Neshamos

NESHAMOS TRAINING

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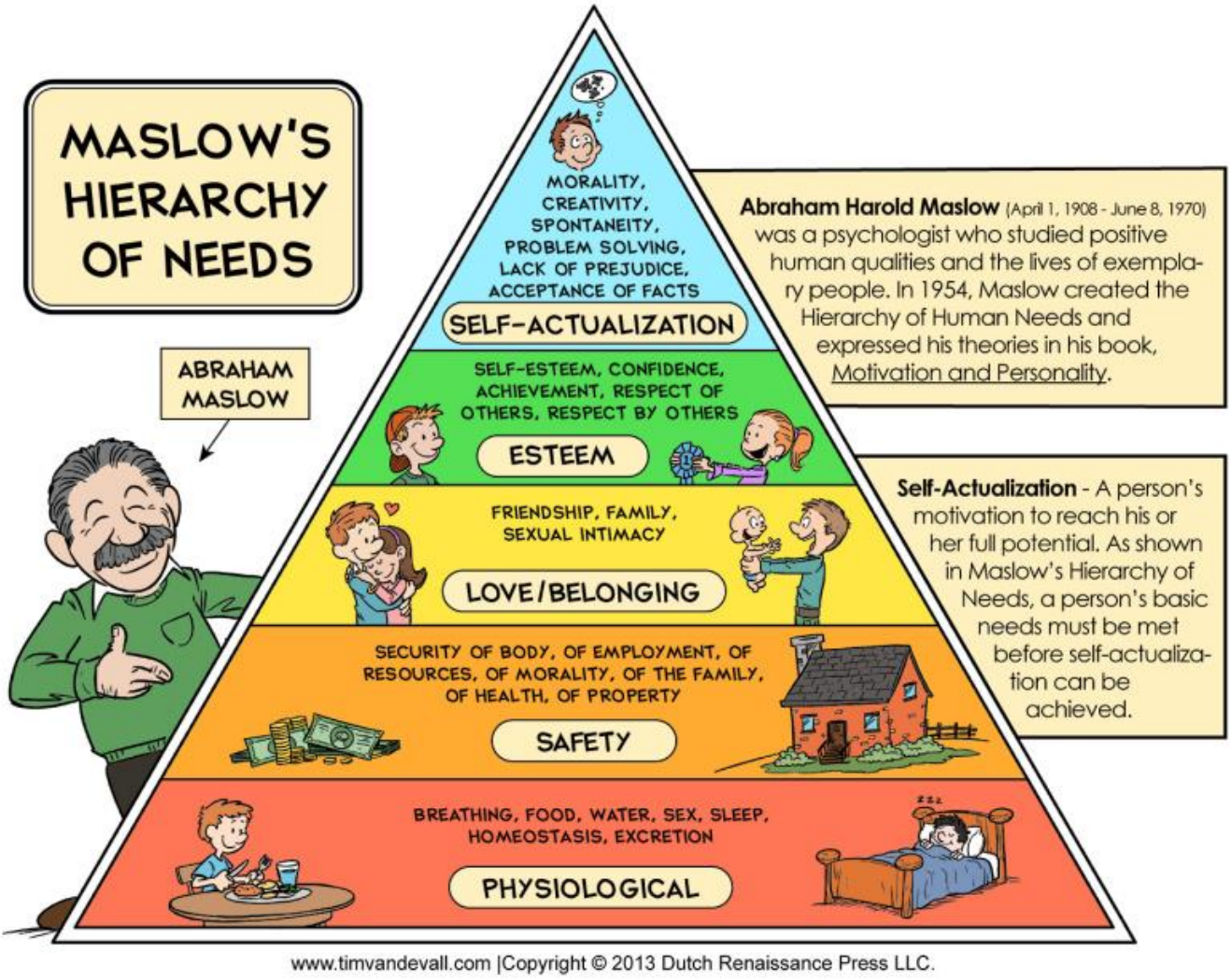
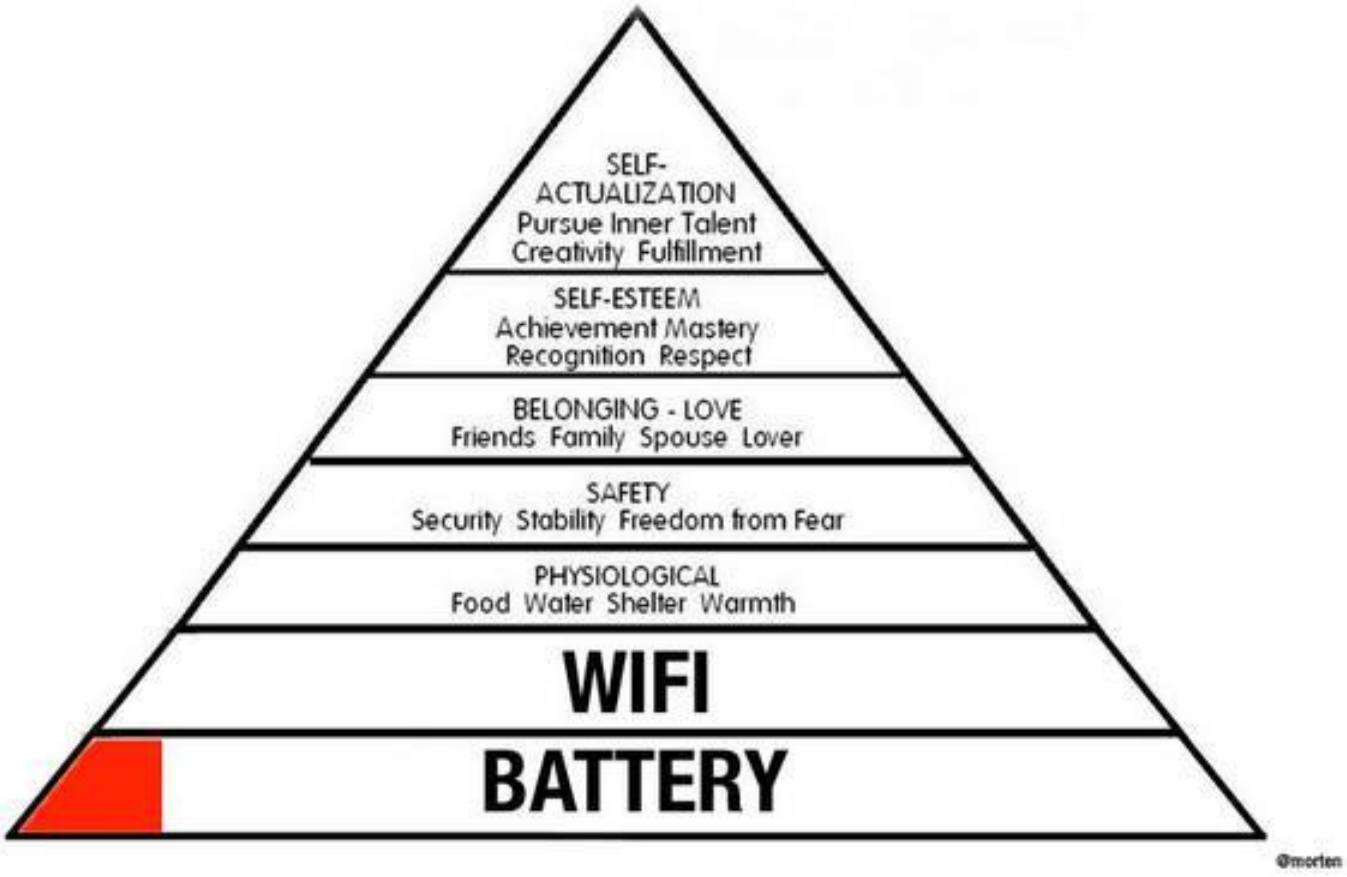
In Memory Of

Basha Liba A"H bas R' Avohom

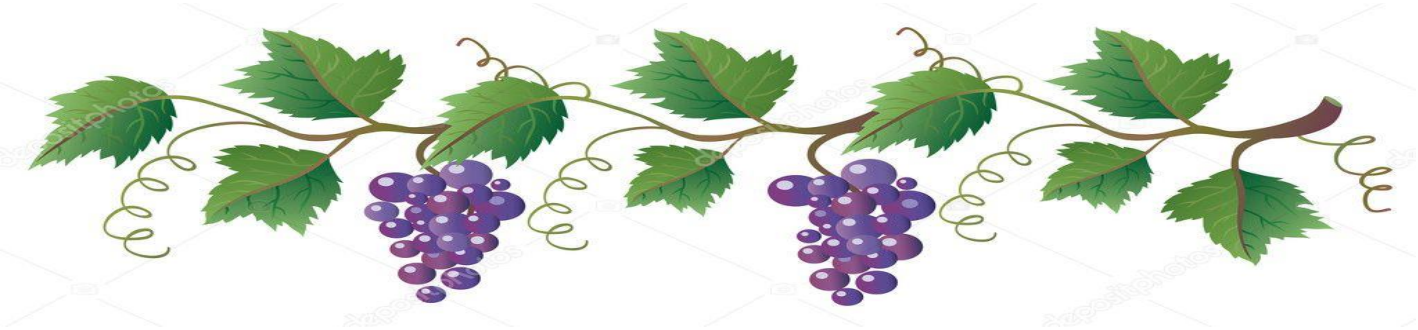
באשע ליבא ע"ה בת ר' אברהם

Her neshama should have an aliyah.




SELF-
ACTUALIZATION
Pursue Inner Talent
Creativity Fulfillment
SELF-ESTEEM
Achievement Mastery
Recognition Respect
BELONGING - LOVE
Friends Family Spouse Lover
SAFETY
Security Stability Freedom from Fear
PHYSIOLOGICAL
Food Water Shelter Warmth
WIFI
BATTERY
@morten

CONFIDENTIALITY



- *Confidentiality is at the core of emotional support. Creating a safe environment is key to helping callers discuss their situations openly.*
- *It's important to establish a very high degree of confidentiality or else callers will quickly lose trust in the referral line.*
- *Trust – sensitive, painful, delicate matters*
- *Grapevine*
    - *Word gets around*
    - *"It's a small world after all…"*
    - *Jew meets a Jew; within 3 minutes they're related*

Examples of violations of confidentiality:

- *Talking about callers to your friends or family*
- *Posting information about callers on social media*
- *Giving information to another agency without the callers' permission*

ANSWERING CALLS

If the caller is known to the volunteer, the volunteer should say before proceeding with the call:
"May I please connect you to one of my colleagues that can help you in this area?"
OR
"I realized that I know you and I want you to know that everything is confidential and even if I meet you somewhere, I will not ask you anything related to this call. However, if you are uncomfortable in any way, I can connect you to a colleague to continue with."

RETURNING CALLS

- Ask the caller the best method of contact
    - Home phone
    - Cell phone
    - Text message
- Ask the caller if it is okay to leave a voicemail

VOICEMAIL

- Assume it is okay to call callers back on the phone number they left on the voicemail

Person-First Language and Recovery

What can we do to end the stigma and discrimination against people with mental health disorders?

- **One, we need to educate ourselves.** By and large, people with mental health disorders are safe and not out to harm others. Those who are unsafe are almost always not in treatment. Often times they are not in treatment due to their shame. If the stigma and discrimination is eliminated, more people will seek treatment.

- **Two, mental health disorders do not discriminate.** They can and do cross all lines of socio-economic status, race, religion, age, gender, profession and all other categories...

- **Three, we must recognize that mental health disorders are medical diseases.** We would never fault one stricken with anemia, diabetes, or cancer. We would also never make disparaging remarks to or about them or their diseases. Mental health disorders are no different.

- **Four, we need to be mindful of the language we use.** People are not their illnesses and should not be addressed as such. He is not "agoraphobic," he experiences agoraphobia. She isn't "schizophrenic," she experiences schizophrenia. People do not belong to a group called "the mentally ill," they experience mental illness. We don't become "depressed" from losing an earring, the weather is not "bipolar" because it keeps changing and he isn't "psychotic" because he accidentally put his shirt on backwards. These terminologies amongst many others are descriptions of true to life disorders and symptoms that many with mental health disorders deal with. When we use them pejoratively, we minimize their experiences.

Placing the person at the center and above all other aspects of the treatment process is the foundation of The Recovery Model.

- The use of language is critical to ensuring a recovery-oriented and person-centered approach. It is important that people are seen first as people and not seen as their mental health condition. People are not cases or illnesses to be managed. When people are seen only as Schizophrenic, it often becomes too easy to focus on just reducing symptoms of psychosis. The problem is that there is so much more to getting better than just getting rid of the bad voices or other symptoms. Recovery involves increasing a person's ability to make the changes they want in their life - the power to get better, to identify their goals, to develop the ability to accomplish their goals, and provide the supports needed to attain their goals. **It means focusing on the person's strengths and the choices they want for their lives - not just their symptoms.**

- It is important to assess the way we use language and how the use of language reinforces negative biases or promotes empowerment and strengths. It is helpful to remember that people often identify by roles where they find meaning. **Strengths-based roles help us to feel better and promote recovery: "I am a father, a sister, an electrician, a friend."** Negative language reinforces discrimination and isolation in society. It is hurtful and detrimental to the recovery process to be called crazy, schizophrenic, wacko...

SPEAK TO THE PERSON FIRST

AND

THE DISABILITY SECOND.

WORDS TO AVOID

- ABNORMAL
- BRAIN DEAD
- CASE
- CRAZY
- DELUSIONAL
- DEMENTED
- DERANGED
- DISTURBED
- HAS ISSUES
- INSANE
- LUNATIC
- NUTS
- ODD
- OUT OF IT
- PSYCHO
- RETARDED
- SCREW LOOSE
- SICKO
- SLOW
- WACKO

STAGES OF A CALL

PREPARATION

- Be ready to talk to the caller when you answer the phone. Have pen/paper/computer available.

OPENING

- Greeting
- Identify yourself by first name and the organization.
- How may I help you? / Tell me about why you called today. / What happened to prompt your call?
- *Empathy. Establish trust. Engage in Active Listening*
- *Reflect, reflect, reflect. . . feelings or thoughts*

  Reflection

  - *You feel _____ because _____.*
  - *I hear you saying _____?*
  - *What you seem to be saying is _____?*
  - *I feel _____ as I hear you.*
- *Open-ended questions*
- *Attending behaviors: "Ear contact," "mmm'mm," "I hear you."*
- *"Take your time." Give permission to ventilate*
- *Silence can be a powerful form of active listening.*

CLARIFICATION OF SITUATION

- Break it into smaller pieces. Gather information.
- Tell me more about that…
- How do you feel about _____?
- I'm wondering if _____?
- I'm not sure I understand. Can you repeat that?
- How long have you been dealing with this?
- Assess the situation for risk, emergency, or danger.

RESOURCES

- What resources/treatment options have you tried thus far? Have they been effective in any way?
- What do you see as the next step for you?
- Do you have insurance? If so, which?
- Which location/s would you travel to?
- Do you have preference of the gender of the clinician? Age range? Personality type? Clinic or private?
- Any special considerations to factor in?

CLOSING

- I want to applaud your courage for calling and sharing with me.
- I have some ideas of resources for you; however, I would like to get back you once I have spent some time reviewing all the options to ensure that I am recommending the best possible resources for your needs.
- Please expect to hear from me within 48 hours. If you do not hear from me by then, or if the situation changes, please feel free to call again. Always try to give more than one referral, if appropriate. (REMEMBER MASLOW!!)
- Allow the caller to hang up first.

FOLLOW UP

- After 3 days call/text the callers (depending on their preferred method) and check in with the caller; any thoughts on what we spoke about? Do you think the referral I provided with is a good fit or would like me to provide you with different referrals?
- After 1-month call/text the callers (depending on their preferred method) and check in with the caller; how is it going with the referral I provided for you? Do we need to make any changes/additions? Then tell the caller that you would be happy to provide continued follow up and ask the caller if they would like subsequent follow up phone calls/text messages.

“HELPING VS. THERAPY”

Remember!!

Neshamos provides information, resources and referrals. It is not a crisis line or hotline.

Avoid providing therapeutic counsel or advice.

If appropriate, volunteers may offer a "suggestion” (not advice.) Advice is sometimes perceived as a very strong term... and can make the caller feel inferior...

STAGES IN THE COUNSELING RELATIONSHIP

STAGE I Establish rapport / Build a relationship

- Unconditional Positive Regard, Genuineness, Empathy
- Establish trust. Engage in Active Listening
- Reflect, reflect, reflect. . .feelings or thoughts
- Open-ended questions
- Attending behaviors: "Ear contact," "mmm'mm," "I hear you."
- Tracking - responding to what he or she has just said.
- "Take your time." Give permission to ventilate
- Silence can be a powerful form of active listening.

STAGE II Clarification / Define the Problem

- Who is this person? What has made this person call today?
- What is at the heart of the call/session?
- Break it into smaller pieces. Gather information.
- What does this problem mean to them?
- Reflect, reflect, reflect . . .
- Open-ended questions or closed-ended questions.
- Assess the situation for risk, emergency, or dan ger.
- Bring up a difficult subject.

STAGE III Explore Resources

- Prior strains? Available resources? Perception of the problem?
- What has this person tried before?
- What options does this person see?
- Who can they turn to for support or help?
- What special considerations need to be factored in?
- Facilitate their development of the solution or options.
- Refrain from giving advice! Let the caller do the work.

STAGE IV Plan of Action

- Pace the caller *and* yourself . . . "Rome wasn't built in a day."
- Break plan into manageable steps - Summarize. Anticipate problems

WHAT IS CRISIS?

We all experience a variety of stressful events in our lifetime. Each of us has unique ways of dealing with these events in order to maintain a comfortable emotional balance, and when the usual coping mechanisms fail, we seek new ways of coping. A crisis state comes into being when these new attempts fail to return us to the pre-crisis level of emotional balance.

Crisis is a state of feeling; an internal experience of confusion and anxiety to the degree that formerly successful coping mechanisms fail us and ineffective decisions and behaviors take their place. As a result, the person in crisis may feel confused, vulnerable, anxious, afraid, angry, guilty, hopeless and helpless.

Crisis is both a time of opportunity and danger. Crisis is useful when it causes one to go beyond familiar coping skills (both internal and external) and to develop new skills, therefore becoming more competent and autonomous. A crisis is dangerous when the person becomes overwhelmed with emotion and copes in negative ways.

Good mental health has been described as the result of a life history of successful crisis resolutions.

Development of a Crisis

1. A precipitating event such as a perceived loss or traumatic experience produces intense anxiety and dependence on problem-solving skills.

2. Usual coping skills fail; the problem is still present and anxiety increases. The individual must look outside himself for help.

3. External resources may fail to return the person to a comfortable emotional level. Anxiety continues to increase and the person may feel helpless. Perceptions are altered and the individual may think of nothing else but his situation.

4. All known internal and external resources fail; this tension and anxiety become unbearable. At this point something must change.

Possible Crisis Outcomes

A person cannot stay in crisis. The body cannot stand the physical and emotional strain indefinitely. Either the situation will change and the person will return to a pre-crisis state; the person will develop new coping skills and resources; or the person will avoid crisis by substance abuse, mental or physical illness, a suicide attempt, or other destructive behavior.

Types of Crisis

Developmental Crisis is a crisis resulting from a normal life change (i.e. puberty, leaving home, marriage, birth of children, retirement). These are changes that are normal parts of life and can only be successfully transitioned through as people learn to cope with their situation.

Situational Crisis is the result of the unexpected trauma such as losses, illness or displacement. Because of the unexpected shock, one typically experiences these events as more stressful.

At times these developmental or situational crises can occur simultaneously, and when that happens the crisis is usually more disruptive.

The Person in Crisis

There is not a clear-cut description of a person in crisis.
Below are some feelings commonly experienced by someone in crisis:

1. **Anxiety –** Any substantial threat produces anxiety that can be helpful in mobilizing us to defend ourselves against the threat through change, action, etc. However, too great an amount of anxiety can lead to confusion, poor judgment, immobilization, and self-defeating behavior.

2. **Helplessness –** Being faced with an external or internal situation that we are not prepared to face can leave one feeling vulnerable. Intense emotions may contribute to the experience of helplessness.

3. **Anger –** Anger may be directed at another person, an event, or at the self.

4. **Shame/guilt –** The person in crisis often feels incompetent and out of control. Individuals may experience feelings that are not acceptable or usual to them. The pain may be further complicated by being ashamed of their plight.

5. **Confusion –** Crisis may interfere with their ability to think straight, problem-solve, or event accurately perceive their experience. This distortion in itself may be frightening and the individuals in crisis may fear they are "losing their mind".

6. **Fear –** The fear may be of actual components and possible outcomes of the crisis situation, as well as of the powerful effects listed above.

CRISES & EMERGENCIES COMPARED

PSYCHOLOGICAL CRISES	PSYCHOLOGICAL EMERGENCIES
A crisis is a loss of psychological equilibrium.	Many emergencies can develop from or involve a crisis.
A crisis is longer lasting in duration than an emergency and does not include the risk of danger.	An emergency is an abrupt, sudden situation in which there is an imminent risk of harm.
In crisis, normal coping responses are insufficient to resolve the situation.	Emergencies can potentially result in harm to self or others in four possible ways:
Secondary attempts to cope are unsuccessful and the crisis is activated.	1. Risk of suicide
There is a marked increase in anxiety, tension, agitation, depression or a sense of defeat.	2. Risk of physical harm to another
Activities of daily living (eating, sleeping, grooming, daily habits, etc.) become impaired or are impossible to carry out.	3. Being in a state of seriously impaired judgment in which an individual is endangered (delirium, dementia, acute psychotic episode, severe dissociation, etc.)
A person cannot remain in crisis permanently.	4. Risk to a defenseless victim (such as a child or elder)
The goal of crisis intervention is brief or short-term counseling designed to stabilize and restore the individual's functioning at a normal and adaptive level as soon as possible.	The goal of emergency intervention is to remove lethality and reduce or eliminate danger.

STEPS TO TAKE DURING CRISIS OR EMERGENCY INTERVENTION

CRISIS INTERVENTION STEPS	EMERGENCY INTERVENTION STEPS
Crisis intervention done well may occur within the next 24 hours and over the next several weeks. Frequent use of Stage 1. Stay in Rapport Building for much of the call.	Emergencies demand an immediate, personal and flexible type of interview if a tragedy is to be averted. Go pretty quickly to Stage 4, Plan of Action after careful assessment.
1. Engage callers in telling their story. Use open-ended questions. Learn how and why things have built up.	1. Contain and define the emotional turmoil of callers. Use closed-ended questions, avoid reflection of feelings, and focus on facts.
2. Obtain an understanding of the meaning of the crisis for callers, prior attempts at coping, and availability of support systems	2. Determine the degree of risk:
3. Assess for the presence of a psychological emergency. If yes, suspend crisis intervention and conduct an emergency intervention.	a. Assess lethality: ask about it in a direct and straightforward manner.
If no psychological emergency is present, resume crisis intervention.	b. What is the level of intent? For example, on a 1-10 scale….?
4. Assess functional impairment (activities of daily living) and impulse control, ego strength, quality of relationships, etc.	c. What is the viability of the plan? For example, access to a method, etc.
5. Take a personal history. Has this ever happened before? How did you cope with this before? How do other earlier difficulties spill over into this one?	d. What is the likelihood that they will act impulsively? (fuse builds up, a prior history of explosive conduct, etc.)
6. Normalize that feelings are normal for an abnormal buildup of strain and stress. Focus on coping strategies, support systems, referrals, etc.	3. Direct them to appropriate care and treatment, such as inpatient or outpatient medical care. Resolve problem and allay crisis.

DEMOGRAPHIC INFORMATION AND COMMON PREDICTORS

FEATURES	MANIFESTATIONS	COMMENTS
Age	Suicide rises with age. For white males, the older he is, the more at risk he is.	White males over 65 have a suicide rate 4 times that of the national average.
Gender	More males complete suicide. More females attempt suicide.	Males choose more lethal means.
Ethnicity	More Caucasians complete suicide than persons of color.	Statistics show an increase in young African-American males, ages 15-24.
Loss	The more irrevocable the loss, the greater the risk.	Suicide is associated with an accumulation of losses throughout life.
Substance Abuse	Alcohol increases the risk of completed suicide.	Drug abuse is correlated with more attempts.
Mental illness	Prior psychiatric hospitalization increases level of risk.	It is estimated that 1/3 of all completed suicides have a diagnosable depressive illness.
Physical illness	Sudden onset of a serious illness or chronic conditions with poor prognosis and/or intense pain indicates greatly increased risk.	Illness generally places a strain on defenses and coping skills, thus increasing risk.
Downward economic mobility	Unemployment, frequent job changes, direction of reduced status or reduced earnings increases risk.	Consider how one's identity is impacted by these setbacks.
Living in the city center	Areas of high crime, alcoholism, mental illness, poverty, or family disorganization.	Urban conditions increase social isolation and alienation.
Relationship disruption	The more final the change, the greater the risk.	Marriage is protection for males. Women survive better without a mate than do men.
Previous attempts	Prior attempts are considered high risk.	The more lethal the earlier attempts, the greater the rate of subsequent completed suicide.
Family or close friends attempted or completed	Presence of loved ones with attempts or completions increases risk.	"Modeling" of behavior plants the seed that suicide is an accepted way of coping.
History of physical or sexual abuse	Themes of vulnerability, post-traumatic stress, etc., complicate coping.	History of abuse reduces chances for self-empathy
Absence of a support system	Lack of resources and social support is correlated with completed suicide.	Consider how capable he/she is of developing new resources

TEN BEHAVIOR WARNING SIGNS THAT SOMEONE MAY BE AT RISK FOR SUICIDE

FEATURES	MANIFESTATIONS	COMMENTS
Quiet, withdrawn, few friends	Often not recognized as significant because the person is not in obvious trouble.	Assess for social isolation.
Changes in behavior	Personality changes, e.g., from being friendly to withdrawn, from being quiet to being a disturbance.	Among adolescents, it's difficult to distinguish "typical" adolescent conduct from risk factor.
Increased failure or role strain	Role strain at school, work, home, with friends and with peers.	Youth often demonstrate role strain at school.
Recent family changes	Illness, job loss, increased consumption of alcohol, poor health.	Past history of prior strains is essential to understand current crisis.
Recent loss of a family member	Death, divorce, end of relationship, separation, someone leaving home, estrangement.	Examine what meaning does the loss have for them.
Despair and hopelessness	Note the manifestation of hopelessness in many forms – behavior, written, verbal.	Hopelessness is even more closely associated with suicide than with depression.
Symptomatic acts	Taking unnecessary risks, drinking and drugging, inappropriate aggression or submission, giving away possessions.	Examine what is a shift from behaviors, say, before things began to feel so bad.
Statements such as	"Life is not worth living." "I'm finished." "No one would care if I was gone." "I want to end it all."	Any statements like this are NOT attention-seeking but rather help-seeking. Treat very seriously.
Presence of a plan	Storing up medication, buying a gun, etc.	The presence of a means or recent attempts to secure a means should be regarded very seriously.
Negative or fearful thoughts	"I must be crazy." "It's the end of the road." "What's the point?"	Refusal of help should be treated seriously.

Watch for the three H's of suicidality:

Hopelessness - Utter despair and inability to see beyond the crisis.

Haplessness - Loss of enjoyment in previously pleasurable activities.

Helplessness - Inability to ask for or to receive help. A belief that nothing will help.

There is no "one type of suicidal person."

Often, a combination of variables may place a person at risk.

F.A.C.T.

Suicide Warning Signs

F for Feelings

- Hopelessness "It will never get any better." "There's nothing anyone can do."
- Fear of losing control, fear of going crazy, fear of harming oneself or others.
- Helplessness, a feeling that "no one cares," "everyone would be better off without me."
- Overwhelming guilt, shame, self-hatred
- Pervasive sadness

A for Actions or Events

- Drug or alcohol abuse
- Themes of death or destruction in talk or written materials (letters, notes)
- Nightmares
- Recent loss through death, divorce, end of relationship, separation, loss of job, money, status, pride, self-esteem.
- Loss of religious faith or spirituality
- Agitation, restlessness
- Aggression, recklessness

C for Change

- In personality - more withdrawn, tired, apathetic, indecisive or more boisterous, talkative, outgoing. Different temperament than usual.
- In thoughts - can't concentrate on schoolwork, routine tasks, etc.
- In sleep patterns - oversleeping, excessive sleeping, insomnia
- In eating habits - loss of appetite, weight gain/loss, overeating, change in eating rituals
- In activities - loss of interest in friends, hobbies, personal grooming, or other activities
- Sudden improvement after a period of being down or withdrawn, "too euphoric"

T for Threats

- Statements, e.g., "How long does it take to bleed to death?"
- Threats, e.g., "I won't be around much longer."
- Plans, e.g., putting affairs in order, giving away favorite things, obtaining a weapon.
- Gestures, or attempts, e.g., overdose, wrist cutting.

Of course, aside from the more overt gestures or threats, none of these signs are a definite indication that the person is going to attempt suicide. Many people are depressed and never end their lives by suicide. Many experience losses or evidence changes in behavior or demeanor with no indication of suicidal tendencies. However, if a number of these signs occur, they may be important clues that help is needed. Act immediately and get resources.

QUESTIONS FOR ASSESSING EMERGENCY VS. SUICIDAL RISK

What is emergency risk?	**What is suicidal risk?**
Emergency risk directly corresponds to warning signs. When you are assessing for emergency risk, you are examining the immediacy of the situation, or the potential that the caller/client will act on his or suicidal ideation or threat.	Suicidal risk suggests that there are some indications that the individual may have a possibility of a suicidal profile, based on history, family dynamics, demographic information, etc., but he or she is not actively suicidal with a plan or a method in place.
ASSESSING EMERGENCY RISK	ASSESSING SUICIDAL RISK
Do you have a plan to attempt suicide? • *Yes, I do… details are clear.*	Do you have a plan or a method/means? • *Not really, I haven't gotten that far.*
When were you planning to kill yourself? • *I'm gonna do it. Today, tomorrow, in the immediate future. I can't go on.*	When were you planning to kill yourself? • *I don't know; it's just something that I've thought about.*
Where would you do it? • *A specific site is mentioned.*	Where would you do it? • *No real particular idea.*
Where are the pills (gun, knife)? How many pills do you have? Gun loaded? • *The means is very readily available, I have the method ready.*	Have you ever tried to kill yourself before? • *If yes, the risk may increase, but without a plan or a means, the risk may not be considered an emergency.*
Have you ever tried to take your life before? When? What happened? • If yes, risk is heightened.	How do you feel about the fact that your first attempt did not result in a completed suicide? • *I am so relieved, or I got the help I needed or I'm a failure at everything… a "failed" attempt may have meaning one way or the other.*
What's happened in your life that makes you want to end everything? • *Look for a sudden and painful loss, or a loss on top of accumulated losses.*	What has happened in your life that makes you want to end everything? • *The reason may be more diffuse.*
Who have you talked with about wanting to end your life? • *Although suicides are not identical, many will have given signs to others of their intent.*	Who have you talked with about wanting to end your life? • *Be curious if he or she has been spreading warning signs to others.*
On a scale of 1-10, (1 being normally upbeat, 10 being extremely depressed or hopeless) how would you say you feel? • *Higher the number = greater the risk.*	On a scale of 1-10, (1 being normally upbeat, 10 being extremely depressed or hopeless) how would you say you feel? • *Lower the number = lower the risk.*
Do you know someone who has died by suicide? • *Increased exposure may increase risk.*	Do you know someone who has died by suicide? • *No one, really.*
Are you currently drinking alcohol or using drugs? • *Intoxication reduces inhibition and results in impaired judgment.*	What is your relationship with alcohol or drugs? • *Look at the possibility that alcohol or drugs may play a part in his or her life and/or risk.*

SUICIDE INTERVENTION

We need to assess whether the person is Low Risk, Medium Risk or High Risk.

Low Risk

When the suicidal person is low risk, your role should be to help with any practical referrals and building up their support network. For instance, someone who is having financial issues, referral to debt counselling would be helpful. Exploring the person's resources to see if there are those they can rely on who they may not be seeing will also be helpful.

Emotional support is most important at this stage so that the person feels comfortable expressing themselves without feeling judged or stigmatized.

Medium Risk

When the suicidal person is medium risk, it's important to work collaboratively. Getting the suicidal person to agree to more comprehensive support will be easier if they know that you care. Taking steps to reduce risk by encouraging the person to remove access to suicide methods is also important.

Ensure that you follow up with the person to make certain that they've taken advantage of the referrals. By checking in with them frequently and continuing to assess their suicide risk (even on a simple 1-10 scale) will help you tell if their suicidal risk is being reduced.

High Risk

When the suicidal person is high risk, it's important to take immediate steps to reduce that risk. You should be directive with the person, taking immediate steps to guarantee their safety. This will involve checking for suicide attempts in progress, referrals that you make with the suicidal person and possible hospitalization if they don't think they can remain safe throughout the night.

In order to assess for immediate risk, you should ask questions like, "Are you in danger?", "Have you taken anything tonight?", "Have you done anything tonight to hurt or kill yourself?" If the person admits that yes, they have, then it's important to get details and make the call to 911 if necessary.

If not, you should explore what they can do to ensure their safety. This may involve calling a crisis line if they don't feel safe, calling 911 or going to a hospital emergency room or staying with someone they can rely on to keep them safe.

MYTHS AND FACTS ABOUT SUICIDE

MYTH 1
A person who talks about trying suicide won't actually do it.
FACT 1
About 80% of persons who die by suicide express their intentions to one and often more than one person.

MYTH 2
Suicide usually occurs without warning.
FACT 2
A person planning suicide usually gives clues about his or her intentions, although in some cases, suicidal intent is carefully concealed.

MYTH 3
A suicidal person fully intends to die.
FACT 3
Most suicidal people feel ambivalent toward death and arrange an attempted suicide in the hope that someone will intervene.

MYTH 4
If a person attempts suicide once, he or she remains at constant risk for suicide throughout life.
FACT 4
Suicidal intentions are often limited to a specific period of time, especially if help is sought and received. Help can be effective.

MYTH 5
If a person shows improvement after a suicidal crisis, the risk has passed.
FACT 5
Most suicides occur within three months or so after the onset of improvement, when the person has the energy to act on intentions.

MYTH 6
Suicide occurs most often among the very rich and the very poor.
FACT 6
Suicide occurs in equal proportions among persons of all socioeconomic levels.

MYTH 7
Families can pass on a predisposition to suicidal behavior.
FACT 7
Suicide is not an inherited trait, but an individual characteristic resulting from a combination of variables. One variable may be that another family member has died by suicide.

Types of Mental Health Treatment Settings and Levels of Care

Treatment and care for mental health-related issues is provided in a variety of settings. The environment, and level or type of care, will depend on multiple factors: the nature and severity of the person's mental condition, their physical health and the type of treatment deemed necessary.

The three primary types of treatment settings for receiving mental health care or services are

1) hospital inpatient, 2) residential and 3) outpatient.

In addition, some mental health care services are delivered via online and telecommunications technologies.

Hospital inpatient settings involve an overnight or longer stay in a psychiatric hospital or psychiatric unit of a general hospital. The facility can be privately owned or public (government-operated). Inpatient hospitals provide treatment for more serious mental illness, usually for less than 30 days. A person admitted to an inpatient setting might be in the acute phase of a mental illness and need help around the clock. Typically, a person who requires long-term care would be transferred to another facility or a different setting within a psychiatric hospital after 30 days of inpatient treatment.

Psychiatric hospitals treat mental illnesses exclusively, although physicians are available to address medical conditions. A few psychiatric hospitals provide drug and alcohol detoxification as well as inpatient drug and alcohol rehabilitation services and provide longer stays. A psychiatric hospital might have specialty units for eating disorders, geriatric concerns, child and adolescent services, as well as substance abuse services.

General medical and surgical hospitals may have a psychiatric inpatient unit and/or a substance abuse unit. They provide medical services that would not be available in a free-standing psychiatric hospital.

Residential mental health treatment environments generally provide longer-term care for individuals. Most residential treatment settings provide medical care but are designed to be more comfortable and less like a hospital ward than inpatient hospitals. Examples:

Psychiatric residential centers are tailored to people with a chronic psychiatric disorder, such as schizophrenia or bipolar disorder, or who have co-occurring disorder, which impairs their ability to function independently.

Alcohol and drug rehabilitation facilities are inpatient centers that treat addictions and may provide detoxification services. Patients typically reside in this type of facility for 30 days but stays may be individualized according to each facility's policy.

Nursing homes have psychiatric consultation available as needed.

Partial hospitalization programs (PHPs), also called "day programs," refer to outpatient programs that patients attend for six or more hours a day, every day or most days of the week. These programs, which are less intensive than inpatient hospitalization, may focus on psychiatric illnesses and/or substance abuse. They will commonly offer group therapy, individual counseling and medication monitoring. A PHP may be part of a hospital's services or a freestanding facility.

Intensive outpatient programs (IOPs) are similar to PHPs, but are only attended for three to four hours and often meet during evening hours to accommodate persons who are working. Most IOPs focus on either substance abuse or mental health issues; though some accommodate co-occurring disorders. IOPs may be part of a hospital's services or freestanding facility.

Outpatient Clinics (OP) are settings where patients obtain therapy services once or twice per week. Depending on the particular clinic, individual therapy, group therapy and medication management may be available.

Practitioners in private practice (OP) Many individuals see a mental health professional in an individual or group private practice at the practitioner's office for mental health treatment. Appointments may be for individual, group or family therapy. Many practitioners accept insurance payments, but practitioners vary in which insurance plans they will accept; some practitioners accept only personal payment for services.

Telepsychiatry, Telemental Health Services (OP) refer to the remote delivery of psychiatric assessment and care, or psychological support and services, via telephone or the Internet using email, online chat or videoconferencing. Most commonly, these services improve access to care for individuals with mental health issues living in remote locations or underserved areas, or who cannot leave home due to illness, emergencies or mobility problems. They also allow clinicians to support their patients or clients between visits.

PSYCHOTHERAPY MODALITIES

ACT - Acceptance and Commitment Therapy – Dr. Steven Hayes

Acceptance and Commitment Therapy is a type of psychotherapy that helps clients accept the difficulties that come with life. ACT is a form of mindfulness-based therapy, theorizing that greater well-being can be attained by overcoming negative thoughts and feelings. Essentially, ACT looks at clients' character traits and behaviors to assist them in reducing avoidant coping styles. ACT also addresses commitment to making changes, and what to do about it when clients cannot stick to their goals.
ACT focuses on 3 areas:
Accept your reactions and be present
Choose a valued direction
Take action

CBT - Cognitive Behavioral Therapy – Aaron Beck, PhD

Cognitive Behavioral Therapy is a psychotherapy that treats problems by modifying dysfunctional emotions, behaviors and thoughts. CBT focuses on solutions, encouraging patients to challenge distorted cognitions, beliefs and perceptions and change destructive patterns of behavior, which leads to improvement in mood and functioning.

DBT - Dialectical Behavior Therapy – Marsha Linehan, PhD

Dialectical Behavior Therapy provides clients with therapeutic skills in four main areas. One, core mindfulness focuses on improving clients' abilities to be present in the current moment. Two, distress tolerance skills aim to increase clients' tolerance and acceptance of intense emotion, rather than trying to escape from it. Three, emotion regulation teaches techniques to manage and change intense emotions that are causing problems in clients' lives. Four, interpersonal effectiveness educates clients how to communicate with others in a way that is assertive, maintains self-respect and strengthens relationships.

EMDR – Eye Movement Desensitization and Reprocessing – Francine Shapiro, PhD

EMDR is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences. EMDR therapy is an eight-phase treatment. Eye movements (or other bilateral stimulation) are used during one part of the session. After clinicians determine which memory to target first, they ask the client to hold different aspects of that event or thought in mind and to use their eyes to track the therapist's hand as it moves back and forth across the client's field of vision. As this happens, for reasons believed by a Harvard researcher to be connected with the biological mechanisms involved in Rapid Eye Movement (REM) sleep, internal associations arise and the clients begin to process the memory and disturbing feelings. Unlike talk therapy, the insights clients gain in EMDR therapy result not so much from clinician interpretation, but from the client's own accelerated intellectual and emotional processes.

Exposure Therapy

Exposure therapy is a psychological treatment that was developed to help people confront their fears. When people are fearful of something, they tend to avoid the feared objects, activities or situations. Although this avoidance might help reduce feelings of fear in the short term, over the long term it can make the fear become even worse. In such situations, a psychologist might recommend a program of exposure therapy in order to help break the pattern of avoidance and fear. In this form of therapy, psychologists create a safe environment in which to "expose" individuals to the things they fear and

avoid. The exposure to the feared objects, activities or situations in a safe environment helps reduce fear and decrease avoidance.

IFS – Internal Family Systems – Richard Schwartz, PhD

Internal Family Systems combines systems thinking with the view that mind is made up of relatively discrete subpersonalities each with its own viewpoint and qualities. IFS use family systems theory to understand how these collections of subpersonalities are organized. IFS see consciousness as composed of three types of subpersonalities or parts: managers, exiles, and firefighters. Each individual part has its own perspective, interests, memories, and viewpoint. A core tenet of IFS is that every part has a positive intent for the person, even if its actions or effects are counterproductive or cause dysfunction. This means that there is never any reason to fight with, coerce, or try to eliminate a part; the IFS method promotes internal connection and harmony.

MBT – Mentalization Based Therapy – Peter Fonagy and Anthony Bateman

Mentalization based therapy is a specific type of psychodynamically oriented psychotherapy designed to help people differentiate and separate out their own thoughts and feelings from those around them. Mentalization is the capacity to understand both behavior and feelings and how they are associated with specific mental states, not just in themselves, but in others as well. In MBT, the concept of mentalization is emphasized, reinforced and practiced within a safe and supportive psychotherapy setting.

MBSR – Mindfulness-Based Stress Reduction – Jon Kabat-Zinn

Mindfulness-Based Stress Reduction is a program that incorporates mindfulness to assist people with pain and a range of conditions and life issues that were initially difficult to treat in a hospital setting. MBSR uses a combination of mindfulness meditation, body awareness and yoga to help people become more mindful.

MI - Motivational Interviewing – William R. Miller and Stephen Rollnick

Motivational Interviewing is a psychotherapeutic approach that helps clients resolve ambivalence and find the internal motivation they need to change their behavior and accomplish established goals. Motivational Interviewing is a practical, empathetic and short-term process that takes into consideration how difficult it is to make life changes.

Play Therapy

Play Therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development. More simply put, child play therapy is a way of being with the child that honors their unique developmental level and looks for ways of helping in the "language" of the child – play.

Positive Psychology – Dr. Martin Seligman

Positive Psychology is the scientific study of the strengths that enable clients to thrive. Positive Psychology suggests that clients want to lead meaningful and purposeful lives, and assists clients in cultivating their values and character strengths, maintaining balanced perspectives on life and enhancing their experiences. Clients will work on satisfying the unmet needs that precipitated their substance use, such as; building connections with others, developing hope and autonomy, gaining meaning from challenges, reducing suffering and learning to be a part of something greater than them. Ultimately, the clients' abstinence will become a by-product of living meaningful and purposeful lives.

PIT - Post Induction Therapy – Pia Mellody

Post Induction Therapy for Developmental Immaturity Treatment (formerly known as co-dependence) is a therapy modality designed to treat the effects of childhood trauma and resulting issues of developmental immaturity. The intervention strategies which compromise Post Induction Therapy originated as a result of experimental application of strategies developed to treat the effects of child hood trauma.

PE- Prolonged Exposure – Edna Foa, PhD

Prolonged exposure therapy is a form of behavior therapy and cognitive behavioral therapy designed to treat post-traumatic stress disorder, characterized by re-experiencing the traumatic event through remembering it and engaging with, rather than avoiding, reminders of the trauma (triggers). Sometimes, this technique is referred to as flooding.

Psychoanalysis – Sigmund Freud

Psychoanalysis is a system of psychological theory and therapy that aims to treat mental disorders by investigating the interaction of conscious and unconscious elements in the mind and bringing repressed fears and conflicts into the conscious mind by techniques such as dream interpretation and free association

Psycho-Education

Psycho-Education groups provide education and information to clients with the goal of the clients understanding and becoming accustomed to living with their Substance Use and Mental Health Disorders. Clients who have a thorough understanding of the challenges they face as well as knowledge of personal coping ability, internal and external resources and their own areas of strength are often better able to address difficulties, feel more in control of their condition(s) and have a greater internal capacity to work toward mental and emotional well-being.

Rational Emotive Behavior Therapy – Dr. Albert Ellis

REBT is an action-oriented approach to managing cognitive, emotional, and behavioral disturbances. According to REBT, it is largely our thinking about events that leads to emotional and behavioral upset. Although we all express ourselves differently, according to REBT, the beliefs that upset us are all variations of three common irrational beliefs. Each of the three common irrational beliefs contains a demand, either about ourselves, other people, or the world in general

Recovery Skills

Recovery Skills involves improvements in areas such as self-care, personal hygiene and nutrition that may have fallen to the wayside due to active Substance Use Disorders. Recovery Skills are important skills for clients to acquire over the course of recovery. Clients will learn the barriers to maintenance of these skills, the consequences of skills deficit, the benefits of these skills, as well as ways to implement and maintain the usage of these skills.

Relapse Prevention Skills

Relapse Prevention is a type of Psycho-Education that helps clients maintain abstinence and avoid relapsing. Goals of the Relapse Prevention group include teaching coping skills, educating clients on how to keep a 'lapse' from turning into a 'relapse' and to help clients feel in control of their behavior.

Schema Therapy - Jeffrey Young, PhD

In cognitive psychology, a schema is an organized pattern of thought and behavior. In schema therapy, schemas specifically refer to early maladaptive schemas, defined as "self-defeating life patterns of perception, emotion, and physical sensation". If a patient's basic emotional needs are not met in childhood, then schemas, coping styles, and modes can develop. Some basic needs that have been identified are: connection, mutuality, reciprocity, flow, and autonomy. The goal of schema therapy is to help patients meet their basic emotional needs by helping the patient learn how to: heal schemas by diminishing the intensity of emotional memories comprising the schema and the intensity of bodily sensations, and by changing the cognitive patterns connected to the schema and to replace maladaptive coping styles and responses with adaptive patterns of behavior.

Somatic Intervention – Ricki Bernstein, LMSW, SEP

Somatic, from the Latin word soma (=body), refers to something that is 'of the body'. Intervention means to come between, interrupt. An intervention is an action taken to improve a situation, to change its course. Somatic Intervention uses body awareness to accomplish this goal. Somatic Intervention is a technique which allows you to sense and interrupt habitual patterns (like anxiety, anger, stress or fear), discharge the bodily tension and associated memories, and move forward in a calmer and more centered way. Somatic Intervention reminds our body/brain of the non-verbal language that we stopped noticing once we began to focus on words. Noticing it now, in the present moment, generates a fine attunement, a sense of being truly seen, which can be deeply gratifying and healing. It is this attunement to the body that creates the opportunity for neuroplastic change, actually rewiring the brain.

EXPERIENTIAL THERAPIES

Art Therapy

Art Therapy is an expressive therapy that uses the creative process of making art to improve clients' mental and emotional well-being. Through creating art and reflecting on the art products and processes involved, clients develop and manage their thoughts, feelings and behaviors, reduce stress and improve self-esteem and awareness. The creation of art is often a nonverbal process, thereby expanding the ways clients can convey ideas and emotions and gives clients the opportunity to explore, understand and resolve issues in their lives that they may not feel comfortable expressing verbally.

Creative Writing

Creative Writing is a form of expressive therapy that uses the act of writing and processing the written word as therapy. Creative Writing has multiple benefits: catharsis, self-awareness, self-development, appreciation and insight, non-verbal self-expression and stress reduction. Creative Writing encompasses reading and writing poetry, letter writing, journal prompts and writing entries based on famous quotes.

DMT - Dance and Movement Therapy

Dance/movement therapy (DMT) is defined by the American Dance Therapy Association (ADTA) as the psychotherapeutic use of movement to promote emotional, social, cognitive and physical integration of the individual, for the purpose of improving health and well-being. It is a holistic approach to healing, based on the empirically supported assertion that mind, body, and spirit are inseparable and interconnected; changes in the body reflect changes in the mind and vice versa.

Life Skills

Life Skills teaches clients skills to manage and live enhanced lives. Oftentimes, clients who have diagnoses of Substance Use Disorders have forgotten how to manage their finances and clients may also have been jobless and/or homeless. In Life Skills, clients learn how to create and live by a budget in order to support themselves, maintain health and auto insurance, become more adept at purchasing food and auto care maintenance and gain employment readiness.

Music Therapy

Music Therapy provides avenues for communication that can be beneficial to clients who find it difficult to express themselves in words. Clients can interact with the music in different ways, such as listening to music, singing along with music, dancing to the beat, playing instruments, song writing and discussion of lyrics. Music can help reduce stress levels, encourage relaxation, improve concentration, serve as an emotional release, assist with spiritual progression, relieve a sense of boredom and feelings of depression and loneliness and provide pleasure and joy.

Process Group

Process Group enables clients to gain insight about themselves, others and the world around them. Through the group dynamic, clients foster hope and examine core issues that exacerbate their Substance Use Disorders. Clients bond with fellow clients who share similar experiences, develop their communication skills, and provide honest feedback to other group members.

Psychodrama – Dr. Jacob Moreno

Psychodrama is an action method, often used as a psychotherapy, in which clients use spontaneous dramatization, role playing, and dramatic self-presentation to investigate and gain insight into their lives. Psychodrama includes elements of theater, often conducted on a stage, or a space that serves as a stage area, where props can be used. A psychodrama therapy group, under the direction of a licensed Psychodramatist, reenacts real-life, past situations (or inner mental processes), acting them out in present time. Participants then have the opportunity to evaluate their behavior, reflect on how the past incident is getting played out in the present and more deeply understand particular situations in their lives. Psychodrama offers a creative way for an individual or group to explore and solve personal problems. It may be used in a variety of clinical and community-based settings; in which, other group members (audience) are invited to become therapeutic agents (stand-ins) to populate the scene of one client. Psychodrama is not a form of group therapy. It is individual psychotherapy executed within a group setting.

Sand Tray – Margaret Lowenfeld; Dora Kalff

Sand Tray therapy is a nonverbal, therapeutic intervention that makes use of a sandbox, toy figures, and sometimes water, to create scenes of miniature worlds that reflect a person's inner thoughts, struggles, and concerns. This form of play therapy is practiced along with talk therapy, using the sandbox and figures as communication tools. Sand Tray therapy is often used with those who have suffered some form of trauma, neglect, or abuse. Although sand tray is especially well suited for working with young children, who often cannot express their inner feelings in words, it is also a technique that is helpful for some teens and adults who are having trouble expressing themselves and who may have suffered some form of severe trauma.

Self-Defense

Self-Defense is a practical, empowering and energizing class that trains clients in safety strategies. Self-Defense classes teach awareness, boundary setting, assertiveness and communication, trusting instincts and physical techniques. Self-Defense training assists clients who have been physically and/or sexually abused in boosting their self-confidence and self-esteem. Clients who learn Self-Defense can be empowered to be in more control of their own lives and to protect themselves against further victimization.

Yoga

Yoga is a holistic health practice, which encompasses a variety of methods and tools to help reduce cravings for substances and maintain sobriety. Yoga is a cost-free outlet that can be utilized at all times to cope with triggers and life stressors. Yoga has many potential benefits, including gaining control of the body and mind, stress relief, increased energy and strength, self-reflection and self-awareness, enhanced self-confidence and improved self-image, better sleep, emotional healing and overall wellness.

LIST OF 12-STEP FELLOWSHIPS

- AA – Alcoholics Anonymous
- ACA – Adult Children of Alcoholics and Dysfunctional Families
- Al-Anon/Alateen, for friends and families of alcoholics
- CA – Cocaine Anonymous
- CLA – Clutterers Anonymous
- CMA – Crystal Meth Anonymous
- Co-Anon, for friends and family of addicts
- CoDA – Co-Dependents Anonymous, for people working to end patterns of dysfunctional relationships and develop functional and healthy relationships
- COSA – an auxiliary group of Sex Addicts Anonymous
- COSLAA – CoSex and Love Addicts Anonymous
- DA – Debtors Anonymous
- EA – Emotions Anonymous, for recovery from mental and emotional illness
- EDA – Eating Disorders Anonymous
- FA – Families Anonymous, for relatives and friends of addicts
- FA – Food Addicts in Recovery Anonymous
- FAA – Food Addicts Anonymous
- GA – Gamblers Anonymous
- Gam-Anon/Gam-A-Teen, for friends and family members of problem gamblers
- HA – Heroin Anonymous
- MA – Marijuana Anonymous
- NA – Narcotics Anonymous
- N/A – Neurotics Anonymous, for recovery from mental and emotional illness
- Nar-Anon, for friends and family members of addicts
- NicA – Nicotine Anonymous
- OA – Overeaters Anonymous
- OLGA – Online Gamers Anonymous
- PA – Pills Anonymous, for recovery from prescription pill addiction.
- PA- Porn Anonymous
- SA – Sexaholics Anonymous
- SA – Suicide Anonymous
- SAA – Sex Addicts Anonymous
- SCA – Sexual Compulsives Anonymous
- SIA – Survivors of Incest Anonymous
- SLAA – Sex and Love Addicts Anonymous
- SRA – Sexual Recovery Anonymous
- UA – Underearners Anonymous
- WA – Workaholics Anonymous

CALLER TRACKING FORM

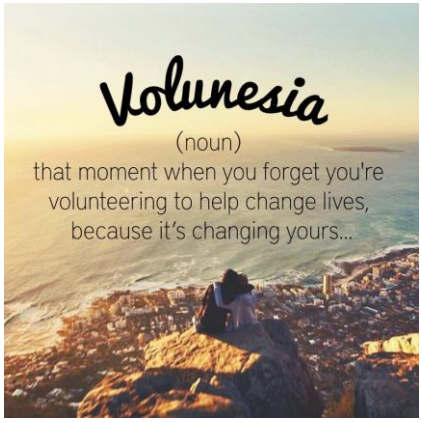
The Referral Tracking Form MUST be completed for each call.

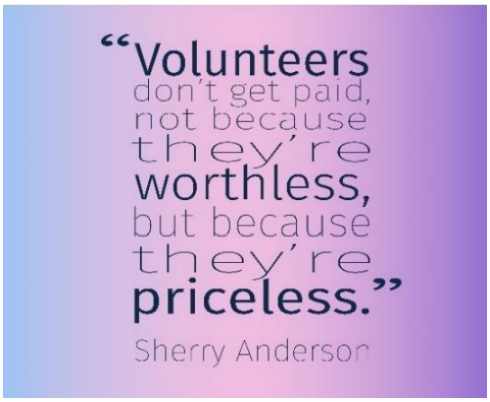
It is best to input the information while the call is taking place.

Keep the form up-to-date.

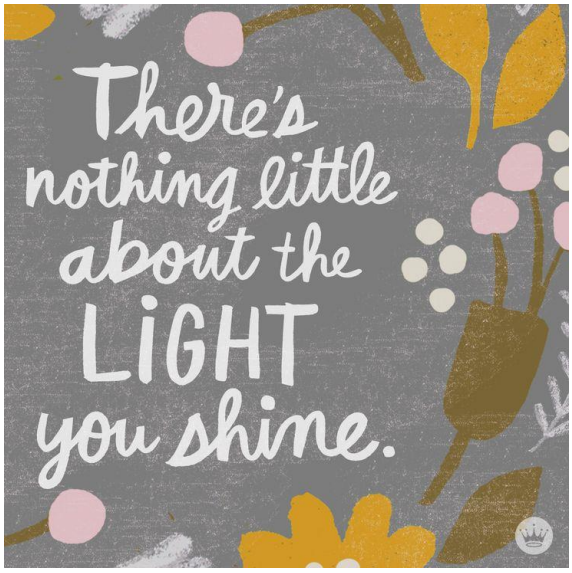
The form will be in Google Docs and all volunteers will have access to the form.

Chaviva will be reviewing the form.


Volunesia
(noun)
that moment when you forget you're volunteering to help change lives, because it's changing yours...

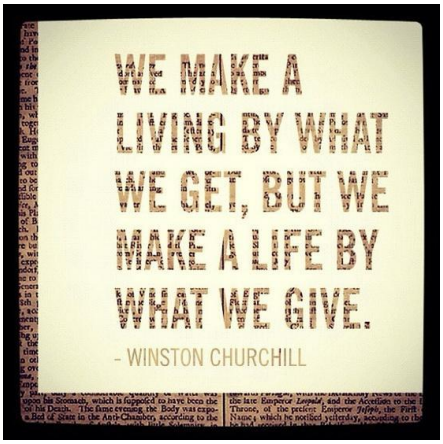

"Volunteers don't get paid, not because they're worthless, but because they're priceless."
Sherry Anderson


{NO ONE} can do everything but {EVERYONE} can do something
- unknown


There's nothing little about the LIGHT you shine.


"NO ACT OF KINDNESS, NO MATTER HOW SMALL, IS EVER WASTED."
-AESOP-


YOU ARE MAKING A DIFFERENCE
EVERY day.


WE MAKE A LIVING BY WHAT WE GET, BUT WE MAKE A LIFE BY WHAT WE GIVE.
- WINSTON CHURCHILL


GOOD VOLUNTEERS ARE LIKE STARS
YOU DON'T ALWAYS SEE THEM
BUT YOU KNOW THEY ARE ALWAYS THERE
vInspired.com


"There Is Nothing More Beautiful Than Someone Who Goes Out Of Their Way To Make Life Beautiful For Others."
The Fresh Quotes


Those who can,
DO
Those who can
do more,
VOLUNTEER
Anon
Lincolnshire Community and Voluntary Service
CVS


When you volunteer, you are not paid in money or recognition, you are paid in love. People may forget what you said, and people may forget what you did, but they will never forget how it made them feel.
WomenOnCall


YOUR GREATNESS
IS NOT WHAT YOU HAVE
IT'S WHAT YOU GIVE.