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Crises, the pillars of life an evaluation of after-hour services.

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CRISES, THE PILLARS OF LIFE:
AN EVALUATION OF AFTER-HOUR SERVICES

by

DAVID WAYNE HILLOCK

A thesis
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ABSTRACT

After-hour telephone counseling is a relatively new development in the field of mental health. Although some research has been conducted in terms of suicide prevention hotlines, very few studies have focused on the concept as a general means of helping people in crisis.

This research project, in general, was a program planning evaluation study of after-hour services in Windsor, Ontario. The purpose of this project was to study the extent, nature, and auspices of such services. To attain this goal, a three component study was conducted. Component I established a common data base that identified the target population and some of its characteristics. In addition, this data formed a foundation for further study and future evaluation. Component II attempted to examine the process of referrals made by after-hour counselors, while Component III described the existing after-hour services offered to the community. In addition, Component III identified the organizational perception of after-hour services.

A total of five agencies participated in Components I and II: Distress Centre of Help Services, Windsor Western Hospital Mental Health Clinic (I.O.D.E.), Roman Catholic and Essex County Children's Aid Societies, and Windsor Police Department.

For the month of March, 1982, data from 553 after-hour telephone calls were recorded for Component I. Analysis of the data revealed, among other things, that females utilize the after-hour hotline substan-

tially more than males and that the peak hour of operation was from 8:00 p.m. to 9:00 p.m. every day of the week. It was observed that the agencies participating in the study recorded the majority of their calls when Help Services was closed.

In terms of sex, contrary to common knowledge expectations, male counselors maintained longer contact with callers, than did their female counterparts, regardless of the callers sex.

In relation to related problems, it was found that the counselors most frequently identified family, interpersonal, and emotional problems, along with various combinations of these problems.

It was also noted that the majority of people who contacted the after-hour services were identified as "previously known", while only a few were known to be the result of a referral from another community organization.

Of the 42 attempts to obtain information that would allow a follow-up on a referral, only one call had the necessary information recorded. As a result, no empirical data related to the content of individual referrals was collected for the second component of this study. It was felt by the researcher that lack of cooperation on behalf of a few data collectors, and unrealistic expectations of the researcher, pertaining to the volume of calls, were responsible for the demise of this second component.

Of the 427 organizations that were surveyed for Component III, 194 questionnaires were returned within a three week period, a response rate of 45.41%. However, a breakdown of the response rate by type of organization revealed that 86% of the social services returned the questionnaires.

Of the organizations that responded, approximately 50% offered after-hour services. However, one-quarter claimed that their services were offered on an informal basis. Spiritual/religious and housing/residential services were the most frequently described services by this sample.

Family crisis, personal counseling, and general emergency assistance were the most salient after-hour needs that were identified, while around-the-clock telephone counseling was perceived to be the most needed service.

Respondents for this component identified accessibility, coordination, referrals, follow-up, and general lack of service to be areas needing improvement. The results obtained from the individual components of the present study appeared to support each other in terms of identifying the existing after-hour situation, the needs of the community, as well as the existing gaps in the system.

By examining the three components as a whole, in terms of what services are needed on an after-hour basis, in relation to the types of problems that were actually identified, duplication of some services, whereas gaps in others, surfaced.

Based on the review of literature in relation to crises and the results of this study, recommendations for future research and the existing after-hour services were made which would enhance our knowledge in this area, thus promoting better services to the community at large.

DEDICATION

This work is dedicated to Therese.
Carriere who helped me struggle through
the most profound crisis of my life and
for encouraging and seeing me for what
I could be, rather than what I was.

"Qui nous sommes, qui nous devenons,
est determine par ceux qui nous aiment"
(Powell).

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A research project of this nature would not be possible without the help and cooperation of many people.

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United Way Staff, Darlene Humeniuk and Lauri Bogucki deserve special thanks for their significant contribution to the organizational survey component of this study. Their accuracy and promptness, especially since United Way relocated in the midst of the survey, is gratefully recognized. I would like to thank Janice Murray for the role she played in developing the instruction manual for the data collection cards. Her past experience as an after-hour telephone counselor proved to be very beneficial.

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work. Thanks Tuz.

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Chapter I

INTRODUCTION

1.1   PROBLEM IDENTIFICATION

Recent problems of inflation, coupled with many other factors, such as unemployment, high interest rates, and stiff competition related to career opportunities, have created an environment in which people are experiencing increasing anxiety. For example, some people report to work on Friday and pick up their pay cheques only to discover that they are going to be laid-off indefinitely. Others find that their employers have filed bankruptcy. Many people, having to support large mortgages, surrender their homes (O'Conner, Forthcoming), only to discover that rental rates have skyrocketed and for many families, are impossible to afford. For the people who are not laid-off, the constant threat that "the hatchet could fall at any moment" hangs over their heads. Of course, job security is but one factor that plagues our society today. Lalonde (1974) sees "environmental pollution, city living, habits of indolence, the abuse of alcohol, tobacco and drugs, and eating patterns" as ominous counter-forces, "which put the pleasing of the senses above the needs of the human body" (p. 5). Others claim that, as a result of improved communication and transportation, people are driven to accomplish more in less time. This situation is compounded because of today's fast moving technology and change which can lead to increased feelings of alienation. Also, more and more people are being influenced

through the mass media (Liebert & Schwartzberg, 1977) to strive for instant pleasures and ready made solutions. In an attempt to do so, one can begin to lose touch with the realities of everyday living, thus creating a gap between the desired and attained.

These problems, among others, can lead to extensive internal and psychological stress. Hans Selye (1978) who has laid the foundation for the educaton of non-physicians regarding stress, states that stress is the "state manifested by the specific syndrome which consists of all the nonspecifically-induced changes within a biologic system" (p. 472). Stated differently, stress is the rate of wear and tear on the body.

In an attempt to close this gap and deal with these ever changing problems, some people cope by channelling their stress toward physical activities such as tennis, golf, handball, and the like. Others develop habitual patterns such as smoking, drinking, and nailbiting to cope with their stress. What some authorities see as symptoms of stress are seen by others as alleviating stress. In actual fact they may work in reverse and one could very easily become "trapped" or "caught-up" in a vicious circle. For example, if a person is at a party and is under excessive stress he/she may feel that, "if I have a couple of drinks I will not feel so uptight". In this case alcohol is perceived as a stimulant. This type of thinking and behavior establishes individual coping patterns, which are seen as socially acceptable behavior. (Hills, 1980). In some situations, drinking has become a required part of social interaction. Posner (1976) speaks of this in terms of the stigmatization of non-drinkers. The circular pattern that develops can lead to addictions, both physiological and psychological.

The specific examples outlined above are only a few of the problems our society is presently facing. Being aware of ever changing problems and their intensity, the influences, and events taken together can easily affect the equilibrium of one's basic system. If the equilibrium is sufficiently disrupted, then a crisis is inevitable. Aguilera and Messick (1974) explain that people in crisis are at a turning point. They are faced with problems that cannot be solved by previously used coping mechanisms. Consequently, tension and anxiety increase, and people become less able to find solutions to their problems. These authors claim that a person in crisis "is caught in a state of great emotional upset and feels unable to take action on his own to solve his problems" (p. 1). As a helping profession, social work needs to develop services that can help people reestablish their equilibrium when immediate help is needed, for example, in crisis situations.

Traditionally, helping professions have attempted to deal with these crises through face-to-face interaction. Professionals are now discovering that this mode of treatment, as the only or the supreme approach, is not practical or even accessible, given today's problems and client life-styles (Williams & Douds, 1973).

One such problem, different from those personal problems outlined previously, is the reduction in services which has resulted, among other problems, in longer waiting lists. A waiting list can be demeaning (Brockopp, 1973), humiliating (Williams & Douds, 1973) and could act as a deterrent to seeking help. Overbeck (1977) has found that his population of subjects had experienced high stress for periods of up to three years before they actually made a contact for help. Possibly the length

of waiting list, or the awareness of it, acted as a deterrent. Long waiting lists are primarily the result of the present economic situation and should not be confused as being representative of a reduction of service in terms of need.

In many cases immediacy of service is of primary importance. If people are unable to deal with their crises immediately, more severe problems could result (Caplan, 1964). In addition, people's problems do not always necessitate a "full face-to-face session" with a "trained professional".

In 1978, Turning Point offered a 24-hour hotline, which in one year recorded 7,372 calls, 70% of which were received during the evening, night-time, and weekend hours (McCarthy, Note 5). This would indicate that a large number of people experience problems outside of the traditional working hours (9 a.m. to 5 p.m.) As a result, mental health professionals must respond by providing relevant services on an immediate or 24-hour basis.

One such relevant service, which is a relatively new development in the field of mental health is telephone counseling (Rosenbalm & Calhoun, 1977), sometimes referred to as "hotlines". Telephone counseling offers some unique therapeutc advantages not present in face-to-face interactions. For example, telephone counseling services, in general, can provide greater penetration into the community. More specifically, clients have more control. They can remain anonymous, and geographic and personal barriers can be bridged. The therapist can remain anonymous too, which in some cases is also advantageous (Williams & Douds, 1973).

It may be stating the obvious to assert that the technique of crisis intervention, for telephone counseling, is the most appropriate method of dealing with people in crisis:

> Yet, all of the theories of behavior, methods of psychother-
> apy, and techniques of intervening into people's problems
> derived from them, the theory and technique of crisis inter-
> vention is the method of choice when working with a person on
> the telephone who is in crisis. (Brockopp, 1973 p. 89)

In summary, people are, because of economic and personal factors, facing rather unique problems; consequently the potential for crises to occur has increased. Thus, new forms of intervention need to be recog- nized and utilized in order to respond appropriately. One such techni- que is telephone counseling which offers direct and distinct benefits different from those of conventional face-to-face therapy. Telephone counseling essentially utilizes similar strategies and techniques pres- ent in crisis intervention.

1.2   PROBLEM FORMULATION

Ripple (1960)   contends that all research has as its initiating impetus a "felt difficulty" which reflects a general uncomfortable state of affairs. The felt difficulty in this project is two-fold. First, approximately ten years ago, the City of Windsor began to organize after-hour services by conducting a number of small studies then amalga- mating services. After the establishment of numerous committees and the amalgamation of several services, the allocation of funds had essen- tially remained the same, taking into consideration inflationary factors. There had however, been a reduction in services provided to the community. For example, at one point Windsor offered a hotline with

around-the-clock coverage, . which does not exist at the present time. This could lead one to believe that the need for such services had also decreased, contrary to the position outlined earlier in this chapter. The second point of felt difficulty is reflected in a statement made by a member of the Advisory Committee (See Appendix A)# while discussing the issue of after-hour services. · This member of the Advisory Committee stated "How can we·design· a more effective after-hour·system that meets the needs of the community if we don't even know what is out there?"

If researchers decide, in a systematic manner, how to explore this felt difficulty , they ultimately arrive at the "purpose" of the research project.

Speaking to the "purpose" of social work research, Ripple (1960) states that,

> the purpose of all problem-solving efforts is to move from a situation characterized by doubt or ambiguity to a situation in which the uncertainties have been removed. (p. 24)

This study is the result of the doubt, ambiguity, and uncertainties expressed by the staff members of many agencies in the Windsor area related to the lack of co-ordination, communication, and knowledge in relation to after-hour services.

The need for emergency and crisis services on a 24-hour basis has generally been acknowledged (Bauman, 1981). However, the extent, nature and auspices of such services has been a matter of considerable discussion over the past several years. More specifically, this study consists of three distinct components: (1) to establish a common data base that will (a) identify the target population and some of its char-

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The Advisory Committee consisted of key individuals from the community identified with after-hour services.

acteristics, and (b) act as a foundation for further study and future evaluation; (2) to examine the process of referrals made by after-hour workers; and (3) to identify the organizational perception of after-hour services.

The procedures used to investigate these components constitute evaluation research methods, generally referred to as "planning evaluation" (Rossi, Freeman & Wright, 1979). Consequently, the data obtained during this study will provide information for the planning and designing of effective telephone counseling services.

To accomplish the goals of this research project, the researcher reviewed the literature which consisted of an overview of crisis theory, the state of crisis, and crisis intervention in Chapter II. Chapter III will discuss the historical perspective of telephone hotline services. Chapter IV consists primarily of four sections: (1) the research classification scheme; (2) data collection methods and procedures; (3) operational definitions; and (4) populations used and sampling techniques employed. The results were tabulated and analyzed by utilizing the Statistical Analysis System (S.A.S.). Chapter VI includes a summary of the major findings, their limitations, and recommendations for future research aimed at improving the existing after-hour services

Chapter II

REVIEW OF THE LITERATURE

This chapter consists of four sections related to crisis.   Section
One discusses the   state of crisis from a   theoretical perspective while
Section Two focuses on crisis intervention.   Telephone opposed to face-
to-face intervention is discussed in Section   Three which is followed by
a discussion of crisis intervention by telephone in Section Four.

2.1   THE STATE OF CRISIS: THEORETICAL CONSIDERATIONS

2.1.1   Crisis Theory

The primary responsibility for the development of crisis theory and
crisis intervention is attributed to   Lindemann (1944).   His ideas were
further developed   by Caplan (1964).   According to Caplan   (1964),   an
organism is normally in a state   of psychological equilibrium,   which is
the hypothesis   on which the conceptual   framework of crisis   theory has
been formulated.

Usually,   the   problems of   life are solved   with minimal   delay by
habitual   mechanisms and   reactions.   Since   people play complementary
roles in   relation to others   in their social   system in terms   of their
positions in society, the larger system of which they are a part is also
perceived to be in equilibrium. However, Caplan cautions us that,

> this does not mean that it is static, but that the various
> social forces produce a pattern which has some consistency
> when viewed against a temporal continuum. (p. 39)

The normal pattern is maintained by homeostatic re-equilibrating mechanisms, "so that the temporary deviations from the pattern call into operation opposing forces which automatically bring the pattern back to its previous state" (p. 38). Stated differently, the individual or system's equilibrium is upset, as it is faced with a situation which alters its pattern of functioning. This is commonly referred to as a "problem".

Characteristically, the problem calls forth a number of habitual problem-solving mechanisms. One of these mechanisms solves the problem in a similar way and length of time in which it was previously resolved. Shortly before the solution, the organism experiences tension, but this tension is not disproportionate if the period does not exceed the previous experience, as the organism has developed the expectation of a successful outcome and confidence in the ability to handle or endure the tension. Confidence is also felt in terms of employing previously developed techniques which harness or limit the tension by means of discharge mechanisms.

Brockopp (1973) asserts that it is important to realize and remember that a crisis does not mean that the individual is confronted with a totally new situation.

> A crisis is more likely to be a situation in which a previously tolerable set of circumstances is suddenly, by the addition of one other factor, rendered wholly intolerable (p. 90).

For example, if the outside temperature is below freezing, an automobile engine, which usually starts promptly, may need a "boost".

In a crisis, the process is exaggerated as the problem stimulus is somewhat different and the re-equilibrating forces are unsuccessful,

given the expected time range. Caplan (1964) expands on this idea by suggesting that the person becomes uncertain about the resolution of the problem; consequently, the situation is emotionally hazardous. A crisis, then, occurs when stressful events are put together in such a way that the body's and mind's coping mechanisms can or do not function adequately. As Caplan puts it,

> when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many different abortive attempts at solution are made. (1966, p. 18)

Brockopp (1973) is even more specific when he states,

> a crisis is the person's response to a hazardous situation, which by the inclusion of one additional event has created an imbalance in his life to the degree that resolution is required. (p. 91)

Having defined a crisis, it is important to understand the related processes and characteristics of such.

2.1.2   Characteristics of Crisis

The essential factor which influences the occurrence of a crisis focuses on the imbalance between the problem and the immediate resources available to deal with it (Caplan, 1964). The usual problem-solving mechanisms are nonfunctional and alternatives cannot be used. In other words,

> The problem is one where the individual is faced by stimuli which signal danger to a fundamental need satisfaction or evoke major need appetite, and the circumstances are such that habitual problem-solving methods are unsuccessful with the time span of past experiences of success. (Caplan, 1964, p. 39)

Consequently, tension arises because of the frustration of need and this can involve problems with maintaining the integrity of the organism.

The intensity and significance of the problem, according to Caplan (1964), affects the disruption of one's equilibrium or functioning. Due to the fact that the individual is "upset", subjective feelings such as fear, guilt, or shame are associated with the individual's state. One feels helpless in the face of the insoluble problem. This in turn is associated with some disorganization of functioning.

The disorganization may take the form of an activity which is not motivated by the external situation such as an attempt to discharge inner tension. Or, this activity could take the form of repeated unsuccessful trial-and-error attempts to solve the external problem. At this point, the tension may rise steadily; it may fluctuate; or may rise steadily, then level off. The total effect has been explained by Caplan (1964) in four characteristic phases. (pp. 40-41).

Phase 1: The first phase is characterized by the initial rise in tension as a reaction to the stimulus which in turn necessitates the habitual problem-solving processes of homeostasis needed to sustain equilibrium.

Phase 2: The second stage is characterized by the lack of success and continuation of the stimulus which is associated with a rise in tension. This enhances the state of disorganization and tension within the organism.

Phase 3: The third phase develops when the individual calls for emergency problem-solving mechanisms. Novel methods are used to attack the problem. At this point the problem may be redefined by the individ-

ual in an attempt to relate it to a previous experience, thereby employ-
ing a familiar problem-solving strategy or technique. Conversely, the
individual may actively resign and give up on a particular aspect of the
goal if it is perceived as unattainable. Exploration by trial-and-
error, in action-or abstract thought, may be explored to discover which
avenues are open or closed. As a result of this mobilization or redefi-
nition, the problem may be solved.

Phase 4: However, if the problem is not solved, the tension mounts
beyond an acceptable threshold or its burden increases. At this point,
major personality disorganization occurs which could lead to, for exam-
ple, a psychotic breakdown, severe withdrawal, or suicide.

Other researchers have examined the phases of crisis in a system-
atic manner in relation to specific hazardous events. For example,
Bowlby (1960) while examining the separation trauma experienced by chil-
dren admitted to the hospital has outlined three distinct phases:
protest, despair, and detachment (pp. 89-113). Lindemann (1944) studied
acute grief following bereavement and found that the duration of grief
was dependent upon how successful individuals deal with their "grief
work". According to this author, grief work is composed of three
phases: (1) People free themselves from the bondage to the deceased, a
readjustment is made to the environment from which the deceased is miss-
ing, and one finally begins to form new relationships (pp. 143-144).
Finally, in studies initially related to premature birth (Caplan, 1960),
which inspired further studies of families in crisis (Parad &
Caplan, 1965), Kaplan and Mason (1965) have isolated four phases that
have to be completed in order to solve a crisis one must, (1) anticipate

grief work, (2) acknowledge maternal failure, (3) resume the process of relating to the baby, and (4) the mother must recognize the special needs of the premature infant.

2.1.3   Types/Kinds of Crisis

Personality development has been described in terms of differential phases, each of which is qualitatively different from its predecessor. The movement between phases, which is characterized by cognitive and affective upset, is called a "transitional period" and is explained by Erikson (1959) in terms of "developmental crises". On the other hand, "accidental crises" are those periods of psychological and behavioral upset which precipitate life hazards. Life hazards could be, as stated by Caplan (1964), an abrupt loss of basic supplies, the threat of loss, or challenge.

Caplan (1966) expands on the significance related to life crises by responding to the question, "What are the various situations of difficulty which precipitate crises?" (p. 40). He divides "situations of difficulty" into two types. One type is a threat which involves the danger of losing an object or a source of satisfaction of one's needs, or one's integrity is jeopardized or threatened in bodily terms. Stated differently, the potential loss of something or someone one loves is realized. For example, one could lose an arm, leg, one's life, or the opportunity to fulfill any basic need such as love (Maslow, 1954, 1962; Globe, 1976). The second type involves the actual loss, rather than the threat of loss: One can actually lose an arm or a loved one.

Edwin Shneidman (1973) in his opening remarks at the Second Annual Symposium in Community-Clinical Psychology distinguished between three kinds of crises. The crises that occur during a stage, for example, within adolescence, middle age, or old age, are termed "intratemporal crises". Often people can continue to do what they have been doing, but when it comes time to move or shift to another phase or developmental stage, difficulty is experienced. Resistance to taking on new tasks is called "intertemporal crises". They occur in the interstices between the major times of one's life. For example, it is difficult to become an adolescent and give up childhood. The difficulty that surrounds this "giving up" is related to adjusting to the new, or fear of the unknown. The third type of crisis is known as "extratemporal". It occurs independent of the time of one's life. Ordinary stage-fright can serve as an illustration.

Once it has been recognized that a person is experiencing a crisis, an appropriate intervention strategy is focused upon.

2.2   CRISIS INTERVENTION

Crisis intervention can be defined as

the set of activities designed to influence the course of crisis so that a more adaptive outcome will result, including the ability to better cope with future crisis. (Jacobson, Strickler & Morley, 1968, p. 339)

Crisis intervention can offer individuals problem-solving techniques to help them re-establish their equilibrium.

2.2.1   Foundations of Crisis Intervention·

Crisis intervention is a unique therapeutic process which began as a technique for ·helping people who were involved in disasters. Brockopp (1973) in an excellent text,   Crisis Intervention and Counselling by Telephone, claims that three mainstreams ·of thought have led to the development of crisis theory.   One stream developed out of military· psychiatry, to which Glass (1965), Tyhurst (1957), and Hausman and Rioch (1967) have contributed. These authors also contributed to the development of the major elements which are necessary to deal with the crisis situation. Then short term ego and teaching therapies were developed by Bellock and Small (1978), Ellis (1962), and others.   Here, the positive characteristics of the· patient and concentration on the "here and now" added a new dimension to crisis intervention.   Finally, situational involvement with the client, in conjunction with community emergency services, was initially developed by Caplan (1966), reorganized by Jacobsen (1965), and more recently systematized by Hansell, Wodarczyk, and Hardlen–Lathrop (1970). ˙ The culmination of these three mainstreams has led to the development of "social behavior crisis counselling", a term that was coined by Brockopp (1973) and defined as "a system of intervention" (p. 95), namely, crisis intervention.

2.2.2   How Crisis Intervention Differs From Other Forms of Inververtion

Crisis intervention differs from the traditional psychiatric therapeutic view of people and their problems in at least six different respects (Brockopp, 1973).   First, the concept of "mental illness" or other similar classifications of people are non–existent.   Second,

features such as ability to cope, personal strength, and potential for problem-solving are of primary concern. Third, healthy aspects, rather than pathological or sick aspects of the personality are emphasized. Fourth, the environment, social structure of the individual and the community are seen as integral influencing factors, rather than just dealing with the dynamics of the personality. Fifth, there is an assumption that individuals will make the right response, provided they are "given information in a setting in which they can use information and that a person's behavior will tend to move towards desirable ends or outcomes".(p. 95). Finally, the counselor takes on an active and directive role in an attempt to help individuals conquer their crises.

Once the the crisis has been identified and the determination to intervene has been established, a counselor can then take a number of therapeutic approaches.

2.2.3   Two Basic Approaches

Crisis intervention is an extension of brief psychotherapy.# (Aguilera & Messick, 1974). The minimum therapeutic goal of crisis intervention is to resolve the present crisis and return the individual to a level of functioning which is at least equal to that preceeding the precipitation of the crisis period. The maximum expectation is that individuals would accelerate their functioning above and beyond the pre-crisis level.

Jacobson, Strickler and Morley (1968) have developed two major conceptual categories, which are complementary in nature, within the crisis intervention framework which they call the individual and generic

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For a discussion of brief psychotherapy see Bellak & Small, 1978.

approach.

Generic Approach

The central thesis of the generic approach is that for each crisis, such as the loss of a loved one, divorce, or bereavement, certain identifiable patterns exist. Some of these patterns result in adaptive outcomes while others have maladaptive outcomes. For example, Lindemann (1944), while studying bereavement, found a well-defined process that a person experienced while trying to adapt to a loss. These sequential phases have been defined as "grief work". If this grief work is not completed, then psychiatric or psychosomatic illness could result.#

The focus of this approach is on the characteristic source of the crisis and the corresponding treatment strategy rather than on the specific psychodynamics of individuals. Approaches taken in crisis intervention include "direct encouragement of adaptive behavior, general support, environmental manipulation, and anticipatory guidance" (Jacobson, et al., 1968, p. 340). These approaches included all the members of a specific group, for example the bereaved, with little emphasis on individual differences.

As the generic approach does not focus on mastering intrapsychic and interpersonal processes of individuals, it can be practised by non-psychiatric physicians, social workers, nurses, and paraprofessionals. The emphasis of the generic approach can be briefly summarized as consisting of (1) specific situational and maturational events which

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For further examples see Janis (1958), Kaplan and Mason (1965), Rapoport (1963), and Caplan (1964). Readings related to the generic approach can also be found under headings such as "situational" or "maturational" crises.

occur in significant population groups, (2) crisis intervention targeted to these specific events, and (3) that intervention can be conducted by non-mental-health professionals (Jacobson et al., 1968, pp. 338-342).

One should be aware of the limitations within the generic perspective (Jacobson, et al., 1968). First, since there are so many types of crisis, there also exist the same number of characteristic patterns which consist of adaptive and maladaptive solutions. Consequently, the work of Janis, Kaplan & Mason, Caplan, and others, has only scratched the surface in terms of identifying these adaptive and maladaptive coping patterns relative to only a few situations. Second, it would be unrealistic for professionals and nonprofessionals alike to expect that an intervention plan, which is developed from universal characteristics, would be effective for all individuals in crisis. Thus, there is a need for another approach to crisis intervention – the individual approach.

Individual Approach

The individual approach differs from the generic approach in that, its emphasis is on the professional assessment of specific intrapsychic and interpersonal processes of the individual in crisis. In spite of the emphasis, this information would not necessarily be presented to the client. The purpose of this focus is to obtain information that will directly influence the swift achievement of a solution relative to the unique circumstances of the individual.

This approach differs from extended psychotherapy as it is not concerned with long-established processes except when they provide information or clues that enhance the understanding of the current

crisis. Rather, the focus is on how and why the previous equilibrium had been upset, as well as how best to restore it. Another difference is that this approach includes the individual processes of family members and significant others.

Jacobson et al. (1968) believe that this strategy, because it involves a greater measure of understanding of psychological and psycho-social processes, is most effectively conducted by individuals with pre-existing skills in the mental health professions. Briefly, the individual approach emphasizes, the unique biopsychosocial events of the individual, individual-directed intervention, and intervention conducted by mental health professionals.

2.2.4 · Basic Concepts of Crisis Intervention

Effective crisis intervention involves the use of five basic concepts which were enunciated by Housman and Rioch (1967) and further outlined by Brockopp (1973). These five concepts are: Immediacy, Proximity, Commitment, Concurrence, and Expectancy (Brockopp, 1973, pp. 97-99). These concepts will be discussed individually.

Immediacy is the cornerstone of effective crisis intervention. It is believed that during the crisis period people are open to change, possibly more so than in a non-crisis situation; consequently, intervention or action should be swift so as to avoid possible personality deterioration. Immediacy also offers individuals in crisis a sense of importance insofar as they are not placed on a waiting list. Brockopp (1973) states that the potential for positive growth through immediacy cannot be overemphasized.

Proximity involves dealing with the problem in the setting where it occurred, rather than removing individuals from the positive social aspects of their environment. By recognizing proximity, individual identity and role value in the environment are not lost. For this reason reintegration becomes easier.

Commitment is an essential element of crisis intervention and probably, during the crisis period, one of the most easily achieved. It is necessary for people in crisis to commit themselves to working towards a solution with the helper. This is usually easy to obtain since the individual wants to resolve the problem. Brockopp (1973) believes a conscious commitment is important, as people must take responsibility for their action and their part in the crisis situation. Commitment involves taking an active, rather than passive, role. Brockopp (1973) communicates this by stating that the "person is not acted on, but acting in concert with the therapist" (p. 98). If a commitment is made, the solution that is formulated is a result of two individuals working together-- the client and therapist-- and not just a treatment plan or prescription offered by the therapist.

Concurrence is an extremely critical element in effective crisis intervention that links the person in crisis to support systems.# Support systems consist of significant people who will support or help the person in crisis. As a prerequisite then, developing a set of caring relationships consisting of individuals who will embrace the clients and who will expect them to get well must be accomplished. Here, the worker becomes a type of transitional social object, "focusing

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For a good reference on support systems see Caplan, G. Support Systems and Community Mental Health, 1974.

the person on those social elements that have a permanent place in his life space" (Brockopp, 1973, p. 98). This in turn emphasizes the social network of the individual. If individuals do not lose sight of their social and cultural communities they can more easily regain their status in the community.

Expectancy involves forecasting for individuals the course of their problems and their eventual outcomes. Emphasis is placed on the potential of the individual and the healthy components of the personality. Confidence that individuals can and will obtain family, social, self, and community esteem is projected. Since the individual is often only aware of anguish or pain, the counselor must cut through this problem, destroy the negative self-fulfilling prophecies, and replace these with neutral or positive ones. Brockopp (1973) states, "if the helper views the person in crisis in a positive way, the family and peer group usually see him in the same way" (p. 99).

2.2.5   Phases of Crisis Intervention

Morley, Messick, and Aguilera (1967, pp. 538-540) have outlined four specific steps or phases of effective crisis intervention. Although each phase cannot be clearly defined in and of itself, these phases taken together would represent a "typical" interventive process.

(1) Assessment of the individual and the situation is characteristic of the first phase. Focusing techniques are used to discover what events precipitate the resulting crisis, however, little time is spent gathering a case history which does not directly relate to the crisis. It is not unusual for the initial hour to be spent assessing the circum-

stances surrounding the incident. If at the end of the assessment it is determined that the client presents a high risk to him/herself or others, then an appropriate referral would be made, for example to a psychiatrist in a hospital emergency ward. However, more often than not, the intervention proceeds.

(2) Following the exploration of precipitating events that led to the individual seeking help and the assessment, the nature of the therapeutic intervention is planned. In this phase the degree and effects of the disruption, which include other individuals in one's social orbit, and the identification of when the crisis began, are determined. Also, the individual's strengths is assessed as well as other possible support systems. Finally, an exploration of alternative coping mechanisms is explored.

(3) The third phase is representative of the intervention itself. Morley et al. (1967) claim that "the number of techniques which may be utilized is limited only by the flexibility and creativity of the consultant" (p. 539). Following are four such techniques.#

1. Intellectual Understanding:

Surprisingly enough, many people do not see the connection that exists between the hazardous situation and the extreme discomfort which is being experienced at that particular point. Consequently, the consultant may describe the crisis and relate it to the precipitating events in the person's life.

For other approaches, such as the "A-B-C" approach or the "four phase" process, see Edwards, Romaine Crisis Intervention and How It Works (1977), and McGee, Richard K. Intervention in the Community (1974), respectively.

2. **Recognition of Feelings:**

> Realizing that the client may not be aware of the just-described relationships, it seems reasonable to suggest that some people in crisis may not have allowed themselves to experience some of their real feelings. Here the counselor can help the client recognize these feelings so that they may be brought to the foreground.

3. **Exploration of Coping Mechanisms:**

> Here the client is asked to examine alternate ways of behaving. This calls for the employment of new coping mechanisms. If the therapist sets the stage, the client will often develop highly creative ways of coping which were not previously utilized.

4. **Reopening the Social World:**

> Resolution and anticipatory planning of the crisis is the final stage. Here the counselor makes every effort to reinforce changes such as a reduction in anxiety, or a restoration of equilibrium.

Counselors communicate openly the changes they see by summarizing the adjustments which have occurred. This enables people to re-experience the gains which they have made. During this phase attention is turned toward making realistic plans for the future. As well, the present experience is explored in terms of future crises.

2.2.6   Process of Crisis Intervention

Brockopp (1973) speaks of crisis intervention as a process which is composed of several characteristics. He asserts that crisis intervention is an active, cognitively oriented process. Individuals' thinking processes, along with the rational and irrational aspects of their behavior are focused on. It is problem-oriented, too. Counselors help individuals to organize their lives in a way that helps solve their problem. Thus, "it is a cross-sectional approach, dealing with an aspect of the individual at one point in time" (Brockopp, 1973, p. 96). The turmoil of the crisis is utilized to establish new cognitive approaches for the person, which is more rational and appropriate. Reintegrating people into the community is enhanced by using the person's social network and soliciting support from members of the social network who are individual parts of the whole system. By engaging in this process, the personality patterns of the individual can be altered in a way that leads to a more competent life style, however, the crisis interventionist must be cognizant of the heavy emphasis that is placed on the concept of "here and now". By working through this problem, individuals not only complete previously incomplete or unresolved problems, they add yet another problem-solving technique to their repertoire.

Until recently, most research on crisis intervention has assumed face-to-face contact. However, researchers and administrators have, for a time, been incorporating crisis theory into new modes of therapy, such as telephone counseling.

25

2.3   TELEPHONE VS. FACE-TO-FACE INTERVENTION.

The majority of psychotherapeutic systems assume that face-to-face intervention is a necessary component of effective therapy. Williams and Douds (1973) state that this "assumption is taken for granted as a sine qua non for 'genuine' therapy" (p. 80). They continue by stating that, even though a telephone contact is better than nothing, it is perceived as a depersonalization of true therapy. The purpose here is not to attack the supremacy of face-to-face therapy, but to increase one's awareness of the unique contributions of telephone counseling.

Traditionally, helping services have reached persons in distress, but they have excluded persons whose problems made it difficult, if not impossible, to seek help. Telephone counselling provides a greater penetration into the community as individuals are as close to help as the nearest telephone (Williams & Douds, 1973).

Williams and Douds (1973), while explaining this unrealized potential, outline and describe four ways that telephone therapy differs from conventional face-to-face therapy. Namely, client control, client anonymity, geographic and personal barriers, and therapist anonymity (pp. 81-85).

2.3.1   Client Control

People in distress may be so psychologically overwhelmed that they may not possess enough psychological energy to physically contact a helping service. Contacting something unknown raises a fear that requires energy. Having a feeling of inner helplessness, a client may not desire to enter into a dominant relationship, according to Williams

and Douds (1973). This writer believes that this "dominance relation-ship" as termed by Williams and Douds (1973) is a rather narrow view of face-to-face counselling. However, it is true that some clients in crisis do feel at the mercy of the counselor, possibly because of the fact that the client must disclose personal information to a stranger in a face-to-face interaction. The concept of client control makes the point that "coming for help may in some instances be positively humili-ating" (p. 82). It then becomes understandable why people who need help do not seek it unless "driven by desperation". The telephone, under these circumstances, offers a unique advantage as a helping instrument.

During a telephone contact, clients have relatively more power or control over the situation. If they feel they are losing control, they simply hang up. This unique quality of telephone counseling can enhance a feeling of freedom within the client. This feeling in turn provides a viable alternative to face-to-face therapy and increases the probability that a client, who otherwise may not have, will make a therapeutic contact.

2.3.2   Client Anonymity

The concept of anonymity has proven to be of great value within the realm of crisis intervention. Being able to hide one's identity can facilitate greater self-revelation and openness, which has been previ-ously outlined as a necessary element in the therapeutic process. It is very easy to increase one's sense of inadequacy and helplessness when someone is vulnerable. Anonymity offers the opportunity of reducing the fear of being ridiculed while vulnerable. Also, client anonymity can

preserve social status. All in all, anonymity offers a less-threatening alternative which could open the door for many clients who experience difficulty in approaching a helping service.

2.3.3 Geographic and Personal Barriers

Many people who are psychologically overwhelmed are restricted by geographic mobility. One's sense of security is sometimes threatened when forced out of one's physical or social environment. This insecurity can maintain an unstable equilibrium. Williams and Douds (1973) state that these people "have locked themselves into feeling safe and secure, but have paid the price of locking out new creative experiences" (p. 83).

The telephone, for these individuals, may provide the opportunity to begin a process which involves talking with other human beings in a safe way. Through such an effort, individuals can interact socially from a safe distance. Experiencing this support, the client may develop a sense of confidence that could lead to other forms of social interaction.

2.3.4 Therapist Anonymity

Up to this point the unique characteristics of telephone intervention that benefit the client have been outlined. Attention will now be turned to the therapist. When a client enters an unfamiliar environment with a stranger, some anxiety related to the unknown will likely be experienced. For the therapist, anxiety of the unknown is also present. What type of problem does this individual have? Will I be able to help?

How can I intervene meaningfully in a psychologically distressed person's life? These are some of the questions that are associated with anxiety and the unknown.

In addition, the client enters this therapeutic environment with particular expectations of the therapist. For example, the client may be looking for a therapist who has strong, forceful, masculine quali- ties, in hopes that the therapist will control his/her behavior. Whether the expectations are realistic or not, it is still painful if one's illusions are shattered. Over the telephone the therapists can more easily be perceived as whatever their clients wish them to be. However, during a telephone contact, the therapist is unable, as is the client, to rely on visual cues such as facial expression or body language. For clients, the implication is that they can perceive the therapist in ways that meet their needs.

In general,

the anonymity of the therapist facilitates the development of transference, which can be used, within limits, to facilitate positive growth on the part of the patient (Williams & Douds, 1973, p. 85).

Having recognized the potentials of telephone counseling, adapta- tions of traditional techniques are focused upon.

2.4

A CRISIS INTERVENTION TECHNIQUE BY TELEPHONE

Throughout the last section the uniqueness of telephone therapy has been touched upon. As a result of this uniqueness, telephone interven- tion techniques are somewhat different from those used in face-to-face therapy. Since "general crisis lines" are relatively new, techniques

focusing on their emphasis have not been extensively developed. Instead, techniques developed by suicide prevention centres were slightly modified in order to make them appropriate for most crisis situations. One such technique has been developed by the Suicide Prevention Center in Los Angeles (Brockopp, 1973). This technique consists of five contiguous and overlapping guidelines (pp. 100-102):

(1) Making an initial evaluation regarding the severity of the crisis situation: "How much time do I have before I must make a decision regarding a person?" (Brockopp, 1973, p. 100) is the first question telephone counselors must ask themselves. The answer to this question reduces the anxiety of working with individuals in crisis, "for in most cases one will have sufficient time to work with the person, since most crises do not include the emergency of life and death" (p. 100). This question also helps to place the crisis into the perspective of time, thereby reducing the anxiety of the worker, and setting the stage for dealing with the person more objectively.

(2) Developing a relationship with the person in crisis: Developing a relationship with the individual in crisis is the initial step taken by the worker. This relationship consists of elements such as trust, feelings of interest, and a nonjudgemental attitude. An indication of whether or not a trusting relationship has been formed is the free flow of information from the client to the therapist. Brockopp (1973) asserts that when handling a more severe crisis, the therapist should place less emphasis on emotion and focus on cognitive components involved in helping to resolve the problem.

(3) Assisting the person in identifying the specific problem:
Clients in crisis are usually confused, disorganized, and sometimes
struggle to define the problem. A therapist should not immediately
focus on the specific problem(s) without first exploring the client's
total field of interaction. The pressure towards an immediate solution
may lead the helper astray.

(4) Assessing and mobilizing the patient's strength and resources:
At this point the therapist often locates resources that the person in
crisis has forgotten. Since clients are often confused or disorganized,
they often overlook people who could help them. However, this does not
imply that the therapist should take total responsibility for the
client, although this may be necessary during the initial stages of
confusion and disorganization.

(5) Developing an action plan: This final task of telephone crisis
intervention surrounds the issue of action and decision making. After
all, this is why the initial contact was made. It is of great impor-
tance that callers become involved in developing a strategy for coping
with the problem. This involvement enhances the client's commitment to
carry out the plan. Therapeutic interventions range from hospitaliza-
tion to other alternatives, such as counselors contacting the client at
least once a day for a period. The general rule in terms of planning
is,

> if a plan can be made that does not include involvement of
> dependence on community, welfare, or mental health agencies,
> the plan is usually of higher quality and has more chance of
> succeeding than those plans which include dependence upon the
> agencies. (Brockopp, 1973, p. 102)

Once the benefits and techniques of crisis intervention by telephone had been developed, a number of organizations began to incorporate them in terms of services offered to the community.

Chapter III

HISTORICAL PERSPECTIVE OF TELEPHONE HOTLINE SERVICES

The birth of Canadian telephone intervention services can be traced to three distinct influences: the suicide prevention centres in the United States, specifically, Los Angeles, the Samaritans in England,.and Life Line in Australia (Winch & Roberton, Note 1).

3.1 UNITED STATES

Telephone intervention services in the United States grew out of early programs for suicide prevention. The first recorded effort to develop a suicide prevention centre occurred in 1906 with the formation of the National Save-A-Life League in New York City (McGee, 1974). According to McGee (1974) this league played a relatively minor role in the recent development of such services. The single most influential program responsible for the actual development of telephone intervention was the Los Angeles Suicide Prevention Center (LASPC). In 1958 the National Institute of Mental Health (NIMH) awarded to the LA'SPC the first of two major project grants which enabled the Center to establish and develop itself (Shneidman, Farberow & Litman, 1961).

The LASPC is unique in that it did not begin with a telephone service (McGee, 1974). It was not until several months later that the staff realized that they could function effectively outside the hospital ward. As the program increased in popularity, ever-increasing contacts

were made through the telephone during office hours. Within months, the staff realized they could no longer ignore the telephone when it rang in their offices after office hours and on weekends. Consequently, in 1961 the "Night Watch" corps was established. As a result of this program, in 1963 a 24-hour telephone intervention service was offered. McGee (1974) reminds us that, although nearly 60 years earlier the National Save-A-Life League had established a 24-hour telephone service for suicidal people, it was the LASPC that took the lead in the "analysis, careful evaluation, and extensive description" (p. 6) of such services. The LASPC also publicly described the program and its potential benefits to clients and professionals alike.

3.2 ENGLAND

Several years earlier, and halfway around the world another movement was developing. First known as the "Samaritan Priest", Reverend Chad Varah, in London, England, discovered, quite by accident, that an alarming number of potential suicide victims existed (Varah, 1966, 1973).

In the summer of 1953 Varah wrote an article which communicated what he "believed to be an enlightened, .Christian philosophy of sex" (1966, p. 19). The day following the publication, Varah received 100 letters, of which "fourteen were written by people who appeared to be in so much agony of mind about their sexual problems that they were on the verge of suicide" (p. 19). From a total of 235 letters, 24 appeared to be suicidal, three of which he advised to seek medical help. Once Varah was reasonably certain that non-medical counselling had some contribution, he felt it was his duty to take steps to provide such a service.

For Varah, the idea of an emergency service automatically invoked the thought of a telephone "on the dial of which appear the words: 'Emergency calls-- for police, fire, ambulance dial 999' " (1966, p. 21). Varah could think of no good reason why a fourth emergency service - suicide prevention - could not be included. In November of 1955 (Farberow & Shneidman, 1961) the Samaritans were established and Mansion House 9000 was publicized as an emergency telephone number.

Ten years later, in 1963, it became imperative to form an Association, according to Varah (1966). At that time 21 centres existed and "banded together as Foundation Members of a Company Limited by Guarantee, licensed by the Board of Trade to omit the word 'Limited' from its title" (1966, p. 84). As of 1973 the Samaritans consisted of approximately 17,000 counselors who answered over 125 emergency telephones and claimed to save 5,000 lives. (Varah 1973, p. 13).

3.3 AUSTRALIA

Every time Evangelist Alan Walker, a Sydney-born Methodist, delivered a sermon on the radio or television, his telephone rang half the night with pleas for personal help ("Evangelism", 1964). This experience told Walker that Australia's largest city had a crying need - and also a means to solve it. Walker (1979) maintains that he began actively thinking about responding to this cry for help through a telephone ministry in 1958. Following is Walker's first entry, dated July 1958, from a diary which he used to record the beginning of his new idea.

> 'I am astonished' ... at the way people come to the Mission for help. We should find a way of meeting need, in the homes of the people just where they are. It offers a thrilling new

> possibility of throwing the 'Mantle of Christ' over this vast
> city of Sydney. (Walker, 1979, p. 10)

During meetings with the congregation of the Central Methodist Mission, people became excited about establishing a round-the-clock telephone counselling centre. However, almost three years elapsed before the group took action.

Once the Central Methodist Mission Executive Board gave its approval, another year passed before the telephone centre opened (Walker, 1967). During that year attention was focused on raising money and training personnel. In June, 1962, the first training courses were held.

Membership of the Life Line Movement, then known as the "Mantle of Christ", was open to all who were willing "to counsel according to the insights of Jesus" (Walker, 1979, p. 15). In order to become an accredited telephone counselor, the following steps must be followed:

1. biblical and doctrinal subjects, one on counseling problems and Life Line procedures.

2. An interview or interviews with members of the Life Line Executive Board, where psychological and personality qualities are tested.

3. Where any doubt exists as to suitability, further interviews with professionally trained people would be arranged.

4. Nomination to the Life Line Executive Board, where a majority vote for acceptance is necessary.

5. Sit-in sessions with experienced counselors at work on the telephone.

6. Where it is thought wise, an applicant is placed on a period of probation.

7. A service of dedication is held when the pledge of the Movement is publicly accepted and repeated. (Walker, 1967, pp. 29-30)

Once the counselors were accredited, they followed the "Twelve Rules of a Telephone Counselor". The rules are as follows:

1. men and women to Christ.

2. The weaving of people into therapy groups and into worship is part of the complete answer to much human need.

3. Treat every call as serious and genuine, yet be alert for the humbug and the hoaxer.

4. Record name and address of callers whenever possible.

5. Telephone counselors must at all times remain anonymous.

6. Careful and full written records are to be made from notes taken down during every telephone conversation.

7. Channel all action from calls as far as possible into the normal nine-to-five working day. Only in extreme emergencies envisage sending a 'trouble team' during the night.

8. No action can be taken on the invitation of another person other than the one in need. It is almost impossible to aid someone who does not desire it.

9. Where possible, urge people to come to the Life Line Centre for interviews.

10. Counselors must not take action alone in answer to calls without consulting the Life Line staff members. Financial aid must not be given by counselors from their personal or Life Line resources. All assistance must be distributed through the Life Line organization.

11. A telephone counselor is a contact person; those in need must be referred to the appropriate division of Life Line.

12. Trust and expect the guidance of the Holy Spirit in every conversation and all counseling situations. (Walker, 1967, pp. 31-32)

As opening day neared, one issue remained, the name for the centre. At first it was called "Mantle of Christ", but after realizing that this was too religious, which could frighten some people, "Christian Service Centre" was attempted next. After covering a public meeting to support this venture, the assistant editor of a local newspaper, wrote a report

the following day entitled "Telephone Life Line". Walker realized at once that the search was over. He thought,

> every Australian knows the imagery of the 'life line' on the beaches, where the voluntary life saver plunges into the surf to rescue a drowning swimmer who is then pulled to safety by the life line. (Walker, 1979, p. 12)

Life Line was offically opened on Saturday, March 16, 1963, by the Lord Mayor of Sydney in front of a forum numbering over 2500 people (Walker, 1979). By the end of the first year of operation, Life Line recorded "10,033 serious first contact appeals for help" (Walker, 1979, p. 16).

3.4 CANADIAN DEVELOPMENT

On the Canadian scene, centres began to develop in the mid-60's. However, it is extremely difficult to pinpoint exactly where and when the very first telephone intervention service was established. The Canadian situation is particularly difficult to trace due to the lack of published literature; consequently, the following represents this researcher's findings, which are primarily based on telephone calls, interviews, and a collection of agency brochures.

Sudbury, Ontario is purported as being the location of Canada's first telephone intervention service (Daniels & Wright, 1971; "Canadian Directory of Crisis Centres", Note 2; Winch & Roberton, Note 1). A number of months after reading about the establishment of Australia's Life Line in Time magazine ("Evangelism", 1964) Reverend Bruce MacDougall opened and directed "the first 24-hour telephone counseling service in North America which was staffed by trained lay volunteers" (Lamb, Note 3). This service was operated independently from Life Line

and opened on October 4, 1965. Two years later, October 4, 1967,
another branch was established in Belleville, Ontario by Reverend
William Lamb, a United Church minister, who later (1973) became National
Director of Life Line. In September of 1968 the "National Committee for
Life Line Canada" was established to co-ordinate and supervise the grow-
ing number of centres, using this model.

This National body also granted accreditaton to the local centres
based on the Minimum Standards of Life Line International. Following
are the requirements for the accreditation of a Life Line worker:

1. participation in a local church.

2. Personal and emotional maturity and completion of a prescribed
   Life Line Training Programme.

3. Respect for the confidentiality of the caller.
   (Daniels & Wright, 1971, p. 26)

In 1970 the National Committee for Life Line Canada changed its
name to "Telecare" and with its logo are registered trademarks of Tele-
care Canada. William Lamb ("Canadian Directory of Crisis
Centres", Note 2) claimed that "Telecare is affiliated with Life Line
International-- a network of 140 centres in eleven countries, with
national committees in five countries" (No Page).

In 1966 Reverend Gordon Winch began to train volunteers for a tele-
phone intervention service in Toronto, Ontario which differed somewhat
from Life Line. However, it did not emphasize a religious component
(Winch & Roberton, Note 1). This service more closely resembled that of
the Samaritan operation which was "not a church organization, nor a
Christian organization. It includes among its members people of all
faiths and of no explicit faith" (Varah, 1973, p. 39). On November 1,

1967, the first telephone call was taken by staff who worked in pairs·
for four hours at a time, and Reverend.Andrew Todd became the founding.
Director of Distress Centre I. This Centre was the first in Canada to
choose this name, which has become the generic term for this type of
service throughout Ontario (Lamb, Note 3). Shortly after Distress
Centre I became operationalized, Reverend Gordon Winch became the Direc-
tor and is currently holding the position. Funding for this service
came from five sources: the United Church of Canada, the Anglican
Church, the Addiction Research Foundation, Metropolitan Toronto Welfare,
and private contributions.

Not long after the Distress Centre opened, other centres began to
spring up all over Canada. As a result, other Associations both at the
Provincial and Federal levels were established. For example, Reverend
Gordon Winch, in the fall of 1970, founded the Ontario Association of
Telephone Distress Centres. Approximately five or six years after the
establishment of this Association, the word "Telephone" was dropped from
the title, which resulted in the Ontario Association of Distress
Centres, (O.A.D.C.). This organization had the following goals:

1. To help centres get to know one another.

2. To provide a forum for sharing experience and skills;

3. To give support to each other. ("Canadian Directory of Crisis
   Centres", Note 2, No Page)

O.A.D.C. later developed criteria for the accreditation of member
centres. These criteria are as follows:

1.

   Essentials:

   - Minimum daily service 12 hours.

- Basic training of workers 18-20 hours-- to be both experiential and didactic.

- To observe guidelines of anonymity, confidentiality, and client initiative.

- To have a provision of back up for workers.

- To advertise publicly the availability of the service.

- To provide a service geared to befriending and referral.

- To have a selection process that ensures workers have basic maturity and capacity for caring.

- A responsible Board of Directors drawn from a variety of community interests.

- A demonstrated capacity to keep records of the work in a retrievable form.

- A designated person who is known by all volunteers to be in charge of the service.

2. Additional Values:

- Staff paid or volunteer who co-ordinate and organize screening, training, and monitoring.

- A public education programe based on telephone experience.

- Some research and study programs based on experiences in the phone room.

- A capacity to give field work supervision to students.

- Organized resources for student studies. (Winch & Roberton, Note 1)

The last meeting of the Ontario Association of Distress Centres was held in Mississauga, Ontario and was attended by approximately 150 members in May, 1982.

Other Associations include Metro and Area Distress Centres (MADC) which were established in 1974 when a staff member from Distress Centre I in Toronto, Ontario initiated a series of meetings between directors of other centres. In 1975 informal meetings led to the establishment of

the South Western Ontario Region of Telephone Distress Centres (SWORTDC). As of 1979, the Canadian Directory of Crisis Centres lists 93 organizations across Canada, but Powicki (Note 4) claims at one time there were as many as 150 crisis intervention centres in this country.

3.4.1 History of Help Services

The history of Help Services is a short one, as it did not begin to offer services to Windsor and Essex County until January 1, 1982. However, its background is more extensive. Before a discussion of this background begins, a brief outline of the organizations involved will ensue.

Turning Point, was sponsored by the Addiction Research Foundation (A.R.F.) and funded by an annual grant from the City of Windsor, offered a 24-hour personal help service. Primarily known as a drug crisis centre, from April 1, 1977, through March 31, 1978, Turning Point received 7,372 calls; 70% of which were received during the evening, night-time, and weekend hours, as was previously stated (McCarthy, Note 5)

Community Information Service (C.I.S.) was established in 1966 by the United Way as an information and referral service in the field of health and welfare. In January, 1975, C.I.S. was accepted as a full member agency of the United Way and was incorporated under the name Windsor-Essex Community Information Service on February 11, 1975. The location of their first separate headquarters was at 65 Wyandotte Street West (Sheehan, Note 6).

Tel-A-Friend, previously referred to as the Distress Line, grew out
of the Windsor Committee of the Ecumenical Institute of Canada in the
fall of 1968. This Institute suggested the establishment of an emer-
gency telephone line as an action-oriented means of showing concern for
people and their problems. After the appointment of a Steering Commit-
tee, a recommendation came forth to design a befriending/listening
service that would help alleviate loneliness, lower anxiety, and help
people make their own decisions (Daniels & Wright, 1971). In 1979,
Tel-A-Friend responded to 3,227 calls (Bauman, Note 7), and was a member
agency of United Way.

Volunteer Services grew out of the Opportunities For Youth Feasi-
bility Study conducted by Student Affairs at the University of Windsor.
Funded initially by a Local Initiatives Projects (L.I.P.) Federal Grant
in October, 1974, and later a Special Projects Fund from United Way,
Volunteer Services became incorporated on January 1, 1978. In 1979 this
service submitted an application for admission as a member agency of
United Way. Volunteer Services Incorporated recruited, screened, and
referred volunteers to non-profit social service agencies, and encour-
aged the agencies to utilize and recognize their volunteers in a mean-
ingful way (Robinson, Note 8).

According to Chandler (Note 9), Turning Point offered a 24-hour,
seven-day-a-week drug crisis centre which was operated under the auspi-
ces of the Addiction Research Foundation (ARF). In the mid 1970's ARF
shifted its focus from the provision of direct service to that of
consultation. As a result, the City of Windsor was faced with a poten-
tial crisis. Chandler (Note 9) reported that the City, trying to avoid

the disruption of its equilibrium, responded by asking the Civic Committee on Drugs to examine more carefully this threat and its implications. This Committee had been instituted in 1970 to respond to the teen drug problem. From this came the Drop-In Centre, then POST, which was followed by Turning Point. The Committee's report, in relation to its new task, was submitted to Mayor A. H. Weeks in the spring of 1976. This would prove to be the first of a string of influential committees which led to the eventual development of five other committees, one new service, and, finally, the formation of one more comprehensive agency - Help Services.

On June 8, 1976, Mayor Weeks called a meeting to explore the possibility of maintaining an "after-hours helping crisis service" ("Mayor's Committee On After Hour and Crisis Services", Note 10) for the City of Windsor. This meeting was the result of a resolution which came from the Civic Committee on Drugs. The resolution was as follows:

> that the Mayor be requested to convene a meeting for all agencies that have an interest in these related areas with a view to determine a commitment and explore the economic feasibility of maintaining a structure that will ensure a continued delivery of a 24-hour crisis intervention service for the City of Windsor ("Mayor's Committee On After Hour and Crisis Services", Note 10, p. 1).

As a result of this meeting, an Ad Hoc Committee (See Appendix B) was formed to examine the proposal more closely. The Ad Hoc Committee, and the Mayor's Committee On After Hour and Crisis Services, first met on June 22, 1976, at which time the following objectives were set.

1. the City of Windsor.

2. Survey existing services that operate on a 24-hour basis in order to obtain their comments.

3. Review the terms of reference of other 24-hour crisis services operating throughout Canada and the United States.

4. Make recommendations to the Mayor on the type of service required and the extent of the program including possible funding sources. ("Mayor's Committee on After Hour and Crisis Services", Note 10, p. 2)

On February 28, 1978, the Mayor's Committee submitted its report and on March 22, 1978, the following recommendations were presented to the Mayor. ,ss

1. A 24-hour distress centre to be established in the City of Windsor in order to provide for the centralization of services dealing with crisis situations.

2. The distress centre be divided into a 2-level administrative structure:

a) Level 1 or Primary Contact Service:

A non-hospital based service to respond to, screen, and refer if necessary, all crisis situations not presently provided for on a 24-hour basis. Ideally, this should be both a telephone and walk-in service available 24-hours per day. It would accept direct referrals as well as referrals from health and social agencies. It should be staffed by professionals and volunteers, largely by the latter, but with professionals always present. It should maintain adequate records and statistics and be subject to continuous evaluation procedures through Level 2 or Secondary Contact Service.

The present staff of Turning Point, through the development of their program, has expertise and credibility in the area of Level 1 intervention and could well form the nucleus of the recommended expanded distress service. Community Information Service and Tel-A-Friend could be incorporated

into this structure if they so desired. However, the area of service of the above groups is sufficiently distinct that all three services could remain operative without overlap. There are distinct financial advantages to this proposed unification.

b) Level 2 or Secondary Contact Service.

The Secondary Contact Service would be a professionally staffed service, therapeutically oriented, which should be hospital based. Level 2 would respond to the most serious crisis situations. This service would operate on a referral basis only, with referrals from the Level 1 service or direct referrals from other health or social professionals.

This level would be staffed only by professionals who ideally, are available on a 24-hour basis but with the built-in guarantee that they would be readily available to deal with the serious crisis situations on short notice. They would be responsible for training, supervision and evaluation of Level 1 staff and operation. This group would also function as a tactical mobile force (similar to London's Flying Squad operation), available to Police and other professionals in crisis situations occurring away from home base. Windsor Western Hospital Centre is presently operating a limited crisis service with the potential for meeting all of the above criteria.

c) There should be established a Senior Advisory Board to act in an advisory capacity to the Mayor and the Council of the City of Windsor with responsibility in the following areas.

d) Identify gaps in existing services.

e) Assist community groups in establishing new resources.

f) Act as the liaison between the public and the private sector.

g) Make recommendations regarding submissions for grants and other projects for groups soliciting public funds.

h) Establish sound criteria for making all such projects accountable for their actions.

i) Make recommendations for establishing minimum criteria for organizational structure of community agencies.

j) The whole area of the female alcoholic needs systematic and detailed investigation which is not presently available. The Addiction Research Foundation should continue their study of this problem and prepare recommendations.

k) A central emergency "hotline" telephone number should be established which will be answered on a 24-hour basis by the Primary Contact Service, Level 1. ("Mayor's Committee On After Hour and Crisis Services", Note 10 pp. 15-16)

At the June 1976 meeting, there was agreement to Mayor Weeks request that an Implementation Committee (Appendix C), to be chaired by Gary McCarthy, presently the Executive Director of United Way, to examine the program and budget implications of establishing a 24-hour emergency service that would have as its core the amalgamation of Turning Point and C.I.S. (McCarthy, Note 5). On July 26, 1978 the Implementation Committee submitted its report to the Mayor and in January, 1979, Turning Point and C.I.S. were amalgamated and funded by the City of Windsor.

Four months later, May, 1979, United Way of Windsor-Essex County

accepted a recommendation from their Admissions Committee to take steps

that would effect the merging of C.I.S., Tel-A-Friend, and Volunteer

Services Incorporated. This action occurred as a result of an

> application for admission as a member agency by Volunteer
> Service Bureau and concern regarding the resource implications
> of establishing a new agency whose functions overlapped
> significantly with . those of existing agencies.
> (Walker, Note 11)

United Way's intent in combining these three services was to "bring

about a greater efficiency in delivering services that would result in

both cost savings and service expansion" (Walker, Note 11). United Way

then established a committee with nine members, called the Joint Agency

Committee to investigate more thoroughly and submit a report related to

the possible merger. This committee (Appendix D) was composed of two

persons from each of the three agencies involved in the possible merger,

two people from the Board of United Way, and was chaired by a person who

was not at that time a member of any of the agency boards. After numer-

ous meetings the Committee decided to endorse the proposed merger and

submitted the following purpose for the new organization in a report to

the United Way (Walker, Note 11): It should be noted that the Joint

Agency Committee was aware that a letter was sent to the United Way

Board of Directors by its President, Richard Rosenthal, stating in a

"matter-of-fact" way that the funding of the three agencies would be

discontinued at the end of 1981. Since over 60% of the Joint Agency

Committee consisted of Board members of the "soon-to-be broke" agencies,

it is not difficult to imagine how the final decision to merge may have

been influenced. The purpose of the new organization was to provide

comprehensive information and referral services, crisis intervention programs, and the development of volunteer opportunities and leadership in the community. (p. 2)

It was expected, and outlined in their report, that this new comprehensive agency would be functional January 1, 1981.

For several months nothing happened. In October, 1980, a Provisional Board of Directors for this new agency was created and one year later, Robert Shepherd was appointed Executive Director. Opening its doors and telephone lines on January 1, 1982, this new agency – Help Services – began to serve the community.

Currently, this service consists of three program areas: Community Information Services, Volunteer Services, and the Distress Centre. The Distress Centre, directed by Marilyn Smee, has the following program objectives:

1. service by listening to and talking with people who call. Both the caller and the volunteer remain anonymous.

2. To assist callers to explore alternative solutions to problems and help them to identify services in the community that might help them.

3. To work with other community organizations providing after hour services to determine community needs and availability of service, and to fill any service gaps.

4. To recruit, train, supervise, and support volunteers who provide the direct service to callers. (Shepherd & Smee, Note 12)

At present, the Distress Centre has two telephone lines which are operated by approximately 50 volunteers, and offers its service from 8 p.m. to 9 a.m., seven days a week.

Chapter IV

METHODOLOGY

The term "methodology" refers to the research design which speci-
fies the approach, or as Suchman (1977) states, "the plan of study"
(p. 40), used to answer the research questions.

4.1 RESEARCH CLASSIFICATION

This study, according to Rossi et al. (1979) is primarily classi-
fied as an evaluation research project. The definition of evaluation
research employed for the study has been taken from Rutman and Hudson
(1974) and is as follows:

> Evaluation research is, first and foremost, a process of
> applying scientific procedures to accumulate reliable and
> valid evidence on the manner and extent to which specified
> activities produce particular effects or outcomes. (p. 410)

Rossi et al. (1979) have outlined four classes of evaluation research:
program planning, program monitoring, impact assessment, and research on
project efficiency. The present project can be sub-typed as program
planning research. At this level, program planning research, sometimes
referred to as "formative research" enables a service "to be designed
optimally using firm knowledge concerning the dimensions of the problem
and its location" (Rossi et at., 1979, p. 27). Speaking of program
planning and development in terms of formative research, Rutman (1977)
reports that it is mainly aimed at discovery and can be used to facili-
tate program development.

Rossi et al. (1979) break down research for program planning and development into four phases: (1) assessment of needs, (2) target problem and population identification, (3) selecting targets, and (4) formative research on delivery systems. Of these four, the present research is primarily concerned with target problem and population identification. This phase employs techniques

> to estimate the scope of problems requiring intervention action efforts and to estimate the target population implied in ways that allow for the most effective deployment of available resources and staff. (pp. 99-101)

One can take several approaches to accomplish this goal. Rossi et al. (1979) contend that "the most direct and accurate data on target problem and population can be obtained by conducting special censuses or sample surveys" (p. 112). This type of inquiry is referred to by Tripodi et al. (1979), Selltiz et al. (1976), and Finestone and Kahn (1975), and further classified, as a descriptive study.

A descriptive study, in general, is concerned with describing characteristics of communities (Selltiz, 1976). Within the community one could study individuals, families, groups, facilities, or patterns of behavior: the options are endless. The unit of study could be larger than a community, such as a province, a country, or even the world! In its simplest form, descriptive studies describe a unit by reporting characteristics one at a time (Finestone & Kahn, 1975).

Tripodi et al. (1979) refine their definition of a quantitative-descriptive study to include two general categories: (1) the testing of hypotheses; and (2) the description of quantitative relations among specified variables. The second category is subdivided into two separate objectives: (2-A) to measure a number of specific variables that

will enable one to answer specific questions posed by the researcher; and (2-B) to search for relationships among designated variables that will enhance the articulation of more precise hypotheses for subsequent investigations. This study is defined by Tripodi et al's. (1979) second category and first-level objective. That is, to describe the quantitative relations among specific variables in order to answer specific questions constructed by this researcher. Therefore, the definition of a quantitative-descriptive study accepted for this research is as follows;

> Quantitative-descriptive studies are empirical research
> investigations which have as their major purpose the delinea-
> tion or assessment of characteristics of phenomena, program
> evaluation, or the isolation of key variables.... All of
> these studies use quantitative devices for systematically
> collecting data from populations, programs, or samples of
> populations or programs. They employ personal interviews,
> mailed questionnaires, and/or rigorous data gathering devices
> and survey sampling procedures. (Tripodi et al., 1979, p. 38)

The classification system for empirical social research studies is comprised of four sub-types: hypothesis testing; program evaluation; population description studies; and variable relationship studies (Tripodi et al., 1979, pp. 38-45). This study utilized the population description sub-type and is defined as follows:

> Population description studies are those quantitative-descrip-
> tive studies which have as their primary function the accurate
> description of quantitative characteristics of selected popu-
> lations, organizations, or other collectivities. (Tripodi et
> al., 1979, p. 42)

Model 1 outlines the classification scheme used in this study.

In summary, as can be seen in Model 1, this project is primarily classified as an evaluation research project, more specifically, research for program development. It has been typed as a quantative-de-

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|                                                                    |
|                            Model 1                                 |
|                      Classification Scheme                         |
|                                                                    |
|                                                                    |
|     - EVALUATION RESEARCH                                          |
|                                                                    |
|         - Program Planning and Development                         |
|                                                                    |
|             - Quantitative-Descriptive                             |
|                                                                    |
|               - Population Description                             |
|                                                                    |
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scriptive study and sub-typed in terms of a population description

study.

4.2   RESEARCH QUESTIONS

The purpose of the research questions is to determine "the nature
of the evidence sought" and "the facts derived from the evidence"
(Stuart, 1981, p. 319).   Following are the specific research questions
that were developed for the three components of this study.

Component I

1. What are the demographic characteristics of the people who
    contact after-hour services?

2. What is the nature of the related problems of people who
    contact after-hour services?

3. What types of intervention are employed by counselors of
    after-hour services?

4. How people become aware of the existing after-hour services?

5. What is the volume of misplaced calls being received by after-hour services?

Component II

1. Do callers follow-through on referrals that are made by after-hour workers?

2. What factors inhibit or increase the probability that a caller will follow through on a referral made by an after-hour worker?

Component III

1. What is the overall perception of existing after-hour services by specific segments of the community?

2. What is the overall perception related to the needs of after-hour services by specific segment of the community?

Within the above questions apear a number of concepts that will now be operationally defined.

4.3 OPERATIONAL DEFINITIONS

An operational definition "consists of all the steps, actions, 'operations' one performs in order to relate the concept to events in the real world" (Polansky, 1975, p. 23). Stated differently, according to Bridgman (1927), a concept is simply a label for the measurement that is necessitated. Following are the labels that will make explicit the concepts used throughout this study.

4.3.1   After-Hours

After-hours, in a general sense, are those services that exist outside of the traditional nine-to-five office hours.   More specifically, for this study, after-hours is defined as those services which are offered from 4:30 p.m. until 8:30 a.m., Monday through Friday. Weekend coverage begins at 4:30 p.m. Friday afternoon and continues through until 8:30 a.m. Monday.

4.3.2   After-Hour Services.

After-hour services are those services that are offered during the above-stated hours.   For example, these services could include hospitals, crisis centres, telephone hotlines, as well as police, fire, and ambulance services.

4.3.3   After-Hour Telephone Counselling

There are two types of after-hour telephone counselling services, sometimes referred to as "hotlines":   general, and specific. Help Services, the agency participating in this study, is a "general" telephone counselling service.   Whether one's problem is related to finances, loneliness, or suicide, the call is appropriate.   Conversely, examples of "specific" telephone counselling services are (a) Hiatus House, which offers a 24-hour service for battered women, and (b) the Sexual Assault Crisis Centre.

4.3.4 Crisis

A crisis occurs when,

> a person faces an obstacle to important life goals that is,
> for a time, insurmountable through the customary methods of
> problem-solving. A period of disorganization ensues, a period
> of upset, during which many abortive attempts at solution are
> made. (Caplan, 1966, p. 18)

A crisis, then,

> is the person's response to a hazardous situation, which by
> the inclusion of one additional event has created an imbalance
> in his life to the degree that resolution is required.
> (Brockopp, 1973, p. 91)

Quite simply stated, a crisis is an intolerable situation which, if not

resolved, has the potential to cause psychological damage.

4.3.5 Crisis Intervention

Crisis intervention is an approach,

> based on theory that aims at definitive resolution of crisis
> in order to restore an optimum level of functioning. In addi-
> tion, it involves ready access to sources of help without
> delay or waiting list, time-limited treatment lasting no more
> than four to six weeks. (Jacobson, 1980, p. viii)

This simply means attempting to intervene in people's crises so as to

avoid the possibility of them hurting themselves or others.

Befriending

Befriending, sometimes referred to as non-directive counselling, is

a type of crisis intervention. Used by the Samaritans, Varah (1973)

states that one simply "listens, accepts, cares" (p. 28). Befriending

is not advice-giving nor problem-solving. Listeners form relationships

with callers that will support or give encouragement to them.

4.3.6 Crisis Intervention Centres

An attempt to define a "crisis centre" in a simple and understandable fashion is extremely difficult, if not impossible. Since many centres are unique, it is more beneficial to look at common characteristics of crisis intervention centres:

1. for immediately available, accessible, and appropriate help for people under stress, particularly those whose needs were not being met by the resources of existing agencies, or whose distress peaked in the hours after these agencies closed.

2. In most cases the answer seemed to be a 24-hour telephone service, manned by volunteers, providing befriending, referral, and crisis intervention. Some centres, responding to a particular community's needs, also provided a drop-in centre, or information post, or even emergency medical, psychiatric, or legal services.

3. Most centres operate under the principles of anonymity, confidentiality, and client (or caller) initiative.

4. Most of these centres are independent of other agencies, and are funded locally by municipal government or agencies or the United Way or individuals or foundations. A few exist under the wing of some agency like a Social Planning Council or an organization such as a Mental Health Association; a few get all their support from provincial departments, and a number get a boost through LIP grants. (Canadian Directory of Crisis Centres, Note 13)

4.3.7 Misplaced Calls

The concept of a "misplaced call", to this researcher's knowledge, has neither been documented in the literature, nor studied. It is believed that, when dealing with a general telephone counselling service, the concept of an "inappropriate call" is nonexistent. Conversely, other available services which happen to use a telephone can receive "misplaced" calls. For example, if people telephones the police station "because they are lonely", since this is not incorporated as part of the police job description, they are not trained to deal profes-

sionally with such calls; consequently, this would be termed a misplaced call.

4.4 POPULATION

"In everyday language the term population is used to refer to groups or aggregates of people" (Ferguson, 1981, p. 6). However, in statistical terminology, population does not necessarily refer to groups of people. In research, the term is employed to "refer to a collection of cases that fit certain defined limits, made explicit by the investigator" (Yeakel & Ganter, 1975, p. 95). The term "case" is used in a broad sense to signify an individual member, event, or object of a population. In this study, the population was defined for each separate component of the study as follows.

4.4.1 Telephone Counselling Services

For purposes of this study, telephone counselling services was operationally defined as "all the general after-hour telephone counselling services offered in Windsor, Ontario". Within this population of services, one can define the population of telephone calls received. The population of calls consisted of "all the after-hour telephone calls received by the general telephone counselling services for the month of March, 1982". In the present study, a case was defined as one individual telephone contact. Whether the call was a wrong number, a misplaced call, or, for example, an obscene call, the call was still recorded as a case.

Referrals that were to be considered for follow-up consisted of "all the referrals made by the counselors who worked at the general telephone counselling services during the month of March, 1982".

4.4.2 Misplaced Calls

In terms of monitoring misplaced calls, the population consisted of "all those organizations that offer after-hour services in Windsor, Ontario". It is worthy of mention to note that the population of overall calls covered an undefinable geographic area. Since callers were neither required to identify themselves nor their location, it was not possible to define the geographic parameters of this population. Discussion with several telephone counselors revealed that some of their regular callers lived out of town and called long distance, which resulted in astronomical telephone bills.

The population of misplaced telephone calls included "all the misplaced calls that were received for the month of March, 1982". After the calls were recorded, the supervisor determined whether the call was a misplaced one or not. It should be noted that only misplaced calls were recorded by the Windsor Police Department. Since a card or a form in the police department had to be filled for all correctly placed calls, a misplaced call was defined as those calls that would not normally be recorded.

4.4.3 Organizational Survey

For the organizational survey, the participating organizations were defined as "those organizations offering a service to the community in Windsor, Ontario". There were three primary sources from which organizations were selected: (1) the September 25, 1981, volume of the Windsor Bell Telephone Directory, (2) the 1980 Directory of Community Services For Greater Windsor, sometimes referred to as "The Blue Book", and (3) mailing lists obtained from Help Services and United Way of Windsor-Essex County. To organize and break down the population into manageable parts, a three step classification structure was developed: (1) categories, (2) rationale, and (3) organizations. The categories that were developed consisted of eight major headings under which several organizations would fall. Rationales were outlined which justified the inclusion of the individual categories into the survey. Based on the experiences of this researcher, and the Thesis and Advisory Committees, eight categories, consisting of 22 organizations, included in the survey. These categories and organizations are outlined in Table 1.

TABLE 1

CATEGORIES & ORGANIZATIONS FOR COMMUNITY SURVEY

(1) RELIGION:
    Churches
    Religious Organizations
    Other Churches

(2) POLITICAL/GOVERNMENT
    Federal M. P's.
    Provincial M. P. P's.
    Alderpersons

(3) MEDICAL:
    Hospitals
    General Practitioners
    Psychiatrists
    Health Organizations

(4) COMMUNITY:
    Neighborhood Associations
    Citizens Groups
    Service Clubs
    Radio Stations
    Television Stations
    Newspapers

(5) EDUCATION:
    Schools
    School Boards

    Telephone Answering Services
    Bell Canada Operators

(6) LEGAL:
    Lawyers

(7) SOCIAL:
    Social Services

(8) EMERGENCY:
    Police, Fire Department, and Ambulance.

4.5   SAMPLING PROCEDURE,

4.5.1   Telephone Counselling Services

Since there exists only one general after-hour telephone counselling service in Windsor, Help Services, a sampling technique was not required. Also, because every call received by Help Services was recorded, a sampling procedure did not have to be employed here either. However, a sampling procedure to monitor referrals was used. In order to conduct structured telephone interviews for referrals, a probability sampling technique was employed. More specifically, of the four types of probability sampling techniques outlined by Seaberg (1981), the "systematic sampling" technique was used.

In systematic or interval sampling we would proceed down the
sampling frame (or population list) selecting for the sample
every kth person, starting with a person randomly selected
from among the first k persons. (p. 80)

The formula used for this procedure was "k = N/n" (where k = size
of the sampling interval," N = population size, and n = sample size).
Since our expected population size was approximately 500, and we desired
a sample size of approximately 50 referrals, the interval size (k)
became 10 (k = 500/50). At that point, pieces of paper numbered 1
through 10 were placed in a container and one piece of paper was
selected at random. Since "1" was selected, a blue card was placed in
every tenth position, beginning with card number one.

4.5.2   Misplaced Calls

The sampling procedure used in this study to select the agencies
for monitoring misplaced calls was a non-probability sampling procedure,
more specifically, availability sampling (Seaberg, 1981). This is some-
times referred to as "accidental sampling" (Sell-
tiz, Wrightsman, & Cook, 1976). The label of availability sampling is
almost self-explanatory: the researcher selects those units which are
convenient, first available, or as Chein (1976) suggests, "one simply
reaches out and takes the cases that are at hand" (p. 517). Units in
this project are organizations.

4.5.3   Organizational Survey

Due to time and financial considerations, it was decided that the
total population of organizations to be included in this survey would be
approximately 400. When the situation arose that there would be too

many organizations, should every existing organization within one category be surveyed, systematic or interval sampling was used to select an appropriate number of organizations. The formula used for this procedure was "k = N/n". Table 2 shows the ratio and number of organizations selected within each category.

It should be noted that the total population of doctors was generated from only those doctors who were registered with the Ontario Hospital Insurance Plan (OHIP). Appendix E shows the wide variety of organizations that were surveyed.

TABLE 2

RATIOS USED FOR COMMUNITY SURVEY

(1) RELIGION:
    Churches
    (116/116)*
    Religious Organizations
    (23/23)
    Other Churches
    (27/27)

(2) POLITICAL/GOVERNMENT
    Federal M. P's.
    (3/3)
    Provincial M. P. P's.
    (3/3)
    Alderpersons
    (10/10)

(3) MEDICAL:
    Hospitals
    (5/5)
    General Practitioners
    (30/150)
    Psychiatrists
    (8/8)
    Health Organizations
    (30/30)

(4) COMMUNITY:
    Neighborhood Associations
    (7/7)
    Citizens Groups
    (12/12)
    Service Clubs
    (27/52)
    Radio Stations
    (5/5)
    Television Stations
    (1/1)
    Newspapers
    (6/6)
    Telephone Answering Services
    (4/4)
    Bell Canada Operators
    (1/1)

(5) EDUCATION:

    Schools
    (26/104)
    School Boards
    (2/2)

(6) LEGAL:
    Lawyers
    (28/280)

(7) SOCIAL:
    Social Services
    (50/50)

(8) EMERGENCY:
    Police, Fire Department, and Ambulance.
    (1/1)   (1/1)   (1/1)

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*(number surveyed/number available) N=427

4.6   INSTRUMENTATION

Instrumentation involves the standardized procedures related to the process of obtaining measurements.   The development and utilization of instruments are discussed in two parts: (1) data collection methods, and (2) data collection procedures.

4.6.1   Data Collection Methods

Data collection methods refer to the scientific instruments used in the research project to collect evidence.   Two types of scientific instruments were employed in this study: interviews, and a question- naire.

Interviews

Interviewing "is a data collection procedure involving verbal communication between the researcher and respondent either by telephone or in a face-to-face situation" (Eckhardt & Ermann, 1977).   This study involved only telephone interviews.

Eckhardt and Ermann (1977), while discussing John Colombotos' (1969) study,   Physicians and Medicare: A Before-After Study of the Effects of Legislation on Attitudes, profess that "information obtained by phone did not differ markedly from that obtained by face-to-face interview" (p. 332).

For describing the incoming calls, due to the nature of telephone counselling, this research had no other alternative than to collect the descriptive information via the telephone.   However,   for monitoring referrals, there were two alternatives: (1) telephone, or (2) face-to- face interviewing.

There are several advantages and disadvantages related to interviewing. Gochros (1981) states that the advantages of interviewing are "related to naturalness and spontaneity, flexibility, and control of the environment" (p. 255), whereas the disadvantages relate to time and expense, f interview intensity, inaccesibility to respondents, loss of anonymity, interviewer distortion, and interviewer influence. With the particular nature of after-hour telephone counselling, the key concept and disadvantage to be considered was anonymity.

Basically, there are two forms of telephone interviews: structured, and unstructured (Selltiz, et al.; 1976; Gochros, 1981), both of which were employed for this study.

UNSTRUCTURED TELEPHONE INTERVIEW

For the first component of this study, describing incoming calls, an unstructured interview format was used. As the term implies, an unstructured interview is one "in which neither the exact questions the interviewer asks nor the responses the subject is permitted to make are predetermined" (Selltiz, et al., 1976, p.317). One could question whether this in fact was an "unstructured" interview, due to the fact that data collection cards were developed and given to the counselors before their shifts. At this point it should be mentioned that the counselors were instructed not to question the caller for specific information just because it was outlined on the data collection cards. If, through the communication, the information was volunteered, the counselors were asked to record it; if not, the counselors were reminded that "the telephone caller should be given higher priority than the data collection instrument". The process of developing the data collection cards consisted of several steps.

White Data Collection Cards

The first step in developing the white data collection cards involved personal contacts with each organization involved in the study to obtain the forms their organization used to record after-hour calls. Next, this researcher constructed a single form that incorporated all the variables of each previously collected form, while avoiding any duplication. The result was a 28 cm x 38 cm small-typed data collection instrument that would have taken approximately 20 minutes to complete. This researcher engaged in this process knowing that the final draft of the data collection instrument could be no larger than 8.2 cm x 18.6 cm. The rationale for the specific size of the data collection card was due to the data-processing system used by the Windsor Police Department. This enormous instrument was presented to the Advisory Committee and was immediately followed by the statement, "Now we have to fit all these variables on this small card". The present researcher engaged in this particular process of designing and redesigning the data collection card for two reasons. First, by compiling all of the possible relevant information, the Advisory Committee was sure not to leave out or overlook any important variable. Second, being limited to a rather small data collection card, the Advisory Committee was required to use specific variables, or collect only the relevant or necessary information. This process resulted in the construction of a rather small data collection card which contained relatively few variables, and with limited experience, took only approximately 15 seconds to complete. (See Appendix F for the white data collection card).

As can be seen from Appendix F, the white data collection card was divided into four main sections: section one contained demographic data such as the date, time, and duration of the call, and the sex and age of the "caller# section two contained 20 "related problems"; section three focused on what was actually done. For example, was a referral made, or was an ambulance called? The fourth section concerned itself with the source of the call: "How did you know about our service?". The term "related problem" was used instead of the term "problem" because it was believed that, for example, if a caller was unsure about some instructions related to medication, one could not state that the problem was medication per se. The problem could have been communication with the doctor. Finally, to keep writing requirements to a minimum, the data collection card was designed to require only a check mark or a circle in most instances. This required a minimal amount of effort by the counselors to complete the cards.

Blue Data Collection Cards

The blue data collection cards (See Appendix G) differed from the white data colletion cards in only one respect. In order to obtain the information necessary to monitor referrals, a "lead-in" statement was developed and printed at the bottom of the card on the reverse side. The blue cards were placed in every tenth position throughout the decks of cards. To capsulate, in order for a caller to be contacted for a follow-up interview, three preconditions had to be met: (1) the data collection card had to be blue, (2) the caller had to be referred, and (3) identifying information pertaining to the caller, whether fictitious

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After the data had been collected, the sex of each counselor was also recorded.

or not, had to be obtained.#

STRUCTURED TELEPHONE INTERVIEW

For the second component of this study, monitoring referrals, a structured interview questionnaire was designed (See Appendix H). A structured interview, sometimes referred to as a standardized interview, presents questions that are worded exactly the same, and in the same order, to all respondents. The rationale of standardization is to "ensure that all respondents are replying to the same question" (Selltiz, et al., 1976, p. 309).

Standardized interviews and questionnaires can differ in the amount of structuring. They may present "fixed-alternative", "open-ended", or "scenario" types of questions (Selltiz; et al., 1976; Gochros, 1981). This interview contained both open-ended and fixed-alternative questions.

Fixed-alternative questions, sometimes referred to as "closed" questions, are those "in which the responses of the subject are limited to stated alternatives" (Selltiz et al., 1976, p.310). The alternatives could seek simple yes-no responses, or they could call for responses which indicate various degrees of approval or agreement. For example, during the interview for this component of the study, responses were sought relating to duration and location of residency in Windsor.

Open-ended questions are "designed to permit a free response from the subject rather than one limited to stated alternatives" (Selltiz, et al., 1976, p. 312). The distinguishing characteristic of an

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It was realized, only after the collection of data, that a fourth precondition had to be met: the counselor had to be willing to record the identifying information. (See the "Data Analysis" chapter for further explanation).

open-ended question is that it raises an issue, but it does not provide direction or structure for the response. Since this study was concerned with whether the referral was followed through, the simple question, "I was wondering if you were able to contact _____?"# was asked. If the answer was "yes", then the question "How did things work out for you?" was asked. Here, the researcher was interested, for example, in whether the caller was given adequate instructions related to the location of the service and, particularly, whether the referral was appropriate or not. If the caller did not connect up with the referral, an open-ended question, "What happened?", was asked.

.Finally, Gochros (1981) discusses a critical aspect of the questionnaire, namely, sequencing of questions. One of the techniques used in the sequencing of questions is referred to as "funnelling". This involves beginning the interview with broad, general, non-threatening questions, then moving on to narrower, more specific, difficult, and sensitive questions.

Bailey (1978) has outlined six guidelines for establishing the ordering of questions in an interview.

- First, open-ended questions and those which are likely to be sensitive or difficult to answer should be placed last in the interview.

- Second, easy-to-answer items should be asked first in the interview.

Prior to the follow-up call, the name of the organization or agency to which the caller was originally referred was written by the telephone research assistants in the space provided. This same procedure held true for all the blank spaces.

- Third, answers should be obtained early in the interview to items that may be necessary to guide the remainder.

- Fourth, items should be asked in a logical order.

- Fifth, the creation of a "response set" should be avoided.

- Sixth, reliability-question pairs should be asked at various points in the interview. (pp. 118-121)

The process of this interview began by giving information, ("My name is _____ "), rather than seeking it. The information provided was predicted to enhance the establishment of rapport with the caller. After asking if contact was made, open-ended questions such as, "How did things work out?", or "What happened?" were asked. The closed-ended or fixed questions, which could very easily be sensitive areas to many, such as location of their residence, were asked near the end of the interview.

Questionnaire

For the third component of this study, seeking the organizational perception of after-hour services, a questionnaire was developed. A questionnaire is a data collection "technique whereby a document containing questions or statements is used, to obtain information from a respondent who records thereon" (Eckhardt & Ermann, 1977, p. 240). The noticeable difference between a questionnaire and an interview is that the questionnaire is read by the respondent, whereas the researcher asks the questions in an interview.

The questionnaire, as opposed to the face-to-face interview, offers unique advantages and are summarized in the following points.

1. Questionnaires are relatively inexpensive in terms of time and money.

2. They require less skill to administer.

3. They require a minimum of explanation.

4. They can be administered to large numbers of individuals simultaneously.

5. Questionnaires usually allow the possibility of obtaining more information from more people.

6. Respondents may feel a greater sense of anonymity which may lead them to feel more comfortable in expressing views that may normally be disapproved. (Selltiz, et al., 1976, pp. 294-296)

Eckhardt and Ermann (1977) communicate two other important advantages: questionnaires reduce interaction between respondent and researcher, which controls for the potential influence that the researcher may personally exercise on the respondents, and questionnaires provide respondents with more time to complete the questions contained in the instrument. They also point out that questionnaires are less expensive than interviews. The key advantages of questionnaires in relation to this study were those of time, expense, obtaining information from a large number of people, and the advantage of no respondent-researcher interaction.

This questionnaire (see Appendix I) was divided primarily into four parts: Question 1A identified the existing after-hour services, while Question 1B attempted to measure the volume of misplaced calls. Questions 2 and 3 were designed to identify the perceptions of after-hour services related to the future, while Questions 4 and 5 focused on the perceptions of existing after-hour services.

4.6.2 Data Collection Procedures

Data collection procedures refer to the processes and specific techniques that are used to implement the research instruments. Following are the processes and techniques used in this study.

The Pretest

After completing several drafts of the data collection instruments, the process of pretesting began. Eckhardt and Ermann (1977) point out that a study, no matter how well-conceived, may encounter unforeseen problems. The pretest, then, "is to try-out the questionnaire to see how it works and whether changes are necessary before the start of the full-scale study" (Kornhauser & Sheatsley, 1976, p. 549). Here, a researcher is concerned with administration, phrasing, and sequencing of the questions. More specifically, Dillman (1978) has outlined eight questions that need to be answered in order to fulfill the "real" purpose of the pretest:

1. Is each item measuring what it is intended to measure?

2. Are all the words understood?

3. Are questions interpreted similarly by all individuals?

4. Does each closed-ended question have a response category that applies to each person?

5. Does the questionnaire create a positive impression, one that motivates people to answer it?

6. Can the questions be answered correctly?

7. Are some items missed? Do some items elicit uninterpretable answers?

8. Does any aspect of the instrument suggest bias on the part of the investigator? (p. 156)

Basically, according to Mindel (1981), three types of groups can be used to pretest an instrument: "(1) fellow colleagues, (2) the potential users of the data, and (3) individuals drawn from the population to be surveyed" (p. 178). Selltiz et al. (1976) assert that a valuable part of the pretest is the discussion with the respondents after they have completed the instrument. This technique of interviewing was used to pretest the instruments in this study.

Following are the specific processes and techniques that were employed in this research to pretest the data collection instruments:

- First, the data collection instruments were presented individually and at different times to the researcher's Thesis Committee.

- Second, the data collection instruments were presented to the Advisory Committee.

- Third, two former workers from after-hour services, one from Help Services and the other from the Essex County Children's Aid Society, were consulted.

The pretesting of the data collection card took place during the first week in March, 1982. At this time a point relating to the data collection procedures should be raised. Since there were few problems during the pretest in relation to the content of the data collection card, the data collected during this phase was included in the study. As a result, the total period of data collection was from March 1 to March 31, 1982. Following are the procedures for the actual data collection.

Data Collection Cards

Following the above process, the supervisors of the after-hour workers in the participating agencies were trained by the researcher to instruct their own workers on how to complete the data collection cards effectively and efficiently. Until this point, this researcher very carefully recorded any feedback and concerns expressed by the pretesters. Based on this feedback, the researcher developed an extensive instruction booklet to be presented to every person who was to collect data for this component of the study. The instruction booklet (See Appendix J) contained a variable-by-variable breakdown of the data collection card, using examples where appropriate. Once the supervisors had instructed their after-hour workers on how to use this instrument, this researcher conducted numerous unscheduled spot checks, where attempts were made to consult with the workers who collected the data. Because of security problems at the Windsor Police Department, this researcher was given a one month security release (See Appendix K) to enter the Central Communications Centre for observational purposes. The data collection cards of the workers who were not spoken to personally were also spot checked. If the content of the cards reflected a possible misunderstanding, supervisors were asked to assist in clarification with the workers.

Follow-up Questionnaire

The pretesting of the follow-up questionnaire, as previously mentioned, employed the same strategy used to pretest the data collection card. The two former workers in after-hour services who were

consulted during the pretesting of the instruments were trained by this researcher to administer the follow-up questionnaire during the structured telephone interview.

When a researcher uses a research assistant, the issue of inter-researcher reliability is raised. Reliability is the amount of measurable variation that is due to inconsistencies of the measurement. Reliability is defined

> as the accuracy or precision of an instrument, as the degree of consistency or agreement between two independently derived sets of scores, and as the extent to which independent administration of the same instrument (or highly similar instruments) yield the same (or similar) results under comparable conditions. (Bostwick & Kyte, 1981, p. 113)

Suchman (1967, pp. 118-120) has outlined five sources of unreliability: subject reliability, observer reliability, situational reliability, instrument reliability, and processing reliability. Since research assistants were used to collect data in the second component of this study, the issue of observer reliability was of concern. Bostwick & Kyte (1981, pp. 119-121) outline two types of observer reliability: intra-observer, and inter-observer reliability. The latter concept is of concern when two or more judges administer the same instrument to different individuals. To measure inter-observer reliability, different data collectors would administer the same instrument to the same individuals at different times. One then assesses the reliability of the measurement by calculating percentages of agreement. Since these research assistants were already familiar with the purposes and procedures of this study, extensive training was not necessary. As a result of their past experience and familiarity with the project, high inter-researcher reliability can safely be assumed.

Organizational Survey

The organizational survey consisted of three steps. First, an introductory letter (see Appendix L) explaining the primary purpose of the survey was enclosed in an envelope along with the questionnaire (see Appendix I) and a stamped, preaddressed envelope. Two weeks later, a follow-up letter (see Appendix M), accompanied by a second copy of the questionnaire, was sent to all of the organizations that had not replied, asking for their cooperation. Last, a thank-you letter (See Appendix N) was sent to every organization which returned the questionnaire. The final cut-off date for excluding questionnaires in this study came six weeks after the initial questionnaire was sent out (June 15, 1982).

Chapter V

RESEARCH FINDINGS & DATA ANALYSIS

The purpose of this chapter is to present a detailed analysis and interpretation of the findings that were obtained from the present research.

In this chapter the data are presented in three major sections. The first section describes the data collected from the data collection cards designed for the first component of this study. These findings are presented in one or a combination of three forms: For all the agencies as a whole, by individual agencies, or in subgroups – Help Services versus the other agencies grouped together. The second section describes the results of the second component of this study which was follow-up on referrals. In the third section of this chapter a description of the organizational survey is disseminated. The purpose of this research was to explore the extent, nature, and auspices of after-hour services in Windsor. For this purpose the following research questions were generated:

COMPONENT I

1. What are the demographic characteristics of the persons, who contact after-hour services?

2. What is the nature of the related problems of people who contact after-hour services?

3. What types of intervention are employed by counselors of after-hour services?

4. How do people become aware of the existing after-hour services?

5. What is the volume of misplaced calls being received by after-hour services?

COMPONENT II

1. Do callers follow-through on referrals that are made by after-hour workers?

2. What factors inhibit or increase the probability that a caller will follow through on a referral made by an after-hour worker?

COMPONENT III

1. What is the overall perception of existing after-hour services by specific segments of the community?

2. What is the overall perception related to the needs of after-hour services by specific segments of the community?

5.1 COMPONENT I: CHARACTERISTICS OF DATA COLLECTION CARDS

5.1.1 Sample Size

For the month of March, a total of 553 after-hour telephone calls were recorded for this study by five agencies: The Distress Centre of Help Services, Windsor Western Hospital Mental Health Clinic (I.O.D.E.), Roman Catholic and Essex County Children's Aid Societies, and the Windsor Police Department. The distribution of recorded calls per agency can be found in Figure 1.

As can be seen in Figure 1, Help Services was responsible for 294, or 53% of the total calls recorded. In their 1971 study, Daniels and

AGENCY		FREQ	PERCENT	N=553
CHILDREN'S AIDS	|*********	178	32.19	
HELP SERVICES	|*************** 294		53.16	
I.O.D.E.	|*	10	1.81	
POLICE DEPT.	|****	71	12.84	

```
              |----+---+----
             .100  200  300
```

FREQUENCY

Figure 1: Frequency Distribution of Calls By Agency

Wright (1971) reported that Tel-A-Friend, an organization similar to the Distress Centre, recorded 256 calls for the month of August.   It would . seem that the use of such services has not increased substantially since the early 70's.   At this point one should be cautioned not to confuse the utilization of such services as being indicative of need.

It is interesting to note that I.O.D.E. recorded only 10 telephone contacts for the entire month, even though this researcher, during unscheduled spot checks, observed the telephone to ring more .than 10 times.   The small number of recorded calls can . be partially explained through the informal conversations that this researcher had with some staff members at I.O.D.E. Hospital. During the spot checks, some staff members communicated in private that they were not recording. all the telephone calls, nor would they ask callers for identifying information if a referral was made.   These staff members believed that this process

crossed the boundaries of confidentiality. This is discussed further in Section II.

5.1.2 Card Colour

Figure 2 shows the colour distribution of cards recorded by each agency.

AGENCY	COLOUR		FREQ	PERCENT	N=553
CHILDREN'S AIDS	BLUE	|**	16	2.89	
	WHITE	|********	162	29.29	
HELP SERVICES	BLUE	|**	21	3.80	
	WHITE	|**************	273	49.37	
I.O.D.E.	BLUE	|*,	1	0.18	
	WHITE	|*	9	1.63	
POLICE DEPT.	BLUE	|*	4	0.72	
	WHITE	|***	67	12.12	

```
            ----+----+----
            100  200
```

FREQUENCY

Figure 2: Colour Distribution of Cards By Agency

Since 10% of the cards were blue, it was expected that, of the 553 recorded calls, approximately 55 blue cards would exist. Figure 2 reveals that approximately 13 blue cards were missing for undetermined reasons, as a total of 42 blue cards were presented for analysis.

It is normally expected that some data collection cards would not be returned. For example, should a staff member fill out a card incorrectly, the tendencency could be to destroy the card and complete the next card in the correct manner. With such a high percentage (24%) of missing blue cards, the researcher's suspicion was raised as to whether the blue cards were taken from their designated place and not filled out or, whether they were just not returned. Since all the cards were grouped together with steel rings, the possibility of cards being lost is slim. This idea will be discussed in more detail in Section II.

5.1.3 Status of Call

In terms of call status (misplaced calls), Figure 3 illustrates that the Police Department received 7,013 calls for the month of March, of which 0.84% were misplaced. The other agencies received relatively more misplaced calls, ranging from 2.8% to 10%.

The frequency of misplaced calls is lower than what was expected. These expectations, in relation to misplaced calls, were based on inter-views with supervisors that were conducted by this reseacher. It was later discovered that the supervisors' beliefs were based on communications with their counselors. Stated differently, staff from the participating agencies frequently complained about misplaced calls, yet there appears to be no empirical evidence to suggest such a problem. Of course the concept of a misplaced call is a new one and agencies have not clearly defined, for their own purposes, just what constitutes a misplaced call. In addition, since it is believed that not all of the telephone calls were recorded and reported, the misplaced call frequency may have been underrepresented.

AGENCY.	MISPLACED CALL		FREQ	PERCENT N=7495
CHILDREN'S AIDS	? *	|*	3	1.68
	NO	|********* ⋅	170	95.50
	YES	|*	5	2.80
HELP SERVICES	?⁻	|	0	0.00
	NO	|**************	281	95.57
	YES	|*	13	4.42
I.O.D.E.	?	|	0	0.00
	NO	|*	9	90.00
	YES	|*	1	10.00
POLICE DEPT.	?	|*	3	0.04
	NO	|	6951	99.11
	YES	|***	59	0.84

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          ----+----+----
          100  200  300
```
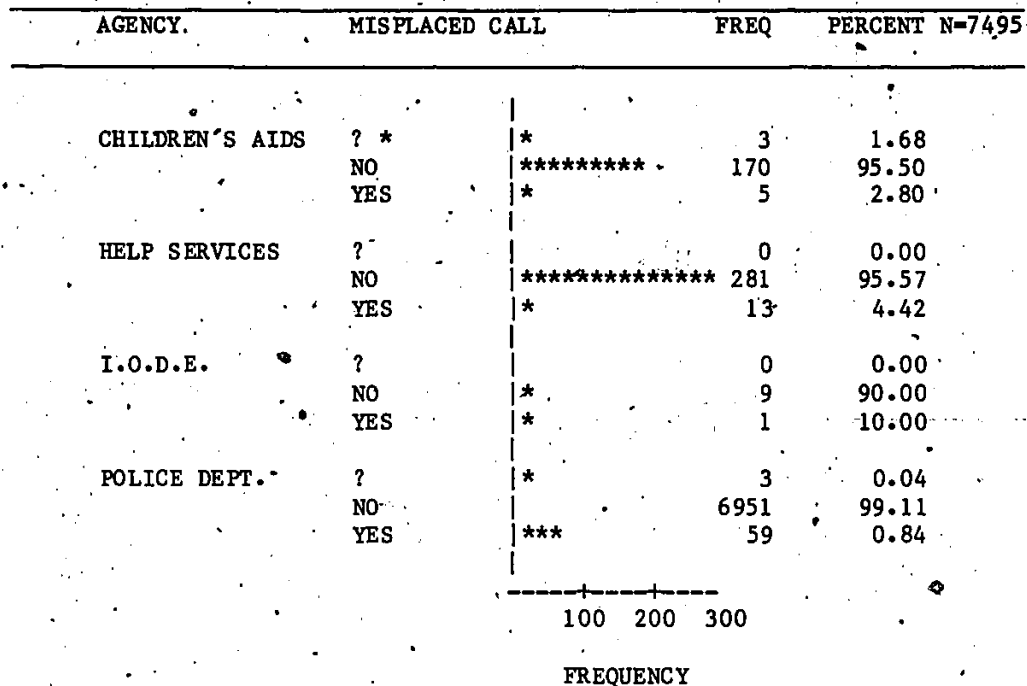
FREQUENCY

Figure 3: Frequency Distribution of Misplaced Calls

* ?=Undetermined

5.1.4   Temporal Data

Date

   Of the 544 calls of which the dates were recorded (See Figure 4),
March 12th and 24th, Friday and Wednesday respectively, were the days in
which the highest number of telephone calls were received and recorded
(11.5% combined).   Conversely, March 25th and 28th, Thursday and Sunday
respectively,   were the days in which only 2.5% of the calls were
received and recorded.   Approximately one half of the calls were
received and recorded during the first half of the month.   Also, the

frequencies were distributed quite evenly throughout the entire month. The mean number of telephone contacts recorded per day was 17.54 calls. There was a total of nine calls for which the dates were not recorded.

DAY IN MARCH		FREQ	CUM. FREQ	PERCENT	CUM. PERCENT
1	*******************	19	19	3.49	3.49
2	*******************	19	38	3.49	6.99
3	*******************	19	57	3.49	10.48
4	*********************	21	78	3.86	14.34
5	*****************	17	95	3.13	17.46
6	****************	16	111	2.94	20.40
7	**********************	22	133	4.04	24.45
8	************	12	145	2.21	26.65
9	**************	14	159	2.57	29.23
10	*************	13	172	2.39	31.62
11	*******************	19	191	3.49	35.11
12	******************************	30	221	5.51	40.63
13	******************	18	239	3.31	43.93
14	**********************	23	262	4.23	48.16
15	*********************	22	284	4.04	52.21
16	**************	14	298	2.57	54.78
17	**********	10	308	1.84	56.62
18	*********	9	317	1.65	58.27
19	******************	19	336	3.49	61.76
20	*********************	22	358	4.04	65.81
21	****************	16	374	2.94	68.75
22	**************	14	388	2.57	71.32
23	************	12	400	2.21	73.53
24	*********************************	33	433	6.07	79.60
25	******	6	439	1.10	80.70
26	*********************	22	461	4.04	84.74
27	****************	16	477	2.94	87.68
28	********	8	485	1.47	89.15
29	******************	20	505	3.68	92.83
30	*******************	21	526	3.86	96.69
31	*****************	18	544	3.31	100.00

```
     ----+----+----+----+----+----+----
         5   10   15   20   25   30   40
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FREQUENCY

Figure 4: Frequency Distribution of Calls Per Day

Table 3 shows that Fridays are the days in which most calls are received with Thursdays representing the fewest number of calls.

TABLE 3

Frequency of Calls Per Week Day

DAY**	NUMBER OF CALLS	MEAN	PRESENT PERCENT	BERMAN* PERCENT	N=544
FRIDAY	88	22.00	17.88	17.00	
WEDNESDAY	93	18.60	15.12	16.00	
SATURDAY	72	18.00	14.63	9.00	
MONDAY	87	17.40	14.14	17.00	
SUNDAY	69	17.25	14.02	9.00	
TUESDAY	80	16.00	13.00	17.00	
THURSDAY	55	13.75	11.17	15.00	

* Taken from Berman et al. (1973)

** Note that the week days were not equally represented in March. -

Here again, there seems to be no pattern in terms of number of calls per week day. However, Table 3 also outlines the findings reported by Berman, Davis, and Phillips (1973) in their descriptive study of a hotline service operated by volunteers at George Washington University. These authors' results show a pattern where Mondays, Tuesdays, and Fridays receive the highest number of calls. One could speculate that this pattern exists because their study took place in a university environment and many students do not stay on campus or in town for the weekends; consequently, the number of calls increase just before students leave school and just after they return.

Time

.The times in which the calls were received are presented in subgroups (Help Services versus other agencies), and depicted in three hour time blocks. Figure 5 reveals that Help Services received almost 50% of their recorded calls between the hours of 8:00 p.m. and 10:30 p.m., whereas the other agencies receive 60.84% of their recorded calls between the hours of 4:30 p.m. and 8:30 p.m. Note that Help Services did not record any calls between the hours of 4:30 p.m. and 8:00 p.m. as the Distress Centre of that agency is closed during that specified time period. Restated, it appears that the other agencies receive the majority of their after-hour calls precisely when the Distress Centre at Help Services is closed. Further, it appears that many callers are "sitting by their phones" as it were, just waiting for the Distress Centre at Help Services to open, as a very high frequency of calls are received between 8:00 p.m. and 8:30 p.m., their first half-hour of operation. Berman et al. (1973) also report that the highest frequency of calls, over a three year period, were recorded between the hours of 6:00 p.m. and 10:00 p.m., while 10:00 p.m. to 2:00 a.m. showed the second highest frequency (28%) (p.365). Given the present figures, an interesting question is raised: Why is the Distress Centre at Help Services closed during the busiest time of day? Figure 6 graphically display the times in which the calls were received.

Length of Call

Of the 502 calls for which the length was recorded, the mean length of call was 16.7 minutes with a median and mode of 10 minutes. Counselors did not record the time for 42 calls.

AGENCIES.	TIME INTERVALS		FREQ (N=505)	PERCENT
HELP SERVICES.	4:30PM- 6:30PM	| ⌐	0	0.00
	6:31PM- 8:30PM	|*******	35	11.94
	8:31PM-10:30PM	|********************	96	32.76
	10:31PM-12:30AM	|*************	66	22.52
	12:31AM- 2:30AM	|*********	45	15.35
	2:31AM- 4:30AM	|****	21	7.16
	4:31AM- 6:30AM	|***	15	5.11
	6:31AM- 8:30AM	|***	15	5.11
		|		
OTHER AGENCIES	4:30PM- 6:30PM	|*****************	80	37.73
	6:31PM- 8:30PM	|**********	49	23.11
	8:31PM-10:30PM	|******	32	15.09
	10:31PM-12:30AM	|****	20	9.43
	12:31AM- 2:30AM	|***	16	7.54
	2:31AM- 4:30AM	|**	9	4.24
	4:31AM- 6:30AM	|*	2	0.90
	6:31AM- 8:30AM	|*	4	1.88

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            ----+---+---+---+---
            20  40  60  80
```

FREQUENCY

Figure 5: Frequency of Calls By Two Hour Time Blocks

Grouping the length of the telephone contacts into five minute intervals, Figure 7 depicts the frequency distribution.

Figure 7 indicates, as the length of call increases, the frequency count decreases, the majority of calls (33.7%) being five minutes or less. Slightly more than half of all calls were 10 minutes or less, and approximately 80% of the calls were shorter than 25 minutes. Referring back to Table 7, it could be concluded that the median and mode, in this case, are more reliable descriptive statistics than the mean, since the latter is vulnerable to the influence of outliers, a deviant observation(s). In this case, 10 observations in the "over 60 Min." category could be the outliers.
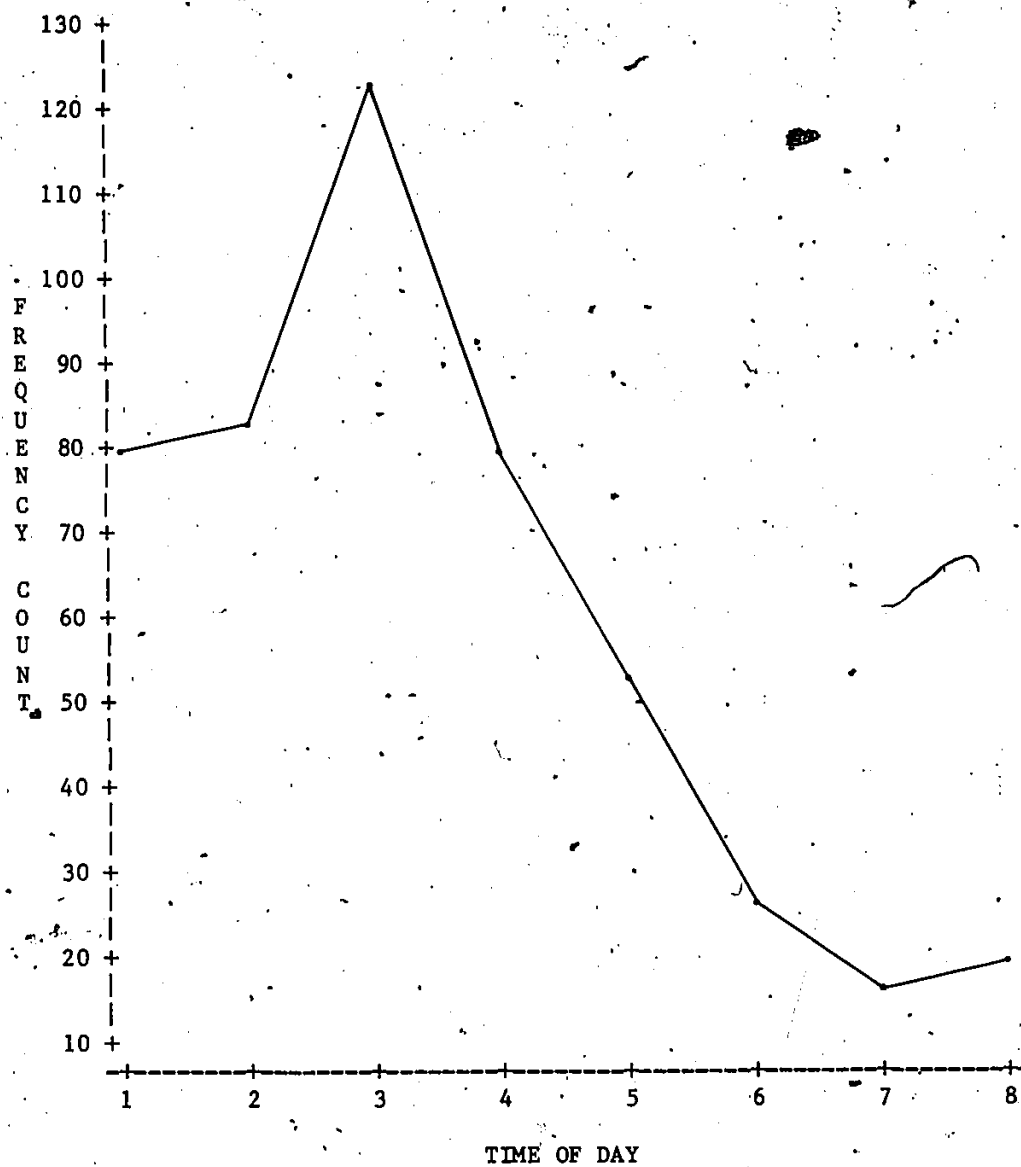
Figure 6:   Time of Day By Frequency of Calls

LEGEND: 1=04:30PM-06:30PM   2=06:31PM-08:30PM   3=08:31PM-10:30PM
          4=10:31PM-12:30AM   5=12:31AM-02:30AM   6=02:31AM-04:30AM
          7=04:31AM-06:30AM   8=06:31AM-08:30AM

TABLE 4

Statistics For Length of Call

STATISTICS	LENGTH*	N=502
MEAN	16.70	
MEDIAN	10.00	
MODE	10.00	
MINIMUM	1.00	
MAXIMUM	99.00	

*Recorded in minutes

TIME INTERVALS		FREQ	CUM. FREQ	PERCENT	CUM. PERCENT
1 TO 5 MIN.	|**********************	169	169	33.67	33.67
6 TO 10 MIN.	|***********	86	255	17.13	50.80
11 TO 15 MIN.	|********	67	322	13.35	64.14
16 TO 20 MIN.	|*******	60	382	11.95	76.10
21 TO 25 MIN.	|***	21	403	4.18	80.28
26 TO 30 MIN.	|****	28	431	5.58	85.86
31 TO 35 MIN.	|**	13	444	2.59	88.45
36 TO 40 MIN.	|**	12	456	2.39	90.84
41 TO 45 MIN.	|**	14	470	2.79	93.63
46 TO 50 MIN.	|*	7	477	1.39	95.02
51 TO 55 MIN.	|*	8	485	1.59	96.61
56 TO 60 MIN.	|*	7	492	1.39	98.01
OVER 60 MIN.	|*	10	502	1.99	100.00

```
        ---+---+---+---+---+---
        30  60  90  120 150
```

FREQUENCY

Figure 7: Length of Call in Five Minute Intervals

5.1.5 Demogaphic Characteristics of Callers

Sex

Of the 544 calls of which the caller's sex was recorded, 61.5% were believed to be female, while 38.4% were believed to be male.   Figure 8 graphically depicts the callers' sex distribution.

CALLER SEX		FREQ	PERCENT N=544
FEMALE	|**********************************	335	61.58
MALE	|*********************	209	38.42

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         ----+----+----+----+----+----+----
            50   100  150  200  250  300
```
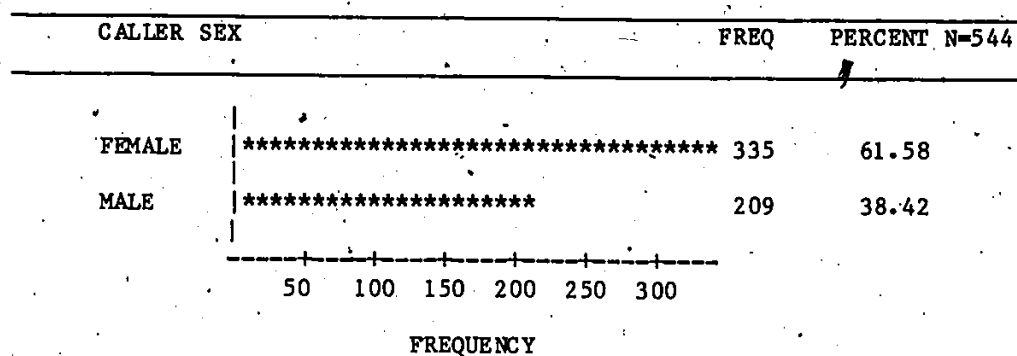
FREQUENCY

Figure 8:   Sex of Callers

The observed difference in the frequency distribution between the sex of the callers is a striking one in two respects: The first strik-ing feature is that these figures are almost identical to those figures which Daniels and Wright (1971) reported in their study of Tel-A-Friend in Windsor.   In this study, Daniels and Wright (1971) also report the fact that their Windsor sex ratio figures were identical to the figures reported by the Distress Centre in Toronto, Ontario. As a result, it would seem that telephone counseling is utilized predominantly by females and that the shift, in terms of sex, has been very little, if any, over the past ten years.   Shneidman and Farberow (1961), in a study that compared the results of persons who attempted suicide and persons who committed suicide during the year 1957 in Los Angeles County, found that the sex ratio of attempted suicide was very similar to the results of this study (31% males and 69% females).   An interesting point, and the second striking fact about these figures is that Shneidman and Farberow (1961) reported that, in terms of actual suicide, the figures

were reversed (70% male and 30% female). One should be cautioned here that there is an inherent danger in comparing the data of a general telephone counseling service with a suicide prevention program, as the focus and client population of each is possibly quite different. However, if these limitations are recognized in terms of not making direct generalizations, some comparisons such as sex ratios could be made. However, Walsh and Phelan (1974) assert that it is generally recognized that suicide prevention centres are called upon to deal not only with suicidally inclined individuals, but those seeking solutions to a broader range of problems. These authors further state,

> In fact, it is not known at present what proportion of those served are actively suicidal and what proportion present other kinds of problems instead. (Walsh & Phelan, 1974, p. 314)

It would appear from the callers sex statistics that women find it easier to talk about their problems over the telephone, as opposed to men. It is a well known fact that women are encouraged through socialization to express their feelings and problems, whereas men are taught, to protect their macho images and control their emotions (Birns, 1976). This study would indicate that, at least in terms of telephone counseling, this behavioral difference is still true.

The counselor's sex was also recorded (See Figure 9). Figure 9 indicates that 70.07% of the telephone calls were answered by a female, while 29.93% were answered by male employees which is very similar to the callers' sex (See Figure 8).

To test whether the length of the telephone call was related to the caller's and/or counselor's sex, an analysis of variance was calculated. Results indicated significant main effects for both counselor and caller

EMPLOYEE SEX		FREQ	PERCENT	N=294
FEMALE	**************************	206	70.07	
MALE	************	88	29.93	

```
    30  60  90  120 150 180
```
FREQUENCY

Figure 9: Sex of Counselor

sex variables, $F(1, 270) = 5.55$ $p < .01$, and $F(1, 270) = 3.09$ $p < .05$, (See Table 5 for the cell means). The interaction affect was not significant.

TABLE 5

Mean Length of Call By Sex

COUNSELORS' SEX	CALLERS' SEX	MEAN LENGTH*	N=282
FEMALE	FEMALE	22.35	
MALE	FEMALE	28.75	
FEMALE	MALE	18.47	
MALE	MALE	20.92	

* RECORDED IN MINUTES

The main effects of the sex of counselor is due to the fact that male counselors have remained on the lines longer than their female counterparts, regardless of the sex of the caller. This is very interesting, due to the fact that it is contrary to common knowledge expectations, and the assertions of studies that have found women to be more verbal than men. One possible explanation of these unexpected findings could be that males are more verbal in non face-to-face interactions (i.e. over the telephone), since this mode of interaction could be more like a "business" environment which is congruent with male socialization. Another possibility could be that there exists a higher level of evaluation apprehension in the male counselors, especially during the period of time when an evaluation study was being conducted, such as the present one. The fact still remains that these are speculative attempts which are open to further exploration.

The main effects of caller sex, as indicated in Figure 5 shows that female callers, regardless of the sex of the counselor, have talked for a longer period of time than their male counterparts. Even though the interaction effect is not found to be statistically significant in the analysis of the present data, there is a slight tendency for female callers to talk longer to female counselors, whereas male callers seem not to be affected by the sex of the counselors (See Figure 10). Although no concrete recommendations could be made on the basis of a single research project, and although the length of call is not a direct indicator of the effectiveness of counseling per se, if the cathartic effect of talking about one's problem(s) is a viable assumption, then one possible suggestion might be to employ more male counselors for

MEAN LENGTH
OF CALL
IN MINUTES

```
30 +
   |
   |
   |
   |
25 +
   |
   |
   |
20 +
   |
   |
   |
   |                                    — — ·— FEMALE CALLERS
   |                                    ——— MALE CALLERS
   |
15 +
   +--------+--------+--------------+--------+------------
           MALE              FEMALE
              COUNSELORS' SEX
```
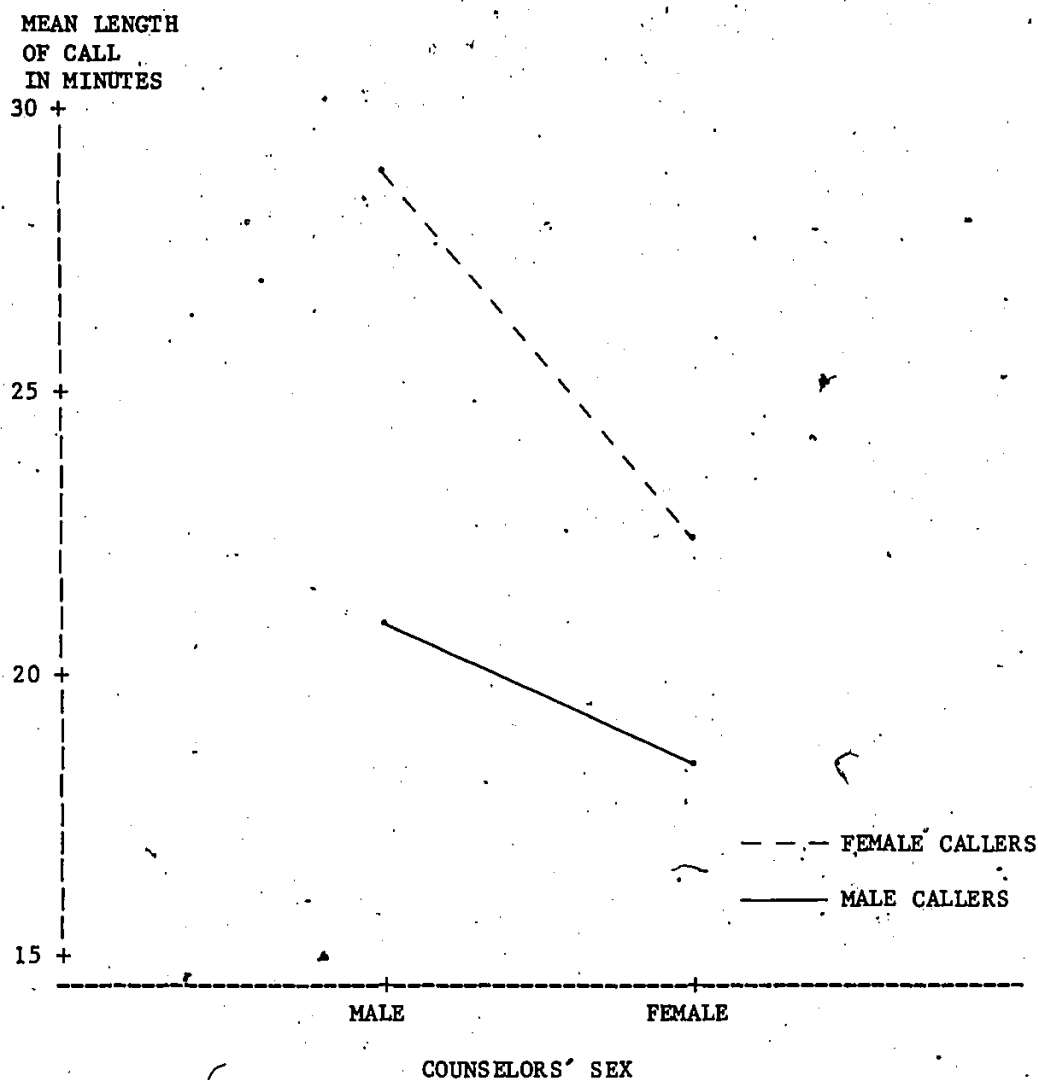
Figure 10:   Mean Length of Call by Counselor & Caller Sex

hot-line services,   or incorporate the benefits of this finding into

training programs for females.

Age

Of the 95 stated ages that were recorded, the mean age was 36.7 years. Since the age of 73 was recorded a total of 15 times (15.78%), and there is a high possibility that it belongs to the same caller, a more appropriate statistic than the mean which is vulnerable to the effect of outliers would be the median. The median age was 30 years. Table 6 outlines the descriptive statistics related to the age variable.

TABLE 6

Statistics For Stated Age

STATISTICS	STATED AGE*	N=95
MEAN	36.76	
MEDIAN	30.00	
MODE	73.00	
MINIMUM	9.00	
MAXIMUM	76.00	

*Recorded in years

The estimated age was divided into three main categories: below 20, 21 to 50, and above 50 years. (See Figure 11). It was observed that 83% of the population of callers were between the ages of 20 to 50 years.

The caller's stated age was not known 82.83% of the time. Walker (1967), in Life Line's third year of operation (March 1965 to March 1966) found that 30% of their cases fell between the ages of 20 to 29 years and 33% fell between 40-49 years. Shneidman and Farberow (1961)

FREQUENCY PIE CHART OF ESTIMATED AGE   N=447

```
                    *******************
              ****                    ***
            **                 .      ***
          **                          ***
         **                            ***
        **                              **
       **                               **
       *                                **
       *                                **
       *                                **
21-50  *                           . .**
       *                    . .         *   BELOW 20
       *    373               . .22     *
       *    83.45%         . .    4.92%  *
       *                . . . . .  . . . .*
          +               . .           *
       *                . .             *
       *                                *
       *                  52           **
       *           . .    11.63%        *
       *              .              ** ABOVE 50
        **                  . .     **
         **                   .    **
          **                 .  ..**
           **                   ***
            **                  ***
              **                ***
               ****      .    ***
                 ******************
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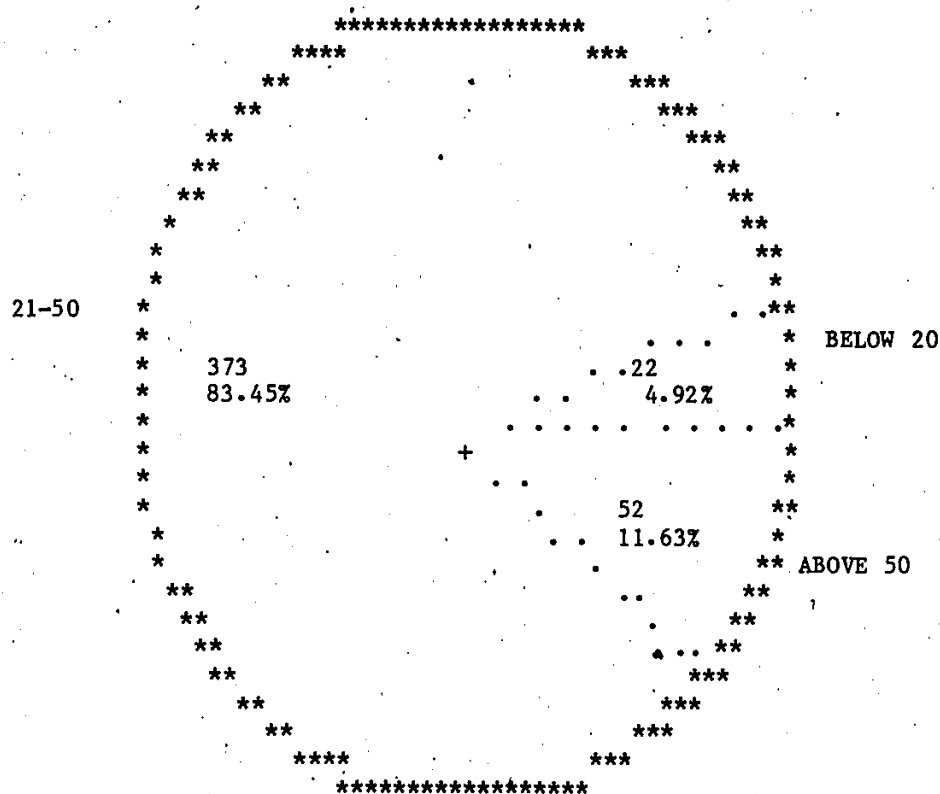
Figure 11: Estimated Age of Callers

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reported that 52% of their subjects ranged from 20-49 years.   One can

see that Walker's as well as Shneidman and Farberow's results are only

separated by 10%, whereas the results of this study are much higher.

One explanation for this could be that in the other studies, <u>actual</u> ages

were calculated, whereas they were estimated in the present study.   It

is difficult to obtain a precise mean age, even from "stated ages" as this study has shown that one client has called the Distress Centre a number of times and stated her age to be 73 years, at least 15 of those times. As a result, the high incidence (67.44%) of "previously known" callers (See Figure 16) distort the age statistics.

Related Problems

In terms of related problems, one would have to explore economic factors, particular characteristics of this city, and individual's psychological disposition or constitution, among other factors, to discover "why" the particular problems discovered here exist. Since this is not the focus of the present study, the data on related problems can only be described. A second point worth mentioning is that it is very difficult to compare the results of this study with other studies, in terms of related problems because the classification of problems varies considerably between studies. The data for related problems will first be described as individual problems, then as they appeared in combinations.

Of the 902 different types of related problems that were identified, the "family" classification was mentioned most often (17.07%). Other classifications which showed high frequencies included emotional (15.29%), interpersonal (12.52%), and physical/medical (5.65%). On the other extreme, suicide act was the least mentioned (0.55%). This observation, again, reinforces the suggestion made previously that caution should be used in making generalizations between hotline and suicide study results, as previously noted by the researcher. Figure 12 shows the obtained frequencies for each related problem classification.

RELATED PROBLEM		FREQ (N=902)*	PERCENT
GEN. COMM. INFO.	************	59	6.54
ALCOHOL	********	40	4.43
DRUGS	**	11	1.21
MEDICATION	**	10	1.21
POLICE	*****	26	2.88
LEGAL	********	38	4.21
BEREAVEMENT	**	7	0.77
FAMILY	*****************************	154	17.07
PHYSICAL/MEDICAL	**********	51	5.65
FINANCIAL	*****	26	2.88
OTHER	*********************	108	11.97
INTERPERSONAL	***********************	113	12.52
HOUSING	*******	36	3.99
EMOTIONAL	**************************	138	15.29
VIOLENCE	*****	24	2.66
WORK RELATED	***	13	1.44
SUICIDE THOUGHTS	***	15	1.66
SUICIDE METHODOLOGY	**	7	0.77
SUICIDE ACT	*	5	0.55
SEXUAL	****	21	2.32

```
        ---+---+---+---+---+--+---+---
          20  40  60  80  100 120 140 160
                    FREQUENCY
```

Figure 12: Related Problems

*.Note that, at times, more than one related problem was identified.

The combination of related problems, which defines the problem more specifically, are outlined in Table 7.

As can be seen from Table 7, the "Family" category has been identified most often, along with "Interpersonal". These two categories were expected to be interrelated, as interpersonal problems are often associated with members of the family. However, Table 7 also indicates a high frequency of family problems associated with violence. The "Other" category also shows high frequencies, which was expected. An attempt to identify, define, and outline most types of related problems would be an impossible task and an unrealistic expectation to place upon the data collectors in terms of efficient and accurate recording. Some frequently outlined examples of the "Other" category were time-checks and hangups. Most often the "Other" category was used to more specifically describe the already identified problems. For example, "Emotional" was circled and in the "Other" category, the word "angry" was written.

Action Taken

Figure 13 gives a graphic illustration of the type of action that was taken for the 540 calls of which the action was recorded.

Figure 13 shows that for 61% of the recorded calls, the counselors "listened", whereas 26% resulted in referrals. It is assumed here, that for the majority of the "listened" category, the counselors believed that they could help the callers deal with their problem(s) personally. This is a rather safe assumption because if the counselors did not believe this, they conceivably would have intervened in some other way,

TABLE 7.

Combination of Related Problems

RELATED PROBLEMS	FREQUENCY*	PERCENT	N=9022
GENERAL COMMUNITY INFO..........33		5.978	
GEN. COMM. INFO. & LEGAL.......10		1.812	
GEN COMM INFO & HOUSING......... 3		0.543	
GEN COMM INFO & EMOTIONAL....... 3		0.543	
ALCOHOL........................ 7		1.268	
ALCOHOL & FAMILY............... 5		0.906	
ALCOHOL & PHY/MEDICAL.......... 3		0.543	
ALCOHOL & EMOTIONAL............ 3		0.543	
DRUGS......................... 3		0.543	
DRUGS & FAMILY................. 3		0.543	
POLICE........................ 9		1.630	
LEGAL......................... 6		1.087	
LEGAL & FAMILY................. 6		1.087	
LEGAL & FAMILY & EMOTIONAL..... 3		0.543	
LEGAL & HOUSING................ 4		0.725	
BEREAVEMENT & FAMILY........... 3		0.543	
FAMILY........................35		6.341	
FAMILY & PHYSICAL MEDICAL...... 6		1.087	
FAMILY & OTHER................. 3		0.543	
FAMILY & INTERPERSONAL.........28		5.072	
FAMILY INTERPERSONAL & EMOT.... 7		1.268	
FAM. INTERPER. EMOT. & VIOLENCE 3		0.543	
FAMILY INTERPER. & VIOLENCE.... 3		0.543	
FAMILY & EMOTIONAL............. 6		1.087	
FAMILY & VIOLENCE.............. 3		0.543	
PHYSICAL/MEDICAL............... 8		1.449	
PHY/MEDICAL & INTERPERSONAL.... 3		0.543	
PHY/MEDICAL & EMOTIONAL........ 8		1.449	
FINANCIAL...................... 7		1.268	
INTERPERSONAL..................19		3.442	
INTERPERSONAL & EMOTIONAL......16		2.899	
HOUSING....................... 8		1.449	
HOUSING & EMOTIONAL............ 3		0.543	
EMOTIONAL.....................46		8.333	
EMOTIONAL & SEXUAL............. 4		0.725	
VIOLENCE...................... 4		0.725	
WORK RELATED................... 4		0.725	
SUICIDE THOUGHTS............... 4		0.725	
SEXUAL........................13		2.355	
OTHER.........................93		16.848	

* Problems with a frequency of less than three are not presented here.

ACTION TAKEN		FREQ	PERCENT	N=540
LISTENED	|*****************	332	61.48	
NO SERVICE AVAILABLE	|*	6	1.11	
EMERG VEH CALLED	|*	1	0.19	
REFERRAL	|*******	141	26.11.	
OTHER	|***	60	11.11	

```
        ----+----+----+--
        100  200  300
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FREQUENCY

Figure 13:   Type of Action Taken

such as making a referral.   Consequently, we can assume that for these calls, the counselors attempted to. help the callers deal with their problem(s).

Of·the 141 referrals recorded, 34 callers (24.11%) were referred to two or more sources.   Figure 14 portrays the primary referrals while Figure 15 outlines the secondary referrals.

Figures 14 and 15 reveal that most of the referrals were made to social workers (19.17%) telephone operators (10.07%) and lawyers (6.33%). Twenty-one of the 22 referrals that were made to social workers were referred by the Children's Aid Societies after-hour workers.

When one examines the referrals in relation to the types of prob- lems identified, interesting questions are raised. For example, if most of the problems are identified as "family" related, why are most of the

PRIMARY REFERRAL		FREQ*	PERCENT	N=129
ADD.RES. FOUNDATION	**	2	1.27	
R.C.C.A.S.	**	2	1.27	
CAN. MENTAL HEALTH	**	4	2.54	
CROWN'S OFFICE	**	2	1.27	
DEPT.TRANS.& COMM.	***	3	1.90	
ESSEX C.A.S.	***	3	1.90	
FAMILY PLANNING	**	2	1.27	
FAMILY SERVICES	**	2	1.27	
HELP SERVICES	******	6	3.80	
HIATUS HOUSE	***	3	1.90	
HOSPITAL	******	6	4.65	
HOUSE OF SOP	****	4	2.53	
HUMANE SOCIETY	**	2	1.27	
INTERNAL	**	2	1.27	
LANDLORD TENANT	****	4	2.53	
LAWYER	**********	10	6.33	
LEGAL AID SOCIETY	***	3	1.90	
LEGAL ASSISTANCE	**	2	1.27	
PAR.WITHOUT PARTNER	**	2	1.27	
BELL TELEPHONE	*************	13	10.07	
POLICE	***	3	1.90	
PROV. COURTS	**	2	1.27	
PSYCHIATRIST	**	2	1.27	
PUBLIC WORKS	****	4	2.53	
R.C.M.P.	**	2	1.27	
SOCIAL SERVICES	*******	7	4.43	
SOCIAL WORKER	*********************	21	13.29	
I.O.D.E.	**	2	1.27	
WINDSOR HOUSING	***	3	1.90	
WOMEN'S INCENTIVE	****	4	2.53	

```
----+----+----+----+
    5   10   15   20
```

FREQUENCY

Figure 14: Frequency of Primary Referrals

* Frequencies of less than 2 are not reported here.

referrals made to lawyers? Why are only a very small number of refer-rals directed to family counseling agencies? Could one explanation be

SECONDARY REFERRAL		FREQ	PERCENT	N=17
ALCOHOLICS ANON	|**********	1	5.88	
CHILDREN'S AIDS	|*******************	2	11.76	
CRISIS CENTRE	|***********	1	5.88	
HELP SERVICES	|**********	1	5.88	
HIATUS HOUSE	|**********	1	5.88	
HOSPITAL	|*******************	2	11.76	
LANDLORD TENANT	|**********	1	5.88	
LEGAL AID SOCIETY	|*******************	2	11.76	
LEONE RESIDENCE	|**********	1	5.88	
MAIN OFFICE	|**********	1	5.88	
PROV. COURTS	|**********	1	5.88	
SALVATION ARMY	|**********	1	5.88	
SOCIAL WORKER	|**********	1	5.88	
I.O.D.E.	|**********	1	5.88	

```
                  --------+---------
                    1         2
```

FREQUENCY

Figure 15: Frequency of Secondary Referrals

that the counselors are suggesting to the callers that legal action is the route to take? These figures would seem to indicate such. √Also, family violence has been frequently identified by the counselors, yet agencies such as Hiatus House was only identified a total of four times as the referral agency.

Source of Call

Figure 16 represents the frequency distribution of the six sources (how the caller knew or found out about the service) of calls.

SOURCE OF CALL		FREQ	PERCENT	N=433
MEDIA	|**	38	8.78	
PHONE BOOK	|***	56	12.93	
PREVIOUSLY KNOWN	|***************	292	67.44	
REFERRAL	|*	16	3.70	
FRIEND	|	8	1.85	
OTHER	|*	23	5.31	

```
          ----+----+----
          100  200  300

          FREQUENCY
```

Figure 16: Source of Call Frequency Distribution

As can be seen from Figure 16, 67.44% of the sample were previously known callers, while 12.93% of the callers claimed that they found out about the service through the telephone book. It should be noted that this last statistic can be misleading unless it is realized that the Police Department recorded 36 of the 56 (64.28%) calls that were classified "phone book" and that the staff of this agency assumed that the callers learned about their service through the telephone directory even though most of the callers did not state such. This recording error was

not realized until the latter part of this study. It was recognized earlier (See Figure 13) and stated that the majority of telephone counselors attempt to help callers resolve their problems. However, it is interesting to note that the category of "previously known" callers (See Figure 16) is representative of 67.44% of the calls. This observation could be explained in a number of ways. For example, the effectiveness of the counselors could be questioned, which would account for the fact that callers keep phoning back. Another, less obvious explanation, could be that callers are phoning back with different problems and that they can best solve them through this 'S.O.S.'# type of counseling.

Of the 16 callers who were referred to the agencies participating in this study, 25% were referred by hospitals. Figure 17 shows the frequency distribution of the referral source.

In general, one can see that very few (3.7%) of the calls are the result of referrals. As a result, it would appear that the network of after-hour services are not inter-woven in terms of utilizing each other's services. Instead, evidence would suggest that agencies are attempting to help the client "no matter what the problem is", or that very few professionals in the community are aware of the existing after-hour services.

_____

The term "S.O.S." is used by Dr. Ashok Malla (See Note 14) to describe emergency or crisis counseling.

REFERRAL FROM		FREQ	PERCENT	N=16
BELL TELEPHONE	|*****	1	6.25	
ESSEX C.A.S.	|*****	1	6.25	
FAM SERV BUREAU	|*****	1	6.25	
FOSTER PARENT	|*****	1	6.25	
HOSPITAL	|******************	4	25.00	
LONDON C.A.S.	|*****	1	6.25	
MARYVALE	|*****	1	6.25	
POLICE	|**********	2	12.50	
SCHOOL	|*****	1	6.25	
SOCIAL SERVICES	|**************	3	18.75	

```
      ---+---+---+---
         1   2   3.  4
              FREQUENCY
```

Figure 17: Source of Referral

5.2 COMPONENT II: REFERRAL FOLLOW-UP

As stated earlier (See Figure 2) a total of 42 blue cards were completed and returned for analysis.. Of these 42 cards, 71.43% did not record the actual or fictitious names of the callers (See Figure 18).

The frequency of recorded telephone numbers was even lower than that of recorded names.   Figure 19 reveals that only 7.14% of the blue cards had a recorded telephone number.

Of the 42 blue cards, seven (16.66%) were referrals and of those seven, only one card had recorded a name and telephone number or other

NAME		FREQ	PERCENT	N=42
NO	|******************************	30	71.43	
YES	|************.	12	28.57	

```
        ----+----+----+----+----+----
            5   10   15   20   25   30
                    FREQUENCY
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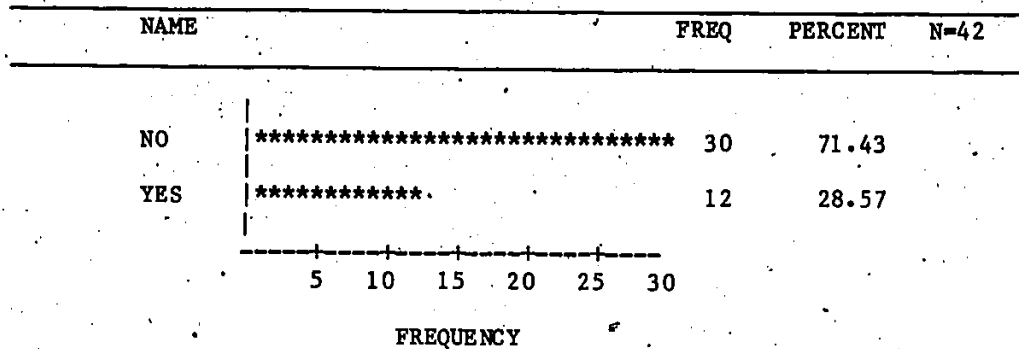
Figure 18: Frequency of Recorded Names For Blue Cards

PHONE		FREQ	PERCENT	N=42
NO	|*******************	39	92.86	
YES	|**	3	7.14	

```
        ----+----+----+----,
            10   20   30   40
                FREQUENCY
```
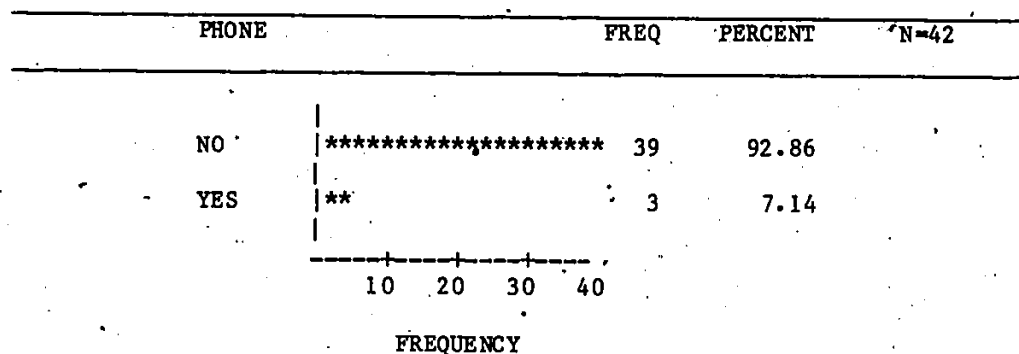
Figure 19: Frequency of Recorded Telephone Numbers

identifying information that would enable a future contact to be made. The caller whose card had the necessary identifying information was unable to be contacted during the alloted time period. As a result, no empirical data on the content of individual referrals was collected for the second component of this study.

The question of why the necessary information was not recorded on referrals is an interesting one. The obvious reason would be that "the callers would not reveal it". A not-so-obvious reason could be related to cooperation of the telephone counselors. Earlier, it was mentioned that some people involved in data collection, blatantly refused to cooperate, while others' behavior and attitudes were less conspicuous. The rationale behind this behavior was related to client confidentiality and anonymity. While these concepts are valid ones, they are only valid to a certain degree. It is suspected by this researcher that peoples' resistance to cooperate cannot fully be explained through the need to protect their clients. Other studies have shown callers to be very cooperative in terms of providing information for follow-up. For example, Lester (1970) found that, within only a 15 day period, 21 callers of 344 referrals gave sufficient information so they could be recontacted. It is this researcher's opinion that many clients would look forward to, and appreciate the fact that someone was interested and willing to take the time to see if "everything went okay" after the referral was made. A possible explanation might be the evaluation apprehension experienced by the counselors, themselves. Some counselors may have felt threatened if they thought that their own work was being evaluated by an outsider (in this case, the researcher), and might have consciously or unconsciously avoided that possibility through passivity, in terms of either failing to gather the extra information or not recording it at all. Of course, this is a speculation which can not be supported empirically, and only is raised due to the non-cooperation demonstrated by a few counselors during numerous contacts that the

researcher had with different agencies. However,. full responsibility
for the demise of this component cannot be shifted to the lack of coop-
eration of a few data collectors. Looking back on the expectations of
this researcher reveals other possible explanations. For example, in
order for a follow-up to be possible, four conditions had to exist: (1)
the card had to be blue, (2) the caller had to be referred, (3) the
caller had to be willing to reveal the necessary identifying informa-
tion, and (4) the counselor had to cooperate by first, asking for the
information, and second, by recording it. Possibly, too many conditions
existed for the volume of calls that were received. As well, due to
time factors, the data collectors were not involved in the study as much
as they could have been. It is possible that, if they had been more
involved in the planning phase of this research, more realistic expecta-
tions, as well as cooperation may have resulted.

5.3   COMPONENT III: ORGANIZATIONAL SURVEY

5.3.1   Sample Size

Questionnaires were mailed to 427 organizations throughout the
Windsor area. Of the 427 questionnaires that were mailed, 194 were
returned within a three week period, a response rate of. 45.43%.
However, of the 50 social services that were surveyed (See Table 2), 43,
or 86% responded, while community organizations only returned 10.52%.
According to Selltiz et al. (1976), when questionnaires are mailed to a
random sample population, response rates usually range from 10 to 50
percent (p. 297). These authors further state that "High response rates
(70 to 80 percent) are possible, if somewhat unusual" (Seltiz et al.,

1976, p. 297). Based on the obtained response rates (especially from social services), one possible conclusion would be that after-hour services is of great concern to many organizations within this community.

At the same time, the success of this survey cannot be solely interpreted as being an indication of "a problem". One should recognize that the sponsor of this survey, the United Way, a funding agency, would also have an impact on the response rate. For example, some agency directors could have believed "if I do not cooperate by returning this questionnaire, negative implications could affect our future funding". As well, the questionnaire's format along with other factors, such as a preaddressed stamped envelope and the follow-up questionnaire (See Appendix H) could have facilitated the number of returns.

5.3.2 Services Offered

Of the 194 questionnaires that were returned, 51.54% claimed to offer some type of after-hour service. It is interesting to note that there was no uniformity among the churches that were surveyed in terms of Question 1A (Does your organization offer an after-hour service?). Many churches stated that they did offer an after-hour service, (spiritual/religious counseling) while many others claimed that they did not. It would appear from this discrepency that not all church organizations see after-hour counseling as a "formal" role in the community. Since the intent of this research was not to identify the number of church organizations which offer spiritual/religious counseling, and how many do not, church organizations were deleted from the analysis of ques-

tions la and lb.   Figure 20 shows that, of the 125 returns excluding
churches, 48% stated that their organizations do offer some type of
after-hour service.

RESPONSE		FREQ	PERCENT	N=125
YES	|**********************	60	48	
NO	|********************	55	44	
NO RESPONSE	|****	10	8	

```
        ---+---+---+---+---+---
        10  20  30  40  50  60
```

FREQUENCY

Figure 20: After-Hour Services Offered

5.3.3   Formal Versus Informal Services

Figure 21 reveals that, of the organizations that do offer these
type of services, 26.67% offer them on an informal basis.   This means
that more than one quarter of the group offers an after-hour service,
even though no "official" funding or staff have been allocated. This
could indicate that, while funding or other variables that act as "road-
blocks" to establishing after-hour services exist,   approximately one
quarter of the respondents believe that because the service is so vital,
it will be offered, even if it is informal.

RESPONSE		FREQ	PERCENT	N=60
YES	|******************	38	63.33	
NO	|********	16	26.67	
NO RESPONSE	|***	6	10.00	
	----+----+----+----			
	10 20 30			
	FREQUENCY			

Figure 21:   Formal Services Offered

5.3.4   Potential Misplaced Calls

Of the organizations that do not offer a formal after-hour service, 56.36% of the organizations have staff who are contacted outside of the specified hours (See Figure 22).   In a sense, the percentage of staff who are contacted after-hours can be viewed as representing misplaced calls.   For example, if someone is experiencing an "emergency" and that person knows the name of a staff person connected with a particular agency, whether the relationship is a client/therapist one or not, and the person contacts the staff at home, one can assume that (1) the person is not aware of the existing after-hour service associated with his/her particular problem, or (2) no service exists.   Either way, the call can be viewed as a misplaced one.

RESPONSE		FREQ	PERCENT	N=55
YES	|***************	31	56.36	
NO	|***********	21	38.18	
NO RESPONSE	|**	3	5.45	

```
----+----+----+-
   10   20   30
```

FREQUENCY
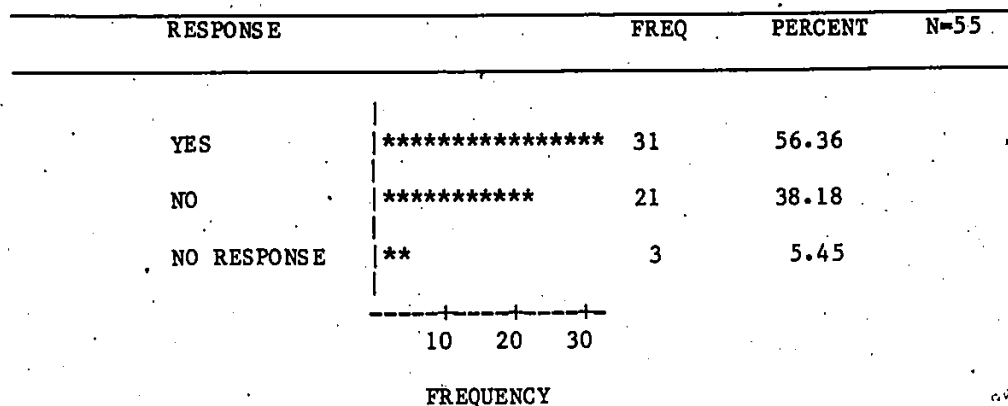
Figure 22: Staff Contacted After Hours

5.3.5 Service Description of Sample

For the remainder of the questionnaire, the description of existing services and the perceived needs and services, based on the closed response format, specific categories were constructed. From these specific responses, general classifications were formed in order to tabulate and present the data in an orderly fashion. As a result, the data will first be described in general classifications, then in more specific categories.

As can be seen from Figure 23, 21.35% of the offered services have been classified as crisis counseling, whereas only 1.45% are social/recreational services.

Figure 24 gives a graphic illustration of the more specific services that were described.

Of the 117 specific services that were described, spiritual/religious counseling was mentioned 35, or 29.91% of the time. It should be remem-

RESPONSE		FREQ	PERCENT	N=206*
NO RESPONSE	|******************	89	45.87**	
EMERGENCY ASSIST.	|*****	24	11.65	
CRISIS COUNSELING	|********	44	21.35	
MEDICAL SERVICES	|***	15	7.28	
EDUC. SERVICES	|**	8	3.88	
SOCIAL/RECREATIONAL	|*	3	1.45	
OTHER	|******	23	11.16	

```
    ----+---+---+---+--
    20  40  60  80
```

FREQUENCY

Figure 23:   General Service Description

* Note that some organizations offer more than one type of service.

** This frequency and percentage was calculated from the
   total number of questionnaires that were received.

bered that 16% churches and related organizations, of the 427 question-
naires (38.87%) were present in the survey (See Table 2). This seems to
show that the majority of church related organizations do not offer
spiritual/religious counseling after-hours, which would imply that, if
they do not offer spiritual/religious counseling, then the probability
that they do not offer other types of counseling is high. This assump-
tion is congruent with the observation stated earlier that many church
organizations have not been listing or advertising their telephone
numbers.

GENERAL CLASSIFICATION	RESPONSE		FREQ (N=117)	PERCENT
EMERGENCY ASSISTANCE (24/11.65)*	HOUSING/RESIDENTIAL	|****	10	8.54
	FOOD	|*	3	2.56
	FINANCIAL	|*	1	0.85
	LANGUAGE INTERPRET.	|*	1	0.85
	POLICE/FIRE/AMB.	|**	3	2.56
	GENERAL	|****	6	5.12
CRISIS COUNSELING (44/21.35)	PERSONAL/EMOTIONAL	|**	3	2.56
	SPIRITUAL/RELIG.	|*****************	35	29.91
	FAMILY CRISIS	|*	1	0.85
	MENTAL HEALTH/PSYCH	|**	3	2.56
	TELEPHONE HOTLINE	|*****	2	1.70
MEDICAL (15/7.28)	MEDICAL EMERGENCY	|**	4	3.41
	VISITING NURSE	|*	2	1.70
	OTHER	|*****	9	7.69
EDUCATIONAL (8/3.88)	HEALTH/FITNESS	|****	8	6.83
SOCIAL/ RECREATIONAL (3/1.45)	SENIOR CITIZENS	|*	1	0.85
	YOUTH	|*	2	1.70
OTHER (23/11.16)	POLITICAL	|***	5	4.27
	LEGAL	|***	5	4.27
	PAROLE SUPERVISION	|*	1	0.85
	CHILD WELFARE	|*	2	1.70
	ANSWERING SERVICE	|****	8	6.83
	NEWS MEDIUM	|*	2	1.70

```
             ---+---+---+---
             10  20  30  40
```

FREQUENCY

Figure 24: Specific Service Description

* (Total number per category/percent across categories)

Other than spiritual/religious counseling, one can see that emergency housing is the most frequently offered service within this

sample population. It is not surprising that emergency housing shows a

high frequency, as this is a basic need. If someone's home is flooded

or burnt, for example, then accommodations must be provided. There is

no question about it.

It would also appear, from the small number of grouped frequencies,

such as "housing/residential" and "spiritual/religious", that some over-

lapping or duplication exists.

5.3.6   Identified Needs

When asked, "What do you consider as the most important needs to be met

by after-hour services?" 31.61 percent of the responses were classified

as crisis counseling (See Figure 25).

Figure 25 would indicate that this population does not believe that

"all" or "just any" service should be offered on a 24-hour basis, but at

least emergency assistance and crisis counseling should.   It is inter-

esting to note that 35.05% of the sample did not respond to this ques-

tion at all.   One speculation could be that the respondents' did not

understand the question, or as some respondents wrote,   "Don't know

enough".   An examination of Figure 26 indicates that family crisis,

personal counseling, and general emergency assistance are the most

salient after-hour needs to be met in this community. Conversely, emer-

gency clothing, language interpretation, visiting nurses and social/rec-

reational activities for senior citizens are given low priority.   It is

interesting that the pattern here appears to give psychological needs a

higher priority than basic needs, such as food, clothing and shelter.

Could this indicate that the economical situation in Windsor is getting

RESPONSE		FREQ	PERCENT N=272*
NO RESPONSE	|*************	68	35.05**
EMERGENCY ASSIST.	|*************	69	25.36
CRISIS COUNSELLING	|****************	86	31.61
MEDICAL SERVICES	|****	18	·6.61
EDUCATIONAL SERVICE	|*	4	1.47
SOCIAL/RECREATIONAL	|**	8	2.94
SERVICE ADMIN.	|****	19	6.98

```
    ---+---+---+---+--
    20  40  60  80
```

FREQUENCY

Figure 25: Perceived Needs of After-Hour Services (General)

* Note that some organizations identified more than one need.

** This frequency and percentage was calculated from the
   total number of questionnaires that were received.

better; consequently, people are not worried about their basic needs,
but are still trying to recover psychologically?

Another explanation could be that an accumulation of wealth in the
affluent times has been substantial enough to carry the individuals
through a less desirable economic period.   Although the basic needs of
people are still not affected substantially, the ambiguity of the length
of hardship is directly affecting their psychological wellbeing.   The
present research was neither intended, nor in the position to provid
answers to these complex processes. Yet, the questions raised are worth
pursuing in later, similar attempts.

GENERAL CLASSIFICATION	RESPONSE		FREQ (N=204)	PERCENT
EMERGENCY ASSISTANCE (69/25.36)*	HOUSING/RESIDENTIAL	|******	14	6.86
	CLOTHING	|*	1	0.49
	FOOD	|*********	17	8.33
	FINANCIAL	|***	6	2.94
	LANGUAGE INTERPRET.	|*	1	0.49
	GENERAL	|***************	30	14.70
CRISIS COUNSELING (86/31.61)	PERSONAL/EMOTIONAL	|***************	30	14.70
	SPIRITUAL/RELIG.	|******	12	5.88
	MENTAL HEALTH/PSYCH	|**	3	1.47
	FRIENDLY VISITNG	|**	3	1.47
	ALCOHOL/DRUG ABUSE	|***	5	2.54
	FAMILY CRISIS	|*****************	33	16.17
MEDICAL (18/6.61)	MEDICAL EMERGENCY	|*****	9	4.41
	VISITING NURSE	|*	1	0.49
	OTHER	|****	8	3.92
EDUCATIONAL (4/1.47)	HEALTH/FITNESS	|*	2	0.98
	OCCUPATIONAL SKILLS	|*	2	0.98
SOCIAL/ RECREATIONAL (8/2.94)	SENIOR CITIZENS	|*	1	0.49
	YOUTH	|****	7	3.43
SERVICE ADMINISTRATION (19/6.98)	INCREASE AVAIL/KNOW	|******	11	5.39
	IMPROVE REF/COMM.	|**	4	1.96
	MONITOR ABUSES	|**	4	1.96

```
        ----+----+----+--
        10   20   30
```

FREQUENCY

Figure 26:   Perceived Need of After-Hour Services (Specific)

* (Total number per category/percent across categories)

5.3.7   Identified Services Needed

In terms of general services, Figure 27 indicates that emergency assistance and crisis intervention should have the highest priority, while "no additional services" was indicated only four times. It is worth noting that the four organizations which indicated that no additional services were necessary, were churches. Normally, telephone hotlines would be classified within the category of crisis intervention; but because this particular service was identified so frequently, the researcher felt it warranted its own classification. It should be kept in mind that the organizations that were surveyed were unaware of the fact that a component of this research was also studying a hotline service. If they were aware of this fact, their indicated concern about hotline services could have been partially attributable to their prior knowledge about the focus of the study, manifesting itself as an unintended experimental bias. Since this is not the case, the genuine concern about emergency and/or hotline services can be explained in terms of a genuine perceived need in this area.

Figure 28 shows that, of the specific hotline services that were identified, a 24-hour distress and referral service was mentioned 58.33% of the time. Personal counseling and emergency housing were also identified frequently (9.90% and 9.00% respectively). It is interesting to note that the number of organizations that answered this question is considerably lower than that of the previous question (230 opposed to 111). For question three "In your view, what additional services should be provided on an after-hour basis?", a high percentage of responses indicated "See Question 2" which led the researcher to believe that the

RESPONSE		FREQ	PERCENT N=230*
TELEPHONE HOTLINE	*****	24	10.43
EMERGENCY ASSIST.	******	32	13.91
SOCIAL/RECREATIONAL	**	7	3.04
EDUCATIONAL	*	5	2.17
CRISIS INTERVENTION	******	27	11.73
AFTER-HOUR SYSTEM	**	11	4.78
LEGAL	*	1	0.43
NONE	*	4	1.73
NO RESPONSE	***********************	119	61.34**

```
----+---+---+---+---+--
 20  40  60  80 100 120
```

FREQUENCY

Figure 27: Additional Services Needed (General)

* Note that some organizations identified more than one general service.

** This frequency and percentage was calculated from the total number of questionnaires that were received.

respondents did not understand the questions insofar as they appeared not to distinguish between "needs" and "services". As well, a large number of responses referred only to their own organization, which reflects a respondent bias, or lack of knowledge about other organizations.

GENERAL CLASSIFICATION	RESPONSE		FREQ (N=111)	PERCENT
	NONE	|****	4	3.60
TELEPHONE HOTLINE (24/10.34)*	DRUG HOTLINE	|*	1	0.90
	SUICIDE HOTLINE	|*	1	0.90
	FRIENDLY LISTENING	|***	3	2.70
	24-HR DISTRESS/REF.	|**************	14	12.61
	SENIORS HOTLINE	|***	3	2.70
	V.D. HOTLINE	|*	1	0.90
	PARENTS' HOTLINE	|*	1	0.90
EMERGENCY ASSISTANCE (32/13.91)	GENERAL	|******	6	5.40
	HOUSING	|**********	11	9.90
	FINANCIAL	|*****	5	4.50
	FOOD	|******	6	5.40
	DEAF	|*	1	0.90
	TRANSPORTATION	|**	2	1.80
	MEDICAL	|*	1	0.90
SOCIAL/ RECREATIONAL (7/3.04)	YOUTH	|****	4	3.60
	SENIORS	|*	1	0.90
	ALCOHOLICS	|*	1	0.90
	MENTAL RETARDATION	|*	1	0.90
EDUCATIONAL (5/2.17)	PARENTING	|**	2	1.80
	JOB SKILLS	|*	1	0.90
	LIFE SKILLS	|*	1	0.90
	ACADEMIC UPGRADE	|*	1	0.90
CRISIS INTERVENTION (27/11.73)	CHILD WELFARE	|*******	7	6.30
	FRIENDLY VISITING	|*	1	0.90
	PERSONAL COUNSELING	|*********	10	9.00
	FAMILY STRESS	|****	4	3.60
	POLICE/S.W. TEAM	|***	3	2.70
	DRUGS/ALCOHOL	|**	2	1.80
AFTER-HOUR SYSTEM (11/4.78)	MONITOR ABUSES	|***	3	2.70
	BETTER REFERRAL SYS	|***	3	2.70
	SERVICE INFORMATION	|**	2	1.80
	FOLLOW-UP	|**	2	1.80
	EVALUATE SYSTEM	|*	1	0.90
LEGAL (1/.043)	LAWYER POLICE ST.	|*	1	0.90

```
                        ----+----+----
                        5   10   15
                        FREQUENCY
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Figure 28: Additional Services Needed (Specific)
* (Total number per category/percent across categories)

The open ended nature of this question, as can be seen from Figure 28, has resulted in a scattered distribution of responses, which makes the non-frequent entries difficult to interpret. In spite of this open-ended format, it is still interesting to observe constellations of responses around 24-hour distress relief in terms of telephone hotlines, housing and personal counseling categories. These are closely followed by food, child welfare, and financial assistance. From the nature of the above distribution, one could speculate that the perceived and actual needs of the community may be a function of the economical pressure experienced by a community which is highly dependent on the fluctuations of the automotive industry. Although for the purposes of this study, this remains a speculation, but it is furtile ground for future research to find trends in economical affluency and perception of needs of the community itself.

5.3.8   Identified Strengths of Existing Services

Basically, Question four, "What do you see the major strengths to be of the existing after-hour services?", appeared to be misunderstood by the majority of the sample. A large proportion (58.76%) of the sample did not answer the question at all. Many people appeared to respond to this question from a theoretical or utopic point of view, or just in terms of their own service. For example, some wrote, "availability when needed", or "support to the patient and family" or "service to the public". Of the people who appeared to understand, Windsor's after-hour telephone service, and Children's Aid Societies were identified several times. Possibly the misunderstanding of this question could have been avoided if the word "Windsor" had been included

5.3.9 Identified Shortcomings of Existing Services

Question five, "What do you see the major shortcomings to be of the existing after-hour services?", also appeared to be misunderstood, although not to the same extent as Question four. A total of 62.88% of the respondents did not answer this question. One cannot infer that, because the percentage of respondents who did not answer Question five is higher than that of Question four, that Question five was misunderstood to a greater extent. Here again, many answered in terms of their own service. For example, several respondents stated, "We really don't have after-hour services". However, of the questions that were answered as intended, lack of publicity was, by far, the most frequently stated shortcoming. Other shortcomings within the existing system surrounded the areas of accessibility, coordination, referrals, follow-up, and generally, lack of service.

Chapter VI

SUMMARY, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS

6.1   INTRODUCTION

This study was a research investigation which focused on the after-hour services offered in the Windsor area.

The purpose of the project was to study the extent, nature, and auspices of after-hour services. To attain this goal, a study was designed and conducted which consisted of three components. Component I established a common data base that identified the target population and some of its characteristics, and forms a foundation for further study and future evaluation. Component II attempted to examine the process of referrals made by after-hour counselors, while Component III identified the organizational perception of after-hour services. In addition, Component III described the existing after-hour services in the community.

To accomplish these goals, the researcher reviewed the literature in four areas: (1) an overview of the state of crisis, (2) crisis theory, (3) crisis intervention, and (4) the historical perspective of telephone hotline services.

The present chapter is intended as a general overview of the study as well as a synthesis of its findings. The presentation will be carried out in four sections. The first section will summarize each component of the research while the limitations of the findings will be

discussed in the second section. The third section will draw general conclusions in light of the limitations and strengths. The final section will be devoted to recommendations in terms of possible alternatives to improve the present research tools, which in turn suggest future research and possible improvements of the existing after-hour services.

6.2 SUMMARY

6.2.1 Component I

For the month of March, a total of 553 after-hour telephone calls were recorded for this study by five agencies: The Distress Centre of Help Services, Windsor Western Hospital Mental Health Clinic (I.O.D.E.), the Roman Catholic and Essex County Children's Aid Societies, and the Windsor Police Department. These calls were distributed quite evenly throughout the entire month with over 50% being recorded by the Distress Centre of Help Services.

Analysis of the data revealed that the majority of calls were recorded between the hours of 5:00 p.m. and 1:00 a.m., with the peak hour being 8:00 p.m. to 9:00 p.m. However, an interesting observation was made insofar as recognizing that other agencies received the majority of their calls while Help Services was closed and people appeared to be "sitting by their telephone, just waiting for Help Services to open", since Help Services received a high frequency of calls in their first half-hour of operation.

It was found that females utilize these services substantially more than males and that the callers' ages ranged from nine to 76 years. The

mean length of telephone contact was 16.7 minutes with a range from one minute to over one and one-half hours. In terms of caller/counselor sex, in relation to length of telephone contact, analysis of variance showed significant main effects for both counselor and caller sex, indicating that male counselors have remained on the telephone for longer periods of time than their female counterparts, regardless of the callers' sex. This finding is contrary to common knowledge expectations. The female callers, however, talked to counselors for longer periods of time than their male counterparts, regardless of the counselors' sex.

It appears from the data collected in Component I that the majority of "Related Problems" of people who contact these after-hour services are in the areas of family, interpersonal, and emotional problems, along with various combinations of these problems. Of course, it should be remembered that these data reflect the perception of counselors, pertaining to the problems of the callers and may or may not be an accurate representation of the actual problems of the callers.

Further analysis showed that, while for the majority of calls, the counselors intervened by "listening", a substantial number of calls led to referrals. However, it was noted that very few of the callers were referred to family-type agencies, in spite of the fact that the majority of problems were diagnosed as such.

In terms of trying to establish how the callers knew about the services, it was observed that the highest percentage of callers were "previously known", while very few were known to be the result of a referral from other organizations within the community. This appeared

to indicate that many people in the professional community are not aware of the existing after-hour services, or that agencies are trying to deal with all callers, no matter what their problems are.

6.2.2 Component II

Of the 42 attempts to obtain information that would allow a follow-up on a referral, only one call had all of the necessary information recorded. However, this caller could not be contacted during the allotted time period. As a result, no empirical data related to the content of individual referrals were collected for the second component of this study. It was felt by the researcher that lack of cooperation on behalf of a few data collectors, and unrealistic expectations of the researcher pertaining to the volume of calls, were responsible for the demise of this component.

6.2.3 Component III

Of the 427 organizations surveyed, 194 questionnaires were returned within a three week period, a response rate of 45.43%. However, the response rate for social service organizations was 86%.

It was observed that, approximately one-half of the organizations surveyed offer some type of after-hour service, while approximately one-quarter of these organizations offer their service on an informal basis. On the basis of the obtained information, it was postulated that, even though it was difficult to establish an after-hour service (because of funding, staff, etc.) many believed that the service was so essential that they found some means to offer it anyway.

In terms of existing services, evidence indicated that spiritual/religious, and housing/residential services are the most available ones. It was not surprising that housing/residential services showed a high frequency, since these are basic needs.

Family crisis, personal counseling, and general emergency assistance were the most salient after-hour needs that were identified, while around-the-clock telephone counseling was perceived to be the most needed service. It is suggested by the researcher that the respondents had some difficulty distinguishing between the questions pertaining to "needs" and those pertaining to "services".

In relation to strengths and shortcomings, Questions Four and Five, of the existing after-hour services in Windsor, the majority of respondents did not respond specifically. A high percent of respondents justified their lack of a response by stating "Don't know enough", which could indicate a problem of community awareness. Windsor's after-hour telephone service and the Children's Aid Societies were identified as strengths, while accessibility, coordination, referrals, follow-up, and general lack of service were mentioned as areas that need improvement.

6.3   LIMITATIONS

There are limitations inherent in any research investigation. Those recognized as pertaining to the present work are outlined in this section. The major limitations are undoubtedly due to the scope and to the parameters of the research itself. The first limitation can be discussed in terms of Component I. It should be noted that the calls which constituted the data base for this component were recorded only in

the month of March. With the exception of suicide studies, there are no previous studies which can shed light on the representativeness of "March" in relation to the other months of the year. Thus, unless further similar information is gathered during other months of the year, and even more desirably, through many years, the overall representativeness of the current data base will remain an open question.

It should also be remembered that, due to the lack of similar studies and the nonexistence of already tested methodology, this researcher had no alternative but to design the data collection tools and methodologies "from scratch". This difficulty was not present to the same extent in the development of the data collection cards, however, since these cards were formulated on the basis of basic information-gathering methods presently in use by the participating after-hour services. In spite of the difficulties mentioned, the internal reliability of most measures have been substantiated through similar findings in different components of this study in terms of major issues. To increase the reliability and the validity of the instruments, certain recommendations for further studies will be made in the following section of this work.

Another limitation which can be deduced from the present experience is the non-cooperative orientation of a few data collectors. This issue was raised during the analysis of the blue cards, especially in terms of missing blue cards and the unavailability of necessary information for follow-up on the remaining ones. To what extent, if at all, this non-cooperation has affected the white data collection cards is beyond the possibility of empirical estimation. The apparent issue of concern was for the confidentiality and anonymity of the callers and to what degree

and through which methods each individual counselor has chosen to deal with this central issue is not known. Therefore, there is the possibility that some problems could have been concealed through more socially acceptable forms. A hypothetical example might be a counselor, having heard of an incestual problem, recording it as an interpersonal one. Thus, as interesting as the present findings are, it should be remembered that the data were collected through counselors' perceptions and, in a sense, have a "second hand" nature.

In relation to the generalizability of the study's findings, again, certain limitations surface. Since the present research was carried out in Windsor, this particular city's population, its economic and industrial structures, and its particular location as a border city, are factors that have to be taken into consideration. To what extent Windsor's "uniqueness" limits the generalizability of the present research findings is open to speculation since few Canadian cities demonstrate the above-mentioned qualities. On the other hand, it could be argued that the intention of this study was to gain insight into the functioning of the after-hour services within this area alone, which will eliminate the concerns about generalizability. If the latter is a "given", then it could be concluded that the present research has attained its goal.

6.4 CONCLUSIONS

In conclusion, by linking together the three components of this research and examining them globally, certain facts emerge. In general, the data obtained in each of the three components of this study appear to be congruent with each other.

It was identified in Figure 12 and Table 7 that family, interpersonal, and emotional problems, and combinations of these, obtained the highest frequencies in terms of Related Problems. While attempting to identify the organizational perception of community problems, crisis counseling, personal counseling, and general emergency assistance were identified (See Figure 26). This would indicate that the respondents' perception of community problems was an accurate one, thus validating both components of the study in this area: consequently, invalidating the sometimes heard statement "No one knows what's going on out there". This evidence would indicate that people do in fact "know what's out there", it is just a matter of synthesizing and coordinating the knowledge and available information.

When one examines what services are needed on an after-hour basis in relation to the types of problems that were actually identified (See Figure 12 and Table 7) and the services that in fact exist (See Figure 24), a gap in the system surfaces. It appears that problems in the area of family, emotional, interpersonal, and combinations of each, were identified by after-hour counselors answering the calls, while the majority of existing services focus on spiritual/religious, and housing/ residential services. The reliability of the data collected from the organizational survey is once again increased by that fact that the

organizations surveyed also identified this gap through their responses (or lack of response) to Questions Four and Five. These questions were specifically designed to focus on the organizational perception of potential gaps. In those questions, high frequencies were recorded in the crisis intervention, emergency assistance, and telephone hotline categories.

The problems identified by this researcher in relation to referrals, which appeared in both the first and second components of the present research, also surfaced in the organizational survey when the respondents identified similar problems. To recapitulate, the researcher pointed out that many family-type problems were being identified, but very few callers were being referred to family-type agencies, even though 141 referrals were made (See Figure 13).

Another shortcoming mentioned by the respondents of the organizational survey was the lack of knowledge in relation to the existing services. Here too, the finding of the first component of this research that only 16 of 553 calls (3.7%) were known to be the result of a referral is substantiated (See Figure 16). It should be remembered that the people surveyed were executives of community organizations, the survey did not include the general public. The point here is, if these executives, "people in the business", are not aware of the existing services, then how familiar is the general public with them?

Finally, the problems experienced by this researcher in terms of follow-up (See section II) were also mentioned in the organizational survey as an area to be improved upon within the existing system.

In summary, the results obtained from the individual components of the present research appeared to support each other in terms of identifying the existing after-hour situation, the needs of the community, as well as the existing gaps in the system.

6.5   RECOMMENDATIONS

Based on the data analysis, a review of the literature, and the experiences of conducting this project, specific recommendations will be outlined in three areas: (1) Instrument Recommendations, (2) Process Recommendations, and (3) After-Hour Service Recommendations.

6.5.1   Instrument Recommendations

Data Collection Cards

In terms of the estimated age variable, it was shown that a very high percentage of callere were estimated to be between the ages of 21 to 50 years, which is not very descriptive. As a result, it is recommended that the age range be broken down into smaller categories. This would provide more accurate information.

"Related Problems" is a major area of concern in this type of study. It was found through the data collection that some of the Related Problems overlap and some others are ambiguous. Terms like "emotional" and "interpersonal" have proven to be "catch-all" categories that do not clarify the type of Related Problem the caller is faced with. Not only should the terms be more carefully defined, researchers and administrators should strive to define the problems so that they are generalizable across agencies. By accomplishing this, research results can be more easily compared.

Based on the data obtained from the "Action Taken" variable, it is recommended that this nominal variable be converted to an open-ended question that would require qualitative analysis. Barnes and Srivenkataramana (1982) in their critical analysis of Wilensky's (1975) thesis, state that "Some problems are inherent in an approach that relies almost solely on statistical information" (p. 242). Their contention is that the employment of quantitative analysis in isolation, "are blunt instruments to employ on more delicate material that connects with human aspirations and human will" (p. 243), which this researcher supports. By further examining the area of "Action Taken" in the manner just mentioned, the door to counselor effectiveness can be opened.

The "Source of Call" variable in this research was only recorded when known. It is recommended that the counselors ask the callers a question about their source of information about the service. Such a question is relatively non-threatening if asked at the end of the contact, whereas the information provided is invaluable to administrators in terms of publicity.

It is further recommended that the variables and format of the data collection card be used by after-hour services (after the recommended changes have taken place) on a daily basis. This card and format has proven to be very efficient in terms of recording, and it also can provide a wealth of relevant information. Another benefit of its use is that a research component would automatically be built-in to the existing services which could act as a "finger on the pulse of the community", thereby increasing efficiency and effectiveness.

In general, the information obtained from the data collection cards in the first component of this study, was recorded "only if it was known through the 'normal' process of the contact". Stated differently, the data collection played a "low-key" role within the participating agencies. Another example of this low-key role is that employees were not required to record their employee number, if they chose not to. At the same time it should be mentioned that this low-key role was intended to, and did serve specific functions. For example, because of time factors, the counselors were not included in the planning phase of this project, and since many had not previously been involved in social research projects, the researcher was sensitive to the potential threatening attitude that may have resulted if the researcher would have "imposed a high-priority research project" on the counselors. Based on the above facts, observations, and perceptions, the researcher recommends that data collectors be included in the planning phase of future research and that the data collection be given higher priority, which would result in greater amounts and more accurate information in the same period of time.

Organizational Survey

In general, this researcher would suggest that this relatively open-ended questionnaire be converted to a closed one, based on the categories that were created from the responses (after the following recommendations have been considered). This would avoid the inclusion of numerous categories with low frequencies, as was seen in question three (See Figure 28). As well, a close examination of these categories

will reveal that some overlap does exist. By creating categories before the responses are obtained, this can be avoided. Should a future researcher desire the open ended questionnaire format, specific recommendations will be made pertaining to the individual questions.

In order to clarify the intent of question one ("Does your organization offer any after-hour services?") the sentence "If so, please describe briefly" should be added, since some respondents did answer "yes", but did not describe the service.

It was felt by this researcher while reading the responses to Question Two, "If your organization does not offer a formally established after-hour service, do people contact you or any of your staff with a problem (for example at home) during the abovementioned times?", that the words "for example at home" may have created a positive bias. It is recommended that these words be deleted and the sentence, "If so, please explain briefly", be added.

It is also recommended that the word "not" be underscored, since some respondents answered "yes" to Questions One and Two. It is recognized by this fact that, even though a service is being provided after-hours, some people are still contacted during that time period. However, a further recommendation is that the words "do people..." be replaced with "does the general public...", as it was learned through Component I of this study that staff are sometimes contacted in this time period by other staff or administrators, which could have inflated the "yes" response frequency of this question.

Questions two, three, four, and five, (See Appendix I) should include the words "in Windsor" at the end of each question, which may

eliminate the apparent confusion between one's own service, and "Windsor's after-hour services".

In order to document the reliability of the organizational survey, it is recommended that questions pertaining to the respondents be asked. For example, the question "How long have you lived or worked in Windsor?" would enhance the clarification to responses like "Don't know enough" which occurred in Questions Four and Five. Without qualifying the responses in relation to the respondent, the response "Don't know enough" could be interpreted as meaning either "poor publicity" or "new in the city".

6.5.2   Recommendations For Existing After-Hour Services

Based on the results of the organizational survey, in relation to respondents lack of familiarity with existing services, it is recommended that more attention be paid to the publicity of existing services. Although a limited number of advertisements are disseminated through the local media, volunteers can play a more active role in this area. For example, flyers with small telephone stickers which advertise the telephone numbers of the police, fire, ambulance, and a telephone hotline, can be distributed by volunteers in supermarkets, malls and other heavily populated social areas. Hand distribution of such flyers can be much more effective than other distribution strategies, such as leaving flyers at a store or placing them where there is competition for visibility.

The findings of this study indicate that the operation time of the Distress Centre at Help Services should be altered. Therefore, it is

highly recommended that Help Services increase the operating hours of
its Distress Centre to include the 5:00 p.m. to 8:00 p.m. time period,
if not around-the-clock coverage, 365 days per year. Since Help Servi-
ces has replaced four other services over the past few years, at least
one of which provided a 24-hour service, this is not an unrealistic
recommendation or expectation.

In order to increase the efficiency with regard to "previously
known" callers, as shown in Component I, it is recommended that a file
on each previously known caller be kept, using either a real name (if
communicated freely) or fictitious name. This system has been used by
other hotline services, for example, by Distress Centre I in Toronto,
and has been found to increase the effectiveness of the counselor by
having some background information on the caller, which in turn can
provide a better service to the community.

Since the researcher has made recommendations that call for the
management of what could be vast amounts of data, it is recommended that
Help Services invest in a microcomputer. This computer could be used to
not only store data but also as a tool for on-duty counselors to
retrieve different types of information. For example, at the press of a
button, current information on a number of existing services that relate
to the caller's specific problem could be displayed on a screen within a
matter of seconds. This could alleviate the apparently troubled refer-
ral process identified in different parts of this research. At the same
time, files on previously known callers with the most recent information
or messages from other counselors or supervisors could be readily avail-
able.

To alleviate the duplication of service outlined in Figure 24, it is recommended that inter-agency coordination be given high priority. It is suggested that a board be formed which consists of key people in the community involved in providing after-hour services. Possibly, the United Way could be instrumental in beginning such an effort since they may have access to significant people who are currently involved in this area.

Finally, having defined the concept of a misplaced call, and based on the experiences of conducting this research, it is recommended that a new approach be taken to examine the necessity of after-hour hotline services. Traditionally, two basic approaches have been taken. One approach has been to study, usually by quantitative strategies, the use of existing services. If it were ascertained through the research that the service was making a "significant" impact, then legitimization occurred. The other approach has been to establish a service in an area and carefully monitor its use. An alternate strategy that can be used in conjunction with one of the other basic approaches, or by itself, is to examine every service available, other than the hotline(s), in relation to misplaced calls. If it is shown that the frequency of misplaced calls is high, and the types of misplaced calls can be classified, then the necessity of a hotline can more accurately be determined.

In conclusion, the researcher strongly believes that the data and analysis contained within this study, in conjunction with the recommendations just outlined, can offer a solid foundation on which to improve the existing after-hour services offered in the community, which would in turn meet the needs of people in crisis.

Appendix A

ADVISORY COMMITTEE

1. Bob Atkinson:

   - Representative for the Children's Aid Society of the County of
     Essex and the Roman Catholic Children's Aid Society for the
     County of Essex.

2. Gale Bauman:

   - Director, Social Planning and Allocations Division, United Way.

3. James Chacko:

   - Chairperson, Advocacy and Forward Planning Committee of the
     United Way. Director, School of Social Work, University of
     Windsor.

4. Randy Goon:

   - Representative, Windsor Western Hospital.

5. David Hillock:

   - Researcher, Research and Development Unit, School of Social
     Work, University of Windsor.

6. Rod Mombourquette:

   - Inspector, Windsor Police Department, Research and Planning.

7. Monty Schooley:

   - Acting Deputy Director, Windsor Social Services.

8. Robert Shepherd:

   - Director, Help Services Windsor/Essex, Incorporated.

Members are presented in alphabetical order.

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Appendix B

AD HOC COMMITTEE FOR AFTER HOUR AND CRISIS SERVICES

Mr. James Broderick   Windsor-Western Hospital Centre .

Dr. Barry Taub   Psychology Centre, University of Windsor

Dr. Walter Wren   Health Services, University of Windsor

Mr. Michael Pfaff   United Community Services

Mr. D. (Red) Wilson   Local 444, U.A.W. ,

Ms. Delores Blonde   Legal Assistance of Windsor

Rev. Ken Jaggs   Addiction Research Foundation

Mr. R. Hartleib   Social Services, City of Windsor

Mr. M. Schooley   Social Services, City of Windsor

Mr. Jack Bevan   Children's Aid Society

Dr. J. Jones   Metro Windsor--Essex County Health Unit

Const. B. Gunn   Windsor Police Department

Mr. R. Riddell   Social Services, City of Windsor

Appendix C

IMPLEMENTATION COMMITTEE

Chairperson

Gary McCarthy

Executive Director, United Way

Jim Broderick

Assistant Director, Windsor-Western Hospital

Al McCann

Executive Director, Y.M.-Y.W.C.A.

Ross Riddell

Director, City of Windsor Social Services

Barry Taub

Psychology Centre, University of Windsor

Appendix D

JOINT AGENCY COMMITTEE

Chairperson

Richard R. Walker

Community Information Service

Fred Israel

Robert Chandler

Tel-A-Friend

Al Buchanan

Lyle Browning

Volunteer Services

Christine Lee

Douglas Phillips

United Way

Mario Mollicone

Dale Swaisgood

Ontario Ministry of Culture and Recreation

John Fisher

Staff-- Gale Bauman

Appendix E

MAILING LIST FOR ORGANIZATIONAL SURVEY

I.RELIGIOUS ORGANIZATIONS

1. Churches

Assumption Church	Parish of the Atonement
350 Huron Church	2940 Forest Glade Dr.
Blessed Sacrament	Christ the King
3707 Queen	2930 Dominion
Holy Name of Mary	Holy Trinity
711 McEwan	1035 Ellis E.
Immaculate Conception	Our Lady of Fatima
686 Marentette	525 Elinor
Our Lady of Guadalupe	Our Lady of Mt. Carmel
834 Raymo	4401 Mount Royal
Our Lady of Perpetual Help	Our Lady of the Rosary
804 Grand Marais	229 Cadillac
Precious Blood	Sacred Heart
1947 Meldrum	1125 Ottawa

St. Alphonsus	St. Angela Merici
65 Park E.	980 Louis
St. Theresa	St. Anne
1991 Norman	1138 Argyle
St. Anthony	St. Casimir
1504 Ellsmere	808 Marion
St. Christopher	St. Clare
3335 Woodward	166 Tecumseh W.
Sts. Cyril and Methodius	St. Francis
1532 Alexis	1701 Turner
St. Gabriel	St. Jerome
1400 Cabana	3739 Ypres
St. John Vianney	St. Joseph
385 Dieppe	4258 Seminole
St. Martin de Porres	St. Mary
1808 Labelle	631 Giles E.
St. Michael	St. Michael
2120 Byng	2153 Parkwood
St. Patrick	St. Paul
1630 Partington	5885 Malden
St. Peter	St. Rose of Lima
875 Niagara	891 St. Rose

St. Thomas the Apostle

7830 Edgar

Sts. Vladimir and Olga

1505 Langlois

Church of the Ascension

1385 University W.

St. Barnabas

2115 Chilver

St. George's

1949 Devonshire Ct.

St. John's

3305 Sandwich

St. Mark's

1636 Tecumseh W.

St. Mary's

1983 St. Mary's Gate

St. Michael and All Angels

8700 Jerome

St. Paul's

1561 Ouellette

St. Vincent de Paul

2015 Balfour

All Saints Church

City Hall Sq.

St. Aidan's

5145 Wyandotte E.

St. David's

3400 Byng

St. James

4276 Roseland Dr. E.

St. Luke in the Fields

Lillian at Capital

St. Mark's by the Lake

150 St. Mark's,

St. Clair Beach

St. Matthew's

1620 Norfolk

St. Peter's

1994 Ellrose

Ambassador Baptist

3285 Manchester

First Baptist Church

710 Mercer

Grace Baptist

3150 Tecumseh E.

Olivet Baptist

579 Logan

Temple Baptist

664 Victoria

Bethel Baptist

1240 Pierre

Church of the Open Bible

5675 Malden

Fundamental Baptist

315 Cabana E.

Windsor Baptist Temple

315 Cabana E.

Ukrainian Evangelical

1059 Albert

First Lutheran

160 Giles W.

Nativity Slovak

1396 Langlois

Forest Glade Baptist

3385 Forest Glade Dr.

Nobles Memorial

2555 McKay

Sandwich Baptist

3653 Peter

First Romanian

1696 Cadillac

Campbell Baptist

1821 Wyandotte W.

Emmanuel Baptist

3407 Woodward

Riverside Baptist

8300 Little River

Walkerville Baptist

815 Windermere

Christ Lutheran

1140 Lauzon

Gethsemane Lutheran

1921 Cabana W.

Trinity Lutheran

1215 Parent

Peace Lutheran

Tecumseh at Rossini·

Descent of the Holy Ghost

2895 Seminole

Holy Trinity

2839 Metcalfe

St. John the Divine

1094 Drouillard .

St. Dimitrius

2690 Seminole

Calvary Community Church

1731 Lesperance,.

Finnish Pentecostal

397 Pierre

United Penecostal

909 Moy

Forest Glade Presbyterian

9675 Esplanade

Paulin Memorial

3200 Woodland

St. Andrew's Presbyterian

405 Victoria

Assumption of Our Lady

1960 Meldrum

Holy Cross

65 Ellis E.

St. George's

1960 Tecumseh E.

St. Vladimir's

2000 Tecumseh E.

St. Nicholas

5225 Howard

Church of God

3325 Walker

Italian Pentecostal

2425 Clemenceau

University Gospel Temple

510 University W.

Knox Presbyterian

3200 Wyandotte W.

Riverside Presbyterian

840 Esdras

Calvary United

1099 University W.

Central United

638 Ouellette

Emmanuel United

1728 Lincoln

Glenwood United

1825 Grand Marais W.

Lincoln Rd. United

659 Lincoln

Roseland United

3919 Howard

St. Paul's United

973 Pillette

Tecumseh United

333 Lacasse,

Victoria United

2491 Jos. St. Louis

Chalmers United

897 Windermere

Giles Boulevard

795 Giles E.

Grace United

3109 Riberdy

Riverside United

881 Glidden

St. James United

2595 Remington

Sandwich United

3340 Sandwich W.

Trinity United

1966 Tourangeau

Westminster United

1680 Dougall

2. Religious Organizations

Anglican Church

1035 Lena

Y.M.-Y.W.C.A.

3775 St. Patrick's

Canadian British Israel Assoc.

1361 Ouellette

Catholic Women's League

1373 Moy

Christian Women's Club

1117 Victoria

Essex Priests Conference

Box 130, BELLE RIVER

Holy Family Retreat House

R.R. 1, HARROW

Iona College

208 Sunset

Metropolitan Windsor Clergy

4276 Roseland E.

St. Vincent de Paul Society

357 Pitt E.

Seventh Day Adventist

40 Martin Lane,

Canterbury College

172 Patricia

Christian Business Mens

Comm.

3220 St. Patrick's

Downtown Mission

254 Wyandotte St. E.

Windsor Deanery

891 St. Rose

Holy Redeemer College

925 Cousineau

John XXIII Centre

2275 Wellesley

Pastoral Counselling Ofc.

3002 Sandwich

Salvation Army Family

Services

134 Wyandotte E.

Pathfinders

P.O. Box 42,

United Church Women-Essex   Women's Inter Church

64-211 Buckingham   Council

                                      342 Cameron

Youth For Christ

801 Lincoln

3. Other Religious Groups

Ambassador Christian Church   British Methodist

3307 Academy Dr.   Episcopal

                                      685 University E.

Christian Church   Christian Science

130 Giles E.   114 Giles W.

Church of Jesus Christ   Church of Jesus Christ

2274 Louis   3550 Forest Glade Dr.

Church of the Nazarene   Church of Scientology

7380 Wyandotte E.   437 Ouellette

First Church of Christ   Free Hungarian Reformed

114 Giles W.   Church

                                      1396 Ellsmere

Grace & Truth Chapel Brethren

1593 Dougall

Berean Baptist Church

949 Giles E.

Jehovah's Witnesses

1356 Tecumseh W.

Prince Memorial African

   Methodist Episcopal Ch.

2433 Longfellow

Mount Zion Church of God

795 McDougall

New Apostolic

5265 Wyandotte E.

Oakwood Bible Chapel.

2514 Cabana W.

Ontario Church of God

810 Mercer

Seventh Day Adventist Church

5350 Haig

Tanner African Methodist

733 McDougall

Turner Road Chapel

2100 Turner

Westside Church of Christ

2555 Totten

Windsor Alliance Church

706 Goyeau

Windsor Gospel Hall

644 Partington

Windsor Mosque

1320 Northwood

Shaar Hashomayim Synagogue

115 Giles E.

Temple Bethel

1600 Third Concession

II. POLITICAL/GOVERNMENT

1. Federal Members of Parliament

Hon. Herb Gray, M.P.   Hon. Mark McGuigan, M.P.

880 Ouellette   7041 Wyandotte E.

Hon. Eugene Whelan, M.P.

3108 Howard

2. Provincial Members of Parliament

Mr. B. Newman, M.P.P.   Mr. Dave S. Cooke, M.P.P.

1299 Erie E.   1491 Pillette

Mr. Bill Wrye, M.P.P.

506 Wyandotte W.

3. Alderpersons

Mr. David Burr   Mr. Peter Mackenzie

2890 Forest Glade Dr.   1531 Parkside Ct.

Mr. Howard D. McCurdy

2979 Stillmeadow

Mr. Al Santing

9510 Ridge Rd.

Mr. Tom Toth

2360 Leonard

Mr. Frank Wansbrough

125 Ouellette

Mr. Michael Ray

3696 Huntington

Mrs. Peggy Simpson

3303 Peter

Mr. Ron Wagenberg

748 Rosedale

Mrs. Elizabeth Kishkon

2102-8888 Riverside E.

III. MEDICAL

1. Hospitals

Grace Hospital

339 Crawford

Windsor-Western Hospital

1453 Prince

Metropolitan General

1995 Lens

Hotel Dieu Hospital

1030 Ouellette

Riverview Unit

3177 Riverside E.

2. General Practitioners

Dr. R. J. Bluett
1286 Dougall

Dr. A. K. Carte
185 Hanna W.

Dr. J. G. Dignan
7775 Wyandotte E.

Dr. K. H. Foster
1604-1608 Tecumseh W.

Dr. G. G. Henkel
1558 Ouellette

Dr. L Jovanovic
c/o Dr. A. K. Carter
185 Hanna W.

Dr. L. H. Lager
188 Giles E.

Dr. F. D. Linton
5720 Wyandotte E.

Dr. D. J. Broadwell
2085 Tecumseh E.

Dr. W. R. Danter
c/o Grace Hospital

Dr. T. Dziubanowsky
833 Ottawa

Dr. P. A. Gresko
2085 Tecumseh E.

Dr. M. E. Irwin
700 Tecumseh E.

Dr. N. Koleszar
2255 Pelissier

Dr. R. E. Leduc
2085 Tecumseh E.

Dr. M. Mattis
Windsor-Western Hospital
1453 Prince

Dr. V. R. Messer

1604 Tecumseh W.

Dr. A. Oswald

1604 Tecumseh W.

Dr. J. A. Renaud

1030 Ouellette

Dr. R. Scott

1106 Ouellette

Dr. A. B. Sundheimer

2085 Tecumseh E.

Dr. B. M. White

261 St. Louis

Dr. Zahrebelny

1604-1608 Tecumseh W.

Dr. S. G. Naylor

2-630 Tecumseh E.

Dr. S. N. Prakash

107-630 Tecumseh E.

Dr. V. K. Satersmoen

1310 Ouellette

Dr. F. R. Smeeton

1909 Tecumseh E.

Dr. A. T. Wachna

504 Medical Arts Bldg.

1011 Ouellette

Dr. W. W. Wren

University of Windsor

Dr. T. I. Barnby

1011 Ouellette

3. Psychiatrists

Dr. W. J. Cassidy

Windsor-Western Hospital

1453 Prince

Dr. N. A. Fretz

Windsor-Western Hospital

1453 Prince

Dr. A. G. Letourneau

1995 Lens

Dr. A. A. MacVicar

Hotel Dieu Hospital

1030 Ouellette

Dr. R. J. Mason

Windsor-Western Hospital

1453 Prince

Dr. D. C. Ross

1310 Ouellette

Dr. E. A. Schumacher

700 Tecumseh E.

Dr. W. Yaworsky

290 Giles E.

4. Health Organizations

Essex County District

Health Council

207-76 University W.

Essex County Lung Assoc.

969 Ouellette

Essex County Medical Society

604-1011 Ouellette

Canadian Diabetic Assoc.

PO Box 1141, Windsor

Canadian Cancer Society

1226 Ouellette

Cystic Fibrosis Found.

PO Box 7187, Sandwich PO

Canadian Foundation for the

Study of Infant Death

c/o 4656 Howard

Canadian Hearing Society

1082 Wyandotte E.

Canadian National Institute

 for the Blind

230 Strabane

Canadian Save the Children Fund

1133 Belle Isle View

Huntington Society of Canada

243 Patrice

La Leche League

1410 Victoria

Muscular Dystrophy Association

 of. Canada

c/o 815 Goyeau

Ontario Heart Foundation

405-404--76 University W.

St. John Ambulance Association

547 Victoria

Canadian Red Cross

1226 Ouellette

Canadian Schizophrenia

 Foundation

1074 Wyandotte W.

Kidney Found. of Canada

(Windsor & District)

PO Box 1222, Windsor

Multiple Sclerosis

 Society of Canada

PO Box 2054,

Walkerville PO

Ontario Cancer Foundation

2220 Kildare

Ontario March of Dimes

2260 University W.

St. Jude Children's

 Research Foundation

PO Box 2144,

Walkerville PO

Windsor Association of Riding

  for the Handicapped

c/o 100 Ouellette

Windsor Right to Life

3366 Parkwood

Canadian Celiac Sprue Assoc.

1-8416 Little River Rd.

Metro Windsor/Essex County

  Health Unit

1550 Ouellette

Windsor Council on

  Smoking and Health

451 Park W.

Stroke Recovery Assoc.

  (Windsor Chapter)

1568 Ouellette

The Arthritis Society

309-1428 Ouellette

Canadian Mental Health

  Assoc. (Windsor-Essex)

1226 Ouellette

IV. COMMUNITY

1. Neighbourhood Associations and Citizens' Groups

Ms. Lynn Lebeznick

Curry-McKay Action Centre

c/o 1481 Curry

Donna Gamble

Downtown Community Centre

c/o 1830 Byng

Mr. G. Marcus

East Windsor Citizens Org.

c/o 1154 Hickory

Ms. Janet Harris

Ford-Ferndale Citizens Org.

c/o #3-5459 Reginald

Ms. Marina Clemens

Drouillard Place

1102 Drouillard

Mr. Gino Marcus

Drouillard Road Neighbourhood

c/o 1154 Hickory

Mrs. Peggy Kainz

Fontainebleu Community Assoc.

2812 Rivard

Mrs. Janet Glass

Keep the Village Green Comm.

13566 Riverside E.,

St. Clair Beach

Ms. Ruby Tessier

Essex Court Citizens

Associations

c/o 3531 Wells

Ms. Mary Deans

Windsor West Citizens

Organization

c/o 558 St. Joseph

Dr. Gordon Henderson

CP Rail- Powell Siding

c/o 2524 Lincoln

Mr. Ted Reed

Forest Glade Association

2949 Wildwood

Mr. George Dubauskas

Goyeau Ratepayers Assoc.

1641 Goyeau

Mr. Ed Drouillard

Lakeshore Property Owners

Association

12858 Riverside E.,

Mrs. Meis Geraedts

Little River Golf Course Group

3024 Lauzon

Dr. J. C. Macdonald

Old Walkerville Assoc.

840 Argyle

Mrs. Joan Strahl

Riverside Ratepayers Assoc.

1244 Cottage Pl.

Mr. Carl Lavoy

Victoria Ave. Residential

  Association

718 Victoria

Mr. John Abott

Villages of Riverside Com. Grp.

9185 Blencarn Ct.

2. Service Clubs

Alhambra

1715 Mark

Beta Sigma Phi

3044 Rushton

B'nai B'rith

2833 Avondale

Essex County Dental Soc.

1172 Goyeau

Goodfellows of Windsor

401 Park W.

Jaycees

PO Box 653, Windsor

Jaycettes

1259 Wigle

Kinsmen Club of Windsor

PO Box 907, Windsor

Kiwanis Club of Windsor

PO Box 1084, Windsor

Knights of Columbus, #4924

1286 Lauzon

Knights of Columbus, #1453

1140 Goyeau

Lions Club

PO Box 304, Stn. A

May Court Club of Windsor

1122 Wyandotte E.

Oddfellows

1271 Erie E.

Optimist Club of Windsor

1673 Central

Pilot Club of Windsor

61 Day St, ESSEX

Royal Arcanum Fraternity,

#2224

3116 Harmony Dr.

Shrine Club, Moramos

4081 E. C. Row

University Women

PO Box 7220, Sandwich PO,

Windsor

Lioness Club

4155 Mount Royal

Magic Circle, Windsor

934 Grand Marais E.

Loyal Order of the Moose,

#1499

777 Tecumseh W.

Optimist Club

3760 Morris Dr.

South Windsor

R. R. 4, AMHERSTBURG

Rotary Club of Windsor

787 Ouellette

Sertoma Club

1803-99 Chatham E.

Associated Canadian

Travellers

1030 Bouffard

3. Radio and Television Stations

CJOM 88 FM

1120 Ouellette

CKWW-Radio 58

1150 Ouellette

CBEF

267 Pelissier

CKLW-AM Radio

1640 Ouellette

CBC

267 Pelissier

CBET-TV

267 Riverside W.

4. Newspapers

La Gazzetta

501 Erie E.

Tidas News

585 Pelissier

The Windsor Star

167 Ferry

Riverside News

1640 Cataraqui

Voice of Canadian Serbs

1297 Drouillard

Star Alert

167 Ferry

5. Telephone Answering Services and Bell Canada

Barbara Wood Ltd.

504 Victoria

Downtown Office Services

327 Chatham W.

Mrs. Flo Romiens, Mgr.

Windsor Telephone Answering

  Service

32 Giles E.

Western Telephone

  Answering Service

1172 Goyeau

Mr. Wayne Conroy

Customer Service, Bell Canada

1149 Goyeau

V. EDUCATION

1. Schools

Dougall Ave.

811 Dougall

Gordon McGregor

1646 Alexis

King Edward

853 Chilver

Prince of Wales

2285 Wyandotte W.

Forster Secondary

749 Felix

Frank Begley

1093 Assumption

John Campbell

1255 Tecumseh E.

Parkview

3070 Stillmeadow

W. G. Davis

2855 Rivard

Alicia Mason

284 Cameron

Lowe Secondary

874 Giles E.

Roseville

6265 Rose Ville Garden Dr.

Holy Family

1562 Rossini

Our Lady of Lourdes

4130 Franklyn

St. Anne

1140 Monmouth

St. Edward

3735 King

St. Jules

1982 Norman

St. Vincent de Paul

6038 Empress

Shawnee Secondary

5420 Empress

Bishop J. C. Cody

1285 E. C. Row E.

L. A. Desmarais

10715 Eastcourt

St. Alexander

5304 Adstoll

St. Christopher

3355 Woodward

St. James

1601 St. James

St. Paul

5881 Malden

H. E. Bondy

1676 Mark

2. School Boards

Windsor Board of Education

451 Park W.

Windsor Separate School

Board

1485 Janette

VI.LEGAL

1. Lawyers

Mr. Bently & Mr. Koss

241 Dougall

Mr. Ronald Burnett

42 Pitt W.

Mr. David Cole

219-29 Park W.

Mr. R. Lawrence DeShield

251 Goyeau, 5th flr.

Mr. Ian R. Fisher

42 Pitt W.

Mr. Gregory D. Goulin

307-251 Goyeau

Ms. Patricia Kondruk

875 Ouellette

Mr. Neil J. MacPhee, QC

100 Ouellette

Mr. John Brockenshire, QC

176 University W.

Kwok Wai Cheung

875 Ouellette

Mr. John Coughlin

176 University W.

Mr. W. K. Donaldson

374 Ouellette

Mr. Hugh B. Geddes

374 Ouellette

Mr. Kamin & Mr. Burnett

42 Pitt W.

Mr. Thomas Levasseur

201-2471 Ouellette

Mr. Leon Z. McPherson, QC

374 Ouellette

Mr. Robert G. Millson

302-586 Ouellette

Mr. John G. Ohler

201-134 University W.

Mr. Quinn, Mr. Ouellette,

and Mr. McCullough

2828 Howard

Mr. Roger A. Skinner

374 Ouellette

Mr. Sammy Vucinic

607-251 Goyeau

Mr. Floyd S. Zalev

2776 Whelpton

Mr. Mousseau, Mr. Deluca,

and Mr. Phillips

176 University W.

Mr. Paroian, Mr. Courey,

Mr. Cohen, & Mr. Houston

875 Ouellette

Ms. Linda Roulet

374 Ouellette

Mr. Richard A. Sutton

501-251 Goyeau

Mr. William Willson, QC

251 Goyeau, 5th flr.

Mr. Sam Balsamo

447 Wyandotte E.

VII. SOCIAL

1. Social Services

The Child's Place
2861 Howard

Children's Rehabilitation
 Centre
3945 Matchette

Greater Windsor Senior Citizens
 Centres Association
65 Elliot E.

Birthright of Greater Windsor
121 Wyandotte W.   —

Catholic Family Service Bureau
677 Victoria

Hiatus House
694 Victoria

John XXIII Centre
2275 Wellesley

Children's Aid Society
690 Cataraqui

Credit Counselling
 Service
602-2260 University W.

Big Brothers of Windsor-
 Essex County
1767 Walker

Brentwood
3020 Sandwich

Glengarda School for
 Exceptional Children
5043 Riverside E.

John Howard Society
203-635 Ouellette

Legal Assistance of
 Windsor
85 Wyandotte W.

Multicultural Council of

   Windsor & Essex County

1100 University W.

Ontario Legal Aid Plan-

   Essex County

163 University W.

Roman Catholic Children's

   Aid Society

1700 Assumption

The Inn of Windsor

1687 Wyandotte E.

Windsor Housing Company

68 Chatham E.

Windsor Group Therapy Project

267 Bridge

Unemployed Help Centre

1511 University W.

Scouts Canada Windsor District

3085 Marentette

National Parole Service

217-660 Ouellette

Director, Mental

   Retardation

250 Windsor

St.Leonard's House

491 Victoria

Windsor Association for

   the Mentally Retarded

961 Ouellette

City of Windsor Social

   Services

755 Louis

Y.M.-Y.W.C.A.

511 Pelissier

St. Leonard's Society

1787 Walker

Sexual Assault Crisis

   Centre

1598 Ouellette

Maryvale

3640 Wells

Goodwill Industries of

Windsor, Inc.

369 Dougall

Children's Achievement Centre

1015 Highland

Leone Residence

509 Kildare

St. Vincent de Paul Society

357 Pitt E.

Director, Child Development

Services

2400 Virginia Park

Director, Support Services

961 Ouellette

Drouillard Place

1102 Drouillard

House of Sophrosyne

1771 Chappell .

Girl Guides of Canada

5760 Malden

Addiction Research

Foundation

2090 Wyandotte E.

Family Service Bureau

450 Victoria

Salvation Army

207-29 Park W.

Director, Residential

Services

961 Ouellette

Director, Vocational

Services

870 Ottawa

Downtown Mission

583 McDougall

Victorian Order of Nurses

410 Giles E.

Apartments for Living for

Physically Handicapped

3185 Forest Glade Dr.

C.O.P.E.   Essex County Humane Soc.

306-108 McDougall   1375 Provincial

VIII. EMERGENCY

1. Fire

Capt. Long, Dispatcher

Windsor Fire Dept.

851 Goyeau

2. Police Dept.

Insp. Mombourquette

Chief of Police

445 City Hall Sq.

3. Ambulance

Mr. Brian Bilfil

Ambulance Services

1995 Lens

Appendix F

WHITE DATA COLLECTION CARD

```
EMPLOYEE # _____MARCH_____,1982. *
FROM_____M. TO_____M.
MALE:_____,   FEMALE_____.
STATED AGE:____ESTIMATED AGE:
BELOW 20,___21-50___,ABOVE 50___.
```

RELATED PROBLEM

```
1 GENERAL COMMUNITY INFORMATION
2 ALCOHOL      12 INTERPERSONAL
3 DRUGS        13 HOUSING
4 MEDICATION   14 EMOTIONAL
5 POLICE       15 VIOLENCE
6 LEGAL        16 WORK RELATED
7 BEREAVEMENT  17 SUICIDE/THOUG
8 FAMILY       18 SUICIDE/METHO
9 PHY/MEDICAL  19 SUICIDE/ACT
10 FINANCIAL   20 SEXUAL
11 OTHER(SPECIFY) _____
```

ACTION TAKEN

```
1 LISTENING
2 NO SERVICE AVAILABLE (SPEC/REV)
3 EMERGENCY VEHICLE CALLED
4 REFERRAL (a) _____

         (b) _____

5 OTHER (SPECIFY/REVERSE)
```

SOURCE OF CALL

```
1 MEDIA
2 TEHEHPONE DIRECTORY
3 PREVIOUSLY KNOWN
4 REFERRAL _____
5 FRIEND

6 OTHER _____
```

* FRONT SIDE OF CARD

NAME: (If Possible)

_____

Telephone #: _____

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

* REVERSE SIDE OF CARD

Appendix G

BLUE DATA COLLECTION CARD

EMPLOYEE # _____ MARCH _____,1982. *

FROM _____ M. TO _____ M.

MALE: _____, FEMALE _____ .

STATED AGE: _____ ESTIMATED AGE:

BELOW 20, ___21-50___, ABOVE 50___ .

RELATED PROBLEM

1 GENERAL COMMUNITY INFORMATION
2 ALCOHOL   12 INTERPERSONAL
3 DRUGS   13 HOUSING
4 MEDICATION   14 EMOTIONAL
5 POLICE   15 VIOLENCE
6 LEGAL   16 WORK RELATED
7 BEREAVEMENT 17 SUICIDE/THOUG
8 FAMILY   18 SUICIDE/METHO
9 PHY/MEDICAL 19 SUICIDE/ACT
10 FINANCIAL   20 SEXUAL
11 OTHER(SPECIFY) _____

_____

ACTION TAKEN

1 LISTENING
2 NO SERVICE AVAILABLE (SPEC/REV)
3 EMERGENCY VEHICLE CALLED
4 REFERRAL (a) _____

(b) _____

5 OTHER (SPECIFY/REVERSE)

SOURCE OF CALL

1 MEDIA
2 TEHEHPONE DIRECTORY
3 PREVIOUSLY KNOWN
4 REFERRAL _____
5 FRIEND

6 OTHER _____

* FRONT SIDE OF CARD

NAME: (If Possible)

_____

Telephone #: _____

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Our agency is really interested
to see if everything works out
for you. Would you mind if some-
one called you within the next
week to see if everything went
okay?

Appendix H

FOLLOW-UP INTERVIEW QUESTIONNAIRE

FOLLOW-UP QUESTIONNAIRE

CARD #._____.

(Please fill in the appropriate blanks before the call is attempted.)

Date(s)/Time(s) Called: (Day/Quarter) ._____

Date/Time contacted: _____.

Hello, Mr./Mrs./Miss./Ms. (circle one) ._____? My name is

_____ and I am calling for the ._____. I was

wondering if you were able to contact the ._____?

(I-A) If yes, how did things work out for you?

     DISSATISFIED: I'm really sorry that you didn't get what you were
           after. What seemed to be the problem?
           APPROPRIATE REFERRAL ___ INAPPROPRIATE ___

     SATISFIED: I'm really glad things worked out for you?

(I-B) If no, what happened?

(II) We are trying to improve our service to the community, would you
mind answering a few questions, for example, how did you hear
about us? _____

Was this the first time you called us? YES _____ NO _____

How long have you lived in this area? _____.

We have divided the city into four areas, do you live North or South.

of Tecumseh Road (circle one); do you live East or West of

Ouellette (circle one).

Thank you very much for the information, I hope things work out for you.
Good bye.

Appendix I

ORGANIZATIONAL SURVEY QUESTIONNAIRE

Name of Organization:_____

1a. Does your organization offer any "after-hour" services? (After-hour services
    operate between 4:30 p.m. and 8:30 a.m. and also all day Saturday and Sunday.)

1b. If your organization does not offer a formally established after-hour service,
    do people contact you or any of your staff with a problem (for example at home)
    during the abovementioned times?

2. What do you consider as the most important needs to be met by after-hour services?

3. In your view, what additional services should be provided on an after-hour basis?

4. What do you see the major strengths to be of the existing after-hour services?

5. What do you see the major shortcomings to be of the existing after-hour services?

Appendix J

DATA COLLECTION CARD INSTRUCTION BOOKLET

February, 1982

Dear Staff:

A number of agencies in the community, including your agency, have expressed an interest in studying the after-hour services offered in the Windsor area. A data collection instrument has been developed to help describe the type or kind of calls received by your agency.

Please attempt to provide as much information as possible on the cards that have been presented to you, either during, or immediately after the call has been received, which ever is most appropriate in your agency. Remember, the telephone caller should be given higher priority than data collection cards.

Please be assured that these data collection cards will in no way be used to evaluate the effectiveness of yourself, or your agency. If you feel strongly about not recording your employee number on the card, feel free to omit it. Thank you for your cooperation; it is greatly appreciated.

Sincerely yours,

INSTRUCTIONS FOR THE WHITE DATA COLLECTION CARDS:*

These data collection cards have been designed to require a minimal amount of effort to be completed. In most instances the time involved to complete a card will be less than 30 seconds. To keep writing requirements to a minimum, a simple check mark or circle will suffice in most areas on the card.

For the purpose of this study, "after-hour services" has been defined as the services which are offered from 4:30 p.m. until 8:30 a.m., Monday to Friday morning. Weekend coverage begins at 4:30 p.m. Friday afternoon and continues straight through until Monday morning at 8:30 a.m.

If the shifts in your agency do not correspond to the ones outlined above, please complete the cards only within the specified times. For example, if your shift begins at 4:00 p.m. on Monday evening, do not begin to complete the cards until 4:00 p.m. Conversely, if your shift ends at 9:00 a.m. on Tuesday morning, do not complete any cards after 8:30 a.m. If a call is in progress during a cut-off time, please record that call.

This study will begin Monday evening, March 1st, 1982 at 12:00 midnight, and will terminate Wednesday evening, March 31st, 1982 at 12:00 midnight.

Attached to this form is an example of a "typical" data collection card after it has been completed.

_____

*If parts of this data collection card do not apply to your agency, please disregard them.

EMPLOYEE # 593 MARCH 17, 1982.

FROM 11:58 PM. TO 12:05 AM.

MALE: X , FEMALE .

STATED AGE: ___ ESTIMATED AGE: ___

BELOW 20, 21-50 X, ABOVE 50 .

RELATED PROBLEM

1 GENERAL COMMUNITY INFORMATION
2 ALCOHOL   12 INTERPERSONAL
3 DRUGS   13 HOUSING
④ MEDICATION   14 EMOTIONAL
5 POLICE   15 VIOLENCE
6 LEGAL   16 WORK RELATED
⑦ BEREAVEMENT   17 SUICIDE/THOUG
8 FAMILY   18 SUICIDE/METHO
9 PHY/MEDICAL   ⑲ SUICIDE/ACT
10 FINANCIAL   20 SEXUAL
11 OTHER(SPECIFY) _____

_____

ACTION TAKEN

1 LISTENING
2. NO SERVICE AVAILABLE (SPEC/REV)
③ EMERGENCY VEHICLE CALLED
4 REFERRAL (a) C.M.H.A.

          (b) ._____

5 OTHER (SPECIFY/REVERSE)

SOURCE OF CALL

1 MEDIA
② TEHEHPONE DIRECTORY
3 PREVIOUSLY KNOWN
4 REFERRAL _____
5 FRIEND _____
6 OTHER _____

NAME: (If Possible)

1234 First Street

Telephone #: _____

COMMENTS:

The caller stated
he ingested a bottle
of sleeping pills he
received from his
doctor. I called an
ambulance after he
gave me his address
The call terminated
when the ambulance
arrived Referred to
the Canadian Mental
Health Association

_____

_____

Our agency is really interested
to see if everything works out
for you. Would you mind if some-
one called you within the next
week to see if everything went
okay?

As can be seen from the card, employee 593 received this call on March 17, 1982 at 11:58 p.m. The call was terminated at 12:05 a.m. The caller in this particular case initiated the discussion by stating he found your telephone number in the telephone directory. Because this caller did not state his specific age, the employee estimated it to be between 20 and 50 years. This caller stated he had taken an overdose of sleeping pills because his wife had been recently killed in an automobile accident and he could not cope with the loss. The employee called an ambulance and suggested the caller contact the Canadian Mental Health Association for breavement counselling following his discharge from the hospital.

5.

INSTRUCTIONS FOR THE BLUE DATA COLLECTION CARDS

The blue data collection cards were designed to help monitor what happens after a referral has been made. For example, if a caller is referred to the Canadian Mental Health Association for counselling, did the caller make the contact, or did the caller "forget it" because of unknown reasons?

The front of the blue data collection cards are identical to the white cards and should be completed accordingly. The only difference between the two cards is that the blue cards require a limited amount of additional information to be completed on the reverse side of the cards which will allow someone from our research staff to contact the caller in some way. This additional information is only required if (1) the card is blue, and (2) if a referral has been made. Thus, if the card is blue, but a referral has not been made, the additional information will not be required. The blue card does not imply that a referral should be made.

Because we are only interested in contacting every 10th caller, if it is a referral, the cards have been arranged so that a blue card is located in every 10th position, and numbered accordingly. By placing a blue card in every 10th position, a maximum of 20 follow-ups could be conducted for every 200 calls.

As stated earlier, the additional information (usually a name and/or telephone number), on the blue card is required for follow-up purposes which will be conducted by our research

staff. To obtain the necessary information, a "lead-in" state-
ment has been designed to help you obtain the additional in-
formation. This statement has been printed on the reverse side
of every blue card, at the bottom. Please make this statement
(when you feel the appropriate time has arrived - usually near
the end of the contact), to every caller who has been referred,
if the card is blue. The following approach may be helpful to
obtain the additional information when it is required.

> CALLER: Okay, I will call the Mental Association
> tomorrow. Thank you for your help.

> STAFF : "Our agency is really interested to see if
> everything works out for you. Would you
> mind if someone called you within the next
> week to see if everything went okay?"
>
> You don't have to give your real name or
> anything like that if you don't want to.
> We are just concerned and would like to
> know what happens.
>
> How could we contact you?

If at that point the caller becomes hesitant and/or you
believe to persue the matter would be unproductive, there are
two alternatives: (1) you could explain that your agency is
trying to improve the service it is offering to the people of
the community and it would be extremely helpful if you (the
caller) would allow someone to contact you to see if every-
thing went okay; or (2) you could "back-off" and not collect
the information.

Because this is a research project, following the stated
procedures is very important. If you have any questions at
all, concerning the project or any of the procedures, please

do not hesitate to contact your supervisor for clarification.
Following is an item-by-item breakdown, using examples, of
the data collection instrument. Again, thank you for your co-
operation, it is greatly appreciated.

AN ITEM-BY-ITEM BREAKDOWN OF THE DATA COLLECTION INSTRUMENT:

DEMOGRAPHIC DATA

EMPLOYEE #:

In many agencies employees have an "employee number". If you do not have an employee number, please use your initials.

MARCH   , 1982:

Record the day of the call in this area.

MALE   FEMALE   :

Record the sex of the caller here.

STATED AGE:

If the caller's age is stated, record it. If it is not stated, please estimate it in one of the three categories provided.

RELATED PROBLEMS

1 GENERAL COMMUNITY INFORMATION:

If a caller is inquiring about general community information (i.e. a non-emergency situation) then record it here. For example, "Is there a mall in town?"; "What time does bus service begin in the morning?"; or, "Is there a home for unwed mothers in Windsor?". If a pregnant woman was "thrown out" of her home in the middle of the night, this would <u>not</u> be a "general community information" call. You would record this situation under number 13 "housing".

2 ALCOHOL

If the problem involves alcohol, record it here.

3 & 4 DRUGS/MEDICATION:

The distinction between "drugs" and "medication" is that of legality. The emphasis is upon "how the drug is acquired". If it is acquired "on the street" (e.g. heroin, marijuana, "uppers" or "downers"), then record this under drugs. Conversely, medication refers to prescribed drugs.

5 & 6 POLICE/LEGAL:

The difference between "police" and "legal" is that legal refers to lawyers, legal aid, law clinic, etc. For example, (legal), "My son was expelled from school because he was caught smoking marijuana. Can they do that?"; (police), "My 12 year old son hasn't been home all day, what should I do?".

7 BEREAVEMENT:

Someone experiencing problems because of a death should be recorded in this area. The death could be that of a person or a pet.

8 FAMILY:

This area includes all family related problems. For example, separation, divorce, arguments, or child or spouse abuse. If child or spouse abuse, circle 8 "Family" and 15 "Violence".

9 PHYSICAL/MEDICAL:

If a caller is experiencing a "physical" problem re-
lated to development or their well-being (e.g. de-
formity, handicapped), circle "physical".

If a caller is experiencing a problem requiring medical
attention, which may or may not involve hospitalization
circle "medical".

10 FINANCIAL:

Problems related to money are recorded in this area.
For example, "I can't pay my bills" or "My welfare
cheque didn't arrive, what can I do?".

11 OTHER (SPECIFY):

Any area that is not outlined in 'the "RELATED PROBLEMS"
should be described here. If there is not enough space,
use the "COMMENTS" area on the reverse side of the card.

12 INTERPERSONAL:

This area includes difficulties that occur <u>between</u>
people. For example, girlfriend/boyfriend, teacher/
student, neighbours, etc.

13 HOUSING:

Housing includes problems such as "My home has burnt
down, what can I do?"; or, "I need a place to stay for
the night, do you know where I can go?".

14 EMOTIONAL:

Emotinal includes psychiatric problems, mental health
problems, etc.

15 VIOLENCE:

When violence is used or related to the problem, record
. it here.

16 WORK RELATED:

Problems here could include unemployment, laid-off,
problems with one's boss, or fellow workers.

17 SUICIDAL/THOUGHTS:

Suicide in this study is divided into three stages:
(1) suicidal thoughts; (2) suicide methodology; and
(3) suicide acts. In this level the caller does not
have to make the statement "I'm going to kill myself."
He/she may make a statement such as "It's hopeless" or
"there is just no sense in going on." If you believe
the caller is suicidal, record it here.

18 SUICIDE/METHODOLOGY:

The caller in this situation would mention the "method"
of suicide. For example, "that's it, I've had it, I'm
going to jump off the bridge."

NOTE:

Some people remark "I'm going to kill myself..." as an
expression, rather than intention. Do not record an
"expression" here.

19 SUICIDE/ACT:

In this area the caller has, or is in the process of
committing suicide. For example, "I just took a whole
bottle of sleeping pills.".

20 SEXUAL:

This could be incestuous behaviour, sexual problems such as impotency, or rape. Please specify on reverse of card.

ACTION TAKEN

1 LISTENING:

If you listened to the client, record it here. This does not imply that the problem was resolved.

2. NO SERVICE AVAILABLE (SPECIFY/REVERSE):

If the caller is enquiring about a service that, to your knowledge, is not available in this area, record it here.

3 EMERGENCY VEHICLE CALLED:

An emergency vehicle is defined as a police, ambulance, or fire truck.

4 REFERRAL: (a) _____

(b) _____

There is enough space to record two referrals here. If more space is needed, record on the reverse of the card.

5 OTHER (SPECIFY):

Areas that are not outlined in the "ACTION TAKEN" section should be recorded here. For example, clarification of documents, or help required to fill out forms. Please specify on the reverse of the form.

SOURCE OF CALL

This area is to specify "how the caller knew about your agency."

1 MEDIA:

This includes the radio, television, or newspaper.

2 TELEPHONE DIRECTORY:

If the caller found your number in the telephone book, record it here.

3 PREVIOUSLY KNOWN:

Please specify whether this is a long-term chronic caller, or just a caller who has contacted the agency previously.

4 REFERRAL:

If the caller was referred, please specify.

5 FRIEND:

If the caller learned about the service through a friend, record it here.

6 OTHER:

If the caller learned about your service from a source not outlined, please specify.

If you are not sure where or how to record a specific call or category, and your supervisor is not available, please make a note in the "COMMENTS" section on the reverse of the card.

PLEASE KEEP THIS FORM HANDY FOR QUICK REFERENCE. THANK YOU.

Appendix K

SECURITY CLEARANCE LETTER

THE CORPORATION OF THE

CITY OF WINDSOR

JOHN SHUTTLEWORTH
CHIEF OF POLICE

ADDRESS ALL CORRESPONDENCE TO
OFFICE OF CHIEF OF POLICE AND NOT
TO INDIVIDUALS BY NAME

. P.O. BOX 60
WINDSOR, ONTARIO N9A 6J5

POLICE FORCE
February 24, 1982

TO: ALL PERSONNEL

RE: AFTER-HOURS AND EMERGENCY SERVICES

     The bearer of this letter is Mr. Dave HILLOCK who is co-operating in a study with this Force to identify and document the level of service provided to the citizens of Windsor, specifically after-hours calls when access to many agencies is not readily available.

     Mr. HILLOCK is granted permission to observe our Communications Centre operation between March 1, 1982 and March 31, 1982.

     Upon presenting this letter Mr. HILLOCK will be escorted to the Communications Centre and placed in charge of the supervisor. Upon completion of his period of observation and study, the communications supervisor will escort Mr. HILLOCK to the main lobby.

BY ORDER OF,

J.E. SHUTTLEWORTH,
CHIEF OF POLICE.

JES:es

Appendix L

ORGANIZATIONAL SURVEY INTRODUCTORY COVER LETTER

United Way
OF WINDSOR-ESSEX COUNTY

2260 UNIVERSITY AVENUE, WEST
SUITE 302
WINDSOR, ONTARIO N9B 1E5
PHONE 519 254-3135

May 4, 1982

Dear Sir/Madam:

Concern has been expressed by many agencies about the lack of co-ordination between the organizations providing after-hour services in this area. The need for emergency and crisis services on a 24-hour basis is generally acknowledged. However, the extent, nature, and auspices of such services has been a matter of considerable discussion over the past several years.

A report to the City of Windsor on After-Hours and Crisis Services in July, 1981, recommended that Help Services request assistance from United Way Social Planning. Consequently, the Advocacy and Forward Planning Committee of United Way has undertaken the endeavour. A research project is being directed toward the existing after-hour services offered locally. Presently, the Committee is constructing an inventory of existing after-hour services in the community. The coalition of such information will assist in identifying needs and overlaps of services or programs.

Would you please co-operate in this study by completing the attacded questionnaire. A preaddressed stamped envelope has been included for your convenience. The Committee would appreciate if the questionnaire was returned by May 15, 1982.

If you have any questions concerning this matter, please do not hesitate to contact me personally. Thank you for your co-operation, it is greatly appreciated.

Sincerely yours,

James Chacko,
Chairperson,
Advocacy & Forward
Planning Committee.

JC:lb
Enclosure

Appendix M

ORGANIZATIONAL SURVEY FOLLOW-UP LETTER

United Way
OF WINDSOR-ESSEX COUNTY

2260 UNIVERSITY AVENUE, WEST
SUITE 302
WINDSOR, ONTARIO N9B 1E5
PHONE 519 256-3135

May 18, 1982.

Dear Sir/Madam:

    During May, 1982, a questionnaire was sent to you from the Advocacy & Forward Planning Committee. At this point, we have not received your reply, I would appreciate if you could return the completed questionnaire as soon as possible. Another questionnaire has been enclosed in case you have misplaced the first one.

    Again, thank you for your co-operation, it is greatly appreciated.

                      Sincerely yours,

                      James Chacko,
                      Chairperson,
                      Advocacy & Forward
                      Planning Committee.

JC:lb
Enclosure

Appendix N

ORGANIZATIONAL SURVEY THANK YOU LETTER

June 1, 1982.

Dear Sir/Madam:

    Thank you for returning the questionnaire sent to you from the Advocacy & Forward Planning Committee.

    Your co-operation has been greatly appreciated.

                    Sincerely yours,

                    James Chacko,
                    Chairperson,
                    Advocacy & Foward
                    Planning Committee.

JC:lb

BIBLIOGRAPHY

Aguilera, D. C., & Messick, J. M. Crisis intervention: Theory and methodology (2nd ed.). Saint Louis: C. V. Mosby Company, 1974.

Bailey, K. D. Methods of social research. New York: Free Press, 1978.

Barnes, J., & Srivenkataramana, T. Ideology and the welfare state: An examination of Wilensky's Conclusions. Social Service Review, June 1982, 230-245.

Bellak, L., & Small, L. Emergency psychotherapy and brief psyhotherapy (2nd ed.). New York: Grune & Stratton, Inc., 1978.

Berman, P. J., Davis A. & Phillips, L. Geroge Washington University Hotline, A descriptive study. Psychological Reports, 33, 1973, 364-366.

Birns, B. The emergence of socialization of sex differences in the earliest years. Merrill-Palmer, 22(3), 1976, 229-254.

Bostwick, G. J., Jr., & Kyte, N. S. Measurement. In R. M. Grinnell, Jr. (Ed.), Social work research and evaluation. Illinois: Peacock Inc., 1981.

Bowlby, J. Separation anxiety. International Journal of Psychoanalysis, 1960, 41, 89-113.

Bridgman, P. W. The logic of modern physics. New York: Macmillan, 1927.

Brockopp, G. W. Crisis intervention: Theory, process, and practice. In D. Lester & G. W, Brockopp (Eds.), Crisis intervention and counselling by telephone. Illinois: Charles C. Thomas, 1973.

Caplan, G. Patterns of parental response to the crisis of premature birth: A preliminary approach to modifying mental health outcome. Psychiatry, 1960, 23, 365-374.

Caplan, G. Principles of preventive psychiatry. New York: Basic Books, Inc., 1964.

Caplan, G. An approach to community mental health. New York: Grune & Stratton, 1966.

Caplan, G. Support systems and community mental health. New York: Behavioral Publications, 1974.

Chein, I. An introduction to sampling. In C. Selltiz, L. S. Wrightsman, & S. W. Cook, Research methods in social relations (3rd ed.). New York: Holt, Rinehart and Winston, 1976.

Colombotos, J. Physicians and medicare: A before-after study of the effects of legislation on attitudes. American Sociological Review, 1969, 34, 318-334.

Daniels, R. A., & Wright, A. K. Telephone crisis intervention: A comparative and exploratory study of Tel-A-Friend, Windsor, and the Distress Centre, Toronto. Unpublished master's thesis, University of Windsor, 1971.

Dillman, D. Mail and telephone surveys: Total design method. New York: John Wiley & Sons, 1978.

Edwards, R. Crisis intervention and how it works. Illinois: Charles C. Thomas, 1977.

Ellis, A. Reason and emotion in psychotherapy. New York: Lyle & Stewart, 1962.

Erikson, E. H. Identity and the life cycle. Psychol. Issues Monograph, 1959, 1, No. 1. New York: International Universities Press.

Evangelism: Throwing out the life line. Time, January 24, 1964, 34.

Ferguson, G. A. Statistical analysis in psychology and education (5th ed). New York: McGraw-Hill, 1981.

Finestone, S., & Kahn, A. J. The design of research. In N. A. Polansky (Ed.), Social work research (Rev. ed.). Chicago: University of Chicago Press, 1975.

Glass, A. J. Principles of combat psychiatry. Military, 1965, 117, 27-33.

Globe, F. G. The third force. New York: Pocket Books, 1976.

Gochros, H. L. Research interviewing. In R. M. Grinnell, Jr. (Ed.), Social work research and evaluation. Illinois: Peacock Inc., 1981.

Hansell, N., Wodarczyk, M., & Hardlin-Lathrop, B. Decision counselling method. Archives of General Psychiatry, 1970, 22, 462-467.

Hausman, W., & Rioch, D. Military psychiatry. Archives of General Psychiatry, 1967, 16, 727-739.

Hills, S. L. Demystifying social deviance. New York: McGraw-Hill, 1980.

Jacobson, G. F. Crisis theory and treatment strategy. Journal of Nervous and Mental Disorders, 1965, 141, 209-218.

Jacobson, G. F., Strickler, M., & Morley, W. E. Generic and individual approaches to crisis intervention. _American Journal of Public Health_, 1968, _58_, 338-343.

Jacobson, G. F. Editor's note. In G. F. Jacobson (Ed.), _New directions for mental health services_ (Vol. 6). San Francisco: Jossey-Bass Inc., 1980.

Janis, I. L. _Psychological stress: Psychoanalytical and behavioral studies of surgical patients_. New York: John Wiley & Sons, Inc., 1958.

Kaplan, D. M., and Mason, E. A. Maternal reactions to premature birth viewed as an acute emotional disorder. In H. J. Parad (Ed.), _Crisis intervention: Selected readings_. New York: Family Service Association of America, 1965.

Kornhauser, A., & Sheatsley, P. B. Questionnaire construction and interview procedure. In C. Selltiz, L. S. Wrightsman, & S. W. Cook, _Research methods in social relations_ (3rd ed.). New York: Holt, Rinehart and Winston, 1976.

Lalonde, M. _A new perspective on the health of Canadians_. Ottawa: Government of Canada, 1974.

Lester, D. Steps toward the evaluation of a suicide prevention center: Part one. _Crisis Intervention_, _2_(1), 1970, 42-45.

Liebert, R. M., & Schwartzberg. Effects of mass media. _Annual Review of Psychology_, _28_, 1977, 141-173.

Lindemann, E. Symptomatology and management of acute grief. _American Journal of Psychiatry_, 1944, _101_, 141-148.

Maslow, A. H. _Motivation and personality_. New York: Harper and Row, 1954.

Maslow, A.H. _Toward a psychology of being_. New York: Van Nostrand, 1962.

McGee, R. K. _Crisis intervention in the community_. Maryland, University Park Press, 1974.

Mindel, C. H. Instrument design and construction. In R. M. Grinnell, Jr. (Ed.), _Social work research and evaluation_. Illinois: Peacock Inc., 1981.

Morley, W. E., Messick, J. M., & Aguilera, D. C. Crisis: Paradigms of intervention. _Journal of Psychiatric Nursing_, 1967, _5_, 531-544.

O'Connor, M. A. _The impact on the family of loss of their home_. Unpublished masters thesis, University of Windsor, Forthcoming.

Overbeck, A. L. Life stress antecendents to application for help at a mental health center - A clinical study of adaptation. Smith College Studies, 1977, 47(3), 192-233.

Parad, H., and Caplan, G. A framework for studying families in crisis. In H. J. Parad (Ed.), Crisis intervention: Selected readings. New York: Family Service Association of America, 1965.

Polansky, N. A. Theory construction and the scientific method. In N. A. Polansky (Ed.), Social work research (Rev. ed.). Chicago: University of Chicago Press, 1975.

Posner, J. The stigma of excellence: On being just right. Sociological Inquiry, 1976, 46(2), 141-144.

Rapoport, R. Normal crises, family structure, and mental health. Family Process, 1963, 2, 68-80.

Ripple, L. Problem identification and formulation. In N. A. Polansky (Ed.), Social work research. Illinois: University of Chicago Press, 1960.

Rosenbalm, A., & Calhoun, J. The use of the telephone hotline in crisis intervention: A review. Journal of Community Psychology, 1977, 5(4), 325-339.

Rossi, P. H., Freeman, H. E., & Wright, S. R. Evaluation: A systematic approach. Beverly Hills: Sage Publications, 1979.

Rutman, L., & Hudson, J. Evaluating human services: A process approach. In B. R. Compton & B. Galaway (Eds.), Social work processes. Illinois: Dorsey Press, 1974.

Rutman, L. (Ed.), Evaluation research methods: A basic guide. Beverly Hills: Sage Publications, 1977.

Seaberg, J. R. Sampling procedures and techniques. In R. M. Grinnell, Jr. (Ed.), Social work research and evaluation. Illinois: Peacock Inc., 1981.

Selltiz, C., Wrightsman, L. S., & Cook, S. W. Research methods in social relations (3rd ed.). New York: Holt, Rinehart and Winston, 1976.

Selye, H. The stress of life. New York: McGraw-Hill, 1978.

Shneidman, E. S., Farberow, N. L., & Litman, R. E. The suicide prevention center. In N. L. Farberow & E. S. Shneidman (Eds.), The cry for help. New York: McGraw-Hill, 1961.

Shneidman, E. S., & Farberow, N. L. A survey of agencies for the prevention of suicide. In N. L. Farberow & E. S. Shneidman (Eds.), The cry for help. New York: McGraw-Hill, 1961.

Shneidman, E.   Crisis intervention: some thoughts and perspectives. In
    G. A. Specter and W. L. Claiborn (Eds.), Crisis intervention (Vol.
    2).   New York: Behavioral Publications, 1973.   Suchman, E. A.
    General considerations of research design. In D. C. Miller (Ed.),
    Handbook of research design and social measurement (3rd ed.). New
    York: David McKay Company, Inc., 1977.

Tripodi, T., Fellin, P., & Meyer, H. J.   The assessment of social
    research: Guidelines for use of research in social work and social
    sciences.   Illinois: Peacock Publishers, Inc., 1979.

Tyhurst, J. S.   The role of transition states. In Symposium on
    Preventative and Social Psychiatry.   U. S. Government Printing
    Office, 1957.

Varah, C. (Ed.), The Samaritans. New York: Macmillan, 1966.

Varah, C. (Ed.), The Samaritans in the '70s (Rev. ed.).   Constable
    London: Anchor Press, 1973.

Walker, A.   As close as the telephone.   New York: Abingdon Press, 1967.

Walker, A.   Caring for the world.   Glasgow: William Collins & Co. Ltd.,
    1979.

Walsh, J. A. & Phelan, T. W.   People in crisis: An experimental group.
    Community Mental Health Journal, 10, 1974, 3-8.

Williams, T., & Douds, J.   The unique contribution of telephone therapy.
    In D. Lester & G. W. Brockopp (Eds.), Crisis intervention and
    counselling by telephone.   Illinois: Charles C. Thomas, 1973.

Yeakel, M., & Ganter, G.   Some principles and methods of sampling.   In
    N. A. Polansky (Ed.), Social work research (Rev. ed.).   Chicago:
    University of Chicago Press, 1975.

REFERENCE NOTES

1 Winch, G., & Roberton, H. Distress Centre I, Toronto, Ontario.
  Interview, 8 June 1982.

2 The Canadian directory of crisis centres. Toronto: Canadian Council
  of Crisis Centres, 1976.

3 Lamb, W. Telecare, Toronto, Ontario. Interview, 13 June 1982.

4 Powicke, H. History of crisis intervention movement in Canada. In
  Handbook for volunteers. Toronto: Distress Centre I, (year unknown).

5 McCarthy, G. Proposal for a 24-hour emergency service. Windsor:
  Implementation Committee, Mayor's Committee on After Hour and Crisis
  Services, 25 July 1978.

6 Sheehan, B. Annual report 1980. Windsor: Windsor-Essex Community
  Information Service, April 1981.

7 Bauman, G. After-hour and crisis service. Windsor: Social Planning
  and Allocations, United Way of Windsor-Essex County, 31 July 1981.

8 Robinson, L. Help Services, Windsor, Ontario. Interview, 25 June
  1982.

9 Chandler, R. Joint Agency Committee, Windsor, Ontario. Interview, 25
  June 1982.

10 Mayor's Committee on After-hour services. Submitted to City of
   Windsor, Ontario, 28 February 1978.

11 Walker, R. R. Report of the Joint Agency Committee. Submitted to
   United Way of Windsor-Essex County, March, 1980.

12 Shepherd, R., & Smee, M. Help Services, Windsor, Ontario.
   Interview, 21 June 1982.

13 The Canadian directory of crisis centres (2nd ed.). Toronto:
   Canadian Council of Crisis Centres, 1979.

14 Malla, A. Chatham General Public Hospital, Chatham, Ontario.
   Interview, 21 July, 1982.

VITA AUCTORIS

David Wayne Hillock was born in Ottawa, Ontario, on April 28, 1954. After working five years as a photographer and reporter for North Essex News in Belle River, David worked for Chrysler Canada in Windsor as a welder for approximately seven years. In January 1978 he applied and was accepted to the University of Windsor as an adult student in the social work program. During this course of study, David worked part-time for the Essex County Children's Aid Society, Maryvale, and as a teaching assistant for a social work intervention course. After being named to the President's Roll of Scholars for three consecutive years and being awarded the Board of Governor's Gold Medal, David received his B.S.W. (honors) in June, 1981. In September, 1981, David enrolled in the M.S.W. program at the University of Windsor, specializing in Health, with a concentration in research. David's Directed Field Study during his graduate year was at the Research and Development Unit associated with the School of Social Work, where he participated in a number of research projects with several community organizations. In addition, he was a teaching assistant for social work research and statistics courses. During this time, David also was employed as a computer consultant at the graduate level. David plans to graduate from the M.S.W. program in October, 1982 and has been accepted in the D.S.W. program at the University of Toronto where he will begin his studies in September, 1982.