# CRISIS INTERVENTION 1970

## Supplement to Volume 2, Number 2

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CRISIS INTERVENTION

The staff of the SPCS of Buffalo believes that there is a need to develop a method by which the ideas and programs of the more than 100 suicide prevention centers in the United States can be shared. The history of suicide prevention centers is very short and the process of development and the programs of each center differ greatly. Yet all are designed to reach a very special individual and to do so primarily through telephone contact. If we can share the ideas and programs which we have developed through the difficult and arduous process of experience, we can learn from each other's successes and mistakes and, having a greater fund of experiences at our disposal, improve the quality of service to the individual in need.

With this goal in mind, we have established a new bulletin CRISIS INTERVENTION: The Bulletin Of The Suicide Prevention And Crisis Service Of Buffalo, New York. Each issue will be concerned with 3 major areas:

1. Programs of suicide prevention centers,
2. Clinical aspects of crisis intervention and suicide prevention, and
3. Current issues and research in suicidology and crisis intervention.

This issue of CRISIS INTERVENTION is devoted to articles which are felt to be of local rather than national interest. If you have any comments upon the articles included here, the Editors would greatly appreciate hearing from you.

The Suicide-Prevention and Crisis Service, Inc., is a contract agency of the Erie County Department of Mental Health and is funded by county and state monies. To provide these services, the organization is staffed by people with varied backgrounds – professionals (trained personnel from all the mental health disciplines), counselors (lay people who receive specialized intensive training at the center), and clinical associates (professional and pre-professional people who are trained to answer the telephone during the night). All staff members are qualified to assist people in an emotional crisis.

The service, directed by Gene W. Brockopp, Ph. D., has as its goals developing a model center and assisting present and proposed agencies throughout the county to make crisis intervention and suicide prevention and integral part of their service.

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## Suicide in Buffalo: Some Facts and Figures

**David Lester, Erie County SPCS**

The incidence of suicide in Buffalo is remarkably low. The annual suicide rate was 7.6 per 100,000 in 1960 and Buffalo ranked 50$^{th}$ among the 56 largest metropolitan areas in America. Seattle, for example, in 1960 had a rate of 17.1 per 100,000. It may be that Buffalo does have a truly low suicide rate. However, it is more likely that the manner of deciding which deaths are suicidal in Buffalo militates against a death being classified as suicidal.

### Autopsies in Buffalo

The Erie County medical examiners do not carry out a large proportion of autopsies on potentially suicidal deaths. For example, Table 1 reports data from 1968. Only 6.7% of deaths classified as suicide and 64.5% of deaths classified as undetermined were autopsied.

TABLE 1
The number of autopsies carried by the Erie County Medical Examiners in 1968

| | Cases | Autopsies | Proportion with Autopsies |
|---|---|---|---|
| Homicides | 47 | 47 | 100.0% |
| Suicides | 89 | 6 | 6.7% |
| Undetermined | 31 | 20 | 64.5% |
| Natural | 928 | 30 | 3.2% |
| Traffic Accidents | 205 | 27 | 13.2% |
| Home Accidents | 92 | 13 | 14.1% |

It has been found in Los Angeles, where almost all potentially suicidal deaths are autopsied, that the proportion of individuals found with drugs in their bodies at death is directly proportional to the proportion autopsied. It is clear that the certification of death in Erie County is based on less than ideal information. (Mildred Spencer has written a series of articles in the Buffalo Evening News that document the inefficiency of the operation of the Erie County Medical Examiner.)

**Suicide Rates In Buffalo And Erie County**

Suicide rates for different groups of the population have been computed for Erie County. Because of the relatively small number of suicidal deaths, the rates for each year vary widely. In order to compute reasonably reliable rates, the rates were computed for five-years intervals around the two years in which census counts were taken, 1960 and 1966. The rates are shown in Table 2

Table 2

Suicidal rates for Erie County for 1960 and 1966

The rates were computed over 5 year intervals, that is, 1985-1962 and 1964-1968. Rates are number per 100,000 of the total population per year.

| | 1960 | 1966 |
|---|---|---|
| Buffalo | 7.8 | 7.7 |
| Erie County (Excluding Buffalo) | 7.5 | 6.8 |
| Erie County (Including Buffalo) | 7.6 | 7.2 |
| White | 7.9 | 7.5 |
| Non-White | 3.8 | 4.2 |
| Male | 11.7 | 10.6 |
| Female | 3.8 | 4.1 |
| 0-9 | — | — |
| 10-19 | 1.1 | 2.2 |
| 20-24 | 7.2 | 9.1 |
| 25-34 | 5.5 | 7.5 |
| 35-44 | 7.2 | 9.8 |
| 45-54 | 12.3 | 11.1 |
| 55-64 | 19.8 | 12.8 |
| 65-74 | 22.7 | 14.3 |
| 75+ | 20.0 | 21.5 |

The suicide rate appears to have dropped slightly from 1960 to 1966. The high risk suicidal population is white, male, from Buffalo, aged 55 years or more. Since 1960 the

percentage increase of whites, males, residents of Buffalo, and those aged 55 years or more in the population has been less than the alternative categories (see Table 3). It appears, therefore, that the population in Erie County is moving toward a demographically distributed population that has a lower suicide rate than the present population.

TABLE 3

Changes in the demographic distribution of the population of Erie County from 1960 to 1966.

| | Percentage change from 1960 to 1966 (calculated using 1960 as the base) |
|---|---|
| Total | 2.11% |
| Buffalo | -9.63% |
| Erie County | 13.87% |
| Whites | 1.16% |
| Blacks | 14.01% |
| Males | 1.19% |
| Females | 2.99% |
| 0-55 years | 2.18% |
| 55 years and more | 1.84% |

**Suicide Rates In Erie County And The United States**

The suicide rates in Erie County can be compared with those for the whole United States for 1960 and the data are shown in Table 4. It can be seen that the Erie County approaches the national rates only for those aged 15-24 and 65-74.

TABLE 4

Suicide rates in Erie County and the United States in 1960

| | Erie County | United States |
|---|---|---|
| White | 7.9 | 11.4 |
| Non-white | 3.8 | 4.5 |
| Male | 11.7 | 16.5 |
| Female | 3.8 | 4.9 |
| 5-14 | 0.2 | 0.3 |
| 15-24 | 4.6 | 5.2 |
| 25-34 | 5.5 | 10.0 |

| | | |
|---|---|---|
| 35-44 | 7.2 | 14.2 |
| 45-54 | 12.3 | 20.7 |
| 55-64 | 19.8 | 23.7 |
| 65-74 | 22.7 | 23.0 |
| 75-84 | 20.6 | 27.9 |
| 85+ | 16.9 | 26.0 |

**Suicide in Buffalo, 1930-1954**

MacAulay[1] carried out a study of suicide in the City of Buffalo from 1930 to 1954. In what follows I shall try to summarize her findings.

(1) Suicide and age:[2]Males who completed suicide were older than females who completed suicide and this was found in both whites and nonwhites. The age of nonwhite suicides was lower than the age of white suicides. The mean ages of these groups are shown in Table 5

TABLE 5
The mean ages of those killings themselves in Buffalo, 1930-1954.

| | Males | Females |
|---|---|---|
| Whites | 51.0 | 46.1 |
| Nonwhites | 38.2 | 27.6 |

The suicide rates for each age group are shown below in Table 6. The rates were computed for a 20 year period and the distribution over age for both males and females was unimodal. Examination of the distributions for shorter periods of time occasionally produces bimodal distributions.

TABLE 6

The suicide rates for different age groups. The rates are per 100,000 per year for 1930-1949 based on the 1940 population. Only data on whites were used since the number of non-white suicide was very small.

| | Males | Females |
|---|---|---|
| 15-24 | 4.6 | 2.7 |
| 25-34 | 9.2 | 6.2 |
| 35-44 | 19.1 | 6.6 |
| 45-54 | 30.1 | 8.8 |
| 55-64 | 46.3 | 9.1 |

[1] MacAulay, I. A. Suicide and social integration: Buffalo, New York, 1930-1954. M. S. thesis, University of Buffalo, 1962.

[2] The variables that are examined (age, sex, nativity, marital status, occupation and social class) may not be unrelated. Thus, foreign-born individuals may be found more often as laborers than in other professions. In the following analysis, these variables are confounded.

| | | |
|---|---|---|
| 65-74 | 46.5 | 10.0 |
| 75+ | 36.6 | 6.6 |

(2) Suicide and sex: The suicide rate of males in Buffalo from 1930 to 1949 (using the population of 1940 as the base) was 21.0 per 100,000 per year, and the rate for females was 6.5.[3] (The rate for females remained roughly the same if adjustments for the difference in age composition of males and females were made.)

The ratio of the number of male suicides to the number of females suicides varied widely in different groups:

| | |
|---|---|
| whites | 3.1:1 |
| nonwhites | 2.1:1 |
| | |
| native born | 2.7:1 |
| foreign born | 4.0:1 |

(3) Suicide and nativity: The suicide rate of those foreign born was higher than the rate of the native born even when a correction was made for the differences in age composition of the samples. The crude uncorrected rates are shown in Table 7.

TABLE 7

The crude suicide rates per 100,000 per year for those foreign-born and native-born 1930-1954 based on the 1945 population.

| | Native Born | Foreign Born |
|---|---|---|
| Males | 16.3 | 36.8 |
| Females | 5.5 | 9.9 |

(4) Suicide and marital status: The suicide rates for males and females with different marital statuses are shown in Table 8. It is clear that the rates are highest in the divorced and lowest in the single individuals.

[3] MacAulay computed rates based on the population 15 years and over. Rates in previous sections of this paper were based on the total population.

TABLE 8

The crude suicide rates per 100,000 per year for different marital statuses in Buffalo 1960-1949 based on the 1940 population.

| | Males | Females |
|---|---|---|
| Single | 14.6 | 4.3 |
| Married | 19.3 | 6.3 |
| Widowed | 55.5 | 9.4 |
| Divorced | 91.3 | 27.8 |

In fact, if these rates are standardized for age, the suicide rate for the single male is higher than that for the married male. However, standardizing the rate for age does not change the direction of the differences for females.

(5) Suicide and the labor force: Owing to the fact that census categories of jobs changed from 1930 to 1954, accurate computing of suicide rates is difficult. However, estimates of the rates are possible and MacAulay's data are shown in Table 9.

TABLE 9

The suicide rates be sex for the white population from 1930-1954 per 100,000 per year based on the 1950 population.

| | Males | Females |
|---|---|---|
| Professional, Technical & Kindred | 11.6 | 5.3 |
| Farm and Farm Managers | 5.8 | 19.1 |
| Managers, Officials, Proprietors, except farm | 15.0 | 3.1 |
| Clerical & Kindred Workers | 14.0 | 2.5 |
| Sales Workers | 7.8 | 0.7 |
| Craftsmen, Foremen & Kindred Workers | 11.6 | 1.8 |
| Private Household Workers and Service Workers | 16.8 | 4.5 |
| Farm Laborers & Foremen | 9.3 | 3.3 |
| Laborers except Mine | 27.2 | 18.5 |
| Operatives & Kindred Workers | 7.8 | 1.2 |

(6) Suicides and method: The most common method for suicide in men is hanging and about 40% of males kill themselves this way. The second most common way is by shooting and a further 20% use this method. For women, in 1930 poison was the most common method for suicide (used by about 35% of those killing themselves) and hanging was the second most popular method (used by a further 25%). By 1950 the use of poisons had dropped to about 10% and the use of hanging had risen to about 40%.

From 1930 to 1954 there was great increase in the use of barbiturates: in women from 2% to 18% and in men from 1% to 6%. This obviously reflects their increased availability for medicinal purposes.

(7) Suicide and social class: MacAulay divided the census tracts in Buffalo into three socio-economic groups and assigned each case of suicide a social class based on where the individual lived. (Obviously, this is a very approximate method of assigning social class status.) The crude suicide rates for men and women of different social classes are shown on Table 10

TABLE 10

The crude suicide rates per 100,000 per year for men and women of different social classes, for 1930-1949, based on the population of 1949.

| | Males | Females |
|---|---|---|
| High | 17.8 | 3.4 |
| Middle | 16.7 | 6.6 |
| Low | 22.3 | 5.1 |

Standardizing these rates for differences in age of the groups did not affect the rank ordering of the groups.

**Suicide in Buffalo, 1930 and 1960**

Suicide rates were computed for Buffalo for 1930, 1940, 1950 and 1960 for men and women separately. The rates were crude rates based on population over 14 years of age so as to make the rates for 1960 comparable to MacAulay's rates. Rates were computed by taking the suicides occurring in five-year periods centered around the date, except for 1930 where data were available only for 1930-1932. The suicide rate is clearly decreasing. (see Table 11).

TABLE 11

The crude suicide rate per 100,000 per year based on the population 15 years of age and over.

| | | Males | Females | Total |
|---|---|---|---|---|
| | 1930 | 26.1 | 8.8 | 17.3 |
| | 1940 | 19.0 | 5.8 | 12.3 |
| | 1950 | 17.6 | 4.9 | 10.9 |
| | 1960 | 16.6 | 5.3 | 10.6 |
| Native born | 1930-1954 | 16.3 | 5.5 | ? |

The suicide rates for men and women in 1960 are quite close to those for native born individuals from 1930-1954 and MacAulay felt that the high rate of suicide in the earlier years of the period studied was chiefly the result of the high suicide rates in those who were foreign-born.

Since 1930, the proportion of foreign-born individuals in Buffalo has decreased considerably. Thus the suicide rate of native-born individuals in Buffalo appears to have remained quite stable.

**Suicide and Measures of Social Disorganization in Buffalo**

Lester[4] examined whether areas of the City of Buffalo with high rates of suicide were characterized by high rates of indices of social disorganization. Census tracts with high rates of suicide were found to have significantly: (1) a higher proportion of people over 65 years of age, (2) a higher proportion of widowed and divorced people, and (3) a higher proportion of college educated people than census tracts with low rates of suicide.

No association was found between the incidence of suicide and the following variables:

percent change in population, 1950-1960,
population per residential acre,
percent of newcomers, 1955-1960,
percent of nonwhites,
percent population under 14 years of age,
percent of population over 21 years of age,
median school years completed,
percent professional, managers & proprietors,
median family income,
percent unemployed males in civilian labor force,
median gross rent,
median property value of owner occupied housing units,
percent dwelling units overcrowded,
percent of housing dilapidated or deteriorating, and
rate of youthful offenders.

Buffalo appears to differ from cities such as Edinburgh, Scotland, where areas of the city with incidence of overcrowding, juvenile delinquency, and cruelty to children also have a high rate of completed suicide (and of attempted suicide too).[5] The reasons for the discrepancies between Buffalo and cities such as Edinburgh is not clear at the present time but it may indicate that different kinds of individuals kill themselves in Buffalo compared to those who kill themselves in these other cities.

[4] Lester, D. Social disorganization and completed suicide. Social Psychiatry 1970, in press.
[5] McCulloch, J. W., Philip, A. E., & Carstairs, G.M. The ecology of suicidal behavior. Brit. J. Psychiat., 1967, 113, 313-319.

# THE MEDICAL EXAMINER IN ERIE COUNTY[6]

**Mildred Spencer**

## Criticism Is More Often Reward Than Praise For Job Well-Done

The phone in the home at 325 Delaware Rd., Kenmore, rang at 8:57 AM Tuesday, February 3. Dr. Harry N. Taylor, the Erie County medical examiner on duty that day, answered it. It was the county Morgue. A man had jumped or fallen from the top floor of the building at Main and Swan Sts. and the police wanted Dr. Taylor immediately. Under state law, the body could not be moved until he had made an on-the-scene examination.

Dr. Taylor was in his car and on the way before a second call came at 9:10. The morgue attendant, unable to reach him asked the police to do so directly on the police radio. There was a second death to be investigated in a parked car at 456 Fuhrmann Blvd. Before Dr. Taylor, fighting a blinding snowstorm and rush hour traffic, had reached his destination, there was a third call. A man was dead in a car at Main and Fairfield Sts.

### Moved in Half Hour

Dr. Taylor arrived at Main and Swan Sts. to answer the first call at 9:45 AM. He examined the victim, talked to bystanders to get their version of what had happened, went up to the 10th floor of the building to check, if possible, what had happened. Within a half hour of his arrival, his investigation had been completed so that the body could be removed.

The medical examiner, followed by a morgue wagon, arrived at the Fuhrmann Blvd. site at 10:30 AM. There was no parked car. He contacted the police on his car radio and learned that the automobile he was seeking was actually parked off a service road near the Coast Guard station. Following the corrected directions, Dr. Taylor found the car, examined the victim, presumably a suicide, and the automobile. Then he ordered the second body placed in the morgue wagon.

### Given Misinformation

It still was snowing hard. In order to reach his third destination as soon as possible, the medical examiner requested and received a police escort to get him through Downtown Buffalo. The street sign at Main and Fairfield was missing and he passed the corner. A poorly informed pedestrian gave him wrong directions and took him six blocks out of his way.

Finally, finding the street, he was still unable to locate the car he was looking for, nor could he see the police car which was to be waiting for him there. Eventually, when the snow let up, he spotted the police car in a nearby gasoline station and the officers pointed out the automobile he was seeking. When the victim had been examined, the morgue wagon took all three bodies to Meyer Memorial Hospital

### Condemned, Not Praised

[6] This series of articles is reprinted from the Buffalo Evening News by permission of the publishers.

It arrived shortly before 1 PM. In view of the fact that he had completed three examinations in widely separated parts of the city within less than four hours of the time he received the first call, despite blizzard conditions, Dr. Taylor might well have expected words of praise. Instead he received little but condemnation.

"All the time we were fighting the storm, trying to get from one site to another," he recalled today, "one of the local radio stations kept broadcasting that the body of the first victim was still lying at Main and Swan Sts. waiting for the Medical Examiner. Later, there was a letter in the paper protesting that the body wasn't picked up until 11AM. That just wasn't true."

**Criticism From Families**

Dr. Taylor's boss, Dr. W. Donald Leslie, the county medical director, agrees that the medical examiner completed the three investigations in a phenomenally short time, considering the weather.

Unfortunately, because of the circumstances of their calling, Erie County's medical examiners are rewarded with criticism more often than with praise. Sometimes that criticism comes from a family, unable to make funeral arrangements until an investigation has been completed. Sometimes it comes from the public at large, when a body must lie what seems an unconscionably long time in a public place. Sometimes it comes from the police, who may themselves have been responsible for some of the delay.

**Could Call Back-up Man**

On Jan. 7., when the body of a 15-year old boy was recovered from Buffalo Creek at 1:45 PM, his father had to wait three hours before the body could be moved. The medical examiner on duty that day, Dr. Edmond J. Gicewicz, had had calls in other parts of the city at 1:10 and 1:30 PM and police were unable to reach him until 2:50 PM.

On another recent occasion, police, after summoning a medical examiner to examine a dead man found in a deserted house, left the scene before he arrived. The physician, finding the house dark and no one around, refused to enter to make the examination.

**Undue Delay Charged**

Police were scornful of his courage - but persons familiar with the area are frank to admit that they too would have refused to enter a dark house there without police protection.

In June there was public criticism of the investigation conducted by a medical examiner into the unexpected death of a 35-year old man in the Erie County Penitentiary. It was claimed that there was undue delay in filing a death certificate, and that the forms filled out by the medical examiner did not meet the requirements of the State Public Health Law.

Recently NEWSpower received letter from a wife who complained that she was notified by telephone of the death of her husband from a heart attack nearly four hours after it occurred. An investigation indicated that the medical examiner had been delayed for an hour by another case,

but that the real reason for the delay was the inability of police officers to contact the wife when they visited the home earlier.

**Pays $7000 a year**

All of the complaints make it increasingly difficult for Dr. Leslie to attract qualified men for the position of medical examiner. It pays $7,000 a year. Medical examiners also receive 11 cents a mile for the use of their cars, and get pension and sick leave benefits. Six of the eight examiners are on call 24 hours every eighth day: the other two, 12 hours every fourth day. But their responsibilities don't stop there. If an autopsy is done, the medical examiner must be present when the pathologist performs it. He must fill out forms required by law. And he must be prepared to take time out from his private practice, if necessary, to appear as a witness if criminal or civil charges are involved.

"The job doesn't attract many physicians at its best." Dr. Leslie says. "Public criticism just makes it worse. It took six months to full the last vacancy."

But if the fault doesn't lie with the medical examiners themselves - and in most cases investigation shows that it doesn't - where does it lie?

**County's System To Probe Creaks Under Weight Of Years**

Erie County's medical examiner system is beginning to fall apart at the seams. It was born in 1902, when the county's population was less than half what it is today. The first medical examiners traveled by horse and buggy to the scene of any death they investigated. Today's medical examiners get there faster, by automobile, but the system under which they work is still a horse-and-buggy one in a jet world

When it came into being 68 years ago, our medical examiner system was hailed as a big improvement over the old coroner system under which an elected coroner, who might have been a tavern keeper or a furniture store owner did any investigation that was done. In those days forensic pathologists - physicians specializing in the legal aspects of medicine – were virtually unknown, and there were considerably fewer scientific aids for detecting the cause of death. The change from a lay investigator to a physician was in itself a step forward. Since then the system has grown by bits and pieces as conditions demands it.

**Big Advance in 1940's**

At one time, for example, the common council ruled that police might move a body before the arrival of the medical examiner if it was lying on a streetcar track at rush hour. The greatest growth came in the 1940's under Erie County's first medical director, the late Dr. William H. Handel.

Dr. Handel arranged to have autopsies done by a qualified pathologist - a specialist in laboratory medicine - instead of by the medical examiners themselves. The latter, all general practitioners, were not trained to do the thorough procedures demanded for scientific accuracy and seldom made more than a cursory examination of the body. Dr. Handel named Dr. Samuel

Sanes county pathologist, and autopsies of medical examiner cases were thereafter done at Meyer Memorial Hospital rather than in the cramped downtown quarters that then housed the Erie County Morgue.

**Medical Panel Set Up**

It was Dr. Handel, too, who set up the first panel of medical dental experts to whom medical examiners and the county pathologist could turn for specialized information outside of their own fields of knowledge.

It included Dr. Oliver P. Jones, chairman of the Department of Anatomy in the University of Buffalo Medical School and an expert on bones. The late Dr. Ernest Witebsky, chairman of the UB Department of Bacteriology and Immunology, and authority on blood groups; Dr. Edward G. Eschner, Chief of Radiology at Meyer Memorial Hospital and Dr. Sheldon Koepf, who headed the Dental Department there. Dr. Handel was also instrumental in setting up the first toxicology laboratory to test for poisoning.

With District Attorney Gordon Steele and three members of the UB Medical School faculty - Dr. Kornel Terplan, chairman of the Department of Pathology; Dr. Sanes, and Dr. Niels C. Klendsoj - he helped establish the laboratory under university auspices in Buffalo General Hospital. Previously any tests for poisoning were done by the police laboratory, which could do only simple procedures.

**Records Scattered**

The laboratory remained at Buffalo General until Dr. Klendshoj's retirement recently when its functions were transferred to the Department of Biochemistry in the Erie County Laboratory at Meyer Memorial. Dr. W. Donald Leslie, who succeeded Dr. Handel as medical director has made only minor changes in the medical examiner system. The pay of medical examiners has been increased to $7,000 a year. Autopsies are no longer done by the county pathologist but by a panel of five community pathologists who rotate the responsibility and receive $200 per autopsy. He also moved the morgue to Meyer Memorial Hospital.

But the system is beginning to fall apart. It looked good in a county of fewer than 435,000 persons in 1902 but it is far from becoming to a metropolitan area of more than a million. It is not centralized. Some of the records are kept in the County Hall, in the offices of the medical director who has overall responsibility for the program. Others are kept in a room adjacent to the County Morgue in Meyer Memorial. Medical examiners work out of their own homes and offices dispatched on calls by a morgue attendant who phones them when requested by police. Autopsies are done at Meyer Memorial.

The medical examiners have no special training for their job - the scientific investigation of crime. They are required to have only five years experience in the practice of medicine, which can include their internship. There are eight of them - one pathologist, four general practitioners, and three surgeons. Six are on call 24 hours a day every eighth day, the other two 12 hours a day every fourth day. They work in pairs, with one backing up another if the first cannot be located or is busy. But all have their own medical practices, often busy ones, in addition to their work as

medical examiners. A surgeon may be operating when he gets a call - his back-up man may be attending a critically-ill patient. There are delays which, under the present system cannot be avoided.

**Violent Deaths Probed**

State law gives the medical examiner jurisdiction and authority to investigate the death of anyone within his county, or whose body is found within his county, which is or appears to be:

1. A violent death, whether by criminal violence, suicide or casualty.
2. A death caused by unlawful act or criminal neglect.
3. A death occurring in a suspicious, unusual or unexplained manner.
4. A death caused by suspected criminal abortion.
5. A death while unattended by a physician, so far as can be discovered, or where no physician is able to certify the cause of death as provided in the public health law and in form as prescribed by the commissioner of health can be found.
6. A death of a person confined in a public institution other than a hospital, infirmary or nursing home.

**Autopsies Lag**

The generally accepted rule for large urban areas is that 25-30% of the total number of deaths should be investigated by the medical examiner's office. In Erie County in 1968, only 1,501 of an approximate 11,400 deaths were investigated - or 13%. Of the deaths investigated, medical-legal experts say that 20-25% should be autopsied. In Erie County, only 11% were autopsied in 1968-163 of the 1,501. The percentages range from 100% for homicides down to 3% of supposedly natural deaths.

The discrepancy between what is considered good medical-legal practice and what is done in Erie County indicates the deficiencies of the local system. The number of cases investigated in first place is kept down by Dr. Leslie's ruling that a death unattended by a physician need not be investigated if the patient had seen a physician at any time within the past 30 days. Certain accidental deaths normally investigated elsewhere are excluded from investigation here.

**A Major Drawback**

Medical examiners, with many demands upon their time from their own practices, seldom ask for an autopsy unless it is unequivocally indicated. If one is done, they will have to spend several hours with the pathologist, witnessing the procedure, then fill out papers and perhaps testify if the findings support civil or criminal charges. They cannot order an autopsy themselves. They must request the district attorney to order it.

Specialists in legal medicine here and elsewhere believe that this is a major drawback of the Erie County system. District attorneys, they say, are quick to order an autopsy in cases of suspected homicide or hit-and-run accidents where their own work will be made easier by the findings. They are less willing to risk losing potential votes of employers or relatives by ordering autopsies of persons killed in industrial accidents, possible suicides and those who have died of

what appear to be natural causes. Why should Erie County's poor record matter to the average citizen?

**Who Needs a Good Medical-Legal System? Just Ask the Parents of Mary Jo Kopechne**

If someone had asked Mary Jo Kopechne's parents a year ago why a good medical examiner system is important, the chances are that they would have had no ready answer. They know now. If the Massachusetts system had been as that state thought it was, Mary Jo's body would have been thoroughly examined when it was found July 19 in Sen. Edward Kennedy's car in a pond on Chappaquiddick Island.

Dr. John Prutting, President of the Foundation for the Advancement of Knowledge, finds it "incredible" that an autopsy of Mary Jo's body was neglected, and that such an autopsy is not legally compulsory in all such cases. "Miss Kopechne," he has pointed out, "may well have died at once of a fractured skull or a broken neck - and a knowledge of that fact would automatically erase the gnawing speculation that she might have lived (and suffered) for several for several hours in a bubble of air trapped within the car.

**Detrimental Results**

"Or, instead of drowning, she might have died quickly of a ruptured spleen, other internal hemorrhage or similar injuries often characteristic of traumatic accidents. "Yet, in the absence of a fact-findings autopsy sensational-minded and neurotic persons have been expounding possibilities that are detrimental to the senator and cruel to the dead girl's family."

Dr. James L. Luke, the Oklahoma State medical examiner, has called a functional medical-legal system "one of the cornerstones of a civilized society." It is generally agreed that such a system makes a community a safer and healthier place to live. The medical examiner, as everyone knows who reads detective stories or watches them on TV, plays an invaluable role in gathering evidence in murder cases - scientific evidence that courts now insist on even when a suspect has confessed.

**Case in Point**

Few of us expect to come in contact with a murderer. Neither did the pre-teen boy who died suddenly in Buffalo some years ago. The family physician called the medical examiner's office in the County Morgue to ask for an autopsy. The morgue attendant refused to send out a medical examiner on the grounds that the boy had been seen by a physician a short time before his death, and it was the physician's responsibility to sign the death certificate. The physician refused to do so without an autopsy. The funeral director, unable to take the body until a death certificate had been signed, persuaded the parents to agree to an autopsy by a private pathologist. The autopsy revealed that the boy had died of rat poison. A subsequent investigation resulted in the arrest of the member of his own family who had fed it to him. The suspect was convicted of first-degree manslaughter.

Richard S. Childs, chairman of the executive committee of the National Municipal League, wrote recently, “If you are intent upon committing a murder, you should take care to select the state or county in which your victim is to be found.”

**“A Loud Witness”**

“In a district where the body will be given the benefit of the modern resources of forensic pathology, the body may be a loud witness against you!” But only about 3 percent of the cases investigated by any medical examiner’s office involve murder.

What other reasons are there for maintaining a modern, professionally-staffed, well-equipped system. Here are a few.

(1) A fatal contagious disease may be first diagnosed in an autopsy on a medical examiner’s case. When the nature of the disease is recognized, the family, the general public and public health authorities can be notified. Those who have been in contact with the dead person can be given any available protection against the disease and measures instituted to prevent it from spreading.

**Uncovered “Carrier”**

Meningococcemia - blood poisoning by the meningitis germ - has been diagnosed in this way. So had tuberculosis. In Buffalo several years ago, an autopsy on a child who had died unexpectedly indicated that he was a victim of bacillary dysentery. Further investigation revealed that two other children in the family were hospitalized with the same disease, which had not yet been diagnosed by hospital personnel. A follow-up by public health authorities uncovered the “carrier” of the infection - a grandmother who had recently come to live with the family. If there had been no medical examiner’s investigation of the child’s death, the grandmother might have infected many other persons.

(2) Routine investigation of sudden deaths frequently uncovers unexpected hazards to health and life in home and industry.

**Can Save Others**

The first clue to a poorly-installed or improperly-ventilated gas heater may come from the diagnosis of fatal asphyxia in a death investigated by the medical examiner. Correction of the defect may save the lives of others in the family. Some years ago, a succession of carbon monoxide deaths investigated in New York City led to the discovery that a particular make of gas refrigerator leaked fatal amounts of gas.

In Cleveland a trained forensic pathologist examined a man who had collapsed at his machine while at work. He found minute electrical burns on the dead man’s finger. This led to the discovery of a short circuit in his machine that had resulted in fatal electrocution. If it had not been discovered other workers, too, might have died.

(3) Medical examiner's records are used by Cornell Aeronautical Laboratory and automotive engineers to study the type and number of injuries sustained by persons killed in motor vehicle accidents - and to design safer automobiles.

**May Relieve Family**

The use of seat belts and shoulder harnesses and the elimination of projecting hardware can be traced to the investigation and analysis of injuries to victims of fatal as well as non-fatal accidents.

(4) A medical examiner's investigation may rule out suicide as a cause of death even when it seems the most likely explanation, thus relieving the minds of family and friends and making it possible to collect insurance which is not payable in cases of suicide. In Cleveland, which has a modern, efficient investigative system, a middle-aged woman, who had been sick and despondent, was found dead of strangulation with a tightly-knotted stocking around her neck. The death looked like a suicide. The woman had frequently expressed the wish to die.

**Vital to Community**

The investigation disclosed that she had been murdered by her husband, who was indicted for first-degree murder and permitted to plead guilty to second-degree murder.

(5) A medical examiner's thorough examination, including an autopsy, can disclose the menace of certain types of drugs - not only narcotics, but those sometimes administered by physicians. In Rochester only this week, the death of two teenage girls was traced to diet pills they had taken.

(6) Medical examiner autopsies often show that a baby who has supposedly "smothered" really died of other causes. The knowledge that the death was not their fault relieves parents' guilt feelings. An up-to-date, efficient medical examiner system is vital to the health, safety and general well-being of the entire community.

## Low Autopsy Ratio Opens Way to Injustice on Deaths in County

A murderer in Erie County who chooses poison as his weapon has three times the chance of getting away with it than he would in Rochester and is also safer here than he would be in Syracuse, New York, Cleveland or almost any other large metropolitan area. In Erie Count, only 13 percent of the total number of deaths that occur are investigated by the medical examiner's office - and only 11 percent of the number investigated are autopsied. The generally accepted standards for good medical-legal practice in an urban setting call for investigation of 25-30 percent of those.

Here's how Erie County stacks up with the other cities and counties mentioned.

| County or City | % of Total Deaths Investigated | %of Deaths Investigated that are Autopsied |
|---|---|---|
| Erie (Buffalo) | 13 | 11 |

| | | |
|---|---|---|
| Monroe (Rochester) | 40 | 28 |
| Onondaga (Syracuse) | 25 | 33 |
| New York (five boroughs) | 34 | 25 |
| Cuyahoga, Ohio (Cleveland) | 25 | 42 |

The number, as well as the percentage, of deaths investigated in Erie County is lower than it is in Monroe, which had only 60 percent as many people. The last published annual reports for the two counties show that Erie County investigated 1,501 deaths, Monroe County 1,900. The autopsy figures are equally revealing. Monroe autopsied 530. Erie less than a third of that number - 163. Even Onondaga County, which had only 42 percent as many people as Erie, did more than twice as many autopsies - 389.

**Changed System**

The Legislatures in both Monroe and Onondaga Counties have approved the model medical examiner law passed by the state legislature in 1965. The law must be ratified by the local legislatures to become effective. Erie County still operates under pre-existing legislation.

Dr. John F. Edland, the 35-year old forensic pathologist who is Monroe County's medical examiner, is enthusiastic about the changeover. Until 1961, he told a Buffalo Evening News reporter, Monroe County operated under the old coroner's system, with all of its drawbacks except that the elected coroner did have to be a physician. He was not, however, required to have any special training in medical-legal matters.

In 1961 Monroe County changed over to a medical examiner's system similar to that in Erie. Autopsies could be performed only with the consent of the family unless authorized by the district attorney.

**Could be Sued**

"Obviously," Dr. Edland pointed out, "a man who has poisoned his wife or a mother who had smothered her child is not going to agree readily to an autopsy. Nor will some families, even when there is no question of guilt, when the relative had died from an accident or an illness.

"The district attorney is not going to do so, either, when there is no overt evidence of wrong-doing. Why antagonize voters? Under the old law a medical examiner who insisted in getting to the bottom of the cause of death and ordered an autopsy himself, without the proper consent, could be sued - and sometimes was - by the family."

Under the new law, the medical examiner himself can order an autopsy whenever he deems it necessary, without any other authorization. Here's how the Rochester system works. The medical examiner's office operates under the aegis of the Monroe County Health Department. It has its own building - a wing of the Monroe County Hospital.

**Everything Necessary**

Housed there are not only the offices of the medical examiner and his assistant, Dr. Lawrence Henry, but also morgue facilities, an autopsy room, tissue pathology laboratory, photographic darkroom, X-ray equipment and everything else necessary to the complete medical investigation of the cause of death. Dr. Edland is a graduate of the University of Syracuse School of Medicine who did his postgraduate training in pathology at the University of Rochester and studied forensic (medical-legal pathology for a year at the Medical College of Virginia. He came to Rochester in 1964 as assistant medical examiner and took over the top job in 1968.

**Ties With University**

The medical examiner is a member of the Board of Health and an assistant professor of pathology in the University of Rochester School of Medicine. The association with the university, he explained, is important because it enables him to offer training in forensic pathology to medical students, interns and resident physicians. Dr. Henry, 28, the assistant medical examiner, is a fully-qualified pathologist who is getting his training in forensic pathology while working with Dr. Edland. On Monday through Friday, Dr. Edland and Dr. Henry handle all of the daytime investigations with the aid of two trained lay investigators. When a death is reported, one of the lay investigators and an attendant go to the scene in the medical examiner's special ambulance. If the death is a homicide, or if they report any unusual or suspicious circumstances, Dr. Edland or Dr. Henry goes out too.

**No Deputizing**

When a death occurs at night, or on weekends, it is investigated by one of the three board-qualified surgeons who work part-time for the office. One is on call at all times. Every death that is reported in Monroe County, no matter how distant from Rochester, is investigated in this way. The office never deputizes physicians, inexperienced in medical-legal matters, to investigate deaths in outlying towns as Erie County does in case of supposedly normal deaths or those resulting from traffic accidents. Bodies to be autopsied are brought back to the medical examiner's building. Ninety-five percent of all autopsies are performed by either Dr. Edland or Dr. Henry. This includes all in which civil or criminal charges may be involved. The surgeons who are on call night and weekends do autopsies on some of the other cases that they investigate.

**Only Homicides**

The medical examiner's office autopsies 100 percent of all homicides, suicides, vehicular homicides, miscellaneous, industrial and traffic accidents, drowning, sudden death in infants, deaths from narcotics and those that occur when a person is in legal custody. In Erie County, only homicide cases are autopsied automatically. The percentage for other categories includes: suicides, 8 percent; miscellaneous accidents, 22 percent; industrial accidents, 8 percent; traffic accident, 13 percent. When civil or criminal charges are involved, Dr. Edland or Dr. Henry testify. Between them, in 1969, they logged all or part of 110 days in court.

The Cleveland - Cuyahoga County - system is similar to that in Rochester, except that it operates under an elected coroner instead of an appointed medical examiner. But the coroner, Dr. S. R. Gerber, is a physician and a recognized specialist in legal medicine.

**Has Own Building**

He has a chief deputy, Dr. Lester Adelson, a forensic pathologist, and two other forensic pathologists, a forensic pathologist in training and a part-time pathologist. As in Monroe County, the initial investigation is made by a trained lay investigator. The forensic pathologists go out when special circumstances demand it. Cuyahoga County, too, has its own building (in Cleveland), with facilities for autopsies, toxicology, X-ray, photography, tissue tests and even a laboratory to examine "trace" evidence found at the scene of a death. The coroner's office is affiliated with Case Western Reserve University School of Medicine. It, too, investigates 100 percent of several categories of death - homicides, suicides, infant deaths, traffic accidents, and deaths in persons under 50 who have not been under treatment for illness. If smaller counties like Onondaga and Monroe - and larger ones like Ohio's Cuyahoga - can have the benefits of modern, efficient medical examiner system, why can't Buffalo and Erie County?

**The Time Has Come For County To Upgrade Standards Of Office**

If the Erie County medical examiner's office functioned as part of the Health Department, 45 percent of its budget could come from the state. As it is, county taxpayers pay everything. And they are getting no bargain for their money. Medical-legal experts call the 68-year-old system the worst now operating in any major urban area of the state. The public, the police, the medical examiners and even the county medical director, who has over-all supervision of the office, have voiced their dissatisfaction. In the face of this concern, Dr. W. Donald Leslie, the medical director has suggested three changes. But they are piecemeal ones, patches on a garment that the county has long outgrown.

He has proposed:

(1) The creation of the post of chief medical examiner for a physician whose assignment would be to answer an emergency call when other medical examiners could not do so. Dr. Leslie does not envision a full-time man in this role or one with any special training, he told a Buffalo Evening News reporter. Instead he would promote one of the present medical examiners.

**The Short Supply**

"Maybe if we paid him $3000 or $4000 more (they now get $7000), he would be willing to devote more time to the job," he added.

(2) Installation of a two-way radio system linking each of the examiners with the county morgue in Meyer Memorial Hospital. Each examiner would carry a small radio receiver so that he could be reached even if in a hospital or the home of a patient.

(3) Enactment of legislation permitting the training of lay persons in the responsibilities of pronouncing death when that death is due to supposedly natural causes. Such persons would report their findings to the medical examiners, who would sign the death certificate. Dr. Leslie is inclined to blame all of Erie County's problems on the shortage of physicians. Last year he advertised for six months before he filled a vacancy for one of the eight medical examiner posts. "The problem," he told the Public Health Committee of the County Legislature last week,

"probably will not be solved until a substantially larger number of doctors are available." But other counties have solved it, including Onondaga and Monroe, both of which have considerably smaller populations than Erie.

**Without Direction**

In the past week, a Buffalo Evening News reporter talked to medical-legal authorities in this and adjoining states. Erie County's difficulties, they agree, stem from an over-all lack of expert direction, the decentralization of the system, and the inability of medical examiners to order autopsies without going to the district attorney. Dr. Leslie, as county medical director, has many other responsibilities, as well as a private practice. He spends only part time in his County Hall office, which is at other times in charge of his assistant, Miss Marie M. Satison. Nor does he have any qualifications or special training to direct a program of medical-legal investigation. He is a general practitioner and surgeon. The medical examiners, who themselves have no special training for their jobs, thus work virtually without direction. The system has no central headquarters. Dr. Leslie's office is downtown. Calls to medical examiners are dispatched by a morgue attendant in Meyer Memorial Hospital, where autopsies and toxicological tests are performed in laboratories also used for hospital patients.

The first step in improving things locally might be for the County Legislature to approve the model state medical examiner law passed in 1965, as Onondaga and Monroe Counties have done. This would take the power to order autopsies out of the hands of the district attorney and place it in those of the medical examiner.

**Overhaul Needed**

If the program were then transferred from the office of the medical director to the Health Department, Erie County could be reimbursed for nearly half of its overall budget. The consensus of the experts consulted by The News is that the entire system needs overhauling to create a modern, efficient medical examiner's office capable of meeting the needs of a large metropolitan area. Such an office, they agree, should have:

(1) A chief medical examiner who is a board-qualified forensic pathologist or has the training and experience to obtain such qualification.

(2) At least one assistant medical examiner with similar qualifications.

(3) One or another of these men should go out on all murders and other deaths in which criminal or civil charges may result. They should perform all autopsies - now done by community pathologists on a fee-for-service basis. And they should testify in court if necessary.

**No Deputizing Allowed**

Such men are in admittedly short supply, but it is not impossible to find them. Rochester has one, and another is completing his training. Philadelphia has five and is seeking another for a top job. Cleveland has five - four full-time and one part-time, and another in training.

(4) Trained investigators - either part-time physicians or laymen - to go to the scene of accidents and supposedly normal deaths and do the initial investigations, summoning a medical examiner only if the circumstances of the death are suspicious. This procedure should be followed even if the death occurs in an outlying town or village. There should be no deputizing of physicians in such areas to investigate normal and traumatic deaths as is currently done in Erie County for fees of $20 and $25.

(5) A separate building, or wing of a building, housing all of the functions of the system. This would include staff offices, a morgue, autopsy room, tissue laboratory, photographic and X-ray facilities, a toxicology laboratory, a record room, and a comfortably-furnished reception room where families and others concerned with a death can wait during the investigation. They must now wait in an office or dingy corridor at Meyer Memorial.

**Could Meyer be Used?**

The building should be adjacent to a hospital where special studies can be performed if needed. Perhaps one of the existing buildings on the Meyer Memorial Hospital grounds might be converted for use by the medical examiner system when the new hospital is built.

(6) A staff adequate to man these facilities.

(7) A close liaison with the State University of Buffalo, particularly the Schools of Medicine and Law. The medical examiner should, if possible, be the head of a Department of Legal Medicine in the Medical School. This relationship would have many advantages. It would enable the medical examiner to call upon university specialists for help in solving problems in which his own staff is not qualified - identification of a body by blood, teeth or bones, for example. And it would provide a training facility in forensic pathology for medical students, interns and resident physicians, thus helping to reduce the shortage of men and women trained in the field.

(8) Better working relationships with the Police Department. Police should stay with a body until the arrival of the medical examiner or one of his investigators and, if necessary, guide him to it. They have not always done so in the past.

(9) A good record system. Dr. Charles S. Perry, professor of forensic pathology at the Indian University Medical School, urges a standardized nationwide system of reporting deaths to a central computer. “If the computer became a clearing house for donor requests,” he says. “The medical examiner investigating a violent death could then become the first link in saving organs for transplantation.”

**Key for the Future**

Dr. Gene W. Brockopp, executive director of the Suicide Prevention Crisis Center has another suggestion. If the medical examiner’s office would notify the center, financed by county and state funds, a trained professional could go out with the medical examiner to the scene of the death, and aid in comforting and reassuring the family. He could also study the psychological circumstances surrounding the death in hope of acquiring information which conceivably could

help prevent other such deaths in the future. The children of suicide victims, for example, often go on to commit suicide themselves.

A program like this would not be cheap, even with state reimbursement. The budget for the Monroe County system - county and state founds combined - is $328,000 this year. Erie County's medical examiners office is currently budgeted at $93,005, all paid by the county. Forensic pathologists command salaries generally ranging from $20,000 to $30,000. Dr. John F. Edland, who heads the Monroe County office, gets $27,000. Philadelphia pays $26,688 to $32,334. The Ontario Centre of Forensic Sciences in Toronto recently advertised for a forensic pathologist for $22,100 to $27,100.

But you get what you pay for. Widespread dissatisfaction with Erie County's present system indicates that the time has come for the county to bring it up to date -- to give its citizens at least the protection that Onondaga and Monroe Counties give theirs.

## The Suicide Prevention Center: County Government Sponsorship[7]

**Gene Brockopp, Erie County SPCS**

Suicide prevention centers in our country have been developed under a number of different parent organizations. Most commonly they have developed as volunteer organizations related to a mental health unit, a mental health association, or a church in the community. In a few places they have begun in conjunction with a mental health clinic. To my knowledge, the development of the Suicide Prevention and Crisis Service in Buffalo is the first time that an agency of this nature has been initiated and developed as a direct result of the cooperative planning of the social welfare and mental health agencies in the community and a county mental health department. As a result of careful planning, which took over a year and a half, this agency was established in November, 1968, as a separate, autonomous unit which is operated by a board of directors elected by a membership corporation of individuals from the community. This corporation contracts with the Erie County Department of Mental Health to provide specialized services in the area of suicide prevention and crisis to the residents of Erie County. Its total operating budget, which is now in excess of $400,000 per year, is obtained through the county mental health department which, in turn, obtains 45% of its operating funds from the State of New York and 55% from county taxes.

This relationship has turned out to be a very excellent one. It allows the agency to have a great deal of freedom within its area of concern, to relate to other agencies within community on an equal basis and to have adequate operating funds through tax monies.

The function of the center also has a number of unique aspects to it because of this relationship. The Commissioner of Mental Health and the Department of Mental Health look upon the agency as one of the organizations in the community which, because of its nature of dealing with crisis and suicide, is more prone to change and modification than many other agencies in the community. Since the SPCS must operate on a very pragmatic level, it views mental health problems in a crisis orientation and looks at the community, not in terms of the existing services, or what has been done in the past, but in terms of what needs to be done in the future to meet the needs of people in crisis. As a result, the agency has taken on an image both in the Mental Health Department and in the community as being an innovative, catalytic unit which explores new methods of working with patients and new approaches to handling individuals' problems, an agency which attempts to change the status quo, and to modify the procedures for the care of the emotionally disturbed that presently exist in the community. The Commissioner of Mental Health views the unit as one which attempts to demonstrate in Erie County what can be done through a community mental health unit. As a result, the agency has made a number of dramatic moves in the community in setting up programs which have opened up new avenues of mental health service. These include modifying the telephone therapy service from a crisis and suicide orientation to three telephone services and 11 lines, (a Suicide Prevention and Crisis Service, a teens and twenties Hotline, and a Problems of Living telephone line), the development of an out-reach program through which trained people move into crisis areas of the community at night to facilitate therapeutic contact with potential crisis populations, the development of a training program for full time paid nonprofessionals first in the agency and then for the county,

[7] A paper presented at the American Association of Suicidology meeting in San Francisco, 1970.

and the modeling of the concept of crisis intervention with emergency mental health patients with immediate service for an individual in need of counseling or psychotherapy.

Presently we are exploring two new areas of service in the community. First, an out-reach program through which we will have trained counselors available day and night to move into homes in crisis or to relate to people who are in need of mental health counseling but are not able to leave their homes, or to people who are suicidal and who need to have an immediate face-to-face contact. Secondly, a program of suicide prevention through working with high risk groups in the community in an attempt to reduce the lethality potential or perturbation of the individuals in the group.

We now have a staff of 7 full-time professionals, 5 full-time mental health counselors, 10 part-time clinical associates, 20 teen counselors and 40-50 volunteer telephone therapists in a suite of 18 offices and therapy rooms. Our location in a downtown Buffalo office building allows easy access to all areas of the county.

We feel that the relationship between the Suicide Prevention and Crisis Service and the Mental Health Department is a particularly advantageous one for both units in that it allows the Mental Health Department to work in close operation with an agency that is dedicated to the immediate response of people in emotional or suicidal crises and which, by its very nature, is characterized by immediacy of assistance for these people. In addition, by having a governing board which is based in the community and which represents most of the business, professional and community facets of the county, the agency has a firm grounding in the community it serves.

The association between the County Mental Health Department, contrary to some of our fears and the expectations of some of our consultants, has not resulted in a limiting of our service and involvement to a geographic area. They have urged and supported our move to have an effect throughout the region. We are very active in working with groups and organizations in the Eastern United States in consultations regarding setting up suicide prevention centers and in training people to organize or work in these centers. In addition, the Department and the Board of the agency has enthusiastically supported our initiation and development of a national journal “Crisis Intervention” published six times a year and devoted to pragmatic practical and theoretical aspects of the development of centers, crisis intervention, and the use of the telephone as a therapeutic tool. Presently this bulletin is being sent out to over 1,000 organizations and individuals in the country who are concerned with crisis intervention and suicide prevention. Our intent in developing the bulletin has been to complement the erudite and theoretical orientation of the Bulletin of Suicidology published by NIMH with a publication concerned with the practical day-to-day operation of a center or those problems which are unique to our common concern. Possibly because of this practical, service orientation, we have received such excellent support from our funding organization.

Because of our relationship with the Mental Health Department, the purpose of the agency is quite different from that of a volunteer group which develops out of a community organization. Both as we conceive our role and as the Mental Health Department sees it, we are a unit which is to explore the problems of dealing with people in difficultly, develop new ways of functioning in the community and establish programs to ameliorate the problems people have, with a view toward developing new modes of service and new ways of operation within existing and

developing community agencies and organizations. We do not see our role as a continuing one, but one which is primarily based on the pragmatics of the situation and one which research will determine as we delineate the situation and move from theory to the modeling of a service entity in the community, then to the education of existing and developing agencies in the handling of these problem situations, and finally to a release of this function of the agency into a broader, more comprehensive mental health unit in the community. Our role then is both catalytic and developmental with the ultimate purpose being the spreading of the concepts of suicide prevention and crisis services throughout all of the organizations related to mental health in the community with the intent that the Suicide Prevention Center as a separate and distinct agency will cease to exist within a short period of time. The dissolution of this center, *of course*, will be contingent on the development of the methods of handling suicidal patients in existing agencies. But this is the goal of the agency, and one which we are committed to achieve.

In summary, we conceive of a suicide prevention center as a unit being involved with crisis intervention, suicide prevention and mental health problems in the community which may lead to crisis or suicide. It attempts to do this through exploring and delineating problem areas, through defining what is necessary to meet the needs of the community and developing new and better ways of handling problems of the future. Its task includes modeling the new process or method and then moving these out into the broader, more comprehensive units of mental health services. To accomplish this, we have established an organization which is extremely flexible and open to change and which has a good resource to tap in terms of money and a close association with both the community and the Mental Health Department. It has been necessary to select staff very carefully who are not tied to a traditional method of service but who will be able to examine very carefully and critically what they are doing with the view toward changing and remolding the structure of clinic services. As a result of these, the agency has changed quite rapidly and thoroughly throughout the past 15 months of its existence and has become, itself, a model of change directed by the needs which have become evident in the community. Through its association with the Mental Health Department, it has become a model of what an agency committed to community mental health can be and, in this way, a precursor for the development of community mental health in the future.

In conclusion we feel that of all of the organizations in the world, a dynamic and pragmatic concept such as a suicide prevention center should not be allowed to die simply because of tired blood or through the strangulation of bureaucratization. When an organization such as this has performed its function in a community, that is, has served as a catalytic unit in the development of broader community mental health centers, and has provided within those centers the range of activities, that it, by itself, had previously provided for the community, it would seem only fitting and proper that the center should be allowed to go out of existence, so that the process of fresh, new, dynamic and innovative approaches to mental health problems can remain alive or be reborn under the aegis of a new organization which will be committed to goals similar to those which suicide prevention centers have been committed: to isolate, define, understand, and prevention centers have been committed: to isolate, define, understand, and meet the needs of a lonely, detached, despairing and hopeless segment of humanity and, thereby be instrumental in their search for a more meaningful and richer existence.

# A Training Program for Nonprofessional Counselors

**The Staff, Erie County SPCS**

## General Philosophy and Purpose

We are living in an era when more and more notice is being given to the fact that there is a critical shortage of professional personnel to handle the increasing incidence of emotional disorders. For that reason, it is necessary, not only that professionals, but also para-professionals be more adequately trained to augment the ranks of present caretakers. The professional community often lags behind new developments and therapeutic techniques, and demonstrates resistance to the inclusion of those caretakers who do not reflect their own background. Yet it is likely that the basic sensitivity of some nonprofessionals can enable them to offer therapeutic aid to the emotionally disturbed.

The philosophy of the SPCS training program is that basic sensitivity, either in a professional or a non-professional, is necessary but not sufficient. Highly specialized learning is also necessary.

The goal of the counselor training program at the Suicide Prevention and Crisis Service is to help each counselor make the most creative use of this or her own style of helpfulness, while developing knowledge and skill about the problem-solving process, including a variety of counseling techniques. The counselors in this agency are trained specifically in certain specialties in a program that runs for 52 weeks of full-time study (counseling over the telephone, counseling with suicidal patients, and crisis intervention).

The mental health counselors have been exposed to formal learning. No psychodynamic or psychiatric knowledge has been withheld from them because of a feeling that it was over their heads. Rather, they have been exposed to aspects of theory which may or may not, in the long run, be useful to them but which they have at least been able to confront in some mild way.

The teaching approach of the counselor training program is related to an exercise in crisis intervention, the apprenticeship model, and to the concept of an educational diagnosis as has been written about by Lucile Austin for the Smith College School for Social Work. This may reflect simply the background of the first director of training, and it is entirely conceivable that a teacher from another discipline or another school might approach this in a very different but equally viable way. However, given the fact that the original director of training was a psychiatric caseworker, her conviction was that the training program needed to be individually tailored to meet the special needs of each particular learner, and that each trainee's learning should be in line with a formulated diagnosis of educational need, rather than forcing the trainee to adapt rigidly to a formalized "program." The concept of crisis intervention is applicable here because of the connection with the concept of teaching which suggests that trainee, just as patients, need to confront various kinds of exacerbation of anxiety so that they can then make decisions about moving ahead or staying behind psychologically. Through the predominantly traditional supervision of cases, of telephone contacts, and of face to face interviewing, decisions have been made about when counselors are ready to be confronted and stressed and in what

situations. All of this activity was geared toward the freeing up of energy for learning rather than the maintenance of defensiveness.

A deeply held conviction on the part of the director of training was that counselors are not to be turned into pseudoprofessionals. There was to be no attempt to provide a slick and facile use of meaningless terms and labels. Since one can reasonably assume in this program that the beginning counselor is a person with basic interpersonal skills, those skills are to be enhanced entirely within the context of their usefulness to the particular counselor. This suggests then that each counselor's idiosyncratic style is to be made conscious, verbal and then reasonably used in the counseling process, and means that continuing respect must be accorded to different but creative ways of handling emotional disorders in widely varying situations. In short, the purpose of the training is to expand natural skills rather than to convert those skills into circumscribed, rigid, and perhaps uncreative stances.

It seemed to the director of training that a number of aspects were important:

1. Easy and informal accessibility to the director of training, including knowing where she is so that the counselor can call in case of an emergency. This is felt to be indicated because of the high level of anxiety and responsibility involved with working with suicidal and/or upset people over the phone and/or in the office setting. Back-up must be real, not just verbal.

2. It is also felt that people of other disciplines are important to the learning of the counselor. There are two aspects to this conviction. The first is that a teacher who is not directly responsible for the learning of a trainee becomes somehow safer in terms of criticism and dialogue. The second is that a teacher who holds no administrative responsibility over a trainee is more open to challenge and confrontation than one who can theoretically fire the trainee who is too abrasive in her questioning. It cannot help but be useful to have someone who is supportive, interested, but non-administrative involved with the counselor training program so that, if there are serious complaints, they can be addressed to someone who is not directly involved in the project and who can, with some safety, take action with whatever complaints are registered.

3. The third aspect of the counselor training program which would seem to be facilitative is a conviction about mutual and open criticism between the director of training and the mental health counselor. It would seem that, within this year or so, this particular conviction has been demonstrated in a very direct way. This suggests that here has indeed been the kind of informal openness back and forth which has led to direct confrontation and criticism from the director of training to the counselor, and in a reasonable, appropriate and healthy confrontation back in the other direction by the learner to the figure in authority. Although this is a difficult concept to maintain because of numerous threats and numerous aspects of appropriateness, it would seem to me that this approach has worked in a constructive way up to the present time.

**The Process of Selecting A Counselor**

1. After the applicant has submitted a completed application to the Director of Training, there begins a series of clinical interviews and introductory discussion of the purpose of the agency's policy, outlook and an initial impression by the Director of Training relative to the appropriateness of the applicant for the position.

2. There is then a follow-up interview for the purpose of discussing a written autobiography which must be submitted by the applicant. The purpose of such an autobiography is to assess the applicant's perception of his own life and to take note of what is included and what is omitted.

3. Then there is the taking of certain intelligence and psychological tests which are used principally as a means of confrontation for the applicant around the issues of potential difficulties in learning.

4. There is an interview with the Executive Director so as to assist him in helping with a final decision in terms of choice, and there is interviewing by other interested parties in the agency such as other staff members or the current counselors.

**The Criteria For Selection Of Counselors**

The selection of a group of mental health counselors is a very difficult and involved business to attempt to describe. The selection was based on clinical judgment (which is equally hard to define) and idiosyncratic convictions of one particular Director of Training, and the biases are difficult to specify. A certain set of qualifications seems important however.

1. Guts and the willingness to expose and/or to explore those guts.
2. Personal maturity by which is meant the ability to relate realistically and to assess oneself and those around one with a relative amount of reality.
3. A treatment commitment to learning regardless of what the learning brings in terms of future job goals.
4. Commitment and motivation relative to the emerging importance of the nonprofessional mental health counselor.
5. The ability of fit into an already formulated agency of widely different personalities and with the kinds of difficult ramifications in any new endeavor.
6. Basic sensitivity and intelligence by which is meant a certain inherent perception relative to the needs of other human beings and a certain ability to sort those things out, almost transcending the need of direct supervision and/or teaching.
7. Self-aspirations by which is meant the desire to achieve something worthwhile and valued by oneself.
8. Beginning self-awareness and the capacity to think beyond whatever convictions one currently holds about the way one operates, that is, to entertain the possibility that, without a thorough understanding of one's behavior, one is controlled by that behavior.
9. The exhibition of no major disabling personality defects or, if some defects are discernable, a relative awareness of them.
10. The capacity to fit into a sometimes difficult and always confrontive group of current mental health counselors and to learn from that encounter.

11. The capacity to be self-directed and to challenge whatever authority figures are around in order to redefine one's present level of learning and to discern whether the capacity for self-direction can be adapted to that authority in a constructive way.
12. A sense of being internally and comfortably directed and a general feeling of comfort with oneself.
13. The ability actively to experience a social existence.
14. A difficult-to-define quality which we may describe as a love of life or a capacity for "peak experience," that is, the willingness to experience aspects of life in a deeply intense way.

**The Content of The Formal Training**

In general, the initial two months are spent in becoming comfortable with the agency, the people with whom one is working, and the counselor group. This kind of comfort includes beginning familiarity with the job through inclusion in the nightwatch training program. This program begins to prepare the counselor to be effective on the phone and to begin to think of concepts of lethality, suicidal behavior, and so forth. Then follows the taking and intense supervision of their first call and a beginning move into more formal, didactic material.

During this beginning period and indeed throughout the training, there is constant discussion with the Director of Training around the anxieties connected with performance and greater understanding of the expectations of the counselor.

This is not a group for whom reading seems the best way to learn. However, certain readings have been required, some formal and some informal. As the counselors seem to progress in their understanding, they have often requested information on certain specified subjects, and this has been offered to them, as has the opportunity to discuss what they are reading.

Much of the meaningful reading has been through a notebook of informal articles, that is, articles not essentially directed to the mental health professions but rather garnered from so called popular magazines which suggests that they are expressed and written in a way which facilitates learning among a group who are not particularly knowledgeable about psychiatric terms.

Because the mental health counselors were selected and/or trained at different times, it is especially difficult to attempt to keep them in some kind of regimented program in terms of therapeutic development. They are, in fact, allowed to move around in a way which is most comfortable for them, with continuing training for those who still need it and increased independence for those who feel adequately trained. Clearly, a number of concepts which have meaning to one counselor have no meaning to another just as one teaching style has one meaning to one counselor and a profound lack of meaning to another. I would hope that the training has been sufficiently varied that they have also begun to learn from very different styles of teaching and have been able to sort out from those teaching approaches which aspects they wish to incorporate and to make a part of their own functioning rather than to imitate the approach of one particular person.

Although the Director of Training had only limited knowledge about what kinds of things had been covered by other consultants, the following topics have been studied in her weekly seminar:

All aspects of mental illness including psychosis, neurosis and character disorders
Symptoms and their symbolic meaning
The role and conflicts of the nonprofessional
The anxiety theory of neurosis and diagnosis
Crisis intervention
Sociocultural factors and the importance of understanding one's value system
Early and normal child development
Transference and countertransference
Various biases about the mentally ill
Fixation versus regression
Confidentiality
Physical aspects of mental illness
Family therapy and multiple client interviewing
The use of case records
System theory
Ego-assessment
Interviewing skills

It is impossible to list all of the discussions which the counselors themselves have implemented relative to particular cases and particular concerns. It is sufficient to say that when these questions have come about, there has been real availability of some person who has been able to sit down with the counselor and to deal with their particular questions.

# Recruitment Of A Counselor

**David Lester, Erie County SPCS**

During the summer of 1969, it was necessary to hire a new counselor for the training program of the Erie County SPCS. In order to do this an advertisement was placed in the weekend newspapers for one weekend. It appeared in the Buffalo Evening News on Friday and Saturday (there being no Sunday edition) and in the Courier Express on Friday, Saturday, and Sunday. The advertisement read as follows:

> Help - Male, Female
>
> WANTED, non-professional mental health counselor trainee, good salary, fringe benefits, Suicide Prevention and Crisis Service, Miss Porebski, 854-1966.

From this advertisement (and from other sources) a total of 148 applicants were obtained. The majority of these heard of the opening through the newspaper advertisement directly but the exact number is difficult to estimate accurately. Each applicant was sent an application form to complete and requested to write an autobiography. Fifty-nine applicants completed this part of the application process and, of these, 74.6% had heard of the position directly from the newspaper advertisement.

Sixty of the 148 applicants (40.5%) were male and 88 (59.5%) were female. The number of females completing the application process was slightly higher than for the males. Of the 59 applicants who completed the form 35.6% were male and 64.4% were female. The characteristics of the applicants are shown in Table 1.

## Personality Test Results

In the description of the program in the previous article the criteria for selecting counselors were outlined. The following analyses were carried out to examine whether the new counselor fitted these criteria and to describe the kind of person who was considered suitable for the position.

### General Questionnaire

Each applicant was asked a series of questions dealing with attitudes and feelings. Eighteen of the items dealt with attitudes toward people (such as suicide, homosexuals, Jews, and so on) and the behaviors (such as gambling, sex, and so on). The applicant selected for the position scored a total of 2.5 on these items, indicating more tolerance and acceptance as compared to the average score obtained by all those completing the application form of 3.2.

TABLE 1
Characteristics Of Those Who Applied And Who Have Been Selected For The Position of Counselor

| | Applicants | Five Final Candidates | Final Choice | Four Present Counselors |
|---|---|---|---|---|
| Sex: | | | | |
| male | 21 | 1 | 0 | 0 |
| female | 38 | 4 | 1 | 4 |
| Marital Status: | | | | |
| single | 19 | 0 | 0 | 2 |
| married | 26 | 3 | 0 | 1 |
| separated | 4 | 1 | 0 | 0 |
| divorced | 7 | 1 | 1 | 1 |
| widowed | 3 | 0 | 0 | 0 |
| Age | | | | |
| 0-20 | 2 | 0 | 0 | 0 |
| 21-30 | 28 | 1 | 0 | 0 |
| 31-40 | 7 | 1 | 1 | 2 |
| 41-50 | 14 | 2 | 0 | 2 |
| 51-60 | 8 | 1 | 0 | 0 |
| 61+ | 0 | 0 | 0 | 0 |
| Education: | | | | |
| grammar | 3 | 1 | 0 | 0 |
| high school | 16 | 2 | 1 | 4 |
| some college | 20 | 2 | 0 | 0 |
| BA | 18 | 0 | 0 | 0 |
| MA | 2 | 0 | 0 | 0 |
| Employment Status: | | | | |
| employed | 30 | 4 | 1 | 4 |
| unemployed | 27 | 1 | 0 | 0 |
| retired | 0 | 0 | 0 | 0 |
| self-employed | 2 | 0 | 0 | 0 |
| Suicide Potential Scale Score (Devries, 1966) | | | | |
| 0 | 11 | 1 | 1 | did |
| 1 | 21 | 1 | 0 | not |
| 2 | 8 | 1 | 0 | take |
| 3 | 11 | 0 | 0 | |
| 4 | 2 | 2 | 0 | |
| 5 | 2 | 0 | 0 | |
| 6 | 1 | 0 | 0 | |

| | | | |
|---|---|---|---|
| 7 | 1 | 0 | 0 |
| 8+ | 0 | 0 | 0 |

Five of the items dealt with personal involvement with the training program (such as “I have attempted suicide at least once in my life” and “I am anxious about a personal problem of my own”). The applicant selected for the position obtained a score of 1.0 on these items compared to a mean score of 1.3 obtained by the whole group of applicants.

The applicant selected differed from the majority of candidates most on the items dealing with personal feelings and behaviors. For example, she admitted eating compulsively sometimes, losing her temper easily sometimes, and sometimes preferring not to get involved with other people’s troubles, and stating firmly that there are some subjects that she would not discuss with others. On these items 75% of the applicants did not admit these feelings and behaviors.

One problem with these items from the application form is that the social desirability of the different responses is clear. The applicant selected appeared to be more tolerant of the different behaviors and less personally involved with not looking to solve her own problems through her training, both the best guess as to what the person hiring the counselor would be looking for. However, in describing her personal feelings, the counselor deviated from the norm and perhaps both indicated greater freedom of expression and less involvement in presenting a good picture to the employer.

Each of the 5 final candidates for the position of counselor were administered the Personal Orientation Inventory (POI) (Shostrom, 1966) and the Sixteen Personality Factor Questionnaire (Cattell and Eber, 1957).

**The POI**

The POI indicates the extent to which a person’s attitudes and values complare with those of self-actualizing people. A self-actualizing person is a more fully functioning person and lives a more enriched life than the average person. A self-actualized person develops and utilized his talents to the fullest extent.

The applicant selected was more self-actualized on the two ratio measures of the POI than the average adult. All the four rejected applicants were less self-actualized than the average adult.

The applicant selected scored higher than the average adult on all 12 scales of the POI except that of the nature of man (sees man as essentially good rather than evil). She scored very high (a standard score of 70 or above) on the scales of acceptance of aggression (accepts rather than denies feelings of anger and aggression) and she scored high (above the standard score of 60) on the scales of feelings reactivity (sensitive rather than insensitive to own needs and feelings), time competence (lives in the present rather than the past or future), and self-actualizing values (holds rather than rejects values of self-actualizing people).

Of the 4 rejected applicants two obtained profiles that were the antithesis of self-actualization one was average except for high scores on spontaneity and self-regard and acceptance of aggression and very low scores on the nature of man and synergy.

It is clear that the applicant selected was the most self-actualized of the five final candidates and was more self-actualized than the average adult.

**The 16 P-F Test**

All candidates were above average intelligence on the 16 P-F Test. The applicant selected was one of the two with the highest score on this scale of the 16 P-F, being in top 16% of the population used for standardizing the test.

On the scales of humble/assertive, tough-minded/tender-mined, and practical/imaginative, the applicant selected obtained average score. On the scales of expedient/conscientious, self-assured/apprehensive, group-dependent/group-independent, and relaxes/tense she scored just outside of the average range.[8]

Of the other candidates, one was about average on all scales, one had high scores indicating high intelligence, assertive, conscientious, self-assured, and relaxed, one obtained, high scores indicating expedient, tough-minded, practical, self-assured, and relaxed, and one obtained high scores indicting humble, expedient, practical, and group-dependent.

## Conclusions

The choice for the position of counselor appeared to be differentiated from the other applicants on the following characteristics. She was a female over 30 years of age, not married at the present time, presently employed, and with no more than high school education. She was not, nor had been, suicidal and had not been in therapy. She seemed not to be interested in the position for working out personal problems.

The psychological tests indicated that she was self-actualizing and intelligent and it appears that, on other more general personality dimensions, she was about average.

It seems that some of the characteristics of the selected applicant were determined by the plan for the program and the preferences of the training director. Data from the personality tests indicated that the selected applicant did fit the criteria outlined in the previous article.

## References

Cattell, R. B., and Eber, H. W. Handbook for the Sixteen Personality Factor Questionnaire, Champaign, IL: Institute for Personality and Ability Testing, 1957.

Devries, A. G. A potential suicide personality inventory. Psychol. Rep., 1966, 18,731-738.

[8] Scores on the other scales of the 16 P-F Test were not available owing to the test protocols being mislaid.

Shostrom, E. L. Manual for the Personal Orientation Inventory San Diego: Educational and Industrial Testing Service, 1963.

## CRISIS THEORY AND SUICIDE PREVENTION

**Gene W. Brockopp, Ph. D.**

Suicide by its very nature is a crisis situation. This is true whether we are speaking about a suicide that is already in process, a suicidal individual or a person who makes vague threats to commit suicide. In each case, the person is overwhelmed by a problem in his life, and suicide becomes a means to find a solution.

Since most of the therapeutic efforts by the therapist to cope with the suicidal patient are based on crisis theory, it may be well to briefly discuss some of the concepts that have been developed in this area. Most of these have been developed by Eric Lindeman and Gerald Kaplan although extensions of their theory are to be found in the work of Hausman and Rioch. The conceptual framework of crisis theory, as expressed by Kaplan, is based on the concept that an individual is normally in a state of relative equilibrium. This state is maintained through the use of behavioral patterns with which the individual is familiar and which allow him to interact with the environment, solve his problems, maintain a type of homeostatic balance or a point of equilibrium on a continuum of mental health. One end of this continuum represents various types of mental health illness and the other, the theoretically mentally healthful individual. Where the individual will be on this continuum will depend on his life style, the way he handles crises, the type of living he does, his normal response to stress, etc. When facing a problem of his everyday life, the individual may become upset, but he usually is able to return to his point of balance on the mental health continuum. These temporary upsets are generally solved by means of previously learned problem solving techniques or various means of coping behavior. When he is confronted by a problem situation in which the previously used methods of restructuring his life or his environment are either not available to him or he is not successful in his obtaining a point of equilibrium, the individual is confronted by a critical situation, that is, one which he is uncertain concerning its end or resolution. The individual is then in an emotionally hazardous situation and is rapidly moving toward a state of crisis. The crisis, it must be remembered, is not the situation itself, but is the person's response to it. The critical issue of the crisis, then, is the psychological state in which the individual lives. Uncertainly is the essential core of a crisis, not knowing where he is or what he needs to do, or can do, to solve the problem and to regain his point of equilibrium on the mental health continuum.

Kaplan divides the crisis period into four contiguous and sometimes overlapping units. The first is characterized by the critical situation and the increase in activity, tension and disorganization of the individual which arises from the problem stimulus and the utilization of normal problem-solving techniques in an attempt to return to a point of equilibrium. The second is characterized by a lack of success of the normal coping mechanism with a continuation of the problem. This results in exacerbation of the state of disorganization and tension in the individual. In the third stage, the tensions developed by the critical situation reach a point where the individual is forced to bring additional resources, both external and internal, to bear on his attempt to resolve the problem. As a result of this move, the problem may decrease in intensity; the person may use emergency problem-solving methods; he may see the problem in a new way

or he may give it up, and withdraw from the situation, seeing it as impossible or the goal as unobtainable. In the fourth stage, if the problem remains and it cannot be solved by the techniques available to the individual or avoided by him, major personality disorganization occurs.

A crisis implies an emergency or serious situation. The criticalness of the crisis depends on a number of factors. (1) The character structure of the person. The self-concept of the individual is critical in the way he responds to a crisis situation. (2) The quality and nature of previous crisis situations. If they are similar to the one with which the individual is presently confronted they may have helped him to develop techniques which he can use to solve the present problem. (3) The amount of support given to the individual. Just knowing someone else is there often helps the person to mobilize his resources and to resolve the crisis. (4) The person's armamentarium of responses to crisis situations.

Most crises are predictable, at least in a limited sense. We can place all crises into one of two categories:

1. Developmental crises. These are the normal crises that individuals go through between birth and death. They are predictable. We know that certain crises will arise in the individual's life. Often we cannot influence them, for they are necessary in the stages of development.

2. Incidental crises. These can be prevented or influenced. Most crises fall into this category. Even those that appear accidental are quite predictable. For example, most car accidents are not accidents at all, but are a combination of a number of factors, such as the type of road, speed of the vehicle, condition of the driver, and the mechanical condition of the car. Other examples of incidental crises are loss of job, marriage, illness, moving, death and raising children. These are predictable stresses in each individual's life. We can do something to modify their effect on the person through a type of psychological immunization or through making each crisis a learning situation.

A crisis is a serious situation, but it can be a very useful learning and therapeutic tool because:

1. The individual is in a state of dis-equilibrium and tension, and considerable change is possible within a relatively short period of time. Normal patterns of behavior have been broken, defenses are open and the person is more susceptible to new ideas. He now needs a relationship with someone who can give him an opportunity to solve the problem he has. A minimum amount of effort on the part of the therapist can move the patient a considerable psychological distance, since the person feels committed to solve the problem.

2. Crisis resolution depends on isolating the patient's strength and mobilizing them in reference to the problem. Emphasis is placed on the positive aspects of the patient's personality and not on his deficits.

3. The patient learns to symbolize his problems in verbal terms and to deal with it both verbally and behaviorally. This allows him to separate himself from the problem and to

look at it more objectively. It also gives him an opportunity to try an idea symbolically before using it in a problem situation.

4. Future methods of handling crisis situations can be developed. A different way of approaching a crisis, a new way of problem solving, and a better way of resolving the crisis, can be learned.

5. By resolving the crisis, the person may reestablish himself at a higher point on the mental health continuum and thereby improve his everyday functioning in his social group.

Some basic concepts to guide the therapist in his work with the person in a crisis have been developed through the handling of psychiatric casualties in the military. These are the concepts of immediacy and proximity. We emphasize giving the individual the needed help without delay and doing so in an environment with which he is familiar. Expectancy implies that the critical aspect of the therapist's message to the patient is that he will get well. It emphasizes the use of coping behavior in an active role, rather than through a sick role. Embodied in it is our belief that he was a competent person in the past and can be a competent person again. Rather than helping the person to help himself, we would expect the person to again become himself. Concurrence involves the use of other individuals, or a group, as a means to support him in his new behavior. Commitment, of course, refers to the patient's commitment to the goals of being a competent member of the social group to which he belongs. To achieve this, he must be involved in setting those goals.

The Suicide Prevention Center in Los Angeles has developed a technique for helping the suicidal person, which is largely based on the foregoing concepts. It has been organized into six phases.

1. Developing a relationship with the suicidal individual. If the helping person does not have a relationship with the individual, his initial step is to establish one. Essential in this relationship is the concept of trust and which will be characterized by the free flow of information from the patient to the therapist. Also inherent in this relationship is the feeling which the therapist will transmit to the suicidal patient, that of interest, concern and a non-judgmental attitude.

2. Helping the person to identify and specify the basic problem he has. The suicidal individual is usually confused and disorganized and has difficulty defining his problems. When the problem is placed into perspective and specified, that patient will often feel relieved.

3. Evaluating the suicidal potential for acting out. This is usually done in conjunction with clarifying the focal problem of the patient. Immediate intervention or hospitalization may be needed. The subsequent action of this therapist would be largely dependent on this evaluation.

4. Assessing the patient's strength and resources. Individuals who are in crisis often feel that they have no resources to draw on and no friends who will help them. In their confusion and disorganization, they often overlook people who will be willing to help.

Examining the crisis situation and the significant individuals in this person's life space often results in finding resources that the person had forgotten about and which can be crucial in his recovery.

5. Mobilizing the patient's resources. The therapist's next step is to attempt to mobilize the resources, both within the person and external to him. In general, the patient should be encouraged to do as much of it as possible for himself, but the therapist must be willing to accept responsibility to assist the patient in this activity.

6. Development of a therapeutic plan. A crisis is a call for action. Plans may include hospitalization, psychotherapy or other alternatives. The patient should be included in making this plan, or he may not be willing to take his role in it and make it succeed.

In working with patients in suicidal crises, the focus must always be keeping the individual alive. The therapist must be willing to take any action necessary to achieve this, and he must take an active role in mobilizing resources and must take responsibility in the crisis situation, letting the patient use his ego as a means of shoring up his own weak defenses. The emphasis is on the present problem, and the therapist must obtain all information relative to the crisis situation. Data on the individual's past life may be regarded as potentially of value in the long-tem treatment of the patient, but is not essential unless it helps to resolve the suicidal crisis.

Crisis work is emotionally very difficult and taxing for the therapist. The elements of death and dying which are normally only tangential to the therapy situation come into the foreground and are now central in the relationship. It is critical that he examine his own attitudes about death and that he has resolved the possibility that one of his patients may die. Professional competence in itself is no guarantee that the strain of working with individuals who are suicidal will not develop conflicts in the therapist. Because of the critical and essential role that the therapist plays in this situation, it is easy to fall into a Jehovah complex in which he thinks of himself as being very powerful in the life of other individuals. When the therapist plays this role, it is not only difficult for the patient to get well, but it is also hard for the therapist to resolve the possibility of the patient's death. In dealing with suicidal patients, it is necessary that the therapist accepts the possibility that one of them might die as a fact of life and not the grim result of his failure in treatment.

Working with suicidal individuals requires much emotional strength on the part of the therapist. He must remain calm, exhibit clear thinking, maintain a sense of balance, while knowing that the patient may impulsively act out and that from the patient's point of view it may take less courage to face death than to face life. He is probably one of the few stable elements in the patient's life.

Therapy with suicidal patients involves a difficult art of attempting to balance the weakness of the individual and his need for external control with the freedom which is essential for his recovery. The therapist must be able to accept responsibility for a tragic error in treatment, in which the patient, for unknown reasons, takes his own life.

Above all, the therapist needs to be secure himself for he must put himself into the therapeutic situation wholeheartedly and unflinchingly. He must give of himself to the patient to satisfy the patient's dependency needs, yet he must be careful not to get so involved that he loses his perspective. It requires real maturity to become involved with people and not get mixed up. He also needs to be able to sever the relationship, a relationship in which transference and counter-transference develop very rapidly and intensively, a relationship in which a life depends on the slender thread of a meaningful communication.

# Steps Toward The Evaluation Of A Suicide Prevention Center: Part One

**David Lester, Erie County SPCS**

## Counselor-Rated Improvement of Patient

For each patient who calls the SPCS an intake form is completed by the counselor. One of the questions included on a formerly used intake form was "Improvement through phone contact?" This was an open-ended question, and the replies were coded by a staff member into six categories.

The counselor-ratings of improvement for the first 100 new patients calling in each of four successive months in 1969 is shown below:

| | July | August | September | October | Total | |
|---|---|---|---|---|---|---|
| excellent | 0 | 0 | 0 | 1 | 1 | (0%) |
| very good | 21 | 27 | 15 | 31 | 94 | (22%) |
| moderate | 17 | 8 | 8 | 6 | 39 | (10%) |
| very little | 1 | 0 | 0 | 0 | 1 | (0%) |
| none | 17 | 11 | 4 | 12 | 44 | (11%) |
| unknown | 44 | 54 | 73 | 50 | 221 | (55%) |

It is clear that this question is not completed for a large proportion of calls (about 55%). For the patients for whom the item is completed, there appears to be a good deal of improvement as rated by the counselors. However, the large proportion unknown data makes and adequate estimate of the degree of counselor-rated improvement impossible.

## Success In Referring Patients To The SPCS

One of the alternatives open to the telephone counselor at the SPCS is to refer a patient into the center to meet with a therapist in a face-to-face situation. A large proportion of such referrals do not appear at the center. The number of referrals to the SPCS and the proportion showing for their scheduled interview for a period from June to October, 1969, is shown below:

| | June | July | August | Sept. | October |
|---|---|---|---|---|---|
| total number of callers | 812 | 1109 | 1001 | 902 | 858 |
| number of new callers | 390 | 488 | 449 | 461 | 512 |
| number of referrals by night-watch staff | 34 | 51 | 33 | 19 | 25 |
| proportion of these referrals showing | 29% | 33% | 42% | 42% | 56% |

It should be noted from these data that the activity of the center in terms of the number of patients calling the center for the first time ("new patients") has increased, the number of

referrals to the SPCS has declined, and the proportion of referrals who show for their interview has increased.

The success of night-watchers in referring patients to the center varies greatly. If we look at those who referred three or more individuals to the center for interviews during the period June, 1969 to October, 1969 we can compute the proportion of patients showing for each night-watcher. The success of the night-watchers is shown below:

| number of night-watchers with the given percentage of shows | percentage of shows |
|---|---|
| 1 | 0% |
| 0 | 1%-10% |
| 1 | 10%-19% |
| 4 | 20%-29% |
| 4 | 30%-39% |
| 0 | 40%-49% |
| 5 | 50%-59% |
| 4 | 60%-69% |
| 1 | 70%-79% |
| 0 | 80%-89% |
| 0 | 90%-99% |
| 0 | 100% |

The distribution is bimodal. A large proportion of night-watchers operate with a successful referral rate of 10% to 39% and a large proportion with a success rate of 50% to 75%.

**The Extent And Success Of Referrals At the SPCS[9]**

The aim here was to examine how many referrals are made by the SPCS telephone therapists, to which agencies are the referrals made, and to what extent do patients follow through with the referral.

Data were collected for 15 consecutive days (2/26/70 to 3/12/70) and all patients (new and old) calling on all three lines were included. During this period of time a total of 728 calls were received. Of these 384 were recorded as not having been given a resource to contact. The majority of these were handled over the telephone or the patient hung-up. It is possible that referrals were suggested but not recorded. However, discounting this possibility, 52.7% of callers to the SPCS were not referred to any resource.

Of the total sample, 344 were given a referral to a resource (47.3%) and of these 16 were given referrals to two resources. The resources used in these referrals are listed below.

[9] Yolanda Marlow collected the data reported here.

| Resource | Number of Referrals | |
|---|---|---|
| Visit SPCS | 128 | |
| Call friend or relative | 124 | |
| Hospital | 27 | (20 of these were to Meyer) |
| Police | 10 | |
| Call doctor | 9 | |
| Planned Parenthood | 7 | |
| Alcoholics Anonymous | 6 | |
| Family Service | 6 | |
| Legal Aid | 4 | |
| Department of Social Welfare | 4 | |
| Joe Vetter's drug addiction program | 4 | |
| Minister or priest | 3 | |
| Newspaper | 3 | |
| Consumer Credit | 2 | |
| Employment Service | 2 | |
| Hotel | 2 | |
| School | 2 | |
| Another counselor at SPCS | 2 | |
| Children's Aid | 2 | |
| Library | 2 | |
| Veterans Administration | 1 | |
| Jewish Center | 1 | |
| Family Court | 1 | |
| Lawyer | 1 | |
| Psychiatric Clinic | 1 | |
| Msgr. Carr Clinic | 1 | |
| City Hall | 1 | |
| Alanon (for wives of alcoholics) | 1 | |
| Traveler's Aid | 1 | |
| Parents without Partners | 1 | |
| Probation Officer | 1 | |

Within this 15 day period, there were 21 patients who had either a telephone number listed or an address recorded so that they could be contacted. Of these 21 patients, 13 were reached. The remaining 8 could not be reached because the name given was insufficient, the telephone had been disconnected, or the caller could not be reached after 5 attempts. Of these 13 patients, 9 had made the referral suggested to them by the counselor, a total of 69.2%.

Of the 128 patients who were referral suggested to the SPCS, 38 were given appointments. Of these 38, total of 20 showed for their appointment (52.6%.

## High Risk Groups And Their Knowledge Of The SPCS[10]

A number of attempted suicides are seen in the First Aid Unit in General Admissions at Edward J. Meyer Memorial Hospital and then sent home. A number of these are called and asked questions about their subsequent disposition. Among the questions asked are two concerned with the knowledge of and the use of the Suicide-Prevention and Crisis Service. Data are available for the last seven months of 1969 and are presented below:

| | June | July | Aug. | Sept. | Oct. | Nov. | Dec. | Total |
|---|---|---|---|---|---|---|---|---|
| Total number treated and sent home | 17 | 42 | 33 | 40 | 43 | 24 | 19 | 218 |
| Total number questioned | 11 | 21 | 14 | 19 | 22 | 10 | 9 | 106 |
| Number who knew of SPCS | 4 | 13 | 5 | 5 | 11 | 5 | 4 | 47 |
| Number who had called SPCS | 1 | 4 | 2 | 2 | 1 | 0 | 2 | 12 |
| | | | | | | | | |

Of 106 patients, 47 (or 44%) had heard of the SPCS and 12 (or 11%) had called the SPCS.

## Completed Suicides Who Called The SPCS

The names of those in Erie County who completed suicide in 1969 were obtained and the files of the SPCS were searched to locate these names. Only one name was located. One person had called in 1968 about his brother-in-law who was threatening suicide. The possibility of psychiatric hospitalization was discussed. A call-back two weeks later reached the original caller's wife who was emotionally upset and didn't want to talk about it. The patient was then missing and the police had been notified. No further call-backs were made. The patient killed himself in 1969, several months after the original call.

No matching name could be found for the remaining 77 completed suicides. Of course, the majority of patients remain anonymous and there is the possibility that the patients's name may have been misspelled. Also there remains the possibility that close relatives and friends of the completed suicides had called the SPCS. However, we have no simple way of discovering any further information on contacts made by or about the remaining completed suicides in Erie County in 1969.

## The Snowfall And Suicide In Buffalo

**David Lester, Erie County SPCS**

We wondered whether severe winters had any effect on the suicide rate in Buffalo. The severity of the winters in Buffalo was measured by nothing the number of inches of snow that fell during the winter. This information is released by the United States Weather Bureau which measures the snowfall each winter from October through April.

[10] These data were obtained through the assistance of Mrs. Audrey Malin.

The number of suicides occurring in Buffalo and Erie County each month from 1958 to 1969 was obtained from the Department of Biostatistics of the Erie County Health Department.

Considering the City of Buffalo alone, the number of suicides occurring in each three-month period of the year was correlated with the snowfall of the previous winter.[11] For example, the number of suicides from January to March, 1958 was compare with the snowfall in the 1957-1958 winter and so on. The resulting product-moment correlations are shown in Table 1.

A similar analysis was conducted for the total number of suicides in Erie County (excluding the City of Buffalo.) These correlations are also shown in Table 1.

Table 1: The correlations between the amount of the snowfall and the number of suicides

| | Product-moment correlations between the snowfall in the winter of n/n+l and the number of suicides in | | | | |
|---|---|---|---|---|---|
| | Oct-Dec year n | Jan-March year n+l | April-June year n+l | July-Sept year n+l | Oct-Nov year n+l |
| Buffalo | 0.20 | 0.32 | -0.23 | -0.14 | 0.12 |
| Erie County (exec. Buffalo | 0.27 | 0.31 | -0.01 | -0.33 | 0.15 |
| # of pairs of data | 11 | 12 | 12 | 12 | 12 |

A similar pattern of correlations appeared when the proportion of suicides occurring in each three months period was used in the correlations rather than the absolute number.

The results indicated that there is an association between a heavy snowfall in winter and a large number of suicides in the same winter followed by a small number of suicides in the summer. To test this with better data, the suicides from the City of Buffalo and the remainder of Erie County were combined and the years were divided into six-month periods (October to March and April to September).

The correlation between the snowfall and the number of suicides in the same winter (October to March) was 0.58 (one-tailed $p<0.05$). The correlation between the snowfall and the number of suicides in the following summer (April to September) was -0.32 (not significant).

Thus, a severe winter in Erie County as indicated by the amount of snow that falls is associated with a higher than usual number of suicides that winter and a lower number the following summer, although this latter result did not reach statistical significance.

[11] A correlation between the snowfall in the year n/n+l and the total number of suicides in the year n+l in Buffalo for the years 1930-1954 was -0.08 (not significant). So it was decided to consider time periods shorter than one year.

## How Common Is Suicidal Behavior?

**David Lester, Erie County SPCS**

To justify their existence, suicide prevention centers often present figures to show how prevalent suicidal behavior is and now important a problem it presents for the community. Frequently these figures are very rough approximations and guesses, and the estimates are often stated in such a way that the listener feels that they are hearing a biased selection of the data. This feeling is one that I had recently, and so I decided to compute for myself the incidence of suicidal behavior in the community.

There are many ways of summarizing the prevalence of suicidal behavior and data from each of these ways will be presented.

**The suicide rate:**

Data on suicide can be presented as rates per 100,000 per year and I computed the rates for 1960 and 1966 for Erie County which has a population of just over one million.[12] The rates are shown below:

| | 1960 | 1966 |
|---|---|---|
| | | |
| Buffalo | 7.8 | 7.7 |
| Erie County (excl. Buffalo) | 7.5 | 6.8 |
| Erie County (incl. Buffalo) | 7.6 | 7.2 |
| | | |
| white | 7.9 | 7.5 |
| non-white | 3.8 | 4.2 |
| | | |
| male | 11.7 | 10.6 |
| female | 3.8 | 4.1 |
| | | |
| 0-9 | – | – |
| 10-19 | 1.1 | 2.2 |
| 20-24 | 7.2 | 9.1 |
| 25-34 | 5.5 | 7.5 |
| 35-44 | 7.2 | 9.8 |
| 45-54 | 12.3 | 11.1 |
| 55-64 | 19.8 | 12.8 |
| 65-74 | 22.7 | 14.3 |
| 75+ | 20.0 | 21.5 |

[12] 1960-1966 were the years when accurate census counts were taken.

These suicide rates were computed for the periods 1958-1962 and 1964-1968 respectively. I took five year intervals because the incidence of suicide is so low that numbers fluctuate quite largely from year to year. The use of a five-year interval gives the computed rates some degree of reliability. To illustrate the misuse of these data, in Erie County in 1968 there were three suicides reported by African Americans (two by males and one by females). To say that the suicide rate in Erie County for black males is twice that for black females is not really meaningful.

**Proportion of suicidal deaths**

Another way of looking at the data is to compute how many deaths are due to suicide as a proportion of all deaths (rather than as a proportion of all living individuals as in the previous section). I obtained data for Upstate New York (that is, New York State less New York City) which enabled me to compute these proportions.

| | 1966 | 1967 |
|---|---|---|
| total population | 0.70% | 0.82% |
| | | |
| males | 0.99% | 1.05% |
| females | 0.35% | 0.54% |
| | | |
| < 15 years | 0.08% | 0.04% |
| 15-19 | 3.81 | 3.60 |
| 20-24 | 6.31 | 4.68 |
| 25-29 | 6.27 | 5.41 |
| 30-34 | 5.93 | 6.97 |
| 35-39 | 4.52 | 5.43 |
| 40-44 | 2.77 | 3.54 |
| 45-49 | 1.89 | 2.28 |
| 50-54 | 1.19 | 1.47 |
| 55-59 | 1.15 | 1.32 |
| 60-64 | 0.61 | 1.10 |
| 65-69 | 0.48 | 0.52 |
| 70-74 | 0.39 | 0.34 |
| 75+ | 0.14 | 0.20 |

It is clear that, although the suicide rate increases with age the actual proportion of deaths from suicide as a proportion of deaths from all causes peaks at 20-34 years of age.

**The number of suicides**

A third equally useful way of presenting the data on suicidal behavior is to look at the absolute numbers. For Upstate New York again for 1966 and 1967 the absolute numbers of suicides in different groups is shown below.

| | 1966 | 1967 |
|---|---|---|
| total population | 665 | 777 |
| males | 513 | 544 |
| females | 152 | 233 |
| < 15 years | 4 | 2 |
| 15-19 | 29 | 24 |
| 20-24 | 43 | 38 |
| 25-29 | 36 | 32 |
| 30-34 | 40 | 50 |
| 35-39 | 54 | 65 |
| 40-44 | 58 | 73 |
| 45-49 | 62 | 74 |
| 50-54 | 56 | 69 |
| 55-59 | 75 | 85 |
| 60-64 | 51 | 91 |
| 65-69 | 51 | 54 |
| 70-74 | 51 | 45 |
| 75+ | 55 | 75 |

(In Erie County the number of suicides each year has varied between 63 and 93 in the last ten years and the population of Erie County in 1960 was 1,064,688 and in 1966 1,087,103.)

**The number of attempted suicides**

It is often estimated that there are about 8 to 10 attempts at suicide for every successful suicidal act. The only good data on this come from a study by Shneidman and Farberow (1961) in Los Angeles in 1957 where they traced 768 completed suicides and 5,906 attempted suicides, a ratio of 7.69:1. This ratio is often inflated because it is assumed that Shneidman and Farberow missed many attempts at suicide. However, they also probably missed some completed suicides, and so the ratio may be a good approximation to the actual ratio.

Let us assume that the suicide rate for the total nation is 10 per 100,000 per year. Therefore, the attempted suicide rate will be about 77 per 100,000 per year. People typically assume that, each year, another 77 people attempt suicide and so after ten years in a population of 100,000 a total of 770 people will have attempted suicide. If we take a hypothetical population of 100,000 who have a life expectancy of 70 years each year from age 15 to 70 we can assume that 77 will attempt suicide and so by age 70 a total of 4,235 will have attempted suicide or about one in 24 of the population.

However, this figure is an overestimate. Wilkins (1967) reviewed large number of studies investigating how many of those who attempt suicide make repeated attempts at suicide. The estimates of the different studies ranged from 1% to 40% with a median percentage of 21.5%.

Similarly, a review of studies of how many completed suicides made prior attempts at suicide indicated that estimates ranged from 7% to 33% with a median percentage of 11.5%.

Thus, although an estimate of the rate of suicide attempts is 77 per 100,000 per year, the number of different individuals involved here is more like 53 per 100,000 per year. This reduces the estimate of the proportion of the population who will attempt suicide at some point in their life to about one in 34.

This is still likely to be an overestimate since we have assumed that repeaters only attempt suicide twice. It is very clear from available data that some individuals make multiple attempts. Thus, the number of individuals who will attempt suicide at some point in their life is somewhat less than one in 34.

## REFERENCES

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