DISTRESS CENTRE

24 HOUR SUPPORT | COUNSELLING | RESOURCES

CRISIS LINE RESPONDER MANUAL
UPDATED JANUARY 2023

Note: Information in this document is subject to revision and therefore may not be current. Please contact Distress Centre staff for up to date content.

TABLE OF CONTENTS

MODULE ONE: INTRODUCTION

SUMMARY

Welcome to the Distress Centre's training program! In this module trainees will be introduced to the Distress Centre as an organization including the mission, vision, and values as well as important contacts in the Crisis Centre. Trainees will understand important policies, timelines and will establish expectations for the training period.

OBJECTIVES

Attitudes

- Trainees will understand what Distress Centre expects from responders and what responders can expect from Distress Centre

Knowledge

- Trainees will learn about Distress Centre, its purpose, and the appropriate team members

Behaviour

- Trainees will be prepared for upcoming processes and timelines

PHILOSOPHY

Distress Centre is an essential service in the social infrastructure of the city. We act as the first point of contact for someone seeking help; when they just can't cope on their own anymore.

Our services are available free of charge, 24 hours a day; to stabilize crisis situations and connect people with ongoing resources that will help them over time.

We engage Calgarians to get involved, to learn and respond to their peers in need by recruiting and training volunteers to provide our front-line service.

Since 1970 we maintain a legacy built on volunteerism, partnerships and innovation.

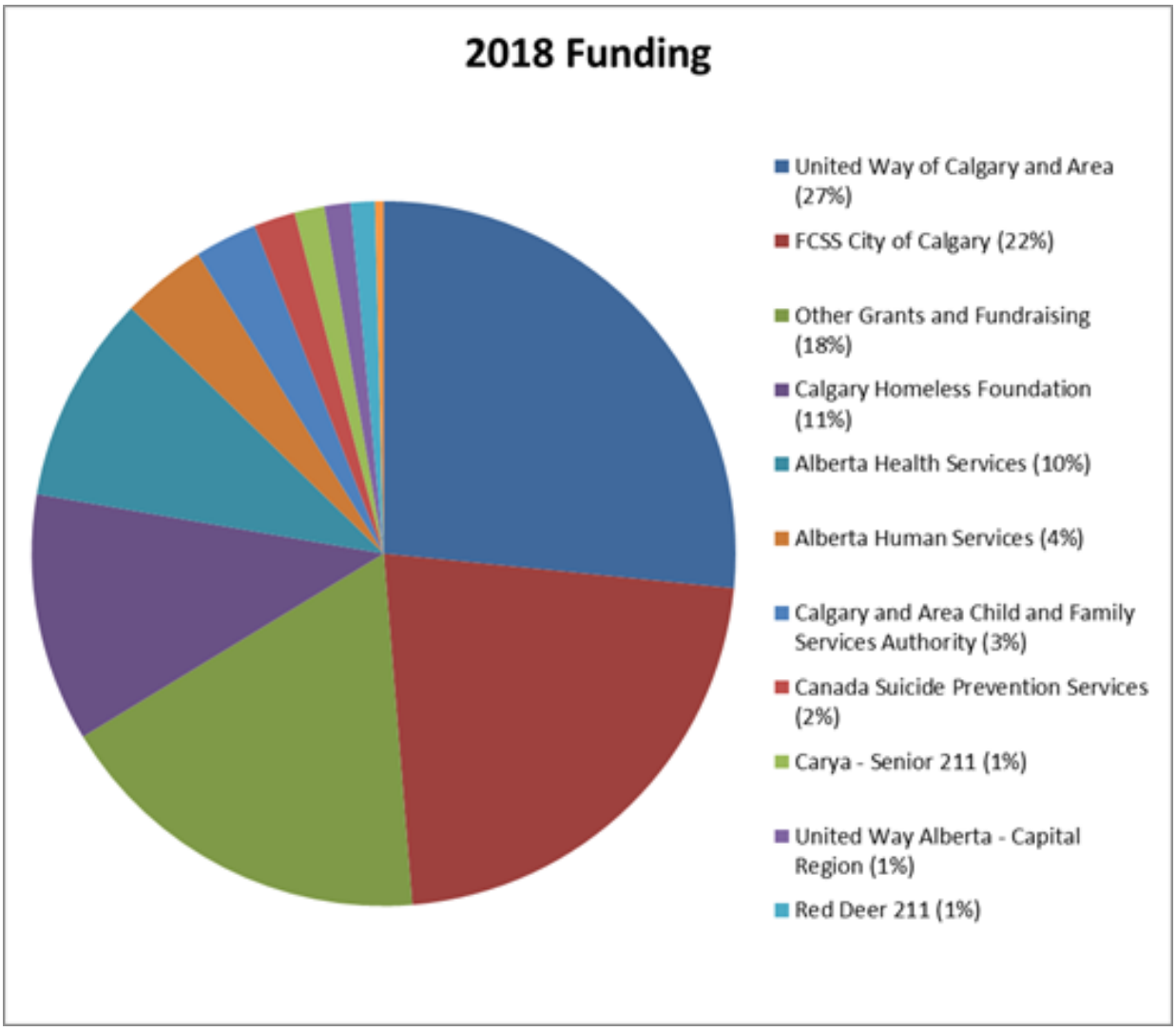
Mission	Provide compassionate, accessible crisis support that enhances the health, well-being and resiliency of individuals in distress.
Values	Accessibility, collaboration, compassion, excellence, inclusivity, innovation, leadership, partnerships, respect, and volunteerism.
Vision	Everyone is heard.

HISTORY

1970	On April 14th, the Drug Information Centre opened its doors with the goal of providing unbiased drug information and education, crisis intervention and research anytime, day or night. In the first year of operation, the volunteers responded to 3,837 calls and 1,724 drop-ins.
1973	The Centre began to shift from purely drug related calls to a dual emphasis on crisis and addictions.
1975	The 24-hour crisis line was launched, and the City of Calgary became one of the principle funders.
1977	The Drug Information Centre changed its name to Distress Centre/Drug Centre and was accepted as a member of the United Way.
1983	Teen Line was established to provide the youth of Calgary with a place to call that was specifically focused on their needs. This service was the first of its kind in Canada.
1990	Distress Centre sought to secure additional sources of funding throughout the '90s to meet the growing demand for crisis support.
1999	Distress Centre continued to experience tremendous growth as we introduced several new programs and partnerships. These included partnerships with mobile teams such as the Mobile Response Team. This paved the way for our current structure of effective partnerships and further established Distress Centre as an innovative leader in the community.
2005	Distress Centre partnered with the City of Calgary and United Way, launched 211 Calgary. This further established Distress Centre as the hub of crisis support and the "go-to" place for community referrals in Calgary.
2009	Due to the recession, Distress Centre responded to the increase in complexity of issues as well as severity of risk. To respond to the increased need, Distress Centre began to leverage social data from 211 to help with mapping issues in communities throughout the city, develop programs in areas of need, and targeting assistance to the hardest hit populations.
2010	Distress Centre's 40th Anniversary. The refreshed brand made its debut, along with the introduction of one memorable crisis line number, 403-266-HELP (4357).
2011	Distress Centre announced the launch of their refurbished youth peer support program, ConnecTeen, which now, in addition to 24-hour phone support at 403.264.TEEN (8336), offers online crisis chat and email support online at calgaryconnecteen.com.
2012	Distress Centre launched online services by expanding their current service offerings to include daily online chat and email support at distresscentre.com.

2013	Following the June floods, Distress Centre responded to a 40% increase in help-seeking calls to 211. In July, the 211 service is expanded to High River to help those impacted by the floods. In November, ConnecTeen announced the launch of their new youth peer support texting program, the first program of its kind in North America. The texting service is now available to all Calgary & area youth daily by texting 587-333-2724. Distress Centre was selected by the Calgary Homeless Foundation to provide coordinated intake into Calgary's homeless-serving system. Distress Centre's CAA team operates out of the Safe Communities Opportunity and Resource Centre (SORCe) and assists people at risk of or experiencing homelessness by providing a single point of access to housing and support services.
2015	ConnecTeen online service hours were expanded to 3pm-10pm weekdays and noon-10pm on weekends. Distress Centre online chat hours were expanded to 3pm-10pm weekdays and noon-10pm on weekends. Distress Centre developed a new, bold 2016-20 Strategic Plan.
2016	211 played a critical role in supporting the Fort McMurray/Wood Buffalo evacuees when wildfires ravaged the area in May. 211 provided evacuees with up-to-date information and connected donors/volunteers with agencies they could support. Online chat was launched province-wide to give evacuees another way to contact 211. 211 collateral and staff were also available at evacuation centres.
2017	A refreshed brand and website for ConnecTeen was launched in September. Our former Director of Operations, Jerilyn Dressler became our new Executive Director on June 1st.
2020	Distress Centre celebrated its 50th year of operations. In February, Distress Centre moved to new office space but due to COVID-19 pandemic our operations went fully remote in March.

FUNDING



PARTNERS

No agency can respond to complex social issues alone. While we can do a lot to help over the phone, some problems are more complex or urgent and require working with someone face-to-face. To do so, we rely on meaningful, effective partnerships to create success for our service users. With our service user's permission, we can connect them directly to various teams of professionals to respond to people in crisis. Our many partnerships include:

- Senior Connect
- Eastside Community Mental Health Services – ECMHS (formerly CRT)
- Mobile Response Team - MRT

- Southern Alberta Child Intervention Services - SACIS
- Calgary Communities Against Sexual Abuse - CCASA

BREAKDOWN OF SERVICES

Crisis Line Support	We are available to talk anytime – 24 hours a day, 7 days a week, 365 days a year. Crisis doesn't take time off, so neither do we. When an individual makes a call to Distress Centre, they will always get an answer, an open mind and a caring ear. For the ConnecTeen Line and Chat Being a teen can be tough. One has more independence than ever before, but probably has more questions, concerns and responsibility than ever before too. If a service user ever has a question, a problem or just need someone to talk to, they can give us a call or chat online. Some things can be really difficult to open up about, so it's best to talk to someone who knows exactly where you're coming from. We can connect youth service users directly with someone of similar age who understands their unique perspective and can help talk through their problems. ConnecTeen crisis line responders are on the lines between 3-10pm weekday and 12pm – 10pm weekends, all other hours the line is forward to Distress Centre's other crisis line responders. Hours of operation All Phone Lines 24 hours All Online Support (text or chat) 3 pm – 10 pm weekdays & 12 pm to 10 pm weekends https://www.distresscentre.com/need-help/
Counselling	To help with more complex issues, our professional crisis counsellors provide free counselling for individuals, couples and families at Distress Centre. We have both evening and emergency appointments available. Please note that counselling is not a 24-hour service. Counsellors at Distress Centre are all Registered Social Workers with the Alberta College of Social Workers.

	https://www.distresscentre.com/need-help/counselling/
Information and Referral	Call 211 and you will have access to an entire network of community, social, health and government services. Your call will be answered by a professional information and referral specialist who is trained to assess your need and refer you to the most appropriate service or services. We offer this service in over 170 languages and it is available in many communities in Alberta, including Calgary. 211 is on its way to becoming a full provincial service. 211 is free, confidential, multilingual and available 24 hours a day, 365 days a year. To reach 211, dial 2-1-1, text INFO to 211 or visit ab.211.ca and click "live chat." https://www.distresscentre.com/need-help/211-2/

SOME INDIVIDUALS ON THE DISTRESS CENTRE TEAM

Volunteer Team Lead	Provides leadership to the volunteer team including employees, practicum students and volunteers.
Volunteer Engagement Coordinator	Supports Team Lead with volunteer engagement
Training Coordinators	Oversees and facilitates training of volunteers and staff
Scheduling Coordinator	Oversees all scheduling systems
Recruitment Coordinator	Oversees Recruitment and mentors Leadership Volunteers
Youth Program Coordinator	Directs ConnecTeen chat, lines, and Youth Volunteers
Leadership Volunteers (LVs or Coaches)	Support training and mentoring
Mentors	Support crisis line responders in ongoing engagement
Contact Centre Coordinators (CCCs)	Provide support to crisis line responders on calls and during shifts.

There are many other individuals who play significant roles at Distress Centre who you will meet over time.

POLICIES AND PROCEDURES

CONFIDENTIALITY POLICY

- The Volunteer will only disclose Confidential Information to current staff and volunteers of the Distress Centre for the purposes of providing volunteer services.
- Unless required by law, the Volunteer will not for any reason whatsoever disclose Confidential Information to any person who is not a current staff or volunteer of the Distress Centre, without the prior written consent of the Distress Centre.
- The Volunteer acknowledges and agrees that all Confidential Information is and shall remain the exclusive property of the Distress Centre.

- The Volunteer agrees to deliver to the Distress Centre, immediately upon the conclusion of his or her volunteer services or at any other time when the Distress Centre so requests, all confidential materials and any copies thereof in any form whatsoever.
- In the event that the Volunteer breaches this agreement, the Volunteer shall be liable to the Distress Centre and excuses the Distress Centre from and against all losses, costs, claims, damages, expenses and any liabilities suffered, sustained, paid or incurred by the Distress Centre which would not have been suffered, sustained, paid or incurred had the volunteer maintained confidentiality.
- This agreement shall be governed and interpreted according to the laws of the Province of Alberta and the federal laws of Canada.

LIFE OR LIMB POLICY

- The Volunteer agrees to comply with the Distress Centre Client Emergency Policy. This means that if, while providing volunteer services to the Distress Centre, the Volunteer becomes aware of a person who is at risk of harm or violence to self or another person, the Volunteer will immediately notify a member of the Distress Centre staff and take appropriate measures to help the person, which may include breaching confidentiality by disclosing the identity, location and other information about the individual and accessing emergency services (i.e. Police, EMS, Child and Family Services).

NON-SOCIALIZATION POLICY

- The Volunteer may not become personally involved with a client either within or outside of the Distress Centre. Contact of any kind outside of the Distress Centre is strictly forbidden.

Any breach of the above policies will be reviewed on an individual basis. Disciplinary measures may be taken depending on the severity of breach up to and including dismissal.

WHAT IS A ROLE PLAY?

- A learning tool used to help train new crisis line responders.
- Helps new crisis line responders apply knowledge gained through reading the training manual as well as the classroom presentation.
- *A chance to practice your skills and learn through making mistakes and watching others in a safe and comfortable environment.*

ROLE OF THE LEADERSHIP VOLUNTEER/COACH

- To guide the new crisis line responder's through the process
- To evaluate new crisis line responder's progress of
    - Crisis Line Skills

    - Knowledge and resources
- To assist in self-identification of feelings
- To make new crisis line responders aware of resources
- To follow-up and give feedback to enhance performance
- Re-enforce empathy for the service user
- Fill the role of the CCC during 'calls'

COACHING SHIFTS

These shifts allow new crisis line responders to consolidate and solidify knowledge absorbed throughout classroom training and role-plays. This is an opportunity where you get to practice your new crisis intervention skills and polish any aspect needing to be improved. In fact, many crisis line responders describe Coaching Shifts as the period in their training where they learned the most.

ROLE OF LEADERSHIP VOLUNTEERS DURING COACHING SHIFTS:

An understanding and supportive leadership volunteer beside you helps make you feel more comfortable and help you out along the way. Leadership Volunteers are not there to judge or grade new crisis line responders. They are there to offer support and make sure new crisis line responder's skills are strong enough for them to go on the lines solo.

MODULE TWO: CRISIS INTERVENTION

SUMMARY:

In this module trainees will be introduced to crisis theory including a definition of crisis, core features, origins, and impacts. Trainees will become familiar with the Roberts' Seven Stage Crisis Intervention Model and utilize this to employ their established listening and questioning skills to become more effective in managing crisis.

OBJECTIVES:

Attitudes

- Trainees will appreciate the impacts of crisis in a person's life and suspending disbelief regarding personal definitions of crisis
- Trainees will be aware of their role in crisis intervention and maintain balanced and realistic expectations as a helper

Knowledge

- Trainees will understand the definition, origins, and the core features of crisis situations
- Trainees will understand the factors that determine successful crisis resolution
- Trainees will understand Roberts' Seven-Stage Crisis Intervention Model as a framework for crisis management

Behaviour

- Trainees will effectively move through Roberts' Seven-Stage Crisis Intervention Model
- Trainees will employ active listening skills and effective questioning techniques

DEFINITIONS OF CRISIS

We can appreciate that developing a good understanding of what a 'crisis' is and isn't will allow us to assist someone in crisis hopefully more effectively. Importantly, the term 'crisis' is meaningfully different from other key terms such as 'stress', or 'emergency', or 'emotional or mental breakdown' (Hoff et al., 2009). All of these terms, while seemingly to refer to the impacts of a crisis situation, are not to be used or thought of as being synonymous with 'crisis'. As defined below, a crisis is a unique situation involving an event, one's perception of the challenge posed by that event, and one's perceptions related to one's own resources. The following descriptions help us understand what a crisis is from multiple perspectives:

- Roberts and Ottens (2005) describe a crisis state as an intense felt sense of psychological disruption:
  "An acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and there exists evidence of distress and functional impairment." (p. 331)

- Similarly, James (2008) identifies the importance of perception or subjectivity in a crisis situation:
  "… a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms." (p. 3)

- Hoff et al. (2009) additionally relate that crisis states must be understood as unstable, with tendencies to improve or get worse:
  "Fundamentally, 'crisis' can be understood…as a serious occasion or turning point presenting both danger and opportunity." (p. 4)

CORE FEATURES OF CRISIS SITUATIONS

- From the previous definitions, we can understand three core features of any crisis situation (Roberts, 2005):

  (1) something happened or changed in an individual's life (i.e. an event) that the individual experiences subjectively as intolerable (e.g. an obstacle to significant life goals),

  (2) the individual perceives the event or change as being 'a problem', and

  (3) the individual is unable to resolve that problem by any previously used coping strategies

- Crisis involves short periods of psychological upset occurring time to time as a person wrestles with problems temporarily beyond their capacity.
- A turning point in one's life with the simultaneous opportunity to learn and grow as a human being and the danger of being utterly overwhelmed
- Important to remember that it is not just the external event itself that cause the crisis situation but also the person's perception of their situation and their own ability to meet the perceived challenges.
- A crisis is really any situation where a person perceives themselves to be deficient in coping resources. Therefore, crisis is self- defined.

- The nature of a crisis differs from person to person, depending on the person's maturity, history of coping, nature of the problem, and previous successes in managing similar situations.
- May range from seemingly minor situations (ex: not being prepared for class) to major life changes (ex: death or divorce).

CRISIS IMPACTS

- Overwhelming intensity of feelings and emotions (anxiety, fear, anger, sadness, confusion) interfering with the ability to think clearly and make adaptive coping decisions.
- Cognitive skills diminish. Sense of "cognitive constriction" during which time the situation seems completely unmanageable as all options or solutions seem to recede.
- A critical situation creating emotional impact on those involved and has the potential of changing a person's life.
- Anxiety typically stimulates use of problem solving however the problem-solving is often random or trial and error based, often worsening how one sees the situation and their ability to manage it.
- If the problem remains unsolved and anxiety continues to increase, serious mental and physical health complications may emerge (e.g. depression, ulcers, loss of sleep, loss of appetite, etc.) which often may worsen the effects of the crisis on the person and impact those immediately around them (i.e. family, children, friends).

SOME FACTS ABOUT CRISIS

- It is self- limiting. Over time, crises tend to resolve, emphasizing their short-term nature.
- Resolution, i.e. return to pre-crisis functioning, depends on the individual's inner resources/responses and help of others.
- During crisis individuals may be more open to help (vs. more stable times) and early intervention will help successful resolution.
- In times of crisis people will often attempt to reach out for help, in recognition of their own limitations in coping with an upsetting situation.

CHARACTERISTICS OF A PERSON IN CRISIS

- Lowered attention span
- 'Cognitive constriction', narrowed focus on limited details or aspects of the situation often negating possibilities for effective action
- Lack of flexible perspective
- Emotionally unstable (i.e. crying more often, easily irritated or frustrated, difficulty managing daily affairs, etc.)
- Impulsive behaviour, may involve substance use or abuse, excessive spending, gambling, etc.
- Negative changes in relationships
- Intense anger, frustration, confusion, worry, etc.

CRISIS ORIGINS

Hoff, Hallisey, and Hoff (2009) are helpful in identifying how we can understand crisis situations as having essentially three different origins or major sources.

Situational	Transitional	Social/Cultural
Material or environmental basis, usually unanticipated: • personal loss • sudden financial loss • sudden relationship loss • death of loved ones • physical health loss • disease, illness • mental health vulnerability • traumatic events • natural disasters	Normative life passages in human development and turning points in social status or roles, largely anticipated: • human life span development transitional states (i.e. infancy to childhood, childhood to adolescence, adulthood, etc.) • finding employment, developing career • birth of children for new parents • children leaving home • retirement, giving up social roles related to employment or economic identities • old age • preparations for end of life	Arise from cultural values and the social structure, largely beyond the individual's control: • discrimination based on age, gender, race, disability, or sexual identity that affects employment, educational opportunities, or access to 'the good life' • may involve combinations of personal and social factors, i.e. poverty, living in high-crime areas, influence of domestic violence, available safe housing, etc.

Note that the crisis context for anybody can involve a complex interaction between one or all three crisis origins. Many of Distress Centre crisis service users have very unique and complex lived histories involving crisis impacts from all three crisis origins, compounding the challenges of overcoming any one or several crisis events or stressors.

CRISIS INTERVENTION

Crisis intervention is working through/exploring what happened and the service user's perception of the crisis

- Emphasis is placed on helping the person do the following (Roberts, 2005):
    - Make behavioural changes and interpersonal adjustments.
    - Look at internal and external resources and supports.
    - Reduce unpleasant or disturbing effects of the crisis.
    - Integrate the event and its aftermath into the individual's other life experiences.

- Only deals with immediate problem, is active and directive, and involves realistic goals and planning with the crisis situation.

- Facilitates the healing process and will minimize impact on the individual.

- Temporary but immediate relief for an emergency situation as presented by a person in distress.

- Purpose of crisis intervention is (Roberts, 2005):

    - Restore the person's ability to function at the level that existed before the crisis period (maintain pre-crisis level of functioning). The role of the crisis line responder is to get the service user going again, NOT to identify/resolve all conflicts for the service user via 'telephone therapy.'

    - To assist the individual to return to pre- crisis level of functioning (or a level of functioning which is better than the pre-crisis level). This is accomplished through facilitating the person's usual coping skills and their accessing social and community resources.

- Provides the opportunity/mechanisms for change to those who experiencing psychological disequilibrium; those feeling overwhelmed by their current situation, have exhausted their skills for coping, and are experiencing personal discomfort.

- A process by which the crisis line responder identifies, assesses, and intervenes with the service user in crisis (to restore balance and reduce the effects of the crisis in his/ her life). The service user is then connected with a resource network to reinforce the change.

SOME CRISIS INTERVENTION SKILLS

Responding	Enable crisis line responder to communicate warmth, empathy and genuineness to service user as well as an understanding of the service user's situation.
Perceptiveness	How accurately the crisis line responder understands the service user's situation. This involves careful, active listening. In order to avoid misreading a situation, crisis line responder should ask clarifying questions to make sure they have it right.
Assertiveness	Being able to respond honestly and directly in situations requiring the crisis line responder to take a more active role in acquiring information or responding to risk or vulnerability concerns. Sometimes this may also relate to occasions when the crisis line responder needs to address abusive behaviour directed toward them by the service user, indicating the need to establish limits with the service user (note please advise the CCC of these difficult calls or situations for additional support and suggestions). The crisis line responder must always be careful that their needs do not minimize the needs of the service user.
Supportive Statements	Help a person to feel more encouraged or more competent in their coping attempts. These statements often encourage a service user to feel more hopeful about resolving their situation.
Paraphrasing	Feeding back what the service user is saying by putting it into their own words. This skill is useful to clarify the exact meaning of the message.
Interpreting	Attempt to point out alternative meanings or special significance of an event. Must be done very cautiously and only when it makes sense in the flow and context of the call, i.e. after having established the service user's safety and built good rapport. The risk of interpreting is that it may provoke the service user to feel incompetent, ashamed, or inferior to the crisis line responder providing the interpretation.
Feedback	Giving information pertaining to how a person is relating to another. Feedback should be descriptive versus evaluating or judgmental.
Confrontation	May be used to address inconsistencies or contradictory information in the service user's story. Confrontation is also used when the service user is using the line in inappropriate ways (discuss with CCC before confronting on this basis).

Clarification	Asking the service user to repeat or further explain particular details in their story for greater clarity. Enables the crisis line responder to understand the situation without making assumptions or having to fill the gaps of the story by themselves.
Empathy	Should be used throughout the call and communicated to the service user.
Questioning	Enables crisis line responder to assess the service user' situation. Purpose is to: • Stimulate service users to share information • Focus attention on one or more aspects of the service user's situation • Stimulate problem- solving thinking and feeling • Help organize the service user's thoughts • Help both the service user and the crisis line responder understand the situation • Clarify information by addressing ambiguities
Apologizing	Perhaps the most useful tool in any crisis line responder's 'tool box'. Issuing a well-meaning apology for any perceived offense or disruption in the rapport will often repair any damage done and enhance the quality of the service user's engagement and rapport.

OPEN VS. CLOSED QUESTIONS

OPEN questions used to:	**CLOSED questions used to:**
• Encourage service users to provide detailed information • Invite expressions of service users feelings • Maximize the service user's freedom to talk about what is important for them. • Open questions often begin with words such as: WHO, WHAT, WHEN, WHERE, HOW	• Elicit a "yes" or "no" response when answering more urgent calls, e.g. suicide • Gather specific details about a situation • Slow down the conversation and focus the service user • Help engage quiet service users • Closed questions often begin with words such as: IS, DID, CAN, HAVE, DO, DOES

SOME COMMON PITFALLS IN QUESTIONING:

Leading or Suggestive Questioning	These pressure service users to provide an answer the crisis line responder desires. For many new crisis line responders, they fear having service users admit to having thoughts of suicide, for example, and may attempt to implicitly coach the service user into providing a negative response because they fear not knowing what to do. Crisis line responders will ideally pay attention to what they might be asking indirectly or ask a leading question, in terms of whose needs are being served by the question, the service user's or the crisis line responders.
Yes/No Questions	Useful in situations where specific information is required, e.g. risk assessment, or when starting to engage with a service user at the beginning of the call. Not so useful in situations where elaboration is required or more detail is desired.
Double Questioning	When the crisis line responder asks more than one question at a time (after asking the first question, the crisis line responder decides a second question might be better and asks it before the service user has a chance to answer the first one. Obviously, this can result in much confusion for the service user and lead to a disruption in rapport building.
Garbled Questions	Asked when the crisis line responder is unclear about what they want to ask. These questions confuse service users and may heighten their anxiety.
The WHY Question	Requires the service user to have a degree of insight into their situation that they may not have and provoke anxiety or anger if they feel they are being blamed for the situation. Typically, "what" and "how" questions are much better alternatives. So rather than ask "why" something happened, responders might inquire "what were you thinking of doing next?" or "how have you thought of getting through this situation?"

STRATEGIES FOR SUCCESSFUL QUESTIONING

- Short, direct questions (For example: *how are you feeling?*)
- One question at a time
- Allow service user enough time to answer

- Avoid bombarding service user with questions
- Accept your discomfort with silence.
- Periodic interruptions can clarify and check your understanding of the service user's situation, but no more than necessary.
- Allow the service user's crisis to be their crisis (no matter what it may seem like to you). This is part of meeting the service users where they are at.
- Your personal attributes can contribute to overall effectiveness, remaining calm, supportiveness and caring.
- Allow service users to speak freely and vent feelings
- Help service users to see crisis as a temporary vs. chronic situation.

LISTENING

This enables the service user to actively/attentively listen to and grasp the service user's crisis situation. Active and attentive listening can help crisis line responders to:

- Grasp essential points of the service user's story
- Ask appropriate questions
- Use responding skills effectively
- Reduce service user's anxiety and guilt
- Unleash energy for more constructive problem solving

Active listening involves tuning into and feeding back the service user's situation. It means staying with the service user's agenda and working towards understanding.

COMMON SKILLS IN ACTIVE LISTENING

Skill	**Explanation**
Attending, acknowledging	Providing verbal or non- verbal awareness of the other, i.e. eye contact
Restating, paraphrasing	Responding to person's basic verbal message
Reflecting	Reflecting feelings, experiences, or content that has been heard or perceived through cues
Interpreting	Offering a tentative interpretation about the other's feelings, desires, or meanings
Summarizing, synthesizing	Bringing together in some way feelings and experiences; providing a focus

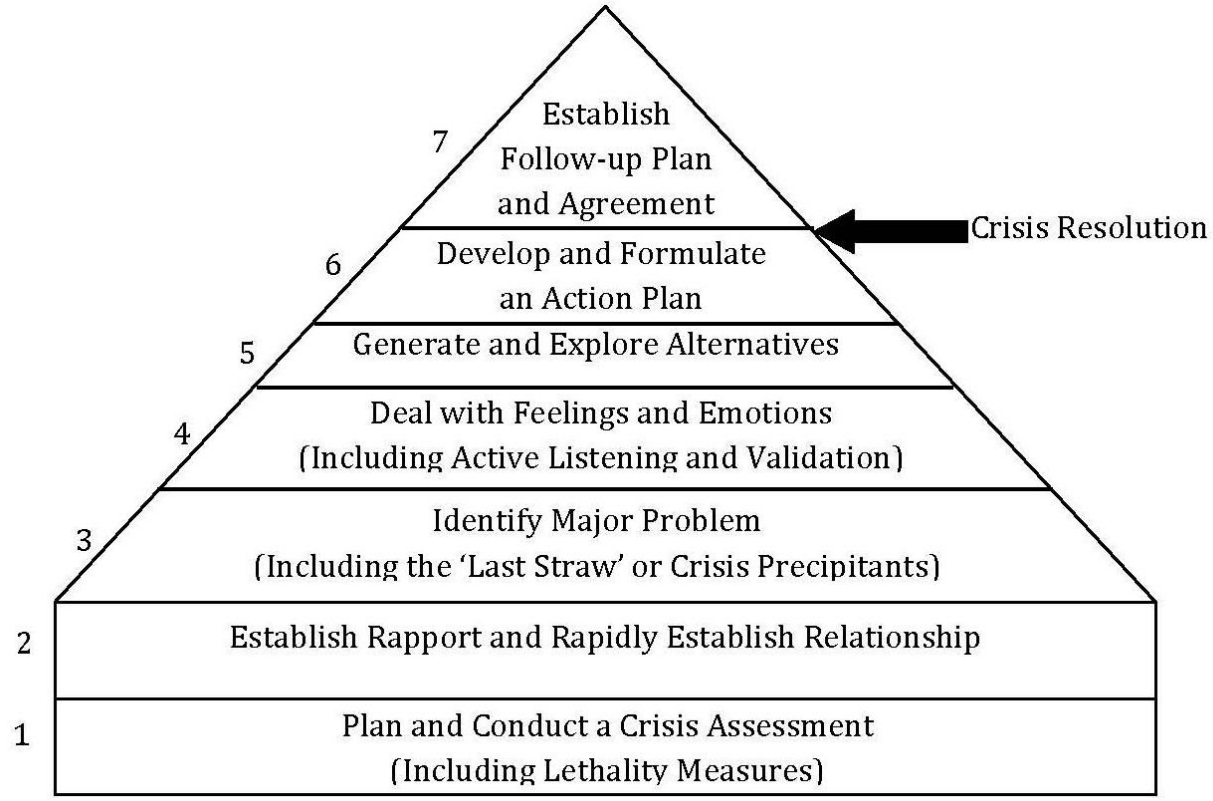
Probing	Questioning in a supportive that requests more information or that attempts to clear up.
Giving feedback	Sharing perceptions of the other's ideas or feelings; disclosing relevant personal information
Supporting	Showing warmth and caring in own individual way
Checking perceptions	Finding out if interpretations and perceptions are valid and accurate
Being quiet	Giving the other time to think as well as to talk

COMMON PITFALLS IN LISTENING

Active listening will help crisis line responders carefully 'tune into' the service user and better understand their presenting concerns. Any disruption in active listening will typically create problems building rapport and enhancing rapport, the following are typical examples of how of active listening is disrupted.

- Passive listening: When a listener exerts little/no effort in attending to what is being communicated. This can be due to boredom, hunger, disinterest (most common), and apathy. A passive listener:
    - Hears words but does not really listen.
    - Stays at the surface of the communication and does not understand the deep significance of what is being said.
    - Does hear words but does make much attempt to understand or to empathize with the speaker's intention.
    - Tends to listen logically and is more concerned for content than for feeling.
- Inadequate listening: causes crisis line responders to become disconnected from the service user's story typically because of being distracted (perhaps by loud noise in the contact centre; please keep your conversations to a tolerable volume level), pre-occupied with other calls or demands, pre-occupied with personal situations, not feeling well, etc.
- Judging while listening: when a crisis line responder judges what the service user is saying to be good/ bad, right/ wrong, acceptable/ unacceptable, likeable/ unlikable, etc., this hinders the process of understanding the service user and could lead to inappropriate advice- giving or taking too strong a directive approach with the service user.
- Filtered listening: is when crisis line responders let their own values, beliefs, attitudes, or culture influence what they are hearing and what they service user should or should not be doing.
- Rehearsing: is when the crisis line responder is thinking about the response they are going to make and not hearing everything that is said.
- Sympathy: when the crisis line responder starts to feel sorry for the service user, rather than feeling empathy with the service user.
- Interrupting: not letting the service user finish or completing sentences or thoughts for the service user.

ROBERTS' SEVEN- STAGE CRISIS INTERVENTION MODEL



1. PLAN AND CONDUCT A LETHALITY ASSESSMENT

Roberts (2005) emphasizes that basic information needs to be gathered to determine if service user is in imminent danger. In any crisis (no matter what the crisis is) there is potential for danger and harm. Assessments of imminent danger and potential lethality should examine the following factors:

- Does crisis service user need medical attention (Ex: drug overdose, suicide attempt or domestic violence)?
- Is the service user a victim of domestic violence, sexual assault, and/or other violent crime? If a victim, ask the service user whether the batterer is nearby or likely to return soon.
- Are there any children are in danger?
- Does the victim need emergency transportation to the shelter/hospital?
- Is the crisis service user under the influence of any drugs/alcohol?
- Does the service user have an intention to take their own life or someone else's life? If so, then how do they plan on doing that?

2. ESTABLISH RAPPORT AND RAPIDLY ESTABLISH RELATIONSHIP

The main task of the second stage is to establish rapport by conveying GENUINE respect for and acceptance of the service user. The service user also needs reassurance, and they are calling an appropriate place for help (Roberts, 2005). Warmth, empathy, and genuineness are keys in establishing a relationship with this service user.

3. IDENTIFY MAJOR PROBLEMS

In this stage, Roberts (2005) suggests the crisis line responder should examine the dimensions of the problem in order to define it. It is useful to try to identify the following:

- The "last straw" or the precipitating event that led the service user to call 'now.'
- Previous coping methods.
- What solutions have been attempted
- What previous successes or failures the service user has experienced in coping with this problem

These dimensions are best explored through open ended questions. The focus should be on "now and how" rather than on "then and why" (Roberts, 2005).

For example, what was it that made you call in today?" or "When did this even take place?" Crisis line responders should help service user rank and prioritize several problems. It is important and most productive to help service user ventilate about precipitating events or events; this will lead to problem identification.

Sometimes service users are in a state of denial. Other times service users have an all- consuming need to vent. Venting of feelings is important as long as the crisis line responder gradually returns to the central focus; the crisis. The goal of crisis intervention is to restore the level of functioning so that the service user might more effectively deal with their crisis. This is done by focusing in on the immediate situation and what can be done about it (Roberts, 2005).

4. ENCOURAGE AND EXPLORATION OF FEELINGS AND EMOTIONS

Roberts' (2005) identifies active listening to be the primary technique for identifying a service user's feelings and emotions. This involves the crisis line responder listening in an empathetic and supportive way to both the service user's reflection of what happened and how the service user feels about the crisis event.

Active listening involves tuning into and feeding back the service user's situation. It means staying with the service user's agenda, their definition of the problem (not ours) and working towards understanding.

5. GENERATE AND EXPLORE ALTERNATIVES

During this stage the crisis line responder should be exploring internal and external resources. The crisis line responder should be facilitating the service user in identifying alternative ways of dealing with the crisis.

It is the crisis line responder's role to be helping the service user explore other areas of hope and assistance. The crisis line responder should help the service user to identify past coping skills/ways of dealing with similar situations. What worked for them previously and how could these skills or strategies help the service user again.

6. DEVELOP AND FORMULATE AN ACTION PLAN

In this stage, Roberts (2005) describes the importance of the service user obtaining a realistic understanding of what happened and what lead to the crisis so that they can move forward trying new solutions or acting more effectively than previously. The crisis line responder can assist this process by summarizing the call, clarifying what was learned and what issues still remain unresolved for further action.

They can help the service user discover limiting beliefs that may have been caused due to the crisis and are restricting their response choices and options. This may consist of several different aspects depending on each service user's crisis. Additional focus for this stage involves clarifying what the service user will do once the call is over, what they plan to do in order to continue resolving the crisis and what supports they can access over the next hours and days.

7. FOLLOW- UP

In this stage the crisis line responder should talk with the service user about what kind of support they may need after the call is terminated. Some options may include:

- The service user being invited a call back if they are going through a crisis in their life and might need additional support
- A responder or CCC may making a referral to another agency or program such as SACIS, Distress Centre counselling or SeniorConnect
- The service user following up with another resource such as 211, family member or community service
- Safety Follow-Ups – where Distress Centre individuals may follow up with a service user

Follow-up calls to the service user must first be approved in consultation with the CCC who will want to know the details of the service user's situation and have some assurances that adequate safety planning exists to keep the service user safe over the next hours or days. If responders think the service user would benefit from receiving a safety follow up to check-in on them, then speak to the CCC prior to offering this to the service user. Safety Follow- Ups will be covered in more detail during the suicide module.

REFERENCES

Hoff, L. A., Hallisey, B. J., & Hoff, M. (2009). *People in crisis: Clinical and diversity perspectives* (6th ed.). Routledge

James, R.K. (2008). *Crisis intervention strategies* (6th ed.). Nelson Education.

Roberts, A. R. (2005). *Crisis intervention handbook* (3rd ed.). Oxford University Press.

Roberts, A. R. & Ottens, A. J. (2005). The seven-stage crisis intervention model: A road map to goal attainment, problem solving, and crisis resolution. *Brief Treatment and Crisis Intervention, 5*(4), 329-339. https://doi.org/10.1093/brief-treatment/mhi030

MODULE FOUR: GRIEF AND LOSS

SUMMARY:

In this module trainees will explore grief and loss by examining barriers, myths and understand the various methods in which individuals can process grief. Trainees will appreciate the individualization of grief and will review strategies to support individuals experiencing grief and loss.

OBJECTIVES:

Attitudes

- Trainees will have the awareness of how personal experiences can influence effective communication
- Trainees will have the awareness of false grief hierarchies and their own potential to experience loss

Knowledge

- Trainees will understand the concept of grief and loss and expand the definition to include non-death losses
- Trainees will understand how to apply models and theories pertaining to grief and loss
- Trainees will recognize misconceptions and stigmas surrounding grief and loss to facilitate conversations with individuals

Behaviour

- Trainees will demonstrate an ability to identify and respond openly to expressions of grief and loss
- Trainees will demonstrate an ability to explore an individual's experience and meaning behind a loss

GRIEF

All of us have experienced loss in our lives (EX: Loss of a favorite object, job or even a loved one), and we all grieve differently depending on the loss. We live in a grief denying society, which can make it very difficult for people to work through the grieving process. Grieving tends to make people uncomfortable and they will deny or ignore there has been a loss or that grieving is taking place. For example, after the death of a loved one, family members may notice others do not even bring up the deceased person's name anymore and it is like the person has simply disappeared.

Since we all grieve differently, it is really important to help the service user identify that they are grieving (some may not see this). For example, with a couple who have lost a child; each partner may show their grief differently and they may not be able to identify it in each other. In this case, they may not be able to come together and share their grief with each other, which can ultimately cause them to go their separate ways.

The actual loss itself is often an event in time. A partner may leave, someone physically dies, or a job is lost. However, the grief process could have begun even before the event. In the case of a deteriorating relationship or the diagnosis of terminal illness of a loved one, the individuals involved will have already begun the grieving process in preparation of the loss. There are various stages that the grieving person will go through after the occurrence of the event of the loss. This can often be a lengthy process.

MYTHS ABOUT GRIEF

"When do you think the family will get over it?"
"Death is really just a part of life."

Mourning has an Ending Point	It doesn't. It requires work. It does get better. It does become manageable. But the experience changes us as well. A favorite song can still bring a moment of sadness. Seeing a couple stroll through a park can bring a tear or two as you remember how it used to be. Mourning is a natural and personal process that only you can pace. It cannot be rushed and it cannot happen without your participation.
Grief is Like an Illness; There is a Cure	Grief has certain recognizable symptoms some people incorrectly consider signs of illness. That, coupled with your great wish to stop the pain or hurry the grieving process, can prompt you to turn to medications for help in coping, sleeping, and carrying on. Grief is not an illness. It does not just happen to you.

We Should Not Speak about the Dead	Many times, we avoid mentioning the deceased's name, because we don't want to cause undue pain to the griever. Actually, quite the opposite is true. Sharing memories and even talking about what the deceased might think about the current moment— "there's too much garlic", "what an amazing game"— let's everyone know the person is remembered and still loved.
You Do Not Need Counselling	Counselling is not a sign of weakness. Just as we may seek help and guidance from an accountant or attorney for financial or legal matters, it is often beneficial to seek help from a counselor who specializes in grief and loss. Others may prefer to be with other people who have experienced a similar loss. Support groups for grieving men and women are available in many communities.

THE STAGES OF GRIEF

Elizabeth Kubler- Ross has written extensively on the subject of grief. In the grief model, Kubler-Ross takes a look at the various stages of grief a person will typically travel through. The stages do not necessarily occur in order from beginning to end and not everyone goes through all the stages (Axelrod, 2020).

Shock/ Denial	A first reaction to the awareness of the loss, typically by the statement, "No, not me, it cannot be true."
Anger	The pain of loss is projected onto others, shift in thought from "it cannot be true," to the reaction, "Oh yes, it is me, it was not a mistake."
Bargaining	An attempt at an agreement to postpone or to bargain for more time.
Depression	Reaction to letting go of anger is followed by a sense of intense loss.
Acceptance	A stage where the individual is neither depressed nor angry. The individual has worked through feelings of loss and has found some peace.

GRIEVING PARENTS

Parental grieving is an intense form of grieving, it is frequently said that the grief of a child is one of the worst forms of grief that an individual can face. Bereaving parents can feel that a part of themselves has died with the death of the child and how they process this loss can be intensely personal. "Sociologists and psychologists describe parental grief as complex and multilayered and agree that the death of a child is an incredibly traumatic event leaving parents with overwhelming emotional needs." (athealth, 2013, the death of a child, para. 9) How each grieving parent will grieve is unique, however there are some patterns that are observed between different parents.

> "The death of a child is probably the most traumatic and devastating experience a couple can face. Although both mothers and fathers grieve deeply when such a tragedy occurs, they grieve differently, and it is most important that each partner give the other permission to grieve as he/she needs. This may be the greatest gift each can give the other.
>
> Parental grief is strongly influenced by the nature of the bond between child and parent. Bereavement specialists actually speak of "incongruent grieving" patterns in mothers and fathers and of differences in

> the timing and intensity of the parental bond for mothers and fathers." (athealth, 2013, the death of a child, para. 39)

For mothers, the connection between a child is typically more intense at the beginning of life including being more emotionally and physically intimate. This is due to a variety of factors but includes the relationship between pregnancy, birth, and the nursing process. Depending on the cultural context, mothers may demonstrate grieving connected to the immediate needs of the child lost and are often the focus of grief.

For fathers, the paternal bond may be concerned with the future and expectations for the child. However, fathers are demonstrating more intense relationships earlier and many become the direct caregivers for the newborn, developing a closer relationship. Despite forging relationships earlier in the life of the child, the influence of cultural expectations may not allow fathers to be the focus of the loss and they are often referred to as "second class grievers" (Horchler and Morris 1994, 72)

GRIEF WORK

Grief work is many things. It can be defined as learning to fill the hole left by the person who was lost, learning to identify with a new role or title after the loss of a job, or learning to live without something they were able to have previously. Grief work is learning to embrace the loss, rather than denying it.

People do many things to avoid grief work because it is so painful. They might jump into a new relationship or become addicted to alcohol or drugs. They could also engage in other types of escaping behavior, such as gambling, becoming preoccupied with work, or replacing that which was lost immediately.

There are many feelings associated with grief (ex: frustration, sadness, fatigue, numbness, and guilt). Grief also has physical sensations associated with it (ex: hollowness in the stomach, lightness in chest and/or throat, and oversensitivity to noise). These feelings are most intense after the loss has just occurred and may continue for a period of time.

The thoughts associated with grief are also most intense right after the loss has occurred and tend to be of an all-encompassing nature. The loss is all the grieving person can think about.

The grieving person will often change their behavior (ex: experience sleep and appetite disturbances, social withdrawal, and restlessness). They may find themselves crying, searching, and calling out. They may avoid reminders of the lost person, or may be seeking out reminders of the person. They also may experience having dreams of the deceased person. To the service user, it may feel like they are going crazy. It is really important to normalize these behaviors for the person who is grieving. However, the prolonged occurrence of these behaviors could signal a problem, and could turn into a mental health issue.

People grieve in different ways, so there is no right way of doing it. Grief, however, is an important process to go through if the person is to integrate the loss into their lives and move forward. Because of the painful nature of

this process, people will sometimes circumvent by entering into another relationship or behaving in ways that help them avoid grieving. Subsequent losses will then bring up the previous grief as well as the grief associated with current loss. This is called complicated grief.

COMPLICATED GRIEF

Complicated grief is influenced by five factors which include relationship factors, circumstance, history, personality, and social factors.

Relationship	If the relationship was more ambivalent, highly dependent relationship, or there are unresolved issues.
Circumstance	This can be seen in cases where a person has gone missing or simply walked away, or where there are multiple losses that an individual is dealing with. When there are special circumstances surrounding the loss.
History and Personality	If the individual has had complicated grief reactions in the past or if they are not able to tolerate the extreme pain of grief.
Social	Where the individual is dealing with a loss that is socially unacceptable, such as the suicide of a loved one in a society where there is stigma around suicide, a loss that is socially negated where others may not see it as a loss (such as the loss of a pet or dream), or if the grieving individual does not have a supportive social network.

THE DREADED CLICHÉ— BEREAVEMENT PHRASES THAT DON'T WORK

Sometimes, because we think we don't have the right words to express our condolences to a person or family who is grieving, we will pull out the old, worn out phrases that may sound helpful but are really not. We don't know what to say, so we might come up with the following clichés.

- **"Your loved one is in a better place. They don't have to suffer anymore."** The griever actually knows that their loved one isn't suffering anymore. But they are! And they would give anything to have them here with them, not anywhere else, better place or not!
- **"If you look around, there's always someone worse off."** Right now, the griever feels like there isn't anyone worse off than them. They have just lost a treasured loved one and can't imagine anything worse.
- **"Keep your chin up."** When all they want to do is wail, scream, cry, yell, swear, curse, and rage, they do not want someone to tell them to just cut that all off and carry on.

- **"You had many wonderful years together. You're fortunate."** And they would give anything, make any bargain, and trade anything to have more years. This loved one shouldn't have died. Their life may have really just begun.
- **"You're only given as much as you can handle."** Who made that one up? They want to tell you that you have no idea how much they have already handled and now it feels like they can't go another step.
- **Be thankful that you have other children at home."** They want to acknowledge their healthy children at home but also tell you that this child was precious as the other children. No one will ever replace this child in their life.
- **"You can have other children."** They probably can't think about the next minute, never mind the future. Right now, they are in agony because their child died! They have no interest in anything else. And another child will never replace this child.
- **"Count your blessings."** In this state of mind they probably can't, in their wildest imagination, consider all this pain, anger, emptiness, frustration, and fear a blessing. They want to have these feelings acknowledged and supported, not have to worry about your discomfort.
- **"You have to be strong for the children."** They may want to tell you that they can't be strong for themselves, never mind other people. And they may want to know who will support them as they feel themselves falling apart.
- **"I know just how you feel."** No, you don't! No one else can know how this terrible pain feels. Everyone's feelings are uniquely theirs. Acknowledge the feelings by naming them and listening to their story.
- **"Now you have to be the man/ woman of the house."** Telling a child that they have to do something that they know they can't do is frightening, confusing, and overwhelming for them. At any level, this phrase makes absolutely no sense [10].

CRISIS LINE RESPONDERS CAN PROVIDE HELP IN THE SIMPLEST WAYS

(Angelou, n.d.)

ROLE OF THE CRISIS LINE RESPONDER

The best support we can give to someone grieving is non- judgmental and compassionate support. We must be genuine and just be with the grieving person. Use personal stories about your own grief with caution. Silence can be your friend on these calls— you are not expected to know the answer.

It can be very helpful to help the service user identify the different emotions that they are feeling, and to normalize some of the different emotional and physical reactions that they have been feeling. Find out what they need to feel better today in the short term (self- care) and help them formulate a plan for getting help in the long term (perhaps counseling).

Help E.A.S.E. the pain	
E- Express	Find a way to express the pain Embrace it What you resist, persists Talking, writing
A- Allow	Death is the end of life, not the end of the relationship
S- Suspend	Suspend the myths of grief Replace the loss Give it time Need to be strong Stay busy
E- Encourage	Learn to be an encouragement to yourself Self- talk (be your own cheerleader) Help others

GRIEF AND LOSS RESOURCES

- Hospice Calgary
    - Support group and counseling resources for adults and youth facing chronic/ life threatening illness (their own or that of a loved one) or grieving the death of someone close (can include accident, homicide, or suicide)

- Alberta Health Services
    - Assistance to those who admitted with a progressive chronic/terminal disease with care aimed at improving quality of life;
    - Expertise in pain and symptom management, support for individuals and their families;
    - Liaison with other services such as Home Care, Palliative Services or hospices

- Distress Centre Counseling

REFERENCES

Angelou, M. [Image]. (n.d.). http://www.hospicenorthhastings.com/history.php

Athealth. (2013). *The death of a child*. https://athealth.com/topics/the-death-of-a-child-2/

Axelrod, J. (2020, July 8). *The five stages of loss and grief*. PsychCentral. https://psychcentral.com/lib/the-5-stages-of-loss-and-grief/

Horchler, J. N., & Morris, R. R. (1997). The SIDS survival guide: information and comfort for grieving family and friends and professionals who seek to help them. SIDS Educational Services.

MODULE FIVE: MENTAL HEALTH

SUMMARY:

In this module trainees will be able to define mental illness including a more robust definition of mental health. Trainees will delve into common myths and stigma associated with mental illness and will develop strategies for managing conversations and appropriate intervention strategies for individuals with mental illness.

OBJECTIVES:

Attitudes

- Trainees will have a holistic perspective that allows people to be viewed as individuals rather than their mental health concerns

Knowledge

- Trainees will have a general understanding of the different types of mental health concerns that are encountered at Distress Centre and how to effectively support them
- Trainees will understand mental health stigmas and how this creates barriers to those living with mental health concerns
- Trainees will understand the etiology of the most common presenting mental illnesses and challenges individuals may face with mental health concerns

Behaviour

- Trainees will support individuals with mental health concerns in the scope of crisis intervention and employing boundaries when necessary
- Trainees will utilize non-stigmatizing language to empower and support individuals who live with a mental health concern

WHAT IS MENTAL HEALTH?

The Canadian Mental Health Assocation (2020) defines Mental Health as "a state of well-being, and we all have it. Just like we each have a state of physical health, we also each have our mental health to look after. It's not just about surviving, it's about *thriving*. It's enjoying life, having a sense of purpose, and being able to manage life's highs and lows." (Mental Health: What is it really?, para. 4)

Some characteristics of mental health are as follows:

- **The ability to enjoy life-** The ability to enjoy life is essential to good mental health. The practice of mindfulness meditation is one way to cultivate the ability to enjoy the present. We, of course, need to plan for the future at times; and we also need to learn from the past. Too often we make ourselves miserable in the present by worrying about the future.

- **Resilience-** The ability to bounce back from adversity has been referred to as "resilience." It has been long known that some people handle stress better than others. Why are some Vietnam combat veterans handicapped for life, while others become United States senators? Why do some adults raised in alcoholic families do well, while others have repeated problems in life? The characteristic of "resilience" is shared by those who cope well with stress.

- **Balance-** Balance in life seems to result in greater mental health. We all need to balance time spent socially with time spent alone, for example, those who spend all of their time alone may get labelled as "loners", and they may lose many of their social skills. Extreme social isolation may even result in a split with reality. Those who ignore the need for some solitary times also risk such a split. Balancing these two needs seems to be the key—although we all balance these differently. Other areas where balance seems to be important include the balance between work and play, the balance between sleep and wakefulness, the balance between rest and exercise, and even the balance between time spent indoors and time spent outdoors.

- **Flexibility-** We all know people who hold very rigid opinions. No amount of discussion can change their views. Such people often set themselves up for added stress by the rigid expectations that they hold. Working on making our expectations more flexible can improve our mental health. Emotional flexibility may be just as important as cognitive flexibility. Mentally healthy people experience a range of emotions and allow themselves to express these feelings. Some people shut off certain feelings, finding them to be unacceptable. This emotional rigidity may result in other mental health problems.

- **Self-actualization-** What have we made of the gifts that we have been given? We all know people who have surpassed their potential and others who seem to have squandered their gifts. We first need to recognize our gifts, of course, and the process of recognition is part of the path toward self- actualization. Mentally healthy persons are persons who are in the process of actualizing their potential.

These are just a few of the concepts that are important in attempting to define mental health. The ability to form healthy relationships with others is also important. Adult and adolescent mental health also includes the concepts of self- esteem and healthy sexuality. Many groups also emphasize spiritual or religious ties as necessary for mental health.

TIPS FOR MENTAL HEALTH

Build Confidence	Identify your abilities and weaknesses, accept them, build on them and do the best with what you have.
Eat right, Keep fit	A balanced diet, exercise and rest can help you to reduce stress and enjoy life.
Make Time for Family and Friends	These relationships need to be nurtured; if taken for granted they will not be there to share life's joys and sorrows.
Give and Accept Support	Friends and family relationships thrive when they are "put to the test".
Create a Meaningful Budget	Financial problems cause stress. Overspending on our "wants" instead of our "needs" is often the culprit.
Crisis line responder	Being involved in community gives a sense of purpose and satisfaction that paid work cannot.
Manage Stress	We all have stressors in our lives but learning how to deal with them when they threaten to overwhelm us will maintain our mental health.
Find Strength in Numbers	Sharing a problem with others have had similar experiences may help you find a solution and will make you feel less isolated.
Identify and Deal with Moods	We all need to find safe and constructive ways to express our feelings of anger, sadness, joy and fear.
Learn to Be at Peace with Yourself	Get to know who you are, what makes you really happy, and learn to balance what you can and cannot change about yourself.

(Canadian Mental Health Association, 2016).

WHAT IS MENTAL ILLNESS?

The Government of Canada (2020) says mental illness “are characterized by alterations in thinking, mood or behaviour associated with significant distress and impaired functioning.” (para. 1)

Mental illness is common. Statistics show that one in every five Canadians will have a mental health problem at some point in their lives (Canadian Mental Health Association, 2010, Fast Facts).

STIGMA

What is Stigma? Research identifies three types of mental health stigma (Corrigan and O’Shaughnessy, 2007):

- **Self Stigma** – Stigma that behavioral health consumers feel towards themselves, which can prevent people from seeking the support of family, peers and professionals.
- **Public (Societal) Stigma** – Stigma that comes from the general public towards a stigmatized group – learned early in life (Byrne 2000). Prejudices against people with mental health conditions permeate most social milieu and contribute to exclusion in subtle and blatant ways.
- **Structural Stigma** – Inherent in the policies of private and public institutions that restrict opportunities for people with mental illness. Experienced as bias, avoidance, discomfort, and outright discrimination.

Self, societal, and structural stigma combine to form a powerful triad of negativity toward mental health consumers, which delays or altogether obstructs access to mental health services.

MYTHS OF MENTAL ILLNESS

How much do you know about mental illness? Here are some of the common myths—and truths (Can we talk?, n.d., Myths about mental illness).

- **Mental illness is caused by a personal weakness.** A mental illness is not a character flaw. It is an illness, and it has nothing to do with being weak or lacking will- power. Although people with mental illness can play a big part in their own recovery, they did not choose to become ill, and they are not lazy because they cannot just "snap out of it."
- **If I seek help for a mental health issue, others might think I'm a wimp or even crazy. S**eeking appropriate help is a sign of strength, not weakness. No one should delay getting treatment for a mental health problem that is not getting better, just as one would not wait to take care of a medical condition that needed treatment. The wisest, most courageous way to cope is to seek help, especially since early treatment can produce more positive results
- **Mental illness is a single, rare disorder.** Mental illness is not a single disease but a broad classification for many disorders. Anxiety, depression, schizophrenia, personality disorders, eating disorders and organic brain disorders can cause misery, tears and missed opportunities for thousands of Canadians
- **MYTH: People with mental illness never get better.** With the right kind of help, people with mental illnesses often recover and go on to lead healthy, productive lives. While the illness may not go away, the symptoms associated with it can be controlled.
- **People with mental illness are poor and/ or less intelligent.** Many studies show that most mentally ill people have average or above-average intelligence. Mental illness, like physical illness, can affect anyone regardless of intelligence, social class or income level.

MENTAL ILLNESS ON THE CRISIS LINES

The most common mental illnesses encountered on the crisis lines are the following: Mood Disorders, Schizophrenia, Anxiety Disorders, Personality Disorders and Eating Disorders.

MOOD DISORDERS

"Mood disorders may involve depression only or they may include manic episodes (known as **bipolar disorder**, which used to be known as "manic depressive illness"). Individuals with mood disorders suffer significant distress or impairment in social, occupational, educational or other important areas of functioning.

Individuals with depression feel worthless, sad and empty to the extent that these feelings impair functioning. They may also lose interest in their usual activities, experience a change in appetite, suffer from disturbed sleep or have decreased energy" (Health Canada, 2002, p. 32).

SYMPTOMS OF DEPRESSION

- Feeling worthless, helpless, or hopeless
- Loss of interest or pleasure (including hobbies or sexual desire)
- Change in appetite
- Sleep disturbances
- Decreased energy or fatigue
- Sense of worthlessness or guilt
- Poor concentration or difficulty making decisions.
  (Health Canada, 2002, p. 33)

"Individuals with mania are overly energetic and may do things that are out of character, such as spending very freely and acquiring debt, breaking the law or showing lack of judgment in sexual behaviour. These symptoms are severe and last for several weeks, interfering with relationships, social life, education and work" (Health Canada, 2002, p. 32).

SYMPTOMS OF MANIA

- Excessively high or elated mood
- Unreasonable optimism or poor judgment
- Hyperactivity or racing thoughts
- Decreased sleep
- Extremely short attention span
- Rapid shifts to rage or sadness

- Irritability

(Health Canada, 2002, p.33)

Major depressive disorder is characterized by 5 or more symptoms of depression that "have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure." (American Psychiatric Association, 2013, p. 317). Bipolar disorder is characterized by at least one manic or mixed episode (mania and depression) with or without a history of major depression (American Psychiatric Association, 2013).

"As a group, mood disorders are one of the most common mental illnesses in the general population" (Health Canada, 2002, p. 33). "Mood disorders affect individuals of all ages, but usually appear in adolescence or young adulthood. However, late diagnosis is common: the average age of diagnosis of major depressive disorder is in the early twenties to early thirties" (Health Canada, 2002, p 34). "During any 12- month period, between 4% and 5% of the population will experience major depression" (Health Canada, 2002, p. 33). "Women are almost twice as likely to become depressed as men. The higher risk may be due partly to hormonal changes brought on by puberty, menstruation, menopause and pregnancy. Men are more likely to go undiagnosed and less likely to seek help" (Katch et al., 2006, p. 698).

"Mood disorders are treatable. Many people with a mood disorder fail to seek treatment, however, and suffer needlessly. Of those who seek treatment, many remain undiagnosed or receive either incorrect medication or inadequate doses. The delay in seeking and receiving a diagnosis and treatment may be due to a number of factors, such as stigma, lack of knowledge, a lack of human resources and availability or accessibility of services. Current initiatives to relieve the burden of mood disorders include not only improved recognition and use of effective treatments, such as antidepressant medications and education in combination with various forms of psychotherapy, but also education for individuals and families and for the community" (Health Canada, 2002, p. 39).

SUPPORTING SERVICE USERS WITH A MOOD DISORDER

CLUES	• Service user says they are feeling depressed, feel down, they have lost interest in activities, are having difficulty sleeping, loss of energy, feel worthless, thoughts of death • Service user is very elated, has a short attention span or mentions frequent changes in mood • May mention medications such as Prozac, Paxil, Elavil, Effexor, Lithium
WHAT TO DO	• Normalize the experience (often it's a reaction to loss, life changes, stress) • Look for strengths • Use strong supportive statements • Validate their feelings! • Explore the service user's current resources (i.e. counsellor or doctor, family, friends etc.)

	• Offer counseling at the Distress Centre or if not appropriate, refer to another agency • Don't rush into solutions - the service user may only need someone to hear their pain • Assess L.A.S.! • Some service users may be experiencing long term depression. You'll likely not "snap" them out of it in one call. • Instead, it may help to focus on the current situation instead of on the past.

Margaret Trudeau speaks about mania and bipolar disorder, "When you have been in depression for a long time, your family – yourself – are so relieved that the depression is over, that you are up on your feet again. Here's where the caution comes in – when everything seems so good, that's when you have to be the most careful. Because it accelerates into mania. Mania is the most destructive of the forces. Everybody around you will tell you you're in trouble, and you can't hear what they are saying."
(Anderssen, 2010, para. 4)

Schizophrenia

"Schizophrenia is a brain disease and one of the most serious mental illnesses in Canada. Common symptoms are mixed- up thoughts, delusions (false or irrational beliefs), hallucinations (seeing or hearing things that do not exist) and bizarre behaviour. People suffering from schizophrenia have difficulty performing tasks that require abstract memory and sustained attention. Schizophrenia has a profound effect on an individual's ability to function effectively in all aspects of life- self-care, family relationships, income, school, employment, housing, community, and social life.

SYMPTOMS

- Delusions and/or hallucinations
- Lack of motivation
- Social withdrawal
- Thought disorders

Early in the disease process, people with schizophrenia may lose their ability to relax, concentrate or sleep and they may withdraw from friends. Performance at work or school often suffers. With effective early treatment to control symptoms, individuals can prevent further symptoms and optimize their chance of leading full, productive lives. The onset of schizophrenia in the early adulthood years usually leads to disruptions in an individual's education. Individuals with schizophrenia often find it difficult to maintain employment for a sustained period of time … The chronic course of the disorder contributes to ongoing social problems. As a result, individuals with schizophrenia are greatly over- represented in prison and homeless populations.

The onset of schizophrenia typically occurs between the late teens and mid-30s. Onset before adolescence is rare. Men and women are affected equally by schizophrenia, but men usually develop the illness earlier than women. Schizophrenia affects approximately 1% of the population.

The mortality associated with schizophrenia is one of the most distressing consequences of the disorder. Approximately 40% to 60% of individuals with schizophrenia attempt suicide, and they are between 15 to 25 times more likely than the general population to die from a suicide attempt. Approximately 10% will die from suicide.

Public misunderstanding and fear contribute to the serious stigma associated with schizophrenia. Contrary to popular opinion, most individuals with the disorder are withdrawn and not violent. Nonetheless, the stigma of violence interferes with an individual's ability to acquire housing, employment and treatment, and also compounds difficulties in social relationships. These stereotypes also increase the burden on families and care givers. Unfortunately, given our state of knowledge, methods for preventing schizophrenia remain unknown. The most effective treatment for schizophrenia includes antipsychotic medication, education of the individual and his/her family, support groups, social skills training and counseling" (Health Canada, 2002, pp. 49-58).

SUPPORTING SERVICE USERS WITH SCHIZOPHRENIA

CLUES	Service user may have disorganized speech, a story-line that is implausible, disjointed speech, "bizarre" behaviour compared to a typical call. May mention medications such as Thorazine, Haldol, Ativan, Xanax, or Elavil
WHAT TO DO	Remember Warmth, Empathy, and Genuineness Try to focus on the service user's concerns instead of openly confronting inconsistency Present a realistic response to a service user's fears and concerns, even if they seem strange or disorganized While the service user's thoughts may not make sense, the feelings they have are real and need support and validation Explore the service user's connection to the health care system. Do they have a psychiatrist? Are they on medication? Are they taking it? Do they have a counselor? Remember, some service users may have medication but are not taking it. Support them in taking the medication and refer them to their doctor if they have concerns about it. As a crisis line responder, you may have a variety of reactions to these kinds of calls. Be sure to take time to debrief!

ANXIETY DISORDERS

"Individuals with anxiety disorders experience excessive anxiety, fear or worry, causing them either to avoid situations that might bring on the anxiety or to develop compulsive rituals that lessen the anxiety. Everyone feels anxious in response to specific events—but individuals with an anxiety disorder have excessive and unrealistic feelings that interfere with their lives in their relationships, school and work performance, social activities and recreation.

SYMPTOMS

- Intense and prolonged feelings of fear and distress that occur out of proportion to the actual threat or danger.
- Feelings of fear and distress that interfere with normal daily functioning.

TYPES

- **Generalized Anxiety Disorder:** Excessive anxiety and worry about a number of events or activities occurring for more days than not over a period of at least 6 months with associated symptoms (such as fatigue and poor concentration).
- **Specific Phobia:** Obvious and persistent fear of clearly discernible objects or situations (such as flying, heights, and animals).
- **Post-Traumatic Stress Disorder:** Flashbacks, persistent frightening thoughts and memories, anger or irritability in response to a terrifying experience in which physical harm occurred or was threatened (such as rape, child abuse, and war or natural disaster).
- **Social Anxiety Disorder:** Exposure to social or performance situations almost invariably provokes an immediate anxiety response that may include palpitations, tremors, sweating, gastrointestinal discomfort, diarrhoea, muscle tension, blushing or confusion, and which may meet criteria for the panic attack in severe cases.
- **Obsessive- Compulsive Disorder**
    - Obsessions: Persistent thoughts, ideas, impulses or images that are intrusive and inappropriate and that cause marked anxiety or distress. Individuals with obsessions usually attempt to ignore or suppress such thoughts or impulses or to counteract them by other thoughts or actions (compulsions).
      Compulsions: Repetitive behaviours (such as hand washing, ordering or checking) or mental acts (such as praying, counting or repeating words) that occur in response to an obsession or in a ritualistic way.
- **Panic Disorder:** Presence of recurrent, unexpected panic attacks, followed by at least 1 month of persistent concern at having additional attacks, worry about the implication of the attack or its consequences, or a significant change in behaviour related to the attacks. Symptoms of a panic attack include:

    - Palpitations, increased heart rate or pounding heart
    - Sweating
    - Trembling or shaking
    - Sensations of shortness of breath or smothering
    - Feeling of choking
    - Chest pain or discomfort
    - Nausea or abdominal distress
    - Dizziness, unsteadiness, tight headedness or fainting
    - De-realization or de-personalization
    - Fear of losing control or going crazy

- Fear of dying
- Paresthesia (numbness or tingling sensation)
- Chills or hot flashes

Combined anxiety disorders affect approximately 12% of Canadians: about 9% of men and 16% of women during a one-year period. As a group, anxiety disorders represent the most common of all mental illnesses. Women report and are diagnosed with some anxiety disorders more frequently than men. This may reflect the differences between men and women in their health-service-seeking behaviours, however, rather than true differences in prevalence.

Symptoms of anxiety disorders often develop during early adulthood. Although the majority of people have mild or no impairment, anxiety disorders can seriously restrict an individual's education, work. Recreation and social activities because he/she avoid situations that precipitate the symptoms.

Because anxiety disorders are the extension of what most people perceive as normal worry and concern, those who experience them may fear that others would label their excessive worry and fear as simply a weakness. As a result, they may try to ignore the seriousness of their condition and deal with it themselves. They often avoid seeking help and suffer in silence.

A recent review of anxiety disorders suggests that effective treatments include drug therapy (with antidepressants or anti-anxiety drugs) and cognitive-behavioural therapy, which helps people turn their anxious thoughts into more rational and less anxiety producing ideas. Support groups for individuals and families can help develop the tools for minimizing and coping with the symptoms" (Health Canada, 2002, pp. 59-68).

SUPPORTING SERVICE USERS WITH ANXIETY

CUES	• Service user may complain about pounding heart, racing pulse, sweating, shaking, fear of losing control, fear of dying here—now. • May mention Valium, Ubrium, Xanax.
WHAT TO DO	• Remain as calm as possible! A service user's anxiety can upset you too. • Ask if this is their first attack. If not, what helped them before? • Reassure the service user. • Be directive (i.e. "I want you to sit down and breathe with me") • Be honest that there is no quick fix. They have to ride it out but let them know that you can be there for them (don't forget to let them know you also have to answer other incoming calls). • Remember that as a crisis line responder listening, it can be easy to get caught up in the service user's anxiety. Monitor your own reactions to the service user and if possible, take a few moments after the call to wind down.

PERSONALITY DISORDERS

"Personality disorders reflect personality traits that are used inappropriately and become maladaptive. Some deviations may be quite mild and interfere very little with the individual's home or work life; others may cause great disruption in both the family and society. Specific situations or events trigger the behaviours of a personality disorder. In general, individuals with personality disorders have difficulty getting along with others and may be irritable, demanding, hostile, fearful or manipulative.

SYMPTOMS

- Difficulty getting along with other people. May be irritable, demanding, hostile, fearful or manipulative.
- Patterns of behaviour deviate markedly from society's expectations and remain consistent over time.
- Disorder affects thoughts, emotion, interpersonal relationships and impulse control.
- The pattern is inflexible and occurs across a broad range of situations.
- Pattern is stable or of long duration, beginning in childhood or adolescence.

TYPES

Borderline Personality Disorder	Instability in interpersonal relationships, self-image and affects, and marked impulsivity
Antisocial Personality Disorder	Disregard for, and violation of, the rights of others.
Histrionic Personality Disorder	Excessive emotionality and attention seeking.
Narcissistic Personality Disorder	Grandiosity, need for admiration, and lack of empathy.
Avoidant Personality Disorder	Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
Dependent Personality Disorder	Submissive and clinging behaviour related to an excessive need to be taken care of.
Schizoid Personality Disorder	Detachment from social relationships and a restricted range of emotional expression.
Paranoid Personality Disorder	Distrust and suspiciousness in which other people's motivations are interpreted as malicious.
Obsessive-Compulsive Personality Disorder	Preoccupation with orderliness, perfectionism and control.
Schizotypal Personality Disorder	Acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour

There is a sex difference in the personality disorder types. For example, antisocial personality disorder is more common among men, while borderline personality disorder is more common among women.

Since personality disorders usually develop in adolescence or early adulthood, they occur at a time when most people develop adult relationship skills, obtain education, establish careers and generally "build equity" in their lives. The use of maladaptive behaviours during this life stage has implications that extend for a lifetime.

Personality disorders have a major effect on the people who are close to the individual. The individual's fixed patterns make it difficult for them to adjust to various situations. As a result, other people adjust to them. This creates a major strain on all relationships among family and close friends and in the workplace. At the same time, when other people do not adjust, the individual with the personality disorder can become angry, frustrated, depressed or withdrawn. This establishes a vicious cycle of interaction, causing the individuals to persist in the maladaptive behaviour until their needs are met.

Since the behaviours shown in some personality disorders remain close to what is considered "normal", others often assume that the individuals can easily change their behaviour and solve the interpersonal problem. When the behaviour persists, however, it may be perceived as a lack of will or willingness to change. The fixed nature of the trait is not well understood by others.

Personality disorders are difficult to treat because of self- denial about the presence of the problem and the pessimism of health professionals based on a lack of success in previous efforts. Intensive individual and group psychotherapy, combined with anti- depressants and mood stabilizers, can be at least partially effective for some people" (Health Canada, 2002, pp. 69-78).

SUPPORTING SERVICE USERS WITH A PERSONALITY DISORDER

CLUES	Service user may be very emotional, irritable, hostile or manipulative. Service user may be self- centered, lack individual accountability, lack empathy or have a distorted understanding of self or others. May mention anti-depressants, anti-psychotics or Lithium.
WHAT TO DO	Warmth, Empathy, Genuineness Focus on the service user's feelings instead of their behaviour Service user may not be diagnosed with a personality disorder—and it is not your job to diagnose them! Offer the service user an intake instead. Concentrate on the service user's strengths

EATING DISORDERS

"Eating disorders involve a serious disturbance in eating behaviour—either eating too much or too little—in addition to great concern over body size and shape. Eating disorders are not a function of will but are, rather,

unhealthy eating patterns that "take on a life of their own." The voluntary eating of smaller or larger portions of food than usual is common, but for some people this develops into a compulsion and the eating behaviours become extreme.

TYPES

- **Anorexia Nervosa:** Refusing to maintain a minimally normal body weight, carrying an intense fear of gaining weight and having a distorted perception of the shape or size of their bodies.
- **Bulimia:** Recurrent episodes of binge eating, accompanied by inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, use of laxatives, or excessive exercise**.**
- **Binge Eating Disorder:** Binge eating without compensatory behaviours, such as vomiting, excessive exercise or laxative abuse. Individuals are often obese.

It is estimated that 3% of women will be affected by eating disorders in their lifetime. Anorexia nervosa and bulimia predominantly affect young women. Some studies have found that young men represent only about 10% of individuals with the disorder.

Individuals with anorexia and bulimia may recover after a single episode of the disorder. Others may have a fluctuating pattern of weight gain and relapse. Still others will continue to have issues with food and weight throughout their lives. Individuals with anorexia and bulimia may develop serious physical problems such as heart conditions, electrolyte imbalance and kidney failure that can lead to death. Eating disorders may cause long-term psychological, social and health problems even after the acute episode has been resolved. Families of individuals with eating disorders also live under great stress. They may blame themselves, feel anxious about their loved one's future, worry that the family member will die, and face the stigma associated with having a child with a mental illness. Parents especially experience the tension between their natural protective instinct to force healthy behaviours on the child (which can often make the situation worse) and the child's need to take control over his/her illness and health.

Anorexia nervosa and bulimia nervosa do not have the same public manifestation as other mental illnesses. In general, public embarrassment due to unusual behaviour is not an issue. Essentially, these illnesses are a private family affair. As a result, the stigma associated with eating disorders comes from the mistaken impression that others (parents in particular) are to blame for the illness. The stigmatization isolates parents from their peers and other family members. Individuals with BED who are obese must contend with negative societal attitudes toward obesity. These attitudes isolate them, and the loss of self-esteem exacerbates the illness.

Eating disorders can be treated and a healthy weight restored. Treatment has changed dramatically over time. The previous emphasis on long-term psychotherapy and potentially harmful medications has been replaced with nutritional stabilization as the initial approach. Once the nutritional status has improved, then a variety of psychotherapy methods are used to improve functioning" (Health Canada, 2002, pp. 79-89).

SUPPORTING SERVICE USERS WITH AN EATING DISORDER

CLUES	Service user may have an excessive concern about weight or a preoccupation with food, discuss weight loss, excessive exercising, feelings of being out of control Service user may be moody, socially isolated, have low self-esteem, be very self-critical
WHAT TO DO	Let the service user know that you care and are there to give them support Don't nag about the importance of eating Help the service user identify their feelings Focus on setting small goals Encourage self-care Focus on the positive aspects of life Ask about resources - would the service user benefit from counseling at the Distress Centre?

RESOURCES

- **Mobile Response Team (MRT)**
  The Mobile Response Team is for service users who are experiencing a psychiatric problem or psychological distress and are over the age of 18. Responders can transfer a service user over to them and they could potentially go out and respond to the situation. Crisis can include: mental health problems; anxiety/panic reactions; depression; post-traumatic stress, stress; suicidal thoughts. They provide crisis prevention by providing support in periods of transition between services, urgent psychiatric assessment in a community setting, crisis intervention by mental health professionals and crisis follow-up. They will also accept 3rd party concerns.

- **Access Mental Health**
  Offers information, options for support of those with mental health concerns, resources, and access to mental health services. Access Mental Health is run through Alberta Health Services.

- **Canadian Mental Health Association**
  The CMHA resource line helps service users identify their needs in a supportive way, and provides information on the most appropriate resources in the community, as well as referrals to CMHA programs. It is not a crisis line. They provide family support, community support, education, support people in finding housing and jobs and make referrals to the appropriate services.

- **Families Matter – Postpartum Depression**
  Offers support groups, and info sessions for families and mothers regarding postpartum depression.

- **Schizophrenia Society**
  Provide support to families, friends and sufferers of schizophrenia. They provide individual support for people newly diagnosed with schizophrenia, suffering a relapse or living in isolation in the community

- **Mood Disorders Society of Canada**
  Provide information and advocacy for those dealing with a variety of mood disorders.

- **DISTRESS CENTRE COUNSELLING!**

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Anderssen, E. (2010, October 12). *Margret Trudeau reflects on her struggle with mental illness*. The Globe and Mail. *https://www.theglobeandmail.com/life/health-and-fitness/health/conditions/margaret-trudeau-reflects-on-her-struggle-with-mental-illness/article4268125/*

Canadian Mental Health Association. (2010). *Fast facts about mental health. https://cmha.ca/fast-facts-about-mental-illness*

Canadian Mental Health Association. (2016). *Mental health for life*. https://cmha.ca/documents/mental-health-for-life

Canadian Mental Health Assocation. (2020). *Mental health: What is it, really?* https://cmha.ca/blogs/mental-health-what-is-it-really#_ftn1

Can We Talk?. (n.d.) *Myths about mental illness*. https://canwetalk.ca/about-mental-illness/myths-about-mental-illness/#:~:text=Reality%3A%20Mental%20illness%20is%20not,altering%20for%20millions%20of%20Canadians.

Corrigan, P., & O'Shaughnessy, J. J. (2007). Changing mental illness stigma as it exists in the real world. *Australian Psychologist, 42*, 90-97. https://doi.org/10.1080/00050060701280573

Government of Canada. (2020). *Mental Illness.* https://www.canada.ca/en/public-health/services/chronic-diseases/mental-illness.html

Health Canada. (2002). *A report on mental illnesses in Canada.* Ottawa, ON. http://www.phac-aspc.gc.ca/publicat/miic-mmac/pdf/men_ill_e.pdf

Katch, F. I., Katch, V. L., McArdle, W. D. (2006). *Essentials of exercise physiology* (3rd ed.). Lippincott Williams & Wilkins.

MODULE SIX: ADDICTIONS

SUMMARY

In this module trainees will learn to identify the effects of addiction, understand the continuum of use and stages of change models to determine where addictions fit into a service user's life. Trainees will be introduced to stigma and barriers surrounding addictions and be aware of methods and barriers to risk assessing and safety planning with those under the influence.

OBJECTIVES

Attitudes

- Trainees will have awareness of the stigma surrounding individuals with addictions
- Trainees will have the awareness that addiction is a mental health concern and not a moral failing, or criminal issue

Knowledge

- Trainees will have an understanding of the different roots, expressions, and outcomes of addiction
- Trainees will recognize the key terms regarding addiction
- Trainees will have an understand of the stages of change with addiction and the unique challenges within each one
- Trainees will recognize the limitations and barriers to working with those under the influence

Behaviour

- Trainees will consider the impact of addictions on risk assessment, specifically regarding the level of urgency
- Trainees will demonstrate the ability to utilize non-stigmatizing language as it relates to individuals with addictions

WHAT IS ADDICTION?

Addiction is defined as:

- A preoccupation with a substance or gambling
- A loss of control over the use of a substance or gambling pattern of behavior
- Continued persistent use of a substance or involvement in gambling in spite of negative consequences in one or more major life areas of a person's life
- Other people expressing concern about someone else's substance use or gambling

Physical Dependence	Tissues of the body require the presence of a substance in order to function normally. The body has adapted to the presence of a drug at a particular concentration. When that concentration falls, the user experiences withdrawal signs and symptoms.
Psychological Dependence	The need to use substances in order to think, feel or function normally. The substance becomes so central to a person's thoughts, emotions and activities that it is extremely difficult to stop using or even stop thinking about it.
Tolerance	When a user becomes less sensitive to the substance and needs to increase the dosage in order to achieve the same effect as was obtained from the original dose.
Cross Tolerance	Accompanying tolerance to other drugs from the same pharmacological group.
Withdrawal	Physical and psychological effects that occur when a substance dependent individual discontinues their substance use and the body has to readjust to this.

(Fisher & Harrison, 2005)

COMMON SIGNS OF WITHDRAWAL

- Severe shakiness or tremors
- mental confusion
- disorientation
- fever
- dehydration
- hallucinations
- high blood pressure
- irritability or anxiety
- nausea/vomiting
- insomnia
- fast pulse
- irregular heartbeat
- weak muscles
- loss of appetite
- headaches
- diarrhea
- sweating
- seizures
- delirium

(Fisher & Harrison, 2005)

Enlist the help of a CCC to see if medical attention or a Detox facility is required for the service user that is detoxifying from a substance(s). If they are in severe withdrawal, they may need immediate assistance.

MAJOR LIFE AREAS AFFECTED BY ADDICTION

Areas would include family, friends, school, job, physical health, mental health, legal, financial, social/leisure, emotional and spiritual. (Alberta Health Services [AHS], 2019)

CONTINUUM OF SUBSTANCE USE/GAMBLING

When trying to evaluate how severe an addiction has become, we often refer to the continuum of substance use/gambling. The continuum helps us define the individual's involvement and level of addiction:

No Use	• Choice not to use may be for several reasons such as religion, health, exposure & availability, values, or personal experiences • People who come from a family with addiction issues may decide not to be like the addicted person.

Experimental Use	• **Use substances or try gambling in order to see what the effects are** • Occasional substance use/gambling, often weekends, holidays • Trying various substances/gambling to see what it is like • Sometimes associated with peer pressure, boredom or curiosity • Low tolerance – easy to get "high" • Very inquisitive about different types of drugs and their effects • Experience (positive or negative) may affect decision to continue use
Social Use/More Regular Use	• Are aware of the effects of the drug, no longer experimenting • Casual substance use or social gambling. The person can take it or leave it • Will join in if it is available and they have the time and/or money but do not go out and seek the activity. • Occasional use without problems • Control and ability to say no • Tolerance will increase with use • Type of substance used or gambling may change (beer to hard liquor, pot to ecstasy, lottery tickets to VLT's)
Serious Social Use	• **A person's life revolves around the substance use or gambling.** • Main form of entertainment/recreation is substance use or gambling • Activities are planned around the substance use or gambling • Little time for family, friends, interests and activities outside of this.

Harmful Involvement	• **Consequences due to their substance use or gambling.** • Problems in at least one of the major life areas due to use (family, friends, school, job, physical health, mental health, legal, financial, social/leisure, emotional and spiritual) • Time and money spent on substances and/or gambling increases • May miss other events or appointments in order to use/gamble • Person may be unaware or denies that problems are substance/gambling related • Consumption increases – sense of pride with being able to "handle it" • Solitary substance use/gambling • Preoccupation with substance use/gambling • Substance use is carefully planned and anticipated – source of supply becomes a matter of worry • Others around user detect problems • Shift to substance using/gambling friends • Begins to identify with sub culture (paraphernalia, clothing, slang) • Using substances/gambling to numb emotional pain – self medicating • Individual may get into financial difficulty or begin chasing losses (in the case of gambling), which can lead to legal difficulties.
Dependency	• **Many consequences to their substance use or gambling** • All of the above listed harmful involvement items worsen • Problems occur in many of the major life areas due to use (family, friends, school, job, physical health, mental health, legal, financial, social/leisure, emotional and spiritual) • Cannot discontinue substance use/gambling due to negative consequences (does not have the control to do so). • Problems increase dramatically as a result of substance use or gambling • Frequency of highs and amount of money spent increases with substance use or gambling • Lying to cover up substance use or gambling. • May try to cut down or convince self that "there is no problem" • Getting high/gambling at school/work (inappropriate times & locations) • Suicidal ideation is common as user/gambler cannot see a way out of their predicament. • Psychological and physical dependence. • Need to use/gamble as a way to cope with daily life.

(AHS, 2019)

SIGNS OF PROBLEM GAMBLING

- Spends large amounts of time gambling; growing debt; borrowing money to gamble with
- Begins to place larger, more frequent bets
- "Chases" losses (attempts to win back money lost)
- Promises to cut back on gambling
- Refusing to explain behavior, lies about it or argues about it
- Feels frequent highs and lows
- Misses the thrill of the action
- Makes promises to cut back on gambling but there's no follow through
- Boasts about wins – downplays or minimizes losses
- Hiding one's gambling
- Pinning hopes on a big win
- Prefers gambling to special family occasions
- "Spaces out" while gambling or loses track of time while gambling.

(AHS, 2019)

STAGES OF CHANGE

This is a tool to help responders understand where a service user is at in wanting to change their substance use or gambling and what kind of strategies would work best for a service user in each stage. The stages of change should be used in conjunction with the continuum of use:

PRE-CONTEMPLATION

- In the pre-contemplation stage, the service user is not aware of the problem, or is not considering making a change. They may be in denial that there is a problem and may be blaming others for the problems they are experiencing. Build rapport and help service user begin to see the consequences of their substance use/gambling behavior. Avoid negative labels and being "preachy". Coercion or aggressive confrontation will be counterproductive at this stage.
- The crisis line responder can raise doubt in the service users mind by asking questions such as "do others think that you have a problem?" With service users in this stage it is really important to stick to the facts about substance use and behaviours as responders do not want to get into a debate. Ask permission to share information "would it help if I gave you some info?" Raise doubt or concerns by gently confronting the person "So you're telling me on the one hand that you don't have a substance abuse issue, but on the other hand, you and partner are fighting about it, you've been driving home drunk and you're unable to pay the bills because of money spent on substances. These 2 ideas don't seem to fit?"

CONTEMPLATION

- In the contemplation stage the service user is aware of the problem and is contemplating making a change. They may not be aware of the severity of the problem and often times there is a lot of ambivalence at this stage.
- The crisis line responder can do a pros and cons list with the service user and congratulate them on having the strength to make such a hard decision. Help motivate a service user and encourage their belief in their ability to change "What makes you optimistic that you could change?" Tell the person, "I think if you decide to change you could do it". Relate the problems identified back to their use" I notice that whenever you and your partner fight it's usually when one or both of you are drinking." Have them track their use or cravings. Help them see that changes in their use could improve other major life areas (family, friends, school, job, physical health, mental health, legal, financial, social/leisure, emotional and spiritual). Offer referrals and counseling at the Distress Centre.

PREPARATION

- The service user in the preparation stage is making a plan to take action soon. They are ready to make the change and have set a time to stop. They may be calling in order to access resources or referrals.
- Congratulate service user for taking such a big step. Look at options for change. Offer referrals and counselling at the Distress Centre, treatment centres, detox and 12 step programs, etc. (see resources sheet). Offer counseling at the Distress Centre if a service user is waiting to get into a treatment program. Help a service user choose a plan of action, set goals or develop a contract "How else could you deal with your stress or cravings besides using substances or gambling?" Motivate service user to move into action.

ACTION

- In this stage the service user has made a conscious decision to change and is making a deliberate quit attempt where they are carrying out their plan. This may look different for different people and can include counseling, treatment programs, self-help groups, or abstinence. Change is a process not an event, and people can be in this stage for a long period of time.
- The crisis line responder can offer support and encouragement, help build self-belief, concentrate on positives, ask the service user what they are doing and what has worked for them in the past if they are struggling. Work with a service user to come up with solutions to obstacles. Discuss any underlying issues as they emerge. Offer counseling at the Distress Centre for extra help or referrals to additional services as needed. Invite service user to access the DC crisis lines whenever needed.

MAINTENANCE

- The service user may have made a change previously but is falling back into bad habits or are having a hard time remaining abstinent. The service user may be looking for information on how to maintain change and/or manage relapse triggers.
- The crisis line responder can congratulate service user on their past successes, help motivate and instill hope. Ask about the support system they have in place. Help them identify high risk conditions that could end up in slips or relapse. Discuss any skill development issues such as self-esteem, assertiveness, social skills, setting boundaries or how to have intimate healthy relationships and offer counseling at the Distress Centre for this. Suggest additional resources or calling the crisis lines for continued support.

RELAPSE

- In this stage the service user has slipped or is using substances and/or gambling again.
- The crisis line responder should create an environment of safety and be supportive, non-judgmental, positive and instill hope. Help a service user to see relapse not as a failure but a useful aspect of lasting change "Ok so you've slipped/relapsed – it's not the end of the world. Don't beat yourself up. How can you get right back on track?" Ask the service user what they have learned from the relapse or tried in the past that was useful. "What helpful learning have you gained from the relapse?" Discuss what support they have in place.

*It's important to note that service users can cycle through the stages many times or be in between stages.

(Fisher & Harrison, 2005)

THIRD PARTY CALLS

This is a situation where another individual(s) is struggling in their attempt to cope with another person's addiction. They may need help to express feelings of anger, resentment, frustration, guilt or being overwhelmed. Co-dependency occurs when one person becomes preoccupied by another's addictive behavior, tries to change that person's behavior and/or protect that person from experiencing the natural consequences of their actions. When assisting a 3rd party service user it can be helpful to:

- Let the third-party service user vent about their situation.
- Help the individual sort out the things they can do from the things that are not within their power and control.
- Help them get clear about what they are responsible for and what the addicted person is responsible for.
- Support them to stop focusing on taking care of the person with the problem and start taking care of themselves.
- Work toward helping them to realize that they did not cause the problem they can't make a person stop. The addict is responsible for their own behavior.

- Discuss issues for the third party around caretaking, rescuing, pleasing, enabling, loss of identity and collusion.
- Help the third party with possible ways to set consequences, boundaries and limits with the addicted person.
- Discuss how the third party could change their approach because it usually isn't working.
- Be aware of co-dependent issues. Is the service user neglecting themselves and their own needs?
- The third party can come in for their own counselling session but we will not do intakes for the addicted person – they must call and make own appointment.
- Try to get service user to focus on their own needs as well – they are often so focused on another that they forget to take care of themselves. The service user is your client, not the addict being discussed.

"HOW CAN I TELL IF SOMEONE IS ON DRUGS?"

We can't say for sure, however encourage the service user to open the lines of communication with the person they are concerned about. They can look for:

- Change in school or work performance
- Change in personal appearance/grooming
- Mood swings or uncharacteristic changes in attitude.
- Withdrawal from usual activities/responsibilities
- Unusual patterns of behavior
- Undue defensiveness
- Actual evidence like drug paraphernalia
- Suggest that they get knowledgeable about substances or gambling to understand the short- or long-term signs or symptoms. Alberta Health Services has a great website for this (www.aadac.com)

"HOW DO I APPROACH SOMEONE IF I AM CONCERNED ABOUT THEIR DRUG/ALCOHOL/GAMBLING?"

Don't react with anger or blame. Their use may simply be experimental.

- Become knowledgeable about drugs and their effects
- You may not be the best person to approach the person – who is close to them, who will they listen to?
- Use a low-key approach that doesn't preach or judge. Be curious about what led them to the behavior
- Be honest about your own fears or concerns with the person
- Suggest that they talk to an addiction counselor themselves before they speak to the individual of concern
- Suggest counseling to the person they are concerned about

RISK ASSESSMENT FOR SERVICE USERS UNDER THE INFLUENCE OF SUBSTANCES

Safety is paramount. Assess risk by asking service user about:

- What substance(s) they are using (previous, today or right now).
- How much they have consumed and in what time frame.
- Are they mixing substances and/or alcohol?
- Is there a possible accidental overdose in progress?
- Find out if there is any suicidal ideation.
- Check if there is a suicide in progress using substances?
- Inform the CCC of any high risk situation to obtain their assistance.
- Use the suicide risk assessment procedure (CPR, LAS) in substance use and gambling situations. People that use substances or gamble are at a higher risk than the rest of the population for suicide.
- If an overdose or suicide is in progress, attempt to get the service user's name, address, phone number and location.
- Ask the service user if there is someone that can take them to the hospital.
- Make a decision with the CCC to rescue the service user if a suicide or overdose is in progress or if the service user becomes unconscious.
- After assessment, if there's no danger, talk with the service user if they are lucid. A supportive role is best. A drunk or high person will not have insights about their use that they will remember the next day
- Invite a service user to call us back when they are sober/straight if conversation isn't possible or if the call seems to go nowhere. Use the usual calm, reassuring voice tone
- Focus the conversation on here and now – concrete things like hunger, fatigue, physical surroundings

SERVICE USERS WHO WANT TO KNOW HOW LONG DRUGS EFFECTS LAST

- Let the service user know that each case is unique so we cannot provide or guarantee information that is accurate for their case.
- The substance use may affect them differently depending on amount taken, last time food was eaten, current mood, etc.

> "Even when I took the drugs I realized that this just wasn't fun anymore. The drugs had become a part of my routine. Something to wake me up. Something to help me sleep. Something to calm my nerves. There was a time when I was able to wake up, go to sleep, and have fun without a pill or a line to help me function. These days it felt like I might have a nervous breakdown if I didn't have them."
> — Cherie Currie

SERVICE USERS WHO WANT TREATMENT

- The Distress Centre counsellors do outpatient addiction counseling and can help people waiting to get into other treatment centres.
- Make a referral to an appropriate agency using the resources available in the handout provided.

SERVICE USERS WHO NEED ASSISTANCE WITH RELAPSE PREVENTION

These are service users who have made the choice to stop using and need assistance with maintaining abstinence. Relapse is an important part of recovery. Use this as a learning opportunity to move forward.

- Have a plan for high risk situations
- Tack urges – avoid triggers
- Manage cravings – thought stopping, challenge self, distractions
- Daily structure – plan ahead
- Leisure resources – have fun, natural highs, diet and exercise
- Having a support system - buddy system, family/friends, DC. Talk about issues with their support.
- Journal about thoughts, feelings and what's happening in their life.
- Make a reasons to quit and reasons to keep using list regarding substance use or gambling. List the costs or consequences of the behavior.
- Exercise, eat well, get plenty of rest and drink lots of water.
- Think positively and watch self talk. Is their self talk rational, positive and realistic?
- Deal with one craving or urge at a time.
- Actively reduce stress (Examples: muscle relaxation, breathing, using music, yoga, meditation, having a balanced life, etc.).
- Use the acronym HALT (don't let yourself let too hungry, angry, lonely or tired as this makes one more susceptible to slips and relapse).
- Use the 4 D's (Delay the craving, drink water, deep breathe or distract yourself).
- Organize yourself and plan ahead for high risk situations that could result in slips or relapse.
- Invite them to try 12 step programs (self-help groups) for support such as Alcoholics Anonymous, Al-anon, Gamblers Anonymous, Gam-anon, Cocaine anonymous, Narcotics Anonymous, Women for Sobriety, etc.
- Readings – daily meditations/affirmations
- Suggest they attend individual or group counseling

(Fisher & Harrison, 2005)

PROTECTION OF CHILDREN USING DRUGS ACT (PCHAD)

- A law in Alberta to help youth under age 18 whose use of substances is likely to cause significant physical or psychological harm to themselves or others.
- This allows a parent or legal guardian to ask the court for an apprehension and confinement order for a period of 5 days, even if that youth doesn't want to go.
- This 5 day process provides a youth with a structured and protective setting to begin detoxification, receive an assessment and treatment recommendations.
- The youth has a right to appeal the confinement and apprehension order.

- The family is engaged in the process and encouraged to choose the treatment and counselling services they feel will work most effectively once the youth has been discharged.
- The goal is for the youth to transition into voluntary treatment.

(PCHAD, 2005)

DRUG ENDANGERED CHILDREN ACT

- An Alberta law that targets parents who deal in drugs are involved in grow operations, etc.
- Police charge parents with exposing their children to drugs.
- Children are removed from the home and Child Welfare determines whether or not it's safe for the children to go back to the home.
- If a Child Welfare file is opened, police can go to the residence at any time to monitor the parents and ensure child safety.
- Fines and prison terms are applicable.

(Bill 2: DECA, 2006)

REFERENCES

Alberta Health Services. (2019, April). *Gambling: How can you tell if it's a problem?*. https://myhealth.alberta.ca/Alberta/Pages/a-gambling-problem-how-can-you-tell.aspx

Drug-endangered Children Act, S.A. 2006, c D-17 https://www.qp.alberta.ca/documents/Acts/d17.pdf

Fisher, G. & Harrison, T. (2005). *Substance Abuse: Information for school counselors, social workers and therapists, and counselors*. Pearson

Protection of Children Abusing Drugs Act, S.A. 2005, c P-27.5 http://www.qp.alberta.ca/documents/Acts/P27P5.pdf

MODULE SEVEN: CALL MANAGEMENT & ASSERTIVENESS

SUMMARY

In this module trainees will learn how assertive communication is beneficial and necessary in keeping a contact with a service user focused and productive. Trainees will be able to identify when assertiveness should be employed and assertiveness methods that address common obstacles during a crisis contact.

OBJECTIVES

Attitudes

- Trainees will be aware of their capacity to act assertively and their own personal boundaries
- Trainees will be aware of situations in which they will need to be assertive to guide a conversation

Knowledge

- Trainees will understand the importance of assertiveness within a conversation and the barriers that affect assertiveness
- Trainees will be aware of the different types of communication styles and how they might affect a conversation
- Trainees will understand various challenging topics that may come up on the crisis lines and how to implement assertiveness in those situations

Behaviour

- Trainees will be able to use assertiveness to guide a service user through Roberts' Model

WHAT IS CALL MANAGEMENT?

Call Management refers to a set of skills that allow the crisis line responder to manage their time, the needs of the caller, and the needs of the contact centre (e.g. handling high call volumes) in a way that is efficient while remaining committed to the tenets of the Robert's Model of Crisis Intervention and the values of Distress Centre.

Skills associated with Call Management include:

- Assertive communication
- Keeping the call focused / directing the conversation with the caller
- Effective notetaking
- Accurate and concise contact documentation
- Knowledge of and comfort with technology (e.g accessing procedural directories, transferring caller to the satisfaction survey)
- Call Wrap-Up & Termination Skills

WHY IS CALL MANAGEMENT IMPORTANT?

Call management is important for a variety of reasons, some main reasons however are:

1) Recognizing the individual - While the process of most calls will be similar, the calls are as unique as the callers and crisis line team themselves. It is important to consider this individuality in order to most effectively manage the call.
2) Ensuring people can access the service - If we are not assertive with our callers, our calls will end up being significantly longer in length. Our resources would be used for those calls and we would not have the capacity to take others. Therefore, being assertive allows us to ensure we have the capacity required so that many people can access our service.
3) Setting realistic expectations - It is important for all contacts that we set realistic expectations for them. It is not uncommon that individuals will believe that they are able to talk about whatever, whenever, and however they would like, but that is not the case. We want to make sure that the call is beneficial for the caller, while still respecting our boundaries as a helper and as an organization. Therefore, it is important we set those boundaries and consistency, which set the stage for realistic & reasonable expectations.

WHAT IS CALL MANAGEMENT?

Call Management refers to a set of skills that allow the crisis line responder to manage their time, the needs of the caller, and the needs of the contact centre (e.g. handling high call volumes) in a way that is efficient while remaining committed to the tenets of the Robert's Model of Crisis Intervention and the values of Distress Centre.

Skills associated with Call Management include:

- Assertive communication
- Keeping the call focused / directing the conversation with the caller
- Effective notetaking
- Accurate and concise contact documentation
- Knowledge of and comfort with technology (e.g accessing procedural directories, transferring caller to the satisfaction survey)
- Call Wrap-Up & Termination Skills

WHY IS CALL MANAGEMENT IMPORTANT

Call management is important for a variety of reasons, some main reasons however are:

1. Recognizing the individual - While the process of most calls will be similar, the calls are as unique as the callers and crisis line team themselves. It is important to consider this individuality in order to most effectively manage the call.

2. Ensuring people can access the service - If we are not assertive with our callers, our calls will end up being significantly longer in length. Our resources would be used for those calls and we would not have the capacity to take others. Therefore, being assertive allows us to ensure we have the capacity required so that many people can access our service.

3. Setting realistic expectations - It is important for all contacts that we set realistic expectations for them. It is not uncommon that individuals will believe that they are able to talk about whatever, whenever, and however they would like, but that is not the case. We want to make sure that the call is beneficial for the caller, while still respecting our boundaries as a helper and as an organization. Therefore, it is important we set those boundaries and consistency, which set the stage for realistic & reasonable expectations.

COMMUNICATION STYLES

It is important to consider the communication styles of yourself and of the service user when supporting individuals on the lines. Overall reflecting on communication styles will allow responders to support the service user and manage the call the best way they possibly can. It is important to understand the tone, pace and use of words might not be indicative of the level of crisis.

Recognizing individual communication styles will allow responders to have a stronger awareness of:

- tone
- pace
- use of words

Recognizing there are differences in communication styles will assist with:

- demonstrating empathy
- building rapport
- supporting with grounding technics where necessary
- managing the pace of the conversation
- remembering how someone is speaking to you is not about you, so to not take it personally
- remembering that what you are hearing may not be the whole communication
- keeping in mind that what you are saying might not be heard the way you intended

THE ASSERTIVE COMMUNICATION STYLE

Assertive communication style occurs when individuals:

- Affirm their own rights as well as the rights of others.
- Express their own feelings, wants and needs openly and respectfully as they occur.
- Act in their own best interest without trying to make others uncomfortable.
- Are open to hearing others express their feelings and needs, and are willing to compromise.
- Maintain a balance between giving, taking and asking for help.
- Try to resolve issues without conflict and to work through them when they occur.

Verbal components:

- Use “I” statements to take personal responsibility for our feelings and opinions (such as “I feel angry when …”, “I feel afraid when …”).
- Avoid blaming others and take responsibility for our actions.
- Can take credit for success and admit our mistakes.
- Make decisions and set limits.
- Good listeners.
- Offer direct and honest feedback.

BENEFITS OF ASSERTIVENESS ON CRISIS LINES

While it can be nerve-racking being assertive to service users who are in crisis or going through difficult times in their lives, it is extremely important that it is done. There are many benefits that come with being assertive:

Focus leads to Progress

In order for a caller to develop an action plan and get the support they need, the call must be focused.

Empowerment

By being assertive and keeping the call focused we're empowering the caller to move forward with problem-solving and coping.

If we let the caller talk in an unfocused direction, often looping and repeating, we're disempowering them. They do not get the encouragement they need to problem solve and are reinforced to call us back, which could lead to dependency. Modelling assertive behaviour may encourage callers to act assertively in dealing with their own crisis.

Avoid Burnout

Unfocused callers and repeat callers can be frustrating for us as listeners; accumulation of frustration can lead to burnout.

Access

Successfully managing calls (i.e. having a reasonable length of time per call) means others trying to access our service will be able to do so.

R.U.D.E

Now that you have learned the importance of being assertive, it is now time to put it into action. A way to do this is by using the acronym R.U.D.E (Canadian Mental Health Association, personal communicaton, 2019):

R - Reboot

Check-in with yourself. Are you noticing your attention drifting? Are you feeling frustrated or lost in the caller's story? Do you notice tension in your body? Have you heard this before? Use your grounding techniques, take a deep breath, and reboot yourself as a crisis worker.

U - Understand

Reflect to the caller that you understand that they are in pain, and that you heard their story. Normalize and validate their pain. Empathize and find common ground to prepare to move forward: ex. "*Going through such a complex situation would be overwhelming for anyone*."

D - Direct

Your goal is not to have a friendly conversation – it is to be a helpful, assertive crisis worker. Direct the caller towards the next stage of the conversation: ex. "*Let's focus right now to use our time together as effectively as we can*"

E - Empower

Part of offering support on this line is empowering callers. If callers are not ready to have a productive, two-way, respectful conversation we may need to empower them by ending the call. If callers are not in crisis or not using our service appropriately, those may be other reasons for us to empower them by ending the call.

This means transferring the responsibility of coping back onto the caller, and sometimes it means letting the caller go before we can complete our normal call structure: ex *"This is the third time I've tried to redirect the call and as I mentioned before I'm going to have to let you go to focus yourself on your coping strategies and take care of yourself"*

Continue to use R.U.D.E. as many times as necessary to keep the call productive

COMMUNICATION WITH CONTACT CENTRE COORDINATORS

Responders are never alone on the lines. The CCCs are always there for you. They are your shift supervisors and will:

- communicate with you on the phone, in person or on our instant messaging system
- support you in managing the calls
- support you in supporting the service users
- answer any questions you have during or after a call
- support you in managing your time
- provide encouragement
- learn with you, share knowledge, and learn from you
- support your development
- let you know of any changes that you need to be aware of
- debrief with you after a call
- provide feedback on your calls
- provide you with resources
- manage the high-risk situations and support you through them

- make the final decisions as they are the ones accountable (i.e. call-outs)
- communicate with emergency services when needed

Just as every service user and every responder has a different personality and style, so does every CCC which is helpful in learning various approaches to supporting those who contact us.

WHEN TO ENGAGE WITH CCC'S

Responders should be engaging with your CCCs:

- every time a **present**, **past** or **potential risk** is mentioned - as soon as you possibly can - NO EXCEPTIONS
- anytime you are unsure about how to support the caller
- when you cannot hear or understand the caller
- if you receive multiple hang-ups
- when you are speaking to a frequent or banned caller, or think you might be
- if a caller has been inappropriate, or you are unsure if their actions are inappropriate
- when you are even wondering if you should be consulting with them
- when you are needing any type of support during a shift (call-related or personal)
- if you are unable to make it to a shift, running late, or have an emergency and need to leave early / during the shift

The CCCs are your most valuable resource while you are on shift. Never hesitate to consult with your CCCs! Whenever you question if you should consult with them on a call, ask them something during your shift, or let them know something, the answer is always **YES**!

WHAT IF I DON'T AGREE WITH THE CCC?

Important to remember:

- The CCCs are accountable for the calls that happen on their shifts.
- The CCCs are not taking their decisions lightly.
- Sometimes the decisions that have to be made are not easy with multiple ways to approach things.
- CCCs receive additional training for their role supporting you and those who contact us.
- CCCs are supported by other CCCs and the Manager on Duty in making hard decisions.

If you are unclear during a conversation about the direction being given, consider:

- if you have passed on all of the necessary information to the CCC, as they may not have been a part of the entire conversation;
- exploring their decision by asking questions to clarify, either during the call (if it doesn't further jeopardize anyone's safety), or afterwards;

- if you still do not feel comfortable with the direction after your shift or have any questions, please follow up with your mentor.

THE CONVERSATION

Starting a Conversation

Remember where you are starting the call. Remember you have no idea what is happening on the other end on the line. Always start with a friendly, welcoming but not over-enthusiastic tone. Something simple that lets the caller know where they have called would be perfect. - "Hello Distress Centre" or "Good Afternoon, ConnecTeen"

Take a moment to think about your greeting. While it may seem simple, it does feel a bit awkward for some when they start their coaching shifts.

Common Types of Beginnings

- Silence
    - Someone hesitant or cannot speak due to a number of reasons including location, who might hear them or not knowing what to say
    - Some people will hang up before they say anything. Make a note and if you hear something concerning, say something to the CCC
- Friendly and calm
    - May not be indicative of the level of crisis
- Immediate state of emergency
    - Some calls it will be important to have the caller get off the line and call 911 or have the CCC support you immediately to call out while you remain on the line
- Overwhelming or complex

OVERWHELMING OR COMPLEX BEGINNINGS

When someone contacts the Distress Centre they will sometimes have an explosion of words and thoughts, some of the situations that might increase this happening are:

- you being the first person they have spoken to;
- you being the first person who has really listened;
- the emotions they are feeling at the time: and
- the level of risk they are currently facing.

CAPTURING THE PRIMARY CONCERN

It is important that we support the caller:

- to slow down and breathe;
- by reassuring them they you are here for them:
- to focus on one or two primary concerns they want to focus on for this conversation;
- by letting them determine what they deem is most important.

Ways to support focusing on the crisis for today is to:

- Summarize or Paraphrase: As we explored when discussing active listening, summarizing is an important technique to let the caller know you are listening and to clarify what the person is telling you by sharing what you heard in your own words back to them.
- Asking them what they were thinking about or doing when they thought about contacting us today.
- Letting them know that while all of their concerns are important, supporting them with their most pressing issue is a priority.
- Interrupt the caller when necessary to bring them back on track

HISTORY AND DETAILS

At times we will be receiving and/or requesting additional information to gain an understanding of the crisis being discussed. This may result in **TMI** otherwise known as **"too much information"**. It is important to continue to move the conversation forward and ask the individual how this impacts them currently.

Sometimes it might be relevant to understand something that has happened in their history, for example:

- an anniversary of a loss, trauma or positive event
- a traumatic event that is relevant to the situation

Getting into too much detail when a caller is discussing their crisis, some situations that this occurs are:

- specific details surrounding abuse
- details in arguments

Even though it is helpful to understand some relevant history and/or details, the amount of detail should remain limited to allow you to support the caller in reaching a place of coping or further action.

Some phrases that might be helpful to use are:

- "Thank you for sharing this information with me, did you learn something from that time which might help you to cope with what you are going through today?"

- "This is a lot of important information that might be helpful to share with a counselor that is supporting you a little more than I can today. Do you have a counselor you have shared this information with? or Have you thought about talking this through with a counselor before?"
- "Those are important details, thank you. Would it be okay with you if we return to what you facing today?"

In this next scenario, you will see one approach to how this might be handled.

RISK ASSESSMENT DETAILS

Sometimes the details you are receiving are important to try and capture but they might not be delivered in a manner that is easy to you to follow because it may be confusing, too fast, or very detailed.

If you do not understand the information being given to you, it is okay to clarify with the person. If it is regarding information to determine if the person is at risk it might be extremely important to clarify.

Some examples might be:

- an adult who discloses they are safe now but they were abused as a child;
- someone who fled a violent relationship several years ago;
- someone has just shared with you they haven't had a suicidal thought in years including today but did attempt once; or
- someone who is mentioning a non-specific traumatic event.

In order to determine how much detail you might require ask your CCC. A simple message to your CCC sharing what you know is all it takes. Something along the lines of:

- "My caller just disclosed they attempted suicide 15 years ago. They are currently not at risk or suicide. They called to discuss an issue with a colleague. To you want me to explore their history of suicide further."

Following such message, examples of what you might receive back are:

- "Keep me posted if anything else comes up"
- "I'm listening, I will confirm with you shortly"
- "Try to revisit this before you wrap up"
- "Thank you for letting me know. No need to explore further at this time"

Remember whenever a risk is mentioned, small or large, current, past or potential you must immediately let the CCC know.

FOCUSING ON THE CALLER

At various points in the conversation, someone you are talking to might spend a period of time focusing their attention on the actions or feelings of others. Of course, there are situations where talking about other people in their life as it relates to the crisis they are wanting to focus on is important but just like history and details, it is important to consider how much.

CREATING A CONVERSATION

Sometimes individuals will not answer your questions when you ask them or sometimes talk over you when you are trying to speak with them. In these situations, inform the individual what is happening and what you might need from them to best support them.

Sometimes an overwhelmed individual may also have trouble answering your questions or may talk over you just because they are too escalated.

Some communication on the lines can appear very one-sided, due to a number of emotions, an ear to listen, and a need to vent. Allowing the caller some time to let out some of these emotions and vent a little is good, however, it is important not to allow this to go on for too long and to efficiently turn this communication into a more collaborative conversation.

SUPPORTING THE 3RD PARTY

In the various training modules, it has been mentioned the importance of risk assessing for the 3rd party. It is also important to support this caller to ensure they are doing okay and/or have a plan for self-care.

Think about how you might feel if someone you cared about was struggling enough for you to call a crisis line about them. That could not happen without having an impact on you in some way.

Even in situations where the caller might need to go immediately to call 911 or drive to the hospital. It is still important to take the time to encourage them to call back if they want to talk or need further support.

When the call allows:

- do not let the point be missed that they are doing something wonderful & admirable by caring about another person;
- support the caller in checking in with themselves;
- remind the caller how important self-care is;
- create a secondary brief action plan with them for their own self-care (if call is not too emergent); and
- invite them to call back if they need any further support for themselves or the person they originally called about.

CAUTIOUSLY WEARING YOUR DETECTIVE CAP

While the majority of our communication remains confidential and we do not need to find out any personal details about a person, there are some circumstances where you will need to find out things about the person you are speaking with to ensure that 911 can support us in responding. Sometimes it is simply asking their name and location, but other times it is not that simple and then you need to work with the CCCs to help find where, and who this person may be.

Remember you are not alone in this. The CCCs will walk you through every step of the way, while you continue to support the caller. There are somethings you can do to assist in this process as the CCC may be talking to the 911 operator while you are still listening to the call. In some circumstances, an alternate CCC may jump on to support as well.

Listen

- to the sounds in the background
- comments they make about their surroundings
- did they mention an event they went to in their neighbourhood recently?

Ask Questions

- how are they feeling about where they are
- are they comfortable
- are they cold
- are they sitting down
- are they alone, with someone they know, or in place with people they don't know
- if they are at home, is there a park or place they like to walk nearby
- can they see the sunset or sunrise from their balcony
- what is something they can see around them right now

These clues might be coming to you throughout the call so it is important to take note of them when you hear them even if you don't know the risk level of the call. Practicing this skill in lower risk situations will help you when emotions and risks are high.

TERMINATING A CALL

Wrapping up a call is something that can be very challenging to do, especially when crisis line responders first start on the lines. Take a moment to reflect on how you might feel when you are hanging up the phone on someone who might be:

- very upset
- angry that you are ending the call

- telling you they are not feeling supported
- wanting to chat further
- extremely lonely

If we allowed the calls to go on as long as our callers would like we would not be serving our community if an effective manner. Remember being assertive is necessary and beneficial, as it:

- focuses the caller on what is important right now
- empowers them
- reduces your chance of burnout
- increases access for others requiring our services

Once you are wrapping up with a caller, you can invite them to call back. However, it is important that you focus the invitation as we do not want to create dependency on our lines. Try to avoid general invitations such as:

- "You can give us a call back anytime."
- "We are open 24/7, feel free to call us anytime."

Instead, focus the invitation for when their coping techniques discussed within the call are failing or if something changed within their life and they need further support. Consider using phrases comparable to:

- "It sounds like you have created a good plan, if you have any challenges with this plan and need talk about it further, please remember we are here."
- "I recognize you are going through a hard time right now. Remember to take some time to focus on your self-care."
- "You shared with me some people or organizations that might be helpful for you. Don't forget there are many people in our community to support you. I glad you reached out to us today."

CALLER SATISFACTION SURVEY

The satisfaction survey provides us important information to ensure that our services are fitting community needs

It is crucial to transfer all semi-urgent (or moderate-low risk), non-frequent callers to the satisfaction survey once the call is completed rather than pressing the end button. Callers are notified **prior** to getting connected to a crisis line responder that they will be sent to a survey once the call is completed. Rather than waiting for the caller to end the call or have the last word, it is important you transfer them before that point, so they get connected to the survey.

SELF CARE

Check-in with Yourself

Practicing self-care throughout the shift is just as important as practicing it after the shift.

Do not jump from conversation to conversation without at least taking a moment to check in on yourself. It might only take one deep breath to know you are ready, but that breath is important. You will not be able to continue to manage the calls effectively and support individuals without being physically and emotionally prepared. Some things to consider:

- Do I need to refill my water?
- Do I need to stand, move or stretch?
- Do I need a quick snack (maybe chocolate)?
- Is there something I want or need to connect with the CCC about before moving on to the next call?

During a call, it is important to consider the following especially during long or high-risk calls:

- Do I need to doodle or fidget with something? Is it helpful or distracting?
- Am I checking my body posturing, to assist not holding the stress in your shoulders?
- How is my breathing?
- How am I responding to the caller?

Always be prepared that your next call might be the longest of the shift. While the average call may last from 10-20 minutes, some high-risk calls can possibly be longer than an hour.

MODULE EIGHT: SUICIDE INTERVENTION

SUMMARY

In this module trainees will develop an understanding of suicidal ideation and ambivalence, developing a confidence in risk assessing for suicide. Trainees will review and employ the Desire, Capabilities, Intention and Buffers model of Suicide Intervention and employ safety planning strategies including understanding barriers and supporting first and third person suicide concerns.

OBJECTIVES

Attitudes

- Trainees will have the awareness of stigmatizing language regarding suicide
- Trainees will overcome the apprehension around assessing for suicide risk

Knowledge

- Trainees will understand the universal risk of suicide and the common myths and misconceptions
- Trainees will understand the components of risk assessment framework and the safety planning intervention
- Trainees will understand the limits to confidentiality and duty to report
- Trainees will understand clues and signs that indicate potential risk

Behaviour

- Trainees will apply a risk assessment framework on all contacts and effectively conduct a safety planning intervention
- Trainees will be able to identify and notify appropriate supports

WHAT IS SUICIDE?

Back in the mid- 17th century, the word suicide began to appear in literature. Until that time, terms like self-murder and self- destruction were used (Alvarez, 1972). The word suicide was first used in 1635, but did not come into popular use for another 200 years (Capuzzi, 2004).

The Centre for Disease Control and Preventions list three essential elements of a completed suicide: death, self-infliction, and intentionality (O' Carroll et al., 1998). Rettersol (1993) provides a definition with a broader sense of the reason for suicide:

> *"An act with a fatal outcome, that is deliberately initiated and performed by the deceased him— or herself, with the knowledge of expectation of its final outcome, the outcome being considered by the actor as instrumental in bringing about desired changes in consciousness and/or social conditions" (p. 2).*

When combining these two definitions, it becomes apparent that a few elements are key; the undesirability of the present condition and desirability of a potentially better future. In addition, the ability to seek and find hope in the midst of these two thoughts is critical.

WHY DO PEOPLE DIE BY SUICIDE?

"There are many unanswered questions, and a multitude of conflicting theories concerning the roles played by environmental influences and mental disorder; the existence and nature of predisposing genetic or biochemical factors, and the parallel issues of proper and effective treatment and prevention. The questions are as complex as they are obvious.

Suicide is an action; it is not an illness. Identifying the causal and triggering factors, which may in any case be highly individual, and deriving from this is an overall prevention and treatment strategy is perhaps one of the most challenging problems facing professionals in the health sciences" (Health Canada, 1994).

There is no one accepted theory that can sufficiently answer the question 'Why do people die by suicide?' One of the more recent, and readily understandable theories originates from Dr. Thomas Joiner. Joiner (2005) breaks the *why* question down into three contributing factors, which must all be present concurrently, to order for a person to take their own life. These factors and a brief breakdown of their meaning are presented below:

THE ABILITY TO ENACT LETHAL SELF- HARM IS ACQUIRED

Acquiring the ability to enact lethal self- harm is a learned phenomenon. It is a process by which the individual loses or overcomes the natural instinct for self- preservation. This can happen when the individual has a history of "provocative experiences" (Joiner, 2005, p. 47). These experiences have the cumulative effect of desensitizing an individual to physical pain and danger. This type of personal history can be acquired by a number of different routes such as repetitive accidents resulting in serious physical injury, chronic debilitating physical and/or mental illness, repetitive exposure to trauma, substance abuse and deliberate acts of self- harm (e.g., cutting).

"When self- injury and other dangerous experiences become unthreatening and mundane— when people work up to the act of death by suicide by getting used to its threat and danger— that is when we might lose them" (Joiner, 2005, p. 48).

This is part of why a history of prior suicide attempts increases the assessed level of risk during a crisis call. Individuals who have prior suicide attempts as part of their personal history have become increasingly competent with suicidal behavior. These same individuals will formulate specific and developed plans and preparations for suicide, which could include means of escalating lethality.

The ability to enact lethal self- harm can be accompanied by unusual perceptions regarding death. Death comes to be seen in a positive light, to be embraced rather than avoided. This psychological vantage point is the result of an extensive process of psychological suffering. This psychological process evolves in conjunction with the physical process of increased tolerance for physical pain and reduced response to dangerous situations. Both of these processes take time to develop, but once established can become an enduring component of an individual's overall make up.

THWARTED EFFECTIVENESS: THE SENSE THAT ONE IS A BURDEN

"People who are contemplating suicide perceive themselves a burden, and perceive that this state is permanent and stable, with death as a solution to the problem" (Joiner 2005, p. 111).

This perceived sense of self as a burden plays a role in feelings of helplessness and hopelessness commonly associated with warning signs of suicidal intent (Joiner, 2005). Some individuals come to believe that dying by suicide is one of the only effective steps they can take on their behalf (Crocker et al., 2006; Joiner, 2005). There can be a relationship between the sense that one is a burden and one feeling honor to remove that burden from specific others or society as a whole through the act of suicide (Crocker et al., 2006; Joiner, 2005).

"Those who view themselves as a burden on others have a negative self- image, feel out of control of their lives, and possess a range of negative emotions stemming from the sense that their incapacity spills over to affect others besides themselves" (Joiner, 2005, p. 97).

THWARTED CONNECTEDNESS: THE SENSE THAT ONE DOES NOT BELONG

"The need to belong is a fundamental human motive. When this need is thwarted numerous effects on health, adjustment and wellbeing have been documented" (Joiner, 2005, p.118.)

Everyone can relate to the desire to belong. Almost everyone can relate to how painful it can be to feel that one does not belong. Often, suicidal individuals feel very alone, many factors can contribute to a feeling of failed

belonging. Often, people who are experiencing a depression cannot access feelings of being connected to others. Depressed individuals may not be able to relate to others in an engaging manner (Joiner, 2005). Other mental health conditions and substance abuse disorders can include symptoms that result in social rejection (e.g., psychosis, dependent behaviors, and self- harm). These symptoms may be interpreted as character flaws rather than components of an illness. The physical effects of aging can also lead to significant isolation from others due to diminished ability (Crocker et al., 2006). Experiences of bullying or identity struggles (e.g. sexuality) can contribute to feelings of aloneness. Incarceration often involves spending long periods of time alone. Many other factors contributing to feelings of isolation could be listed here.

"… there are two components of a fully satisfied need to belong: interactions with others and a feeling of being cared about" (Joiner, 2005, p. 98)

The crisis lines can play an important role in meeting the need for frequent and positive interactions with others and for some of our service users that may otherwise not be met.

Feeling that one is a burden, and having the sense that one does not belong, can create a strong desire for death. When this desire to die is combined with an acquired ability to enact lethal self- harm the risk of suicide becomes a real possibility.

MYTHS AND BELIEFS

There are many myths and beliefs associated with suicide. While many specifically relate to children, adolescents or adults, often these myths can be applied generically to anyone who is suicidal.

- Those who talk about suicide never attempt or die by suicide
- Suicide happens with no warnings
- Children (under age 12) do not attempt or die by suicide
- Children do not understand the concept of finality and death
- Children are incapable of planning suicide
- Most adolescents who attempt suicide fully intend to die
- Adolescents from affluent families attempt or die by suicide more of the than adolescents from poor families
- The most common methods for adolescent suicide involve drug overdose
- Once a person is suicidal, he or she is suicidal forever
- If a person attempts suicide and survives, he or she will never make another attempt
- Those who attempt or die by suicide always leave notes
- Most adolescent suicides happen late at night or during the predawn hours
- Never use the word suicide when talking to people because using the word gives them the idea
- All people who engage in suicidal behavior are mentally ill
- Every person who attempts suicide is depressed
- Suicide is hereditary
- If a person is intent on attempting suicide, there is nothing anyone can do to prevent its occurrence

- Thinking about suicide is rare

STIGMA

Many cultures in the past honoured suicide and saw it as an honorary way to die; suicide is not looked at this way in the modern world. There is a great deal of stigma attached to those who have thought about suicide, attempted suicide, and have died by suicide. Secondary to this, is the stigma that is associated with the survivors of suicide, particularly the families.

For those of us who work in a helping field, we normalize the discussion around suicide and suicidal ideation. Consider that a service user may live in a rural community where everyone within the community knows each other. The stigma around having a mental illness would be tremendous. The options regarding supports such as counseling or group therapy would likely be limited. And the fear of others knowing you were will might outweigh the desire to seek help. Stigma controls the situations and limits the likelihood of accessing resources necessary to keep someone safe. Even crisis lines are not always accessible, hence the introduction of our Southern Alberta 1-800-SUI-CIDE (784-2433) line.

Religion may also play into the concerns and stigma associated with suicide. For example, some faiths teach that those who willfully take their lives are immoral and sinful. They can be denied funeral service, burial in consecrated ground and will not be allowed into heaven. In the Jewish faith, suicide is deemed a grave sin, yet in another faith, legal authorities are alert and aware of mitigating circumstances such as mental illness. Yet another religion sees suicide as a sin because they believe that God is their creator, and He alone has the right to end it. Suicide is forbidden. If a service user identifies as being "religious" or "spiritual", it can often be helpful in finding reasons for them not to die by suicide. This can also be used when considering the repercussions of suicide on the family and their faith when they lose a loved one to suicide.

HIGH RISK GROUPS

Identifying High Risk groups is important when gathering statistics, creating education or training programs and materials, and seeking out target communities for workshops. It can also be extremely helpful when applying for funding for targeted services. However, when assessing risk on the crisis lines, it is important to see a service user`s inclusion in one of these high-risk groups as only one small piece of information in a complete suicide risk assessment. For example, just because a service user identifies as being a member of the Indigenous or LGBTQ community does not mean they are at risk of suicide. However, should they identify as belonging to one of these groups AND have a mental illness, a history of abuse and a history of suicide attempts, the risk is certainly elevated. Some of the high-risk groups are:

- Anyone with an abuse history
- Individuals who identify as Indigenous, First Nations, Métis or Inuit
- Members of the LGBTQQ2TT communities
- Those with a previous history of a psychiatric diagnosis
- Individual who has been recently released from an inpatient group
- Individual who has had previous attempts, especially within the last 20 years

- Men between the ages of 29- 50, and over 80
- Certain professions (e.g., Doctors, Nurses, Police Officers, and Dentists.)
- Widows and widowers, especially with recent loss
- Veterans
- Minorities and the poor

CLUES TO SUICIDE

"Suicidal individuals often have greater environmental burdens than their non- suicidal peers including histories of abuse, family problems, culture considerations, interpersonal relationship difficulties, and exposure to overwhelming or chronic stress. Coupled with depressive mood, these burdens increase the likeliness of suicide. Actually, the additional feeling of hopelessness arising from the burdens of life is an even stronger predictor of suicidal risk than depression alone" (World Health Organization, 2006, p. 5).

> *"The expression of suicidal intent with agitation, guilt, hopelessness and constriction of interests with self-absorption are particularly ominous indicators."* (International Association of Suicide Prevention, n.d., Other Risk Factors).

The following information listed below regarding warning signs can be found at: https://crisis-centre.ca/get-help/worried-about-someone/

"About 80 percent of people who attempt or complete suicide send out warning signs to those around them, although they may not make a direct plea for help" (Crisis Prevention, Intervention and Information Centre for Northern BC, n.d., FAQ's about suicide).

Suicidal people are often undecided about living or dying. They often give clues and then "gamble" on whether or not they will be saved, even though they are unaware of such actions.

Significant losses to look for	• Death of a loved one, especially by suicide • A key relationship unraveling or ending • Instability/turmoil at home/in one's family • A severe change in social status or a sense of belonging • Unemployment, loss of a highly valued ability or activity • Fear of disciplinary action/incarceration/physical violence • Trauma from sexual or other assault • Trauma from serious illness or injury • Major financial/economic loss
Attitudes to look for	• Depression: Nothing seems important anymore. Life's a bad joke. • Hopelessness/helplessness: There is nothing I can do to change this. • Purposelessness: There is nothing to live for; there is no point to anything. • Worthlessness: I can't do anything right. No one cares if I live or die. • Overwhelmed: I can't stand this anymore. This is way too much for me.

	• Intense worry/anxiety: Everything is falling apart. Everyone is going to be disappointed in me. • Recklessness/impulsiveness: I don't care if I break my neck. • Elation: Everything is perfect now! (suddenly, after someone has been in a lot of distress)
Behaviours to look for	• Negative social media posts • Increased use of drugs or alcohol • Withdrawal/isolation from once enjoyable people/activities • Risky impulsive activities • Aggressive, violent behaviour; rage/revengeful acts • Decreased or increased performance (school, work, hobbies, sports) • Self-neglect (appearance or hygiene) • Extreme mood swings • Changes in energy level (up or down) • Complaints about health • Difficulty concentrating • Decreased, increased or otherwise disturbed eating and/or sleeping
	(Crisis Prevention, Intervention and Information Centre for Northern BC, n.d., Worried about someone?)

SUICIDE ACROSS THE LIFESPAN: SPECIAL CONSIDERATIONS, SIGNS AND STRATEGIES

Suicidal behaviours occur from the very young to the very old. Suicide rates vary with age, gender, and with cultural and societal differences. Worldwide, the risk of suicide increases steadily with age with a few cultural variations (De Leo, 2007).

CHILDREN AND YOUNG ADOLESCENTS (UNDER AGE 15)

In all societies, suicide among children and adolescents under the age of 15 is very rare and accounts for less than 2% of all suicides. There is a much greater likelihood of suicidal behaviors in children who come from families where they have experienced or witnessed violence or abuse of any kind. There are also higher occurrences where the family has a history of alcohol and drug abuse, depression and suicidal behaviours.

Depression in children and young adolescents is often much more difficult to recognize and diagnose. Symptoms may include, but are not limited to the following:

- Long- lasting sadness
- Inability to concentrate
- Somatic complaints such as stomach aches and headaches
- Anxiety
- Acting out behaviours

- Anger

If children do present with several of these symptoms or if they are intense and long lasting, a professional consultation is in their best interest, particularly if they become interested in suicide of threaten suicide (Bridges & Murji, 2008).

Some youth populations are more at risk than others. For example, youth who are in confinement and foster care are at a much higher risk for suicide that those from youth in the general population. This is due to the life experiences that put them at higher suicide risk (Youth.Gov., n.d., Increased risk groups). Indigenous and the LGBT youth are two other vulnerable groups that are higher risk of suicide, the WHO found that those who face discrimination were at a higher risk for suicide (World Health Organization, 2019).

One final factor for consideration in this group is the vulnerability towards suicide after a peer has completed. Bearman and Moody (2004) explored this phenomenon and found a substantial increase of suicide ideation and attempts in youth whose friend also died from suicide, regardless of gender. Since we understand the impact a friend's death by suicide can be, we can better support and properly understand the risk involved from youth.

Although the incidence of death is low for this age group, these children will inevitably have knowledge and awareness of suicide through conversations with other children and the media. Adults rarely discuss suicide with children and the negative side of this is that exposure from peers and television is unrealistic. Children tend to understand that suicide is something they should not do, but they do not comprehend the finality of death.

ADOLESCENTS AND YOUNG ADULTS (AGE 15-24)

Suicide among youths has been identified as a major health problem and a leading cause of death in young people in many countries. Since the mid-20th century, youth suicide rates have increased substantially, especially among young men. There is a lot of stressful times during adolescence with major changes, stress, and fear of the future. This on its own can be a lot, but coupled with mental illness, it puts adolescents and yound adults at higher risk.

Some risks for this age group include (Bridges & Murji, 2008):

- Antisocial and offending behaviours
- Childhood adversity, including family violence and parental mental health problems
- Struggle with sexual orientation or identity
- Experience of sexual or physical assault, particularly by young women

ADULTS

Most suicidologists find some consistent patterns and trends in adults who die by suicide:

- Women attempt more than men

- Men complete more often than women
- The elderly die by suicide more than any other age group
- Suicide is more common in the psychiatrically disturbed (Capuzzi, 2004, p. 272).

When comparing suicidal behaviours in adults one needs to look at three groups: Young adults, middle adulthood and elderly. While the elderly die by suicide more frequently than any other age group, there are great differences in the contributing factors.

- Young Adults**:** more likely to self- punish, seek revenge, or respond impulsively to interpersonal problems (Capuzzi, 2004, p. 273).
- Middle Adulthood**:** long dormant feelings of conflict with parents may emerge, "loss related to youthful self-perspectives, children leaving home, changes in perspectives of time, increased use of alcohol, and an increase in multiple negative life events" (Capuzzi, 2004, p. 275). Other feelings that might be emerging are around feelings of disappointment and defeat as well as lowering of expectations of self and others.
- Older Adulthood**:** Older adults tend to use more lethal weapons when attempting suicide. They also suffer more from medical problems and have increasing experience of loss, which leads to considering suicide as a way of escaping physiological and psychological pain.

HOPELESSNESS AND SUICIDE

Hope is by far one of the most fascinating concepts in the field of counseling. It is powerful and its global pervasiveness is recognizable when present, and in the case of those who are suicidal, when absent. While hope is often categorized as part of religion, it is in fact connected to scientific research and has tremendous implications for those in helping professions, particularly those who work in Crisis Intervention.

In Capuzzi's book *Suicide Across the Lifespan* (2004), hope is identified as being a common term. It defines a truly accurate definition and it is freely sprinkled through the language of our culture in a variety of contexts. It is ever present in our society in such phrases as "hope springs eternal," "don't give up hope", and "where there is life there is hope." But what is hope?

Hope in the case of suicide and suicide prevention can be described as the more realistic expectation the service user may have that a change can happen, and that there is a future they might welcome. (Hanna, 1991)

When supporting service users on the line who express suicidal thoughts or ideation, it is important to understand that when suicide seems like the only option, exploring feelings around hopelessness and working towards hope are critical for the service user to see a potential change in their future. Often a service user has some core beliefs that stop hope from manifesting itself in their lives. According to Hanna (1991), these need to be explored and clarified. Some of these beliefs are listed below:

- "Only bad things are in store for me."
- "The world is a cruel place."
- "No matter what you do, things never really get better."

- "The world holds only what others want for me."
- "I am afraid of what will happen to me."
- "The future provides nothing but anxiety."
- "The future is filled with unforeseen catastrophes."
- "I cannot do anything about my future."
- "Nobody has any idea about the future." (pp. 459-472)

Working with a service user to articulate these beliefs and then gently challenging them to see things in a hopeful light is part of the crisis line responder's role on the crisis lines. Exploring very black or white, all or nothing thinking can help a suicidal service user to see that if things could be changed in some way, that they would find reason to be hopeful for a positive outcome.

It is difficult to focus on decreasing or reducing hopelessness. The goal with a service user should be to build hope. The cliché at the beginning of this section "Where there is life there is hope", can easily be reversed to "Where there is hope there is life." Capuzzi (2004) also suggests that hope compels people to contemplate life and living and must be nourished in order to flourish and grow. Being hopeful that life can be different may be the key that is needed in engaging a suicidal service user and helping them find their way to a stronger, more hopeful mindset.

Being genuine on the lines and hopeful for the service user is critical. The message of hope can be shown by your tone of voice, your gentle approach, and your belief that things can be better for the service user. There is a phenomenon called "The Contagion of Hope" that shows that when the listener shows genuine caring, compassion, and empathy, hope can permeate and begin to take root in service users' thoughts and emotions. Never doubt that this genuineness makes the world of difference!

AMBIVALENCE

Research indicates that 80% of people who die by suicide had expressed intent in some way prior to their death (Suicide Awareness Voices of Education, 2008). This suggests that they were reaching out for help and were ambivalent about dying. Unfortunately, their efforts to reach out for help were undetected or misunderstood.

In some cases of completed suicides, especially in persons with Borderline Personality Disorder, they have died by suicide but their intent to die was unclear. An example of this would be a person dying by carbon monoxide poisoning their garage because the expected arrival home of a family member to save them was delayed (Gunderson & Ridolfi, 2007).

The first step in assisting someone identify and give voice to their ambivalence is by spending time and patiently listening to their reasons for suicide. This can be difficult because our first inclination is to have them thinking and talking about all the possible reasons for choosing life. It is helpful for people contemplating suicide to be able to talk aloud about their reasons for dying. This can help release emotions and can help give them a different perspective about their reasons for dying. It can also be helpful to reflect back what is heard as their reasons for suicide. Adding a time dimension to this feedback can start to open the door to a conversation about possible reasons for living. Some examples are, "at this time suicide seems like the answer because…" or "right now suicide

appears to be an answer because…" Responders only need enough information about their reasons for suicide to gain an understanding of what has led them to suicidal ideation. By actively listening, responders are also able to convey to the suicidal person that you care and are empathetic to their situation.

By attentively listening to their reasons for suicide, responders may start to hear some possible reasons for choosing life. Even if no obvious reasons for choosing life emerge, the fact that the person is talking is an indication that they are ambivalent. For some people, any doubt about suicide that can be brought to the forefront can be used as a reason to delay a decision. It is important to be persistent but at the same time not to be too insistent, as this may trigger resentment or the person may shut down. Again, it is helpful to paraphrase what is heard about any reasons for dying in combination with any reasons for choosing life. It might sound like, "Right now suicide appears to be an answer because… but, I also hear you saying that there is a part of you that wants to live because of…"

The Difference Between Self Harm and Suicide		
Characteristic	**Suicide Attempt**	**Self- Harm**
What is the purpose?	To stop living	A coping behaviour to feel better, to relieve pain, stress or hard to express feeling
What is the capability of causing death?	High, usually requires medical attention	Low, rarely requires medical attention
Duration? Frequency?	More likely to be single or occasional	Repetitive, chronic for up to 10- 15 years
What methods are used?	Tend to choose a method they believe will kill them	Tend to use more than one method including: • Cutting arms or legs • Burning with cigarettes • Hitting self, pulling out hair
What thoughts motivate it?	I want to die or I want to stop the pain permanently	I need relief, release from this growing tension
How do others react to it?	Respond with help, treatment concern	Respond with fear or disgust
Age at time of behaviour	Older males most frequently die by suicide	Adolescents age 11- 25 male and female
Frequency in population	Ages 15- 19: 10.2 per 100, 000 Ages 20- 24: 14 per 100, 000	10- 40% of youth

Sources*: Table is adapted from Muehlenkamp (2005) and Centre for Suicide Prevention (n.d.)*

THIRD PARTY SUICIDE CALLS

Responders may take a call from someone who is concerned about someone else who is contemplating or attempting suicide. Most often these types of calls fall within the following categories:

PERMISSION AND SUPPORT TO CALL 911

A service user has information regarding the possibility of an **imminent risk** of suicide by someone they know. This can be a stressful situation for the service user to deal with if they are uncertain how to handle it. At this point, it is imperative responders involve the CCC and utilize the decision tree on 3rd party suicide. Because of the stressful nature of this type of situation, it is always important to acknowledge how difficult this is and invite a callback or offer a follow- up call to enable them to receive support.

RESOURCES AND RISK ASSESSMENT INFORMATION

A service user suspects someone they know is at risk of suicide. In this call your role is to ensure the risk of the 1st party is taken care of (again consulting the CCC and decision tree) understand the immediacy of the risk to both 1st and 3rd party. Responders will also provide the service user with information regarding available resources in their community to assist them, including 24-hour resources in addition to shorter- and longer-term resources. An invite to callback or an offer of a follow- up call is helpful to enable them to receive some support and further information if needed.

SUPPORT

Some service users have been dealing with the on- going chronic mental health issues and related suicide ideation of someone they know. This type of situation can be very taxing to deal with on an on- going basis. With this type of call, the service user needs support and validation. It is also important to pay attention that they are at greater suicide risk themselves. Encourage them to engage in own self-care and to access resources for themselves. An invite to callback or an offer of a follow- up call is helpful to enable them to receive some support and further information if needed.

POSTVENTION

Occasionally we will receive a call from someone who has lost a loved one to suicide. The grieving process for survivors of suicide can be quite difficult and contemplated. There are some considerations to be mindful of in these situations. Bereavement from suicide is similar to bereavement from traumatic death and results in greater degrees of the following:

- More intense guilt, anger and anxiety
- Symptoms of Post-Traumatic Stress Disorder
- Social isolation

- Increased mortality due to poor health
- Prolonged struggle searching for meaning
- Prolonged struggle with acceptance of loss
- Perception of victimization
- Employment difficulties
- Marital problems
- Bereavement guilt
- Increase in suicide ideation, attempts and death by suicide
- Depression
- Family functioning problems

  (Korzekwa, 2007).

"Every day in Alberta…

- **At least 1 person will die as a result of a suicide.**
- **There will be 5 attempted suicide/self-inflicted injury hospital admissions.**
- **There will be 17 attempted suicide/self-inflicted injury emergency department visits."** (Alberta Centre for Injury Control & Research, 2015)

RISK ASSESSMENT FOR SUICIDE

In accordance to the standards of the American Association of Suicidology (2012), Distress Centre utilizes the framework of DCIB to risk assess for suicide with all service users. DCIB stands for:

- Desire
- Capability
- Intent
- Buffers/Connectedness

RESEARCH BEHIND DCIB FRAMEWORK

The National Suicide Prevention Lifeline was launched in 2005 and consists of over 120 crisis centres across the USA. Lifeline's Certification and Training Subcommittee conducted extensive research of both literature and crisis centre best practices to develop this suicide risk assessment framework in an effort to guide crisis line workers in their everyday assessments. All centres accredited by AAS must incorporate this framework into their suicide risk assessment.

For those who are interested in taking a deeper dive into the research, the link to the research informing this change can be found below.

Establishing Standards for the assessment of suicide risk.pdf

RISK ASSESSMENT QUESTIONS

Responders are expected to ask 3 question for EVERY CONTACT to assess the risk of suicide

1. Are you having any thoughts of suicide?
2. Have you had any thoughts of suicide in the past two months?
3. Do you have any previous attempts of suicide?

Joiner et al. (2007) explored these 3 suicide questions and as per the National Suicide Prevention Lifeline, "If the caller denies current suicidal ideation, inquiring about recent suicidal ideation (e.g., past two months) may indicate the caller's emotional instability. In addition, a caller may feel more ready to acknowledge previous thoughts/behaviours rather than to discuss the more immediate situation. Depending on how the crisis centre responds, discussing previous suicidal desire and/or attempts can increase rapport and trust leading to disclosure of current suicidal desire if present" (p. 363)

Whenever a service user responds yes to any of the risk assessment questions (no matter the timeline or risk level) or a responder is unable to get a clear answer from a service user, the responder MUST consult with the Contact Centre Coordinators immediately with any information they have received. CCCs will support continued risk assessment then safety planning.

If a service user ends the contact prior to a full risk assessment including all three questions, the responder must notify the CCC immediately after the call with a explanation as to why the risk assessment was not possible.

RISK ASSESSMENT FOR THIRD-PARTY SUICIDE

The following must be done when supporting a service user on a third-party suicide contact:

1. Consult with a CCC
2. Assess the service user for suicide
3. Assess the third-party of suicide

Please note that all 3 three risk assessment questions must be asked of all parties.

POINTS FOR CONSIDERATION REGARDING DCIB

- The DCIB risk assessment is one part of a process that can guide a responder as they explore a service user's situation and risk for suicide. Elements such as building rapport and weaving risk assessment questions throughout a conversation (avoiding the feel of a checklist) remain equally important.

- It is not always necessary to ask every question associated with each DCIB component. Risk assessment questions should be interwoven into a collaborative conversation between the service user and responder. Look for cues in the service user's words, tone, level of emotionality, etc. to help guide the assessment. For example: A caller states "It just seems like nothing I do ever seems to work out" and the responder can use this as a cue to explore components of Desire with a reply such as "It sounds as though you feel as though you are feeling hopeless, is that correct"?

- DCIB does not replace our collective experience in suicide risk assessment, it only serves to guide us. There are many factors beyond those provided for in DCIB (e.g. level of emotional intensity) that need to be considered in assigning levels of risk or deciding on which interventions are appropriate for each caller.

BREAKING DOWN DCIB

SUICIDAL DESIRE

Suicidal Desire can be understood as one or more of the following components:

- No reasons to continue living
- Wish to die or wish not to carry on
- Passive attempts (ambivalence around suicide)
- Desire for suicide attempt

In addition, the following psychological conditions contribute to suicidal desire:

- Feeling trapped
- Feeling as though there is no escape from the current pain/situation/ feeling trapped
- Feeling overwhelmingly alone
- High levels of psychological pain
- Feelings of hopelessness
- Feelings of helplessness
- Perception that one is a burden on others

Question for Exploring Suicidal Desire:

- Is the service user feeling hopeless?
- Is the service user feeling helpless?
- Does the service user perceive themselves to be a burden on others?
- Is the service user feeling trapped?
- Does the service user perceive their problem(s) to be permanent and stable?
- Is the service user feeling intolerably alone?
- Has the service user engaged in previous self-harming?
- Does the service user have a history of previous and/or current substance use or abuse?
- Is the service user feeling intolerably alone?
- Has the service user engaged in previous self-harming?
- Does the service user have a history of previous and/or current substance use or abuse?
- What is the service user's level of psychological pain (Use a rating scale of 1 to 10)?
- Is the service user experiencing current sleeplessness (i.e. getting less sleep than normally required)?

SUICIDAL CAPABILITY

Suicidal capability can be characterized by the following component(s):

- Sense of fearlessness to make an attempt
- Sense of competence to make an attempt
- Availability of means to and opportunity to make an attempt
- Specificity of plan for attempt
- Preparations for an attempt

Suicidal Capability can also be influenced by the following factors:

- History of suicide attempts
- History of/current violence towards others
- Exposure to/impacted by someone else's death by suicide

- Availability of means
- Current intoxication
- Tendency towards frequent intoxication
- Recent dramatic mood changes
- Out of touch with reality (hallucinations and/or delusions
- Extreme rage
- Decrease in/lack of sleep

Questions for Exploring Suicidal Capability

Does the service user have any previous attempts of suicide and/or a history of suicidal ideation?

- Does the service user engage in self-harm?
- Has the service user been exposed to/impacted by someone else's suicide?
- Does the service user currently have access to means to attempt suicide?
- Is the service user's means likely to cause significant bodily harm or death?
- Does the service user believe his/her plan will lead to death?

Situational Areas to Explore

- Does the service user have a history of current violence to others?
- Is the service user currently intoxicated/have a tendency toward frequent intoxication?
- Is the service user experiencing acute symptoms of mental illness?
- Has the service user experienced a recent dramatic mood change?
- Does the service user seem out of touch with reality? (hallucinations, delusions, etc.)?
- Is the service user feeling or demonstrating extreme rage?
- Is the service user feeling increased agitation?
- Has the service user been getting less sleep than usual?

SUICIDAL INTENT

Suicidal intent is separated from desire and capability for two key reasons:

1. Compared to desire and capability, those who intend a behaviour often enact it
2. Capability or desire do not necessarily imply intent

Suicidal intent is made up of the following components:

- Plan or attempt in progress
- Plan to hurt self/others
- Preparatory behaviours (ex., Leaving possessions to others)
- Expressed intent to die

Questions for exploring suicidal intent:

- Has the service user taken any steps today to end their life?
- Does the service user specifically intend to act out their plan for suicide
- Has the service user set a timeline for carrying out their plan?
- Has the service user engaged in any preparatory behaviours? (ex. Writing a suicide note)
- Does the caller possess the ability to carry out their plan?

BUFFERS/CONNECTEDNESS

The following factors have the potential at providing a protective buffer against a suicide attempt

- Perceived immediate supports
- Other social supports
- Planning for the future
- Engagement with the helper
- Ambivalence for living - Core values/beliefs/sense of purpose (ex. religious beliefs, caregiver)

While these factors have the potential to be a buffer against suicide, there are some important aspects to consider:

- Presence of buffers do not automatically lower the risk
- Buffers can be of little importance if there is acute high risk

Additional Considerations for Buffers

When exploring buffers, and especially when using buffers to collaborate on a safety plan, it can be helpful to tie specific buffers back to the elements in Desire, Capability, and Intent as a strategy to minimize the impacts in each of those areas.

For example:

- Caller mentions they feel incredibly lonely and isolated (Desire) but when discussing buffers, they state that they have a strong relationship with their brother. As loneliness may contribute to Desire, discussing the possibility of reaching out to the brother may be a strategy for the safety plan.
- Caller states that he has access to a gun (Capability) but also mentions that his wife is very supportive and wants to help in any way she can. This information may be used to enlist the wife's help in removing access to lethal means.

Take notes:

- Individuals may identify buffers at any point in the conversation. Pay attention and takes notes these might be extremely helpful, in building rapport, safety planning, or creating an action plan.

LEVELS OF RISK FOR SUICIDE

To assess the level of risk for suicide, responders will use the presence of the different facets of DCIB, along with observations regarding the conversation to determine an appropriate level of risk.

Final Assessment			
Emergent	**High Risk**	**Moderate Risk**	**Low Risk**
- Attempt in progress - Presence of ALL: • Desire • Capability • Intention - Absence of buffers and/or caller is unwilling to engage in safety planning. **Actions to Take** Is the caller willing to receive assistance • Yes: Clarify location and CCC to coordinate rescue • No: Express Concern for caller, inform them that we can't locate them and encourage them to provide their location	- Presence of **ALL:** • Desire • Capability • Intention - Presence of buffers may allow for safety planning **Actions to Take** Provide referrals to community resources as desired by the caller. Complete a comprehensive safety plan with caller (if willing) and offer a safety follow-up call (only to be offered as part of a comprehensive safety plan) **Please confirm with CCC before offering the safety follow-up**	- Suicidal desire with the presence of either: • Intent **OR** • Capability - Presence of buffers may allow for safety planning **Actions to Take** Provide referrals to community resources as desired by the caller. Complete a comprehensive safety plan with caller (if willing) and offer a safety follow-up call (only to be offered as part of a comprehensive safety plan AND at the discretion of the CCC) **Please confirm with CCC before offering the safety follow-up**	- Presence of any **ONE** alone: • Desire • Capability • Intent - Buffers used to formulate comprehensive safety plan **Actions to Take** Provide referrals to community resources as desired by the caller. Complete a comprehensive safety plan with caller when possible

PROCEDURAL DIRECTORY

Above is an image of the Final Assessment view of the Distress Procedural Directory for suicide risk assessment. Procedural directories are created for various risks responders may encounter with service users. Throughout out training and once on the line's responders will be given access to all of the Procedural Directories.

Procedural Directories are available to:

- support responders and CCC's
- assist in guiding the crisis conversation
- remind responders of necessary areas to cover

Procedural Directories are not there to:

- distract responders from supporting the service user
- replace the direction of a CCC
- overwhelm responders

The top priorities during contacts are to listen to the service user and work with the CCCs to support the service user. Take some time to get to know all of the procedural directories available during training and during downtime on shifts. This will make it easier to use as a guide during a crisis conversation.

APPROACHES FOR INDIVIDUALS AT IMMINENT RISK

Our instinct for those who are at risk is to initiate an active rescue. However, this can be very intrusive and not always the best option depending on the situation. The National Suicide Prevention Lifeline (2010) have identified some recommended, less invasive methods that can be used as intervention measures for those are imminent risk:

- Once obtaining agreement from both parties, a significant other can intervene toward better assuring the safety of the individual in crisis
- Once obtaining agreement, conduct a 3-way call between the individual in crisis with their professional which puts the responsibility of safety onto the professional. It is important to the crisis centre staff to explain to the professional why the individual is deemed to be in imminent risk.
- Secure transportation for the individual in crisis to the hospital

If there is no other less invasive method that can be used to determine the safety of the individual in crisis, contact safety officials (e.g., police) to assess the safety of the individual.

These decisions will not be yours as a responder. This is the decision of the CCCs sometimes after discussion with a manager on duty. Information that responders provide to CCCs can support these decisions.

SAFETY PLANNING INTERVENTION

Once a service user presents a safety risk, it is important to create a plan of action to keep them safe. An effective method that was created by Stanley and Brown (2012) is Safety Planning Intervention (SPI). SPI is a "strategy to illustrate how to prevent future suicide attempts, and identified coping and help-seeking skills for use during times of crisis" (Stanley & Brown, 2012, p. 258).

This simple strategy consists of six steps (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts and social settings as a means of distraction from suicidal thoughts; (d) utilizing family members or friends to help resolve the crisis; (e) contacting mental heal professionals or agencies; (f) restricting access to lethal means. This method for safety planning is unique in that SPI is "systematic and comprehensive approach" to suicidal service users (Stanley & Brown, 2012, p. 257). It is comprehensive as it covers all the crucial areas of assessing the risk while identifying both internal and external

resources and copings strategies. It is systematic as one begins implementing the strategies one at a time and only moving to using the next one if the one previous was ineffective.

Explanation of each step and some examples are included in the chart below:

Steps	Definitions / What happens in this	Examples
1. Recognizing warning signs of an impending suicidal crisis	The first step is to recognize the warning signs that proceeded the suicidal crisis.	• Feeling irritable • Depressed • Hopeless • Having thoughts such as "I cannot take it anymore" • Spending increased time alone • Avoiding interactions • Drinking more than usual
2. Employing internal coping strategies	In this step, the service user should attempt to cope on their own with their suicidal thoughts. Ask service user to identify some strategies they can use to cope. The primary aim of this is to create a distraction from the crisis. Once identified, a collaborative approach can be used to discuss any potential roadblocks to using these strategies or alternative strategies are discussed.	• Going for a walk • Listening to inspirational music • Going online • Taking a shower • Playing with a pet • Exercising • Engaging in a hobby • Reading • Doing chores
3. Utilizing social contacts and social settings as a means of distraction from suicidal thoughts	Explain to the service user if the internal coping strategies are not being effective, they can utilize socialization strategies. It can be either in the form of socializing with other people or in a natural social environment. They also do not explicitly reveal their suicidal state as it may serve as a distraction from their problems and suicidal thoughts.	• Friends and families • Coffee shop • Places of worship • Alcoholics Anonymous
4. Utilizing family members or friends to help resolve the crisis	If the internal strategies or social contacts used as a distraction are not helping alleviate the crisis, the service user may choose to inform family or friends that they are experiencing a suicidal crisis. This is different than the previous step as the service user explicitly reveals they are in crisis and need support and assistance in coping with the crisis.	• Mom • Dad • Siblings • Best friend

5. Contacting mental health professionals or agencies	Consists of identifying and seeking help from professionals and other clinicians who could assist the person during crisis. This should only be used if the previous strategies are not effective. Important to talk about the persons expectations when they contact professional and agencies and if there are any roadblocks or challenges in doing so	• Distress Centre • 911 • MRT • Counselor
6. Restricting access to lethal means	A key component of the safety plan intervention involves eliminating or limiting access to any potential lethal means in the environment.	• Safety storing • Dispensing of medication • Restricting access to lethal means

RESOURCES FOR SUICIDE

- **Airdrie Mental Health Clinic** room 117, 104 1 Ave NW, Airdrie Alberta T4B 0R2 **403-948-3878**
- **Banff Mineral Springs Hospital** 301 Lynx Street, Banff, Alberta T1L 1H7 **403-762-4451**
- **Canmore Mental Health Clinic** 302- 800 Railway Ave, Canmore, Alberta T1W 1P1 **403-678-4696**
- **Chestermere Mental Health Clinic** 250- 124 East Chestermere Drive, Chestermere, Alberta **403-207-8770**
- **Child and Adolescent Mental Health Urgent Services**
  Alberta Children's Hospital 2888 Shaganappi Trail NW, Calgary, Alberta T3B 6A8
  403-943-1500 (Access Mental Health)
- **Claresholm Mental Health Clinic** 4901 2 Street W, Claresholm, Alberta T0L 0T0 **403-625-4068**
- **Cochrane Community Health Centre** 60 Grande Boulevard, Cochrane, Alberta T4C 0S4 **403-932-3455**
- **Didsbury Health Centre** 1210 20 Avenue, Didsbury, Alberta T0M 0W0 **403-335-7285**
- **Distress Centre** Suite 300 1010 8th Ave SW, Calgary, Alberta T2P 1J2 **403-266-HELP**
- **Foothills Medical Centre** 1403 29 Street NW, Calgary, Alberta T2N 2T9 **403-943-1500** (Access Mental Health)
- **High River Community Health Centre** 310 MacLeod Trail, High River, Alberta T1V 1M7 **403-652-5450**
- **Individual Counselling Program- Calgary Counselling Centre**
  Place 9- 6 #200- 940 6 Avenue SW, Calgary, Alberta T2P 3T1 **403-265-4980**
- **Information and Education Collection Library- Centre for Suicide Prevention:**
  Kahanoff Centre 1202 Centre Street SE, Calgary, Alberta T2G 5A5 **403-245-3900**
- **Nanton Community Health Centre** 2214 20 Street, Nanton, Alberta T0L 1R0 **403-646-2277**
- **Northwest Calgary Mental Health Clinic** #280- 1620 29 Street NW, Calgary, Alberta T2N 4N7 **403-943-1500** (Access Mental Health)
- **Oilfields General Hospital** 717 Government Road, Black Diamond, Alberta T0H 0H0 **403-933-3800**
- **Okotoks Mental Health Clinic** 11 Cimarron Common, Okotoks, Alberta **403-995-2636**
- **Peter Lougheed Centre** 3500 26th Ave NE, Calgary, Alberta T1Y 6J4 **403-943-1500** (Access Mental Health)
- **Strathmore Mental Health Clinic** 209 3rd Avenue, Strathmore, Alberta T1P 1K3 **403-361-7277**
- **Suicide Bereavement- Canadian Mental Health Association**
  Kahanoff Centre 1202 Centre Street SE, Calgary, Alberta T2G 5A5 **403-297-1744**
- **Suicide Line- Distress Centre**
- **Vulcan Community Health Centre** 610 Elizabeth Street, Vulcan, Alberta T0L 2B0 **403-485-2285**

What You Do *Will* Make A Difference.

REFERENCES

Alvarez, A. (1972). *The savage god: A study of suicide.* Random House.

American Association of Suicidology. (2012). *Organization Accrediation Standards Manual* (13th Ed.). https://suicidology.org/wp-content/uploads/2019/06/13th-EditionFeb-2019-1.pdf

Bearman, P. S., & Moody, J. (2004). Suicide and friendships among American adolescents. *American journal of public health*, *94*(1), 89-95.

Bridges, L., & Murji, R. (2008). *Tattered teddies: An interactive handbook about the awareness and prevention of suicide in children*. Canada: Centre for Suicide Prevention.

Capuzzi, D. E. (2004). *Suicide across the life span: Implications for counselors*. American Counselling Association

Centre for Suicide Prevention. (n.d.). *Self-harm and suicide.* https://www.suicideinfo.ca/resource/self-harm-and-suicide/

Crocker L, Clare L., Evans K. (2006). Giving up or finding a solution? The experience of attempted suicide in later life. *Aging and Mental Health, 10*(6), 638- 647.

Crisis Prevention, Intervention and Information Centre for Northern BC. (n.d.). *FAQ's about suicide. https://crisis-centre.ca/faqs/*

Crisis Prevention, Intervention and Information Centre for Northern BC. (n.d.). *Worried about someone?* https://crisis-centre.ca/get-help/worried-about-someone/

Gunderson, J. G., & Ridolfi, M. E. (2001). Borderline personality disorder: Suicidality and self-mutilation. *Annals of the New York Academy of Sciences, 932*(1), 61-77.

Haley, M. (2004). Risk and protective factors. In D. Capuzzi (Ed.), *Suicide across the lifespan: Implications for counselors* (pp. 111-116). American Counseling Association.

Hanna, F.J. (1991). Suicide and hope: The common ground. *Journal of Mental Health Counseling, 13*(4), 459-472.

Health Canada. (1994). *Suicide in Canada update of the report of the task force on suicide in Canada*. Minister of National Health and Welfare.

Injury Prevention Centre. (2015). *Suicide and self-harm injuries*. https://injurypreventioncentre.ca/issues/suicide

International Association for Suicide Prevention. (n.d.) *IASP guidelines for suicide prevention*. http://www.iasp.info/suicide_guidelines.php

Joiner, T. (2005). *Why people die by suicide*. Harvard University Press.

Joiner, T., Kalafat, J., Draper, J., Stokes, H., Knudson, M., Berman, A. L., & McKeon, R. (2007). Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. *Suicide and Life-Threatening Behavior*, *37*(3), 353-365.

Korzekwa, M. (2007). *Suicide and traumatic/complicated grief*. Workshop at the Canadian Association of Suicidology Conference, Yellowknife.

Muehlenkamp, J. J. (2005). Self-injurious behavior as a separate clinical syndrome. *American Journal of Orthopsychiatry*, *75*(2), 324-333. http://www.doi.org/10.1037/0002-9432.75.2.324

O`Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1998). Beyond the Tower of Babel: A nomenclature of suicidology. In R.J. Kosky, H. S. Eshkevari, R.D. Goldnney, & R. Hassan (Eds.), *Suicide prevention: The global context* (pp. 23- 40). Plenum Press.

Rettersol, N. (1993). *Suicide: A European perspective.* Cambridge University Press.

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256-264. https://doi.org/10.1016/j.cbpra.2011.01.001

Suicide Awareness Voices of Education. (n.d.). *Frequently Asked Questions.* https://save.org/about-suicide/faqs/

World Health Organization. (2006). *Preventing suicide: A resource for counsellors.* Department of Mental Health and Substance Abuse. https://apps.who.int/iris/bitstream/handle/10665/43487/9241594314_eng.pdf;jsessionid=CCD3219283DACFBA1361D9A3B48A11BF?sequence=1

World Health Organization. (2019). *Suicide.* https://www.who.int/news-room/fact-sheets/detail/suicide

Youth.Gov. (n.d.). *Increased Risk Groups. https://youth.gov/youth-topics/youth-suicide-prevention/increased-risk-groups#_ftn*

MODULE NINE: CPR RISK ASSESSMENT

SUMMARY:

In this module trainees will learn about the appropriate frameworks and models for risk assessing self-harm, youth abuse, and domestic violence. Trainees will review the appropriate procedures and understand the recommended strategies associated with the appropriate harms while responding to service users at Distress Centre.

OBJECTIVES:

Attitudes

- Trainees will overcome the apprehension around assessing for self-harm, youth abuse, and domestic violence

Knowledge

- Trainees will understand the components of the risk assessment framework as it relates to self-harm, youth abuse, and domestic violence
- Trainees will understand the clues and signs that indicate a potential risk

Behaviour

- Trainees will apply a risk assessment framework on relevant contacts and effectively conduct a safety planning intervention
- Trainees will be able to identify and notify appropriate supports
- Trainees will be able to identify the appropriate urgency level for high risk contacts excluding suicide

DCIB VS CPR-LAS RISK ASSESSMENT

For all risks that are assessed at Distress Centre we explore and capture all necessary elements to support our service users in accordance with the Social Work Code of Ethics and our Life and Limb Policy.

For assessing suicide risk, as taught in the Suicide Intervention Module, we use the DCIB framework:

- Desire
- Capability
- Intent
- Buffers

For all other risks we utilize the CPR framework:

- Current Plan (Lethality, Availability, Specificity)
- Previous Attempts
- Resources

Important Reminder:

It's important to remember that the CPR-LAS is a framework on how to conduct risk assessments. It doesn't take into account the service user's rapport with the responder, the efficacy of questioning, and the collective experience in crisis intervention. CPR-LAS serves to guide conversations in identifying risks with the responder's in collaboration with the CCC to determine the appropriate intervention.

The information in this module is not set in stone and requires your communication with the CCC's to provide the best support for our service users; keep in mind that we always want to perform the least intrusive intervention when possible.

HOW TO IDENTIFY RISKS

When it comes to risk assessments at Distress Centre, responders:

- Assess for suicide with every service user on every contact
- Do not assess for other risks unless responders or CCCs have reasons to believe that it is necessary
- Assess for all risks we recognize as potential unless otherwise directed by the CCC

How responders might identify there is a risk or potential risk:

- The service user informs you at the beginning of the contact
- It is revealed at any point throughout the conversation, specifically or with inferences
- Hearing something in the background that causes concern
- CCC might inform of a recent risk associated with the service user

- That gut feeling (yes it happens)

It's important to note that the risks might be presented by the person causing or intending to cause harm to another individual.

MAKING AN INITIAL INQUIRY

If there is any reason to believe that anyone is, was, or could be at risk, responders must inquire or report concerns to a CCC.

When inquiring about risk be direct:

- Are you currently safe?
- You mentioned violence, is this a concern?
- I hear you are concerned that something might be happening to this person, can you please be specific?
- Have you asked your friend if they are safe?
- You mentioned your children, are they safe right now?

When to engage the CCC:

- As soon as you believe there is potential for risk
- If you do not know how to approach inquiring about something that may be a risk
- If you learn there is a risk to the service user or anyone else

Whenever a crisis line responder is wondering "should i connect with a ccc about this?" the answer is yes!

3RD PARTY RISK

When a risk is identified by a third party:

- Remember, all parties involved should be assessed for suicide
- Do not assume that person calling is safe from all additional risks
- Check with your CCC about assessing all parties for additional risks if unsure

Even if the service user is not at risk it is important to remember they are also in need of our support to ensure they are heard. When appropriate:

- Check in how they are coping
- Explore self care
- Create a plan with them for after the call
- Invite a call back

BREAKING DOWN CPR-LAS RISK ASSESSMENT

CURRENT PLAN

Depending on the type of risk, Current Plan could be interchanged with Current Risk.

Exploring the current risks identifies what is currently going on for the service user either with plans, their actions or someone else's actions.

Some areas to explore regarding current plan:

- Have they done something to hurt themselves or someone else?
- Has someone else hurt or threatened them?
- Is anyone currently hurt? Or in danger?
- Are they concerned they might harm themselves or someone else?
- Is there a fear of someone being hurt?
- Where is the person they are afraid of?
- What means are being thought of to hurt themselves or someone else? Are these means available?
- Are they safe to talk?
- Where are they?
- Who is with them?
- Are they safe with the people they are with?
- Do they or anyone else need medical attention?
- Is the individual currently intoxicated?

What is meant by "current"?

- There is a plan regarding an action to be taken. This could be today or a number of weeks from now.
- Something that is in progress.
- Fear of action.

PREVIOUS ATTEMPTS

Depending on the type of risk Previous Attempts could be interchanged with Prevalent History.

- Important aspects to explore:
- Has something like this happened before?
- What happened after this happened?
- Has anyone else been involved in the past?
- Has anyone required medical assistance in the past?
- Have Child and Family Services or the Police been involved previously?

- How long has this been going on?
- Have there been previous threats or accusations?

What could be included in prevalent history?

- Anything related to current risk
- Threats
- Attempts
- Criminal Activity
- Legal Action
- Timelines

RESOURCES

This requires a discussion about how the individuals is currently coping, what is available or being accessed.

Ares to explore:

- How is the person currently coping with what is happening?
- What strategies have the learned?
- What has been helpful in the past?
- Is anyone aware of what is happening or how they are feeling?
- Is there someone they trust supporting them in any way right now?
- Have they called the police or 911?
- What supports do they feel they currently have?
- Are they currently being supported by Child and Family Services?
- Have they spoken to a doctor?
- Are they seeing a counselor?

Important Reminder: the resources may be healthy or unhealthy resources. Be sure to capture all, not just those that are healthy.

Take note of the resources as they are mentioned as they may become part of a safety plan but do not replace further discussion.

URGENCY SCALES FOR RISK ASSESSMENTS

LOW RISK

Low risk is the default urgency level for all contacts that have risk and begin escalating from there. Here are some aspects of a low risk contact:

- The situation is currently stable and calm
- There may be thoughts of risk, but there are no current plan or means to carry it out
- There may be thoughts of risk, but there is no intention or specificity

The conversation will generally be focused on their previous history with risk (if applicable), emphasizing the resources that they have as protective factors and their crisis that lead them to these thoughts.

It's important to still create a safety plan with the service users no matter the risk level including low risk, the safety plan may vary therefore it is necessary to seek assistance for the ccc to determine what is required for the service user you are supporting.

MODERATE RISK

In comparison to low and emergent risk, the next two require a lot of information and context to accurately determine their urgency scale.

To classify something as Moderate Risk, there needs to be a factor that is missing in the situation. For example:

- The offender or abuser is not present, but may be returning in the future
- The plan for self-harm may occur in the future
- The target is not accessible
- The time frame for the risk is not certain
- The presence of children is not certain

The absence of these factors allows for some space to conduct further risk assessments, but be prepared that calls may need to end suddenly. Some tools at your disposal are:

- Asking the service user if they can promise to call back if they need to disconnect
- At the CCC's discretion, can a safety follow-up be offered?

HIGH RISK

A high risk contact is one of the most challenging as it shares many of the same elements with an Emergent Risk.

- There is still the perceived threat to cause substantial harm or death to a specific target that is, or may be accessible, **but it is not currently in progress.**
- The individual may have also been recently harmed, but there is **no significant injury or they deny requiring any medical assistance or emergency intervention.**

As with the other urgency ratings, you must create a safety plan with the caller.

EMERGENT RISK

This urgency level is the most clear of the four levels. Rather than looking for warning signs and clues to determine the risk level, emergent contacts are based on three situations:

- Risk (e.g. abuse or physical danger) is in progress
- Risk (e.g. abuse or physical danger) is imminent with confirmation on the following:
    - Threat to cause substantial harm or death to a specific target that is accessible,
- Risk (e.g. abuse or physical danger) had recently completed just before contacting Distress Centre
    - Medical attention is required following substantial injury to self

Emergent risks will result in an active rescue call to emergency services so it is important to follow the ccc's directions.

SAFETY PLANNING INTERVENTION

Crisis Line Responders are first exposed to the six stages to a safety planning intervention framework in the Suicide Intervention module. The same stages and principles also apply when working with the service user and creating a safety plan for their risk that may, or may not, include suicidality.

It is still very important to work through this intervention with the service user to build their resiliency, self-awareness, and empowerment.

For every step, adaptations need to be made according to the risks presented; CCC's can support with that. For example:

- Some individuals performing self-harm are unable to engage in another plan and other coping strategies will not work. A successful safety plan could simply be that the service user will take proper care after their self-harm to minimize physical injury
- Instead of current plan in regards to domestic violence, it is current risk and previous history of abuse

REVIEWING AND ADAPTING THE 6 STEPS OF SAFETY PLANNING INTERVENTION

1) Recognizing warning signs

- Are there any warning signs to the current risk you are discussing
- Depending on the severity or immediacy of the risk a warning sign could indicate a need to move on to the next step or jump straight to contacting 911

2) Employing internal coping strategies

- Reminding the service user that every step they are taking to protect themselves and/others shows incredible strength

- This may appear as creating an exit strategy and putting elements in place for protection
- Coping strategies will vary depending on risk

3) Utilizing social contacts and social settings

- In regards to self-harm like suicide this step is important to support stepping out of current thought pattern even for a small amount of time to cope, distract and potentially reassess
- For some risks potentially placing oneself in a social setting might protect you from the risk temporarily while the chance of harm reduces or awaiting support for trusted or professional supports
- This may be safe people to be with or near, but might not be the same as the people in Step 4

4) Utilizing family members or friends to help

- When having individuals in a safety plan it is important when possible to let them know that they might be called upon in case of potential harm or emergency and what might be needed on them if they are contacted
- This may include a safe haven, a code word to call emergency services or a trusted someone to talk to

5) Contacting professional resources

- Depending on the risk a variety on professional resources may be involved
- Resources may be engaged immediately to support the development of a safety plan, to support the individual at risk ongoing or in an emergency basis

6) Restricting access to risk

- This may include removing the person from harm which may be an immediate step and/or a plan towards long term safety

Safety planning reminders

These are some important pieces of information to keep in mind when performing a safety plan intervention:

- A safety plan is only effective in collaboration with the service user's input and your support
- Safety plans can be a source of empowerment for the service user and/or victims as they regain their sense of self control
- The timelines of a safety plan depends on each individual and the level of urgency
    - Some service users may feel very overwhelmed and the thought of thinking about tomorrow fills them with a sense of dread and anxiety. For them, it may be easier to focus on what they can control in the next 1 hour
    - In an abusive situation the service user may be safe for a few days until their abusive partner comes home. For them, the timeline for their safety plan does not start until then

- The stages of a safety plan can be non-linear as not everyone has access, insight, or supports. It's important to explore as much as you can of the stages to a safety planning intervention with what you have available

PROCEDURAL DIRECTORIES

WHAT ARE PROCEDURAL DIRECTORIES?

As explored in the Suicide Module, a procedural document that supports risk assessing and guides decision-making for action regarding the associated risk.

WHO USES PROCEDURAL DIRECTORIES AT DISTRESS CENTRE?

During a contact

- Responders use Decision Trees to guiding their conversations and work with CCCs.
- CCCs use Decision Trees to support the responders, consult with the Crisis Team and Manager on Duty when needed.

After a contact

- Responders use Decision Trees to appropriately document the contact.
- CCCs use Decision Trees to provide feedback to responders, support learning for the team and verify documentation.

WHEN USING PROCEDURAL DIRECTORIES?

Get to know what is on them when not on calls.

Allow them to be a guide.

Do not allow them to distract you.

RISK ASSESSMENT WRAP UP

Remember:

- Every risk should be reported to the CCCs including past, present and potential
- All risks should be explored enough to assess the safety of all those involved
- A safety plan is required for all risks and that will vary depending on risk
- Multiple risks require multiple assessments and safety plans
- No responder is alone when assessing risks or supporting any service user – the CCCs are there to support

Lastly, remember that CPR-LAS and the urgency scale is a framework that serves to guide decision making. In order to be effective, there needs to be communication and collaboration to take into account crisis experience, rapport, context, etc.

MODULE TEN: CHILD, YOUTH & FAMILY SAFETY

SUMMARY

In this module trainees will be introduced to appropriate legislation regarding sex, age of consent, child abuse and other appropriate documentation to be aware of the types of child abuse and child endangerment. Trainees will learn about their duty to report abuse and the methods to do so appropriately and effectively.

OBJECTIVES

Attitudes

- Trainees will understand how to be compassionate and understanding of the issues surrounding child abuse
- Trainees will be aware of controversial legalities and recognize how that impacts perceptions and conversations

Knowledge

- Trainees will understand the legal duty to report when children are involved in an abusive or potentially abusive situation as it relates to Distress Centre and in their community
- Trainees will recognize the legislation governing sex, age of consent, and child abuse
- Trainees will understand the types of child abuse and recognize warning signs of child endangerment

Behaviour

- Trainees will properly risk assess for child abuse and effectively safety plan with victims and aggressors, if applicable
- Trainees will provide resources and alternatives to aggressors of child abuse

CHILD, YOUTH, AND FAMILY ENHANCEMENT ACT

The *Child, Youth, and Family Enhancement Act of Alberta* (2000) provides authority for Children and Youth Services to provide support to children who are abused, neglected, or otherwise in need of intervention. The guiding principles of the Act focus on:

- The best interests, safety and well-being of the children.
- The well-being of families and communities being crucial to the well-being of children.
- Children benefiting from lasting relationships with people whom they have connections with including but not limited to family, friends, and caregivers.
- Children benefiting from connections with their culture and cultural communities.
- Children benefiting from permanent and formalized ties with people who care about them.
- Involving Indigenous people with respect to the planning and provision of services to and decisions respecting Indigenous families and their children.

*As a last resort, the Act allows for children to be apprehended if they are not safe in their own homes with the primary focus on the least intrusive intervention and supporting the children and their family.

CHILD, YOUTH AND FAMILY ENHANCEMENT ACT CONT…

Child, Youth and Family Enhancement Act (2000):

- Legal authority for providing child intervention services in Alberta.
- Requires the provision of services that can be expected to correct or relieve a situation causing a child to be in need of intervention services.
- States a child (under 18 years of age) is in need of intervention if there are reasonable and probable grounds to believe their survival, security or development is endangered by the action or inaction of the parent/guardian. Principles of the *Act* guide caseworkers in their work with families.
- Stresses the importance of family and provides support services to families to ensure a child is protected and maintained in his or her own home if at all possible and only removed from the home if other, less intrusive, measures are not sufficient to keep the child safe. If the child cannot be protected at home, removal of the child is necessary temporarily (until the family is able to resume protecting the child) or permanently (it is determined they will not be able to do so within a reasonable time). Examples of services that may be provided to support the child and family include:
    - Counselling; in-home supports; parenting courses and aides; social development or therapeutic support workers; mutual support groups; temporary out-of-home placement; ongoing permanency planning for children and transition planning for youth. There is also a focus on connecting families to community resources.

Alberta Children and Youth Services only deals with cases where abuse is caused or allowed by a child's parent or guardian or someone under the direct responsibility of the parent/guardian (e.g. common-law spouse or babysitter). If someone other than a parent/guardian is abusing a child, the situation needs to be reported to the police.

Child Intervention Services are provided in Alberta through local offices in Child and Family Services Authorities and Delegated First Nation Agencies.

Legal Duty to Report

Under the *Child, Youth and Family Enhancement Act (2000)* any person who has "Any person who has reasonable and probable grounds to believe that a child is in need of intervention shall forthwith report the matter" (p. 20) to a caseworker delegated by Alberta Ministry of Children and Youth Services through a local Child and Family Services office, delegated First Nations Child and Family Services Agency or Child Abuse Hotline.

Some important aspects of the legal duty to report include:

- This law applies to anyone
- The report may be made to the police or Child Services
- Any report made to the police will be directed to Child Services.
- It is important to report even if Child Services is already involved (report could be new, helpful information).
- It does not matter who or how the information was obtained or if someone was told to report. Under this law, you must report.
- It does not matter whether you have direct proof. You can report if you have reasonable and probable grounds.
- The legal duty to report overrides the confidentiality agreement as it puts someone else in danger.
- You do not need to report on past abuse unless the current risk still exists.
- Those who report are kept confidential.
- South Alberta Child Intervention Services (SACIS) is the local division of Child Services
- Individuals may reach out to Child Services without breaching confidentiality and ask them questions like:
- What would they do in this situation?
- Would this be reportable?

Failure to report can result in:

- A fine up to $10,000
- And/or imprisonment, up to 6 months

If someone believes a child has been abandoned, is being neglected or abused, they must call to report so the situation can be assessed. The situation must be reported regardless of how the information was obtained and regardless of advice or direction by anyone not to report.

The legal obligation to report suspected child abuse is not fulfilled unless the report is made directly to a Ministry of Children and Youth Services director or delegated caseworker or the police. This must occur even if it is known that Child and Family Services is already involved.

Child and Family Services caseworkers designated to receive such reports are trained to assess the need for intervention. In consultation with a supervisor, they (not you!) are responsible for deciding whether there is sufficient evidence for an assessment and further investigation into the matter.

The *Child, Youth and Family Enhancement Act* (2000) also states that the duty to report child abuse overrides any right of confidentiality or privilege a person may claim.

The identity of the person making a report of child abuse is protected by law and is not to be revealed to anyone by the Ministry of Children and Youth Services.

For more information please review the full *Child, Youth and Family Enhancement Act (2000)* act here.

RECOGNIZING CHILD ABUSE

Child abuse is any act of maltreatment of a child (through commission or omission) by a parent or guardian that results in injury or harm. The *Child, Youth and Family Enhancement Act* defines the four main types of abuse as:

- Neglect
- Emotional Injury
- Physical Abuse
- Sexual Abuse

NEGLECT

Neglect can affect the child's maturation process and can have serious, long-term psychological effects. It is not always obvious, but usually a pattern of ongoing neglect or inadequate care can be seen. Child abuse falls under the category of neglect if the parent/guardian is unable or unwilling to:

- provide the child with age appropriate necessities of life (food, clothing, shelter, love and affection, education and protection from harm);
- obtain, or permit the child to receive, essential medical, surgical or other remedial treatment that is necessary for the health or well-being of the child;
- provide the child with adequate care or supervision.

EMOTIONAL INJURY

Emotional injury is an attack on the child's self-concept and self-worth. It is a pattern of ongoing behavior by the parent/guardian that seriously interferes with the healthy development or the mental or emotional functioning of the child. Emotional abuse results along with other forms of abuse, such as neglect, sexual or physical abuse.

Emotional injury can be the result of:

- exposure to family violence in the home
- exposure to chronic alcohol or drug use in the home
- rejection
- the child being ignored or isolated
- threats, humiliation, unrealistic expectations, or inappropriate accusations/criticism
- corruption (permitting a child to use alcohol or drugs, watch or participate in cruelty to animals, or participate in criminal activities)
- negative exposure to someone with a mental or emotional condition (including suicidal or homicidal ideas) in the home

Emotional injury is the least visible form of child abuse, but has serious, long-term effects often outlasting the impact of neglect or physical injury.

PHYSICAL ABUSE

Physical abuse is an intentional, substantial and observable injury to a child.

Accidental injuries look different and are usually in different places from non-accidental injuries. This is especially true in infants because they do not move around much on their own. Injuries such as broken ribs and femurs, spiral fractures, facial bruising, acceleration/de-acceleration brain injuries (Shaken Baby Syndrome), failure to thrive (dehydration and malnutrition) are taken very seriously.

Children often explain injuries by attributing them to accidents in play or sibling conflict. If any doubt, call a caseworker to consult.

SEXUAL ABUSE

Sexual abuse is inappropriate exposure or subjection to sexual contact, activity or behavior. Sexual abuse can include:

- "non-touching" activities (e.g. obscene phone calls/conversations, indecent exposure or exhibitionism, masturbation in front of a child, deliberate exposure to others engaged in sexual activities, exposure to any forms of pornographic material); Exposing children to child pornography or luring children through the internet are forms of sexual abuse.

- "sexual touching" activities (e.g. fondling a child, making a child touch an adult's genital area, or sexual intercourse);

- "sexual exploitation" (e.g. engaging a child for prostitution, using a child in pornography or luring a child via the internet for sexual purposes). In Alberta, children and youth under the age of 18 who are involved in prostitution are considered to be victims of sexual abuse and have legislation to protect them (*Protection of Sexually Exploited Children Act*).

- Sexual abuse might show itself in a broad range of indicators. Although these indicators might reveal sexual abuse, they might also reveal other psychological or physical trauma. The single most important indicator is a child telling someone about the abuse directly or indirectly.

A child who has been sexually abused may or may not show any behavioural or emotional reaction. Because children commonly delay telling anyone about chronic or acute abuse, all disclosures should be taken seriously.

SPANKING

"Every schoolteacher, parent or person standing in the place of a parent is justified in using force by way of correction toward a pupil or child, as the case may be, who is under his care, if the force does not exceed what is reasonable under the circumstances." (Criminal Code, 1985)

While spanking is not illegal, it is important to understand what is reasonable under the circumstances and the guidelines.

- **Every schoolteacher** cannot use physical punishment towards a child under any circumstances. Teachers are allowed to use reasonable force in appropriate circumstances. For example, picking up and removing a child from the classroom if they are unruly and not following rules or boundaries. Keep in mind that generally school institutions and boards have their own policies regarding schoolteachers and punishment.
- **Force by way of correction** must be transitory and minor in nature; it cannot be used in anger or retaliation for something the child had done. For example, spanking or slapping a child hard enough to leave a mark or bruise is not transitory and would not be reasonable
- Any force on a child cannot be degrading, inhumane, or harmful
- Physical punishment cannot be used on children under two years old, or older than twelve years old
- Objects such as belts and rulers must never be used on a child
- A child must never be hit or slapped on the face, or the head
- Physical punishment cannot be used on a child who is incapable of learning from the situation due to a disability, or some other factor
- The seriousness of the child's misbehaviour is not relevant in deciding the level, or severity, of the physical punishment; it must remain minor

It is important to recognize that everyone has their own opinions on this matter and whether spanking is considered child maltreatment. This is information, but it is still more important to collaborate with the service user's values and perspective.

Southern Alberta Child Intervention Services (SACIS) has multicultural teams with the goal to educate and support parents in this area and what is acceptable.

CONTRIBUTING FACTORS

While some signs might indicate the possibility of abuse, they might also mean that the family is facing other problems that may be contributing to children being potentially more at risk of maltreatment - and that if alleviated, may resolve the child abuse concern.

Child abuse is complex and not as simple are parents wanting to hurt their children. There are many factors that can contribute to child abuse including:

- Functioning or capacity of parents
- Inadequate parenting skills - unrealistic expectations or discipline
- Lack of positive parent-child involvement
- Stress, social isolation, lack of support/resources
- Many children to care for, poverty, unemployment, etc.
- Struggles with excessive alcohol, gambling, or other addictions
- Illegal or unhealthy activity occurring in the home
- Violence occurring within the home
- Family dealing with some other crisis, or multiple crises, together

While child abuse is never okay, it is important to still understand the factors that can contribute to it. With that in mind, some questions that might be helpful in fully understanding the situation are:

- What else might be happening other than the maltreatment?
- What resources/services might be helpful to address and potentially alleviate the concerns?

Ultimately, we don't need **perfect** parents… but good enough parents.

YOUTH AND SEXUAL EXPLOITATION

Under the Criminal Code of Canada (1985), these are the laws for age of consent:

- Youth 12 and 13 years of age can give consent to those up to 2 years older than them (i.e. 14 and 15 years of age)
- Youth 14 and 15 years of age can give consent to those less than 5 years older than them (i.e. up to 19 and 20 years of age)
- 16 years of age is the general age of consent
- Age of consent recently changed (in July 2019) to be EQUAL for gay male youth (changed from 18 years of age to 16 years of age)
- The age of consent for exploitative activity (prostitution, pornography, relationship of trust, etc.) is 18 years of age

A 16 or 17-year-old cannot consent to sexual activity if:

- their sexual partner is in a position of trust or authority towards them, for example, their teacher or coach
- the young person is dependent on their sexual partner, for example for care or support
- the relationship between the young person and their sexual partner is exploitative

The following factors may be taken into account when determining whether a relationship is exploitative of the young person:

- the young person's age
- the age difference between the young person and their partner
- how the relationship developed (for example, quickly, secretly, or over the internet)
- whether the partner may have controlled or influenced the young person

Other important considerations:

- Criminal exposure laws: illegal to have unprotected sex/not disclose HIV status.

LGBTQ YOUTH

Due to stigma and many other reasons, there are staggering rates of LGBTQ youth homelessness (~40% of homeless youth identify with the LGBTQ community) (Josephson & Wright, 2000) and this housing instability can result in survival sex (sexual exploitation of youth).

To assist in supporting the youth, we do not recommend LGBTQ+ youth come out to their parents unless they know how their families will react.

Procedure for Calls Concerning Possible Child Abuse:

When a concern/disclosure of child abuse is made, refer to the appropriate Procedural Directory and alert the CCC immediately and they will determine the appropriate course of action (such as reporting to authorities, such as Child and Family Services and/or Police).

Below are some recommendations for responders if they need to gather information/details in the case it is necessary to report:

- Child's full name, sex, birth date (If a baby is involved, even getting the first name and month/year of birth may be enough to allow identification).
- Child's address and telephone number
- Child's school or child care program and current location
- Name, address, telephone number and relationship of the alleged perpetrator
- Name, address, telephone number and work place of the parents/guardians

- If a child disclosed: when and where the abuse took place; how long the abuse has been going on; whether the situation has worsened; current location of the abuser or parents/guardians
- Whether aware of any efforts made to resolve the situation and the results
- The child's condition and any concerns about the child's immediate safety
- Whether aware of other professionals or agencies involved with the family or anyone else who might provide relevant information
- Whether aware of anything about the situation or alleged perpetrator that might pose a threat to an investigator
- Whether there is any language barrier or disability that would require assistance in communication

It is not going to be a straight-forward "question and answer" experience – asking exploring questions casually throughout a conversation, while continuing to build rapport, may be the way information is gradually gathered and pieced together. Start to become familiar with ways to nonchalantly gather identifying information in any call with children involved so that if a risk of child abuse becomes a concern, responders are already well on the way to having the pertinent information necessary to make a report. Sometimes it is only possible to get very minimal information, but a report may still need to be made.

If the crisis line responder receives info that a child might have been/will be abused, they should advise the service user they have a legal duty to report the matter to a delegated caseworker. The service user should be strongly encouraged to make the report themselves since the closer to first-person account yields the best information for assessment.

It may help to advise the service user the identity of the person making a report of child abuse is protected by law and is not to be revealed to anyone by Children and Youth Services. Concerns may be reported anonymously but having contact information of the person making the report allows follow-up if more information is required (as well as it reduces the frequency of malicious reports being made).

If it is a first-person situation (i.e., the service user is the parent of a child at risk of harm), it may not be most beneficial to alert the service user to your concerns about child abuse – so **consult with a CCC first**!!

Always consult with CCC to determine whether a report needs to be made to Child and Family Services even if the call has already ended and you did not get a chance to alert the CCC earlier.

(Alberta Children's Services, 2006; Government of Alberta, 2005; The Child, Youth and Family Enhancement Act, 2000).

REFERENCES

Alberta Children's Services. (2006). *Protocols for handling child abuse and neglect in child care services*. Alberta Government, Children and Youth Services. http://www.assembly.ab.ca/lao/library/egovdocs/2006/alchs/158779.pdf

Child, Youth, and Family Enhancement Act, RSA 2000, c C-12, https://www.qp.alberta.ca/documents/Acts/c12.pdf

Criminal Code, RSC 1985, c C-46.

Department of Justice. (2016). *Age of consent to sexual activity.* Government of Canada. https://www.justice.gc.ca/eng/rp-pr/other-autre/clp/faq.html\

Government of Alberta. (2005). *Responding to child abuse: A handbook.* https://open.alberta.ca/dataset/b84e0bda-59d8-4c07-8139-6851df4cf9c5/resource/8aaa5fca-6518-4bc4-8bbf-02b91d929b48/download/2005-responding-to-child-abuse-handbook-2006.pdf

Iannelli, V. (2004). *Parenting tips*. http://pediatrics.about.com/od/infantparentingtips/a/04_pntg_styles.htm

Josephson, G., & Wright, A. (2000). *Ottawa GLBT wellness project: Literature review and survey instruments*. Social Data Research Limited. https://www.homelesshub.ca/sites/default/files/attachments/Literature_Review_and_Survey_Instruments.pdf

MODULE ELEVEN: PARTNERSHIPS

SUMMARY

In this module trainees will learn about the established agency partnerships and community resources Distress Centre crisis line responders utilize to support service users. The agencies include but are not limited to Alberta Health Services Mobile Response Team, Wood's Homes Eastside Community Mental Health Services, Calgary Seniors' Resource Society's SeniorConnect, Distress Centre Counselling, ConnecTeen and 211 services.

OBJECTIVES

Attitudes

- Trainees will be comfortable utilizing agency partnerships and community resources to support callers and provide a continuity of care

Knowledge

- Trainees will understand the voluntary and involuntary hospitalization criteria and procedures
- Trainees will understand when and how to utilize agency partnerships for consultation and referrals
- Trainees will understand agency partnerships and community resources and identify situations where they are most appropriate

Behaviour

- Trainees will have the ability to mobilize community resources in an efficient and effective manner

WHY PARTNERSHIPS ARE IMPORTANT

Partnerships are a crucial aspect to the Distress Centre as a leading social agency in mobile crisis support, and to the not for profit sector as a whole. Mobile Partnerships are unique because they assist crisis line responders in giving service users a direct link to solid referrals. Knowledge of Mobile Partnerships not only strengthens the capacity of crisis line responders to ensure the success for our service users, but in partnering with other social agencies, this strengthens the capacity of the Distress Centre as a service provider and the organization as a whole. In providing 24 hour support, the Distress Centre is always available to help support partnering mobile lines which allows service providers to spend more time in other areas that are vital in supporting their clients and organization e.g.) Outreach. As stated on our website "we rely on meaningful, effective partnerships to create success for our clients" (*Distress Centre Calgary*, 2012). Thus, promoting and connecting service users to a network of care.

"Partnerships are effective because problems are complex"

MOBILE RESPONSE TEAM (MRT): WWW.ALBERTAHEALTHSERVICES.CA/MRT

MRT and Distress Centre are in a partnership and work together for the benefit of those who need assistance in Calgary and area.

- MRT is a program through Alberta Health Services providing:
    - MOBILE addiction & mental health service
    - Outreach Crisis Intervention

- Prevention
- Urgent Mental Health Assessments
- Trauma Response Management
- Community Addiction & Mental Health Education and Support
- Professional Consultation

- MRT teams are made up of psychologists, social workers, and nurses.
- Service users/community members access MRT via the Distress Centre Crisis Lines (vs. professionals who access MRT directly). Therefore, when transferring a service user to MRT it is important to obtain the following information from service users:
  - First and last name with correct spelling
  - **PHONE NUMBER.**
  - Date of birth or age.
  - Address
- We assess for risk and patch the service user through to MRT
- Since MRT is a part of Alberta Health Services they have immediate access to health information regarding the service user.
- MRT may attend WITH the Calgary Police if there is a risk to safety.
- MRT does NOT have the ability to transport clients to hospital or to take someone against their will. However, they can help facilitate the transport via cab, bus, etc.

Finally, if at any point you have a question, always consult with the CCC**.**

SENIOR CONNECT: WWW.CALGARYSENIORS.ORG

WHO IS CSRS?

The Calgary Seniors Resource Society provides outreach and volunteer services to seniors who may lack access services due to social isolation, physical, mental, or financial limitations. Their programs and services include *SeniorConnect,* Friendly Visiting, Telephone Reassurance, Escorted Transportation, ABCs of Fraud, Seniors' Social link, as well as information and referral.

WHAT IS THIS PROGRAM ABOUT?

SeniorConnect is a program provided by Calgary Seniors' Resource Society whose mandate is to provide support that creates meaningful and effective change in the overall well-being and quality of life of vulnerable seniors.

SeniorConnect provides an urgent, same-day social work intervention for older adults identified as being at-risk, or in crisis. SeniorConnect are targeted to:

- individuals age 60 and older;
- individuals who are believed to be at risk socially, emotionally, financially or physically; and
- younger older adults may also be considered depending on need.

HOW DOES IT WORK?

SeniorConnect offers these 5 services:

- in person crisis intervention for older adults and their care providers who are experiencing a non-medical crisis
- addressing immediate concerns to stabilize the crisis and connecting individuals to longer term supports
- assistance in accessing basic needs supports such as food, clothing, shelter
- support around complex situations such as caregiver stress, dementia, mental health, addictions, elder abuse and family violence
- a 24 / 7 confidential phone line and follow up service that concerned citizens can call if they see a senior that needs help

GETTING SOMEONE CONNECTED TO SENIORCONNECT

If a caller wants to get connected to SeniorConnect, some necessary information if required:

Caller's Information:

1. Their name

2. Their phone number
3. Their relationship to the older adult
4. If they want to keep their details anonymous
5. If they require a follow-up call

At-Risk or In Crisis' Senior's Information

1. The older adults name
2. The older adults address
3. The older adults phone number
4. The older adult's birthday
5. If the older adult lives with anyone
6. What is the older adult's language?
7. Are they aware of anyone else involved with the older adult?
8. Reason for referral

Once the information is collected, responders will contact SeniorConnect and provide them with this information directly or over the voicemail.

EASTSIDE COMMUNITY MENTAL HEALTH SERVICES (FORMERLY CRT)
WWW.WOODSHOMES.CA

Distress Centre answers calls to ECMHS overnights, as well as when staff are out of their offices on home visits or in other meetings.

WHAT IS ECMHS?

- Effective November 2020, the program formerly known as the Community Resource Team (CRT) at Wood's Homes has combined with Eastside Family Centre and is now known as **Eastside Community Mental Health Services (ECMHS).**
- Began in 1987, as part of Woods Homes. They provide telephone and mobile crisis services in the Calgary area between the hours of 9:00 AM - 11:00 PM.
- Provide telephone crisis support.
- Provide mobile crisis response. They generally conduct between 3 to 6 community crisis visits each day, and these visits are accessed through their crisis line. Visits usually take place in homes, community settings, hospitals, support agencies.

ECMHS REFERRALS ARE APPROPRIATE FOR THE FOLLOWING AREAS OF CONCERN:

- Parent/ child conflict
- Support to parents with developmental disabilities
- Residential/day program/ work related concerns
- High risk behaviour in the community/ suicide concerns
- Community related violence
- Substance use/addictions related concerns
- Conflict with the law
- Mental health/psychiatric concerns
- Loss/grief
- Post-traumatic stress
- Physical/ sexual abuse
- Isolation
- Information around community supports and resources
- Crisis Team is a multi- disciplinary team who we can consult with when necessary

WHAT CAN ECMHS DO?

- Crisis team specializes in managing crisis/ risk in the community and avoiding more intrusive intervention such as hospitalization/ police incarceration whenever possible.
- Able to address and respond to both behavioural and mental health concerns.
- Assess risk in the community related to suicide, self-harm, community safety and assistance in developing/ support safety plans when appropriate.
- Facilitate hospitalization when appropriate.
- Offer a neutral perspective as an outside party.
- Assist individuals with developmental disabilities in learning to "talk through" crisis/stressful situations.
- Note: For a number of POD clients who have accessed CRT support, their tendency to call 911 when experiencing stress has been reduced.
- Take part in case consultations concerning clientele with complex issues and offer a crisis perspective.
- Assist in developing and supporting safety protocols for high risk clients. Note: ECMHS offers the best support when it is involved in regular consultations with the team providing support to individuals with developmental disabilities.
- Provide awareness of community resources.

Consult with CCC if unsure about any call and/ or situation. Fill out call sheets as identified by DC staff. These get sent to ECMHS.

REFERENCES

Alberta Health Services (2011). *Mobile response team*. https://www.albertahealthservices.ca/findhealth/service.aspx?Id=432

Distress Centre Calgary. (2012). *About us: Partnerships*. http://www.distresscentre.com/about-u

MODULE TWELVE: YOUTH ISSUES

SUMMARY

In this module trainees will learn about the unique developmental stages of youth and how this can impact decision making and reasoning as well as methods of strength-based empowerment for youth. Trainees will be introduced to unique youth perspectives and review Distress Centre's youth-specific crisis line, ConnecTeen.

OBJECTIVES

Attitudes

- Trainees will understand the importance of maintaining a youth perspective and minimizing power differentials while validating their experiences

Knowledge

- Trainees will understand the development of executive functioning in youth
- Trainees will understand the relational struggles experienced between youth and their parents
- Trainees will understand the influence of peers on youth and the different forms of bullying
- Trainees will understand the contributing factors to youth suicide and self-harm

Behaviour

- Trainees will appropriately engage in unique safety planning measures and exploring effective coping strategies for youth
- Trainees will effectively build rapport through collaboration and empowerment

INTRODUCTION

"The children now love luxury; they have bad manners, contempt for authority; they show disrespect for elders and love chatter in place of exercise. Children are now tyrants, not the servants of their households. They no longer rise when elders enter the room. They contradict their parents, chatter before company, gobble up dainties at the table, cross their legs, and tyrannize their teachers." (Socrates).

Since Socrates, judgment of youth has not drastically changed over the last 2000 years and youth face a number of barriers in asking for help. A group of youth in care (very familiar with "the system") identified the following barriers they've faced when trying to access support:

- Not being taken seriously
- Not feeling heard or understood
- Getting bumped from agency to agency
- Helping professionals focus on their problems, rather than their strengths

The ConnecTeen Line, and Youth program at the Distress Centre works with youth from a strength- based framework. This advantage in working with youth from this perspective is that it "enhances the youth's motivation for creating change" within their life. (Cox, 2008, p. 20). Crisis line and ConnecTeen responders can incorporate the strength- based framework approach by talking with youth service users about their strengths, capacity, resources, ability, and creativity. Here are a few strengths based supports responders might want to draw on or emphasize when talking to a youth in crisis:

Family	"What do you most value about your family?"
School	"What are the teachers/ guidance counsellors at your school like? Do you think they could be a resource for you?"
Peer Relationships	"It sounds like you have a variety of friendships, who are you close within your circle of friends?"
Creativity	"You mentioned you really like art. How do you feel when you engage in this activity?"
Motivation	"What are three things you do well?"
Self-Esteem	"When people say good things about you, what are they likely to say?"

Self-Harm	“Who in your life makes you feel accepted?”

FRIENDSHIPS AND RELATIONSHIPS

Quick review from Relationships - Intimate relationships have 5 fluid stages:

- Romance
- Power Struggle
- Stability
- Commitment
- Co-Creation

Youth experience these stages as well, often feeling the extremes of romance and power struggle. It's Important to remember that youth experience these stages differently than adults, but that their experiences of falling in love, feeling committed, co creating and falling out of love are still very real and valid.

Experiencing up and downs in both friendships and relationships are a normal, healthy part of adolescent development. Even the dreaded "peer pressure" helps youth to define and enforce their own boundaries.

During adolescence, most friendships and relationships are transient. The most important job of an adolescent is to learn more about themselves and make decisions about the kind of person they want to be. They also have the job of deciding who they want to spend their time with: to make these decisions, they have to spend time with lots of different kinds of people.

The influence of peers impacts the development of a young person’s social identity as youth spend majority of their time with their peers. Youth are often with their peers at school, after school, going to parties and movies on the weekends, and school events such as dances etc. Youth are often found in the midst of other youth which enables peer pressure and external influences to cloud the judgment of their self which creates a loss of self-identity. Our job as crisis line responders is to help young people work through the clouded judgement of whom they are and who they want to be.

Think of the way adolescents experience relationships as going to a restaurant with a broad menu. You might think Chicken Cordon Bleu sounds delicious, but when you order it you decide you never want to eat it again. You thought that chocolate mousse was your favourite dessert in the whole wide world, but now you're finding that you're really looking for something a little less rich. You're sure that no matter what, mashed potatoes will always be there to comfort you when you need them. Just like you have to sample different foods to know what goes into your favourite meal, adolescents have to associate with different people to decide who they want in their circle of friends and acquaintances.

Helping adolescents determine who they want on their plate is an important role of crisis line responders. See Helpers Toolboxes throughout this module for specific things to say in order to help a youth on the phone lines. Our job in working with youth is to help them to identify, communicate and define their relationship boundaries.

HELPERS TOOLBOX #1

"What qualities are important to you in a really good friend/partner? How does this fit with your current relationship?"

"It sounds like that really bothered you. Were you able to tell your friend/partner what that was like for you?"

"Would you agree that you've been hurt a lot by your friend/partner? Would you agree with me that you deserve better? Is this person a good person to have in your life? Why/ why not?

Encourage effective communication with I statements: "When you _____ , I feel _____ , because _____ and I need/ want _____ , what are your thoughts?"

BULLYING

Youth who are experiencing bullying (both being bullied and bullying others) are the ones most in need of our support in developing healthy relationship boundaries. On calls dealing with bullying, crisis line responders often need to identify the behaviour as bullying.

For bullying to take place, there must be "acts of intentional harm, repeated over-time, in a relationship where an imbalance of power exists." (Government of Canada, 2018, para 1)

WHAT IS CYBERBULLYING?

Cyber bullying refers to bullying through information and communication technologies, mediums such as mobile phone text messages, emails, phone calls, internet chat rooms, instant messaging – and the latest trend – social networking websites such as Twitter, Tumblr, Instagram and Facebook. Cyber bullying is a fast-growing trend that experts believe is more harmful than typical schoolyard bullying. Nearly all of us can be contacted 24/7 via the internet or our mobile phones. Victims can be reached anytime and anyplace. For many children, home is no longer a refuge from the bullies. (Webster, n.d)

*"Children can escape threats and abuse in the classroom, only to find text messages and emails from the same tormentors when they arrive home." (*Webster*, n.d)*

"A third of those who experience cyberbullying do not report it. If we are to succeed in preventing bullying, we need to break the climate of silence in which it thrives by empowering children and young people to speak out and seek help." (BBC News, 2006)

If the responder or the service user determines that they're being bullied, the responder has the important job of making sure that the service user knows that they did not deserve the treatment and that they have a right to feel safe. Youth who are bullied usually have a lower self- esteem than other youth, so it's extra important to identify and build on their strengths.

Sometimes youth want to talk about their experiences and feel heard. Other times they're looking for support and coping strategies, this is often the case for service users who are experiencing bullying. Because both youth who are bullied and youth who bully others have poor problem-solving strategies, it's important to form coping strategies, action plans together with back up strategies and plans.

HELPERS TOOLBOX #2

Suggest independent coping strategies, like writing in a journal, listening to music, etc.

Suggest other possible youth networks (i.e. church group? School club? Art/ music/sports?)

Help the service user to identify allies, such as friends/ acquaintances, teachers, and guidance counsellors

Practice/ role play assertive communication. Suggest looking the bully in the eye and walking away, using humor, owning the statement (i.e. "I know, these glasses look so 1980's. I'd get rid of them for sure if I could see without them").

Review and evaluate previous situations and reactions ("So if it happened again, what would you do differently?")

SEX AND SEXUALITY

Adolescents have the additional job of coming to know their sexual selves. Their task is to sort through their parent's values, their own experiences, the expressions of the media and the opinions of their peer groups to determine what will "fit" for them. Under no circumstances should youth who call the ConnecTeen line feel judged by the crisis line responders they speak with about the decisions they've made related to sex and sexuality.

When youth call ConnecTeen to talk about sex/ sexuality, they're usually looking for information and resources or for a sounding board. When youth call looking for sexual health information, such as how long after sex they can take the morning after pill or what really counts as the "same time" every day when taking birth control pills, we always refer them to a medical professional because … we're not medical professionals!

When youth are looking for a sounding board, they usually want to discuss topics like how they will know when they're ready for sex, negative sexual experiences, or how to be in a relationship when they've chosen not to be sexually active. Crisis line responders have the challenging task of balancing their respect for the service user's own decisions with being sure the service user is aware and prepared for the consequences and responsibility of a sexual relationship (see Helpers Toolbox for sample questions). If you're talking to a youth who has decided to pursue a sexual relationship, approach the idea of "safer sex". Condoms, birth control, and a variety of other contraceptives help protect against pregnancy and HIV. Just like with suicide calls, it's ultimately the service user's decision as to whether or not they will follow through with their safety plan—our job is to make sure they know safer options and alternatives.

HELPERS TOOLBOX #3

"What do you think are the pros and cons of bringing sex into your relationship?"

"How do you think your relationship will be affected/changed by sex?"

"Have (or how have) you and your partner discussed a sexual relationship? Protection?"

"What are some of the good and not so good things you get out of this relationship?"

"Is this relationship a good place for you?"

"What are you doing to take care of yourself?"

"You know, there's some really scary stuff out there. We like to think things like AIDS can't happen to us, but it can. What advice would you give to a teen who was thinking about having unprotected sex?"

"You've been using condoms? Good for you for being so responsible. Would you or your partner consider using birth control too?"

"I know it can feel embarrassing and scary, but you could go to the Family Planning Clinic. It's totally confidential and you can get free condoms and birth control for cheap. All the doctors and nurses are trained to work respectfully with youth."

EXPLORING THE SEXUALITY CONTINUUM

During adolescence, teens begin exploring their sexual identity. They may have sexual feelings towards the same sex, sexual and romantic feelings towards the same sex, or a mixture of feelings for both sexes. Since most teens are looking for where they fit in and what's "normal", these feelings can be very confusing and anxiety provoking. When taking calls from questioning youth, our goal is to create a safe and respectful place for the service user to explore their sexuality. As soon as the service user feels judged, we lose our connection with them.

When youth service users identify themselves as gay, lesbian, bisexual, transsexual or transgender, respect their right to self- name. Ask their pronouns to empower them. Remember that the experience of a LGBTQ (lesbian, gay, bisexual, transgender, or questioning) youth may be different than straight youth, but be cautious of talking about sexual identity when the youth has a different reason for calling. Talk about sexual identity when it's a concern for the service user.

"LGBTQ youth are at greater risk for low self- esteem and death by suicide than straight youth" (*Suicide Prevention Resource Center*, 2008). Be on extra alert for clues that a youth may be feeling suicidal or depressed. Some statements that could indicate that a youth is feeling depressed are: "I can't live this way anymore"; "I'm so tired of people not accepting me"; "I wish I could change"; "Even my parents have rejected me. No one cares about me".

HELPERS TOOLBOX #4

"I hear that you're feeling confused and overwhelmed. I want you to know that we can talk about this for a while. I really want to understand what you've been going through."

"You must be finding it hard to be yourself right now."

"A lot of teens think about the same things you're thinking about. It's really normal to question what you're questioning right now."

"It sounds like you've been really open about who you are. That takes guts for anyone. What gave you the courage to do that?"

"I know it's scary, but I want you to know that our calls are totally confidential and anonymous—part of being a crisis line responder is to be open-minded."

"It shows a lot of self- awareness that you can talk about this."

"You know, I've talked to other people who have had a similar experience to yours. A few of them got really depressed about it. Is that how you feel?"

YOUTH AND SELF-HARM

"Young people learn to cope with emotions in different ways. Tears, anger, depression and withdrawal are some of the ways of responding to – and finding relief from – overwhelming feelings. Some teens are troubled by frequent intense and painful emotions. While some are able to cope with these feelings, others react differently to their problems because they have not been taught ways to handle their emotions effectively. They are unable to find the words and the buildup of feelings makes it difficult for them to think clearly. Some teens release this bottleneck by cutting or burning or otherwise hurting themselves. Self-injury provides immediate relief, but this is a short-term solution with serious consequences" (Canadian Mental Health Association, n.d., Youth & Self-Injury).

WHAT IS SELF HARM?

"Self-injury, also called self-harm and self-abuse, refers to deliberate acts that cause harm to one's body, mind and spirit. Examples include cutting the skin with razor blades or pieces of glass; burning and hitting oneself; scratching or picking scabs or preventing wounds from healing; and hair pulling; Cutting is the most common form of self-injury among today's youth" (Canadian Mental Health Association, n.d., What is Self-Injury).

WHY DO YOUTH INJURE THEMSELVES?

Youth injure themselves for many different reasons. Youth who self-injure have usually experienced difficult or painful events or circumstances in their lives. The self-injury may be a way of `dealing with' the pain of these experiences. "Experts describe deliberate self-injury as ineffective problem-solving. People who self-injure are often seeking relief from psychological pain, unbearable tension, loneliness, depression, anger or an absence of feeling or numbness." (Canadian Mental Health Association, n.d., Who does it Affect?).

HELPERS TOOLBOX #6

"Did something happen today that made you feel like you need to self-harm?"

"I understand you must be feeling really overwhelmed right now and you want to self-harm. What kind of self-harm do you do?"

"Thanks for being honest with me, when did you start self-harming?"

"I want to make sure I am fully understanding you and how you are feeling when it comes to self-harm. What are your pros and cons when it comes to self-harming?"

"That totally makes sense, I can see why it can feel really contradicting."

"It's okay, you can talk to me about self-harm. I know it's a taboo subject but I'm not here to judge you."

LAST WORD ON TALKING WITH YOUTH

One of the easiest traps for adults to fall into when talking to youth is overusing their own life experience. When crisis line responders overuse their life experience, our service users lose their forum to share their unique feelings and experiences. Another easy trap for adults is defaulting to acting like a parent, older sibling, or guardian to the youth service user. It's important that we remind ourselves that we are not here to tell the youth what to do or teach them "life lessons". We are here to provide emotional, peer-support and it's important to keep in mind to meet the youth where they are at. At one point in our lives, we have felt or been in similar situations to the youth, but what worked for the responder isn't going to work for everyone. Responders can support the youth by helping them critically think about the situation, provide guidance, and self-reflection questions so that the youth can come to their conclusions. Responder are often surprised at how much they learn something from our youth service users!

Remember getting stuck or not knowing what to say is a common feeling for new crisis line responders. The Helpers Toolbox below also gives some suggestions for keeping the conversation moving.

HELPERS TOOLBOX #7

"You know, I went through something like that when I was in high school and I found it pretty tough to deal with and I get why you are feeling like this now."

"One of the ways I was able to deal was by writing in a journal. Could that help for you?"

"Just because I went through something similar it doesn't make me an expert. What do you think would work for you?"

"I went through something just like that. It was really hard for me, I thought I'd never get through it. Is that how you feel?"

"That seems like a really big problem!"

"Wow that sounds totally confusing!"

"So when he/she/they said that, you felt really ____ , is that right?"

"It's hard for you to make sense of all this because it's such a huge issue right now, am I understanding you correctly?"

"That's so normal!"

"You have every right to feel that way!"

"Tell me some of the things you're good at."

"Makes sense you're having a rough time with that …tell me more."

"I think it's really commendable that you were able to _____."

CONNECTEEN

ConnecTeen is a confidential crisis line specifically for youth in Calgary and area, answered by youth for youth. Peer support from a ConnecTeen crisis line responder is available online or over the phone from 3pm to 10pm during weekdays and 12pm-10pm during weekends and holidays. This is a confidential, anonymous and a non-judgmental service. Outside of the ConnecTeen crisis line responder hours, these lines are answered by other Distress Centre crisis line responders.

Phone: 403.264.TEEN (8336). Phone is the fastest way to get in touch with us. It is answered 24 hours a day, but ConnecTeen crisis line responders are available from 3pm –10pm during the weekdays and 12pm-10pm during weekends and holidays. Outside of those hours, adult crisis line responders will respond to calls.

Chat: On the weekdays, from 3pm-10pm service users can chat online with responders. During weekends and holidays, from 12pm-10pm is when chat is open. The sign in for chat is found on our home page. The current status will tell them when the next available chat session is.

Email: ConnecTeen@distresscentre.com is another way service users can connect with responders. Emails will receive a response within 24-48 hours, so this is best when the question is not urgent and no one is in danger.

Peer Talk: On the ConnecTeen website, if youth do not want to have a real-time conversation and would rather have a question or concern answered Peer Talk is available to them. This is where they have the option to submit more general questions anonymously. A ConnecTeen crisis line responder will write up a response and the response will be posted on the website within 3-5 business days. The answers are available for anyone to read.

Facebook: https://www.facebook.com/yycconnecteen

Twitter: https://twitter.com/YYCConnecTeen

GLOSSARY OF YOUTH LINGO

One common fear of crisis line responders in talking to youth is that they won't be able to decipher the youth's language, or that the youth won't be able to connect to their adult language. Below is a glossary of youth terminology, put together by the ConnecTeen Line crisis line responders. Responders might be surprised to find that you're familiar with many of these terms. Also, if a service user uses a word your unfamiliar with (especially in reference to a drug!) don't be afraid to ask for clarification: youth service users will appreciate your genuineness.

- B/F: boyfriend (pounced "biff'), e.g. "How's your B/F"
- Balla: to act like the alpha male, e.g., "That Balla is quite the shot calla"
- Bone: non-romantic sex, e.g., "Always practice safe boning"
- BRB: Be right back
- Bucking: doing cocaine (also called buck ya), e.g. "Do buck ya?"
- Chill: cool, alright, e.g., "That's chill" or "I was just chillin'"
- Down Low: quiet, to keep secret, also "DL", e.g. "I don't want anyone to find out so keep it on the DL"
- Eff: slang for the f-word. "Get the effing drugs out of here!"
- Epic: really awesome, e.g. "That concert last night was so epic!"
- Emo: emotional, stereotype for group of people, e.g. "Did you hear his music? That guy is so emo"
- Frick: slang for the f-word
- Friend with Benefits: friends who didn't want the emotional relationship but indulge in the physical part, e.g "No, they're not dating, they're just friends with benefits"

- FTF: friend to f"ck, someone who you have sex (but not a relationship) with, also 'friends with benefits'.
- G/F: girlfriend.
- Heat: Trouble, draws attention to self negatively "I'm going to be in serious heat for this"
- Hooking Up: general term for any sexual act one doesn't want to give details for. Could range from meeting to kissing to have sex, e.g., "I hooked up with him last night!"
- J.P. (Joint Point): a place (usually a parking lot close to a park) where people park cars and smoke weed, e.g., "We were at JP's"
- Krunk: drunk and high at the same time (or sometimes just drunk), e.g., "Let's get krunk!"
- Nexopia: Website where people can create their own page with picture and profile info, other users can leave comments and message to different people, e.g., "Just message him on Nexopia if you're scared to talk to him."
- Porking: endearing term to describe people having sex, usually used when the thought of it is pretty much gross, e.g. 'Eew, did they pork?"
- Poser: Someone who tried to fit in with a certain group of people by changing the way they dress, talk, act ,"Julia is such an emo poser!"
- Prego: a pregnant woman/man "She's prego"
- Uber: a lot, great in quantity, e.g., "Everything's uber crazy right now"
- Smurf: replaces the f-word (used mainly by smurfs), e.g., "That's smurfing awesome", "Smurf you"
- Snap: term used when one insults another, like "burn" e.g. John-"Mark, you're such a loser/ Third party—Ohhh… snap!"
- Whack: crazy, unbelievable, e.g., "That is whack!"
- Spaz: to freak out unnecessarily OR someone who spazzes, e.g. "I'm such a spaz", "Don't spaz about it"
- WTF?!: What the f"ck?'

APPLYING ROBERT'S MODEL

RISK

- Is there is conflict in the relationship? What does that conflict look like? Youth relationships include:
    - parent/ child
    - peer/relationship (including bullying)
    - romantic/ intimate relationships
- If the youth is involved in a sexual relationship, what is s/he/they doing to protect themselves from STD's and pregnancy?
- How old is the youth?

RAPPORT

- Can you remember your first break up?
- Can you remember a time when the people who you thought supported you weren't there for you?

- Can you relate to a time when you felt qualified or capable of doing something and you were told you were not?
- Can you relate to a time when the problem you were facing seemed much bigger than you?
- Can you relate to a time you didn't feel heard?
- Did you ever deal with a similar situation in your youth?

IDENTIFY PROBLEMS

- Of everything you've told me, what's weighing on you most heavily right now?
- What's the worst thing that's happening that needs our attention right now?
- What brought you to your breaking point?
- Please remember that asking a youth why they called may make them defensive as they feel they have to justify their reason for calling!

FEELINGS

- Freaked out (scared)
- Stressin' out (overwhelmed)
- Messed up (confused, disappointed, hopeless)
- Just like … UGH!! (angry, frustrated)
- "I want to cry" (sad)
- "I feel like such a loner" (lonely, isolated)
- Understand (listen)
- Validate
- Normalize
- We're crisis line responders, not Teacher- Advisors

OPTIONS

- Distress Centre
- Calgary Outlink
- Eastside Community Mental Health Services
- CHR Family Planning Clinic/Health Link
- CSCA Sexual and Reproductive Wellness Centre
- Alberta Health Services- Addictions and Mental Health Youth Services
- Avenue 15 and Woods Youth Shelter
- Marlborough Teen Resource Centre
- Youth Employment Centre

Phone numbers and addresses with the above resources/ agencies change from time to time; please check with 211 or Inform Alberta for current contact information

PLAN

- What's the game plan for when the service user hangs up the phone?
- What are the backup plans?
- What's the plan the next time the service user encounters a similar situation?
- What are the service user's internal resources for coping? *Time to encourage and praise!
- What are the service user's external resources? Is it necessary for one of these external supports to be involved (i.e., suicide).

FOLLOW UP

- Follow up for welfare?
- Follow up for resources?
- Invite call back, reassure service user that they made a good decision to contact us
- Remind the service user that youth volunteers answer between 3-10pm

REFERENCES

Canadian Mental Health Association. (n.d.). *Youth & self-injury*. https://cmha.calgary.ab.ca/mental-health/understanding-mental-illness/children-and-youth/youth-self-injury/

Cox, K. (2008). Tools for building on youth strengths. *Reclaiming Children and Youth, 16*(4) 19-24.

Government acts on cyber-bullies. (2006, July 25). *BBC News*. http://news.bbc.co.uk/2/hi/uk_news/education/5210886.stm

Government of Canada. (2018). *Bullying prevention: Nature and extent of bullying in Canada*. *https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/bllng-prvntn/index-en.aspx*

Suicide Prevention Resource Center. (2008). *Suicide Risk and Prevention for Lesbian, Gay, Bisexual, and Transgender Youth*. Education Development Center. https://www.sprc.org/sites/default/files/migrate/library/SPRC_LGBT_Youth.pdf

Webster, B. (n.d). *What is cyberbullying?* http://www.cyberbullying.info/resources/downloads/ChrisWebster_WhatIsCyberbullying.pdf

MODULE THIRTEEN: DOMESTIC VIOLENCE

SUMMARY

In this module trainees will be introduced to methods of recognizing and differentiating types of domestic abuse, the cycles of abuse and to better understand the process of risk assessing for domestic violence. Trainees will review key elements of safety planning for domestic violence abusers, victims and third parties.

OBJECTIVES

Attitudes

- Trainees will understand the importance of a victim-defined approach and openness to various definitions of success

Knowledge

- Trainees will understand the different forms of abuse, myths, and misconceptions around abuse
- Trainees will understand the different phases of abuse and their unique characteristics
- Trainees will understand the additional risk factors encountered by vulnerable populations experiencing domestic abuse
- Trainees will understand the components of risk assessment framework and the safety planning intervention for survivors and aggressors

Behaviour

- Trainees will properly risk assess and effectively safety plan with survivors and aggressors
- Trainees will demonstrate an ability to prioritize and manage multiple risks

TYPES OF ABUSE

Domestic Violence is when one person uses force or coercion to control another person that they are either related to or involved with in an intimate relationship.

There are various methods that are used to control the other individual. The person may be threatened or physically harmed, sexually abused, financially abused, or even psychologically (emotionally) abused. Often times a victim is subjected to more than one type of abuse by their partner or relative. Domestic Violence usually continues over a long period of time and gets more frequent and severe as time goes on.

Abusive and violent behaviours can happen in private or in front of others. Some examples include (Alberta Government, n.d., Know the behaviours):

PHYSICAL ABUSE

- hitting, punching, kicking, biting, scratching or pulling hair
- throwing or hitting you with things
- using or threatening to use a weapon

VERBAL ABUSE

- name-calling and put-downs
- yelling
- Swearing

EMOTIONAL OR PSYCHOLOGICAL ABUSE

- making fun of you, your family and friends or your beliefs
- threatening to hurt or kill you, your children, pets, family members or friends
- threatening suicide or to take the children if you leave
- threatening to have you deported
- refusing you to support you or share physical affection because you are pregnant

FINANCIAL ABUSE

- limiting your access to cash, bank accounts, credit cards or other family finances
- preventing you from working
- spending your pay cheque without your consent
- running up debts in your name or selling your possessions without permission
- destroying your personal property

CONTROL, FORCED ISOLATION OR CONFINEMENT

- controlling what you do, where you go, or who you talk to and see
- limiting, delaying or denying your access to health supports or medical care
- controlling your access to food, supplies and prenatal supports when you are pregnant
- forcing you to work beyond your ability
- keeping you a prisoner in your home
- abandoning you somewhere

SEXUAL ABUSE

- saying things or making gestures or sounds that make you feel degraded, uncomfortable or unsafe
- forcing you to be touched, kissed or have sex without your consent
- making you dress in a sexual way
- making you feel like you owe the other person sex
- trying to give you a sexually transmitted disease
- refusing to use condoms or birth control

SPIRITUAL ABUSE

- making fun of your beliefs
- preventing you from taking part in spiritual practices

STALKING

- following you around and watching where you live or work
- sending you unwanted texts or emails
- making unwanted visits or calls to you
- contacting your family, friends or co-workers and asking what you are doing and where you are
- threatening behaviours, like leaving notes on your vehicle or the door to your home or workplace

WHO IS AT RISK?

Domestic violence is a real threat to many people regardless of their religion, sexual orientation, or ethnic background. The most vulnerable individual in a domestic violence situation is often the weakest member in the situation, this is often a women, child, pet or elderly member who is living in the home. Other factors will also contribute to risk in domestic situations. Psych Central (2020) suggest that "the majority, an estimated 90 percent to 95 percent, of domestic violence victims in heterosexual relationships are women" (Who is at risk? section). There are various factors that appear to place individuals at a somewhat greater risk for abuse.

- **Age -** People between the ages of 19 and 29 are at greater risk. This age group reported more violence by intimate partners than any other age group.
- **Marital Status -** Separated or divorced individuals were 14 times more likely than married individuals to report having been a victim of domestic violence. It is, however, possible in some situations that separation or divorce directly resulted from the violence.
- **Pregnancy -** Medical sources suggest that about 37 percent of obstetric patients are physically abused while pregnant. About 21 percent of women who were previously abused report an increase in the abuse during pregnancy. Pregnant women who were already victims of domestic violence face the risk of more severe violence. Advanced stages of pregnancy leave a woman less mobile and less able to avoid a physical attack; therefore, the risk for injuries to the woman and her fetus increases.
- **Possessive Partner -** Individuals in a relationship with an excessively jealous or possessive partner are at a greater risk.
- **Substance Abuse -** Individuals who abuse alcohol or other drugs or have a relationship with someone who abuses alcohol or drugs are at a greater risk.
- **History of Abuse -** Children raised in families in which domestic violence was present are more likely to be the victim or perpetrator of domestic violence in adulthood. Men who have witnessed domestic violence between their parents are three times more likely to abuse their own wives than children of non-violent parents.

(Psych Central, 2020, Who is at risk? section)

There are some additional factors that appear to place individuals at a greater risk of abuse:

- **Immigrant/Newcomers to Canada -** Immigrants are vulnerable to abuse because they come from different cultural or political backgrounds, where there may be different understandings about what constitutes abuse. They may not have knowledge about Canadian law, and abusive partners sometimes threaten deportation or child apprehension if the survivor leaves the relationship. There may be a language barrier which makes accessing help more difficult.
- **Indigenous Populations -** Indigenous people have a cultural history of abuse, which can be passed on through generations. For individuals living on reserves, there may be isolation and a lack of appropriate resources. Indigenous people often have to leave their families and communities to access resources, including shelters.
- **Same-Sex Relationships -** Individuals in same-sex relationships may have a lack of appropriate external resources and role models.
- **Animals -** Animals are the 'weakest' and most vulnerable family. Violence against animals is used to terrorize, manipulate, control and isolate another person. Survivors may stay in abusive relationships out of fear for their animals. Aggressors may use animals as a way to practice further acts of aggressions against humans. In some circumstances, a concern for a pet may prevent a victim from leaving an abusive situation. The Calgary Humane Society has a Pet Safekeeping Program, which provides short-term housing for animals for those who are experiencing domestic violence (Calgary Humane Society, n.d., para. 1). As crisis line responders, it is important to let service users with a concern for their pets know that this support is available to them.

GENDER DIFFERENCES

In their study of Calgarian couples, Brinkerhoff and Lupri (1988) found that of 213 couples reporting violence, both partners reported perpetrating violence in 38% of couples, while in 27% only the husband reported violence and in 35% only the wife reported violence (p. 411). Both men and women can be the victim or the perpetrator in a domestic violence situation. The difference between the sexes is the type of abuse taking place and the severity of abuse.

Gender-Based Denial - The battered women's movement often avoids the fact that women do batter and that men are victims. This denial is also presenting among many police, hospital workers, and people in the criminal justice system.

Male victims of abuse	Beaten, choked, sexual assault, physical injury, medical help, threat/weapons, fear for life, more frequent violence, murder and exiting risk
Female victims of abuse	Slapped, items thrown at them, kicked, bitten, hit, suicide/homicide risk

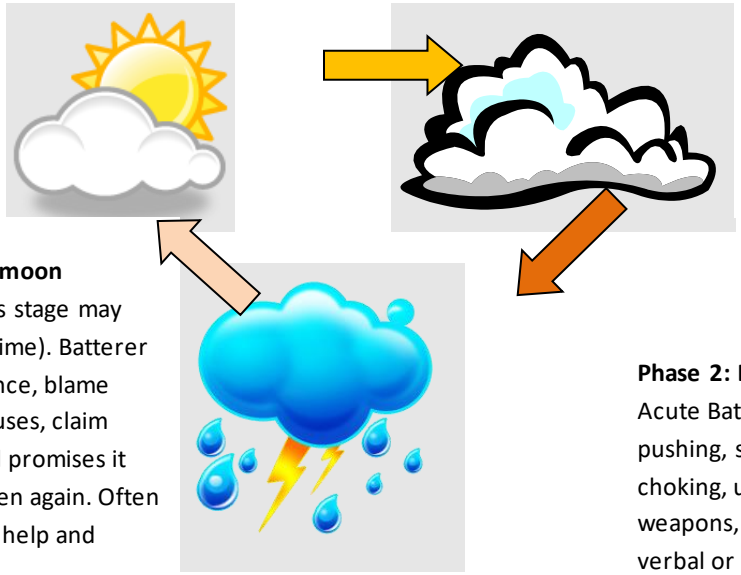
SEXUALITY AND ABUSE

A common question about domestic violence in same-gender relationships is how it differs from domestic violence between heterosexuals. There is a great deal of overlap in the issues surrounding domestic violence for both opposite- gender couples and same-sex couples. In other ways same- gender domestic violence differs from that experienced by opposite- gender couples. According to Another Closet (n.d.), these factors lead to increased power available to Lesbian/ Gay/ Bisexual/ Transsexual (LGBT) batterers, and less support for LGBT victims/ survivors (para. 1):

- **Services -** Lesbians and gay men, bisexual and transgender people who have been abused have fewer services available to them.
- **Isolation -** The isolation that accompanies domestic violence can be compounded by being LGBT in a homophobic society. Silence about domestic violence within the LGBT community further isolates the victim, giving more power to the batterer.
- **Heterosexist Manipulation -** A batterer may threaten to 'out' a person's sexual orientation or gender identity to friends, family, co-workers, or a landlord. In addition to this, existing services may require an individual to "come out" against his or her will.
- **Community Myths -** Many LGBT individuals do not want to challenge the myth of community non-violence.

- **Protectionism about "Queer Love" -** The discrimination LGBT people face can lead to our over- protection of same- gender relationships, and unwillingness to recognize abuse when it happens. Some idolize "queer love" as a deconstruction of many of the power differences in heterosexual relationships, and defend same-gender relationships against a homophobic society bent on invalidating them. This defensiveness can build community denial about abusive relationships.
- **Fear of Further Oppression -** As an oppressed and defamed group, the LGBT community is often hesitant to address issues that many fear will further "slain" the community. "Don't we have enough to deal with?" is a common phrase from people unwilling to discuss domestic violence in the LGBT community.
- **Gender Myths -** People assume that two men in a fight must be equals. Similarly, GBT men often reject the idea that they can be victims.
- **Context of Historical Oppression -** LGBT people often approach shelters, social service agencies, domestic violence service providers, police, and the courts with great caution. LGBT victims may fear re-victimization through homophobia, disbelief, rejection and degradation from institutions that have a history of exclusion, hostility and violence toward LGBT people.

CYCLE OF VIOLENCE & ABUSE



Phase 1: Tension Building
Increased tension, anger blaming and arguing.

Phase 2: Explosion
Acute Battering- hitting, pushing, shoving, kicking, choking, use of objects or weapons, sexual abuse, verbal or emotional threats

Phase 3: Honeymoon
Calm stage: (this stage may decrease over time). Batterer may deny violence, blame others, use excuses, claim s/he's sorry and promises it will never happen again. Often promises to get help and

Battering often occurs in the context of something that we call the *Cycle* of *Violence.* We have found that even though every relationship is unique, abusive relationships often follow similar cycles.

TENSION	We start the cycle in this relationship at the "okay" stage. The couple is basically okay and interactions are positive or close. Then, as "real life" sets in, tensions start building. We call this the tension building stage. These tensions may be anything from a bad day to major life changes like pregnancies or job loss. It's good to note here that all relationships have periods

	of tension. In healthy relationships, the couple may disagree or argue, but both have equal power in the relationship. In battering relationships, the abuser's need for power and control underlie anger and blaming. The tension continues to escalate. Survivors often describe feeling like they're "walking on eggshells" during this time.
EXPLOSION	Ultimately, there is an explosion or battering incident. Abusers may hit, attack, verbally assault, threaten, or scream at their partners. Many people feel battering incidents occur because someone is so angry or so drunk that they lose control of themselves. We hear comments like, "if they hadn't kept nagging me I wouldn't have lost my temper", or "I was so out of it, I didn't know what I was doing." Actually, abusers TAKE CONTROL when they batter. They take control of the immediate situation, their partner, their physical space and usually the outcome of the situation. The abuser is solely responsible for their abuse and violence. No matter how much stress there is in a relationship, the abuser is **not** provoked to use violence. He or she chooses violence as a means of coping with stress
HONEYMOON	After the explosion comes the honeymoon or calm stage. The batterer is likely to have actually experienced a physiological release of tension. The batterer is frequently sorry, feeling guilty and willing to try anything to make up. There may be flowers, gifts, dates and romance similar to the beginning of the relationship. The couple may even make love in an attempt to re-establish intimacy and security after the explosion. The batterer will also be blaming for "having to hit them" and will minimize what just happened. The victim will be in shock, upset, possibly hurt, confused and may feel guilty that somehow, they may have caused it. The victim will want to believe the abuser's promises and both partners will deny how bad the abuse was and that it could happen again. It is important to note that no victim wants a relationship to end; they want the battering to end. In this calm stage, there is increased intimacy, promises to get help, or to never abuse again, which creates hope that things might change.

After a while, the loving stage fades and we start around the circle once more. They both may *believe* that it will never happen again. The couple convinces themselves that each incident is isolated and unrelated to the next. There are two things we know about the cycle, without intervention, this cycle does not get better; it actually becomes more frequent, and the violence escalates over time (Transition House, n.d., para. 11). Without intervention, the abuse gets worse, and the loving and contrite stages are less apologetic. Eventually the loving and contrite stage drops out entirely. When crisis service users describe a *Cycle of Violence* with no calm stage, we know they are probably in a great deal of danger.

RISK ASSESSMENT

If Domestic Violence is brought forth, crisis line responders need to alert the CCC, open the decision tree, and risk assess.

RISK ASSESS USING THE ROBERT'S MODEL

Risk assessment is vital to the service user in order to ensure their safety. Once it is determined that the service user is safe, build rapport, validate and normalize their feelings. This may be the first time the service user has felt safe talking about the abuse; be sure to let them tell their story before developing a plan.

SAFETY PLAN

Every individual in an abusive relationship needs a safety plan. Shelters and crisis counselors have been urging safety plans for years and police departments, victim services, hospitals, and courts have adopted this strategy. Safety plans should be individualized: It is important to make a safety plan that the victim is capable of performing. Safety plans must be developed to take into account the individually specific circumstances, such as age, marital status, whether children are involved, geographic location, and resources available. Most safety plans will have common elements but do not expect that what works for one person will work for the other.

WHEN CREATING A SAFETY PLAN

Crisis line responders can ask the following - What will the service user need in order to be safe? What has the service user tried in the past to protect themselves and their children? Will these same strategies work now?

- **Escape Routes**- Is the service user aware of possible escape routes if they are in danger, such as doors, first-floor windows, basement exits, elevators, stairwells. Rehearse if possible. Are they aware of what rooms in their house are safe, such as rooms with several exits and without weapons? (The kitchen and bathroom have knives, razors, etc.).
- **Choosing a Safe Place**- Is there a safe home of a friend or relative who will offer unconditional support and are they able to make a plan with them ahead of time. Can they go to a motel, hotel, or a shelter and do they have the phone numbers, addresses and information that they need? Most importantly, where can they plan to go where they will feel safe?
- **Packing a Survival Kit**- Money for cab fare, a change of clothes, extra house and car keys, birth certificates, passports, medications and copies of prescriptions, insurance information, check book, credit cards, legal documents such as separation agreements and protection orders, address books, and valuable jewelry, and papers that show jointly owned assets. Conceal it in the home or leave it with a trusted neighbor, friend, or relative. Important papers can also be left in a bank deposit box.
- **Starting an Individual Savings Account**- Have statements sent to a trusted relative or friend.
- **Knowing Resources-** Review telephone numbers and resource numbers in Calgary or local area.

Review the Safety Plan Monthly.

HOW CAN CRISIS LINE RESPONDERS HELP?

Disclosing Domestic Violence can take a lot of strength and courage and the victims can frequently have their situations minimized and disregarded by loved ones, family members and society. Crisis line responders can be supportive of and validate service user's experience by saying,

I Believe You.

It is common that victims of Domestic Violence feel guilty that they caused the abuse, that they want to leave, or that they are a failure in their relationship. You can help ease the guilt and support the service user by saying,

It Is Not Your Fault and You Do Not Deserve This.

Often, the victim can feel helpless in a Domestic Violence situation. Unfortunately, Domestic Violence does exist but it should not happen to anybody. As a crisis line responder, you are there to listen and create hope. Let the service user know,

You Are Not Alone.

There are many service and agencies in Calgary that care and are available to provide support for Domestic Violence Victims. As a crisis line responder, you are vital to the support that is provided to Domestic Violence Victims. Be sure to let every service user know,

Help Is Available.

REFERENCES

Alberta Government. (n.d.). *What family and domestic violence is.* *https://www.alberta.ca/recognize-family-violence.aspx*

Another Closet. (n.d.). *Domestic violence in gay and lesbian relationships.* http://www.anothercloset.com.au/unique-aspects-of-same-sex-dom/

Brinkerhoff, M.B., & Lupri, E. (1988). Interspousal violence. *Canadian Journal of Sociology, 13,* 407-434.

Calgary Humane Society. (2012). *Petsafe keeping.* https://www.calgaryhumane.ca/what-we-do/emergency-boarding-services/petsafe-keeping/

Psych Central. (2020). *Understanding domestic violence.* https://psychcentral.com/lib/understanding-domestic-violence/

Transition House. (n.d.). *Theories about abuse*. http://www.transitionhouse.ca/THEORY.html

MODULE FOURTEEN: BEING AN ALLY

SUMMARY

In this module trainees will learn to define what an ally is including understanding individuals' intersectional identities. Trainees will identify how positionality, privilege and oppression may impact the experience or a service user and responder, recognizing and applying Anti-Oppressive Practice in crisis contacts.

OBJECTIVES

Attitudes

- Trainees will have awareness and acceptance of others differences and appreciating the impacts that intersecting identities have on individuals
- Trainees will have the awareness of their own personal judgments and defensive reactions

Knowledge

- Trainees will understand the concepts of allyship, intersectionality, positionality, privilege, and anti-oppressive practices (AOP) and identify how these concepts impact individuals
- Trainees will understand how perceptions can influence judgments and stereotypes on a personal and societal level

Behaviour

- Trainees will be able to apply AOP principles to all contacts
- Trainees will be able to employ skillful and ethical questioning when communicating with individuals

ALBERTA COLLEGE OF SOCIAL WORK (ACSW) REQUIREMENTS

As a social work agency in Alberta, we are required to follow the ACSW Standards of Practice (2019) on Cultural Competence (p. 20):

A) [A] social worker will acknowledge and respect the impact that their own heritage, values, beliefs and preferences can have on their practice and on clients whose background and values may be different from their own.

B) [A] social worker will be able to work with a wide range of people who are culturally different from the social worker or who may be considered to be members of vulnerable populations on the basis of attributes

C) [A] social worker will obtain a working knowledge and understanding of their clients' racial and cultural affiliations, identities, values, beliefs and customs and will be able to apply this knowledge in the provision of services.

ANTI-OPPRESSIVE PRACTICE (AOP)

To ensure that we are abiding by ACSW standards Distress Centre uses anti-oppressive practice when working with service users. AOP allows us to begin breaking the cycle of stereotypes and discrimination.

AOP is a theory most often found within the field of social work. It "is informed by… progressive, anti-racist, anti-discriminatory, critical, feminist, postmodern and structural social work theory… It promotes equity, inclusion, transformation, and social justice… [AOP] addresses social divisions and structural inequalities… [and] aims to provide more appropriate and sensitive services by responding to people's needs regardless of their social status. AOP embodies a person-centred philosophy; an egalitarian value system concerned with reducing the deleterious effects of structural inequalities on people's lives… A way of structuring relationships between individuals that aims to empower users by reducing the negative effects of social hierarchies on their interaction and the work they do together." (Mogaine & Capous-Desyllas, 2015, p. 24)

As a crisis line responder, there are 5 key concepts needed to apply AOP in your work on the crisis lines (Mogaine & Capous-Desyllas, 2015, p. 24-25):

1) **Engaging in critical self-reflection**
   This "…involves reflecting on the privileges associated with one's intersecting identities and social locations. In social work practice, this entails social workers continuously challenging themselves and maintaining an awareness of differences and power dynamics in the social worker/[service user] relationship… Through this process social workers are less likely to impose their biases and assumptions

on the [clients]… Self-awareness also allows for truly starting where the [service user] "is," instead of starting where the social worker might think they "should be.""

2) **Assessing [service users'] experience of oppression**
"Critical assessment of [service users'] intersecting identities and social locations can provide insight into forms of oppression that the [service users] are experiencing… Creating a space for listening and understanding [clients'] experiences of oppression can take the blame off of the individual [service user], shifting the focus from individual failure to structural issues and inequalities that have played a role in the [service user's] life."

3) **Empowering [clients]**
"Empowerment in a practice context means providing [clients] with tools to address cultural, structural, and personals barriers that prevent them from gaining control over their lives…Methods for implementing empowerment… include education [and] opportunities for [their own] participation [to] take action to improve their… life situations."

4) **Working in partnership - minimizing power differentials**
"To engage in meaningful dialogue, all participants must be considered equals… [we] must learn from each other and teach one another… The aim is to avoid reproducing the same types of social relations that have oppressed the participant in the first place."

5) **Maintaining minimal intervention**
"AOP also calls for minimal intervention or intrusion in the [client's] life." This means that sending police to a service user is our last choice and only used if we cannot guarantee the safety of a client.

OPPRESSION

It is important that when we talk about oppression, we have a reference for what it means. Oppression is often discussed as having Five Faces (Young, 2000): Exploitation, Marginalization, Powerlessness, Cultural Imperialism, and Violence. Below will describe the different facets of oppression: (Heldke & O'Connor, 2004)

Exploitation is the act of using people's labors to produce profit while not compensating them fairly. People who work in sweat shops are exploited. Although they are paid for their efforts and toils, they are not paid a fair wage considering how much money they make for the company. The "haves" end up exploiting the "have-nots" for their hard work. Therefore, exploitation creates a system that perpetuates class differences, keeping the rich richer and the poor poorer.

Marginalization is the act of relegating or confining a group of people to a lower social standing or outer limit or edge of society. Overall, it is a process of exclusion. Marginalization is in some ways worse than exploitation

because society has decided that it cannot or will not use these people even for labor. Most commonly, people are marginalized based upon race.

Yet, marginalization is by no means the fate only of racially marked people. Shamefully large proportion of the population are marginalized: elderly people who are fired from their jobs; young Blacks or Latinos who cannot find their first or second jobs; many single mothers and their children; other people involuntarily unemployed; many mentally and physically disabled people; and First Nations Peoples, especially those on reservations.

Powerlessness is the idea that some people "have" power while others "have-not." Some of the fundamental injustices associated with powerlessness are inhibition to develop one's capacities, lack of decision-making power, and exposure to disrespectful treatment because of the lowered status.

Paulo Freire believes that powerlessness is the strongest form of oppression because it allows people to oppress themselves and others. It is easiest to explain by making a connection to Harriet Tubman, a famous freed African American runaway slave and abolitionist. Tubman once wrote "I would have freed thousands more, if they had known they were slaves." In these words, Tubman conveys that some slaves felt so powerless, thought so little of themselves, and were so indoctrinated by the mindsets of their slave masters that they didn't realize that they were slaves. In fact, it's quite possible some slaves didn't even realize that something was wrong with society and that they were being treated unjustly.

The oppressed may actually believe that they are "naturally inferior" to the ruling class. They are taught by oppressors that their inferiority is normal and a fact of life. They do not feel that they have a voice. This is called internalized oppression, when these negative images are internalized and become a part of the oppressed person's own beliefs.

Cultural Imperialism involves taking the culture of the ruling class and establishing it as the norm. The groups that have power in society control how the people in that society interpret and communicate. Therefore, the beliefs of that society are the most widely disseminated and express the experience, values, goals and achievements of these groups. American culture is built upon the Judeo-Christian belief systems coupled with an Anglo culture derived from Britain. As a result, America's fundamental beliefs and values are the same as Christian beliefs and values and Anglicized/White beliefs and values.

Across the world, sexuality is a common example of cultural imperialism. The dominant group in society is heterosexual, so all other types of sexuality are grouped as Others and viewed as inferior or abnormal. Culture and education systems reinforce the notion that heterosexuality is normal and better (a social phenomenon called "heteronormity"). Those who have different types of sexuality are told to become heterosexual.

Those who are oppressed by cultural imperialism are both marked by stereotypes and made to feel invisible. The stereotypes define what they can and cannot be. At the same time, these same stereotypes turn these people into

a mass of Others that lack separate identities. The White male can have a distinct identity and be an individual because he holds the most power. All other groups are just "groups" of Others.

Violence is probably the most obvious and visible form of oppression. Members of some groups live with the knowledge that they must fear random, unprovoked attacks on their persons or property. These attacks do not necessarily need a motive but are intended to damage, humiliate, or destroy the person. In American society, women, Blacks, Asians, Arabs, gay men, and lesbians live under such threats of violence. All forms of sexual violence and hate crimes are prevalent examples of violent oppression. Most, if not all, violent oppression is the direct result of xenophobia (an intense and irrational fear of people, ideas, or customs that seem strange or foreign).

PRIVILEGE

"Someone who does not see a pane of glass does not know that he does not see it. Someone who, being placed differently, does see it, does not know the other does not see it." -Simone Weil

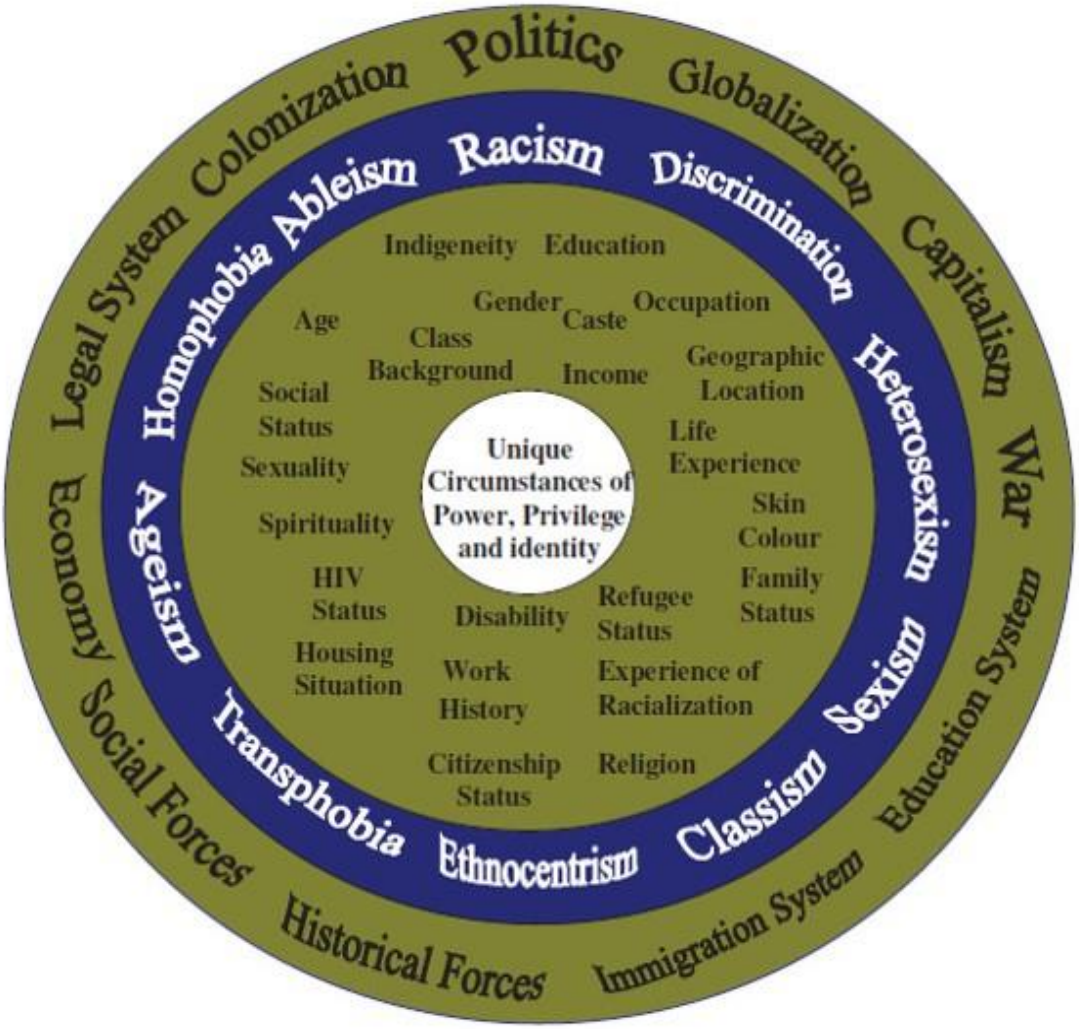
The challenge with privilege is that when we have it, we generally don't see it. This is because we have never had to encounter the struggles of someone experiencing the type of oppression, we are exempt from. For example, a Caucasian person will not have experienced racism like a person of colour would. A heterosexual person has never had to be afraid that showing affection for the person they love could result in physical violence from a stranger. There is nothing wrong with being white or straight, but it means that when we fall into the majority, we cannot experience the struggles of a minority.

Privilege means we can experience hardship in life, but that within a certain context we have one less barrier than a person who does not have the same privilege. Imagine for instance being a woman applying for a job traditionally held by men. The employers may question if the female applicant is strong enough or would have the same abilities as a man. Now if no one else applies they would very likely hire her, but if a man applies with the same qualifications, they may be more likely to hire him because that is what they are familiar with. This doesn't mean the man is any less deserving of a job/income, but it does mean he faces one less barrier than the female applicant.

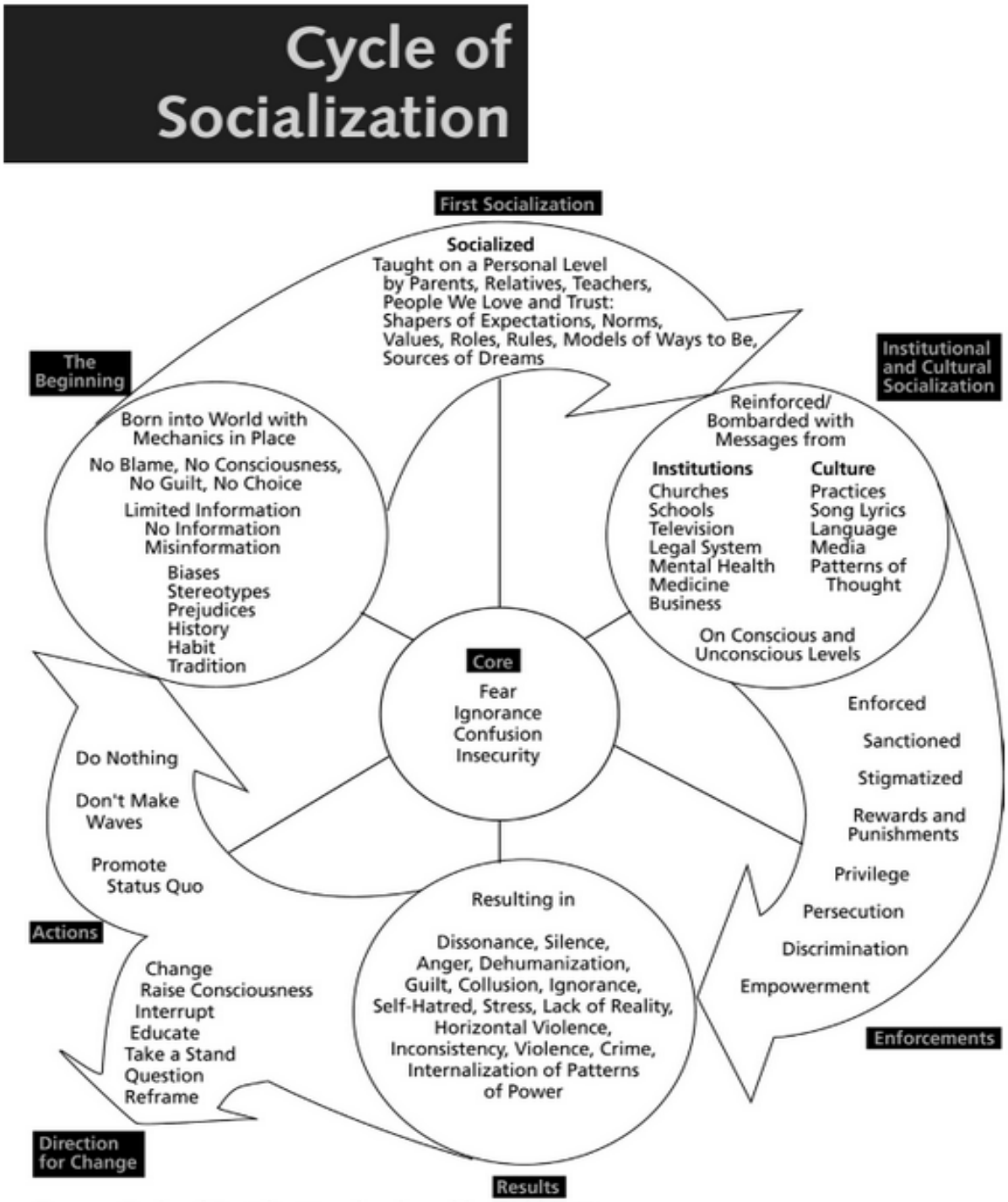
POSITIONALITY

So, what does oppression and privilege have to do with working on the crisis lines? The experiences we have in life, both oppression and privilege, shape our world view and how we interact with others. This unique position we hold in life is called our "positionality." To engage in anti-oppressive practice, we need to be aware of positionality so that we don't blindly reinforce patterns of discrimination and oppression.
Positionality is also based on the idea that we all have intersectional identities. For example, you may be male, have a university education, be in a lot of debt from student loans, have a supportive family, and be gay. Those are all different identities you would hold. Privilege would come with being male, having a university education, and

having a supportive family. However, you may experience oppression from having a lot of debt and being gay. The point is that we will all experience different levels of privilege and/or oppression based on these intersecting identities. The wheel diagram (Simpson, 2009, p.5) on the following page provides a visual example. Take a moment and consider where you might fit on the wheel.

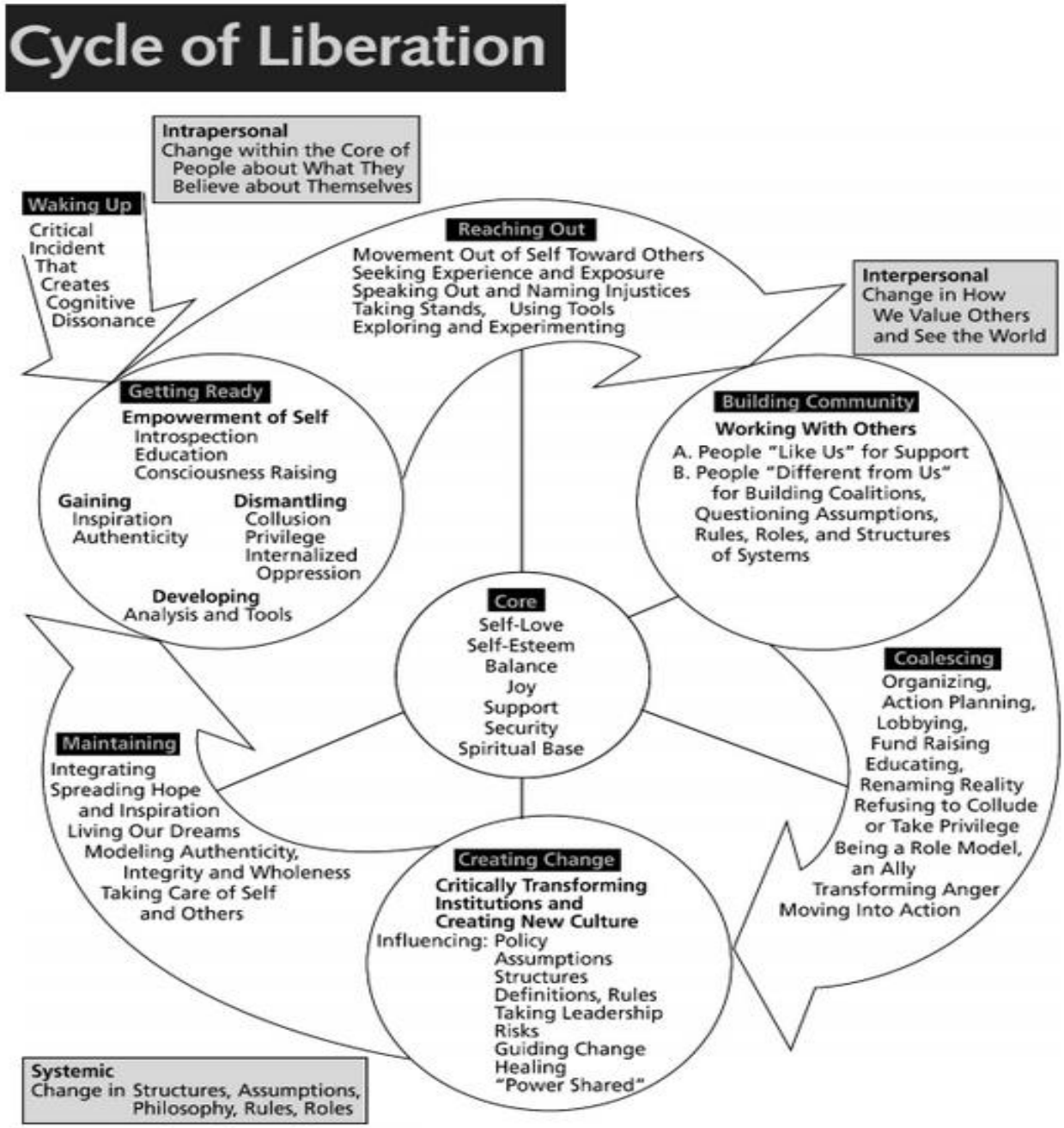


The unique circumstances of power, privilege, and identity that shape our positionality are part of a cycle of socialization. This socialization may form positive traits, but it can also lead to fear, ignorance, confusion, and insecurity when dealing with people who are different from us. This process is examined in the following diagram:



Source: Cycle of Socialization developed by Bobbie Harro

Understanding our positionality and socialization allows us to check our assumptions against reality and to head in a direction for change as can be seen above. By engaging with change we can instead create a cycle of liberation.



Source: Developed by Bobbie Harro

BECOMING AN ALLY

An ally is any person who supports, empowers, or stands up for another person or group.

So now that we understand these ideas and processes how do we use AOP and act as an ally when talking to service users.

According to Bishop (2002), allies are distinguished by several characteristics:

- their sense of connection with other people, all other people;
- their grasp of the concept of social structures and collective responsibility;
- their lack of an individualistic stance and ego, although they have a strong sense of self;
- their sense of process and change;
- their understanding of their own process of learning; their realistic sense of their own power;
- their grasp of "power-with" as an alternative to "power-over;"
- their honesty, openness, and lack of shame about their own limitations;
- their knowledge and sense of history;
- their acceptance of struggle;
- their understanding that good intentions do not matter if there is no action against oppression;
- their knowledge of their own roots.

This can and will be a difficult process as we confront our own roles perpetuating oppression. It is not helpful to get defensive or stuck in shame, this is a system we are all born into, what matters is using our new found knowledge to make things better. On the next page, there is a helpful method of engaging in this process is called the Spiral Model of Learning (Bishop, 2015). Start in the middle with the question "who are we/who am I?"

The process of becoming an ally is continuous; we never reach a point where we know it all, because it would take away the ability for us to hear another person's story. Remember it is important not to be an "expert."

"Additional values that are crucial to a dynamic and critical anti-oppressive practice are humility and "not knowing." Since emancipatory practice highlights the importance of examining power and privilege, and working toward dismantling oppressive structures, it is imperative that social workers who approach their work from this framework are able to appreciate the value of questioning and of not being the "expert."" (Morgaine & Capous-Desyllas, 2015, p. 56)

"Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."

-Letter from a Birmingham Jail, Martin Luther King, Jr

A FINAL REFLECTION ON PRIVILEGE

The following article is from The Huffington Post. It was originally posted on March 14th 2016 by Chris Boeskool.

'When You're Accustomed to Privilege, Equality Feels Like Oppression'

I've never been punched in the face. Not in an actual fight, at least. I'm not much of a fighter, I suppose… more of an "arguer." I don't think I'm "scared" to get into a fight, necessarily — there have been many times I have put myself in situations where a physical fight could easily have happened.

I just can't see myself ever being the guy who throws the first punch, and I'm usually the kind of guy who DE-escalates things with logic or humor. And one of the things about being that sort of person, is that the other sort of guy — the sort who jumps into fights quickly — tends to not really be a big fan of me. Not when he first meets me, at least. They usually like me later. Not always. You can't win 'em all…

When I moved to Nashville, I didn't really know anyone. I got a job as a server on my second day here. And before long, I was one of the servers the management favored, which meant I got better shifts, better sections and better money.

About nine months after I had been there, a new guy started. We instantly disliked each other. He didn't like my smart mouth, and I didn't like how he walked in and immediately acted like he owned the place. He carried himself with this annoying confidence — like it was his world, and he would tolerate our being in it, as long as we stayed out of his damn way.

There were also rumors that this guy had spent some time in jail, and it was very clear that he was not a "DE-escalater." He was the sort of guy who knew exactly how much he could bench, you know? And you could sense that — just below the surface — there was always this restless energy that silently dared you to say something. He was an intimidating dude.

So it bothered me a little bit when — only a month after he started working there - he was already getting rotated into some of the good sections. Another mouth to feed meant less money for me. He was a good server though.

But nothing he did got under my skin nearly as bad as this: When Chuck (we'll call him "Chuck." His name wasn't Chuck, but it was definitely a name in the "Chuck" category of names. It certainly wasn't a pushover name like "Chris") would walk toward you, he always expected you to be the one to move out of the way. He didn't do this when walking toward girls.

But if he and another guy (me, especially) were heading toward each other, he would head straight for the other guy — not making eye contact — and he always assumed he had the right of way. If not, you would get bumped by this stocky, solid mass of aggression who seemed to be just itching for someone to question his intended path. And really, this seemed to best describe how Chuck lived his whole life — walking straight at people, and expecting them to move. Until one day…

I had had enough.

I kept thinking, "Why am I always moving out of this guy's way?" Just about everyone else in the world seemed to agree that if two people were walking toward each other, both people would acquiesce a little, leaning the side closest to the other person back just so.

What gave this guy the right to just expect that I'm going to move out of his way? And then another thought started tugging at my brain: "What if I didn't move? What if I just kept walking too?"

I was done playing by his rules. And that evening, as he walked quickly toward me in the aisle of the restaurant (we both were fairly fast walkers), I walked toward him — and I didn't move. I'm not a giant of a man, but I'm solid enough to hold my own — especially when I see a collision coming — and the impact spun him around.

Right there, in front of guests, he immediately said, "What the F*CK, dude!?"

I said, "You alright?"

He was furious, and insisting to know why I had just bumped into him.

I said, "Chuck, I was just walking. Why did you assume that I was going to move out of your way?"

He followed me around the restaurant, angrily attempting to escalate things. He ended up stopping me by another table, and when I said something along the lines of "Welcome to planet Earth," he shoved me. Hard. And not like a shove where you put your hands on someone and then shove.

It was the sort of shove where his hands were already moving really fast when they hit my chest, and it made a pretty loud noise. All of his bench-pressing muscles let lose on me — this person who dared question his right of way — and I was knocked about two steps back.

I walked away from him, and I could feel my heart beating in my ears. I thought about what I should do, if I should say something to a manager (that didn't seem like a good idea), if I should say anything more to Chuck (that seemed like an even worse idea).

I decided to just try to avoid him for a bit and let him cool off. About 15 minutes later, the GM asked to talk to me. He said that a guest had seen Chuck angrily shove me, and had complained and described what happened (describing it as him "hitting" me, but it was definitely a shove).

I told him what happened — about him always assuming I was going to move, about me simply walking and not moving, and about the arguing and the shove that followed. It was a corporate restaurant, so he took everything very seriously. He filled out an incident report, asked me if I wanted to press charges, and told me if I wanted him gone, he was fired. I said that I didn't want the guy to lose his job. I just wanted him to recognize that other people had every right to be there that he did.

And so, I recently thought about this story again after I had just read this amazing quote (a quote for which I tried very hard to find an attribution, but kept coming up "Unknown):

"When you're accustomed to privilege, equality feels like oppression."

And things started making a little more sense to me. All this anger we see from people screaming "All Lives Matter" in response to black protesters at rallies. All this anger we see from people insisting that their "religious freedom" is being infringed because a gay couple wants to get married. All these people angry about immigrants, angry about Muslims, angry about "Happy Holidays," angry about not being able to say bigoted things without being called a bigot…

They all basically boil down to people who have grown accustomed to walking straight at other folks, and expecting them to move. So when "those people" in their path don't move — when those people start wondering, "Why am I always moving out of this guy's way?"; when those people start asking themselves, "What if I didn't move? What if I just kept walking too?"; when those people start believing that they have every bit as much right to that aisle as anyone else — it can seem like their rights are being taken away.

Equality can feel like oppression. But it's not. What you're feeling is just the discomfort of losing a little bit of your privilege — the same discomfort that an only child feels when she goes to preschool and discovers that there are other kids who want to play with the same toys as she does.

It's like an old man being used to having a community pool all to himself, having that pool actually opened up to everyone in the community, and then that old man yelling, "But what about MY right to swim in a pool all by myself?!"

And what we're seeing politically right now is a bit of anger from both sides. On one side, we see people who are angry about "those people" being let into "our" pool. They're angry about sharing their toys with the other kids in the classroom.

They're angry about being labeled a "racist," just because they say racist things and have racist beliefs. They're angry about having to consider others who might be walking toward them, strangely exerting their right to exist.

On the other side, we see people who believe that pool is for everyone. We see people who realize that when our kids throw a fit in preschool, we teach them about how sharing is the right thing to do. We see people who understand being careful with their language as a way of being respectful to others. We see people who are attempting to stand in solidarity with the ones who are claiming their right to exist — the ones who are rightfully angry about having to always move out of the way, people who are asking themselves the question, "What if I just keep walking?"

Which kind of person are you?

I should mention that "Chuck" and I eventually became friends, proving that people who see the world very differently can get along when they are open to change, and when they are willing to try to see the world though another person's eyes. There is hope.

REFERENCES

Adams, M. & Blumenfeld, W. (2000). Readings for Diversity and Social Justice (1st Ed.). Routledge.

Alberta College of Social Workers. (2019). *Standards of practice.* https://acsw.in1touch.org/document/2672/DOC_FINALACSWStandardsOfPractice_V1_1_20200304.pdf

Bishop, A. (2002). *Becoming an Ally: Breaking the Cycle of Oppression in People* (2nd ed.). Fernwood.

Bishop, A. (2015). *Becoming an Ally: Breaking the Cycle of Oppression in People* (3rd ed.). Fernwood.

Boeskool, C. (2017, December 6). *When you're accustomed to privilege, equality feels like oppression*. http://www.huffingtonpost.com/chris-boeskool/when-youre-accustomed-to-privilege_b_9460662.html

Heldke, L. & O'Conner, P. (Eds.). (2004). *Five faces of oppression.* In Article originally published in Oppression, Privilege, & Resistance. https://mrdevin.files.wordpress.com/2009/06/five-faces-of-oppression.pdf

Morgaine, K. & Capous-Desyllas, M. (2015). *Anti-oppressive social work practice: Putting theory into action.* Sage.

Simpson, J. (2009). *Everyone belongs: A toolkit for applying intersectionality*. CRIAW. http://also-chicago.org/also_site/wp-content/uploads/2017/03/Everyone_Belongs-A-toolkit-for-applying-intersectionality.pdf

Young, I. M. (2000). Five faces of oppression. In M. Adams, W.J. Blumenfeld, R. Castaneda, H.W. Hackman, M.C. Peter & X. Zuniga (Eds.), *Readings for diversity & Social justice. An anthology on racism, anti-Semitism, sexism, heterosexism, ableism, & classism.* Routledge.

MODULE FIFTEEN: ONLINE SERVICES MODULE

SUMMARY:

In this module trainees will learn to utilize the appropriate technology and strategies to effectively communicate with service user's online at Distress Centre. Topics include how to document an online contact and setting appropriate boundaries to ensure the effectiveness of crisis contacts.

OBJECTIVES:

Attitudes

- Trainees will be aware of the differences between online services and crisis phone lines

Knowledge

- Trainees will understand how to engage in an online chat with a service user
- Trainees will understand where to find service user details and how to use that information in high risk situations
- Trainees will understand how to properly document an online services interaction

Behaviour

- Trainees will be able to set appropriate boundaries and establish limits

CHAT OVERVIEW

On our website (www.distresscentre.com), the service user can chat one-on-one in real time through an instant messaging service about any issue they are facing. Distress Centre Chat operates during the evenings and weekends.

*Hours may vary depending on the number of Crisis Line Responders.

EMAIL OVERVIEW

Email support is available to service users via the help@distresscentre.com email account. An automated message responds to the service user informing them, that their email will be responded within 24-48 hours. If the concern is urgent, it is advised to contact the crisis lines. Crisis line responders (who are completing an online services shift) respond to emails, CCC's must always proof-read emails before anything is sent.

CHAT PROCEDURE

Chatting through Instant Messaging (IM) is very different from speaking with someone over the telephone.

Feelings and emotions are not as easily conveyed through IM as it is over the telephone. When someone says "I am upset" over the telephone, it is fairly easy to determine how upset they are through the tone of their voice. However, if someone says they are upset through IM it is difficult to determine how upset they are. Therefore, it is the responder's job to ask the appropriate questions and try to determine what the service user is feeling.

It is important to remember that responders are chatting with an actual person and not just a computer. Responders have to remind themself that the service user has genuine concerns and deserves empathy.

Be professional. Chat is often someone's first interaction with Distress Centre, of their first attempt to get help. It's a tough step to take, and we want to make the experience as positive as possible for them. All service users deserve the same level of care and professionalism, regardless of the medium they choose to connect with us.

It is important for responders to remember the following tips:

- Do not type messages in ALL CAPS; it is considered shouting
- It is difficult to read humour in a message. If responders don't want to offend the service user, they should indicate feelings with an emoticon, such as a wink or a smile: ;)
- Keep abbreviations to a minimum. See "Internet 'Lingo'" for more information.
- Keep spelling errors to a minimum.
- Responders need to be mindful of how they interact. While chatting, typing long responses can make it seem like responders have disappeared to the service user as they wait to hear back. However fast, long responses may seem like overload. Responders can send thier thoughts sentence-by-sentence or every few sentences so that the service user knows they are still there.

- Distress Centre aims for chat conversations to be between 45 mins to 1 hour long. If responders notice that a chat conversation has been going on for a while, attempt to focus the service user and wrap up the chat. Alternatively, encourage the service user to call the Crisis Line at another time

2,4,6 RULE

The 2, 4, 6 Rule is used when the service user becomes inactive during the conversation. The rule can also be used to assist a crisis line responder in ending a conversation. Chat availability along with a suggestion to call the crisis line at, 266-HELP (4357), is sent as well if the person in crisis requires further support. If the chat is urgent or emergent, and the crisis line responder needs to go or it's the end of their shift, a staff member will take over the chat. If it is not urgent or emergent, the chat can be ended at the conclusion of the responders shifts after encouraging the service user to call the Crisis Line at 403. 266.HELP (4357).

2, 4, 6 Rule procedure:

- Used for when the service user is unresponsive/not engaging in conversation (ie. taking 5-10 minutes to respond)
- Can be used for blank conversations (ie. when responders start a conversation and there is no response)
- Can be used for ongoing conversations that contain risk and are semi-urgent. Check in with the CCC and follow their discretion regarding this strategy
- If the service user is unresponsive, responders can send a message to check in. After the message has been sent, wait a total of two minutes (waited a total of 2 minutes at this point)
- After the two mins, if the service user has not responded you can send another message to check in and provide a warning that the chat may close due to inactivity. Once the message has been sent, wait another two mins. (waited a total of 4 mins at this point)
- After the two minutes of waiting again and they have yet to respond you can now send the termination and invitation to chat back again message (waited a total of 6 mins at this point)
- After these steps have been taken, you can end the chat.
- Essentially, you should not be waiting longer than 6 mins for a response from the service user.

EMAIL PROCEDURE

Email is similar to chat in that we do not know who the email is from. Therefore, you must remain professional in replying to the email. Crisis line responders (who are completing an online services shift) respond to emails, CCC's must always proof-read all emails before anything is sent.

1. Emails should be checked twice a shift, ideally once at the beginning of the shift and once at the half way point
    a. ES should assign the task of checking emails to a crisis line responder

2. Emails that will not be responded to should be marked as unread
    a. If the email response will not be sent that day, crisis line responders should make a draft for the email
    b. If the email will be sent, a corresponding call card needs to be made. After the response is sent, the email needs to be deleted from the inbox
    c. The time for the call cards are how long it took you to write the email (email responses should not take longer than 15 mins unless the email is extremely complicated)
3. Emails should be responded to 24-48 hours after the emailers initial contact
    a. The only time an email would be responded to before the 24-48 hours mark is if the email showed immediate risk. *Respond to high-risk emails as soon as they are received. CCC must be consulted with
    b. The crisis line responder must have the ES proof read all drafts before they are sent. This is to ensure the quality of emails as well as ensure that we are not sending multiples as the ES should be able to keep track of the replies during the shift
4. Common forwards
    a. ConnecTeen program related: youthprogram@distresscentre.com & Youth Program Coordinators
    b. Resource update related: communityresourcedatabase@distresscentre.com
    c. Crisis program related: Crisis Team Lead & Crisis Program Manager

Replying to an email can be challenging. It can sometimes be difficult to address all aspects of an issue when you don't often have the back and forth ability with questions. While email is the slowest form of communication with us, and intended for non-urgent concerns, sometimes more complex situations are presented here. Consultation is always key, and it is mandatory to have a CCC read through your intended response before sending the email to make sure it is appropriate and complete.

- Do not type messages in ALL CAPS; it is considered shouting
- It is difficult to read humour in a message. If you don't want to offend the service user, indicate your feelings with an emoticon, such as a wink or a smile: ;)
- Before a service user emails either the Crisis or ConnecTeen email, there is a disclaimer that tells the service user that this email is not monitored 24 hours a day and that if they need help right away to call us. We must commit to responding to each email within 24-48 hours.
- In email, please write as complete an answer as possible (considering the Robert's Model). In this format, we can take our time to craft responses, so these will generally be longer. Don't forget to include referrals to related resources (not simply referring back to our lines), try to include a few options for the email sender to choose from.
- Like chat, be sure to log all your email responses in iCarol.

TYPES OF EMAILS

Regular Email: Both the Crisis and ConnecTeen inbox can receive regular emails. This is when the service user composes and email and sends it directly to either addresses. You can start writing up your email to them by selecting the 'Reply' button.

Contact Form: Occasionally, service users will submit questions through the Contact Form (https://www.distresscentre.com/contact-us/) most are not crisis related but sometimes they are. If they are crisis related, they will be forwarded to the Crisis inbox. From there, the crisis line responder will have to take the information and compose an email to the service user. Essentially, the crisis line responder is starting the thread of messages instead of the service user.

Peer Talk: Will only come in through the ConnecTeen inbox. Youth submit a question for ConnecTeen crisis line responders to answer. The idea is that if one youth has a question, there are likely many more people who may have the same question. Peer Talk is answered in a manner similar to a blog post that is accessible to the public. The ConnecTeen crisis line responder will write up a response and the response will not be sent to the service user as they are anonymous. Instead, the response will be sent to the Youth Program address and the two Youth Program Coordinators will be cc'd in the email. Peer talks do not need to be risk assessed. Refer to https://calgaryconnecteen.com/peer-talk/

Spam or Wrong Email: If the email does not seem genuine in nature, is selling items, asking for donations, etc – Please consult with your CCC. If the email is deemed to be spam, then the email can be deleted and no call card will be made. At times, service users contact the Crisis or ConnecTeen email addresses by accident. If that is the case, please inquire what service they are looking for then direct them to the correct email address by either providing the information or forwarding the email to the correct address. Please make sure to risk assess the service user.

JUGGLING CHATS

When taking chats (whether it be a Crisis or ConnecTeen) you can take up to 2 chats maximum, simultaneously. However, if one becomes high risk, the other one needs to be wrapped up or given to a crisis line responder with the capacity to focus on the conversation. If the chat becomes high risk, it is best practice to focus on the one conversation due to how complex risk can become.

Keep in mind, just as with juggling calls, we want to give respect and empathy to the service user when we have to let them go. As long as, when we bring up letting the service user go, we give an apology, validation, and options, so that the service users have the opportunity to become empowered. For example, saying "I am sorry, what you're telling me is important and I completely hear you; Unfortunately, there is another chat that I need to attend to at the moment. Would you mind chatting back with us later so that we can have a more detailed conversation?". This lets the service user know they are a priority for you, and that they can make the choice themselves about how this call will now go (within the possible parameters you have)….again, this reinforces that no matter who they talk with, they will get consistent service. In the long run we can maintain rapport no matter what we ask….it's all in the wording/tone. Use this option if you have one low risk chat and need to attend a high risk or emergent chat.

If the shift is short on coverage, crisis line responders are permitted to answer both Crisis and ConnecTeen contacts. ConnecTeen crisis line responders under the age of 18 years are not allowed to answer crisis contacts but if a ConnecTeen crisis line responder over the age of 18 is available then they permitted to answer both Crisis and ConnecTeen contacts.

WHAT TO DO WHEN CHATS BREAK DOWN

THE "CHATTY CHAT"

- There is no focus. This usually can happen when the service user or crisis line responder is avoiding the discussion of issues feelings and "crisis" causing events are avoided.
- In order to end this type of chat, you need to be firm and polite. Suggest the service user take some time and think about what they need to do for themselves and say goodbye. For example:
    - *"We've talked for a while now, and it could be a good time to go and think about what we chatted about, as well as do some care for you. I am going to let you go now, feel free to chat again at another time. Goodbye."*
- Try this once or twice. If the user continues, repeat it once more. Be firm, say goodbye and end the chat. Reminder, you don't have to wait for the service users permission to end the chat. If you have gone through the Robert's Model, when through DCIB and Safety Planning Intervention as appropriate – It is okay to let the service user go.

THE "HELPLESS CHAT" ALSO KNOWN AS THE "YEAH BUTTERS."

- The service user's concerns are in-depth and seem to go on forever and they refuses to set priorities as to what is the main concern, or the serice user has a major concern, but does not want to do anything about it.

- If you have tried to get the service user to set priorities and they refuse to, end the chat by empowering them and allowing them to realize that they are able to decide what to do for themselves. For example:
    - *"We've talking about…x, y, z…for a while and it seems you have a lot to deal with right now. It could be helpful to take some time and decide which of your concerns is most important and needs your focus. Why not take some time to think about it and what you would like to see happen. For now, I am going to let you go, but feel free to chat again later. Goodbye."*

- If the service user service user to do anything about their concern after many attempts, end the chat by being firm and polite. For example:
    - *"We've talked about your concern in some detail. I get the feeling it may be useful to take time to think about what's bothering you most and what you can do. I am going to let you go now so you can do that. Feel free to chat again later. Goodbye."*

THE "NEVER ENDING" CHAT

- When it is time to end the chat, this service user may be hesitant to go or start talking about a new concern. You can end the chat by stating something such as:
    - *"We have talked about…x, y, z… and it looks like we were able to think of some things you can try out tonight. How about we take some time to it think over and give those ideas a try. It seems like you know best what you need, so I am going to let you go to get started. Feel free to chat again later. Goodbye."*

- If the service user starts talking about a new concern because you have been so helpful, try:
    - *"We have gone over…x, y, z… and have come up with some ideas for you to try out. That's a lot to think about. Maybe take some time to think about what we've discussed and see what happens. I get the feeling you know what you need to do to take care of yourself. Hope to chat with you again later. Goodbye."*
- It may seem that these methods of ending chats are harsh; however, it is important that we don't allow the service user to become dependent on the crisis line responder or the agency. Imagine what would happen if a service user was not able to speak to their favorite crisis line responder or spend hours on a chat - the service user is likely to become disappointed and discouraged. When a dependency builds, the service user denies responsibility for their own actions, growth does not occur and the service user's cycle of crisis continues. We need to empower and encourage the service user to do things on their own and make their own decisions.

INTERNET LINGO

- If there is an acronym a service users uses and responders are not sure the meaning of, responders are encouraged take a look at http://www.netlingo.com for the meaning.
- Responders are encrouaged to ask the service user what they think the lingo means as there are times different words mean different things to different people. This also gives the service user a chance to display their perspective/understanding of things and demonstrates that we are interested in hearing what they have to say.
- Here are some of the commonly used Internet Lingo shorthand terms. While some short-hand is acceptable, too much short-hand can be a distraction and can increase barriers for communication. When in doubt about an abbreviation or shorthand, don't hesitate to ask the 'service user' for additional information.

ABBREVIATION	DESCRIPTION
A/S/L	Age/Sex/Location

B/C	Because
BBL	Be back later
BF	Boyfriend
BFF	Best Friend Forever
BRB	Be right back
BTW	By the way
CU/CYA	See you/See ya
FML	F*** my life
FTW	For The Win -or- F*** The World
FYI	For your information
GF	Girlfriend
GN	Good-night
GTG	Got to go
HDYK	How do you know
HMW	Homework

IDK	I don’t know
JK	Just Kidding
L8R	Later
LMAO	Laughing my a** off
LOL	Laughing out loud
NP	No Problem
NVM	Nevermind
OMG	Oh my god
POS	Parent over shoulder
ROFL	Rolling on the floor laughing
STFU	Shut the F*** up
TMR	Tomorrow
TTYL	Talk to you later
TY	Thank You
WTF/WTH	What the F***/What the H***

HIGH RISK CHATS

When responders are chatting with a service user who responders suspect is at risk of hurting themselves or someone else, is involved in a domestic violence situation or a child is at risk, responders may try and encourage the service user to call the Crisis Line at 403.266.HELP (4357) or emergency services if the situation is defined as urgent or emergent as assessed within Distress Centre Procedural Directory. If the service user does not want to call the Crisis Line, we will not disengage the chat. Continue to assess the situation and if it is assessed as urgent or emergent within Distress Centre Procedural Directories, and the service user will not provide any information, the IP address will be provided to police. Please ensure that your CCC on shift has been flagged of the situation first thing and allow them to make the decision about whether or not a contact to the Crisis Lines is sufficient for the situation.

Note: if responders are currently on 2 crisis chats, and one becomes high risk, then the lower risk one needs to be wrapped up ASAP or passed off to another crisis line responder or CCC with the capacity to answer the chat.

PRANK CHATS ("GOTCHA," SEX-RELATED)

Responders should work with prank service users as they would with prank calls by simply stating "this behavior/language is not acceptable and if you don't stop, I will have to end this chat." (Refer to pre-set messages). If the behavior does not stop, end the chat.

RACISM/SEXISM/DISCRIMINATION

While we encourage open discussion and allow our youth service users to express their opinions, any opinions that directly attack a particular group of people will not be tolerated.

SERVICE USER DOES NOT TYPE ANYTHING FOR A WHILE

If the service user is logged in but has not engaged in the conversation please refer to the **2, 4, 6, Rule.**