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North Central Mental Health Services

1998 Negley Awards

For Excellence In Risk Management

Suicide Prevention Services (SPS) is a 24 hour telephone response system for three hotlines: suicide prevention, senior information, and teen crisis. The phone lines are answered by volunteers who received 50 hours of training and have committed to serve for six hours a week for six months. Thirty percent of the volunteers continue their commitment after six months - some for several years. SPS is administered by two full-time employees of North Central Mental Health. Approximately 100 regular volunteers responded to over 17,000 calls in 1996.

The Problem

A five year summary of incoming calls to the three SPS hotlines revealed a ten percentage point volume increase per year. Categorizing the data into types of calls revealed that the increase was due to the same people calling more frequently each year. These frequent callers were establishing relationships with the volunteers; especially volunteers who signed up again and again. A case review of each frequent caller suggested they were not addressing their issues in the mental health agencies where they were in treatment. Instead, they were depending on SPS volunteers to calm their daily anxieties through increasing the frequency of their phone calls. For many callers, SPS had become a source of emotional support for their daily concerns. The same frequent callers represented 40% of all the incoming calls in the fifth year of our review.

The negative impact of these frequent callers was in two areas. (1) Volunteers reported they quit volunteering after their six month commitment because the frequent callers were so emotionally draining. The repetitive presentations and seeming unwillingness to change was "tiresome, futile, and unrewarding" to the volunteers. (2) Because the lines were often staffed by only one volunteer per shift, the actual time available to the community was consumed by frequent callers and decreasingly available, we feared, to persons who were higher risk for acting on suicidal impulses. To continue operating the way we had been could only increase time with well-known callers rarely in suicidal crisis and therefore decrease available time to potentially highly suicidal callers. Thereby, increasing liability.

Goals and Objectives

Our goal was to redirect the frequent callers to resources which would serve them with planned therapeutic intervention. If frequent calling could be reduced, the hotlines would remain open for crisis oriented calls. In order to achieve this goal, we identified several objectives: 1) define what constituted a

frequent caller; 2) identify the highest rate callers; engage those callers with their current or potential mental health resource in a meeting to establish mutual goals; 3) train the volunteers to adhere to individualized frequent caller protocols; and 4) monitor data for results.

Initial Modifications

Change had to occur in three arenas: 1) data collection; 2) volunteer training; and 3) engaging the frequent caller to change. We modified our call-logging system so that for every twenty-four hour period we could know how many times each frequent caller called. These twenty-four hour periods could then be tabulated to weekly and monthly totals.

Volunteers were introduced to the new plan through a special mailing from the SPS director asking them to consider two questions: 1) "When an individual cannot get through their activities of daily living (ADLs), day after day, without calling a suicide prevention service, are we really helping them? 2) How many calls or how much time will be sufficient to help them?" We pointed out how we were reinforcing maladaptive behaviors in many of the callers . We coupled increasing their awareness of the problem with creating a frequent caller notebook containing a page for each frequent caller with very specific, concrete instructions about how to respond to each caller. Rather than telling the volunteers to stop talking so much with frequent callers, we offered capsulated explanations for why each was calling and how we could be especially helpful if were all responding in the same way.

When we reported the weekly and monthly totals to the frequent callers, many were surprised that we kept track of their calls and others even suggested that the number was excessive and they would cut down. Engaging eight of the frequent callers in the plan was difficult due to confidentiality issues and not being able to contact those frequent callers who insisted on maintaining their firstname-only status. Because this was a major change for several callers and a few of the volunteers, the SPS Director (a Licensed Independent Social Worker) played the role of both limit-setter and clinical expert in order to reduce triangulation between callers, volunteers, and administration.

Implementation

The data collection system was eagerly adopted by the volunteers because we implemented a new data collection processes and reduced the number of forms from six to two (reducing paperwork was an effective motivator). We kept volunteers informed of the positive, therapeutic effect the protocols would have. This was a change from the usual notes which read "same old, same old..." when frequent callers called. These communications were via a newsletter, posters in the phone room, and tenaciously maintaining the Frequent Caller Protocol Book so the information was current. Engaging the frequent callers in the process required flexibility on the part of SPS administration. The SPS Director arranged meetings with North Central’s and other mental health center’s case managers to talk about their client-callers to SPS. In three out of four cases involving mental health case managers, it was the case manager who requested releases of information to talk with SPS. With the fourth case, SPS mailed a release to the caller first. In some instances, after establishing a baseline number, we set goals with frequent callers to try to reduce their calls from month to month.

Results

By remaining focused on the top twenty most frequent callers, and modifying our protocols routinely, we were able to reduce the number of calls. Change was slow due to the callers testing the volunteers’ ability to follow protocols, and due to a few volunteers who struggled with feeling like they were "giving up" on the

caller. In a 22 month period, the number of calls by frequent callers dropped from over 600 a month to 130 a month (78%). As we end our second year, of this program, we have been able to maintain the lower rate by identifying potential frequent callers and setting protocols early.

Improved Performance Areas

1. The phone line availability for potential suicidal callers has increased an average of 78 hours (10%) a month (based on ten minute average per call with frequent callers).
2. Volunteer satisfaction has been increased as evidenced by veteran volunteers reporting feeling more useful now rather than "same old, same old."
3. By reducing maladaptive behaviors (daily calling of hotline), we supported clinically progressive treatment interventions ("We agreed with your case manager that you need to attend the day time group to learn how to spend your time.")
4. Anecdotal reports from two other large community mental health centers in the county supported SPS being incorporated in clients' treatment plans - an improved perception by community agencies of Suicide Prevention Services.

Cost and Value

The success of SPS is dependent on volunteers - satisfied volunteers. By increasing their sense of providing a worthwhile service, several volunteers have renewed their six month commitments to staff the phones. We made decisions based on data and shared those data routinely. Coincidently, we incurred the expense of buying a computer, but streamlined several aspects of the operation by eliminating forms, paperwork, and rote work time. Demonstrating that we could exercise our clinical acumen and show results has brought us more to the attention of a nearby university which supplies a large volunteer pool. It takes on average $1 ,OOO.OO to train a volunteer, so every volunteer who renews a commitment is a cost savings of comparable value.

How implementation Barriers Were Overcome

Modifying volunteer beliefs that we "had to be there for everyone unconditionally" was a major barrier. We used basic psychosocial treatment planning, drawing from sound practice theory to support the need to alter our approach to frequent callers. Our approach was to design a program specifically to address frequent callers rather than build defenses against them. Once the callers began to respond, the process was self-fulfilling. For example, we sent one frequent caller a bar chart reflecting her decreasing calls each month. She then began to set her own goals for continued improvement. We modified the training program so all new volunteers learned about the dynamics of frequent callers before even starting on the line. By integrating our daily monitoring system with frequent caller identification standards, we designed protocols within the first month of identifying a frequent caller rather than waiting a longer period.

Evaluation

Suicide Prevention Services collects data routinely and compares it to previous months and years. Showing volunteers visual evidence of improvement is positive feedback. Our data show non-crisis calls decreased. We collect feedback from service providers about the frequent callers and these data show improvement in client ADLs. Evaluation will continue as we increase our streamlining of information collection, early identification, and selling protocols.

Summary

Customarily, reducing liability for suicide in mental health delivery systems, is addressed by having clearly written practice standards and monitoring activity to ensure these standards are maintained. Many behavioral health/recovery organizations operate on a 24 hour basis and have problems with frequent callers. Frequent calling ties up scarce resources and inhibits the availability and accessibility of service to those consumers truly in need. A program like the one described can increase suicide prevention availability.

Description of Center:

North Central Mental Health Services, Inc., is located in Franklin County, Columbus, Ohio. North Central's vision is to improve the quality of life for all persons we serve.

The agency first opened its doors in the fall of 1974 as a comprehensive mental health center. Since then programs and services have been added in response to carefully assessed needs. We currently operate numerous residential units, a day treatment facility, family care homes, four satellite offices, an urgent care service, the county suicide prevention services, plus a full range of outpatient and case management services for youth, adults and older adults. The agency employs 285 staff and averages over 13,450 consumer contacts per month. Approximately 600/c of the current caseload meets the State of Ohio definition of severe mentally disturbed adult (SMD) or severe emotionally disturbed youth (SED).

North Central Mental Health Services, Inc., is fully certified as a provider of services by the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS).

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