m·e·l research

Helpline Caller Outcomes Study 2020

Samaritans

Final Report

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Executive Summary

Samaritans commissioned M·E·L Research in May 2019 to undertake research to measure primary outcomes for callers who use the Samaritans Helpline, explore callers' experience of the Helpline, and identify the difference the Helpline makes to them. The study is the first nationwide evaluation of the Samaritans service and follows a Feasibility Study carried out by Samaritans in 2017-18. The study will provide the evidence base to inform service improvements and evidence of the impact of Samaritans' Helpline and serve as a template for future evaluations.

Two primary outcomes for callers were the focus for the study: distress and suicidal thoughts/plans. The study used a combination of quantitative and qualitative research methods to measure and understand caller outcomes and experiences. The study involved a team of 104 Samaritans volunteers from 24 branches. The study was conducted over three points in time: firstly, immediate outcomes were collected at the end of the call to the Helpline in which the caller was recruited to the study; secondly a follow-up survey was sent to study participants one week later; and thirdly in-depth qualitative interviews were carried out with a sub-group of respondents to the online survey to explore their experiences and the impact of the Helpline in more detail. Feedback was also gathered from volunteers who helped deliver the study, via an online survey, to understand their experiences.

Study participants

A total of 2,247 calls for emotional support were answered by volunteers participating in the study, from 1st January to 31st March 2020. Volunteers managed to invite 791 eligible callers to join the study, of which 471 (60%) agreed to participate and completed the study questions at the end of the call. Of the 471 study participants, 417 provided valid contact details which enabled the follow-up survey to be sent one week later, and 123 (29%) responded to this. Twenty-five of the survey respondents took part in an in-depth qualitative interview.

What is the immediate and short-term impact of contact with Samaritans' telephone helpline on callers' levels of distress and suicidality?

There was a significant reduction in levels of distress in the immediate term, from the start to end of a call, and in the short-term, from the start of a call to a week later.

For all callers, at the start of the call, the average score for distress was 7.4 on a scale of 0 – 10 (where 0 = no distress and 10 = severely distressed). **By the end of the call the average level of distress had been reduced to 4.2 – the immediate impact. There was also a reduction in distress over the short-term, with the average score for distress being 5.4 one week later.**

Levels of suicidal thoughts/plans were also reduced in the immediate term. For all those responding to the study questions at the end of the call, **the proportion experiencing suicidal thoughts/plans fell from 33% at the start of the call to 19% at the end of the call. Over the short-term, there was no significant difference** between the proportion of those who had suicidal thoughts/plans at the start of the call and one week later. For survey respondents, the proportion with suicidal thoughts/plans at the start of the call (37%) had gone back to roughly the same level (39%) a week later. The different baseline result for T1a (33% and 37%) reflects the use of different matched bases for analysis and is explained in Section 5.

How does this impact for different groups of callers, depending on patterns of use and /or demographic profile?

The study explored the experiences of the Helpline and the impacts on distress and suicidal thoughts/plans for different groups of callers, including; age groups, gender, ethnicity and frequency of calls.

While there are some differences to consider, the key finding from the study is that **the experience and changes in level of distress are of a similar nature across different groups of callers.** The pattern is consistent, showing a reduction in distress in the immediate term – from the start of a call to the end of the call and, to a lesser extent, there is a reduction over the short-term – from the start of a call to a week later. The changes in levels of distress from the start of the call to a week later are statistically significant for men and women and for younger and older callers.

The one-week follow-up survey included two validated measures of emotional wellbeing, the Suicidal Behaviour Questionnaire – Revised (SBQ-R) and the Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS). These measure how callers felt one week after the call. In the moment, people generally reported a positive impact of the service. However, through the two measures of suicidality and mental wellbeing it is evident that callers were likely to be vulnerable a week after they contacted Samaritans, with poor mental wellbeing. Given the complex needs of many callers, this is unsurprising, as it unlikely they will have become 'better'.

What are the secondary outcomes callers experience, if any, after being supported by a volunteer on Samaritans helpline?

Reductions in levels of distress and suicidal thoughts/plans are not the only benefits of calling the Helpline. **The majority of survey respondents reported an improvement in how they felt on eight secondary outcomes and that their call to the Helpline had a positive impact on these changes**. Since the call:

- 76% felt listened to
- 74% felt they now had options for dealing with difficult situations
- 70% felt more hopeful about the future
- 67% felt better able to cope with everyday life
- 65% of callers felt more able to make choices
- 62% felt more understood
- 62% felt calmer after the call
- 53% felt less lonely and/or isolated

What contribution does Samaritans' telephone helpline make to callers' self-management of emotional distress and suicidal feelings and behaviours?

The study has shown that **the Helpline makes a very positive contribution to callers' self-management of emotional distress and suicidal thoughts/plans**. Almost all 123 respondents to the one-week follow-up survey indicated that the Helpline had helped them manage their current level of distress (95%). More than four in ten survey respondents (44%) felt it helped a lot, 35% that it was of some help, with the rest feeling it helped a little (16%) or not at all (5%). Likewise, 92% of survey respondents indicated that the Helpline had helped them manage their current level of suicidal thoughts/plans. As with distress, more than four in ten (44%) survey respondents indicated it helped a lot, 28% that it was of some help, 20% that it helped a little, with 8% reporting that it was of no help. While these study findings are very positive, the extent to which the support has helped callers shows that there is some room for improvement.

The in-depth interviews with 25 callers also showed that there is a similarity between the reasons why callers choose to use the Helpline and the reasons why callers felt it helped them manage their levels of distress and suicidal thoughts/plans. While these results are from a select group and need to be treated with caution, the overall impression is that the Helpline lives up to callers' expectations. The interviews revealed that the call had helped by giving them the feeling they were:

- better able to cope, feel calmer, to think clearly, see other choices, to have more confidence to make decisions and take actions, feel less alone.

The Helpline did this by providing a service that from the caller's perspective:

- allows the caller time to explain how they are feeling and to reflect on these thoughts
- is available and accessible 24/7, via a real person
- is always there to help, takes them seriously, understands them and really cares about them, makes them feel supported, and is non-judgmental
- is there to listen and provide human contact.

Caller experiences of Samaritans' support

What are callers' experiences of their interaction with volunteers on the helpline?

For over half (55%) of the callers, the interaction with the volunteer exceeded their expectations. This is a particularly positive finding, considering that most respondents are repeat callers and familiar with the Helpline. For other callers, the experience was as expected (37%) and for a few it did not go as well as expected (8%). Six in ten new callers (59%) reported that the call went better than they expected.

The majority of survey respondents reported a very positive experience on each aspect of their interaction with the volunteer – they felt they were treated with respect and dignity, had the volunteers undivided attention, that conversations would remain confidential, the volunteer was caring and compassionate towards them, and they were able to talk openly to the volunteer about their feelings. Analysis of responses from different groups of callers indicates that while there were some differences, the key finding is that there was a consistent experience across the study participants. The intention to call again is another indicator of the positive experience callers have of the service, with eight in ten (81%) reporting they would definitely make a call and around two in ten (18%) who would probably do so. There are, however, differences by types of caller - a higher proportion of repeat callers (84%) would definitely call again, compared to first time callers (62%).

Callers do not feel there are major gaps in the service. Comments tended to place the emphasis on developing the existing type of service and 'doing more of the same'. The study has helped to identify some areas where there may be some room for improvement, the main one being 'understanding the needs of the caller'. The active listening model is highly valued and the response from survey respondents shows that it is being well-delivered. The study has highlighted that for some callers (particularly new callers) the overall approach of listening was new and/or unexpected. The study has also shown that there is a group of callers that are seeking 'advice' and that this means different things to different callers.

How did the interaction with the volunteer on the helpline impact on callers' emotional well-being?

In the short-term, seven out of ten survey respondents indicated they were feeling better one week after the call (71%), with 23% staying about the same and 6% feeling worse. All those feeling better, felt that their call to the Helpline had contributed to this improvement, with 36% indicating it had made a big difference, 52% that it made some difference and 12% that it had made a little difference.

While these improvements and impact of the Helpline are clear, they should also be seen in relation to the results of the measure of suicidality and mental wellbeing at one-week after the call. Both measures show that callers remain at an above average risk of suicide and have low scores for mental wellbeing.

Experience of other forms of support outside Samaritans

What are the experiences of callers in accessing other forms of support, and their help-seeking behaviours?

Most callers (89%) had used other sources of support as well as Samaritans' helpline. GPs were the most popular sources of support – used by six in ten callers. Other sources of support included healthcare organisations, charities, websites, social media, and social services. For each source of help, most callers found them to be of some use. The study shows that from the caller perspective, there is a wide variation in the experience of support. Other charities received the most positive response from callers, with seven in ten reporting they helped a lot/of some help, with others reported they had been of little (22%) or no help (8%). Half of those (51%) using a GP felt this helped a lot/of some help, while the rest felt it helped a little (26%) or not at all (23%).

Feedback from caller interviews highlights the unique aspects of the Helpline that appeal to callers and make it different from other sources of support. The main themes were;

- **immediately accessible** – no appointment needed, put through day and night, available 24/7 and 365 days per year;
- **the tone** - in that volunteers are more empathic and do not have the awkwardness of a GP/NHS appointment, is led by the caller rather than directed by the organisation's objectives and;
- **they really listen** - not to direct callers elsewhere, offer instant solutions or tell them what to do, it helps the caller to reflect and move forwards with their own decisions and solutions.

Experience of callers and volunteers participating in the study

What are the experiences for callers about how they were recruited into the study and data they had to provide?

Most callers were positive about being asked to join the study. Nine out of ten reported that it was fine to be asked to join the study, with one in ten feeling this was a little awkward, but still going on to participate. Many saw it as a way of giving something back to Samaritans. The positive response from callers has not been taken for granted and is built on the results of the Feasibility Study which tested the methodology with callers and volunteers to make sure it works for both parties, is ethically sound and does not harm callers. While there are learning points to take on board (see Appendix 6 – Learning points), the study methodology has proved to be robust and repeatable. Key to the success was the volunteers' ability to build a rapport with callers. The success of the approach is reflected in the proportion of eligible callers who agreed to become study participants (60%) and that there were no complaints about the study.

Has involvement in the research affected the likelihood to use Samaritans services in the future?

Involvement in the study had no negative influence on survey respondents' intentions to contact Samaritans in the future. Almost all (99%) survey respondents indicated that they would contact Samaritans if they needed to in future.

What are volunteers' experiences of recruitment and data collection procedures?

Overall, volunteers felt it was a positive, if sometimes challenging, experience. A total of 153 volunteers from 24 branches attended a training session, with over 104 going on to recruit callers.

Feedback from volunteers has emphasised the value of the training and support. The training sessions enabled volunteers to explore and discuss various concerns about the research process and volunteers' involvement. Volunteers understood the inclusion/exclusion criteria, found it straightforward to find the right words to introduce the study, address queries from callers, collect the data using the study questions, collect caller contact details and work with M·E·L Research. **Most importantly, volunteers reported that they were able to provide 'support as usual' and recruit callers to the study**. Many commented on the positive response from callers when they asked them to join the study.

As expected, while consistent application of the inclusion / exclusion was not without its challenges, volunteers were successful and made it work.

Learning points and development ideas

Throughout the course of the project, learning points on the implementation of the study have been recorded and are presented in Appendix 6 - Learning points. Many of the learning points were made by volunteers. These observations could be a useful resource if this study were to be repeated and could also help inform the design of other research projects undertaken by Samaritans.

The feedback from callers and the results of the study have raised a number of ideas and possible courses of action that Samaritans may wish to consider. The development ideas have been recorded, grouped into themes and are presented in this report in section 10. The ideas fall into one or more of five themes:

1. Interaction with callers
2. Service development
3. Information/promotional activities
4. Working with others
5. Research and monitoring.

1. Introduction

In May 2019 Samaritans commissioned M·E·L Research to undertake research to measure primary and secondary outcomes for callers who use the Samaritans Helpline, explore callers' experiences of the Helpline, and identify the difference the Helpline makes to them. The study is the first nationwide project of its type and follows a Feasibility Study carried out by Samaritans in 2017-18 to test the appropriateness and validity of the research, with this project applying the learning to a larger-scale study.

Samaritans Helpline provides emotional support, through active listening, for those in crisis and those finding it difficult to cope. The Helpline was established in 1953 in the UK and Ireland, has over 200 local branches, is a free service, available 24/7, with more than 20,000 volunteers answering a call for help every 7 seconds. Samaritans' active listening approach revolves around the concepts of open questions, summarising, reflecting, clarifying, encouraging, reacting, and silence. The approach is summarised within the 'Listening Wheel' (see section 6), which has developed over time, but little is known about the outcomes for callers.

Improving the collection and application of evidence so that the organisation is better able to demonstrate the benefits of the service is a key priority set within the Samaritans Strategy 2015- 2021.

This study is an independent evaluation of the Helpline, providing evidence of caller outcomes specific to distress, suicidal thoughts/plans, and actionable insights on the caller experience. The evidence will help to inform the future development of Samaritans helpline, contribute towards the future sustainability of the service, and serve as a template for future evaluations.

Research evidence on helplines

This study aimed to understand outcomes for callers based on Samaritans approach of 'active listening' and contribute to wider learning around caller outcomes and suicide prevention. A significant challenge to Samaritans is that all of the recent, high quality studies have taken place within helplines making use of 'crisis intervention' and 'problem solving' approaches, rather than the 'active listening' model of Samaritans, for which the extant literature does not provide evidential support. For example, studies on caller outcomes from 'crisis intervention' helplines show a positive change for a proportion of callers, reducing crisis and suicidality by the end of the call (Mishara et al., 2007a; Mishara et al., 2007b; Kalafat et al., 2007; Gould et al., 2007), with one study showing that crisis and suicidality continue to reduce for callers in the longer term (3 weeks to 3 months) (Kalafat et al., 2007; Gould et al., 2007). In their literature review, Leitner and colleagues (2008) conclude that suicide helplines may be effective in reducing suicidal ideation (i.e. thoughts) but are unproven in relation to modifying suicidal behaviour, with multiple authors recognising the gap in evidence on cohort

(longitudinal or follow-up) studies of caller outcomes (e.g., O'Connor et al., 2011; Gould & Kalafat, 2009; Mishara et al., 2007a; 2007b).

Within the current evidence there is also insufficient understanding of the diverse nature of callers to helplines, in terms of socio-demographic characteristics and social circumstances, clinical or psychological profile or type of service use. Limited evidence has shown that callers to telephone helplines have a higher risk of suicide, poorer clinical profiles, use other mental health and support services, and if they call repeatedly (i.e. frequent callers) are more likely to be male, unmarried, associated with anxiety disorders, access support from their GP and are social disadvantaged (Bassilios et all 2015; Coveney et al, 2012; Middleton, et al, 2014). Studies have not sufficiently analysed how the characteristics of callers and the ways they use the helpline services may influence desired and achieved outcomes.

However, there is some effort in the literature to divide calls or callers into broad types. These studies tend to differentiate calls into poorly defined categories of 'suicidal', 'non-suicidal crisis' and 'non-crisis' (Mishara et al., 2007a&b; Kalafat et al., 2007; Gould et al., 2007). Some studies have looked at older callers (Deuter et al, 2013) 'frequent callers' (variously and imprecisely defined), and have suggested that these callers require a different, or more directive, approach (Mishara & Diagle., 1997; Middleton, et al, 2014).

Much of the research on helplines has focused on process – how helpline workers or volunteers provide the service through a particular approach or model of support, often based on the assumption that adherence to the model will produce desired outcomes. In general, the evidence shows that empathy and 'supportive interaction' are fundamental, with volunteers' communication of personal views and experiences also associated with positive outcomes during the call, despite being discouraged in helpline practice (Mishara and colleagues, 2007a&b). Crisis intervention models (which include collaborative problem solving, formulation of action plans and referrals to other services) and a degree of directivity are also associated with positive outcomes at the end of the call (Mishara and colleagues, 2007a&b).

Though current research provides useful findings, there remain large gaps in knowledge, and untested assumptions about the benefits to callers and the elements of a helpline interaction which are important for positive outcomes.

The Research Questions

Ten research questions were at the centre of the study within the following themes, exploring: the impact Samaritans Helpline support has on callers; how callers experience the support they receive; how callers and volunteers experience participating in the research; and how Samaritans service fits with other support callers might be receiving.

Impact on callers

RQ1. What is the immediate and short-term (and, if any long-term) impact of contact with Samaritans telephone helpline on the emotional wellbeing of callers, and their levels of distress and suicidality?

RQ2. What are the secondary outcomes callers experience, if any, after being supported by a volunteer on Samaritans helpline?

RQ3. What contribution does Samaritans' telephone helpline make to callers' self-management of emotional distress and suicidal feelings and behaviours?

RQ4. How does this impact for different groups of callers, depending on patterns of use and / or demographic profile?

Experience of Samaritans support interactions

RQ5. What are callers' experiences of their interaction with volunteers on the helpline?

RQ6. How did the interaction with the volunteer on the helpline impact on their emotional well-being?

Experience of participating in research by callers and volunteers

RQ7. What are the experiences for callers in terms of how they were recruited into the study and data they had to provide?

RQ8. Has involvement in the research affected the likelihood to use Samaritans services in the future? If yes, why?

RQ9. What are volunteers' experiences of recruitment and data collection procedures, including use of measures of suicidality and distress?

Experience of other forms of support outside Samaritans

RQ10. What are the experiences of callers in accessing other forms of support, and their help-seeking behaviours?

2. Study methodology

An Advisory Group comprising of academics and experts with a range of related specialisms provided advice to Samaritans and M·E·L Research on the approach, measures and materials used for the study. The research methodology and materials were approved by Samaritans Research Ethics Board.

Two primary outcomes for callers were the focus for the study: distress and suicidal thoughts/plans. The study used a mixture of quantitative and qualitative research methods to measure and understand caller outcomes and experiences.

The methodology was designed to provide the data to help answer the research questions and was informed by the Feasibility Study conducted by Professor Stephen Platt and Samaritans in 2017-18. The Feasibility Study has guided the key elements of the methodology such as: training volunteers to recruit study participants and ask study questions, designing inclusion/exclusion criteria to identify eligible callers; key questions including the use of the distress thermometer scale to measure levels of distress; gathering volunteer feedback to aid learning; and ethical approaches to conducting research with callers. This large-scale study built on these learnings from the Feasibility study and also explored additional areas to better understand the impact of the helpline and the caller experience.

Study timetable

The study team of volunteers recruited participants from 1st January to 31st March 2020. The closing date for callers to complete a T2 one-week follow-up survey was 21st April 2020. The study fieldwork and findings should be seen in the wider context of the coronavirus pandemic – Covid-19, with an increase in publicity, awareness and concerns from February, with the national lockdown starting on the 23rd March 2020. The T3 in-depth interviews with callers were conducted from March-April 2020 and the Volunteers Feedback Survey in April 2020. A detailed study timetable and weekly report on recruitment and survey responses is presented in Appendix 2- Study activity. Each stage is outlined below.

Recruitment of callers

Samaritans Listening volunteers were trained to recruit callers into the study during calls to the helpline for emotional support. A total of 153 Samaritans volunteers from 24 branches were trained, with 104 going on to recruit callers to the study. Appendix 2 – Study activities, contains a flowchart overview of the recruitment of callers.

Volunteers adhered to inclusion/exclusion criteria to establish if a caller should be invited to participate in the study. At the end of a call, the volunteer introduced the study to all eligible callers,

explained what would be required of them, answered any questions raised by the caller, and asked if they wished to participate.

Inclusion/exclusion criteria

The study was of inbound calls to the Helpline, in which emotional support was provided. Callers had to be aged 18+ and able to give informed consent e.g. able to understand what the study is about, what is required of them, and how the data would be used. The assessment of a caller's ability to provide informed consent required judgement from the volunteer, based on the caller's dialogue and behaviours e.g. under the influence of alcohol, drugs. The caller could be in 'extreme emotional distress' and/or 'actively suicidal' (with current suicidal thoughts or feelings) but any caller who was considered to be at imminent risk of suicide (currently attempting or actively planning to take his/her life) was excluded from the study. The detailed inclusion/exclusion criteria and subsequent recruitment are set out in Appendix 2 – Study activity.

Data collection

Data from callers were collected at three points in time:

- **Time 1 (T1): on the call to the helpline - baseline study questions and immediate outcomes.** Eligible callers that provided informed consent were then asked the study questions about their level of distress and, if appropriate, two questions about their suicidal thoughts or plans. Study participants were asked for their preferred method of contact for the T2 one-week follow-up survey (email, text, post) and contact details. Volunteers used an online form to transfer the caller's contact details to M·E·L Research. Samaritans did not retain any contact details. The anonymous study data was linked to Samaritans operational data to enable more in-depth analysis.

  After every call to the Helpline, volunteers record details about the call on elog, the Samaritans call record system.

- **Time 2 (T2): one week after the call to the helpline – one-week follow-up survey**. An invitation to self-complete the survey was sent to each study participant, seven days after their T1 call, using their preferred method of contact. The survey repeated the questions asked at T1 about levels of distress and suicidality, along with over 100 questions including two validated measures of emotional wellbeing, the Short Warwick-Edinburgh Mental Well-being Scale and the Suicidal-Behaviour Questionnaire – Revised (see Appendix 1 – Study materials).

- **Time 3 (T3): after the one-week follow-up survey – in-depth interviews**. Survey respondents were invited to participate in an in-depth telephone interview with M·E·L Research at the end of

the T2 one-week follow-up survey. While the T1 and T2 elements of the study sought to measure caller outcomes and use of the service, the purpose of the interviews was to gain a deeper understanding of the callers' experiences.

Data from volunteers participating in the study, by recruiting callers and collecting data, were also collected after T1 data collection had been completed:

Volunteer Feedback Survey. At the end of the data collection period, all study volunteers were invited to provide feedback on taking part in the study via an online survey, including questions on the training they received, recruiting callers, and collecting data.

Measuring changes in distress and suicidal thoughts/plans

To measure the immediate and short-term outcomes of distress and suicidality, a series of questions were asked of all callers participating in the study.

Distress was measured using an 11-point Distress Scale, which was tested during the Feasibility Study, asking callers how they would rate their own levels of distress at the start and the end of the call. This provided pre- and post-call data on levels of distress. At the end of the call, volunteers asked all study participants:

"Please rate your level of distress on a scale of 0-10 (where 0 means no distress and 10 means severely distressed) at the start of the call"

"Please rate your level of distress on a scale of 0-10 (where 0 means no distress and 10 means severely distressed) at the end of the call"

Suicidality was measured by asking callers to state whether they had *any* suicidal thoughts or plans at the start and end of the call. This provided categorical data that matched those collected routinely by Samaritans when suicide is discussed with callers. For the purposes of the study, volunteers asked all callers if they had suicidal thoughts or plans. Only those study participants who had expressed suicidal thoughts or plans were asked the study questions related to suicide:

"Did you have any suicidal thoughts or plans, at the start of the call"

"Do you have any suicidal thoughts or plans, at the end of the call"

To measure changes in primary outcomes in the short-term, the measures above were repeated in the one-week follow-up survey. (see Appendix 1 – Study materials).

Data analysis

The Analysis Plan sets out the analysis and explanation of statistical tests used to address each research question (see Appendix 4 – Analysis plan).

Data from elog was used to provide an indication as to how representative the survey respondents are of the wider caller population. However, elog data is not comprehensive and therefore any comparisons should be treated as a general guide. The study data gathered at the end of the call (T1), elog and telephony data (length of call, frequency of calls etc) were linked to the one-week follow-up survey response data. This approach enabled the measurement of caller outcomes over the short-term and analysis of the Helpline experience for different types of caller eg. demographics, frequency of use.

Longitudinal analysis has been carried out on the distress and suicidal thoughts/plans data, to explore changes from the start to end of the call and to one week later. Cross sectional analysis has been undertaken to describe and understand the differences between groups of callers eg. demographics, frequency of calls. Detailed description of the statistical tests is presented in Appendix 5 - Outcomes analysis.

The T3 caller interviews were audio-recorded and transcribed verbatim, and the transcripts have been thematically analysed for key themes. The interview findings presented in this report represent the dominant themes which emerged from the interviews. The interviews covered the key research concepts, but each interview was different, and flexibility was needed in how the questions were asked within the natural flow of the conversation with each interviewee.

Reporting and presentation of data

The base size (i.e respondent numbers) noted in tables and charts is the total number of callers that answered the question. Callers could choose not to answer questions. On average, 10% of respondents did not answer a question. The base size for each table and chart differs for each question, as the 'not asked', 'no replies', 'don't know' and 'I prefer not to say' responses have been excluded. For multiple response questions the base size is all callers that were asked the question and are not expected to total to 100% as more than one response could be made. Percentages may not sum to 100%, due to rounding. References to 'the average' are the mean average. Significant differences are calculated and noted as such in the text, when at the 95% confidence level. Comments on any other differences are not statistically different but are included as useful findings.

3. Study response

During the 3-month data collection period, 2,247 calls were answered by study volunteers. Two in three callers were excluded from the study. Most exclusions (81%) from the study population were due to a lack of informed consent. In addition to those that decided they did not wish to participate, volunteers used the category 'lack of informed consent' when they felt the caller was unable to understand what was being discussed or what they would need to do and when calls ending before the study was fully introduced. Other reasons were: in prison (9%), at imminent risk of suicide (6%), under the age of 18 (3%). Details of the reasons for exclusions and response rates are presented in Appendix 2 – Study activity.

Figure 3.1 Study response

There was a **good response from the 791 eligible callers, with six out of ten (n=471) agreeing to participate in the study and answering the study questions at the end of the call**. All 471 study participants provided contact details and were sent an invitation to complete the one-week follow-up survey. However, for 54 of these study participants their contact details proved to be invalid, resulting in 417 potential respondents receiving the one-week follow-up survey, of which 123 (29%) responded.

Around half (52%) of the survey respondents wanted to participate in a telephone interview. A total of 25 telephone **in-depth interviews** (T3) were undertaken. The interviewees were selected to be broadly representative of the demographic profile and patterns of use of the survey respondents. Having carried out 25 interviews the point of data saturation had been reached, with no new findings emerging.

An invitation to complete an online survey was emailed to **Samaritans volunteers** that had attended training and provided an email address (n=143). Fifty-four volunteers (38%) responded, including those that had recruited study participants (n=50) and those that had not (n=4).

4. Respondent characteristics

To place the survey results in context, this section compares the characteristics of callers at each stage of the study. The key elements are:

- **Comparisons across study stages** - using elog data to present characteristics of callers across the study stages and highlights any differences between the groups – in particular, the extent to which the survey respondents are representative of the general study population. Elog data includes; gender, caller concerns, length of call, if explored suicidal feelings/behaviour, history of suicide attempts, if signposted to other organisations, frequency of calls to Samaritans.
- **About the survey respondents** – using the T2 survey data to build upon the elog data to present a profile of the survey respondents. Survey data included; age, sexuality, ethnicity, disability, economic background, region.
- **Risk of suicide and mental wellbeing** – using two validated measures of emotional wellbeing to provide insight into survey respondent's emotional wellbeing, one week after the call.

Comparisons across the study stages

Analysis of **elog data** has been undertaken to explore any differences in the characteristics of callers across the study stages, as set out in Figure 3.1. The terminology used for groups of callers at each stage of the study is:

1. **All callers** – all callers to the Helpline in the study period, 1st January – 31st March 2020
2. **Study population** – callers supported by the study volunteers during the 3-month study period
3. **Eligible callers -** following use of inclusion/exclusion criteria, callers invited to participate in the study
4. **Study participants** - eligible callers who provided informed consent and answered the study questions at the end of the call (T1)
5. **Survey respondents** – Study participants (T1) who completed the one-week follow-up survey (T2)
6. **Interviews** – Survey respondents that participated in an in-depth interview

Table 4.1 provides a summary of elog data at each stage of the study. A more detailed analysis on each variable and frequency of calls is presented in the following section.

Table 4.1 Summary of elog data by study stage

	All callers	Study population	Eligible callers	Study participants	Survey respondents
Gender: female/male	61%/39%	54%/46%	60%/40%	62%/40%	60%/40%
Explored suicidal feelings/behaviour	61%	55%	71%	76%	77%
If explored - % with suicidal thought/plans	70%	55%	47%	50%	49%
History of suicide attempts	13%	9%	11%	13%	13%
Signposted	14%	5%	6%	7%	5%
Caller concerns – mental health	48%	53%	55%	60%	65%
Caller concerns – family	32%	39%	48%	50%	51%
Length of call	24 minutes	26 minutes	38 minutes	40 minutes	43 minutes

Length of call

In terms of the length of call, the study population is representative of all callers, with an average of 26 minutes and 24 minutes respectively. However, those eligible to join the study, study participants and survey respondents **had longer calls** than all callers and the study population. The average length of call was considerably longer for eligible callers (38 minutes), study participants (40 minutes) and the follow-up survey respondents (43 minutes). The **difference between survey respondents and all callers** is **not unexpected**, as volunteers reported that they found it easier to build a rapport, introduce the study and recruit callers who had been on longer calls. Feedback from volunteers highlighted the challenge of recruiting callers to the study when the call was only a few minutes, some of which could include periods of silence and very little interaction.

Exploring suicidal thoughts/plans

For all calls, volunteers record on elog whether or not suicidal thoughts/plans had been discussed. For 61% of all callers in the study period and 55% of the study population, suicidal thoughts/plans were discussed. As expected, suicidal thoughts/plans were far more likely to be explored with eligible callers (71%), study participants (76%) and survey respondents (77%) as volunteers were trained to ensure they explored suicidal feelings with these callers for data collection purposes, and not all of the study population would have been calls where suicide could be explored, i.e. shorter calls.

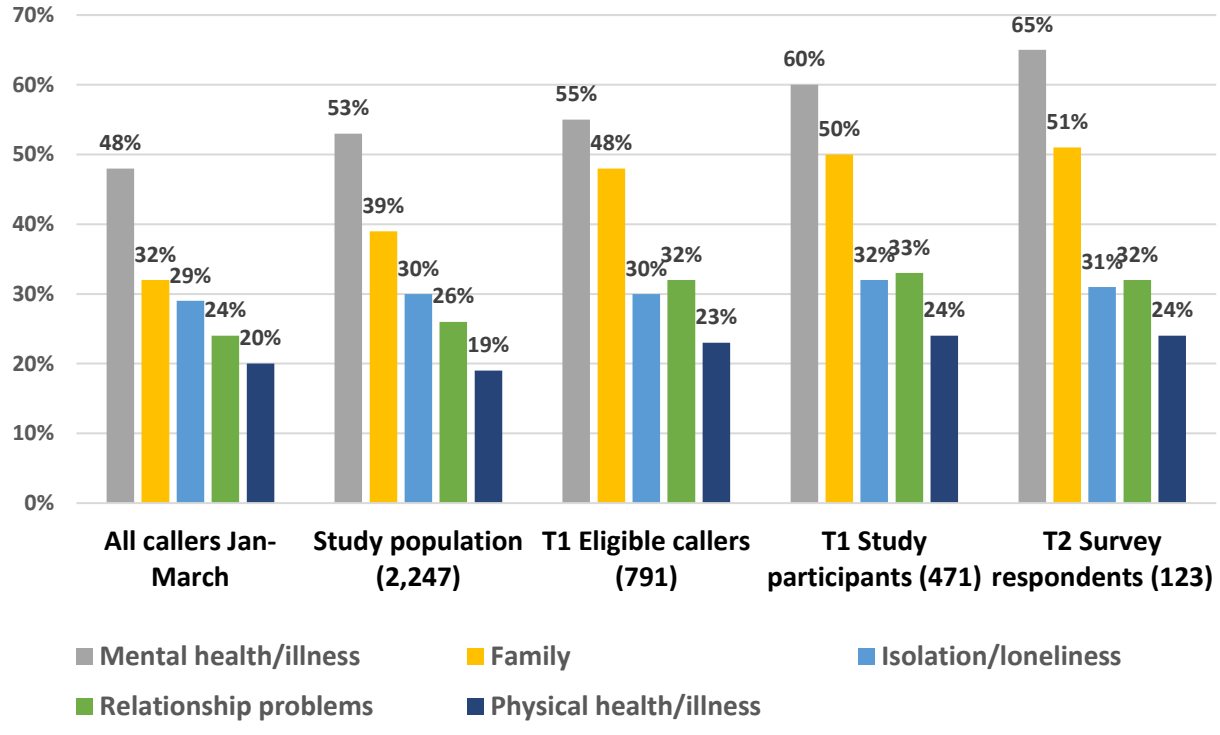
For those that had discussed suicidal thoughts/plans, there is **a difference** to note, with a higher proportion (70%) of all callers having suicidal thoughts plans compared to all other study stages.

- **Where explored,** one in two survey respondents (49%) reported suicidal thoughts/plans, which highlights that callers with these thoughts are willing to participate in the research and is **similar across the study stages:** the study population (55%), eligible callers (47%), study participants (50%).
- Of those with such thoughts/plans, eight out of ten (82%) survey respondents reported that they had thoughts, with the rest having plans (18%). Again, this shows a consistent pattern, with a similar response from across the study stages, all callers (80%, 17%), study population (75%, 21%), eligible callers (83%, 16%), study participants (83%, 16%).

Caller concerns

Data from elog, shows that the survey respondents are largely representative in terms of callers' concerns, with a similar response across all stages of the study. At each study stage the **top five concerns are the same**. However**, two differences are on 'mental health' and 'family'**, which are more likely to be of greater concern to the survey respondents than for all callers and the study population.

Figure 4.1 Top five caller concerns – by study stage



Gender

Women made up around six in ten survey respondents, which (as recorded on elog by volunteers) is the same split for all previous study stages i.e. all callers, eligible callers, the study population and survey participants.

History of suicide attempts

Around one in ten survey respondents had a history of suicide attempts, which is consistent across all study stages.

Signposting

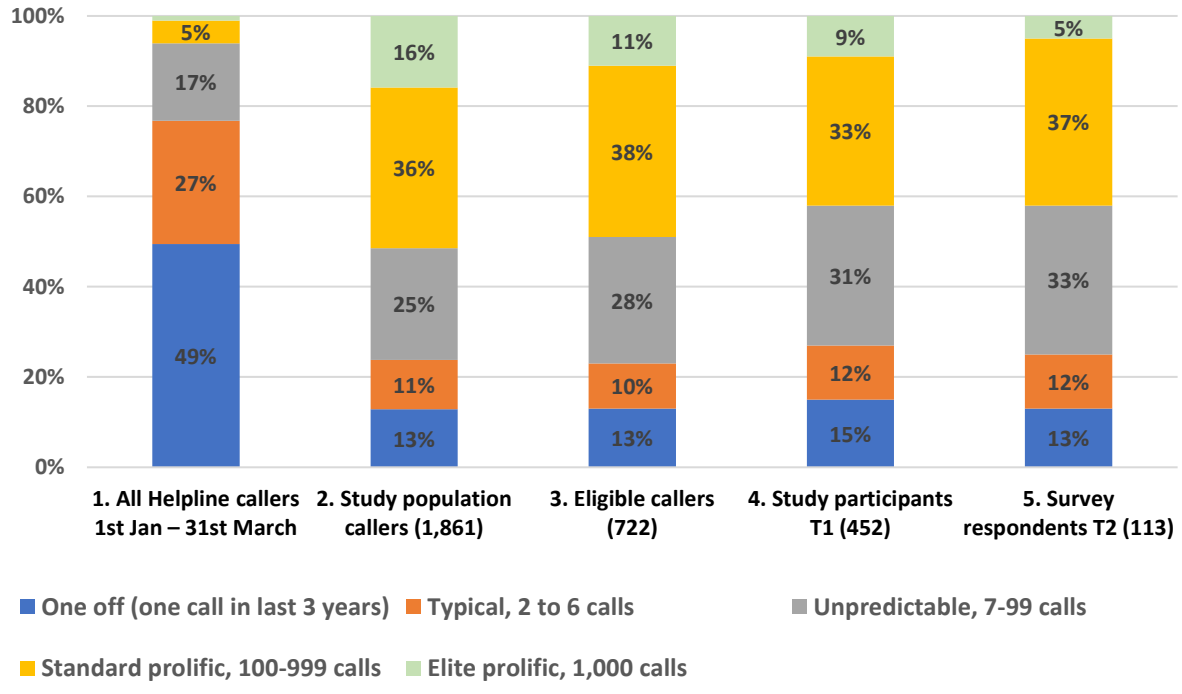
Around a fifth of all survey respondents were signposted to another organization, which is a similar proportion across all study stages.

Frequency of calls

Analysis of Samaritans telephony data from April 2017 to April 2020 was undertaken to identify the number of calls made by all Helpline callers over the study period. The categories are set out in Figure 4.2, according to the number of calls made in the last three years.

The **survey respondents use of the service is similar to the study population**. This indicates that volunteers took a consistent approach in the application of the inclusion/exclusion criteria to identify eligible callers and to recruit study participants.

Figure 4.2 Types of caller – by frequency of calls in the last 3 years



Source: Samaritans elog telephony data analysed by MEL Research. Note. data is not available for all callers.

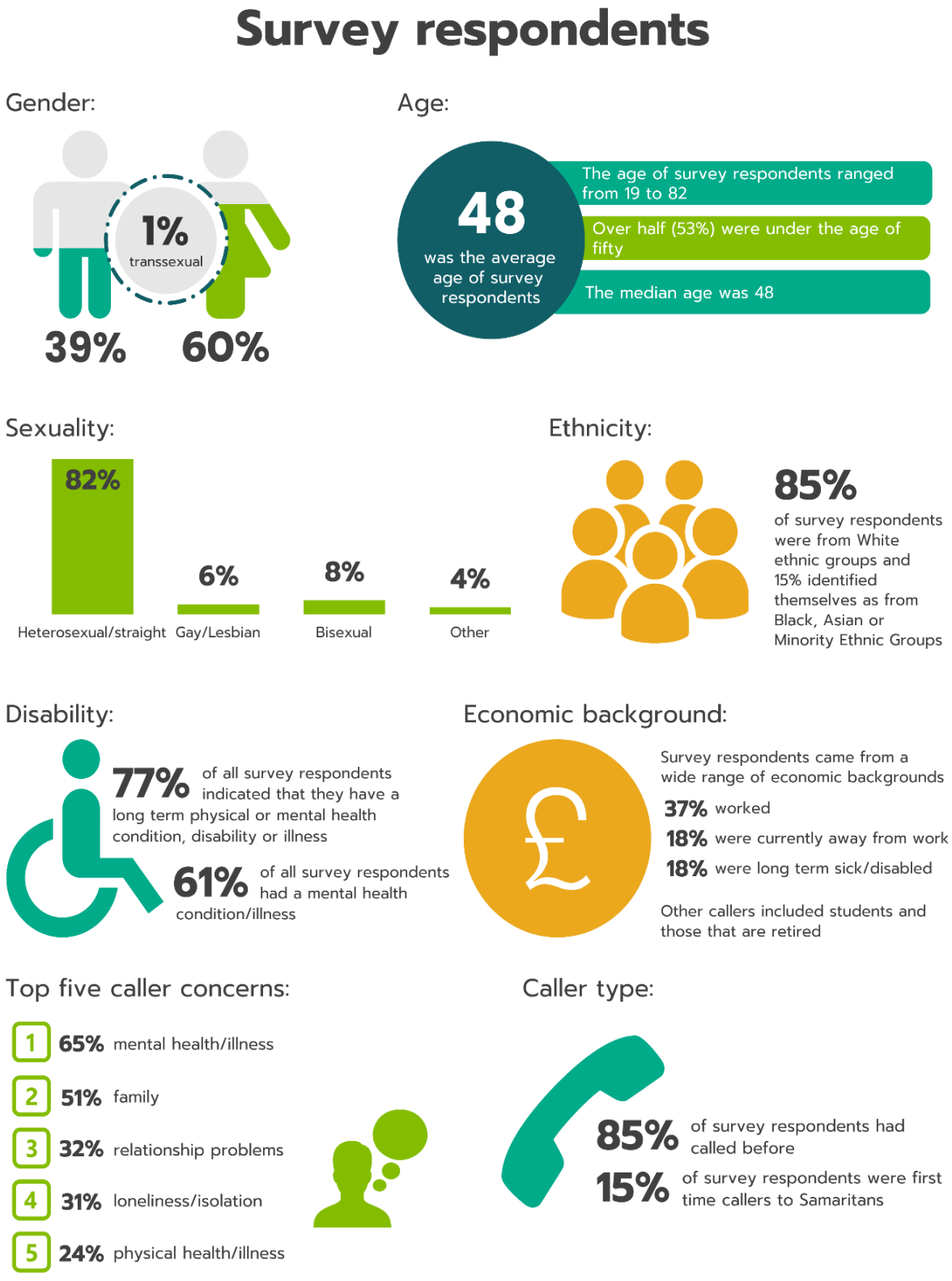
*[*categories and cluster labels are a simplified version of the frequency/duration clusters identified by the University of Ulster for Samaritans: A Research Report on a Data Analytics Approach to Understand Helpline Caller Behaviour. 2017.]*

The **main difference** across the study stages is the profile by frequency of calls, for all callers and the study population. Around half the sample (49%) of all callers consists of those who have made one previous call in the last three years, compared to around one in ten (13%) of the study population. In order to understand more about the differences between these groups, additional data checks were carried out, but there is no clear explanation for the difference between the two stages.

About the survey respondents

The respondent profile in Figure 4.3 is for the 123 callers that responded to the T2 one-week follow-up survey. In addition, this section explores some points in more detail, including; long term conditions, caller concerns, working status and response by region.

Figure 4.3 Survey respondent characteristics

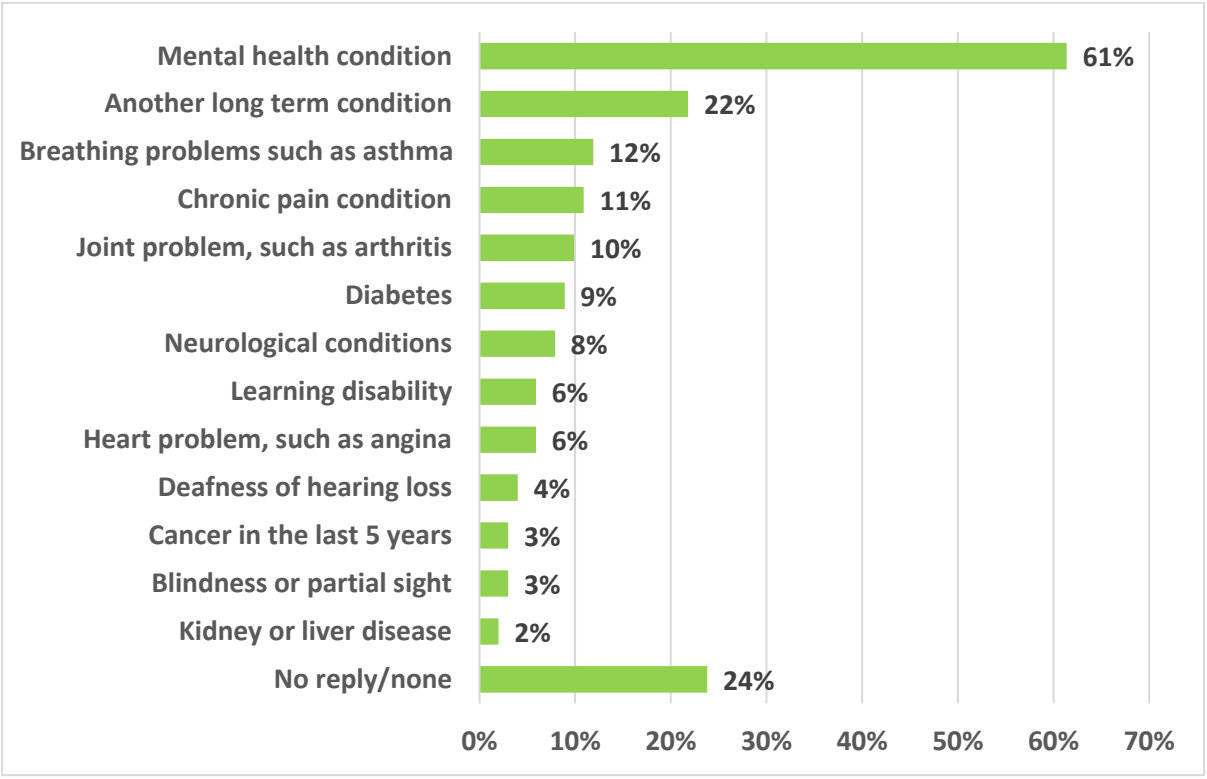


Long-term conditions

The one-week follow-up survey asked about long-term conditions. A long-term condition is a physical or mental health condition, disability or illness that has lasted, or is expected to last for 12 months or more. **Three in four respondents (77%) had a long-term condition**, compared to 30% in the UK population (2011 Census). While there is a wide range of conditions, **mental health is by far the most common long-term condition**, reported by 61% of all survey respondents. For those with a mental health condition, the most commonly reported were depression (69%), panic attacks (31%), PTSD (31%), personality disorder (25%), anxiety (25%).

Figure 4.4 T2 Survey respondents – long-term conditions

Base: 101 % of all survey respondents

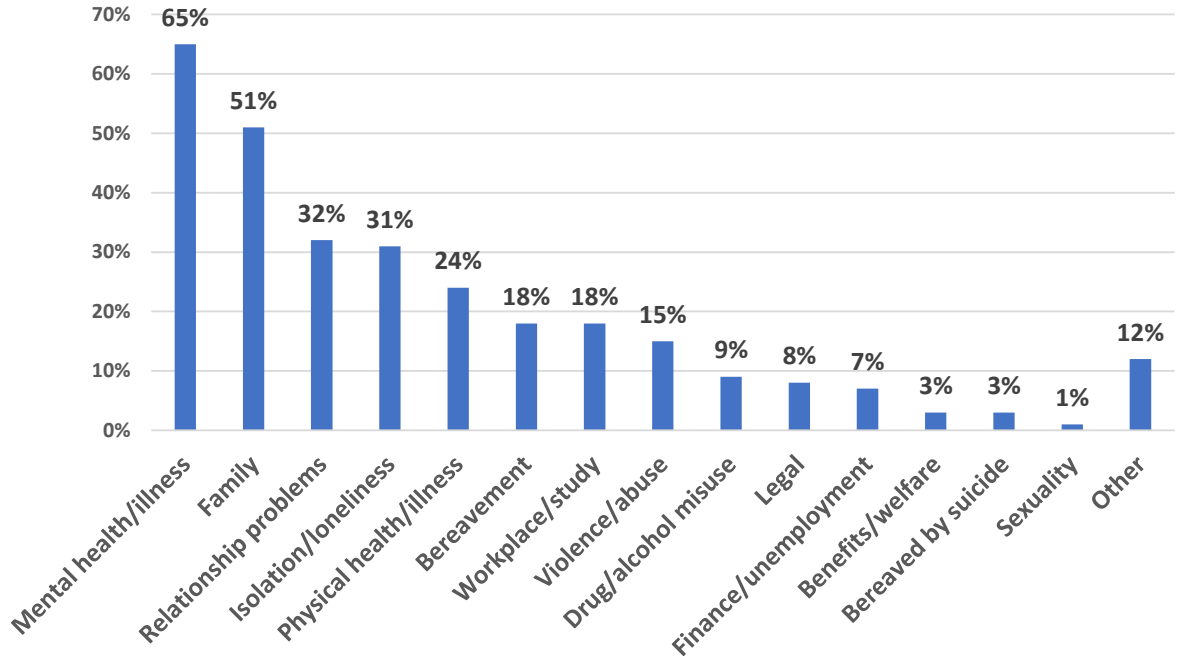


Caller concerns

Volunteers record any concerns expressed by the caller on the elog system. Volunteers could log more than one concern for every call. Analysis of the one-week follow-up survey responses not only highlights the **wide range of concerns**, but also that **two in three callers were concerned about mental health issues** and **half of callers were concerned about family issues.** These concerns are not mutually exclusive, as callers could discuss a number of concerns. As expected, there was a slightly higher proportion of callers (65%) concerned about their mental health, than those who reported a long-term mental health illness / condition (61%).

Figure 4.5 T2 Survey respondents – caller concerns

Base: 123 % of all survey respondents

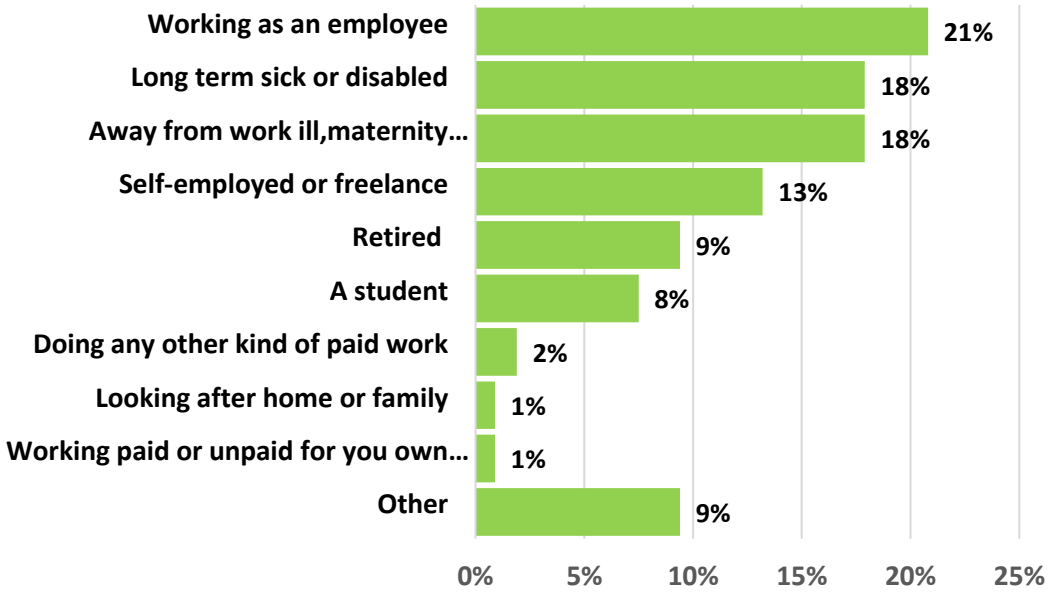


Working status

The survey respondents were from a wide **range of positions in terms of their working status, with half in work and half not in work.** Around a third of all survey respondents (34%) were currently working as an employee or self-employed, with a further 18% employed, but currently away from work due to illness, maternity leave, temporarily laid off. Most of those not in work were long-term sick/disability (18%), retired (9%) or in education (8%).

Figure 4.6 T2 Survey respondents - Working status

Base: 106 % of all survey respondents



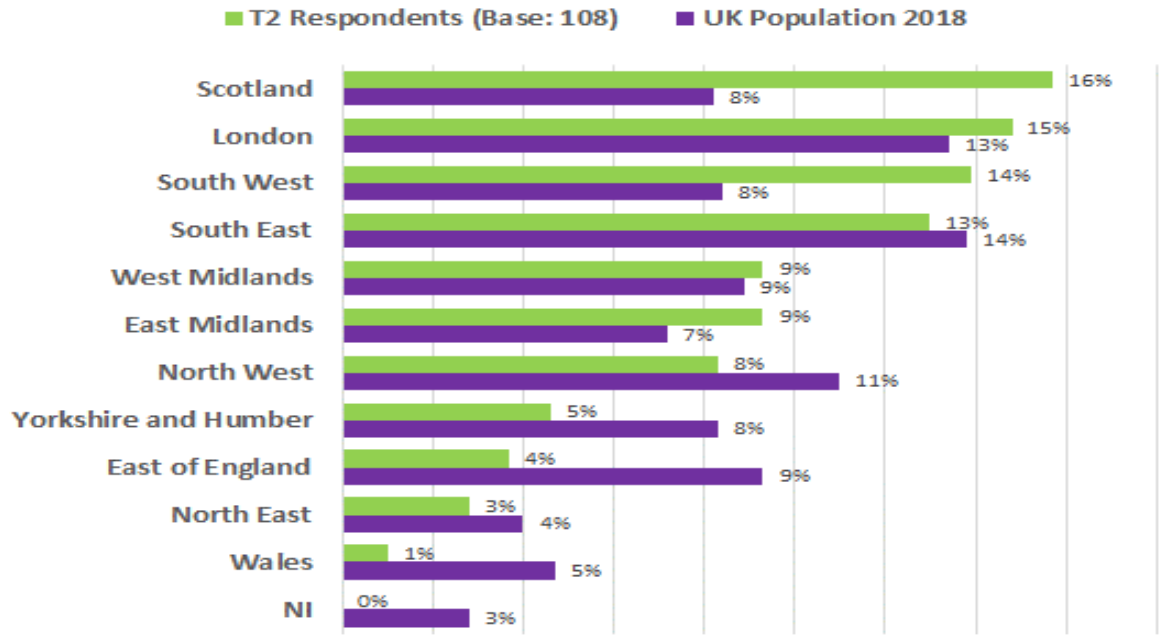
Response by region

Survey respondents came **from across the UK**. In most cases the respondent population is of **a similar proportion to the regional population.** e.g. 9% of the UK population are in the West Midlands and 9% of survey respondents are from here. However, there are **some regions are over-represented** (e.g. Scotland) and other regions that **are under-represented** (e.g. Wales).

The respondent data should be used as a general guide, as the caller defined the region they live in, which may not map precisely to the ONS standard UK regions.

Figure 4.7 Survey respondents - response by region

% of all survey respondents/% of UK population



Further analysis of the characteristics of sub-groups of callers (demographics, patterns of use etc) and experience of using the Helpline is presented in section 7.

Key findings

- **Overall, the survey respondents are representative of the study population on: gender, caller concerns, history of suicide attempts, signposting and type of caller – by frequency of call.**
- **The two main differences between survey respondents and the study population were: survey respondents were more likely to include those making longer calls and to have discussed concerns about mental health/illness and family.**
- **The main difference between all callers and the study population is the type of caller – by frequency of calls over the last three years.**
- **It is possible that study participants are more likely to be those that have had a positive experience. While it is not possible to measure the extent of this bias, the results of this study should be considered with this caveat in mind.**

Risk of suicide and mental wellbeing

The one-week follow-up survey included two validated measures of emotional wellbeing, the Suicidal Behaviour Questionnaire – Revised (SBQ-R) and the Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS).

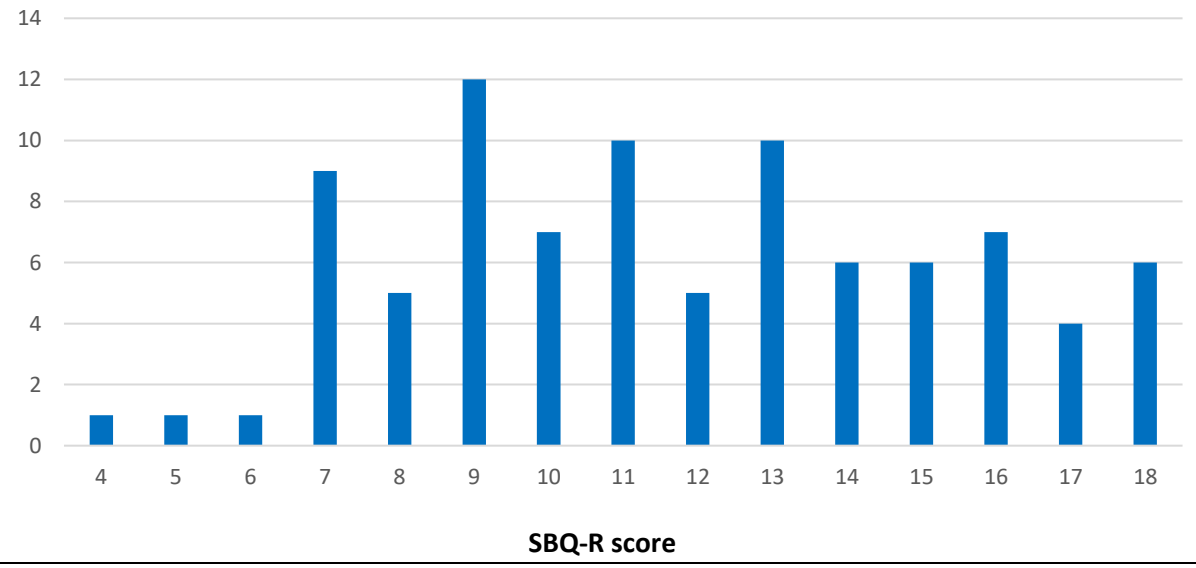
All survey respondents were asked the four SBQ-R questions. A five-point scale is used for the first three questions and a seven-point scale for the fourth question.

- Have you ever thought about or attempted to end your life?
- How often have you thought about killing yourself in the past year?
- Have you ever told someone that you were going to commit suicide, or that you might do it?
- How likely is it that you will attempt suicide someday?

Ninety-three respondents answered all four questions. The responses are combined to calculate a score for each respondent, ranging from 4-22. The results show that one week after the call, almost all (97%) survey respondents generate scores of 7 or more, the SBQ-R cut off point where the respondent is considered to be **at risk of suicide.**

Figure 4.8 T2 Survey respondents, Frequency distribution SBQ-R

Base: 93 Number of respondents for each score



The Short Warwick–Edinburgh Mental Well-being Scale uses seven questions to measure the caller's experience over the last week, on:

- Feeling optimistic about the future
- Feeling useful
- Feeling relaxed
- Dealing with problems well
- Thinking clearly
- Feeling close to other people
- Feeling able to make up their own mind about things

Given the response to SBQ-R measure and that a high proportion of survey respondents had a long-term mental health illness (61%) and have mental health as their leading concerns (65%) it is not unexpected to see the mixed response to the SWEMWBS set of questions.

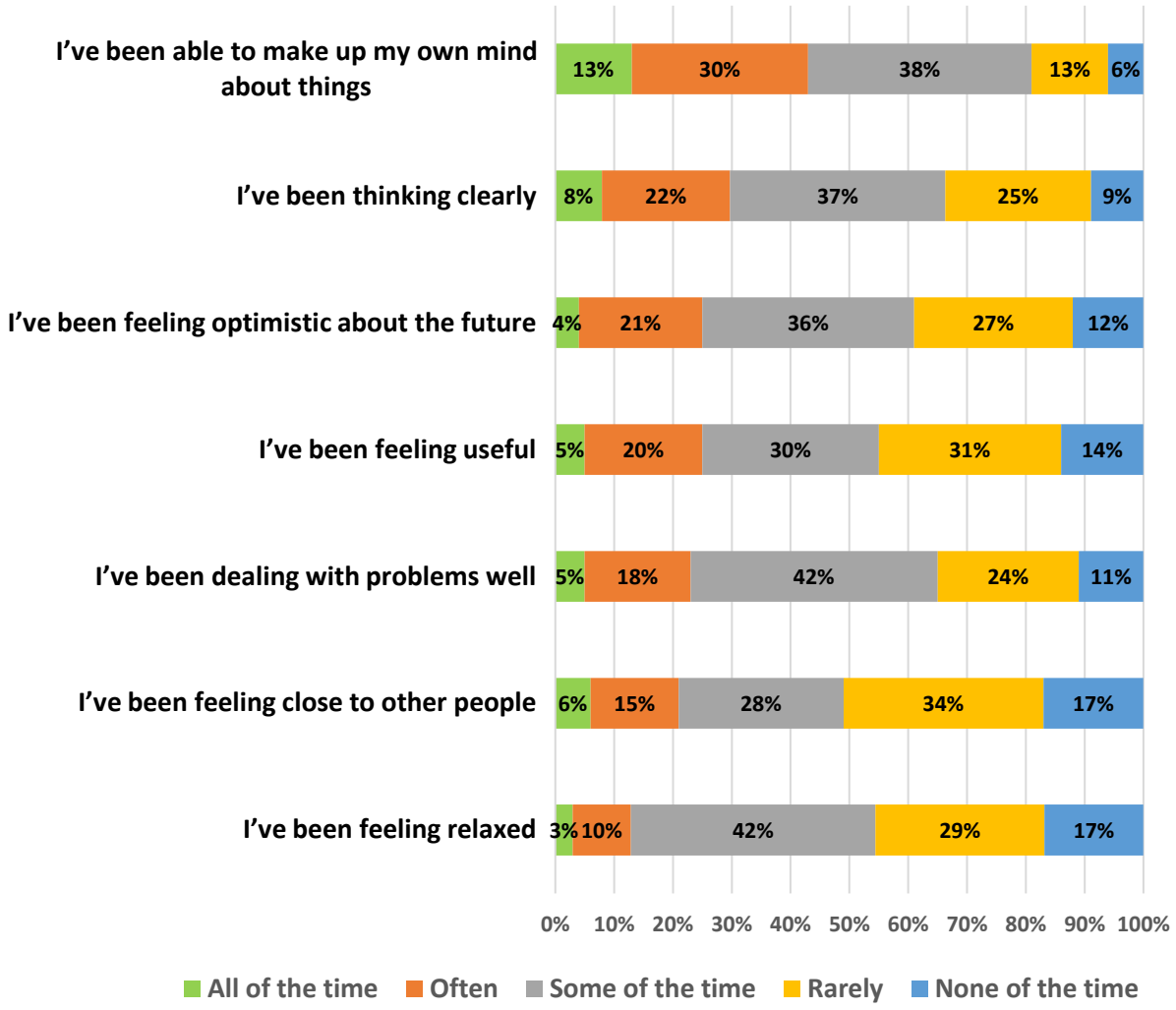
To summarise the data for each question, M·E·L Research created a positive score, by combining 'often' and 'all of the time'. For the survey respondents over the last week, findings show;

- 43% have felt able to make up their own mind about things
- 30% have been thinking clearly
- 25% have been feeling optimistic about the future
- 25% have been feeling useful
- 23% have been dealing with problems well
- 21% have been feeling close to other people
- 13% have been feeling relaxed

Developers of the SWEMWBS questionnaire designed a scoring system to generate a summary result for each respondent. This aggregate score for all respondents can be used to make comparison to the general population. There were 101 respondents who replied to all seven questions in the measure.

Figure 4.9 The Short Warwick–Edinburgh Mental Well-being Scale – 7 questions.

Base: 101

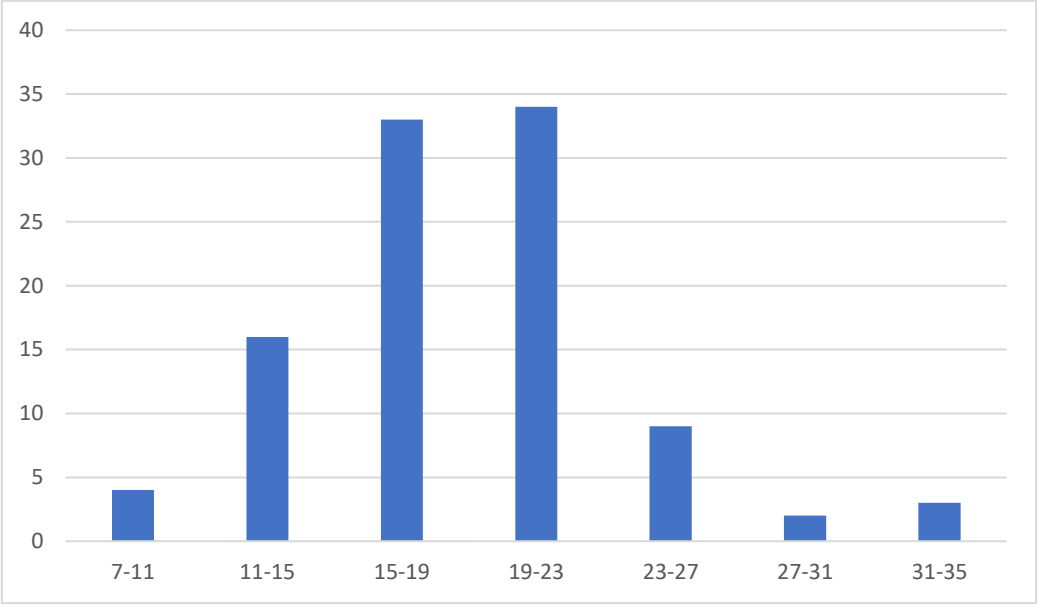


The SWEMWBS score for each respondent ranged from 7 to 35, with the higher number representing greater wellbeing. Scores can be divided into high, average, and low mental wellbeing cut points, with around 15% of participants in the high group and 15% in the low group. For the UK population, the top 15% scores for SWEMWBS range from 28-35 and the bottom 15% range from 7-19. The average score for the general population is 23.6 (Population norms Health Survey for England 2011).

The average score for the survey respondents was 18.8 which, as expected, is lower than the general population average. Figure 4.10 shows the distribution of scores, with most survey respondents generating a **score that was in the lower end of the range for mental wellbeing**. In terms of mental illness, SWEMWBS scores of 7-19 represent probable depression or anxiety and scores of 18-20 suggest possible depression or anxiety.

Figure 4.10 SWEMWBS – Count of scores

Base: 101 Number of respondents in each group



In designing the study, the use of these two measures of wellbeing was considered for use at the end of the call. However, a key learning point from the Feasibility Study was, that for callers and volunteers, there was a limit to the number of questions that could be asked by volunteers at the end of a call. Adding one of these measures would have risked compromising the study and therefore they were only asked in the one-week follow-up survey.

Key findings

- **Even though survey respondents may report an improvement in how they are feeling one-week after the call, the two validated measures show that almost all survey respondents were considered to be at risk of suicide and had a low level of emotional wellbeing.**
- **The emotional health status of Helpline callers a week after a call could be used to inform service developments and how Samaritans decides to develop ongoing relationships with Helpline callers.**

Interviewees

The callers who took part in in-depth interviews (T3) broadly match the survey respondents in terms of demographic profile and use of the Helpline (see Appendix 2 – Study activity).

5. Immediate and short-term outcomes for callers

What is the immediate and short-term impact of contact with Samaritans' telephone helpline on callers' levels of distress and suicidality? (RQ1)

The responses from study participants (T1) and survey respondents (T2) are used to answer each research question. Findings from the caller interviews (T3) are used to explore particular findings in more depth.

As noted in the study methodology, the study questions on levels of distress and suicidal thoughts/plans are presented to study participants at the end of the call (T1) to measure the immediate changes (from start to end of the call) and are repeated in the follow-up survey – one week later, to measure changes over the short-term.

In this section, the immediate and short-term outcomes are presented for all callers and then for different groups of callers. Further details of the statistical analysis are presented in Appendix 5 – Outcomes analysis.

Distress

The measure of change in distress during the call is based on 460 callers providing an answer on how they felt at the start of the call (T1a) and at the call (T1b). For the short-term impact, there is a base of 106 callers who reported their level of distress at the start of the call (T1a) and one week later (T2). The lower base size for the short-term impact is due to the lower number of survey respondents and therefore a lower number of matched responses for both points in time.

Callers were asked to rate their current level of distress using a scale from 0 to 10, with 0 being no distress and 10 being severely distressed. The average score was 7.36 at the start of the call and 4.19 at the end. This change is statistically significant at the 1% level (p value is less than 0.01). There was a reduction of 3.17 in the mean average score from T1a and T1b, which demonstrates that **there is an immediate impact on callers' levels of distress.**

For the short-term impact, there was also a reduction in callers' levels of distress, with the average score falling from 7.43 at the start of the call to 5.43 around one week after the call.

The results for distress in the immediate and short-term are both statistically significant at the 5% level, using the Wilcoxon Signed Ranks Test (see Appendix 5) with a medium to large effect size for both T1a to T1b, and T1a to T2.

Figure 5.1 Immediate and short-term reduction in callers' levels of distress

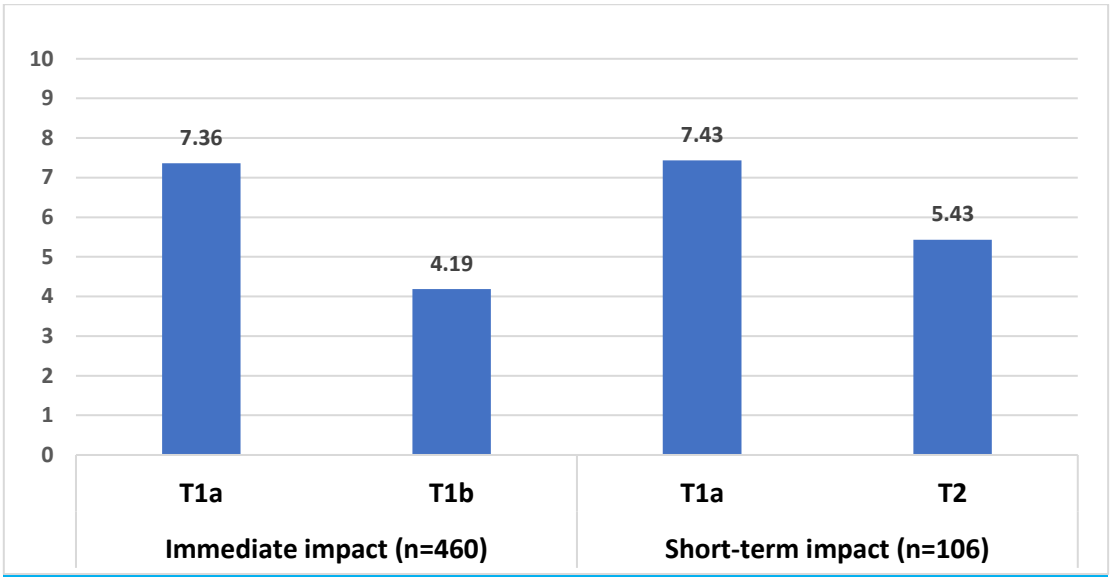


Figure 5.2 shows the frequency distribution of the distress scores in the **immediate term** – from the start to end of the call. At the start of the call, most study participants rated their level of distress towards the upper end of the scale, at 7 – 10 out of 10. At the end of the call, most scores are now in the lower to mid-range, **which is a positive impact**.

Figure 5.2 Frequency distribution of T1a and T1b Distress scores

Base: 460

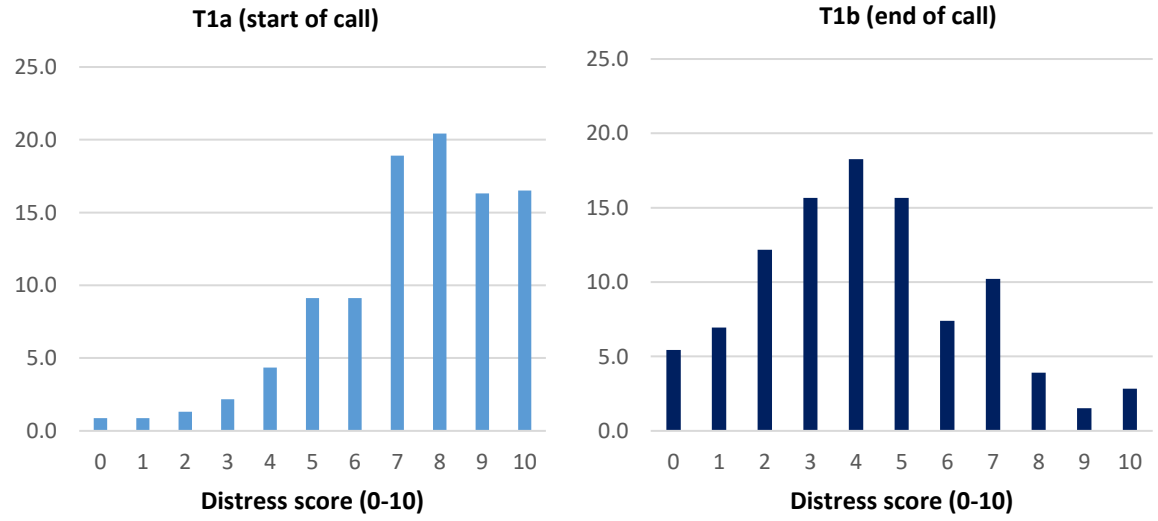
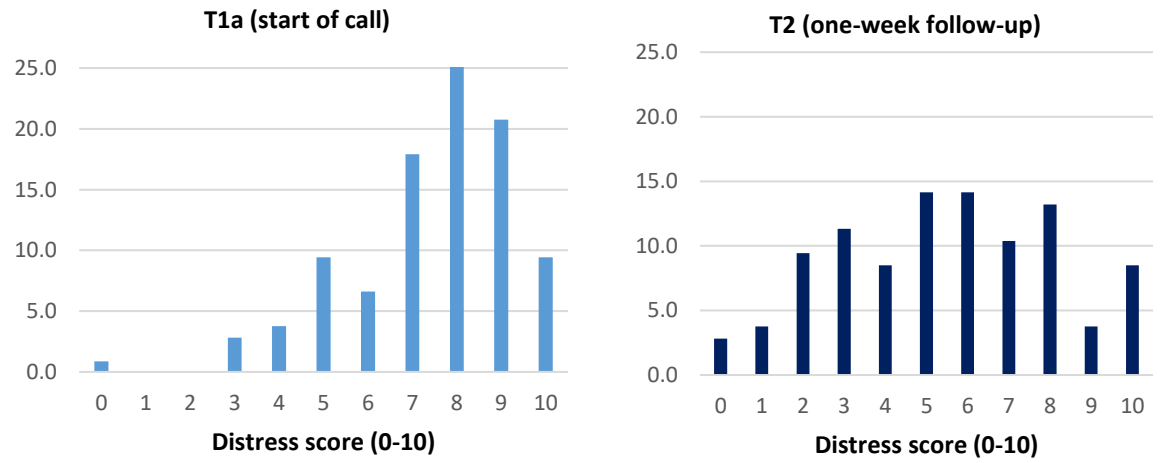


Figure 5.3 shows the frequency distribution of the distress scores in the **short-term** - start of the call and one week later. The chart shows that the curve has flattened, with a wider range of scores. **While not as great as the immediate impact, this illustrates that there is still a positive trend over the short-term.** The change is statistically significant. The base of 106 respondents is lower to that used in Figure 5.2 as this is based on callers who also completed the one-week follow-up survey.

'After the call and since it has made a great difference. I do feel however that I am slowly going downwards again, and I may need to make contact again'

Figure 5.3 Frequency distribution of T1a and T2 Distress scores

Base: 106



If the change is measured from the end of the call, as opposed to the start, there is an increase in distress from 4.16 to 5.54 out of ten, which is statistically significant.

How does this impact vary for different groups of callers, depending on patterns of use and/or demographic profile? (RQ4)

The impact on distress and suicidal thoughts/plans for sub-groups of callers is presented below. The characteristics and experience of using the Helpline for each sub-group is summarised in section 8.

Analysis of the study data has been undertaken by:

- Gender
- Age group (insufficient data for multiple groups, therefore a mid-point of our sample; age 50)
- Black and Minority Ethnic groups
- New callers
- Frequency of use
- Callers with suicidal thoughts/plans

In order to measure and understand **the outcomes for different groups**, two approaches have been taken. Firstly, statistical tests to establish statistical evidence of differences, and secondly where the data did not allow for the use of statistical tests a review of the survey results has been undertaken to highlight any noticeable differences in levels of distress and prevalence of suicidal thoughts/plans.

The data is presented for **T1a** the start of the call**, T1b** the end of the call and **T2** one-week follow-up.

The results (**Error! Reference source not found.**) show that in the immediate term, the change b etween the start and the end of the call for all the sub-groups are statistically significant. There are small differences between the reduction for women (3.3) compared with men (2.9), and the reductions are more noticeable for 'elite prolific callers' (3.7) and 'typical callers' (3.6) than for 'standard prolific callers' (2.8). The sub-group analysis for 'standard prolific callers' is not statistically significant but is reported for completeness.

Figure 5.4 Immediate reduction (T1a to T1b) in level of distress (0-10) by gender and caller type

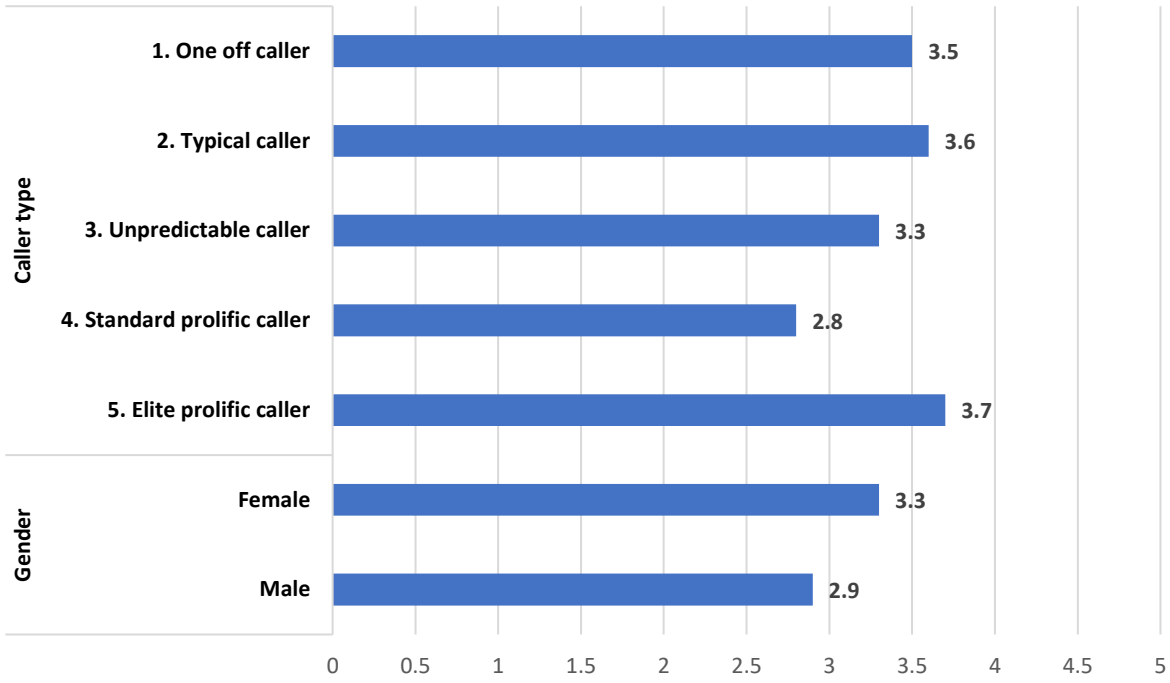


Figure 5.5 shows that in the short-term there are minimal differences comparing male and female callers, and for those callers aged over 50 and under 50 in terms of the changes in levels of distress. Results are only presented for two caller types within each sub-group, as there was insufficient data for other types.

Figure 5.5 Short-term (T1a to T2) reduction in distress by sub-group

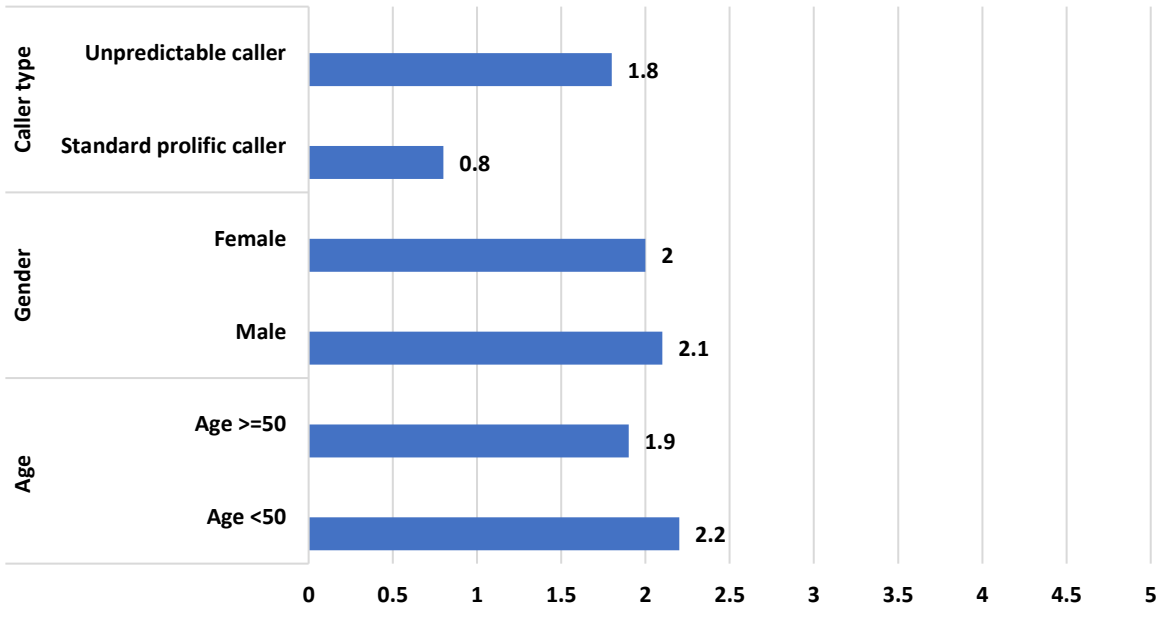
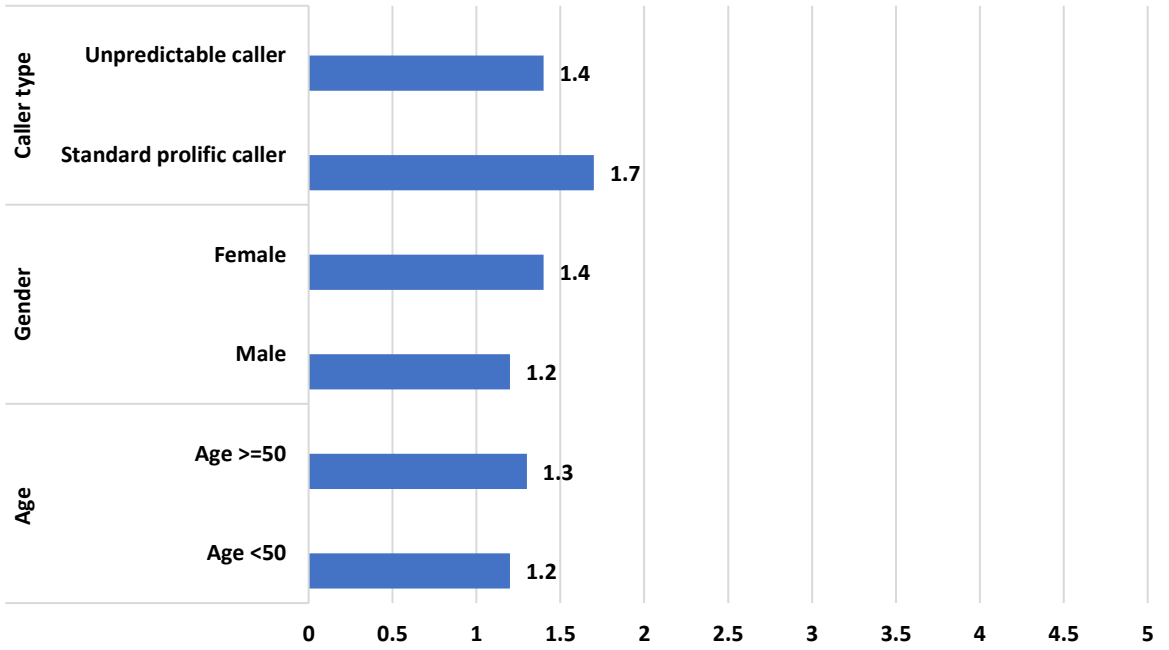


Figure 5.6 shows that the difference in distress between the end of the call and one-week later is positive, but as expected the change is to a lesser extent than at the start of the call and one-week

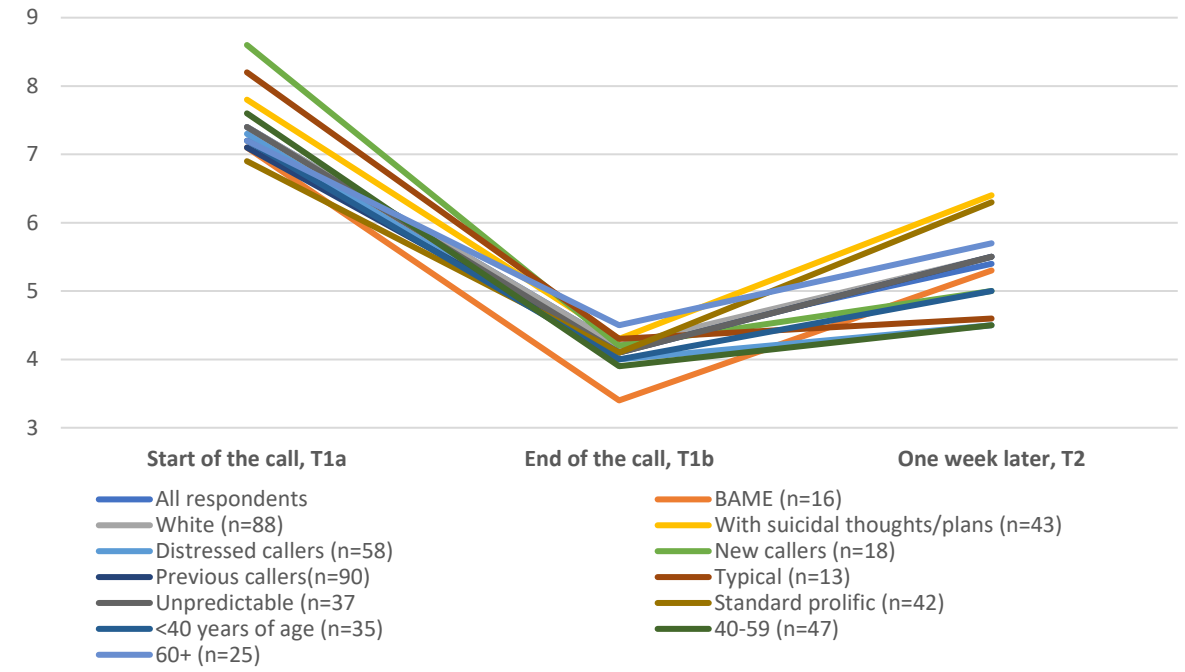
later. This finding holds, regardless of any one of the sub-groups examined. Examining each sub-group reveals little variation in terms of gender, age or type of caller. Results are only presented for two caller types as there was insufficient data for other groups.

Figure 5.6 Short-term (T1b to T2) increases in distress by sub-group



The statistical tests on levels of distress data for sub-groups have been undertaken using matched response data, with the caller answering both questions at the start of the call and one-week later. The small sample size for matched response, has prevented the use of statistical tests for most sub-groups. For a general overview Figure 5.7 shows the results for sub-groups using unmatched data (i.e callers replied to questions are the start of the call but not all responded to the one-week survey). Unmatched data has an element of selection bias and is only used to show a general pattern, rather than results for each group. There is a **consistent pattern across the various groups of callers**.

Figure 5.7 Immediate and short-term reduction in distress level by sub-groups



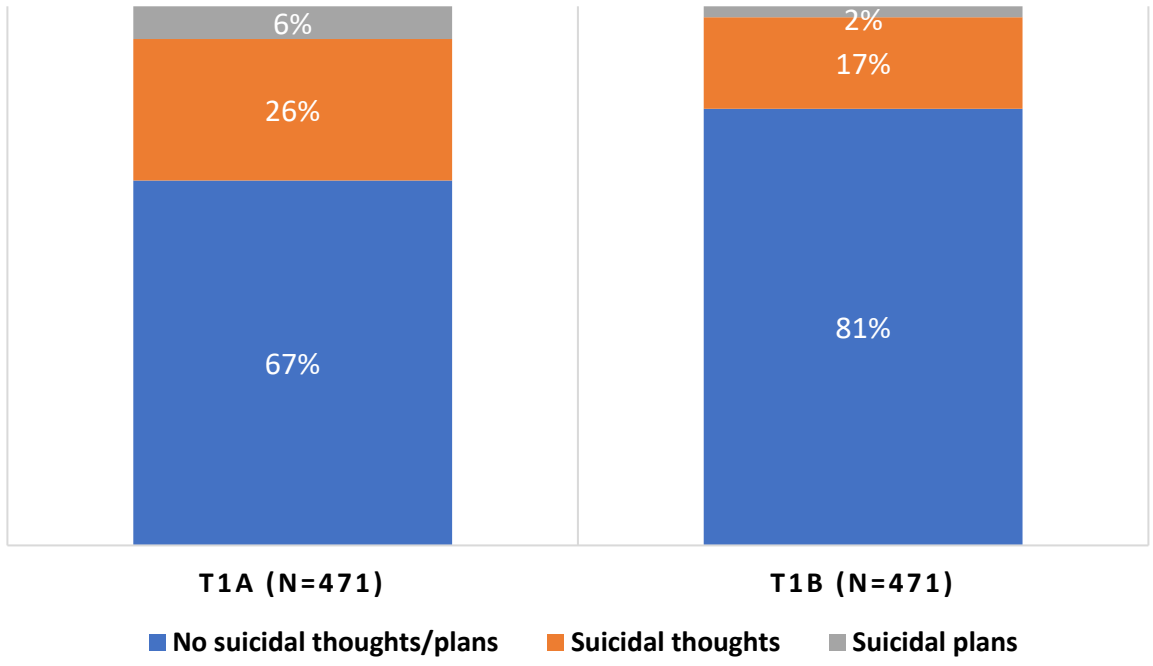
Multivariate analysis finds that the level of wellbeing at T2 (using SWEMWEBS) and the level of distress at the start of the call are significant predictors of the change in distress. **Individuals with higher SWEMWEBS scores (poorer mental wellbeing) tend to be those with smaller changes in distress between the start and the end of the call. Individuals with higher levels of distress at the start of the call, tend to have their distress reduced the most**. Numerous other variables were analysed, but none showed the same statistically significant relationship (cannot be explained by chance alone). The relationships between mental wellbeing at T2 and distress at the start of the call does not change when other demographic and call statistic variables were taken into account, so the result is stable. Overall, the model (i.e. two variables) explains around 30% of the variation in distress – making them strong predictors of those individuals who might see the greatest reductions in distress. However, it is probable that there are other factors that are not accounting for in the model, so the results should be treated with caution.

Suicidal thoughts and plans

For the measure of suicidal thoughts/plans, the 471 study participants provided a response to the study questions at both the start and the end of the call. There were 92 survey respondents who answered the question in the one-week follow-up survey.

The proportion of study participants stating they had **suicidal thoughts decreased** from 26% at the start of the call to 17% at the end. The proportion of study participants with **suicidal plans also decreased** from 6% at the start of the call to 2% at the end. **This demonstrates that there is an immediate impact in the reduction of callers' level of suicidal thoughts/plans.**

Figure 5.8 Immediate reduction (T1a to T1b) in callers' suicidal thoughts and plans



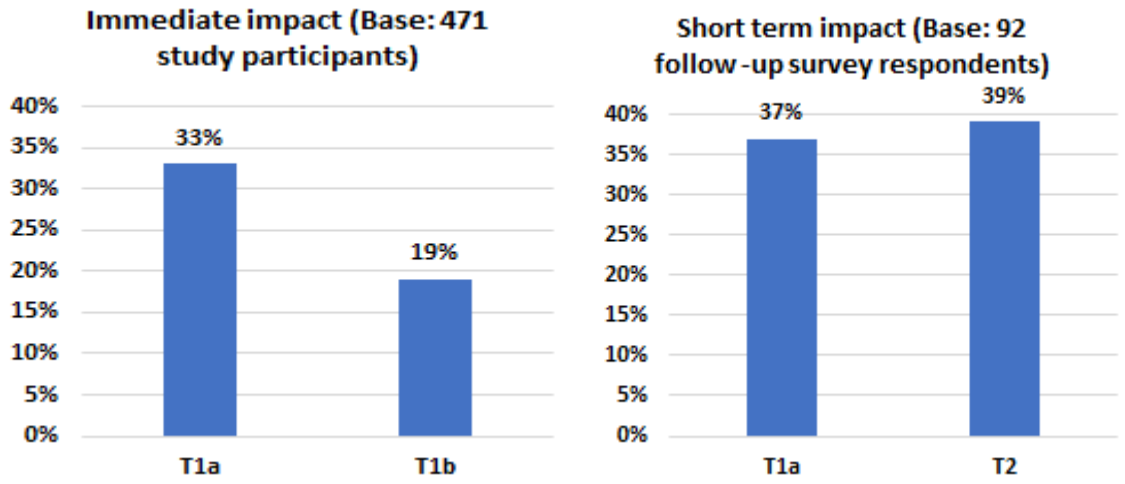
In terms of **immediate impact**, there is a **positive outcome with a reduction in the number of study participants with suicidal thoughts/plans, from the start to the end of the call**. At the start of the call, 33% had suicidal thought/plans, and at the end of the call this had decreased to 19% of callers.

Around 13% of all callers move from having suicidal thoughts or plans at the start of the call, to having no suicidal thoughts or plans by the end. This result is statistically significant at the 5% level ($p<0.01$) according to the McNemar test and with a 'large' effect size compared to standard benchmarks. Responses indicating suicidal thoughts and suicidal plans have been combined for the purposes of statistical testing.

A total of 92 of the 123 survey respondents answered the question on suicidal thoughts or plans a week after their call. The proportion with suicidal thoughts/plans (39%) had gone back to roughly where it was when they made the call (37%). The difference from T1a to T2 was not statistically significant ($p=0.839$) but the difference between T1b and T2 was statistically significant according to the McNemar test.

The different result for T1a (33% and 37%) reflect the use of different matched bases for analysis.

Figure 5.9 Immediate and short-term impact on callers' suicidal thoughts or plans



Further interpretation of this data comes from examining all three time points at once. Combining data from the start of the call, end of the call, and at one-week follow-up, we can examine the degree to which callers were experiencing suicidal thoughts and plans over time. For **the majority of callers there was no change over time** with almost two thirds either having a consistent absence of suicidal thoughts or plans (49%), or consistently experiencing suicidal thoughts or plans (17%). While a **sustained reduction in suicidal thoughts or plans was the least common outcome for callers (5%),** there were similar numbers experiencing an un-sustained improvement (8%), or those experiencing suicidal thoughts or plans at the start and end of the call but no thoughts or plans at one-week follow-up (7%). Furthermore around 14% had no suicidal thoughts or plans during the call but experienced them at follow-up.

The **sub-group analysis for suicidal thoughts/plans** is restricted given data constraints of either a low sample size or lack of survey response data. Sample sizes are presented in Appendix 5 – Outcomes analysis. We were able to present three sub-group analyses for the immediate impact on suicidal thoughts/plans: male/female, aged <50/over 50 and for two types of caller as defined in Figure 4.6, unpredictable callers and standard prolific callers. All subgroups show significant differences, with a fall in suicidal thoughts/plans in the immediate term. Differences between males and females are minimal, with both groups having a third with suicidal thoughts/plans at the start, which diminishes by the same amount by the end of the call. The proportion with suicidal thoughts/plans is higher among 'unpredictable callers' and diminishes by a greater amount between the start and end of a call, compared with 'standard callers'.

None of the sub-group analyses show significant differences (see Appendix 6 – Learning points) between T1a and T2, and T1b and T2, respectively. The only exception is the difference between T1b

and T2 for those aged under 50, where the difference is significant at the 10% level (p=0.057, n=46).

The proportion with suicidal thoughts or plans increases from 33% at T1b to 50% at T2 (n=46).

Key findings

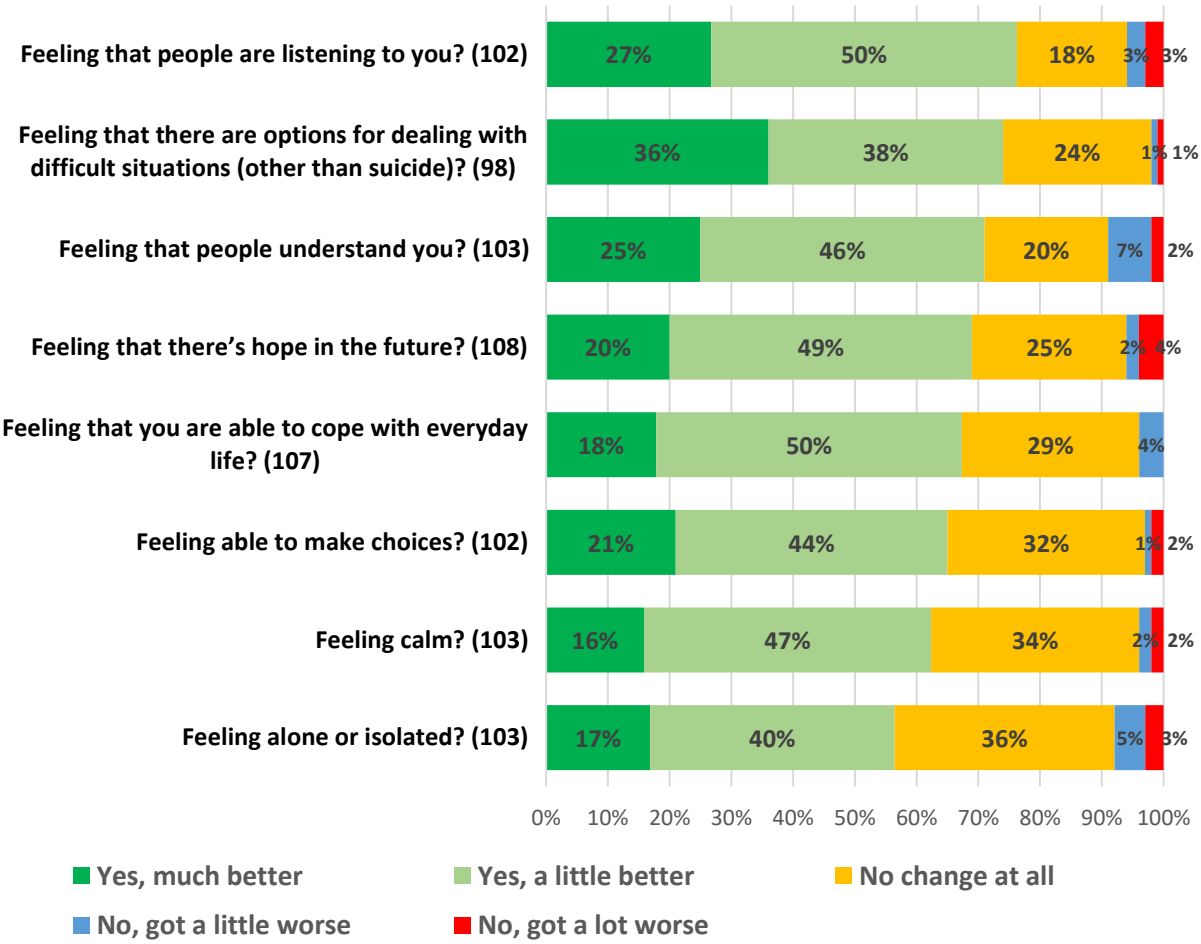
- **Results are positive in the immediate and short-term reduction in levels of distress for all groups. All groups show a decline in levels of distress in the immediate term, from the start to the end of the call, and all show a slight rise in distress levels one week later. In no case has the level gone back to where it was at the start of the call.**
- **The reduction in levels of distress from T1a (start of the call) to T2 (one week later) are statistically significant for men and women and by age groups. The average reduction in level of distress are also similar within these groups.**
- **There are some groups (e.g. new callers) that show a more significant reduction in levels of distress, compared to the average.**
- **Comparing results on distress and suicidal thoughts/plans shows a different impact. Both have a positive impact in the immediate term, but only distress is reduced over the short-term.**
- **In terms of immediate impact, there is a positive trend with a reduction in callers' experiencing suicidal thoughts/plans, from the start to the end of the call. However, in the short-term, there is no significant difference, as the proportion of survey respondents with suicidal thoughts/plans one week later has risen back to the level reported at the start of the call.**

What are the secondary outcomes callers experience, if any, after being supported by a volunteer on Samaritans helpline? (RQ2).

The study has highlighted the positive impact of the call 'in the moment'. In addition, there are eight secondary outcomes, in terms of changes experienced by the caller since the call. Survey respondents were asked to reflect on the changes they might have felt and the extent to which their call to the Helpline had contributed to these changes.

The survey shows that there are differences in the way callers' feel in relation to the eight secondary outcomes. Since the call, 77% of callers felt 'much' or a 'little' better as they felt people were **listening to them**, with 18% feeling no change and 6% feeling worse. Three out of four (74%) reported an improvement when it came to **having options** for dealing with difficult situations (other than suicide), with 24% feeling no change and 2% feeling worse. In contrast, there is a less positive response on 'feeling calm' (63%) and on feeling alone or isolated (57%).

Figure 5.10 Secondary outcomes - one week after the call



Impact of the Helpline on secondary outcomes

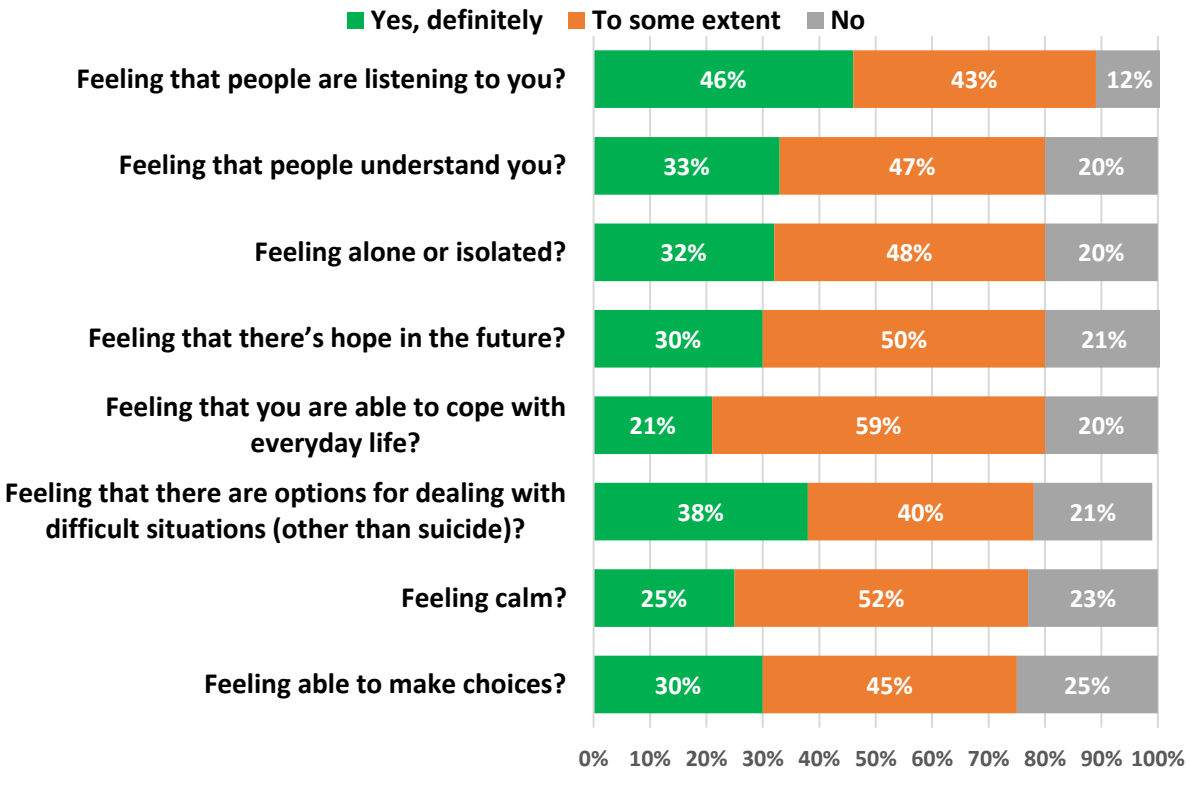
Interviews with callers highlighted that 'no change' is considered to be more of a positive, rather than a negative or neutral response, as 'things have not got worse'. For this reason, the positive and 'no change' scores are combined into a summary score for the following outcomes.

For those with a positive/no change since calling the Helpline, an average of **80% felt that the call had made a positive impact** on these feelings. While these are **very positive results** for Samaritans, the study has highlighted that for two in ten there is still **scope to make a difference** and that the extent of the **impact varies**.

The greatest impact was on 'feeling that people are listening to you', with 46% feeling the call had definitely helped and 43% reporting it had helped to some extent and only 12% reporting that it had made no difference. For all other secondary outcomes there is little difference in the proportion reporting '**no impact', ranging from 20% to 25% of respondents**.

While still considerable, the aspect that had the highest proportion reporting 'no impact' was on feeling able to make choices, where 30% reported a definite impact and 45% an impact that had helped to some extent and 25% no impact.

Figure 5.11 Impact of the Helpline on changes (those reporting positive change/no change)



Other changes since the call

Comments provided by survey respondents and interviewees were of a similar nature. In most cases the comments provided some context to the caller's response to one or more of the eight secondary outcomes. While the feedback did not provide evidence of new secondary outcomes for callers, it has provided the details that help to explain how the interaction impacts on the emotional wellbeing of callers.

Being able to cope was one of the main themes raised by survey respondents and the interviewees. The comments highlight that the call helped callers feel they were getting back in control of the feelings they were struggling with, to have a more positive outlook and enabling them to take decisions and make positive steps. e.g. make a GP appointment, to speak to their employer.

'I think I just felt calmer. I think it just helped with me feeling a bit calmer about everything and just trusting that everything would sort of work out okay'

'What they're doing is often taking me out of a deep pit and at least putting me on the first step and that is invaluable'

'I remember being completely exhausted at the end of it and feeling a hell of a lot better than when I picked up the phone and not feeling like I was going to do anything stupid'

'I definitely felt lighter. More resolved of, 'I can leave the job and that's okay'. And I was sleeping better. And then I handed my notice in, so determined I think, as well'

'I'm looking for that lifeline, the end of the balloon, the string at the end of the balloon, something to keep me getting through the next hour. So I don't think big. So I allow the person, they may be talking to me, I'm listening to their voice, I'm remembering that I'm still alive, so I'm really trying to get back in my body, is what I'm trying to say, and the person helps me do that'

'Before I call because I'm so kind of anxious and can't control my thoughts I feel very foggy and I can't make rational decisions. They're very irrational, they're very emotional. But once I've had a phone call, I've got everything off my chest, you know, my system goes back to normal and I can think more clearly and behave more rationally. And then I can call home, I can have a conversation with my mum, you know like a normal one, and things are okay then'

Callers noted that after a call, they can feel more able to cope and have a wider perspective on things, but then previous feelings can re-emerge over time. The study findings need to be seen in **a wider context**, as for most callers there will be a range of other complex factors at play in their lives and that while the Helpline can make a positive impact on callers, it is not an instant solution.

For some callers, it is evident from the interviews that the Helpline is used as part of a coping strategy to manage their mental health and wellbeing, alongside other support e.g. GP, mental health team, PTSD therapist, psychologists, and psychiatrists.

Key findings

- **Most respondents reported an improvement in secondary outcomes, a week after the call. This ranged from 57% of respondents reporting an improvement in that they felt less alone/isolated, to 77% of callers reporting an improvement in feeling that people were listening to them.**
- **For those reporting a positive change in their feelings or staying the same, the call to the Helpline had made a positive impact in 80% of cases. While this is a positive result, there is room for improvement – as around two in ten respondents felt the Helpline had no impact.**
- **The central theme from callers' feedback was on the improvements in their ability to cope. There are two types of impact, first changing how the caller is feeling e.g. calmer, in control, a more positive outlook, and secondly; enabling the caller to move forward, more able to make decisions and take positive steps.**

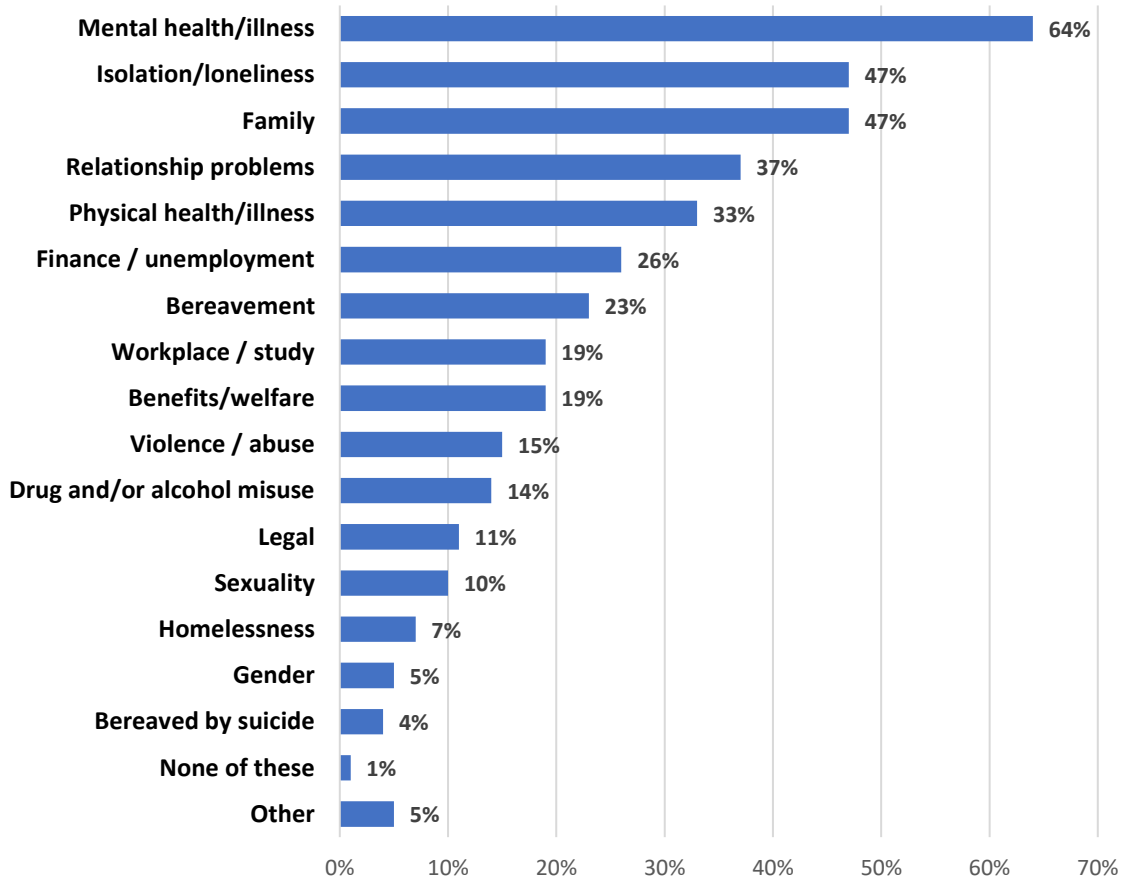
What contribution does Samaritans' telephone helpline make to callers' self-management of emotional distress and suicidal feelings and behaviours? (RQ3)

Influences on a caller's level of distress

There are a wide range of influences on callers' level of distress one-week after the call. The leading responses from survey respondents were; **mental health/illness (64%)** followed by**, isolation/loneliness** (47%), **family** (47%), **relationships problems** (37%), and **physical health** (33%). These influences were similar to the concerns expressed on the call that were recorded by volunteers on elog (see table 3.2).

Figure 5.12 Influences on a caller's level of distress

Base: 123 % of survey respondents



How much did the Helpline help callers?

Data from the one-week follow-up survey showed:

- Almost all (96%) survey respondents indicated that the Helpline had helped them manage their current level of distress and any suicidal thoughts/plans (95%).
- **For distress**, 44% felt it helped a lot, 35% that it was of some help and 16% that it helped a little. The rest (5%) reported it was no help.
- **For managing suicidal thoughts/plans**, 44% felt it helped a lot, 28% that it was of some help and 20% that it helped a little. The rest (8%) reported it was no help.

How did it help?

Comments from the survey respondents and the 25 caller interviews provide insight into how the call helped them to manage their level of distress and suicidal thoughts/plans. The themes emerging from the interviews are similar to the reasons why callers chose to use the Helpline and the secondary outcomes discussed in the previous section. Themes from the survey comments and interviews that illustrate these findings include:

It helped by giving them the feeling they were:

- better able to cope, calmer, able to think clearly, more confident, able to see other choices, less alone

The Helpline did this by providing a service that from the caller's perspective is:

- **not a time-bound service** (like a GP appointment), which allows the caller time to explain how they are feeling and to reflect on these thoughts
- **available and accessible 24/7**, 365 days of the year, which enables the caller to get through quickly, at any time, to a real person
- **always there to help**, to take them seriously, understands them and really cares about them, makes them feel supported and is non-judgemental
- **it is there to listen** and provide human contact

Some powerful illustrative quotes from interviewees about the impact the Helpline made to callers' self-management of emotional distress and suicidal thoughts/plans, include:

'Just that they're amazing. That's it. They're amazing. They've saved me so many times and I wish I would have used them in my life before'

'What I get from it is, if I made a good connection with the person I talked to, it makes me feel able to keep on being human in the situation. You could just not have those conversations, but often they're good for the other people too. I suppose it enables you to continue'

'I really can't think of anything, as I say first time service user and I had no expectations, but it helped me so much and I'm so grateful'

'It's not so much whether they can resolve the issue. It's the fact that someone gives a damn. That they're bothered to stay up all night to listen to your problems. That they give a damn that you know that someone is kind enough to do that'

'When I talk to Samaritans it seems to be a lot stronger and more satisfying. When I do speak to Samaritans. It has helped a lot. Yes. It does really improve my quality of life, really'

'To put it bluntly like the call saved you know my life in some aspects and so you know I'm always going to advocate it as a service to anyone whenever I get the chance'

'Without the Samaritans my life would not have progressed and might have got worse, so it's been a massive support to be honest and I'm very grateful'

Key findings

- **There are a wide range of influences on callers' level of distress. The leading response is mental health/illness.**
- **Almost all survey respondents indicated that the Helpline had helped them manage their current level of distress and to manage suicidal thoughts/plans, though the extent to which it helps varies.**

6. Experience of Samaritans support and interactions

What are callers' experiences of their interaction with volunteers on the helpline? (RQ5)

In this section, five aspects of the caller experience are explored.

- How callers learnt about the Helpline
- Why callers chose the Helpline
- Meeting callers' expectations
- Caller experiences of using the Helpline
- Improvements to the service

Understanding how callers found out about the Helpline and why it appealed to them as a source of support, helps to place the experiences of the call in a broader context and to understand the extent to which it meets expectations. In addition, a better understanding of what leads callers to use the Helpline can help to inform Samaritans' key messages, communications and information, as well as service improvements.

Learning about Samaritans Helpline

There is **no one single means by which callers are made aware of the Helpline**. Awareness is built up through multiple communication channels. Two in three survey respondents (67%) could recall how they found out about the Helpline. For those that could remember (n=87), the leading sources were healthcare staff such as a doctor, nurse (28%), an internet search (22%), friends/family (18%), TV (11%), posters (8%) and radio (2%). 'Other' (23%) ways of learning about the Helpline were yellow pages/phone book, recommendation from a support group, from a work colleague, a presentation at school/college, and a Samaritans branch.

Choosing the Helpline

The leading reasons for choosing the Helpline all involve human contact - it provides the opportunity to talk to someone about their thoughts/feelings (77%), having someone listen to them (63%), to be taken seriously (42%).

'Hearing someone's voice is very important to help me in my distress. So, kind voice, slow, giving me time, I know I can get that with Samaritans usually'

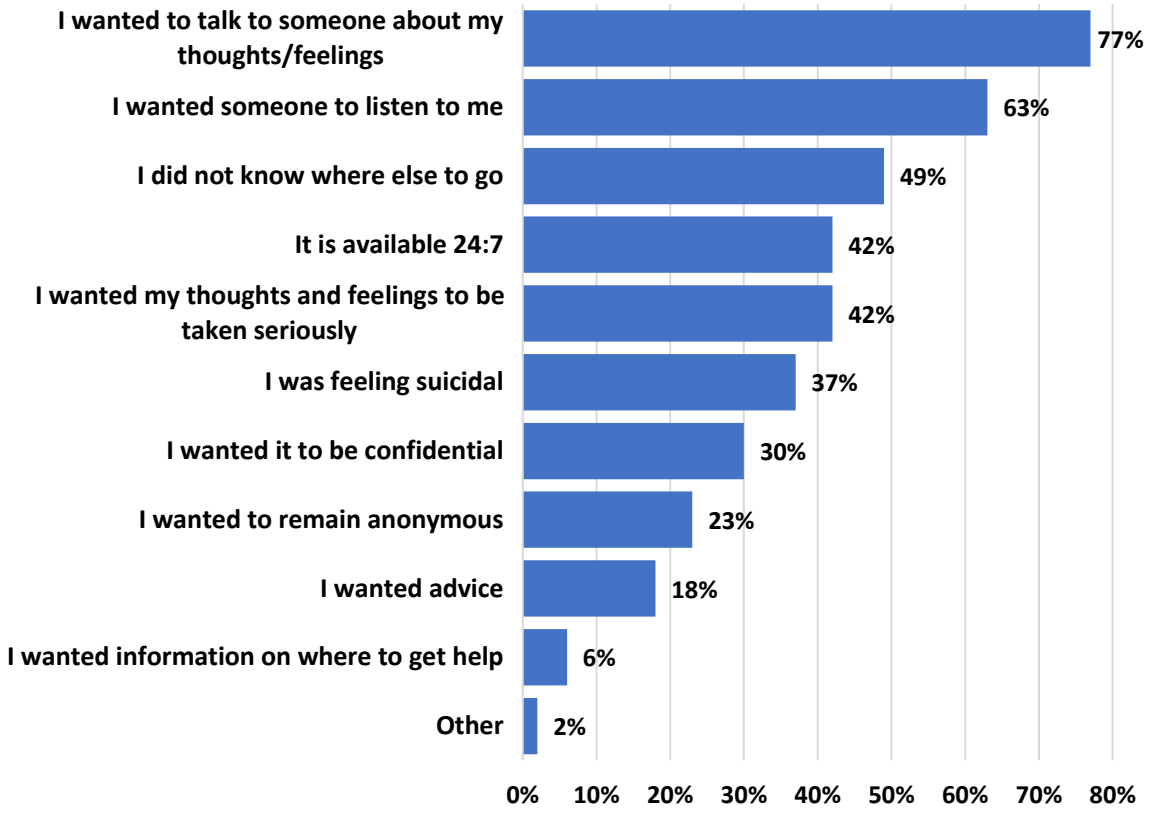
Half of all callers (49%) did not know **where else they could go**. **Confidentiality** (30%) and **anonymity** (23%) were also important features of the Helpline for some callers.

Being available 24/7 was an important factor, with 42% of callers indicating that was a reason for choosing to use it.

Around one in five (18%) callers were looking for **advice**. Comments from the caller interviews show that 'advice' covers a wide range of services e.g. 'how do I stop feeling like this', counselling, coping mechanisms, specialist advice, signposting to other services, information on how to access other support services.

Figure 6.1 T2 Survey respondents. Reasons for choosing Samaritans Helpline

Base: 123 % of survey respondents



Other reason for choosing the Helpline were raised in the caller interviews (T3) including:

- **Get the right connection -** if the caller did not feel completely at ease or 'connected' with one volunteer, they had the option of calling back and speaking to a different volunteer. Another example could be related to gender - for example, a male caller may have been put through to a female volunteer, decided that they would rather speak to a man, ended the call and called again in the hope of being put through to a male volunteer. Feedback from the caller interviews suggests this option was particularly valued and used by frequent callers. Comments from the T3 caller interviews include:

'Whoever I spoke to she was absolutely lovely, she gave the absolute top-level support that I could possibly want, and we were just in sync, we were just in harmony'

'So whoever you speak to on there, it can be extremely different'

'It is quite dependent on the person, as well, because it's the connection you make that helps that to happen''

'I think it depends on the resonance you get with the person that you are talking to'

'90% of the time the person you speak to is great, and sometimes not, but it's not necessarily them; it's just they're probably not right for you at that time'

'I know that Samaritans are highly trained not to share their own stuff, and I totally respect that and I understand why. But there's been moments where you've been talking to somebody about something, and there's just that little bit of a moment. You know what, I get it. I really get it. And you just go, great, I don't have to explain how this feels'

- **Location -** Can be contacted from a setting in which the caller is comfortable, including at home. This is a key point of difference to other services, where the service user's perception is that they may have to physically attend an appointment with a healthcare professional, e.g. at hospital or a health centre.
- **Anonymous setting -** The 'anonymous' nature of contacting Samaritans – not being face-to-face can make it easier to 'offload' and be open, without the caller feeling self-conscious.
- **Anonymous relationship -** Being able to talk to someone unknown to the caller, and who they will never meet in person:

'I could just sort of plonk it there and it could never come back to me, if that makes sense'

'When we share parts of ourselves that we're scared of, to share, it felt just safe, it was so far from me that it would never come back and it would never be shared with people that I knew'

'I need somebody who's objective who isn't going to just tell me what they think I should do based on the fact they've known me forever'

'I think having somebody who doesn't really know me and doesn't have those preconceptions can be an incredible positive thing'

- **Non-judgemental -** An opportunity to talk to someone who will not look down on or judge them, tell them what to do.

Meeting callers' expectations

A key message to take away from the survey is that **55% of survey respondents felt the call went better than they expected**, 37% as expected and 8% not as well as expected. Given that a high proportion of survey respondents have previous experience of the Helpline, this response highlights the positive impact of the service.

For those who felt the call had not gone as well as expected (n=9) the main reason is likely to be that their needs had not been fully understood by the volunteer, with eight of the nine respondents reporting this was their experience.

Experience of using the Helpline

The findings show that survey respondents had **a very positive interaction** with the volunteer.

- 95% felt they were definitely treated with **respect and dignity**
- 92% reporting that they had the volunteer's **undivided attention**
- 89% were confident that conversations would remain **confidential**
- 87% felt that the volunteer was **caring and compassionate** towards them
- 85% felt able to **talk openly to the volunteer** about their feelings.

The feedback from caller interviews highlights that the caller experience and the impact of the call can be influenced by the extent to which there is a positive connection with the volunteer. This relates to the style / manner of how the volunteer provides support, and whether this 'works' for the caller.

Most survey respondents (85%) felt they **definitely got the support they wanted**, with 12% feeling this was true to 'some extent' and 3% not at all. Comments from the caller interviews highlighted the reasons why callers felt they received the support they wanted, most of which are set out in Figure 6.1, including; having a person to talk to, being listened to, being taken seriously, and getting advice/information. Around 15% of respondents indicated that they did not get everything they wanted from the call. The reasons for this gap are reflected in the comments presented in the section below, highlighting possible improvements to the service.

Most survey respondents (84%) felt able to **make their own decisions on the call**, eg. what they talked about, wanted to do.

While most callers felt the **volunteers were well-trained and skilled (81%),** this was not the experience of one in five (19%). The reason for this response could be explained by the comments made by callers, who were hoping for more condition specific advice/counselling/solutions, even though this is not part of Samaritans active listening approach.

Other aspects of the call that were valued were **access to another person – human contact, which is available 24/7**. Callers have a sense of reassurance and comfort in the knowledge that Samaritans is always there for them.

Samaritans Listening Wheel

Overall, the comments from callers reflect the six themes of the Samaritans Listening Wheel – the basis for the volunteers' service.

As this study aims to understand outcomes for callers based on Samaritans' approach of Active Listening, below we summarise the key findings from the one-week follow-up survey and the caller interviews, relating to what works for callers and the improvements needed, in line with the Samaritans' Listening Wheel.

Reflecting: ***Repeating back a key word or phrase from what you've heard to encourage the other person to open up***	**What works for callers:** Most interviewees found the service to be more effective when the volunteer does not purely listen silently, but more actively reflects back, based on what the caller has said, to gently 'nudge' the caller to a more positive way of thinking. The interviewees thought that Samaritans are interested in the wider holistic picture – seeing the whole person, rather than treating symptoms or presenting instant solutions to complex issues. *'Sometimes what you're saying or what you're feeling just… if you're having a conversation with yourself, you can't be objective about it. But when someone reflects it back to you, it throws it into relief'* *'Give you a little nudge, perhaps a bit of advice here, a bit of advice there, but most of the time it comes from within you and it's already there'*

	'They were able to reflect my emotions back to me and helped talk me through what my options were' *'I didn't feel like they were trying to solve the problem for me or fix it, it was just… it was like a voice and a sympathetic ear with some gentle sort of nudges of potential things that I could do'* *'Some Samaritans just see themselves as a sponge, and I think that's not so helpful. Other Samaritans reflect back and that's good. And some Samaritans make sort of suggestions and I find them the most useful".* **What improvements are needed:** The interviewees felt that the more silent listening approach was not what they expected or needed, with most interviewees preferring a more active reflecting back approach. In some cases, callers had hung up on calls to the Helpline and called back to find a volunteer more suited to their needs. *'Some Samaritans see themselves as a sponge where you do all the talking. That's okay sometimes, but personally I like a bit of interaction and response because the whole thing is about talking out your thoughts and reflecting back'* *'Because I must admit, I have had one or two calls, the odd occasion, where they go "Hm", "Hm", "Hm". Then I try and finish the conversation and I say, just say "Thank you".* *'Sometimes I've felt I wanted the person to ask me some more questions about what's going on and to dig a little bit more, which would have been helpful to me. But because they're not trained to and because they don't think they're meant to I've been left a little bit unsatisfied and empty'.*
Clarifying: ***Ask questions to make sure you have understood what the person is talking about. It stops assumptions creeping in and by doing so, shows them you're here, you're listening, and you're trying to really understand what they're telling you***	**What works for callers:** A strength of the Helpline for callers is that when they ring Samaritans, it is not a time-bound service (like it is in a GP appointment), which allows the caller time to explain how they are feeling, for the volunteer to clarify, and for the caller to reflect on these thoughts. It can take callers a bit of time on the call before they can really focus on and discuss the issues that are troubling them. Asking simple and open clarification questions work well from the perspective of the interviewees. These can be small practical things which are very 'human' and give a focus for the caller e.g. the volunteer asking 'What are you going to do now – are you going to make a cup of tea?'. These are practical small steps which can re-focus the caller's thought process on to something practical, manageable and immediate.

	Asking clarification questions, using gentle prompts and positive language are also thought to work well, and provide callers with a sense of perspective and remind them of other current / previous times in their life. For instance, 'Thinking about more positive times…', 'What was your life like before…?', 'What did you used to enjoy doing?' **Where improvements are needed:** The main area for improvement is on volunteers' "understanding the needs of the caller". While 70% of callers reported this to be a positive experience, for 26% this was only to 'some extent' and for 4% 'not at all'. Feedback from the caller interviews and volunteer survey indicates that there are two factors which can lead to a less positive experience: • The volunteer being too passive / silent, and not using approaches like reflecting back and asking open questions • The caller not knowing or being able to articulate what their needs are.
Summarising: ***Outline what the person has told you, to let them know that they've really been heard***	**What works for callers:** Some illustrative quotations which highlight the importance of the summarising element of the Listening Wheel include: *'They pick up on certain things that you say, you know that they're listening to you. And they will come back to things perhaps that you said earlier that are relevant. And they also seem to pick up on things that don't just relate to the immediate situation and what you're feeling at that moment, but that might relate to other aspects of your life or personality, which gives them other avenues to talk to you'* *'So for me it would be, you know, people really engaging, wanting to listen and giving some feedback of what they understand, and again offering alternatives'*
Short words of encouragement: ***Small acknowledgements like 'yeah', 'mmm', 'go on' or 'I'm listening' can create a warm tone to the***	**What works for callers:** The interviewees noted the role of volunteers using short words of encouragement, using positive language and gentle prompts. Examples include: *'I am glad you have called'* *'If you don't want to talk about anything for a while, I will sit here and wait'*

conversation and shows you are actively listening	*'It's been a pleasure talking to you'* *'You can call back if you need to'*
Reacting: ***Respond to someone with non-directive, empathetic responses like 'it sounds like the night's a bad time for you'***	**What works for callers:** The Helpline volunteers are non-judgemental and do not voice their own opinions. An illustrative quotation from the interviewees highlighting the value of the reacting element of the Listening Wheel is when a volunteer comments, *'You have every right to feel that way'* **What improvements are needed:** A small number of interviewees reported having had negative experiences in the past, when they felt that the volunteer had been judgemental.
Open questions: ***Keep questions open so the person can respond in multiple ways, 'How long have you had these thoughts?'***	**What works for callers:** Most of the interviewees found calls were more effective when the volunteer would listen, but also reflect back, based on what the caller has said, interject and 'nudge' the caller to a more positive way of thinking in a very subtle way by asking them open questions, which get the caller to reflect on what they are saying and what they want to do next. By talking things through in this way, the caller can 'stand back' and process their thoughts, and with some open questions from the volunteer, decide to take some positive small steps and gain perspective on their problems. The Helpline allows the caller time to explain how they are feeling and to reflect on these thoughts. *'Just to say that, say you know, 'we're not supposed to give advice, I can't tell you what to do, but have you tried looking at it his way', or you know, 'why don't you think about this''* *'And that's when I say what the problem is and talk about it, and then they'll talk with me for about five or ten minutes about my thoughts, my feelings, why I've called them. And once I've got that out, they kind of say'* *'What interests do you have?' or 'What are you going to do with the rest of your day?'. You know, it takes you down another path'* The importance of volunteers ending the call on a positive note and asking open rather than closed questions at the end of the call is seen as good practice by interviewees e.g. rather than saying 'I'm going to have to go in a few minutes' saying something that leaves it to the caller and makes them

	feel in control of the closing, such as; 'If there's nothing else…' 'Do you want me to help you out with anything else at all?', 'We've been talking for a while. Shall we take a bit of a break?'.
Silence: ***Never underestimate the importance of silence; it gives people the space to speak***	**What works for callers:** The interviewees felt that the more silent listening approach was not what they expected or needed. Most interviewees preferred a more active, reflecting back approach. If the connection isn't present with the volunteer because the caller has an early feeling that the volunteer will not be what they need (e.g. there may be too much silence / they may be too passive), the caller can simply ring back and speak to another volunteer. This is a valued element of the service. **What improvements are needed:** As noted, most of the interviewees prefer a more active, reflecting back approach rather than extensive periods of silence in which the volunteer is not saying anything. *'That for me is the key part, being able to listen and offer something. Not just a pair of ears'* *'So if you're talking and you almost have no feedback, I find that extremely difficult, because I'm not one to consistently talk'*

What could be done to improve callers' experience of the Helpline

Whilst the research has highlighted different experiences of Samaritans Helpline amongst callers and some potential improvements, overall, callers remain generally very happy with the service received because of the support the Helpline provides. Callers accept that some volunteers have different styles, and that sometimes, the connection with the volunteer doesn't work. The qualitative findings highlight that callers acknowledge that volunteers are giving their time for free, and in some ways, this can mean that callers are more accepting of any negative experiences with the Helpline.

While most comments were of a supportive nature there were suggestions on how the service could be developed.

- **Raising awareness of alternatives to calling**. The majority of participants only contacted Samaritans by phone and had little awareness of the other channels by which Samaritans can be reached.
- **A call back option.** On the rare occasions the line is busy, offer a 'call back' service whereby callers can leave a message and be called back.

- **A volunteer that I connect with.** To save making numerous calls, offer the option of being put through to a different volunteer.
- **Repeating information.** A few callers commented on finding it difficult repeating their story when they ring back and speak to a different volunteer.
- **Active listening**. Comments highlight that the active listening approach is a highly valued, and while there were few specific suggestions, the general impression is that developments would be welcomed by callers.

'Just not listening but actually hear it in a way that they actually understand the situation'

'I think it's like a harmonious balance and kind of sensing when it's appropriate to listen and when it might be appropriate to offer advice'

'I just need to talk to somebody and just be listened to or maybe, you know, just be guided down like a positive route towards positive things in my life'

'Instead of just listening to my own thoughts that can confuse me, being able to use and speak to another human being who's a great listener, but also has something to offer too, it's not just a listening service, it's somebody with that dedicated experience that you get with the Samaritans'

'My mind is narrowed [when I call] so your focus is on one thing, whereas to have somebody explore stuff with you, then it opens you out a bit more to see more'

- **Advice**. There were comments about a different type of support, where the caller was looking for the Helpline to provide them with immediate advice or counselling on how to resolve/cope with their situation/condition.
- **Specialist support.** While some participants think there is scope for volunteers to receive more training on common issues others felt this was unrealistic as being 'too specialist' for the volunteers eg. domestic abuse, rape, PTSD, forced marriage, issues facing LGBTQ communities. Some of the interviewees suggested that instead of offering specialist support, Samaritans should do more work with organisations like Women's Aid and Refuge.

Key findings

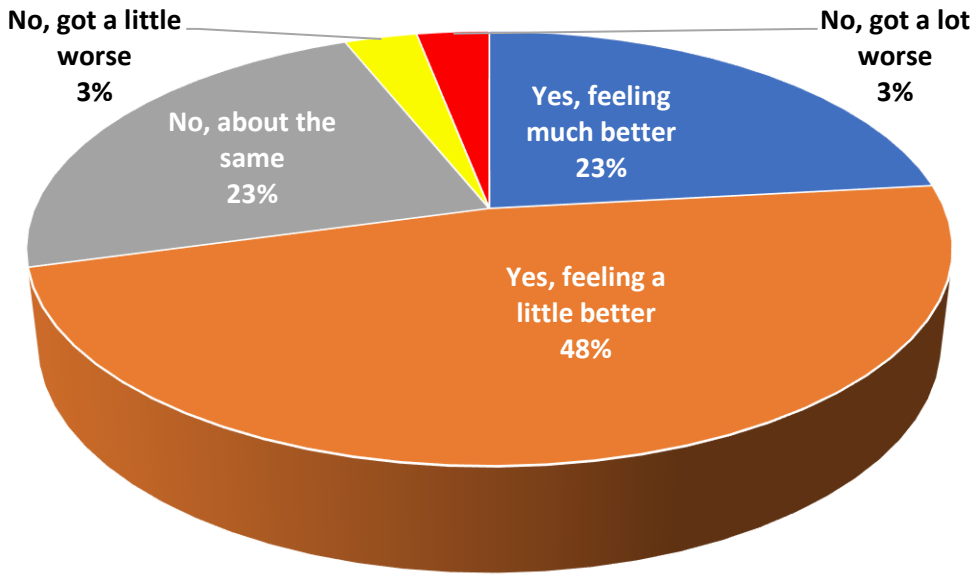
- **Over half of the survey respondents felt the call had gone better than they were expecting. This is a particularly positive finding, as were repeat callers and familiar with the Helpline.**
- **The majority of survey respondents reported a very positive interaction with the Samaritan volunteer.**
- **There may be some room for improvement, the main one being 'understanding the needs of the caller'.**
- **Callers are generally happy with the service they receive from the Helpline because of the support it provides them with, despite some negative experiences. Callers place the emphasis on developing the existing type of service.**

How did the interaction with the volunteer on the helpline impact on their emotional well-being? (RQ6)

Seven out of ten survey respondents indicated they were **feeling better** one week after the call (71%), with 23% staying about the same and 6% feeling worse.

Figure 6.2 Changes in how the caller is feeling since using the Helpline

Base: 116 % of survey respondents



Callers experiencing a change were asked to indicate to what extent this was a result of calling the Helpline. **All those feeling better, felt that their call to the Helpline had contributed to this improvement**, with 36% indicating it had made a big difference, 52% that it made some difference and 12% that it had made a little difference. This is an important finding in terms of attribution, as many other factors could have contributed to positive impacts in the period since the call to Samaritans.

Key findings

- **Seven out of ten survey respondents indicated they were feeling better one week after the call (71%), with 23% staying about the same and 6% feeling worse.**
- **All those feeling better, felt that their call to the Helpline had contributed to this improvement, with 36% indicating it had made a big difference, 52% that it made some difference and 12% that it had made a little difference.**
- **While these improvements and impact of the Helpline are clear, they should also be seen in relation to the results of the measure of suicidality and mental wellbeing one week later. Both measures show that callers remain at an above average risk of suicide and have low scores for mental wellbeing.**

7. Sub-groups characteristics and experience of using the Helpline

Survey response data has been analysed to identify differences in the characteristics and experience of sub-groups. Given the number of respondents for most sub-groups, the survey results should only be viewed as a general guide. The main finding is that the experience of using the Helpline is **broadly similar across different groups**. However, there are certain differences to consider when developing the service, promoting the Helpline, information and communications.

Gender

In general, the use and experience of the Helpline for male (n=40) and female (n=64) survey respondents is similar. Compared to women, men were:

- likely to have more callers in the middle age band, 40-59 (53%/39%), with lower proportion in the under 40 (27%/35%) and over 60 (20%/26%)
- more likely to have a long-term condition (85%/74%)
- more likely to have found out about Samaritans via a web search (25%/10%) or from TV (17%/3%)
- more likely to report that the GP helped a lot/some extent (65%/44%)
- make fewer calls over a 12 month period, with 43% of men calling >11 times over the last 12 months, compared to 81% of women
- less likely to report having have thought about ending their life (5> times) over the last 12 months (29%/46%)
- less likely to report that the call helped a lot/some extent to manage their suicidal thoughts/plans (62%/79%)

Age groups

To measure impacts using statistical tests the available data limited the analysis to two groups, those aged under and over 50. However, for a more general review it is possible to look at three age groups; those aged under 40 (n=35), those aged 40 to 59 (n=47) and those aged 60+ (n=25). Compared to older callers, those in the <40 age group were:

- more likely to be new callers (<40, 29%/40-59, 13%/ >60, 4%)
- more likely to have callers from BAME groups; 19% of callers aged <40 are from BAME groups, 18% of those aged 40-59 and only 4% of callers aged over 60.
- more likely to be in employment (<40, 66%/ 40-59, 51% />60, 44%.
- likely to talk for longer, with 71% of <40 call for 30+ minutes, compared to 48% of those aged 40-59 and 44% of over 60.
- more likely to call as it was their only option / not knowing where else to go (<40, 60%/40-59, 51%/ >60, 20%).
- younger callers were more likely to be seeking advice than those aged 40 and above (<40, 29%/ 40-59, 11%/ >60, 8%).
- more likely to have called because they felt suicidal (<40, 49%/ 40-59, 40%/ >60, 16%).

- a third of callers in the <40 and over 60 age groups are men. For the group aged 40-59, there is a more even split of men to women (47%/53%).
- less likely to report the call was better than expected compared to the middle age group, but similar to those in the older age group (<40 50%/ 40-59 or 69% />60 46%). The difference is likely to be the higher proportion of male respondents in the middle age group, who typically report a more positive experience.
- were more likely to report that the Helpline had made a big difference to changes in how they were feeling a week later (55%) compared to those aged 40-59 (32%) and over 60 (30%) age groups.

For each age group, there are **multiple influences on callers' levels of distress a week after the call**. There are similarities and distinct differences by age group, in the current influences on distress. A detailed breakdown is provided on Table 7.1.

- The top seven influences on distress are similar for those aged under 40 and from 40-59: Mental health/illness, family, isolation/loneliness, relationship problems, physical health/illness, bereavement.
- For those over 60, while the top seven influences match those of the in the two younger age group, the order is different. For example, bereavement is a leading influence on distress for older callers, it is the seventh on the list for younger callers and vice versa for relationship problems.
- Mental health is the leading influence on distress for all three age groups, but is far higher for those aged under 40.
- Family and isolation/loneliness are influences for around 50-60% of respondents in each age group.
- For those under 40, around half were influenced by relationship problems or physical health/illness, with four in ten influenced by finances/unemployment and workplace/study. One in five noted that sexuality was an influence of their level of distress.
- For those aged 40-59, around 35-40% were influenced by relationship problems, physical health/illness or finances/unemployment. Benefits/welfare and legal issues were of greater significance for this group of callers.
- For older callers, aged 60+, bereavement was a greater impact than was the case for other age groups. Six out of ten callers in this age group noted mental health, isolation/loneliness and bereavement as an influence on their levels of distress.

Table 7.1 Influences on current level of distress

	Age group		
	Under 40	40-59	60+
Base	31	44	18
Mental health/illness	90%	75%	61%
Family	61%	55%	50%
Isolation/loneliness	58%	55%	61%
Relationship problems	52%	39%	28%
Physical health/illness	52%	36%	44%
Finance / unemployment	39%	39%	11%
Bereavement	19%	20%	61%
Benefits/welfare	10%	36%	22%
Workplace / study	42%	16%	6%
Violence / abuse	19%	20%	17%
Drug and/or alcohol misuse	19%	16%	11%
Legal	10%	20%	11%
Sexuality	23%	11%	-
Homelessness	10%	11%	-
Gender	6%	9%	-
Other	3%	5%	17%
Bereaved by suicide	6%	7%	-
None of these	-	2%	-

Black and Minority Ethnic Groups

For most questions, the experience reported by BAME survey respondents (n=16) was similar to that of all other callers. BAME callers were:

- more likely to be younger, with only 6% (1 of 16) over the age of 60 compared to 27% of other callers
- more likely to be in employment (60%/29%)
- more likely to have a better experience than they were expecting (70%/56%)
- less likely to have sought help from other organisations (73%/91%). This highlights the importance of the Helpline to BAME callers and raises questions around information, accessibility and barriers for other support services.
- raising some concerns more often than other callers: mental health (87%/67%), physical health (47%/22%) and violence/abuse (27%/15%).

Suicidal thoughts and plans

Overall, the characteristics and experience of using the Helpline of the 43 survey respondents that had suicidal thoughts/plans compared to all other callers are very similar. Callers with suicidal thoughts/plans were:

- more likely to have a history of suicide attempts (35%/1%)
- likely to have positive scores on secondary outcomes one-week after the call, but not to the same extent as other callers: a little or much better on: coping (55%/74%), hopeful (56%/77%), calmer (49%/70%), to have options (67%/78%), less isolated (46%/62%), able to make choices (55%/70%)
- less likely to report that the Helpline call had had a positive impact on these improvements in secondary outcomes: coping (69%/86%), hopeful (68%/85%), calmer (66%/83%), to have options (66%/86%), less isolated (70%/85%), able to make choices (70%/78%)
- less likely to report a positive score on mental wellbeing (using SWEMWBS questions) one-week after the call – they were 'often' or 'all of the time': feeling optimistic (13%/36), useful (11%/33%), relaxed (3%/18%), think clearly (19%/36%) able to deal with problems (16%/27%), close to other people (13%/25%), make up their mind (34%/48%).
- more likely to include those aged 40 to 59 (54%/39%) and less likely to include those aged over 60 (11%/30%)
- less likely to be working (43%/61%) compared to other callers
- more likely to have a long-term mental health/physical condition (89%/71%).

New callers

Eighteen survey respondents reported that the call (they were recruited on) was their first to the Helpline. The key point to note is that for the most part, the characteristics and experience of these new callers is similar to those making repeat callers. New callers were:

- younger, with 59% under the age of 40 compared to 29% in this age group for repeat callers
- less likely to have a long-term condition (54%/80%)
- less likely to have sought help from other organisations (71%) than other callers (93%).
- more likely to call as they 'don't know where else to go', (67%) compared to repeat callers (47%)
- more likely to be looking for advice (33%/15%). Advice is a wide-ranging term, from a gentle nudge from the volunteer to those that were looking for more of a counselling service.
- less likely to feel the volunteer definitely 'understood their needs' (58%/72%), but just as likely to feel that the call went better than they expected (59%/54%)
- less likely to report positive secondary outcomes a week later; e.g. a little/much better on: being able to cope (60%/67%), more hopeful (56%/71%), feeling calmer (53%/63%), less isolated (40%/60%), understood by others (60%/72%)
- less certain about calling the Helpline again (62%/84%)

Frequency of calls to the helpline

As presented in Figure 4.2, survey respondents have been categorised according to their frequency of calls to the Helpline over the past three years, with call data available for 113 of the 123 survey respondents.

1. One-off callers: 1 call (n=15)
2. Typical callers: 2 to 6 calls (n=13)
3. Unpredictable callers: 7 to 99 calls (n=37)
4. Standard Prolific callers: 100 to 999 calls (n=42)
5. Elite Prolific callers: over 1,000 calls (n=6)

Analysis has been undertaken for four groups; One off, Typical, Unpredictable and Standard prolific callers. Elite prolific callers (n=6) have not been included in the analysis due to the small number of respondents in this group. Differences are reported below, but overall the characteristics and **experience of the groups are similar**, including:

- Length of call was similar across the groups: 44 minutes for One off and Standard prolific callers, 41 minutes for Unpredictable callers and 51 minutes for Typical callers.
- The average age for each of Standard prolific, Typical and Unpredictable is 50.
- The split by gender shows a similarity between Unpredictable and (70% female) and Standard Prolific callers (68% female), with Typical callers more evenly divided (45% female, 55% male).

One off callers - one call in last 3 years (n=15)

All 15 'one off' callers are included within the New caller sample (n=18) discussed above, as the telephony data shows that none had called during the last 3 years, or anytime before that. One off callers were:

- likely to be younger, with an average age of 35 (compare to the average of 48) with all 15 respondents under the age of 60.
- to have a higher proportion of males (53%) than females (47%)
- less likely to have long-term conditions (58%/80%)
- more likely to be calling with suicidal thoughts/plans (53%) than others (32%)
- more likely to have called as they did not know where else to go (67%/46%) and wanted advice (27%/17%)
- more likely to have reported that the call went better than expected (71%/53%)
- finance/unemployment was a greater influence on their levels of distress a week after the call (50%/28%)
- less likely to report such positive secondary outcomes e.g. a little/much better on: being able to cope (66%/84%), more hopeful (67%/81%), feeling calmer (60%/80%), having options (71%/80%), less isolated (61%/82%), felt listened to (79%/90%), understood by others (53%/85%), able to make choices (66%/77%).

Typical callers - 2 to 6 calls (n=13) were:

- more likely to be male (55%/37%)
- more likely to be in work (59%/31%)
- less likely to report they have suicidal thoughts/plans a week after the call (17%/42%)
- more likely to report they were generally feeling better since the call (84%/69%)
- likely to report more positive secondary outcomes a week after the call, e.g. a little/much better on: being able to cope (73%/67%), more hopeful (84%/68%), feeling calmer (73%/61%), less isolated (67%/55%), felt listened to (91%/75%), understood by others (91%/68%), able to make choices (83%/62%).
- likely to report a more positive impact from the Helpline in relation to these secondary outcomes, in: feeling better able to cope (100%/77%), feeling hopeful (91%/78%), options (100%/76%) calm (91%/75%), listened to (100%/87%), understood (81%/78%), having choices (83%/74%).
- likely to report a more positive score on mental wellbeing (using SWEMWBS questions) one-week after the call – they were 'often' or 'all of the time': feeling optimistic (45%/22%), useful (36%/23%), able to deal with problems (36%/23%), close to other people (13%/25%), but less likely to report a positive score on feeling able to make up their mind (36%/45%).

Unpredictable callers - 7 to 99 calls (n=37) were:

- more likely to have a mental health condition (93%/72%)
- more likely to have heard about Samaritans via a healthcare profession (30%/15%)
- more likely to have contacted other healthcare organisations (64%/43%)

Standard prolific callers- 100 to 999 calls (n=42) were:

- more likely to have had suicidal thoughts/plans at the start of the call (40%/32%).
- less likely to feel the volunteer completely 'understood their needs' (59%/76%)
- more likely to suicidal thoughts/plans a week after the call than all other respondents (50%/32%)
- less positive when asked if the Helpline had helped (a lot/some help) to manage their current suicidal thoughts/plans (64%/77%)
- less likely to report that the call had made a difference to how they were feeling a week later (72%/89%)
- likely to have less positive scores on secondary outcomes one-week after the call: a little or much better on: coping (52%/75%), hopeful (62%/74%), calmer (46%/71%), less isolated (40%/66%), listened to (68%/82%), understood by others (65%/74%) and able to make choices (46%/76%)
- likely to report a more negative score on mental wellbeing (using SWEMWBS questions) one-week after the call – they were 'often' or 'all of the time': feeling optimistic (8%/33%), useful (11%/33%), able to deal with problems (13%/29%), think clearly (19%/35%), close to other people (13%/24%), able to make up their mind (28%/52%).

The following **caller journey maps** are for those making their first call to the Helpline and those who have made calls in the past. Each caller journey map is a composite picture, drawing on the feedback from a number of caller interviews.

SAMARITANS FIRST TIME CALLER JOURNEY

This new caller journey is based on three new callers to the Samaritans Helpline that we interviewed between April and June 2020.

The first caller, '**Tom**' was a 49 year old man living in the South East. 'Tom' has several long-term health conditions including alcohol dependency. The second caller, '**James**' was a 32 year old man living in Greater London. The third caller '**Jada**' was a 34 year old female living in London.

1 PRE-CALL

All were first time callers who felt they had nowhere else to go.

> *I didn't really have anywhere else to go, I was in potentially the worst headspace I've ever been in my life and at a point of not really knowing who to talk to and to get help.*

WHY SAMARITANS?

James had known about the Samaritans through advertisements and word-of-mouth but was prompted to make the call when various NHS websites directed him to Samaritans.

For Tom, anonymity and the fact that it was more of a general service (as opposed to AA) was important.

> *Someone that had never met me and to be honest, whose respect and trust I didn't really need.*

Jada felt she was going to explode and needed to talk to someone. Currently awaiting NHS referral for MH services, she searched for help online and the Samaritans helpline came up first, so she called.

2

3 PRIOR EXPECTATIONS

As first time callers they didn't really know what to expect.

Although Tom had hoped it would give him the opportunity to vent, and offload his troubles to someone new and independent.

4 CALL EXPERIENCE

All callers supported the listening approach with no agenda or leading into a particular direction.

> *It was almost me time but with someone else in the room.*

They felt that they were able to lead the call, with the Samaritan interjecting in the right way - sympathetic and non-judgemental.

> *I didn't feel like they were trying to solve the problem... it was like a sympathetic ear with some gentle sort of nudges.*

5 FEELINGS POST-CALL

> *I remember being completely exhausted at the end of it and feeling a hell of a lot better than when I picked up the phone and not feeling like I was going to do anything stupid.*

> *By the end of it I had settled on what I was going to do next and that brought about some relative calm in a very difficult time.*

6 ACTIONS POST-CALL

Tom made the decision to proactively call his work and express his feelings. The call also informed his wider private therapy and has helped him to manage his drinking.

For James, the call started a process of reaching out to those around him including a previous therapist and his sister. However, he felt the therapist 'didn't quite get it on the same level' as the Samaritan.

Jada had called Samaritans a further two times but felt the call experience varied, with some volunteers being a better match than others. Alison suggested more training on empathy and connecting with the caller would help.

7 LONGER-TERM IMPACTS

All callers highlighted the benefit of knowing Samaritans is there to call again (even at night), if needed and said the callbacks showed that they really care.

They talked of advocating the service to others in future.

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SAMARITANS REGULAR CALLER JOURNEY

This caller journey is based on three callers who use the Samaritans Helpline as a coping mechanism; calling regularly to help manage their mental health and wellbeing. We interviewed these callers between April and June 2020.

The first caller, '**Alice**' was a 63 year old woman living in the South West. The second, '**Jane**' was a 59 year old woman living in Scotland who suffers from PTSD. The final caller, '**Giorgos**' was a 56 year old man from the North West who suffers from Bipolar disorder.

1 PRE-CALL

Alice, Jane and Giorgos are all regular users of the Samaritans Helpline.

For them, the Helpline is part of their toolkit for managing their emotional wellbeing.

> *I have built it in to my care plan for myself... I know I can call the Samaritans. It's become a lifeline.*

> *It allows you to process your thoughts in a way that I don't always get a chance to.*

2 WHY SAMARITANS?

Whilst callers did mention other areas of support that they access, or have accessed (e.g. GPs, Psychiatrists and Breathing Space), they favour the 24 hour service that Samaritans provides.

Callers also prefer that Samaritans can be called from home, in a safe space, and they advocated the anonymous yet personal service provided by the Helpline.

> *One of the greatest aspects for me is that there is always somebody there, 24 hours a day.*

3 CALL EXPERIENCE

Callers talked about the the variation in experience based on the perceived 'connectivity' between them and the volunteer taking the call.

> *If I made a good connection with the person I talked to, it makes me feel able to keep on being human in the situation.*

> *I've had exceptional experiences where I have felt very safe because I have felt that the volunteer understood me, so not just say, 'Oh it will pass' or something soothing but actually being so skilled, being able to cut through whatever I'm saying and actually really being there for me.*

> *I have put the phone down before when I have had a really bad connection with somebody. It can make you feel worse... It doesn't happen often.*

> *I have had one or two calls, the odd occasion, where they go 'hm', 'hm', 'hm'. Then I try and finish the conversation.*

4 FEELINGS POST-CALL

Giorgos, who suffers from Bipolar disorder, explained that if the call goes well he can feel good afterwards but then quickly go back to 'square one'.

Jane talked about the Helpline giving her perspective and distance to make a plan about what to do next.

> *They enable me to come back a little bit into my body so that I can then pick up on the self-care and have the little bit of insight into how poorly I am ."*

5 ACTIONS POST-CALL

Alice questioned if the call back service was still provided and stated that she thought it was important, particularly if a good connection had been made.

Jane and Giorgos also reiterated the importance of the call back service.

> *A few years ago I had a severe breakdown. The guy on the phone talked me through 'What are you going to do next?'... and he said 'OK, how about I give you a call back?'. When he said that to me, I cried, and I actually felt like I'd come back into my body, that someone would offer that.*

6 POTENTIAL IMPROVEMENTS

Alice noted that an improvement had already been made to the holding message when calling at night - being told it will take longer rather than 'nobody is available'.

Giorgos suggested a call back system could work better - *'You can stay on the line, or if you leave your number, we will give you a call back'.*

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8. Experience of other forms of support outside Samaritans

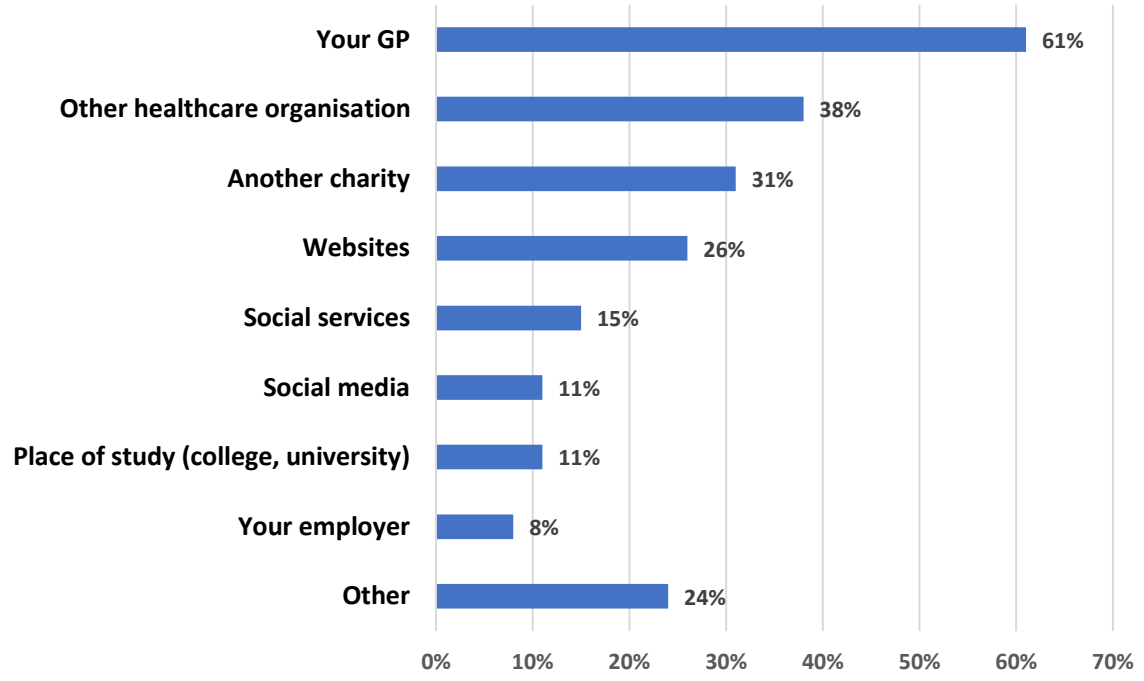
What are the experiences of callers in accessing other forms of support, and their help-seeking behaviours? (RQ10)

Before their call to Samaritans, nine out of ten survey respondents (89%) had sought assistance from other people/organisations. Callers used a **wide range of other sources of help** and the experience varies from one organisation to another. However, around one in ten had not accessed any other support.

The leading source of support was a GP. Six out of ten survey respondents (61%) had consulted a GP for help about the issue they were calling Samaritans for. While this is encouraging, it leaves four in every ten that had not consulted a GP to discuss their current distress / suicidal thoughts.

Figure 8.1 Other support services accessed by callers

Base: 123 % of respondents contacting other services

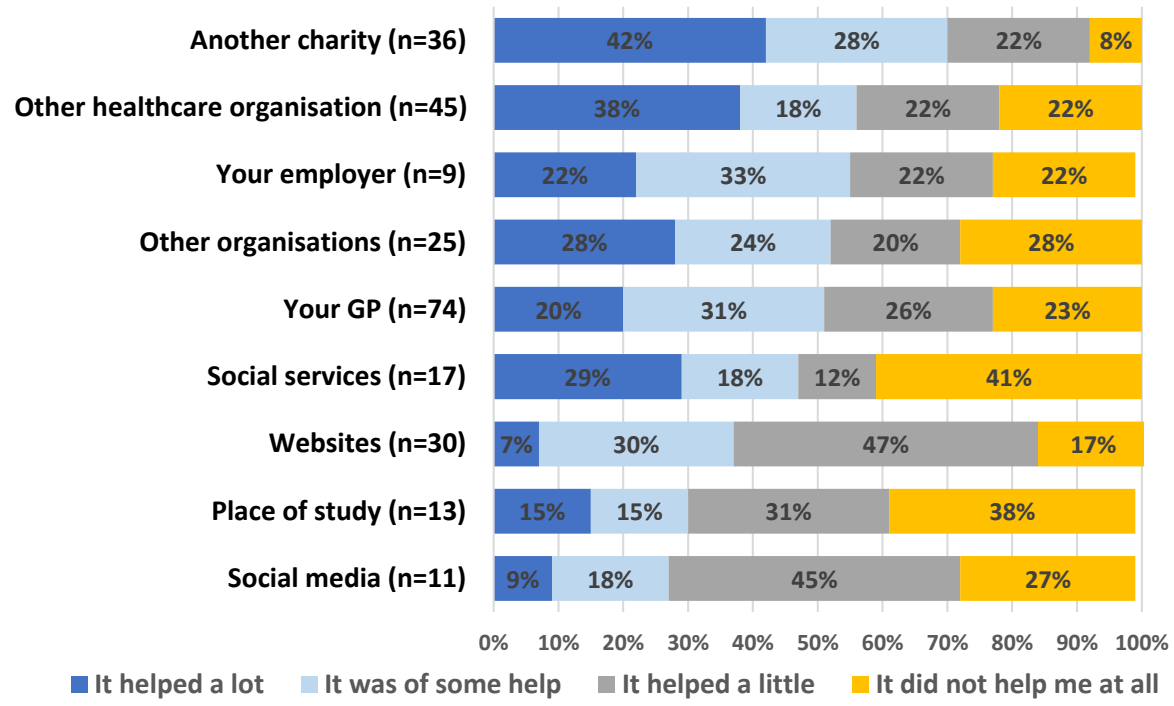


Around half (51%) of those **using the GP** reported that it had helped a lot/of some help, others reported that the GP only **helped a little (26%) or not at all (23%).**

For **GPs,** interviewees raised a number of concerns; the first is on access, with GPs not being immediately accessible, not being available 24/7, and involving a long waiting time for an

appointment. Secondly, getting through to a GP to make an appointment can be challenging – compounding levels of distress. Thirdly, GP appointments are seen as hugely time-limited, which is not a good fit for those with complex issues or those making a first step, who need to share a lot of background information. Fourthly, a face-to-face appointment could itself be a challenge for some callers. There is also an 'imbalance of power' dynamic between a GP and a patient, which does not exist between Samaritans volunteers and a caller.

Figure 8.2 Extent of help received from other support services accessed by callers



After GPs, the next most common source of support was other **healthcare organisations, used by 38% of survey respondents**. These organisations include NHS community mental health trusts, acute trusts and NHS 111 involving hospital psychiatrists, psychologists, therapists, and mental health crisis teams. For other healthcare organisations, 55% of survey respondents found they helped a lot/of some help, with all others reported that **healthcare organisations had been of little (22%) or no help (22%).**

Around three in ten survey respondents had gone to **other charities (31%)** for help. Comments from survey respondents mentioned national charities, such as MIND, SANE, Silverline, Cruse Bereavement, Step Change Debt, Women's Aid, Rape Crisis, Re-Think, NAPAC, Citizens Advice as well as local organisations. **Charities received the most positive response from survey respondents, with 70% reporting they helped a lot/of some help**, with all others reporting that they had been of little (22%) or no help (8%).

A quarter of (24%) of survey respondents had used **websites** as a potential source of help. For websites, there is a far more varied experience, with only 37% of users finding they helped a lot/of some help, with all others reporting that **websites had been of little (47%) or no help (16%).**

Social Services were used by 15% of survey respondents. Social Services showed the most polarised response from callers, with 47% of users reporting that it had helped a lot/of some help, with all others reporting that **social services had been of little (12%) or no help (41%).** Given that around one in six had tried to get help from Social Services and a high proportion found it of no help, this is an area where a small improvement could help a large number of people.

Social media was used by one in ten survey respondents (11%). This is not necessarily Samaritans social media. While the base size (n=11) means results should be treated with caution, **feedback on social media is largely negative, with eight callers reporting that it had been of little or no help.**

Around one in ten (11%) survey respondents had sought help from places of study such as **colleges and universities.** While it is a small base size (n=13), the response is largely negative, **with nine out of the thirteen callers indicating colleges and universities were of little or no help.**

One in four (24%) survey respondents indicated that they had used '**other sources of help'**, the main ones being family /friends (n=7) and counsellors (n=7). Around on in five (18%) learnt about the Helpline from family/friends. The use of family and friends as a source of support is lower, but may be under reported, as callers do not see this as a formal 'service' and because it was not presented as a response option for the question.

When considering survey respondents feedback on each of the services, it is worth noting that there is likely to be a selection effect, with more callers that had a negative experience of a service coming to Samaritans. For example, those using GP services and not finding them useful may have turned to Samaritans, whereas those who had a good GP experience were less likely to turn to Samaritans for support.

Survey respondent comments and feedback from the caller interviews highlights the unique aspects of the Helpline compared to other support services and helps to explain why people use it.

- **Access.** There is an immediacy to the Samaritans service – access and support is immediate. Unlike other services, callers can get through usually without much delay, do not need to make an appointment, there is no waiting list, the caller does not have to wait for someone to call them back and is available 24/7, 365 days a year. A number of interviewees mention ringing Samaritans during the night when their worries and anxieties are far greater. A small number of interviewees contact

Samaritans as a pre-emptive measure as the night-time approaches and they feel that their mood is worsening. Callers feel the Helpline is the only service to turn to at that time, with that level of immediacy.

'It's like saying, "I'll hold your hand through the dark'

'I've always been told with somebody being sincere, if you want to call up, we're always here for you, day or night. And they are genuine in what they say'

- **Time.** Callers noted that Samaritans have time for callers – the service is less time-bound than a GP appointment, enabling callers to discuss what they want, in sufficient detail, without feeling pressured. This is important as a good number of interviewees said they need to talk through a lot of detail and background on the call, before they can start to 'move forward':

'So I think when I've had a good call, somebody would say you know, actually I realise how difficult this is, we're there if you need to speak to us again, you're welcome to ring any time, we're always here, and I think that's good. Because you don't feel then like oh gosh, I've wasted so much time, I can't ring back'

- **Tone.** The caller interviews highlight the personal, one-to-one, human-to-human support of the Helpline. Interviewees indicate that the Helpline volunteers are more empathetic, less patronising and condescending than some helplines, and that the volunteers' tone of voice (low, calm) and how volunteers relate to a caller is also better than other support services. Some callers report that a call to Samaritans is without the awkwardness or 'power dynamic' that there can be with NHS/statutory services e.g. with a GP. There is a feeling that Samaritans is a more human and less 'clinical' service.

'Hearing someone's voice is very important to help me in my distress. So, kind voice, slow, giving me time, I know I can get that with Samaritans usually'

'I just felt the depth of humanity with her, I guess'

'The whole tone of voice and the approach, the way they relate to a caller – there's a kind of compassion and sensitivity to how they treat you, and how they speak to you. They're very gentle, if that's the right word. Even the tone of voice'

'With Samaritans, they make you feel like just at that moment, you're the most important thing they're dealing with'

'You know, I felt like I was taken care of by the way she talked to me'

'She sounded so welcoming, it felt like her arms were opened and she was just there for me and that was amazing'

'Maybe the way that I was conversing with this particular person, I was conversing in this way because he had a voice, a way of being, that was actually quite a practical voice, whereas the two volunteers before, before I got cut off, they had that more silent approach'

- **Caller-led.** Samaritans does not have an 'agenda' or particular service focus. It is led by the caller, not the service. Callers feel that Samaritans really is there to support the caller, on the call and in the long-term – it is always there, and that is hugely reassuring for callers.

- **Active listening**. Samaritans does not tell callers 'what to do' but help callers move towards their own solutions and decisions. Callers value the Samaritans approach, as it is not focused on instant solutions, providing information or directing callers to other services. In some cases, callers felt that the listening approach was not what they expected or that the volunteer was too passive:

'The Samaritans have the power to bring that out of you, which is helpful, or they have the power to not, and sort of freeze you down a little bit so you won't bring things out'

'Just some people they don't give anything back to you. They can listen, but they don't talk. They don't ask you how you feel and they sound like they're bored sometimes. You feel like you're boring them when they sound like they don't want to be there'

An **unexpected output** from the interviews was that several participants expressly said that they would be very keen for the volunteer they had spoken to, to receive feedback about the positive impact their support had on the caller.

The feedback gathered via the caller interviews highlights the benefits and also the **limitations of other sources** of help. An appreciation of callers' experience of accessing and experiences of other services is particularly relevant as feedback from the caller interviews shows that Samaritans acts as an alternative to more formal care - using it as part of their **coping strategies** to manage their mental health and wellbeing.

Key findings

- **Most callers had used other sources of support. There is a wide range of sources of support, led by GPs, healthcare organisations, charities, websites, social media, social services.**
- **For each source of help, the majority of callers found them of some use. However, it is clear that there is a wide variation in the impact of each type of support.**
- **Half of those using a GP felt this helped a lot/of some help, while the rest felt it helped a little/not at all. Other charities received the most positive response from callers, with seven in ten reporting they helped a lot/of some help.**
- **Feedback from caller interviews highlight the aspects of the Helpline that appeal to callers, the gaps it fills and differences from other sources of support. These not only help explain why callers use the Helpline, but also underline the features that callers' value and which should be maintained, developed and promoted.**
- **The Helpline is different because it is immediately accessible, day and night, it allows them time to go at their pace; tone - in that volunteer are more empathic and do not have the awkwardness of a GP/NHS appointment; is led by the caller – rather than directed by the organisation's objectives and; the listening approach is not there to direct callers elsewhere or tell them what to do. It helped the caller to reflect and move forwards with their own decisions and solutions.**
- **A new feature for the Helpline was suggested - the option for a caller to provide feedback directly to a volunteer, on how the call went.**

9. Experience of participating in research for callers and volunteers

What are the experiences for callers about how they were recruited into the study and data they had to provide? (RQ7)

The experiences of survey respondents on joining the study was **very positive**. This is not unexpected, given that they went on to participate in the study.

When asked how they felt about being invited to join the study, nine out of ten (87%) survey respondents said they were 'fine with it'. Even callers that had 'felt a little awkward' (10%) or felt that 'it was inappropriate' (3%) had gone on to participate.

Volunteers found that those that decided not to participate were not critical of the study or being asked to join. Many of those who decided to join the study commented on it as a way of giving something back to Samaritans. Volunteers reported that the study questions were **clearly understood by callers** and that they were **able to provide answers**. The need to provide contact details (a phone number, email or address) to participate in the study was a barrier for some callers, though it was not a concern for most. Volunteers felt able to address any concerns around confidentiality.

The positive response from callers' highlights the importance of the Feasibility Study, in testing the methodology and the quality of volunteer training and support to ensure callers were recruited ethically and not put at risk of harm.

Key to the success, was the volunteers' ability to build a rapport with callers, which helped to recruit them into the study, after supporting them in a high level of distress.

Key findings

- **Most callers were positive about being asked to join the study.**
- **Callers that decided not to participate were not critical of the study or being asked to join.**
- **The study questions were understood by callers and they felt able to provide answers**
- **Providing contact details was not a barrier for most callers.**
- **It was important to offer postal as well as online options for the one-week follow-up survey**

Has involvement in the research affected the likelihood to use Samaritans services in the future? (RQ8)

Eight out of ten survey respondents (81%) reported that, if they needed support, they would definitely use the Helpline again and 18% would probably do so. There are some differences to consider, with a lower proportion of new callers (62%) reporting they would definitely call again, compared to repeat callers (84%).

Only 1 in 109 survey respondents said they would not use the Helpline again. The comments from survey respondents indicate that uncertainty on future use of the Helpline was not to do with the study, but more to do with their needs i.e. looking for specialist advice.

There is no evidence in the survey data that involvement in the research has affected the likelihood of survey respondents using Samaritans services in future. Comments indicate that they were happy to take part and really valued the opportunity to provide feedback to give something back to Samaritans, as they value all that the service has done for them. A number of interviewees said that taking part in the research gave them a sense of value, from being asked their opinion to help the service, rather than Samaritans always helping them.

'To be heard and know that your opinions matter and your experiences matter and that they can work towards changes that are needed'

Key findings

- **Almost all (99%) survey respondents indicated that they would definitely/probably contact Samaritans again if they needed support and that involvement in the study had no impact on their future intentions to use of the Helpline**
- **The feedback from the caller interviews reinforced the survey responses, with participants feeling that they have a positive and long-term relationship with Samaritans and that they welcomed the opportunity to give something back.**

What are volunteers' experiences of recruitment and data collection procedures, including use of measures of suicidality and distress? (RQ9)

Our understanding of the volunteer experience is based on the results of the Volunteer Feedback Survey. 54 study volunteers responded to the survey, including those that had recruited callers (50) and those that had not (4). Respondents included 47 listening volunteers and 7 Branch Directors. The length of time as a volunteer ranged from less than 6 months to over 30 years, with the average being 10 years. The age of volunteers ranged from 30 to 80 years, with the average age being 62 years. A high proportion of respondents were women (70%) and almost all were from White ethnic groups (98%).

Volunteers provided suggestions on how the process could be improved. These are presented in Appendix 6 - Learning points.

Support as usual

- Most volunteers (n=46, 87%) reported that they were **able to provide 'support as usual' and recruit callers to the study**, with a few saying how it 'upped their game' in relation to listening skills. Two (4%) were not sure and five (9%) thought it might have made a slight difference to their support.

  'This was fine as the survey was only raised at the end of the call.'

- Volunteers felt there was **no conflict between meeting Samaritans' values** (i.e. listening, confidentiality and anonymity, non-judgemental, self-determination, human contact) and participating in the study.

  'I was completely able to meet Samaritans' values and I could reassure callers of this too.'

  'Well, I didn't have any problem, it was all very Samaritan!'

- Most volunteers **felt at ease when introducing the study at the end of the call**. Five felt the study tended to lengthen calls. Eight volunteers felt that there was a slightly negative aspect to ending on an 'official' or 'impersonal' note.

- There was a **cautious response to the idea of collecting caller outcomes data on an occasional basis**. While most volunteers (n=35, 66%) were positive, 13 (25%) were supportive but with concerns and five (9%) did not think it was a good idea.

- Twenty-eight (53%) volunteers provided other comments about their involvement in the study or **ways it could be improved.** There were three main themes:

  - ideas to improve training for volunteers (see Appendix 6 - Learning points)
  - changes to eLog to record calls ending abruptly/no opportunity to introduce the study

- suggestions to improve the methodology (e.g. offer a telephone call for one-week follow-up survey)

Recruiting callers to the study

- Volunteers were pleasantly surprised by the **positive response from callers to participate in the study**. Most volunteers (n=46, 96%) reported that they did not encounter distress, negative reactions or complaints from callers about the study. If this did occur, they felt comfortable in dealing with it. Only two volunteers reported occasions where they had a negative reaction to the survey.

'Had no negative reactions or complaints (to my knowledge). People did refuse to participate but that was fine.'

- For most volunteers there were **no problems on the more practical aspects of recruiting callers**, such as introducing the study to callers, asking callers if they would like to participate, requesting callers' contact details, answering questions, managing any distress, negative reactions or complaints from callers, dealing with safeguarding issues and uploading caller contact details.

'It was straightforward. Generally far easier than concerns we had when training.'

'Feeling very positive and well informed about the Survey helped me feel confident to answer callers' questions.'

'Overall, if once asked, the caller gave informed consent to participate, the rest of the process worked well.'

'Many callers seemed very glad of the opportunity to provide feedback on the service. I had not expected this…'

- Volunteers highlighted the **challenge of engaging callers** when the call was very short / ended abruptly.

'I asked all callers unless they had any of the exclusion criteria or they ended the phone call before I had chance (this was often the case)'

'It made me realise how many callers end the call/hang up'

- Volunteers were satisfied with the process of **recording data and uploading contact details** to MEL Research.

- Deciding **which callers to recruit into the study was not a problem for most volunteers**. However, while most volunteers understood and applied the recruitment criteria, there were some (n=11, 21%) who felt it was a real challenge to consistently apply the criteria.

- Volunteers excluded 65% of callers from the study, of which most were due to meeting the exclusion criteria. In most cases the **exclusion criteria made it a straightforward decision.** Feedback from volunteers suggests that in some cases the caller may not have met the exclusion criteria, but for another reason they had not been invited to participate. In most cases, this was

to do with events beyond the volunteer's control, which prevented them introducing the study eg. the call ended abruptly, was a short call, lack of interaction.

Collecting extra data

- Volunteers stated that **callers had no problem in understanding and answering the study questions**. For consistency, a couple of volunteers suggested changing the suicidal thoughts/plans question to match the distress scale.
- Volunteers reported that **they understood the inclusion/exclusion criteria** for the study and that their judgement was only required when deciding whether a caller was able to provide informed consent. This demonstrates that **the training had equipped volunteers to fully understand how important it was to gain informed consent from callers**.
- Six of the 50 volunteers (12%) that recruited callers, highlighted the challenge asking the study questions when the caller was highly distressed.

'Found very hard to ask callers who were very upset to take part.'

Joining the study

- All volunteers felt they had **sufficient information to decide whether to attend the training session and felt no pressure to take part**. Three volunteers highlighted aspects that could have been improved, including their Branch Director being more proactive, and to email information directly to them rather than just using branch noticeboards.

'Good, I was able to make my decision without any pressure from anyone and had the information to do so.'

'My Branch Director was what I might call positively neutral. They were quite happy for volunteers to participate but there was no encouragement to do so.'

- While 153 volunteers attended the training session, there was a high dormancy rate, with a third (n=49) of volunteers not recruiting any callers to the study. At each training session it was made clear that to participate, the volunteer would be expected to adhere to the study protocols, and to use the exclusion criteria. Some felt uncomfortable with this requirement and at the end of the training session told the trainer from M·E·L Research that they did not intend to take any further part in the study. Others took part, but found it too challenging, particularly with callers that were highly distressed and decided to withdraw. For others, the lack of study activity was due to more practical matters, such as moving away, illness, or mentoring duties.

About the Training – collecting study data

- 35 (70%) volunteers felt the **training had prepared them well, to recruit and collect the study data from callers**. Eleven (22%) felt it was ok, 3 (6%) thought it needed improving and 1 (2%) felt it was inadequate. Four did not reply to this question.

'I thought the training was very good in explaining the approach to take to inviting callers to participate. Important issues were explored and discussed e.g. in the case of distressed callers and callers with mental health issues.'

Suggestions for improving training included; more simplified information, alongside more skills/role playing and minimizing the gap between the training and the start of the caller recruitment phase.

'I understood who to recruit, but we could have maybe done a skills practice to run through the end of a call or two.'

'I think it was as good as it could be since all it could describe was what we had to do. The emotional side of managing to recruit callers was challenging and I don't think that could have been dealt with in advance.'

Support from the MEL Research team

- Overall, volunteers were **satisfied with the ongoing support from M·E·L Research** including: knowing who to contact, at ease asking questions, the availability, speed and comprehensive nature of response to their queries. The weekly email from M·E·L Research was welcomed by most volunteers. The email contained feedback from volunteers on issues/solutions, latest number of branches/volunteers joining the team, progress on callers recruited and reminders about getting in touch if there were any concerns. However, some noted that there is a balance to strike in encouraging activity and being too demanding regarding recruitment targets.

'Very well indeed. Really good initial training at my branch made the connections to the MEL team very 'tangible' and the constant follow-up and supportive emails were excellent. A very real strength of the project.'

Key findings

- **Volunteers reported a positive experience. Once underway, initial concerns proved largely unfounded and volunteers felt it was a positive, if sometimes challenging, experience.**
- **Volunteers valued the training and support. They understood the inclusion/exclusion criteria, and found it straightforward to introduce the study, address queries from callers, collect the data using the study questions, collect caller contact details and work with M·E·L Research.**
- **Most importantly, volunteers reported that they were able to provide 'support as usual' and recruit callers to the study. Many commented on the positive response from callers when they asked them to join the study.**
- **As expected, the main challenge for volunteers was the consistent application of the inclusion/exclusion criteria. This was also the main reason why some volunteers that attended the training, decided not to participate any further.**
- **Volunteers have provided useful suggestions on how processes could be adapted, many of which are included in the recommendations and learning points for future research.**

10. Summary and conclusions

There are four elements to this section:

- **Summary** – draws together the key findings from the study to answer each of the Research Questions.
- **Conclusions** –the overall messages from the study.
- **The wider context** –how the findings of this study relate to the current understanding of the Helpline's impact and other evidence about helplines.
- **Learning points and development ideas –** as the first national study, we present the learning points for future studies and development ideas for Samaritans to consider**.**

Summary

Immediate and short-term outcomes for callers

What is the immediate and short-term impact of contact with Samaritans' telephone helpline on callers' levels of distress and suicidality?

There is a significant reduction in levels of distress in the immediate term, from the start to end of a call and in the short-term, from the start of a call to one-week later. In terms of immediate impact, there is a positive trend with a reduction in callers' experiencing suicidal thoughts/plans, from the start to the end of the call. However, in the short-term, there is no significant difference, as for most of these callers, suicidal thoughts/plans had returned a week later.

Seven out of ten (71%) respondents indicated that they were feeling better one week after the call to the Helpline. The positive contribution made by the Helpline is clear, with almost all these callers feeling that their call had contributed to this improvement.

How does this impact for different groups of callers?

While there are some differences to consider, the key finding from the study is that the experience and changes in level of distress are of a similar nature across different groups of callers. The pattern is consistent, showing a reduction in distress in the immediate term – from the start of a call to the end of the call and, to a lesser extent, there is a reduction over the short-term – from the start of a call to a week later. In no case has the level of distress gone back up to where it was at the start of the call. The changes in levels of distress from the start of the call to a week later are statistically significant for men and women and for younger and older age groups.

What are the secondary outcomes for callers to the Helpline?

Reductions in levels of distress and suicidal thoughts/plans are not the only benefits of calling the Helpline. The majority survey respondents reported an improvement in how they felt for each of the eight secondary outcomes that relate to emotional well-being, and that their call to the Helpline had a positive impact on these changes. The eight secondary outcomes are: being listened to, feeling they have options, people understanding them, have hope in the future, able to cope with everyday life, able to make choices, feeling calmer and feeling less alone/isolated.

What contribution does Samaritans' telephone helpline make to callers' self-management of emotional distress and suicidal feelings and behaviours?

The study has shown that the Helpline makes a very positive contribution to callers' self-management of their emotional distress and suicidal behaviours. Almost all survey respondents indicated that the Helpline had helped them manage their current level of distress and to manage suicidal thoughts/plans. On both points, more than four in ten respondents felt it had helped them 'a lot'. The study also showed that there is a strong connection between the reason why callers choose to use the Helpline, the positive changes they report in terms of secondary outcomes and the reasons why callers feel it has helped them manage their levels of distress and suicidal thoughts/plans.

Experience of Samaritan support and interactions

What are callers' experiences of their interaction with volunteers on the helpline?

Over half the survey respondents felt the call had gone better than they were expecting. This is a particularly positive finding, considering that most respondents are previous callers and familiar with the Helpline.

The majority of survey respondents reported a very positive experience on each aspect of their interaction with the volunteer - treated with respect and dignity, have the volunteers undivided attention, conversations would remain confidential, the volunteer was caring and compassionate towards them and were able to talk openly to the volunteer about their feelings.

The study has helped to identify some areas where there may be some room for improvement, the main one being volunteers' understanding the needs of the caller'. While it may not be realistic to achieve 100% on each aspect of the service, given the number of callers, even a small percentage improvement will have a positive impact on many people.

Callers do not feel there are major gaps in the service. Comments tended to place the emphasis on developing the existing type of service.

The Active Listening model is highly valued and the response from callers shows that it is being well-delivered. When we explore the study findings in line with the Listening Wheel, a number of themes emerge:

- **Reflecting**: interviewees reported that the service is more effective when the volunteer does not purely listen silently, but more actively reflects back to gently 'nudge' the caller to a more positive way of thinking
- **Clarifying**: calls are not time-bound which allows the caller time to explain how they are feeling, for the volunteer to clarify, and for the caller to reflect on these thoughts. Asking simple and open clarification questions can re-focus the caller's thought process on to something practical, achievable and immediate. Asking clarification questions using gentle prompts and positive language provides callers with a sense of perspective
- **Short words of encouragement**: interviewees noted the role of volunteers using short words of encouragement, using positive language and gentle prompts
- **Reacting**: interview findings were that the volunteers are non-judgemental and do not voice their own opinions
- **Open questions**: calls were more effective when the volunteer would listen, reflect back, and then 'nudge' the caller to a more positive way of thinking by asking them open questions. The Helpline allows the caller time to explain how they are feeling and to reflect on these thoughts. It is important to end the call on a positive note, in which the caller is in control rather than the volunteer, by asking open questions at the end of the call
- **Silence**: the more silent approach was not what interviewees wanted or needed – most preferred a more active, reflecting back approach. Getting the right connection between the caller and volunteer is vital. If the caller feels the volunteer may be too silent / passive, the caller can ring back and speak to another volunteer.

How did the interaction with the volunteer on the helpline impact on their emotional well-being?

In the short-term, seven out of ten survey respondents indicated they were feeling better one week after the call (71%), with 23% staying about the same and 6% feeling worse. All those feeling better, felt that their call to the Helpline had contributed to this improvement, with 36% indicating it had made a big difference, 52% that it made some difference and 12% that it had made a little difference.

While these improvements and impact of the Helpline are clear, they should also be seen in relation to the results of the measure of suicidal thoughts/plans and mental wellbeing at one week after the call. The one-week follow-up survey included two validated measures of emotional wellbeing, the Suicidal Behaviour Questionnaire – Revised (SBQ-R) and the Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS). While the survey results demonstrate the positive impacts of the service, the two measures of emotional wellbeing show that callers were likely to be vulnerable a week after they contacted Samaritans, with poor mental wellbeing.

What are the experiences of callers in accessing other forms of support, and their help-seeking behaviours?

Most callers had used other sources of support. There is a wide range of sources of support, led by GPs, healthcare organisations, charities, websites, social media, social services. While for each source of help, the majority of callers found them to be of some use., the survey results show that from the caller' perspective, there is a wide variation in the impact of each organisation's support. Other charities received the most positive response from callers, with seven in ten reporting they helped a lot/of some help, with half of those using a GP feeling this had helped a lot/of some help.

Experience of participating in research by callers and volunteers

What are the experiences for callers on how they were recruited into the study and data they had to provide?

Most callers were positive about being asked to join the study. Many saw it as a way of giving something back to Samaritans. The completion rate of the study questions at the end of the call and the high proportion of survey respondents willing to participate in a telephone interview reinforces the positive response to the study.

The positive response from callers has not been taken for granted and is built on the approach taken by Samaritans, in particular the Feasibility Study. The Feasibility study tested the study methodology, helped design the right training and support for volunteers and ensured the larger study was ethically sound, to ensure no harm to participants occurs. While there are improvements to make, the study methodology is robust and repeatable. Key to the success, was the volunteer's ability to build a rapport with callers, which helped to recruit them into the study, after supporting them in a high level of distress. The success of the approach meant that a high proportion of eligible callers (60%) agreed to become study participants. There we no complaints about the study and as far as we know no harm to callers.

Has involvement in the research affected the likelihood to use Samaritans services in the future?

Almost all respondents indicated that they would definitely/probably call again and that involvement in the study had no impact on their intentions to use of the Helpline. The feedback from the caller interviews reinforced this response, with participants feeling that they have a positive and long-term relationship with Samaritans and that they welcomed the opportunity to give something back.

What are volunteers' experiences of recruitment and data collection procedures?

Although the study had various challenges, volunteers felt it was a positive experience. Volunteers understood the study's inclusion/exclusion criteria, found it straightforward to; introduce the study, address queries from callers, collect data on suicidality and distress using the study questions, collect caller contact details and working with M·E·L Research. Most importantly, volunteers reported that they were able to provide 'support as usual' and recruit callers to the study. Many commented on the positive response from callers when they asked them to join the study.

The main challenge for volunteers was the consistent application of the inclusion/exclusion criteria, particularly when a caller was in a highly distressed state, when the call was brief or where there had been little interaction. Volunteers have provided useful suggestions on how processes could be adapted, many of which are included in the learning points for future research.

Conclusions

The positive nature of the responses to each of the Research Questions clearly shows the value of the Helpline to callers. The study has provided a wealth of new evidence about the positive impact of the Helpline and the experience of callers. In addition to reductions in levels of distress and suicidal thoughts/plans the study has highlighted the secondary outcomes on callers' emotional well-being, and the role played by the Helpline. While the feedback from callers is overwhelming positive, the study has also raised a number of points that suggest there is scope for continual improvement. These survey results can be used to inform decisions on the on-going development of the Helpline and a range of associated activities, such as; the training programme for volunteers, the content of communications/information for callers and how Samaritans might work with other organisations that provide support. A key message is that, while there are some differences to consider, the impact and experience is similar for different types of caller. The study has also highlighted the aspects of the Helpline that have particular appeal to callers and that differentiate it from other sources of support.

The wider context

This study has not only provided data on the outcomes for callers, but also helped to develop a deeper understanding of the callers' experience of the 'active listening' approach, what works and does not work. While research studies have been undertaken on helplines that are focussed on 'crisis intervention' and 'problem solving' approaches, less is known about the 'active listening' model used by Samaritans.

Studies on caller outcomes from 'crisis intervention' helplines show a positive change for a proportion of callers, reducing crisis and suicidality by the end of the call, and in the longer term. This study adds a new perspective, showing that the 'active listening' model also has positive outcomes for callers, in the immediate and short term. The study has gone beyond looking at the primary outcomes of callers' levels of distress and suicidal thought/plans, by exploring secondary outcomes and measuring callers' emotional wellbeing a week after the call.

Within the current evidence there is also limited understanding of the diverse nature of callers to helplines, in terms of socio-demographic characteristics, those in crisis/distressed, social circumstances, frequency of calls etc. There is also a lack of information about the characteristics of callers and outcomes. This study has provided information that has helped to build a better understanding of who is calling the Helpline and an analysis of the experience and outcomes of the service for various sub-groups.

Other helpline research has shown that empathy and supportive interaction are fundamental, with volunteers' communication of personal views and experiences also associated with positive outcomes during the call, despite being discouraged in helpline practice. This study has found that while callers appreciate the silence and space the Helpline gives them, they also favour the more pro-active aspects of the Samaritans' Listening Wheel, such as the reflecting back and summarising.

Helplines that use crisis intervention models are also associated with positive outcomes at the end of the call. The study has also shown the positive response from callers to the aspects of the Helpline service that are of a more interventionist nature, such as reflecting back, allowing the caller to find a more positive way of thinking, gentle nudges and encouragement that could help them take what could be a small, yet positive step forward.

Though current research provides useful findings, there remain large gaps in knowledge, and untested assumptions about the benefits to callers and the elements of a helpline interaction which are important for positive outcomes. This study has helped to address some of these gaps, with a focus

on what happened from the callers' perspective, what is important from the callers' perspective and the impact of their interaction with the volunteer on the primary and secondary outcomes for callers.

Learning points and development ideas

The focus of this study has been on answering the research questions. Throughout the course of the work programme, learning points on the implementation of the study have been recorded and are presented in Appendix 6 – Learning points. These observations could be a useful resource if this study were to be repeated and could also help inform the design of other research projects undertaken by Samaritans.

Feedback from callers and the results of the study have raised a number of ideas and possible courses of action for the Helpline. It is likely that Samaritans will already have considered many of these points and in some cases they may be part of existing work programmes. The development ideas have been recorded, grouped into five themes and are presented below.

1. Interaction with the caller
2. Service development
3. Information/promotional activities
4. Working with others
5. Research and monitoring.

Interaction with the caller

1. There is an opportunity for Samaritans to consider the impact and experience of the Helpline in relation to difference types of caller (age, new/repeat callers and those that have suicidal thoughts/plans or are in distress). This approach could help tailor the service, to build on the positive outcomes.

2. There is an opportunity for Samaritans to carry out a policy review on the subject of caller profiling. It can be useful but may also have a negative impact on callers and Samaritans. The review could explore the practical as well as ethical aspects of this approach.

3. While there are improvements to consider, a priority for Samaritans could be to highlight and protect the unique features that make the Helpline different (to other sources of support) and are the reasons why callers choose to contact Samaritans.

4. The survey data suggests that the Helpline has a greater impact on new callers, compared to repeat callers. They have different reasons for calling and differing awareness levels of the service. This may be one area that would benefit from tailored support e.g. different information/messages provided by the volunteer at the end of the call, automatic offer of a follow-up call at a set point in time.

5. In order to provide a more tailored interaction, Samaritans could explore whether background information available via eLog could be used by the volunteer to provide more appropriate type of support for a callers e.g. whether they are a first time or repeat caller, caller type, average length of their calls, concerns from previous calls and history of suicide attempts.

6. Repeat callers make up the vast majority of calls. To improve the caller experience, one approach could be to avoid them having to repeat their story each time they contact the Helpline. Samaritans could explore whether there are more effective ways of managing repeat callers, for the benefit of the caller. This might include asking the caller if they want notes of the call kept for the next time they call.

7. Feedback from callers (and volunteers) highlighted the challenge of articulating how they are feeling/what they want to get out of the call - particularly those that are not frequent callers. This could be an area for continued improvement, with a review of Samaritans' training and guidance.

8. To provide a more informed response for a caller, Samaritans could consider whether caller-routing (i.e. a new telephone number) is an option, to route first time / new callers through as distinct from repeat callers for instance.

9. To improve the experience of callers, Samaritans could consider offering a call back option, if callers cannot get through to the Helpline. This could be particularly relevant for first time callers/those in crisis, to avoid them having to wait on the phone if demand is high.

Service development

1. To improve secondary outcomes of the call, focus on one or two aspects that are most in need of improvement and of greatest importance to callers. Survey results indicate that these could include; social isolation, i.e. callers' feelings of being alone/isolation and callers feeling that the volunteer has a clear understanding of their needs.

2. To continually improve the service offered by the Helpline, explore opportunities' to develop the current approach of the highly valued 'Listening Wheel', focussing on the elements of the caller/volunteer interaction that callers' favour - the gentle encouragement, suggestions, nudging.

3. While active listening is the foundation of the Helpline, this study has found that some callers report a better outcome from a more interactive/pro-active call. To meet this need, Samaritans could use the findings of this study to review and develop the volunteer training programme around these particular aspects of the active listening model e.g. useful phrasing, what to say, what not to say, asking open questions.

4. The study has highlighted that some callers have an expectation that the Helpline will provide advice. To manage these expectations, there may be a need to review and if necessary revise promotional material/information and volunteer training around the messages and signposting for those seeking specific advice/counselling on their situation, condition/illness.

5. To improve the outcomes in terms of helping callers with their self-management of suicidal thoughts/plans (leading to longer-term positive impacts on suicidality) Samaritans could further develop materials that support callers in this task.

6. The Samaritans 'call back' option is highly valued by callers who have been offered it and used it, but it does not appear to be widely known about, even amongst more regular Helpline users. Samaritans could review levels of awareness of the call back service amongst volunteers, as well as the criteria used by volunteers when offering the service. If resources allow, Samaritans could consider offering this element of the service more widely if the criterion is met.

Working with others

1. The Helpline is one of many sources of support used by callers. To increase awareness and use of the Helpline, Samaritans could focus on developing more key partnerships

2. As the Helpline is used by some callers as a way of helping to manage a long-term mental health condition/illness, the relationship and integration of the Helpline with other support services (GP, NHS etc) could be of benefit to callers. Samaritans could explore offering new services that improve the outcomes for callers. For example, offering support to access other support services e.g. the use of social prescribing, a Samaritans befriending option, a patient guide on what to say to a GP during a consultation, what help you can expect from a GP.

3. To improve awareness and understanding of what the Helpline offers, Samaritans could undertake research to understand which websites and social media are used most frequently by Helpline callers and explore opportunities to work with these provider organisations to further promote the Helpline and other Samaritans services (e.g. email contact, appointments in branch).

4. Given that callers are likely to use other support services with helplines, Samaritans could share good practice emerging from this research with other charities that provide support to callers.

5. To have a wider impact, Samaritans could promote and share the positive caller outcomes on distress and suicidality and key finding from this study with other suicide prevention organisations.

Information / promotional activities

1. To encourage support for Samaritans, highlight the impact that a volunteer can have, help to further sustain and recruit new volunteers, and encourage callers to take the first step in seeking help. The survey findings could be shared with partnership organisations, sponsors, those that have used the Helpline and those who may in future.

2. To help encourage callers to take the first step or make a repeat call to Samaritans, review the information / promotional material to ensure the positive outcomes identified in this research are highlighted.

3. To further encourage and motivate existing volunteers, Samaritans could share the many positive findings from this study and demonstrate the positive impact they have. Findings could also be used to assist in the recruitment of new volunteers by showing the value of the vital role that volunteers play.

4. To increase awareness and access, Samaritans could use the survey findings to inform decisions around the use of resources across a broad spread of promotional channels, including websites, social media, TV, radio and print media.

5. The Helpline has some unique features, that appeal to callers. Samaritans could enhance the use of the study findings to further increase awareness amongst the general public of these features e.g. immediacy, available 24/7 365 days per year, the value of the human to human interaction, anonymity, and that it is run by volunteers.

6. To encourage new callers (who may currently think it is not appropriate for them), Samaritans could review their communications around the change from a Helpline focused on suicide prevention to one that now has a broader role, in helping callers in emotional distress.

7. To appeal to a wide an audience as possible, Samaritans could increase the use of powerful caller stories in promotional material to demonstrate the benefits and impact the Helpline can have for all members of society eg. young and older age groups.

8. The study findings and subsequent / planned actions could be shared as widely as possible with the general public (and study participants) via Samaritans website and social media. Findings could also be shared with Samaritans volunteers, in particular those that took part in the study. We recommend a 'You Said, We Did' format be used.

Research and monitoring

1. To monitor trends and assess the impact of any changes to the service going forward, Samaritans could use these results as a baseline against which to measure progress.

2. The study has explored some variations in the outcomes and experience by different groups of callers, that could help develop the service and improve outcomes. Understanding the experience for, and impact of, the Helpline for some groups will require further work e.g. the differences within the BAME groups.

3. Samaritans could introduce an ongoing research programme to monitor the core elements of the interaction between callers and volunteers. Options could include an annual (or biannual) caller survey, a caller research panel, online focus groups to gather feedback, and hosting surveys on the Samaritans website.

4. To inform other research projects, the learning points from this study could be incorporated into research guidance for the Samaritans.

References

Bassilios, B., Harris, M., Middleton, A. *et al.* Characteristics of People Who Use Telephone Counseling: Findings from Secondary Analysis of a Population-Based Study. *Adm Policy Ment Health* **42,** 621–632 (2015). https://doi.org/10.1007/s10488-014-0595-8

Coveney, C. M., Pollock, Armstrong, S. & Moore, J. (2012) Callers' Experiences of Contacting a National Suicide Prevention Helpline. Report of an Online Survey. Crisis; Vol. 33(6):313–324.

Deuter, K., Procter, N. & Rogers, J. (2013) The Emergency Telephone Conversation in the Context of the Older Person in Suicidal Crisis: A Qualitative Study. Crisis; Vol. 34(4):262–272.

Gould, M., & Kalafat, J. (2009). Crisis hotlines. In: D Wasserman & C Wasserman (eds.). *Oxford Textbook of Suicidology and Suicide Prevention. A Global Perspective*. Oxford University Press: New York, 459-462.

Gould, M. S., Kalafat, J., Munfakh, J. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes part 2: Suicidal callers. *Suicide & Life-Threatening Behavior, 37*(3), 338-352.

Kalafat, J., Gould, M. S., Munfakh, J. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes part 1: Nonsuicidal crisis callers. *Suicide & Life-Threatening Behavior, 37*(3), 322-337.

Leitner, M. Barr, W. Hobby, L. (2008). *Effectiveness of Interventions to Prevent Suicide and Suicidal Behaviour: A Systematic Review.* Scottish Government Social Research.

Litman, R. E. (1970). Suicide prevention center patients: a follow-up study. *Bulletin of Suicidology, 12-17.*

Middleton, A., Gunn, J., Bassilios, B. & Pirkis, J. (2014) Systematic review of research into frequent callers to crisis helplines. Journal of Telemedicine and Telecare, Vol. 20(2) 89–98.

Mishara, B. L., Chagnon, F., Daigle, M., Balan, B., Raymond, S., Marcoux, I., et al. (2007a). Comparing models of helper behavior to actual practice in telephone crisis intervention: A silent monitoring study of calls to the US 1–800-SUICIDE network. *Suicide and Life-Threatening Behavior, 37*(3), 291-307.

Mishara, B. L., Chagnon, F., Daigle, M., Balan, B., Raymond, S., Marcoux, et al. (2007b). Which helper behaviors and intervention styles are related to better short-term outcomes in telephone crisis intervention? results from a silent monitoring study of calls to the U.S. 1-800-SUICIDE network. *Suicide & Life-Threatening Behavior, 37*(3), 308-321.

Mishara, B. L., & Daigle, M. S. (1997). Effects of different telephone intervention styles with suicidal callers at two suicide prevention centers: An empirical investigation. *American Journal of Community Psychology, 25*(6), 861-885.

O'Connor, R. C., Rasmussen, S., & Beautrais, A. (2011). Recognition of suicide risk, crisis helplines, and psychosocial interventions: a selective review. In: R O'Connor, S Platt & J Gordon (eds) *International Handbook of Suicide Prevention: Research, Policy and Practice.* Wiley-Blackwell: 435-456.