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The Prediction of "Shows" and "No-Shows" to a Crisis Center

A Replication[1]

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The relationship between measures of worker effectiveness in a therapeutic telephone intervention and whether a caller shows for a scheduled appointment can be used to assess the variables that contribute to "successful" telephone counseling. This study replicated the findings of a previous investigation in showing that the motivation of a caller in response to the question of a referral was positively correlated with "showing" for the appointment. Further, the identification of a specific problem related negatively to the caller's response to the referral. However, the concreteness of the phone worker was not correlated with whether the scheduled appointment was kept by the caller.

The advent of telephone counseling into the delivery of mental health services has been characterized as providing rapid access, on a 24-hour basis, to a population that might not have such services available otherwise. McGee, Knickerbocker, Fowler, Jennings, Ansel, Zelenka, and Marcus (1972) have suggested that the evaluation of worker performance be based on the technical effective-

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ness of the phone counselors' ability to identify specifics within the context of a phone call and on their capacity to relate therapeutically to the caller. They have argued further that these variables be used to evaluate the outcome of the call; unfortunately, there are few studies which relate these variables to outcome.

In an attempt to relate worker effectiveness to the outcome of a telephone intervention, we have examined the intercorrelations between clinical and technical effectiveness and the outcome measure of whether a caller appears for a scheduled appointment to a crisis center (Tapp, Slaikeu, & Tulkin, 1974). We found that ratings of therapeutic concreteness (Carkhuff, 1969), the identification of a specific problem (item 3 from the Fowler Scale of Technical Effectiveness, Fowler & McGee, 1973), and a rating of the client's responsiveness to the suggested referral combined to correlate very highly ($R = .93$) with this measure of outcome. This finding was based on 40 taped telephone calls in which a referral was made to the Suicide Prevention and Crisis Service of Erie County, New York. The present study reports a replication of that investigation with a new sample of 70 calls.

METHOD

The data were ratings taken from 70 taped telephone calls made to the Suicide Prevention and Crisis Service of Erie County during the month of October, 1972, during which a referral was made to the crisis clinic operated by the same agency. The calls were coded on the Fowler scale by volunteers trained in its use. Specific items on the Fowler scale and interobserver reliabilities are reported in the previous publication (Tapp et al., 1974). Referral responsiveness was coded as 3, 2, or 1. A call was given a rating of 3 if the call began with the caller asking for an appointment. It was rated 2 if the caller raised the referral question later in the call, or if the volunteer raised the referral question and the caller responded with a clear, affirmative yes. Referral responsiveness was coded 1 if the volunteer was the first to raise the referral question and the caller's response was anything less than a clear, affirmative yes (e.g., "Well, I don't know," "Who would I have to talk to?"). The Truax and Carkhuff scales include empathy, positive regard, genuineness, concreteness, and self-disclosure. Descriptions of the scales appear in Carkhuff (1969). Concreteness (the scale which contributed to the multiple correlation in our previous study) is defined by the therapist's specificity of expression on a five-point scale. At the lowest level, the therapist "leads or allows all discussion with the second person to deal only with vague and anonymous generalities." At the highest level, the therapist "is always helpful in guiding the discussion, so that the second person may discuss fluently, directly and completely specific feelings and experiences" (Carkhuff, 1969, pp. 323–324).

Table I. Comparisons of Observed Correlations, Clinical Variables, and "Shows" and "No-Shows" for Two Studies

	Tapp, Slaikeu, and Tulkin (1974)				Present investigation			
	I3	C	RR	S-NS	I3	C	RR	S-NS
Fowler item 3 (I3)		.06	−.49	−.44		.01	−.47	−.11
Concreteness (C)			−.16	.37			.21	.12
Referral responsiveness (RR)				.37				.42
Show vs. no-show (S-NS)								
Multiple correlation with S-NS			.93				.46	

RESULTS

In general, the study replicated the results of the previous investigation, though there was a general tendency for the magnitude of the correlations to decrease.[4] Items 4, 5, and 6 of the Fowler Scale correlated perfectly with each other in this sample, possibly because the plan in all cases was the referral appointment. Items 2 and 3 and items 7, 8, and 9 seemed to reflect different interrelated clusters of items in contrast to the previous study where these five items were all interrelated. The Truax and Carkhuff scales were also interrelated, but contrary to the previous study, self-disclosure did not correlate with the other scales, while concreteness did. Referral responsiveness again correlated significantly with items 2 (−.44), 3 (−.46), and 7 (−.32) of the Fowler scale, but not with any of the other variables.

The more critical aspects of this replication relate to the multiple correlations reported in the previous study. Table I summarizes the intercorrelations of the four major variables from the original study and the present replication. In the present sample, the observed multiple correlation between concreteness, referral responsiveness, and show–no-show was .31 ($p < .05$). Similarly, the correlation between these variables, including item 3 on the Fowler scale, was significant ($R = .46, p < .01$). In both instances, there was a decrease in the magnitude of the size of the multiple correlation from what we previously reported mostly due to the decrease in the correlation between Truax and Carkhuff measure of concreteness and the other variables.

[4] A complete correlation matrix is available on request from Jack Tapp.

DISCUSSION AND IMPLICATIONS

It becomes evident from both studies taken together that identification of a specific problem (Fowler, item 3) together with the responsiveness of the caller to the referral question consistently predicts shows and no-shows for the scheduled appointment. Concreteness as defined by the Truax and Carkhuff scaling procedure does not appear to be a consistent variable which contributes to the prediction of this measure of outcome of the telephone intervention.

In theory, identifying a specific problem can be viewed as being the result of concrete actions or a series of responses by the counselor to the client's presenting problem. Perhaps more refinement is needed in the concreteness rating scale to make it more applicable to telephone counseling, focusing on those aspects of the counselor's behavior which facilitate the identification of the client's problems which can be "worked out" without clinical intervention. Indeed, a face-to-face appointment might be most appropriate when a client is experiencing difficulty identifying specific problems and developing alternative plans for resolving problems.

The results of these studies have programatic implications for telephone crisis services. Specifically, if the telephone intervention is to have impact in helping the client resolve problems without further clinical intervention, workers need to focus on the identification of a clear statement of the client's problems in order to effect a solution. This suggestion should be emphasized in training programs for telephone counselors. Further it is perhaps most appropriate to make a referral to a counseling agency when the client has difficulties in identifying a problem over the telephone. Perhaps this criterion needs to be included as a part of the definition of the service's "appropriate" referral process.

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