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# National Alliance on Mental Illness (NAMI) New Orleans Helpline Analysis

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NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) NEW ORLEANS  
HELPLINE ANALYSIS

A Thesis

Submitted to the Graduate Faculty of the  
Louisiana State University and  
Agricultural and Mechanical College  
in partial fulfillment of the  
requirements for the degree of  
Master of Social Work

in

The School of Social Work

by

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M.A., University of New Orleans, 2002  
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I dedicate this thesis to my son, Foster, whom I miss every day and know that he is with me through every challenge I encounter. He taught me much about courage, bravery, persistence, social justice, and determination in the face of adversity and inspired me to pursue this dream.

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## ABSTRACT

This study built on prior research about helplines that focused on descriptive accounts of caller profiles (frequent callers, children callers, male/female, reason for calls, help seeking intentions/beliefs, attitudes and expectations of callers); counselor profiles (active listening skills, motivation, empathy, altruism, family peer advocates); and helpline profiles (advantages and limitations of telephone, chat rooms, emails, and texting). The intention of this study was to assess the needs of the organization in order to build a helpline that meets the needs of the clients. It assessed existing data from calls made to the National Alliance on Mental Illness (NAMI) New Orleans where staff members handle approximately 1000 calls and emails yearly from individuals with mental illness, their families, or loved ones. For six weeks during the fall of 2015, NAMI staff logged incoming calls to their *de facto* helpline and the existing data was analyzed. Emails and Facebook queries to the agency were also included in the analysis.

Findings indicate that most people called to have someone listen to their concerns and provide support. In terms of type of callers, most callers were family members of persons living with mental illness. Individuals living with mental illness were the second most frequent type of caller. Family members called more frequently than other types of callers and women called three times more than men. The support provided to callers was mainly referrals to NAMI New Orleans support and/or education groups and then to outside agencies. Those who referred callers to NAMI were principally from the internal (support groups) and external (media) realms of NAMI New Orleans, although it was often not known who referred the calls. The duration of calls and the types of referrals

made varied greatly by the responders, or those who logged the calls, however, the mean call duration of 8.9 minutes was close to the industry standard.

Implications for practice and policy are discussed showing suggestions for ways to work with family members in order to accommodate their need for support; for providing volunteer recruitment, orientation, and training; and for creating a call-response decision tree.

## CHAPTER 1: INTRODUCTION

### National Alliance on Mental Illness (NAMI) New Orleans Helpline Analysis

The New Orleans office of the National Alliance on Mental Illness (NAMI) has been an affiliate of the NAMI National Office since 1979. It offers education, support, services and advocacy for individuals with mental illness and their loved ones who, over the past few years, have made more frequent and complicated calls and requests for services, support, and information regarding a number of unmet needs: e.g., how to deal with a non-compliant, mentally ill family member; where to find affordable, appropriate housing; and where to receive free counseling.

In response to the increase in queries, NAMI New Orleans is now in the process of creating its first organized telephone helpline to meet the needs of callers who are often unable to connect with critical services. Up to now, these calls have been handled on a more or less ad hoc basis by available staff, in the absence of a formally organized helpline. This *de facto* helpline uses the agency's main telephone lines, answered by staff, to address callers' mental health concerns. NAMI New Orleans is now systematically recording all requests made by phone, email, and Facebook. This study will use administrative data to create caller profiles for planning purposes for the NAMI helpline and look at queries sent to the agency via email and Facebook. It will identify caller demographics, roles, reasons for calling, referrals made, and organizations making referrals to NAMI.

This study builds on prior research about helplines that focused on descriptive accounts of caller profiles (frequent callers, children callers, male/female, reason for calls, help seeking intentions/beliefs, as well as attitudes and expectations of callers).

Much of this prior research has presented various aspects regarding counselor profiles (adversarial growth impact, active listening skills, family peer advocate, motivation, and empathy). It also discussed several types and attributes of helpline profiles (advantages and limitations of telephone, online chats, or texting services, cost-effectiveness, anonymity, and non-stigmatizing nature). The purpose of the present study is to document caller profiles, requests for mental health-related services, and counselor attributes in order to better understand local service needs and identify needed services.

## **CHAPTER 2: LITERATURE REVIEW**

This literature review concerns the various types and aspects of telephone and internet helplines, the profiles of their counselors, and profiles of their callers. After reviewing prior research, it presents a history of the National Alliance on Mental Illness (NAMI) New Orleans, what they are attempting to do, and the nine research questions guiding this study.

### **Telephone Helpline Profiles**

Since inception in the 1950s, the telephone helpline has been defined as a form of communication to assist those searching for support or information. This service technology has spread across the world and provided services such as mental and emotional support, links to practical resources, interactive support, advice and information for all age groups on a wide range of subjects or specific issues (e.g., gambling, domestic violence, and homework), and a focus on broad populations or narrowly defined ones, such as children or parents, as well as frequent callers (Bassilios, Gunn, Middleton, & Pirkis, 2014; Fukkink & Hermanns, 2009; Gohr et al., 2008). Helplines are anonymous, convenient, and cost-effective (usually free), emotionally safe, non-stigmatizing, non-threatening, and immediately accessible (when available); additionally, they are user-friendly, with the caller feeling in control, free to talk, and able to end the discussion (hang up) at any time (Bassilios et al., 2014; Brossart, Conoley, & Reese, 2006; Christogiorgos et al., 2010; Fukkink & Hermanns, 2009; Gohr et al., 2008).

Telephone helplines, hotlines, warm lines, crisis lines were the main focus of this research, however, those considered counseling lines were not. Hotlines are considered closer to crisis lines in that they are generally more equipped for crisis calls although both

will take calls that are non-crisis related. Warm lines are primarily open during the night, whereas telephone helplines, hotlines, and crisis lines are generally open during the day yet may also be available for part or all of the night.

Starting with helplines that have a focus on broad populations and objectives, Juen et al. (2013) studied the process of developing a training guide for lay counselors to provide substantial psycho-social support in a variety of settings, including telephone helplines. By examining the literature reviews and identifying existing materials and questionnaires showing the resources and gaps in today's training approaches, the study found the range of issues and target groups to be broad, going from anyone needing support to specific target groups with specific issues (Juen et al., 2013). Using resources from around the world, the study exposed five main areas of intervention that a lay counselor is expected to cover: to listen to and comfort those in distress; to help them find their own solutions to their problems; to provide them with information about available services and support; to make referrals to targeted mental health care; and to give emotional and practical support in any type of crisis situation (Juen et al., 2013).

Boddy, Smith, and Simon (2005) reported that for the parenting helpline *Parentline Plus*, there was a high proportion of calls made from those in crisis or in problematic situations with children (e.g., challenging behavior, mental health issues) and adults (e.g., parental conflict, divorce); these situations were quite different from the intended purpose of the helpline which was to offer support, advice, and guidance for everyday parenting concerns. Although the majority of callers were from female parents, a large proportion was from single male parents, parents in stepfamilies, and individuals from abroad (Boddy et al., 2005).

Bureau et al. (2012) carried out a study on a community-based crisis hotline, staffed by mental health professionals in Mumbai, India to discover how ninety-two people with first episode psychosis sought help after reaching the hotline. A majority chose to first seek counseling with a non-psychiatric healthcare professional, after receiving a psychiatric assessment (Bureau et al., 2012). When compared to those who had already been treated for psychosis, the illness of these first-time sufferers lasted 17 months versus 53 months for the previously treated ones (Bureau et al., 2012). Most individuals or families resist seeking treatment until the later, more severe periods of an illness, possibly due to stigma of being labeled as mentally ill; yet, the study showed that having easy, anonymous access to a helpline in a community-based clinic contributed toward obtaining early intervention in treatment for a mental illness (Bureau et al., 2012).

A study in the UK by Brodie, Hardyman, Hardy, and Stephens (2005) found that, contrary to what they had assumed, the cancer hotline was more likely to receive queries regarding certain sensitive topics, whereas requests to their website were for information about more tangible subjects like specific cancers or cancer treatments. This seemed to indicate that some people prefer not to utilize impersonal support such as a website in order to address personal concerns. They found, in addition, that it is not so difficult for callers to talk about these topics as was first thought (Brodie et al., 2005). Furthermore, the study contended that inquiries through a helpline are not equivalent to ones through the Internet. Websites apparently lack the emotional support of a helpline, whereas talking provides a more conscious, personal act; emails seemed to be one step above the Internet for seeking information since they may be anonymous, are convenient, and offer an individual, personalized answer (Brodie et al., 2005).

Dalgin, Driscoll and Maline (2011) conducted a study of a peer-run (individuals with a mental illness who are receiving treatment) *warm-line* (WL) that operated after business hours when other types of providers are not accessible, a comparatively new service for those with psychiatric problems seeking non-crisis support. It was staffed by paid peer specialists working in shifts with an on-call supervisor and provided with 16-hour warm line training and weekly individual and group supervision (Dalgin, et al., 2011).

Ashdown-Lambert, Madoc-Jones, Parry, Warren, and Williams (2007) studied a helpline offering telephone support in North Wales on the basis of planned communication for those who have difficulty in accessing face-to-face services, especially in rural areas, and for those of low socio-economic status who are isolated and with few resources. It was set up to assist parents having problems with children (from improving poor communication to setting boundaries) through weekly 45 minute calls for 12 weeks to address parents' specific needs (Ashdown-Lambert et al., 2007). The clients felt relatively comfortable with issues raised, parents were empowered to speak, and their concerns validated; in addition, clients reported that the counselors listened well and were accommodating, non-judgmental, non-threatening, and they were consistent and dependable. Ashdown-Lambert et al. (2007) contended that the helpline was highly valued by both those using it and by those providing the service. Clients expressed a desire to also be able to access the helpline when needed, outside of office hours, without set time limitations.

Christogiorgos et al. (2010) conducted a study of a helpline in Greece for teens and found that the beneficial factors of helplines were in four areas: providing user-

friendly, meaningful, immediate contact; anonymity; confidentiality; and respectful, accepting responses. Both the counselor and caller were aware that the caller had control of the interchange. In regards to adolescents, who generally have a need for control over boundaries, the situation can be challenging, especially when there is severe pathology which can give rise to strong transference and countertransference reactions (Christogiorgos et al., 2010).

Birnbaum and Shor (2012) evaluated the qualities of a family peer support hotline in Israel for and by families of individuals with mental illness, concentrating on the types of emotional support, advice, specific information, and links to treatment services available to their callers. This helpline tried to avoid a professional image by working with the unique, shared, life experiences of the peer and client using trained, family peers who were current or former caregivers to family members with mental illness (Birnbaum & Shor, 2012). The highest number of calls came from family members, namely parents and siblings, groups that often receive little or no support from mental health services (Birnbaum & Shor, 2012). In follow-up interviews of 77 family members they felt the most helpful assistance they received related to emotional support (37%), overcoming the challenges of navigating the mental healthcare system (37%), finding information for their loved one with mental illness (28.5%), and learning coping techniques (26%); furthermore, callers felt empowered by receiving advice from peer counselors who possessed shared experiences similar to theirs (Birnbaum & Shor, 2012).

### **Internet Helpline Profiles**

The research on the forms of assistance available through the Internet focus mainly on chat services, emails, on-line community forums, community games, and

texting. Each has its followers who prefer to use one type of assistance instead of another for their own particular reasons. Studies took place in the United States unless otherwise noted.

Fukkink and Hermanns (2009) compared communication used in a Dutch telephone helpline and in an internet chat line for children: with the telephone helpline, the callers' emotions are felt through their speech (the speed and intonation) and certain forms of understanding can be conveyed through certain language; whereas, in a chat line the callers' voices cannot be heard. The two forms are similar in that they both offer emotional support, transpire at the same time, are interactive, occur one-on-one yet faces are not seen with either one; also, they are complementary in that both improved children's well-being and made them feel their problems were not as serious as they thought (Fukkink & Hermanns, 2009). Some callers preferred the chat line since there was less direct contact which made it easier to discuss personal stories, it gave users more time to think and, they felt, it prevented eavesdropping. Several reported they considered the voice on a phone line to be intimidating, making them feel uneasy (Fukkink & Hermanns, 2009). Some callers preferred the telephone line due to more direct contact providing personal feedback and less chance of being hacked. In evaluations by the children and a jury composed of adults, both groups felt the quality of the chat conversations were equal to those of the telephone (Fukkink & Hermanns, 2009).

Gould, Munfakh, Lubell, Kleinman, and Parker (2003) carried out a study of 9<sup>th</sup> to 12<sup>th</sup> graders of varying socio-economic levels who were just as likely to access the Internet for assistance as they would seek assistance from a school counselor or mental health professional. The study indicated the Internet was used in conjunction with other

types of support, rather than a substitute, for mostly problems about romance, friends, families, and schoolwork (Gould et al., 2003). The chat room was preferred over websites or instant messaging (IM) and the use and user satisfaction was equally split between males and females; however, a weakness was that misinformation could be easily shared when not supervised (Gould et al., 2003).

A study about the Australian website *Reach Out* showed its value in reducing stigma of mental illness and facilitating help-seeking in the realm of mental health (Burns, Durkin, & Nicholas, J., 2009). Based on the needs of young people, the advances in technology, and clinical evidence, Burns et al. showed that the *Reach Out* website contains a broad scope of mental health resources. It houses fact sheets on youth-related and mental health issues, is an on-line community forum facilitated by trained peers and staff, and has an on-line game with ways to practice life skills in a virtual setting. In addition, it has links to social networking sites and podcasts played, on demand, about mental health topics (Burns et al., 2009). The study found that *Reach Out* had loyal followers with 87% repeat visitors, and 40% who had been using it for more than a year. Also, the trust, respect, and use of service were high: 85% found the site was *trustworthy*, 80% felt it was *dependable*, 72% said it made them feel not so alone (Burns et al., 2009). Over eight users in ten (81%) said they would tell a friend about it, and nearly six of ten (59%) spoke with a mental health professional after visiting the website (Burns et al., 2009).

### **Counselor Profiles**

Research on counselor profiles will be of particular interest when the time comes to establish a helpline and to recruit counselors. Helpline counselors may be paid, non-

paid, either lay or professional; they may be trained or untrained, volunteer or recruited. Most try to resolve and improve a crisis situation, advise, provide information, listen, counsel, and refer (Hope, Paukert & Stagner, 2004; Aguirre & Bolton, 2013). Some counselors may go a step further by providing direct links to services which keep the callers from having to become lost in a web of information or telephone calls that often lead to endless waits or disconnects, and by following up with some callers to verify if they obtained the services needed (L. Rombach, personal communication, 2015).

In a study in the UK of volunteers and non-volunteers on a university campus, prior to any training, Paterson, Reniers, & Vollm (2009) contended that students who volunteered (self-referred) to work at a telephone helpline possessed two particularly strong counseling traits: they showed a stronger ability to empathize and were more agreeable individuals (valuing harmony with others) than students who had been recruited and accepted to volunteer. The study sought, but did not find, a link to any current or past mental health issues of the volunteers as motivating factors to volunteer which indicated that they did not want to volunteer in order to resolve their own mental problems (Paterson et al., 2009). This research finding has potentially broad implications for the quality of services offered by helplines, as it suggests that motivation to volunteer is an important indicator of the quality of engagement with callers.

Hope et al., 2004, conducted a study on 20 student volunteers from the Texas A&M Counseling Helpline to discover how training, experience, or education impacted the volunteers' active listening skills. Volunteers followed a six-day, 45-hour training, not just for active listening skills but also counseling, suicide assessment, crisis intervention, and referrals; in addition, they attended weekly meetings to discuss calls and

took one hour of continuing education training monthly (Hope et al., 2004). After six to nine months on the job, their study participants' skills improved through training and working on helplines as measured by their supervisors. Their active listening skills were maintained through continuing education consisting of weekly, supervised meetings and monthly one-hour lectures (Hope et al., 2004).

Juen et al., (2013) carried out a study that identified several key psychosocial skills of lay counselors: active listening; knowledge about resilience, grief, and of stress and trauma; and an ability to show support in non-intrusive ways so that those affected could find their own solutions. This study also culled resources from 31 organizations in Europe in order to develop a training guide for lay counselors to work in any type of setting so that they may assist with those recovering from life changing experiences (Juen et al., 2013).

In a qualitative interpretive study, Aguirre and Bolton (2013) looked at why volunteers work at a telephone crisis line and found that motivating factors included altruism, or a way to give back; personal fulfillment, or doing a deed and experiencing value, and a desire to help others in crisis. These motivations have an impact on the recruitment, training, and management of volunteers (Aguirre & Bolton, 2013). The reasons volunteers choose to leave are lack of direction from the agency and lack of support in fulfilling assigned roles. It was suggested that organizers of crisis helplines meet with volunteers to debrief, to continue to train, and to evaluate, enhance and strengthen the communication skills essential to crisis helpline effectiveness (Aguirre & Bolton, 2013).

Gilat and Rosenau (2011) carried out a study in Israel about how helpline volunteers viewed the effectiveness of their interactions with callers by their reconstructing calls by memory and defining why they felt they had successful outcomes. Gilat and Rosenau asked the volunteer counselors to provide descriptions of effective calls and explanations of favorable results, using emotion-focused, cognitive-focused, and/or behavioral-focused strategies in crisis interventions. The aim of the interventions was to achieve immediate modification in the temporary state of instability of the caller (Gilat & Rosenau, 2011). The four defining factors of a successful result were: changing the mental state of the caller from the start to the finish of the conversation; second, focusing on one problem at a time; third, managing the pace and duration according to the client's needs; and fourth, using a range of solid strategies producing change in the caller's status (Gilat & Rosenau, 2011).

O'Sullivan (2011) conducted a study in Australia that revealed how telephone counselors may, in the struggle with compassion fatigue, come to grow, presumably through high demands for increased levels of skill and expertise. However, there is a stress and demand threshold, where if it is surpassed, there is less probability of continued growth. In addition, O'Sullivan (2011) showed that adversarial growth, or growth through adversity, is different from post-traumatic growth, since adversity covers a broader spectrum of problems than just traumatic experiences. This growth was positively linked to the counselors' empathy and need for strong professional boundaries in order to protect against negative outcomes. Two stressors for telephone counselors, different from face-to-face encounters, are: the caller's terminating a call, especially during a crisis situation, and the lack of eye contact, where the counselor may end up

focusing too much on certain stimuli (e.g., caller's voice) and envisioning the caller's state in an unsettling way (O'Sullivan, 2011).

### **Caller Profiles**

Some helpline research focuses on the characteristics of the individuals who request assistance over telephone or the Internet. This research has developed caller profiles such as those who are frequent, of a certain age or gender, with mental or physical problems, and those with certain help-seeking intentions, beliefs, attitudes, and expectations.

Numerous articles sought to understand the characteristics and needs of people who use telephone helplines. In one study, the call topic ranged from wanting to commit suicide to just needing to talk (Hope et al., 2004). Therefore, it is important to determine if helpline callers are principally in need of crisis intervention or if they are in need of ongoing assistance as found in a study carried out in Australia (Burgess, Christensen, Farrer, Griffiths, & Leach, 2008). Regarding those choosing to use a telephone helpline or the Internet, one study in the UK (Brodie et al. 2005) found that cancer patients searched mainly for facts and basic information on the Internet while those who wanted to discuss more sensitive subjects such as relationships, sexuality, and living with cancer contacted the helpline. A study in Greece about adolescent callers found the telephone helpline attractive since it fulfilled their need for flexibility, self-determination, independence, and anonymity (Christogiorgos et al.,2010).

Another common focus in the literature concerns those who are frequent callers, because they can impede a helpline's ability to serve all callers in the best way possible (Burgess et al., 2008). This study showed that callers to *Lifeline*, a generalist helpline in

Australia, were frequent users (29% of the sample study cohort) and very frequent users (14%) – those who called 10 times or more in a month (Burgess et al., 2008). Using a 60-item questionnaire at the end of each call with 270 callers, Burgess et al., (2008) reported that callers felt loneliness, physical illness, as well as anxiety and panic attacks, were less likely to drink alcohol and more likely to access case-workers and psychiatrists. In addition, the study showed that more frequent callers had less access to the Internet than less frequent users and were chiefly women, older adults, divorced, separated, or never married (Burgess et al., 2008).

In a systematic review of research of 63 articles mostly conducted in the United States, Bassilios et al. (2014) noted that factors associated with calling a crisis helpline frequently were lack of employment (and therefore low income) together with increased age, and being male or transgendered, unmarried, and seeking social support. As many as 90% of calls were made by people who called twice or more and it was indicated that the inappropriate use of these services lengthens the waiting time for other callers. Assigning a particular counselor, limiting the number and length of calls allowed, meeting with the caller in person, and initiating a call to the person were some of the suggestions to decrease call frequency (Bassilios et al., 2014).

Subsequently, in another study about the helpline, *Lifeline*, in Australia, Bassilios et al. (2015) found that frequent callers, defined as individuals who call 20 times or more per month, represented approximately 3% of all callers but 60% of all calls, and their calls were less likely to be long. The study suggested that the callers' needs are complex and numerous, therefore, it would be helpful to study their socio-demographic and clinical status, as well the reasons they call and the benefits they reap since their calls

impact many: the callers, other callers, helpline staff, and managers (Bassilios et al., 2015).

A study on callers to the *Mensline*, in Australia by Feo and LeCouteur (2013) found that the reason most men called was to talk about their troubles (82% of calls) instead of to seek explicit advice. This did not support the statement of purpose of the organization, nor one of the expected outcomes of their study, which was that men focus more on outcomes and practical solutions rather than on their emotions and private issues (Feo & LeCouteur, 2013). This study demonstrated that counselors felt their role was to provide a service rather than just listen to troubles; therefore, after listening, many of them attempted find a reason for the call, feeling this would fulfill their role as service provider (Feo & LeCouteur, 2013).

Armstrong, Coveney, Moore, and Pollock (2012) reported that *Samaritans*, a volunteer hotline in the UK, found that most callers were heterosexual (76.2%), females (77.9%) and the reasons for their calls was that they were distressed (with mental health problems, relationship breakdown, self-harm, family problems), feeling sad and low, isolated and lonely, yet not suicidal. Armstrong et al. (2012) further found that evaluations of callers' experience and satisfaction with the service showed that three-quarters rated the services as *excellent* or *good* and those who called or visited one of the offices were more satisfied by the response time than those who had used texting or email. Over a third of callers were in touch with other services and over half had gotten in touch with *Samaritans* more than once (Armstrong et al., 2012).

Gohr et al. (2008) carried out a five-year study on a 24-hour crisis hotline focusing on parent and adult issues, youth issues, and mental health, separated into males

and females and age groups 10 to 89. The hotline employed a flexible, systematic, problem-solving approach entitled POP (problems, options, plan) that aspired for the caller to be the owner of the problem and not the crisis counselor (Gohr et al., 2008). The study showed that this approach provided callers with the assistance they were seeking and that, by the end of the call, they were more composed, more confident, and more determined than they were at the start of the call (Gohr et al., 2008).

Boddy et al. (2005) studied findings of interviews with callers of *Parentline Plus* in the UK to determine if its services were universally accessible as sources of support for parents. The subjects of calls received were more complex and severe in nature than expected and the reasons for the calls were mainly to seek advice, get reassurance, and vent frustrations; very few wanted their problems resolved (Boddy et al., 2005). Caller satisfaction was high since over half the callers rated the calls as *good* or *very good* in providing advice and information; in addition, the majority of callers highly valued the services they received and felt reassured by the discussions about serious parenting concerns (Boddy et al., 2005).

A study by Dalgin, Driscoll and Maline (2011) focused on the impact a warm-line had on the recovery process of callers with mental health issues who sought social, not crisis, support. For those who accepted to be surveyed by phone, following their initial call, 72% found new coping strategies, 72% felt an increased sense of well-being, 61 % felt an increased sense of personal empowerment (ability to make one's own choices), and 73% felt an improved recovery process by providing structure and stability which helps keep them from returning to the hospital. Caller satisfaction was high: nearly 9 of 10 callers (89 %) were *satisfied* or *very satisfied* for reasons such as having someone to

talk to, speaking with someone who can relate and understand, and feeling at ease with speaking with non-judgmental, trained, and compassionate, non-clinical staff (Dalgin et al., 2011). The warm-line also had a positive impact on the callers by reducing their social isolation, sense of loneliness, their use of crisis services, and hospitalization, according to the callers' reports gathered from four sets of survey data with 120 participants in each, over a four year period.

Backett-Milburn and Jackson (2012) carried out a study in Scotland focusing on children's calls to *ChildLine*, a helpline for children about their parent's health and well-being, and how this had an impact on the children's lives. The reasons for calls by children ages 11-15 years were mainly about parents abusing alcohol and/or drugs or physically abusing each other, the child, or others in the household. Backett-Milburn and Jackson (2012) showed that in spite of these problems, some children could see the good in their parents; however, some children expressed feelings of rage, hatred, and violence towards them. The children expressed how they had to take on roles of caretakers for siblings, suffer being bullied because of their lack of cleanliness, and keep their problems hidden from authorities, fearing they would be removed from families (Backett-Milburn & Jackson, 2012).

The main categories of the caller profile research presented here were the reasons for or topics of calls, the types of callers, the caller frequency, and the outcome of the calls relative to the callers' satisfaction. Findings showed that callers to helplines use them for social support, for talking about problems, having someone listen, for discussing problems, finding ways to cope, solving their own problems, finding support, and feeling empowered. Contrary to what was expected, some callers just wanted to talk rather than

find solutions and some felt it better to talk about sensitive subjects on the telephone rather than consult through the Internet.

### **History and Function of the National Alliance on Mental Illness (NAMI) New Orleans**

The National Alliance on Mental Illness (NAMI) New Orleans receives a large number of calls each month requesting assistance with issues related to mental health services. Similar to the study by Birnbaum and Shor, NAMI New Orleans wishes to address the unmet needs of callers through a helpline staffed largely by peer volunteers supplying assistance for individuals with mental illness and their loved ones. NAMI New Orleans is one of hundreds of NAMI state organizations and affiliates who work to raise awareness and provide essential and free education, advocacy, and support group programs coming out of the NAMI National office.

The main offices of NAMI National, located in Arlington, Virginia, started in 1979 with a small group of families. It has become the largest grassroots organization in the United States devoted to improving the lives of Americans affected by mental illness (National Alliance on Mental Illness, 2015).

The NAMI New Orleans office, a local affiliate of NAMI National, began as a psychosocial program and subsequently became the Friends of the Psychologically Handicapped in 1978. It aimed to provide psychosocial support for individuals with mental illness, to assist their families, and to advocate in the local community. It had a volunteer-run drop in center, which remains one of its core programs today, and based its services on the Fountain House Clubhouse of New York, whose premise was that the mentally ill are capable of helping each other. In 1979 the NAMI National offices invited the Friends of the Psychologically Handicapped in New Orleans to become an affiliate

and the board accepted. In 1980, the organization's name became the Friends' Alliance for the Mentally Ill, and a few years later it became NAMI New Orleans (National Alliance on Mental Illness New Orleans, 2015).

NAMI New Orleans serves Orleans, Jefferson, Plaquemines and St. Bernard parishes. Its profile in staffing and services is far larger than most of the other U.S. affiliates, providing psychosocial services for adults with mental illness through its Medicaid funded day treatment programs, counseling, medication management, and community-based case management. It also provides educational, advocacy, and support programs. It has a total staff of 49 with 39 full-time and 10 part-time workers: five are administrative, 31 case managers and supervisors, two social workers, and eight peer counselors. NAMI New Orleans served a total of 4272 individuals in fiscal year 2014 – 2015 with, for example, 468 served by case managers, 606 by community education and awareness programs, and 1180 by information, referrals and health fairs (L. Romback, personal communication, 2015).

The mission of NAMI New Orleans is to:

offer hope, help, and healing to people with mental illness - and to those who share their lives - through family support, education and advocacy, and quality psychosocial services. Their work helps individuals live with dignity and independence within the community, enriching all of their lives (National Alliance on Mental Illness New Orleans, 2015).

Educational programs include a twelve-week Family-to-Family course, led by trained family members for family members of individuals with mental illness and offered three times a year. There is also a ten-week Peer-to-Peer course, offered twice a year, for individuals with mental illness led by trained peer mentors who are in recovery. *In Our Own Voice* is a ninety-minute community education presentation offered by two

trained presenters who share their experiences with mental illness. It addresses participants in law enforcement, health agencies, and community organizations to help them gain a better understanding of what it is like to live with mental illness and stay in recovery. *Sharing Hope* is a presentation and discussion, led by an individual with mental illness and a family member of someone with a mental illness, about the state of mental health in the African- American community. It focuses on the significant disparities in mental health outcomes that African-Americans experience. Support groups are open to all and include monthly family support groups in four different locations, two weekly peer support groups, and two bi-monthly groups for survivors of suicide loss. There are two consumer-run Drop-In Centers with one in New Orleans and one in Harvey, Louisiana. All of the services are offered in various locations throughout the prescribed area and are free of charge. There is a full-time fundraising coordinator who carries out all funding requests. NAMI New Orleans services are funded partially through the annual NAMI Walks event (\$143,000 raised through sponsors and walk teams in 2015); various grants such as the Greater New Orleans Foundation for the future helpline entitled Mental Health Navigation Team (MHNT) (\$20,000), and the New Orleans Theater Association (\$5,000) for a play on mental illness; foundations; memberships (\$45,000); and in-kind (all education and support groups are run by volunteers) donations.

NAMI New Orleans publishes and distributes, free of charge, the forty-page *Family Guide: A Roadmap to Resources and Support*. It provides a vast array of information specific to the New Orleans region, useful for individuals living with mental illness and their families in this area.

NAMI New Orleans now receives, through their main telephone lines, over 1,000 calls and emails yearly from individuals with mental illness and/or their family members; in addition, requests for assistance come from individuals who walk into the facilities located in Orleans and Jefferson Parishes. The majority of queries come by phone and are answered by staff through a *de facto* telephone helpline to address callers' concerns.

The idea to create a telephone helpline stemmed from the fact that personal assistance that is supportive, knowledgeable, and caring is not always available for someone with a pressing need related to a serious mental illness. This assistance, if available, could ultimately lead to improved outcomes for the individual in need. Timely connection to appropriate services could prevent unnecessary hospitalizations, arrests, and/or incarceration, homelessness, and financial burden on the community. It is for these reasons NAMI New Orleans wishes to create such a helpline.

According to Lisa Romback, Executive Director of NAMI New Orleans (L. Romback, personal communication, 2015), when an individual is experiencing symptoms of a serious mental illness and has low health literacy, knowing whom to call and navigating a complicated call system - where there is no one to speak to and only buttons to press which often leads the caller nowhere - can be too overwhelming to manage. Family members or caregivers, especially those who may have a family member with a newly diagnosed condition, may be too overwhelmed to contact multiple services or programs in attempting to obtain care for their loved one. In these cases, the helpline will be available with information, resources, and personalized assistance in making calls, scheduling appointments, and/or assisting in completing a lengthy application for housing

or Medicaid. When individuals or family members present in a pre-crisis situation, the goal is to avoid having it develop into a full-blown crisis.

NAMI New Orleans has an informally organized *de facto* telephone helpline. It is now in the planning phase of creating its first formally organized helpline that will have a separate line and listing to serve individuals with mental illness and their loved ones by providing assistance, information, resources, and referrals. In the event NAMI New Orleans refers callers to an external service or support agency, a helpline counselor will serve as a navigator by contacting the agency first to assure that it is in a position to assist with the problem at hand. For this reason, the helpline is tentatively named the Mental Health Navigation Team (MHNT). It will be open to calls eight hours each weekday and be located at the main office of NAMI New Orleans on Louisiana Ave. The agency will hire and train a part-time helpline and volunteer coordinator who will recruit and train volunteers to provide assistance via telephone, email, Facebook, and in-person.

Following the recent Greater New Orleans Foundation (GNOF) grant of \$20,000 awarded for the MHNT, the timeline is set as follows: by March 31, 2016: the agency will create the written MHNT Policies and Procedures as well as orientation and training materials for the MHNT staff, interns, and volunteers. By June, 2016: the agency will create a decision tree (a collection of appropriate and effective resources to help make decisions) to assist the MHNT in responses, will hire a paid, part-time MHNT coordinator, and train up to three volunteers. By December 31, 2016: the MHNT will provide assistance for up to 300 unduplicated callers, up to 200 follow-up communications, and thereby offer 500 total interactions.

The expected outcomes are that at least 50% of individuals will be connected to any needed service, up to 50% of those surveyed will report that their interactions with the MHNT increased their health literacy and/or health awareness, and that 75% of individuals will report being satisfied or beyond satisfied with the assistance provided by the MHNT.

The MHNT will collect data in a phone log to track, for instance, the type of caller calling for what reasons, types of support provided, how the callers heard about the organization, the date and time when the call came in, how long it lasted, and the gender, age, and race, when available.

To assist the many individuals and their families who struggle to navigate the fragmented mental health system of care - many find it difficult to successfully connect with critical services they desperately need – the MHNT can provide a streamlined connection to information and services provided by NAMI New Orleans and other community partners.

### **Research Questions**

The nine research questions noted below were derived from previously reviewed prior research on helplines, discussions with NAMI New Orleans regarding agency plans and needs, and the current calls made to the informal, *de facto* helpline using the agency's main telephone lines. Calls logged were those addressing callers' mental health concerns answered by four staff members and one intern.

Research Question 1:

- a. What was the *nature of the call*?
- b. Were the expressed needs of callers the same as what NAMI expected?

Research Question 2: Which *type of callers* (individuals with mental illness, family members, friends, neighbors, providers, and others) called most frequently?

Research Question 3:

- a. What was the average weekly *call frequency*?
- b. Does call volume vary by day of the week?
- c. Does call volume vary by times of day?

Research Question 4: What *type of support* was provided or to whom were callers referred?

Research Question 5: *Who or what agencies referred* callers to NAMI?

Research Question 6: Was there a *difference between the queries* made to the helpline and those made through email or Facebook posts?

Research 7: Did the duration of calls differ by call logger?

Research 8: Did the type of support provided differ by call logger?

Research 9: Did the nature of the call differ by type of caller?

## CHAPTER 3: METHODOLOGY

This is an exploratory, descriptive study, designed to report on caller and logger characteristics and on the 72 calls made to NAMI New Orleans over a six-week period from October 15 to November 25, 2015.

### **Target**

The National Alliance on Mental Illness (NAMI) New Orleans is developing a helpline because the organization regularly receives calls asking for assistance and they want to address callers' needs more systematically. This study evaluated calls made to the NAMI New Orleans office by individuals with mental illness as well as their family, friends, or acquaintances requesting assistance during the six-week period between October 15 and November 25, 2015. During this time some staff and one intern systematically recorded call interactions on a call log. This is the preliminary stage to the creation of the previously described MHNT to serve as the official helpline that will be staffed part-time by a social worker as coordinator along with volunteers and interns.

Four NAMI staff members, ranging from the receptionist to the director, and one intern, answered and logged information about these calls. The staff members are fulltime employees, however, two are consistently present in the office and two are intermittently away for meetings or not always available to answer the phones. The latter two were sometimes requested to respond to calls that required more in depth responses. The fifth person was an intern whose express job was to assist in setting up a helpline, and part of her job was to answer and log phone calls twice a week. Whether callers sought mental health care or appropriate, affordable housing, the staff and intern assisted callers by

listening, providing empathy, and connecting them to services provided either by NAMI New Orleans or by other community partners.

### **Instruments**

A semi-structured call log was designed to determine the nature of the calls, the types of support provided, the types of individuals calling and the individual about whom they were calling. The content and questions asked on the call log were based on previous calls that had come in on a regular basis over the past few years and included information in nine categories analyzed quantitatively and qualitatively.

The first category was the *nature of the call* that included both closed-ended and open-ended items. The closed-ended items generated six binary variables indicating the presence or absence of the following reasons for the call: crisis, housing, listening and support (listening to and acknowledging the caller's problems; and providing support, guidance, and suggestions for ways to cope with the stress of their situation), assistance with completing forms, counseling/mental health services, or repeat calls. Staff could select more than one item that applied to the call. The *nature of the call* category also contained a section for open-ended responses where staff could post more detailed comments regarding the nature of the calls.

The second category was the *type of caller* that included both closed-ended and open-ended items. The closed-ended items generated one nominal level variable with the following indicating if the caller was an individual w/mental illness, a family member, a friend, a provider, a neighbor, or other. The *type of caller* category also contained a section for open-ended responses where staff could indicate if another type of caller had called. These were included in the other category.

The third category pertained to the *call frequency*: average weekly call frequency, the differences in call frequency by day of the week, the time of day that callers most often called, as well as the duration of calls logged.

The fourth category contained the *type of support provided*, including both closed-ended and open-ended items. The closed-ended items generated eight binary variables indicating whether or not the callers proposed any of the following referrals: to mental health facilities, such as Metropolitan Human Services District (MHSD) serving three parishes, for evaluation and assessment or the Jefferson Parish Human Services Agency (JPHSA); Unity for the Homeless providing housing and services for homeless individuals; shelters providing temporary housing and services; NAMI New Orleans programs such as family support groups, peer to peer education classes; the Family Guide; other types of agencies; and to coroners' offices of any parish to obtain assistance with someone having a psychiatric crisis (in Louisiana, for psychiatric civil commitments, these offices respond to the public on a 365 days and 24/7 hours basis in mental health crisis situations, particularly when persons are unwilling or unable to seek treatment themselves). Staff selected all items that applied to the call. Staff could select more than one item that applied to the call.

The fifth category was the *type of agencies or individuals making the referrals*, including both closed-ended and open-ended items. The closed-ended items generated six binary variables indicating whether or not the following agencies or individuals referred the caller to NAMI New Orleans: the internal aspects of NAMI New Orleans (e.g., support groups or educational programs), the agency's external aspects (e.g., publicity, Internet), family, friend, provider (e.g., behavioral health agency), and those not known.

The sixth category looked at the *types of queries* made via email. Only a univariate analysis was done since there were only six emails which was an insufficient amount of information to be generalizable.

The seventh category was *logger differences in call duration*. Means and standard deviations for the ratio –level variables of the call duration were determined for each person who logged calls. This indicated which loggers spent which amounts of time with calls.

The eighth category was the *difference in type of support by call logger*. This bivariate analysis crossed the types of support provided with the different loggers. This indicated which loggers recommended which types of support.

The ninth category was the *difference in the nature of the call by the type of caller*. The bivariate analysis crossed the nature of the call with two different types of callers: individuals with mental illness and family members. This indicated which types of callers called for which types of reasons.

### **Data Analysis Plan**

The secondary data collected from the semi-structured call log completed by the staff after each phone call used both closed-ended and open-ended questions and was, therefore, analyzed quantitatively and qualitatively.

**Quantitative Analysis.** Variables created using closed-ended responses were analyzed using quantitative data analysis methods. **Coding.** Binary variables were coded as the presence (1=yes) or absence (0=no) of a characteristic or condition. These included the binary variables indicating the nature of the call, type of caller and type of support provided. It was expected that the principal *nature of the call* was housing, that the *type*

*of caller* would be a family member of an individual with mental illness, and the *type of support* provided would be to give information on various ways a staff member of NAMI New Orleans could assist with finding housing. For instance, if an individual with mental illness needed housing once leaving jail, the staff member contacted a certain program to inquire into whether the program could help this person.

Additionally, three ratio level variables indicating the number of requests/needs, the number of referrals made, and call duration were created. Three nominal level variables were also created: The study week variable contained six attributes, one for each study week when the calls were answered. The weekday variable included one category for each day of the week. The time of day variable included two-hour time slots: 8:30 – 10:30am; 10:30am – 12:30pm; 12:30 – 2:30 pm; and 2:30 – 4:30pm

Other binary variables were the type of agencies or individuals making the referrals, and categorical variables of whether or not queries were made by phone, email or on Facebook.

Bivariate analysis was done for the logger difference in call duration, type of support provided by call logger, and the nature of call by type of caller.

**Statistics.** Frequencies and percentages for the binary variables were created. Means, standard deviations and ranges were determined for the ratio –level variables for logger differences in call duration. Cross tabs and chi square analyses were determined for the difference in the nature of the call by the type of caller.

**Qualitative Data Analysis.** Data regarding notes on the nature of the call, the other types of individuals calling, other types of referrals made, how the caller heard about NAMI, and the type of follow-up needed were analyzed with qualitative content

analysis. The meaning of the qualitative data of any of these entities came from gathering similar answers into groups or themes. For example, in the case where the caller was asked how he/she heard about NAMI New Orleans, different types of responses occurred. If a variety of institutions were given as to where the caller had heard about NAMI New Orleans, all institutions were clustered together to represent one theme.

To increase the trustworthiness of the study, the author engaged in peer debriefing with the chair of the thesis committee, Dr. Livermore, and NAMI staff involved in logging calls.

### **Research Questions and Related Variables**

Research Question 1: What was the nature of the call and was it the same as what NAMI expected it to be? The *nature of the call* variable was used to answer this question. The percentage of the requests about crisis or housing was determined and compared to the other responses. It was possible that a call contained two or more responses for the nature of the call; e.g. it could pertain to both crisis and housing.

Research Question 2: What was the *type of caller* who most frequently called? The percentage of the requests from an individual with mental illness or a parent was determined and it was compared to the other responses for the *type of caller*.

Research Question 3: What was the *mean call frequency*: what was the mean weekly call frequency, and what were the days of the week and times of day when calls were most often made? The study took the responses of how many calls were made each day, at what time, and it recorded the total number of calls per week. The percentage of calls for each day was calculated in order to see which days of the week the calls were

most often made. The percentage of calls made during certain time periods was calculated in order to see when the majority of calls came in.

Research Question 4: What *type of support* was provided or to whom were callers referred? If a referral to the coroner's office or to a family support group was made, it was compared to the other responses for the *type of support*.

Research Question 5: *Who or what agencies referred* the callers to NAMI? If the referrals from a friend or DCFS was determined, it was compared to the other responses for the agencies or individuals who made referrals.

Research Question 6: Was there a *difference between the queries* made to the helpline and those made through email or Facebook posts? The nature of the call variable was also used to answer this question. The percentage of the queries about crisis or housing to the helpline was determined and compared to the queries made through email or Facebook posts.

Research Question 7: Did the *duration of calls differ by call loggers*? An analysis of the mean time duration of the calls was run in regards to the persons who logged the calls in order to see which loggers spent the most and the least amount of time with calls.

Research 8: Did the *type of support provided differ by call loggers*? A bivariate analysis of the type of support each logger provided was conducted to determine which loggers referred which types of support. For instance, the percentage of referrals to Unity of New Orleans provided by one logger was compared to the percentage of referrals to Unity provided by another logger.

Research 9: Did the *nature of the call differ by the type of caller*? A bivariate analysis of the nature of the call in regards to the type of caller was run in order to

determine which types of caller called for which reasons. For example, the percentage of the calls for request for counseling and mental health services by one type of caller was compared to the percentage for request for counseling and mental health services by another caller.

## CHAPTER 4: RESULTS

The characteristics of 72 calls logged at NAMI New Orleans from October 15 to November 25, 2016 were recorded. Descriptive statistics for ten variables are presented first followed by two bivariate analyses.

### Descriptive Statistics

#### Caller Demographics

Table 4.1 depicts caller demographic characteristics. The large majority were females (75%) followed by males (15.6%), and then gender unknown (11.1%). For most callers, race was unknown (75%). For the rest, there was an even split between black (12.5 %) and white (12.5 %) callers.

Table 4.1  
Caller Demographics

	N	Percent
<b>Gender</b>		
Male	10	13.9
Female	54	75
Unknown	8	11.1
<b>Race</b>		
White	9	12.5
Black	9	12.5
Unknown	54	75

*Note.* N=72

## **Nature of the Call**

Table 4.2 shows that the nature of the large majority of calls involved listening and support (73.6%), followed by seeking assistance in finding counseling and/or mental health services (45.8%). A small number of calls sought help with finding housing (9.7%), with a crisis (2.8%) and with additional assistance (2.8%). These calls requesting additional assistance were referred to as repeat calls since they were made by callers who called back. There were no callers looking for assistance in completing forms needed for insurance or medical needs.

An example of a call for listening and support was when a mother of a 35 year old daughter with schizophrenia called. Her daughter had tried to attack one of her own two children while living with the mother. The mother then had an Order of Police Custody (OPC) taken out on her daughter whereby the police came and brought her to a hospital where she was treated for five days. The daughter returned wanting to live with her mother but had to live in the mother's backyard since she was not willing to receive treatment or seek out other forms of housing. The mother called to ask for advice on what to do next. The logger discussed with the mother what she had done right, what she could do for herself (attend family support group), what her daughter could do (go to a shelter, or speak with Unity of New Orleans to apply for housing), and what she could do for the children (speak with the social worker at their schools). The logger also sent the mother the NAMI Family Guide. The mother called back to say she really appreciated the Family Guide after reading it all. She said she cannot attend a meeting (she has no car or anyone to drive her), she was starting to speak with the children's teachers, however, her daughter spoke with no one to get assistance, treatment, or housing.

Table 4.2  
Nature of the Call

Nature	N	Percent
Crisis	2	2.8
Housing	7	9.7
Listening/Support	53	73.6
Assistance with Insurance/Medical forms	0	0
Counseling and Mental Health Services	33	45.8
Repeat Caller	2	2.8

*Note.* N=72. Calls could be included in more than one category so the total percent is greater than 100.

### **Type of Caller**

The type of callers, displayed in Table 4.3, ranged from family members of persons living with mental illness (43.1%) to those living with mental illness (30.6%), service providers (11.1%), and friends (9.7%). Other types of callers (5.6%) sought assistance as well, particularly those who were not individuals with a mental illness (e.g., for grief support). There were no calls from neighbors.

Table 4.3  
Type of Caller

Caller	N	Percent
Individual with mental illness	22	30.6
Family member	31	43.1
Friend	7	9.7
Service provider	8	11.1
Other	4	5.6

*Note.* N=72.

### **Call Frequency: Weekly, Daily, Time of Day, and Duration**

Results regarding call frequency and timing are depicted in Table 4.4. The majority of calls was made during the fourth and fifth weeks of the data collection period (26.4% each) followed by week two (16.7%), week one (13.9%), then weeks three and six (8.3% each).

The majority of callers were logged on Wednesdays (30.6%), Thursdays (25%), and Mondays (23.6%), followed by Tuesdays (8.4%), Fridays (8.3%), Saturdays and Sundays (both 1.4%). The low numbers that appear for the weekend were due to the office being closed. These calls were returned on the following workday.

The peak time for calls was from 12:30 pm to 2:30 pm (35.9%), then from 10:30 am to 12:30 pm (23.1%), and from 2:30 pm to 4:30 pm (23.1%), and finally from 8:30 am to 10:30 am (17.9%).

The total mean duration of calls was 8.90 minutes with a standard deviation of 5.73 minutes. The majority of calls lasted five minutes or less (56.3%) followed by calls lasting between five and ten minutes (25%). Calls lasting between ten and fifteen minutes

(9.4%), between twenty and twenty-five minutes (6.3%), and those lasting between fifteen and twenty minutes (3.1%) were the least frequent.

Table 4.4  
Call Frequency: Weekly

Week of Call	N	Percent
Oct. 15 – 21	10	13.9
Oct. 22 – 28	12	16.7
Oct. 28 – Nov. 4	5	8.3
Nov. 5 – 11	19	26.4
Nov. 12 – 18	19	26.4
Nov. 18 – 25	6	8.3

*Note.* N=72

Table 4.5  
Call Frequency: Daily

Day	N	Valid Percent
Monday	17	23.6
Tuesday	6	8.4
Wednesday	22	30.6
Thursday	18	25
Friday	6	8.3
Saturday	1	1.4
Sunday	1	1.4

*Note.* N=72.

Table 4.6  
Call Frequency: Time of day

Time	N	Percent	Valid percent
8:30 - 10:30	7	9.7	17.9
10:30 - 12:30	9	12	23.1
12:30 - 2:30	14	19.4	35.9
2:30 - 4:30	9	12.5	23.1
Unknown	33	45.8	

*Note.* N=72.

Table 4.7  
Call Frequency: Call Duration

Duration	N	Percent	Valid percent
Five minutes	36	50	56.3
Ten minutes	6	22.2	25
Fifteen minutes	6	8.3	9.4
Twenty minutees	2	2.8	3.1
Twenty-five minutes and above	4	5.6	6.3
Unknown	8	11.1	

*Note.* N=72.

### **Type of Support Provided**

Table 4.8 shows callers were most frequently referred to agencies, programs, or information, with the largest number of referrals made to NAMI New Orleans programs (56.9%) such as the support and/or education groups. Referrals were also made to a variety of other outside agencies (33.3%), whereas 18.1 % were made to the Metropolitan Human Services District (MHSD) of Orleans Parish, 6.9% were sent the NAMI Family

Guide, and 2.8% were made to the Jefferson Parish Human Services District (JPHSA), Unity for the Homeless, and/or shelters.

Table 4.8

Type of Support Provided

Support Provided	N	Percent
Metropolitan Human Services District	13	18.1
Jefferson Parish Human Services	2	2.8
Unity for the Homeless	2	2.8
Shelters	2	2.8
NAMI NO Programs	41	56.9
NAMI NO family guide	5	6.9
Other	24	33.3

*Note.* N=72.

**Type of Agencies or Individuals Making Referrals**

The institutions or individuals who referred the callers to NAMI New Orleans are presented in Table 4.9. Most often, it was not known (58.3%) who referred the caller to NAMI New Orleans. Known referrals came from NAMI New Orleans externally (Internet, radio, signage, flyer) (15.3%), from NAMI New Orleans internally (support groups and education programs) (11.1%), and from a friend (4.2%) or family member (2.8%).

Table 4.9  
Type of Agencies or Individuals Making Referrals

Agencies or individuals	N	Percent	Valid percent
NAMI internal	8	11.1	11.1
Family member	2	2.8	2.8
Friend	3	4.2	4.2
Provider	5	6.9	6.9
NAMI NO external	12	16.7	15.3
Unknown	42	58.3	58.3

*Note.* N=72.

### **Difference between Types of Queries**

No queries were made by Facebook and six queries were made by email which were not different from those made by phone. The queries by email were for listening and support (n=5; 83%) followed by seeking assistance in finding counseling and/or mental health services (n=3; 50%), housing (n=1; 17%), and repeat call (n=1; 17%). Only a univariate analysis was done since there was not enough information to do otherwise.

### **Logger Differences in Call Duration**

Four staff members and one intern logged the calls. The descriptive results for each logger are presented in table 4.10. One full-time employee logged the majority (36.1%) of calls and the intern working two days per week, logged 33.3%. Full-time employees logged subsequent calls (12.5%, 12.5%, and 5.6%). Of the two people who logged the most calls, one had a mean time of 5.8 minutes with a standard deviation of 1.90 and the other had a mean time of 9.8 minutes with a standard deviation of 5.41. The person with the next greatest number of calls logged had a mean time of 5.7 with a

standard deviation of 1.88, the next call logger had a mean time of 15.8 with a standard deviation of 5.84, and the logger with the least number of calls had a mean time of 20.0 minutes with a standard deviation of 8.55.

Table 4.10  
Logger Differences in Call Duration

Logger	N	Valid Percent
GT	26	36.1
MC	9	12.5
SW	9	12.5
LR	4	5.6
DD	24	33.3

*Note.* N=72.

Table 4.11  
Mean Duration of Calls

Call Loggers	N	Mean	Standard Deviation
1	24	5.8	1.90
2	7	5.7	1.88
3	6	15.8	5.84
4	3	20.0	8.55
5	24	9.8	5.41
Total	64	8.90	5.73

*Note.* N=72.

### **Difference in Type of Support by Call Logger**

Table 4.12 presents the type of support given by each call logger. The first logger referred the majority of calls (50%) to MHSD followed by referrals to NAMI New Orleans programs (30.8%), to other agencies (26.9%), to NAMI NO Family Guide (7.7%), to shelters (7.7%), and to Unity for the Homeless (3.8%). The second one referred the majority of calls to NAMI NO programs (88.9%), to JPHSA (11%), and other agencies (11%). The third person referred the majority of calls (100%) to NAMI NO programs or to another agency (11.1%). The fourth one referred the majority of calls to other agencies (75%) and to NAMI NO programs (50%). The fifth person referred the majority of calls to NAMI NO programs (58.5%), to other agencies (54.2%), to NAMI NO Family Guide (12.5%), to Unity for the Homeless (4.2%), and to JPHSA (4.2%). Four of the five loggers referred most of their calls (over half) to NAMI New Orleans programs. The first logger was different, referring most (50%) of calls to MHSD.

Table 4.12  
 Difference in Type of Support by Call Logger

Loggers	MHSD		JPHSA		Unity of New Orleans		Shelters		NAMI NO Programs		NAMI NO Family Guide		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
1	13	50	0	0	1	3.8	2	7.7	8	30.8	1	7.7	7	26.9
2	0	0	1	11	0	0	0	0	8	88.9	0	0	1	11.1
3	0	0	0	0	0	0	0	0	9	100	0	0	1	11.1
4	0	0	0	0	0	0	0	0	2	50	0	0	3	75
5	0	0	1	4.2	1	4.2	0	0	14	58.3	3	12.5	13	54.2

Notes: MHSD = Metropolitan Human Services District, JPHSA = Jefferson Parish Human Services

### **Bivariate Analyses: Difference in Nature of the Call by Type of Caller**

This section contains an analysis of the relationship between the type of caller and the nature of the call.

Table 4.13 compares the nature of the call for individuals with mental illness, for family members, and for others who called NAMI New Orleans. Individuals with mental illness did not call about a crisis, housing, or as a repeat caller. Family members of individuals with mental illness called in a crisis (100.0%), about housing (42.9%), for listening and support (52.8%), for counseling and mental health services (33.3%), and as repeat callers (100.0%). Other callers called about housing (57.1%), for listening and support (47.2%), and to find counseling and mental health (66.7%).

Chi square analyses indicate the family members called for listening and support significantly more frequently than other types of callers ( $X^2$  (df 2, N = 72) = 7.913,  $p < .02$ ). No other difference in nature of call by caller type was found to be statistically significant.

Table 4.13  
Difference in Nature of the Call by Type of Caller

	Crisis		Housing		Listening/ support		Counseling/ Mental Health		Repeat	
	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
Individual w/Mental Illness	22 (100%)	0 (0%)	22 (100%)	0 (0%)	9 (40.9%)	13 (59.1%)	9 (40.9 %)	13 (59.1%)	22 (100 %)	0 (0%)
Family Member	29 (93.5%)	2 (6.5%)	28 (90.3%)	3 (9.7%)	3 (9.7%)	28 (90.3%)	20 (64.5%)	11 (35.5%)	29 (93.5%)	2 (6.5%)
Other callers	19 (100%)	0 (0%)	15 (78.9%)	4 (21.1%)	7 (36.8%)	12 (63.2%)	10 (52.2 %)	9 (47.4%)	19 (100%)	0 (0%)
Chi square	2.721		5.148		7.913**		2.913		2.721	
Df	2		2		2		2		2	
N	72		72		72		72		72	

*Note.* \*\* p < .02

## CHAPTER 5: DISCUSSION

This chapter discusses study findings within the context of the research questions, academic literature, and agency context. In conclusion, it presents study limitations and implications for theory, practice, and future research.

### **Caller Demographics**

**Gender.** This study revealed a dominance of females callers. This relates to a study about the volunteer hotline *Samaritans* in the UK (Armstrong et al., 2012) that found that 77.9% of callers were females calling due to feeling sad and low, isolated, and lonely, themes similar to those of females calling NAMI New Orleans. The study by Boddy et al. (2005) about a parenting helpline also found most of the callers were female parents. Another study by Gohr et al. (2008) showed that females called a 24-hour crisis hotline twice as often as their male counterparts.

**Race of caller.** Since such a small percentage of calls had no race noted, no conclusions can be drawn about race and caller characteristics. The lack of data for this variable does indicate that if this information is desired by NAMI, volunteers should be explicitly trained to gather it.

### **Nature of the Call**

Calls to NAMI were classified into six different types: crisis, housing, listening/support, counseling and mental health services referrals, assistance with forms, and repeat calls. Some calls were classified in two or more categories e.g., the call involved both listening/support and housing.

Contrary to what was expected by NAMI New Orleans staff, calls for assistance with housing were not the most frequent call type, and there were no calls requesting

assistance with filling in forms. In addition, there were no frequent callers - those who called more than twice or as much as 20 times in a month - which had been profiled as problematic in two studies. One study, by Bassilios et al. (2014), was a systematic review of research of 63 articles mostly conducted in the United States and the other, by Burgess et al. (2008), was carried out in Australia.

The findings reveal that the largest number of calls included listening and support, defined for this study as providing support, guidance, and suggestions for ways to cope with the stress of the caller's situation. This corresponds to two studies, one on training student volunteers showing that active listening skills play a vital role (Hope et al., 2004) and another, by Dalgin et al. (2011), that found new coping strategies were highly useful when dealing with mental health issues. Also, in a study on a family peer support hotline in Israel, Birnbaum and Shor (2012) showed, in follow-up interviews, that two of the most important types of assistance families felt they received were for emotional support (37%) and learning coping techniques (26%).

### **Type of Caller**

Five types of callers made contact with NAMI New Orleans during the study period: individuals with mental illness, family members, friends, neighbors, providers, and others. A majority of calls came from family members trying to cope with problems they were having with a loved one living with a mental illness. This was similar to findings about someone calling about problems with a family member. The Birnbaum and Shor (2012) study about a peer support hotline set up for family members of individuals with mental illness calling about their loved ones contended that family members often receive little or no support from mental health services. In the study of

*Parentline* parents sought advice about problems they were having with family members, such as children with challenging behavior and mental health issues (Boddy et al., 2005). The study about *Childline* in Scotland discussed children looking for assistance with concerns, especially those regarding their parents' health and well-being.

The second highest number of callers to NAMI New Orleans was from individuals living with mental illness, reflecting the majority of the studies in the literature where the individual with the primary problem (mental illness, parenting, or cancer) was the caller. Such callers in the literature ranged from high school students seeking help with emotional problems through a chat room (Gould et al., 2003) to Australian males calling to talk about their troubles (Feo & LeCouteur, 2013).

NAMI New Orleans focuses on advocacy and programs for persons living with mental illness and their families and friends, and the combined calls from these two groups represent almost three-fourths of all callers. This indicates that the expected target consumers have been calling the agency for assistance.

### **Call Frequency: Weekly, Daily, Time of Day, and Duration**

This study investigated average, weekly call frequency, the differences in call frequency by day of the week and time of day that callers most often called, as well as the duration of calls logged.

The frequency of calls varied within the six weeks of this study, with the largest number of calls logged during two weeks when the intern was present for the entire time during her two days of internships. During the weeks with the smallest number of calls, the intern was more often away from the office attending health fairs or NAMI New Orleans presentations. Therefore, calls were logged when the four staff members and one

intern were available. If they weren't available, other staff members answered the calls but did not log them.

Call volume varied according to the day of the week. The prevalence of calls answered on Wednesdays and Thursdays may reflect the fact that the intern logging the calls worked only on these two days. Her ability to capture most of the calls those days makes this a plausible, yet not provable, explanation. The low numbers that appear for the weekend were due to the office being closed.

For the times of day of calls, the tendency was for calls to peak around midday to early afternoon, which could mean some people call during their lunch break, although this is not certain.

The findings of the duration of the calls varied from more than 25 minutes to five minutes. In a study in Israel about the effectiveness of helpline volunteers, Gilat and Rosenau (2011) saw that one of the defining factors of successful results was the volunteers' abilities to manage the pace and duration (temporality) of calls. Volunteers were sensitive enough to give callers the time needed, to let them set the pace of the conversation, and to know the volunteer would stay on the phone as long as needed, even though the instructions were to limit calls to 30 minutes. In a study by Fukkink and Hermanns (2009) on a Dutch telephone-base and Web-based helpline for children, the average duration of telephone conversations was 8.9 minutes which was close to the 9.8 minute average of call duration for the NAMI New Orleans helpline.

### **Type of Support Provided**

The type of support provided indicated to whom or to which agencies the callers were referred in order to assist them in resolving a problem concerning themselves or one

concerning a person living with mental illness. In most cases, referrals were made to NAMI New Orleans programs such as their support groups and education courses. The next most frequent referrals were made to a variety of outside agencies for concerns such as counseling, behavioral health, pharmaceuticals, other support groups, and legal issues. This aligns with the Birnbaum and Schor (2012) study on a family peer support hotline where two of the four most helpful types of assistance were overcoming the challenges of navigating the mental healthcare system (37%) and finding information for their loved ones (28.5%). Contrary to what had been expected, there were no calls referred to the coroner's office to seek assistance with someone having a psychiatric crisis and so this variable was not included in data analysis.

### **Type of Agencies or Individuals Making Referrals**

This category indicated which agencies or individuals suggested that the caller contact NAMI New Orleans. Where most of the referrals came from was unknown. Findings showed that the bulk of the known referrals originated from the internal and external aspects associated with the NAMI New Orleans office. This indicates that NAMI programs and publicity have a substantial impact in spreading the word about the organization. The fewest referrals originated from providers, friends, and family members.

### **Differences Between Types of Queries**

Only six of the seventy-two queries were by email and the nature of these queries was similar to the majority of calls made in this study, which was for listening and support followed by seeking assistance in finding counseling and mental health services. This differed from findings of a related study about a helpline whose users were assisted

through the Internet, a telephone helpline, or emails. In a study by Brodie et al. (2005) in the UK, emails were considered not as emotionally supportive as speaking with a person dealing with cancer but they seemed to be a step above the Internet for seeking information since they are anonymous, convenient, and offer an individual, personalized answer.

This may suggest that callers felt little difference in making a request by email rather than by phone, but the small number of individuals using this mode of communications means these results cannot be generalized.

### **Call Loggers**

This study differed considerably from those found in the literature because NAMI New Orleans currently has no official telephone helpline, although approximately 1,000 calls requesting assistance arrive each year. The agency has a *de facto* telephone helpline using their main telephone lines answered by staff to address callers' concerns. Their loggers, or call responders, differed as well from those found in the literature since they were never trained for working on a helpline, and four of the five call loggers were not volunteers. Rather, they were agency staff hired to perform other job duties and had learned, through experience, to respond to helpline-type questions. The fifth person was an intern whose express job was to assist in setting up a helpline, and part of her job was to answer and log phone calls twice a week. Therefore, the NAMI New Orleans *de facto* helpline was staffed in a way that did not conform to commonly understood best practices. Helpline studies often indicate the use of volunteers, interns, and a few paid staff to respond only to calls solely dedicated towards a telephone helpline. A study by O'Sullivan (2011) of 64 telephone counselors from five counseling services in Australia

showed that most were volunteers, followed by those with paid positions. Most performed the telephone counseling role on an intermittent basis while most of the remainder was part-time and only one was full-time.

The three people who responded less frequently at NAMI New Orleans did so when available and as needed. If all of the five responders were busy with other job duties, another staff member typically answered the calls but did not log them. This was also not in alignment with the usual profile of a typical helpline that has a more consistent pattern in logging calls and has responders who are dedicated to responding to calls and not to performing duties outside of the helpline.

### **Logger Differences in Call Duration**

An analysis of the mean time duration of the calls was run in regards to the five persons who logged calls. The person who logged the largest number of calls logged a mean time of 5.8 minutes with calls ranging from up to five minutes (20) and to ten minutes (4). The person who logged the next to highest number of calls recorded a mean time of 9.8 minutes with calls ranging from up to five minutes (8) to ten (5), to 15 (7), to 20 (3) to 25 minutes or more (1) in length. The agency accountant had the shortest call mean time with calls ranging from up to five minutes (7) and to 10 (1). The education director had a high call mean time of 15.8 minutes with calls ranging from up to fifteen minutes (4) and to twenty (1). The executive director had the highest call mean time of 20 minutes with calls ranging from up to five minutes (1), to ten (2), and to 25 or more (1).

This *de facto* helpline or informal call-answering system, the subject of this study, was not established to focus entirely on meeting the needs of callers seeking assistance, which is contrary to the norm of helplines. Staff at NAMI New Orleans (the executive

director, the education director, the receptionist, the accountant, and the intern) could spend a limited amount of time on calls due to other duties that demanded their time. Information provided was mostly available from the NAMI New Orleans Family Guide, yet it was sometimes not enough to answer some questions in detail. All of these could be reasons that call times were sometimes fairly brief and varied a lot. The longer calls tended to be held with the agency professionals (the executive director and education director) with educational and professional backgrounds related to behavioral health.

### **Difference in Type of Support by Call Logger**

There was a difference in the types of referrals made by different loggers. For instance, the receptionist of twenty years who handled most calls and had the second to shortest call mean time sent half of her callers to MHSD, which provides services for psychiatric evaluation, case management, and crisis intervention. She recommended MHSD all 13 of the times that it was used as a referral to an agency in the call log. The rest of her referrals were made to NAMI New Orleans programs and other agencies. The accountant sent the large majority of her calls to NAMI New Orleans programs. The education director made all but one of her referrals to the NAMI New Orleans programs. The executive director made part of her five referrals to NAMI New Orleans programs and part to other agencies. The intern made referrals mainly to NAMI New Orleans program and to other agencies. This indicates that the loggers' referrals could be based on which ones the loggers are most familiar with and what they feel to be the most dependable types of support to provide. It could also indicate that different professional and personal characteristics of those who answered the calls at NAMI New Orleans came into play, although this could not be determined.

### **Difference in Nature of the Call by Type of Caller**

The majority of callers were from family members or individuals with mental illness. The responses about the nature of the calls were compared to the types of caller. The only statistically significant difference was found with family members calling more frequently for listening and support than other callers. Two studies provide evidence that listening and support are vital to helplines: one by Boddy et al. (2005) stated that reasons for calls to a telephone helpline for parents were to mainly seek advice, get reassurance, and vent frustrations. These authors also reported that listening skills of responders were highly valued. The other study by Feo and LeCouteur (2013) contended that most males calling a men's helpline just wanted to talk about their problems and not necessarily obtain advice.

### **Limitations**

In 2014, NAMI New Orleans received over 1,000 calls through its general phone number and emails from individuals with mental illness and/or their family members; in addition, requests for assistance came from individuals who walk into the facilities located in Orleans and Jefferson Parishes. Calls logged were but a small percentage of all incoming calls since there were many calls for various staff members about matters such as accounting or clients at the rehab center. It seemed, but could not be determined, that the majority of the incoming calls concerned those types of office matters and not ones regarding requests for assistance. In addition, since only four of the approximately 14 staff members logged calls, some of the calls that came in requesting assistance were not logged, however, it could not be determined how many there were.

The staffing and organization of this helpline is a study limitation. Since incoming calls were part of the general calls of the agency and not all calls were for those requesting assistance, the findings apply to informal call-answering systems that are not reflective of a typical telephone helpline. In addition, the sample size of calls was small (72 calls). Thus, results are not generalizable to dedicated helplines. A similar study could be done once the MHNT is operational.

### **Conclusions and Implications**

This study was undertaken to assist in the creation of the Mental Health Navigation Team (MHNT) for NAMI New Orleans to meet the needs of those who call to seek help and guide those who respond to the calls. Since the MHNT will be new, NAMI New Orleans will need to set up policies and procedures, a decision tree, and a MHNT team. Several of the findings in this study may have implications for policy and practice.

### **The MHNT**

The part-time paid coordinator of the MHNT, discussed in the literature review chapter, will recruit and train the volunteers and interns who will fill out an application form along with the basic information about the applicants. There will be questions about any experience (educational or personal) they have with mental illness, if they are living with a mental illness, or know someone who does, if they have prior experience working on a helpline, why they want to volunteer for this one, and what do they hope to gain by being involved in this effort. They will also be asked to submit to a background check and to sign a consent form.

When looking at possible recruits, the coordinator will want to attempt to find the volunteers or interns who possess one or all of three motivating factors for volunteers as a study by Aguirre and Bolton (2013) showed: altruism, personal fulfillment and a desire to help others in crisis. A volunteer will also need to be discreet and understand that one of the reasons people call telephone helplines is because of their anonymity and confidentiality, two aspects which will be important to uphold, as described in a study about telephone counseling in Greece (Christogiorgos et al., 2010). Also, in a study of a university helpline in the UK, Paterson et al. (2009) found that volunteers ability to empathize and value harmony with others suggests that these attributes will be valuable traits to look for as well.

NAMI New Orleans will supply for every volunteer a day-long initial training session which is fairly shortly in comparison to the industry standard. However, the MHNT may have only two to three volunteers in training at one time, which is smaller than the standard. Juen et al., (2013) discussed in a study about lay counseling for a group of 42, that there was a training session of two days, whereas Dalgin et al. (2011) looked at a 16-hour training for a peer-run warm line. In the training session, there will be a review of the MHNT booklet which describes the policies and procedures, an overview of what the MHNT does (e.g., support and assistance) or does not do (e.g., counseling or casework); how to best communicate with callers, to write emails, to trouble shoot (e.g., if a caller is silent or frustrated); how to get help for a difficult call and to maintain a call log. The booklet will also contain separate information sheets about procedures such as the most frequently asked questions, the best ways to reply to callers by email or calling them back. For instance, knowing that callers in this study often sought assistance to find

counseling services, a list of dependable counseling services will be compiled. A study by Bureau et al. (2012) reported that after contacting a telephone hotline in Mumbai, India, people with first time psychosis start off by seeing a non-psychiatric healthcare professional such as a counselor, after receiving psychiatric assessment (Bureau et al., 2012), possibly hoping counseling will suffice.

The MHNT members will need to show compassion and be non-judgmental and non-critical towards any callers. At a minimum, they should show they do not believe in stereotypes about them or blame them or their family members for their illness. This also suggests that having peers as responders, such as those who are living with a mental illness and family members, will be desirable. Birnbaum and Shor (2012) discussed this approach in the study about the family peer support hotline, wherein family members using the hotline felt empowered by receiving advice from peer counselors who had shared experiences similar to theirs.

Knowing the days of the week and times of day that most calls come in will help set the MHNT schedule. For example, a higher number of volunteers can be scheduled towards the middle of the day. As for the duration of calls, there were wide variations in the amounts of time call loggers spent on calls. This could suggest the need for discussions about the recommended length of time to spend and understanding the reasons for short or long calls. All responders should be ready and able to spend the time to devote to callers' concerns by exploring which materials, resources, and contacts will best assist them. The team can set time limits, particularly for longer calls, if needed.

Discussions not just during training but also on a regular, ongoing basis about the content of calls answered, will also enrich the experience of the MHNT. Volunteers

should feel that they are doing their best for the callers and that they can learn from each other. Discussions may also evolve around key psychosocial skills responders should possess as shown in a study by Juen et al., (2013) of helplines from around the world: active listening; knowledge about resilience, grief, and of stress and trauma; and an ability to show support in non-intrusive ways so that those affected could find their own solutions. Other qualities of counselors, as Ashdown-Lambert et al. (2007) pointed out in their study in North Wales, are that they accommodating, non-judgmental, non-threatening, as well as consistent and dependable. Discussions could occur about any pitfalls such as described in the study by Boddy et al. (2004) about problems callers encounter such as *signposting*. This occurs when callers are recommended to call another agency but callers were not able to connect with referred agencies (e.g. call not returned) or, if they did connect, it was not in a timely manner. Providing ineffective referrals could cause callers to view the organization in a negative way (Boddy et al., 2004).

Once established, the MHNT will need to be promoted to the community it serves. Since certain agencies refer callers to NAMI New Orleans, the MHNT should maintain relationships with them, thank them for sending people to them, encourage them to promote the MHNT and offer materials to do so. There could be mention of the MHNT's mission and how to reach it on any correspondence, flyers, and events announcements that NAMI New Orleans sends out.

Since some of the referrals come from the support groups and education courses, the MHNT could let the leaders of those groups know that their attendees are welcome to use the helpline and that any others who want to can do the same. The MHNT could also promote the services of this team via the agencies and networks NAMI New Orleans

works with in behavioral health care along with a wider range of media outlets throughout their prescribed area.

### **The Decision Tree**

The MHNT will need to maintain a well-established decision tree to supply as rich a range as possible of information, suggestions, ideas, and resources that will support the members of the MHNT. It will include all the information contained in the Family Guide, which addresses many issues affecting family members and individuals with mental illness such as counseling services, types of mental illnesses, medications, housing, and insurance. There will also be information sheets, such as those contained in the MHNT booklet, with fuller descriptions on subjects that appear to be more complex such as giving advice in a crisis situation, how to obtain a case manager, and how to find work after incarceration. Brief descriptions or brochures about agencies and contacts that are considered trustworthy, dependable, and frequently requested (e.g. MHSD, all NAMI New Orleans programs) will also be filed in the decision tree. All materials will be updated on a regular basis.

Any suggestions made to callers should be those that are known to be useful and reliable. For example, when someone calls to say that a family member with a mental illness is about to leave prison and wants to know how to get that person into a job program, the decision tree should have the information about which agencies provide services for such a person. If the MHNT does not have this, a member of the team will contact agencies to see which ones will be able to assist such a caller. The MHNT can then arrange to call back or write the caller to supply as complete an answer as possible. Answers might not always be positive since many agencies have programs, housing or

other services which either lack availability and/or have a long wait list. The decision tree will maintain any information for future use. This case would be a good example of helping to improve the caller's chances of finding employment for their loved one. Helplines try to resolve or improve a specific situation of callers, not really their long-term situation (Paterson et al., 2009).

Booklets, guides, or directories for the local community are available online such as the 44 page "Unity of New Orleans Housing Directory" and the 83 page "Common Ground Health Clinic Resource Guide." Selections from these resources can serve as reference and supplements to information in the decision tree.

The decision tree will grow over time by gathering and adding information that appears to be useful, not already in the tree, but in demand; for instance, a brief description about housing options and their eligibility requirements accompanied by a list of contacts. Since the large majority of callers are females, more than likely either living with a mental illness or caring for a loved one living with a mental illness, the MHNT could also create a separate information sheet providing resources for women on housing, mental health services, and/or shelters. The fact that women call often could also be a reason to recruit female volunteers for the MHNT.

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## APPENDIX A CALL LOG

<b>Nature of call:</b> crisis, housing, listening/support, assistance with disability, insurance or other forms, request for counseling, individual does not know, repeat call. Explain.	<b>Notes</b> related to nature of call.	<b>Type of caller:</b> individual w/mental illness, family member, friend, provider, neighbor; other. Explain.	<b>Referrals</b> made to: Orleans or Jefferson coroner, MHSD/Metropolitan Human services, JPHSA/Jefferson Human Services, NAMI support group (which one), Family guide sent, Other. Explain.	<b>How did you hear about us?</b>	<b>Date, time, duration of call.</b>	Is follow-up needed- Y or N?	<b>Contact information of caller:</b> Name, address, phone, email	<b>Logged in by:</b>	<b>Additional question</b> to ask, if willing: We're interested in creating a log of information in order to provide better services to our clients. Would you mind providing us with your <b>gender, age, and race?</b>

**APPENDIX B  
IRB APPROVAL**

ACTION ON EXEMPTION APPROVAL REQUEST



TO: Michelle Livermore  
Social Work

FROM: Dennis Landin  
Chair, Institutional Review Board

DATE: September 30, 2015

RE: IRB# E9520

TITLE: National Alliance on Mental Illness of New Orleans Helpline Analysis

Institutional Review Board  
Dr. Dennis Landin, Chair  
130 David Boyd Hall  
Baton Rouge, LA 70803  
P: 225.578.8802  
F: 225.578.5983  
[irb@lsu.edu](mailto:irb@lsu.edu) | [lsu.edu/irb](http://lsu.edu/irb)

New Protocol/Modification/Continuation: New Protocol

Review Date: 9/28/2015

Approved  Disapproved

Approval Date: 9/28/2015 Approval Expiration Date: 9/27/2018

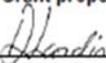
Exemption Category/Paragraph: 4a

Signed Consent Waived?: NA. All data aggregated.

Re-review frequency: (three years unless otherwise stated)

LSU Proposal Number (if applicable):

Protocol Matches Scope of Work in Grant proposal: (if applicable)

By: Dennis Landin, Chairman 

**PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING –**  
Continuing approval is **CONDITIONAL** on:

1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects\*
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins); notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants, including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
7. Notification of the IRB of a serious compliance failure.
8. **SPECIAL NOTE:**

*\*All investigators and support staff have access to copies of the Belmont Report, LSU's Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at <http://www.lsu.edu/irb>*

## VITA

Deborah de la Houssaye, a native of New Orleans, Louisiana took a Bachelor of Arts degree in French and studied abroad. She graduated from the University of New Orleans with a Master of Arts in Romance Languages. She worked at the French Consulate in New Orleans for 24 years and has taught both French and English as a Second Language. She is a candidate for her master's degree in May, 2016 and plans to continue her work in the field of helpline services.