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ORIGINAL PAPER

A Longitudinal Analysis of the Influence of a Peer Run Warm Line Phone Service on Psychiatric Recovery

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Abstract This article focuses on the impact of a peer run warm line as part of the psychiatric recovery process. It utilized data including the Recovery Assessment Scale, community integration measures and crisis service usage. Longitudinal statistical analysis was completed on 48 sets of data from 2011, 2012, and 2013. Although no statistically significant differences were observed for the RAS score, community integration data showed increases in visits to primary care doctors, leisure/recreation activities and socialization with others. This study highlights the complexity of psychiatric recovery and that nonclinical peer services like peer run warm lines may be critical to the process.

Keywords Warm-line · Intentional peer support · Recovery assessment scale · Crisis usage · Community integration

Introduction

As with all complex illnesses, individuals experiencing long-term psychiatric illness need multiple treatment and support options. The psychiatric rehabilitation literature supports a holistic conceptualization of recovery, which integrates clinical and nonclinical dimensions as important to improving quality of life (Davis et al. 2013). Once individuals with mental illness have moved out of crisis and intensive inpatient treatment and return to their communities, the opportunities for support along the recovery journey can be limited, especially in rural areas. Social isolation and loneliness continue to be challenges for consumers on their recovery journey (Davidson et al. 2004). Often, individuals with mental illness are at a loss for places to turn in times of distress, and end up inappropriately using crisis services or hospital emergency departments (ED). As Stefan (2006) noted, "when the community mental health system does not have a continuum of 24-hour, 7-day crisis services for people with psychiatric disabilities, substantial, unnecessary, and expensive use of the ED (or the criminal justice system) is inevitable" (p. 112).

To help fill this void, many communities have developed various peer services. Peer delivered services have been defined as "services provided by individuals who identify themselves as having a mental illness and are receiving or have received mental health services and are delivering a service with the primary purpose of helping others with mental illness" (Solomon 2004, p. 393). Peers provide the social support that can offer friendship, reduce stigma, and build hope (Solomon 2004). Peer delivered services have been found to benefit the receiver and the provider, as well as the mental health delivery system itself (Davidson et al. 1999; Solomon 2004; Solomon and Draine 2001).

One place where peers have become essential is within the network of telephone peer support services called Warm Lines. Peer-run warm lines function like other helplines and can play an important role in the mental health system, often fulfilling mental health consumers' need for 24/7 support (Chidwick 2007). Warm Lines are a pre-crisis service designed to provide social support to adults with mental health issues (Pudlinski 2001). A peer-run warm line is a phone service typically operating after business hours when other providers are not available (i.e. therapists, counselors,

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peer support center, etc.). A "warm line" is designed as an alternative to traditional "hot line" crisis services, used by callers who are not actually in crisis but are seeking support.

Generally, warm lines are operated by trained peer specialists who can offer hope, strength, and knowledge gained from their own personal experience of the recovery process. Peer specialists are trained in empathic listening, disclosure, providing possible ideas for coping strategies, and how to bridge to crisis services (Dalgin et al. 2011). These warm line services are now available in in over 30 U.S. states and in a number of countries. Some are toll-free statewide lines, while others are only available locally depending on funding sources (for a complete list see http://www.warmline.org). There are several different models of operation (on-site call center, beeper system, call-forwarding system), and some lines have paid peer employees while others run on a volunteer basis (Pudlinski 2004).

There have been very few empirical articles published on warm line services and their impact on community mental health and personal recovery. However, Stefan (2006) suggested "in a system with adequate case management, hot and warm lines, respite care, and well-trained, flexible community providers, use of EDs by people in psychiatric crisis could be expected to drop substantially" (p. 112). In 2011, Dalgin, Maline, and Driscoll conducted phone surveys with 480 warm line callers over 4 years. Warm line callers reported a reduction in the use of crisis services and a reduction of feelings of isolation. The results indicate that peer-run warm lines can fill an important void in the lives of individuals living with mental illnesses.

After a number of years of operating a state-wide peer run warm line service in a north-eastern state, one agency observed that there were a number of frequent callers. These frequent callers were individuals who called the line more than 30 times in 1 month over a 6 month period of time, and in the process became quite familiar to the staff. This program decided to focus their warm line on providing *intentional peer support* throughout the recovery process. Intentional peer support (IPS) focuses not on illness, symptoms, or assessment of crisis, but on what the caller is experiencing and what is behind the experience (Mead et al. 2003). It is about relational change; a commitment to mutuality, negotiation, noticing power dynamics, and a transparent agreement that both people are there to learn through the process of their relationship. This starts with the very first contact and is carried through by an on-going process of self/relational assessment (Mead and MacNeil 2006). Utilizing intentional peer support within a warm line model allows callers and peer specialist staff to better utilize the warm line services in a healthy and productive way, thereby increasing independence and recovery.

This study described the impact of a peer-run warm line on the recovery process, including reported use of crisis services and increased community engagement. More specifically, it looked at an Intentional Warm Line (IWL) staffed by paid peer support specialists trained in intentional peer support. This service is distinct from a crisis service, and it is designed to engage with adult mental health consumers by developing mutual relationships that lead to growth, change, and development of natural supports in one's own community. Care is taken to explain the focus of the program to callers; it is not a "listening" line, but rather a mutual conversation focused on moving forward in recovery. Using a Wellness and Recovery Conversation format, the staff works to guide the discussion with frequent IWL callers to focus on strengths, supports, and the life they want to live. Unlike a crisis plan, this process is primarily for the caller's use and is not shared with other IWL staff, unless the caller chooses to do that. It is a discussion of self-discovery and reflection that focuses on strengths, rather than deficits.

Methods

The state-wide IWL described in this manuscript is located in a primarily rural state in the northeastern United States and has been open 24 h a day, 7 days a week since 2010. Paid peer support specialists work from 15 to 37.5 h a week. During the 2014–2015 fiscal year, there were 2470 calls per month. Of those calls, there were 368 unique callers who called, on average, 6.7 times. Over the course of that year, there was an average of 79 new callers per month. Peer support specialists were trained to work with a crisis protocol and to have a mutual conversation with callers in significant distress to determine if it is necessary to bridge the call to his/her local crisis agency. In 2014–2015, 19 calls were bridged to the crisis hot line.

In 2011, every 10th individual was selected from a list of callers to be called back to request participation in a program evaluation survey until 100 participants were reached. If they consented to the survey, the Peer specialist delivered the survey questions on the phone. The survey contained questions about crisis service usage, the Recovery Assessment Scale (RAS), and questions designed to assess community integration. There were 58 questions in total. The majority of callers were able to complete the survey in one call; however, for a few callers, a return call was made at another time to complete all the items.

In 2011, the telephone survey process resulted in 92 usable surveys. In 2012, those same 92 IWL callers were re-contacted; this process resulted in 64 usable surveys, a return rate of 70%. In 2013, the 64 callers from 2012 were re-contacted, resulting in a final cohort of 48 usable surveys, a return rate of 75%. There were a variety of reasons for the reduction in the survey group, including callers being unreachable due to phone disconnection or no longer in

service, moving, hospitalization, or declining participation. Callers ranged in age from 18 to 70 years old. Due to the unique, nonclinical, and voluntary relationship with warm line callers, psychiatric diagnosis information is not regularly collected. Surveys were assigned a number by the agency and then provided to the main author with no identifiable information. IRB approval was received through the primary author's institution for use of this pre-existing, non-identifiable data.

The survey began with an evaluation of crisis usage. A question was asked regarding the callers' use of a variety of crisis services since their original call to the IWL. Although self-reported, it provided information on the use, or decrease in use, of emergency rooms, crisis hot-lines, and law enforcement. Additionally, callers were able to report if they had not used any alternate crisis services.

The RAS was developed as an outcome measure for program evaluations. It is based on a process model of recovery and attempts to assess aspects of recovery with a special focus on hope and self-determination. It has 41 items, all of which are rated using the same five-point likert scale that ranges from 1 = "strongly disagree" to 5 = "strongly agree" for a total possible score of 205 (Giffort et al. 1995).

The RAS also measures five domains:

Personal Confidence and Hope

People are optimistic about their future and believe personal goals are achievable.

Goal Success Orientation

Rather than focus on problems and on issues that cannot be achieved, recovery means that goals are self-determined and success is a reality.

Not Dominated by Symptoms

Mental illness is not the sole, or most prominent, focus of life. Recovery also means goals and life satisfaction.

Willingness to Ask for Help

Others (e.g., family and friends) play a central role in addressing problems and challenges.

Reliance on Others

In addition to help, others play a central role in goal attainment. This is consistent with what we know about this group of 48 respondents from 2013; they are fairly independent (living alone) but are also fairly isolated and lonely, and use the IWL as a resource for talking to peers (Corrigan et al. 2004).

The RAS has a strong reliability with an internal consistency of Cronbach's alpha = 0.93 and a test–retest reliability of Pearson Product Moment Correlation r = .88. Validity relationships with established measures include stepwise multiple regression, indicating that the Rosenberg self-esteem scale and the empowerment scale scores are significant predictors of the total RAS score (Giffort et al. 1995). More recently, Salzer and Brusilovskiy (2014) reviewed 77 studies, which all used the RAS and found substantial evidence that the RAS has solid and consistent psychometric properties and high construct validity.

The final section of the survey was designed to capture community integration activity. Although community integration has been recognized as a vital component of recovery, it can be a significant challenge for individuals with severe mental illness (Townley et al. 2009). This section included ten questions based on the Community Integration Domains outlined by Salzer and Baron (2006). The domains included housing, employment, education, health, leisure/recreation, spirituality, citizenship, social roles, peer support, and self-determination. All statistics were conducted using the STATA 10.0 statistical software program.

Results

The findings from the survey will be presented by section. The Crisis Service Utilization questions will be presented first, followed by the RAS data, followed by the questions related to the ten domains of community integration.

Crisis Service Usage Questions

IWL survey participants were asked *what types of support services had they actually used since their initial call to the IWL*. The data, across the 3 years (see Table 1), indicated reductions (38.7–29.2%) in the percentage of respondents who reported use of the Crisis Hot Line, and larger reductions (from 40.8 to 22.9%) in use of ED/ER

Table 1 Caller reported crisis service usage

Support Services used since first call to the IWL	2013 N = 48* # of Ob., (%)	2012 N = 64* # of Ob., (%)	2011 N = 92* # of Ob., (%)
Crisis hot line	14 (29.2%)	22 (33.3%)	36 (38.7%)
ED/ER	11 (22.9%)	18 (27.2%)	38 (40.8%)
Law enforcement	5 (10.4%)	6 (9.0%)	10 (10.7%)
No alternate services utilized	16 (33.3%)	38 (57.6%)	23 (24.7%)

*Callers could respond to more than one category

Table 2 RAS total score for 2011, 2012, 2013

RAS total score DATA	N	Possible score	Mean	Std. Dev.	Min.	Max.
RAS score 2011	48	205	165.42	18.70	126	202
RAS score 2012	48	205	165.44	22.72	104	205
RAS score 2013	48	205	169.41	20.53	125	202

Table 3 Two-sample *t*-test with equal variances—2011 and 2013 RAS mean scores

2011 RAS total mean (SD) N = 48	2013 RAS total mean (SD) N = 48	Level of significance
165.42 (18.70)	169.41 (20.54)	*p = 0.16*

Table 4 Two-sample *t*-test with equal variances—2011 and 2013 RAS Mean Scores

2011 RAS total mean (SD) N = 92	2013 RAS total mean (SD) N = 48	Level of significance
161.52 (20.35)	169.40 (20.54)	*p = 0.01*

services since they began using the IWL. There were also changes in those who reported using no alternate service (from 24.7% in 2011, to 57.6% in 2012, and back to 33.3% in 2013). Although there was an overall increase in those who reported not using any additional services over the 3 years, the reasons for the large change in 2012 were unclear. No inferential statistics were performed, as the callers could respond to more than one category.

RAS

Analysis of the RAS data was performed on two levels. First, RAS data was examined year to year while looking at the cohort of 48 individuals who responded in all 3 years; 2013, 2012, and 2011. During this analysis, the data from the 48 callers who responded to the survey in 2013 was matched with the same specific caller data from 2011 to 2012. This would show any possible movement in recovery, as measured by the RAS, over the 3 year period. When looking at this cohort group of 48 callers, a moderate increase was observed in the RAS scores from 2011 to 2013 (see Table 2).

To understand if there was any variance in the RAS scores, a two sample *t*-test was conducted, and results for the means of the RAS total scores. There was no statistical significance in the means from year 2011 to year 2013 (Table 3).

The second level of analysis was conducted examining RAS data when looking at the entire group of respondents in the first and last year; 92 in 2011 and 48 in 2013. In this stage of the RAS analysis, the two sample *t*-test was conducted with the means from the entire group of respondents in 2011 and 2013. Again, the mean RAS score for 2011 included people that did not participate in 2012 or 2013 for some reason or another. When this test was conducted, a statistically significant difference of *p = 0.01* was found (see Table 4).

Table 5 Tests for significance in five domain areas of the RAS—original 48 respondents

Domain area	2011 (n = 48) Mean (SD)	2013 (n = 48) Mean (SD)	Level of significance (P value)
Personal confidence and hope	34.39 (5.46)	35.17 (6.00)	*p = 0.26*
Willingness to ask for help	13.13 (1.99)	13.38 (2.27)	*p = 0.28*
Goal success orientation	20.63 (3.69)	21.15 (3.19)	*p = 0.23*
Reliance on others	16.94 (2.31)	16.69 (2.97)	*p = 0.68*
Not dominated by symptoms	10.81 (2.61)	11.48 (2.59)	*p = 0.11*

Five Domain Areas of RAS

Similar two sample *t*-tests were conducted on each of the two domain areas for the cohort of 48 survey respondents that participated in 2011and 2013; no statistically significant differences were observed (see Table 5).

In stage 2 of the RAS analysis, the same two sample *t*-tests were conducted with the means from the entire group of respondents on each of the five domain Areas in 2011 and 2013. Again, the mean RAS score for 2011 included people that have not participated in 2012 or 2013 for some reason or another. When these tests were conducted, statistically significant differences were found in three domains (Personal confidence and hope, goal success orientation, and not dominated by symptoms), as noted in Table 6.

Community Integration (N = 48)

Housing

IWL callers are primarily living independently in homes available to anyone in the community at 79.2% (n = 38), which was an increase from 68.8% in 2012. Another 10% (n = 5) reported living with family or friends, and another

Table 6 Tests for significance in five domain areas of the RAS—entire sample 2011 and 2013

Domain area	2011 (n = 92) Mean (sd)	2013 (n = 48)	Test of significance
Personal confidence and hope	33.44 (5.76)	35.17 (6.00)	*p = 0.05*
Willingness to ask for help	12.92 (2.11)	13.38 (2.27)	*p = 0.12*
Goal success orientation	20.11 (3.37)	21.15 (3.19)	*p = 0.04*
Reliance on others	16.70 (2.40)	16.69 (2.97)	*p = 0.51*
Not dominated by symptoms	10.17 (2.50)	11.48 (2.59)	*p = 0.01*

10% are living in agency owned apartments. In 2013, no callers reported living in group homes, institutional settings, or being homeless (shelters).

Employment

Callers surveyed reported very little work activity. In fact, they reported less work activity in 2013 than in the previous two survey years. In 2013, the majority reported not working at all (93.7%), in 2012 it was 88.3%, and in 2011 it was 86.9%. In 2013, one caller (2.1%) reported working full time, one caller reported working part time, and one (2.1%) reported volunteering. This data is very similar to the 2011 and 2012 data with very little changes in employment status.

Education

Over the 3 years, there was a decrease in reported educational activity. In 2011, 19.6% of callers reported participating in an educational program, but only 10.4% in 2013. Callers surveyed primarily reported not participating in an educational program; 89.6% in 2013, 82.8% in 2012, and 80.4% in 2011.

Health

All of the callers surveyed see a primary care physician, however there was a large change this year with the majority of callers reporting they go to see their physician annually. The number of callers who regularly see a primary care physician went from 20% in 2011 to 30% in 2012, to a large increase of 96% in 2013. It is difficult to know the reasons for this increase. It could be related to increases in wellness initiatives in mental health care in the past 5 years.

Leisure/Recreation

Most callers reported having hobbies and participating in recreational activities.

Although most callers reported doing things alone, there were increases in reported leisure activities with peers with mental illness (2011—12.2% to 2013—29.2%) and an increase in reported leisure activities with friends without mental illness (2011—12.2% to 2013—37.5%). In general, there is much more activity occurring with others than there was in 2011. This appears to be a positive step toward increased community integration. Activities reported included watching tv, reading, collecting coins or other items, walking pets, gardening, listening to music, reading the bible, using a computer, going to movies, visiting friends, fishing, swimming, doing crafts, and bingo.

Spirituality

Survey participants were asked if they participate in religious or spiritual activities. Slightly more than half (54%) reported yes. This data presents a slight decrease in spiritual activity from data in 2012 (yes—61.0%,) and 2011 (yes—68.5%).

Citizenship

Survey participants were asked if they engage in civic activities (i.e., registered to vote, voting, attend gatherings about public issues). More than half said yes (65%) and mentioned this mostly involved voting. Responses to this question were similar in 2012 and 2011.

Volunteering

Survey participants were asked if they do any volunteering. The majority reported that no, they do not volunteer (75%), although 25% do volunteer (this included formal and informal volunteering). Responses to this question were similar in 2012 and 2011.

Social Roles

Survey participants were asked if they speak with or see *friends who do not experience disabilities* as much as they would like to. Although the majority (56%) said yes, this is a large decrease from 72.6% in 2012, while 37% said no they do not socialize with people without disabilities compared to 27% in 2012. This data is a bit contradictory to Domain

5, where there was a reported increase in leisure activities performed with friends without mental illness. One note on this question is that there could have been some difficulty answering this question if the individual did not feel they had many 'friends' without disabilities, which is noted in the 6% of callers who responded 'don't know'. It also might be another indication of the amount of isolation and loneliness of these particular 48 callers, which may be why they continue to use the service.

Social Roles

Survey participants were asked if they speak with or see *friends who experience disabilities* as much as they would like to. The majority (81%) said yes, while 13% said no they do not socialize with people with disabilities. There was a slight decrease in responses on this question (85.9%—yes, in 2012), indicating less time spent with peers.

Peer Support

Survey participants were asked if they give and/or receive support from others with mental illnesses (peer support). The majority said yes (70%), which is not surprising as the IWL is a form of peer support and many respondents may have been referring to calling the line itself. Responses to this question were similar in 2012 and 2011.

Self Determination

Survey participants were asked if they make most of their own decisions about what they do on a daily basis. An overwhelming majority (96%) of the respondents said "yes", while only one respondent said "no" and one said "don't know". This is not surprising considering the majority of survey participants live in their own homes independently (79%). Responses to this question were similar in 2012 and 2011.

Discussion

To better understand these data, it may be important to look at who is using the IWL and where they might be in their recovery journey. In general, the cohort of 48 repeat callers being surveyed for this analysis were individuals whom are living independently, farther along in the recovery process, and stable enough to be able to access this type of self-initiated service. Additionally, *intentional peer support* is being provided with mutual relationships being developed, as each caller is making approximately seven calls per month. Clearly, the connection is meaningful to callers.

It is important to observe that during the 3-year period, the survey group was reduced by 44 people. The reasons for this attrition (phones disconnected or no longer in services, people moving, and a few were re-hospitalized) may indicate the callers lost were possibly a more transient population. If the 44 callers who stopped participating were in a more acute stage of the recovery process, this may indicate why more of a change was noted on the RAS total score when we compared the first group of 92 to the final group of 48. In their analysis of the psychometric qualities of the RAS, Salzer and Brusilovskiy (2014) commented that "the sensitivity of the RAS could also be affected by plausible ceiling effects" especially for studies where participants scored relatively high on the RAS at the baseline (p. 451). Additionally, the three domain areas that showed statistical change were personal confidence and hope, goal success orientation, and not dominated by symptoms. All of these areas contribute to the hypothesis that the cohort of 48 were farther along on their recovery journey than the original 92 callers.

Regarding community integration, more callers are living independently in their own home, 79% in 2013. They report a number of hobbies and activities, and an increase in social activity was noted regarding more of these activities being done with other people (with and without psychiatric disabilities) than in 2011. Nearly all IWL callers surveyed reported not working (96%), which is a startling number and even higher that the 90% reported by the President's New Freedom Commission on Mental Health (2003).

Implications for Practice

In summary, the IWL appears to provide a valuable service for callers. Users surveyed reported a decrease in use of crisis services, indicating increased mental health stability. Additionally, although there were no statistically significant differences noted on the RAS for the cohort of 48 repeat callers, there were some increases in measures of community integration (i.e., leisure/recreation activities done with others and alone, and socialization with others with and without disabilities). These data indicate improvements along recovery goals of competency, independence, self-worth, and a regained sense of self-control. Additionally, participants were more optimistic about their future and believed personal goals are achievable, as evidenced by the increases in the RAS domain of Personal Confidence and Hope. All of these outcomes reiterate the importance of a holistic conceptualization of recovery, integrating both clinical and nonclinical dimensions of support. Additionally, exploration as to the lack of vocational activity for this group of callers is warranted.

Limitations

There are a number of limitations to this study, the largest being the lack of a rigorous control such as a comparison longitudinal cohort without exposure to such a warm line. This does not allow for causal inferences due to possible, and even likely, confounding variables that cannot be known with the descriptive design of this study. The group of respondents to this survey (N = 48) is a small representative sample of all of the users of the IWL, and careful consideration should be given to generalization. It should also be noted that although the telephone survey response each year remains strong at 75%, questions arise as to the unique characteristics of those who continue to participate and those who decline or are no longer using the IWL for various reasons. For example, it is possible that the remaining participants had a different usage pattern with mental health services in general, and this may have affected the data regarding crisis service usage. Additionally, for logistical reasons, the survey methodology focused on repeat callers. Therefore, this does not give us a comprehensive picture of all IWL users, as many people call the IWL only once but may still find it beneficial.

Moreover, the nature of the program is voluntary and based on brief interactions, which decreased the ability to gather significant demographic characteristics about the duration and type of psychiatric symptoms/diagnosis the callers are living with, which might be impacting the results. Additionally, the lack of change on the RAS for these 48 regular callers could be due to a number of factors. The survey was delivered via phone calls, but perhaps an online or mailed survey would be something to explore, as the phone method might be affecting the responses individuals are providing. Finally, it may be that the RAS instrument is not sensitive enough to measure changes in recovery for people who are not in an acute phase. It is possible that recovery is a longer-term process, and more time is needed to observe changes in the stated concepts of recovery the RAS was designed to measure.

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Compliance with Ethical Standards

Conflict of interest Rebecca Spirito Dalgin was contracted to do program evaluation for Sweetser. Rebecca Spirito Dalgin and M. Halim Dalgin are married and work at separate institutions.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. IRB approval was received through the primary author's institution for use of this pre-existing, non-identifiable data and for this type of study formal consent is not required.

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