Project Warmline: Someone calls. Someone listens.

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Project Warmline: Someone calls. Someone listens.

In 2005 in partnership with David Romprey, an Oregon mental health advocate, Community Counseling Solutions, started what is referred to as a “warmline.” The service assists people across the country, but is primarily focused toward Oregon residents, who just need to talk to someone and someone to listen.

In the beginning, the David Romprey Oregon Warmline (Oregon Warmline) was staffed with two peer operators in rural Wheeler County answering calls 5 hours per week. Currently the Oregon Warmline provides more than 70 hours per week of free call-in service to callers and employment for approximately 30 peer phone operators across the state of Oregon.

Since its inception the Oregon Warmline has been funded by the state of Oregon, many of Oregon’s counties, and several of the nine Mental Health Organizations (MHO’s) in Oregon. The state of Oregon’s funding ends on December 31, 2012.

Other funding streams have not been consistent enough to ensure a sustained future for the Oregon Warmline’s basic 50 hour per week service (20 plus hours per week are funded through individual contracts with counties wanting more coverage than can be provided within the 50 hours).

Study Purpose:

The use of peer support programs is not a new idea to mental and behavioral health organizations. In fact, it is an accepted and respected piece of many integrated recovery models; however, many programs rely strongly on the use of anecdotal quotes and stories to gain financial support.

The purpose of this study is to provide a comprehensive report of the Oregon Warmline. The information collected will be used to help funders better accomplish their organization’s objectives through informed decision making.

The study will also illuminate the benefits for those who call in hoping to have someone listen during a time of need and for the operators who have found meaningful employment, as well as the thoughts, comments and reasons for funding the program from current decision makers. Operator #20—"I feel there are lots of people in pain, sad, and lonely. They just need someone to talk to. MHO#2—"I would expect to see less usage of higher cost care, i.e. emergency room services, jail, critical admission."
Methodology:

**Literature Review:**

There is a plethora of literature and articles on peer support programs and a large amount of research work concerning creating and funding such programs.

In the beginning the study team focused their review on small and large research projects that provided a wide range of knowledge and opinion of mental health and behavioral health. As lay people the team wanted to understand the depth and breadth of such studies and how they come about, what they dig into, and whether they were written for funders, founders, or program service providers, or for peers and social science professionals?

The articles, white papers, research studies and tool chests ranged in the number of pages from two pages to hundreds of pages. Sometimes one article led to several other works, or maybe a large paper covered several topics that were pertinent. Mostly the study team was looking for what was written, what issues were discussed, and what and who had success sustaining peer programs.

This work was conducted and discussed as the interviews were occurring. By doing so, the team learned to identify some shared phrases and jargon that were used by operators, directors and researchers alike leaving the team with the impression that operators and callers understood and used the same mental and behavioral health language as the professionals. *Operator #17—I was taught how to talk with people and be nonjudgmental and treat people with respect.*

The state’s MHO directors gave the study team the direction that they wanted more than another study made up of “a 60 page summary of interviews with callers that documented the reason the caller was calling in” (personal communication with MHO Director, February 2012). The team reviewed more than enough of those types of studies that asked the same questions only in a different way in each study. The study could not be based solely on caller and operator anecdotal accounts; there had to be quantitative and qualitative analysis as well as a literature review.

At times it was tedious work, daunting. There were mounds of paper stacks all tabbed with colored sticky notes. The review took place over the same three months as the interviews, work sessions, and meetings. Along with the study, the regular work of the Economic Development office had to continue. Business plans had to be reviewed, clients had to be interviewed, meetings had to be attended, note-taking commitments had to be met, out-of-town travel didn’t stop, and three other studies had to be continued.

The aforementioned comments are made, not in complaint, but to impress on the readers that the study team took this work to heart because of the sheer amount of literature; and as the literature review progressed it became more and more obvious to the team that this was serious, warranted work.
Interviews:

The study team interviewed many of the Oregon Warmline’s stakeholders: operators, callers and MHO staff; the Executive Director and the Business Operations Manager of Community Counseling Solutions; and the Manager of the Clackamas County’s Team Leader and the Coordinator for the Oregon Warmline.

The interviews took place over a three-month period. It was not easy to pin down interview times or locations with these groups. The professionals, operators and callers all have busy schedules, sometimes fluid and changing at a moment’s notice. In the end some of the caller interviews had to be abandoned for the sake of time. They were contacted a minimum of three times and then they were marked off the calls list as “cannot be reached, won’t take the call, or other.” For whatever reason, they were not interested or had changed their minds or their contact information. They could not be reached to be interviewed.

Overall, more than 40 people were interviewed. The study team leader interviewed the MHO directors or staff, and all other interviews were conducted by the project assistant to ensure consistency. The operator and caller interviews were recorded as well as transcribed. The MHO interviews were recorded via note taking. All the interview questions, thoughts, comments, and responses were transcribed into a data analysis program.

The study team did see the need to quote answers and comments from those who were interviewed. Highlighted throughout the study, these direct quotes are used to record the emotions and appreciation of those whom the Warmline touches directly. Directors were as passionate in their descriptions as were the operators and callers. It is important to note that even though anecdotal stories do not provide concrete data, they do emphasize the human need to be listened to. Caller #10—the warmline really helps when I am in crisis. It gives me someone to talk to until I can work through it.

Visits, Meetings and Work Sessions:

The study team attended the MHO Director’s monthly meeting in Salem in February 2012 to gain an insight into how the directors viewed the Oregon Warmline, how it was funded and to introduce ourselves to the directors. This meeting put names to faces.

The study team’s project assistant visited the Clackamas County call center in Oregon City. While stopped for gas, the assistant asked the service station attendant if he could direct her to the location—he had no knowledge of where the Mental Health Department was located.

The next morning, the assistant met with the Oregon Warmline project manager. The program manager does not have her office at this location, but met the assistant there. They met in the lunch/break room where there was a semblance of privacy. The program manager provided history of the Oregon Warmline and briefly explained current operations. The program manager is an Intentional Peer Support (IPS) Trainer and does the training not only for the Oregon Warmline but for
other groups and corporate organizations. The program manager expresses pride in being a former consumer and says that being an IPS trainer is her “Master’s degree in Street Life,” which she believes is competitive with medical degrees in the study of treating mental illness. She works closely with Community Counseling Solutions to manage the Oregon Warmline operations in Oregon. *(See IPS Defined below)*.

Following the interview with the program manager, the project assistant spent time with the Oregon Warmline Coordinator who also acts as the team leader to the more rural operations. She started as an operator and has recently been promoted to coordinator. She is learning to be an IPS trainer and works mainly with the Clackamas County Oregon Warmline staff as well as coordinating schedules for other operators around the state, such as in Wheeler County.

This set of meetings also included observing an Oregon Warmline operator and a team leader answering calls. The two operators worked in close proximity to each other in a two-person cubicle with one phone and one computer. As one answered a call and talked with a caller, the other entered data on the computer. The cubicle was stocked with supplies such as pens and paper, some resource materials and several notebooks.

As the operator answered a call, she began the conversation by gathering information as requested on the “call log.” Basic information was requested and the caller had the option of
giving accurate information or information that would protect his/her identity. It was noted, that some callers opt to give nicknames rather than their full name. Others refuse to answer some of the questions. Some question the necessity of the information. Others give all the information willingly. Caller #9—Operators are compassionate and friendly. Operator #13—I want to be real, open, honest period. The IPS model was an open training, not specifically for operators.

It seemed that the operator then began the conversation by asking how the caller “is today?” The caller then began to talk. The operator listened attentively and gave minimal responses. The operator was respectful and responsive to the caller’s situation. The team leader worked diligently at the computer entering data from call logs. The project assistant learned that some operators send their call logs to this office to be entered, while other locations enter their own call logs.

This office was in the process of moving to a drop-in center that is still located in Clackamas County, but in a more central location, close to stores and public transportation. The drop-in center houses several different service agencies that typically serve those with mental illness and addiction recovery. The Oregon Warmline staff was excited about the new location.

The team met with the Executive Director and Business Operations Manager for Community Counseling Solutions. This work session included the proposed budget for the Oregon Warmline for the next two years, other funding opportunities discovered over the course of the study, and possibilities for increasing prevention, outreach and education materials.

Two work sessions were conducted with the consultant who prepared the Cost Avoidance analysis. The consultant has expertise in Medicaid usage, cost avoidance, and research skills. The agenda for both meetings included an in-depth data review, study formatting and discussion to determine which literature to cite (See Review of Collected Data).

All other work was completed at the Grant County Economic Development Office in John Day, Oregon.
Intentional Peer Support Defined:

Intentional Peer Support (IPS) is a curriculum that is taught worldwide and was created by Shery Mead. Mead is an independent consultant and trainer working with peer support programs towards the development of strong theoretical, practice and research reflecting true peer support values. IPS is a way of thinking about and inviting powerfully transformative for co-creative relationships. It is a process where two people (or a group of people) use the relationship to look at things from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as we try new things.

As defined in the David Romprey Oregon Warmline brochure, IPS is centered on four consecutive tasks:

- **Connection** – Creating a connection in peer support isn’t always easy, but is possible.
- **World View** — Identifying and validating everyone for having their own world views and stories.
- **Mutuality** — Remaining mutual in our support to one another helps build trust in the relationship and allows the help to go both ways.
- **Moving Towards** — A new story or moving towards “something we want” instead of moving away from what “we don’t want.” Operator #16—we are not counselors, rather people who have like problems and similar life issues and experiences.

The four tasks are in a specific order so that when narrative disconnect happens, a person will know how to reconnect. To be used effectively, IPS requires a deep self-awareness of personal biases and assumptions. Through peer support services, relationships are offered that are respectful of personal experiences, ways of communicating, and “learned” personal stories. Peers challenge each other to both face and move beyond these stories and patterns.

In an email, David Romprey Oregon Warmline Program Manager and IPS Trainer, described Intentional Peer Support in this way: *IPS is different from traditional service relationships because:*

- It doesn’t start with the assumption of “a problem.” Instead, we learn to listen for how and why each of us has learned to make sense of our experiences—and then use the relationship to create new ways of seeing, thinking, and doing.
- IPS promotes a “trauma-informed” way of relating—instead of asking “what’s wrong?” we learn to ask “what happened?”
- IPS looks beyond the mere notion of individual responsibility for change and examines our lives in the context of mutually accountable relationships and communities.
- IPS relationships are viewed as partnerships that invite and inspire both parties to learn and grow—rather than as one person needing to “help” another.
- Instead of focusing on what we need to stop or avoid doing, we find encouragement to increasingly live and move into what and where we want to be.
- At the end of the day, it is really about building stronger, healthier, interconnected communities.

Peer support programs are grounded in the knowledge that crisis can be transforming, that mutually supportive relationships
provide necessary connection, and that new contexts offer new ways of thinking about one’s experience. Rather than objectifying and naming the crisis experience (e.g. “you’re getting sick again”), a peer builds a relationship offering a mutual respect and an opportunity of new ways of thinking, doing, and living become possible. Having the situation “shared” rather than “handled” offers an opportunity for community growth (Mead, 2003).

Shery Mead states, “It is no small feat for peer programs to develop this level of critical self-awareness. We are asking people to act in ways that are not instinctual and we are operating on a level of discomfort that shakes our very realities. It is here however, in community, that narrative becomes transformed.

This means an entirely new interpretive framework for our construction of crisis/problem and our construction of help. In other words, we begin to understand change and learning not as an individual process, but rather one where we continuously construct knowledge from actions and reactions, conversations and the on-going building of consensus ... rather than thinking about personal symptom reduction we are talking about real social change” (Mead, 2003).

To qualify for the position of a Warmline Operator with Community Counseling Solutions, the Intentional Peer Support must be completed successfully.
**Review of collected data:**

Data reports and articles provided by David Romprey Oregon Warmline, as well as information from their website, [http://www.communitycounselingsolutions.org/warmline.html](http://www.communitycounselingsolutions.org/warmline.html), were utilized to structure the cost avoidance comparison.

Material was prepared and organized in a Word document, with charts and graphs from excel and word.

The research protocol consisted of a literature review on cost avoidance values by conducting a literature search to identify articles published with economic evaluations on state of Oregon costs, and national costs of hospitalizations due to mental health concerns, and individuals incarcerated due to mental health and/or substance abuse issues.

Any cost-benefit analysis must have estimates of the costs. Sometimes the costs of a program are straightforward, but other times they are very difficult to estimate. For the David Romprey Oregon Warmline the cost estimates are fairly straightforward. Calculations were formed by multiplying the number of calls logged by the average cost of a call. Measurements were formed and data analyzed by comparing the calculation result to the literature search results on the economic evaluations identified above.

A Review of Literature: What has previously been written?

Warmline, Inc., *a Description of Services, Milwaukee, WI*

One of the newest and pertinent pieces of literature reviewed was a study completed by the Planning Council for Health and Human Services, Inc. (Planning Council), Milwaukee, Wisconsin, “Warmline, Inc.: A Description of Services, Caller Voices and Community Perspectives.” The study was funded through a grant from the Faye McBeath Foundation. Warmline, Inc., contracted with the Planning Council to evaluate and document their services.

Since opening in 2000, Warmline, Inc. has answered more than 50,000 calls and trained some 110 volunteers. Unlike the David Romprey Oregon Warmline, it is not staffed by paid employees, but by volunteers. Some of Warmline, Inc.’s operators are peer support specialists. Warmline Inc. is only open during the hours between 7:00 pm and 11:00 pm for approximately 20-30 hours per week depending on the time of year. It only operates five days a week in the summer.

Warmline, Inc. budget is approximately $20,000 per year. The David Romprey Oregon Warmline budget is approximately $225,000 which provides funding for approximately 50 hours per week year round; however, the 50 hours does not include the other hours funded through individual county contracts for extra hours (Larson, Malcolm, & Tikkanen, 2010).

At times during the ten years of operation Warmline, Inc., has not been able to pay their Executive Director and the other two paid staffers. All of the employees are people with mental illness. The Milwaukee County Behavioral Health Division provides office space and phone lines for the organization. Although it does not mention the David Romprey Oregon Warmline, the following is an excerpt from the study that gives a good summary of warmline models nationwide:

*Some states have fairly established warmlines, either through a single statewide line or through a consortium of regional lines. For example, Maine has a toll-free, statewide warmline that has been around by a nonprofit corporation since 2005. It is accessible to all Maine residents and is open every day from 5:00 PM to 8:00 AM. An alternative statewide model has been established in Connecticut, which supports 12 regional warmlines funded (at least in part) by the state’s Department of Mental Health and Addiction Services. Most of the Connecticut lines are open every day of the year, and several have their own toll-free numbers. However, each regional line is operated by a separate agency, with unique operating hours and approaches. In contrast to these statewide examples, Wisconsin residents have more limited access to warmline services. While there are a small number of other communities in the state that do have Warmlines, some are not specifically designed for supportive listening (e.g., COPE Services in Ozaukee County, which provides emotional support, crisis intervention, and information and referral services), and others have very limited hours (Warm Line of Washington County, which is open only two nights per week).*
or improve their program would be well served to review the study and adapt its suggestions. Since it was an ongoing project that allowed for adjustment and change as the study was being completed, it did improve the overall data gathering process for the people in Milwaukee’s program. Caller #2—The Warmline in California is not open on the weekends so I call Oregon’s Warmline.

Implementing Behavioral Intervention Components in a Cost-Effective Manner: An Analysis of the Incredible Years Program, February 7, 2005; Running Head: Cost Effectiveness of the Incredible Years Program.

For time and space sake, the above-noted study will be referred to as: Intervention Components instead of its full title. It may seem odd that the study team included this document in the literature review but Intervention Components supported the understanding of cost comparison and cost avoidance as well as providing a different way of looking at costs versus benefits of a program.

Intervention Components gave a thorough description of Cost effectiveness analysis (CEA) which “does not assign monetary costs to all benefits; program costs are assigned monetary values while program benefits are valued in non-monetary units” (Olchowski & Foster, 2005).

While written primarily for treatments and intervention programs targeted at young children with Conduct Disorder, Intervention Components suggest that cost comparison or cost avoidance is not the only thing to consider when judging the effectiveness of a program.

The CEA methodology presented in this paper allows health decision makers to examine a treatment’s effectiveness according to a specific type of outcome. If health decision makers are most interested in a particular result, they can perform CEA to gain insight into treatment effectiveness for the primary outcome of interest. For example, if an agency considers parent skills training to be the most important proximal outcome, and child skills training is distal to parent change, decision makers are able to perform CEA analyses using parent behavior outcome data (i.e. parenting style or parent discipline data). Therefore, CEA analysis aids decision makers not only in choosing a treatment that maximizes gains while minimizing
costs, but in choosing a treatment that maximizes specifically desired gains while minimizing costs. Despite its versatility and utility, however, CEA alone will not provide health decision makers with a fool-proof method of determining the “best” program to implement with their target population (Barry & Huskamp, 2005).

• Could CEA help determine the cost effectiveness of the Oregon Warmline?

This question will have to be pondered by the funders and decision makers, but it is an interesting methodology with some possible merit, especially when developing ways and means to appreciate a program’s advantages compared to the cost of other treatments, i.e. hospitalization or incarceration. In the above excerpt from Intervention Components, the language could just as well read:

If an agency considers fewer trips to the emergency room to be the most important proximal outcome, and learning to call the Oregon Warmline is distal to the caller’s overall health, decision makers are able to perform CEA analyses using emergency room admittance data for that particular caller, if the caller would allow the organization to track such data. Therefore, CEA analysis aids decision makers not only in choosing a treatment that maximizes gains while minimizing costs, but choosing a treatment that maximizes specifically desired gains while minimizing costs.

When interviewed, all of the MHO Directors or staff acknowledge that peer support programs such as the Oregon Warmline are a beneficial and an intricate piece of the recovery process for people with mental illness or substance abuse addictions; therefore, it was surmised that there is an expected outcome and, therefore, CEA could be used to clarify that outcome’s financial worth to the system through the CEA methodology. MHO#3—I am a firm believer that peer support is absolute piece of the process.

Moving beyond the Parity—Mental Health and Addiction Care under the ACA, by Colleen L. Barry, Ph.D., & Haiden A. Huskamp, Ph.D., September 15, 2011

Barry and Huskamp hold that the Affordable Care Act (ACA) will have a profound effect on how to finance and deliver mental health and addiction care in the United States. They vigorously describe ACA’s ability to change the delivery system for mental health and addiction disorders, making it possible, they say, for more than 3.7 million people to have coverage for mental health and addiction treatment. Barry and Huskamp make the claim that ACA could improve the system’s ability to integrate primary care and behavioral health deliver to people with mental illness and addiction disorders. Furthermore, they state, the way the system operates now it is very expensive to provide consistent, overlapping care for individuals in this particular group.
They propose that cuts will be made by states to direct-service funding and to safety-net providers (non-Medicaid) for behavioral health services because of deals made during the debt-ceiling bill passage last fall and that evidence-based services and supported employment will be even more financially threatened. Barry and Huskamp insist that these services “can improve the well-being of people with more severe disorders,” and that it will be important to sustain funding for these programs through other sources. MHO# 3--it is important to the bigger economic picture as well, but the important issue is keeping people out of hospitals and the higher cost services: Keeping them healthy, longer.

This article led the way to in-depth discussion about using different avenues of funding for the Oregon Warmline. These questions were asked:

- Could the Oregon Warmline play a bigger role in the economic situation of Oregon’s rural areas, particularly?
- By employing more people who normally have a hard time finding employment could the Oregon Warmline financially support stand-alone call centers?
- Could the Oregon Warmline be used as the delivery system for preventive, outreach and education materials?

These questions are addressed in Exhibit C: Expanding the Oregon Warmline.

Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems, 2010.

The National Association of Counties prepared the above study through a grant provided by the Bureau of Justice Assistance, part of the larger Office of Justice Programs. It also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention and the Office of Victims of Crime. The study was written by Maeghan Gilmore and Mary-Kathleen Guerra. NACo calls itself “The Voice of America’s Counties” and represents and promotes important issues for the more than 3000 counties across America (2010).

Gilmore and Guerra report that more than fifteen percent of the men and thirty-one percent of the women in jail have mental illness. The study’s focus was to highlight counties nationwide who provide crisis care services that help to prevent unnecessary arrest and opportunities for diversion. They conclude that by doing so, county governments can more effectively provide better care and serve their communities more positively as well as save money, resources and time.

One guiding attribute of each of these counties was the leadership recognized in their administrators and commissioners to understand and support the difference realized...
by addressing this issue. Also the authors recognized a strong partnership between local governments and law enforcement to implement such programs. MHO#7—Fewer visits to the emergency room; lower of rates to harm to self or others; lower utilizations of state hospital beds, that’s what I want to see.

The research includes a substantial amount of documented interviews and observations of programs in the identified counties. Through this methodology the writers prepared a thorough examination of the crisis service programs that each of the counties supports, the cost of the programs and the need for more community based services instead of spending more on incarceration of individuals with mental illness.

The study team cited this piece of literature because it noted that on every count it was far less expensive to recognize the need and implement a service for people in crisis than to incarcerate them, better for the overall good of the community, and consistently saving resources as well as personnel costs. While the study doesn’t address the strengths of a community Oregon Warmline program, it supported the idea that across the country, treating mental illness with traditional, costly treatments does not have to continue and positive changes and programs are being implemented similar to the Oregon Warmline.

There seems to be an outcry for change to happen and for peer and community support programs and services to be funded in a more sustainable way since it is proven over and over again that these programs work, not only for the individual, but for the mental health care system and funders.

Forced Treatment Doesn’t Work, 2012

Joseph A Rogers, Executive Director of the National Mental Health Consumers’ Self-Help Clearinghouse wrote an article and posted it to the Clearinghouse’s website on January, 6, 2012, as to the terrible side effects of forced treatment. He states that:

*Studies have shown that what works is not force but access to effective services. We don’t need to change the laws to make it easier to lock people up; existing laws provide for that when warranted. Instead, we need to create and fund effective community-based mental health services and supports that would make it attractive for people to come in and receive care, and that would support them in their recovery. We also need to end the discrimination that discourages people from seeking help* (Rogers, 2012).

In the article Rogers labeled himself as having a psychiatric diagnosis and that coercive treatment forces people not to seek treatment at all. He says that just because we have laws that force people in to jail or incarceration doesn’t mean that people don’t want help. His
feeling is that most of the time people seek help and want help long before such they get involved in the legal system. Operator #8—be respected, listen to, and validation.

Rogers is not a mental health professional, but a consumer such as those who use the Oregon Warmline. His platform is in support of services and programs that keep people safe without the involvement of law enforcement and before the situation reaches an emergency level.

While short, the article reinforces the necessity for community and peer support intervention and prevention programs. The research team was impressed with Rogers’ direct approach and the lack of portrayal of being the victim. It was apparent that he had personal experience but also that he had been involved in the discussion behind such concerns. The team quoted this article because it was from a consumer of mental health services (other than those in the study’s interviewees) in a perceived position that warrants respect, and because of the touching style in which it was written.

It brought to life the realities of people who are using the Oregon Warmline and to those millions of people that have no one to talk to. As the study team moved through the literature, often one or more of us would mention that this or that article would be a great resource for someone working in the mental health or behavioral health field. It was with this effort that the team continued to review the literature, trying to give a glimmer as to the amount and range of the literature about such issues.


The Pillars of Peer Support report is a summary of the Pillars of Peer Support Summit in Atlanta, Georgia in 2009. It was a gathering for and about states that were providing formal training and certification for peer support specialists who were working in mental health programs and were funded through Medicaid reimbursement. Oregon was one of those states in 2009.

The Pillars of Peer Support report gives an overview of peer support program literature from President Carter’s Commission on Mental Health in 1978 to literature available in 2009. According to the literature review, in 1978, almost 35 years ago, Carter’s Commission recommended that community support programs be recognized as an important piece of the process of providing overall mental health care.
The report quotes from the Commission’s report:

*A major effort must be developed in the area of personal and community support which will recognize and strengthen the natural networks to which people belong and depend.*

The report continues with this thought:

*This first President’s Commission on Mental Health provided groundbreaking attention and insight into the problems that people face in dealing with mental illnesses and the challenges and limitations that the systems of care encounter in providing care.*

The report documents the process of certification for peer support services to be billed under Medicaid; however, treatment had to be supervised by a qualified mental health professional and provided in mental health centers, inpatient and outpatient settings, emergency rooms, and crisis centers. According to what the state of Oregon reported in the report’s survey question, “Approximately how many consumers are employed as peer specialists in your state?” Oregon had approximately 150 Certified Peer Specialists whose work was being billed for under Medicaid in 2009 (*Daniels, Grant, Filson, et al., 2010*).

Under the survey results for the question, “What is your state’s Medicaid reimbursement rate for peer support?” Oregon did not report a pay rate. Oregon also reported that there was no minimum number of training hours, but there was a requirement to complete a module-based training. Whether Oregon had a certification process for Certified Peer Specialists in 2009 is not documented in the report since states were not identified when answering the question, “Does your state have a certification process?”

The report’s survey also listed barriers and concerns of using Certified Peer Specialists. Findings included the following: the acceptance of Certified Peer Specialists at mental health centers, financial issues; for the Certified Peer Specialists centered their concerns about the following: loss of disability benefits, afraid to ask for help, fear of job loss, burn out and turn over.
The state representatives to the summit developed these 25 steps to improve peer specialist programs. The study team identified several that are similar to the characteristics of the Oregon Warmline. They appear in boldface in the below list:

1. Clear Job & Service Descriptions
2. Job-Related Competencies
3. Skills-Based Recovery and Whole Health Training Programs
4. Competencies-Based Testing Process
5. Employment-Related Certification
6. Ongoing Continuing Education
7. Professional Advancement Opportunities
8. Expanded Employment Opportunities
9. Strong Consumer Movement
10. Unifying Symbols and Celebrations
11. Networking and Information Exchange
12. Media and Technology Access
13. Program Support Team
14. Research and Evaluation Component
15. Peer Workforce Development
16. Comprehensive Stakeholders Training Program
17. Consumer-Run Organization
18. Multiple Training Sessions
19. Train-the-Trainer Program
20. Sustainable Funding
21. Multi-Level Support
22. Peer Specialist Code of Ethics/Code of Conduct
23. Culturally Diverse Peer Workforce
24. Competency-Based Training for Supervisors
25. Peer Support Whole Health Services

Further recommendations from this study were tools such as prototype letters to state directors addressing the benefits of peer support programs. These letters also identified a paradigm shift in delivering mental health services through Medicaid and Medicare programs. When asked, “What do you think are the strengths, unique qualities or innovations of your program?” Oregon’s response described well-developed peer support and peer-directed programs and job opportunities for peer support specialists. However, when asked about funding sources, Oregon said that funding is an issue for such programs in Oregon and that states should be open to alternative funding sources.
The Interviews: Who Said What

**MHO Organizations:**
The interviews took place from March 1 through June 9, 2012. To best identify what information and data the decision makers might need to make the best decisions for their organizations as well as the Oregon Warmline, the interview process started with the MHO staff, primarily directors. Four questions were asked of the MHO staff. The study team contacted 12 different staff, and was able to interview seven. There were no “yes-no” or multiple questions asked of this group. They were the starting block for the study. The following are the questions they were asked:

**Question #1:** What outcomes would you expect to see as a result of funding the Warmline?

43% of the interviewees answered that they would like to see fewer visits to emergency rooms and less use of crisis services. 28% wanted to see more collaboration and continuity between their organization and the Warmline. 14% wanted to know that the service was being used.

**Question #2:** Do you consider peer support an important part of an integrated mental health coordinated care system?

100% said, “Absolutely!” They all consider peer support a fundamental part of the integrated mental health. Not one of them said, “Maybe.”

**Question #3:** Is cost avoidance a factor you consider when providing funding to a program?

86% said yes, but not the biggest factor. In addition, they all answered that it was important to keep consumers in their own environment as much for mental health as for primary care. 86% were hopeful that the new coordinated care in Oregon would bring good changes to the system.

**Question #4:** Is job creation a factor you consider when providing funding to a program?

72% answered, “Yes.” One said that it is very important in rural Oregon where even one job can make a difference to a rural community’s economy. One said that keeping people out of the hospital is the more important aspect. One answered that employment was secondary to keeping people out of the hospital.

Overall the MHO staff agreed that peer support services were an important piece of the mental health system and that having employment could help in the recovery process. Keeping people out of the emergency room and other more expensive services was high on their lists of outcomes they would like to see from the Warmline data. They wanted data to be more accessible and compared to other treatment options in the terms of costs.

**Warmline Operators:**
The Warmline Operators were the biggest interview group with 24 respondents. They were the easiest to contact and most willing to answer the questions. Each received a $25.00 VISA card for their commitment to the process. They took time from their own schedules and returned calls in a judicious manner. They were asked thirty-one questions. Seven questions were graphed. The other remaining questions were open-ended and were recorded as answered.

Sixteen operators answered that they have worked for the Warmline for 2 years or more. Eight interviewees answered that they had worked for the Warmline less than a year (Exhibit F). When asked how long the operators work for the Warmline on average, the Manager and the Coordinator answered “around two years.”
The following questions were graphed and can be found in Exhibit F: Interviews, Section Operators.

**Question #7:** Are you provided ongoing training opportunities? 50% answered, “Yes.” 41.7% answered, “Not sure.”

**Question #8:** Has being involved with the Warmline helped you make changes to your life? 87.5% answered, “Yes.” 12.5% answered, “No.”

**Question #10:** Do you feel your work as a Warmline Operator/Teamleader has made a meaningful contribution to the lives and recovery of others? 91.7% answered, “Yes.” 8.3% answered, “No.”

**Question #12:** In your opinion, do you consider peer support an important part of mental health care? 100% answered, “Yes.”

**Question #19:** Is there a time limit on a call? 25% answered, “Yes.” 45.8% answered, “Yes, but unenforced.” 29.2% answered, “No.”

**Question #20:** Is there a limit on how many times a day a caller may call? 8.3% answered, “Yes.” 8.3% answered, “Yes, but unenforced.” 83.3% answered, “No.” The manager and the coordinator answered this question by saying, “We have an imaginary 20 minute limit, but it is at the discretion of the operator,” and “Yes and no. We try to set for 20 minutes.”

**Question #24:** Do you feel the method to document calls is effective or could it be improved? 75% answered, “Yes.” 25% answered, “No.”

The red circles in the map below highlight Warmline Operator work locations in Oregon as noted in the operator interviews.
Warmline Manager and Coordinator:
The Warmline Manager and Coordinator were interviewed in face-to-face interview settings. They were asked the same 16 questions. Some of the questions were purposely related to questions that the Warmline operators were asked in relationship to training, call limits, and number of times a caller can call in during one day’s time, what changes have you seen in operators since being employed by the Warmline, and average time of employment for operators in months and years.

All of the questions for the Manager and the Coordinator were open-ended. As with the operators and the MHO staff members, the Manager and the Coordinator were asked the question: Do you consider peer support an important part of an integrated mental health coordinated care system? Both answered, “Yes.”

Callers:
Forty callers signed up to be interviewed. In the end, only 11 actually were interviewed. During the month of February operators asked callers if they would consider being interviewed for a study that was being conducted about the Warmline. If they said, “yes,” their name and telephone number was added to the interview list. As calls were being scheduled, more and more of the callers declined to be interviewed. Ten of the phone numbers given were not working by the time the caller was contacted to be interviewed.

The research assistant surmised that some of the callers did not want their identity known since they had to give their name and mailing address to accept the $25.00 VISA card stipend. Unfortunately, there was no other way to get the stipend to them because many of them do not drive or did not have a way to get the card picked up for them. There was no centralized pick-up location since they were located all over the state and several were located in California.

Six of the 17 questions the callers were asked were open-ended. The graphed questions can be found in Exhibit F: Section Callers. Six of the eleven callers said they called the Warmline daily. One said he/she learned about the Warmline via printed material or advertising. Of the other callers, 5 said they learned about the Warmline from friends and 5 said they learned of the Warmline by referral.

When asked how many times they called in the last six months, 10 of them said they called in more than 3 times in that period. Six said they were satisfied with the access time and 7 of the callers rated the hours of operation high. Six rated the availability of the Warmline as a 4 with 5 being the highest value. All 11 answered that the Warmline is a valuable service. Caller #7—you can trust in their confidentiality. It is a peer to peer conversation with someone who has faced similar challenges. They have been in the same boat and want to help you keep your boat afloat.
Asked if anything could be improved, two said that the hours and staff needed to be increased; one wanted improvement in the music which plays while someone is on hold; one said, “Nothing;” and one wanted the hours of operation to be 24/7.

Asked what services the callers would use if the Warmline was not available, 8 of the 11 said they would access a Crisis Line. Two said they would access an emergency room and 7 said, “Other.”

Callers answered positively when asked how they would describe the service to a friend whom they felt might benefit from using the Warmline. Comments such as, “good people, can trust them, and friendly,” were used to describe the Warmline operators. Operator #13—I feel more confident—and have sense of value and look forward and through helping people. You usually find out what you need for yourself.

Transcripts of the interviews can be found in Exhibit F.

Discussion:

From the literature review to the interviews to the cost avoidance data collected, themes and similarities kept surfacing and re-surfacing into the study team’s discussion. The literature review provided broad coverage of information that attested to the need and value of peer support programs when providing mental and behavioral health care, and especially when providing a coordinated care approach for the whole health and wellbeing of an individual. As with the literature review the interview process from all four study groups confirmed their support for peer support programs. From MHO staff to the callers themselves they undeniably attested to the benefits for peer support programs. They were adamantly vocal as to their support. All of the MHO’s—Absolutely!

The literature wholeheartedly supports funding such programs, but as with all unfunded services, the authors thought that funding can be difficult to access and illusive for those wanting to finance peer support programs.

During the interviews the MHO staff were asked what they expected as a result of funding the Warmline, and they answered: 1) they wanted to know that it was being used, 2) that data was being collected and that the data would be compiled in an organized format and shared on a regular basis, 3) that the program helped keep the callers from using other high-cost alternative treatments, and 4) that the operators were provided the opportunity to have gainful employment and not expected to volunteer their time. None of them responded that they would not fund the program.

The cost avoidance analysis shows that the cost of funding the Warmline is far less expensive than the cost of hospitalization or incarceration or other similar emergency treatments under the traditional health model. Beyond the momentary cost savings of the Warmline, the whole wellbeing of the individual is also addressed as a benefit.

Between January 1, 2010 and December 31, 2011 more than 103,000 calls were logged by the 800 number telephone tracking system that provides service for the Warmline. In 2010, the total number of calls to the Warmline was 45,485 and in 2011 the total number of calls was 57,763. Of these 103,248 calls, only 19,599 calls connected to Warmline peer operators.
The other 80,000 + calls were either dropped, received the busy tone, or were missed in some other way, i.e. the caller had dialed the wrong number, or etc.

The real point is that more than 80,000 calls were lost which could mean that 80,000 callers did not receive the help they needed when they called in to the toll-free service. The cost avoidance analysis is based on data from the Warmline that was charted over the course of 2010 and 2011 on the 19,599 calls that were connected to Warmline operators.

The cost avoidance analysis provides sufficient evidence that one could use the same theory and methodology to quantify the cost savings, if applied to the 80,000 missed calls.

In addition to the three objectives, the study team provided a list of other funding opportunities that Community Counseling Solutions and decision makers can benefit from reviewing, and a Program Evaluation Toolkit that can be used for evaluating the program (See Exhibits D and G, respectfully). Along with the Business Plan (Exhibit B), an accompanying document was provided to outline what an expanded Warmline might look like (See Exhibit: C). In this model, instead of helping other states to develop a warmlines, call centers are created throughout Oregon that could take calls from people across the nation. The David Romprey Oregon Warmline would become the David Romprey National Warmline with enough lines to handle thousands of calls every day and employ hundreds of Oregonians, primarily in rural Oregon.

The Cost Avoidance Analysis can be found in Exhibit A and the Business Plan for the Warmline is Exhibit B. These two pieces of the study are meant to be used as stand-alone documents. The Business Plan can aid in the organization’s own evaluation and development of the David Romprey Oregon Warmline program.

Because only one caller referenced printed materials as a source for learning about the Warmline, the strategies and materials for prevention, outreach and education materials will benefit not only the Warmline but also Community Counseling Solutions and the funders. Included in this section are ideas and quasi-marketing tactics that will help to spread the word about the Warmline via a more uniform model of distribution, expanding on the current methods of referral and finding out from a “friend.”

Overall the study produced documents and tools that can be used separately or as a synopsis of the David Romprey Oregon Warmline. While by no means complete, the study covered issues and concerns originated by the MHO staff. Through research and discussion with stakeholders it is apparent that peer to peer conversations and support are recognized as a valuable tool to decrease the usage of crisis lines, emergency services, and hospitalization while empowering individuals to move toward recovery.
**Recommendations:**

Based on the study’s discussion, three recommendations are advanced to promote the David Romprey Oregon Warmline and could help support future expansion or improvement activities.

1) As the new model for Oregon and the nation’s health care systems are developed, further research could be conducted as to the possibility of becoming the national warmline center provider, looking not only at state but also national funding sources for job development, peer support program expansion, and mental and behavioral health initiatives targeting specific groups of individuals facing challenges. A similar goal is stated in CCS’s current mission and statement and strategic objectives.

2) To better facilitate consistent and reliable data, further research could be completed as to the possibility for investing in a data analysis software program, such as SharePoint or another existing program that is generally accepted and used by mental health professionals. By doing so, operators and staff could be confident that the data entered is increasing the credibility of the compiled information to funders and decision makers. While the current system works, an industry-recognized program would allow the manager, team leaders and coordinator to generate meaningful reports immediately without having to wait for data to be entered into the main system. It would allow for data entry in real time as the call is being answered. The program could be customized for the Warmline’s specific needs.

3) To expand funding opportunities further, research could be conducted as to the viability of working with other demographic groups such as Veterans and youth who are struggling with drug and alcohol abuse or homelessness. For example, if there was an 800 number created specifically targeting youth between the ages of 12 and 18, then funding could be sought from organizations that support healthy teen development. This could be an opportunity to provide prevention, outreach and education through the Warmline for mental health programs and services. This type of outreach might prevent a young person from entering the mental health and addiction care system as an adult. It might keep a returning Veteran off the streets and in appropriate housing.

*Operator # 17—while listening to a caller my PTSD was triggered and I used all the training and skills I had learned to get through the call. Talking and listening helps them.*
References


