairs.

Audrey was a member and youth leader in the United Church of Canada, and became interested in a church vocation. She took a three year religious education course at Emmanuel Bible College in Kitchener, Ontario, and after a brief commitment to the Waterloo County W.C.T.U., became a church social service worker at Archer Memorial Hospital, a United Church hospital in Lamont, Alberta. Audrey returned to Ontario after four years in Alberta and joined a Christian community, Hidden Springs Centre, near Brantford, a residential treatment centre for the emotionally disturbed. While functioning as business manager, she also gave leadership in arts and crafts, recreation, worship services and group therapy.

In 1963 Audrey was accepted at the University of Waterloo, graduating in 1966 with a General B.A. in Sociology. Following graduation she worked for three years with Brown Camps Ltd., a residential treatment centre for emotionally disturbed children in Vancouver, B.C. During the first two years she was a child care worker, and then became a caseworker.

Audrey entered the make-up year of the graduate programme in social work at the University of Windsor in the fall of 1969, and expects to receive her M.S.W. in May 1971.