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An Evaluation of Samaritans Telephone and Email Emotional Support Service

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Cover photograph courtesy of John Moore
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Note on Transcribing Conventions for Data Extracts

As interview transcripts are already representations of data, the extracts reproduced in this report have been edited in places for clarity and conciseness. However, as 'raw' data, the email messages and responses and callers' written responses to the open questions in the online questionnaire are reproduced exactly as they were written in the original sources.

Prefixes

V (V202) = volunteer interview respondent

S (S110) = caller interview respondent

ES (ES514) = extract from caller email message. The number in parenthesis indicates the position of the message in the exchange (ES514 (2)).

EV (EV514) = extract from volunteer response to caller email message. The number in parenthesis indicates the position of the message in the exchange (EV514 (3)).

EMFB = an extract from email correspondence sent by callers directly to the research team in which they comment on, or give an assessment of, their experience of contact with Samaritans (email feedback).

ID (ID1125) = an extract from a caller's written response to open questions in the online survey.

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Chapter One: Introduction

Introduction

This report presents the key findings from an independent two year evaluation of Samaritans telephone and email support services carried out by researchers from Nottingham University. For more than fifty years Samaritans have been providing round the clock confidential emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide[1]. Samaritans also work to reduce the frequency with which people take their own lives by promoting a better public understanding of suicide and suicidal behaviour and an acceptance of the value of expressing feelings which may otherwise result in suicidal action[2]. The hallmark of Samaritans support is respect for the autonomy of the individual and their right to independent decision making, extending even to the decision to end their life. Another tenet is the value of non-judgemental and supportive listening in enabling individuals themselves to work through their problems or at least develop viable coping strategies for managing difficulties. A singular feature of Samaritans is a focus on suicide and acceptance of the need callers may have to explore their suicidal feelings and intentions within the security of an anonymous, confidential and non-judgemental setting. However, the organisation has made itself available to anyone experiencing emotional difficulty or distress and in the past has taken a notably inclusive attitude in allowing callers to define their own need and determine their own use of the service. While Samaritans will not actively dissuade callers from taking their own lives, a primary goal is that the emotional support volunteers provide will deter people from resorting to suicidal actions. Thus the core principle of self determination co-exists with a primary organisational goal to contribute to a reduction in suicide.

In 2008 Samaritans recorded a total of 5,159,698 contacts, by phone, email, text, letter, minicom, face-to-face at a branch, and at local and national festivals and other events and settings outside branches. Nearly 15,000 active volunteers responded to 2,715,226 overt (dialogue) calls for support. An additional 2,444,472 (47.4%) phone contacts were 'snap' or silent calls in which no dialogue could be established [1]. In recent years Samaritans has expanded the means by which callers can make contact, including email and SMS messaging. The email service began in 1994 and had been implemented in the majority of branches (193) by the end of 2008 by which time it accounted for 6.7% of dialogue contact (160,351 messages sent). SMS Text messaging was initiated in 2006 and operated by 32 branches by the end of 2008, accounting for 3.9% of total contacts.

Callers have responded positively to these new services, with their use increasing rapidly in the few years since their initiation. However, most contacts (88.5%) are still made by phone. The majority of contacts with Samaritans are judged to be from people in distress rather than intense despair. Callers were assessed by volunteers to express suicidal thoughts and feelings in a fifth of dialogue calls although only a very small number of callers were judged to be actively suicidal at the time of the call. Suicidal feelings were expressed more commonly (36%) in emails. Twenty per cent of calls were reported to involve inappropriate use of the service, the same proportion as is judged to be made by callers expressing some degree of suicidal thoughts and feelings [1]. Despite its long established position as the foremost – and one of the oldest - telephone helpline services in the UK the efficacy of the emotional support provided by Samaritans has been largely assumed, and lacks a firm evidence base derived from independent

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[1] http://www.samaritans.org/about_samaritans.aspx
[2] http://www.samaritans.org/about_samaritans/introduction_to_samaritans.aspx

examination and research. The case for such evaluation becomes more pressing as the organisation finds itself positioned within an increasingly competitive 'market' of voluntary helpline agencies and a mixed economy of health and social care and also as it extends the range of traditional telephone support to encompass new technologies such as email and text messaging.

In recent years Samaritans has reoriented itself from a largely reactive crisis service to providing more pre-emptive forms of support. The organisation underwent a 'rebranding' in 2002 to promote a culture of change through increased public awareness of emotional health and wellbeing [2, 3]. A rapidly expanding programme of outreach education and training initiatives has actively promoted increased awareness of 'emotional literacy' in a range of different institutional settings including schools, prisons, and the workplace. The rationale is that an emotionally healthy society enables individuals to develop personal insight and resilience and to respond more sensitively to the distress of others: improved emotional wellbeing will result in fewer deaths from suicide. The current Samaritans Strategy 2009 – 2015 [4] restates the organisation's fundamental commitment to supporting people who are suicidal and specifically prioritises vulnerable groups who are recognised to be particularly at risk of suicide. These include people who self harm and those who have been bereaved by the suicide of others. The current strategy document lays out an ambitious role for Samaritans in its aim to influence public policy on suicide reduction and extend involvement with agencies in both statutory and voluntary sectors through active programmes of referral and partnership working [4].

It is in this context of organisational, technological and policy change that Samaritans has commissioned this two year evaluation of its telephone and email emotional support services to develop evidence about the impact of the services provided, and to better understand the needs and expectations of those who use them.

Research aims

1. To explore the views and experiences of Samaritans volunteers in delivering services.

2. To investigate the needs and expectations callers have of contacting Samaritans.

3. To identify and explore callers' in-depth experiences of making contact with Samaritans services.

4. To examine the nature of the support offered by Samaritans services and describe the current caller centred approach taken in relation to best practice across the service.

The research has adopted a mixed methods approach to data collection, combining observation of activity in Samaritans branches, individual interviews with callers and volunteers, an online survey of callers' experience of using the service, and a textual analysis of email messages and responses accessed with caller permission. The following brief outline of the initiation and development of Samaritans provides the context for the detailed presentation of the research design. Method and findings of the research are presented in succeeding chapters.

Background: The Samaritans

Origins

For more than fifty years Samaritans has been supporting callers according to its mission of providing 'confidential emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide'. The organisation was started by Chad Varah, a London vicar, in 1953. For many years Varah had been active in promoting sex education and counselling and it was a spontaneous response to an article (Ushering in the Permissive Society[3]) he had written for the Picture Post alongside his awareness of the lack of support available for those who struggled with suicidal feelings, that prompted him to set up a confidential counselling service [2, 5], based at St Stephen's Church, Walbrook. Varah's initial aim was to provide 'an emergency service for the suicidal' by offering personal counselling support by phone or face to face. He was able to make use of his established media links to publicise the service, which soon began to attract volunteers offering to help as well as callers in need of support. Varah describes quickly noticing that callers waiting to consult him in his office were leaving in a much more positive state of mind after spontaneously sharing their troubles with volunteers who had come along to help by making tea and answering the door bell and the phone. He realised that what most of these individuals needed was simply the chance to share their troubles with someone who was prepared to listen with kindness and impartiality. At the outset he estimated that perhaps one in eight callers required more specialised help either from him or by referral to specialist mental health services. Within a few months the service was turned over to the volunteers with Varah remaining as director. The first branch of Samaritans served as a model for the rapid development of a network of branches throughout the UK and the Republic of Ireland. At the end of 2008 nearly 15,000 active volunteers manned 99 'brick branches' in addition to a Correspondence and a Festival Branch, which provides an outreach service offering face to face support to those attending music festivals and other events throughout the country.

Samaritan befriending

The lay befriending service instigated by Chad Varah incorporated a number of the core Samaritans elements that have continued from the outset: callers were free to initiate and break contact as they wished, and callers who claimed that they wanted to take their lives would have their wishes respected. In an edited volume on the Samaritans, Varah describes the emerging service as propelled onwards by the compassion for others held by the volunteers, who offered concern and friendship rather than professional expertise[6]. The befriending discussed in early writings about the organisation does indeed invoke a sense of volunteers providing something which greatly resembled friendship; there were a great deal of assigned pairings where one volunteer would be assigned to one caller, and they would engage in social activities together [7, 8]. Yet the relationship was considered to be time limited, something to be brought to an end when the volunteer, or a more senior Samaritan, decided the caller no longer needed their support. The time-limited nature of volunteer support has remained a core element of Samaritan befriending and the organisation has formally remained true to Varah's vision in providing an 'emergency' service to people in crisis, rather than ongoing support.

Stengel proposed that the role of the Samaritan is not that of doctor or psychiatrist, but one of "standing in for a member of the family which acts as a source of strength and as a refuge in times of crisis" [9:114]. Yet Stengel also argues that the Samaritan must not

[3] http://www.samaritans.org/about_samaritans/governance_and_history/why_samaritans_started.aspx

"get too personal" [9:13]. This also invokes the time limited nature of Samaritan befriending, and the delicate balance which must be achieved by volunteers: supporting, accepting, and befriending while maintaining a distance (Chapter 6). In a later description of Samaritan befriending, Varah [5] likens the Samaritan approach to a philosophy or way of life, where there is a natural respect for all others, and an acceptance and tolerance for those who would be callers. Varah also maintained from the outset that an aim of befriending is to help callers to find their own solutions or answers, where solutions or answers exist, not to offer external direction or advice.

Structure of the organisation

Samaritans is a national charity and the coordinating body for the network of 201 branches throughout the UK, Republic of Ireland, the Channel Islands and the Isle of Man. Each branch is an independent charitable organisation. The Council of Samaritans consists of a representative of each branch (often the branch director / chair), together with 13 regional representatives and the Samaritans chairperson. The council serves as an advisory body for the Board of Trustees, and it is this board which formulates the various policies for the Samaritan branches to follow. The branches are led by a director (or chair, in Scotland) and various deputy directors who have specific areas of responsibility such as caller care, volunteer care, recruitment, and training. Branch directors are voted in by the volunteers of that branch, and generally must have held a deputy director position. The deputy directors are in turn chosen by the branch director.

Each branch will also have a system of leaders who cover the working hours of the branch in shifts, and who are the first point of support for the volunteers on duty during the day or shift they cover. In addition to listening volunteers, each branch has a smaller number of support volunteers who assist with a wide range of functions, such as fundraising, administration and publicity. The length of duty in these roles is tied at a maximum of three years. Branches are responsible for their own fundraising activities, and make an annual contribution to the running costs of General Office.

Samaritans operates on a regional structure with thirteen regions of varying size. Each region has a volunteer who oversees a specific element of branch work such as caller care, outreach, or volunteer care. For example, the regional officer for caller care in the North-East will support all of the deputy directors for caller care in that region, representing them at a national level and feeding back to them following national meetings. Samaritans General Office supports the various branches as well as the governing board through various administrative, didactic, and coordinating functions, as well as housing most of the organisation's small number (circa 70) of paid staff. Additional paid staff members operate with similar functions in Scotland and Ireland.

Samaritans offers a twenty-four hour service, every day of the year, although most of the individual branches now have some periods each week when they are not manned, especially at night [10]. The volunteers work in shifts, with at least two on duty at any time. Each branch can decide upon the type of shift pattern it operates. Volunteers 'sign up' for the shifts they can cover, and will have to meet a minimum commitment to their branch (e.g. three day shifts and one night shift per month). Volunteers typically undertake a three hour shift each week, though some evening and night shifts are longer. In addition, many are involved in supporting their branch through a number other roles and activities, as specified above. Each volunteer gives an estimated average of 23 days each year to their work for Samaritans. The majority (69%) are women [11]. Since a recent (2007) directive from the board of trustees, volunteers cannot undertake shifts of more than six hours, which includes combining two shifts 'back-to-back' if this would take them over this limit. Branches are usually very flexible in terms of allowing volunteers to choose the shifts and shift patterns convenient for them to meet their commitment. Branch size may determine commitment levels and outreach activities and

branches can differ greatly in their capacity to offer services, usually due to volunteer numbers. In 2008 the average number of active branch volunteers was 74, with a range of 497 in Central London branch to 13 in the Isle of Lewis [1, 12].

Volunteer training and recruitment

Samaritans branches have their own methods for recruiting volunteers, but branches typically arrange 'open session' or 'information evenings' so that anyone interested in volunteering can attend a talk or a question-and-answer session at the branch. For those interested in becoming a listening volunteer, there is a selection process before being accepted onto the training course. SIT (Samaritans Initial Training) is a standardised training packaged used by branches, which has been developed by the Regional Training Teams and the Training Team at general office, and has been used nationally since 2005. SIT is a two-part, modular program which prepares new volunteers for the role of a Samaritan. SIT is followed by a probation period in which new volunteers may 'shadow' or 'be shadowed' by an experienced Samaritan before supporting callers on their own. Ongoing training opportunities are offered regularly at branch, regional, and national levels. As well as their commitment to a certain number of shifts per month, volunteers must also attend a certain number of ongoing training hours each year.

Nature of service

Historically, volunteers have worked within the guidelines of Samaritans' 'Principles and Practices'. These have been amended over time from the initial 'Twenty Principles of the Samaritans' to the 'Seven Principles and Seven Practices' which were agreed by the council of management in 1981. These serve as both a guide for practice and an explication of the Samaritan approach (Appendix I). The principles state that befriending will be delivered impartially and without reference to the beliefs of the individual volunteer, that the caller is free to make their own decisions (including ending their life and ending contact), that anything discussed will be kept confidentially within the organisation, volunteers will be guided by leaders and by professional advice when appropriate, and that in some cases a caller may be encouraged to seek help from outside agencies. The Seven Principles also state that:

- The primary aim of Samaritans is to be available at any hour of the day or night to befriend those passing through personal crises and in imminent danger of taking their own lives.
- The Samaritans seek to alleviate human misery, loneliness, and despair and depression by listening to and befriending those who feel that they have no-one else to turn to who would understand and accept them.

The Seven Practices specify that Samaritan volunteers are carefully selected and trained, are available at all hours to callers and may be contacted anonymously if desired, will seek the caller's permission to maintain contact if they are in danger of suicidal action, may set limits on the length of any befriending, may initiate third-party contact to individuals where appropriate, will be identified to callers using a forename only, and that branches are banded together in a legally constituted association whose council of Management represents all the branches and reserves to itself the appointment of the person in charge of each branch.

More recently these principles and practices have been superseded by the 'Nature of Service Policies' (Appendix II). These are points about the service which incorporate the main aspects of the principles and practices, and are grouped under the headings of '24 Hour Availability', 'Confidentiality', 'Honesty', 'Emotionally Supportive', 'Carefully Structured', and 'Self-Determination'. The policies state that 'Callers in need of

Samaritans' service are accepted without prejudice and encouraged to talk or write about their feelings, acknowledge their emotions and explore options'. This allusion to whom callers may be does not make reference to loneliness, despair, suicidality, or depression in the way that the Principles and Practices had done, and as such may be thought of as more broad-ranging by simply referring to those who need the service. Nelson and Armson discussed the rebranding of the organisation in 2002 following brand consultation with Wolff Olins [2]. Not only was this a physical rebranding (e.g. change in colour scheme of Samaritan materials) but a re-launching of the service as one which continued to work towards reducing suicide though the provision of support but also aimed to promote general emotional well-being, working more closely with other organisations to achieve this aim. Samaritans was to be a "first step rather than a last call on the issue of suicide and emotional health in general' [2:303] with the launch of the 'Emotional Health Promotion Strategy ' in 2003 [3].

The Emotional Health Promotion Strategy set out a rationale and set of priorities for working in various arenas and settings, such as rural communities, schools, and with the media. Since then, Samaritans has increasingly fostered links to what Nelson and Armson refer to as "gatekeeper groups" [2:298] who work regularly with those at risk of suicide, such as homeless charities and health trusts, and have a number of referral schemes in place at various branches where such groups will refer clients to a branch for support [11, 13]. The most recent statement of the Samaritans strategy, introduced in 2009, seems to be turning away from the previous emotional promotion policy and reverting to a more specific focus on achieving suicide prevention and reduction by supporting individuals in *crisis,* identifying and prioritising groups at increased risk of suicide, and influencing national suicide reduction policies [4].

Suicide prevention

The World Health Organisation reports claim that death by suicide will increase in numbers globally over the coming decades and argues that an increase in treatments for the suicidal does not necessarily lead to a reduction in a country's suicide rate [14]. The prevention of suicide is hindered by the sheer range and complex interrelations of actions and intentions to be considered within any prevention programme [15]. Although a number of countries, including the UK, have implemented national suicide prevention strategies [16], these are hard to evaluate and there is as yet no clear evidence for the effectiveness of specific strategies in reducing suicide [17-19]. Previous studies of suicide crisis helplines report that many callers appear to derive benefit from the support provided in the short term, but it has not been possible to establish a more enduring impact, or that this results in suicide prevention [20-22]. Evidence is, however, emerging for the effectiveness of more structured interventions involving brief, supportive contacts in reducing rates of death by suicide in at-risk populations. The evaluation of a telephone based support service for the elderly found that a combination of information and emotional support provided by telephone, accessed as needed on a 24 / 7 basis but with at least two contacts per week initiated by the service providers, served to reduce suicide rates among an elderly population. The researchers proposed that a sense of "connectedness" (p.226) was a key element in the success of the service, which yielded results in both short-term (4 years) and long term (11 years) evaluations [23, 24]. Fleischmann et al reported on a multi-national, randomised control trial with a population of adults who had previously attempted suicide, and found that regular supportive contact decreased the risk of death by suicide [25]. These contacts were carried out by trained professionals (nurses, psychologists) and consisted of information on alternatives to suicide, where further support could be accessed, and referrals for more immediate support where necessary. Contacts were made either by telephone or face-to-face. This constitutes a directive, information based approach to support, although the researchers suggested that an element of its success was the social nature of the contacts which allowed the participants to feel listened to. Also discussed was the

cost-effectiveness of the support, as the training required was minimal in comparison to the clinical training of health professionals, and few resources were needed to deliver the support (an initial one-hour meeting, and eight subsequent five-minute calls / meetings). The frequency of contacts was decreased over time while still providing positive results. This has been a feature of other work in the area which also led to reductions in suicide rates. Therefore, it may be that the "keeping in contact" element of these trials is an important aspect of the support.

Social support from another person is often cited as an important element in alleviating despair, emotional distress, depression, and suicidal ideation, the importance of which has been acknowledged in the literature for a number of decades [26, 27]. For example, Nock *et al* undertook a large scale review of previous epidemiological studies which focussed on suicide and found that having "perceptions of social and family support and connectedness" was a protective factor, and that the prevention strategies of means-restriction and training health professionals to recognise and treat depressive and suicidal patients showed the most promise [14]. A more recent systematic review of studies which examined the effects of 'befriending' (emotional support often offered in the voluntary / community sector) on depressive symptoms found a mild positive effect, and again discussed the cost-effectiveness of such support as a major benefit [28]. These studies suggest the potential effectiveness of voluntary sector services such as Samaritans in providing a sense of 'connectedness' for callers as a means of deflecting or reducing impulses to suicide or self harm. However, the studies outlined above suggest that it may be that such 'connectedness' derives from the experience of relatively structured and enduring support, rather than sort term contact with crisis services.

Accessing the service

The methods through which people may contact Samaritans have expanded from telephone and face-to-face contacts, to now include letter, email, minicom, and text message contacts. After initial piloting the email support service was rolled out from 1994 and is now provided by 193 of 199 'brick' branches. The SMS (phone) text message service was initiated in 2006 and is being extended as individual branches become accredited, with 32 offering this form of support by the end of 2008[1]. Both of these innovations aimed to provide access options more readily utilised by young people (a high risk group in terms of vulnerability to suicide) but have also increased accessibility for those unable to hear or speak effectively, and for those who may generally feel more comfortable communicating in these ways.

Although an increasing number of callers choose these newer channels as their method of contact, telephone call volume has remained relatively stable since the early nineties. Email and text message contacts have surpassed face-to-face in terms of numbers of separate contacts, and indeed face-to-face contacts have decreased substantially in number over the same period[1]. While each branch has an individual phone number, the national 'one number' is the most heavily promoted point of telephone access for people to call Samaritans and be put through to the nearest available volunteer within a specified range. This is an 0845 number which is charged at variable rates set by individual service providers. Branches work on a 'daisy chain' system with this number. The regional branches are linked so that calls will be forwarded to particular branches. This system allows callers to be connected quickly to a volunteer and has substantially reduced the engaged call rate (currently at 7.7%). However, the majority (80%) of calls are still made to local branch numbers [11]. This suggests a deliberate choice of callers which could relate to costs of calls, but may also result from the high proportion of regular callers who prefer to maintain a relationship with their local branch [10].

Samaritans aims to support callers on a short-term basis, either in just one contact, or over the course of a small number of contacts while they may be going through a particular crisis or trouble. Callers making frequent or prolonged contact may be subject to a care-plan to limit and structure their use of the service. Callers who contact repeatedly can cause operational problems for organisations such as Samaritans, and the provision of support in this manner may be contra the founding principles [29]. Care plans are usually constructed in consultation with the caller, so that a pattern of contact that the caller accepts and understands can be mutually agreed. Callers judged to be at particular risk of suicide may be offered follow up contact by the organisation, where a volunteer will contact the caller at an agreed date and time to offer continued support. This is typically offered where it is clear that the caller is at risk but it is uncertain whether they would call again of their own volition.

Samaritans operates a policy of 'self determination' which holds that callers remain responsible for their lives and that this capacity extends to the right to make the decision to end their own life. Samaritans does not routinely direct callers towards other organisations, and even callers who are in the process of suicide during a contact will be asked if they would like emergency services to be called and if possible, to contact these directly. If the caller does not wish this to happen, the volunteer will stay with them on the line and offer support. Callers visiting a branch are an exception to this policy, as are callers who have previously provided phone or other contact details, as Samaritans have a duty of care to ensure the health and safety of those on branch premises, and also to comply with current legislation regarding the illegality of assisting suicide.

Restrictions on who may call

It may seem from the information above, particularly the 'Nature of Service Policies', that the organisation is open to all those in need of emotional support. The Samaritans website, at the time of writing, claims that 'Samaritans provides confidential non-judgmental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide' [4] . Indeed, much of the Samaritan advertising makes the organisation seem open to all those who feel a need to discuss their troubles. From the outset, however, callers judged to be either inappropriate or abusing the service were excluded from entitlement to contact Samaritans [5]. In practice, it has proved difficult to exclude unwanted callers and the attribution of inappropriate contacts currently stands at 20% [1].

Conclusion

This brief review has outlined the enduring mission of Samaritans to provide confidential, non-judgemental emotional support to anyone passing through crisis, especially when this has led to suicidal thoughts and intent. Much has changed within the organisation in terms of methods of contact, organisational structure and governance and the shifting emphasis on the definition and prioritisation of policy. Samaritans has adapted to external changes of many different kinds. Technological innovations such as the internet and mobile phones have transformed the means by which people communicate. New treatments such as antidepressants and anti-psychotic drugs have transformed the management of mental health problems [30]. Contemporary notions of citizenship have been reconfigured with an emphasis on autonomy and personal responsibility alongside entitlement to responsive, tailored, high quality health and social services [31]. Demographic changes have resulted in an ageing population and prolonged morbidity

[4] www.samaritans.org

from chronic degenerative ill health with an escalation in associated health and social costs which modern governments are struggling to support. The boundaries between the statutory and voluntary (Third) sector agencies and organisations have blurred. The rapid increase in Third sector organisations has generated a degree of competition reflected in the current concern to raise organisational profile through the adoption of social marketing techniques and establish credibility through the development of a firm evidence base. Voluntary organisations have an increasing role in developing policy and engage with partnership working with professional services and care delivery [32, 33]. This policy commitment to closer working between the statutory and Third sector services is reflected in the current Samaritans strategy. However, closer relationships with professional agencies augur changes in the organisation's principles and practice and possibly also, its character [34]. It is in this complex climate of social, policy and organisational change that the current research has been commissioned to investigate the impact and efficacy of the emotional support offered to those who contact Samaritans.

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Chapter Two: Design and Method

Introduction

The sensitive nature of the discussions between volunteers and callers and the anonymous nature of their contact posed some challenging issues of ethics, design and recruitment for the study. Prior to the start of the research Samaritans undertook a consultation exercise to obtain volunteer and caller views about how the research should be carried out and the acceptability of different methods of data collection [1]. A series of five workshops involving 108 volunteers was held during September and October 2007 at different locations throughout the UK. Throughout the same period, an online survey was posted on the Samaritans website inviting the views of volunteers, callers and members of the general public. Survey responses were received from 132 people, most of whom were volunteers. The prospect of the evaluation aroused mixed feelings among the 240 respondents (in total) who took part in the consultation exercise. Overall, however, there was agreement that independent evidence regarding the effectiveness of the organisation would be beneficial in a number of ways. The results of the study would enable the organisation to learn about itself and apply insights about callers' expectations and assessment of the service. They would contribute to the development of a more professional profile, particularly in relation to other voluntary sector organisations, which could help Samaritans to attract funding, raise its public profile and increase its influence on government policy relating to suicide prevention strategies. At the same time, volunteers were concerned that the research should not contravene Samaritans' fundamental principle of caller confidentiality nor threaten caller perceptions of the organisation's reputation and trustworthiness. Accordingly, the majority view was that volunteers should not be involved in any aspect of recruitment of callers, that the researchers should not listen in directly to calls, and that calls should not be recorded. These restrictions were understandable, but placed obvious limitations on the researchers' capacity to directly explore the interactions between volunteers and callers. However, volunteers accepted the proposal that the researchers could access the content of email and text messages and volunteer responses provided callers had given permission for them to do so. They endorsed the inclusion of both volunteer and caller perspectives, and felt that it was important that the researchers should undertake direct observation of the volunteers at work. The very useful suggestion that members of the research team should undertake training as volunteers also came from the consultation exercise.

Working within the remit provided by the consultation exercise, the research team made use of a combination of qualitative and quantitative methods as a means of exploring caller and volunteer experiences and views of the service offered by Samaritans from a variety of different perspectives. An online survey of callers' views was developed to reach a large number of callers, while a smaller series of interviews with both callers and volunteers enabled the exploration of such perspectives in depth. In addition, callers were invited to participate in the research by giving permission for the content of their email and text messages to be retrieved and made available to the researchers for analysis. Direct observation of activities in a range of branches across the UK was proposed as a means of gaining insight into the work of the volunteers in different settings. This was extended by the participation of two members of the research team in the training programme for new volunteers.

There was a strong desire within the organisation for the research to be oriented towards establishing clear evidence of Samaritans' impact in reducing suicide. However, the researchers made it very clear from the outset that this was not a proper or feasible goal of the study. The complex mix of variables involved alongside the difficulties of accurately evaluating the nature of 'suicidality' and the extent of individual risk

jeopardise the accuracy of any such assessment[5]. However, the research methods selected for the study provide a valid and innovative means of exploring participants' in-depth accounts and assessments of the service they have received. It may never be possible to establish 'objectively' that Samaritans and other suicide support helplines contribute to reducing suicide [2, 3]. However, the study findings will extend insight into caller and volunteer experiences of using and delivering Samaritans emotional support services and the nature of the support received by callers and desired by different groups of user. They will also point to routes for further development of the service in future.

Ethical approval

The research was approved by the University of Nottingham Medical School Ethics Committee in November 2007 and by Samaritans Operations Development Committee in December 2007. The study commenced in January 2008 with the appointment of a full time Research Associate.

The project website and promotion of the study

The unique nature of Samaritans and the confidential and anonymous service it provides to callers posed particular challenges in recruiting callers to take part in the study. Identifying and directly approaching people who use Samaritans services was not possible, and so we had to devise ways of prompting both callers and volunteers to take the initiative in contacting us to take part in the study. The project website was developed during the early months of the study and went live in May 2008. This was an important means of providing information about the research and recruiting callers and volunteers to take part. It held detailed information about the project, including the Participant Information Sheets and Consent Forms which could be viewed or downloaded and kept for reference. The website hosted the online survey which could be completed and submitted online, or downloaded and returned by post. Volunteers and callers were invited to contact the researchers by phone or email if they were interested in taking part in a telephone interview. Callers were also asked to give their permission for the team to have access to the content of their email messages and volunteer responses to be included as a source of data within the study.

Although the website was the primary means of promoting the research, the project was also advertised in a number of other ways in order to reach sections of the population who lacked access or confidence in using the internet. Leaflets and posters were displayed in all Samaritans branches and through local branch publicity networks as well as local doctors' surgeries, hospitals and public places such as supermarkets and library notice boards. Information about the study and links to the project were posted on relevant websites such as Men's Health, Brightplace, Papyrus and Mind and disseminated informally through local networks of organisations within both voluntary and statutory sectors. Adverts inviting people to participate in the study were placed in local newspapers across the UK including the Metro.

The online survey

An online survey was developed to collect data from users of the Samaritans service primarily to obtain an understanding of their experience but also to obtain information on their expectations of the service and their views on how the service could be

[5] These issues are discussed in Chapter 8.

improved (Appendix IV). The aim was to collect information from people who had contacted the Samaritans by telephone, e-mail, or SMS text message. The development of the survey started in January 2008. The questions from an earlier online survey used by Samaritans to obtain feedback from callers were used as the basis for developing a more detailed questionnaire [4]. The survey designed for this research study comprised four sections:

- *Section A: Introduction and consent* – on the first page of the questionnaire the survey was introduced. Statements to say that information given by the respondent would be used only for the purpose of the research study, that the questionnaire was anonymous and that all answers would be treated in the strictest confidence were included. This page also informed respondents that they were free to leave out any questions that they did not wish to answer. Before proceeding to complete the survey respondents were required to tick a box indicating that they had read and understood the information provided about the study and the questionnaire.
- *Section B* collected information on the characteristics of respondents.
- *Section C* focussed on the last time the respondent contacted the Samaritans. It collected information on the method of contact used, why this was chosen, how the respondent was feeling at the point of contact with Samaritans and what their experience was like. This section also included questions on whether respondents were asked if they were feeling suicidal and how being asked this made them feel.
- *Section D* focussed on previous contacts with Samaritans (if applicable) and the respondent's general perception of the service.

The questionnaire was finalised in March 2008 and then designed and tested as an online survey. In the testing stage members of the research team and other members of staff within the University completed the survey questionnaire and gave feedback on the questions asked, whether there were ambiguities in these, whether all questions were necessary, whether questions needed to be changed or additional questions were needed, whether enough space was allowed for responders to enter their comments in the boxes provided for the free text questions, and also how long it took to complete the survey. The questionnaire was refined in response to the feedback. Examples of changes that were made included an increase in the amount of space provided for responders to enter their comments in the free text boxes and the removal of a question asking responders to rate how they felt during their last contact with Samaritans. This question was of the same format as question 8 in Section B of the survey (see Appendix IV) where responders are asked to rate how they felt at the end of the contact but was removed because the research team felt that having two almost identical questions in succession could compromise the reliability of the responses given to the second question and it was felt that it was more important to capture how people felt at the end of the contact rather that during it. The refined questionnaire became available to the public on the project website in May 2008 and remained on the website until the end of May 2009. A downloadable version of the questionnaire was available for respondents to print and mail back by freepost if they preferred.

The interviews

Volunteers and callers were invited to take part in an interview to explore their views and experiences of delivering and receiving Samaritans services. Some volunteers were recruited directly and took part in face to face interviews during branch visits. However, many volunteers and most callers made initial contact with the researchers by email or, more usually, phone. After answering any questions about the study, and encouraging respondents to review the website information, the researchers arranged a convenient

time to call back to carry out the interview. A few callers who phoned obviously wanted to give on the spot views of their experience of Samaritans, rather than to arrange a call back. In these cases the researchers responded flexibly to individual preferences and always attempted to be sensitive to the caller's emotional state and how best to manage the content and duration of the interview. A small number of callers and volunteers took up the option of completing an interview by email.

Respondents could take part in the study anonymously and we did not ask telephone or email interviewees to provide written consent. However, we did ask that they read the consent form that was available on the website to ensure that they were aware of and accepted what participation in the study involved. Confirmation that each respondent felt adequately informed about the study was also established at the start of the interview, and a verbal run through of the content of the consent forms was given if required. Respondents were assured that participation was confidential, that they were under no pressure to discuss topics or reveal any information they preferred not to disclose and that the study outputs would be anonymised to prevent the identification of individuals. They were also told that they were free to withdraw their participation at any point. Where respondents' permission was gained, the telephone and face to face interviews were tape recorded and subsequently transcribed for content analysis using the NVivo8 software programme [5-7]. Untaped interviews were written up from notes and the accounts were entered in the NVivo data base along with researchers' field notes of the interviews.

The purpose of the qualitative interviews was to explore callers' and volunteers' experiences and perspectives of using and delivering Samaritans services. A topic guide was prepared for each group of respondents which reflected the researchers' initial expectations of questions and issues of obvious relevance (e.g. reasons for calling Samaritans, perceived impact of support received). However, the aim was to prompt respondents to provide a personal account in their own terms and to provide time and space to explore the issues and topics which they consider to have greatest salience, rather than restrict the discussion to questions which have been pre-defined by the researcher.

Branch observations

Case study branches were selected to incorporate a range of characteristics in terms of size, location and activities. Each case study branch was visited at least once for a period of 2 – 3 days. The purpose of the visits was to undertake intensive informal observation of the work of different branches and to recruit and interview volunteers for the study. With the exception of one branch which did not allow direct observation of the volunteers, the researchers were given open access to the operations room and attended shifts on weekdays and weekends as well as different times throughout the day and night. To preserve the Samaritans' principle of upholding caller confidentiality the researchers did not listen in to calls or read email messages and responses. However, they were able to observe and listen to the volunteers taking calls and collaborating on the construction of email responses and to participate in subsequent discussion of calls, callers and messages with the volunteers. The observations provided an opportunity for researchers to learn about wider aspects of the volunteers' roles in supporting local branch organisation and to engage in much informal discussion of the views and experiences of many volunteers who did not take part in scheduled interviews.

Information about the study was posted in the branch offices, though there was some variation in the ways and effectiveness with which information about the study was circulated prior to the observations. Although not all volunteers were aware of the study at the time of the branch observation visits, most were very positive and accepting in their response. At the start of every shift the researchers introduced themselves,

answered any questions and checked that the volunteers coming on duty were comfortable about being observed. Volunteers were assured that this was entirely voluntary and that they were free to decline or withdraw their participation at any time, in which case the researcher would leave the operations room until the end of the shift. Over the course of the observations reservations were expressed by only one volunteer, who did not refuse to be observed, but was clearly not keen. In this case the researcher felt it appropriate to leave the branch until near the end of the shift.

In addition to the branch observations, members of the research team have visited General Office at Ewell and attended a variety of events, including the annual York conferences, a weekend Council meeting, a branch AGM and a volunteer selection day.

SIT training

A valuable suggestion emerging from the consultation exercise was that the researchers should undergo the Samaritans training programme for new volunteers as a means of extending their insight into the organisation's principles and culture. MS and KP attended different cohorts of the first part of the Standard Initial Training (SIT1). This involved a nine week course of three hour evening sessions. KP was offered the opportunity to attend the second part of training (SIT 2), which comprised a course of 4 further sessions. Eligibility to SIT 2 requires trainees to undertake attendance as observers at mentored weekly shifts before moving on to take calls under guidance and finally as independent volunteers. It was agreed that KP should shadow the training experience of new volunteers by attending as an observer during one shift per week. Regular observations were maintained between June 2008 and March 2009.

Overall, substantially in excess of 200 hours was spent in direct contact with Samaritans volunteers, branches and activities over the period of data collection between March 2008 and May 2009. Detailed notes were typed up following branch visits and observation sessions and included within the NVivo database. This extensive observation and training at case study branches has been invaluable in deepening the researchers' knowledge of Samaritans as an organisation and developing their understanding of the volunteers and their work. It has been an important complement to the data collected from other sources and has provided a valuable framework for the contextualisation and integration of material from the online survey, interviews and email messages.

Email and SMS text messages

The original research brief included an evaluation of text as well as email services. When it emerged both that the roll out of the SMS service was proceeding more slowly than originally envisaged, and because we received very few permissions to access callers' text message strings, it was subsequently agreed with Samaritans that the research should concentrate on the email and telephone services. However, we have included the available material relating to the text service from the different data sources in our analysis. Samaritans retain the content of email and text messages for review by volunteers for a period of one month. Several text and email message strings could not be retrieved because callers' permission to access these had been given more than a month after their last contact. In addition to the small number of text message strings available to the study, information about callers' experience of using the service was available from interviews and the online survey. A shift observation was also carried out in a branch using text messaging, and volunteers subsequently took part in a discussion of this service.

The email message strings amount to a substantial body of data in their own right, extending to nearly 350 pages of text. This is a significant corpus of data as it represents

the only source of direct interaction between callers and volunteers that was available to the research team. This report includes an analysis of material from the messages that were coded within the NVivo database, as well as relevant content from the branch observations, online survey and caller and volunteer interviews.

Callers using the email and text messaging service were invited to contact the researchers via the website and all promotional materials featuring the study. In addition, a brief invitation to access information about the study was included as a footer in all outgoing email responses and in the automatic acknowledgement sent to callers on receipt of their initial text message. Emails from callers giving permission for their text and email messages to be included in the study were forwarded to Samaritans who retrieved the message string and returned it to the research team. In a few cases callers forwarded the messages directly, sometimes with an accompanying gloss or commentary. It was apparent that a number of such permissions came from callers from abroad, most commonly the USA, although it was not always possible to determine the caller's nationality or country of residence. This finding, along with the responses to the online survey which came from callers outside the UK, highlights the international nature of the service provided by the UK Samaritans.

A number of callers mentioned that they had completed the online survey as well as taking part in an interview. As the survey was completed anonymously their survey responses could not be matched up with the content of the interviews. However, it was possible to relate the content of email or text message strings with interview data for a small number of caller interview respondents. These constitute particularly valuable data sets as they enable direct comparison of 'live' interaction between callers and volunteers with caller reflections of their contact.

Data analysis

Survey data

Data were analysed according to a pre-specified analysis plan using the statistical package SPSS version 16.0. Descriptive statistics were used to summarise the characteristics of the survey respondents, their use of, experience, and satisfaction with the service. Categorical data were described using frequency counts and percentages. Ordinal data were summarised using the median and lower and upper quartiles. Since this was an exploratory study, gathering information on the needs and opinions of users of Samaritans with no specific hypotheses to be tested, individual comparisons between two categorical variables were made informally using cross tabulations.

Qualitative data

The qualitative software programme NVivo 8 was used to facilitate organisation of the different qualitative data sets and to support a thematic analysis of interview transcripts, observation and field notes, and email and text messages. This has been undertaken in line with established procedures for qualitative analysis [5, 6, 8, 9]. A coding frame was constructed from an initial reading of the data and subsequently refined through further reading, reflection and discussion within the research team to identify recurring themes and patterns of ideas and topics throughout the different data sets [8, 10]. An initial coding frame for the interview data was developed collaboratively by KP, MA and MLS who each independently coded a sample of caller and volunteer transcripts and then developed a frame through an iterative process of discussion, adjustment and further coding This included some a priori categories derived from questions and topics included in the interview topic guide (e.g. 'asking/being asked about suicide', 'reasons for calling', 'confidentiality') and others which emerged from the discussions with

respondents, (such as 'concealment', 'dependency' and 'manipulative callers'). Complex parallel coding frames were developed for caller and volunteer interview data, which subsequently incorporated coding of the email data. There was a considerable overlap in coding categories for the volunteer and caller data, but also codes which were specific to each. Most data units were relevant to, and coded at, two or more separate nodes.

KP went on to code all caller and volunteer interviews, field notes and the corpus of email messages and responses and also developed a separate coding frame for the observation data. A substantial number of interview transcripts were double coded by MLS prior to her departure from the project. More refined coding was undertaken by KP, JM and CC in the course of developing the analysis of the data. Major coding categories were allocated to two members of the research team who combined independent analysis of the node contents into a written synthesis which was the basis for discussion and further modification. After joint working on core categories had enabled JM and CC to gain a detailed knowledge of the data, further categories were divided between KP JM and CC for detailed analysis and a written synthesis to be discussed and moderated during regular meetings of the research team.

During analysis of the survey data it became apparent that the responses to a number of open questions included in the online questionnaire had provided a very substantial body of rich additional data: some questions had attracted up to 700 written responses from callers. A separate NVivo data base was established to facilitate the analysis of this data. This involved a relatively simple coding frame, as the responses related directly to each question. Most of the detailed coding of the survey responses was undertaken by CC, with additional input from JM and KP. The loss of two members of the original research team (MA and MLS) inevitably caused some disruption to the project. However, the subsequent input of CC and JM brought additional and independent perspectives which have contributed to the robustness of the analysis of the different data strands.

Particular attention has been paid to the triangulation of different data sources and analysis of areas of contrast and difference between these. In addition to the comparative cross sectional analysis of themes and issues across data sets and respondent sub-groups, the caller interviews and email message strings provide an opportunity for detailed exploration of individual experiences of help seeking and assessment of Samaritans support.

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Chapter Three: The Volunteers

Introduction

Samaritans is a volunteer based organisation with the ratio of volunteers to paid staff at 212:1. The figures from the 2009 Information Resource Pack (relating to 2008) put the number of listening Samaritan volunteers at 16,768, of whom 1,863 were temporarily inactive. A further 1,409 volunteers support the organisation in ways that do not include listening to callers, such as working in Samaritans charity shops or engaging in fundraising activities. This figure for listening volunteers shows an increase of 500 from 2007, after a steady decrease in volunteer numbers since a peak of 20,902 in 1993. This decrease reflects a general decline in the number of new volunteers completing training over much of the same period, although this has been increasing since a low of 2,905 in 2003. That 2008 was the first year to show an increase in total volunteer numbers suggests a higher rate of attrition than growth in volunteer numbers between 2003 and 2007. The number of annual contacts containing dialogue increased by 214,740 in roughly the same period, from 2,545,608 in 2004 to 2,760,348 in 2007[1].
Individual branches are responsible for the recruitment, selection, and training of their own volunteers, and all branches generally follow a similar process. Recruitment typically involves various forms of public advertising and events to raise the profile of the branch and highlight the need for volunteers. Interested individuals are invited to an information evening, where information is given on the nature of the organisation and of volunteering. Those still interested are given the opportunity to formally say so, and are invited to a selection event, where they are vetted by existing volunteers for their suitability. If accepted, they are then recommended for SIT (Samaritans Initial Training). New volunteers are requested to provide a disclosure from the Criminal Records Bureau which displays any criminal record.

Training typically involves attending a number of weekly sessions, and some weekend dates, across a period of several months. If existing volunteers deem any trainee to be unsuitable, they may be asked to withdraw rather than complete the training. Successful trainees will become probationer Samaritans, and each branch will have its own probation system involving support from peer groups and individual mentors. If no issues have arisen regarding the new volunteers abilities by the end of the probation period, they are formally deemed to be 'full' Samaritans and provided with written confirmation of this from the branch director / chair.

Volunteer recruitment and retention is an important issue within the organisation, with the emergence of what has been termed the 'capacity debate'. Volunteer numbers have been decreasing while demand for the service appears to be increasing, yet these issues manifest in quite a complex manner. Many branches are struggling to meet the commitment to provide a service 24 hours per day, 7 days per week, and have taken to closing for certain periods each week. An 'engaged' rate (where callers do not get connected and receive an engaged tone) of 7.7% was reported for 2008. This is an increase from a rate of 6.6% in 2007 but still within the target of 10% [1]. 68% of these (2008) engaged occurrences were for contacts attempted between 2:00AM and 8:00AM [2]. Yet there are also times at which volunteers in some areas report not taking many, if indeed any, calls. This raises the challenge of organising resources (in terms of volunteer time) to meet the patterns of demand.

The Volunteers

Sixty-six volunteers took part in in-depth interviews to discuss a wide range of issues related to being a Samaritan. An equal number completed face-to-face interviews and

interviews via telephone (32 in each case, 48.5%). Two others were interviewed via email (3%). Of those whose age is known, (N=62, 93%) the range was from 22 to 76 years, with a mean of 52. All identified as White British, with roughly equivalent numbers of male and female volunteers (33 Male, 50%; 31 Female, 47%), with one case missing the datum, and one volunteer identifying as Transgender. This is somewhat reflective of the general volunteer body, the majority of whom are white British, although the 2009 Samaritans Information Resource pack records that 67.7% of volunteers are female. Four volunteers were Listeners (6.1%) who took part in face to face interviews at their prison. The Listening scheme is a well established peer support scheme[6] established in partnership with HM Prisons. Prisoners are trained by Samaritans to provide a confidential listening service to fellow inmates experiencing distress or suicidal feelings. Exactly half of the volunteers interviewed had not held other roles within the organisation. Twelve were, or had been directors / chair (18.1%) and three were or had been deputy directors (4.5%). Three others had held multiple roles (4.5%) and two were or had been involved in Caller Care (3%). Single volunteers (1.5%) were listed in the following roles; Branch Committee, Branch Manager, Branch Statistician, Leader, Prison Service, Referral Scheme, SIC[7], and Training. There was wide variation in volunteers' length of service with seven volunteering for one year or less (10.6%) while at the other end of the spectrum one volunteer had put in thirty-six years of service (1.5%). This data was not collected in five of the interviews, and for the remaining volunteers, the average length of service was 10.7 years.

The volunteers interviewed for the project provided much information about their experiences as a volunteer. The work of this chapter incorporates this interview data as well as drawing upon a wealth of interactions with volunteers during branch observations, conferences, and other Samaritan events.

Reasons for becoming a Samaritan

Volunteers gave a number of reasons for joining the Samaritans. Being prompted to apply after chancing upon an advertisement was commonly reported. The adverts were sometimes described as being quite striking and memorable, and as having had a strong impact. On some occasions, previous thoughts about joining, or some connection to the organisation were mentioned which predated seeing an advert and which perhaps reinforced its effects. Others were drawn to Samaritans by a specific campaign or an outreach event which drew attention to the organisation and its need for volunteers. It appears that an advert, campaign, television programme or other event may have acted as a catalyst or trigger which prompted the person to start the application process.

> *Every day I passed the branch and every day I kept thinking 'I must pop in there some time and see if they need volunteers.' But I didn't, it looked a little bit like it didn't want you to walk in. It was a bit intimidating. And I still think that's so. I mean the branches are a bit fortress-like. So I never did. And then when I moved to ******, I saw an invitation in the newspaper saying 'Come to an open evening,' which is how they do it. I mean we don't want people calling in to volunteer off the street.* V251

Some individuals had spent a great deal of time thinking about applying before doing so, although practical reasons were provided to account for the gap, such as other commitments or living abroad.

[6] http://www.samaritans.org/your_emotional_health/our_work_in_prisons/the_listener_scheme.aspx

[7] Samaritan In Charge: a volunteer who coordinates calls and volunteer activity in the biggest and busiest urban branches.

The grandmother of a friend was a Samaritan and she didn't talk much about it but it stayed in my head really, for quite a long time. I'd thought of doing in the future … and when I had more time, that's how it started. But also, I mean, I can't say this is the real reason, and it is only really in retrospect that I thought a lot about it but there is, there is a history of suicide in my family. V245

The mixture of events or circumstances which were cited by volunteers when discussing their reasons for volunteering also contained personal experiences (or experiences of a family member or friend) relating to suicide, mental health problems, or severe life stressors.

While knowing someone who had been a Samaritan was given as a reason for applying, knowing someone who had attempted suicide or who had died by suicide was more commonly reported. Whether it was their own troubles or those of others which were discussed, volunteers related these to the support offered by Samaritans. An appreciation for emotional support they had received (from various sources) was discussed, as were volunteers' attempts to understand more about suicidal ideation and the desire to use their experiences to support others going through similar troubles. This is not a discourse of 'giving back' (discussed below), but rather one of 'being able to help' as a result of their personal experiences.

Someone that I knew pretty well, hanged herself … it just shattered me because I really couldn't understand it...it shattered me and I couldn't join then, but it hung there with me for years and it must have been five years later before I had the time then and knew I could give the commitment. V241

Volunteers did speak about their application to become a Samaritan stemming from a desire to 'give something back' after receiving support during their own time of trouble and need. In some cases, receiving help from Samaritans was discussed, and the desire to return something to the organisation was a large element in the decision to become a volunteer. More generally, the notion of 'giving back' was not typically explained or unpacked in any detail in the interviews, but some respondents linked it with the notion of personal privilege in having been blessed with 'good fortune' throughout their lives, or alternatively as a response to having come through some particular trauma or difficulty.

Just wanting to give something back after me Mum died. V227

I think a lot of the volunteers that we have, have been through hard times … I just want to give something back, because I was very lucky … I think that people who've been through difficult times are maybe more empathetic, and ready to listen. V214

Having experience of personal troubles was not invoked routinely as a *requirement* for being a good volunteer, but some respondents implied that having difficult life experiences may make one a better Samaritan.

I've had my down moments as I think everybody does but nothing to that level. ...it's an area where you need to tread carefully but I don't think you need to have that experience to become a Samaritan but if you have, you can make a very good Samaritan. V225

I don't know whether this is true or not but I mean, it's always, it's always the theory that most Samaritans have gone through something. V213

Apart from personal familiarity with emotional or mental health troubles, other experiences and skills were discussed as a significant factor in the decision to become a Samaritan. These may be professional skills (coaching and management are mentioned below) but personal skills and abilities were referred to more often, such as being a good listener, or being empathetic. Sometimes volunteers discussed this in a manner which avoided discussing their own personal abilities and addressed experiences instead for example, explaining how people would 'always come to them to solve their problems' or 'phone them up for help'. It may have been the volunteer themselves or someone around them who first raised the connection between these skills and abilities and the work of Samaritans, leading to the application to become a volunteer.

> *I just thought I'd try and help, there was a time in my work when I was always solving people's problems, they always came to me ... I thought that I would be good at it.* V222

> *I hadn't even thought of it and there was an advert in Cosmopolitan, back then, wanting volunteer Samaritans, and my daughter said, 'Oh Mum, people are always phoning you and talking to you when they don't know what to do, I think you could do that' and I applied.* V263

Although this was not a strong theme, a few respondents described being drawn to volunteering as a result of a direct interest in the general topics which Samaritans aims to address through its work, and the type of callers they help.

> *I'm very interested in psychology so it was a way of learning more about that, so, kind of, not all altruistic, I was interested in the subject as well, not in the subject, but in people and, and, so, yeah, it's been very rewarding.* V220

> *First thing that I found was (...) their website and I remember at the time they had some downloadable clips with callers' experiences. I listened to a number of them and just found it really interesting and wanted to get involved* V240

Applying to become a Samaritan following retirement or finishing paid work was also discussed. This allowed more time for volunteering but becoming a Samaritan was seen as a way of keeping busy and occupied, as well as providing a social network. A further issue arising from this data relates to why volunteers chose to apply to Samaritans in particular. There was an element of randomness or fortuity; a combination of events including personal circumstances and some kind of trigger such as, again, an advert. The choice was not always a simple one to explain.

> *I retired early, and I decided that I wanted to, not just sit at home and to do something that was useful. And I also decided that I wasn't going to jump into it and I'd take some time and consider the number of options available really and, I really don't know why I chose Samaritans to be honest. I chose them because it seemed to me that it was a worthwhile (hackneyed old phrase) something to do. I had no previous experience of them at all. It was a leap in the dark, really, in a sense.* V201

Joining Samaritans as a way of being challenged and doing something 'useful' and 'worthwhile' was discussed on many occasions. Volunteers also wanted to be sure that their time would be well utilised for a worthy cause. This ties in with why Samaritans was chosen over another voluntary organisation. Having a desire to be of help to those in need through a charity that was hands-on or at the frontline of the issues was important also, with volunteers wanting to work directly with those in need.

I went and investigated charities around X, and … it was very much behind-the-scenes work rather than anything that you'd see, you wouldn't necessarily have much contact with people, you wouldn't necessarily feel like, on a day to day basis, that you were really doing something to help people. So I kind of decided that I actually wanted something much more hands-on, felt like I was actually helping people a bit more, so I looked at Samaritans. V209

Partly, I thought it might be useful for my training as a counsellor and partly because I wanted to, I wanted to feel like I was doing something useful, I wanted to feel like I was helping people, you know? And, I thought I wanted to do some voluntary work, so it all tied in together really V204

The preceding excerpt discusses a mixture of doing 'something useful' for others as well as for themselves (becoming a counsellor). Volunteering for Samaritans was discussed as a means of improving professional counselling skills or as method of gaining experience which would help the volunteer gain a place on a counselling course. There was no mention in any of the interviews of the benefits going in the other direction (i.e. that counselling training enabled the volunteer to be a better Samaritan).

I'd been doing a certificate in counselling following some sort of personal development work, and the group I was with, the tutor of it, said, 'You're interested in mental health, aren't you? What about the Samaritans, their training is very good'. And, to be honest, the Samaritans, for some reason, had never entered my head in that context V211

The respondents who had been drawn to volunteering as a means of furthering their training or professional skills all described having become committed to their role as a Samaritan once they realised how rewarding it was. However, the issue of volunteers using Samaritans training as a way of gaining experience which would tie in with counselling or other professional courses was raised, and resented, by other volunteers as a current problem for those involved in recruitment and selection within Samaritans.

But I've known people join Samaritans, go through the training etc, etc...probably would have been really excellent volunteers but then they've left. Because they were focusing on getting their experience on their way to getting a diploma. And counselling seems to have a bit of a bad name in Samaritans I'd say. V224

Section summary

Volunteers considered a wide range of reasons for applying to become a Samaritan. These included: exposure to Samaritans advertising campaigns, personal experience of issues on, or sympathies with, the organisation's agenda; the desire to do something worthwhile or 'give something back'; and to use and develop specific skills. These issues rarely appeared in isolation, such that becoming a Samaritan appears to be linked to a combination of triggers, motives, and experiences. Some volunteers had deliberated about becoming a Samaritan for a considerable time, perhaps waiting until their personal circumstances allowed them to take on the commitment. Others acted more on impulse, in response to a chance exposure to information or advertising.

Expectations and prior knowledge of Samaritans

When asked about their expectations about volunteering, many respondents were vague and unsure, claiming not to remember whether they had any expectations. Signing up

was something of a 'leap in the dark'. This may be a commentary on the public profile of the organisation. Although Samaritans is clearly held by many to be a national institution, and known to support people who are suicidal [2, 3] many respondents only came to understand the remit of Samaritans after becoming a caller or a volunteer.

> *I didn't really have any thoughts about what I was going into before, other than kind of feeling, 'This is something I really want to do'. I didn't really picture how it was going to be.* V216

> *I don't, I can't remember having any expectations really, I just knew that they helped people. And that they listen to people on the telephone. So, I didn't have any real expectations that I wanted to be met.* V204

Expectations were discussed by other volunteers as having been exceeded, typically as a result of the personal benefits of working in the organisation or of progressing through differing roles within the organisation and 'moving up' the hierarchy.

> *Well, yes, I suppose mostly done a few more things within the branch which I hadn't expected to do. So I've been a (local) secretary and I'm on the prison team and I've done a selection and I'm on the committee, and I haven't expected [laughs] to do all these things.* V206

> *I'm not sure I had any expectations apart from trying to give something back, and I think as far as that's concerned that has been met.* V261

When volunteers spoke in negative terms about whether their prior expectations had been met, it was typically regarding the type of call that they deal with on shift. They expressed disappointment with the proportion of calls which came from those who were not in despair or suicidal crisis (as more had been expected) and at the proportion of inappropriate and abusive calls they received (as these were not expected).

> *I think that the actual type of people who have phoned the Samaritans is very much broader than I expected. I was quite astonished to begin with how many people, I hesitate to call them time-wasters, but how many, many people try to use the service inappropriately.* V219

> *I was always under the impression that the calls were from people who were really down and desperate and couldn't see a future. But I think there's more time wasters than genuine callers. V265*

Section summary

Volunteers often had no clear expectations of what becoming a Samaritan would involve. Little was known about the remit of Samaritans, what volunteering would entail, nor about what kind of callers came to the organisation for support. Many volunteers felt that a large proportion of calls were inappropriate and viewed this as a negative aspect of being a volunteer.

Training

A standard training package is provided by Samaritans' General Office which all branches are encouraged to utilise. This package, known as SIT is a modular course in two parts designed to educate new volunteers about the nature and remit of the organisation and

how to engage in the work of a Samaritan volunteer. Listening skills and displaying empathy are discussed, and volunteers are expected to demonstrate the acquisition of these skills through (what is now termed) 'Skills Practice'. This involves participating in practice calls, with existing volunteers playing the role of caller, and new volunteers practicing their skills. Training typically involves attending a number of weekly sessions, across a period of about nine weeks for SIT 1 and five additional sessions spread out over several months for SIT 2 (with some variation across the organisation).

The training package is designed around the values, practices, and policies of Samaritans, and covers issues such as supporting those who are suicidal and managing inappropriate calls. There is still an element of selection at this stage and not all of those selected for training will be forwarded for duties. Those who are approved are assigned a personal mentor to assist and support them as they move from training to engaging with callers. After a period of being a probationary Samaritan there is a formal change to being considered a full volunteer.

The volunteers interviewed in the present study offered diverse and at times contrasting viewpoints on various aspects of the training. Volunteers had generally found it a positive experience. They reported enjoying it and that they had looked forward to it each week. Training was considered essential for engaging in the work of being a Samaritan.

> *I found it great. … we just sort of, sort of looked forward to each session really. So, it was a nice time.* V234

> *I think it was very useful. I certainly couldn't operate as a Samaritan without it.* V219

Volunteers compared SIT very favourably with other training they had attended, either in the private or voluntary sectors, and also with counselling training. On occasion this praise came from some volunteers who acted in the role of trainer in other aspects of their life outside of Samaritans. This endorsement was not just for the actual Samaritans training package and materials but also for those delivering the training.

> *I think as charities go it's one of the better ones … I certainly think its volunteer training and volunteer support is better than many. I've done some work with a mental health helpline and I didn't have any formal training with that and I was quite astonished at how poor the training was and the support that was given to callers in some ways. But I'm very happy that the training for Samaritans is excellent.* V202

Samaritans training was described as very intense, challenging and difficult at times. In almost all cases though, this was considered a positive thing: a necessary and sometimes enjoyable element of the training.

> *It was quite emotionally difficult or, not difficult but challenging. But that wasn't a negative thing.* V204

> *Very full-on … it was very, very intense, right from the selection … the selection day was really being put through the mill. And it was great. It was really, really good.* V216

Samaritans' training was also seen as a resource to be drawn upon throughout one's time as a volunteer. Respondents claimed that remembering the things which they

learned during training had helped them to maintain good working practices while on duty.

I mean I can always remember in the training, remember it after 32 years, being told that if you come off the phone feeling absolutely terrible and a whole lot worse, actually the caller will be coming off feeling a whole lot better because you have relieved them of some of what they're going through. V207

Well, I think, because of the training and because the fact you know what you're supposed to be doing … the way that you deal with it is try and get the person to do the talking and to talk about their feelings … I think one of the reasons why … so far I haven't got so upset … maybe I'm hard, but they don't upset me that much … but in terms of how I dealt with it, it's through the training. V210

The ongoing relationship that new volunteers have with a mentor was also discussed as being very beneficial, in terms of support, and in terms of the reinforcement and continuation of the training. Training was considered to be an ongoing thing, which may even intensify, once the initial formal training ends and volunteers begin to take calls. Mentors were also discussed as a kind of support 'safety-net' for volunteers.

But it's more intense after training because you have a tutor. I never needed to call my tutor but it was made very, very clear that I could call her anytime I needed to, if I was having problems. And that was very reassuring to know that safety blanket was there. V219

I suppose, the biggest challenge for me about training was the training that goes on once you're on the phone, if you see what I mean. Because I think there was the sense that the training didn't stop, so we had a mentoring scheme where I had someone sit with me for my first half a dozen shifts, and she'd actually listen in to my calls, sit next to me and write little notes if I seemed to be stuck and not quite sure what to do. Which I found extremely helpful. V270

Many volunteers commented on the adequacy of the preparation provided by the training. Some volunteers felt very prepared to go on duties. Others felt that the training was not enough to prepare volunteers for the work of being a Samaritan, and that it was actually going on duty and experiencing calls that complete the preparation to do this. This was not necessarily perceived to be a specific fault of the training, but rather that 'real' experience is vital in ensuring volunteers are prepared and able to take calls.

I don't feel you ever feel fully prepared until you start taking calls. V202

I was as prepared as I could have been without actually taking the calls. V204

Additional benefits from training

Additional benefits associated with Samaritans training were discussed. These fell into two categories; personal growth and improvement, and a valued, fruitful fellowship with the other volunteers in the training group.

It's being pushed into the difficult spaces that really challenges one but really grows through that. V216

Very good, excellent training. Yes, I wish I'd had it many years before as a parent. I think I would have been a better father. V220

A strong discourse of transformation was present in the data. This personal development was attributed both to the nature of the training and the cumulative experiences gained as a Samaritan.

It also provided valuable learning outside the Sams/branch context. When added to the constantly widening experience gained from caller contacts, (and never-ceasing ongoing training) it's significantly changed me and my views. It's an artificial statistic but I'd describe the whole process as yielding 40% benefit to callers and 60% to me. V228

Oh, exceptional, life changing. At the time, for me, being that young, and being exposed to two terribly competent trainers, one of whom was a vicar and the other of whom was just worldly wise, it was, yeah, it was a remarkable (time). V229

Consistency

Volunteers acknowledged the standardised training package (SIT) as an attempt to achieve consistency across the organisation, but felt that consistent training does not necessarily lead to consistent standards of practice.

I just don't think we're consistent. … it's not that we're not trained consistent, … we've got a homogenous training system throughout the whole of the organisation, we're all singing from the same hymnbook, but we all sing in a different key. V213

V251: Well, I'd like to say we were consistent, but we're not.

I: Do you have any views on how that could be worked on, how that could be improved?

V251: Well, better training….

Elements missing from training

Respondents found that specific aspects of volunteering were different in practice to what they had been led to believe during training, for example: how busy the shifts are, how serious the calls tend to be (i.e. the level of crisis callers are in), and the number of suicidal callers they speak to during duties. This was spoken of as a negative aspect of the training, and respondents argued for a more realistic representation of the actual shifts they would experience after training to be given during SIT. There was some acceptance that training was designed to prepare them for the most difficult calls rather than the more frequently occurring, but less challenging, calls.

I think that the impression you get as you do your training is slightly different to what it is in reality. It's a lot less fast paced, if you like *V209*

I think the other thing with the SIT and any training for Samaritans … is that the scenarios tend to be a little bit extreme and I think that's necessary because we want people to be able to cope with a range of issues, but then, they're much more strained than the normal run of calls, I think. V240

Respondents felt that a number of specific areas of importance were not covered adequately in the training. These included handling regular callers, dealing with sexually demanding calls (and coping with the large amount of these), and self-harm.

> *The thing I think is most important is the topic of people self harming and cutting. … I understand it a bit more now but I didn't when I started taking those first few calls. So I think that should be included in the first round of training.* V264

> *Some sexual demanding callers can be quite manipulative and they're not always obvious, not quite as obvious as perhaps might be shown in SIT.* V239

Mental health seemed to be a major issue in this context, with insufficient attention given during training to discussing callers' mental health problems and needs. However, another view was that incorporating this into the training would be a bad thing, perhaps leading to volunteers attempting to make a diagnosis, and that this would distract them from listening to and supporting the caller. One volunteer argued that knowing more about the mental health issues that callers may be dealing with is irrelevant to being able to support them. Another argued that increased knowledge of mental illness may lead to callers being treated as a homogenous group of some kind, which would distract volunteers from seeing their individual needs and issues. Mental health issues are discussed in greater detail in Chapter 9.

> *If we know about mental health problems we might try and diagnose people on the phone or pigeonhole people and change the way we support them…..but I do feel that we need to have a little bit of understanding about mental health problems.* V202

> *I think this is a double edged sword really. On the one hand I think yes, but I think the danger is with the nature of what Samaritans do, the fact that we listen to how people are feeling. The danger is that if you give training in specific areas you run a bigger risk then of volunteers not sticking to policies and procedures because it becomes a little bit of knowledge. So I'm really not too sure if I'd go for that extra training or not. I'm all for extra training in how to handle calls but I'm not too sure that I necessarily need as a Samaritan information about illnesses, mental illnesses.* V227

SIT versus training pre-SIT ('Prep')

Volunteers raised the issue of how SIT compares to the 'prep' training which preceded it. Generally, SIT was favoured over 'Prep', without detail about why it was considered to be better, but there were some comments referring to SIT as more extensive, sophisticated, and able to offer consistency. Again there were some conflicting views. Not all volunteers saw one as better than the other.

> *It (prep) was very good. It prepared me for what was going to happen. I mean, it's improved a great lot.* V263

> *It's much, much better than it used to be when it was prep and branches did the wrong thing. So I think consistency that we've got now has got to be good.* V227

Role play ('skills practice')

The single most discussed element of the training was 'role play' or 'skills practice' where scenarios are acted out as if for real under the observation of other trainees (role play seems to be quite an enduring term despite the re-naming of these to skills practice, and sometimes volunteers specifically marked skills practice as the 'new' name). This aspect of the training was considered to be most difficult, and respondents used terms such as 'horrific', 'loathed', and 'terrifying' when referring to it. Role play proved to be quite a stumbling block for many, and was discussed by one volunteer as almost leading to her withdrawing from training

> *We did role plays and I really found it difficult, I nearly gave up.* V222

> *One of the most stressful things I've ever put myself through, which is Something … I absolutely loathe and detest role playing.* V218

Again, a few contrasting views emerged here: some volunteers claimed to have enjoyed role play, or were quick to discuss the merits of role play in training. The positive element to role play for these volunteers seemed to be that it helped to provide a realistic example of what calls will be like, which helped to prepare volunteers for real shifts.

> *The role playing aspect of it is fantastic, it really does prepare you well.* V219

> *The……role plays were particularly helpful. I don't think I found any of it particularly hard.* V202

Despite finding it difficult initially, respondents also discussed role play as something which volunteers-in-training eventually accept and get used to. This may be due to the development of a bond between them and their fellow trainees and trainers.

> *You get more used to it because they become, you will come up close during the time of the training but for the first few, it's rather uncomfortable.* V229

> *I guess the most difficult part … is actually undergoing the skills practice. … people actually fear it to begin with … most people very, very quickly get used to it and realise that there isn't anything to fear, really.* V213

Branch relationships with General Office regarding training

There were reports from volunteers on tensions between branch trainers and General Office as a result of universal implementation of a standardised training package. General Office was considered to be too prescriptive about the use and delivery of training materials, leaving very little scope for individual input and variation.

> *They put a lot of effort into providing us with stuff but they make it really awkward to use for some reason … The training material all comes out in a form which seems to them would be handy to just use in the training course, but, it's not always the case. But very deliberately, I think, I'm told,[they] produce it in PDF format so that we have to present it as produced.* V240

> *She felt that all of this is difficult because GO/HQ want a standardised way of working. She said that branches are measured on how they manage their training.*

This is a 'goal based model'. She felt that SIT was not fitting the bill.
V267 Interview Notes

Some branches appeared to do things their own way, even though they knew that it caused tension with General Office.

Ongoing training

Ongoing training (OGT) refers to the educational events which occur at branch, regional, or national level, where volunteers attend lectures, talks, or workshops pertaining to aspects of their role as a Samaritan. Volunteers are required to attend a certain number of hours of ongoing training each year, but there is flexibility in what may count, e.g. working on training sessions for new volunteers can count as OGT hours. Attending OGT is considered important to the continuing development of volunteers as Samaritans, through the expansion of their skills and knowledge, and through 'refreshing' the skills learnt in initial training. OGT sessions may include for example, lecture-style talks on depression and its symptoms, workshops on bereavement, or sessions on best-practice in responding to emails. These may be delivered by volunteers, training directors, or invited speakers. An organisational directive requires all volunteers to meet their commitment for ongoing training and volunteers discussed the importance of continued training as a Samaritan as a way of ensuring the quality of the service beyond the initial training. Only one respondent spoke negatively of ongoing training, claiming that it did not suit their individual training needs.

> *Very useful indeed. … Its intention is to keep your skills up to date and it has an element of basic skills training and following the guidelines and principles for the service we offer.* V225
>
> *Because the ongoing training that I did earlier this year, ...I just felt I wasn't getting anything from it and it was another evening to give up which I didn't feel was adding value so, I think ongoing training is important, but I think the way it's looked at is not working for me at the moment.* V261

Variance between branches

Finally, the data indicates that there is a degree of variance in the way training is structured, and specifically the way volunteers are placed into probationary categories following initial training. Respondents described different branches as offering post-SIT training and mentoring of varying length, and a great deal of difference in terms of when a volunteer can be described as being a fully-fledged Samaritan.

Volunteers at this branch receive training before they are 'Made up' as fully fledged volunteers. For two months they complete the SIT 1 course and they are then assigned a mentor and go on duty as the 3rd volunteer on a shift (this is known as a P3). After four months they become a P2 and then after six months they become fully fledged volunteers and get to go on the rota with any other volunteer. Branch Observation Notes

> *And, you know, once the sort of probationary period, which we still have the same, you know, for three months, the way we do it, I was a red (team) which meant, I mainly was with my mentor. And then, you get through that, another three months of being a black (team), and then at the end of that, if everything's okay, fully fledged.* V243

Section summary

Volunteers were generally positive in their discussions of training, and many good experiences and benefits of training were discussed. Undergoing SIT was described as an enjoyable experience, essential to being prepared for the role, and as better than other training which people had experienced. Although descriptions of training as intense and challenging appeared, these were also used as positive terms, and some deemed the training to be 'life-changing', leading to personal change and growth. Having a personal mentor was another valued element of the training. The main problematic issue was skills practice (role plays). Volunteers found these to be stressful and very difficult to face each week, at least initially. Some volunteers felt that SIT training should give a more realistic idea of what to expect during actual shifts, especially in responding to calls from people with serious mental health problems and the frequency of inappropriate calls. Volunteers seemed keen to compare SIT with the 'Prep' training which preceded it and there were mixed comments on the relative standing of each. Occasional tensions within the relationship between General Office and the individual branches were discussed, as some branches may differ (in action or in opinion) from the strongly prescribed method and format of training which General Office proffers. Finally, it would appear that branches vary somewhat in the form given to the time and labels given to the probation periods for new volunteers.

The experience of volunteering

Being a Samaritan volunteer was generally discussed in very positive terms. Certain difficulties were mentioned and will be discussed below, but these were far outweighed by the positive aspects of the role.

Being a Samaritan

In the previous section, many volunteers expressed the desire to do something worthwhile as a main reason for becoming a Samaritan. When discussing their continuing work as a Samaritan, respondents described feeling that they felt fulfilled by the role, and that they were doing something worthwhile.

> *Somebody once said, 'Do you know, I never thought I would laugh again' … And something like that really gives you a great big boost.* V211
>
> *The reality is, it's very interesting, and you get a lot back. And so it's quite a fulfilling thing to do rather than 'Look how nice I am' … I personally have had people who I've thought, well, I have helped there. And so that makes you, I suppose, feel probably in a very selfish way, you know, you feel like you've been useful to them, but it's, so you feel a connection in some way, maybe.* V220.

Fulfilment was linked to the reward of helping, reinforced by occasional individual expressions of thanks from callers. Such thanks were also discussed as having a restorative effect which helped to outweigh the negative effects of inappropriate calls or callers' expressions of dissatisfaction with the service. One volunteer observed that statements of caller appreciation should be treated with some caution, as they are potentially an expression of politeness and not always to be taken at face value.

> *Well, I do feel sometimes that the person, either because they said it was a help, thanks for being on the phone, whether they're just being polite.* V210.
>
> *Well, on the whole, it's been very, very good and very well worthwhile. I've had a tremendous number of calls where people say thank you, thank you for being*

there, and that makes it worthwhile. I mean, you get TM[8]s and whacky calls and you think, Oh, goodness me, what's that about? but I've had so many people, as I say, just saying 'Thank you for being there', and that makes it worthwhile for me. *V214*

A large, positive element of being a Samaritan was the notion of 'being there' for callers. This was linked to 'being useful' and 'feeling as though the work is worthwhile'. However, being there for callers may not always be easy, particularly when the callers are going through intensely difficult troubles.

I think having an appreciation of what other people go through and just being there for that person at that time. *V202*

I care a lot about the huge amount of suffering that there is in this world, the huge amount of inequalities, and there's so many things that there's nothing that as an individual I can do anything about. But here on the phone lines, as a Samaritan, all I've ever tried to do – is why I do it – it's just literally pick up the phone and try and be there for whoever is on the other end. ... You come off the phone absolutely drained ... all we try and do is support someone and just be there, you know, which is not always easy. *V218*

Having such intimate contact with callers was considered a privilege by some volunteers. They felt honoured to be allowed into the callers' life at the most difficult times and to be trusted to keep all disclosures confidential. The sense of privilege may also come from the way in which some callers express that they have been helped by volunteers. This again is not a standalone issue, and the following two excerpts display the ways in which various benefits of volunteering were spoken about together.

I think the privilege is in having someone take you into their confidence, that's the privilege. The real reward is having an opportunity to listen and try and help someone when they're unhappy and have an insight into somebody else's life and it's a very confidential, private thing that. Yeah, and if you feel that you've helped, it's enormously rewarding, you know, and sometimes, you do get that, you get someone going, 'Thank you very much', I feel just sort of, sorting out the thoughts, helping someone examine what they're thinking by talking about it, you know, and they go, 'Thank you so much', I mean, that's a privilege. *V220*

I'm a Samaritan because I think it's important work. I enjoy the fact that I'm giving a little bit back, I'm attempting to help people. I'm fascinated by people, and I enjoy talking to callers. I feel very privileged that they kind of allow you into their lives for some forty five minutes to an hour. *V219*

A commonly used phrase when discussing beneficial aspects or results of volunteering was 'satisfaction'. This may well overlap with the notions of fulfilment, reward, and doing something worthwhile.

I wouldn't do it if I didn't enjoy it, I think you've got to give it some, enjoyment, satisfaction. *V262*

The Listener said he feels like there is nothing to gain from being a listener other than self satisfaction. There is no other reward; it doesn't help with parole or anything like that. *L262 Interview notes*

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[8] 'TM' calls refer to sexually demanding calls.

Volunteers described long lasting, personally beneficial effects of being a Samaritan, including personal growth and development. In some cases this is reminiscent of the discourse of transformation found in discussions of the training (above), and specific areas of change are sometimes mentioned in this context, such as improved listening skills which could be used outside of Samaritans.

> *It obviously helps with people's listening skills. I mean, I think that people who come along tend to be reasonably good listeners. I think most people realise that's going to be part of the... well one skill they're going to need. And I think it makes people more .... what's the word? Something better than tolerant, but more .... they'll listen to other people's point of view.....It's just a very positive experience, that people become more worldly, they're not as easily embarrassed.*
> V251

Another commonly discussed aspect of being a Samaritan was the new sense of perspective gained over time through contact with callers. Volunteers discussed gaining a better perspective on their own lives, as well as gaining a better general perspective of the world and of the lives of others. They may come to see how 'well' their own lives are going, in comparison with the lives of people who are full of pain and troubles.

> *It's also given me an appreciation of how lucky I am in that I'm healthy in my mind and my body and I am able to do lots of things and I am lucky in that sense ... this is what I was talking about in terms of how I've changed, how I've changed how I support my friends, my own friend. In the past maybe I would have been inclined to say "Oh, well that happened to me" and then say, 'Listen to my story,' thinking that that was helpful when actually I think it's not. So having an understanding of that has been great and I think that's been very useful.*
> V202

> *Many people out there are, you know, lonely, mentally ill, unhappy. That's not something you see in the street sometimes, so it's given me a broader insight into an aspect of society which I wouldn't normally have come across in the normal day to day living. 'Cos I'm dealing with people who come from different backgrounds than I have, and they're not of my social circle, that's... educational.*
> V220

The fellowship gained by being a volunteer was also frequently discussed, again as a positive benefit to volunteers. From strong friendships to great on-duty acquaintances formed during time on shift together as volunteers, respondents repeatedly expressed the value of the company and camaraderie of their fellow Samaritans. They reported learning from each other, being able to confide in and gain support from each other, and this is quite similar to the talk of friendships built during training (above). Chad Varah recognised this issue in the early days of the organisation, writing that these friendships are 'rare and precious', and that individuals became 'more truly Samaritans by their association with one another' [4:36]. The value gained from the relationships built with others and the sense of belonging to a community of volunteers, has been discussed as important to sustained volunteering within an organisation [5].

> *I've met some wonderful people through Samaritans, and if ever I have sort of dodgy patches, then there are lots of lovely people I can talk to about it. So, you know, it is a very positive thing in my life, I think ... And that's part of what keeps people in Samaritans, actually, is that communal sense of doing things.* V236

One volunteer mentioned that this camaraderie may occasionally inhibit the work of Samaritans as the branch can become sidetracked by chatting during a duty, and that some volunteers may see their time at a branch as based around the social aspects of volunteering more than the supporting of callers. The observations of activities at branches support this notion, as volunteers on duty sometimes seemed to be preoccupied with each other in quite a social manner, to the point where emails did not feature as part of a shift.

> *Volunteers coming in for an hour and chatting and not bothering to switch an email computer on because they're too busy chatting but equally that's where a lot of volunteers in some branches will get upset because they will see it as, it's more of a social thing for them.* V227

One volunteer claimed that there may *not* be anything to gain personally from being a volunteer, but that they would continue to do it because the aims of the organisation match things that they themselves 'believe in'. Another volunteer discussed the value that volunteering holds for them and a strong desire to continue doing the work, such that they could not imagine not being a volunteer. Together, these comments indicate that being a Samaritan is a strong element of these volunteers' self-identities, as being a Samaritan was constructed as an extension of the individuals own beliefs or personality.

> *I mean what is there to gain from being a volunteer? … What is there? … I mean I wouldn't not do it, ok, and the Samaritans, because it's confidentiality, and all the things that [it] tries to do I do believe in. V218*

> *I certainly feel I'm doing some good. I mean, having been a Sam for 33 years, I almost can't imagine life without it. It's almost a compete part of my personality. And, it's something that I value enormously. And, you know, they, the idea of not being a Sam would be, I almost find it difficult to imagine, you know. V236*

Problems encountered by volunteers

Respondents spoke about how the experience of a shift, or a run of shifts, where they deal repeatedly with very few calls, or with a large number of inappropriate or snap calls, may make them feel as though they have not achieved anything, or that their time has not been well spent. Such feelings could be compounded by the volunteer's personal state at the time of being on shift (for example, whether they are tired). Having such shifts may be an accepted as an occasional occurrence, but they may also lead the volunteer to question why they continue to give their time to the organisation.

> *I think it's full of ups and downs, really. People say, 'Why are you a Samaritan?' And there's no simple answer to that, but there's some times when you feel you're really doing something useful for the caller and there are other times when you think, 'Why am I actually doing this job?' V224*

> *Occasionally I've felt, after a run of nights where you have a very, what I would call, unsatisfactory calls, people wasting your time, people abusing the service, lots of silent calls, lots of stupid calls, drunks, aggressive people perhaps phoning up to spar with you intellectually, you certainly think, well, you know:' is it worth it? I'm tired, I'm working all week, do I really have to put myself through five hours of this when I'm really doing nothing, I'm not helping anyone? And haven't helped anyone for a time' … A lot depends on one's own state of mind at the time. You could be tired and weary, in which case, you know, you get a skewed*

perspective on things, and one has to be aware of that. But, yeah, I do have times when I think, well, you know, is this really worth it? V220

Extra responsibilities

Many of the volunteers interviewed mentioned holding various roles within their branch or the wider organisation, additional to their regular Samaritan shifts. Some had held more than one such additional position at a time and others listed a succession of various roles which they had moved between over the course of their Samaritan career. It is likely that the sample of Samaritans who came forward to take part in interviews included a disproportionately high number of volunteers who were highly involved and committed to the organisation. However, a number of respondents had declined to become involved in the organisation beyond the role of a listening volunteer as they felt that supporting callers was what they 'signed up' to do, and they did not want to move away from this.

> *I was never drawn, driven to become more senior in the organisation which one easily could have done ... I wanted to try and sort of do what I wanted to do in the first place. I don't like going into the Samaritans and not being a Samaritan ... It's difficult to get people to take office, I'm one of these people, I'd rather be an Indian than a chief, I want to come in and do the job and then just go home.* V214

> *I think I've been disappointed that people in the branch are becoming more and more busy outside the branch and have much more commitment than they used to so it's quite difficult to fill posts within the branch, particularly deputy directors. It's difficult to get really good people there* V240

Volunteers' time commitment

Volunteers reported spending various amounts of time at Samaritans, but most fell within the range of doing between four and five hours per week. Slight variations exist between branches, but the volunteering requirement tends to follow a pattern of one daytime shift per week and one night shift per month. Day shifts are usually either three or four hours in length, with night shifts being slightly longer, and a directive exists which holds that no volunteer should be on duty for longer than six hours. Volunteers followed a range of shift patterns; some reported doing one shift each week, whereas others reported more idiosyncratic patterns such as for example, doing two night shifts and one day shift per month. Where volunteers did report their shift pattern, it typically consisted of a total of two or three day shifts and one night shift per month. Taking on an extra role at Samaritans can mean that volunteers work beyond this time commitment, and it may sometimes be difficult to keep track of how many hours are actually being done, particularly when a volunteer is on call. Branch observations found that the role of a director was extremely time consuming, although the individual directors accepted this without issue.

> *You probably don't get a call at all but you are on call so I don't know quite how you count that kind of thing ... It's very difficult to say quite how much I give it but it could certainly be.....I don't know it must be somewhere between six and twelve hours a week. I don't know; ten to twelve? I don't know. It's difficult to say.* V207

> *Probably about eleven hours a week, so in a month, including the training, about forty hours a month, actually, or in a five week period.* V202

Night duties were generally considered to be 'worth more' than a daytime shift in terms of meeting a monthly commitment. If a volunteer cannot do night shifts, then they may be required to take on a higher number of day shifts to make up for this. Volunteers may arrange this sort of schedule if they are over a certain age or if they find the night shifts disproportionally difficult, perhaps due to work commitments. Doing more night shifts may in turn mean having to do less day shifts. One volunteer reported doing only night shifts as this reduced the number of shifts which must be done each month. As well as the flexibility offered in how volunteers may meet their shift commitment, an option to take a sabbatical was also available, either if the volunteer felt they needed a break or needed to deal with pressing family or other commitments for a period. However, if a break from active duties exceeded three months, the volunteer would be required to undergo further training before resuming duties.

> *The night shifts are more heavily weighted than the day shifts purely because of the unsociable hours. So, the commitment is actually slightly less but obviously, because of the unsociable hours, and them being weighted more heavily, it kind of balances out the commitment level.* *V239*

> *My commitment is to do a duty a week but because I'm over seventy, I don't have to do night duties so I tend to do extra day duties.* *V268*

Doing extra shifts simply as a matter of routine, whether these were extra day or night shifts, was also reported by volunteers. Doing extra shifts was sometimes seen as a necessity if a branch was very short of volunteers. Some volunteers were just generally happy to do extra shifts, and exceeding the commitment was constructed as something that they 'just do'.

> *You're knackered the next day ... But I've actually been doing extra night watches, so well we're just desperate for volunteers at the moment.* *V218*

> *I do a minimum of four hours a week but I'm also happy to do some extra shifts, depending obviously on what else I'm doing. But, you know if the rota secretary for the week gets stuck on some shift, you know just fill in some shifts.* *V226*

Maintaining rotas to keep each branch open throughout the shifts to which it was committed could be difficult, especially over holiday periods, though respondents reported no difficulties for manning shifts over the Christmas and New Year periods. Some branches where activities were observed were occasionally forced to cancel shifts at short notice, due to illness or an inability to fill the rota. Difficulties were discussed regarding volunteers who missed their target substantially or frequently. However, reprimanding someone who was giving up their time voluntarily was discussed as problematic.

> *So I guess the rules around you know the point system coming in recently, we have to try and do 100 points and all this. I'm doing what I can and I have spoken to 'X' and at the end of the day I hope that's enough. If I don't make 100 points or I don't do the right amount that is because I can't physically do it in my life at the moment ... I still want to go to Samaritans it's just that I can't always do the full commitment that I signed up for because my circumstances were different.* *V261*

> *...because they're doing something for nothing, how do you sack them? ... things like not meeting a commitment, that's difficult, because, in a sense, you're shooting yourself in the foot, because you're not prepared to be flexible about it. So I try to be flexible and fair about it.* *V213*

Age and experience

Younger volunteers were generally considered a great benefit to the organisation. As well as being 'fresh' and not cynical or jaded, they were also regarded by some as being better able (physically) to meet the demands of doing night duties.

> *It's good to get a lot of people around the twenty to twenty-five year age group so they must naturally be thinking slightly differently and they've been brought up differently and there is a slightly different culture in a way. So our callers might be better served by having someone on their wavelength shall we say, than by talking to some of our older people. In fact, some of our older people are very very good with younger people, so it's a bit of a sweeping statement, but a spread of people I think is nice 'cos I think we get a spread of people calling, a spread of age group.* V201

> *Seeing somebody coming in fresh and starting completely from scratch, it sort of brings it home to you how, what the sort of danger is of getting stale and cynical.* V207

Section summary

The experience of being a volunteer was largely discussed in positive terms. Volunteers felt that they were engaged in something worthwhile, satisfying, and fulfilling. 'Being there' for callers was rewarding, and volunteers discussed feeling privileged to be given access to callers' lives. This in turn was seen to lead to personal growth and development as a person. The social fellowship gained from being part of a branch was valued greatly by volunteers, although this could sometimes detract from attention to work while on duty. Inappropriate calls and shifts where there are little or no contacts with callers impacted negatively on volunteers' feelings of doing something worthwhile and could lead to questioning of commitment. While the time commitment required of volunteers is similar across the organisation, individual volunteers managed this in different ways, adapting their shift patterns where necessary, particularly in terms of night shifts. Many volunteers readily take on extra duties and are prepared to fit in additional shifts when required. New and younger volunteers were welcomed in a context where there is a risk of longstanding volunteers becoming 'jaded' and in need of periodic breaks or sabbaticals.

Support for volunteers

Respondents were generally positive about support for volunteers within Samaritans. Support is a priority for all types and levels of volunteer, and it is offered in varying forms. Discussing calls with the others on a shift, debriefing with a leader at the end of a shift, mentoring new volunteers, and informal support such as just asking how a fellow volunteer is, were all given as evidence of the 'culture of support' for volunteers. Support itself generally involved sharing any aspect of volunteering with another Samaritan. Creating this supportive environment is a collaborative thing, and all volunteers at all of the hierarchical levels are involved in this.

> *And I think the trust element between volunteers, just from what I've noticed in the branch that I've been working in recently is quite incredible actually. The network of support and trust and I think it's quite amazing actually the way everyone works together.* V401

And one of the leaders are there, your colleague you're on duty with is always there. And, yes, I think there's more support, if you need it there's a lot of support there. V403

Support for the volunteers was discussed as a constantly available resource, with a feeling of a '24/7' commitment on the part of the volunteers to each other. Volunteers saw it as a core principle and element of Samaritan work and ethos, just as strongly as the commitment to callers. It may indeed be as much of a defining element of the Samaritans (at least for those within the organisation) as the support for callers.

You do, sometimes, particularly with very distressed or suicidal people, you come off the phone to your colleague. That's the beauty of never being alone on duty. V225

But if you need you still have another Samaritan with you, still have the option of taking the phones off the hook for five minutes and to just talk about it. V226

Indeed, volunteers were clear that the safety and wellbeing of the volunteers took priority over the interests of the callers. This was one justification for the exclusion of some callers from the support of Samaritans. As the preceding extract also illustrates, it was quite common practice for volunteers to disengage the phone lines for periods of time to debrief or provide support to a colleague following a particularly difficult or harrowing call.

Volunteers were, with few exceptions, very positive in their appreciation of the support available to them within Samaritans. This was compared favourably with support available in other spheres, personal or professional.

Compared to many non-voluntary organisations, we're good; not perfect, but better than three out of the four large companies I worked for. The internal support within branches is fine – it's close to home and comes from personal interaction which is at the core of the organisation anyway. V228

Benefits of the volunteer support system

The support system for volunteers has a range of benefits. Firstly, the effective running of the support system, and having volunteers actively access it, is essential for engaging in the demanding work of supporting callers and dealing with the most difficult calls.

But, very few of them (difficult calls) will have to the point that I can't, you know, put it out of my mind ...and you get huge support from the shift and if you need to talk about stuff, you do it right away and that's fine. V206

That's important, very important, I think. It's just great to be able to talk to people about it, and the more you talk, the easier it feels for you, you know? V204

The major benefit, in terms of helping volunteers continue in their role, is that the support system allows them to gain a kind of closure. This may follow individual calls, at the end of a shift, or both, and is important regardless of whether it is sought through debriefing with the leader or discussing calls with other volunteer(s) on shift. The notion of leaving calls behind may be a difficult one to achieve in practice, if volunteers wait

(for whatever reason) until after their shift to debrief with or unload to another Samaritan.

I think it's quite important to leave it on your shift. And people are trained to help people to do that now as well, to give people plenty of time to download after they've had a tricky conversation or to follow up with them, if you think they might be taking it away with them.....I learned very quickly early on that you need to do that. V229

So I've already dealt with most of it with the other volunteer and then it's helpful to talk to the leader because then it just finalises it, you know? It helps me just make sure that I'm all right, just give me a bit of closure, you know? V204

Volunteers mentioned occasions when they had been contacted after a difficult shift by another volunteer. This was in addition to support received on shift and by the shift leader. Such occurrences were welcomed as an expression of mutual commitment between volunteers. The sense of feeling 'looked after' may be a direct result of how well volunteers are supported as Samaritans, and of the extent to which they themselves have actively accessed the support system. Not being supported adequately, and thus not 'feeling looked after', is potentially quite damaging, and may well lead to volunteers leaving the organisation.

I think sometimes we don't support the volunteer as much as we should. I know, because volunteers have left and told me that they felt unsupported. V234

It is important because that's how you keep people for a long time. You really need to look after the volunteers. And whenever someone comes off a long call, you really need to talk to them about it, you shouldn't ignore them, you know, you should really discuss and talk about how the volunteer feels as well as the caller. V251

The role of the duty leader

When discussing the structure of the support system, most volunteers seemed to orient to the leader system as the main or initial point of formal support (there are only occasional mentions of specific 'volunteer care' roles within branches). Calling the leader on duty at the end of a shift is a Samaritan protocol, although leaders can also be called at any other point if a volunteer wants to debrief or get support (e.g. after a difficult call or if help is needed with a decision such as whether to call an ambulance or allow a particular caller into the building). Volunteers generally spoke well of this system, and leaders were seen as a resource to support volunteers, especially when they had concerns or negative feelings about calls and they way they had dealt with these.

I felt I'd failed … and I did ring the leader in the night and I said, Well, I don't know … just needed to talk … about it, and that's why the leader thing works so well. V263

Offloading aims to ensure that volunteers do not take issues relating to calls home with them. However, it was also recognised that some calls could leave a residue for which additional support was required.

When you come off the phone....you get it out of your system there and then. If you've had a particularly bad call, the leader will phone you back the following

day to see what you're feeling about it then, and if you've still got a problem with it, to talk it out again. You know, it will go on for a few days. *V265*

If you're very worried, the leader will phone you back later in the evening to see if it's still worrying you. If you're a leader and someone's downloading something, you think it's really got to them, you'll make a point of phoning a few hours later to see how they're feeling then. So that support is brilliant. *V263*

Problems and issues in accessing volunteer support

Some problematic elements to the volunteer care system were discussed, and a number of these seemed to be related to personal characteristics. Firstly, volunteers may not want to debrief, unload, or seek support in general from a shift leader if they do not happen to 'get on' with that particular leader, or if they are not be particularly familiar with them. Personal characteristics seemed to determine whether support is sought from anyone, but the quality of support was seen as dependent on the quality of those offering it. Some volunteers simply prefer to discuss their calls or shift with the other volunteer on duty or with fellow Samaritans who are better known to them.

I think the actual way of things is that you will gel with some volunteers better than others, that's the way it goes ... And I think, depending on who you are on duty with will maybe depend how well supported you feel immediately after you've taken such a call ... I think it's just the way things are ... I think the system is, actually, the system of support really is very good. But, you know, what you get immediately after you've come off a call may depend on the volunteer that you're on duty with. V239

Volunteers may not always feel as though they are able to seek support very easily. Problems in accessing support may be due to a volunteer feeling as though having a difficult call is a reflection on them or on their abilities as a Samaritan. Also, some volunteers reported that they had never accessed volunteer support, as they had never felt the need to. These volunteers appreciated that support was available to them when and if they should need it.

I think sometimes it's too easy at the end of a shift to go and not talk to the leader for example. But that again is understandable because sometimes I know for myself sometimes you know, I want to get home I might not feel that I need to talk to the leader or anybody. But I think if I really felt I needed to it's there for you. V261

I'm more able to ask for help in a way, which I think a lot of volunteers are, but there's quite a lot who aren't as well. They do feel a bit reticent about explaining if a call has got them, or even if they've just got nagging doubts about something. *V270*

One barrier to providing adequate support for volunteers was the night-shift system. As volunteers are not permitted to remain on duty for any longer than six hours, this has led to night-shifts ending very late at night or in the early hours of the morning. Having leaders signed up to cover all of the nights can be difficult as it can be very intrusive to home life. Leaders may also not be at their best when woken up in the middle of the night, thus leading to reduced quality support. Similarly, volunteers will be tired and want to go home, or they may be reluctant to call the leader at such a late hour so debriefing does not always occur. Flexibility within this system was noticed during branch observations, with leaders making arrangements with the night-duty volunteers

regarding when the best time to contact them would be. These issues tie in with the concern that volunteers should not take problems away from their shift, but rather should address them before leaving.

> *It works well until someone does have a bad call on the first overnight shift and would probably of benefitted from talking to the leader but hadn't felt they could disturb someone, as much as you tell someone, and the leaders can be disturbed. It's such a difficult one this, to me, when I was Director I needed guidance or I needed a policy that said what we've got to do so that once you've got a policy it's much easier to implement it to a branch.* V227

> *Good practice within the Sams is for each volunteer to 'offload' to the shift leader in the final period of the shift. At night the leaders are not usually present in the branch so this is done by phone. But this means phoning the leaders late at night, which is not popular – and also there are problems sometimes when leaders are woken from sleep and not clearly oriented or responsive to the volunteer's reported account.* *Notes - Council Meeting Jan 08*

A final issue here is that, while volunteers spoke quite favourably about receiving support from those equal to or above them in their branch hierarchy, the system may not work so well when support is needed by those higher up the ladder. One volunteer mentioned that those who are not in an extra-volunteer role may not recognise that leaders need support themselves.

> *One of the things is that I don't feel that I am proactively supported … by the ordinary fellow volunteers and the reason that I say that is because I'm expected [to give support] and not vice versa.* V402

Listening-in to calls as a method of support

A final way of offering support, as well as supervision and feedback, was the practice of listening in to the calls of another volunteer, and then offering feedback on how they handled it and sharing interpretations about the nature of the call.

> *We do active listening so it's not just when you're in training but part or all of all calls are listened to by a colleague, not all but some of them, so you are in and out and you are listening to both sides of the call, I think it's really important, not just for the caller but as a way of giving support to your fellow Samaritan. V401*

> *Well, it's very good here because you can call your colleague over and they'll often listen in and write down things that perhaps you should be thinking about saying. So, there's kind of two minds working on it, which is good. V219*

Section summary

The provision of support for volunteers was seen as a cornerstone of the organisation, essential for continued service as a Samaritan. The main forms of support were the leader system, ad-hoc support provided among volunteers themselves during or following duties. The leader system operates by having volunteers debrief to leaders after each shift, or at any other time should a problem arise. All of the support is greatly valued, but the organisation often depends on volunteers to actively access the support available to them and problems do sometimes arise. These problems appear to centre on volunteers being reluctant to seek support from certain other volunteers, and on

practical difficulties in implementing the leader system, particularly at night. Despite some difficulties, the support available was discussed in favourable terms when compared to the support systems of other organisations.

Volunteer turnover

Attrition of volunteers was related to the problems associated with the role mentioned above (inappropriate calls, not feeling as though the time spent on shift is worthwhile or useful, unmet expectations, difficulties accessing support). Having a certain number of 'good calls' amongst the inappropriate ones may have a kind of mediating effect, and may help to keep volunteers returning each week, but it may be the feelings associated with these negative calls, and whether or not these feelings are dealt with, which determines volunteer retention.

> *It does in the sense that when you're on a shift and you get lots of those [inappropriate calls] or no calls at all, I do wonder why the hell I'm spending four hours of my time sitting there for. But when I get some good calls, it sort of brings it all back in perspective and I haven't got any thoughts at the moment of leaving, for that reason.* *V264*

> *If you do three shifts in a row, and all you get are sex callers, you know, and you think, you know, 'I was here for people who were despairing and they're not phoning, and so this isn't a good use of my time', or, ' I don't feel like I'm making a difference'. … I think that's why, you know, as leaders, we do try to make sure we support people through those shifts where sometimes people don't feel like they've accomplished. Rather than it being sex callers are what make people leave.* *V237*

A number of respondents discussed taking periodic breaks from volunteering. Sometimes this was for personal reasons or commitments, but could also be to avoid becoming "jaded" or "cynical" after being a Samaritan for an extended period of time. Regular breaks may help to extend the overall length of a volunteer's service to the organisation, as well as allowing the individual volunteer to offer the best possible service to callers. Whether it is discussed in the context of taking a break or not, serving as a volunteer for a long, continuous period of time is generally discussed in negative terms because of how it can lead to cynicism.

> *Part of the reason I took a break was because I started to get a bit jaded and I think I was having a lot of stuff going on in my personal life as well … But I think that was a largely to do with the space I was in as much as anything and I thought, 'Actually, I just need a break from this', To refresh myself a bit, and that has been very good, actually. Come back in a different space.* *V216*

Section summary

Volunteer turnover was, not surprisingly, linked to aspects of the work considered most problematic, such as dealing with un-worthwhile or unduly demanding calls, or not feeling sufficiently supported within the organisation. Support following shifts and breaks in service were discussed as valuable in helping to prevent a type of fatigue, whereby volunteers could become 'jaded' from long periods of service. Taking a leave of absence was discussed as having a restorative effect.

Chapter summary

The decision to volunteer appears to be one which is often deliberated over for long periods of time, with chance exposure to advertising and outreach events acting as a trigger or catalyst to taking action. Personal or vicarious experiences of issues relating to Samaritans' remit such as having mental health problems and suicidal feelings or acts, were also discussed as part of the decision to apply, tying in with the notion of 'giving back' something to either the organisation or to society in general, and sometimes as an expression of gratitude or recompense for personal good fortune.

Having specific skills such as listening skills or the ability to support others were also discussed, as was the relationship between Samaritans training and developing skills as a counsellor. Accessing Samaritan training as a way of extending or supporting counselling training was also a prompt to join Samaritans, although the attrition rate among such newly trained volunteers was regarded as problematic and resented by some respondents. The desires to do something worthwhile and to remain actively engaged within a social network were important also, particularly following retirement.

The experience of being a Samaritan appears to have quite a profound effect on the ' volunteers. Volunteers find their work at Samaritans 'life- changing' in many respects, with the development of new skills as well as a new perspective on life, a sense of fulfilment and of privilege. Volunteers reported becoming more 'worldly' and informed, more open and accepting, and developing skills they could use outside their Samaritans role. Being a Samaritan appeared to be a strong part of volunteers' self identity, and many held a number of roles within the organisation, additional to being a listening volunteer. While the time commitment required of volunteers is similar across the organisation, it is clear that individual volunteers manage this in different ways, adapting their shift patterns where necessary, particularly in terms of night shifts.
Some volunteers will readily take on extra duties when required. New and younger volunteers were welcomed and in a context where it was recognised that long-service may lead to volunteers becoming 'jaded'.

SIT was discussed as thorough, but as needing to include more information on two aspects of being a Samaritan; information on mental health issues so that callers with such conditions could be better supported, and information on the amount, type, and frequency of appropriate and inappropriate calls. Consistency in the support provided to callers was considered to be linked to the standardised training. Ongoing training was considered beneficial by almost all volunteers, as being necessary to keep skills updated and fresh and as ensuring a continued level of caller support.

The social fellowship gained through volunteering is valued, as is the support received within the organisation from leaders and other volunteers. Support is essential to continuing as a volunteer, and in dealing with the negative aspects of the role, namely inappropriate or highly demanding calls and the experience of quiet shifts.

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Chapter Four: The Online Survey: Callers' perspectives on Samaritans emotional support services

Introduction

At an organisational level, Samaritans lacks access to detailed information about the characteristics of callers such as age, education, occupation, ethnic origin, wider social and economic circumstances or the reasons for contact. Data regarding the frequency of contact from suicidal callers are based on subjective assessments of volunteers, often on the basis of brief and ambiguous encounters. A primary aim of the current research was to collect more detailed and extensive information about callers than has previously been available, as well as to develop an understanding of their reasons for contact, and their assessment of the service they receive. The research incorporated a range of different methods of data collection. Individual interviews with callers and volunteers provided the opportunity for a detailed exploration of a relatively small number of personal perspectives of Samaritans. A much wider range of caller assessment was obtained through over 1300 completed questionnaires in the online survey which was available through the project website from May 2008 to May 2009. For comparison and as a reference point, an outline of Samaritans national caller data is given before presentation of the survey findings.

Samaritans data regarding annual callers and contacts

Data on contacts with Samaritans is collected in each branch and collated annually at General Office. At branch level, this relies on volunteers making a log of every call coming into the organisation and rating it on a seven point scale according to their assessment of the caller's emotional health at the point of contact and the nature and purpose of the call (Appendix V). In 2008 Samaritans received 5,159,698 contacts, by phone, email, text, letter, minicom, face-to-face at a branch, and at local and national festivals and other events and settings outside branches. Snap calls (where the caller ended the call very quickly without dialogue), accounted for 47.4% of total contacts received (5,159,698) in 2008. Samaritans figures show that the number of dialogue contacts has remained relatively constant since 1992, with moderate fluctuations over this period. However, in comparison, the number of snap calls has increased each year until 2008 which saw a modest decline for the first time since records on snap calls began in 1992 [1]. According to Samaritan's figures the organisation receives a similar number of contacts from male and female callers annually [1].

Callers are able to contact Samaritans using the telephone, face-to face in branch or via letter. Email service was introduced in 1994 and an SMS text messaging service began roll-out in 2007 [1]. Since 1994 there has been a slight increase in telephone contacts, compared to a dramatic increase in email contacts. Face-to-face contacts and letters have experienced significant declines. The most common method of contacting the organisation in 2008 was by telephone (88.5%, 2,402,315); 6.7% (160,351) responses were given via email and a further 3.9% (104,763) by text message. Additionally, 46,269 face to face contacts took place and 1,506 contacts were replied to by letter[1].

When calls are recorded the volunteer assesses and records the feelings expressed by callers using the 'Samaritans Nature of Contact scale'. This is a 7-point rating system ranging from +3 to -3, where a score of +3 denotes that a suicide was in progress during the call and -3 indicates the caller was abusing the service, and may also have been violent or threatening. From this information the organisation estimates the percentage of dialogue contacts where callers are suicidal, distressed or making inappropriate use of the service.

In 2008 the majority of contacts were from callers described as distressed but not expressing suicidal feelings (54.5% telephone, 40% email). Samaritans report that in 19.1% of dialogue contacts the caller expressed suicidal feelings during contact. For email contacts this figure was significantly higher at 35.6%. Typically, less than one percent of calls annually are from those who indicate that they are, or are judged by the volunteer to be, in the process of ending their life.

The online survey

Between May 2008 and May 2009, 1396 respondents completed a structured questionnaire, almost all using the online facility available on the project website. Paper and downloaded versions were available. However, only two respondents used these versions (Appendix IV). The questionnaire was divided into four main sections. Firstly, a range of demographic data was collected including the age, ethnicity, living arrangements and employment status of respondents. The second section of the questionnaire focused on the respondents' usage and experience of Samaritans support services at time of last contact. Questions addressed included the means of contact used and why this was chosen, main reason for contact, feelings before and after last contact and how the respondent felt if asked about suicidal feelings. In the third section respondents were asked questions relating to their previous experiences of Samaritans services (if applicable), including which methods of contact they had used in the past, how satisfied they were with these services, main reasons for previous contacts with the organisation and consistency of service. All respondents were asked about: their expectations of the service prior to their first contact; the extent to which their expectations had been met; if they had ever felt judged or listened to; how they thought the service might be improved. Finally, respondents were asked if they would consider contacting Samaritans again.

During the data cleaning period it became apparent that there were some duplicate data, incomplete datasets (where no feedback on the service was given) and non-genuine or inconsistent responders. After the elimination of these, 1309 (93.8%) respondents were included in the data analysis (See Table 1 for further details).

Table 1: Reasons for exclusion

Reason for exclusion	Number (%)
Duplicate data	72 (5.2%)
Non genuine responders	3 (0.2%)
Large amount of missing data with no feedback on service	12 (0.9%)
Total	87 (6.2%)

As shown in Table 2, the majority of survey respondents had found out about Samaritans online (41.5%, n=543) or via word of mouth (23.7%, n=310).

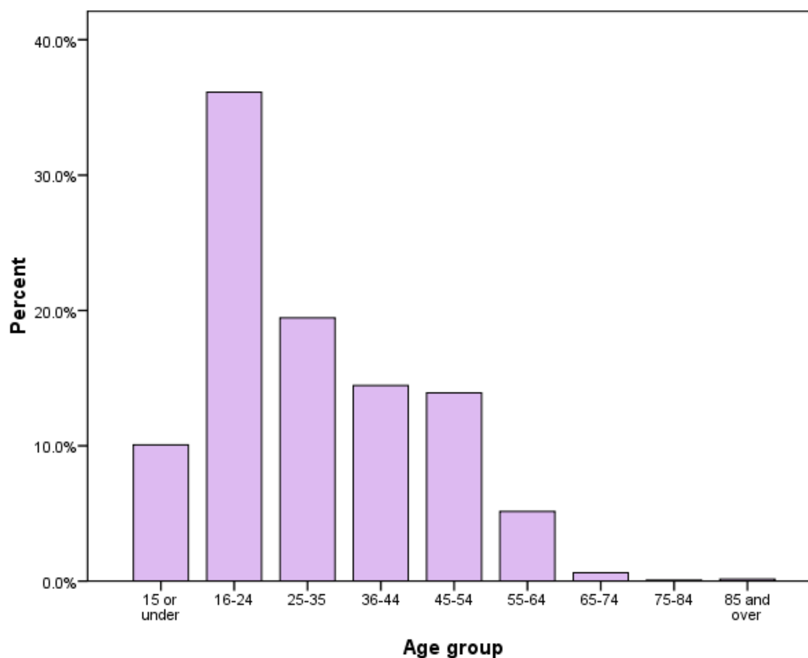
Table 2: Awareness of Samaritans

How participant became aware of Samaritans	Number (%)
Radio	95 (7.3%)
Newspaper/magazine	185 (14.1%)
Poster	205 (15.7%)
Online	543 (41.5%)
Word of Mouth	310 (23.7%)
Recommendation	171 (13.1%)
Telephone directory	126 (9.6%)
Meeting a Samaritan on the street	33 (2.5%)
Don't know/can't remember	237 (18.1%)

Demographics

Survey respondents were predominately female (77.9%, n=1002), aged between 16 and 44 years old[9] (70%, n=911, see Chart 1) and of white British or Irish (82.3%, n=1049) ethnicity (see Table 3). The majority of respondents were heterosexual[9] (76.2%, n=958), single (62.2%, n=792) and lived with other people (79.1%, n=1005), most commonly with parents (36.1%, n=459, see Chart 2). Approximately two thirds of the respondents were UK residents at the time of taking the survey (67.8%, n=869). Additionally, 75.2% (n=1037) of respondents were in some form of education or employment with the majority group being employed full time (23.6%, n= 296)[10].

Chart 1: Age group of survey respondents

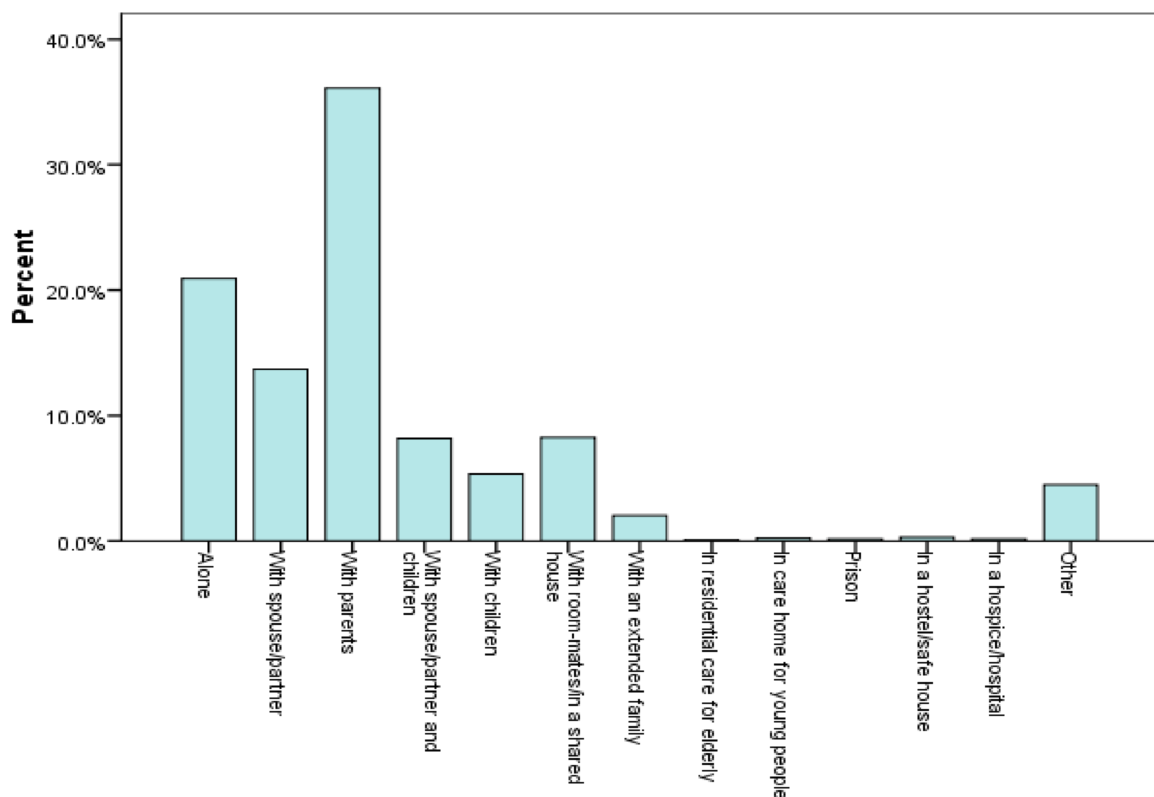


[9] See Table 1, Appendix VI.
[10] 3.5% [n=44] of respondents gave other employment details. These included voluntary work; temporary employment; training or apprenticeships; holding down two jobs; working part-time/ full-time and studying. Some gave reasons why they were not in employment [e.g. redundancy, on benefits, waiting for work visa, actively seeking work]. Others gave a more specific answer to the question than was available in the survey [e.g. gap year student, high school student]. See table 1, appendix iv for further details.

Table 3: Ethnic origin of survey respondents

Ethnicity[11]	Number (%)
White British or White Irish	1049 (82.3%)
White and Asian	18 (1.4%)
White and Black Caribbean	6 (0.5%)
White and Black African	4 (0.3%)
Asian or Asian British	17 (1.3%)
Indian	15 (1.2%)
Pakistani	7 (0.5%)
Bangladeshi	2 (0.2%)
Black or Black British	11 (0.9%)
Caribbean	2 (0.2%)
African	6 (0.5%)
Chinese British	3 (0.2%)
Other Ethnic Group	135 (10.6%)

Chart 2: Living arrangements[12]



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21.8% (n=269) of respondents identified themselves as having a disability[13]. When asked to explain their answer in an open text box the majority of these respondents provided further details of what they considered to be disabling to them (n=228). As illustrated in the data extracts below, the answers given were varied and complex as many of the respondents gave details of more than one disability, disorder or problem. Overall, 72.4% (n=165) of the problems described were mental health problems, 47.4% (n=108) were descriptions of physical disabilities. 19.7% (n=45) of respondents described both physical and mental problems they considered to be disabling to them. Amongst others, mental health problems listed as disabilities included: depression (n=57); various learning difficulties (n=33); anxiety (n=14); bipolar disorder (n=13); post-traumatic stress disorder (n=8); schizophrenia (n=8); and Asperger's syndrome (n=6).

ID282: Technically my depression is a disability

ID655: I have bipolar affective disorder

ID1236: bad back injury manic depression and anxiety

ID736: mental health service user, fibromyalgia, diabetes

A variety of physical health problems was specified by respondents, the most common of which were: back problems [n=15]; arthritis [n=14]; heart problems [n=11]; fibromyalgia (n=10); and mobility problems [n=10].

Use and experience of Samaritans' services at the last time of contact

Means of contact

The majority of respondents to the online survey used email as their last method of contacting Samaritans (59.9%, n=723). The next most common method of contacting the service was via telephone (34.6%, n=420) (See Chart 3). Only a small number of survey respondents had used the text messaging service (3.4%, n=41), visited a branch (including festival branch) for face-to-face contact[14] (2.3%, n=29), or posted a letter (0.2%, n=2)[15]. There was no considerable difference in method of contact used according to gender of caller. There was a tendency for younger callers to use email and text more frequently than older callers. However, email usage was relatively high across all age groups, with the exception of those who were aged 75 and over (see chart 4).

[13] See Table 1, Appendix VI.
[14] The invitation to complete the survey was directed to callers who had used the phone email or text services. However, a number of respondents had also had experience of using additional methods of contact.
[15] See Table 2, Appendix VI for further details.

Chart 3: Method of last contact

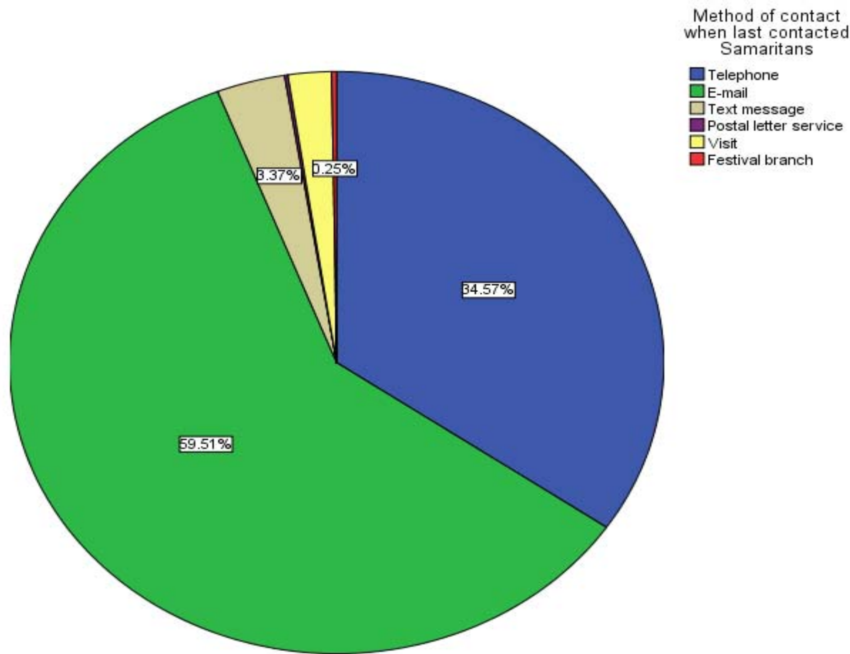
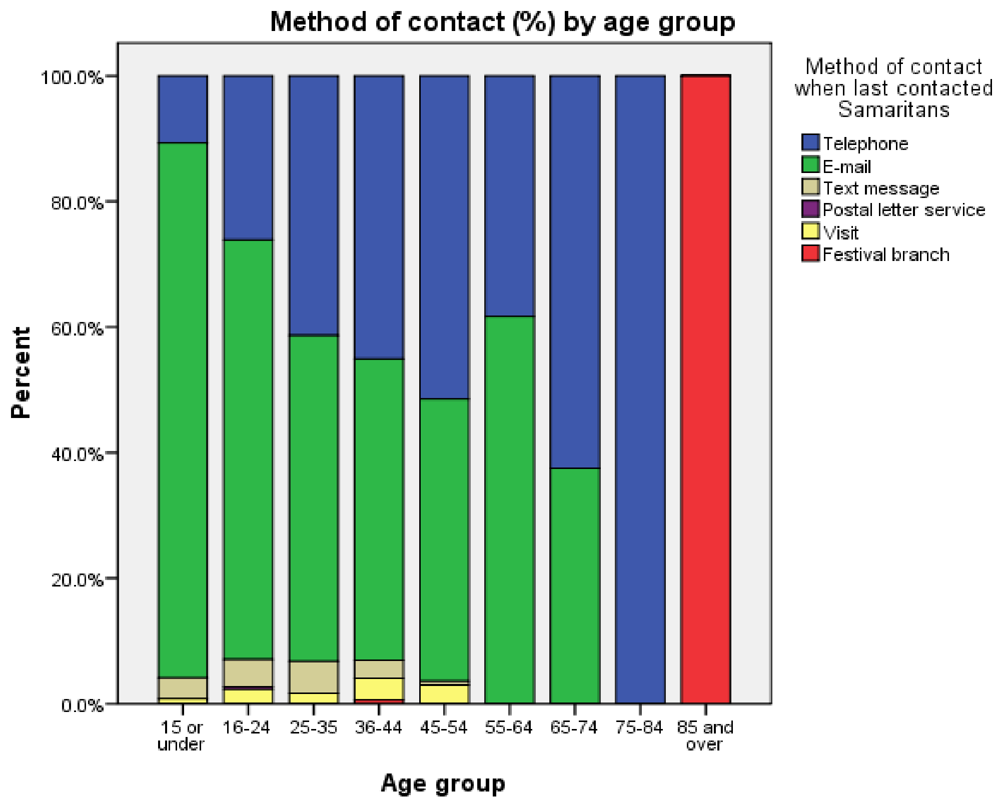


Chart 4: Comparison of method of last contact by age group of respondents



Respondents' reasons for choosing the method of contact they used are shown in Table 4.

Table 4: Reasons for choosing method of contact

	Method of contact used at last contact with Samaritans[16]						
Reason for choosing method of contact[17]	Telephone Number (%)	E-mail Number (%)	Text message Number (%)	Postal letter service Number (%)	Visit Number (%)	Festival branch Number (%)	Total (%)
Felt more anonymous	143 (34%)	464 (64.2%)	19 (46.3%)	2 (100%)	2 (7.7%)	0	630 (51.9%)
Cheaper	13 (3.1%)	166 (23%)	6 (14.6%)	1 (50%)	2 (7.7%)	2 (66.7%)	190 (15.6%)
Wanted to talk to someone	356 (84.8%)	233 (32.2%)	11 (26.8%)	1 (50%)	23 (88.5%)	1 (33.3%)	625 (51.4%)
Easier to talk over the phone	61 (14.5%)	135 (18.7%)	7 (17.1%)	1 (50%)	6 (23.1%)	0	210 (17.3%)
Easier to write/text than talk	14 (3.3%)	581 (80.4%)	37 (90.2%)	1 (50%)	3 (11.5%)	0	636 (52.3%)
Felt less embarrassed	71 (16.9%)	448 (62%)	25 (61%)	1 (50%)	1 (3.8%)	0	546 (44.9%)

The most popular reason for choosing to use the telephone as method of contact was because callers felt like they wanted to talk to someone (84.8%, n=356). Second to this, respondents said they chose to use the telephone to contact Samaritans because it felt more anonymous (34%, n=143). All participants gave other reasons for using the telephone, some examples of which are illustrated in the data extracts presented below. These included perceptions of the telephone service as being 'more immediate', callers finding it easier to talk over the phone, and telephone contact being the only method the caller was aware of at the time or had available to them.

ID1419: I didn't know I could contact them online

ID584: I was in no fit state to leave the house or to use a computer

ID521: I needed to talk to someone immediately. There is a wait through emails.

The main reasons given for choosing email as a method of contact were that respondents found it easier to write than talk (80.4%, n=581), felt less embarrassed (62%, n=448) and thought email would enable them to maintain their anonymity (64.2%, n=464). Again, all respondents who had used email also listed other reasons as to why they had chosen this method of contact. These included perceptions that email was more private than phone calls, allowed the caller to take their time and avoided the caller having to repeat their story each time they contacted the organisation. The majority of those who were not UK residents at the time of completing the survey (78.1%, n=296) reported using email in their last contact with Samaritans. Many email callers explained how they used email as this was the only method of contact available

[16] Column percentages are presented in this table e.g. of those who used telephone as their method of contact, 143 (34%) respondents did so because it felt more anonymous. Percentages do not add up to 100% since multiple reasons for choosing the method of contact could be selected.
[17] 7.2% missing data (n=94)

to them at the time.

> *ID1370: When contacting by email, it was easier to do so in private, without any friends or family knowing or hearing.*

> *ID1151: I can continue a conversation without having to start at the beginning every time and try and explain everything*

> *ID506: I have no other means to contact Samaritans as I'm not a UK neither an Irish resident*

> *ID617: Didn't feel ready to talk on the phone, so email was the alternative.*

A smaller number of participants had used text message (n=41) or visited a branch (n=26) as their most recent method of contacting Samaritans. The most popular reasons given for choosing text message were the same as those given for choosing email: finding it easier to write than talk (90.2%, n=37), less embarrassing (61%, n=25) and more anonymous (46.3%, n=19). The majority of those that had visited a branch did so because they wanted to talk to someone (88.5%, n=23). Similar to those outlined above, the other reasons given for choosing to use these methods of contacting Samaritans included wanting immediate support, a desire for face-to-face contact, and also convenience.

> *ID619: Was passing the branch on my way*

> *ID819: I wanted to speak to someone face to face and get out of the house*

Only a very small number of participants had used the postal letter service (n=2) or visited a festival branch (n=3). For the former of these respondents anonymity was most important, whereas for the latter group cost of accessing the service and wanting to talk to someone were motivating factors.

Sex of volunteer

One explanation for 'snap' calls is that callers may put the phone down quickly if it is not answered by a volunteer of the desired sex. 60.7% (n=219) of respondents who had last contacted via telephone reported their call being answered by a female volunteer, 35% (n=127) by a male with a further 4.2% (n=15) being unsure if they had spoken to a male or female volunteer[18]. The majority of respondents (81%, n=17) of those who had had face-to-face contact reported being in contact with a female volunteer. It is not clear how text and email callers could establish the sex of the volunteers who respond to their messages, since these adopt the unisex signature 'Jo'. However, some apparently had established, or at least assumed, that they knew this, 15% (n=76) of email respondents thought they knew the gender of volunteer they had been in contact with. Similarly, this figure was high for those who used text message (25%, n=8).

[18] 68% of active volunteers are women 1. Samaritans, *Information Resource Pack 2009*. 2009, Samaritans.

Table 5: Details of respondents experience when they last contacted Samaritans

Gender of Samaritan [19]	Number (%)
Male	155 (16.6%)
Female	304 (32.5%)
Not sure	475 (50.9%)
Ease of communicating with Samaritan[20]	
Yes - very easy	367 (49.8%)
Yes - quite easy	247 (33.5%)
A bit difficult	89 (12.1%)
Very difficult	34 (4.6%)

Overall 92.8% (n=675) of respondents were comfortable communicating with a person of the gender they had encountered in their last contact. This did not vary greatly according to method of contact used. When broken down further: 82.4% were comfortable communicating with a male volunteer; 97.6% felt comfortable communicating with a female volunteer; and 93.4% of respondents felt comfortable communicating with a volunteer whose gender they were unsure of. Across the data as a whole, 83.3% (n=614) of respondents found it either 'very easy' or 'quite easy' to speak to a person of the gender they had encountered during last contact (see Table 5). This did not vary greatly according to the gender of the volunteer or by method of contact used. These data suggest that the sex of the volunteer was not an important issue for the online survey respondents, regardless of method of contact.

Speed of response

Overall, the majority of survey respondents reported receiving a prompt response from Samaritans (88.1%, n=1025) that was about the right length (65%, n=735)[21]. This did vary somewhat according to method of contact used. The percentage of those reporting a prompt response was very high for those who used telephone (96.3%, n=388), email (84.8%, n=585) or visited a branch (92%, n=23) during their last contact. However, the figures were notably lower for those who had contacted via text message with around a third of callers not considering the response they received to have been prompt (32.5%, n=13).

Recency of last contact

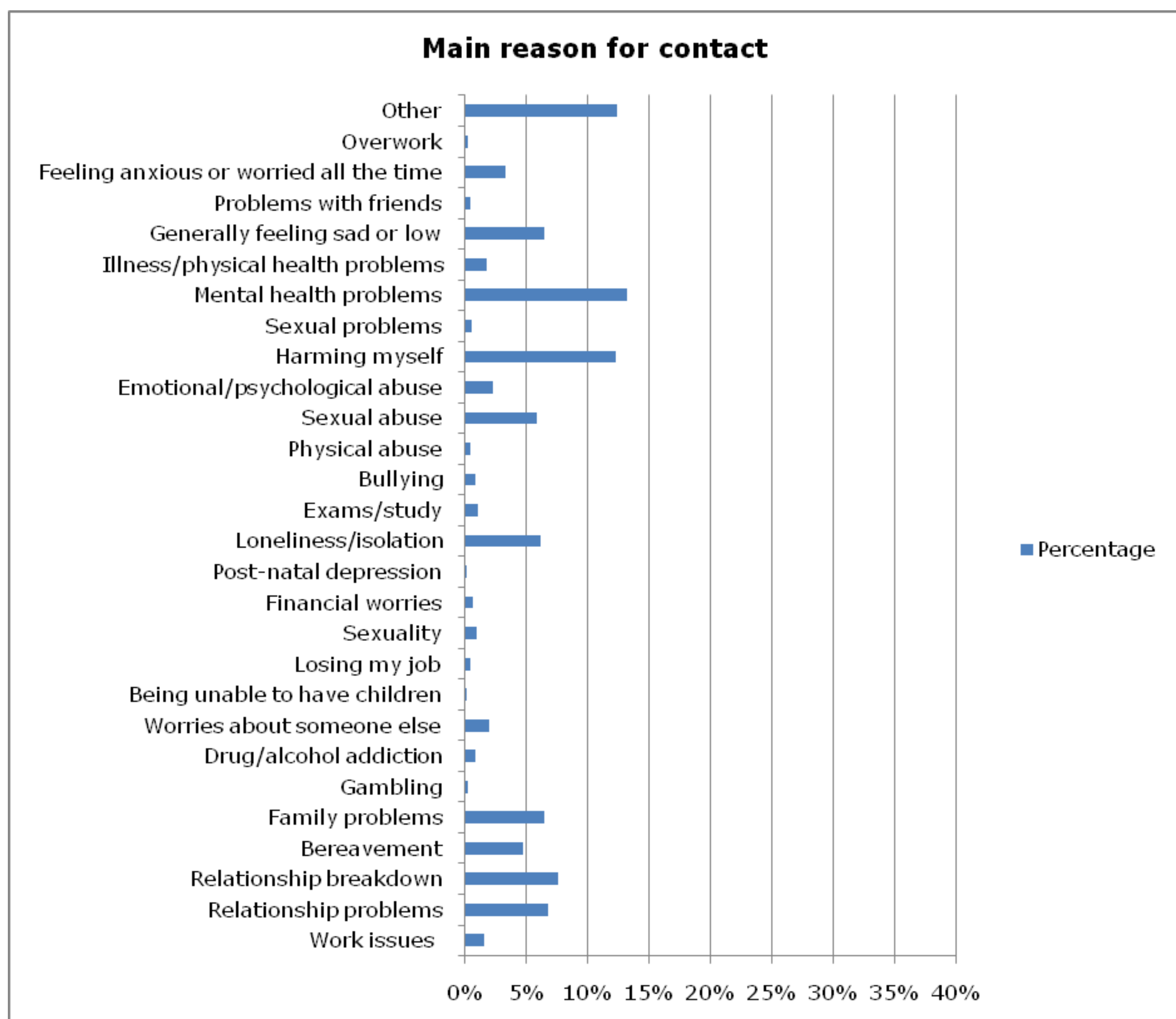
Respondents were asked to indicate the approximate date they were last in contact with Samaritans. The majority of respondents said their last contact with the Samaritans had been within the last month (51.7%, n=460), 15.7% (n=140) said it had been 1-6 months ago and 21.9% (n=195) said it had been 7-12 months ago. A few people (1.2%, n=11) said their last contact with Samaritans was more than 10 years ago[22].

[19] 28.6% missing data (n=375)
[20] 43.7% missing data (n=572)
[21] See Table 3, Appendix VI for further details.
[22] See Table 4, Appendix VI for further details.

Main reason for contact

Respondents were asked to provide details of their main reason for last contacting Samaritans by selecting one of the options displayed on the chart below (Chart 5). Responses were split amongst the categories provided[23]. The ten most common reasons selected for last contacting the organisation were mental health problems (13.2%, n=153), self harm (12.3%, n=142), relationship breakdown (7.6%, n=88), relationship problems (6.8%, n=79) and family problems (6.5%, n=75). Additionally, 6.5% (n=75) of participants said their main reason for contacting Samaritans was because they were feeling generally sad or low and a further 6.2% (n=72) of respondents contacted due to feeling isolated or lonely. Lower but still significant numbers of callers identified their main reason for last contact as sexual abuse (5.9%, n=68) and bereavement (4.7%, n=55)[24].

Chart 5: Main reason for contacting Samaritans



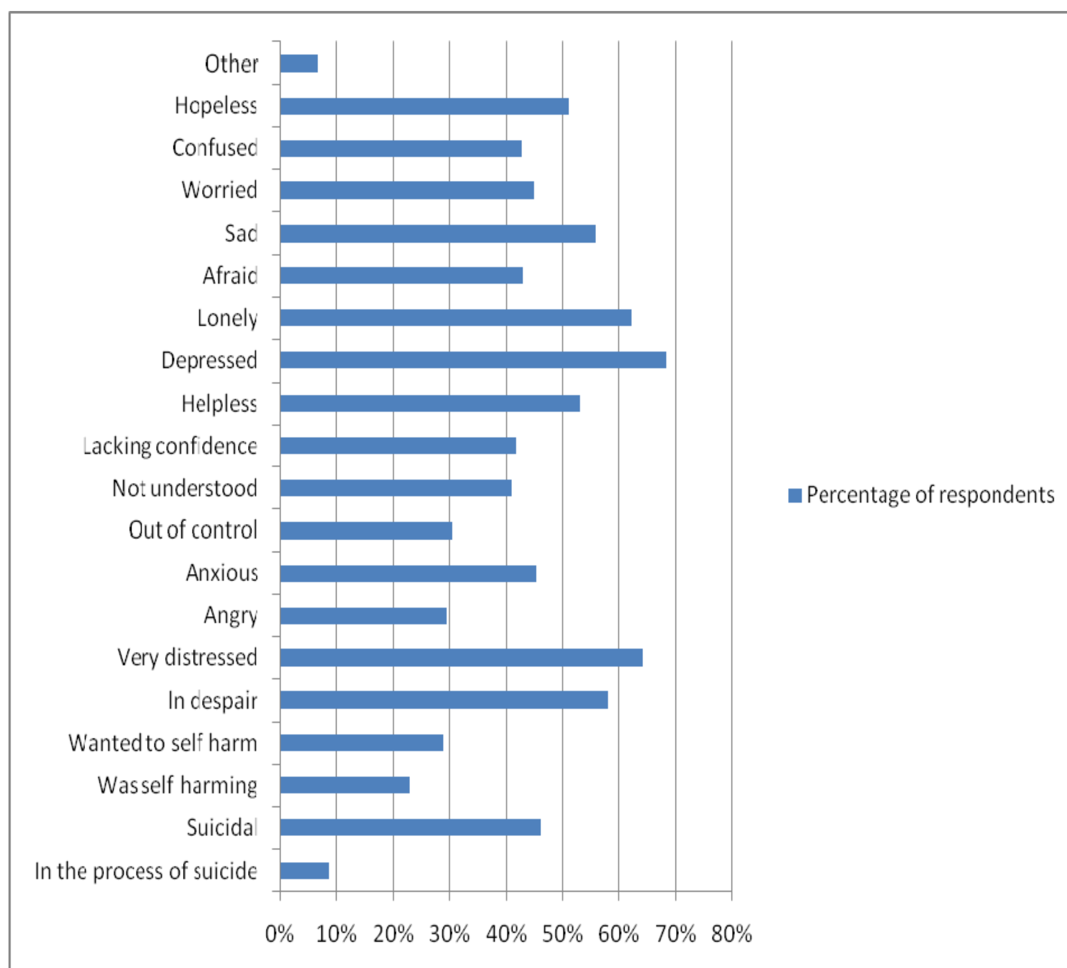
[23] See Table 5, Appendix VI for further details.
[24] *12.6% (n=144) of respondents gave details of other main reasons for contact.*

Feelings before last contact with Samaritans

Survey respondents were asked to describe how they were feeling before their last contact with Samaritans by selecting the appropriate feelings from those displayed on the Chart 6. The majority of survey respondents selected more than one option from the list. Most commonly, callers reported feeling depressed (68.3%, n=894), very distressed (64.1%, n=839), lonely (62.1%, n=813), in despair (58.1%, n= 761), sad (55.7%, n=729), helpless (53%, n=694) and hopeless (51.1%, n=669). Additionally, 46.3% (n=606) of respondents reported feeling suicidal before their last contact with Samaritans. A significant minority 8.6% (n=113) indicated that they had called whilst in the process of suicide[25].

An open text box was provided to enable respondents to give details of other ways they were feeling. Only a relatively small number of respondents chose to provide further details of their feelings prior to last contact with Samaritans (6.7%, n=88). A wide range of feelings was described, although all but one of these was negatively orientated. These included feelings of: being unloved, stress, uselessness, unattractiveness and grief.

Chart 6: Feelings before last contact



[25] See Table 6, Appendix VI for further details.

Feelings after last contact with Samaritans

How the respondent recalled feeling at the *end* of last contact was measured on a scale of one to ten for a variety of variables (See Table 6).

Table 6: Respondent's feelings at the end of last contact with Samaritans

Feelings	Endpoints of Scale ranging from 1 to 10:		Median Score [Inter-quartile range]
	1	10	
Listened to	"Not listened to"	"Listened to"	9 [7,10]
Suicidal	"Suicidal"	"Not suicidal"	7 [4,10]
Lonely	"Alone"	"Not Alone"	6 [4,8]
Afraid	"Afraid"	"Unafraid"	6 [4,8]
Anxious	"Anxious"	"Not anxious"	6 [4,8]
Happy	"Unhappy"	"Happy"	5 [2,6]
Confident	"Not confident"	"Confident"	5 [3,6.25]
Understood	"Not understood"	"Understood"	7 [4,9]
Hopeful	"Hopeless"	"Hopeful"	6 [3,7]
Depressed	"Depressed"	"Not depressed"	4 [2,7]
Wanted to live	"Don't want to live"	"Want to live"	6 [3,9]
Cared for	"Not cared for"	"Cared for"	5 [2,6]
Supported	"Not supported"	"Supported"	6 [3,9]
Solution had been found	"No solution"	"Solution found"	7 [5,9]
Given advice	"No advice"	"Advice given"	8 [5,10]

After contact with Samaritans respondents tended to report more positive feelings than negative ones with median values being greater than the midpoint of the scale. The highest median values were for feeling listened to (9 [7,10])[26] and feeling understood (7 [4,9]). Many felt as though they had been given advice (8 [5,10]) and as though a solution had been found for their problems (7[5,9]). Overall, there was a tendency for respondents to report feeling a little less suicidal (7 [4,10]), alone (6 [4,8]), afraid (6 [4,8]) and anxious (6 [4,8]) and slightly more hopeful (6 [3,7]), supported (6 [3,9]) and wanting to live (6 [3,9]) after contact. Median scores for the remaining variables indicated that after contact with Samaritans participants felt neither more or less confident (5 [3,6.25]), happy (5 [2,6]) or cared for (5 [2,6]). Additionally, respondents reported feeling more depressed than not (4 [2,7]).

Comparison of feelings before and after last contact with Samaritans

Respondents were asked to rate how they were feeling *overall* after their last contact with Samaritans compared to how they felt before the contact on a scale of 1 to 10 (1 being 'worse' and 10 'better'). The majority of respondents scored this question highly with a median score of 7 [5,8] indicating that most recalled their contact with Samaritans to be of immediate positive effect.

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[26] The median score is presented first, followed by the inter-quartile range.

Table 7: Impact of contact with Samaritans on respondent's feelings

	Median Score [Inter-quartile range] (1=worse, 10=better)
Feelings at end of last contact compared to before the contact[27]	7 [5,8]
Feelings at time of completing online questionnaire compared to after the last contact[28]	6 [3,8]
Extent to which contact with Samaritans helped [29]	7 [5,9]

How participants recalled feeling at the end of last contact compared to how they felt before the contact did not differ markedly between males (median score was 7 [5,9]) and females (median score of 7 [5,8]). When looking at age groups, most groups again had a median score of 7 with the exception of the under 15s and 65-74s who had a higher median score of 8, and the 55-64s, 75-84s and 85 and over's who all had lower median scores of 5, 6 and 1.5 respectively. All of these groups, with the exception of the under 15s had considerably fewer participants than in the other age groups making the data less reliable[30]. When the data were split by method of contact, telephone, email and text message groups again showed a median of 7. The postal service and visit groups were slightly higher with median scores of 9 and 8, respectively. The festival branch group had a very low median score of 2, although there were only 3 respondents in this category.

Comparison of how respondents felt at the time of completing the online survey and how they felt after last contact with Samaritans

Respondents were asked to indicate how they felt at the time of last contact compared to when they completed the survey (i.e. the present) to provide some indication of change or stability of mood (see Table 7). In general, callers reported feeling slightly better at the time of completing the online survey than they did immediately after their last contact with Samaritans (6[3,8]). This did not vary greatly according to how recent their last contact with Samaritans was, with those who had last been in touch with Samaritans less than a month ago and those last in touch 7-12 months ago having a median score of 6 and those whose last contact had been 1-6 months ago having a mean score of 5. Responses from those whose last contact with Samaritans had been more than a year ago were more variable but less reliable due to the smaller number of respondents in each group (median [IQ] scores for last contact 13months-4 years, 5-10 years and >10 years being 7 [3,9], 9 [5.75,10], 3 [1,8] respectively). How respondents felt at the time of completing the online questionnaire compared to how they felt at the end of last contact did not differ markedly according to gender, with both male and female groups scoring a median of 6. This was also the median score for all age groups, with the exception of 55-64 (5 [3,8]); 65-74 (9 [5.25,10]; 75-84 (7); and 85 and over (median score of 1.5). Again, all of these groups had considerably fewer participants than in the other age groups making the data less reliable.

Responses differed slightly according to method of contact. Telephone, email and branch

[27] 9.8% missing data (n=128)
[28] 9.5% missing data (n=125)
[29] 11.1% missing data (n=145)
[30] Nb. Some of these groups were very small: 55-64 age group n=56; Text message n=40; Visit to branch n=23; 65-74 age group n=8; Festival branch n=3; 85 and over n=2; Postal service n=1; 75-84 age group n=1.

visit all had a median score of 6. Those who used text message as their last method of contact reported feeling on average neither better nor worse at time of completing the questionnaire than they did at the end of last contact, with a median score of 5 [3,6]. The one participant who used the postal service as last method of contact gave a high score of 10, whereas the three participants who had visited a festival branch gave a very low median score of 2 [1,2].

Overall, the extent to which contact with Samaritans was perceived as being of help by respondents was scored highly, achieving a median score of 7 across most groups. Exceptions to this were 65-74 year olds (9 [5.75, 9.75]) and those who used the telephone as last method of contact (8 [6,9]) who scored the question higher. Additionally, the one person who had used the postal service rated the extent to which contact with Samaritans had helped as 10. Those who were 85 and over (1.5 [1,2]) and festival branch users (1.5 [1,2]) thought on average that the extent to which the service had helped was much lower.

Reactions to being asked about suicide during last contact

59% (n=655) of respondents reported being asked if they were feeling suicidal during their last contact with Samaritans. The percentage was relatively consistent (at around 70% of callers) when comparing methods of contact with the exception of email where only 50% (n=317) of respondents were asked if they were feeling suicidal, and postal letter service where the one person who did use this service and answered this question also had not been asked if they were feeling suicidal. As explained in the data extracts below, in some cases (n=10) the caller might not have been asked if they were feeling suicidal by the volunteer due to their prior disclosure of suicidal or non-suicidal feelings during the call.

> *ID273: note. i told THEM i was feeling suicidal. they did not have to ask.*
>
> *ID1414: I called and said immediately that I wasn't suicidal just incase they had priorities.*

How respondents felt after being asked if they were feeling suicidal during their last contact was assessed both quantitatively and qualitatively. Responses were organised into four categories: positive feelings; negative feelings; feeling embarrassed or surprised; and those who were not sure how they felt. As illustrated in Table 8, respondents' reactions to being asked whether they were feeling suicidal did not vary extensively according to the caller's main reason for contact.

Table 8: Comparing main reason for last contact with caller's reaction to being asked whether they were feeling suicidal[31]

Main reason for contacting Samaritans	Feelings[32]			
	Positive (%)	Negative (%)	Embarrassed /surprised (%)	Not sure (%)
Health problems	134 (48.6%)	18 (6.5%)	73 (26.4%)	51 (18.5%)
Problems with Family/Friends	20 (57.1%)	1 (2.9%)	8 (22.9%)	6 (17.1%)
Work/school problems	15 (75%)	0	4 (20%)	1 (5%)
Relationship problems	55 (56.1%)	4 (4%)	27 (27.6%)	12 (12.2%)
Abuse	43 (48.3%)	7 (7.9%)	27 (30%)	12 (13.5%)
Bereavement	19 (57.6%)	1 (3%)	7 (21.2%)	7 (21.2%)
Worry	18 (56.2%)	2 (6%)	9 (28.1%)	3 (9.4%)
Loneliness/isolation	20 (46.5%)	5 (12.5%)	9 (20.9%)	9 (20.9%)
Sexuality	5 (62.5%)	1 (11.6%)	2 (25%)	1 (12.5%)
Gambling	2 (100%)	0	1 (50%)	1 (50%)
Drug/alcohol addition	4 (50%)	0	2 (25%)	2 (25%)
Other	41 (51.9%)	8 (10.1%)	23 (29.1%)	17 (21.5%)
TOTAL (%)	376 (51%)	47 (6.4%)	192 (26%)	122 (16.5%)

Positive feelings

Overall, just over half (51%, n=376) of those who were asked if they were feeling suicidal during their last contact with Samaritans reported feeling positive about being asked the question. 170 respondents went on to explain their reasons for feeling this way in the open text box provided on the survey. The reasons given for feeling positive varied between callers. For some callers being asked this question made them feel cared for, understood, less alone and listened to even if they were not feeling suicidal when asked the question. Others felt comforted that someone was there to support them in a non-judgemental way. Many respondents described feeling a great sense of relief at being able to talk about suicidal feelings, explaining how it had felt good to be honest and open and admit how they were feeling to both themselves and the volunteer.

> *ID1257: I wasn't suicidal but it was nice that someone cared enough to ask*

> *ID1035: i felt listened to and understood about things i could never say face to face with someone*

[31] See Table 7, Appendix VI for a more detailed breakdown of results.

[32] Row percentages are presented in this Table e.g. of those whose main reason for contacting Samaritans was because of problems with family/friends, 20 (57.1%) respondents felt positive about being asked whether they were feeling suicidal. Percentages do not add up to 100% since multiple feelings about being asked the question could be selected.

ID705: gave me opportunity to be honest and open about my true feelings

ID1095: It is a huge relief to be able to acknowledge that line of thought, with someone who isn't scared

Being asked if they were feeling suicidal was seen as an opportunity for callers to ‘release’ all the feelings they had bottled up and have these feelings acknowledged and accepted. Callers expressed how it felt good to be able to discuss the topic of suicide with someone who understands, is not judgemental and is not scared by the subject. Being asked about suicidal feelings also helped from the callers’ perspective as many expressed how they would have found it difficult to bring up the subject themselves. Callers described feeling better or even ‘liberated’ after discussing suicidal feelings with someone, with some callers saying that the discussion of these feelings had made them realise that they did not want to die and that there were ‘other options’ to suicide available. Others felt relieved that they were able to talk about suicidal feelings or past suicide attempts without being judged and felt less afraid and less guilty for having suicidal feelings.

ID1377: i bottled it up so long, it just felt so good to be able to release it all

ID280: By expressing these ideas I realised I didn't really want to die even though I was suicidal.

ID995: I was relived to talk about the fact i didn't want to live anymore. and not be judged for this

ID105: I wouldn't have been able to bring it up myself

Even if not feeling suicidal at the time, some callers said it felt good to be asked the question and that this helped them realise that they were not feeling suicidal; were feeling better compared to previous contact or helped them to better understand how they were feeling. When volunteers brought the subject up these callers felt that it was permissible to talk about suicide and thought that volunteers were right to ask the question because it is such a serious and important issue that deserves attention.

ID234: While not suicidal at the time, it's nice to know that I could talk if I wanted, that it was OK to

ID491: It felt good to say, no, I'm past that, and I don't want to any more

ID496: The question helped me realise I didn't feel suicidal.

23 respondents explained how they felt unable to talk about suicidal feelings to anyone other than Samaritans. Having the subject brought up allowed callers to discuss feelings they thought would be seen as taboo, not understood or taken seriously, that might scare people they knew or lead to them being hospitalised if discussed in other situations. Callers described how in being able to discuss suicidal feelings with Samaritans they felt less alone and more understood.

ID286: as i felt that i couldnt talk about this with anyone else it was good to hear that i wasnt alone

ID1186: it is the type of thing you cannot talk about generally in society

ID212: I can't tell anyone else I am suicidal - I would be put in a psych ward, which I know doesn't help

ID685: no one else ever asked

Overall, three types of positive response were obtained from participants. Firstly, being asked if they were feeling suicidal induced positive feelings in the caller (made them feel better about themselves or situation); second, callers felt positive about being asked the question even if not feeling suicidal (saw suicide as an important topic worthy of discussion); and third, being asked the question made callers feel positive towards Samaritans (that Samaritans care, want to help and are there for them).

Negative feelings

Only 6.4% (n=47) of respondents recorded that they reacted negatively when asked if they were feeling suicidal. However, 137 (19.5%) of survey respondents described their feelings when asked about suicide in negative terms (some of these answered 'not sure' on the survey and then went on to explain their answer in more negative terms). These callers reported feeling upset, scared and nervous that someone else knew they were considering suicide and worried what the consequences of this might be. They explained that despite the topic of suicide being broached during their contact with Samaritans, they were no less likely to attempt suicide. Callers described how after the topic was brought up and discussed with Samaritans, they still felt suicidal, did not feel any better, were unable to see a way forward, felt more afraid and hopeless. Some callers felt worse upon realising the depth of their own feelings whereas others reported feeling 'stupid' or 'pathetic' and were uncomfortable with being asked about suicidal feelings.

ID583: feel worse realizing i was really at the bottom to be feeling like this

ID1362: i felt really stupid

ID455: felt sort of nervous that someone else knew i was considering suicide

ID458: just felt deeply upset that id got in such a state,ashamed

ID799: quite worried cause not sure if they pass it on

Callers described feeling guilty and ashamed for thinking about suicide, for finding it difficult or being too scared to admit suicidal feelings or guilty that they did not feel suicidal so might be wasting Samaritans time. Some felt as though their problems were not important or the volunteer was not interested if they did not feel suicidal that the volunteer wanted the caller to feel this way or would have been more helpful if they did.

ID589: guilty because I know there are alot of poeple out there with much bigger problems

ID350: Because I wasn't feeling suicidal, the question made me wonder whether I was wasting their time

ID599: It felt odd to be asked, like I had to be suicidal to have called you, which I know isn't true

ID988: They usually ask this, and if you say no, it seems they try and ditch you as quickly as possible

Twelve callers reported still feeling suicidal, or as having a desire to attempt suicide, after the call. Six of these callers appear to hold Samaritans responsible for inducing suicidal feelings in them or introducing suicide as an option to them.

> *ID890: i was surprised, when they asked me if i was suicidal, it put suicidal feelings in me."*
>
> *ID640: it made me actually consider it as an option.*

Whilst some callers felt asking about suicide was a 'standard question' that was irrelevant to them and asked unnecessarily in their case others felt as though in asking the question the volunteer was making unwarranted assumptions about how they must be feeling. In some instances this induced feelings of anger towards volunteers. Some of these callers stated that they did not like being asked 'that question' or had problems with the way in which the subject was approached by volunteers, referring to the way in which the question was asked as too direct or insensitive. Others found the question awkward, not fitting well into the conversation. In these instances callers felt that they were not being listened to or understood. They were not comfortable with the subject being raised and did not want to talk about these feelings or would have rather brought the subject up in their own time.

> *ID1033:i didn't think it was needed. i believe the volunteer was obliged to ask it.*
>
> *ID100: angry that just because I was at a awful point in my life the samaritan would assume I was suicidal*
>
> *ID1214: They did not ask in sensitive way. Horrible in fact*
>
> *ID1162 they were quick to ask this as though it was on a check list... i wanted to try to say it myself.*

Callers described feeling unsure how to respond when asked and tried to avoid answering the question or reported concealing their true feelings about the subject from volunteers.

> *ID1252: i lied and said i didn't feel suicidal*
>
> *ID1062: was easier to say yes than trying to say how i felt*
>
> *ID1291: I didn't want to respond or think about what my response may be.*
>
> *ID118: email so they didn't ask- but it is the main reason I don't phone because I can't stand being ask*

Overall, three types of negative response were obtained from respondents. Firstly, being asked if they were feeling suicidal induced negative feelings in the caller (made them feel negatively about themselves or situation); second, callers felt negative about being asked the question even if feeling suicidal (e.g. did not want to talk about suicidal feelings, or thought the subject was handled inappropriately); and third, being asked the question made callers feel negative towards Samaritans (that volunteers do not care about those who are not feeling suicidal or that they had been judged).

Feeling embarrassed or surprised by the question

26% (n=192) of respondents reported feeling embarrassed or surprised when asked about suicidal feelings. Often, callers also described other positive or negative feelings in addition to reported feeling embarrassed or surprised by the subject. The reasons callers gave for being surprised by the question were varied. Two callers were surprised by the way the topic of suicide was handled by volunteers. Whilst some callers were surprised that the volunteer had been able to pick up on their feelings and bring them 'into the open', others were surprised to be asked about suicide when such feelings had not occurred to them.

> *ID540: it wasn't what I was thinking, so i was surprised to be asked*
>
> *ID331: I was surprised at the volunteer being shocked at my equivoal attitude towards suicide*
>
> *ID83: I was suprised to have it brought into the open*

Reasons for feeling embarrassed were rarely given with participants simply stating that they had felt embarrassed to be asked if they were feeling suicidal. The stated reasons included embarrassment because the caller was feeling suicidal when asked or that the caller was not sure if they would be taken seriously. Several of those who reported feeling embarrassed also said they were relieved that the topic was brought up.

> *ID535: Embarrised I did, Suprised that is was that blunt. Better that it wasnt beating around the bush*
>
> *ID342: It was embarassing at first because I dont know if they will believe me but they did*
>
> *ID317: I say embarrassed because I was all weepy and choked back sobs - but it was a big relief to feel that*

Other feelings

31 callers mentioned how they were expecting to be asked if they were feeling suicidal, either because they had been asked during previous contact with Samaritans, had previously been a Samaritans volunteer themselves, had been asked the same question by others, or were expecting to be asked because this was how they were feeling.

> *ID1076: Have worked as a sam before, so was expecting the question*
>
> *ID188: Been through counselling a few times. Its a question thats been asked before*
>
> *ID289: I expected it, I've been asked in previous calls.*
>
> *ID1430: I can see how people who may have the issues I called about would be suicidal which is why she asked*

In addition, 10 respondents reported having 'no feelings' or not feeling any different after being asked if they were feeling suicidal during contact with Samaritans. Most did not explain their answer, or of those that did the reasons given included that the caller had had suicidal thoughts or was feeling suicidal when asked, had already disclosed

suicidal feelings in a previous contact or that they were expecting the question.

> *ID1403: I brought it up in the initial e-mail so I didn't feel any different*

> *ID1020: I was expecting them to ask so ddin't feel any of teh above*

> *ID1196: I was feeling suicidal,so no matter the question*

> *ID958: had no feelings abvout it*

For a number of respondents being asked openly about suicidal feelings and having the opportunity to talk about these feelings made their situation feel more real. For some, this was clearly a positive step, enabling them to admit how they were feeling and helping them to understand their own feelings. For others, thinking about the reality of their situation induced more negative feelings.

> *ID913: It felt good to admit it and bad at the same time cuz that ment the problem was real.*

> *ID606: by making it real i could talk about it and understand my feelings towards it more*

> *ID1173:i was sort of shocked into thinking about the realit of it and i just felt a bit stupid*

In the main, respondents described their feelings in either positive or negative terms. Only 26 participants gave a mixed response, expressing both positive and negative feelings. In the open text box provided on the survey several other types of response were detailed. These included: no feelings; was expecting the question so did not feel any differently; made the situation seem more real- but no better or worse; and a few callers explained how they felt unable to share these feelings with anyone else.

Previous experiences of Samaritans' services

In addition to being asked about the details of their last contact with Samaritans, respondents who had made previous contacts were also asked about these earlier experiences. Just over half of the survey respondents had been in contact with Samaritans on more than one occasion (54%, n=593). The majority of these respondents had only used one method of contact (61.1%, n=350) (see Table 9). Of those using only one method of contact, email (53.7%, n=188) and telephone (42.3%, n=148) were the most common methods used. Those who had contacted via text message (9.3%) had used the service the most frequently (median score of 12.5 [5,50]). Those using telephone, email and postal letter to contact Samaritans used the service a median number of 4, 5 and 7 times respectively, whereas the median score was lower for face-to-face visits at 2 for branch visit and 1.5 for festival branch. When considering method of contact used by age group, a higher proportion of respondents aged 25 and older reported using the telephone and visiting a branch than those aged under 25. No-one over the age of 54 reported using text message or postal letter service. Those reporting the highest use of the text messaging were aged between 18 and 35. Those reporting the highest use of postal letter service were aged between 25 and 35. Email usage was relatively consistent across all age groups although it tended to be higher in those under 25 years and was not used by anyone over the age of 75. Overall, females were more likely to use each method of contact more frequently than males, with the

exception of branch visits where males reported using this method more frequently than females.

Table 9: Details of services used in previous contacts

Number of methods of contact used	Number (%)
1	350 (61.1%)
2	150 (26.2%)
3	61 (10.6%)
4 or more	12 (2.1%)
Most frequently used method of contact[33]	
Telephone	381 (43%)
Email	404 (44.4%)
Text message	60 (10.6%)
Postal letter service	18 (3.4%)
Visit	93 (15.5%)
Festival branch	4 (0.8%)
Frequency of use	Median [Inter-quartile range]
Telephone	4 [2,10]
Email	5 [2,10]
Text message	12.5 [5,50]
Postal letter service	7 [1, 16]
Visit	2 [1,5]
Festival branch	1.5 [1,2]

Reasons for past contact

When asked to provide details of reasons for previous contact with Samaritans respondents were able to select as many options from the list as were appropriate to them (see Chart 7). 57.0% (n=338) had contacted Samaritans in the past because they were feeling generally sad or low, 55.5% (n=329) were feeling lonely and isolated and 47.2% (n=280) reported making contact because they were feeling anxious or worried all of the time. Other prevalent reasons given for previous contact were self- harm (50.9%, n=302), mental health problems (47%, n=279), family problems (40.3%, n=239) and relationship problems (29.3%, n=174). 12.3% (n=73) of respondents gave details of other main reasons for previous contact[34].

[33] These results correspond to respondents who had used one or more methods of contact.
[34] See Table 8, Appendix VI for further details.

Chart 7: Reasons for past contact

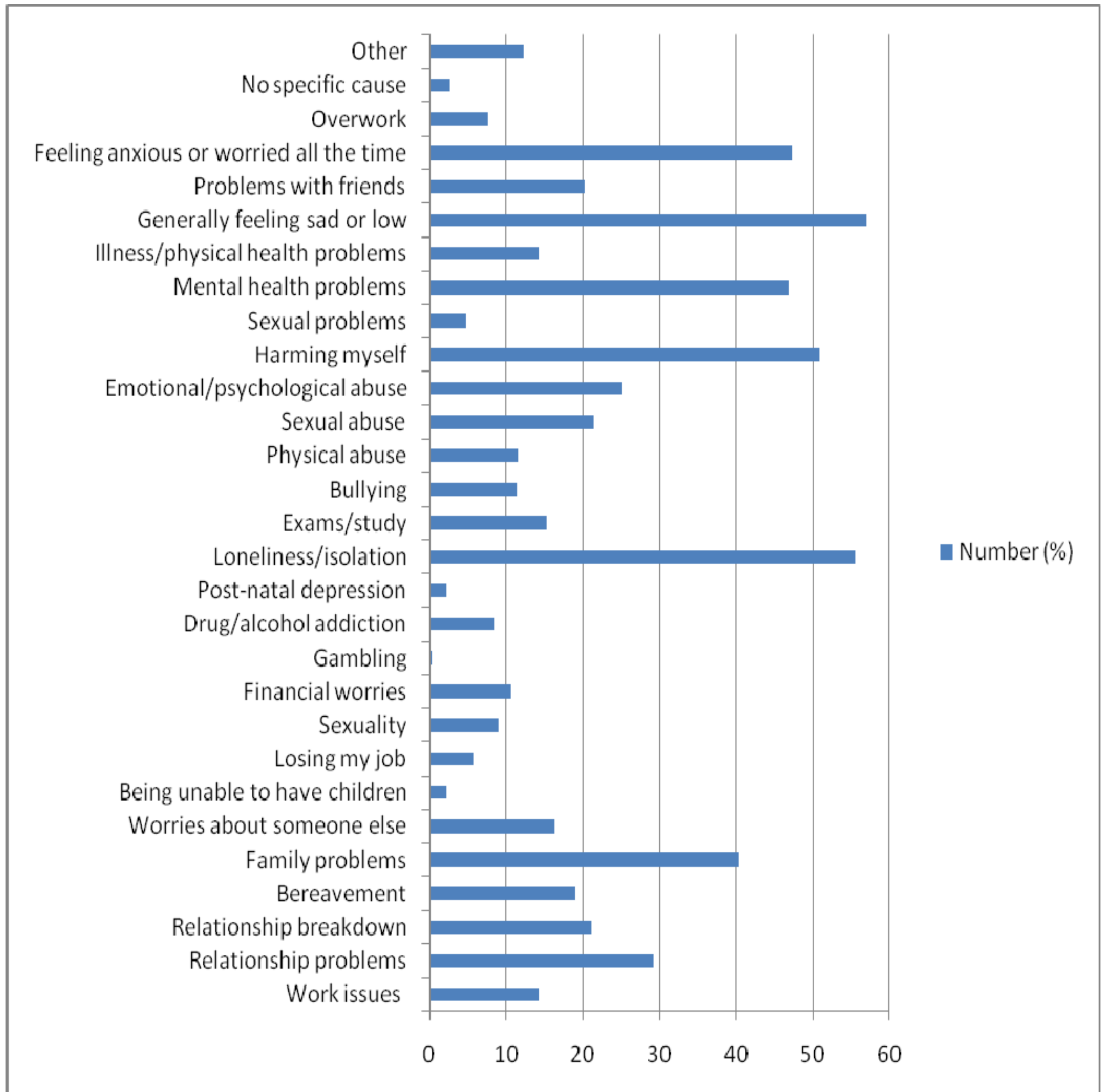
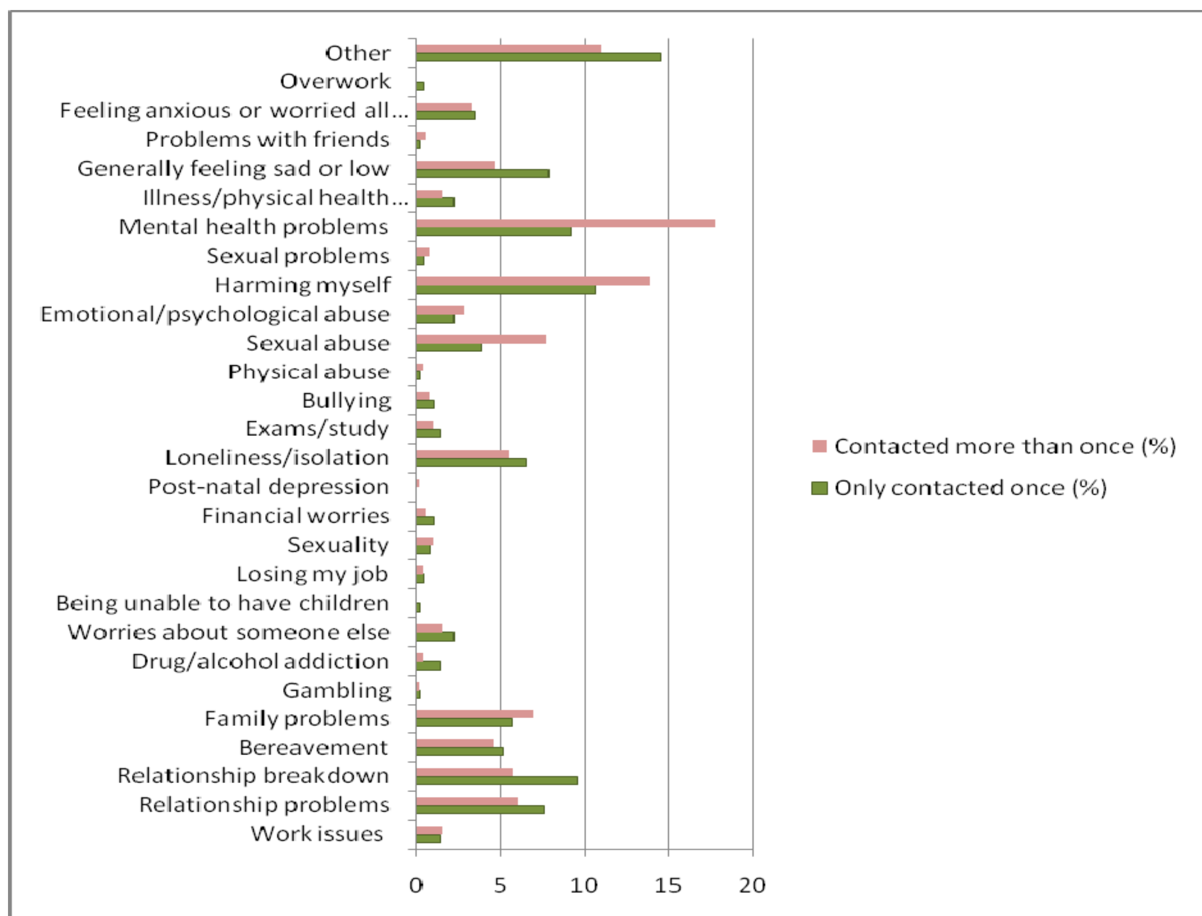


Chart 8 compares the main reason for last contact between those who had only used the service once and those who had used the service on more than one occasion. A re-examination of this data, alongside the reasons for past contact that were disclosed, suggests a different configuration of reasons for contact between people who are first-time users of the service, or had only used it once compared to those who have contacted more frequently. The data shows a higher percentage of those who had only contacted once were contacting when feeling generally sad or low or about relationship problems compared to those who had used the service more frequently. A higher proportion of those who had used the service on more than once occasion reported their main reason for contact to be related to mental health issues, self-harm and sexual abuse than those who had only contacted once. Similar frequencies of other issues, such as loneliness and isolation, bereavement and family problems were reported by both groups of respondents.

Chart 8: Comparing main reason for last contact between those who have only contacted once and those that have used the service more than once



Satisfaction with previous contacts

Overall, most respondents were either moderately or very satisfied with the service they received in previous contacts. Again, this did vary somewhat according to the method of contact used. In general, there was a trend for those who used the telephone or visited a branch to report higher levels of satisfaction with the service received than those who used email or text message (see Table 10).

Table 10: General satisfaction with previous contacts with Samaritans

	Method of contact used[35]					
	Telephone[36] Number (%)	E-mail[37] Number (%)	Text message[38] Number (%)	Postal letter service[39] Number (%)	Visit[40] Number (%)	Festival branch[41] Number (%)
Satisfaction with length of time for response						
Not satisfied	19 (5.6%)	17 (4.8%)	8 (14.8%)	1 (6.2%)	5 (5.9%)	0
Fairly satisfied	53 (15.5%)	78 (22.1%)	12 (22.2%)	2 (12.5%)	13 (15.3%)	1 (25%)
Moderately satisfied	46 (13.5%)	83 (23.5%)	13 (24.1%)	3 (18.8%)	12 (14.1%)	1 (25%)
Very satisfied	175 (51.2%)	128 (36.3%)	16 (29.6%)	9 (56.2%)	51 (60.0%)	1 (25%)
Not sure/varies	49 (14.3%)	47 (13.3%)	5 (9.3%)	1 (6.2%)	4 (4.7%)	1 (25%)
Participants perception of service						
Excellent	115 (33.9%)	100 (28.7%)	13 (24.1%)	7 (43.8%)	32 (39.5%)	1 (25%)
Good	127 (37.5%)	152 (43.7%)	21 (38.9%)	6 (37.5%)	25 (30.9%)	1 (25%)
Reasonable	37 (10.9%)	62 (17.8%)	7 (13.0%)	2 (12.5%)	14 (17.3%)	1 (25%)
Bad	14 (4.1%)	12 (3.4%)	8 (14.8%)	1 (6.2%)	5 (6.2%)	0
Variable	46 (13.6%)	22 (6.3%)	5 (9.3%)	0	5 (6.2%)	1 (25%)

When asked whether the service they had received had been consistent, 357 (66%) said it had been (see Table 11). Respondents were also asked to rate how helpful they found the service on a score of 1 (no help at all) to 10 (very helpful). Respondents scored the helpfulness of service highly with a median score of 8 [7, 10].

[35] Column percentages are presented in this Table e.g. of those who used telephone as their method of contact, 175 (51.2%) respondents said they were very satisfied with the length of time for response.
[36] 4.2% missing data (n=15), 5.0% missing data (n=18) for satisfaction with service and perception of service respectively
[37] 2.5% missing data (n=9), 3.9% missing data (n=14) for satisfaction with service and perception of service respectively
[38] 1.8% missing data (n=1) for satisfaction with service and perception of service
[39] 5.9% missing data (n=1) for satisfaction with service and perception of service
[40] 4.5% missing data (n=4), 9.0% missing data (n=8) for satisfaction with service and perception of service respectively
[41] No missing data for satisfaction with service and perception of service

Table 11: Consistency and helpfulness of service

Consistent service[42]	Number (%)
Yes	357 (66.0)
No	149 (27.5)
No answer	35 (6.5)
	Median [Inter-quartile range]
Helpfulness of service[43]	8 [7,10]

Expectations and evaluation of service

In the fourth section of the questionnaire all respondents were asked about their expectations of the service prior to using it, their experience of the service, how it could be improved, and whether they anticipated making further contacts in future.

Expectations prior to contact

Only 25.2% (n=281) of respondents reported having expectations of the service prior to contacting Samaritans. These respondents expressed a large range of hopes, fears, thoughts and feelings when asked to describe their expectations of the service prior to use. Positively, many of these matched Samaritans' own aims for the service they offer. As shown in the examples below, many respondents felt desperate before calling and contacted the organisation expecting to be listened to, supported, empathised with, having someone 'be there' for them. 97.1% (n=1092) of survey participants were aware that Samaritans are a confidential service. A relatively high number of participants, 73.3% (n=803), said this was very important in their decision to contact Samaritans, compared to 9.1% (n=100) who thought confidentiality was unimportant.

> *ID534: Just someone who would listen without judging me.*
>
> *ID450: That the Samaritans are there 24/7 if you're feeling suicidal and can talk in confidence.*
>
> *ID1074: I expected I'd be listened to, and have people try to see where I was coming from.*

Those harbouring positive images of the service expected volunteers to be warm, kind and caring. Respondents expected that volunteers would help them to 'open up' and discuss difficult issues. Quite a few respondents mention an expectation that any topic could be discussed at Samaritans, and a number also recognised that there were some limits: they should not be "abusive or obscene".

> *ID303: I thought that they would be very kind and caring and sort of listen indefinitely even if there wasn't much they could do to help.*
>
> *ID475: Friendly warm voice, just someone to listen and help me open up.*

[42] 8.8% missing data (n=52)
[43] 4.9% missing data (n=29)

ID 481: Could talk about anything as long as I was not abusive or obscene.

Respondents expected that they would be able to engage in a discussion about their problems, such that there would be the capacity within the contact to reflect upon their situation, and that volunteers would also discuss or offer their hearing of the problems or issues the caller was describing. This was linked in a few occurrences to an expectation that it would be cathartic in some way to disclose to the volunteer, with callers also hoping to feel better after the call.

ID272: Just happy to get it out of the head.

ID693: Thought I may be able to have a useful dialogue to try to see my situation in a different way.

ID636: Thought it would help and I'd feel a bit better.

Several respondents claimed to know what to expect before first contacting Samaritans. In most cases, this was because they themselves had previously been a Samaritan, or because they knew someone who was, or who had been, a volunteer. Three respondents reported that they had used another helpline prior to Samaritans, and in each case the other line mentioned was Childline.

ID1203: Volunteered for the Samaritans myself 2 years ago - professional, careful, prudent, caution first.

ID233: As my mother worked for the Samaritans in the past, I knew that I didn't have to worry about confidentiality.

ID86: I'd used Childline and thought it would be similar to that.

However, callers also reported expectations of help or assistance which Samaritans do not offer, such as specific advice, interventions, or practical help. They wanted to be told directly what to do to remedy their situation, or to work out a solution together with the Samaritan during the contact. Indeed, when grouped together these issues were more frequently listed as 'expected' than were core aspects of Samaritans' service such as being listened to and not judged. Respondents also reported expectations that Samaritans would provide them with the contact details of various organisations or professionals who would be able to remedy their situation, if not to actively assist by putting them in contact with these sources of help. Respondents combined expectations of unoffered services (advice, solutions, etc) with expectations which were more reflective of Samaritans' service, displaying perhaps some correspondence between what the respondent hoped to get out their contact and the type of service the organisation claims to provide.

ID876: I thought there would be someone who, if they couldn't help, could find me someone who could (Support group etc.).

ID969: I thought they may be able to offer useful advice. Put the caller/emailer in contact with someone who could help professionally.

ID74: Expected volunteer to be non judgemental, helpful, offer some advice.

ID468: Helpful, talkative, caring person who would tell me to some extent what to do.

Some respondents had explicitly negative expectations of the service. Where the initial reply from Samaritans (typically pertaining to email, but not exclusively) was perceived as somewhat automated, scripted, or not particularly tailored to their personal disclosures, callers stated that they had expected to be judged, not understood or rejected and had little hope that the organisation would be able to help them or offer them something different to other sources of information and support available. Respondents also reported fearing that their problems may not have been considered important or severe enough to warrant the support of Samaritans. Many expected that upon disclosure of their problem or feelings, volunteers would think that they were 'being stupid' or 'being silly'.

ID1341: a fake automated response

ID58: A robot computer that just on the other side of the telephone and answer questions too

ID131: Fear of being judged, that my problems aren't real problems, using up someone's time when there are people who need it more.

ID685: That they would tell me I was silly to want to kill myself and no relationship was worth it.

ID662: I thought it would be hard to talk about or that they wouldn't understand like everyone else.

Similarly, many of the negative expectations listed were based around a perception that the callers may not be treated as though they were serious or important enough to warrant Samaritan support, if they were not actively suicidal. A few respondents expected that they would not be believed by Samaritans. However, no indications were given as to whether this was due to the nature of the problem, or something pertaining to the organisation. This general negative sense that callers would be judged or not understood by Samaritans without further divulgence of why this was expected to be the case.

ID527: Was not sure if they would talk to me as I wasn't calling because suicidal.

ID546: Not to be believed

ID1035: I was expecting to not be taken seriously. I assumed they'd think I was lying.

ID1120: thought they'd be judgemental and won't understand

Many of the negative expectations related to the nature of the interaction anticipated with the volunteer. These respondents claimed to have expected an awkward, formal, perhaps overtly institutional interaction, with an uncaring or cold person, or that the volunteer would be a 'do gooder' with little experience or knowledge of the type of problems they faced. Fears were expressed that Samaritans would have an agenda which did not match the callers', attempting to 'force' or 'persuade' them in a specific direction. For instance, an expectation that Samaritans would urge the caller to seek medical help for something they have disclosed was reported. In a more general sense, religion was mentioned as something that respondents feared might be thrust upon them.

ID 538: They would just listen and it would be a bit awkward

ID 252: Bit of a good person sitting there who'd never known trouble themselves.

ID 1379: I expected them to be quite cold and hard to talk to.

ID 1021: Was worried someone would suggest god or going to church.

Similarly, some respondents expected that the topic of suicide would be viewed negatively, and that volunteers would engage in a process of 'changing the caller's mind' or discussing suicide as something' wrong'. Fears were raised that upon disclosure of a suicide attempt Samaritans would breach caller confidentiality to contact the emergency services. Such actions and attitudes were certainly constructed as negative and unwanted through the use of terms such as "force", "frightened" and "turned in".

ID 664: Frightened that they would contact a doctor/hospital and have me locked up.

ID 704: They would tell me how wrong suicide is.

ID 225: I thought they'd try and persuade you not to follow through on suicide.

37.6% (n=420) of respondents reported that they had no prior expectations of what a Samaritans contact would be like, and a further 37.2% (n=415) of respondents either did not know or could not remember what they initially expected (See Table 12). Despite many callers' expressing a sense of uncertainty about the organisation and what it offered prior to contact, they still considered Samaritans to be a place to go when they needed help. It appears that these respondents turned to Samaritans at a time of desperation where being in crisis or despair was the main causal factor in their decision to contact the organisation rather than an expectation of a specific service provision.

ID 995: Needed help, didn't know what else to do.

ID 514: No expectations. All I knew was I needed help.

ID 1313: I had no expectations. I was desperate and did not know what to do.

A significant feature of respondents' initial expectations was the reference to fear or anxiety about calling Samaritans. These generally clustered around a fear of disclosing problems and how the interaction would unfold, or around a general unspecified fear. The data extracts below illustrate the overt nature in which such fears were expressed on the survey. Despite the fact that these statements were made by respondents who did go on to call, such comments are perhaps indicative of a wider resistance to making contact with Samaritans which may deter others from ever doing so.

ID 1164: I remember being scared because I didn't know what to expect.

ID 1173: No expectation, just trepidation.

ID 107: I had no idea what to expect except a voice on a phone, was anxious of what the outcome of the call would be.

Table 12: Expectations of service prior to contacting Samaritans

Expectations[44]	Number (%)
Yes	281 (25.2%)
No	420 (37.6%)
Not sure	294 (26.3%)
Don't know	43 (3.9%)
Can't remember	78 (7%)
	Median [Inter-quartile range] (1=Worse, 10=Better)
Perception of service compared to what was expected[45]	8 [5,9]

Extent to which expectations were met

Survey respondents were asked to rate their perceptions of the service they received from Samaritans compared to what they had expected prior to first using the service on a ten-point scale (where 1= 'worse' and 10= 'better'). This question was completed by 1061 (81.1%) respondents. Overall, respondents scored their perceptions of the service highly, giving a median score of 8 [5, 9] (see Table 12). This was slightly higher than the rating given by those who said they had had expectations prior to using the service (median score of 7 [4,9]). Just over half of the respondents (53.4%, n=596) explained why the response they received from Samaritans was better or worse than they had expected in the open text box provided.

Better than expected

60.1% (n=355) respondents explained why they thought their contact with Samaritans had been better than they had expected. The experience of contacting Samaritans was a positive one for each of these respondents and in many cases, dispelled some of the negative expectations and assumptions that respondents had held about the organisation prior to contact. The majority did not give much detail regarding why their expectations had been low, instead listing reasons why the service was better than they had expected.

Collectively, these respondents found volunteers to be more: sincere, attentive, non-directive, caring, genuine, polite, non-judgemental, nice, patient, understanding, compassionate, kind, calm, empathetic, sympathetic, gentle, supportive, warm and interested in what the caller had to say then they had expected. A couple of respondents specifically mentioned how they were expecting an automated or impersonal response, but received something personal and "real".

> *ID286: I was surprised there was e-mail and that you got a real response from a real person*

> *ID1176: More human than I expected, perfect listener, made me comfortable and at ease.*

Respondents found volunteers to be better listeners than they had imagined, allowing callers the time and space they needed to talk, acknowledging their problems and taking them seriously. Volunteers were described as open and willing to talk about difficult

[44] 14.7% missing data (n=193)
[45] 18.9% missing data (n=248)

issues, asking relevant questions, offering suggestions and not blaming callers for their problems, but treating them with respect by giving thoughtful and personal responses which reassured callers that it was OK for them to have made contact with the organisation. Responses were often referred to as prompt, private and more detailed than expected. Callers described talking to volunteers as easier than they had expected and in some cases likened the experience to talking to a friend or a parent. Other callers found talking to a stranger was more helpful than seeking help from within their family or social network.

> *ID887: I think they might have actually read/listend to what I said/wrote. I didn't think they would.*
>
> *ID1305: i thought my problem wasnt serious enough to call, but then the volunteer said it was very important*
>
> *ID492: better because they only wanted to help me, rather than say what is and isnt right*

Respondents stated that they had expected to be rejected after a judgement on the level of their need but instead they were given time and were supported by Samaritans, not treated as silly, or stupid as was feared.

> *ID877: I had always thought you had to be really desperate to contact Samaritans, but the reply assured me that my problem was just as valid.*
>
> *ID121: I thought I would be treated like I was being silly for feeling so unhappy and needing to talk to a complete stranger but this wasn't the case.*
>
> *ID360: I thought that they would judge me and tell me not to stupid but I got a different response.*

Some callers felt they had been given helpful advice, whereas others were grateful that they were not told what to do. On several occasions, respondents reported that while they had expected to receive advice or practical help, they were happy to accept that these could not be offered (either in that there may not be a solution, or in that Samaritans cannot provide solutions, advice[46]). Going further, several respondents also expressed an appreciation for what was offered. As a result of their contact with Samaritans these callers described feeling: better, less alone, safe, cared about, valued, calmer, relieved, more positive, hopeful, confident and supported.

> *ID262: unexpected. The best thing i recieved were the tools to help myself and not advise on what i should do for that situation.*
>
> *ID1038: I didn't realise they would discuss issues with me or offer advice, i thought they were only allowed to listen so glad that it was more of a conversation*
>
> *ID 908: I thought they could sort all my problems out but now I realize that's not what they are for.*

---

[46] A core value of Samaritans is to not offer advice. Samaritans advocate people making their own decisions wherever possible, believe that people have the right to find their own solution and that telling people what to do takes responsibility away from them. See: http://www.samaritans.org/about_samaritans/governance_and_history/our_mission.aspx

ID 234: Well I thought I might get advice but this emotional support thing helps too. I understand advice can't be given.

ID 766: Thought they would give me advice, but they made me feel like I can come to the conclusion on my own. Turned out to be a much better way to deal with.

Worse than expected

28.2% (n=168) respondents gave details about why the response they had received from Samaritans was worse than they had anticipated. These respondents found volunteers more difficult to talk to than they had expected and described feeling unable to open up and admit their true feelings. They found volunteers to be patronising, judgemental, embarrassed and uncomfortable talking to them, not sympathetic or empathetic, uncaring and not interested in listening what they had to say. Callers described volunteers as sounding distracted, making invalid assumptions about their situation, reprimanding or blaming them for their problems, treating them as though they were children or unintelligent, being dismissive and not wanting to help. Callers felt under pressure to end the conversation or were upset when the call was ended by the volunteer when they were expecting to be given longer to talk and Samaritans to 'always be there for them'.

ID293: I felt they didn't listen & just wanted to get rid of me as soon as possible.

ID1316: i thought someone would listen to me no matter what and help me talk

ID754: The operator was embarrassed to talk to me, often parrotted stock platitudes before I had even finished describing something.

Callers felt let down by the organisation referring to the responses they received as: generic, automated, scripted, cold, clinical, detached and impersonal. Some callers were disappointed with the length of the response they received, others with the length of time taken for their email/ text to be replied to. Several callers described how their emails or texts were not replied to at all. A number of callers were surprised when asked about suicide or self-harm when this was not what they were calling about, others thought that their problems were not taken seriously or treated as important because they were not feeling suicidal.

ID1060: Didn't feel I was listened to propoerly. just generation of standard questions/responses. Felt like I was inconveniencing them.

ID1267: felt like a scripted canned response - not even sure if "jo" represented a male or female - could have been a robot.

ID136: Last call asked if I could talk to someone Samaritan replied "Yes, if you're depressed or suicidal", Samaritans deal with more issues than that

ID342: The replies I received felt cold, clinical and distant. Almost like an automated response.

ID 1377: I thought someone would act as if they cared rather than digging for information about suicide methods.

Those callers who were expecting to be given advice or specific information expressed

their disappointment when no solutions were offered. Instead they described their questions and comments as being met by lots of silences, vague statements and generic responses that were not considered to be helpful. On some occasions respondents expressed annoyance or disappointment that they were not given advice. Respondents expected contact with Samaritans to be helpful to them and to make them feel better. However, after contact these callers described feeling: not supported, insulted, not understood, anxious, alone, at fault for their problems, scared, intimidated, not cared for and not listened to.

> *ID1063: I didn't realize that there would be no one to offer advice or to pass me on to someone who could offer advice or medical assistance.*
>
> *ID76: he insulted and scared me*
>
> *ID1162: Volunteer left too many long silences....it was intimidating*
>
> *ID1221: Volunteer seemed to form opinions about my situation;i.e that things weren't that bad.Also said no advice available.*
>
> *ID143: I expected them to work out a solution with me again but they didn't.*

Advice giving was raised as a significant issue by those complaining about the service. Some callers were disappointed that no practical help was given, accusing volunteers of being only interested in 'small talk'. Several respondents suggested that volunteers should be able to guide callers 'in the right direction' by offering some advice, or suggesting other agencies and services that might be able to help them. Others reported feeling let down by Samaritans when they had received inappropriate advice which they felt had made them feel worthless, judged, criticised, not listened to and guilty for not being able to 'pull themselves together'.

> ID1156: *I think they should repeat what was said in the sender's email less, and maybe have more definite suggestions as to what to do.*
>
> *ID1137: I was given no alternative about what to do in my current situation. i felt i was treated like a number and not a person.*
>
> *ID1264: It isn't helpful to have the Samaritan say how they are not active but lead a goodlife and I should do some gardening – I just wanted someone to listen not tell my I was inadequate.*

Neither better nor worse than expected

9.7% (n=58) respondents explained why the response they had received was neither better nor worse than they had expected. Several different reasons were put forward, for example, some respondents had not yet received a response to their email from Samaritans whereas for others contact was too long ago for them to remember what their expectations were and therefore if they were met. A number of respondents repeated their answer to the previous question on the survey stating that they did not know what to expect prior to contact or did not have any expectations of the service. Others considered the service they had received to be 'different' to what they thought it would be, but no better or worse.

> *ID939: Neither better or worse - different.*
>
> *ID957: did not know what to expect*

ID1120: Too early to tell

However, the majority (74%, n=43) of these respondents described how contact with the organisation had met their expectations. Many respondents were reticent and few in depth explanations were offered. For some, contact with Samaritans was a positive experience and validated expectations that the service would be 'good'. Respondents expected that: they would get a quick response from Samaritans; the service would always be available; volunteers would be well trained, friendly, helpful, understanding and supportive so able to listen and not judge; they would make contact with a 'real person'; contact would be anonymous; and that after contact they would feel better.

ID791: pretty much as I expected - which was a well trained volunteer - able to listen - not judge and just be there.

ID764: Always had a theoretical impression that they would be supportive, but nice to have it confirmed!

ID438: It was good but I expected good.

ID197: knew they would understand, but was still happy and relievevd they did

In some cases, those harbouring lower expectations of the service also explained how their expectations had been met. These respondents did not expect Samaritans to be helpful to them and felt as though through their contact with the organisation they had had this confirmed.

ID992: did not think they would help - and got what i expeted - so no worse or better

ID251: I felt the same. What the hell, no one else could help, why could you do different?

ID376: just the same as i expect becuas they cannot make the problem go away?

The remaining 14 respondents that answered this question on the survey thought that on some occasions contact with Samaritans had met or exceeded their expectations, whereas other times the response they received was worse than expected. Often this variability was attributed to the particular volunteer who answered the call and their skill or experience in dealing with callers.

ID371: Some Samaritans are great, others aren't so great

ID636: this varied---sometimes the response made me feel better,,, other times i felt worse/more confused

ID491: Sometimes felt that if I wasn't suicidal then my problem wasn't that important

ID452: some calls were answered better than others, likewise with e-mails

Experience of service

When asked about their experiences of contact with Samaritans, 85.7% (n=120) of respondents reported that they sometimes had 'felt judged 'and a further 14.3% (n=20) of respondents felt that they had been judged during every past contact (See Table 13). However, the reliability of this finding is undermined by a very high proportion of missing data to this question (89.9%, n=1169). On the other hand, a more positive finding was that 62.3% (n=673) of callers felt they had always been listened to during previous contacts with a further 30.4% (n=329) reporting that they had sometimes felt listened to. Only a small number of callers reported experiencing a language barrier when attempting to use the service (3.3%).

Table 13: Experience of previous contact with Samaritans

	Number (%)
Felt Judged[47]	
Yes, every time	20 (14.3%)
Yes sometimes	120 (85.7%)
Not very often	0
Not at all	0
Only contacted once, did feel judged	0
Only contacted once, did not feel judged	0
Felt listened to[48]	
Yes, every time	673 (62.3%)
Yes sometimes	329 (30.4%)
Not very often	33 (3.1%)
Not at all	46 (4.3%)
Encountered a language barrier[49]	
Yes	35 (3.3%)
No	1036 (96.7%)

Emails

Good email contacts were described by callers as ones in which they felt as though the answers given and questions asked by the volunteers were personal and specific to their problems. Being acknowledged and listened to was very important to both phone and email callers. However, some emailers commented explicitly on the constructive aspects of organizing their thoughts and setting them down and reflecting about them on paper. This seems to be an important part of the exercise, though the feeling that someone will read and respond to what is written is also valued. In callers' descriptions of good contacts with Samaritans they regularly spoke about practical issues, such as receiving responses quickly, and not feeling under pressure to talk or end the call,

Good volunteers

An image of the good Samaritan emerged from the survey data. A 'good volunteer' was someone who was genuinely concerned about the caller and wanted to help them. They

[47] 89.9% missing data (m=1169)
[48] 17.4% missing data (n=228)
[49] 18.2% missing data (n=238)

would be understanding, patient, empathetic, intelligent, open, non-judgemental and polite. 'Good volunteers' listen to callers, giving the caller all the time and space they need, allowing them to control the topic of conversation and display their emotions, whilst volunteers demonstrate their understanding and are clear in their responses. Contact with this type of volunteer made callers feel safe, cared about, as though they were being listened to, understood and less alone. Such a response allowed callers to feel more positive about their situation and gave them a sense of comfort and relief. Being listened to confidentially and anonymously without being judged was important to many callers, and helped them to feel better, even if their problem was not resolved after the call. Just being able to talk to someone who was caring and understanding was experienced very positively and in some cases callers described this as enough to deter them from further acts of self harm or 'going over the edge'.

> *ID819: Thank you so much. When I was feeling so low and lonely that I couldn't really think straight and was worried about what I might do (as I have been suicidal in the past) the kindness in the volunteer's voice just made me feel instantly cared for. He said some really kind things and it felt like a real conversation between two people who've known each other for years – not a clinical therapist and a distressed patient. He got me through a period in which I might have harmed myself and I am very grateful for that.*

Callers explained how they felt that they could rely on Samaritans at times when they have no-one else to turn to. Having 'someone real' to communicate with, listen to and 'be there' for them was valued highly and acted to reassure callers that they would be able 'to hold themselves together'. The service provided was referred to as a 'final safety net' that is always there when one needs it.

In addition to positive appreciation of contact, shortcomings in the volunteer responses which callers had received were reported. Callers described experiencing some volunteers to be distant and disinterested, going through a list of 'stock questions' or issuing 'standard responses' instead of engaging with the caller. Respondents reported that their feelings had not been taken seriously, that they had not felt helped or supported, that they had been judged, or that assumptions had been made about them that were unwarranted or did not reflect how they were feeling. This made callers feel as though they were wasting Samaritans time.

> *ID1359: Samaritans was my last hope and it wasn't at all like I expected. There were incredibly long pauses. I felt as if I had to do all the talking and all I got in response was a set of what sounded like very obvious stock questions/comments. It was a very false conversation and I felt no sense of empathy or feedback. Nothing was said which hadn't already been going round in my mind and it just confirmed all the bad things I feel about myself.*

> *ID1188: You provide a valuable service, however, it sometimes feels like I am talking to someone in 1959 instead of 2009. The massive assumptions I've had pushed on me have made me feel angry. Not everyone is white, straight and able-bodied. Being different is not always a problem in itself.*

Thus, when one or more elements of the good call was missing, for example when the caller was met with what they felt to be unhelpful or impersonal content, an unsupportive volunteer, lack of or delayed response, inappropriate and hasty termination of the call or restriction of contact through a caller care plan, respondents were, understandably, more critical or negative about the impact the service had had on them. Sometimes callers discussed the impact this type of call had on them in more detail, declaring that it led them to self-harm or to attempt suicide. They suggested that

volunteers should be better trained or a more stringent selection programme implemented. A few responses indicated that contact with Samaritans had actually made the caller feel worse, because Samaritans as a last hope or expected source of support had not lived up to expectations, or because in the course of reflection the caller had realized the extent to which there were no other preferred options to dying.

> *ID160: I would hope that other people who contact samaritans get more help/support than I did.I am really struggling not to kill myself, and if anything, contacting samaritans has made that struggle even harder.*
>
> *ID1176: If I had the medication, I feel that when the phone was put down on me I may have taken the whole lot of pills, I just needed to talk to someone who wasn't impatient and prepared to listen to me even though I spoke quiet.*
>
> *ID1370: I felt the response I recieved was very dismissive. I didn't feel I recieved any advice, help or reassurance, which is what I wanted.*
>
> *ID958: I am now more suicidal than before contact, as they made me realise how ready for dying I am*

In some instances callers expressed disappointment that their problems persisted and had not been resolved during their contact with Samaritans.

'Moving on'

A core aim of Samaritans service is to help callers who contact them in crisis to feel supported in the moment but also to find that the process of talking through their distress enables them to gain insight into how they can 'move on' from their current state and regain capacity for managing their lives. Although many callers described being helped by talking to someone who cared about what they had to say, a much smaller number referred to this experience as one of facilitating this process of 'moving on'. These callers explained how talking to a volunteer had started the process of 'healing' for them which led to their self-acceptance, admitting the reality or gaining clarity of their situation and seeking other sources of help. In such instances, callers recognised and appreciated the support offered by Samaritans as having an enduring effect in helping them to help themselves, very much in line with the organisation's ideals about the purpose and impact of the support it provides.

> *ID1347: im 13 and it is the 1st time i have talked to a samaritan. i would like to say thank you so much. im much clearer now and im going to seek thurther help about my depression*
>
> *ID1095: Samaritans are really the only people I feel I can speak openly and frankly about my problems, without being judged or interrupted or feel like I'm bothering someone. Both times I called, afterwards I felt like a huge weight had been taken off my shoulders. I felt ready to work through and face my problems rather than just burying them.*
>
> *ID891: It was a catalyst to working out my own responsibilities regarding my life. I had choices.*

Overall, (12.2%, n=82) of survey respondents expressed quite clearly that the impact of the contact had been long term. These callers experienced their contact with Samaritans as resulting in constructive 'work on the self' leading to a sense of increased agency. Indeed, it was apparent from the survey responses that many callers do not contact Samaritans with the goal of 'moving on' with their lives. Regarding their problems to be intrinsically unsolvable, they still valued the transient relief or improvement in their emotional state which followed a call.

> *ID595: Emotionally the same but appreciated talking to someone anyway.*

> *ID471: I think smaritans are doing a good job. however, I have been having more thoughts of suiside recently. and my cutting isn't gone yet.*

Contacting the organisation to gain a short term impact or recurring support was by far the most common type of response, with just over a third of survey respondents falling into this category (n=392). Often these were regular callers who were very appreciative of the support they received from Samaritans on an ongoing basis (regular or episodic). There was no sense here of disappointment that the impact of contact was not long lasting – rather acceptance and the expectation that the action will have to be repeated regularly in the future as the presenting situation builds up/recurs. Typically these callers were looking for, and received, an opportunity to vent their distress, unburden their problems, feel listened to and cared for by an impartial, non-judgemental stranger. Callers typically described contacting Samaritans periodically when situations of emotional crisis occur – this helps to calm them down and relieves the pressure. They described how they would contact Samaritans when they were 'in need' and volunteers would give them their time and a space to talk about their feelings. The point that it is helpful to make contact anonymously and to talk to a stranger frequently recurred as did a sense of great appreciation that Samaritans provide a reliable and effective resource which these callers expect to access indefinitely.

> *ID252: It is really helpfull to be able to know I can contact them at any time+ someone will allways listen*

> *ID291: I know the support is there if I need it.*

> *ID746: I feel a bit better in that I know there is somewhere to go if things get really bad again.*

Anonymity helps some callers to feel less burdensome, guilty or embarrassed by their need to call Samaritans and the nature of their disclosures. There is a stronger sense here than in some of the other data sources of an awareness of stigma in contacting Samaritans, possibly linked to a sense of incompetence in not being able to manage one's difficulties autonomously. There is also strong appreciation about being cared for by strangers. Callers also indicate the relief and sense of reassurance gained from the knowledge that Samaritans will always be there for them when they need them. Samaritans is valued as an ongoing resource which callers can use as needed – but without any suggestion of future change or resolution of the problems that cause them to make contact.

> *ID1002: its made me feel like someone actually cares even if they are a complete stranger and do not know me*

> *ID474: Good to get it off my chest anonymously*

> *ID664: at times when im desperate and theres no one else, Samaritans listen*

Typically callers seemed to reach for Samaritans when things have built up – either acutely or chronically – so they reach a state where they cannot deal with their distress, anxiety, and worry. A few expressed the idea that phoning Samaritans was a distraction – sometimes at a critical moment – to prevent them taking some other kind of action, such as self harm.

> *ID1288: it helps me to sit at my computer to stop me from going downstairs to get meds and overdosing on them*

> *ID1233: i had a response to my email..home alone i was lookin at bad bad site like harming/sucuide*

Section summary

To summarise, most respondents were fairly positive about the service with far more expressing that the service had exceeded their expectations than not. Negative comments were made by around one fifth of respondents. Strong images of the 'good call' and 'good volunteers' emerged in the survey data. All callers appear to value similar aspects of the service for example, that they would get a quick response; the service would always be available; volunteers would be well trained, friendly, helpful, understanding and supportive so able to listen and not judge; they would make contact with a 'real person'; contact would be anonymous; and that after contact they would feel better. Respondents expressed how they felt grateful, appreciative and positive about Samaritans when good calls were achieved, and disappointed, angry, let down when they were was not. It was also evident that only a small number of survey respondents had been positively helped to move on through their contact with Samaritans. Typically, survey respondents described their use of the service more as an ongoing resource that they could draw upon as a distraction or way of dealing with their distress in times of need.

Perception of service and anticipation of future contact

Overall, 39.6% (n=408) of respondents thought that Samaritans could improve their service. The suggestions made were grouped into four main categories: recruitment and training of volunteers; interactional issues between caller and volunteer; practical issues to do with use of the service; and the wider promotion of Samaritans. These issues are discussed in more detail in Chapter 10 (Improving the Service.)

Table 14: Suggested ways in which Samaritans could improve their service

Suggested areas for improvement	Number (%)
Recruitment and training of volunteers	32 (7%)
Interactional issues between caller and volunteer (e.g. beginning the call, 'being human', silence and engagement, ending the call)	192 (43.8%)
Practical issues to do with use of the service	240 (54.8%)
• *Access and availability*	*31*
• *Cost of calling*	*17*
• *Length and speed of contact*	*83*
• *New technologies*	*74*
• *Choice of volunteer*	*50*
• *Links with other services*	*17*
Wider promotion of Samaritans	26 (5.9%)

The vast majority of callers said they would consider contacting Samaritans again (84.3%, n=925). This figure varied slightly between callers who had only used the service once (79.5%, n=372) and those who had already used the service on more than one occasion (88.9%, n= 503) with more frequent users reporting a greater likelihood of future use (see Table 15).

Table 15: Anticipation of future contact

Would contact Samaritans again[50]	Used the service once (%)[51]	Used the service more than once (%)[52]	Total (%)
Yes	372 (79.5%)	503 (88.9%)	875 (84.6%)
No	28 (6%)	11 (1.9%)	39 (3.7%)
Not sure	68 (14. 5)	52 (9.2%)	120 (11.6%)

Respondents who had been satisfied with previous contacts and felt helped in some way by Samaritans regularly asserted that they would use the service again, should they feel the need to. They reported feeling reassured in the knowledge that Samaritans are there for them to turn to and often expressed their gratitude to the organisation.

> *ID1328: I really appreciate how much samaritans helped me, i will definatly contact them in the future when i feel low, its nice to know there's somebody to talk to when you feel you have nobody to turn to :]*
>
> *ID969: I think that the Samaritans are doing a wonderful job and I genuinely feel better having talked to them. I'm sure if I ever had to, I would talk to the Samaritans again.*

Several respondents also mentioned how they already recommend Samaritans services to others or would not hesitate do in the future. A few respondents explained how they are also Samaritans volunteers or have been in the past. Through their positive experience of contacting Samaritans, other respondents expressed their desire to become a Samaritan in the future in order to help others in the way they had been helped. Some thought that because of their problems they might not be suitable as a volunteer so instead were going to make a donation to the organisation as a way of expressing their gratitude and appreciation.

> *ID693: They are so helpful. if they hadnt helped me, i probably wouldnt be here today. i was so depressed. thank you so much for being there when everything else had failed. i would recommend it to anyone.*
>
> *ID609: Your number is on my mobile phone and when I have spoken to other people who are struggling who are finding it hard to cope I pass on your number. Sometimes it is easier to talk to a complete stranger who will not judge you but will listen and guide you without you realising what they are doing then that is a great quality. Keep doing it.....*
>
> *ID761: I've only contacted the Samaritans once so far. I wouldn't hesitate in the future to make contact again. I'm even considering becoming a volunteer. I've contacted my local branch for details now. Thank you!*

[50] 20.8% missing data (n=272)
[51] 7.5% (n=38) did not indicate whether they would contact Samaritans again
[52] 4.6% (n=27) did not indicate whether they would contact Samaritans again

As discussed above, 28.2% (n=168) of callers found their experience of contacting Samaritans worse than they had expected. Some of these callers stated that as they felt so let down or disappointed by their contact with Samaritans they would not use the service again. However, several others callers explained that despite their dissatisfaction with Samaritans they would continue to use the service when alternative helplines or services are not available.

> ID1313: I am very unimpressed with the service. I was not listened to which infuriated me and was made to feel as though the person whom contacted me did not care that made me feel even worse which did not help at all within the circumstances. I personally shall not be using the organisation again.
>
> ID1049: I have mostly found samaritans helpful, but on occasions, I have felt judged. I think my name became well known at my local branch and that is how I was judged...However, I still use the samaritan service, because when I am alone and desperate, they are an understanding ear.

Contact with other services

38.2% (n=425) respondents reported that they were in touch with other services at the time when they were in last contact with Samaritans. Of these, 330 (77.6%) provided further details of the service(s) they used and rated how helpful they thought these other services had been in comparison to their contact with Samaritans. 51% (n=169) respondents reported being in touch with one other service about the same issue they were in contact with Samaritans about. 27.9% (n=92) were in contact with two other services, 15.2% (n=50) reported contacting three other services, 3.6% (n=12) were in touch with four other services and 2.1% (n= 7) respondents gave details of five other services they were in contact with when they last contacted Samaritans.

A wide range of other services and organisations were reported. Some were formal, official and specialised or professional services whereas others were more informal in nature and ranged from self-help groups to exercise clubs and religious groups. Details of other services were grouped into three categories: voluntary organisations and help groups, statutory and other professional services, and alternative services (see Table 16).

Additionally, 34.2% (n=393) of all survey respondents reported that they were taking medication for a mental health-related problem at the time of last contacting Samaritans. The length of time the respondent had been taking the medication ranged from less than one month to 35 years. The median time was 2 years for those who had been taking the medication for a year or more. For those who had been taking the medication for less than a year the median time reported was 3 months. 77% (n=296) respondents were still taking this medication at the time of completing the online survey. An additional 10.4% (n=40) respondents indicated that they were still on medication, but their medication had changed.

A wide range of medications were listed by respondents including 21 different types of anti-depressants; 14 different anti-psychotic drugs; and 12 types of anti-anxiety medications. Other substances listed included anti-epileptic medications, various hypnotics, painkillers, drug dependence substances (e.g. methadone and naltraxone) and beta-blockers. In addition, respondents reported using two non-prescription substances: the herbal remedy St. John’s wort and marijuana.

Voluntary organisations

27% (n=89) respondents reported being in touch with other voluntary organisations when they last contact Samaritans. 62 different voluntary organisations were listed by callers[53]. Mostly commonly mentioned were MIND (N=8), Childline (n=7), Victim Support (n=6) and National Self-harm Network (n=4). In addition nine respondents stated they were in contact with an unspecified helpline or charity organisation. 94.4% (n=84) rated the helpfulness of this contact compared to Samaritans. Respondents' opinions were divided as to how helpful contact with other voluntary organisations was in comparison to Samaritans (see Table 16). 91.2% (n=82) of respondents who were in contact with other voluntary services at the same time as their last contact with Samaritans explained why they found their contact to be more, equal to or less helpful than Samaritans in the open text box provided on the survey.

Table 16: Other services respondents were in touch with when they last contacted Samaritans

Service	How helpful service was in comparison to Samaritans	
		Number (%)
Voluntary	More	25 (29.8%)
	Equal	31 (36.9%)
	Less	28 (33.3%)
Statutory	More	72 (26.1%)
	Equal	101 (36.6%)
	Less	103 (37.3%)
Alternative	More	9 (34.6%)
	Equal	12 (42.2%)
	Less	5 (19.2%)

Most commonly, other voluntary services were perceived to be of equal helpfulness to Samaritans (36.9%, n=31). 29 respondents explained why their contact with other voluntary services had been equally as helpful as Samaritans. 23 different services were discussed. Responses were categorised into two main themes. Firstly, other voluntary services were perceived to be of equal helpfulness to Samaritans because of the similarity in experience of contacting both. For instance, some callers felt as though they were given time to confidentially talk or write about their feelings in both contexts and felt as though they had been listened to and not judged by both services. Others felt as though they were given the same advice, information, options or solutions by both services.

> *ID428: I talked on the phone with the woman [from childline] and she really helped me and she gave me some options/solutions. The same has happened with emailing the Samaritans.*

> *ID972: was same advice more or less [from MIND]*

> *ID1242: I felt I was listened to [by shared concern] in the same way as I was by a samaritans volunteer.*

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[53] See Table 9, Appendix VI for further details.

For the most part, the evaluation of other services and Samaritans was positive, however, on occasion, other voluntary services and Samaritans were perceived to be equally unhelpful to the caller.

> *ID188: It was hard to get answers from the counsellor [at Shared Concern]*

> *ID807: felt i was repremanded for not doing what [MABS cancer support] said*

Secondly, other voluntary services were considered to have a different approach to Samaritans (e.g. in-depth sessions; building a relationship with a real person) or deal with different aspects of the problem (e.g. provide specific advice and information) that was perceived to be of equal help to the caller as Samaritans services. In these instances, both services were thought of as trying to help the caller but in different ways.

> *ID664: [NSHN and Samaritans are] helpful in different ways*

> *ID622: [Women's Aid] dealt with different aspects of the problem*

> *ID541: [Connexions] Had a different approach*

> *ID188: [health in mind] was really useful for advice and information*

Similar numbers of respondents thought other voluntary organisations were more helpful (29.8%, n=25) and less helpful (33.3%, n=28) than Samaritans. 24 respondents explained why their contact with other voluntary services had been more helpful than their contact with Samaritans. These respondents felt as though the other voluntary services had been more supportive, professional and more understanding than Samaritans. They reported feeling listened to, valued, respected and cared for. Accessibility of the service featured in the explanations given. Whereas some callers found it more helpful to contact other services that were local to them over the telephone, others were more comfortable talking face-to-face with someone who knew them better. Some callers found it easier to talk to someone online on a one-to-one basis. Talking to a 'real person' was considered to be important.

> *ID933: There was someone there [at MIND] I could talk to face to face who kind of knows me*

> *ID218: [Childline] Listened to me more, felt like they understood and wanted to care and help me more*

> *ID1140: [Sumithrayo] was the local thing, so i could call them on the phone*

Other voluntary services were perceived as being more helpful and wanting to help more than Samaritans because they were able to provide callers with time and space to discuss their feelings in addition to help, information or advice on specific topics (such as rape, abuse and eating disorders) and liaise with other services such as legal teams and social services. Ongoing support was also important. In some cases, callers described how they had built up support networks and made friends over the course of many years.

> *ID224: Have used [recoveryourlife.com] for many years, and have built up a support network of friends that know me*

> *ID783: [HARP] Provided help, not just a chance to vent.*

ID1006: [I can] talk to [harmless] without feeling scared and they give better service to self harm

ID205: [Victim Support is] helping me with feelings and my case

28 respondents explained why their contact with other voluntary services had been less helpful than their contact with Samaritans about the same issue. 25 different voluntary organisations or services were discussed. Other voluntary services were perceived to be less helpful than Samaritans for several reasons. Respondents expressed how they were not able to disclose their true feelings to other services because of concerns about confidentiality and anonymity. Also, other services were perceived to be less helpful than Samaritans due to limited availability or poor accessibility

ID474: Easier to be more open with the Samaritans because it's anonymous

ID86: Cannot contact [self-help group] in middle of night or about certain issues

ID454: [Youth2Youth] didn't reply for a long time, sometimes up to a week, so I stopped to contact them and contacted Samaritans instead.

Callers complained that other voluntary services had taken too long to respond to them, that volunteers were poorly trained to deal with their issues and that they were given scripted responses. This left callers feeling like they had not been understood, listened to or treated with respect. Others expressed how they had felt as though they were not provided with sufficient information or advice by other services or quickly referred on without been given enough time to explore their issues. In some cases, contact with other services was still thought of as being helpful, just not as helpful as contact with Samaritans.

ID998: [Childline] Seemed less caring, more like good if slightly impersonal advice, but still very helpful.

ID744: They [Connexions] did not listen properly, it was as if they had a script to read off "person says they are depressed, tell them to go to doctor"

ID792: Students [at Nightline] - not as well qualified - always sound on edge and panicky

ID1175: [to write love on her harms was] supportive, though did not understand problem

Statutory Services

Of the other services callers were in contact with, the statutory services emerged as by far the most frequent. 84.2% (n=278) of those who were in contact with other services at the same time as their last contact with Samaritans reported being in contact with the statutory services about the same issue. 130 survey respondents reported being in contact with a GP, 97 with a therapist or counsellor, 86 with community mental health teams and 84 with a psychiatrist or psychologist at the time of their last contact with Samaritans. 81.7% (n=227) of respondents who were in contact with the statutory services at the same time as their last contact with Samaritans explained why they found their contact to be more, equal to or less helpful than Samaritans in the open text box provided on the survey.

37.3% (n=103) of respondents considered their contact with statutory services to be less helpful than Samaritans (see Table 16). All of the responses falling into this category were highly critical of statutory service provision and described such services in negative terms. When in contact with the statutory services respondents described feeling concerned that any information that they disclosed would be passed on and may lead to further action being taken. They described feeling limited in what they were able to say to health professionals for fears of repercussions (e.g. hospitalisation). The statutory services were accused of not listening to an individual's needs, instead attempting to steer the caller in a specific direction that matches their own agenda.

> *ID312: [counselling] couldn't be anonymous, so couldn't talk about everything I wanted to*
>
> *ID1063: I feel I can't contact [my doctor] anytime, self-conscious, afraid that she'll commit me*
>
> *ID318: harder to talk to, [counsellor] tried to much too steer me towards options I wasn't comfortable with*

Health professionals were described as uncaring, judgemental, rude, unsympathetic, patronising and only interested in the physical as opposed to the emotional side to their problems. Respondents perceived the statutory services to be stretched and time limited meaning that they are often not available when needed. Mental health teams were referred to as being 'over-worked'. Respondents described difficulties in accessing the services, for example, instances where appointments had been cancelled, when it had take a long time for them to be seen or when their visits had felt rushed.

> *ID963: [Psychotherapist is] not equipped to deal with emotional distress beyond medicating it.*
>
> *ID536: Unable to see [counsellor] them as much as I would think beneficial and they have cancelled my last two appointments without making follow up appointments.*
>
> *ID567: [psychiatrist is] patronising, rushed, doesn't listen or care*

In some cases respondents felt as though they were not believed by the statutory services and left feeling foolish, worthless and alone. In these instances, respondents felt that they were not being listened to, taken seriously, or supported. Conversely, Samaritans was described in positive terms as confidential service that is there for the caller on a 24/7 basis. Sometimes callers expressed how they found it easier to talk to a stranger about certain issues or problems as opposed to mental health professionals whom they had built a relationship with. Samaritans were described as giving callers more time to talk, listening more and trying to understand more than the statutory services.

> *ID452: Samaritans made me feel important and there 24/7*
>
> *ID1374: samaritans take more time to understand me*
>
> *ID631: samaritans seem to listen more*

However a similar numbers of respondents rated their contact with statutory services and Samaritans as equal in terms of helpfulness (36.6%, n=101). Three types of

response featured in the data. Firstly, respondents explained how Samaritans and the statutory services they were in contact with were providing different types of service so helpfulness was difficult to compare. Respondents explained how they use different services for different reasons. Health professionals were perceived as offering practical help (e.g. medication and other treatments) and specific information whereas respondents used Samaritans services for emotional support when they wanted to talk to someone about their feelings.

> *ID1458: GP gives pills! but cant talk as long*
>
> *ID592: Medical Information given by clinic, counselling by Samaritans*
>
> *ID206: just diff, meds are good but [doctors] dont listen*
>
> *ID197: [CPN] provides practical help more than emotional support*

Second, both Samaritans and the statutory services were perceived as being of equal help to the respondent on the account of the similarity in nature of contact. Both were described as caring, understanding, supportive and non-judgemental, giving their time to listen and offer help. However, the statutory services were also perceived to be busy and time-limited and irregular contact was raised as an issue. Again, some respondents explained how they prefer face-to-face contact whereas others found it more difficult to discuss some issues face-to-face. Additionally, lack of anonymity was raised as problematic in some instances. The limited availability of the statutory services alongside possible difficulties in disclosing some information due to lack of anonymity were given as reasons why respondents felt it was necessary for them to have contact with both Samaritans and the statutory services.

> *ID419: i love my counsellor and she helps me a lot but i only see her fortnightly and i need someone to talk to between sessions*
>
> *ID311: [my counsellor] she understood like you but was not there 24/7*
>
> *ID402: [Psychotherapist and Samaritans] both give similar advice and practical ways of exploring issues, both are easy to talk to and want to listen*
>
> *ID823: Just times feel want to talk anonymous*

The third theme featured much less prevalently in the data. Reponses categorised into this theme expressed equal dissatisfaction for both Samaritans and the statutory services. Both types of service were described as 'equally useless' and respondents felt as though they had not been listened to, understood or that no practical action had been taken.

> *ID1082: [my doctor is] EQUALLY USELESSS NO TIME NO DRUGS NO UNDERSTANDING*
>
> *ID309: [Community Mental Health Team] couldn't help any more than the Samaritans*

Just over a quarter of those who were in contact with statutory services rated this contact as more helpful than contact with Samaritans (26.1%, n=72). Respondents discussed their contact with the community mental health teams, GPs, clinical

psychologists, psychiatrists, various types of therapist and counsellors. Contact with these persons was perceived to be more personal than contact with Samaritans on account of respondents being able to build an on-going supportive relationship with these services. Several benefits of prolonged contact with the same individual or team were identified. These included respondents feeling more able to open up and talk because they felt as though their situation and history was known. In consequence, callers felt these practitioners were able to achieve a deeper level of empathy and understanding without them having to repeat their story in every contact. Again, the ability to meet a real person and talk face-to-face was valued.

> *ID1212: [my counsellor is] easier to talk to, she knows my past and understands why I feel the way i do.*
>
> *ID178: they know me, i feel able to talk to my Social worker and CPN*
>
> *ID784: continuous support and long time relationship [with my therapist]*

In addition, statutory services were described as more helpful and supportive than Samaritans because they provide non-judgemental listening in addition to more constructive and practical suggestions. They were perceived to be more experienced and knowledgeable about callers' problems so therefore able to provide medication, help respondents make decisions, give definite answers to questions, make referrals to other services, suggest other sources of support and discuss coping strategies.

> *ID694: I could talk face to face with someone experienced with rape counselling*
>
> *ID260: [Psychiatrist] is expert and can answer my questions and provide*
>
> *ID1284: [Doctor] prescribed medication, offered psychoanalysis (longer chat than the phone call)*
>
> *ID1081: [Mental health nurse] Got to talk to someone face to face and discuss coping stratergies*

These services were viewed in a positive light as being clear and helpful, taking the callers' problems seriously, treating them with respect and caring about their individual needs. Despite this, contact with the statutory services was constructed as 'time limited' and respondents discussed using Samaritans when statutory services were not available.

> *ID135: [counsellor is] more helpful as she makes suggestions but she is not available outside of appointments*
>
> *ID425: helpful but limited hours I can contact them*
>
> *ID1158: [Psychologist/ psychotherapist] face to face, more feedback, but time restricted*

Alternative services

7.9% (n=26) respondents were in touch with alternative services. Alternative sources of support detailed included church groups, a range of alternative therapists (e.g. acupuncturist, holistic healer) and exercise groups (e.g. yoga teacher). Interestingly, seven respondents also listed friends or family members as another service they were

accessing at the point of last contact with Samaritans. The majority of respondents perceived alternative sources of support to be either equal to (42.2%, n=12) or more helpful (34.6%, n=9) than Samaritans.
Six respondents explained why their contact with alternative services was more helpful than their contact with Samaritans about the same issue. These respondents described strong relationships with family members, friends and church groups. Such persons were perceived as being more knowledgeable about the individual and their situation so in a better position to offer support, either through the provision of advice or through listening. Respondents described their contact with alternative services in positive terms, as making them feel more hopeful.

> *ID629: Only more in that I could recieve advice and counsel from them because they knew me personally. Otherwise, listening and such, it was equal*

> *ID277: more positive and hopeful*

> *ID506: He was close to me physically and emotionally, I have strong relationship with him*

Again, bearing similarity to the points made above in relation to use of other voluntary or statutory services, respondents who were of the opinion that Samaritans and alternative support services were equally as helpful saw each type of service as performing different functions. Others found both Samaritans and alternative services to be of equal help to them due to the perceived similarity in contact.

> *ID1413: they deal with physical stuff*

> *ID1425: [life coach and Samaritans have] different approaches to same issues*

> *ID236: [Acupuncturist] gives advice and support*

Only 19.2% (n=5) rated these other services of support as less helpful than Samaritans. Four respondents commented on why their contact with alternative services was perceived to be less helpful than contact with Samaritans. For these respondents, Samaritan volunteers were perceived as more understanding and less selfish than family or friends. Respondents also expressed not wanting to bother friends with their problems.

> *ID99: didn't want to bother her*

> *ID129: they don't understand like you do*

Section summary

It appears that the perceived helpfulness of contact with other services and sources of support was extremely variable and dependent somewhat on the individual, the nature of their problem, their personal situation and attributes. However, from this data it is clear that many Samaritan callers do not access Samaritans in isolation or as a last resort, instead selectively contacting the service with specific intent at particular times of need, often in tandem with many other sources and types of support that are available to them.

Chapter Summary

Survey respondents were typically younger females contacting the organisation via email or telephone. Therefore, the data collected is skewed compared to Samaritans reference data so does not constitute a representative sample of callers. Nevertheless, the data collected provides a wealth of detail about who these callers are and their reasons for contacting Samaritans. Further to this, the data constitutes a substantial number of caller perspectives and a great deal of information about callers' personal experiences of using the service. Such detailed information about what callers expect from the service prior to use and how they experience and perceive Samaritans' support services has not previously been available to the organisation.

A higher percentage (46.3%) of respondents reported experiencing suicidal feelings or being in the process of suicide (8.6%) when contacting Samaritans than the organisation reports in its own contact data (19.1% and less than 1% respectively) [1]. This may be explained in part by the high proportion of survey respondents who used email as their last method of contact, and the fact that Samaritans figures represent numbers of callers on an annual level, whereas those taking the survey could have contacted when feeling suicidal or in the process of suicide at any period over the lifetime of the organisation. Also, a possible issue to consider is that in Samaritans' own figures it is the volunteer rather than the caller who assess the nature of contact. There is the possibility then, that the 7-point scale is open to subjective interpretations by individual volunteers, leading to an underestimate of callers who are experiencing suicidal feelings, even in spite of the policy to ask every caller whether they are feeling suicidal which may aid in such an assessment. In this survey we also found that 26.3% of respondents were not asked whether they were feeling suicidal during their last contact with Samaritans. There was a wide range of responses amongst callers to being asked about suicidal feelings. Another explanation for the high reported suicidality of the survey respondents could be due to the subjective uses and meanings of the language of suicide within this group. (These issues and topic of suicide will be returned to and analysed in greater depth in Chapter 8: Suicide).

In addition, a high proportion of respondents disclosed mental health issues. Many of those who had contacted the organisation on more than one occasion reported their main reason for past contact to be mental health issues or self harm. Empirically, this is an important finding as it may be indicative of the type of caller who forms an ongoing relationship with the organisation. (Mental health issues will be discussed in greater detail in Chapter 9). Related to this is the relatively low incidence of issues such as bereavement and work problems as stated reasons for contacting Samaritans (although within the organisation, these are assumed to be significant motivations for callers to use the service[54]).

In relation to the nature of service offered by Samaritans, the issue of advice-giving featured strongly across the data collected. Whilst some callers expected to be given advice and thought that more advice could be given, others explicitly stated that they were not looking for advice. In particular, it is worth noting that the majority of survey respondents reported feeling that they had been offered advice during contact with the organisation. (The issues surrounding Samaritans policy of non-directiveness and advice-giving were also significant features of the interview data and are taken up for discussion in Chapter 7).

Respondents were generally positive about the service, reporting that they felt better after contacting the organisation. Most callers reported that they were happy speaking to a volunteer regardless of whether they were male, female or if gender was unknown. Satisfaction with the service did not differ markedly between methods of contact

[54] http://www.samaritans.org/talk_to_someone.aspx

(telephone, visit, email and text) with the majority of respondents rating the service as 'good' and reporting being 'very satisfied'. The exception to this was the text message service where just over a third of respondents did not consider the response they received to be prompt enough.

Generally high levels of satisfaction were reported and the majority of callers said they would consider contacting Samaritans again. Around half of the respondents explained why the response they received from Samaritans was better or worse than they had expected. Just under 30% of these respondents thought that their experience had been worse than expected. Embedded within the caller data were powerful images of the 'good volunteer' and 'the good call'. A good call was described as one in which the caller had a quick response, made contact with 'real person' who was well-trained, friendly, helpful and supportive, felt listened to, understood and not judged and felt better after contact To some extent, the negative experiences described by callers were the opposite of the positive comments made. In a sense, all callers valued similar aspects of the service, and felt disappointed when it did not achieve this standard.

Over half of the callers had used the service on more than one occasion and for many it was used as a way to cope with or distract them from their problems on a regular or episodic basis rather than a tool for 'moving forward'. Different types of caller were evident, those who were suicidal or feeling suicidal and felt they had nowhere else to turn, those with ongoing mental health problems who used Samaritans as part of their support network, and callers who were distressed but not suicidal: some seeking advice, others human contact.

Around 40% of survey respondents also gave suggestions as to how the service could be improved or better tailored to meet their needs. The suggestions made were grouped into four main categories: recruitment and training of volunteers; interactional issues between caller and volunteer; practical issues to do with use of the service; and the wider promotion of Samaritans. (Suggested improvements to service are discussed further in Chapter 11).

Reference

1. Samaritans, *Information Resource Pack 2009*. 2009, Samaritans.

Chapter Five: Callers' Perspectives in Interviews and Emails

Introduction

In addition to the online survey, in-depth qualitative interviews were conducted with forty-eight callers[55]. The majority of interviews were conducted over the telephone (90%, n=43). Four (8%) were conducted via email and one interview was carried out face-to-face (2%). The caller interview data presented in this chapter is extended by material from text and email strings from 58[56] callers who permitted access to the content of their messages and volunteer responses.

Through an in-depth qualitative analysis of interview data this chapter aims to provide a deeper and more nuanced understanding of callers' perceptions and experiences of using Samaritans support services. Firstly, the demographics of the interview population are described. The second section explores the means by which these callers have contacted Samaritans and the frequency of contact. Third, the importance of informal support networks to callers is discussed. The fourth section considers callers' expectations and evaluation of the service.

Demographics

The majority of callers interviewed were female (81%, n=39) and identified themselves as White British (96%, n=46). Two were listed as Asian British (4%). On average those interviewed were older than the survey population. They ranged in age from eighteen to ninety-four, with an average age of forty-six.

Just over half of the callers were single (54%, n=26), and almost a third were married or in a civil partnership (29%, n=14). Of the remaining respondents, five (10%) were divorced or separated, two (4%) were widowed and one (2%) respondent did not disclose this information. Around a third were in full-time (31% n=15) or part-time employment (4%, n=2), with the remainder not working (unable to work 31%, n=15) unemployed (19%, n=9), retired (8%, n=4), full-time students (4%, n=2).

A much higher proportion (77%, n=37) of those interviewed identified as having experience of a mental illness than those who responded to the survey[57]. The starkest difference was in the severe mental illness category with 46% of interview respondents (n=22) reporting experience of this. 13% of interviewed callers (n=6) identified as having been suicidal at the point of contact. This contrasts with the survey population where 46.3% (n=606) of participants reported feeling suicidal before their last contact with the Samaritans and 8.6% (n=113) claimed to have called whilst in the process of suicide.

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[55] In addition three respondents who were both callers and volunteers were categorised primarily as volunteers, as this reflected their principle orientation to Samaritans at the time of the study. However, where relevant, material from these interviews has also been included in this chapter. Several caller respondents referred also to experience of volunteering with Samaritans at some time in the past. These respondents were categorised as callers as this reflected their principal orientation at the point of interview.

[56] Very little demographic information is available for this group of callers.

[57] 13.2% (n=153) of survey respondents cited mental health problems as their main reason for last contact. 47% (n=279) of those who had contacted the organisation on more than one occasion cited mental health issues as their main reason for past contact.

Use of the service

This section reports on the methods of contact used by interview respondents and explores the reasons respondents gave for choosing how they make contact with the organisation. Frequency of contact and patterns of contact are then discussed in relation to when and why contact with the organisation was made.

Means of contact

Telephone was the most common means by which those interviewed contacted Samaritans, with 39 of the 48 callers reporting that they had used this method of contact. Just under a third of respondents had used the email service (n=14), and around a fifth had had face-to-face contact with a volunteer (n=10). Four of those interviewed had used the text messaging service and only two had used the postal letter service.

Respondents gave several reasons why they chose to use the telephone service as opposed to contacting via other means. For many, having human contact was raised as an important issue. Typically these callers felt isolated or lived alone and valued being able to interact with another human being. Whilst some found it helpful and easier to express themselves by talking directly to a volunteer, others described the difficulty they experienced in picking up the phone to make initial contact. The immediacy of response was also considered important with some callers explaining how they would not use email because they would not want to wait for a response. Other callers gave more practical reasons for choosing to use the telephone service. For some, this was the only service they were aware of or had access to. Others explained how they were not 'IT literate' and felt more comfortable using the telephone than text or email.

> *I did actually want to hear another human being and their response really and interact, rather than do it by text or E-mail.* S131

> *I don't visit because of the difficulty I have getting to the branch. Because I don't drive. And, I'm not that mobile anymore, so it's sort of like difficult getting to the branch. And I suppose the phone is there and it's sort of like, easy, as is internet, it's (just) there and you don't have to go anywhere to get it. Yeah.* S170

> *I think, using computers is good, but, not everyone is IT literate are they, and (they don't have) a computer, so it's good that you're offering a range of ways that people can communicate with this service.* S130

Several reasons were given for using the email service. For instance, some callers expressed how they found writing about their feelings easier than talking about them, especially when feeling particularly upset, nervous or tired. Others found it helpful to write down and re-read their thoughts, thinking of their email almost like a 'journal entry'. Privacy was also a motivating factor for using both the text and email services. This is illustrated in the extract below where S104 is explaining how she would like to use the telephone to make contact, but this is not always viable when family members are at home. In these instances she will use email and considers this to be a more discrete and private form of contact.

> *I: Could you tell me why you chose to email rather than say to telephone?*
> *S133: Because my husband's normally around.*
> *I: Ah, okay right. So it's sort of privacy?*

S133: Yeah… I'd probably like to phone them but in fact (email is) good because my husband is normally here.

In the email data analysed it was evident that some callers also used email as a way to arrange or discuss other means of contact with the Samaritans. For instance, the following email extract shows E512 explaining why she did not visit the branch as she had arranged the night before.

I had a bit of abad nigth but I was going to come down to see you lastnigth but AIam trying very hard to cope on my own but I did ring up to say that I may comedown there that nigth but I ring back up and said that I will wait till tomz nigth ok? ES512

Likewise, ES525 expresses appreciation for being able to email the Samaritans until he feels able to use the telephone service.

Sorry I haven't been brave enough to phone. I'm worried that my family would overhear me. I still might try to ring but at least this way I'm not upsetting anyone. Email gives me the chance to express myself without reservation and I'm grateful for this as it keeps the pressure pot just simmering and, so far, not boiling over. ES525

Those that had visited a branch and experienced face-to-face contact were generally positive about this means of support. Again, having human contact and being able to talk to someone about how they were feeling were valued aspects of the service. Several respondents described how they used to have face-to-face contacts or had been befriended by a volunteer in the past and expressed their disappointment that this aspect of the service was no longer available to them. Others expressed their desire to visit a branch for face-to-face contact and explained how they were no longer able to for several reasons, including lack of service provision in their area and mobility or health problems.

Because I don't feel all that comfortable on the phone anyway, it's not my chosen medium. And, when I'm very depressed, I often am very silent for long periods of time, and I felt uncomfortable doing that on the phone… Whilst, I think in a face to face situation, they can see that I am there, I'm struggling to say something. And so I think that that's really why I much prefer the face to face. S119

Neither of the respondents who had contacted via postal letter appeared satisfied with the service. One caller claimed she had been asked to write to a volunteer during a phone call (S101) only to have had her letter destroyed for containing 'inappropriate' content (which she says was her telephone number and explains that she included this so the volunteer could call her back and she would be sure the letter had arrived). The other respondent claimed not to have had a response to her letter which left her feeling disappointed and upset (S110).

Fifteen of the callers interviewed reported having used more than one method of contacting the organisation. This was usually a combination of telephone and visit or telephone and email contact. Choice of method of contact appeared to be somewhat dependent upon both the callers' reason for contacting the organisation and the convenience of using one particular method over another. For instance, S113 reported having using the telephone, email and text to make contact with the organisation. She

explained that she used text during her last contact because it was the most convenient method available to her at that particular time.

The texting and the email, I think at times is a bit slow in terms of response. So if I was in need of immediate support, I would ring, I wouldn't rely on the texting or the email. But for people who find that, bit difficult to talk, I think the texting and the email service which is relatively new, I think, is invaluable. Yeah. I think that you can do it anywhere, more or less, you know. If you're on a train, you don't have to fear that people can hear you, especially in the day and age of texting and all of that. And I think, I guess it's that silence on the phone that people find difficult: how does one start a conversation, and to sort of pour their heart out. *S113*

Frequency of contact

The interview respondents differed greatly in frequency of contact, with some contacting many times each day, others phoning and visiting branches only episodically or outside office hours when other sources of support were not available. Some had a single preferred method of contact, and others using multiple methods. Callers tended to be vague about frequency of contacts, the length of time they had used Samaritans, why they called, and whether or not they had a care plan.

> *I can't remember, I have to be honest. It was a long time ago. I probably used them off and on for probably about twenty years really.* *S113*
>
> *Then I was in touch for about… an occasional call….about probably every few months.* *S402*
>
> *That was, that was some time ago, now, that must have been two years ago and then, more like about a year ago, I rang.* *S164*

Many callers described periods of intense contact where they had multiple daily contacts with the organisation interspersed with periods of little or no contact. Callers typically oriented to this pattern as normative, and it ties in with the notion of contacting Samaritans during difficult times or for the duration of some problematic issue.

> *It does vary. I mean you know there are times when I might call several times a week and there've been months where I haven't rung at all.* *S161*
>
> *But no, in the last seven years not at all, except that three year period. Uh I was pretty much on the phone to them every day.* *S403*

Amid such responses there was also the notion that high frequency contact may be considered inappropriate by Samaritans or become burdensome to the organisation. This is possibly a reason for the vagueness of some callers in describing the nature and frequency of their contact.

> *The only thing, I wanted to know, is it really okay to ring them as often as I feel the need? Or is there a perception, oh, you mustn't ring more than a certain time, you know, like, your limit is up now woman, so don't call again.* *S175*
>
> *I get so wound up, in such a desperate state that I need to use Samaritans services. I wish I didn't I really do, I feel like I'm dependent on them and sometimes that I'm a burden and I worry that they will think, 'Oh no, it's her again', and recognise my voice.* *S104*

Some callers contacted Samaritans when they perceived their level of crisis or risk of attempting suicide to be high. Many of these cited mental health problems as the cause of their crisis (mental health issues are discussed further in chapter 9). Frequency and length of engagement with the service varied between callers and over time, for instance, contacts may be years apart but very frequent during episodes of illness.

> *Well, I think, I was going through a really difficult time. I had a nervous breakdown when I was at university and I found it extraordinarily difficult. I was diagnosed with bi-polar disorder and I was just going through an extraordinarily difficult time.* S136

> *I contacted, I was desperately suicidal, I am bi-polar, and was having strong suicidal drives, very, very frightening, was very suicidal. I first contacted twenty years ago and latterly two years ago when these suicidal drives reared again.* S401

Calling frequently during crisis times may be part of a broader pattern of contact for some callers, who will still remain in regular contact during the non-crisis times. These callers seemed to stay in continuous contact with the organisation, which lessened in frequency outside of crisis times.

> *And, as I said, there have been days I've rung, I think the maximum probably has been four or five times when it's been a real rough day. A lot happening. Some days, (I think it's) only once, or some days not at all. S175*

Other respondents reported that when they were in severe crisis or at most risk of suicide, they turned to other services for a different type of support. These callers reported using Samaritans support services at points of 'lesser' need, for example, when 'just needing to talk with someone' (S161). The appropriateness of such calls may raise issues for volunteers, but may be of great benefit to callers (inappropriate calls are discussed further in Chapter 6).

Informal support networks

There is a significant literature which suggests that individuals experiencing distress benefit from emotional and social support. Much research has specifically focused on assessing how the provision of social support affects the onset, course and outcome of depression [1]. For instance, the findings of a study by Sheber et al [2] suggest that the quality of family interactions is relevant for understanding the development of depressive symptoms in adolescents. A few studies have paid attention to the particular role played by members of an individuals' existing support network in the provision of emotional support. Of particular note here is the association found between suicidal ideation or acts and the perception of low levels of family and peer support [3].

In contrast to a widespread assumption that people call Samaritans because they have no-one else to turn to, it became clear that many callers have access to an informal support network consisting of family members and friends. Appreciation for these informal support networks also featured prominently in the data. Callers described using friends and family members for support at certain times and for particular reasons. However, the informal support available was often limited in some way, for example, in terms of times when it was available or the extent to which the caller felt able to disclose their true level of need. Callers often found that intense feelings or sensitive topics (e.g. mental health issues; suicidal feelings; past experiences such as sexual abuse) were difficult or inappropriate to discuss with family or friends, or feared that such topics

would not be understood. Additionally, callers did not want to worry, scare or embarrass those close to them.

> *I have been married and, for 38 years, and if it hadn't been for the fact that my husband has supported me carefully, I wouldn't be alive.* S111

> *It's also very, very difficult to talk to friends or family because you feel embarrassed about having depression/mental illness.* S109

> *She wanted to know how I was doing. She thinks I am suicidal. I told her I was a lright and I wasn't going to do anything. I can't tell her how I really felt.* ES559

> *I have issues with showing vulnerability really, I suppose, so, in that case, I think yes, someone who doesn't know me, no idea who I am, quite safe to show them vulnerability. Whereas, you know, I know my friends can be completely empathetic and brilliant about it, I don't always want them to know how upset I can be.* S144

Callers were also reluctant to disclose sensitive issues with friends or family because they could not be sure of confidentiality and it exposed their level of vulnerability. As S144 explains in the data extract above and ES564 in the email extract below, this could lead the caller to disclose such issues to a stranger; someone who they are not linked with or attached to in any other way.

> *I don't want Samaritans to contact me by physical post as my wife would find out I was talking to you and it would cause an almighty row as she wouldn't understand why I was talking to you instead of her. But I find talking to you has eased my mind greatly, a bit like talking to a friend who doesn't carry on the story to someone else.* ES564

The individual's self-perception and social role within their existing support network was influential in their decision to contact Samaritans. In this sense, Samaritans was used as a resource to support the caller's capacity to sustain their preferred social roles and personae. For instance, those who perceived themselves to be the one who provides support or care to others in their social network expressed a reluctance to reverse roles and take on the identity of 'a friend in need'. Therefore, although not considering themselves to be socially isolated, they considered themselves to be 'not the type of person' who would 'burden' friends or family members with their problems or felt unable to confide in those closest to them, instead turning to Samaritans. Related to this was how when talking to a friend, one must also take their feelings and problems into consideration. Callers expressed how they felt that their problems might be too much to 'unload' on their friends and how they were unwilling to add to others' problems. This was particularly the case late at the night, when callers described contacting Samaritans rather than those in their support networks.

> *I've got friends. I would hesitate to load them up too much with my problems, I feel I'm in a position where I'm more of a friend who listens to the other people.* S125

> *My friends were around at other times but they weren't around during the night and that's when I found it invaluable … I'm not sure it's fair to call your friends at two o'clock in the morning.* S106

Other factors came into play when callers decided whether to seek support from family and friends or turn to Samaritans. There was a general concern that the disclosure of serious problems or crises could distress, frighten or worry those around them, even those who are supportive on other occasions. Callers wished to conceal the extent of their troubles, particularly from those they were close to. In addition, callers worried that friends or family members might not understand their problems or accept how they are feeling without judgement. Callers also discussed family and friends as putting pressure on them to deal with their problems, for example, by engaging in (or indeed rejecting as in the case of ES548) psychiatric treatment or urging them to simply 'cheer up'.

> *I'm gonna go to the hospital near here tomorrow for mental health. I was going to go last Tuesday but my wife talked me out of it. She doesn't like me taking any drugs.* *ES548*

> *Part of the reason why you don't tell these people everything because it's actually not safe for you either…. Because then your family don't let it drop … every time they see you that'll be well, what's happened now? what?, how are you? what have you done about this? … it actually becomes more of a pressure.* *S131*

It appears that while many callers do have a network of people around them, the people in these networks may not always understand or be able to accept the level of distress or the nature of issues or problems that the caller is dealing with.

> *The extremeness of the feelings that I did have, so it wasn't just feeling a little bit low, it was, kind of, you know, thinking of suicide and all that kind of thing. And I think it, that kind of subject is very difficult to talk to family and friends, even if you're, you have close friends and family.* *S113*

> *Because ten years ago I was suicidal. I was depressed, everything was going wrong, the people who are there now, who were there ten years ago, if I turn round to them and say look, 'I am struggling a little bit today', they would run a mile, and I can't put that pressure on them, so to talk to the Samaritans … totally non-judgemental, totally independent, it gives me a release.* *S403*

At the other end of the continuum were callers who described their situation as one of social isolation where they had either no access to informal support networks or considered the other people in their life to be unsupportive. This was often the case when there had been a relationship breakdown or if the caller was experiencing other relationship problems which left them feeling unable to effectively communicate with those around them. Poor social relationships were often given as a key element in the onset of callers' problems and were sometimes linked to suicidal ideation. This was particularly striking in the emails, as illustrated in the examples presented below. In these instances of social isolation, Samaritans was positioned as the callers' main source of emotional support.

> *I don't have a bad life. But I feel emotionally starved in my marriage and feel like I am left out in the cold just struggling on alone all the time. He never asks how I feel or how I am coping - he would rather not know.* *ES514*

> *My family have been horrible to me and their present attempts at affection shock me. Their nonchalant attitude, as if one can go on without acknowledging past wrongs, have upset me. I do not see this attitude as apologies. I see it as hypocrisy. Death would be bliss.* *ES533*

Section summary

Discussion of support from friends and family members featured strongly in the data. Some callers had regular access to informal support networks others had no support network at all. Callers considered these networks to be a valued source of support. However, such relationships were also associated with the negotiation of various practical and interpersonal issues which could constitute a barrier to accessing this support during specific times of need or crisis.

Attitude to seeking help

It is worth highlighting that respondents repeatedly discussed 'asking for help' as a very difficult thing to do. The perceived cultural stigma surrounding the need for help for emotional difficulties meant that using the Samaritans was viewed as a 'last resort' by some callers. Callers frequently described allowing themselves to 'get into a state' before contacting Samaritans. Additionally, respondents reported experiencing intense feelings of worry or nervousness before calling. As demonstrated in the data extracts below, callers were often reticent about needing to call.

> *It's almost like you mustn't ask anyone else for help. I think that somehow got drummed into me as a child.* *S175*

> *I think I thought it was quite a, (probably) quite a stigmatised thing to do, I think, probably, you know, phone the Samaritans...* *S136*

Reasons for calling

A deeper exploration of reasons for calling was achieved in the interview data than was possible in the survey data. A range of reasons for calling were given, several of which involved a particular outcome for the caller. This may have been during a period of crisis and aimed at getting out of a 'state' of some kind, or at a point before crisis as a way of avoiding becoming worse. Contacting Samaritans was described as a practical way to distract one's self from problems, from having specific thoughts or from engaging in a particular pattern of behaviour such as periodic self harm.

> Again it is the middle of the night and I am contacting you when I cannot sleep properly. I was feeling very low and had lots of worries going round in my head and needed to get them written down and try to stop thinking about them. *S103*

> *And it was trying to stop myself from cutting (...) the very first time why I rang. So it was kind of a distraction.* *S147*

It was evident that these callers knew, typically through experience, what kind of interaction to expect and used this as a way of achieving their particular goal. For example, several callers described how they used the space provided by Samaritans in which they were allowed to talk openly about their thoughts and feelings to manage their mental states. In fact, there was a great deal of data in the caller interviews suggesting that the caller's mental health problems were a reason for initiating contact with Samaritans.

> *I was having quite strong suicidal thoughts and urges ... so I wanted to talk to someone to try and put the lid on it straight away.* *S131*

It was as a result of getting depressed again. *S111*

However, sometimes the outcome the caller was hoping for was beyond Samaritans' remit. This is illustrated in the email extract below where the caller overtly expresses hope that contact with Samaritans would lead to advice, which was not provided:

> *I was hoping that by talking to you you would suggest an alternative option, however so far you have not.* *ES507*

(Issues around advice-giving are discussed in more depth in chapter 7)

Expectations of service

During the interview, respondents were asked what their expectations of the service had been prior to contacting Samaritans for the first time. For several of those interviewed their first contact with the organisation had been many years ago and they found it difficult to remember what they had been expecting. Alternatively, respondents tended to talk about what they now expect when they use Samaritans support services, and whether or not their expectations are met.

Some callers reported that they had known exactly what to expect from contact with Samaritans, claiming prior knowledge of what the organisation does and does not offer. It was evident that such knowledge could be gained in various ways through, for example, knowing someone who volunteers for the organisation; previous experience of being a volunteer; or researching what the organisation does online prior to contact.

> *The trouble with 2003-2004, at that time I was already a volunteer, so at that point because you're aware of what happens on both ends of the phone it changed the expectation somewhat.* S402

> *Yeah, I knew about them. I looked through different parts of the website. It let me know about what they do and, the sort of things I could expect from them, yeah.* S132

> *I do expect them to be as open, especially when (considering) suicidal feelings…I've got (a couple of) friends who volunteer.* S170

For some, such as S140, prior experience of Samaritans services, in this case gained through his previous training as a volunteer, is attributed to holding high expectations which were not met.

> *It could also be (because) I've trained with them and my expectations are a bit too high, if you see what I mean* S140

To some extent expectations of the service are mediated through contact with the organisation. Some callers had learnt over time what the service can and cannot offer and adjusted their expectations accordingly.

> *I would like help with my problems…When I first phoned back in the 1980s I was really distressed and frustrated that Samaritans couldn't help more. But it's too much to expect people to have solutions to these problems.* *S117*

I think I was just hoping for general support, and also some specific advice about how to deal with work – e.g. what are my rights re sick leave. I got more sympathy than I expected! I think I expected it to be quite matter-of-fact, but the emails I received were very warm and caring. S117

The expectation that one would be 'listened to' was strong within the data. Some respondents hoped that they might be offered some advice in addition (Chapter 7), whilst others expected not to be judged and for volunteers to empathise and support them through listening. 'Being listened to' was valued highly and linked to feeling understood, not judged, empathised with and cared about which were considered by callers to be good outcomes of the call, despite the absence of advice.

I: Did the contact turn out the way you expected?

S176: Better. Felt like I was listened too.

I: How did you feel about the contact you had?

S176: I feel good about it.

It was really important, when I had flash backs, to have someone present to witness…and they were very, very good route for me. And they'd always listen. I keep going back to the listening but yeah. S106

I hoped that I would be, well I suppose all the things that I described in that other phone call you know listened to, understood, not judged. Possibly that I'd have a bit of information flung in- because it was about self harming and it was all very new to me. S161

Callers expected that in listening to a caller the volunteer would also talk to them. The provision of responses would then indicate that the volunteer had understood the callers' disclosures and also demonstrate empathy. This is illustrated in the account of S131, where it is clear that interaction with the volunteer as opposed to silence was expected. Interaction was also valued on another level, that of providing the caller with the human contact they desired (See Ch. 6 for an account of the relationship between listening and empathy).

I understand you have to have listening skills. I understand that there's gaps to give people, don't fill in their answers for them, but complete s silence! Who has conversations like that? That's not normal. And things are abnormal enough when you phone up. You want more normal thank you. And I actually felt quite humiliated at the end of it, really as though my problems had been belittled. I began to think maybe I should keep my mouth shut, keep it to myself. S131

It depends upon the skill of the listener. Most of the time that was good. I can think of at least one occasion when the person didn't know what to do with my distress and was sort of almost, well, if you're not going to talk to me, what's the point in being here, sort of, approach, which, yeah, I thought they lacked the empathetic skills. S119

Email data

The email data provided clear indications of what the callers had expected from their interaction with Samaritans. In particular, the expectation that the service would answer questions, provide direction or offer sometimes quite specific information or advice was evident in the email data. Often repeated questions were asked with emailers making it clear that they expected to receive answers to their questions, advice or information. As in the extracts below, when such information or advice was not provided some callers overtly expressed that this was what they had expected from the service.

> *DO YOU HAVE ANY INFO ON MAJOR DEPRESSION SCHIZOPHRENIA AND BORDERLINE PERSONALITY DISORDER?* *ES504*

> *I don't mean to be ungrateful, and I understand you must have a lot of e-mails to respond to, but no, it didn't really help. I was hoping for some answers to my problems I guess. I don't think there are any, so, yes, I am still going to kill myself.* *ES501*

Often a level of uncertainty about what to expect was expressed by those in first contact with the organisation. Respondents held various expectations of what the service might offer them. In the extracts below, ES517 is not sure what to expect but is clear that she is not expecting a solution for her problems, whereas ES534 explicitly asks for advice on how to deal with her current situation.

> I'm not asking for an answer that will solve all of this, whatever this is. I don't really know why I wrote this: one of my caring online friends suggested I try it out. *ES517*

> I'm not sure how this works, so apologies for jumping straight in! Any advice on how to deal with work would be hugely appreciated. *ES534*

Prolonged contact with Samaritans mediated expectations, and some callers gradually 'learned' their role. Others were clearly disappointed that the service they received was different to what they were expecting.

> *Why are you not able to give advice over email and or why can't you use your real names when you write using this address? I think it would be nice for these options for people who ask for them.* *ES523*

> *The samaritans I have spoken to on the phone, however, through no fault of their own, have left me feeling even more irritable than I was before I called because I want 'intervention'' When I hear 'hmmm' I really want to reach down into the phone and shake them. I want someone to do what I can't do myself...I want proactivity. I don't want the onus to be on me.* *ES533*

> *You never ansewr my questions. i dont know why iask them. i wishyou were here with me so i wouldnt be al alone wating to hear form you.* *ES524*

Other emailers seemed to hold more realistic expectations of what the service could offer them, asking to be listened to:

> *I have been unable to send an e-mail as my mental health got so bad and my suicidal thoughts were invading me that I was assessed by my GP, seen by a Crisis Team and have been in a psyhiatric ward in hospital for the last 3ish*

weeks. If this could be sent to the [specified) branch who know me, I would be grateful please, however, I am desparate and any Samaritan who will "listen" to me is much needed. *ES512*

Good calls

The caller construction of the 'good call' was more diverse than that of the volunteers (Chapter 6). Some valued and expected advice, other resented being offered opinions and suggestions. Some liked the volunteer just to 'be there' and give time and space in which they could find and express their thoughts. Others callers found long silences very off-putting, preferring volunteers to be 'proactive', asking questions and engaging directly in the call as a two way process, rather than simply acting as a 'sponge': 'sitting at the other end and saying nothing' (S163). Callers stated a preference for their interactions with Samaritans to be a 'two way process' enabling them to feel a link with another person. Establishing 'human' contact was very important in helping the caller to feel less isolated and alone.

Chapter Summary

The interview respondents can be differentiated from the survey sample on several grounds. Whilst those interviewed tended to use the telephone as mean of contact, survey respondents were more likely to use email. Demographically, the interview population was, on average, older than the survey population. Those who were interviewed had a higher prevalence of mental health issues than in the survey population. Both groups of respondents were predominantly female and of white British ethnicity. Therefore, neither group of respondents constituted a representative sample of callers and neither corresponds to Samaritans reference data. The caller interview data considered in this chapter was extended by material from the text and email strings from 58 callers who permitted access to the content of their messages and volunteer responses.

The interview data conveyed a strong sense of the difficultly callers often face in asking for help. Choice of method of contact appeared to be dependent upon both the callers' reasons for contacting the organisation and the convenience of using one particular method over another. Contact patterns were influenced by social networks and relationships and the sort of behaviour was seen to be permissible or tolerable within that support system. Complex relationships with family, friends and other groups were discussed, positioning Samaritans as a service which not only provides the main source of emotional support to isolated callers, but which is also accessed by those whose informal support networks cannot accommodate the intensity or nature of their distress.

Callers' expectations of the service were not static but changed over time partly in response to their experience of contacting the organisation, changes in the nature of service offered by the Samaritans (e.g. past practice of volunteer befriending) and means to contact the organisation that have occurred. Callers had varying views about what constituted a 'good call'. Whilst in some cases advice was valued and expected, in other cases callers resented being offered opinions and suggestions. In general, callers preferred interactions with Samaritans to be a 'two-way process' enabling them to establish 'human' contact in order to feel less isolated and alone. These issues are returned to and discussed further in Chapters 6 and 7.

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Chapter Six: Handling Calls

Introduction

This chapter explores different aspects of volunteer practice in taking calls, drawing upon data from volunteer (and occasionally caller) interviews. Various aspects of the ways in which calls are managed will be discussed as will a number of ways in which an appropriate relationship with callers is achieved. The practices engaged in by volunteers during contacts will be discussed in relation to the stated aims and principles of Samaritans.

The emotional support proffered by Samaritans is described as both unconditional, perhaps even exceptional, and also bound by quite specific rules of engagement [1]. The volunteer's role involves 'being there' for the caller and listening non-judgementally and non-directively to what the caller wishes to say, with a particular focus on the exploration of 'feelings' and emotional despair, particularly where these involve suicidal thoughts and intentions. The Samaritans' offer of emotional support provides the caller with an opportunity to vent distress. This can be therapeutic in its own right, as can the space to think and talk through problems as a way of developing insight into how current difficulties can be managed, if not resolved, in future. It is not about offering advice, being prescriptive or even giving sympathy (as opposed to empathy). Sympathy is patronising ('you poor thing'). Empathy involves being able to understand and acknowledge the perspective of the other.

Within the volunteers' remit there is a boundary to be maintained between 'accompanying' the caller and 'joining' him on the call. It is a mistake to think that the volunteer can ever have knowledge or experience of the caller's feelings and perspective, even if both caller and volunteer have been through apparently similar experiences. The volunteer must never assume that this is the case, or claim such a privileged understanding in a call. This is also a strong reason why the volunteer must never answer direct questions or disclose any personal details. The asymmetry of disclosure maintains a necessary and desirable boundary between the caller and the volunteer. It is also a means of protecting the volunteer by limiting his role and responsibility for the caller and reducing the temptation for the volunteer to become emotionally involved in the call or be drawn into adopting a 'problem solving' or 'rescuing' approach. This is a risk of over-long calls, which tend also to be viewed as an inappropriate use of resources. The role of the volunteer as facilitator provides an opportunity for the caller to direct the conversation so that it can be tailored responsively to his needs (provided these fall within the Samaritans nature of service). Crucially, this non-judgemental, active listening provides an opportunity for the caller to take responsibility for himself. The call 'empowers a caller to move forward'. The role of the volunteer is to 'hold' the caller, providing a 'safe space' in which he can focus his feelings about issues of particular concern and consider the options open to him in taking these forward. The volunteer is with the caller 'in the moment' of the call, but not beyond it. Although volunteers subscribed unreservedly to Samaritans principles, there was considerable variation in how these were interpreted and applied.

Individual Approaches to Handling Calls

A standardised volunteer training programme (SIT 1 and SIT 2) was introduced in all Samaritans branches during 2004-2005. This was widely, though not unanimously, welcomed by respondents, who appreciated both the quality of the training and also its impact in promoting consistency of the service provided to callers across the entire organisation (Chapter 3). Volunteer respondents expressed a strong commitment to

Samaritan's principles and acceptance of the need to adhere to the resulting rules of engagement when handling calls. Respect for individuals applies to volunteers as well as callers. This is reflected in respondents' recognition and acceptance of differences in personal styles of taking calls. However, the desirable qualities which volunteers described as required in a good volunteer were widely accepted, and corresponded closely to the attributes set out in the training manual.

> *Non-judgmental attitude. To be a good listener. Sympathy. Trying to empathise with people.* V221

> *... empathy and unconditional (policy) of regard, and being genuine and present in the moment. Without, obviously, self-disclosing and coupled with active listening skills, give them the room to explore without them needing to meet any conditions of worth, so, yeah.* V240

In theory, anonymous volunteers operating within the guidelines for practice should be interchangeable, so that it makes no difference to the caller who answers their call. At the same time, respondents acknowledged the individuality of volunteers, and how inevitably this was expressed in differences of style and personality when handling calls.

> *I think Samaritans does value the individuality of its volunteers and that each volunteer can give a very different style of befriending within the kind of parameters of the training and the Samaritans policy.* V219

> *You can't be too individual in the way you take a call, as the rules Samaritans have make sense and should be strictly adhered too.* V280

The volunteer interviews contained many insightful statements of respondents' commitment to volunteering, and the branch observations provided evidence of volunteers supporting callers with great skill and sensitivity. Handling calls in general seemed to be characterised by a need for balance, as individual volunteers try to support callers in a way which incorporates their individual talents and personalities, while utilising and remaining within the boundaries of the framework given to them in training. New volunteers reported some trepidation about taking their first calls, especially independent of mentor support. The rapidity and (relative) confidence with which new recruits seemed to engage with the considerable interactive challenges of their role as Samaritans was striking. It is a testament to the effectiveness of the training as well as the supportive environment provided within the branches and by their fellow volunteers. The development of expertise as a volunteer was constituted as a continual learning process.

> *I think it's coming. I think my style is developing, the more I listen to other people and the sort of, pick up the best of different ways of doing things, my style is developing but it's a bit early, just yet, to say I've got my own style, I think.* V264

> *And so you just do find yourself thinking, I know how to do this, I didn't know how to do this ten years ago and now I do. When did that happen? Well, it happened gradually.* V214

Although they could be critical of how other volunteers sometimes handled calls, respondents welcomed the opportunity to learn from listening to the techniques and skills they observed among their colleagues, as well as calibrate their own. New volunteers, in particular, described both how much they learned from other volunteers

post training and also how the initially formulaic responses they had learned during training were gradually replaced by a more individual style as they gained in experience and confidence.

> *I've heard anything from 'Hello' to very sharp 'How can I help you?' to long winded, 'Hello this is Samaritans how do you think I can help you?' It's hugely different and it's the way the phone is answered and the voice and sometimes you'd get the impression that they [volunteers] were hassled.* V401

> *I think what happened in the first couple of years is I behaved very by rote. So it was concentrating but working with words that others used and approaches that others used and everything else…as I mature, still a Samaritan approach but my own personality a little bit more, so it became a little less bland, I think is probably the best description.* V229

Respondents accepted, and even welcomed, the rules and boundaries provided by the Samaritans. However, some described a tension between the requirement to follow rules on the one hand and to 'be oneself' on the other. This applied particularly to the commitment to ask callers about suicidal ideation and intent during every call (Chapters 4 and 8). Some respondents reported that initial difficulties in accepting aspects of the volunteers' code of practice were resolved with time and experience of their value. However, increasing confidence and experience could also lead to a desire for greater independence in handling calls.

> *It's getting easier the longer I do it. I didn't find it easy during training, coming to terms with that concept. But the more experience I get, the more I understand why that's the right way and therefore the easier it's becoming to do it.* V264

> *One of the (dangers) that I witness quite often is something I'd call the litany of prohibition. And that's where your training is actually set to say you must work in this way and that way and here's what to do in this situation and that situation. Whereas I think, in my learning and in the training of others, the preparation of others, I've concentrated on allowing the natural flair and style to come out within the bounds of Samaritans. So you need to be very conscious of where the edges of what you're doing are, and where what you do would drift into a more active style of counselling.* V229

Reflection and self-appraisal

Volunteers expressed confidence in their ability to take even the most challenging calls. Supporting the suicidal was what Samaritans signed up to do, and was reported to be a uniquely gratifying and privileged experience. Respondents appreciated both the quality of their training and the ongoing support of their colleagues in underpinning their ability to handle suicidal callers. Expression of doubts or uncertainties about the handling of a call, or acknowledgement that they had not responded positively to individual callers, were not common. At the same time there was a normative orientation to the volunteer's capacity for continuing development and improvement. Volunteers could also be wary of growing cynical, and constructed this as a potential danger of being a Samaritan for an extended period of time (Chapter 3).

> *Times when I feel, I come off the phone, I feel absolutely terrible, I can't put my finger on what it is that makes me think that. It maybe that I'm.. not up to taking that call on that particular day. I didn't do very well, and, okay, I didn't have patience to deal with it properly, I wasn't alert enough to, you know, to be*

responsive to what was happening. It's just, you know, we're all human and this kind of thing does happen from time to time. *V213*

Yes, there are times when you think, 'I didn't do that, I didn't do that as I should have done'. I think when the day comes that you never ever think that, it's almost certainly the time to go. *V207*

And those are the times that sort of bring you up short and you think, you know, I've been doing this too long, I've got cynical about this. [laughs] And I might have stopped that person from ever getting to sort of what they needed to say. *V211*

The Good Call

Volunteers varied in their responses to different types of calls and callers and described the importance of dealing with each one on their own terms. However, the prospect of a 'good' or 'worthwhile' call was eagerly anticipated. 'Good calls' involved interaction which the volunteer judged had made a significant difference to the way the caller was feeling and had helped the caller in some way so that as a result of the call he was able to 'move on' in terms of gaining some insight into his current situation and how best to deal with it.

Well, I suppose with apprehension when the phone goes, because you never know what you're going to be faced with. A certain amount of excitement, if you like, in the hope that it's going to be a call that will be worthwhile and not necessarily challenging but certainly worthwhile. We do get a lot of calls which probably are not so worthwhile as you probably know. *V244*

Yeah, I had a caller on Monday, it was jolly good…I was speaking to a woman who … … having various issues with her mother who's suffering from dementia and that kind of issue. And what is good? Well, the call concentrated on her, she was able to talk through the situation, we were able to talk through her options for the future, and kept it focused on her feelings and I think I built a good rapport with her. *V219*

Good' or 'worthwhile' calls were those involving a caller experiencing genuine distress. Descriptions of good calls often focused on callers with a high degree of expressed suicidal intent and ideation, where the volunteer considered that their interaction may had a significant impact in turning the caller away from suicidal action. These were intensely rewarding, albeit challenging, calls which validated the role of the volunteer.

I remember a young man phoning, he was about twenty…he was going to take his life and he was talking about it and we were on the phone over an hour and he said he was tired, 'Can I get someone to call you back in the morning?' And he said, 'Yes'. So from being suicidal, he said yes to a follow-up, and he gave me his number, that meant he intended to be there in the morning so that was good. *V263*

It's really very pleasing if somebody comes on the phone and they're too upset to speak or almost too upset to say anything, and you manage to, perhaps, coax them to stay on the line in the first instance, and then gradually manage to find a bit more about what's really got them into this state and they get talking about it, and then, you're really doing something. *V211*

In practice, as new Samaritans quickly found, and often in contrast to the expectations they may have had before and even during training, volunteers were confronted with a diverse range of calls including many which were not so good and frequently fell outside the prescribed nature of the Samaritans service. Responses to the different categories of inappropriate calls (e.g. from the lonely, mentally ill, abusive, sexually demanding and manipulative) are considered below. In addition, new volunteers reported being surprised by the relative infrequency of *any* calls, especially during day shifts when there could be long periods during which the phones never rang, or the calls were virtually all of an unrewarding nature (e.g. snap calls and inappropriate or sexually demanding (TM) calls). The following sections discuss volunteer responses to different types and stages of taking calls and the strategies used to provide emotional support to Samaritans callers.

Beginning Calls

While callers may end a call abruptly and without warning at any time, the volunteer's initial response in answering a call was recognised to be critical to its success. There may be only a few seconds for the volunteer to convey to the caller that they are a trustworthy and acceptable source of support. Nearly half the calls made to the Samaritans are 'snap' calls, where the caller ends the call within a few seconds, and before dialogue can be established [2]. This is a puzzling and frustrating phenomenon. Volunteers attribute this behaviour to a range of factors, including the caller's search for a volunteer of a preferred sex, to avoid or engage contact with particular volunteers with whom contact has previously been established, because the caller is trying out the service, exploring what happens in response to a call, and perhaps simply making several attempts to summon sufficient courage to initiate dialogue with a volunteer. These attributions were echoed in the relatively small amount of relevant caller data but are unlikely to constitute a sufficient or satisfactory explanation of this phenomenon. The frequency of snap calls and approaches from callers, often those who are sexually demanding, alongside the frequently quite extensive gaps between calls, pose difficulties of adjustment for the volunteers in being ready to answer each call in anticipation that it might be from a 'genuine', 'worthwhile' and perhaps even suicidal caller. Respondents described the difficulty of remaining aware and always prepared for the next call turning out to be a relatively rare 'serious' or 'worthwhile' one, especially after dealing with a string of snap, nuisance or trivial calls.

> *I try not to be too prejudiced when I first answer the call. I really try to give people the benefit of the doubt. You know, It's easy to pigeon hole people, 'Oh, this is such and such a call', or, 'This is a call from someone with mental health problems', or, 'This is a call that's going to be sexually demanding'. So I really do try to give them time to tell their story and just listen.* V202

> *I wait for the two rings that we're, in training, tells us, and I find that very helpful actually, because it makes you, often, you know, you might have a magazine or a book out or whatever if you haven't had a call for a while, and it allows you a few seconds to just sort of focus.* V220

Volunteers were aware that putting care and attention into the answering of each call is important, as callers may need time to become able to speak. When calls start with silence, this may be because the caller is waiting to get a sense of whether they can speak to the individual volunteer who has answered their call, hence the need for a calm and inviting tone. Allowing a certain number of rings also allows the caller time to prepare for the call to be answered, and volunteers may feel in the early moments of a call that they are gently coaxing the caller into speaking. Leaving space and time for callers at the start of a call is discussed as an important element of call openings, as it

can be a very difficult thing for callers to begin speaking, especially in the first contact they have made to the Samaritans.

> *But it is a very scary thing picking up the phone and I think people are testing the waters when they make these calls, checking someone is answering the phone, not a machine at the other end that could be one thing. You know, they're just sort of getting up the courage and I think it's quite scary starting to talk … I mean when I was trained I was taught to say 'Hello, Samaritans.', and then you pause and then you say. 'Can I help you?' And the reason is you are calm, you're saying it nice and slowly and you're giving the caller time to decide whether to talk to you or not.* V401

> *Sometimes the calls where it's silent and there's nothing there, or there might be an odd noise, and I don't consider those to be nuisance calls at all because, as far as I'm concerned, that could be somebody plucking up courage and seeing what happens when you ring the Samaritans number.* V243

The first few seconds of a call can also reveal a great deal to the volunteer, alerting him to the type of call that is being initiated, whether the caller has a care plan, 'knows the system' (see below), or at the very least that they have called before (actions such as asking which branch they are through to, or whether a particular volunteer is on duty). This can inform the volunteer as to how to progress (e.g. to search for a care plan) and what to expect.

> *The caller gives you quite a good indication from the very start what it is. If they ask you what branch it is, that implies to you that they've called before and they know the system. In which case they might have a care plan or they might be someone who's used to using the Samaritans for negative or positive purposes, whatever, but they know the system.* V220

Engaging with the caller

Volunteers discussed the relationship and connection they have with callers as something they manage and monitor throughout the contact. Maintaining an appropriate balance between empathy and emotional detachment was considered to be critical to engaging effectively with the caller, but sometimes difficult to achieve. It was also subject to variable interpretation and application in the response styles of different volunteers. Whilst getting too close, emotionally, to callers was discussed as not beneficial to either party, effective 'befriending' necessarily entails establishing empathy and rapport. Some respondents favoured a stance of emotional detachment from the caller. Others emphasised the intrinsic emotional engagement required to establish rapport and empathy. In some contacts, a suitable connection with the caller may not be achieved, or may be lost when a difficult issue, or difficult element of a call, arises.

> *It may sound terrible but I don't get emotionally involved with callers … I keep that level of separation between me and them.* V403

> *It's almost detachment, but it's a very kind of involved, engaged detachment…* V216

> *Keeping your cool and serenity, having … compassion for what you're hearing … some degree of empathy but not getting involved in their upsets and their trauma and desperation. Holding it together… calm, but quite firm … it's going to give them something to hold on to, not crumble alongside them, basically.* V229

I just have to accept that there are certain callers who are not going to (develop) a rapport with you as much as other callers do … sometimes it's going along okay and you ask the difficult question and it kind of ruins the rapport that you've built with the caller. V219

Establishing Empathy

Respondents often described the core of the volunteer's commitment as 'being there' for the caller. This seemed to relate closely to the achievement of empathy in effectively demonstrating to callers that their concerns had been acknowledged and understood by the volunteer. Empathy was often identified as the most important element of the work with callers, and an important quality in volunteers. It was grouped with the ability to listen, and other core principles such as the avoidance of giving advice, and discussed as one of the strongest skills of Samaritans. It is a quality sought in potential volunteers, but whether it is something that volunteers can be trained in is a contested matter. Some believe that they have been trained to be empathetic, while others propose that people are either naturally empathetic or not.

The main thing I do is really try to, try to empathise with them. I find it very difficult at times but what, [I] try is to get the sense of really being there with them. And communicating to them a sense that they're being heard and understood. *V216*

We're looking for volunteers who are empathetic, and not directional, you know, they don't give advice, they appreciate the value of timing, of silence and so on and so forth and the way they deal with the callers. I suppose we're looking for things like good tone of voice, just a sort of a caring attitude, and patience, I suppose, all those kinds of qualities that you would expect of somebody, you know, to whom you're spilling your heart out. *V213*

As the previous extract illustrates, empathy was connected to an appreciation for a sense of timing, pace and tone of voice. The combination of carefully chosen words and the way in which they are delivered is treated by volunteers as the method most used in conveying empathy to callers. Trust is also discussed as an important (sometimes as the most important) element in the relationship with callers. Callers need to be able to trust the individual volunteer they are in contact with in calls and face-to-face support, so that they can feel comfortable enough to share difficult things. Volunteers will work at this, trying to build the caller's trust in them, and helping them to feel at ease so that they can open up and talk about things.

We've got to come over as empathetic on the phone so that your tone of voice and everything else will, you know, will be supportive. *V206*

It became clear that how we said things was much more important than what we said – even though in our thinking and to some extent in training, we tend to focus on content. I'm convinced this is true for actual callers. *V228*

It makes the difference between a good call and a bad call, it's simply building a sense of trust with the caller. *V219*

Empathy itself may be difficult to define. Hepburn and Potter state that empathy is typically defined in the relevant literature as "the imaginative sharing of someone else's experiences" [3:99], although they do acknowledge that there is much overlap in the various academic definitions of sympathy and empathy. They quote the model of

empathetic communication by Schumann et al (1997, as cited in Hepburn & Potter) as one of the most influential recent approaches to empathy from an interactional perspective. This model stresses the importance of an accurate *understanding* of the other person's situation, and the effective communication of this understanding *back to the person*, when displaying empathy.

A number of researchers have examined activities which people engage in which may be considered methods for displaying empathy in interactions. Beach & Dixson [4] found that when problematic or emotionally difficult issues were revealed in medical history interviews, the interviewers used formulations of these disclosed troubles to demonstrate an understanding of the situation. Displaying an understanding of the patient's various issues through offering formulations of what they have said (which are grounded in the patient's own talk; "You said.....") is described by Beach & Dixson as a way of displaying *empathy* with/for the interviewee. Interestingly, Ruusuvuori [5] argued that finishing patient sentences during medical consultations was a method for displaying empathy, as this collaborative telling of the patients' situations also demonstrated an understanding of the situation. Ruusuvuori also argued that maintaining an emphasis on the patients' experiences was crucial to the production of empathy, as opposed to interviewers demonstrating understanding through telling personal stories of their own experiences.

Hepburn and Potter studied calls to the UK based NSPCC Child Protection Helpline and found that call-takers regularly engaged in practices when callers cried, including offering a formulation of the caller's psychological or emotional state. Hepburn and Potter refer to these formulations as 'empathetic receipts' [3:89]. These receipts were used to acknowledge and display an understanding of the caller's state. In calls to a UK based mental health information line (MIND Infoline), Moore [6] found that call-takers regularly offered formulations of callers' situations following episodes of caller crying or other displays of upset, e.g. 'It sounds like a very upsetting and frustrating situation'. These formulations were again seen to display that the call-takers understood the callers and their issues, and were again grounded in the callers' talk and displays through the use of phrases such as 'It sounds / seems like....'. Moore argued that this grounding served to avoid an alternate form which may be heard as telling the caller what they feel.

The research has clear implications for the work of the Samaritans. The practices of summarising and reformulating callers' talk, and reflecting these back to the caller, are taught to new volunteers as part of Samaritan listening skills (SIT 1, Module 2). Although these practices are indeed discussed as listening skills and not methods for achieving empathy, they arguable achieve both, as in line with the existing research findings, these practices would display that volunteers understand the callers' situations.

Listening to Callers

Volunteers discussed listening as a core element to their work as Samaritans. While Samaritans style of 'active listening' is a complex process, listening was discussed by a number of volunteers as being the same regardless of the type of caller, and regardless of the content of the call. 'Truly' listening to callers should mean that initial, and often incorrect, assumptions are set aside, and callers are accepted without question. It involves actively encouraging the caller to continue, and displaying that they are being heard through the use of probing questions, and reflecting or summarising. Listening can help Samaritans to avoid making mistakes such as identifying callers as inappropriate, which in turn prevents true listening as the volunteer may automatically close themselves off from such callers.

> *It's easy to pigeon hole people you know, think, 'Oh, this is such and such a call', or, 'This is a call from someone with mental health problem', or, 'This is a call*

that's going to be sexually demanding'. So I really do try to give them time to tell their story and just listen … Best practice, I really feel is about listening … I think it's really easy to think that we hear things or that it's a certain type of caller and put a barrier up and not listen actually to what they are saying. V202

To listen. To accept callers the way they present themselves. To acknowledge them, if you like. To not judge them. V268

Volunteers described engaging in specific practices to demonstrate to callers that they were listening, and regularly discussed these practices as a method of ensuring that callers felt listened to. A strong theme in the talk about listening was the balance between saying things to callers, and not saying very much. Not talking too much, and the strategic use of silence to give the caller space and encouragement to talk, were widely featured strategies. At the same time, not saying *anything* may be taken as a sign that the volunteer is not listening. Allowing silences to occur was discussed as a method for allowing callers to have enough space to openly discuss difficult and painful feelings. Yet silence was also discussed as potentially dangerous, as too much of it may display inattentiveness to the caller, and this may even lead them to hang up. Repeating certain elements of what the caller has said not only demonstrates that the volunteer is being active in his listening, but may also be an element of displaying empathy with the caller.

I really do try and listen and I try and show empathy because I do realise that sometimes silence can come across as you're not really listening so I do try and use encouraging words. V202

… it's quite helpful to sometimes repeat phrases from what someone's said, which allows them perhaps to hear it back, allows you also to show that you're listening. V220

Offering certain phrases and sounds was also discussed as important to show that the volunteer is listening, but too much talk from the volunteer was felt to be inappropriate, and bad for callers. Volunteers who talk a great deal in a call were described as not listening, and as inadvertently supporting an inappropriate agenda of the caller. The data from volunteers shows an attempt to capture and describe this balance, and can indeed appear conflicting and contradictory as they argue for both silence, and a certain amount of talk from volunteers.

Well, yes, there are so many different styles but one thing I think that's important is not rushing the caller, giving them space, just allowing silence or just, not asking too many questions. Yes, and you know practice that is not quite so good when you hear too much of the Samaritan's voice on the call, then you think that the caller is, you know, maybe not getting enough space. I don't want to be too categorical about this, because you get a lot of callers who are very tongue-tied and you have to say things or you'd never stimulate anything. V211

We're trained to listen, and the way we do listen in the phone rooms is a very active listening process … it's reflecting back words and emotions and in certain situations, tones of voice or that sort of thing. To show that you're really acknowledging what people are saying to you and showing an interest in what they're saying, and following it up with open questions and, in a sense, trying to speak as little as possible. I'm always someone that believes in speaking as little as possible on the phone. V270

In this perspective the volunteer must remain focused on the distinctive opportunity the Samaritans offer, to provide a space for callers to confront their feelings and to stay with them, perhaps even encourage them to 'steer into the pain' rather than shirk from such a difficult encounter.

> *Exploring suicidal feeling is what we're really there for in the majority of callers we're there to talk to them about how it feels. So, you know, finding out whether they're suicidal is just the start of it, you know? Talking with them about the shape of their feelings, how they felt, have they done it, have they attempted before, have they thought through the plans, what was it like last time, all those kinds of exploration thing* V229

> *If we get to the point where someone says they feel so bad they don't want to wake up, they don't feel like they want to be around tomorrow. You know, whatever it is, when the conversation gets around to that, if it does, people value being able to talk about. No one else wants to hear this stuff, right? Nobody else wants to hear this stuff.* V251

Feelings

Volunteers talked a great deal about the focus of calls being – appropriately and actually – on an exploration of callers' feelings. Unwillingness of callers to orient the call in this way was a common reason for judging it to be inappropriate and even to end it. Callers who were assessed as not willing or able to discuss their feelings were regarded as unable to benefit from the emotional support service offered by the Samaritans. Branch observations, however, revealed an extended focus on feelings during calls to be unusual. Callers undoubtedly often welcomed – and benefited from – the opportunity to vent their emotions during a call, but this is different from the more reflective exploration of 'feelings' which is the ostensive purpose of the Samaritans brand of emotional support. In practice, volunteers tended to accept that callers could benefit from calls which were not about feelings, and that the service extended, albeit in a somewhat indeterminate way, beyond this focus. Observations in the case study branches revealed that the most characteristic volunteer response constituted a direct question to the caller. These often aimed at eliciting a detailed background to the caller's current circumstances. Many callers had a story to tell and wished to share this with the volunteer as the basis for understanding and discussion of their situation. Closed or direct questions helped the volunteer to piece together a coherent account of the caller's predicament, but could also deflect attention from the focus on feelings.

> *Sticking to emotions and feelings and things is sometimes …difficult. Because you obviously need to know a bit about the background of the caller, and the reasons why they're feeling bad, and the reasons why they're phoning you. And it's sometimes difficult to be able to know how much background you need to know and then, kind of, stop them from going on too much more about things, and people do sometimes have a tendency just to talk about the situation, not actually focussing on why they are feeling…. the way they are feeling. And I think that sometimes can be quite difficult for certain callers who don't want to talk about feelings.* V209

Volunteers attributed to the failure of a call to engage successfully with feelings to callers' unwillingness or inability to maintain such a focus. However, it was evident that in subsequently discussing the nature of calls with other volunteers, they themselves tended to focus on the context and narrative of the caller's situation rather than on his emotional state or response. In practice, it seems difficult, at least for many UK callers, to maintain a sustained discussion of their feelings. This activity lacks cultural sanction

and many people are simply not practiced in expressing themselves in such a manner. Callers may derive great benefit from contact with the Samaritans, but perhaps for reasons other than the opportunity to explore their feelings. Many phone not with any aim or aspiration to increase their agency in finding a means of 'moving on' from personal crisis and despair, but rather for support with everyday problems and 'ordinary' unhappiness in lives that are chronically difficult and unhappy.

In the context of many callers' desire to talk about things which deviate from the Samaritans nature of service, bringing a call back around to a focus on feelings is also a method of 'training' callers about what represents appropriate call content. At the same time, callers may learn that maintaining a discourse on 'feelings' is a successful strategy for continuing to engage a volunteer in a call.

> *People can moan, people who just want to chat … I don't have a lot of time for them, and I do tend to [end] the call quickly. Uh we're not a chat line, we're not somebody to have a natter to and off you go. Somebody who's genuinely lonely, then yes, I'm happy to talk to them about how they're feeling and why they're feeling how they are. But again, that sometimes tends to turn into a genuine chat and once that happens I'll close the call down fairly quickly.* V403

> *There seem to be periods of time when you maybe get quite a few of those sort of calls. Someone is wanting to just chat about what they're doing and where they're going and you know, someone's obviously very lonely and wants to chat about various aspects of that. Again, it's trying to get them focussed back onto talking about how they're feeling, or you know, just, just, in the end, just winding up the call really.* V243

What to say and how to say it

The volunteer data incorporates considerable attention to the topics of tone, pacing, and timing when talking to callers. Volunteers must have a suitable tone of voice, they must go at a suitable pace, and must have a sense of timing for when to deliver particular elements of a call. An appreciation for these things is discussed as an essential quality in volunteers (and potential volunteers) and is addressed in training. Managing these issues was discussed as essential in encouraging callers to open up to volunteers and discuss difficult subjects.

> *Well, handling the calls, we go through the various qualities we expect out of the Samaritans; the training, we're looking for volunteers who are empathetic, and not directional, they don't give advice, they appreciate the value of timing, of silence and so on and so forth and the way they deal with the callers. I suppose we're looking for things like good tone of voice.* V213

> *When I was with my mentor, sort of the first couple of calls I took, it was [chirpy] 'Samaritans, can I help you?' and you know, obviously it's the tone of your voice, it's how you talk and it's also how you don't talk.* V226

Apart from ensuring that they ask the caller about their level of suicidal ideation, call content is discussed as not being pre-determined and as following the content of the callers' talk. Volunteers claimed not to work according to any kind of script, and take their cue from the caller in terms of what to say and how to move the call forward. The tone and pacing of the volunteers' talk should be 'well fitted' to that of the caller, and also during a call should the 'mood' change. Not only will these paralinguistic features be fitted to those of the callers, but the content of the volunteers' talk will also be altered from call to call depending on the content of the callers' talk.

Whatever I say is totally dependent upon what I hear because you have to take your cue from the caller. I don't see there's any other way of dealing with that. I always try and focus on feelings and we always ask the suicide question … I think any response or anything I say is totally dependent on what the caller's actually saying. *V218*

We don't have a script of any type, so we take what the caller says, you know we follow up on what they're saying so we don't have a list of questions or anything. *V251*

Notwithstanding these assertions that each call was taken entirely on its own terms it was evident throughout all data sources that volunteers routinely utilise stereotypical phrases in response to specific prompts from callers, or to manage key transitions in the call.

It tends to get to a certain point I will say something like, 'Right, well, we've been speaking for over an hour now, maybe it's time we wrapped up the call.' V216

There are lots of phrases one gets to use. ... I suppose I have a selection, you know, 'Does it ever get so bad that you think of taking your life?' I must have said that a great many hundreds of times, but I don't always say it quite the same way. *V207*

Although volunteers described using silence strategically as a means of respecting the caller, and allowing space to gather and express thoughts, callers tended to be less enthusiastic about this device (Chapters 4 and 10). A few volunteer respondents described taking a more proactive stance, actively challenging the caller and pushing them to think about what they are doing, rather than 'giving them an easy time' . The tension between maintaining a focus on the caller's feelings, and either permitting the caller to engage in, or allowing oneself to be drawn into, 'general chat' was often unresolved, and reflects the difficulties of maintaining a uniform stance in the face of the diversity of calls and callers with which the volunteers have to engage. There is another tension between the commitment to allowing the caller to remain 'in control' of the call, and the resistance to permitting him to deviate from the appropriate agenda set out by the nature of service.

I think it's very important that the caller is in control of the call. Quite often when people are feeling in the way that they are, very distressed, they feel that they are disempowered and I think that it's very important that they feel empowered during these calls. *V202*

It sounds so basic but you know, you will occasionally hear volunteers and you can hear that they've been dragged into a conversation they shouldn't be having. Because they're doing most of the talking. *V214*

Defining and categorising inappropriate calls

As discussed earlier (Chapters 4 and 5) the number of calls made to the Samaritans from people who fall within the paradigmatic category of 'the good caller' is relatively small. Many calls are from regular or repeat callers, often people affected by quite severe mental illness, those seeking sexual gratification, or whose lives are chronically lonely and unhappy. Volunteers expressed a range of views about the appropriateness or otherwise of such calls, depending on their perspectives on the nature of the Samaritans service.

A frequent type of caller discussed by volunteers is the chatty and / or lonely caller. Volunteers treated the supporting of such callers as a long-standing and troubling issue, and expressed uncertainty as to whether the organisation should be allowing contact from them and whether, indeed, it was possible to achieve a 'good call' with such individuals. They also recognised that these callers had a level of need which Samaritans was able to meet. Thus, while such callers were treated as a difficult issue for the organisation, they were still allowed some time by volunteers.

> *Yeah. Tricky, isn't it, because we're not here to provide a service for people that are lonely, and sometimes it can feel like that's the case. Especially if someone's been phoning for ages. It's frustrating,, but at the same time, you feel sorry for these people who are phoning just because they're lonely... It's a very tricky situation, I think, very difficult subject.* V209

> *Yeah. I actually, [laughs] feel very sympathetic towards a lot of these people. And, usually, when that happens, they're people whose lives are very lonely and loneliness, it's very painful. It is really difficult to try and draw a line because you know, it's no real answer to their problems, to become dependent on the Samaritans as well.... quite often it's... nothing is upsetting them. So, you've got that side of it but then, to try and keep it to sort of five or ten minutes or so.* V211

> *Give you an example of a client who suffers from acute loneliness and she's very she's very isolated, and she has no one, basically, in her life that's close to her, and as a result, she suffers from acute loneliness leading to depression and I try and encourage her.* V220

> *To be quite honest, we cannot be on the line, phone with them all day, just because they're scared of being alone.* V263

Volunteers tended to use an organisational footing when justifying why these callers will not be spoken with (e.g. 'We cannot be on the phone with them all day'), and a more personal footing when describing why they do talk to them (e.g. 'I try and encourage her'). This may be because it is easier for Samaritan volunteers to invoke an organisational approach when discussing who they will not support, as opposed to marking such reticence as a purely personal decision. As is apparent from the data presented above, volunteers varied greatly in their attitude to, and handling of, different types of call. In addition, there is a difference between the abstract idealisation of the volunteer's approach to taking 'good calls' and the more pragmatic response to those which are more typical and mundane. Despite the orientation of the organisation and the volunteers towards 'being there' to provide emotional support for individuals passing through crisis, the reality is that the majority of calls are of a very different nature. This is not to say that callers do not derive great benefit from their contact. However, it does raise a dilemma about how the volunteers should best respond to the diversity of needs and expectations expressed by callers, and how understandings of the proper remit of Samaritans should be negotiated between those who use, and those who provide, the service.

Callers with mental health problems

Samaritans receive many calls from people experiencing mental health problems, including conditions which are chronic and severe. This was borne out by the study respondents. Nearly half the online survey respondents who had contacted Samaritans more than once specified mental health issues as at least a contributory reason for their calls (Chapter 4). This figure was higher for interview respondents, the majority (77%)

of whom described experience of (often severe) mental illness (Chapter 5). Many of the email messages available to the study also report ongoing issues regarding mental health problems. These calls could be very difficult to handle, and volunteers sometimes expressed doubts both about their ability to provide support for such callers, and whether the Samaritans was an appropriate service for people with mental health problems to use (Chapter 9).

> *I think it's when you have particularly manipulative calls, callers who, perhaps suffer with mental illness as well, I find those quite difficult because it's much harder I think when someone has a mental illness for them to understand what we can and we can't do and I find those calls quite difficult.* *V227*

In addition to doubts about whether the mentally ill constituted an appropriate category of caller, volunteers experienced difficulties in employing the techniques of active listening and exploring feelings with people who were severely ill or floridly psychotic. Some volunteers were prepared to abandon any attempt to stick to the rules and used their best judgement about how best to respond, acknowledging the universal value of simple human contact and kindness for all callers. Several volunteers reported having been reassured by branch psychiatrists who endorsed the value of their role in simply 'holding' the caller for the time they spent together on the phone. Volunteers acknowledged their status as 'amateurs', and the absence of training on mental health issues figured prominently in discussions of Samaritan training (Chapter 3). They felt out of their depth in dealing with people who were severely ill, and reluctant to get further involved in ways which would require them to make judgements about issues of diagnosis and referral. However, the occurrence of such judgements was apparent in the frequency with which callers were advised to consult, or comply with, professional medical and psychiatric help (Chapter 7). At the same time, the view that the Samaritans functioned informally as a de facto extension of the professional support services, especially out of normal office hours, was widespread. Volunteers perceived not only that many people with mental health issues contacted the Samaritans when their normal support team was not available but also that this course of action was formalised in their care plans. These views were endorsed by data from the caller respondents (Chapter 9).

Within the branches volunteers entertain doubts about whether Samaritans should accept those with severe mental health issues as appropriate callers. However, at an organisational level, there has been an increased focus on establishing partnership working with other agencies, including voluntary organisations as well as professional health care and social services. Several branches have already established referral schemes with local services and a number of study respondents had either been involved in these or were interested in their development. However, the reservations of many volunteers in dealing with callers with serious mental illness, and the ambiguity of their status as appropriate callers within the remit of the Samaritans aim and purpose, raise some issues for the future development of the organisation (Chapters 9 and 11).

Judgement

A fundamental principle of Samaritans' support is that the volunteer abstains from making judgements or suppositions about the caller. As discussed above, there is a tension between maintaining a non-judgemental attitude and protecting the self and the organisation against manipulation and abuse. Thus, in practice and inevitably, the volunteer is always on the alert both for the 'genuine' and particularly the suicidal caller and, at the other end of the spectrum, the 'inappropriate', particularly the 'TM' caller. The difficulty lies in deciding not just which are genuine and appropriate, but also what the underlying motivation for the call might be. Apparent chattiness might mask a

deeper distress in a caller who was trying to pluck up courage to disclose this to the volunteer. Or it might simply be that the caller was feeling lonely and found talking to the Samaritans an enjoyable distraction in an empty day.

Volunteers were well aware that the accounts of some callers should not be taken at face value. However, it could be extremely difficult to differentiate the 'genuine' from the fake, fantasy or wind up call.

> *He sounded like somebody who does ring as a sex caller and so I was kind of ready to drop him with, 'I'm sorry, we can't take this call anymore', or whatever. And so, then thought, 'No, stop, slow down, really start listening to what he said.'. And it turned out he wasn't a telephone sex caller at all and that has made me slow down a lot, I think, on the calls that I take and just give people a chance to get into it.* *V229*

> *I've probably got questions now that would enable me to at least suspect that this might not be altogether right. Sometimes, I mean, part of her story, …was that you couldn't imagine anything sort of more dreadful. It was one thing piled on another. And I think, now, I would think, really? Then, of course, you've got to be careful because it might be absolutely true.* *V214*

> *In broad terms, I 'go by the book', especially the importance of 'listening'. I suppose I've developed one or two personal attitudes through experience. One is a 95% rule for the inescapable tendency we all have to try to gauge the call:– if it's obviously a 'bad' call – inappropriate/just chatting etc, try to hold back a 5% 'margin' against the possibility that beneath/behind what comes out, is a 'real' call. Or, if the caller's story is totally believable and demanding of sympathy, try to keep the same very narrow credibility margin, in case of the later emergence of a different 'truth'. It's nothing to do with how the caller is treated, it's a bit of self-protection in how you* feel*.* *V228*

The nature of the anonymous and disembodied context in which volunteers engage with callers means that it could be extremely difficult to know if a call in which they may have invested a considerable amount of time was 'genuine'. This applies even to some sexually inappropriate calls, the nature of which may only gradually become apparent, and may even remain permanently ambiguous. Whilst the gambits of some regular callers may be picked up and their details recorded within individual branches or even across the country, it could still be difficult for different volunteers, even within the same branch, to recognise such calls.

In these circumstances, it was difficult for volunteers to sidestep the tendency to develop expectations of calls in terms of some degree of typification and stereotyping of callers. This could be a particular issue in dealing with regular callers. Talking regularly to the same caller, whatever their troubles may be, can lead to difficulties. Frequent encounters with the same person made it difficult not to develop some kind of familiarity, if not relationship. At the same time, volunteers could find it difficult to offer something new or fresh in calls which essentially repeated issues and content rehearsed many times before.

> *Just last night a call from one of our very regular callers, I can't take the calls afresh because she recognises me every time. I try really hard, it's really hard to keep that professional person, but she wants to relate to you as if you're her friend and you're not and so you just don't know how hard to push it half the time. I came off that call and I was talking to my colleagues about… how could I have handled that within what Samaritans principles are and it gets very blurry at that point.* *V402.*

To a degree, I think we should help people who are lonely, who need some contact with some organisation when, you know, whether it be Samaritans, that's fine. Personally, I have no problem with that. I have a problem with myself in being able to cope with some of those callers. Because when I recognise a regular caller who comes on, and I know that the call is going to go exactly like it did last time, and like the times before, my heart sinks and I wonder, and I've tried, to sort of progress the conversation some way, to move it forward, but no, whatever happens, these people are just, they just want to talk and they just want to talk about things they want to talk about and so be it. And I think you've just got to have a strategy of saying, 'Okay, well, I'll allow you to talk for so long', and then, I'll make gentle hints about winding the call up and they usually take those hints and they will go and they're quite happy with that. But I think that's okay, that kind of thing. V213

Avoiding the development of relationships with regular callers may be difficult. Indeed, the opportunity to engage in a relatively easy, familiar contact may sometimes be a welcome option over a contact with an unknown, distressed or suicidal caller. Observations revealed that each branch has a number of known 'characters' among callers, who tend to be on care plans, and some of whom are regarded with a degree of indulgence if not affection. Some volunteers may enjoy speaking to regular callers, and will be permissive with them, even, as illustrated below, allowing them to have the local branch number so they may maintain contact with local volunteers (even though this is acknowledged to be inappropriate). Volunteers were aware of the issue of dependency and how they are meant to handle repeat callers, but avoiding familiarity could be difficult. Not only did different branches and individual volunteers vary in the way contact with regular callers was handled, a further source of variation could be the volunteers' perception of the busyness of shifts: lonely callers were more likely to be given time if the volunteers did not feel under pressure, and may even welcome the opportunity to engage with callers as a means of passing time.

There are callers that you, you do get to know. And, so you develop a shorthand with them because you know their scenario and it's fairly easy to at least have some touch base instead of your brain racing and thinking, 'God, what am I, what can I say next?'... This lovely old lady, she just likes to talk, and to me, if we'll help her, that's what matters. I must confess, she likes the X branch and I actually gave her our number last time, because she prefers talking to us, and maybe I've done the wrong thing but we all know her and she enjoys talking to us. V214

With an average of about 80 volunteers manning the rotas in each branch even regular callers are likely to be answered by a range of different people. This makes it easier for volunteers to avoid developing a relationship with individual callers, and to spread the strain of taking difficult calls. At the same time, the diversity of volunteers also makes it difficult for individuals to recognise callers who have been designated 'inappropriate' and/or subject to care plans.

Volunteers are required to field a wide range of different types of call, in which they deal with people who may be not only deeply distressed and disturbed, but also obscene, aggressive and abusive. Many volunteers, in the branches and in interviews, accepted this as part of their role: something they set themselves up for in providing the service, but a price worth paying in order to make themselves available to the genuinely 'needy caller' ('I don't mind being had'). Others found this harder to accept, and several respondents commented that they found inappropriate calls more difficult to deal with than those from callers who were overtly desperate and suicidal. Nevertheless, only

occasionally was a sense of frustration and admission of a 'non-Samaritan' or 'unprofessional' response expressed.

> *The most difficult ones to deal with are the ones like the abuse, you know, abusive callers, people who are abusing the service, people who are really being nasty with you and being insulting and that kind of thing, and that's the most difficult thing to deal with* V213

> *One in particular, a man was obscenely and, you know, violently abusive to me, and I didn't exactly stay cool, calm and collected and in control, I did ask him some non-Samaritan questions, shall we say?* V268

> *Well, I mean, you get TM calls, that's part of life. And you get very, very persistent ones. There's one that we have in particular, I've had them three times in one night. And I (think) the last time I said to him, 'Just get a life'. And I know that's the wrong thing to say, but he's very persistent and he's very sad really, you know? If he's having to call us, then he obviously doesn't have much of a life and he's obviously very lonely. And there's lots of that about. V214*

Nature of service

The recognition and handling of inappropriate calls relate closely to volunteer constructs of the nature of service provided by the Samaritans. Dealing with 'inappropriate' callers – who phone because they are lonely, dependent or want a chat – is challenging from the point of view of applying the core volunteer qualities which are devised for 'genuine callers'. This is one reason for variation among the volunteers in their handling of calls. Although volunteers were consistent in their acceptance of 'what Samaritans do', they varied widely in their interpretations of how nature of the service should be interpreted and applied and how they responded to the many calls which fall outside this remit.

Regardless of their stance in relation to inappropriate, manipulative and abusive calls, respondents acknowledged that the nature of calls the Samaritans received was very different from their initial expectations as a newly trained volunteer (Chapter 3).

> *I think that's one of the things that surprises all new Samaritans, certainly surprised me and most people is the number of calls that aren't [laughs] about deep emotional feelings of distress. And there are an awful lot of them. But since I've been doing emails, they seem to be much more poignant really, the emails. You don't, you don't get crap emails, silly emails, you know, very, very heartfelt and deep, you know. But then not everybody likes to do emails, do they?* V245

As with other types of call there was variation in the volunteer responses to TM and abusive calls, from zero tolerance through to amused albeit derisive forbearance. Echoing Chad Varah's stance when founding the Samaritans [8], a few volunteers, mainly male, expressed the view that even the sex callers were motivated by underlying legitimate problems if only the volunteer was patient and skilful enough to unearth them.

> *Sex calls don't get to me except feeling, you know, you can easily be keeping somebody off the line that needs the service. And, you do try to see if you can coax somebody into a different way of, or talking about the emotional side 'Do you need to do this?', You know, if they can talk about the gaps in their life or something, if you can get them on to that, and I try as far as possible. But very often, it's difficult to do.* V211

I: What do you find the most difficult aspect of being a volunteer?

V222 Paedophile calls..... I don't actually know why they phone. Some times they may be, I've not had it a lot really but to think that you can't judge anybody and you have to take everybody the same is really, really hard to be empathetic……….

Oh well, I mean, sometimes. I would be a liar if I said I hadn't felt really, really, really, really, really, what's the word? negative, about some of the calls that we've had and we get. But most of the time, I hold myself. I try and do two things, the first is I hold myself back, to treat everybody as a person who has a right to call us. And the second is I often focus back on suicide and suicidal feeling. V229

In theory, even when the call was closed down rapidly in response to a TM caller, the volunteer should offer the standard invitation for the caller to phone back any time they wished to talk about their feelings, alongside the explanation that as they were making an inappropriate call, it was about to be ended. In practice this did not always happen. Where the nature of the call was evident from the outset the phone might be put down very abruptly. During the branch observations, a few volunteers, all male, ventured the opinion that some of their female colleagues were inclined to be too hasty in assessing a male caller as TM, and also in instantly ending such calls. However, male volunteers acknowledged as they were on the receiving end of few, if any, TM calls, it was difficult to share the experience or understand the unpleasantness of such calls for female colleagues.

The offensive nature of some calls strained the volunteers' tolerance and capacity for impartiality. From the outset, Samaritans has excluded those who abuse, as well as those who are considered unable to benefit from, entitlement to use their service [8]. However, the criteria for such exclusion may be variable, uncertain and hard to apply with consistency, especially given the uncertain, ambiguous nature of many calls and the difficulty of identifying the 'genuine' from the manipulative, abusive or inappropriate caller. Although non-judgmentalism is a core principle of Samaritans, it appears that, in practice, a great deal of judgement necessarily goes into the effort to establish which callers merit such entitlement and which do not.

Manipulative Callers

Many callers could be construed as in some way manipulative, in attempting to subvert the purpose of the call to meet their own purposes rather than complying with Samaritans' agenda. The out and out sex callers were the most troublesome category. However the lonely, dependent and needy callers who phoned very frequently, and often with an identical script were considered by some volunteers to be at best time wasting and at worst abusing the service. A further category was the fantasy callers, those who phoned again and again, with an apparently dreadful story to tell, and with declarations of active suicidality which were never acted out. These were all difficult categories to deal with – indeed, a number of volunteer respondents described the various kinds of inappropriate calls to be much more difficult than the genuinely desperate and suicidal. The suspect nature of many calls, alongside the requirement to retain an open mind and give each caller the benefit of doubt, meant that volunteers were constantly at risk of being duped. Volunteers were well aware that they risked being the target of such manipulation, and even that some callers were, more or less deliberately 'playing games'. These could be the most deeply resented calls of all.

Sometimes, yes, yes, especially if you haven't heard that person before, can lead you along for quite a while, and I'm sure ...they're getting some kind of satisfaction out of outwitting you in a sense. And, other kinds of calls where people are sort of pretending to be in a situation and you, and you find out about this over time, because their stories don't quite tally and other, you know, things that happened, sometimes, it's done out of a sense of acting , especially with younger people. *V211*

I find sex calls much less of a problem than people who, I had one man who was very, very convincing ...and it was extremely scary. And that I found more damaging to me, because I genuinely thought I was stopping someone from, you know, pulling the trigger or whatever he was going to, actually, it was rape, that's right. So, that was very manipulative and after a while, and I was there, and there was another very experienced Sam helping me say stuff and then eventually someone recognised, he said something that rang a bell and it was an End On Recognition. And I found that more... You know, that I find more upsetting than the sex calls. Realising that I had been played like I'm a puppet. That is more upsetting. *V220*

Callers could be subtle in their approaches, with the nature of the caller's purpose only being uncovered some considerable way into the call, or even afterwards, as the volunteer reflected or in the course of discussing the call with other volunteers when the known profile of the caller might emerge. These doubts were observed to be a common response to calls. Volunteers could engage in extended and very intense calls, perhaps from callers claiming to be in process of suicide, but which were subsequently recognised to be from repeat or manipulative callers. Such calls go undetected unless and until a caller profile has been established, by which time earlier calls will have been inappropriately rated in the nature of contact form. Reluctance to risk alienating a genuine caller may inhibit an urge to challenge callers even when the volunteer feels quite confident that a caller's story may not be true.

Yes. And the dilemma, I suppose, partly because you realise when you put the phone down, after a quarter of an hour [laughs] and it suddenly becomes clear what this was, and you feel annoyed at yourself for having been strung along like that. But, if you don't give the benefit of the doubt and allow yourself to, you know, that to happen to you, then, in some instances, a genuine caller would have been put off because they don't, I mean, they're sometimes, you think this is going to turn out to be a sex call and it isn't. *V211*

An established strategy of flushing out the inappropriate caller – particularly TM calls – is to 'challenge' the caller by abruptly focusing the call on 'feelings', and specifically by asking about suicidal feelings. Thus it is thought that the 'genuine' caller will respond positively to such an intervention, while the 'inappropriate' caller will be wrong-footed and 'turned off'. Although evidently quite effective, this is an aggressive and perhaps a dangerous strategy to pursue, given the risk that a 'genuine' caller may be precipitously confronted with the prospect of discussing issues in advance of his readiness to disclose them. The dilemma for the volunteer, being only human, is how to reconcile the need, as a Samaritan, to take every call at face value and give the caller the benefit of the doubt whilst at the same time observing due respect for his own sense of self esteem and competence as well as protecting the service from abuse. Some respondents were philosophical about this, others clearly found it difficult.

Caller Care

The caller care system is designed to monitor caller use of the service, and intervene to restrict access of callers who are deemed to be either mis-using or becoming dependent on this. A previous investigation of volunteer experience of taking calls in 20 branches across the UK reported that a small group of regular callers (1.5% of the 65% of callers who gave their name) accounted for an average of 25% of caller contacts. Nearly two thirds of calls were from repeat or regular callers and 17.5% of contacts (on average) were with callers on care plans [9]. Although the support available to callers is ostensibly unlimited and unconditional, in practice there are limits to supply in relation to an excessive demand for listening. It is the job of each branch caller care team to regularly review the call logs to pick up on the pattern of use of callers already on a care plan and identify others who should be placed on one. Plans may be devised for phone and email callers. Profiles of such callers are posted on notice boards and in branch record books and may be distributed regionally or nationally, depending on the nature of the caller and his designated plan. Action plans indicate an abusive caller and that contact should end on recognition (EOR). Care plans are typically applied to those who make contact very frequently especially if they are deemed to be manipulative or demanding. When the decision has been made to implement a plan the caller will be phoned by the caller care leader (or a member of the caller care team) and ideally the suggested restriction on use of service will be discussed and agreed with him or her. The rationale for such action is to prevent the caller from becoming 'dependent' on the service which rather than helping has become an obstacle to the individual's capacity to 'move on'.

Care plans typically specify that the caller is allowed a maximum number of calls within a specified period (day or week) and/or of a limited duration (e.g. 10 or 20 minutes). The caller care scheme constitutes unregulated use of the Samaritans service as being unhelpful and inappropriate, whilst serving to reduce the demands made by frequent and needy callers. Although care plans are supposed to benefit the caller in discouraging dependency, it was evident that some callers – whether on or off care plans – had been supported extensively by individual branches, making very frequent contacts over an extensive period, perhaps over many years. The caller care scheme is difficult to implement even at branch level. Although frequent callers may acquire a regional or even a national profile, they can be difficult for volunteers to recognise and identify, especially if they have not spoken to them previously. This difficulty is compounded by the tendency of some callers to operate with several different personae. Callers on care plans have a good chance of getting through to a volunteer who, being unaware of their status, does not implement the specified restriction. They may also direct their calls to other branches in an effort to evade the plan. Different branches seemed to have developed distinctive cultures of tolerance in relation to longstanding and regular callers, and how they record and manage information relating to them. Within each branch individual volunteers also differed in terms of their response. The demeanour of the volunteers was observed to change markedly in dealing with a caller recognised to be subject to restricted use of service. Such callers appeared to be awarded a different, and often less valued, status. Indeed, as a general rule, there appeared to be an inverse relationship between frequency of contact and caller credibility. One volunteer acknowledged that for a caller to have an established record within the branch constituted a kind of stigma. This certainly makes sense within the precepts of the service: almost by definition emotional 'emergencies' such as those the Samaritans support are not continuous or frequent occurrences. Calls could be terminated brusquely and abruptly when allotted care plan time was up, and volunteers were sometimes heard to engage in argument or remonstrations about the nature and justification of the plan.

> *I: Has there ever been a time you've found it difficult to deal with a call in the way prescribed by Samaritans?*

V215: Erm..yes...callers that ...where there is a care plan to follow and if you don't have any recognition of them, if that's not recognised immediately, it can sometimes take a while to end the call.. Having built up a relationship during the process of the call ...-that I actually have to say to them, ' I'm not supposed to talk to you-'

I: -not supposed to talk to you! [laughs]-

V215: -[laughs] – ' this isn't supposed to be helping you' [laughs].

Although some reservations were voiced about the caller care system, most volunteers seemed to accept the scheme as being of benefit to callers. Volunteers were never heard to question the reasons for a caller being placed on a care plan, or consider that this was not appropriate. In contrast, frustration was sometimes expressed that certain callers had not been subject to such plans. From the callers' perspective, however, the rationale for such actions could be far from clear. A number of caller interview respondents described making extensive use of the service, apparently without being subject to any constraint. Some callers appeared to accept the terms of contact imposed by their care plan. Others respondents described their devastation, especially when the care plan had come with no warning and, as they saw it, without justification. However, few volunteers commented on, or expressed awareness of, how care plans could impact on callers.

Then, about two weeks ago, out of the blue, when she was visiting the branch for a face to face (apparently offered and encouraged by the volunteers) a volunteer (she does not know his status within the branch) walked in, interrupting the face to face and told her in a peremptory fashion that she was phoning too often, and that henceforth she would be put on a call restriction – so that she can call only three times a week. She said that she had only been doing what the volunteers were encouraging her to do – phone back anytime she needed to.
S168 Interview Notes

She has made lots of calls by phone. She has been told that she is using the service as crutch and has been asked the question –'What makes you think that we can help you?' Said that she cannot stand the term "move on". She would never use that term – especially when referring to grief. S173 Interview Notes

I think, they're expecting to be listened to. Some of our callers get quite upset when you tell them that you can't listen to them, for instance, and you've said, you know, we can't help you and then they're slightly off, because they say 'But you're supposed to listen,' and all of that stuff. V206

Dependency

The caller care scheme is oriented towards the wellbeing of callers. It is also a means of excluding inappropriate and abusive use of the service, and rationing access to overly demanding (dependent) callers. However, callers are routinely encouraged to contact the Samaritans whenever they need support, and are assured that the volunteers are there for them at any time. This is a standard ending routine of the majority of contacts. Within the Samaritans, there is an expectation that such use will be episodic rather than indefinite, and that callers who exhibit a pattern of frequent or ongoing contact are in fact becoming dependent on the service which, rather than helping, has become an obstacle to their capacity to 'move on' and re-establish autonomy in managing their lives: the aim and purpose of the Samaritans is to 'provide a crutch in a crisis' and not 'a walking stick for life' (V218).

If somebody's having a really bad time, and it's up to the caller to define what a bad time is, but whatever a crisis is we're quite happy to support them through that if that helps. But we do expect that there will come a time when they will be able to move on and literally stand on their own and not need to call us.
V218

The difficulty with this position, highlighting a basic tension within the nature of service offered by Samaritans, concerns the reconciliation of the caller and the volunteer definition of crisis or 'what a bad time is'. Callers could take a very different stance on this compared to volunteers. Some respondents described being in a permanent or recurring state of crisis. Many clearly expected the service to provide ongoing support for people who were chronically unhappy including many who experienced severe and enduring mental health problems, i.e. who had no expectations or felt capacity to achieve a state of resolution or recovery (Chapters 4 and 5). Unconditional respect for the individual and his right to use the service, and acceptance of the caller's perspective and reasons for calling, are core Samaritans principles. In practice, however, in delivering the service it proves necessary both to impose boundaries and restrictions on entitlement, and make judgements about the appropriateness of callers and the legitimacy of their reasons for contact.

Self disclosure and exchange relations in the contact between caller and volunteer

A basic principle of active listening is to focus the call entirely on the caller. The volunteer is there to listen and to facilitate the caller's exploration of his feelings. Consequently, it is important that the volunteer avoids being drawn into a general discussion of either the caller's situation or his own.

That is very dangerous, to share that with the caller, because they then think you're their friend and a friend we're not. We are there to listen and help ease their pain but a friend on the phone, we can't be, can we, really? So that is a very dangerous thing to slip into really. *V263*

... in an attempt, I think, to avoid dependency on a particular volunteer, it's always advised that, you know, you don't disclose or become too attached to callers. *V240*

In addition to remaining anonymous, the volunteer should not disclose personal information or give any intimation of his feelings or judgements about the caller or the caller's options. For the volunteer to assume that it is possible to really know what the caller is experiencing, even in the face of apparent similarities, is presumptuous and unwarranted.

And to say things like we do in everyday conversation 'I know how you feel!' well, no, we've learnt that, I learnt very quickly before in training that ... you don't know how someone else feels at all. Even if you've been through what might be as near as makes no difference exactly the same accident or whatever, you don't know how they're feeling. *V224*

Non-disclosure is a protective and distancing device, enabling the volunteer to avoid any sense of personal engagement or the development of a relationship with the caller which is the normal consequence of social exchange [10]. Non-disclosure produces asymmetry, positioning the caller in an unequal relation vis-a-vis the volunteer and maintaining the volunteer's superiority in the transaction of the call. The caller is encouraged to divulge

his most intimate thoughts and feelings, while the volunteer makes no response in kind. This asymmetry constructs the caller as intrinsically a flawed and suspect person. The caller reveals a spoiled identity while the volunteer maintains an organisational persona which is inscrutable. This violates a deeply engrained principle of social reciprocity and moves towards more medicalised formats of exchange. As a form of interaction it is both difficult and troubling [10].

> *I sometimes find it hard not to disclose personal stories or details if asked directly so I try to use a different name and develop a different persona when I'm on the phone.* *V215*

> *I try to bypass the questions, but, sometimes I have said, you know, 'The call's not about me. It's about yourself', or just try to say it in a nice way but sometimes you think, 'Ooh, would it have hurt to have just said a little bit about that?' But I do understand the reasons, it's because of the befriending really.* *V261*

Although respondents expressed a clear commitment to the principle of non-disclosure, in practice, the boundaries could be hard to maintain. As discussed in Chapter 7 volunteers frequently offer advice to callers – more or less overtly - and this can be construed as entailing a degree of personal involvement in the call. For volunteers as well as callers, non-disclosure could impede the development of rapport or empathy within a call. Maintaining distance was especially difficult in relation to regular callers who were well known throughout the branch, and may have spoken to local volunteers frequently.

> *I guess sometimes I find it sometimes a little bit difficult to...not give anything away about yourself. So, for example, a caller might sort of ask a question about yourself which can seem almost quite innocuous, you know quite gentle, but we're not supposed to give anything back about ourselves and I think that's quite hard sometimes when you're trying to build rapport. You've not got to give back.* *V261*

> *You know, you do speak to the same people, they do ring up again and again and, a lot of the same people who remember me, I remember them, so* *V240*

In addition to focusing attention on the caller, non-disclosure protects the volunteer from the violation involved in sharing the self with strangers, especially where these might be persons of dubious character or integrity. Indeed, callers who persist in requesting personal details of the volunteer are likely to arouse suspicion. Samaritans receive many calls of an inappropriate, offensive and manipulative nature [11]. Many of these are 'sexually demanding' ('TM') calls. Others may be from people who phone to be intentionally offensive, or who may present with hoax or fantasy calls. Thus, in every call, the volunteer risks an assault on his personal identity through being deceived or 'wound up' by callers.

> *You know, you really want to be angry. But a very difficult part of that is picking up the phone the next time and not letting it show in your voice that you've already picked it up thirty times and there's been nobody at the other end or.... I don't find it difficult to dismiss them from my mind though. I don't feel that either the sex callers or aggressive callers are aiming anything at me because they don't know me. And so I don't feel threatened by the one or particularly distressed by the other.* *V205*

A more equal exchange of self during calls would result in a more intense sense of betrayal and loss of face afterwards [12], in the event that the call is assessed to be in some way fake, and the volunteer a dupe. Some volunteers routinely adopt a pseudonym when talking to callers. Others use this only when they sense or anticipate that a call might be in some way inappropriate: indeed, to the observer, hearing a volunteer identify themselves by pseudonym was an immediate cue to the nature of such calls. The vulnerability of the volunteer is made particularly acute due to the stricture to abstain from judgement and censure and to accept the credibility of the caller throughout the call, unless or until it becomes apparent that the call is fake. Some calls may be instantly recognised as sexually demanding or otherwise inappropriate. In others, it may never be apparent whether or not this was the case, or it may take a considerable time before the volunteer realises the underlying motivation and purpose of the caller, and perhaps that he is speaking to someone with a history of similar calls.

Setting oneself up for 'being had' is an occupational hazard of the volunteer. Although acknowledged, the experience is never pleasant. It is understandable that volunteers should seek to buffer themselves from the identity threat entailed. However adherence to non-disclosure, especially through resorting to formulaic responses could be experienced as a rebuff ('This call is not about me, it is about you'). They illustrate the complaint by callers that the volunteers' responses could be 'robotic', 'scripted', 'formulaic' or 'impersonal' (Chapters 4 and 10). Especially if they are new to Samaritans, callers may ask for details of the volunteer as a means of finding out if this is a person he can trust and in whom he can confide. Some may innocently be trying to observe normal niceties of interaction, or perhaps attempting to resist or at least reduce the interactional asymmetry of the call. Yet others may welcome the opportunity to focus the call entirely on themselves. This would not normally be available in interactions with friends and family or wider social networks.

Ending calls

Although the Samaritans service may ostensibly be presented as demand led, as discussed above, in practice there are limits to the length as well as frequency of caller contact. The duration and ending of calls is another area in which volunteers frequently exert active management. Long calls may be regarded as inappropriate, and even an inefficient use of resources. In theory, and ideally, the caller will take the initiative in ending the call – and this does happen. Often, however, it was evident that the Samaritan would instigate a process of winding up and concluding contact. This could be because the call had been long, no new or relevant material was emerging and the caller had started to go round in circles. Alternatively it might emerge – sometimes after a considerable time – that the call was malicious or inappropriate in some way.

> *V216: No, not, no, no. I mean, most of the time, we finish the call.*
>
> *I: Oh, right. Oh.*
>
> *V216:Yes. Oh, well, certainly with me anyway. ...I mean, I do tend to have quite long calls. I mean, we're told in training, Usually your call won't last more than forty five minutes because after that point, you're starting to go round in circles... I've had very good calls where ..I've talked for an hour and a half, maybe two hours and it hasn't felt like that but, generally, I think, supervisors have tended to take a dim view of me having a call any longer than an hour, I think. So, it tends to get to a certain point I will say something like, 'Right, well, we've been speaking for over an hour now, maybe it's time we wrapped up the call', and gently kind of, so a lot of the time, yeah, and that I've found really difficult. Really, really difficult...*

Unless I'm ending the call, obviously, then ... as you know, we normally stay on for at most an hour. If the caller's still going round in circles and nothing new is being made or they're a regular caller, and you don't think it would help them stay on the phone for much longer, then I suggest that they call back another time when they're feeling they'd like to talk V240

So, we tend, it tends to get to a certain point I will say something like, 'Right, well, we've been speaking for over an hour now, maybe it's time we wrapped up the call,' and gently kind of... V216

Volunteers have a variety of strategies for winding up calls. For example, they might ask, 'Has it been helpful for you to talk to Samaritans today'; suggest the caller now needs time to sleep, or to reflect on the discussion, or sometimes to bluntly mention that 'We have been talking for a long time now', and call attention to the fact that the discussion has become repetitive and is 'going round in circles'. Closing sequences routinely include an assurance that the caller can phone again at any time ('when you need us'), and that there will always be someone there to answer the call. Sometimes the volunteer will take a very strong and directive approach to ending a call – perhaps even to the point of being curt and perfunctory. This happens most obviously when the volunteer identifies a malicious or TM call, in which case they may very quickly end the contact. The phone might quite literally be slammed down – perhaps with a perfunctory admonition about the call being inappropriate. However, as seen above, the assurance that the caller can *always* contact Samaritans again in the case of genuine need and distress extended even to abusive and TM callers, who are consequently offered a mixed message about whether or not they can contact the service again. Another abrupt ending involves callers on care plans, when the volunteer assesses that they are on a regional or national care plan, and should not be talked to at all, or sometimes when they caller is given an allocated frequency and duration of call. Again, the volunteer in this case may terminate the call abruptly, reminding the caller that she has had her allotted ration of time, and telling her that she is going to put the phone down. Relatively few of the caller respondents reported the ending of calls to be an issue. Some felt that they had been in control of the length and ending of the call, and had had as much time as they needed. Others accepted the volunteer's initiative in bringing the call to a conclusion, acknowledging that they had needed help in ending it, either because they had become stuck in a rut, or perhaps lacked confidence and skill to engineer a conclusion to a very particular and unusual type of social interaction. A sense of doubtful or limited entitlement, and a desire not to make unreasonable demands on the service or the volunteer's time was also expressed by some respondents.

Chapter Summary

The Samaritans' offer of emotional support promises to be unconditional. However, in practice its delivery is subject to boundaries and restriction. Calls may be subject to limits of time, frequency and content. The prohibition on volunteer self- disclosure involves an interactional asymmetry which protects the volunteer against being impositioned, but assigns the caller a subordinate status. The data contained evidence of volunteers supporting callers with great skill and sensitivity. However, it was also apparent that the principles of active listening are difficult to implement consistently. Volunteers varied considerably in their styles and practices of taking calls. Respondents described the techniques and strategies for engaging with the caller in the course of 'active listening', to establish empathy, focus on feelings, and encourage candid self-disclosure by the caller, while withholding their own. The 'good call' for which such active listening skills are devised and primarily intended, is highly valued but relatively rare. Volunteers are presented with a great diversity of callers across a spectrum from the flagrantly abusive, regular, demanding, lonely, despairing, mentally ill and suicidal.

Many calls present pragmatic problems of management which are inimical to such principles of active listening. Contrary to the edict that all callers will be accepted without prejudice or judgement, volunteers are required to categorise callers in many ways, particularly with regard to whether or not they are 'appropriate'. While flagrantly abusive and sexually demanding callers invite rebuff, there is considerable variation in the boundaries volunteers set and how they deal with calls from persons judged to be lonely, chatty, dependent, manipulative or suffering from serious mental illness. Establishing the 'genuine' nature of such calls is problematic, and volunteers are vulnerable to being led on and duped by disingenuous and manipulative people. This was a source of frustration among respondents which some accepted more easily than others. The caller care scheme is intended to detect and ration access to callers deemed to be inappropriate or overly demanding users of the service. Though framed in terms of promoting callers' welfare (pre-empting dependency), in practice it provides a means of managing demand and protects the volunteers to some extent from unrewarding calls. However, the scheme is difficult to apply consistently or implement effectively within single branches, far less at regional or national levels. Volunteers generally accepted the plans applied to callers and the judgements of the caller care team. However, callers could be devastated by what they perceived to be an arbitrary and unwarranted restriction, especially when they felt they had been encouraged by the volunteers to make open and repeated use of the service. Volunteers could be viewed as encouraging dependency for which the caller was subsequently punished.

The Samaritans' offer of emotional support is contingent on the caller being able to take advantage of the opportunity to find a reflective space in which to develop insight and 'move on' in terms of regaining the capacity to cope with their lives. Thus the service defines the needs to which it wants to cater, the type of caller it wishes to engage, and the benefit to be derived from contact. However, the study findings indicate that the 'good caller' in these terms is empirically rare, and that many callers, perhaps the majority, define their needs and capacity to benefit from the service differently. Many callers orient to Samaritans as an organisation to support those who suffer from mental ill health, and value contact with the volunteers as an ongoing resource to support them during recurring crises or ongoing difficulties: they have no goal or possibility of 'moving on'. The nature of service as defined by Samaritans is misaligned with the needs of many callers who look for ongoing support to help them cope with the challenges of chronic illness or 'ordinary unhappiness', rather than the rigours of extraordinary despair.

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Chapter Seven: Giving Advice and Exploring Options

Introduction

This chapter discusses another aspect of handling calls, specifically the issue of giving advice and exploring options. It begins with an exploration of the salience of these topics for Samaritans before moving on to a closer look at the concept of advice, and then an analysis of relevant data from the current study. In SIT, new volunteers are told that exploring options is part of the role of a volunteer, and that they will be expected to discuss the options that the caller sees as open to them. This is in an attempt to respect the caller's autonomy in managing their own situation, and in an attempt to avoid the provision of advice. The information for trainers (taken from module 5B of SIT) is that new volunteers should be told that "Offering advice, self-disclosing, making assumptions and problem solving cause barriers and diminish our ability to offer emotional support". The practice of exploring options with callers is more in line with Samaritan listening, as the impetus is on the caller to discuss what they see as their available options. The prohibition on advice giving also protects volunteers from the consequences of providing advice which may be inappropriate, and which may result in negative effects for the caller. The provision of advice would also be at odds with the Samaritans approach of using volunteers who are lay individuals rather than professionals, who will support without judging the needs of the caller and without imposing their own beliefs.

Samaritans emotional support service: Giving advice versus exploring options

The data gathered for this study show clearly that the prohibition on giving advice and the Samaritan practice of 'exploring options' were important issues for both volunteers and callers. Advice was discussed by some callers as something they know is prohibited on the line, and as something they did not wish to receive, while being repeatedly discussed by other respondents as something they had been given on a number of occasions, as something they sought from volunteers, and as something which could be added to the Samaritan repertoire as a method for improving the service (as discussed in Chapters 4 and 10). While volunteers mainly claimed that advice is not provided to callers, callers reported that they had acted upon the advice of volunteers, leading to both positive and negative outcomes for them. Advice was also a topic of some concern and comment for the volunteers during discussions of the service, and it became clear during analysis that a great deal of advice was embedded in various elements of volunteer emails, in the form of questions, or posed as volunteers' thoughts (discussed in detail below).

Callers who ask directly for advice pose a dilemma for volunteers who must respond in ways which decline the request while remaining supportive, and which encourage the caller to continue to discuss their troubles. Additionally, in the attempt to follow the Samaritan practice of 'exploring options' with callers, volunteers must engage in talk about potential courses of future action which may remedy the caller's issues, or at least allow them to manage these. For example, a discussion on the impact of financial difficulties on emotional well-being on the website states[58]:

[58] http://www.samaritans.org/default.aspx?page=7769

Samaritans doesn't offer advice to people with financial or debt problems but we do discuss options with people who contact us. Samaritans believes that, given the time and space to work problems or difficulties through in confidence, people can develop an inner strength and perspective to find their own way forward.

To avoid the provision of anything which could be heard as advice, volunteers would have to discuss these potential courses of action in ways which do not exhibit any preference, or any notions of whether the actions are normative for a specific situation. This may be difficult to achieve in practice, requiring much careful navigation through these discussions. This is not to say that volunteers do not engage in these practices successfully, and it may at times be achieved quite well (as in some examples from emails below).

A further issue is that, in the current study, when discussing advice in interviews, and when answering survey questions regarding advice, both callers and volunteers discussed the provision of information on other services as related to the notion of advice. The Samaritans' website discusses such 'signposting' and says that if information on other services is held at a branch, then it *may* be provided to callers. While this may be organisational policy, researcher observations found little evidence of awareness of this in branches. As illustrated below, volunteers treated the provision of such information as a restricted, if not prohibited, practice. The website states that 'after *consultation with the person responsible for Caller Care, a referral may be made on their behalf.*' [59] Therefore, while advice about a caller's situation is treated as something which will not be provided, direction towards other organisations which may help is treated as something potentially available, but contingent upon branch resources and upon the caller having contact with caller care. The website also provides a list of organisations under the heading of "other sources of help" which includes helplines, charities, and websites which address issues ranging from mental health to debt to domestic abuse[60].

While direction towards other services is presented as an option on the website, the information provided to the general public regarding Samaritans' stance on advice quite clearly marks this as prohibited. For example, in various information sections on http://www.samaritans.org advice is discussed as something which will not be given to callers during contacts and an ability to refrain from providing advice is listed as an aspect of being a volunteer (and this is listed with an ability to "instead" offer emotional support).

Through the observation of training sessions and branch visits it was clear that advice was widely thought of as being outside of the remit and abilities of a volunteer. It was proposed that volunteers would never be suitably informed about a caller's situation, and about the range of potential remedial actions, to ever proffer advice on what a caller should do, and that telling a caller what they should be doing was quite removed from the remit of providing emotional support through active listening. All volunteers should thus be aware of the organisational prohibition on advice as Samaritan initial training clearly treats advice-giving as a prohibited practice.

In 2005 Samaritans reported on an evaluation of the email service [1] and found that there were a number of issues regarding the quality of responses. The issues raised included the provision of advice and attempts at problem solving by volunteers. It was acknowledged in the report that these practices were also occurring "without doubt" in telephone calls and in face-to-face contacts also

[59] http://www.samaritans.org/default.aspx?page=7299)
[60] http://www.samaritans.org/your_emotional_health/other_sources_of_help.aspx

(p.2). A number of methods for addressing these issues were contained in the report, but it will be clear from the analysis below that advice does still occur in Samaritan contacts. The report also discussed how callers often appeared to not fully understand the nature of the service and would express frustration or disappointment when advice and practical help were refused. This issue will again be apparent as currently pervasive in contacts, as respondents discussed their expectations that advice would be provided, and their negative reactions when this was refused.

Aspects of advice-giving

The concept of advice is complex. However, a clear definition of what qualifies as advice is needed to ensure a high level of analytic quality in research, and a clear notion of what activities are to be managed in practice. The 2005 Samaritan report on the email service noted that there was not any information available within the organisation regarding what constitutes advice and that this impeded the delivery of a consistent service to callers. Indeed, while Samaritan training informs new volunteers that advising is a prohibited activity, no information is given on what may or may not constitute an occurrence of advising. Defining advice offers a challenge as common-sense notions of what counts as advice may differ widely among individuals, and any academic definition may thus not relate well to individuals' experience or practice. For this reason, many academics who write on advice will avoid issuing their own definition, preferring to either provide something from a dictionary or to follow one of the few writers who have offered a definition. A popular and accessible definition comes from Heritage and Sefi [2] who describe advice as courses of action which are proffered (raised by one person) to remedy a trouble or problematic issue. Analysing occurrences of courses of action being proffered by one person, aimed at remedying particular problems of another, is what the (large amount of) research papers in the area have in common. Apart from utterances or sentences which are explicit examples of advice giving (e.g. 'You should call the Citizens Advice Bureau' (CAB)) other forms such as 'information' or 'suggestions' ('There's always the CAB.') or some questions ('Have you tried the CAB?') are treated in the literature as ways of introducing a potential course of action, which avoids the delivery of something plainly hearable as advice [3, 4].

The existing literature on advice-giving focuses mainly on the ways in which advice-type sentences are formed by the advice-giver, with some work available on how the recipients of advice orient to it, or to what may be *hearable* as advice. Some work exists, however, which examines both the delivery and receipting of advice. The earliest example of this work comes from Jefferson and Lee [5], who explored data from both 'ordinary' (lay) and workplace settings. They found that advice was often delivered following both requests for advice and the telling of troubles, even though requesting advice and the telling of troubles are very different conversational projects. Their analysis showed that speakers accepted advice more when it was delivered after they had directly requested it. Yet where a speaker had described or disclosed a 'trouble' they were having (or had been having) and another speaker responded by offering advice, the advice was typically rejected. Jefferson and Lee argued that when people describe a 'trouble', they position the listener as "troubles recipient", whose correct response to the troubles telling is a troubles receipt (something which may be hearable as perhaps surprise, or sympathy). When a person gives *advice* in response to a troubles telling however, Jefferson and Lee claimed that this re-positions them as an advice giver (as opposed to troubles recipient) and correspondingly repositions the troubles teller as an advice recipient. Jefferson and Lee showed how such

occurrences led to interactional trouble, with the advice being resisted, and they discussed this in terms of an "interactional asynchrony" [5:402].

This issue may be an important one for Samaritans in that, as we have seen in Chapter 4, caller responses to survey items contained claims that at least some callers do not want advice when they contact. A caller engaged in a telling of their troubles, who goes on to receive advice, may react badly to it or at least reject the advice, according to the notion of asynchrony discussed above. A further issue here may be that if the topic of a contact moves towards advice and solutions, then it will be moving away from the core Samaritan goal of allowing callers to talk about problems, reflective of the training statement that advice giving diminishes the ability to provide emotional support. This would also tie in with the findings of Jefferson & Lee which show that advice is often treated as unwanted when it follows the telling of troubles, as well as with the data from volunteers who associate refraining from advice-giving with a focus on listening to the caller's issues (Chapter 5). It would appear that unless it is sought, advice-giving is misplaced when it follows the disclosure of personal troubles.

Heritage and Sefi [2] also discuss the interactional *roles* involved in the giving, resisting, and accepting of advice. Regardless of how advice is delivered (i.e. whether it is in the form of a question about existing practices, or statements about best practice) the recipient may treat it as advice. Heritage and Sefi showed how the offering of advice marks a speaker as knowledgeable on a particular topic. In accepting advice, the recipient positions themselves as less knowledgeable on that topic. This represents another reason why the provision of advice as a response to a disclosure of personal trouble may be inappropriate and difficult to manage. Advice giving marks the recipient as the less knowledgeable party regarding suitable courses of action to remedy their situation, and this may be taken as an affront to their autonomy or competence in managing their own situation. This clearly also contrasts quite starkly with the Samaritan philosophy that the caller is the person best placed to discover their own options and courses of actions. Interestingly, Heritage & Sefi [6] and also Waring [7] found that when advice is resisted, it is often done through a display of personal competence in the area in question.

Section summary

Advice is a live issue in the realm of Samaritan contacts. Samaritan training discusses advice as prohibited, and as falling outside of the abilities and remit of a Samaritan, and thus all volunteers should be aware that advising is a prohibited practice. In the responses to survey items discussed in Chapter 4, callers ranged between wanting advice and considering the provision of advice as a way to improve the service, and clearly not wanting advice from volunteers. Volunteers themselves must manage the institutional prohibition on advising, while still discussing potential options and courses of action with callers, as part of the Samaritan practice of 'exploring options'.

Analysis

The data and analysis presented in this chapter provides evidence that advice-giving by volunteers during Samaritan contacts does indeed occur, and as will be evidenced in the email and text message data, such practices occur relatively frequently. A range of views is discussed on whether advice is a desired part of the service for callers, and on whether it is something which should be offered, and if so to what extent, by volunteers. Differences in what is expected and what

is offered will represent, for some callers, a mismatch between expectations of the service and the service as provided. Discussing future courses of action with callers is indeed a core element of the Samaritans service, but as we have discussed above, volunteers are required to engage in this in a manner which embodies the 'exploring of options' rather than the provision of advice, and this may be difficult to manage in practice.

Analysis of survey open questions

The data from the open questions on the survey suggest that discussions of future courses of action are at times oriented to as advice and at others as exploring options in a manner which allows the caller to lead on this. In the "Other Comments" section of the survey, many callers expressed that they had been given helpful advice or guidance during their contact with Samaritans, and some expressed that this had even 'saved their life'. Others found that after speaking to Samaritans they were able to see their situation from another perspective and were aware of different options available to them. On several occasions callers explained how talking to Samaritans had started the process of 'healing' for them which led to their self-acceptance, admitting the reality or gaining clarity of their situation and seeking other sources of help. Even when advice was not offered, some callers thought of the support offered by Samaritans as helping callers to help themselves. These points support the notion that exploring options can be achieved in contacts, with callers feeling as though they are being supported to help themselves, and to come to their own conclusions about future actions and solutions rather than being given advice. Yet it also suggests that at times, the practice of discussing options is treated as volunteers furnishing callers with advice.

> *ID532: I am fairly sure that had I not contacted the Samaritans that night, I might not be here now. She advised me to urgently see my GP, which I did first thing the next morning; from that contact with the Samaritans, things began to get better. It took a long time but I managed it and am so very grateful to the Samaritan I spoke with. She saved my life. I will always be thankful for that and to her and the Samaritans in general.*
>
> *ID329: I would just like to say that I'm very grateful that there is a service like this that is accessible to everyone. As I said briefly, "Jo" didn't try and fix my one problem but helped me help myself. Thank you again. Sometimes it's better to speak to someone dissociated from the social circle. :)*

Specifically, advice-giving was raised as a significant issue by those using the other comments text box to complain about the service. There were reports of callers feeling let down by Samaritans when they had received inappropriate advice, saying this had made them feel worthless, judged, criticised, not listened to and guilty for not being able to 'pull themselves together'. Others were disappointed that no practical help was given, accusing volunteers of only being interested in 'small talk'. There were also suggestions that volunteers should be able to guide callers 'in the right direction' by offering some advice or suggesting other agencies and services that might be able to help them, which may indicate that these were not provided during their contact.

> *ID1156: I think they should repeat what was said in the sender's email less, and maybe have more definite suggestions as to what to do - although I know this is difficult in many circumstances.*

ID1137: I was given no alternative about what to do in my current situation. I felt I was treated like a number and not a person.

The issue of advice giving also featured prominently in the "Suggested Improvements to Service" section, with many respondents simply writing 'give more advice'. Advice giving was thought of as a more useful form of communication to callers than offering standard questions, giving scripted responses, or remaining silent, as explained below (suggested improvements to service are discussed in more detail in chapter 10). The 2004 'Hearing the caller's voice' research project carried out by Samaritans which studied the reported nature and content of calls as recorded by volunteers, claimed that around 5.5% of callers wanted advice, and that some became angry when they found this would not be provided. The report suggested that callers may not have been fully informed before calling as to the precise nature of the service, and this suggestion may also apply to the current findings.

ID143: BY DIOING SOMETHING USEFUL IE COMMUNICATE. ADVISE EMPHASISE AND NOT PARRROT "HOW DID THAT MAKE YUOU FEEEL

Many callers reported that if advice was sought, it should be provided by volunteers. The provision of advice was in the main part conceptualised as volunteers being more helpful, more human, and as recognising the severity of callers' problems. As demonstrated in the data extract below, several callers also reported receiving advice that had really helped them:

ID369: Volunteers SHOULD sometimes give a little advice. I HAVE had advice from volunteers which is apparently against their guidelines... this advice may well have saved my life!

ID206: Samaritans boast that they don't offer advice, just listen and help to let you explore your feelings. Sometimes I think that suggestions could be warranted. Nobody has to follow the suggestions. I think that if someone asks specifically for advice, it should at least be offered

Overall, opinion was split in these responses on advice giving. While many callers requested more advice, for others this was not the reason they were calling so when given advice they felt rushed, not listened to or not taken seriously (supporting the notion of the incompatibility of listening and advising). Some callers felt that they had received advice that was not appropriate or feasible, for instance, ID389 says that Samaritans had advised her to go and see a counsellor, which was not feasible for her without parental supervision as she was aged under 18. She would have preferred to have been offered guidance and advice directly from Samaritans. Callers raised the issue as to whether, if advice is not given explicitly, Samaritans could direct those who requested advice to another service which would be able to provide advice, again suggesting that this may have been refused or avoided during contacts. Notions of 'gentle guidance', 'suggestions' or 'starting points' were discussed as needed in order to help an individual to sort out their own problems and stop them from going around in circles. This may indicate that, for the caller, the practice of exploring options was not achieved during the contact.

Section summary

The data from two of the open questions in the survey indicate that callers have a wide range of caller expectations, requests, and experiences regarding discussions of future actions. Whilst the practice of exploring options is successfully achieved at times, occurrences of advice giving are also prevalent. Contrasting statements were also found in the interview data, discussed next, indicating that callers' experiences of discussing remedial actions with volunteers are quite wide ranging.

Analysis of caller and volunteer interview data

Discussions of advice in the caller and volunteer interviews generated much interesting and informative data. Beginning with data from callers, a range of different caller and volunteer experiences are discussed. Callers reported quite varied experience in terms of being furnished with advice by volunteers, and volunteers offered quite wide-ranging accounts as to what exactly constitutes advice, and discussed engaging in quite varied practices during contacts with callers.

In their discussions of advice during interviews, caller claims about their experience ranged from never having received advice during Samaritan contacts to receiving advice as regular occurrence. In the data extract below, S123 reports having received specific advice which he then acted upon.

> *They've never given me advice, never.* *S111*
>
> *…one of them … made a suggestion like have you thought of going to stay somewhere else tonight? I hadn't even thought of that. And when he said that I thought I haven't even thought of that and I went and stayed with somebody else and that helped as well.* *S123*

Callers were also mixed in their comments on many aspects of the issue. Arguments were made that it would be helpful if Samaritans could issue even the most basic advice and negative comments were offered on the policy of not advising. The argument also appeared that the Samaritan policy on advising was to be valued as callers were often subject to much advice elsewhere, and clear statements were offered about not wanting advice from Samaritans. Most of the callers who were interviewed claimed to have known before they contacted that advice would not be given.

> *I knew they didn't give advice and I didn't want advice … I don't think anyone else can give you good advice really because no one else can really know what you yourself are feeling like exactly.* S103
>
> *Well that ((advice)) would be nice.* S131

Reflecting the points from volunteers (see below) on the issue of whether Samaritan volunteers were in a suitable position to give advice, callers again offered quite varied statements. Volunteers were constructed by some as suitably positioned to offer advice, and conversely by others as 'unqualified' or as not getting enough information during contacts to advise suitably (also see S103 above).

I do think that, if they're trained and.... they're experienced ... they're mature people that they're not young trainees... there are occasions where advice can be very helpfully given, but it has to be very carefully done and appropriately done and by the right people. S130

I find that really helpful, because everyone is full of, you should do this, or you should do that and that just really winds me up, because they're not in my position, they don't know what it's like, so how the hell can they tell me what to do sort of thing, you know. S170

Callers also seemed divided on the issue of whether forms such as suggestions and questions may count as occurrences of advice-giving, with some addressing it as a 'grey area'. Some callers also associated being directed to other organisations with the notion of advice (e.g. S143 below). The issue was discussed from all angles, with both callers and volunteers providing conflicting statements about whether it should be allowed. Within discussions of advice and options, the issue of getting contact details for other organisations seemed to be one of the most specific recurring issues, and as seen below, volunteers also often linked this to advice but did seem more willing to forward a caller to an organisation than to provide explicit advice (this seems to be in line with the information available on the Samaritans' website mentioned above).

I've met all the other agencies and we sort of interact in as much as they have our numbers and we have their number and, although we don't signpost anyone to these numbers, at least you know a bit what they're doing. V263

They said they don't offer advice ... so I sort of questioned that and they said, 'Well, you know, we can't really guarantee the advice that we would offer'. But I found that a bit presumptuous because a lot of organisations have been around as long as the Samaritans if not longer. For instance, if somebody's got financial problems, you can't refer them to the Citizen's Advice Bureau or Debt Counselling Agencies. S143

Samaritan volunteers also seem to be divided on the issue of advice. Many claimed that it happens either regularly or periodically, while others claim firmly that it does not happen. Some volunteers discussed occasions on which they themselves had given advice and referred to it as a 'slip' or as necessary at the time for that particular caller. For some volunteers the policy of not providing advice was something to be 'gotten around'.

I have actually once or twice, actually, ended up giving advice even very acute advice and I have really thought, 'Why did I say that.' But it's sometimes so hard not to, you know if you sort of say to somebody 'Why don't you go to the doctors?', you know we're not really allowed to say that, but I have actually said, 'You know, if you go to the doctors..', and I've really sort of thought, I wish I hadn't said that, I hope no one has heard my say that' [laughs]. V203

There are kind of ways round that, I mean, well, I say ways round it, [laughs] (...) Machiavellian kind of way of [laughter] like, how can I give them (advice), [laughter] but there are kind of, you know, you can talk about, you know, you can sort of suggest options and things, there are kind of, you know, there are plenty of ways of kind of doing it. V216

Volunteers again also seemed to vary on whether interactional elements such as issuing suggestions or asking questions should be considered as examples of advice giving, and also on whether discussing other sources of help represents advising. Some saw such elements as ways to sneak advice in, and others discussed them as acceptable practices which do not embody advice.

> *… you might be able to at least steer them to options but that's not the same thing as giving advice, you know. If I were you, I'd do this. But you might be able to say "Have you ever thought about so and so and so and so?" And then, they might say "Oh yes, hopeless". Or they might say "Well, no, but, you know". But it, I think with most of our, of what we do, there is an area of malleability about it.* *V214*
>
> *Occasionally, your questions will, may verge into advice, like you can ask the question, 'Have you thought about seeing a counsellor?'* *V219*

The use of questions which ask callers about actions they may have engaged in, or which they may in future engage in, were repeatedly discussed, and will be examined in more detail below. Such questions may be linked to what one volunteer describes as an acceptable practice of 'encouraging callers to think about where to get advice'.

> *I can understand the reasons why advice isn't given, why as an organisation we don't give advice and, and I accept that. But what I do find is that most times, if you feel in conversation with somebody, that these people need a pointer, then there are ways of directing them to the pointer which doesn't actually mean that we're giving advice but we are encouraging people to ask (us) the questions or to make the suggestions which would give a positive response to. So you, know, in a roundabout sort of way, you don't give advice but you are able to encourage people to think where they might get advice.* V262

Callers were discussed by some volunteers as often wanting advice from Samaritans, and as expecting that advice is part of the Samaritan service. Other volunteers discussed callers as not wanting advice. There is however an element of 'learning about advice as-you-go' in both the caller and volunteer interviews, with callers often thinking that advice is available and learning otherwise during contacts, and volunteers claiming that a caller's level of contact modulates whether they will request or expect advice. Some volunteer reports considered the policy of not giving advice to be difficult to either adhere to, or to police when on duty. Occasionally, volunteers reported being frustrated at not being able to offer advice when they felt in a position to do so, and expressed frustration with the organisation's policy on advice. Again there were some conflicting responses in this area, as some volunteers considered the policy easy to manage and adhere to, and argued that it would be inappropriate to advise due to the limited contact they have with callers, or due to their lack of suitable knowledge or 'qualifications'. As V262 mentions above, many volunteers value the policy of not providing advice to callers. The policy was discussed as one which assists them to remain focussed on callers' feelings rather than on solutions, or on their own experiences or opinions (this is reminiscent of the previously mentioned 'offering support *instead* of advice' notion on the 'How to volunteer' section of the website). The policy was also discussed as protecting volunteers from the consequences of offering unsuitable advice, such as negative ramifications for callers who may act upon advice, as any advice provided by volunteers may render them accountable for the consequences.

I don't think that we're qualified to offer advice. So I don't think we should do that. V220

In so far as the advice-giving is concerned, I've always felt that the Samaritans have been at fault in emphasising that we don't give advice because of course, we don't give advice by black and white sort of advice but we do talk about options and if I thought that something might be a good idea, we can suggest it to a caller, 'Have you thought of doing something? 'Would going to the doctor be a good idea at this stage?' to see what their reaction is, and that, in a way, is a form of giving advice although it's tacit. So, in that sense, I think the policy has been a bit silly over the years, because I think it's, it may very well have cost us callers. But, I can find I don't have any problems with dealing within the restrictions that we're given, that's fine. Over the years I've got used to it, I suppose. V244

When discussing the support given to callers, and the ways in which calls are handled and managed, many volunteers claimed that not giving advice is an important aspect of good practice, and linked it to also not disclosing personal experiences with callers (as sharing experiences may be taken as a recommendation to engage in the same actions as the volunteer has). The importance of not giving advice was again raised in discussions of caller support as an element of good listening, of staying focussed on what the caller is saying about their troubles and feelings, and not moving into other areas such as solutions or remedies. Better and more standardised organisation-wide practices (in terms of refraining from giving advice) were discussed as needed, and as a potential improvement to the service.

… some branches may even be more strict than us on, you know, things such as giving advice … I think that there's inconsistency across the service which, because it's a national helpline number, and you know, you can speak to anybody from anywhere … because of that, I think that maybe there needs to be a bit more consistency across the branches. But how you go about doing that, I don't know. V209

I think we're not in the business of solving or helping sorting our people's problems. It's ultimately what they're going to do about it, and I think, the thing that we're doing is listening. V243

Personal competence seemed to be an issue for Samaritan callers when it comes to advice. In the interview data, there were various occurrences of callers saying that they do not want advice during contacts as they do not want solutions from Samaritans, and can arrive at these themselves. Callers also claimed on occasion that volunteers would not be in a position to offer advice, as they cannot know enough about a caller's specific situation. Relatedly, callers expressed an appreciation for contacts where they are *supported in coming to their own conclusions and decisions* about any actions they may engage in, and volunteers discussed this as a particular practice which avoids advising.

I: Do you ever phone hoping to be given advice?

S163: No.

I: No.

S163: No, because I mean, I know, A, you can't, and B, not being (...) I'm quite intelligent and I think if, you know, if there was a solution [laughs] I could probably sort it out for myself.

And although they don't give advice they help you reach your own conclusions and just listen ... I don't think anyone else can give you good advice really because no one else can really know what you yourself are feeling like exactly S103

As mentioned above, sensitivity regarding personal competence in managing one's own situation is also discussed in the literature on advice as a cause of advice being rejected. Volunteers can also not always know what kind of competencies callers possess, and thus this may a highly relevant issue to be addressed when discussing courses of remedial action with callers.

Unwarranted advice is frequently treated as such and resisted by clients in many of the studies on advice giving in institutional interactions. Indeed, Waring claims that advice giving needs to be delicately managed as it is a 'face-threatening act' [7:368], as do Goldsmith & MacGeorge who claim that advice challenges the recipient's "identity as a competent and autonomous social actor" [8:235]. Silverman found that advice was often delivered to clients in counselling sessions in a form that he calls "advice as information" [3:154]. This involved the counsellors proffering courses of action which were relevant to client issues in ways which made them hearable as the delivery of information. In the interview data, both volunteers and callers discussed the provision of information about solutions during Samaritan contacts as related to (or an alternative to) advice-giving, or indeed as a covert method for advising. This is not surprising at it would seem from the literature that the advice-as-information format is a successful method in contexts where advice delivery is problematic.

I know about giving advice has to just be information, okay, information shall we say rather than advice, you know, you could possibly do this, or possibly go there, or... rather than saying this would be the best thing for you... I think. I can understand why they'd be cautious about.... Advising too strongly shall we say. S131

I suppose it's really sort of the thin line between information and advice, it's always difficult to know quite where that stands ... I suppose, then, I occasionally gave people the odd piece of information which, you know, the rules would have, at that time. V211

Section summary

Both callers and volunteers offered mixed, often conflicting comments on issues regarding advice, such as whether advising occurs during contacts, whether it is requested, whether volunteers should provide advice, and whether certain interactional practices such as asking questions were covert methods for delivering advice in contacts. Many valued the policy of advice prohibition, and it may serve institutional functions such as protecting volunteers from any negative consequences of advising callers, and allowing them to maintain their focus on listening to callers.

Analysis of email and text message data

The 2005 Samaritans report on the email service [1] found that emails to callers frequently contained examples of advising and problem solving. The emails and text messages analysed for the current study also contained many occurrences of what may be considered advice, typically embedded in questions, and also couched as information or as volunteers 'thoughts' or 'wonderings'. These occurrences were most often *not* in response to requests for advice from callers, and occasionally they were aimed at remedying something which the volunteer themselves has deemed to be a problem for the caller. This represents a troubling practice, considering the difficult relationship outlined above between the telling of troubles and the delivery of advice, as unwanted advice is typically troublesome for, and rejected by, the recipient.

One noticeable element of the emails is that they often contained claims that advice cannot be offered to callers. These occasionally came with an explanation as to why, and were usually followed by a gloss on what can be offered.

> *Unfortunately Samaritans are not medical and cannot give you advice but we are here to share and explore your feelings with you as long as you feel it is helping you along the way.* *EV504(2)*

Questions embodying advice

Both the giving of advice and the asking of a question can create asymmetries between speakers in terms of assumed knowledge, although these move in opposite directions; giving advice positions the speaker as more knowledgeable, and asking a question can position the speaker as less knowledgeable. Institutional interactions are already typically asymmetric in nature as the clients seek a particular service from the institution but advice giving itself specifically "assumes or establishes an asymmetry between participants' [4:221] by positioning the advice giver as more knowledgeable on the specific issue. This can be problematic for many reasons, including the issue of callers sometimes preferring to find their own solutions and considering themselves competent enough to find them. It may be for this reason that a question is a particularly suitable interactional 'vehicle' to use in contexts where advice giving is restricted or prohibited. In their work on advice delivery, Butler et al [9] and Locher and Hoffmann [10] found that a frequently used method of managing advice was to embed a potential course of action within a question. These questions alluded to a course of action which, if engaged in, may remedy the callers' issues, e.g. *'Do you have a counsellor or guidance officer at school?'* or *'Have you spoken to her about what you want?'. T*he questions treat the caller as being in a knowledgeable position regarding the course of action, thus reducing the asymmetry between the speakers which direct advice-giving would create.
A second main feature of advice which is relevant here is the normative element of the advice (that it is a highly relevant course of action to engage in for the specific situation; that it is a 'best' next action). Delivering a course of remedial action through the use of questions manages this issue also. Although the course of action which is embedded within a question may be fitted to a client's specific issues, and as such may be considered advisory in nature, the question format softens the normative or prescriptive ('best') nature of the action. This makes it less hearable as advice (i.e. it is not delivered as what a client *should* do).
These issues will be at play in Samaritan calls where questions are used which have a course of action embedded within them, e.g. 'Have you told your doctor about this?', and again they may still be problematic for callers who may not want

to move the contact towards solution focussed talk, and who may treat the question as addressing an action which they should normally be engaged in. The following are examples of questions from volunteer emails, which illustrate these issues.

> *Have you considered seeing your GP to maybe access some counselling or support from the community mental health team? Are your family aware of the low you have reached?* EV501(2)
>
> *Concerning my family, it's not going to happen. I cannot and do not wish to communicate with them regarding this issue, because their advice will be similar to yours - see a psychiatrist.* ES501(3)

In the first question from the volunteer we have sources of help (the GP) and the actual help or actions to be engaged in (accessing services of the local mental health team). Embedded within the second question is the action of discussing things with family. Both of these convey that the actions are relevant to the caller's situation, and they are hearable as normative actions in this scenario. Importantly, we can see in the caller's reply that they did indeed orient to these questions as a form of advice giving. Firstly, they followed the question about talking to their family with an explanation for why they have not engaged in that particular course of action, and they referred directly to the question about seeking professional help as advice. This is also an example of how a question containing a course of action moves the contact away from the caller's troubles, and onto a solution focussed sequence.

The next example shows a similar question about discussing problems with family members, which again the caller responds to with an account as to why this has not been done.

> *You mentioned your brother and sister-in-law; do you have any other siblings? Do you think it would help to discuss your concerns about your father with them?* EV503(1)
>
> *Dear Jo, I have three siblings, they are all over the world and have families, they don't really have time to talk much and they are not close to my parents* ES503(2)

It may be the case that such questions are routinely used by volunteers as a (successful) way of gathering information about the caller's situation, but these will still be potentially hearable as proffering advice regardless of the volunteer's intent, and still move the discussion into solutions. Occurrences of volunteers prefacing such questions with a formulation of the caller's experience, or the caller's perspective were also easily found in the data.

> *You certainly are having a bad time with your mental health care team in what you say about your local PCT[61]. Have you ever thought of writing to them telling them how you feel about the service, as you come across as quite articulate.* EV502(1)

[61] Primary Care Trust

Invoking these perspectives sets up a more 'natural' environment for the issuing of advice, regardless of what form it is issued in. The question form again proffers a course of action as a remedy to a problem, and in this instance the volunteer also offers an additional reason for this action (that the caller is 'quite articulate'). This format of (formulation of perspective or experience) + (question) does indeed appear to be a robust format for the delivery of advice, and this may be because there is a *readily available reason* for the course of action embedded within the initial formulation. With this in mind, consider the examples which follow.

> *You say that your husband's idea of writing to your father to tell him how you feel will not change anything, but have you any other ideas about how to let him know your anxieties? Have you talked to anyone else in the family about your concerns?* *EV503(3)*
>
> *You have already acknowledged that you are aware of the help and support that is available to you. How would you feel about taking the step and accessing that help?* *EV506(14)*
>
> *This must have been a difficult experience. Have you spoken about this to anyone else?* *TV402(26)*

Placing such questions after a formulation of the caller's experience or perspective serves two related functions. Firstly, it sets up the advice by invoking the reason for why the course of action is appropriate, i.e. it makes the volunteers 'reasons' for issuing the advice somewhat clear to the caller. Secondly, this format helps to ensure that the advice is not deployed in an 'out of the blue' manner, which is frequently cited as a main cause for the resistance or challenging of advice. [2, 3].

The question format does indeed help to 'ward off' advice resistance, through a reduction in the typical asymmetry in the advising relationship. Consider the next example;

> *Would it be a good idea to see the GP again to let him know about your suicidal feelings? Maybe he would take you more seriously this time … How is your relationship with your mother? Can you share your thoughts with her?* *EV517(6)*

The question format is a helpful alternative to a more prescriptive sounding sentence. Compare the two previous examples with an alternative format such as 'It would be a good idea…' and 'You can share your thoughts with her', which sound more 'forceful' than the question form, as they would privilege the volunteer's knowledge. In the question form, it is the caller's knowledge which is privileged.

Using 'hedges' and 'mitigations'

Although much less common than questions, sentences embodying advice will often appear as something designed as information, suggestions, or general musings by volunteers. This is commonly achieved through the use of 'hedges' such as 'maybe', 'might', and 'perhaps' as in the following examples.

Perhaps it may be helpful to discuss the agitation you experienced at your G.P.'s visit when you see your psychiatrist. EV506(18)

Glad you managed to get into town. Maybe thinking about just getting through one day at a time might make coping with the next few days easier? TV401(12)

What makes you think she will not like your new books? Maybe she can come with you to yoga and share the pleasures - a good idea or just crazy! EV509(2)

All of the examples above have a course of action embedded within them, and are hearable as aimed at a particular trouble. They are designed as suggestions or information about what 'may' be done, which is a common finding in the literature on advice-giving, and a practice discussed by Samaritan volunteers and callers as related to advice, or a method for managing the prohibition on advising. They are indeed arguably hearable as advice for the specific recipients, to target their troubles and offer some remedy or relief. Callers' orientation to them as such is clear in some cases.

Do u have a local paper sometimes there r events going on where u could be around other people or u could try the local library & u could go 2 (Town) 4 one day TV401(6)

Thank u 4 the ideas. There's no paper but there is an asda nearby & they may have an event board. I think I will go into (City) one day, possibly 2moro or Wednesday. TS401(7)

Direct forwarding to other organisations

This does not regularly occur in the emails and texts, although it is clear from the interview data above that it is an issue in Samaritan contacts. When it does occur in the emails and texts, it is oriented to as forwarding *away from* Samaritans, as it is always followed by an encouragement to 'stay in touch'. This may be done directly by introducing the action of contacting an organisation, and then providing their contact details, as below;

You mentioned that the reason you wanted a copy [of caller's earlier message] was to forward it on to Saneline as you really wanted advice on how to deal with your situation. The phone number for Saneline is 0845 767 8000, but please continue to contact us if you feel that we may be able to help and support you. EV501(6)

Forwarding to other organisations, arguably, also overlaps with the question format (discussed above) when volunteers introduce the action of contacting a specific service or organisation relevant to their issue, as below.

Have you considered talking to a student counsellor or your tutor who may have some real understanding of what you are going through? We are here to support you while things are tough for you. Let us know how you get on. EV568(2)

Other methods

There were also some idiosyncratic ways in which volunteers proffered a course of action for callers. Occasionally, they would offer a telling about some subjective internal 'goings on' of theirs. In this first example, the volunteer claims that they are "wondering" about something.

> *D although I know it is difficult, I was wondering if there was one thing you could do today that might give you a little hope for the future?* *EV570(6)*

> *As far as things I can do to cheer myself up I cannot really think of anything. I could spend some money on myself but there is not really a lot of point.* *ES570(7)*

> *I hope that you get some support from a CPN[62].* *EV514(3)*

> *You have been very honest about how you feel about yourself, and also extremely hard on yourself, so I hope you feel able to perhaps look at why you think this way.* *EV501(2)*

In the latter excerpt we have a course of action (introspection) which may act as a remedy for something the *volunteer themselves* had marked as problematic (the caller being 'hard on themselves'). In the following example, the normative aspect of attending a referral to a psychiatrist is invoked using what is designed to be read as an observation 'This would seem to be an offer that could be helpful', and even more strongly in the question which follows the observation which requests an account for why the caller did not engage in the course of action.

> *You have said that your GP mentioned a referral to a psychiatrist, but that you didn't want to go. This would seem to be an offer that could be helpful. Can you tell us why you didn't accept this offer?* *EV506(10)*

In some cases, the volunteer has not engaged in much work to issue the advice in a format which makes it hearable as something other than advice. The following is somewhat blatant, as the mitigating 'perhaps' is followed by the modal verb 'should'. The use of should is indeed a rare occurrence in places where advice is prohibited, probably due to its strong normative and directional loadings (interactional 'baggage').

> *Reading through your emails, we also sense that remaining in control is very important to you, but perhaps you should try and be kinder to yourself, and accept the help of your friends, family and professional support workers. I'm sure they won't think anything less of you for opening up and trying to work through your feelings.* *EV506(13)*

> *sorry u so isolated. it is not easy, but it gets easier. u can talk to ur family though. see how it goes and if to bad talk to ur mam again. u may like it.* *TV401(3)*

[62] Community Psychiatric Nurse

The various types of sentences which embody advice can also be found in quick succession in the data, rather than occurring in isolated incidents.

> *Have you tried talking to a rape crisis centre about how you are feeling and what you have been through? Here is a web site you might find helpful, www.wrasacdundee.org What you are feeling now is a normal response to what you have been through, And you should not be feeling guilty about feeling angry or hostile towards other people.* *EV504(1)*

> *It's good to know that you have been referred to a Psychiatrist to review your medication. I hope that you will find this visit helpful, and that you will having some support from the Community Team. Perhaps it may be helpful to discuss the agitation you experienced at your GPs visit when you see your psychiatrist. Do you feel able to tell your doctor about your self-harming?* *EV506(18)*

Finally, some elements of the emails relate to what one volunteer described in interview as Samaritans not being an "emotional CAB". There seem to be occasions where volunteers will proffer a normative 'way of feeling' to callers. This may be hearable as advice on how to feel, or as an endorsement of actions already engaged in by the caller. All certainly have a strong normative element.

> *It sounds as if you are embarrassed by having a cry when other people are about. If this is the case, please don't be so hard on yourself, especially if crying helps to release the pressure and pain you feel inside.* *EV506(16)*

> *The Wildlife Trust walk seemed to go well. Aren't you just a little bit proud of yourself?* *EV506(17)*

> *It is great that you have your running to help you unwind during the ongoing stress of the tribunal.* *EV570(5)*

Of course, many if not all of the volunteers who have offered advice in these forms above may be surprised to have someone consider them as examples of advice, claiming that they were intended as something else. However, as they contain courses of action to be engaged in by callers in remedying specific troubles, they are hearable as advice.

Section summary

Various methods are used by volunteers to proffer courses of action to callers, such as questions, 'mitigations' and 'hedges'. Questions are frequently used, and also appear in other services as a method for managing advice prohibition.

Chapter summary

The available literature on advice treats any discussion of courses of action as something which may be heard as advice, and many dilemmas exist when advising, such as misaligning with those who seek acknowledgement of their troubles as opposed to remedies, and treating the advisee as being less knowledgeable regarding solutions to their own situation. It would appear that in the context of a Samaritan contact, advice giving is incompatible with the practices, remit, and values of the organisation.

This chapter has revealed a wide range of caller expectations and experiences regarding the discussion of future actions and an equally wide range of practices and opinions from volunteers. Whilst some callers consider themselves to have been given advice on occasions, others have been able to engage in the practice of exploring options. Conversely, for other callers, advice is something they requested but were not provided with, and others indicated a complete lack of discussion of options in their contacts. Indeed, some callers have indicated being happy and satisfied with the service, with others engaging in complaints about the service relating to advice and discussing options.

A number of methods are used by volunteers which insert a mention of courses of action into email and text message contacts, such as questions and 'hedges'. While these may be designed to be hearable as something other than advice, callers can still orient to these as advice, and often take time to explain why these are unsuitable, and to account for why they have not engaged in these actions. Questions which embody advice are seemingly common in contexts where advice is prohibited, and they featured heavily in the email and text message data. Other examples were found where volunteers proffered a course of action without engaging in much work to prevent it from sounding like advice. With this mixture of expectations, wants, and practices, there will inevitably be a failure to meet the expectations of the service which some callers have. It is also clear that discussions of future course of action for callers' needs careful management, and is an important matter for the organisation.

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Chapter Eight: Suicide

Introduction

Supporting people who are actively despairing and suicidal is the raison d'être of the Samaritans, and the focus on suicide is perhaps the most singular aspect of the organization and a large element of what sets it apart from other telephone support lines. As already discussed, the support extends beyond this focus to callers who are distressed and despairing. A description of the organisation on the front page of Samaritans website [63]states that 'Samaritans provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide.' Samaritans' 'Nature of Service' policies (Appendix II) also include statements on how volunteers are trained to provide support to those in distress and despair, and makes it clear that they will ask callers about suicide in every contact. A rationale for doing this is provided for prospective volunteers in the third module of SIT which states that 'Samaritans recognises the importance of having the opportunity to explore difficult feelings' and that being listened to and accepted '... can alleviate despair and suicidal feelings'. Samaritans Strategy 2009 – 2015 reaffirms the commitment to reducing occurrences of suicide through providing emotional support, and that discussing suicide will remain a priority within Samaritan contacts [1].

Within the social and medical sciences, the field of suicide prediction and prevention represents a substantial area of research activity. Suicide remains a leading cause of avoidable death worldwide [2, 3], and following two centuries of academic investigation in the area, very little has confidently been established about the impact and effectiveness of different interventions. Many academic writers acknowledge that those working in the area will need to address a wide range of behaviours, outcomes, and intentions as suicidality manifests itself in many ways [4, 5]. An important focus within modern suicide research is the assessment of risk. Draper *et al* [6] found that in over 60% of cases of suicide in their study, the individuals had been assessed in their last contact with a health professional and deemed not to be at risk. Assessment was more successful when the professional was a psychiatrist, with other health professionals, nurses, and GPs all faring poorly. A Finnish study which examined the contacts with health professionals made by 100 completed suicides on the day of the suicide found that only 21% had communicated suicidal intent [7]. Researchers typically discuss these contacts with health professionals as missed opportunities for suicide prevention. However, suicidal intent may be purposefully concealed, and also those who engage in suicidal actions soon after contact with health professionals may not necessarily have intended to act *at the time of meeting* and so did not have intent to disclose. Despite findings which discuss differences between attempted and completed suicides (e.g. higher rates of females in the attempted category and higher rates of males in the completed category), an attempt at suicide has been found to be a strong predictor of an eventual death by suicide across all groups [8-10]. While risk may decrease somewhat over time, a significant risk of death by suicide remains for decades following an attempt [9]. However, the relationship between engaging in suicidal behaviours and eventual death by suicide is enormously complex. One complication is the prevalence of individuals presenting as having suicidal ideation and as engaging in suicidal behaviours over long periods of time, without any of the behaviours ever resulting in death [11, 12]. In addition, risk factors linked to repeated non-fatal

[63] www.Samaritans.org

suicidal behaviours may also be preventative of fatal suicidal behaviour, such as having a young child in the home [13, 14]. Studies have also found that a past history of suicidal ideation without an attempt at suicide was a strong predictor of *continuing* to experience suicidal ideation without ever making a suicide attempt [13, 15, 16]. The data presented below illustrate this complexity and that the relationship between the language of suicidal intentions and suicidal intent and action is multifaceted and opaque. In this context, the volunteers' task in routinely asking and assessing the suicidality of individual callers is highly problematic.

Analysis of volunteer interview data

The frequency of suicidality in contacts

Volunteer estimates of the frequency of calls received from those who are suicidal or in severe distress varied widely (from 5% to 80%), although almost half of the volunteers who made such an assessment proposed a figure of around one quarter. This is relatively close to the figures provided in the most recent data available from Samaritans. The latest information resource pack [17] states that in dialogue contacts during 2008, 19.1% of callers indicated having suicidal feelings at the time of contact, although the figure rises to 35.6% for email callers. The wide range of volunteer estimates may reflect variations in respondents' individual notions of what constitutes 'being suicidal' and 'in severe distress' and in how they assess where the boundaries lie between these. As discussed below, the relationship between expressions of suicidality and the intention to engage in suicidal behaviours is very complex, making it difficult for volunteers to accurately gauge callers' states. This may be further compounded by the huge variations in call length, with volunteers expected to rate callers' emotional state in all calls from those lasting just a few minutes in length, where little information may be available on which to base an assessment, to those lasting over an hour. Volunteer accounts indicated that many shifts occurred where no calls were received from someone who expressed suicidal feelings. These tallied with the branch observations. Others sometimes described having multiple calls in one shift from suicidal callers, or those in the process of a suicide attempt. Such variance has an impact on volunteers, as feelings of 'doing something worthwhile' and of 'being needed' are discussed as important aspects of remaining as a volunteer (see Chapters 3 & 6).

> *… you wouldn't even necessarily get one of those on a shift … but I mean the last shift I did 2 weeks ago, I had 2 +3s in one shift … I've had nothing but sex calls this afternoon.* *V218*

> *Well far too few is a good thing, but, I mean… I've been on shifts where I've not spoken to a single person who has been genuinely needy and it's like 20% of people (are suicidal), that's all.* *V403*

As an organisation, Samaritans is committed to improving emotional health and reducing the incidence of despair and suicide. In this sense, fewer calls from those who are despairing and suicidal may be considered as positive. However, the remit of the organisation and the continuing work of the volunteers depend on callers who need support. Quiet shifts are frustrating and a higher volume of 'genuine' or 'crisis' calls is valued. While it can be seen as positive when there are fewer suicidal callers, questions arise as to what volunteers are doing during quiet shifts, and as to the fit between the organization's remit and wider caller base. Many volunteers felt that supporting the suicidal is what they signed up to do,

and their intended remit. It was apparent both in the observations and in the interviews with volunteers that the number of actively despairing and suicidal calls was actually small and made up a relatively minor (albeit significant) part of the volunteer's business. This could come as a surprise and perhaps even a disappointment to new volunteers who had signed up in the expectation that their work with Samaritans would involve routinely dealing with people actively at risk of suicide, as was discussed in Chapter 3.

> *Some people do get disillusioned by it because it turns out not what you expect it to be. You know, you naïvely expect every single call is going to be quite challenging and it's going to be somebody suicidal at the end of the phone* V213

> *Well, maybe the only surprise was that all of the calls were not people who were definitely suicidal* V221

Asking about suicide in contacts

Volunteers were generally positive about the policy of asking callers about whether they were feeling suicidal, and they discussed a range of benefits to this. By raising the topic of suicide through asking about the caller's current feelings and thoughts, Samaritans display their stance towards the topic, and show that it is not taboo. This allows callers to openly discuss very difficult thoughts and emotions. Callers will not always raise the topic themselves, and so the volunteer may never know about what the caller is experiencing unless they broach the topic and ask. Generally, asking about suicide is seen as helpful for callers, and by some volunteers as being the main purpose of the organisation.

> *... people quite like to be allowed to say what they want, what they're thinking, but they won't broach it, so you can sometimes broach it for them.* V214

> *... the great thing about Samaritans is that we ask the question, as I'm sure you know, which doesn't really happen in everyday life. I mean I don't know how the conversation starts in everyday life that ends up by someone saying 'Yes, I feel suicidal'.* V251

Three volunteers discussed some difficulty with the issue of asking about suicide. Of these, two described having difficulty during training but that they had since learned and accepted the value of, and reasons for, the policy. The third discussed the question about suicide as sometimes being an uncomfortable thing to fit in to the call. Asking about suicide was discussed as having to be done in a way that fits in with the rest of the conversation, and so requiring careful timing. Volunteers also felt that it should be phrased in a way that it is not blunt or jarring. Indeed, the issue may not have to be raised through questioning in any direct manner, but can alternatively be addressed through following the caller's lead and getting to the topic in a more natural manner.

> *I hate the term 'the suicide question' because it's not a question, it's about exploring any feelings relating to suicide in whatever way is appropriate in their context...and the conversation with the caller, the question may not even get asked you can just lead into it, it's certainly not prescriptive that we ask 'Are you feeling suicidal?' It's much more about going with the caller's way of talking about things.* V225

I perhaps didn't always understand the suicide question, and the importance of that because where somebody perhaps could be giving you the right words it's sort of listening to the whole thing and tone of voice and things like that and then sometimes you know you ask them the suicide question which can seem inappropriate in the situation. V261

The issues of timing and of finding an appropriate place in the call to raise the topic of suicide were discussed by volunteers as the main reason for why suicide may never actually be raised in a call. Volunteers reported that they had waited at times for an appropriate point in a call to broach the topic, only to find that caller ended the contact before such a point occurred. It was also reported that sometimes suicide was purposely not asked about in a call because a suitable moment never arose, and the volunteer let the caller go without 'squeezing' the question in before they end of the call. The volunteer has no control, and often no anticipation, of when the caller may decide to end the call abruptly and before the opportunity to raise the question of suicidal feelings has been found.

... when you get talking to someone I think you have to make a judgement on whether asking the suicide question is appropriate. You know, and with that, I don't always ask, the suicide question. V226

So it's a very tricky one, when you do ask it. And sometimes, you just can't. You know, you just can't do it. V214

Samaritans earlier evaluation of the email service [18] identified some confusion as to how the practice of asking about suicide in each contact should be handled in emails, and found that suicide was not addressed in almost 20% of emails. This may be due to volunteers being reluctant to repeatedly ask about suicide across a string of emails from a single caller, once suicide has initially been addressed with them. The report also acknowledged that caller feedback indicated that it could be irritating to be repeatedly asked about being suicidal. This could be taken as an indication that callers were not being listened to and could cause them to break contact. In the present study, volunteers understood the organisational focus on suicide as something which callers accept or even expect. As a result, some callers begin with a disclaimer of some kind which explains that they are not suicidal but do need to talk about something. Volunteers accepted that such callers should be encouraged to continue, and be reassured that it is okay to contact Samaritans without being suicidal. It could be hard to fit in the suicide question, either because it was judged inappropriate to raise the matter, or because the caller ended the contact abruptly before the appropriate opportunity to do so had presented itself. In practice, a substantial number of calls do not include the question or an explicit discussion of suicidal feelings. A previous evaluation of volunteer experience of calls found that 33.5% of calls did not ascertain or log whether the caller was suicidal [19].

Asking about suicide was also considered helpful as it allows the volunteer to gain a more complete picture of the caller's state, and what their needs may be. Interestingly, asking about suicide in inappropriate calls was discussed as a way of 'refocusing' the call, and displaying to the caller what the main purpose of the organisation is.

... people generally know that is our focus, the people we talk to who call us on an everyday sort of level, in fact, will often start the conversation, with, 'I'm not feeling suicidal but...' and then they know that's our focus but I think therefore, it is always important to broach that subject,

otherwise we might be letting them down. But you have to ask it and they will often say, 'Ooh no I'm not that bad' or 'Not at all' and then immediately the trick is to then reassure them that that does not invalidate them talking to us. *V225*

... I often focus back on suicide and suicidal feelings. So talking with somebody who's maybe masturbating or making inappropriate type of calls and I've said ... 'so does that ever leave you feeling suicidal?' and I'll take it back to suicide, because if somebody's getting their rocks off sexually on the fact that they're telling their story to another person, talking about suicide often has a (deflammatory [sic]) effect. And it can help focus them back on what we're really there for. *V229*

As the last extract illustrates, asking a caller about suicidal feelings could be used as a deliberate strategy to 'flush out' or deter an inappropriate caller from proceeding with the call.

In asking about suicidal feelings, volunteers needed to be prepared for, and able to follow through on a range of different types of response.

... I've been trained very recently. I didn't just ask the suicide question, I explored the suicide issue in some depth or tried to. *V224*

The main thing is, if you ask someone if they're suicidal and they say 'Yes,' you've got to follow that up. You can't change the subject, you can't go back, you can't pretend they haven't said it. ... So you have to explore what they feel about their suicidal feelings. That's the important thing. *V251*

Within the Samaritans it is a truism that inviting callers to talk about suicidal thoughts and intentions postpones or diminishes the likelihood of subsequent action. This concept is at the core of the organisation's mission and values, and is a view generally held by researchers and clinicians [20]. There were some instances of callers supporting this notion (discussed further below) through claims that contacting Samaritans can help them 'step down' from an imminent attempt to kill themselves. Although maintaining a focus purely on suicidal ideation may be difficult to sustain within a call for extended periods of time, volunteers reported a commitment to engaging callers on their suicidal thoughts and feelings where possible.

I feel is really important and we must bear in mind is that whilst we always respect peoples wish to die if they wanted to, the very fact that they talk to about it will often turn the tables, not that that's what we're trying to do but what we do often has that outcome. *V201*

Well, you just want them to tell you how they're feeling and just keep them there, really, talking to you and see if you can, you know, sometimes, it's not as bad as they think when they start planning, when they start thinking about what they could do, if you give them an option they could try, if you know what I mean, sometimes. *V263*

Being suicidal

The ways in which suicidality was discussed by volunteers varied greatly and was quite complex. 'Suicidal' is improper as a blanket term here, as it will be applied differently to different callers (see below). Volunteers discussed being suicidal as a coping mechanism or a mode which some people switch into and which helps them to carry on. This 'way of being' can help them to deal with (or avoid) their problems, and may even be a comfort of sorts, as knowing that there is a potential 'exit' or end to the problems which they can control allows them to keep going. This is a difficult concept, partly as thinking about suicide may be very different to thinking about the finality of death and to engaging in suicidal behaviours. 'Being suicidal' in this sense may act as a buffer against the actual act of making a suicide attempt. There are obvious connections here with the data from callers (see below) who discuss a 'state' of being engaged in suicidal activity over periods of time, without intending to die from their actions.

> *It's very important to remember there is a difference (between) a wish and an act and from my experience, a lot of the time it does seem to be a comfort thought, I think it was Nietzsche or someone said that suicide, the thought of it, can get someone through a long night.* *V240*
>
> *I think it's a solace to people, and that's probably why they don't do it. Because they know, in the end, they could. Is that a strange thing to say?* *V245*

According to volunteers, *being suicidal* may be a particular state which not everyone who seriously contemplates suicide would necessarily fall into, with more people occasionally contemplating suicide for some reason than would actually identify as 'being suicidal'. The contemplation of suicide could be undertaken as an intellectual exercise or thought experiment rather than a manifestation of suicidal intent. Having suicidal thoughts and feelings may be a habitual response to stressors, perhaps learned or perhaps innate or personal. Again, there is a difference (as volunteers discuss it) between the suicidal state where one is feeling, thinking and talking about suicide, and actually being in the type of suicidal state where one goes ahead with an attempt. Such action will always be something which occurs when the person is in a troubled state, dealing with something painful or difficult. For one volunteer, continued attempts may be dangerous as it may become easier to eventually 'move on' into the next state where a successful attempt occurs. (This again reflects the ways in which many callers describe suicidality below.)

> *...it just becomes almost a habitual response to stress ... it's hard to tell whether the sort of the feelings, the thoughts of suicide, the threats of suicide ... have any likelihood of resulting in a suicide attempt or not ... it's almost like their way of coping.* *V216*
>
> *... lots of people in their lives do contemplate suicide ... but very few of those would necessarily describe themselves as suicidal.* *V207*

This means that often there may be a lack of correspondence between the words callers' use to describe their thoughts and inner feelings, and their intentions. Volunteers recognized the volatility of callers' emotional experiences: feelings of great intensity and desperation could dissipate - and reappear - rapidly.

Often, things in the night which seem unanswerable, in the morning, in the light, you know, cold light of day, and often when you do a follow-up for someone else, and you talk to the person, they say, 'Oh no, everything's fine now, I'm, really, I'm fine', and you wouldn't think it was the same call. *V263*

Degree of intent to die, wonderful issue. One person's highly expressed degree of intent to die can switch in a nano-second. At a point of personal realisation. And another one's suicidal or, attention-seeking behaviour, personal self-control behaviour in the case of self-harming, can actually lead to death. But that wasn't the intent....It's an interesting issue. *V229*

A further theme evident in the volunteer data, which also supports some of the notions above, is the concept that when callers are seemingly at their lowest point, and in the very lowest depths of despair, they are not very likely to commit suicide. This may be because they do not have the energy, strength, or general ability to put plans into action. This issue is also recognised by clinicians and academics in the field [6, 21]. Therefore, the most worrying callers may be the ones who seem to be coming out of the worst of their despair, or perhaps just heading for the worst. They may seem better, or calm, when they are nearer to making a suicide attempt. These 'calm' suicides which occur when the caller has deliberated greatly over the act may be rare however, or not the norm for Samaritans.

The other interesting thing about prisons is that there is a theory that when people are at their worst they won't commit suicide … if you hit a kerb at the bottom part of depression they won't take their lives there they tend to take it either just before they hit their lowest point or more likely when they're just coming out of it. They've got sufficient energy it seems, to just do the act and in the prison situation we can almost track that. *V201*

He talked about the fact that he wanted peace … he didn't want to go on and … there wasn't any intensity to it. This, I think, was one of the reasons why I felt he was, he was very calm at that point, that he knew he wanted, he'd made the decision he wanted to die. *V262*

Volunteers discussed other ways of telling when a person may be near to making an attempt at suicide such as giving away belongings or becoming withdrawn. Particular vulnerability may be associated with specific stages of experience, such as bereavement or release from prison. Unfortunately, these things may not be considered as signs of a potential suicide until after the event.

Where the most risk is the first week in prison, that's in a normal prison, ours is a local prison where there are a lot of remand prisoners, and the people who are at the most risk are clearly those that are in for the first few weeks … there are broad patterns of behaviour, I mean one of the biggest giveaways is that the person literally starts to do that, starts to give away things that are of value to them, but [also] changes of behaviour and more lonely, solo way of life. *V201*

And my uncle who took his own life at the age of sixty five when he was just on the verge of retirement which, an unusual step really. But, and all

the signs were there in retrospect, but none of them had been picked up by anyone. *V220*

Predicting which callers may be close to a suicide attempt was discussed as being very difficult. Callers presenting as suicidal may not actually attempt suicide. Callers may experience rapid changes to their emotional state and the likelihood of making an attempt will increase or decrease across time. Volunteers may have no way of knowing which callers will actually make an attempt. When callers tell Samaritans that they intend to end their lives, this may be more a way of expressing emotional tension than a statement of deliberate intent.

In Samaritan contacts, a long history of claiming to be making a suicide attempt may not be an indicator of whether a caller will actually commit suicide, and some callers will repeatedly ring claiming to be on the verge of ending their lives. Volunteers reported occasions when it had been difficult to trust or believe callers who said they are close to making an attempt. This may be a direct result of callers repeatedly presenting as suicidal, without ever actually committing suicide. Predicting such things is difficult for volunteers, and callers' situations and behaviours can change rapidly.

> *… there are some callers who phone very regularly who are quite often quite dramatically suicidal so they'll explain that they're sitting with, sitting, you know, next to a railway line or the bridge or next to a bottle of pills or something.* *V270*

> *… most of the callers who phone up, even the ones who are saying they're attempting, the back of your mind, you feel that they're probably not going to. And a lot of the regular callers who are particularly stressed will call up and say, and present, you know, an attempt but there were several attempts in the file but they've never actually gone through with it. So. I mean, I see the suicide aspect of the calls as, you know, a symptom of the intense kind of distressful situations that we're talking about in the calls more than anything else.* *V219*

To complicate this, some callers may deliberately appear to die while in contact. Callers who present as suicidal or as dying, sometimes as part of a broader fantasy, are known to contact the organisation (repeatedly in some cases).

> *you get the people wind us up doing things like that, which I think is absolutely hideous … and you can hear them go quiet, you can hear them sort of slip off and you can hear them breathing and not breathing.* *V403*

Assessment of suicide risk is extremely difficult, even for experienced volunteers, and over long term contact. The often brief but always decontextualised encounters between the volunteers and callers cannot be considered an adequate basis for reliably assessing the degree of suicidal risk. Indeed, assessing suicide risk is a difficult task, even among professionals [6, 7, 22]. The current logging of calls on a seven point scale is potentially inappropriate and misleading, and may over-represent the frequency and severity of suicidal behavior and intent among callers. Volunteer judgements are highly variable and subjective and often based on very brief encounters. Callers can clearly mean very different things when using words relating to suicide and suicidal intent. For this purpose, it is not so much a question of whether callers are 'genuine' or not, in how they describe their intentions and distress, but one of *what they mean* by the use of words

relating to suicide and self harm. As we shall see below, it is evident that callers themselves may not be clear about their intentions, and that suicidal impulses can be highly volatile [23-25].

Handling calls from people who are suicidal

When volunteers discussed handling and managing calls from people who are suicidal, they tended to describe following the usual procedures of Samaritan support. Listening to callers, 'being there' for them, focussing on feelings, being non-judgemental, and respecting the choices of the caller were all discussed as part of the repertoire of supporting the suicidal.

> *I'm not sure I'd try and do anything very differently from how I do normally, I think it's the same process.* V270

> *So, you know, I talk to them in the normal way and found that, won't say I found it easy but I found it straightforward, in terms of, yeah, that's what we do.* V264

A commonly reported practice during contacts with people who are suicidal was that of getting support from other volunteers while befriending the caller. This might be through the formal hierarchical structure available, or through the practice of getting support from the fellow (call-taking) volunteer on duty. Accessing this support can help the volunteer know what to say or do, to ensure that they are doing everything correctly, and also to ensure that they themselves are supported while supporting the suicidal person.

> *.. that's where I wanted the other , you know, colleagues, the other Samaritan just to make sure I was doing everything, 'cause that supports me* V261

> *… the ones that sound the most distressing … can be emails … it's easier and harder in that you haven't got the person to lead things through with … because it's an email, you have the opportunity of discussing it with fellow (Samaritans) on shift.* V210

Very interesting accounts were offered of the ways volunteers behave and feel when they are supporting severely suicidal callers. They reported focussing in on a caller in a very intense manner, or even 'changing state' or switching to a different kind of supportive mode, such that they become detached from everything around them, and even from how they themselves were feeling. This may be instinctive, something learned in training, or a completely natural and unconscious process. It is perhaps due to this process that volunteers at times described calls from the very suicidal as relatively easy to manage and deal with.

> *.. it makes you sort of physically and mentally and emotionally sit up, as it were, when you're faced with a suicidal situation, and I think all your, all your faculties are sort of sharpened a bit … I don't find them, I don't find them the most difficult calls.* V268

> *You just, I think you just deal with it, with, you know, my instinct takes over, I forget what's going on outside the call. And I just focus completely on them really. So it's not that you feel, I couldn't say how I feel because*

you just deal with it, you know, you cope as best you can and you just focus on them, you know? V204

Suicide prevention and intervention

Volunteers discussed how they do not routinely intervene in cases where callers appear to be close to suicide, but that they hoped to prevent at least some suicides by being available to listen to and support callers. Should a caller claim to be in the process of ending their life during a telephone contact, the volunteer would ask if the caller wanted some kind of intervention. This would only occur when a caller accepted the volunteer's offer (unless the caller is at a branch, or falls unconscious during a call following the provision of contact details). Following the policy of self-determination, when supporting suicidal callers who say they do not want any intervention, the volunteers accept the caller's intention to end their life. Yet when talking about how they react to callers with such an intent, volunteers discussed actively steering the dialogue in a manner which encourages the caller to 'focus on the positives' in their life, and / or to reconsider committing suicide. Even those volunteers who described taking a more neutral stance discussed giving the caller the opportunity in the conversation to find an alternative to suicide.

… my role is not to say, you know, don't do it, there's another choice out there … if you're a skilful Samaritan, I think you can explore other issues … in ways that allow people to see beyond the reasons why they want to end their life … I think sometimes you can help people just at that very particular moment in time see an alternative. V237

… I look for something by asking them different questions, of what they used to do or what they think their life is going to be like and, you know, look for a positive. And develop on that. V265

These data support the discussion in the previous chapter on how volunteers aim to support callers to find their own options and solutions, rather than telling them what to do, or providing them with directions or advice. Yet steering the dialogue with a suicidal caller into an area where positives are discussed, or such that alternatives to suicide are discussed, may be a difficult practice to manage and to align with the Samaritan notion of listening to callers rather than directing them. More typically, volunteers claimed that they merely supported suicidal callers in the standard, Samaritan manner. A reduction in the number of people who commit suicide is still hoped or aimed for, whichever approach is taken.

When you listen to somebody, you're acknowledging what they're saying, they know you're not judging them, you're witnessing their deepest feelings. You're taking them seriously, which not everybody does. You're listening to difficult stuff but you're not getting upset yourself … we don't get into suicide prevention, because if we did people wouldn't ring us like they do. V251

Volunteers discussed the decision to commit suicide as being typically due to very severe circumstances, and on occasion discussed how mental illness may affect a caller's ability to make such decisions (as well as claiming that this may be an issue on which the organisation does not support callers well). More or less explicitly, there was a distinction between suicidal callers who had made a rational decision to end their lives, and those whose impulses and inability to

consider alternatives might be driven by illness. These impulse–driven suicides may be seen by volunteers as requiring a more proactive response, and as prime cases for Samaritan support. Some volunteers suggested that the Samaritans 'brand' of suicide prevention works best among those who are not long-term suicidal, i.e. among those who are in a sudden or temporary suicidal phase.

> *... a person does have a right to take their life ... but when a person is in a manic phase ... it's a window that happens to mentally ill people, that happens where they have this urge to do it, and, you know, one has always thought, if only, if only something had intervened in that period, you know, then it might not have happened ... that to me is a big role for the Samaritans.* *V245*
>
> *The real power of some of our work is amongst the undecided and distressed, you know, most people who are feeling suicidal are actually in what I would call, emotional and mental (tumult), so they're boiling over and hardly able to focus on one thing or another and the only way out of this crucifying pain, the only way they can see is their own death and simply to be able to help calm that (tumult) is support them in thinking about what they want and what the other options, potentially are, for them, I think is a great offering.* *V229*

This issue relates to the relationship between suicide and impulsivity. Suicidal behaviours may result from sudden impulses to act, regardless of intent. Support for this stems from findings that many completed suicides appear to happen without much prior planning, and many attempters report that they had contemplated suicide for less than fifteen minutes before acting [26, 27]. There is much debate in this area. The psychological construct of impulsivity (considered as a personality trait) has been found to measure more strongly in individuals who contemplate and plan their suicide attempts than in those who engage in 'spur of the moment' attempts [26]. Impulsivity as a trait has also been strongly linked to pre-attempt suicidal ideation [27]. It may be the case that the personality concept of 'impulsivity' does not relate to the impulsive element of unplanned or sudden suicidal behaviour. A recent systematic review of papers in this area found that hopelessness was one of the main traits repeatedly associated with suicide, with more research needed to determine the role of impulsivity [28]. Recent work from a large, national review of mental health in the U.S.A. has found that when individuals with a depressive disorder begin to experience suicidal ideation, the co-presence of a further disorder (specifically anxiety, neurotic disorders, and disorders which reduce impulse control such as conduct or substance-abuse disorders) are a stronger predictor of suicidal behaviour than the depressive disorder alone [29]. 'Impulse control' was used to link a number of disorders as the poor impulse control element of these was found to be an important factor. It is perhaps impulse control as an element of a disorder, rather than impulsivity as a personality trait, that is thus more associated with 'spur of the moment' suicidal behaviour.

Samaritans' policy of self determination

A potential tension arises between the desire (and organizational aim) to reduce the number of suicides, and the core Samaritans principle of self-determination which respects and supports the right of the individual to make choices about his life, including when and how to end it. The 'professional' position here is to maintain a display of neutrality about the outcome. This is clearly asking a lot of the volunteer.

I'm not sure you would get totally unalloyed pleasure feeling from somebody having decided not to commit suicide because … I hope I wouldn't feel a sense of, you know, not satisfaction but joy and relief about that, because that's not, not (quite the package) if you see what I mean. V206

… during training I questioned self determination … I mean as a normal human being to have someone on the phone who is telling you that they are actually taking their life, that is a really, really difficult thing to try and listen and understand. V226

Volunteers accepted, and were often strongly committed to, the self determination policy. While one volunteer discussed having some difficulty with this issue during training, all reported that they abide by it and do not force or coerce callers into receiving help when they appear to be in the process of committing suicide (even when they may be upset by this and would like the caller to live). Volunteers accepted, and seemed to believe personally, that callers have the right to end their life should they wish to. However, this may never be tested as not all volunteers had experienced a suicide in progress during their time as a Samaritan.

Volunteers reported that while they respect the self determination policy and a person's right to end their life, they do often hope that the caller will accept help. This is typically in the form of an ambulance being sent to the person's address (no volunteers mentioned the former option of sending a 'flying squad' of volunteers out to suicidal callers).

… we do keep saying to a caller who is, says they've taken tablets, Do you want assistance? And giving them every chance to let them, to get them help or try to talk them into phoning the ambulance. V263

Samaritans say we'll accept it if you're feeling like that but if you do want help then, then, that's okay too. V204

Such interventions may be positive and affirming actions to take for some volunteers, as it may help them to feel that they are following procedure and 'doing all they can' for the caller. Sending ambulances may be problematic in some cases as there are callers who repeatedly have ambulances sent out to them, and the ambulance service may then begin to have issues with going. This practice may be difficult for volunteers to manage in cases where callers give contact details during one call, but then become unresponsive after a suicide attempt during another call. For these reasons, the preferred practice of having the caller get in touch with the emergency services themselves was discussed as a necessary option for Samaritans. If there is any doubt about what is going on in a contact, then the volunteers' preference is usually to 'err on the side of life' by arranging for an ambulance, and to consider that the caller can die at another time should that be what they really want.

Self-determination allows a person to have the right to take their own life and we should not or do not prevent it. But … we are on the side of life … you can only die once … on the basis that if the person comes round and … if they really, really, really want to, they can still go off and kill themselves. V229

Staying with callers to the point of death

When a telephone caller contacts Samaritans after initiating a suicide attempt, or begins to attempt suicide during a contact, volunteers will stay with the caller for as long as they want them to. This is the volunteers' most extreme commitment as it will sometimes involve staying on the line to accompany the caller to the point of death. Practice is different for face-to-face calls where volunteers are bound by law to seek medical help as it is illegal to assist a suicide in the UK (and not intervening could be construed as assisting).

> *If there is a suicide or an attempt within a prison the Listeners will alert their local branch of Samaritans and extra support is offered. A Listener cannot breach the confidentiality of their meeting with a caller but it gets complicated if the caller is actively suicidal because the listener has to be careful not to be seen as aiding and abetting suicide.* *V253*

A critical aspect of volunteer support is to allow for the unique opportunity for personal reflection through non-judgemental listening and acceptance. When a caller is able to use this discursive space as a route to concluding that they still wish to end their life, this could be considered, from the volunteer's perspective as 'a job well done'. The final accompaniment could be considered one of the most challenging aspects of the volunteer role, but also, in a sense constitutes its ultimate gratification, as volunteers discuss this as an 'honour' and a 'privilege'.

> *If they don't want an ambulance, and they do genuinely die on you it's a huge honour, to share that last few minutes with that person. And I kind of, although I don't get involved with them I don't emotionally connect to them, I think, I'm the last person, that person, they spoke to ... although I can't tell you about it, it matters.* *V403*

> *I: How do you feel about handling calls were the caller is feeling suicidal?*

> *V233: Privileged to give an opportunity to that person.*

In telephone calls, the volunteer will follow the procedure of informing the caller that help will only be sought if the caller wishes, or if they provide contact details and then become unresponsive. Otherwise, the volunteer should contact the leader on duty, and remain on the phone with the caller until they become unresponsive. Unresponsiveness may or may not mean that the caller has died. After a while the volunteer will have to hang up, but will have no idea what has actually happened to the caller. Volunteers seem to be generally accepting of these practices, and report trying to support and reassure the caller without pressuring them to do anything, for as long as possible. This is a potentially painful aspect of their work.

> *I have been on the line where, of course you don't know if somebody dies, all you know is, you know, that they've gone to sleep or become unconscious.* *V211*

> *It's only happened a few times and they tend to be very long calls and you don't know what's happened at the end because it just goes quiet, so you don't know, you just don't know. I try and say that it's ok that they've called and that it is fine for us to be there for them whilst that is happening and we say to them that we don't want people to be alone at*

that time, it's a very difficult time and I like to tell them that we are there to support them and we're not there to change their mind. V202

Volunteers are well aware that not all apparent cases of suicides in progress, or of dying while in contact, are real. Although this may sometimes lead volunteers to challenge the caller, those who present as suicidal appear be treated as such in practice. Even when a volunteer may be uncertain as to the true nature of the contact, at least for the duration of the call, the caller will be allowed the 'benefit of the doubt'

Only one volunteer offered a contrasting version of the procedure for staying with callers while they die. Despite it being quite clear in (module 4 of) SIT that volunteers will stay with callers until the point of death if this is the caller's wish, this respondent reported that the policy is to hang up before the caller becomes unresponsive, and they had actually done this with a caller.

I talked to her for a long time and then, she said I'm still going to do it and I said, Well, I can't be on the phone whilst you, you know, I can't listen to you kill yourself ... we will, you know, not talk you … while you're dying. That is a policy, (you're meant) to do that. I can talk to you until you get drowsy but I will stop the call before you die. V220

Related to the above discussion are the claims of volunteers (and indeed some callers) that callers will not contact Samaritans if they *do truly intend* to commit suicide. Callers in general are constructed by volunteers as, on some level, wanting intervention or encouragement to live. Any callers who do not fit this pattern (i.e. those who have contacted but do actually want to die) will be supported in this decision, as we have seen above. It appears that callers do not have to voice any hesitancy regarding a suicide attempt; the mere fact that they have called is sufficient for them to be considered by some volunteers as hesitant, or undecided in some way. As discussed earlier, callers who are subject to some kind of intervention are discussed as being able to commit suicide at a later point on their own should they wish to.

I don't think the people who are hell-bent on killing themselves is going to phone Samaritans to tell them. V265

Knowing what happens to suicidal callers

Volunteers reported that they typically have no knowledge of what happens to callers once the contact has been ended, whether it is ended by the caller or the volunteer. Callers who appear to be in the process of committing suicide may or may not die, and volunteers often have to guess when to hang up on an unresponsive caller. Cues such as silence and or breathing sounds will be used to gauge whether a call should be kept open or whether the volunteer should hang up. To complicate this, as mentioned above, some callers may deliberately mislead volunteers by appearing to die while in contact. Typical procedure appears to be taking time to be sure that a caller is completely unresponsive, and will probably not speak again. This may help the volunteer to feel that they have done 'all they could'. Indeed, the volunteer data suggests a strong desire not to end the call prematurely, and much time and consideration will be given to discerning whether a caller has truly lost consciousness.

I have been on the line where, of course you don't know if somebody dies, all you know is that they've gone to sleep or become unconscious. The times when they don't put the phone down (...) and sometimes they do, they say they're just going to end the call now and you just don't know what happens. On another occasion, I just stayed on the phone for quarter of an hour or twenty minutes, when the mixture of silence and you know, somebody's regular breathing, maybe slow breathing, and me trying to get a response and not getting a response, you know, you're pretty sure that you couldn't do more at that time. V211

Volunteers are not able to purposely seek out information on callers after a contact, but will sometimes inadvertently find out what happened to a caller by taking another contact from them, by seeing something about them in the branch (a note or a log entry perhaps), or by hearing or seeing something more public, like a newspaper report. This could be very difficult for volunteers if the news is bad, or it may be a relief should the 'news' be good.

And that was brilliant. Was such a relief to get that call... V241

... on several occasions, I've come off the call not knowing whether she would commit suicide or not, which left me pretty, pretty raw, I suppose. V238

Being affected by suicidal callers

Not knowing or hearing anything about what had happened to a suicidal caller could be difficult for volunteers to deal with, and the cause of much emotional distress. However, some volunteers indicated that they were not affected by callers who were severely suicidal, or who attempted suicide during contacts. They may feel sad for the caller, but while they continued to think about them, they did not continue to feel upset about them. Feeling as though they had done all they could and not knowing for certain whether the caller had actually died may act as a kind of 'buffer' against feeling upset or distressed by the call. Additionally, feeling that the caller was calm and 'at peace' with their decision may help prevent volunteers from becoming distressed. Supporting callers who are unsure or distressed about suicide may be more difficult for volunteers.

Personally it doesn't cause me any difficulties. I've sat on three calls now where the person's died whilst I've been on the phone ... I can't say I don't think about them ... I do feel sorry for people, and I wish I could change it. But I do know that I can't so there's no point in beating myself up over it. V403

I wasn't as affected by it as I was by some other calls, I think it's because they were very calm and they felt like they were doing the right thing. But actually I felt happy that they felt happy that they'd decided. It's often very distressing calls that can be difficult. Where you feel that they're not sure what they are doing. V202

Other volunteers reported feeling very upset and distressed when callers had been very suicidal or in the process of committing suicide during a contact. Such callers 'stay with them' for a while after the contact had ended.

There are very few calls that will actually stay with me once I've gone. Two or three in the time that I've been here. So, yes, of course, I've had, and sometimes you feel upset when you come off the phone. V206

Oh, it happened, you know, people were definitely overdosed and on the phone ... and, these instances, they do tend to, if you've been on the phone for quite a while with them, you know, they do tend to live on with you for a long time ... the first time it ever happened, I think I was very sort of affected, deeply affected by it and thought about it for a long time... V211

'Being affected' by suicidal callers was spoken about by many volunteers as something understandable, and as a natural or 'human' response or reaction (whether referring to their own emotional responses or those of volunteers in general).

I think that's quite common thing, actually. Definitely, certainly, to worry about someone afterwards, to think about whether the call has helped them and, yeah, I mean, there's definitely cases (where I) wondered about what's happened to the caller afterwards... V209

It does affect you because you're completely, you're completely empathising with these people, so you're really feeling what they're feeling, you know? ... you don't always know how situations will turn out but, you just kind of hope that they'll call back if they're needed again and that things will get better, you know? That's all you can do. V204

As seen in the previous extract, feelings of hope that things turned out okay for the caller and that they did not die by their actions were also reported. Volunteers, of course, do not want callers to commit suicide, and empathising with callers may increase this feeling of 'hoping they make it through'. When 'not knowing' is mixed with strong feelings of empathy for a caller the distress felt by volunteers may be increased.

Well, I felt quite devastated because he'd told me about his earlier life and he hadn't had an easy time, he didn't have a good childhood, he hadn't been happy as an adult, and I could understand why he did it, although I didn't want him to do it but, that was his choice. V214

Added to which is that you feel/hope your listening will make a difference, bringing a degree of comfort, whatever the outcome. That said, of course individual callers can have a personality, a situation, just a way of expressing themselves, that can somehow touch a particular chord. They then become more memorable, more affecting, more liable to create an emotional 'I hope they make it through' response. V228

Volunteers offered differing reports on whether increased experience of supporting suicidal callers leads to a decrease in negative feelings following such contacts. Some reported that it became easier with experience, and others not. Occasionally, volunteers experienced strong reactions to supporting suicidal callers, with physical effects on occasion such as being unable to sleep, or being physically ill.

And I've had it since, and whether it's just more experience y'know I'm not sure, but I haven't; I've been able to cope with it a lot better.
V226

… due to the nature of the story and the severity, I suppose, of the caller's situation, I was actually physically ill after the call. And, by that I mean, I had severe stomach upset, I was vomiting. And, I actually had, I actually broke down four times after that weekend as a result of the call.
V234

One respondent felt that while it is understandable to be affected by suicidal callers, it should be something that volunteers expect, and also that it will only be a problem if the volunteer has 'misjudged' their capacity to support the suicidal. Other volunteers do not put their feelings in such strong terms, but claim that while supporting the suicidal is difficult, it is the core purpose of being a Samaritan.

It would be foolish to say that it's not affecting to talk to someone who is so unhappy with their life that they want to end it. Even if they are simply saying it seems a good (or even just a possible) option. However, I'd guess that every single volunteer who joins expects that to be a key element in the contacts they would be involved in – indeed the incidence of such calls is invariably lower than the expectation. So unless you badly misjudged your own capacity to listen to the expression of suicidal feelings, it's not a problem. *V228*

I think they can be draining but at the end of the day to me they're what I'm there for. *V227*

Section summary

Engaging with and supporting suicidal callers was described as the provision of normal Samaritan support, albeit in perhaps a more focussed manner, and as requiring the support of other volunteers. There is much more to this issue than a single question about suicide, and volunteers discussed needing to delve into the topic, exploring the caller's experience as deeply as possible. This was seen as allowing callers the opportunity to reflect upon their options, and to hopefully avert any immediate attempt at suicide. Suicidality itself was seen as a long term state or way of being for some callers, and expressions of 'being suicidal' were considered to not be good indicators of proximity to a suicide attempt. Volunteers perceived great variation in the ways callers experience suicidal ideation, and within their meanings when presenting as suicidal. Callers considered to be at particular risk were those with mental health issues as these may lead to more irrational, impulsive attempts, as well as those who appear to be improving, as they may have the 'energy' at that point to go through with an attempt. Yet the assessment of a caller's level of suicidality was considered to be very difficult, with great variation within the usage of terms and with callers' states and experiences oscillating across time in terms of severity (these points are generally mirrored by callers' data below). These difficulties also raise issues regarding the use of the seven point scale for logging callers' levels of suicidality, which may over-represent suicidality among callers.

Analysis of callers' interviews and emails

Being asked about suicide in contacts

The interview and email data from callers reflected the results from the online survey (Chapter 4). Many callers were positive about their experiences of being asked about suicide in Samaritan contacts, while others reported these in quite negative terms. Interviewed callers generally appeared to accept Samaritans' policy of routinely asking about suicide, and reported either being either just 'okay' about it, or being greatly appreciative of being asked (regardless of whether or not they considered themselves to be actively suicidal). One interview respondent reported having been shocked by the question, because she felt like the volunteer was *suggesting* suicide to her. This appeared to have been an issue on only one occasion, and had not put her off phoning again. Talking to Samaritans about suicidal thoughts and feelings was typically experienced as a release, and helped the caller to feel better and calmer. Callers also discussed an appreciation for being able to cover the topic of suicide without the need to raise it themselves.

> *Yes they ask me and I usually find this question helpful as it gets it out in the open and lets me talk.* *S116*
>
> I: So, when you were speaking to this lady this morning, did she ask you whether you had suicidal thoughts or feelings?
>
> S175: Do you know, I think she did not. ...They normally do. I'm used to that. ...Maybe she picked up that I definitely wasn't in that state.

This preceding comment may mirror the points from volunteers where they discussed needing to wait until an appropriate point to ask about suicide, and as not asking if such a point does not arise before the end of a call. Related to this is how callers at times found being asked routinely about suicidal thoughts and feelings inappropriate and even irritating, typically because they were not suicidal, or because of issues with the terminology used by Samaritans[64] which do not readily allow for the expression of indeterminacy or uncertainty. Also, while it was discussed above that volunteers claimed to routinely accept and support callers who are not suicidal, this was not always the experience reported by all callers. For example, EMFB 527 below reports a lack of such acceptance and support once identifying as not suicidal.

> *I know they've got to ask it, but for me it's frustrating because I try and explain to them that what I do is self-harm.* *S135*
>
> *My experience of the Samaritans is not very encouraging. I have rung them about half a dozen times over the last few years. On each occasion they have been quite curt. They will listen for two or three minutes, but then seemed programmed to ask whether you are considering killing yourself. If your answer is no, then they quickly lose interest.* *EMFB527*

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[64] When a speaker is asked a question which requires a 'Yes' or 'No' response, providing either of these indicates an acceptance of the terms embedded within the question. E.G. in replying to a question such as 'Are you suicidal?', a 'yes' or 'no' would accept the 'either / or' nature of the question. Speakers will have to engage in much conversational work to challenge such assumptions. See Raymond [30]. for a review.

Some callers also experienced poor responses from volunteers when they did discuss suicidal feelings with them. Volunteers may have offered unwarranted explanations to the caller for why they feel suicidal, which the caller may consider to be wildly inappropriate. There was also evidence in the email data which suggests that callers were asked about suicidality across a number of occasions which they felt was excessive or displayed that volunteers were not listening or paying attention to their emails. This issue of repeatedly asking about suicide in email contacts had been marked as problematic in the 2005 report on the email service, and appears to remain an issue. Such issues appeared to lead to much frustration, and may lead callers to break contact.

> *If you have seen previous emails then you will know what the edge is and what happened the last time this happened, I will not go thru that again. You will also know that I will not answer the "harm" question as that will start the avalanche again.* ES507

> *... once a volunteer started telling him that the reason for his suicidal feelings were to do with his meridian lines being out of sync in his body and she told him he needed to get help with that. Again, he said, he felt too shocked and unprepared to confront her and say that he hadn't called to hear that so he just ended the call.* Interview Notes S102

Reported reasons for acts of suicide

Callers explained their suicidal behaviour in terms of potentially delivering an end to something they were going through. Often this 'something' was referred to in vague or general terms, such as the end of 'the hurt' or 'the pain'. In some cases, what they hoped to end was the actual coping with or management of a particular trouble, or general pain and suffering. Suicide was also discussed as offering a 'release'. Although suicide would bring an end to suffering, death itself was not always mentioned. In some instances, the method used in an attempt was discussed as what will bring about the end of suffering, as in the first extract below.

> *I'm sorry but I desperately want someone to hold me and tell me that it will all go away, even if that's holding me while I overdose. Just so that I know all the hurt is over and will be gone forever.* ES525

> *Coping with it is terrible. it is the reason why i feel like i have to kill myself to be relieved.* ES530

Sometimes callers had very specific social goals in mind when discussing suicide. They either claimed directly that these specific goals were the reason for committing suicide, or saw these goals as a 'hoped for' outcome of their suicide. Whether callers discussed emotional or practical reasons for their past or future suicide attempts, attempts were linked in various ways to emotional distress. Callers did not consider their reasons as incommensurate with suicide as a method for achieving them, nor did they see suicide as an excessive method for achieving their goals. Death was not always an intended outcome in these cases. As discussed below, it seems that the relationship between actions and intentions is highly individual.

> *I used to go to great lengths to get him to listen when I was seriously ill, taking many many serious overdoses in an attempt to show him I was in pain and needed help.* ES503

Visions of killing myself for insurance money or getting hit by a car so I can get disability are going through my mind. *ES548*

Another common reason for suicide offered by callers was a desire to avoid something in the future. This may again be something specific, but was more often a general picture of a very painful future which they did not feel they could live through, or did not want to try, or to have to, live through. There was much variation in the things which callers listed as wanting to avoid, although a general fear or rejection of an anticipated future typically featured as part of callers' accounts when discussing a problematic future as the reason for wanting to end their life.

I was going to try to start my life over there and if it doesn't work out then yes I probably will want to end my life. *ES559*

I'm willing to go through the temporary physical pain knowing that I'll never be conscious again. … And I could just go day to day, have a pathetic loser life but, really, why bother? One act is just a release from that, a last minute reprieve from a 50 year prison sentence. *ES501*

Related to this is the way that callers claimed that their past, current, or future suicide attempts coincided with or were in part caused by a sense of hopelessness. Whatever the issue the caller was dealing with, they claimed that there was no hope for an end to it, and suicide was sometimes referred to as the caller's only option, or only method for dealing with their situation. Callers may not be unequivocally resigned to this, and sometimes claimed to be reluctantly considering suicide as there was no other option for them. Hopelessness is of course a major focus of much empirical, deductive work in suicide research, and it is often discussed as a major causal or modulating factor in suicide [21, 31]

I don't want to kill myself but I don't think I have another option. *ES524*

… things had just got so bad and hopeless and empty and whatever. *S109*

Being suicidal

Callers who were interviewed often engaged in extended narratives on the nature of various events and happenings which had led to them feeling suicidal, or to a suicide attempt. In both the interview data and the emails from callers, a prevalent concept was that of an overwhelming 'build-up' of emotions or events which preceded feeling suicidal or an actual suicide attempt. Specific events or emotions were sometimes discussed, and at other times a general gloss of 'difficult times' was given which invokes a sense of multiple troubles over a period of time. The notion of a 'build-up' was often linked to a kind of crisis point where the pressure became too much for the caller to manage or cope with.

Hey I am just writing cause I am dealing with a lot in my life right now and it s at the point where I am, well want to kill myself really bad cause of it. *ES547*

It's just all piling up there, I've got no out let. Just like a pressure cooker. I just want to go to sleep and never wake up. Ever. *ES519*

The ways in which callers discussed other emotions invoked a very complex relationship between feeling suicidal and feeling distressed or despairing. Some callers described distress or despair as co-occurring with suicidal feelings. Others seemed to invoke a kind of continuum, with being suicidal further along the continuum, and following on from despair. Others, however, discussed being suicidal as a very different way of feeling from being in despair or being distressed. Thus, the ways in which callers described their experiences in terms of distress, despair, and feeling suicidal, seemed highly individual, varying greatly across the different narratives.

> *I'd been depressed for quite a long time … I was going to hang myself.*
> *S133*

> *I was extremely distressed but not suicidal and there's a difference.*
> *S106*

Seeing such a complex emotional 'landscape' arise from the data, where callers differed greatly in these ways, is perhaps not surprising. But when in great despair or emotional pain, some callers claimed that they are close to a suicide attempt despite not wanting to commit suicide at all. They may be distressed at the thought of committing suicide, and even perhaps be against suicide as a way of dealing with their pain, but will still be feeling as though they are close to making an attempt. Nevertheless, the prospect of suicide was still considered as perhaps the only option or way forward.

> *I don't believe in suicide as an answer - but I don't see that the pain will ever stop. I know people say that it gets easier with time, but it seems to have got worse so far with time. I can't keep on doing this for another 30 years.* *ES506*

> *… it makes me sad to think I am actually carrying this through … I wish there was another way because I think I am really going to hurt my children. I just can't stand this pain any longer.* *ES524*

In many of the caller emails, there was a strong theme of suicidal feelings wavering between strong and weak phases. Over the course of multiple contacts, callers described varying levels of suicidal ideation, and sometimes they claimed in a contact that they were unsure about, or were debating whether to carry out a suicide attempt. Suicidal feelings may change in a short period of time, or may be in a more constant, unstable state, wavering persistently. Some callers appeared to feel that they may never be completely sure that suicide is the right decision for them, even when being close to making an attempt.

> *Although I see dying as the easier option in actual fact I know it isn't, in reality it is really hard to kill oneself as to get to that place where you are 100% certain and don't have any regrets is tricky.* *ES503*

> *Think I'm quite determined now … But how many other times was I sure about it and, just because my house wasn't tidy (one of the conditions before dying), I didn't do it. So maybe I didn't really want it after all.*
> *ES544*

This may be crucial to Samaritans effectiveness at suicide prevention. Apart from having wavering uncertainty, many callers who claimed to be suicidal also

appeared open to intervention of some kind. Others appeared to be openly seeking intervention. Callers may also become open to prevention following some persuasive work by volunteers, or they may seek help out themselves even some time after the beginning of an attempt. They may also be contacting Samaritans at a time when they are close to an attempt, and while claiming to be seeking another opinion, or some impartial input on their situation. This of course supports the notion discussed by volunteers above which holds that callers will often 'step down' from a suicide attempt after being allowed time and space to talk. It must be acknowledged also that for some of these callers, the language of suicide may be drawn upon to describe their experiences and internal states, without there ever being a serious attempt at suicide.

> *I think Samaritans are the best thing since sliced bread and I have been dealing with suicidal thoughts on a daily basis for 15 years and they are crucial to my survival. To talk to Samaritans helps release the pressure and takes away the impulse to overdose, I know this, it's definitely true... I can't think of a word that's good enough to describe Samaritans and what they do for me. I don't think I'd be here without them.* *S104*

> *I tried to kill myself last week ... I'm not too sure why I'm writing this but I guess it's a good idea to get another person's opinion before I do it again.* *ES501*

Suicidal language, action, and intent

It is clear from the data available that callers and volunteers were drawing upon a restricted set of words and terms, such as suicide, self-harm and attempted suicide to refer to a very wide ranging set of behaviours with varying associated outcomes. These behaviours will vary greatly in type of action, intention to die, desired social outcomes, lethality of method, and other, more individual aspects. Fairbairn [32] laments the restricted linguistic resources available within the English language to address such diversity, and claims that no other language uses one single word (as we use 'suicide') to refer to such a broad range of individual behaviours and intents. Fairbairn argues that the only commonality among the range of occurrences described by suicide is that the actions are aimed at oneself, but that we typically treat the term suicide as conveying an *attempt at death* when this may not actually be the case. Similarly, a range of writers discuss how we (mistakenly) use the results of a person's behaviours to determine the label for their actions, by following an 'alive = questionable intent / cry for help, dead = suicide' format, and call for the adoption of a more expansive terminology to avoid this [32, 33].

In the interview and email data there were also cases of callers expressing the intent behind their actions in relatively clear terms. For example, there was much data available from callers in which they reported having engaged in highly lethal suicidal behaviours, but where they convey that these are less about wanting to die, and more about engaging in a patterned set of behaviours which could possibly lead to death. There are links here to the section above on wanting an end to pain and suffering, but here, the data also indicate a clear orientation to the behaviours as *not necessarily being about a desire to die*. For some callers, this may lead to difficulty with labels such as 'suicidal', as these labels do not allow for the 'grey area' of using such behaviours for ends other than death (e.g. as a reaction to severe emotional pain). Indeed, some callers clearly described their apparently suicidal actions as *a way of being*, or as a coping mechanism. These may be long standing and patterned, with numerous events which outwardly appear to be suicide attempts. There are again obvious links here to

how volunteers discussed some callers as repeatedly presenting as suicidal, without engaging in lethal suicidal acts. Overdoses appear to be a frequently cited method in these cases.

> *Sometimes I take overdoses of tablets just to take the edge off things. It's a way of carrying on.* ES514

> *I do take overdoses and I have threatened to jump off the suspension bridge and all things like that but it's more to get rid of the pain rather than having a long standing plan to actually kill myself. So I, sometimes try and explain that to them, so, it's really hard, to say to them, it's really hard to say whether they're suicidal or not.* S135

The way that callers discussed death and their behaviours indicates a very complex relationship between these behaviours and the desire to actually die as a result of them, with great variation in the intended outcomes of suicidal behaviours. Callers who discussed having engaged in suicidal behaviour at times also displayed regret that they were still alive (and being alive after a suicide attempt in such cases seems to often lead to extremely difficult and painful feelings).

> *I took a massive overdose and as I say I woke up in intensive care ... angry that I hadn't died and the whole thing I just thought, I can't believe this.* S130

Perhaps nearer the other end of what may appear to be theoretical continuum of suicidality are callers who presented as having suicidal thoughts but who also clearly expressed that they do not want to end their lives, in some cases despite having even engaged in what may surface appear to be suicidal behaviours. For these callers, engaging in suicidal behaviours seems to be heavily related to the notion of ending pain and suffering, and as such relates to the data mentioned above from callers whose suicidality stems from a desire to bring about an end to pain. The callers here, however, have trouble with various other, physical results from suicide, as they clearly stated that they do not want to die.

> *I do think about suicide a lot at the moment, not because I want to die, but because I don't want to carry on like this anymore.* ES534

> *I don't really want to kill myself, that's the reality. If I did, I'd have done it by now. But I get to the stage that I just want to switch off, but switching off creates a backlog in the hospitals ... the last time I did it ... I realised the implications on other people.* S138

As the previous excerpt shows, callers can engage in what we would deem to be suicidal actions, and as they are still alive these actions may have been labelled as 'unsuccessful' suicides. Yet this would be misrepresenting the callers' experiences, as death was not their aim, rather, the simple state of 'being' or existing felt unbearable at that time. Some callers went a step further than those above and claimed that, despite having suicidal thoughts and feelings, they would *never* commit suicide. It may even be the case that a caller will be dealing with such thoughts and feelings on a daily basis (see extract from S104 above), but they may still have expressed a certainty that they would never kill themselves. This certainty may of course be for a number of reasons, but where reasons were mentioned they were frequently related to avoiding the pain that loved ones

would feel were the caller to die. These callers at times described a desire for a natural death to come more quickly, or a hope that they could die soon by some kind of accidental cause. Terminology may again be difficult here, particularly for the volunteers supporting these callers, as the callers may still describe themselves as feeling or being suicidal, despite also claiming that they would never commit suicide.

> *The closest I have gotten would be somewhat planning it. I wouldn't do it but I would want to. I think about it a lot. I'm not dangerous, but I could admit, even though I don't like saying it, I am suicidal. When I say I'm not dangerous I mean that I don't really attempt to kill myself when I plan to.* *ES530*

Thus the language of feeling suicidal was often used to express great distress, but without carrying any desire to engage in suicidal behaviour, or any intention to die. The caller accounts vigorously conveyed the expressive and communicative nature of suicidal terminology (or at least among those who contact the Samaritans), and the rhetorical use of suicidal language to express misery and despair.

> *How I was feeling before I phoned them?....Probably sort of, what I would call, sort of like, stable suicidal. .... Just kind of empty, empty, bottomless, it came into my head then, empty and bottomless.* *S164*

Finally, committing suicide was actually often described as something which is difficult to do, even when there was an apparent desire and intent to die. This is a separate issue from that discussed above where callers do not wish to die but see suicide as the best or only option. Rather, it is where callers discussed suicide as being *physically difficult to carry out*. Engaging in an attempt may be frightening or painful, and feelings of fear or indeed panic may only emerge after the attempt has begun. There may also be a physical barrier, a kind of survival instinct as one caller described it, which needs to be overcome before a suicide attempt can be completed.

> *I knew I was going to kill myself. I suppose it was just... I dunno, finding the courage to do it. I wanted to do it. But I was also scared of doing it.* *S130*

> *I tried it[65] a couple of times and it just made my heart was going ba-ba-ba boom and I was going dizzy and then it started to like really hurt and you get into that stage of like well can I carry on, can I carry on? But I guess the sense of survival overtakes and you just whip it off your head and go [sucks in air] and take a deep breath.* *S109*

These variations in intent expressed in callers' descriptions reflect the findings of academics who address the measurement of intention to die by suicidal actions. This concept is typically addressed in work with those who survive suicide attempts, rather than in post-mortem attempts to determine the intentions of those who have died by suicide. Research has found that not all those who engage in potentially lethal acts of suicide wanted to or intended to die from their actions, and conversely that many of those classified as 'attempters' or as 'parasuicides' had acted with suicidal intent [8, 34]. Gauging a person's intent to die may be difficult for social relational reasons (e.g. a wish to avoid

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[65] This caller reported having tried to end his life by suffocation, placing a plastic bag over his head.

consequences of disclosing what the actual intent was due to interpersonal, legal, or medical ramifications) and also because suicidal intent has been found to be a fluid phenomenon, shifting across time [35, 36].

An assessment tool frequently used in research is the Beck Suicide Intent Scale (SIS) which aims to measure the intent to die in those who have survived a suicide attempt [37], and which addresses points such as the length of time contemplating the attempt and whether a note was written, and more subjective issues such as the person's reported expectations and perceptions of their actions. A recent meta-analysis of 158 studies which utilised the SIS found that the subjective section of the scale was repeatedly scoring much higher than the more objective section [9]. This may be due to respondents over-stating their intent so as to justify their actions (and this may be an issue at play within Samaritan contacts), or having a higher intent to die before the attempt than would allow time for planned activities such as note writing. Intending to die may indeed be a very different experiential phenomenon from suicidal ideation, as ideation may be a manifestation of a desire or intent to die, or separately it may be a reflection of emotional distress [4, 38, 39].

Caller issues when 'actively suicidal'.

As mentioned, callers who are sometimes very intent on dying may oscillate between periods of varying desire to die. There may be occasions where callers who seem to clearly want to die do indeed also want to talk to someone, and may even pull back from making an attempt because they have spoken to Samaritans. Supporting such callers may be difficult for volunteers, as the volunteer may not be aware of this oscillating element of the caller's intent, and callers may offer conflicting details within one contact which make their intent to die difficult for volunteers to gauge. Even the accounts of callers who described having experienced, and acted on, ostensibly committed impulses to kill themselves, were permeated with ambivalence and uncertainty.

> *I MENT TO KILL MYSELF WHEN I STABBED MYSELF. I TOOK AN OVERDOSE ON ABILIFY AND PAIN PILLS AND ASPRIN I CALLED THE NEAREST HOSPITAL AND AN AMBULANCE IS ON ITS WAY NOW.*
> *ES504*

> *I wanted to die, but at the same time all I wanted was to talk to someone.*
> *S116*

On some occasions respondents indicated genuine fear and uncertainty about where their suicidal thoughts and impulses might lead, and discussed Samaritans as a valuable resource in helping them to calm down and so avert the possibility of action they fundamentally did not want to take. These included some descriptions of how helpful contact with the volunteers is in terms of the organisation's core principle of providing an opportunity for the caller to reflect and explore options. This strongly supports the volunteer data above where the effectiveness of Samaritans' style of support was discussed, and where callers were described as often reconsidering a suicide attempt during or following a Samaritan contact.

> *So that was the state I always was in then, and I didn't want to get back into that state … I was having quite strong suicidal thoughts and urges… so I wanted to talk to someone to try and put the lid on it straight away.*
> *S131*

I just felt safe, and I think they helped you to face up to things. They helped me, they help you to really challenge your thoughts about you, whether it's whether you really want to die or whether it's something else. And it, it does encourage you to, uh, sort of try and sort out what your feelings are, even when you don't really know yourself. S111

Conversely, one caller expressed a sense of comfort at knowing that he would be able to be in contact with a volunteer while he died, when he felt the time had come for him to end his life. Callers did not routinely discuss the Samaritan policy of self determination, or whether they would contact before (or during) dying by their own actions.

He knows that When (and he seemed very sure of this) he did commit suicide, he would be able to call Samaritans and they would be with him whilst he died. Interview Notes (unrecorded interview) S102

Suicide and self-harm

Callers who self-harmed were typically explicit that such actions were a coping strategy, entirely distinct in intent from suicidal behaviour, even if their behaviours included regular or repeated overdosing or 'threats' to kill themselves. In this context, the volunteers' treatment of self harm as equivalent to, or a pre-cursor to, suicidal behaviour was perceived to be unhelpful. Callers more generally described behaviours (which may appear to some as suicide attempts) as an act of self harm and a coping strategy rather than a deliberate attempt to end their life. Therefore, the language of suicide could again be highly elastic and the underlying referent very hard to make out, even, sometimes, for the callers themselves.

Sometimes cutting doesn't give me the satisfaction that I need, so I have taken a couple of overdoses…the intention then wasn't to die, it was the only way I knew how to … stop the mental pain. S147

I am feeling increasingly distressed and there are thoughts within my mind of running away, taking tablets and killing myself and also seriously slashing my skin with a knife but somehow I need to fight these thoughts … when your desperate those feelings and thoughts are there because you would do anything to take the internal pain and desperation away. ES503

Callers also seem to discuss being suicidal as something which can co-occur with engaging in self-harming behaviours. Both may stem from the same feelings of distress, but may be engaged in at different times. Unlike the data presented above, some callers discussed the co-occurrence of being suicidal / making suicide attempts and engaging in self-harm in such a way as to clearly differentiate between them, and mark them as separate activities.

I spent about six years in and out of psychiatric hospitals with multiple suicide attempts (I was even a failure at that) as well as the self-harming (mostly cutting my arms or hitting myself to cause bruising). ES506

Related to this is how other callers discussed self-harm and suicidal behaviours as engaged in at different stages of distress, and often clearly oriented to self-harm is a less severe option than committing suicide. Both however may be a response

to the same stressor, and a method for bringing an end to emotional pain and suffering. Suicide attempts may be made when self-harm behaviours do not provide enough respite from pain, and self-harm may be engaged in when suicide attempts are deemed a step too far. Self-harm is clearly discussed by some as not being about wanting to die, but it may also be more difficult for some to 'stop at' self-harm behaviours and not move into a suicide attempt. It is perhaps not surprising that the relationship between self-harm and suicide may be a closer one for some callers than for others, and this may indeed be a tricky issue for volunteers unless they can discuss individual caller's thoughts and feelings on the matter.

> *Instead of drinking the cleaning fluid I stuck a key into my arm and that hurt but didn't do any harm, so it was a better choice.* *ES514*

> *Sometimes cutting doesn't give me the satisfaction that I need. So, I have taken a couple of overdoses ... I don't cut to kill myself.* *S147*

> *I do really value their [Samaritans] help, but they, the way they seem to think is you're either suicidal or you're not. Whereas, in reality, there's many others (...) that curve in between, where, we set off self-harming because of the distress we're in, and some people might get to the suicide point, because of the self-harm going too far. I'm not sure they understand that.* *S135*

The relationship between suicide and mental illness

When discussing mental health problems, callers oriented to suicidal thoughts and feelings as occurring naturally with mental health problems. There was rarely any attempt to discuss *how* suicidality may be related to mental health issues, and there is a taken-for-granted nature about the way callers discuss the two as co-occurring; as though they expect others to understand that there is a relationship between the two. In plain terms, callers discuss suicidal ideation as an element or symptom of mental health problems, although they may also discuss some specific things as 'triggers' or 'last-straws'.

> *From just about my 17th birthday however I fell into a serious repeat of depression on more than one occasion to the point of contemplating suicide.* *ES517*

> *I have a very severe depression and I have borderline personality disorder so that whole sort of, self harming and just suicidal, the whole package that goes with that.* *S161*

There were some occurrences of callers orienting to suicide as more of a result or outcome of having a mental health problem rather than as a symptom of mental illness. Suicide may be what they see as their only option to escape their symptoms, or as something they are more vulnerable to as a result of having a mental illness. It is an interesting point that different callers with the same mental illness diagnosis discuss their relationship with suicidal ideation in these ways, with some discussing it as more symptomatic, and others discussing it as a separately occurring result of the illness. (Mental health issues are discussed in more detail in Chapter 9.)

I think sometimes it's purely because I'm bi-polar. Other times, of course, being bi-polar affects how you see life and so if something negative happens … (then you) then it makes you, it makes you more vulnerable.
S118

Relationships with others while suicidal

As discussed above, callers may have a very difficult relationship with those around them when they are suicidal. When discussing their suicidal ideations, some callers claimed that what prevents them from attempting suicide is a fear of hurting those around them; that family and friends would be so hurt by the suicide that they cannot bear to put them through it.

I've still got both parents at my age, I'm sixty three and they would be so hurt if I did anything to myself now, that I wouldn't contemplate doing it...
S125

The issue of personal relationships is a complex one. There were reports from callers who claimed that they do not think about whether they might hurt others when they are suicidal, as the pain is so immense it prevents them from considering anyone else. Other reports from callers claimed that their family and friends would be 'better off' without them, and this was presented as a reason for committing suicide. The type of relationship may also have an impact on this, and one caller displayed a kind of confusion about whether he could upset those around him as they do not care about him.

I hurt so much and feel that everyone would be better off without me.
ES525

... I don't really want to upset anyone but at the same time nobody gives a fuck about me so why should I worry. *ES532*

Callers also discussed the relationships they have (when suicidal) with health professionals and other services, and the most pervasive theme emerging from this was that callers may be resistant to disclosing suicidal thoughts and feelings because of fears that they will be forced to have treatment. This is also mentioned in the section on 'Reasons for Calling', but the data here also includes a reluctance to disclose suicidal ideation with professionals for fear of the more social ramifications it may have, such as facing the person at later times and being treated differently by them. This issue has links to the occurrences of Samaritans encouraging callers to seek or comply with professional advice (as discussed in the previous chapter), when for callers, the separateness of Samaritans was seen as a strong point of the service.

Death would feel like sleeping, like a break. I have not mentioned any of this to the team because, this morning, I was in danger of being sectioned
ES533

Also common was data which covered callers' relationships with religious organisations. Where callers discussed these relationships and how they related to suicidal thoughts and feelings, they always cited their particular faith as being something which prevents or delays a suicide attempt. This was often related to fear of the consequences as laid out in the doctrine of their particular faith

(typically a fear of going to hell because of committing suicide), but occasionally it was because they felt supported by their faith in a way that allowed them to 'carry on'.

> *... I can't kill myself as I will go to hell. I believe God put suffering on this earth as a test and if we live through it we get eternal bliss after death, but if we have bad lives or kill ourselves to escape, we will go to some form of hell. This is why I can't injure or kill myself.* *ES520*

Section summary

Being suicidal was linked to various causal events and experiences, with suicide frequently discussed as what would bring an end to various issues and personal states. The concepts of hopelessness and of an emotional 'build-up' were also common to many callers' descriptions of their experience. Personal experiences differed greatly, and while identifying as suicidal, callers ranged from stating that they wished to die, to stating that they would never attempt to end their life. The relationships between being suicidal, intent to die, the various actions engaged in while suicidal and deliberate self harm as a form of coping with distress was complex, and understandably difficult for volunteers to gauge and to capture using the Nature of Contact scale.

Suicide was discussed as something physically difficult to carry out, and those who described wanting to die, and as having initiated a suicide attempt, at times discussed stepping down from this to seek help and support. Suicidality was discussed as oscillating in intensity for some callers, and these points relate to an important window in which Samaritans can be most effective in providing support. Suicidality was discussed as strongly related to mental health issues, either as a symptom or as a consequence of mental illness, and always oriented to as an understood and accepted element of mental illness. Samaritans was described as important at times of mental distress, as suicidality was difficult for some callers to discuss with other services, due to the fear of unwanted intervention. This may have implications for the Samaritan practice of supporting interactions with statutory or voluntary organisations as callers may be in contact as they have already chosen Samaritans over these other services. Relationships in general were discussed as in important issue, and family and friends were described as both a cause for suicidal behaviour, and as a reason for not attempting suicide. Religious belief was also described as a support and a preventative element in the lives of some callers.

Chapter summary

While the support of the suicidal is central to the role of volunteers, it represents a small proportion of their work on shift. This may be seen as a positive, as the reduction of suicide is an organisational aim, yet it may also act as a negative in working practice as 'quiet' shifts, or shifts with a high proportion of inappropriate calls, have a negative impact upon volunteers. Nevertheless, volunteers viewed support of the suicidal as an important element of their role, and were positive about the policy and practice of asking callers about suicidal ideation. This was seen as beneficial for callers, allowing them to begin talking about a difficult topic, but as something which needs to be carefully placed in the contact, and to be carried out in a delicate manner. Waiting for an appropriate point at which to broach the topic means that there are occasions where suicide is not discussed, as this moment may never arise.

While volunteers believed that their support could help callers to move away from a suicide attempt, many claimed to actively incorporate the policy of self determination into their support, albeit with a tendency to 'err on the side of life' in cases where intervention was an issue. Indeed, the act of calling was discussed as a potential indicator of hesitancy, or request for assistance. Volunteers were ready to stay with callers until the point of death if necessary, although gauging what is actually happening on the other end of the line is difficult at times. Volunteers knew that some callers who present as suicidal or as dying will not truly be so. Not knowing the outcome for callers was reported by some as emotionally difficult, but by others as unproblematic. Being affected emotionally by callers was deemed understandable, but as something volunteers need to accept as supporting the suicidal is at the core of their role.

Many opportunities exist for difficulties in the interactions between callers and volunteers. In interviews, callers typically expressed an appreciation for the policy of asking about suicide in contacts, and those who described themselves as not suicidal displayed an acceptance for the policy and rationale of asking about suicide. An issue arising was the terminology used by some volunteers, as it is difficult for some callers to answer in terms of 'yes' or 'no' to questions about being suicidal. Indeed, suicidal language and terminology was seen to be used by callers to express a very wide range of experiences, actions, and intentions. Similarly, actions which may commonly be perceived as either self-harm or as a suicide attempt, were also seen as conveying very different aspects of callers' experiences. The relationship between self harm and suicide was discussed as complex and varied, difficult to distinguish between for some, but as very separate concepts for others. Additionally, suicidality was strongly linked to mental health issues. This issue will be returned to and discussed further in the following chapter.

The intended outcome of any behaviour is difficult to gauge, even for the individual as they act. Volunteers need to capture and log caller experiences and this may be problematic for the reasons mentioned above. Yet both volunteers and callers attest to the success of Samaritans in supporting callers struggling with complex feelings of emotional distress which they express using the language of suicide.

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Chapter Nine: Mental Health Issues

Introduction

Suicidal behaviour is strongly associated with mental illnesses [1-4]. Increased risk is attributed to a period of acute illness, recent hospital discharge, social factors such as being unemployed and living alone, substance misuse, non-fatal self harm and a sense of hopelessness [5, 6]. According to Appleby *et al*. [5] only a quarter of people who die by suicide have been in contact with the mental health services in the year before death and loss of contact with services is common before death. More recent studies support the finding that individuals who die by suicide have one or more mental disorders, for which only a minority have been receiving psychological or psychiatric treatment [7, 8]. Mental health problems are cited in various theoretical models of suicide but often as part of a larger constellation of causal issues. Those with severe mental health problems, such as bipolar and unipolar depressive disorders or schizophrenia are at greater risk of death by suicide following a previous attempt [9]. A systematic review of research programmes involving the psychological 'autopsy' of large numbers of completed suicides found that in most cases a mental health disorder of some kind was a component, although not a sufficient condition for suicide to occur. Co-morbidity also appeared to be common [10]. A further review of studies in this area found that over 90% of suicides were diagnosed with a mental health disorder (specifically a depressive disorder in more than 60% of these cases) [3]. A 2001 review of the research on depression and suicide found that depression was documented in 30% – 90% of suicides, but that the majority of these had not been receiving treatment of any kind [10]. Of course, suicidal behaviours may also occur in the absence of any mental health issues and the majority of people with a mental health disorder will never attempt suicide [11]. However, the question arises as to how often, and in what circumstances, within our present social and clinical culture it is possible to be classified as sane and also suicidal.

There is a debate within the literature as to the most effective ways of reducing suicidal behaviour in those with mental illnesses. Whilst some scholars argue that the most effective interventions are non-directional techniques much like those employed by Samaritans which focus on reinforcing client autonomy [12], others maintain that specific and targeted therapies are more appropriate. For instance, in a study assessing suicidality and its relationship to treatment outcomes in depressed adolescents, Barbe *et al* found that suicidal adolescents respond poorly to non-directive supportive therapy (NST). Consequently, they propose that a specific treatment like Cognitive Behavioural Therapy (CBT) is more appropriate [6].

Taking a different approach, Eagles *et al* [13] studied the views of patients' with a history of suicidal ideation about suicide prevention. They found that three-quarters of patients were in contact with psychiatric services when feeling at their lowest, and this contact was generally deemed to be helpful. However, half of the respondents considered discussing their feelings with family members or friends to be just as helpful as the psychiatric services illustrating the importance of wider and more informal social networks as sources of support. In addition, religious beliefs and affiliations were helpful in preventing suicide, whereas the media and the stigma associated with psychiatric illness had a more negative influence. They conclude that efforts at suicide prevention might usefully focus on enhancing patients' social networks, increasing the likelihood of early contact with psychiatric services and decreasing the social stigma attached to psychiatric illness.

Samaritans as an organisation has recognised an association between mental illness and suicidal behaviour since its inception in 1953. At this point, however, Chad Varah estimated that only a minority (about one in eight) of people who contacted the

organisation needed referral for professional help [14] though he was positive about the input of specialist services where appropriate. Varah positioned Samaritans as 'an emergency service for the suicidal' which initially incorporated a much more proactive and interventionist stance in the early days (with active befriending relationships, 'flying squad' services). However, the Samaritans was established as a 'crisis based' organisation where the provision of volunteer support for the caller was intended to be time limited rather than ongoing [15].

The founding of The Samaritans in 1953 preceded the development and widespread use of psychiatric drugs such as antidepressants and antipsychotics. The emergence of such substances has transformed the way in which mental illness is understood and treated and contributed towards the widespread medicalisation of misery and pathologisation of emotional distress [16-19]. It appears that Samaritans as an organisation, and also its callers, reflect these wider social changes that have taken place with regard to the changing cultural and medical landscape of mental illness over the past five decades. In recent years, while suicide prevention has remained a core commitment, Samaritans has extended its services to encompass the promotion of emotional wellbeing as a way of pre-empting the development of extreme distress and suicidal feelings that may lead to active suicide [20]. In addition, it has embarked on a proactive programme of outreach work and moved to establish active partnerships statutory and voluntary agencies as well as working with government bodies to influence suicide prevention policy [9].

The recent strategy document released in 2009 describes another shift in direction, refocusing the core business of Samaritans on suicide and targeting groups and individuals at particular risk [21]. Ongoing and more casual uses of the service are again downplayed in an attempt to position the organisation as a national player influencing government policy on suicide reduction and taking a more interventionist stance on identifying and reaching out to high risk groups. However, in its public face and self-promotion Samaritans continues to maintain an inclusive orientation whilst also linking mental health and emotional wellbeing. The website and promotional literature refer extensively to 'emotional health' or 'wellbeing' rather than 'mental health' or 'illness'. Such language may be avoided to reduce stigma, and allow subjective descriptions of mental health in terms enabling the expression of individual needs.

> *As mental health becomes increasingly synonymous with well being it is seen by Samaritans as a subjective concept...This is because caught up in the issue of whether a person accesses mental health services, is how they feel about their mental health and whether they consider such services relevant or helpful. Samaritans now talks about emotional health, since this is arguably a less threatening and medicalised term...we recognise that people express their needs differently and as such may wish to use other language to describe their mental health.* (Langan [22:3])

The stance adopted here is interesting in that it seems to resist the current psychiatric model on the one hand, but at the same makes the boundaries between wellness and illness entirely individual and subjective, and the potential for pathology almost universal [16]. This document details how Samaritans aims to move into closer association and foster greater links with the formal health services. A partnerships working initiative was implemented in 2006 to build and extend relationships between Samaritans and statutory agencies such as A&E departments, primary care trusts and social services [23]. In practice this usually involves patients being offered the option of referral to Samaritans, although more rarely a caller may be referred to a professional service [24]. In addition, Samaritans website also provides a list of helpful sources, including a link to the NHS direct website. This seems to indicate a closer alignment with the medical/psychiatric establishment. However, a closer relationship with formal services

raises issues of increased regulation and professional dominance as well as having implications for the organisation's stance on upholding self determination through the offer of non-directive support.

The return to focus on suicide and the support of those passing through crisis as the core business of the Samaritans seems equivocal in relation to the continuing promotion of the organisation as a provider of emotional support/ promoter of emotional health and wellbeing. It is not clear where psychiatric illness fits within this programme, although a focus on mental health issues is evident in the section of Samaritans website entitled 'personal experiences of callers' where the circumstances in which six callers contacted the service and how they were helped are described. These stories function to promote Samaritans services in two ways. Firstly, they illustrate for potential callers the kinds of people and types of problems Samaritans are used to dealing with. Second, they serve to shape their expectations of the type of service offered. Three of these stories (Mary's, Janet's and Cassie's)[66] feature serious and ongoing mental illness as a reason for the caller to make regular user of the service. It is not clear then, whether the organisation positions itself as a lay befriending service, or a para-professional 'mental health organisation' or where the boundaries of caller entitlement to use of the service are drawn. On the web these are presented in a very inclusive manner but the policy described in the strategy appears to be more restrictive. In some domains of social life the organisation appears to be framing itself as a 'mental health charity'. Samaritans is one of 48 members of the The Mental Health Helplines Partnership (MHHP) which was set up in 2001, facilitated by THA and supported by the Department of Health (THA, 2006). The 'official Samaritans page' of a widely used social networking website (Bebo.com) describes the organisation 'the oldest UK community mental health charity' and asks:

> *Interested in putting an end to mental health related stigma and discrimination? want to access daily resources and news relevant to mental health? how about giving support to the oldest UK community mental health charity?*[67]

However, despite acknowledging the relationship between mental illness and suicide and the prevalence of mental health problems amongst their callers, suicide is accepted as a possible consequence of personal autonomy. The commitment to self determination is a core principle of Samaritans. 'Callers remain responsible for their lives and do not lose the right to make decisions even if that decision is to take their own life'[68]. Therefore, the organisations' stance on mental illness, the relation between emotional distress and pathology and the proper remit of the organisation currently appears ambiguous. This was reflected in the accounts of volunteers and callers.

In this chapter the use of the Samaritans emotional support services by study respondents reporting mental health issues will be described. The analysis of all data strands (caller survey responses, caller and volunteer interview data, emails and branch observations) will be drawn upon to explore the ways in which those with mental health problems use Samaritans, compare caller and volunteer perceptions of how Samaritans is positioned in relation to mental health services, and consider how this data reflects on the status of Samaritans as a mental health charity.

[66] Personal stories: http://www.samaritans.org/talk_to_someone/case_studies.aspx
[67] Samaritans on Bebo.com: http://www.bebo.com/Profile.jsp?MemberId=4487264949
[68] www.samaritans.org

Volunteer perspectives

This section explores how callers with mental health problems were talked about by volunteers and how this relates to the official/ written account of Samaritans as an organisation that is open to all types of people with all types of problem.

There was a strong recognition in the volunteer data that talking to callers with mental health problems is 'part and parcel' of a Samaritan's job and that a substantial proportion of callers do have mental health problems. Estimates as to the number of calls taken from callers with mental health problems or a history of mental illness varied considerably between volunteers ranging from somewhere between 10% to over 50% of callers. The challenges volunteers face when dealing with those with severe mental health problems were regularly expressed throughout the data. Chiefly, these involved difficulties in following the conversation or engaging with callers with mental health problems who might for example, present with delusional stories or alternate between different personas during the call. However, by no means were all callers with mental health problems considered to be difficult to deal with. Some callers with mental health issues were considered to be very articulate and able to express their feelings and problems coherently.

In the interview accounts volunteers positioned the role of Samaritans in relation to those with mental health problems in two ways, each bearing similarity to callers' perceptions of the service (discussed in the next section). Firstly, volunteers situated Samaritans as providing a service that those with mental health problems use when other sources of support are not available. Secondly, volunteers situated Samaritans as offering a service that is complementary to but different from other services through the provision of emotional support. In this case, statutory service provision was perceived to be inadequate or insufficient to meet callers' needs. It is interesting to note however, that to some extent, in both configurations discussed in volunteer data, links to other mental health services were perceived as desirable.

Samaritans services as filling a gap in mental health service provision

In both branch observations and interviews a perceived increase in the number of calls to Samaritans from people with mental health problems was sometimes attributed to the closure of the asylums and move to community care of psychiatric patients from the middle decades of the last century [25, 26]. This resulted in closure of many psychiatric and statutory 24 hour services and a consequent re-housing of large numbers of psychiatric patients in the community. Volunteers and callers both described the practice of health and social services and staff in referring patients and clients to Samaritans or other volunteer agencies (e.g. Nightline) if they needed to talk to someone when their health care team was not available. It was acknowledged that out of hours contact with Samaritans was formally written into the care plans of some callers by mental health professionals. In this context, the status of Samaritans as a 24/7 organisation was drawn upon to explain the role of Samaritans as being there to 'pick up the pieces' (V403) in instances when mental health service provision is lacking. The opinion was expressed that if the mental health services were better equipped to manage patients these callers would not need to contact Samaritans in the first instance.

> *I believe that, accepting calls from people who often declare that they are mentally ill is part of the job because we're the only people, I mean the CPNs finish work at six and the local crisis line finishes at 9 or 10 and then they've got till nine o'clock the next morning and the only people who will be here for definite, for these services are the Samaritans.* V201

In these instances Samaritans was described as acting like a 'crutch for life' (V218) rather than providing support in times of crisis, although it was not necessarily the case that all dependent callers were regarded by volunteers as suffering from mental illnesses. However, the needs of those with mental health problems and their reasons for calling were often differentiated from those of other types of caller. Volunteers described how ultimately, this can lead to those with mental health issues being treated differently to other callers by the organisation.

Some volunteers were openly against the ongoing use of the service by those with mental health issues, arguing that Samaritans should remain a 'crisis line'.

> *We get a lot of people with depression. The mental health thing in terms of what we do, I think that's different really. When you've someone with a personality disorder, you can't be a crutch in a crisis, you've got to be a crutch for life basically...I mean there are quite a few where you get the type, what I would call psychiatric illness. But there's nothing you can do. It is a containment exercise because we cannot, I mean [volunteers] find it difficult to deal with, and why are we continuing to take their calls? You know? But I think it's not a person that you're dealing with it's the symptoms of a psychiatric disease. They can't help that- that's what they're like. It's difficult, but it's why we have our Caller Care – we're lucky that we've got psychiatrists who we can consult. They can give advice to us because we're not professionals.* V218

The view that by accepting calls from mentally ill persons Samaritans is engaging in a form of 'containment' was also apparent during branch observations. Volunteers worried that as non-professionals who were not trained in mental health issues they were not qualified or indeed able to offer the sort of help and support these callers' needs. Concerns that contact with Samaritans might not actually be helpful to some callers with mental health problems featured in the data.

> *And you see, a lot of our callers have psychiatrists, psychologists, GPs, community psychiatric nurses, and all the rest of it and we're just part of a package. So I suspect in the end, it's only a limited amount we can do... V205*

Several volunteers however, recounted how they had been encouraged by a talk given by a branch psychiatrist in which he had reassured the volunteers that they did serve a valuable function, and that their role was simply to 'hold' the caller, containing their emotion and supporting them for the duration of the call. This was not considered to be in any way therapeutic - that role was reserved for the professionals in their subsequent/routine contacts with the caller as patient. Very similar ideas were expressed in a talk given by a Samaritans consultant psychiatrist at a regional conference in 2009, which stressed also the singular and very powerful role of the volunteer as a source of kindness.

In such instances volunteers conveyed how they would advise callers to contact other services, for example, by suggesting that 'maybe they go and see a doctor' (V243). As discussed in Chapter 7, suggestions that visiting a health professional might be a worthwhile option for callers to consider were common in the email data. Often, the presentation of this information had a strong normative dimension, implicitly suggesting that the caller should comply with or seek professional help of some kind, and reifying medical treatment over other alternatives.

> *It sounds as if you feel afraid and anxious about the possibility of relapsing to the time 20 years ago when you were treated for depression, were suicidal, and regularly self-harmed. That's completely understandable, but*

remember that you did come through that time, and professionals were there to help and support you...With the right support, there is no reason why you wouldn't be able to work through your current feelings and emotions and move forward with your life. Reading through your emails, we also sense that remaining in control is very important to you, but perhaps you should try and be kinder to yourself, and accept the help of your friends, family and professional support workers. *EV506*

You said in one of your emails that you have recently felt that you are going into the 'dark areas of depression'. Would it be a good idea to see the GP again to let him know about your suicidal feelings? Maybe he would take you more seriously this time...Could you share these feelings with a counsellor if your doctor managed to arrange for you to see one this time? *EV517*

The readiness of volunteers to recommend contact with health professionals and especially psychiatric services contrasts with their diffidence about signposting callers to other organisations in the voluntary sector. In the observations and email data instances of such signposting were rare, although such action has been within the organisation's remit from the outset [14, 24]. Some volunteers expressed resistance to a consequence of the policy of not giving advice being that direct signposting of callers to other organisations was not allowed. However, in practice signposting was regarded as falling outside the volunteer's remit and was not done, even in the face of overt requests from callers (Chapter 7).

To summarise, in this view of the organisation callers with mental health problems were assumed to contact Samaritans because of insufficient mental health service provision. Questions were raised as to whether Samaritans is the right place for these callers and about the perceived limits on what the organisation can do for them. Talking to callers with mental health problems was constructed as a type of containment exercise or act of kindness that was not considered to be therapeutic. Greater links with and signposting to other services was thought to be desirable but often perceived by volunteers to be outside the remit of the organisation.

Samaritans services as complementary to statutory services

Secondly, volunteers situated Samaritans as offering a service that is complementary to but different from those available through statutory services through their provision of emotional support. Although acknowledging the difficulties (e.g. callers 'not understanding what Samaritans can and cannot do' V277) in dealing with callers with mental health problems in the prescribed way, volunteers were adamant that Samaritans are not professionals so are not qualified to make judgements about an individual's health. In this context, the non-professional status of volunteers was used to argue that all callers should be treated in the same way regardless of their mental health status.

We don't duplicate the kind of support given by health workers, CAB, and the like ... but there doesn't seem to be nearly enough referral to us for the kind of support which may well be complementary, that we can provide. *V228*

Samaritans was therefore thought of as reaching out to and providing a valuable resource for both existing service users and those with mental health problems who might be deterred by the thought of going to a psychiatrist or GP, for example. Within this view, volunteers thought that Samaritans had something additional to offer those with mental health problems that would complement the type of support they received

from other services. The notion that the organisation could foster greater links with other services, agencies and support groups in order to take advantage of this was prevalent in the data. However, the difficulties of doing so were regularly acknowledged, as this would involve, for example, a necessary breach in caller anonymity and confidentiality.

Although referral and signposting to other organisations was often considered a form of ad hoc and informal 'advice giving' (Chapters 6 and 7) that is contrary to volunteer practice, the organisation has been reviewing and changing its policy on third party referrals and signposting callers to other agencies [27]. Some case study branches have already established such links with other organisations and take referrals from CPNs and mental health teams, or were actively trying to do so. One volunteer described an instance where he accompanied a caller in a visit to their GP (V229). Local branch resources have a strong bearing on the capacity to develop such schemes, along with the interests and motivations of individual volunteers. Additionally, all branches have an affiliated psychiatrist who can give advice to volunteers if necessary and aid in the development of caller care plans to help volunteers deal with 'difficult' or 'problematic' callers. Despite this, most relationships with other services appeared to be sporadic and informal. This was echoed in the accounts of volunteers who thought that although Samaritans have a vital role to play in the support of those with mental health problems they do not manage this very well. For instance, one prison Listener raised concerns that that the prison service does not do enough to identify mental illness which can sometimes cause difficulties for the Listener. There was also criticism of the caller care plans as serving the interests of the organisation rather than the caller:

> *We're only judging, really, the amount of our time that they take up when we develop caller care, we're saying 'this demand on us is excessive'. We have to limit it for our own sakes.* V205

To summarise, in this view it was assumed callers contact Samaritans as their needs are not being met elsewhere. Samaritans is different from other services because if offers emotional support, which is both available and valuable to all callers, regardless of their mental health status. Because of this, Samaritans could foster greater links with other services, having callers directed to them and also being able to refer them on for a different type of support if necessary or desirable.

Education and training in mental health issues

Although regularly referring to themselves as 'just a lay person' (V264), 'not qualified' (V220) or 'not an expert' (V240), in mental health it was apparent in the interview data that through their contact with people with a variety of mental health problems volunteers feel they do gain a certain level of knowledge or even expertise about these issues. Some callers speak about their clinical diagnosis, medications or contact with other services and have told volunteers that they use Samaritans as a strategy for dealing with their issues (e.g. blocking out voices). However, volunteers also appear to develop ways of recognising if callers have a mental health problem. In the interview data volunteers explained how they are able to identify that some callers have mental health problems from their stories without being informed directly by the caller:

> *Being a volunteer for two years…particularly these callers who have anxieties that you feel, that would be great for kind of CBT treatment there's a sense, you feel a few sessions of that and you could really sort this out…they either refer to the illness that they're suffering from. Or, I don't know, in my amateur way, I diagnose, [laughs] you know, they're clearly socially anxious or they're clearly depressed…* V219

Similarly, V265 described 'putting callers into pigeon holes even though you shouldn't' and V214 explained how she had 'learnt a lot' about self harm and understood it a lot more now than she did when she first became a Samaritan. On occasion, volunteers explained how they could recognise the symptoms of disorders that they themselves had experienced and that this enabled them to practise a deeper level of empathy with the caller. In contrast, V220 suggested that he could recognise when someone was bipolar and described how he had developed particular strategies for ending such calls, even although he also acknowledged that this was a diagnosis which he was not qualified to make. Others also described how they might treat a caller differently if they thought they had mental health problems. For instance, based on his own knowledge of bipolar disorder V245 understood mania to be associated with suicidal urges. He explained that even though he believed a person has the right to take their own life if they so choose, if he thought a caller might be bipolar he would not share this with the individual concerned. He referred to bipolar disorder as a 'psychotic illness'. Through his understanding of the condition he believed that those with the disorder were no longer in a rational state in mind and so 'not in a condition to make that choice'.

Despite efforts not to judge callers or assume they could have an awareness of another's unique experience, volunteers fell back on their personal knowledge to help them relate to alien and unfamiliar experiences. It was evident that volunteers did acquire knowledge about mental health problems and possible treatments and used this information in their assessment of callers to some degree, whether intentionally or not. For example, V240 explained how he would 'never make a clinical diagnosis' due to his 'lack of medical training' but described making a note on a caller's record if he thought they might have a mental health problem. The question then arises as to whether volunteers should receive more formal training about mental health problems, often discussed as a missing element of SIT (Chapter 3).

Some training in mental health issues is available to volunteers at branch level in the form of lectures from mental health professionals and talks from those diagnosed with mental disorders. Additionally, the branch psychiatrists can be consulted to advise on how to respond to individual callers. The benefit of extending this type of training was understood as increasing awareness of different types of mental health problems and enabling volunteers to make better sense of the way such callers present themselves. This in turn, would benefit callers as volunteers could support them more effectively.

> *I think one thing which I felt wasn't particularly addressed was the amount of people who were coming or phoning who have obviously got severe mental health problems and who are obviously very much into the, locked into the mental health support services. I don't think enough attention was given in the training to the fact that these do form quite a high proportion of calls and although one can accept the distress despair element which the people have, I think, more could be done to prepare people as to how best to deal with these cases, that people who are locked into the system almost, and use us as part of their mental health support service but who are often people whose situation is not going to be changed by, in any degree, by phoning up Samaritans, if that makes sense.*
> *V262*

While some volunteers expressed a desire for more training about mental health issues, others remained sceptical about this arguing that one of the strengths of Samaritans lies in the fact that volunteers are not experts in mental health and therefore are not there to advise, diagnose or judge callers but to just listen to and be there for them. Coming back to the role of Samaritans as a listening service, according to one volunteer, if one makes assumptions about a caller's mental health they are 'not doing the Samaritan thing' (V402). Resistance towards further training in mental health issues resulted from a concern that if volunteers knew more about mental health conditions they might not be

so good at offering the core Samaritans listening service: too much knowledge could be a dangerous thing (as discussed in Chapter 3).

> *I think I have a personal opinion that if we knew a lot more about it we might not be so good at it. You know the idea that we become, "experts at mental health issues" would probably spoil our service. We don't pretend to know and therefore we don't have to know and therefore we can talk to them, about the price of cheese almost, it doesn't matter in a sense, generally we talk to them about their voices, we talk to them about their suicidal feelings but after that we can talk about, you know, who are you? What are you going to do tomorrow? Just ordinary conversational bits and pieces.* *V201*

Although not against volunteers receiving further training in how to better handle calls, these respondents were sceptical that providing volunteers with more information about mental illnesses would be beneficial. A related concern was that if Samaritans were to be considered 'experts in mental health' it could skew the future direction of the service into more specialist areas of activity rather than current holistic approach to support (Samaritans conference, September 2007). Therefore, caution was raised about a move to establish closer links between the organisation and professional mental health services.

Caller perspectives: survey data

As discussed in Chapter 4, 13.2% of survey respondents identified mental health issues as their main reason for last contacting Samaritans, with 47% citing mental health issues as a reason for previously contacting the organisation. As survey respondents were not directly asked to disclose their mental health status the exact number of respondents with experience of mental health problems is not known. However, it is clear from these figures, and indeed other types of data collected, that mental health issues and a history of contact with the mental health services is very common amongst Samaritans callers.

Many survey respondents were in contact with a wide range of other services and organisations when they last contacted Samaritans. Some were formal, official and specialised or professional services whereas others were more informal in nature and ranged from self-help groups to exercise clubs and religious groups. Of the other services callers were in contact with, the statutory services emerged as by far the most frequent. 84.2% (n=278) of those who were in contact with other services at the same time as their last contact with Samaritans reported being in contact with the statutory services about the same issue. The perceived helpfulness of contact with these other services and sources of support was extremely variable and dependent somewhat on the individual, the nature of their problem, their personal situation and attributes. For instance, similar numbers of those who were in contact with the statutory services rated their contact as more helpful (26.1%, n=72), equal to (36.6%, n=101) to and less helpful (37.3%, n=103) than Samaritans.

It became apparent throughout the data that callers may attempt to conceal their mental health problems from volunteers when contacting Samaritans. This indicates that perhaps an even higher number of callers experience mental health issues than is made known to volunteers. Callers may do this for several reasons, for example, due to the stigma associated with mental health issues and fear of being judged, or perhaps the caller did not perceive their mental health issue to be a primary, relevant or perhaps even legitimate reason for calling. However, reasons for such concealment were rarely articulated by callers, and the success of these actions cannot be assessed so such suggestions remain speculative.

ID535: I have used the Samaritans since the age of 13. I am now 44. Throughout this time I have found the samaritans to be a life-line. Knowing the service is 24 hours is in and of itself a source of comfort. I look forward to a time when I will not need Samaritans but I fear I am too damaged. The diagnosis of Borderline Personality Disorder (something i've never mentioned to the Samaritans, by the way) makes me realise i will probably always have severe bouts of depression. One of my most effective coping strategies is to call the samaritans. Thank them for me.

As illustrated in the data extract above, callers with mental health problems often disclosed a long-term or on-going relationship with Samaritans, describing their continued use of the service over a period of many years as a way of helping them cope with their mental health issues. Callers praised Samaritans for its 24/7 availability, and valued this aspect of the service especially during the night. Callers explained how they derived comfort from the knowledge that Samaritans are always there and can be contacted when the need arises. In this frame, Samaritans was referred to as a 'life saving tool' or a 'lifeline' that filled a gap in mental health service provision. Throughout the data it became apparent that the limited availability of other mental health support services was one of the reasons why those with mental health issues contacted Samaritans. Additionally, using the service in this way was reported to have been recommended to callers by mental health professionals. As expressed by ID709 in the data extract below, knowing that one can rely on Samaritans in times of need helps callers in and of itself, providing reassurance, security and a source of comfort. The additional support offered by Samaritans was described as making callers feel less alone and in some instances, giving them hope and confidence for the future and enabling them to get on with their lives on a day-to-day basis.

ID709: The Samaritans are invaluable and do great work. If I hadn't contacted them I could possibly be dead now. It's a security to know that there is someone there 24 hours a day in case you need them. My crises never happen between 9 and 5.

ID939: I find it interesting that the statutory services all recommend that the Samaritans are the people to contact FIRST when in a crisis...even the Crisis Team!

ID331: My family, friends and psychiatrist/therapist and I are all incredible grateful to the Samaritans for their invaluable part in keeping me alive and safer. It is such a relief to know that I can ring anytime day or night, any day of the year.

Contact with Samaritans was frequently positioned within a wider circle of support that included health professionals and also informal support from family and friends. Not only was the provision of support from the mental health services perceived as limited, but this also was the case for informal support callers received from family members and friends. As discussed in Chapter 5 informal support was constructed as limited in several ways. For example, callers felt unable to speak about sensitive issues to those close to them without being judged, or used Samaritans as a way to 'offload' at times when they did not want to burden family members or friends.

ID322: It was really great. I was in a total crisis, as I was at my family home and due to the situation couldn't talk to my parents, and felt totally lost and couldn't call friends as it was too late and I didn't want to worry them with my crap, and talking with someone helped me gain control somewhat. Was so good to know that there was someone to talk to, who wouldn't be overly worrying

about me or reading too much into it. Thanks.

ID754: So helpful to talk to someone - I have many friends and supportive family members but don't want to call them in the middle of the night when I'm feeling low and don't want to worry them. Thank you so much. X

Another reason for contacting Samaritans prevalent in the survey data was related to the nature of the support offered. Often, Samaritans was differentiated from other services on the basis that the support offered is non-judgemental and confidential. Fears were expressed about the repercussions (i.e. being hospitalised) disclosures about mental health problems and particularly suicidal feelings could have if the caller had contacted, or disclosed their difficulties to, the statutory services. In these instances, callers thought of Samaritans as more helpful than their GP or psychiatrists. Samaritans was considered to be the only service they felt comfortable speaking with about such issues.

ID616: I use samaritans when I go through periods of depression. They are the only help I have and without them I would probably be dead, in the gutter, or in prison.

Caller perspectives: Interview data

In some cases, callers interviewed demonstrated a general reluctance to talk about mental health issues expressing how they did not want to be labelled or were unsure as to whether their problems were associated with mental illness. However, in the main, these respondents seemed open about their mental health problems, revealing details of their diagnoses, medications, relationships with mental health professionals and periods of hospitalisation. Mental health issues were discussed by 40 of the 48 callers interviewed and raised in 28 of the 55 email correspondence strings analysed. As discussed in Chapter 5 the prevalence of mental health issues, specifically the disclosure of severe mental health problems, was very high amongst the caller interview population (77% with experience of mental illness; 46% (n=22) disclosure of severe mental illness).

Callers varied in the ways they spoke about their contact with mental health professionals or their attitude towards taking medication. Some thought medication and psychiatric treatment were helping to make them feel better. Others were reluctant to take prescription medication in the belief that this was not effective or helpful for them. As in the following extract several callers had not had any specific diagnosis or their diagnosis had been changed over time.

Yeah. I've been diagnosed with, well, initially it was borderline personality disorder? [laughs] And that's, I think, they don't really use that one now for me. I was for, a couple of years, initially, and generally, on my certificates, it's depression and anxiety. So that's, you know, that's the main thing, which I take anti-depressants for. S133

Much as in 'Mary's story' on the Samaritans website[69], a popular way in which callers described their mental health was in terms of periods of stability and periods of crisis:

I go in a cycle, I've got a personality disorder and I go in a cycle where I'm ok and then things deteriorate y'know go into crisis and then I'm ok again. And I've been in that cycle a long time. S108

[69] See: http://www.samaritans.org/talk_to_someone/case_studies/pams_story.aspx

The most common mental health issues identified by callers were depression, anxiety, personality disorders, bipolar disorder and schizophrenia. However, the picture was much more complex than this as many respondents identified themselves as having a range of mental (and physical) health problems (and associated social problems), many of which were described as long term conditions that had been diagnosed over a number of years. For example, S175 described her health problems in complex terms. She had had glandular fever, ME and cancer in the past, and now considered herself to be healthy compared to how she was, but not compared to other people her age. She did not consider herself mentally ill despite experiencing despair, panic and 'very difficult emotions' but regarded herself as strong and able to cope with these most of the time. Although she did not want to be labelled as mentally ill and did not take any medication, she did see a psychotherapist once a week in addition to regularly contacting Samaritans (although unwilling to disclose how often). The various ways in which callers positioned Samaritans in relation to the mental health services will be discussed in the following section.

Samaritans, other services and support networks

The ways in which Samaritans services were discussed and positioned in relation to other sources of support available to callers with mental health problems were somewhat variable. Four main themes emerged in the data in each of which Samaritans services were framed in different ways. Callers positioned Samaritans services as: different from, but complementary to, other services; filling a gap in mental health service provision; the only source of support available; and an equally unhelpful service compared to others they have access to. In this section each of these themes will be discussed in turn. Following this, the ways in which caller perspectives corroborate and confound Samaritans own perception of these issues will be explored.

Samaritans as a complementary form of support

In this view, Samaritans was thought of possessing a different agenda to the mental health services and therefore as offering a different type of support to those with mental health issues. As illustrated in the interview extract below, whereas mental health services were thought of as controlling behaviour and taking choice away from the individual through sectioning, medication and labelling, contact with Samaritans was seen as something which was on more on the callers' own terms allowing them to retain a level of control over what happened to them.

> S401: *I contacted [Samaritans], I was desperately suicidal, I am bi-polar, and was having strong suicidal drives, very, very frightening, was very suicidal… I am in touch with mental health services and do have a psychiatrist.*
>
> I: *How does this compare with help received from Samaritans?*
>
> S401: *I think at the time I definitely needed both, I am lucky I've got a very good psychiatrist and psychologist and they are very committed...the difference with the mental health team is that they are always sitting there with the section papers and I have been honest, been entirely honest and they have a different agenda.*

When Samaritans was situated as a complementary source of support that is available to those with mental health issues, contact with mental health professionals generally tended to be referred to in positive terms. For instance, psychiatrists, therapists, GPs and crisis teams were described as committed, good, amazing, trustworthy and helpful.

However, callers discussed how they felt able to 'admit' things to the Samaritans that they did not feel able to talk about with anyone else (e.g. suicidal feelings). In concurrence with the survey data, the reluctance to talk about such issues with mental health professionals was linked to the fear of repercussions such disclosures could have. Callers explained how they might conceal their true feelings from mental health professionals, instead turning to Samaritans as a source of comfort and support when they were feeling frightened or overwhelmed. As in the email extract below, there were some callers who found it difficult or were reluctant to share their feelings about particular issues with anyone other than Samaritans.

> *Been struggling with suicidal thoughts (part of clinical depression and OCD, apparently) for more than 10 years now...have often been resolved about 'doing it' but no attempts whatsoever. Not many people know that I am struggling with death fantasies on a daily basis either and I can't talk to anyone except you.* *ES544*

The time and space provided by Samaritans could therefore be utilised by callers with mental health issues to talk about their feelings in confidence without the threat of action being taken. As such, the need for simultaneous access to both types of service was frequently expressed by callers throughout the data.

> *I have a serious mental health problem, I'm a manic depressive. And, I used the Samaritans perhaps a dozen times, I suppose, well, more than a dozen times. The times when I was feeling very depressed, I didn't want to contact statutory services because I knew that they would operate on a sort of, assess and control basis, and I didn't really want that. I didn't want to go into hospital if I could avoid it, and so, I preferred the fact that I was still in control with the Samaritans. And, I didn't want them just assessing me, you know, I was listened to without everything having to be interpreted or written down.* *S119*

Callers also appeared to use the time and space provided by Samaritans to discuss or even as in the case of ES533 below, prepare them for contact with mental health professionals, rehearsing expressions of their feelings in preparation for their next visit. As indicated above, respondents' attitudes towards other services were generally favourable. However, as mentioned in Chapters 4 and 5, respondents expressed fears over future hospitalisation and side effects of taking medication, in addition to the desire for more contact or better provision of specific services (e.g. CBT, psychotherapy). Although two callers likened a call to the Samaritans to a 'one-off psychotherapy session' or counselling, the dominant view was that Samaritans offer a different service from mental health professionals (as listeners rather than proactive therapists).

> *I was finally discharged by the Home Treatment Team two days ago, which was a good sign. I will be getting a psychiatric nurse who'll meet me once a week and counselling once a week, with a review every 6 weeks. So I should be fine, shouldn't I? I find myself, however, wracked with anxiety attacks. It's like an unbearable pain in my head. My temper is also flaring up. I'm trying to list all of this so I can tell the counsellor when I meet her next Friday.* *ES533*

One caller was under the impression that Samaritans are not interested in people with mental health problems because they have access to other sources of support through the mental health services. However, she explains how she calls Samaritans to get an outside perspective on her problems and thinks that Samaritans should not underestimate the value of this. Similarly, S164 describes a network of support he uses to help him, justifying his use of Samaritans services as a necessary part of that network.

I have got a couple of good people around me who can support me but friends are too close and still people like counsellors or Samaritans are very necessary, because you need to have someone who's not attached to you. S164

Respondents acknowledged that volunteers must sometimes find it difficult to comprehend or deal with some of the information they are told (e.g. hearing voices) by callers with mental health problems. As such, there was much appreciation for the service expressed throughout the caller interview data. Respondents discussed the idea of Samaritans forging greater links with medical professionals and mental health teams. Although benefits were identified, for instance contacting other organisations on the callers' behalf and informing them of their need for an appointment, concerns were also raised that such links could change the nature of service offered by Samaritans.

I wonder about if they could liaise with Mental Health Teams or GPs, you know, contact them on your behalf and say to them, look we've been dealing with this person and they really need you to make them an appointment or sort them out soon. But then I worry that it would change the nature of the service you see. It does worry me...I'm not sure if they got too involved whether it would make it too complicated and change the way they do the things they do. S103

Samaritans as filling a gap in service provision

Bearing some similarity to the volunteer data, the second main theme emerging in the caller data was the depiction of Samaritans by callers as filling a gap in the provision of other services. When configured in this way, callers explained how they used Samaritans at times when other sources of support were not available to them, or not considered to be appropriate. With some overlap to the position outlined previously, Samaritans were situated as one part of a wider circle of support that included mental health services, medical professionals and family members and friends.

Callers explained how they would contact Samaritans in preference to 'continually burdening' family and friends with their problems and thus, provide 'relief' to those in their informal support network. This was also the case when discussing statutory services as callers described for instance, only calling crisis teams in emergencies (i.e. at risk of attempting suicide) to avoid 'blocking up their line' and using them in the 'wrong way'. Of interest here was the view expressed by several caller interviewees that with the help of a new psychiatrist/counsellor or an effective review of their medication the caller would be able to sort out their problems and not need to contact Samaritans anymore.

I've got a close friend. But, the difficulty, one of the main reasons I end up ringing Samaritans as well is my personality disorder is very extreme. So like, one minute, I'm very able and delivering trainings and all sorts and the next minute, I can barely speak or function. And people find that very hard and quite distressing. So, it's easier to ring sort of Samaritans. S135

I still feel like I just, I want to find somebody to talk to and I don't feel like it's a reflection on the counselling profession, I think I just haven't found the right counsellor. S162

In another example, one respondent describes her mental health problems as being like a 'black hole' that she has to pull herself out of using various 'ropes'. She describes the Samaritans as her 'night time rope', using her sister and mental health practitioners as

other sources of support during the daytime and evenings. The perception that Samaritans is used as an out-of-hours service by those with mental health issues was a common theme in the data.

> *I don't want to burden my sister with it all the time and although she says she doesn't mind I wouldn't call her in the middle of the night or want to tell her everything. I feel like my anxiety and depression is like a black hole and people can throw me ropes but they can't pull me out, I have to climb up. I have different ropes, my sister, the Samaritans and the CPN. The Samaritans are my night time rope.* S103

Samaritans as the callers only source of support

Responses falling into this category were from callers who appeared disillusioned with the mental health services, often turning to Samaritans when feeling 'forgotten', neglected, let down or scared while waiting for professionals to respond or make contact. The psychiatric services were depicted as uncaring and unsympathetic and callers regularly expressed how they felt that they were not being listened to. There was a general perception that the statutory services are overstretched with psychiatrists only seeing patients when 'they were desperately ill', rushing through consultations and overprescribing psychiatric drugs that often do no help.

> *I'm supposed to be getting mental health care from the local PCT but I couldn't make the appointments the offered because I want to go to work. I don't want to be forced into the sick role by taking time off work. I've told them I will compromise and leave work early but I've had no reply - I sent the message a month ago and a reminder 2 weeks ago and another reminder today. I believed all the 'Patients First' stuff, but it seems to be just spin. It is really resources first.* ES502

Other callers spoke about how they felt their problems were not being taken seriously by their GP preventing them access to psychiatric services and medication that might be able to help in the first instance. Alternatively, although in contact with mental health professionals, some respondents expressed how this was not something they wanted but rather had been coerced into through their GP or family members.

Respondents who positioned Samaritans as their only source of support tended also to be socially isolated (this was attributed to both physical and mental health problems) with little or no access to avenues of informal support. Contacting Samaritans was, therefore, considered a way to 'let off steam' and talk to someone who understands what they are going through. Gratitude towards Samaritans was often expressed with callers praising the service offered in extreme terms (e.g. 'If it was not for them I would not be alive today' S147).

> *I once rang and I said, I so much would like to have friends in my life with whom I could talk like that. And then the guy said, Well, he said, now you have got forty five or, forty five and a half thousand or forty six and a half thousand friends. [laughter] And, wow, I am actually really lucky. [laughs] I've got more, potentially got more friends than anyone. [laughter] Ah. And they have that quality, you know?* S175

There was also the indication in some of the data that callers who do not have access to other sources of support, particularly informal support networks, may treat contact with

Samaritans more like a social activity then a therapeutic one. Samaritans has promoted itself as available to those who are 'lonely' in the past, and in some areas, including at branch level, the advertising still encourages people to call if they are 'lonely, despairing, or suicidal' [70]

> *Very occasionally I still use them, because the way my life is now, I don't have anybody to talk things over with.* S403

Certainly, some callers with mental health problems discuss their contact with Samaritans as being borne out of a complete lack of social networks, invoking a sense of isolation, or not having anyone to talk about their problems (as discussed in Chapter 5). While this may be a more appropriate position to call from than that of treating Samaritans as 'friends', it would still need to be matched with a level of need, or crisis, to be a wholly appropriate contact according to Samaritans current policy stance [21].

Samaritans and other services as equally unhelpful

The final way in which Samaritans was discussed was as a service that is equally unhelpful to callers as other services. Although this view was expressed in the data, it was far less prevalent than the other themes discussed above. When adopting this position, callers expressed dissatisfaction with both Samaritans and other mental health services. For example, S171 identified as having 'ongoing schizoparanoia', being under stress at home and at work and reported having previously been sectioned three times. She contacted Samaritans because she felt distressed and wanted help with her problems which she lists as 'vulnerability to coughing, traffic and laughter and feelings of suicide, guilt and embarrassment'. She felt that none of the services (doctors, psychiatrists and care teams) she has had previous contact with have helped with these problems, including Samaritans, and was frustrated that Samaritans could not help more. Another caller (S168) also expressed dissatisfaction with her GP, crisis team and Samaritans. She has been put on a care plan for excessive use of Samaritans - a service which she assumed should minister to the needs of those with mental health problems feeling that 'anyone with mental health problems is so screwed up, they need all the help they can take'.

S140 thought that although contact with Samaritans was helpful, there were limits to what they could do for her because of her mental health problems. She described a recent call where she was given the impression that she was a hindrance, that there were other people that needed to speak to Samaritans more than she did. She felt that the volunteer was impatient with her, advising her to go and see her GP and get her medications changed. Being treated in this way made her feel worse after the call than before. Based on this experience she thinks that if volunteers had a little more training in understanding mental health issues it would be of benefit to callers. This was, in fact, a suggestion commonly made by survey respondents and those interviewed alike (improvements to service are discussed fully in Chapter 10). Similarly, another caller discussed how although he found the service helpful, a friend of his who had been diagnosed with paranoid schizophrenia did not like calling Samaritans because he 'needs people to talk to him' and 'does not cope well with the silence' (S143).

To summarise, most of those interviewed with mental health problems were not one-off callers, but people who had contacted the Samaritans regularly, often over periods of many years. Mental health issues were rarely discussed in isolation by callers, but

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[70] http://www.samaritans.org/; http://www.weybridgesamaritans.org/.

intertwined in a complex web of current and historical health and social problems. These respondents valued Samaritans' support as an ongoing resource to help them deal with difficulties – sometimes episodic, sometimes chronic – that had no clear of likely means of resolution.

Chapter summary

Many callers suffer from mental illness of varying degrees of severity and are heavily represented among the substantial proportion of callers – perhaps even the majority – who derive great support from regular and ongoing contact with the Samaritans. Samaritans is described as providing a complementary rather than alternative source of support to that provided by a wide range of statutory and voluntary services, as well as friends and family. Although such callers clearly orient to the organisation as a mental health charity, it is difficult to make out if the Samaritans currently positions itself in these terms, or wishes to retain a more secular orientation. Most volunteers whose views are represented in this study did not view the core business of the organisation as being to support the mentally ill. They expressed a range of views about their role supporting callers with psychiatric problems, especially if these were severe. Some felt that these constituted a category of inappropriate callers, others were keen to formalise active partnership working with local health and psychiatric services. Most took up a position somewhere in between, doing their best to support callers despite misgivings about whether they were doing any good, and whether the Samaritans offered an appropriate service for people suffering from serious mental health problems.

The current Samaritans strategy prioritises the suicidal and those in crisis and aims to target groups and individuals at particular risk. This document makes little reference to mental illness, retaining a more neutral focus on those who are suicidal and experiencing 'emotional distress'. However, in other documents and contexts, the link between suicidal behaviour and mental illness is clearly recognised [28, 29]. The organisation is a member of the MHHP and promotes itself on Bebo as a 'mental health charity'. This raises implications for the principle of self determination, since current norms concerning mental illness view the suicidal as (in most cases) lacking capacity to make rational and well considered decisions, and in urgent need of intervention to protect them from themselves [30]. The relationship between suicidal impulses and rational decision making in those with clinically defined mental illness, or the appropriateness of upholding self-determination when dealing with this type of caller are not clearly articulated. Callers often expressed strong ambivalence to their suicidal thoughts and impulses, but were often clear that they *did not want to* die. While many callers approached the Samaritans as an organisation that should be accepting and supportive of those with mental health problems, they also valued the difference between the support they received from the volunteers and that provided by the professional services with which they were in contact. It is not possible to establish whether contact with Samaritans *prevents* suicide. The evidence regarding effectiveness of different types of intervention is inconclusive. There is evidence for the positive nature of non-directional techniques similar to those employed by the Samaritans [12], and for the value of informal social support [13]. Other evidence suggests that specific and targeted therapies (such as CBT) are most effective for particular groups at risk of suicide, and that non-directive therapies akin to the form of emotional support offered by Samaritans are not recommended [6]. At issue here is whether callers known to suffer from severe psychiatric illness contact the organisation as 'patient' or 'person', whether they are or should be treated differently from other callers, and whether Samaritans is, or will become, allied to professional mental health services, or remain independent from them.

Many callers, including but by no means only, those experiencing mental ill health sought and received on-going support, often from other agencies as well as Samaritans. However, their status or entitlement to use of Samaritans seemed ambiguous. This

uncertainty was reflected in the accounts of volunteers as well as callers. Ongoing contact with Samaritans is not encouraged or thought to be appropriate. Yet many callers articulated their needs for recurring support for problems which they experienced as chronic, troubling and without realistic scope for resolution. In practice, despite its stated mission to orient to those in crisis, a large part of the Samaritans constituency is composed of regular 'dependent' callers trying to fashion the service in a form to meet needs which they define in very different terms to those proposed by the project of increasing, or recovering, agency and 'moving on' through constructive work on the self.

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Chapter Ten: Improving the Service

Introduction

In this chapter the analysis of data drawn from the online survey and interviews with callers and volunteers will be presented. The chapter draws together various issues relating to potential areas where respondents felt that Samaritans services could be improved. Many of these have been raised in preceding chapters of this report. The suggested improvements to service made across the data as a whole were grouped into four main categories: interactional issues between caller and volunteer, practical issues to do with use of the service, recruitment and training of volunteers and the wider promotion of Samaritans services. Each of these themes will be discussed in turn. Although this chapter focuses on respondents' views about how the service offered by Samaritans could be improved, it should be noted that in response to this question, almost half of the survey respondents claimed they could not think of any improvements. Instead they discussed the value and quality of the service and expressed their gratitude that such a service exists. 39.6% (n=408) of survey respondents made comments or suggestions about ways in which Samaritans could improve their service. However, when asked to explain their answer, a slightly higher number (42.3%, n=438) offered suggestions for improvement. In addition, volunteer and caller interview respondents were asked if they had any suggestions for how Samaritans services might be improved.

Interactional issues

Interactional issues featured prominently in both the survey and interview data discussing prospective improvements to Samaritans services. Several such issues were raised by callers as points where changes could be implemented to improve the service offered. The most prevalent of these issues were related to: beginning the call, 'being human', silence and repetition, scripted responses, sharing opinions and giving advice and ending the call. In the following section each of these issues is discussed in turn.

Caller perspectives

Beginning the call

The difficulties callers experienced in making initial contact with Samaritans were expressed throughout both the survey and interview data. Callers and volunteers made a number of suggestions about how this could be made easier. Presently, Samaritans train volunteers to wait for three rings and then answer telephone calls with the phrase 'Samaritans, can I help you?' which is designed to both identify the line and provide an indication of how the caller might begin the conversation. Despite this, it appears that on occasion callers may still be met by an 'empty line' in which case they find it difficult to know if they have called the right number and begin the conversation. Further to this, it was suggested that there could be a short period of talk at the beginning of a call where callers could find out some information about the volunteer such as how they respond to and interact with the caller, their geographical location and gender. This would enable the caller to get a sense of who they were talking to, get to know their voice and to assess their mood and personality. From the callers' perspective, this would be of benefit by allowing them time to gauge whether or not they felt they would be able to open up to or gel with the volunteer during the call. However, as expressed in the volunteer data, there is a reluctance to share personal information with callers for security reasons and also related to caller care issues, where callers are discouraged from building a relationship with a specific volunteer (Chapter 6).

Callers expressed a desire for more information about what would happen during the contact to first time callers, either verbally at the beginning of the call or on the website, so callers would know what to expect. Further to this, callers thought that the limits to the service should be made clear at the outset. For example, when told during earlier contacts with Samaritans that they could call back 'whenever they needed' and then to find themselves placed on a care plan with restricted access was described as giving callers a 'false sense of security'. Several caller respondents described being both surprised and devastated by experiences of being put on care plans in what they perceived to be an arbitrary, unexpected and inconsiderate way. Others were upset when prohibited from using the service or from talking about a particular topic requesting feedback as to why the content of their call had been inappropriate or for taboo areas to be made more explicit.

There is some detail provided on Samaritans website about what to expect from contact in the 'frequently asked questions' section and this is also featured to an extent in the personal stories of callers that are available for prospective callers to access. However, it appears that this information can be easily missed by callers in some instances, and may not be available to others, particularly if the caller is contacting by telephone or does not have access to the Internet.

Being human

Samaritans conducted research to evaluate the email service in March 2005 [1]. Their study found that the most common problem with email responses from the callers' perspective was related to tone (28% of all responses). Common problems included lack of empathy, patronising tone, business-like or formal tone, cold and even dismissive responses. Drawing on the findings of this study Samaritans postulated that not all volunteers are able to express empathy in the written word and concluded that:

> *Whilst training may help address some of the problems identified in this evaluation, it is highly likely that some volunteers are not suited to providing emotional support by email. (Email Project, conclusions and recommendations, 2005).*

This project encompassed a wider evaluation of services than has previously been carried out to include email, telephone and SMS text messaging. Where applicable, respondents also gave details of face to face visits and use of the postal letter service, although these methods of contact were not the primary focus of the study. It appears that problems relating to the tone of response identified during the 2005 evaluation of the email service are still regarded as significant issues by callers and therefore were identified as areas for potential improvement. However, such problems were not restricted to the email service and were also raised in data relating to telephone contact.

A common feature of the improvements to service proposed by callers was the suggestion that volunteers could act a little 'more human' and less automated or robotic. Callers wanted volunteers to 'really listen' to them and allow them to talk without making assumptions as to how they were feeling. This idea of having human contact, the feeling that they were speaking to a 'real person' or indeed able to have face to face contact in the case of branch visits, was given high importance in the caller data. Callers expressed their desire for volunteers to be friendlier, non-judgemental, patient, caring, empathetic, kind, compassionate, and warm. Callers thought that such improvements to the interpersonal skills of some volunteers would allow them to act in a more human way thus enhancing the level of service offered. In email responses, giving a real first name instead of all volunteers signing emails as 'Jo' was proposed as one way of making email contact feel more real as opposed to talking to a machine.

ID922: I guess they felt robotic in the end, to me. No judgement does not mean no emotions. Be a little more human.

ID1221: Whilst it is good that the advisers all use the name Jo, it gives a false feeling that you're talking to the same person every time. People using their real first names as a contact would give a feeling that you're talking to a real person.

Several other methods were proposed in order to achieve a stronger sense of personal contact including: less use of scripted responses or formulaic questions to give a response tailored to each individual caller; taking a more proactive approach to include less silence, less repetition and more opinion-giving or advice.

Silence

Discussion of the use of silence during calls was a recurring feature in both survey and interview data. Volunteers are trained to allow for silence and to use silence to allow the caller time and space to express difficult thoughts and feelings. Callers certainly valued being listened to, and some positively appreciated volunteers' staying with them while they took their time to articulate their distress. However, expressions of discontent about (what was perceived to be) unresponsiveness on the part of volunteers was a more common occurrence. Prolonged silence on the part of the volunteer in response to silence from the caller was said to induce feelings of awkwardness. Callers described feeling as though they were talking to themselves, that the volunteer was at a loss as how to help or that the volunteer was not really listening to, or interested in, what they had to say. Callers explained that times when they were finding it difficult to speak were also the times when they felt they needed the most reassurance, and some expressly commented on their preference for the volunteer to be more proactive in helping to draw them into a conversation. This may of course be a difficult task for volunteers, as gentle encouragement may be received by some as pressure to talk, and indeed volunteers are taught during SIT that it is important to allow silence as it will allow callers to reflect and will demonstrate that the volunteer is not judging or pressuring them (SIT module 5). As discussed in previous chapters, there were suggestions from respondents throughout the data of a need for volunteers to be better trained to interact appropriately with callers.

ID984: Very silent samaritans should be taught to talk - how can somebody feel listened to if nobody is talking to them?

ID369: Some volunteers go silent if the caller does... this is NOT good. They should maybe ask "are you ok?" The awkward silence really caused me distress in the past with these seemingly uncaring volunteers.

If a person contacts them and they don't talk or something they could perhaps do something there because they are just quite nasty, quite nasty some of them. S101

People that are profoundly depressed often can't string words together. Therefore, how can they actually benefit from the system? If someone listens, they're not actually talking. So that I found, with a depressive, it's not useful because nobody would be talking. If you're not speaking to the counsellor, the advisor, and all they can do is respond by saying Yes and No, it seems a pretty pointless conversation. S143

Repetition

The issue of repetition in email responses also featured heavily in the data. Respondents expressed their dissatisfaction or frustration with responses that either repeated what had already been said in previous replies or repeated back what the caller had written in question form. Highly repetitive responses were referred to as patronising and unhelpful.

> *ID316: Email service is much lower quality, slow and much less helpful; reply was patronising and stilted, mostly just seemed to repeat what I'd already said.*

> *ID757: It is a good email service but when they reply they ask you specific questions to get you talking and explaining whats wrong, and when you answer and reply you dont always get the same person again so the new person can sometimes need you to explain whats going on again. It can get a bit repetitive.*

Callers' reactions to being asked questions by volunteers were mixed. Whilst some described feeling intimidated or under pressure when asked a lot of questions and thought of these as unnecessary or irrelevant, others liked being asked questions and saw this as a way of helping them to open up.

> *ID397: whilst i understand that samritans are not there to advise or counsell, when you email you feel like the replies are abit standardised. I find it very hard to open up and need to be questioned more. the volunteers when using email could use both more open and direct questions to help you open up. although i do understand that this may be seen as intrusive by some people. but although i did get a eply and appreciated it, i dont feel like i ave been able to express all i wanted to.*

Asking about suicidal feelings

As discussed in Chapters 4 and 8, being asked if one was feeling suicidal was also raised as a problematic issue. When asked this question some callers reported feeling as though they *should* be suicidal in order to legitimately call Samaritans and that volunteers were making assumptions about how they must be feeling rather than seeking to understand their situation. Other callers reported feeling worse after being asked if they were feeling suicidal when they thought they had already made it clear that they were not feeling this way. In these instances callers felt like they were not being listened to.

> *ID883: Stop going on and on about the methods of suicide. I have noticed that you do this a lot and it is strange. You make a person talk about it then respond by saying "It's up to you if you want to kill yourself" or words to that effect. If you think about it logically do you really think that sounds supportive? It just makes a person feel even more suicidal and alone!*

Contrary to the beliefs of the organisation, a small number of callers did mention how being asked about suicidal intent and ideation put the idea of suicide into their mind at a vulnerable time. Callers proposed that the service could be improved by giving volunteers more discretion whether they asked this question or not. Caller feedback from Samaritans' 2005 email project [1:7] also suggested that continuing to explore suicidal feelings when a caller has said they are not suicidal can cause irritation, frustration and even lead a caller to break off contact. Despite these issues being brought to the attention of the organisation almost five years ago, it appears that little has changed in this regard.

Scripted responses

Another significant interactional issue raised by callers was the provision of 'standard replies' or responses to their questions that sounded 'automated'. Callers found this type of response disappointing and made them feel as if they were not being listened to or supported. Indeed, respondents reported that receiving scripted responses had made them feel a great deal worse than they did before contacting Samaritans in the first instance. Rather, callers expected replies which were appropriate and actually engaged with and addressed the specific issues they had raised in their email. Again, this problem with service provision was recognised in the email project conducted in 2005.

> *ID1111: Less formulaic responses to emails. Always just listing questions sometimes masks the fact that people care. It feels a little robotic particularly if you've used the servcie before as you can almost predict the reply. It sometimes feels as though you're not really listening just dispatching the required answer.*

Offering a more specific example, ID1696 describes an instance where she had disclosed aspects of her past experience only to be responded to with a clichéd or standard response which made her feel unimportant:

> *ID1696: Just listen, and never tell a rape victim or adult survivor of child abuse that they are letting them win by having it still effect them - of course the survivor will have tried to beat it all and be ok, but they're not managing hence calling the samaritans in the first place. Never patronise, or laugh, or talk down, or do the standard easy answer that is no help at all ☹ .*

As illustrated in the preceding extract, the perception that the service would be improved if volunteers were more careful in the way they responded to callers was quite widespread. Responses which gave the impression that volunteers were interested in what the caller had to say, were longer and asked relevant questions were generally appreciated. Callers expressed the desire for a more personal response from the volunteer to the information they had disclosed, providing them with some feedback, a sense of understanding or a response that would show some level of comprehension of their problems. It was also important for email callers that volunteers were able to relate their questions and responses to the content of previous emails. Complaints made specifically about the email service included: correspondence had not been read properly, responses were not appropriate to what had been said in previous emails and that not all of the questions asked were answered. These points also reflect the findings of the 2005 report which found that responses to caller emails were not addressing the content of previous emails from the same caller.

> *ID124: The whole "Jo" thing - whereby you're talking to this imaginary "Jo" - is I think indicative of the problems I experienced with the service, in that there was nothing personal about the email, to the extent that it didn't take what I'd revealed into account. For someone like me, and I think lots of people, opening up like that about depression is far from easy, and the impersonal experience, characterised also by a lack of listening, left me feeling more hopeless and alone than when I had emailed.*

> *ID691: It would be good if they would react all the things what someone writes in an e-mail. Cheap platitudes (I am / We are sorry you feel so low, ..and so on) make me disappointed when they dont respond to the point...with reacting ALL of the problems about what I have written them.*

In other instances, callers thought it would be beneficial for Samaritans to provide them with more specific information clearly beyond the remit of the organisation, for example, about their illness or legal advice.

Sharing opinions and giving advice

When asked how the Samaritans could improve their service many respondents put simply 'give more advice'. Chapter 7 provides a more in-depth discussion of issues surrounding advice giving in Samaritan contacts. However, the subject of advice giving featured prominently in the suggested improvements to the service posited by callers and a few of the issues raised are revisited here. Advice giving was often thought of by callers as a more useful form of communication to them than offering standard questions, giving scripted responses or remaining silent, as explained by ID143:

> *ID143: "BY DIOING SOMETHING USEFUL IE COMMUNICATE. ADVISE EMPHASISE AND NOT PARRROT "HOW DID THAT MAKE YUOU FEEEL"*

Callers thought that if advice was sought during contact with Samaritans it should be provided by volunteers. As indicated in Chapter 7, unsolicited advice from volunteers was likely to be unwelcome and interactionally problematic. The provision of advice was in the main part conceptualised as a way in which volunteers could be more helpful, more human and would indicate some recognition of the severity of callers' problems.

> *ID206: Samaritans boast that they don't offer advice, just listen and help to let you explore your feelings. Sometimes I think that suggestions could be warranted. Nobody has to follow the suggestions. I think that if someone asks specifically for advice, it should at least be offered.*

Overall in the caller data, opinion was split over the value of and desire for advice. As demonstrated in the data extract below and discussed in Chapter 7 some callers reported receiving advice that had really helped them:

> *ID369: Volunteers SHOULD sometimes give a little advice. I HAVE had advice from volunteers which is apparently against their guidelines... this advice may well have saved my life!*

Although many callers requested more advice, for others this was not the reason they were calling so when given advice they reported feeling rushed, not listened to or not taken seriously. In some instances, callers felt that they had received advice that was not appropriate or feasible, for instance, as discussed in chapter 7, being advised to go and see a counsellor, when too young to undertake such an initiative without parental guidance and intervention.

The issue of signposting to other organisations was raised. Even if advice was not given explicitly, callers wondered if Samaritans could direct those who requested advice to another service which would be able to provide it. Respondents proposed that 'gentle guidance', 'suggestions' or 'starting points' were sometimes needed in order to help an individual to sort out their own problems and stop them from 'going around in circles'.

Ending the call

Ending the call emerged as a salient interactional issue. Several respondents complained

that the volunteer they had been speaking to had prematurely ended their conversation. One caller described her experience of having the call ended as making her feel that she was 'on a timer' whereas others described being hurried by volunteers too busy to listen to them and feeling pressured to come to the end of the conversation. Callers found this experience difficult to deal with, describing volunteers as 'cold' and 'rude', and as having felt 'abused' 'betrayed', 'unwanted' and alone. As illustrated in the data extract below, respondents stressed that despite appearing calm or not showing their feelings, people might feel different inside and this was not a valid reason for volunteers to end their contact.

> *ID955: ONE OF YOUR ADVISORS LEFT ME WITHOUT A LIFELINE LEFT ME FEELING THAT THERE WERE OTHER MORE IMPORTANT CALLERS GOODBYE - (GO KILL YOURSELF?) THAT WAS ROCK BOTTOM FOR ME I WAS ON THE PHONE MAYBE 15 MINUTES IF THAT I WILL NEVER FORGET THAT WOMANS VOICE*

As discussed in Chapter 6 how, and after how long, a call is ended was a significant issue for both callers and volunteers. The idea that a caller can use the service as much as they want is widely reiterated in contacts with the organisation and on the website. It was, however, clear from the data collected that this was far from being the case. This was particularly striking during the branch observations where in some instances abrupt terminations of calls by the volunteers were observed, particularly if a caller was recognised to be on a care plan. Indeed, several callers complained about being 'led on' by such false promises only to find themselves on a call plan with restricted access to the service (Chapter 6).

Callers suggested that the Samaritans service would be improved by giving callers more time to speak, especially those who were finding it difficult to talk and allowing them to end the call in their own time. If this was not attainable, another suggestion was the provision of information or advice about where else the caller could go to seek help.

The words used to end a call were also important to some callers who felt that statements such as 'remember we're always here if you need us' and 'we're always here to support you' made the caller feel as though contact should be ended whereas 'take care' and 'we are concerned about you' made them feel cared for and that the door remained open for them to get back in contact with the organisation.

Volunteer perspectives

Several of these interactional issues were also discussed by volunteers as potential sites for improving the service. Volunteers suggested that a more consistent approach to important Samaritan policies would be beneficial to the organisation, such that all branches across the UK should offer the same stance on issues like giving advice. Volunteers recognised that current working practice in responding to emails and texts may result in callers being frustrated at having to repeat things, and a change in practice may remedy this. They envisioned that volunteers could deliver a better service to callers who text or email by reading the history of contacts and not repeating things asked by other volunteers in previous contacts. However, volunteers recognised that achieving such improvements would be difficult and would involve changes in working practices (e.g. in the amount of time spent on each email or text response).

> *Some branches may even be more strict than us on things such as giving advice … I think that there's inconsistency across the service which, because it's a national helpline number, and you know, you can speak to anybody from anywhere … because of that, I think that maybe there needs to be a bit more*

consistency across the branches. But how you go about doing that, I don't know. *V209*

A lot of callers are asked the same questions over and over and over again, I ought to, I mean, I hardly ever search the (full thirty) days of history on a caller, because doing a text would probably take about twenty minutes, twenty five minutes to write...they're often asked the same questions, I think the texters sometimes get frustrated, I feel they want something more from the service. And sometimes they get angry that they've been asked the same question again. Or they've gone through that particular bit of the history. *V219*

Section summary

To summarise, interactional issues between caller and volunteer were regularly discussed in the improvements to service data. Callers expressed the desire for volunteers to act in a more human fashion by engaging with them during the contact, not only listening to them but also asking questions and perhaps even offering advice. Many of the issues described by callers as problematic were recognised by Samaritans as requiring attention in the 2005 report on the email service. In general the type of service requested by callers was one which was more personal and tailored to their individual needs than is currently available. These limitations to the service were also recognised by volunteers and featured in the suggested improvements to service emerging in volunteer data. They envisioned that a more consistent approach to core Samaritan policies was needed in order to improve the service. However, many of the interactional issues identified as potential sites for improvement would be difficult to implement without a change in working practices.

Practical issues

Just over fifty percent of the suggestions as to how Samaritans services could be improved made by survey respondents focused on practical issues. Practical issues were also regularly raised by those interviewed. These have been coded into five main categories: access and availability of the service; new technologies; length and speed of contact; choice of volunteer; and links with other services. In this section each will be discussed in turn.

Access and availability

9% (n=48) of survey respondents who suggested ways in which Samaritans services might be improved wrote about access and availability issues. In the main part, issues around access and availability related to face-to-face contact with Samaritan volunteers. Greater access to a 'drop in services', particularly in rural areas was requested with some suggestion that this should be available 24 hours a day much like the telephone and email options. Callers from outside of the UK expressed the desire for more international branches to be set up or for more information about how those outside of the UK can access the service, particularly in North America.

ID1300: I have sometimes wished there were more volunteers as at times they have been too busy to see me and I find it a lot easier to speak to someone in person than on the phone.

Although expressing gratitude that the email, telephone and text services are available to them, a small number of respondents expressed the desire for a 'befriending' service where a volunteer could come and visit them in their own home in times of need. It was also suggested that Samaritans could run or facilitate the creation of support groups where callers with similar problems could meet face-to-face and support each other. In addition, callers suggested that a follow-up visit or telephone call a few days after contact would be beneficial to callers in order to show that Samaritans do 'really care' and thus 'completing the circle' of support. The provision of follow-up calls is something which Samaritans presently do offer callers. However, the value of this aspect of the service was sometimes questioned by volunteers on the grounds that while such calls are clearly welcomed by some callers, others find them unnecessary or even inappropriate once they have returned to a much calmer state of mind even a short time after making an initial call to Samaritans.

Similarly, in the volunteer data the continuity of support from individual volunteers offered in assigned befriending was discussed in various parts of the corpus as a lost, but effective service. Elements of Samaritan befriending which have been discontinued by many branches mainly for reasons of volunteer safety, such as one-to-one 'assigned' befriending or the old emergency response 'flying-squads', were discussed as having been of great benefit to callers. Safety issues, lack of resources, and worries about creating dependency may be the main reasons for not continuing such a service throughout the organisation. Volunteers also recognised that reinstating such a service would be difficult to manage.

> *Regular befriending, a personal befriender … would have a lot to offer the users because for a lot of them, they have nobody in their lives, nobody regular, let alone somebody who's already there for them … to really kind of get into the sort of the messy stuff within them, whatever, just to be accepted non-judgmentally … I think a lot of callers would really, really benefit from that.* *V216*

> *Older volunteers very much regret the passing of things like flying squads and befriending … I think they're, in a way, they're victims of being a rather more dangerous world out there than it used to be. So, I wouldn't want to go back to that, but on the other hand, I think we've probably lost something of on the emotional support side.* *V268*

Callers also requested that Samaritans should allow everyone to access their service by not barring or restricting callers and welcoming people with all kinds of problems, not only those who are feeling suicidal or in severe distress.

> *ID1259: Offer open house policy, where people who feel bad can go and have a cup of tea.*

As mentioned above and discussed in Chapter 7, if this was not possible callers suggested volunteers could point out other sources of help that those who are not feeling suicidal could turn to. In some instances callers thought that more provision could be made to support the family and friends of those in distress or feeling suicidal. Only one respondent expressed concerns about Samaritans adopting an all-inclusive support policy:

> *ID1345: Samaritans should not offer support to rapists/murderers/seriously violent individuals, who intend to offend similar crimes again. A supportive phone call may encourage more crime.*

In the main, volunteers agreed with the idea of an inclusive support policy and as outlined in Chapter 8, suggested that informing people that they do not have to be suicidal to call and perhaps even explaining what a Samaritan call is like to prospective callers could reduce fears and uncertainties about calling, and improve accessibility of the service.

> *I would like us to reach out to more people … there are particular groups of people that we are not very good at … young men, particularly … I would like, well, I don't even know how to word this exactly, it's kind of like communicate more widely…if one is despairing, what a contact with the Samaritans would actually feel like…because they're still always going to have to cross that threshold and there's always that fear, the terror of the first time call. V216*

The cost of calling emerged as a significant access issue for callers, with some discouraged from using the service because of this factor. As illustrated in the extract below, several callers explained how they had assumed that the helpline number would be free to call and were shocked when charged for the call, urging Samaritans to make this information more explicit to callers.

> *ID277: After half an hour my conversation with the samaritan came to an abrupt end and the guy told me i could call back any time. i put the phone down and realised i had been charged for the call - i didnt realise it wasnt a free number!!! make that more obvious and i wouldnt have called samaritans on my mobile, i would probly have called a free helpline.*

A prominent suggestion in the data regarding how to make the service more accessible in times of immediate need was that the cost of telephone calls- particularly from mobile phones- could be reduced. Fears related to using the telephone service were regularly expressed including concern that the number would be visible on the phone bill or that the bill would be noticeably higher than usual to others in their household. Others expressed how they simply could not afford the cost of calling the national number even if their call was of a short duration to request a call back. Likewise, some callers expressed that they found the cost of texting too high saying that this prevented them access to the service. It emerged that callers may experience difficulties in accessing the cheaper, local landline number of their nearest branch. Samaritans is aware of this issue and operates a policy where volunteers will phone people back if they can provide a telephone number. Reverse charge calls will also be accepted, unless the caller has been identified as barred because of excessive or inappropriate use of service. This however, may be off-putting to callers as they may have to explain their financial situation to benefit from this.

> *ID848: It costs to phone Samaritans so it is not always accessible when the support is needed there and then emails and letters take too long sometimes.*
>
> *Can I ask about the telephone number, because service users are always really bothered about 084-whatever numbers, because they're more expensive … I know for myself, I always ring the [local] number because I know it's gonna be a lot cheaper, and that is a big concern for some people, might put people off ringing.* *S108*
>
> *I suppose the only thing I would raise is for people on very limited incomes, it can be expensive, even the 08457 numbers … some have rung me back when I've explained the situation but it's been embarrassing to have to do that.* *S163*

Callers suggested that Samaritans could offer a non-0845 number to make contact more affordable for those using mobile phones or payphones. Respondents were in favour of a free phone number being introduced or proposed alternative methods of accessing immediate one-to-one contact that would not be of significant cost to the caller (discussed below).

Length and speed of contact

19% (n=83) of survey respondents discussed how Samaritans service could be improved through paying more attention to the length of contact and speed of email and text replies. Again, these issues featured in interview accounts with some overlap to discussions about ending the call. The provision of longer responses was a common suggestion as to how the email service could be improved throughout the data. Again, this issue was raised during Samaritans 2005 evaluation of the email service. Callers thought that longer responses that were tailored to the callers' needs would be a way of showing that the Samaritans 'really are listening and really do care' (ID642). In addition, faster response times were thought of as desirable. In some cases, respondents reported waiting for longer than 12 hours for a response to their email, which they found difficult or inadequate in times of desperation or crisis. Those familiar with the text message service also raised similar concerns.

> *ID1208: Just longer responses, and my first email took a long time to be answered (maybe 20 hours, which felt very long when I was really desperate).*
>
> *ID303: I generally think that the text message service needs to be improved. Firstly time is an issue, yet I do understand how busy you may get. But you can text and not get a reply for a good few hours! Sometimes you can type a long text out about something serious and you just get a reply, "that must be hard" or something random like that.*
>
> *ID1199: Though it may be difficult with volunteer staffing, having a way of answering e-mails more swiftly would help. Sometime people can't handle a phone conversation, but can still be in as much distress, and having a faster responce could help prevent situations from developing.*

The introduction of the 'intelligent platform' to distribute calls to available volunteer lines has substantially reduced the frequency of callers finding an engaged tone [2]. A small number of callers still expressed frustration when trying to contact Samaritans over the telephone only to be blocked by a busy line. It was suggested that calls could be longer, with volunteers taking more time to speak to callers over the telephone, particularly those who find it difficult to talk, before 'cutting them off'. However, as the preceding extracts illustrate, even when they had experienced some frustration in contacting Samaritans, callers also expressed appreciation for the services they had experienced and acknowledged the reasons which could cause these difficulties with the service to exist, e.g. a shortage of volunteers, high demand for service or cost of service provision.

Other suggested solutions included the recruitment and training of more volunteers or new methods of service provision (discussed in the next section). Another idea was that some sort of call waiting could be introduced to let callers who were met with an engaged tone know that their call will be answered if they remained on the line.

New technologies

17% (n=74) of survey respondents requested the extension of Samaritans services to include the availability of a webchat facility or Instant Messaging service. Several benefits of this type of service were identified by callers. An instant messaging service would enable callers to talk/type in 'realtime' to volunteers over the Internet and receive an instant response. This type of contact would still be anonymous and confidential, with the added benefits of being faster than email or letter contact and cheaper than using the telephone and SMS services.

> *ID265: Instant messaging would be good, because it wouldn't cost any money and you'd get an immediate response, and I think that's what a lot of people are looking for when they need to be listened to.*

Many of the callers who thought a web chat service would be beneficial to them were those who had used email in previous contacts. Several of these callers explained how they would like instant feedback or contact with someone but are too afraid or find it too difficult to talk to someone over the telephone. Others said they found writing easier, more private, less embarrassing and there was less chance of them being overheard. A two-way web chat facility would also be beneficial to those who are hard of hearing or otherwise disabled and find it difficult to use the telephone.

> *ID1412: I think they should further investigate instant messaging or chat room facilities. I understand the confidentiality barriers to this, but feel it would be of real benefit, especially for internet users who don't want to 'talk' or people who may be in a situation where phone calls would be inappropriate (family members listening etc). Emails take too long and people need an instant response.*

A few callers requested the provision of a means to contact Samaritans using online call services such as Skype. This would allow callers from outside of the UK to speak directly to volunteers and also be cheaper to use. However, the problems such a service raises with maintaining both caller and volunteer anonymity were also recognised.

Choice of volunteer

92.8% of survey respondents reported that they were comfortable speaking to a volunteer of either gender, or when unsure of the volunteer's gender (Chapter 4). However, for a number of respondents gender of volunteer was perceived to influence ease of communication with 16.7% (n=123) reporting that they found communication with either a male/ female volunteer difficult. This issue of choice of volunteer was raised by 11.4% (n=50) of survey respondents who thought that the service would be improved if they could specify their preferred sex of volunteer. Callers explained that presently they often hang up and call back again if the volunteer they are put in touch with does not meet their requirements. Often the reason for this was that they wanted to speak to a volunteer of a specific gender.

> *ID671: Sometimes I have used the email because I find it hard to talk on the phone, in particular to males. I have called in the past and asked to speak to a female when a male has answered and there has not been one available. I am not sure how you can remedy this situation but it would be nice to have a choice what gender you can speak to me. When I couldn't speak to a female I terminated the call, and rather than speak to someone about I was feeling I ended up self harming*

Respondents suggested several different ways in which the caller could have some choice over which volunteer they were able to contact. These included callers being able to indicate whether they would prefer speaking to a male or female volunteer; specify which branch (or general geographical location of the branch) they wanted to be put in touch with; have the choice to speak to a volunteer with particular expertise, of a particular religion, or speaker of a particular language. It was also suggested that younger callers could be given the option of talking to younger volunteers trained to deal with 'young people's issues'. These suggestions all directly conflict with the nature of the service offered by Samaritans.

> *ID1313: Somehow make it easier to ask to speak to a female. At the moment if a male answers i can't talk and end up hanging up and then keep trying until i get a female to speak to.*

> *ID984: maybe an option like dial 1 for a male samaritan dial 2 for a female samaritan dial 3 for next available samaritan ... sometimes it makes a big difference*

> *ID1257: More men volunteers if it was possible! I just feel better talking to men, and i guess (uneducated!) that other men do too. Also, sometimes more helpful if you can perhaps call two nights in a row and get the same person. however not a big issue.*

Secondly, the ability to contact a specific volunteer that the caller has had past contact with was proposed as an improvement to the service and discussed in relation to all means of contact available. In relation to email contact, having the same volunteer answering a caller's emails was suggested as a way to improve the continuity and quality of email contact and allow a supportive and trusting relationship between caller and volunteer to be built up.

> *ID1404: Because of the way the system works, while you are still the same person emailing the same organisation, the person replying to you changes everytime (even in the same string of messages). This lack of continuity can become apparent, and I myself have been asked the same questions in consequtive emails.*

> *ID1073: When visiting in person, it would be great to be able to see the same volunteer on a regular basis, as i find it extremely difficult to open up to different people.*

> Y*ou can explain to one person about how you feel and the next time it'll be someone totally different so that does get a bit frustrating at times, you have to go over the same things two or three times.* *S133*

Callers also thought being able to re-establish contact with the same volunteer would enable them to thank volunteers for their help and/or issue complaints.

> *ID277: A way in which a person who's called can contact the Samaritan they spoke to to thank them for everything they've done for them.*

An alternative suggestion was that volunteers should be able to quickly access a written history for callers who identify themselves although how the reading of this would be incorporated into the contact is not mentioned, and may be quite difficult. This type of

suggestion seems to indicate a desire on the part of the caller for Samaritans to behave much more like a conventional counselling/mental health service.

> *I've had so much this year to cope with, it's not just been one incident, like a whole series of things, the impact is on my mental health, it would be nice in a way if when you phoned you could say who you are and they could maybe tap in, to a computer and just have a summary of where you are or what's happened.... I don't know how it could be done, whether you could give people a code, a number, that they could then tap into your, their computers that end*
> S130

Other suggested practical improvements from callers included: less background noise when calling and making sure volunteers were alert and happy to do their job.

Links with other services

Ways in which Samaritans could liaise with other service and public agencies was a recurring theme across all data strands and was discussed in detail in Chapter 9. Other services and agencies mentioned were GPs, social services, police, mental health crisis teams, local support groups, and other charities. It was suggested that strengthening such relationships could both promote Samaritans service generally, and echoing the stated purpose of the organisational rebranding exercise, also be a way of reaching people before they reached a point where they would need to call. Callers proposed that other organisations could encourage Samaritans to contact their clients, or that Samaritans could act as intermediaries and help callers to manage their relationships with other organisations.

> *Getting in touch with people, whether it be who, you know, I mean, when I, when I've had trouble or been, I've had friends that have had trouble as well, like, various things ... doctors never suggest it or counsellors at school never suggest it or, I think, for the younger generation it's quite difficult to go, pick up the phone.* S162

The issue of advice-giving was again raised in this context. However, this was often geared towards advice in the form of signposting to other organisations, rather than more conventional, practical direction. Callers thought that if Samaritans fostered more links with other agencies they would be able to 'refer clients on' so they are able to get the practical help they need. Although appreciative of the non-judgemental and confidential service offered by Samaritans, respondents felt that if intervention was requested or desired by the caller the organisation could offer it. However, as discussed in Chapter 9, inter-agency working was not proposed without caution, as several callers worried that strengthening such links could alter the nature of Samaritans services.

> *ID530: Try to make some arrangements with either GPs or locl support groups, anything to be able to offer some options to the caller if they are needing help outside of a call or e-mail.*
>
> *I wonder about if they could liaise with Mental Health Teams or GPs, you know, contact them on your behalf and say to them, 'look we've been dealing with this person and they really need you to make them an appointment or sort them out soon'. But then I worry that it would change the nature of the service you see. It does worry me.* S103

While a number of callers discussed careful liaising with other organisations as a method for improving the service, only once was this mentioned by a volunteer. V219 suggested a more systematic method for forwarding callers to professionals such as counsellors, as a way of ensuring that callers progress with their issues.

> *There's the occasional caller that is referred to pro bono counsellor but, you know, I'd certainly like to see some more of that.* *V219*

Some volunteers described their awareness or involvement in partnership working with a number of local agencies, but these involved schemes which referred callers to Samaritans, rather than from Samaritans to another service. It was suggested in the caller data that Samaritans could possibly extend the service they offer to include counselling and other talking therapies for those with mental health conditions. It was also evident that many callers positioned the organisation as an adjunct of the mental health services (Chapter 9).

> *ID405: Extending services by providing separate no cost counselling mental health services based on eclectic talking therapies.*

Section summary

Concrete suggestions for ways in which Samaritans could alter or add to aspects of service provision were abundant across both the survey and interview data. Callers proposed that the service could be improved through the provision of longer contacts and faster replies via email and text. Desire for increased accessibility to existing services was expressed and new ways of accessing the service suggested by callers. In particular, callers appeared to want more choice in not only how they were able to access the service but also with whom they were able to get in contact. Greater links with other services and means of support were also desirable.

Recruitment and training of volunteers

Caller perspectives

As mentioned above, problems were raised with consistency of the service, especially in regard to email correspondence. Callers reported occasions when they had felt judged or had not being taken seriously during their contact with the organisation. They described this treatment as making them feel isolated and worse about their situation. Six survey respondents even went as far to say that this treatment had *made* them feel suicidal.

Specifically with regard to email correspondence, callers claimed that their emails were not being read thoroughly by volunteers before being answered. When talking about phone calls, problems with consistency of service were also raised, particularly around the issue of advice-giving and talking to actively suicidal callers. Whilst callers recognised and accepted that all volunteers are different they also believed that it would be helpful for volunteers to adhere to Samaritans policy in order to meet the expectations of callers. This led to suggestions for improvements to the service that focused on more training for volunteers which callers hoped would enable them to communicate more effectively, especially via email and provide a more consistent level of service.

> *ID1430: Either it's policy to wait on the phone if someone ODs or it isn't. If you expect one thing and get another, it can make you feel a good deal worse.*

Throughout the data callers depicted their image of the ideal volunteer- someone who was intelligent, empathetic, non-judgemental, patient and accepting of everyone. They stated that Samaritans should be more prudent in the selection and recruitment of suitable volunteers to ensure a consistent level of service to meet callers' expectations. It was suggested that Samaritans could use 'mystery callers' to both monitor the quality of service provided and 'weed out' those volunteers not performing satisfactorily.

The consistent provision of non-judgemental support was an area in which callers felt volunteers would benefit from more training. It was also suggested that volunteers might benefit from more training in mental health issues to equip them with a deeper understanding and skills to deal with those suffering from mental illness. Respondents reported feeling 'misunderstood' because the volunteer was not aware of their mental health condition or the ways in which it manifests during interaction.

> *ID64: Better training for all volunteers, helping them to understand how it is to feel desperate/sad/alone/panicky. Often because I can joke about my condition, they seem to feel I'm "not too bad" rather than it is a survival technique!*

> *ID1188: You have GOT to train people better about dealing with angry people...anger and irritability are classic symptoms of severe depression in some people. Telling me not to display those symptoms when my mind is screaming at me to do so is absurd. Like telling someone a torn achilles tendon not to limp!*

One suggestion was that such training could be delivered by people who have personal experience of mental illness. Callers thought that this would provide context to enable volunteers to 'put themselves in the caller's shoes' and perhaps resolve some of the difficulties they had experienced when using the service. Similarly, it was proposed that if volunteers were better trained in mental health issues they would be better positioned to offer advice to callers or better help them search for solutions to their problems. In this sense, callers could be seen as making a case for more involvement of service users throughout the organisation, especially in relation to training, to direct and tailor the service offered to the needs of the user.

> *I think if they did know more about the difference between self harm and suicide, I think that would help.* *S108*

> *I would say first of all training needs to be improved, maybe mental health awareness because I think it's a lot to do with mental health, when people ring.* *S114*

Callers claimed that training in mental health issues for the volunteers would be helpful to them, as volunteers could better understand their problems if they had some information about (for example) the nature of depression, or the symptoms of schizophrenia. Knowledge of self-harm and its relationship with suicide was a common topic discussed. Generally, callers were of the impression that volunteers have no training whatsoever on mental health issues. As discussed in Chapters 3 and 9, the issue of training in mental health issues also featured in the volunteer data. Overall, opinion was split amongst both callers and volunteers as to whether more training in mental health issues would be entirely beneficial. Often uncertainty around this issue was based upon fears that the provision of more detailed information could lead to a change in status of volunteer from amateur to expert and that this would fundamentally alter the nature of service offered.

Volunteer perspectives

The most frequently recurring issue arising from discussions about improvements to the service in the volunteer data which would initially benefit volunteers (and then, in turn, callers) was that of volunteer training and development. Ways in which volunteers could progress and develop as Samaritans were discussed, such as improving ongoing training by recognising the varying needs and levels of experience of volunteers, introducing a more formal system of reviews for volunteers (which is not an aspect of initial service or training), and encouraging peers and / or leaders to listen in to calls more with the aim of providing feedback on a volunteer's performance. Volunteers recognised that introducing such elements into the workings of a branch or the organisation as a whole would indeed be difficult, and may trouble many existing volunteers (particularly the listening in to calls). In addition, respondents acknowledged that achieving such systems of quality control is difficult when people are giving up their time without payment.

> W*e don't actually go in and listen as part of a quality control thing. There's been debate about whether we should do that and, my feeling is that yes, I think we should do it. But if we do implement that, I think we'll lose fifty percent of our volunteers.* *V213*

> *Formal coaching, peer review and enabling individuals to improve the quality of what they do … and that is not a training issue, that's an operational issue in running a centre. And it's not something you can actually prescribe very easily. It's something you have to get built into the culture.* V229

> *I think we could make more of the ongoing training … the ongoing training that I did earlier this year … I just felt I wasn't getting anything from it and it was another evening to give up which I didn't feel was adding value … for me as a Samaritan for two and a half years, it's what is my individual development for the future. We've all got development needs but I think mine are probably different to somebody else's.* V261

Also of importance to volunteers was the way in which abusive and sexually demanding callers are dealt with by the organisation. Such calls were discussed as massively damaging to volunteer morale and thought of as causing many volunteers to leave as well as preventing potential volunteers from joining the organisation, as discussed in Chapter 3. While volunteers recognised and appreciated that there are systems in place to address these types of caller, they also felt as though such callers were still causing problems and that more could be done to support them in dealing with this type of contact. The practical management of the recognition system was also discussed as needing improvement. Volunteers on duty may find it difficult to work with a large and cumbersome document or folder containing details and recognition points about banned or restricted callers, and recognition itself is very difficult, particularly as a great deal of information about such callers is listed in the folder. Again, it may be difficult for volunteers to generate ideas on how to improve this aspect of the service.

> *The only thing I would like to say is you know just to put it on record is I really do fear for future volunteers if the Samaritans as an organisation doesn't address the sex calls thing a little bit more seriously. Because all the people that I know that have left that's been a major factor. Because it can take up a good 50 – 60% of your calls in one evening and it just, it's very demoralising … I think perhaps if they don't do a little bit more research into it they are going to be losing a lot of volunteers I would have thought, or people coming forward to do it.* V203

There's one part of me who, that gets really, really angry about it, and there's another part of me that thinks Okay, yeah, but, just hang on, I'm a Samaritan and the organisation has got certain policies and so on and so forth so if I'm going to do anything about it, I ought to deal with it in the right way. But aggressive, really aggressive and abusive callers, I know the organisation is doing a lot to face up to these and to actually reduce the incidence of them. They're looking at technology ways of doing this ... I think we've really got to go at that, and stop it because it's, it's actually quite corrosive to the service, quite corrosive to the morale of the volunteers. V213

You flip to the national caller section and it's very difficult to know whether someone on the phone is one of those national callers or not. I would say that that area is something that could do with work but I've absolutely no idea how to implement that. V209

Induction and training of volunteers arose as an issue for volunteers, as this has an impact on many varying aspects of the service, such as being able to keep a good quality of service for callers, and being able to man branches twenty-four hours a day, seven days a week. The quality of selection, initial training, and ongoing training could be improved according to some, and this may be so for prison listeners as well as branch-based volunteers. The involvement of existing listeners in the selection process is discussed as potentially beneficial due to their knowledge of what prison listening is really like. Concerns were raised that the commitment towards 24/7 operations and thus the requirement for certain staffing levels in each branch may force recruitment and training to the extent that it is acceptable to have less-than-desirable new volunteers coming through just to keep the branch open.

If we were to attack this quality thing from the Samaritans' point of view, I think you've got to look at the selection procedure to start with ... I don't think it's good enough. I've done selections here for ages. Each time you do them, I think to myself, well, we selected another ten people and, to be honest with you, I don't really know whether we've got the right ones or not ... selection, training, I think they just need beefing up, to try and get the quality there and I, and on ongoing training ... everybody's got to be listening. And I'm not sure that everybody always is. So occasionally, you'll get weak people in any branch ... we've got to have X number of volunteers here, and we don't want to lose them, and we want to keep getting them in. And that's what's driving us all the time. Now, you know, if we had a bit more breathing space, we could perhaps be a little bit more selective and a bit more rigorous in the way we train people. V213

Section summary

Both callers and volunteers placed importance on improving volunteer selection and training. For callers, better training in handling calls and in specific areas (for example, mental health issues) were suggested as ways in which consistency of service and greater understanding on the part of volunteers could be achieved. For volunteers, the issues raised focused primarily on professional development and volunteer support. It was suggested that on-going training could be better tailored to suit the individual which would be more beneficial for the volunteer in terms of skills development. In addition, it was proposed that if volunteers were given more support and training in how to deal with inappropriate callers, staffing levels could be maintained more easily.

The wider promotion of Samaritans services

A frequently raised issue which does not relate to the actual delivery of the service is that of Samaritans' profile. Callers thought that Samaritans as an organisation would benefit from a wider promotion of their services. Respondents suggested that the organisation needs to advertise itself more in an effort to convey to the public that they are open to all, and not solely a suicide-support service. This is an indication that callers would like the organisation to maintain this wider, more inclusive remit. There was some indication in the data that callers may not be aware of all of the methods of contact available, (usually pertaining to the email or text messaging service) and callers expressed a desire for these services to be better publicised.

> *ID1162: Publicise their text service more, I didn't know about that before.*
>
> *ID1158: let callers know at the end that the email and text contact mediums are available, as I didn't know that and might use them in future*

Callers mentioned how they had recommended Samaritans to friends or family members who had never heard of the organisation, or thought of it as 'just for older people'. Whilst some felt that the public are relatively unaware of the organisation, others claimed that the current profile is outdated or misleading (for example, that there are still religious connotations due to the name 'Samaritans'). They proposed that this could be remedied through a broader and more effective advertising campaign that would make more people aware of the service and who it caters for in addition to more public fundraising events.

> ID886: *They could show TV adverts to make people aware of what is on offer to help you with your emotional support.*
>
> ID1090: *You could make youselves more well-known to teens, none of my friends have ever heard of you.*
>
> *Maybe dust off their old image, because they could be, they could be a modern Samaritan organisation that, unfortunately, people do have really dark times and we're there for them, kind of thing … bring their image away from the fifty years ago and modernise their image a degree.* S164

General outreach involving Samaritans leaving branches and having a public presence was also discussed (many branches already do this as part of a response to specific local events). Volunteers considered such activities to be beneficial in reaching target groups of callers and helping the general public become better informed about the service so that they are more comfortable in accessing it. Some volunteers discussed the general public perception of Samaritans as needing to be improved through various efforts by the organisation.

> *I think their profile could be higher … if it were a, more in the public eye as being something that you can phone before you reach suicidal point, I think that would be helpful.* V220
>
> *Probably better working leaflets and things.* V222

Other suggestions for improvements at an organisational level were discussed by volunteers, all of which related to the effective use of volunteer time. These included suggestions to produce less paperwork (in terms of notices for volunteers to read when

on duty, for example), utilise non-listening volunteers more productively, and utilising the skills of existing volunteers more wisely, through schemes such as sending very experienced volunteers around their region to offer help to branches.

> *I think, just to flag up one thing, it's the amount of paperwork the organisation generates … there's an awful lot … if you're going in on duty, you don't want to be faced with a wall full of, you know, sort of A4 sheets about somebody who's got some axe to grind in another office.* V262

> *I think greater use of non-listening volunteers … to help with administration and fundraising. I suppose that's down to individual branches really, because there's nothing to stop you doing that.* V268

> *A region could have like a sort of good ideas person that would go round just sharing, saying 'Hey, do you know N do this, or do you know S do that'? And, helping them bring it in because people are really pushed for time. We've developed stuff at our branch which might be useful to other branches and I know other branches I've been to, I've seen stuff there and in fact, I've picked some stuff up but it takes a long time and it's quite an effort….sharing ideas and we talk and we meet up a couple of times, about three or four times a year and share ideas and we email each other and all that but there's no, there's no process for it now.* V240

Section summary

Collectively, callers and volunteers proposed that the wider promotion of Samaritans services through initiatives such as advertising campaigns would benefit the organisation and callers on several levels. Through such activities the organisation may be able to shed old images it may be associated with and promote the services currently available to those who need them. In addition, volunteers proposed several ways that the day-to-day running of the organisation could be altered to improve efficiency and quality of service delivery.

Chapter summary

Many respondents were very positive about Samaritans and the service they had received and so the suggestions for improvement presented above should be considered in this context. However callers and volunteers had many points to offer on how the Samaritans service could be improved. This typically involves altering an existing aspect of the service, such as the policy on not providing advice. Some callers suggested improvements based on additions to the service or a return to previously offered services, such as liaising with other caregivers and support services and accompanying callers during consultations.

In general, callers proposed that volunteers could take a more proactive approach when handling calls. They wanted volunteers to give callers the space they need, treat everyone with equal importance, not patronise or insult callers, to be more sparing in their use of silence during calls, and to respond to callers needs. They proposed this could be achieved by, for example, providing callers with feedback, information, useful telephone numbers, help with contacting other agencies and services, giving advice if (this is what the caller wants) and encouraging them to get the help they need by asking questions and providing reassurance. Longer and faster responses were also requested by a substantial number of callers, especially those using the email facility. Callers thought these changes would allow volunteers to appear more human and show genuine concern which would be more helpful, useful and make callers feel cared for. In turn this

would make it easier for callers to open up and express their feelings.

The most recurrent issue arising from discussions about improvements to the service with volunteers was that of volunteer training and development. Ways in which volunteers could progress and develop as Samaritans were discussed, such as improving ongoing training by recognising the varying needs and levels of experience of volunteers, introducing a more formal system of reviews for volunteers, and encouraging more 'listening in' to calls with the aim of providing feedback on a volunteer's performance.

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Chapter Eleven: Discussion

Introduction

Previous research conducted within, or commissioned by, Samaritans has included a focus on the quality of email responses [1] volunteer perceptions of calls [2] and volunteering [3]. In addition, the Telephones Helpline Association carried out a comprehensive review of the quality of service provided by the organisation in 2006 [4]. There are many interesting points of similarity between the findings of the present research and those of previous studies. However, the current research constitutes the most wide ranging and comprehensive independent investigation of Samaritans emotional support services that has been carried out to date, and crucially incorporates extensive data relating to caller perspectives and experience of using the service, access to which has previously been extremely limited. Mixed methods have been used to combine a number of different data strands including direct observation of Samaritans branches and activities, qualitative interviews with callers and volunteers, analysis of email and text messages and responses, and an online survey. The survey also included a large amount of qualitative data in the form of respondents' written responses to open–ended questions. The result has been the collection of a very substantial body of data relating to volunteer and caller perspectives of the organisation, its core aims and mission and its provision of emotional support services. The findings incorporate a great diversity of views from both volunteers and callers. The present chapter discusses the key issues and themes arising from the study in relation to each of the four primary objectives.

Samaritans has, from the outset, embraced the prevention of suicide as a core part of its mission. Within a commitment to individual self determination, it is hoped that providing those in crisis with an opportunity to be listened to and to develop insight through the exploration of intense and difficult feelings can alleviate the experience of distress and despair that may lead to suicidal action. Chad Varah's initial vision in founding the organisation in 1953 was that it should be 'an emergency service for the suicidal' [5]. In subsequent decades Samaritans has repositioned itself from being largely a reactive service for those experiencing emotional crises to adopting a more proactive preventive orientation. In 2002 the organisation was 'rebranded' as a more inclusive service available for anyone experiencing unhappiness or emotional difficulty, rather than acute despair [6, 7]. The rationale underlying this development was that by reaching and supporting people at an early stage it should be possible to avert a downward spiral of despair and pre-empt suicidal action. An extensive programme of outreach activities has been undertaken, for example, in schools, prisons, and the workplace, to promote the importance of emotional wellbeing within society and to increase the level of 'emotional literacy' among the public [7]. More recently, the strategy has returned to focus on suicide prevention among those in crisis as the core attribute of the service [8]. Whilst other callers and reasons for calling are not specifically excluded, it is not clear how they are positioned within the current remit of the organisation. In addition to maintaining support of individual callers through the helpline services, the organisation aims to make a wider social impact on suicide reduction by contributing to, and influencing, national suicide prevention strategies [9, 10] as well as through the development of outreach programmes to target groups identified to be at particular risk of suicidal action, and more extensive partnership working with professional services and voluntary agencies.

The impact of Samaritans in achieving its primary goal of suicide prevention eludes empirical confirmation or evaluation. The benefits of emotional and social support for individuals experiencing distress, particularly depression, are well established [11, 12]. The effect of 'befriending' on depressive symptoms across a range of clients has been subject to some (limited) empirical investigation. A recent review of the available data

(from 24 studies) found that befriending has a modest effect on depressive symptoms in varied patient groups when compared to usual therapeutic regimens or no treatment [13]. There is also some evidence of the effectiveness of telephone helplines in improving the mental state of callers, including a reduction in suicidal ideation and intent, at least in the short term [13-17]. Establishing longer term effects is more difficult. The sheer complexity of factors influencing suicidal action at societal and individual levels confounds the possibility of developing an evidence base for such a link [6]. The present study cannot contribute to the development of such an evidence base, and it has never been its aim or intention to do so. However, it has collected an unprecedented amount of empirical data as the basis of an analysis of the effectiveness of the Samaritans from the perspectives of those who use and deliver the service.

The views and experiences of Samaritans volunteers in delivering services

Sixty six volunteers from a wide range of branches across the country took part in individual interviews about their perspectives and experience of being a Samaritan. In addition, a great deal of further knowledge was gained through over 200 hours of branch observation of Samaritans taking calls as well as many discussions with volunteers on shift, and through attendance at local and national Samaritans events (Chapters 2 and 3).

Recruitment and training

Volunteers were predominantly positive in describing their experience of training and being a volunteer. It was evident that volunteers gained a great deal from their experience as Samaritans, in terms of personal skills development as well as membership of a supportive community [18]. The decision to become a Samaritan was influenced by a variety of factors, for example, personal experience of suicide and bereavement, the desire to be useful and to 'give something back', or to utilise and extend existing skills (Chapter 3). Respondents often described a chance encounter, sometimes with a volunteer, more often with an advert or media item about the Samaritans, as a trigger in sparking their interest. However, many had also deliberated for some time before acting on this. Thus a chance advert could set the seeds of future commitment, or act as a catalyst for existing receptivity. Respondents sometimes waited for a reduction in their family or work commitments before taking up the role of volunteer. In response to falling numbers, a recent campaign has been carried out to boost recruitment of new volunteers ('Everybody has it in them to be a Samaritan'). This has been credited with a substantial increase in enquiries (an additional 2,300) and the anticipation of a subsequent rise in recruitment [19]. However, some concerns were expressed about whether current procedures for selecting volunteers were sufficiently stringent, especially when there was pressure to increase recruitment.
Despite the public profile of Samaritans, respondents described only learning what Samaritans 'do' and what being a volunteer involves during training. The quality of training was positively assessed and respondents described this as a sound resource to draw on in their subsequent experience as a volunteer (Chapter 3). However, several omissions were noted, and volunteers described being surprised to discover the *frequency* of sex calls, the *rarity* of calls from suicidal callers, and also the overall *lack* of calls during many shifts. Respondents reported having expected that a much greater proportion of their time would be engaged in speaking to people who were actively suicidal. Some felt that more specific guidance about handling calls from regular callers, people with severe mental illness and those who self harmed would also have been very relevant and helpful. The current training package (SIT) was favourably compared with the preceding 'Prep' materials, and the consistency fostered by a national training package was welcomed. However, the question of how to balance

standardisation/uniformity in training and the scope for retaining some flexibility in how SIT was implemented within each branch was raised by several respondents.

Organisational and peer support

Volunteers described, and strongly appreciated, the very high level of support provided within the organisation both informally, by fellow volunteers, and through the procedures for offloading with the branch leader at the end of each shift (Chapter 3). Leaders were rarely present in the branches during shifts, but were available should a volunteer require advice and assistance. Offloading usually took place by phone. There was considerable variation in volunteers' attitude to offloading and in practice this could be a perfunctory interaction, especially if no 'significant' calls had been taken during the shift. Volunteers raised the importance of being able to 'leave any difficulties behind them on the shift'. This was marked as an important function of the leaders particularly as individuals may not always want, or find, an opportunity to disclose any problems to the other volunteers on shift. A pertinent issue affecting most branches at the present time concerns offloading at the end of night shifts. Since the introduction of split shifts, volunteers go off duty around 2.00 – 4.00 am. Branches vary in the arrangements in place, but there are concerns about disturbing the leader at this time, especially if there is nothing significant to report. Some branches have opted for the volunteers to call the leader the following morning. Branch observations revealed that offloading to the leader at the end of the night shift may not always occur – sometimes simply because the volunteers are tired and anxious to head home. Occasionally the leader was not contactable. This does not necessarily pose difficulties for volunteers, as effective offloading may have already taken place to the co-volunteer on shift, but it remains a logistical and procedural issue for the organisation.

Good calls and inappropriate calls

Volunteers regarded the provision of emotional support for callers who were actively despairing or suicidal to be the core and distinctive purpose of the Samaritans, and what they had signed up to do. Many volunteers described being surprised to discover the range of calls with which they were confronted, and also how few of these were in any sense 'good calls', i.e. calls involving the expression of suicidal ideation or at least a state of acute emotional turmoil. The feeling of having supported callers to achieve a degree of insight and to help them regain composure during the call was described as a very gratifying experience. Much more often, volunteers were confronted with calls of a less satisfactory nature: these are a familiar hazard for telephone helplines [20]. Inappropriate contacts included calls expressing abusive or sexually demanding content. However, they also constituted a wide range of calls of a more ambiguous and uncertain status. Many were from regular callers who were lonely or struggling with chronic problems and difficult lives which lacked any obvious means of resolution or improvement. Many callers suffered from varying degrees of mental illness (Chapters 4, 5 and 9). Respondents varied widely in their tolerance and approach to handling such calls, but frequently experienced them to be a source of frustration and annoyance. The lack of calls during quiet shifts could also be discouraging and sometimes prompted doubts about whether the time and effort committed to volunteering was justified. A common qualifier to this kind of thought was that the prospect, and the occurrence, of genuinely 'good' calls was sufficient motivation to carry on. Within the branches volunteers were observed to deal with 'inappropriate' callers in a broadly tolerant manner. However, this was frequently at variance with the manner of handling calls prescribed in training. In practice, and perhaps inevitably, given the nature of the caller and the subject of the call, branch observations and analysis of the emails indicated that many calls involved little if any focus on the discussion of 'options' or the exploration of 'feelings'. Especially with suspect callers, and those who were well known within the

branch, volunteers were observed to respond in a robust, familiar and sometimes challenging manner (Chapter 6). A substantial minority of callers are known to be disingenuous. There is an ongoing problem of recognising the 'genuine' call in a context where the caller's identity and credentials are unverifiable, and the volunteer's personal competence and integrity is constantly challenged by potential failure to detect the malicious or inauthentic call (Chapter 6).

Caller care

A core principle of active listening is to accept the caller unconditionally and without judgement. In practice, the volunteers routinely make judgements. For example, callers are assessed as being regular, manipulative, needy, chatty, lonely, dependent, and sexually demanding. These attributions are applied to many of the types of caller who expressed the greatest need and appreciation for Samaritans support (Chapters 4, 5 and 6). Volunteers varied widely in their views about the nature of 'inappropriate' calls and how they should be handled. At one extreme some volunteers accepted that everyone who contacted the organisation had a need of some kind to which it was the obligation of the volunteer to respond. Others adopted a more restrictive view of the nature of service. They deeply resented what they perceived to be extensive misuse of scarce resources which risked depriving genuine callers of much needed support. The high incidence of nuisance, particularly TM, calls was attributed as a significant cause of volunteer attrition.

The caller care scheme is intended to pick up regular or demanding callers who are perceived to be either misusing the service, or not benefitting from contact, including those who are judged to be developing 'dependence' on Samaritans. While framed in terms of benefit to callers, caller care plans function as a means of rationing demand and protecting volunteers from difficult calls and the need to make judgements about how they should be handled. Volunteer respondents tended to be vague about the operation and processes of caller care, but also to respect the expertise behind the judgements made, and to accept that the plans are for the caller's benefit. A few respondents felt that the system was oriented too much to limiting and restricting callers rather than to helping and enabling them. However, there was wider acknowledgement that it was necessary to impose some kind of limitation on excessive use of the service. Indeed, volunteers were sometimes critical about the failure of the care plan team to target individual callers that they judged to be using the service inappropriately or excessively. The problem of how to channel a service which presents as always accessible and open to all comers in such a way as to target those for whom it is intended and deter those for whom it is not, offers no obvious or easy solution [20].

Care plans are difficult to implement within each branch and also more widely within regions and across the country. Volunteers might fail to recognise that the caller was on a plan, or override its limits if their judgement was that the call in question was 'doing some good'. Branches varied in their tolerance for regular and demanding callers and the number of care plans in operation [2]. Some callers had established longstanding patterns of regular contact – perhaps phoning several times a day – without being placed on a care plan, while others had been allocated plans after relatively short periods of contact. Some callers had a longstanding history with individual branches, and could be treated with indulgence and affection, while others attracted criticism and impatience. Callers were not easily identified as subject to call plans by volunteers within individual branches, far less more widely across regions or the UK. The Intelligent Platform technology for distributing calls on a regional basis has increased accessibility of service but has made it more difficult for volunteers to detect and monitor problem callers. However, the ability to recognise these is key to achieving consistency in implementing care plans at local, regional and national levels. Diversification of service through email and text messaging has compounded this problem. Since callers may remain

anonymous, the different media of contact (such as text and email) open up new opportunities for evading detection. Callers assigned to a care plan at a local branch stand a very good chance of being able to email and text prolifically without being recognised as subject to a restriction on service (and conversely). The result can be a more or less acrimonious contest between callers and volunteers each trying to outwit the other in gaining or restricting access to the service.

Advice

Contrary to the core principle of non-directive active listening, it was evident from observation, interviews and analysis of the email corpus that advice giving is a regular feature of many calls (Chapter 7). Concerns about the quality and consistency of the email service were voiced by a number of volunteers in interviews and during observations. Respondents varied widely in their enthusiasm for doing emails, and in practice, may avoid doing any. Some volunteers acknowledged new services such as text and email to be valuable innovations, but did not themselves feel comfortable with them. The rare occasions of inter-personal tension observed between volunteers in the branches usually centred on some aspect of email composition and service delivery. The email and text services have introduced a degree of transparency into the interaction between caller and volunteer that has made it easier to pick up on poor practice. The ongoing monitoring of email messages is one reason for volunteer reluctance to engage with this aspect of the service. The open availability of email messages for scrutiny by all volunteers constitutes an overt form of surveillance within the organisation and has raised awareness of the extent to which responses are often poor. As indicated in the earlier Samaritans survey of the email service, it is likely that poor practice in emails (especially inappropriate and unresponsive tone, and the giving of advice) is replicated in phone and other contacts [1]. However, as several respondents acknowledged, it can be difficult to take up issues of 'quality control' and how to improve service delivery with individual volunteers who are donating their time, especially when the issue of maintaining volunteer numbers remains of concern.

Mental Health Issues

Volunteers were aware that many callers have a history of psychiatric problems and expressed concerns about their ability to handle calls in an appropriately supportive manner. Doubts were expressed about the capacity of the service to benefit such callers, and the appropriateness of engaging with them (Chapter 9). As with other issues, volunteers took a range of positions in relation to the issue of mental health issues and the nature of Samaritans service. At one extreme was the view that the mental health status of the caller was irrelevant and the task of the volunteer was to suspend judgement and listen to all callers with the same impartial commitment. Others accepted that many callers suffered from mental health problems, and were prepared to support them as best they could. Opinions varied about the desirability of increased training in mental illness and handling calls with those who were manifestly ill. Some felt this would be helpful, while others did not want to enter into the territory – or responsibility - of specialist knowledge and intervention. At the other end of the spectrum, volunteers expressed their disquiet in dealing with callers who were clearly mentally ill. They questioned whether the Samaritans brand of active listening was helpful to them and were concerned that such callers' continuing use of the service merely created dependency.

Volunteers were aware that callers used Samaritans as an out of hours support service when professional services were closed, and that they were sometimes encouraged to do so by their professional advisors. Again, opinion varied. Some saw this as amounting effectively to the provision by Samaritans of an inappropriate subsidy for the NHS.

Others adopted a more positive perspective. They welcomed formal recognition of the role and value of Samaritans and were also, in line with the aims of current strategy, proactive in developing closer partnership working with the other services and agencies. The extent and nature of such activity varies between branches. Several volunteer respondents described variants of referral schemes negotiated between the branch and local GP practices and mental health trusts. Samaritans has been promoting active working partnership with professional services for a number of years. The THA review reported 40 such schemes to be in operation in different branches in 2006 [4, 21]. Typically, such schemes enable health professionals to offer patients a referral to Samaritans to provide additional support over a difficult period of illness, or perhaps while the patient is on a waiting list for a referred service. While such schemes offer scope for diversification and further outreach of Samaritans, some volunteers recognised that they raise a number of implications regarding the organisation's nature of service and continuing independence.

Supply and demand

The struggle to recruit and retain a sufficient number of volunteers was a topic of concern and discussion within the organisation and in the individual branches. In recent years, active volunteer numbers have been decreasing while the number of recorded contacts has risen [22]. The problem lies in securing sufficient volunteer input to keep the branches open during the night, when the greatest volume of calls is received, and when the highest incidence of engaged responses is currently recorded (68% between 2am and 8am [19] (Chapter 3). Volunteers often experience difficulties in doing night shifts (especially after 2.00am) and some do not do them at all. Nevertheless, volunteers were strongly committed to Samaritans being and remaining a 24/7 organisation (a view also strongly endorsed by callers) and at branch level there was evident regret that this was often not possible. Only a minority of branches now remain open round the clock (in 2006 this was 27 out of 200) [2]. Nevertheless, it is recognised within the organisation that the problem is one of distribution of resources rather than an absolute shortage. There are enough volunteers to meet existing demand but their input is not distributed effectively. There are regional variations in call frequency and an unequal distribution of volunteers in relation to this, particularly in the larger cities, especially London [21]. Filling night rotas is difficult for many branches. During observations many day time shifts received few calls, and volunteers could spend a considerable period of their time being idle. The distribution of branch shift opening hours is managed at regional level. While many branches limit their open shifts during the nights because of difficulties in filling the rota, some shifts close during the day in response to lack of sufficient calls at a regional level to justify manning all branches within the region. When a branch is closed, calls are diverted to neighbouring branches through the Intelligent Platform. Although volunteers are positive and committed to their role as Samaritans, the experience of quiet shifts, with no or very few 'good' calls was a source of evident frustration (Chapter 3). The issue is thus raised as how best to organise existing resources (in terms of volunteer time) to meet the pattern of demand. In addition to taking calls, many volunteers put in a considerable amount of additional time in undertaking other roles, for example, leader, deputy director, prison visitor, publicity and trainer, to support the branch. Given the diversity of such roles there could be scope for reducing the minimum time volunteers are required to take calls, in return for increased diversification of activities and perhaps a more varied portfolio of tasks. Current policy goals to extend outreach activities and increase partnership working with other organisations, and the scope for further innovation in methods of caller contact, such as instant messaging, or online forums (see below) point towards the likely development of a greater task diversification among the volunteers in future. At the same time, it was evident within the branches that volunteers remain committed to their role as listening Samaritans and to their membership of a local community of fellow volunteers. Most respondents appeared to be unaware of, and largely uninterested in,

the developments and changes proposed for the organisation, as indicated, for example, in the current strategy document [8]. Indeed, there was sometimes a degree of resistance towards the role and influence of General Office (GO). Shaping the future development of the organisation within the constraints of available resources and commitment is evidently not straightforward.

A further issue concerned the perceived tendency of students from medical and related professional occupations to use Samaritans training as a means of boosting their personal skills development and enhancing their CVs, and then to leave shortly after training was completed. The study included several respondents who described being initially motivated to undertake training for such a reason. All emphasised that they had since found the experience of volunteering to be engaging and enjoyable and intended to remain as Samaritans. For obvious reasons, it is unlikely that those who were not intending to stay within the organisation would have volunteered to do an interview, or to report such intentions to the researchers. The study did not include interviews with respondents who had left the organisation, or intended to do so, so we have no information about volunteers' reasons for leaving. The range and diversity of voluntary and self help groups have created a competitive market for the recruitment of volunteers, especially within a population characterised by chronic time shortage [23]. In such a climate, the need to capitalise on existing resource is self-evident. 'Under-using' existing volunteers in manning shifts in local branches which regularly take few calls, seems profligate. However, it is likely that a move to rationalise the use of volunteer time across the organisation would not be welcomed by some volunteers, for whom the value of being a member of the local branch community provides the hub of their continuing commitment to Samaritans.

The needs and expectations callers have of contacting Samaritans

Information about callers' expectations and experience of using Samaritans was derived from 48 telephone interviews with callers, 58 text and email message strings and 1309 responses to a complex online survey. This included many written comments which expanded on and qualified the questionnaire responses, often in considerable detail (Chapters 4 and 5). This very substantial body of data was supplemented during branch observations in which the nature of calls and callers was discussed with volunteers. Interview and survey respondents contained a higher proportion of women, in comparison to the nearly equal numbers of calls from both sexes which are logged by Samaritans. Younger, female callers with a preference for email contact were over represented among the survey respondents. The caller interviewees tended to be older, more regular and longstanding users of the service. Many of these reported experience of mental illness, often severe, and that this was an important reason for contacting Samaritans. We know very little about the personal characteristics of most authors of the email messages. While the study respondents cannot be regarded as a representative sample of the caller population, the different sources of data collection complement each other, and in combination incorporate a very wide range of views and perspectives on the service currently delivered by the organisation.

Since the Samaritans was founded in 1953 support services in both statutory and voluntary sectors have mushroomed and spread across a range of media including, notably, the internet. Service users have been engaged as central stakeholders to service provision and lay input has been extended through informal networking through self help groups and online blogs and forums [16, 24-35]. The Samaritans emotional support services are now delivered within the context of a complex, and competitive, economy of care. The modern service user/consumer has many potential options for help, information and advice. The study findings indicate that far from being a resource of last resort, many callers call Samaritans selectively and as one among a number of different sources of support (Chapter 4). Thus, Samaritans are often used as well as,

rather than instead of, other agencies and services. Callers particularly valued the twenty four hour availability of Samaritans, still a rarity, and the confidential and anonymous nature of the service. Respondents chose to offload to Samaritans to spare family and friends the burden of awareness of their troubles, and to disclose thoughts and feelings to the volunteers that they preferred to conceal from professionals rather than risk unwelcome consequences such as unwanted treatment or intervention.

Initial expectations

Callers tended to report having no clear expectations of what would happen when they called Samaritans: this was something they learned through the process of contact. Asking for help was experienced as a difficult thing to do, and callers evidently deliberated and hesitated about doing this. This was especially true in relation to the first call, but even regular callers reported also feeling trepidation and anxiety about the decision to make contact on subsequent occasions (Chapter 4). Some callers, especially when inhibited by feelings of low self worth, anticipated that the volunteer's response would be judgemental and negative. They doubted that their problems were sufficiently severe or appropriate to entitle them to make demands on the service. It was evident that callers frequently had initially expected – and wanted – to be given advice. Others indicated that they had specifically not wanted advice, merely to make contact with someone who would support them through listening to their problems. Regular callers learn over time what Samaritans offer, and what they can expect to obtain from using the service, and their retrospective accounts of their initial anticipations will be modified by these subsequent experiences.

Callers' in-depth experiences of contacting Samaritans

Over half of the survey respondents, and a higher proportion of the interview respondents, had used Samaritans on more than one occasion. Contact was made for a wide range of reasons. Some callers reported wanting support when they were feeling emotional distress or struggling with suicidal thoughts and behaviour. Others had ongoing mental health problems and used Samaritans as part of their wider support network. Some people preferred to discuss their difficulties with volunteers rather than reveal them to friends and family or to the members of their professional support team. Some phoned for advice and information, and others simply for human contact (Chapters 4, 5, 9 and 10). Many respondents reported using, and valuing, Samaritans as an enduring resource to help them cope with ongoing problems which they perceived to have little prospect of improvement, far less resolution.

Overall, respondents were positive in their assessment of Samaritans service. Throughout all data strands, many expressed great appreciation for the support they had received from the volunteers, regardless of whether this was ongoing, or related to a single contact. The majority of survey respondents rated the service as 'good', indicated that they had been 'very satisfied' and reported feeling better after their last contact with the organisation. However, only a minority (82; 12.2%) indicated that contact with Samaritans had had a longer term impact. In line with Samaritans' mission, these calls were described as a turning point, enabling the caller to reflect constructively on their situation, and how to move forward in terms of coping with their problems and even regaining a sense of control and purpose in their lives (Chapter 4). This finding is mirrored in the interview data, which included a higher proportion of regular users, and many of the email responses, also from callers with a clearly established pattern of long term and sometimes frequent correspondence (Chapter 5). Thus, one of the most significant findings of the study was the extent to which callers value Samaritans as an

ongoing, rather than occasional, source of support, and for chronic rather than short-term problems.

Negative experiences

Despite positive overall assessment of the service, and as might be expected from such a large and diverse population, a substantial minority of respondents reported areas of disappointment and dissatisfaction. Just under a third of survey respondents assessed their experience of contact as worse than they had expected (Chapter 4). Experience of the email and text service in particular, was a source of dissatisfaction, with callers reporting that the responses they received were impersonal, formulaic, too brief and generally unhelpful. Although some callers were offended when they received advice – and the majority of survey respondents considered that they had been offered this – the refusal of volunteers to give advice, or even signpost the caller to alternative services and sources of practical help and support was a common complaint. Our analysis of the findings differentiates solicited and unsolicited advice, and points to the interactional consequences and troubles that may arise from these (Chapter 7). Throughout all data strands, callers expressed a desire for a personal and interactive encounter with the volunteers, in which they were given sufficient encouragement and time to disclose their concerns. While many respondents were appreciative of volunteers who provided them with such an opportunity, others reported a less satisfactory, or even an inconsistent response (Chapters 4, 5 and 10). Issues relating to entitlement to use of service, and the duration and frequency of contact were not raised frequently, but tended to be a source of great dissatisfaction and upset when they did occur. Several interview respondents described their distress on finding themselves subject to a caller care plan, with no prior warning or anticipation (Chapter 5 and 6). These cases exemplify the preceding analysis of caller care and the extent to which this is experienced as an arbitrary and unwarranted restriction on callers' use of a service which they have been led by volunteers to believe is a continually available and ongoing resource.

Improvements to service

Though positive, overall, in their assessment of Samaritans and appreciative of the volunteers' support, callers had many suggestions for how improvements could be made in future. Forty percent of survey respondents made concrete suggestions, and similar points also occurred in caller interviews and some emails. These fell into four broad categories: the recruitment and training of volunteers, interactional issues between caller and volunteer, practical issues to do with use of the service and a wider promotion of the service (Chapter 10). Specific suggestions included: more volunteer training in communication skills and a better understanding of mental health issues, involving callers in the delivery of volunteer training, a more interactive and 'human' versus impersonal and robotic response from the volunteers especially in answering emails, faster text and email responses, greater availability of face to face and drop in services and raising the profile of the organisation through more effective advertising. Callers indicated a preference for volunteers to take a more proactive approach when handling calls, and to be more sparing in their use of silence. They wanted more active encouragement to talk, and the feeling that they were taking part in a two way interaction. They would welcome clearer indications of the nature of service, what they could expect when they contact Samaritans, and the limits and boundaries to the use of the service. Greater continuity through being assigned a specific volunteer throughout a series of related contacts was also suggested, as was the introduction of more proactive 'befriending' services, such as home visits, or coordinating peer support groups. Giving advice was frequently suggested as desirable, and also signposting or referral on to other organisations and sources of help. Increasing access to the service by reducing the

cost of calls was a recurring suggestion, possibly by making use of available internet technologies such as Skype or instant messaging (Chapter 10).

Mental health issues

Callers who disclosed mental health problems and specified these as a reason for contact tended to be highly appreciative and supportive of the service. This is interesting in view of the ambivalence expressed by volunteers towards such callers, and the ambiguous nature of their entitlement in relation to the current statement of the organisation's nature of service. There was a high incidence of reported mental health illness among all callers, and this was often given as a reason for contact, especially among interviewees (77%) and survey respondents especially those who were regular callers (47%). Thus, many of those who had contacted Samaritans on more than one occasion reported their main reason for past contact to be mental health issues or self harm. This is an important finding as it may be indicative of the type of caller who forms an ongoing relationship with the organisation, especially since the formation of such relationships is actively discouraged.

Callers associated a longstanding history of chronic suicidal ideation or attempts and/or self harm with the experience of serious mental health problems (Chapter 8). However, within the Samaritans remit the status and entitlement of callers experiencing mental illness is an area of uncertainty: the mission refers simply to Samaritans being available for people who are 'experiencing feelings of distress or despair, including those which could lead to suicide' [71] . Many callers clearly oriented to Samaritans as a mental health charity, and some respondents complained about volunteers' lack of knowledge or training in mental health issues. As discussed above, volunteers tended to distance themselves from such callers, lacking confidence in their ability to handle such calls and doubting that contact with Samaritans was helpful or even appropriate for callers experiencing serious mental illness (Chapter 9). Thus, it seems that volunteers do not generally operate with the strong association between suicidal ideation and behaviour and psychiatric illness which many callers assumed to be self evident. Given the organisations' core commitment to support the suicidal, volunteer ambivalence about callers suffering from mental illness is a significant finding with considerable implications for Samaritans nature of service (and see below).

Suicide

A higher proportion (46%) of survey respondents reported contacting Samaritans because they were feeling suicidal in comparison to national Samaritans data which puts the figure at about 20% [22]. However, while the majority of survey respondents felt positive, or at least accepting, of the volunteer's question about their suicidal feelings, a substantial minority (25. 9%) experienced this question negatively, and indicated that they had been surprised or embarrassed (Chapter 4). A similar range of responses featured in of the caller interviews and emails. Some respondents welcomed the question and were glad to take up the invitation to discuss their suicidal feelings. Others accepted the question, even though they were not suicidal, while a few indicated that they were shocked to be asked about suicide, and would deny such thoughts. A few respondents considered the question itself to constitute a suggestion which had not been previously contemplated. Email callers sometimes expressed irritation that the suicide question was repeated unnecessarily, especially if they had previously indicated that they were not feeling suicidal (Chapters 5 and 9).

[71] www.samaritans.org

A striking feature of the caller data was the extent to which respondents described engaging in suicidal thoughts and action as a deliberate coping strategy, and referenced this quite explicitly as involving no intent or desire to die (Chapter 8). This contrasts starkly with the conventional understandings assigned to such terms, and raises the question directly of what it means to say that someone is 'suicidal' or 'expressing suicidal thoughts and feelings' as a complex and uncertain, rather than self-evident, issue. Some callers described 'chronic' suicidality, almost as a way of being. For others, urgent destructive feelings could arise, including an impulse to self harm, but which was not associated with a desire to die. Callers also indicated that when they called Samaritans they were in a state of fear, ambivalence and inner conflict, struggling with strong suicidal and destructive impulses which they actively wanted to resist. Such feelings could be intense but highly volatile, arising and dissipating rapidly. Rather than engage in a rational appraisal and talking through their options, callers wanted to be talked down from harming themselves. However, respondents revealed that contact with Samaritans at these times could be beneficial in helping them regain composure following critical episodes which may be regular and even frequent occurrences. Other callers, - and this was particularly in evidence in the emails – made extensive use of a language of suicidality as an expressive and communicative device, but were quite specific in stating that this is not associated with the intention ever to kill themselves. All types of response may be associated with regular resort to self harm of one sort or another. A strong theme throughout callers' accounts of their suicidal experience is the ambivalence and uncertainty they feel towards death and dying and also the sense that this may not be something they feel will ever resolve, or at least that they lack the requisite agency to achieve this by themselves (Chapter 8). These accounts support the role of the volunteer in providing a discursive space for callers to unburden themselves of difficult and confusing thoughts and feelings. However, they also point to a complex tangle of connections between language and intent, which suggest that the language of suicide does not necessarily bear any close or indicative connection with behaviour. While Samaritans may be of great benefit to callers reporting suicidal thoughts and actions, it is difficult to establish any pre-emptive role the volunteers might have in preventing (especially as opposed to averting) suicide in any individual case.

Meeting and defining needs

Samaritans' mission has always been to provide emotional support for those experiencing emotional distress, especially where this results in suicidal thoughts and feelings. However, regardless of what the volunteers aim to provide it is the caller who determines whether or not he feels supported, and how effectively. The study findings suggest that callers tend to operate with a more inclusive construct of emotional support and orient towards a wider remit than Samaritans has currently defined. The organisation's assessment of protracted and ongoing contact as inappropriate and counterproductive contrasts with the value many callers place on Samaritans as a resource to help them cope with recurring or ongoing difficulties which brook no easy resolution. In recent years misery has come to be subsumed within pathology and self harm and suicidal feelings with psychiatric disorder [36-38]. Callers tended to take for granted the relationship between the two, and to orient to Samaritans as a mental health support service. This view was not widely shared among the volunteers, who viewed their focus to be the exploration of callers' 'feelings'. Callers affected by mental illness were considered hard to handle, if not actually outside their remit. In consequence, volunteers spend much time fielding calls they feel do not relate to the Samaritans purpose, and doing this in ways which deviate substantially from the principles of active listening (Chapter 6).

The nature of support offered by Samaritans services and the current caller centred approach taken in relation to best practice across the service

Chad Varah's original notion of the Samaritans as an 'emergency service for the suicidal' focused on providing support to individuals at a fateful moment as they confronted a singular and unprecedented experience of emotional crisis [5]. Effective intervention at such a critical juncture could deflect the caller from acting on suicidal impulse or intent, perhaps conclusively, or at least until additional professional assistance could be secured. Although the current promotion of Samaritans remains ambiguous about the nature and intensity of personal distress it is intended to support, Varah's original intentions are echoed in the current depiction of the service as being for callers 'a lifeline at their moment of distress' [72]. The research findings indicate that there was a wide range of opinion among volunteers as well as callers regarding the organisational remit of Samaritans. This ambiguity is perpetuated by the current self promotion of the organisation. It is difficult to recognise clear boundaries of entitlement to use the service, and whether this is intended only for the suicidal and despairing, or if others, with less pressing (but often enduring) troubles, including mental illness, are equally welcome to call.

Samaritans was founded with a clear vision of the service to be provided, the benefit to be derived and the population to be targeted [5]. Regular, repeated and heavy use of volunteer support was not considered appropriate or conducive to achieving benefit. Indeed, such contact may serve to damage, rather than promote, the caller's wellbeing. By fostering dependence the service prevents, rather than helps the caller to 'move on'. The research findings indicate a misalignment between the Samaritans ascription of callers' needs and those which many callers themselves identify, as well as the benefit to be derived from using the service. Many callers present with ongoing, long term problems, often including severe psychiatric illness, with no real hope or aspiration of being able to 'move on', and that is not the purpose of their contact.

Supporting the suicidal

Regardless of shifts in emphasis on policy and strategy, supporting the suicidal remains core to the Samaritans' mission. It is the policy of the organisation that volunteers enquire about callers' suicidal ideation at every contact, and it appears that this occurs in about 60% of calls [2]. The research findings raise many issues regarding the nature of 'suicidality' and how this is recognised and assessed by callers as well as volunteers. As discussed in Chapter 6, volunteers are well aware that callers' accounts should not always be taken at face value, and that it can be extremely difficult to establish if a call, perhaps even one which reports that suicide is in process, is 'genuine' or not. Nationally, the proportion of callers expressing suicidal thoughts and feelings is recorded as approximately 20% (higher (36%) in emails) with about 1% indicating that they are actively engaged in the process of suicide during the call [22]. These data are based on branch records of volunteer assessments which are compiled monthly and submitted to general office for aggregation. As discussed in Chapter 8, there are grounds for regarding such figures with great caution.

Volunteer assessments of 'suicidality' are variable and subjective, and often based on brief and ambiguous encounters. This is not a satisfactory basis on which to make critical judgements about callers' emotional states. Analysis of the caller data revealed the

[72] www.samaritans.org/about_samaritans/frequent_questions/how_know_works.aspx

complex and subtle meanings deployed in the language of suicide, and it is evident that both volunteers and callers can mean very different things when using words relating to suicide and suicidal intent (Chapter 8). In this context, it is not a question of whether callers are 'genuine' or not in how they describe their intentions and distress, but one of what they mean by the use of words relating to suicide and self harm and the functions of such language within a call. Callers themselves may not be clear about their thoughts and intentions, and suicidal impulses may be highly volatile [39, 40]. Suicidal behaviour carries a strong communicative function within the caller's social network. The language of suicide may also be used as a currency of entitlement and continued communication with the volunteer, especially when this is routinely introduced into the call through questioning the caller's suicidality. Such discourse may be internalised: If Samaritans exists to support the suicidal and I am supported by the Samaritans then I am suicidal. Some respondents expressed unease that they would not be allowed access to the service unless they were suicidal, and even that the volunteers might regard their problems as unimportant if they were not. A few reported feeling that they had been rejected on these grounds (Chapter 4).

As discussed in Chapter 8, assessing the nature and intent of suicidality from the language and even the behaviour described by callers is extremely difficult, and precludes any meaningful assessment of risk such as the nature of contact rating aims to provide. However, even within this rating scheme, only a minority of callers are deemed to be 'suicidal' to any extent. A higher proportion of callers described the opportunity to explain their difficulties, vent their worries and frustrations, and to receive the volunteer's acknowledgement of their distress, to be extremely valuable in helping them to cope with problems which may be of varying kinds and severity but often of a chronic or ongoing nature. However, this largest category of callers seems currently to occupy an uncertain ambiguous and disvalued status in relation to the Samaritans' definition of its purpose.

Suicide and mental illness

Although willing from the outset to engage in a cooperative relationship with professional agencies, Varah initially estimated that only one in eight of the callers required professional psychiatric help [5]. The 'medicalisation of misery' had not yet taken place. The advent and widespread prescribing of treatments such as antidepressants and antipsychotics has changed the diagnosis and management of psychiatric disorders, and led to the widespread generalisation of emotional pathology across the population [36-38, 41]. Suicidal thoughts and behaviour and self harm have become appropriated within a modern discourse of mental health and illness. Within our current cultural landscape these are difficult to separate: by default, anyone expressing such thoughts and action would be regarded as in need of professional help and treatment.

In recent years Samaritans has positioned itself as a mental health charity in partnership with government agencies and professional psychiatric services [10, 21]. The Samaritans website includes publications and factsheets about depression and other mental illness, including an emphasis on suicide as an expression of mental illness [42, 43]. This orientation of Samaritans as a 'mental health' or 'mental health promotion' charity is also evidenced in its membership of the Mental Health Healthlines Partnership (MHHP). In contrast, in branch observations and the individual interviews, there was little indication that volunteers embraced the idea that Samaritans was a mental health organisation or that their purpose was to support the mentally ill, although volunteers were aware that many callers had mental health problems. Often uncomfortable dealing with people suffering from severe psychiatric illness, especially psychosis, some volunteers wondered both what good they could do such callers, and whether it was appropriate for the organisation to be dealing with them. As mentioned, some commented on the dearth of information on mental health issues included in current

training and considered the inclusion of this topic would be a useful addition to SIT. Callers also considered this to be an issue for improvement of the service. One source of dissatisfaction was that volunteers were insufficiently expert in recognising and supporting people experiencing mental ill health and not sufficiently supportive of their problems and difficulties.

A substantial proportion of Samaritans callers, particularly those who report suicidal ideation, identify themselves as suffering from mental health problems, often severe in nature. Many such respondents were deeply appreciative of the ongoing support derived from regular contact with Samaritans. However, such individuals fall outside the remit of the 'good caller'. These are not people who can ever easily 'move on' in the Samaritans sense of using volunteer support as a springboard to achieve increased personal agency through reflective 'work on the self'. That is, in any case, not what they may be seeking from Samaritans contact. Rather, these callers report hoping to obtain short term support during the experience of recurring crises, a process which may be repeated many times. Samaritans is valued as an ongoing resource, accessible at any time, to help callers deal with such episodes. Data from the online survey indicate that while most respondent felt somewhat better after contacting the Samaritans, only a minority (12.2%; n= 82) reported that the effects of contact had been longer lasting. In this context, there is a further misalignment between the current organisational stance, the position of volunteers and that of callers in terms of the nature of service and how Samaritans is positioned as a mental health charity.

Self determination

The label of a psychiatric diagnosis does not of itself signify loss of rationality or decision making capacity. However, it does suggest a degree of vulnerability which make judgements about such capacity a great deal more difficult, and calls into question how and whether the Samaritans principle of self determination should be universally applied. This becomes particularly salient in view of the organisation's self characterisation as a 'mental health' or 'mental health promotion' charity, and current moves to develop closer partnership with statutory and professional services. Respect for the individual and its manifestation in the commitment – even the requirement – that individuals remain responsible for their own lives is a core principle of Samaritans and deeply engrained among the volunteers. It is on this basis that the right of the individual to end his life is upheld, and his decision to do so is respected. However, dominant cultural constructs of the individual posit the desire to self harm and for self destruction to be intrinsically irrational and indicative of pathology [44, 45]. Under normal circumstances, suicide would not be construed as the act of a rational, autonomous being. Consequently, intervention is justified – and even required - to protect the individual from himself and even in order to respect and reinstate his autonomy. Volunteers were aware that many callers have a history of mental illness, and reported managing calls with those who are severely ill and psychotic to be difficult and troubling. However, they rarely reflected on the close association between suicide and mental illness or the significance of pathology for judgements about capacity and how this might have implications for the principle of self determination.

Categorising callers

Many callers, perhaps most, are repeating, and often regular, users of the service [2]. The majority, also, are not categorised as being in severe distress or expressing suicidal feelings during the call. Over half (55%) are rated '0' in the seven point scale of the Nature of Contact chart: 'distressed but able to tolerate feelings'. 'Chatting' callers, those who are 'dependent' or who are not prepared to talk about their feelings constitute 12.5% of recorded calls, with a smaller proportion (7.5%) designated to be frankly

inappropriate. This last category includes 'sex calls' [22]. However, as indicated above, the degree of variation and subjective assessment involved in recording calls renders the Nature of Contact data an unreliable basis for compiling national data – and subsequent representations – of caller profiles. The boundaries between '-1' and '0' and '+1' in particular are hard to draw. Branch observations revealed considerable variation in the way that individual volunteers rated calls, and the ratings applied to the same caller in relation to repeated contacts within short periods of time.

Volunteers varied widely in their definitions of the nature of service and how inappropriate calls should be defined and answered. Some maintained a commitment simply to 'be there' for any caller who felt the need to phone the Samaritans, and effectively were content to let the caller define and express the nature of this need. Others expressed frustration about the number of inappropriate or trivial calls, but considered that the opportunity to support even a small number of 'genuine' or 'worthwhile' callers compensated for the rest, and was a sufficient motivation and justification for continuing to volunteer. At the other extreme, some volunteers viewed the proper business of Samaritans being to support the suicidal and resented having to deal with a high proportion of 'inappropriate' calls. This more restrictive definition of the Samaritans nature of service seems to correspond more closely to the current five year strategy which prioritises support for the suicidal as the core business of the organisation [8]. However, this policy would seem to call into question the entitlement of many people who currently use and report benefit from Samaritans.

Contrasting agendas

Callers varied in their expectations and desire to receive advice. However, the majority of survey respondents reported that this was offered during their contact with volunteers (Chapter 4). Some of the interactional difficulties that can arise from advice giving, especially when this is unsolicited were considered in Chapter 7. While callers disclose personal troubles of varying severity to volunteers, any talk of how to remedy these troubles, even in the form of a question about what the caller has tried, may be treated as a form of advice, or as a move towards solutions. These are likely to be rejected by callers who are seeking empathy rather than solutions. However the situation may be different when the caller positions himself in the role of 'help seeker' and it appears that, in the case of at least some of those who contact Samaritans, including those who may be struggling with impulses to self harm that they wish to resist, that this is what is being sought. Within the present service, the caller tends to be positioned as 'beneficiary', someone who 'receives' emotional support in line with the Samaritans' definition of 'need'. As a beneficiary the caller endeavours to accept and conform to Samaritans rules of engagement. These may correspond to the callers felt needs to a greater or lesser degree, and may even come to constitute the caller's expectations and requirements regarding the support to be derived from using the service. The role of consumer involves a more active and sometimes resistant stance and the effort by the caller to assert or maintain agency. This could be evidenced for example, in either the rejection of unsolicited advice, or a direct request for advice, depending on the caller's purpose. The caller's goal is to configure the service to deliver benefit in terms of their own, rather than Samaritans', agenda. Callers who orient to a 'consumerist' stance may take a more active and resistant position in setting an agenda for what they want from the service and how they use it. Regular callers may become very knowledgeable about the organisation and its procedures and systems. They may position themselves in the position of beneficiary or consumer of the service – and these roles may be combined in different ways and at difference times, depending on the reasons for calling and the kind of support sought. Given the heterogeneity of callers, consistency in service delivery is an ongoing challenge. The research findings indicate that callers approach Samaritans with needs which frequently extend beyond the remit of the organisation, and that volunteers at present respond to these in a pragmatic but variable manner. This may

result in callers' needs being met, but in ways which fall outside the remit of 'active listening' in which the volunteers are trained. The question that arises concerns the extent to which the organisation maintains its current focus, or modifies these in response to caller driven definitions of need and capacity to benefit from Samaritans support, and how the boundaries of access and entitlement to use the service are drawn.

Outreach and Referral

Partnership working and referral schemes with statutory sector health and social service agencies offer scope for diversification and further outreach of Samaritans, and a number of such schemes have been established throughout the branches [4]. Several volunteer respondents had been involved in setting up such local partnerships, although many others seemed unaware of these initiatives, or how they may impact on the delivery of service (Chapter 4). Working with referrals from statutory services, volunteers may be subject to contractual obligations including the same duty of care as professionals to break confidentiality if the patient/caller reveals himself or others to be at risk of harm. Some schemes require the patient's permission for the volunteer to pass information back to the referring health professional. This raises the prospect of a two tier system, with some callers subject to different nature of service policies than others. Given the high value callers place on the independence, confidentiality and non-interventionist stance of Samaritans, it is likely that the development of such links to statutory services would raise concerns about continuing autonomy and independence. Indeed, for some callers, it is the nature of the difficulties they experience with health professionals and statutory services to which they have been referred that constitute one of the problems they wish to disclose to Samaritans. Even those who accept the diagnostic labels applied to them by health professionals may still wish to engage with the volunteers on the basis of being a 'person' rather than a 'patient', and the current capacity to do this may be a highly valued aspect of Samaritans service. Thus, closer working relationships with formal services could lead to organisational subordination and increased regulation.

Entitlement and restriction

It is not hard to understand the efforts made to exclude callers who are flagrantly abusive from using the Samaritans service, though as discussed in Chapter 6 volunteers vary in their definitions of what constitutes 'abuse' and also may find some callers very difficult to classify. However, the contest between volunteers and callers in terms of establishing and applying the ground rules for delivering the service would seem to belie the stated commitment to accepting all without prejudice or judgement. Callers are, perhaps inevitably, subject to routine judgements, for example, about whether they are 'genuine', 'appropriate', 'suicidal', 'manipulative', 'dependent', 'needy', 'chatty', 'lonely', 'abusive', or 'mentally ill'. Further judgements are made about the appropriateness and level of their use of service, their level of dependency and whether or not they have capacity to benefit. As discussed in Chapter 6 the 'good call' is empirically rare, in comparison to other types of call and also as an occurrence. In laying themselves open to all comers Samaritans invite abuse, which may in practice, be difficult to detect. Volunteers put their personal competence and judgement on the line in the course of responding to the call. The possibility is always present that they are being targeted by individuals with unscrupulous or manipulative intent. Respondents varied in their attitudes to this, and in their tolerance to being duped by disingenuous callers. Although inviting - and highly valuing – the caller's trust in the Samaritan, it may be difficult for the volunteer to reciprocate: in evaluating and assessing the caller's perspective, he remains attuned always to suspicion.

A recurring issue throughout our analysis has been the nature and consequences of ambiguity about the Samaritans' nature of service and how this is variously interpreted and applied in contact between volunteers and callers: is the Samaritans primarily for the suicidal (and if so, what is the entitlement of those who are not)? Is it a mental health charity (and if so how does and should it relate to statutory services)? What are the boundaries of entitlement to use the service (and what scope does the caller have in setting these)? Callers may learn over time what the service can and cannot offer, and adjust their expectations accordingly. Those who do not find what they require presumably look elsewhere for support. However, mutual dissatisfaction between caller and volunteer seems often to arise from a difference in expectations and perceptions of the organisation and the service it delivers. Responses to the online survey indicated that callers' expectations of service seemed to be framed more in terms of 'needing help' rather than actively seeking 'emotional support' though many clearly felt that they received the help they sought as an outcome of contact. A further recurring issue was related to advice: do volunteers give advice to callers, and should they do so? Some callers wanted advice and were upset when this was not forthcoming; others did not, and were annoyed when they thought it had been offered. Although the volunteers were consistent in their commitment to the principle of not offering advice there was considerable variation in how 'advice giving' was interpreted. It was apparent throughout the data, especially the email messages and responses that advice is offered routinely by many volunteers (Chapter 7). Callers could be critical of the volunteers' refusal to signpost them to other agencies and sources of concrete advice and help, even if this was not itself directly within the Samaritans' remit. The formal policy that the volunteers' should not provide information or signpost callers in this way is somewhat qualified by the inclusion of an extensive list of other organisations and sources of support on the Samaritans' main website. This issue has been raised for reconsideration in Samaritans' policy and literature, especially in relation to closer partnership working with other agencies. Again, formal changes in these policies would have far reaching effects on the nature of service provided by the organisation.

Limitations

Although the study incorporates the views and perspectives of a wide range of volunteers and callers, these cannot be considered representative of the wider populations of either group. The volunteers who came forward to be interviewed included a high proportion of individuals who were strongly committed to Samaritans and had been active in a variety of roles, including those of branch director and deputy director. However, these respondents contributed a wealth of experience and perhaps a wider perspective on the work of the organisation than may have been available to many more typical volunteers. The case study branches were offered their participation in the study were also self selecting. Although chosen to obtain a spread of different types of branch across the country, it is likely that they may have been characterised by a degree of openness which was not typical of the generality of branches. However, the study incorporates extensive observation and discussion with many volunteers over the course of their work in manning shifts in a variety of different settings and locations. Although we have very little information about the characteristics of most of the callers who allowed access to their text and email messages, it is likely that, as with the other caller populations, men are under-represented. The survey respondents were oriented towards younger women who used email as their preferred means of contact. This profile is balanced to some extent by the composition of the caller interview respondents, who tended to be older, more regular, callers who used the phone as their preferred method of contact, and also reported a high level of (often severe) mental illness. However, this caller profile accounts for a substantial part of the volunteers' work. Not being able to listen in to calls or have direct access to the interaction between callers and volunteers is a substantial limitation, but a given condition under which the research could be undertaken. Again, this is partly compensated for by the access provided by

callers to their email messages and responses. This amounted to a substantial body of data. In addition, branch observations provided the opportunity to observe the volunteers while taking calls, and to discuss these extensively with them, as well as review the subsequent content of the records logged about these. A strength of the study has been the combination of different data strands and methods, each one of which has partly offset the limitations of the others. Together they have contributed to a very substantial body of data. The analysis of this has extended knowledge and understanding of the work of Samaritans and the experience of callers to the service.

Conclusion

It is a prerogative of those who provide a service to define its scope and nature, and to specify its intended outcome. However, within both statutory and voluntary service sectors, it has become fashionable to take great account of the self-defined needs of service users, as a quality marker of provision which is responsive and patient/client centred, rather than merely reflecting provider assumptions about needs or preferences regarding the nature of service that should be made available. Samaritans is strongly committed to develop a service which best meets the needs of callers. However, it has not yet engaged extensively in consultation with callers or incorporated service user involvement within organisational governance or policy formation [21]. The study findings suggest that caller priorities would retain an inclusive remit, beyond the overtly suicidal, which extends unreservedly to those who suffer from ongoing and often serious mental health problems, including self harm, as well as those whose distress results from difficulties in personal relationships. In orienting to Samaritans as a mental health charity, callers also expect, and value, that support should be provided on an ongoing, repeated basis, and to people who may have no realistic aspirations of 'moving on' from chronic and often irresolvable difficulties. Thus, callers may derive great benefit from contact with Samaritans but perhaps for reasons other than the opportunity to explore their feelings, suicidal or otherwise, and on an ongoing rather than an episodic basis. In orienting to Samaritans as a mental health charity, callers place a high value on the accessibility of the service (24/7), its independence and the anonymity and confidentiality of contact. These are important characteristics to preserve in future development of the organisation, especially as this may extend to greater partnership working with professional services and agencies.

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Chapter Twelve: Summary and Conclusion

Introduction

This report presents the key findings from an independent two year evaluation of Samaritans telephone and email support services undertaken by researchers at Nottingham University. Samaritans has been providing emotional support for people experiencing distress and despair for nearly 60 years. Its mission is to contribute to a reduction in suicide by providing a non-directive active listening service which provides callers with reflective space to appraise their options and hopefully arrive at alternative strategies for coping with their difficulties other than suicide. However, the Samaritans commitment to the principle of self determination means that they respect an individual's right to direct their own life, including the decision to end it. Consequently, they do not offer advice or intervention, even in the event that a caller reports that they are in the process of suicide, unless this is specifically requested. The listening service remains the core activity of the organisation and most contacts are by phone (88.5%). Callers may also contact Samaritans by letter, face to face (branch and festival visits) and, more recently, email and SMS text messaging. In 2008 nearly 15,000 volunteers from 201 branches across the UK responded to 2,715,266 dialogue calls. An additional 2,444,472 (47.4%) phone contacts were 'snap' or silent calls in which no dialogue could be established.

People contact the Samaritans for many reasons, including a large number deemed to be either inappropriate (20%) or outside the intended remit of the organisation. The majority of calls (~60%) are judged to be from those who are upset or distressed rather than in despair or actively suicidal. Callers are assessed by volunteers to express suicidal thoughts and feelings in a fifth of dialogue calls, although only a small proportion of callers (~1%) are judged to be in the process of suicide at the time of making a call [1]. In addition to the helpline service, Samaritans aims to contribute to the reduction of suicide through a wide range of outreach activities, in developing partnerships with other agencies and organisations in the voluntary and statutory sectors, and in securing representation on the development and implementation of national suicide prevention strategies [2, 3]. The current Samaritans Strategy 2009 – 2015 restates a core commitment to supporting the suicidal and orients the organisation towards a more active targeting and prioritisation of individuals and groups at particular risk of self destructive behaviour [4]. These include people who self harm and those who have been bereaved by suicide.

Samaritans has established a position as one of the oldest and most respected helpline services in the UK. The very high and continuing number of calls received by the volunteers testifies to a significant level of expressed need for support by a diverse population of callers who present with a wide range of troubles and concerns. However, the anonymous and confidential nature of the contact between callers and volunteers has made it difficult to establish an evidence base for the quality and effectiveness of the service it provides, or to develop awareness of callers' expectations, experience and assessment of contact with Samaritans, and their perceptions of how the service could be improved to better meet their needs in future. The difficulties involved in accurately assessing the impact and effectiveness of any kind of suicide prevention strategies, including telephone support lines, in terms of reduced incidence of death pre-empt any attempt at specifying to what extent Samaritans may contribute to this end [5-10]. It was not the intention or purpose of this study to undertake such an assessment. However, the study findings extend insight into caller and volunteer experiences of using and delivering Samaritans emotional support services, the nature of the support received by callers and desired by different groups of user. They also point to routes for further service development in future.

Aims and objectives of the research

The current research has focused primarily on the telephone and email support services provided by Samaritans and has been commissioned with the following aims:

1. To explore the views and experiences of Samaritans volunteers in delivering services.
2. To investigate the needs and expectations callers have of contacting Samaritans
3. To identify and explore callers' in depth experiences of making contact with Samaritans services.
4. To examine the nature of the support offered by Samaritans services and describe the current caller centred approach taken in relation to best practice across the service.

Design and method

Following consultation with Samaritans regarding the most acceptable and appropriate means of collecting data and carrying out the research [11], a mixed methods approach was adopted. This combined direct observation of Samaritans branches and volunteer training, individual interviews with callers and volunteers, an online survey of callers' experience of using the service, and a textual analysis of email messages and responses accessed with caller permission. To avoid infringing caller confidentiality the researchers did not listen in directly to calls, or read caller emails or texts being answered by volunteers in the branches. The study received ethical approval from the University of Nottingham Medical School Ethics and the Samaritans Operations Development Committees.

Data collection

A project website provided the principal interface for recruitment of 48 callers who took part in individual telephone interviews, and 58 text and email callers who granted permission for their messages to be accessed for the research. In a small number of cases, callers who allowed access to their email messages took part in a telephone interview. The research was also advertised in a number of ways, including relevant websites, newspaper and magazine features and adverts, as well as in public locations such as libraries and supermarkets, and GP surgeries. Half of the 66 volunteers who took part in individual interviews were recruited during visits to nine case study branches. The others contacted the researchers directly and took part in telephone interviews. Interviews were taped with respondents' permission, or otherwise recorded by detailed notes taken during the interview and subsequently typed up. The case study branches were selected to incorporate a range of characteristics in terms of size, location and activities. Over 200 hours of direct branch observations were undertaken and extensive notes were incorporated within the qualitative database. An online survey was completed by over 1300 callers over the course of a year. A substantial amount of additional qualitative data was provided by a large number of survey respondents who wrote additional and often detailed comments to expand on their questionnaire responses. In addition, two of the researchers completed the Samaritans volunteer training, and one member of the team went on to mirror the involvement of new recruits by undertaking weekly observations of branch shifts between June 2008 and March 2009.

Analysis

Survey data were analysed using the statistical package SPSS version 16.0. Descriptive statistics were used to summarise the characteristics of the survey respondents, their use of, experience, and satisfaction with the service. Categorical data were described using frequency counts and percentages. Ordinal data were summarised using the median and lower and upper quartiles, Comparisons between two categorical variables were made informally using cross tabulations.

The qualitative software programme NVivo 8 was used to facilitate organisation of the different qualitative data sets and to support a thematic analysis of interview transcripts, observation and field notes, responses to open survey questions and email and text messages. This has been undertaken in line with established procedures for qualitative analysis [12-15]. A coding frame was constructed from an initial reading of the data and subsequently refined through further reading, reflection and discussion within the research team to identify recurring themes and patterns of ideas and topics throughout the different data sets [14, 16]. Particular attention has been paid to the triangulation of different data sources and analysis of areas of contrast and difference between these. In addition to the comparative cross sectional analysis of themes and issues across data sets and respondent sub-groups, the caller case studies provide an opportunity for detailed exploration of individual experiences of help seeking and assessment of Samaritans support.

The views and experiences of Samaritans volunteers in delivering services

The study examined different aspects of respondents' experience of volunteering. These included the reasons for becoming a volunteer, assessment of training and ongoing support, perceptions of the role and impact of the volunteer, and understanding and application of the Samaritans nature of service in proving support to callers. Respondents' motivation to volunteer was influenced by a number of often inter-relating factors. These included life events, personal experience of suicide, exposure to advertising and outreach events, and the desire either to use existing knowledge and skills or develop professional expertise in active listening. A number of respondents reported that the prospect of becoming a Samaritan had been the subject of extended deliberation, finally being taken up when personal circumstances left room for further commitment. Volunteers tended to know little about Samaritans, or what volunteering would entail, before undergoing initial training. Volunteering was considered a way 'to do something worthwhile' or give 'something back' to either the organisation specifically, or society more generally, and occasionally as a means of feeling 'good about oneself'. In addition to their role as listening volunteers, respondents also reported taking on a wide range of further roles within their local branches and also the wider organisation. These included involvement as trainer, prison visitor, publicity officer, fundraiser, director, leader, caller care team member, and recruitment officer. Most volunteers committed around four hours a week to volunteering as a Samaritan.

Respondents were positive in their appraisal of Samaritans training (SIT) as a preparation for volunteering, and for the strong peer support provided within the organisation. However, although the topics were covered during SIT sessions, a common response was that training had not helped develop realistic expectations about the nature and frequency of inappropriate calls, the rarity of contact from callers who were suicidal, and also the relative infrequency of calls of any sort during shifts, especially daytime. Anticipation of the number of calls from people with mental health problems and how to handle these was another area which was reported to be missing from the SIT training. The introduction (in 2005) of SIT as a standardised training

programme for all branches was welcomed as a means of achieving consistency in service delivery. However, there was some variation between branches in how they structured the period of induction for new volunteers and the style and content of subsequent ongoing training sessions for all volunteers.

A strong discourse of personal transformation was present in the data, with the cumulative experience of training and working as a volunteer described as 'life changing' in many respects, leading to personal growth, fulfilment and a sense of belonging to a supportive community of peers. Volunteers described a strong commitment to the organisation and to callers. The experience of 'being there' to support individuals through a period of crisis and despair was described as highly satisfying, and the opportunity to provide such support to individuals contemplating or even in the process of ending their lives was described as 'a privilege'. The high proportion of abusive and inappropriate calls was a frequent source of frustration, as well as the experience of shifts with few, if any, significant calls. Respondents sometimes questioned whether volunteering in these circumstances represented a worthwhile use of time. However, the prospect and experience of even an occasional 'good' call was said to compensate for these negative aspects of the volunteering experience. Respondents enjoyed being part of a supportive local community of volunteers and were positive in their assessment of the organisational processes for peer support and mentoring and the requirement for each volunteer to 'offload' to the shift leader at the end of each shift. This was described as an effective means of protecting the volunteer from possibly damaging effects of taking difficult and emotionally demanding calls.

Although twenty-four hour access to the telephone service is maintained through a national call distribution service only a minority of branches remain open round the clock. Difficulties in manning night shifts have caused most branches to close on a number of nights each week. However, some branches also close during daytime shifts when there is insufficient demand from callers to justify all branches remaining open throughout a region. Limitations on the length of shifts resulting in volunteers coming off duty in the middle of the night pose some procedural difficulties in relation to offloading at the close of shift. There is a reluctance to disturb leaders at this time, especially if no 'significant' calls have occurred. Volunteers often considered that the discussion of calls with their fellow volunteer(s) on shift was an effective and sufficient means of offloading. Some branches opt for night shift volunteers to phone their leader the following morning. However, it was evident that offloading does not always occur at the end of, or following, night shifts and there is some inconsistency in terms of how night shift volunteers are officially supported.

Branches are responsible for recruitment and training of new volunteers, and the difficulty of maintaining volunteer numbers is a current issue for the organisation (the 'capacity debate'). Volunteers regularly take a break from active duties, and respondents considered this to be a positive, perhaps even a necessary practice, in order to avoid becoming jaded or cynical in responding to callers. Negative experiences resulting from the high level of inappropriate calls, especially in proportion to the low rate of calls from those who were genuinely despairing or suicidal, as well as the low incidence of any calls on some shifts were attributed as reasons for volunteers leaving the organisation. Further attrition was thought to result from an increasingly frequent practice of students from a range of medical and psychology courses taking advantage of 'free' skills training provided by Samaritans and also to use a short term stint as a volunteer to enhance their professional CVs. In view of the difficulty of maintaining a viable level of active volunteers in each branch, respondents expressed some concerns about whether the selection criteria for new recruits were being maintained at a sufficiently high level. Some volunteers also questioned the organisational commitment to extending and diversifying outreach activities in view of the strain on existing volunteer resources.

Investigating the needs and expectations of callers

A primary aim of the research was to collect more detailed and extensive information about callers than has previously been available to Samaritans, as well as to develop an understanding of their reasons for contact, their expectations of what contact would entail and assessment of the service they received. Individual interviews with callers and volunteers provided the opportunity for a detailed exploration of a relatively small number of personal perspectives of Samaritans. A much wider range of caller assessment was obtained through over 1300 completed questionnaires to an online survey, completed between May 2008 and May 2009. The analysis of caller data was extended by material from three text and fifty-five email strings from callers who permitted access to the content of their messages and volunteer responses. Survey and interview respondents contained a higher proportion of women (78% and 81%) to men and identified predominantly as White British. Survey respondents tended to be younger and more likely to use email as the sole or preferred method of contact. Interview respondents contained more long term and frequent callers, and also a higher proportion of those who had experienced mental health problems (77%; in 46% of cases this was reported to be severe). However, just over a third of survey respondents reported that they were taking medication for a mental-health related problem at the time of last contacting Samaritans, and over half of the survey respondents had used the service on more than one occasion. Repeated use of Samaritans was associated with issues of mental health, self harm and sexual abuse being a main reason for making contact. A high proportion (46.3%) of survey respondents reported experiencing suicidal feelings or being in the process of suicide (8.6%) during contact. Although a higher proportion of interview respondents reported severe mental health problems, a smaller proportion (13%) described feeling suicidal at the point of last contact with the Samaritans.

Respondents from all data sets reported making extensive use of a wide range of other services from both voluntary and statutory services, often using these selectively, for different reasons. Many respondents also described relationships with family, friends and other groups. These could be sources of support as well as difficulty. Survey respondents presented a fairly even spread of opinion about whether these other services had been more, less or of equal help in comparison with Samaritans. Those who perceived statutory services to be less helpful tended to be very negative about their experience of contact. However, just over a quarter of those who used statutory services rated this contact as more helpful than Samaritans. This was attributed to being able to develop a strong personal relationship with individual practitioners over time who could also offer practical help and advice, as well as treatment.

The most common main reasons given by survey respondents for last contacting the Samaritans were mental health problems, self harm, relationship problems of some kind, or because of feelings of sadness or loneliness. Sexual abuse and bereavement were mentioned slightly less often. Survey respondents tended to report more positive than negative feelings after their last contact with Samaritans and to report feeling a little less suicidal. Most recalled their last contact with Samaritans to have been of immediate positive effect, but relatively few (n=82:12.2%) considered that their contact had had a significant or long lasting impact. In addition, the majority considered that they had received advice. Fifty-nine percent of survey respondents recalled having been asked if they were feeling suicidal during their last contact with Samaritans. Just over half felt positive about this question, even if they were not feeling suicidal at the time. However, a quarter described their feelings about this in negative terms, and a quarter reported feeling embarrassed or surprised when asked about suicidal feelings.

Particularly in the interviews, respondents reported asking for help to be a very difficult thing to do, and described the trepidation and uncertainty with which they approached calling Samaritans, especially for the first time. Some callers described a very low sense of entitlement, or negative expectations of the volunteer's response. Regular callers

learned over time what to expect from the service and tended to adjust their expectations accordingly. In addition to 'being listened to', and 'not judged', many callers expected or wanted to be given advice. This was a strong feature of the email messages, and for solicited advice not to be given was a common source of frustration and disappointment. Caller respondents from all data strands had a wide range of ideas and expectations regarding what constitutes a 'good call'. Some valued and expected advice while others resented it. Some wanted the volunteer just to 'be there' and to listen, while others preferred a more proactive approach. However, all valued being listened to in their contact with Samaritans, and being supported through a feeling of being understood, not judged, empathised with and cared about. This was often considered to be a sufficient outcome of their call.

Overall, survey respondents were positive about the service with far more expressing that contact had exceeded their expectations than not. Negative comments were made by around one fifth of these callers. Two thirds felt the response from the volunteers had been consistent. Although many respondents (both survey and interview) described being helped by their contact with Samaritans a much smaller number referred to this having a longer term impact. As mentioned above, eighty-two (12.2%) survey respondents described the outcome of their contact in terms which correspond to the Samaritans goal of 'moving on' through constructive 'work on the self' and an increased sense of agency. Survey respondents more typically described and valued their use of the service as an ongoing resource to draw on as a distraction or way of dealing with episodes of crisis or distress in times of recurring need. Confidentiality, anonymity and 24/7 access were considered to be important aspects of the Samaritans service. The majority of survey respondents (84%) said they would consider contacting Samaritans again. Preferred method of contact was determined partly by reasons for contact, but also convenience.

Handling calls

The Samaritans brand of non-judgemental, active listening aims to provide an opportunity for the caller to take responsibility for himself. The call 'empowers the caller to move forward'. The role of the volunteer is to 'hold' the caller, providing a 'safe space' in which they can focus their feelings about issues of particular concern and consider the options open to him in taking these forward. It is hoped that such support delivered at a critical moment will enable callers, particularly those who are feeling suicidal, to reappraise their options and find an alternative solution to their difficulties. Volunteers were strongly supportive of the core Samaritans principles regarding active, non-judgemental listening and the caller's right to self determination. However, there was considerable variation in how these were interpreted and applied. Volunteers were confident in their ability to support suicidal callers, even those who reported being in the process of ending their life. The paradigmatic 'good call' involved interaction which the volunteer judged had made a significant difference to the way the caller was feeling, and had helped in some way in enabling the caller to 'move on' in terms of gaining insight into their current situation and how to deal with it. 'Good calls' did not necessarily involve suicidal thoughts or feelings, but those that did were eagerly anticipated and highly valued by the volunteers. They were also empirically rare. Many more calls fell into different categories of inappropriate or unsatisfactory: for example snap[73] calls or calls from people who were lonely, mentally ill, abusive, sexually demanding (TM) or manipulative. Especially during the day, shifts could contain very few calls of any kind.

The Samaritans' offer of emotional support promises to be unconditional. However, in practice it is subject to boundaries and restriction. Calls may be subject to limits of time,

[73] Snap calls constitute nearly 50% of all phone calls to Samaritans, in which callers put the phone down almost immediately after the volunteer answers, without establishing any dialogue.

frequency and content. The prohibition on volunteer self- disclosure involves an interactional asymmetry which protects the volunteer against being impositioned, but assigns to the caller a subordinate status, and maintains an institutional nature within contacts. The data contained evidence of volunteers supporting callers with great skill and sensitivity. Respondents described the techniques and strategies for engaging with the caller in the course of 'active listening': to establish empathy, focus on feelings, and encourage candid self-disclosure by the caller, while withholding any personal details of their own. As might be expected, volunteers varied considerably in their styles and practices of taking calls. As discussed above, the 'good call' for which such active listening skills are devised and primarily intended, is highly valued but relatively rare. Volunteers are presented with a great diversity of callers across a spectrum from the flagrantly abusive, regular, demanding, lonely, despairing, mentally ill and suicidal. Many calls present pragmatic problems of management which are inimical to the principles of active listening. Contrary to the edict that all callers will be accepted without prejudice or judgement, volunteers are required to categorise callers in many ways, particularly with regard to whether or not they are 'appropriate'. While flagrantly abusive and sexually demanding callers invite immediate rebuff, there is considerable variation in the boundaries volunteers set and how they deal with the frequent calls from persons judged to be lonely, chatty, dependent, manipulative or suffering from serious mental illness. Establishing the 'genuine' nature of such calls is problematic, and volunteers are vulnerable to being led on and duped by disingenuous and manipulative people. This was a source of frustration among respondents which some accepted more easily than others. The caller care scheme identifies callers who are frequent or demanding users of the service, and places them on call plans to restrict their access. Though framed in terms of promoting callers' welfare (pre-empting dependency), in practice the caller care scheme provides a means of managing demand and protects the volunteers to some extent from unrewarding calls and needy callers. The scheme is difficult to apply consistently or implement effectively within single branches, far less at regional or national levels. Volunteers generally accepted the plans applied to callers and the judgements of the caller care team. However, callers could be devastated by what they perceived to be an arbitrary and unwarranted restriction, especially when they felt they had been encouraged (in every call) by the volunteers to make open and repeated use of the service. Volunteers could be viewed as encouraging the dependency for which the caller was subsequently punished.

The Samaritans' offer of emotional support is contingent on the caller being able to take advantage of the opportunity to find a reflective space in which to develop insight and 'move on' in terms of regaining the capacity to cope with their lives. Thus, the service defines the needs to which it wants to cater, the type of caller it wishes to engage, and the benefit to be derived from contact. However, the study findings indicate that the 'good caller' in these terms is empirically rare, and that many callers, perhaps the majority, define their needs and capacity to benefit from the service in a variety of different ways. Many callers value contact with the volunteers as an ongoing resource to support them during recurring crises or ongoing difficulties: they have no goal or possibility of 'moving on'. This is particularly true of callers experiencing a wide range and severity of mental health problems who orient to Samaritans as an organisation to support those who suffer from mental ill health. Therefore, the nature of service as defined by Samaritans is misaligned with that which is constructed and desired by many callers.

Giving advice versus exploring options

Samaritans policy of not giving advice was an important issue for both callers and volunteers. 'Active listening' provides an opportunity for the caller to explore their options. Any offer of advice from the volunteer would be an infringement of caller autonomy, and also a presumption. This prohibition also protects volunteers from the

consequences of providing bad advice which could impact negatively on the caller. The data indicated wide variation in caller and volunteer responses in terms of what counts as advice and whether this was deemed desirable or appropriate. Some callers expected, and wanted, to be given advice. Others did not and were offended when it was given. Volunteers expressed themselves to be committed to the policy of not giving advice, but varied in terms of how this was applied. As noted above, the majority of survey respondents reported feeling that they *had* been offered advice, and it became evident throughout all data strands that a great deal of advice was embedded within volunteer responses. These were typically presented in the form of questions, or posed as volunteers' thoughts. Similar findings have been previously reported in an internal evaluation of Samaritans email service, alongside the recognition that practices in email responses will be found also in phone contacts [17].

An important distinction concerns whether or not advice is solicited by the caller or offered gratuitously by the volunteer. Callers who want or expect advice may feel rebuffed and dissatisfied if it is not forthcoming. A similar result may follow from the proffering of advice which was neither anticipated nor sought. However, one of the most frequent suggestions from callers for improving the service was simply that volunteers should be willing to offer advice. In their formal commitment to not giving advice, volunteers were rarely aware of existing contingencies within the Samaritans nature of service principles for callers to be referred from Samaritans to other agencies, following discussion with the caller care team. Whilst sometimes questioning the policy, few knew about the reappraisal of signposting callers to other agencies which is been ongoing within the organisation as part of the move to develop closer partnership working with other agencies [74] [2, 4]. Although volunteers indicated that they could not point callers in the direction of other agencies an extensive list of these is currently provided on the Samaritans website [75]. There is considerable ambiguity about the current principles and practice of the organisation in relation to the nature and provision of advice in different contexts which is currently a source of confusion and inconsistency for both callers and volunteers.

Suicide

Supporting the despairing and suicidal is the Samaritans' raison d'être. The focus on suicide and the aim to reduce its incidence are perhaps the most singular aspects of the organization. However, while support of the suicidal is central to the role of volunteers, it represents a small proportion of their work on shift. Volunteer respondents varied widely in their estimates, but the latest data for the organisation as a whole indicates that 20% of calls are from callers expressing some degree of suicidal ideation (the figure is higher in email contacts) [1]. However, the study data reveal the complex relationship between expressions of suicidality and the intention to engage in suicidal behaviours, and call in question what it means to say that a caller is 'suicidal'. It is not feasible for volunteers to accurately gauge callers' emotional states, especially during calls which may be very brief. Consequently, the assessments of caller suicidality based on entries to the caller contact log should be treated with great caution.

Volunteers hope that providing support at a critical moment can help callers to step down from attempting suicide in favour of a life affirming option. All claimed to incorporate the policy of self determination into their support, albeit with a tendency to 'err on the side of life' in cases where intervention is an issue. Indeed, the act of calling was discussed as a potential indicator of hesitancy, or request for assistance. Volunteers are ready to stay with callers until the point of death if necessary, although gauging what is actually happening on the other end of the line is always difficult. Volunteers

[74] http://www.samaritans.org/about_samaritans/introduction_to_samaritans/about_our_service.aspx
[75] http://www.samaritans.org/your_emotional_health/other_sources_of_help.aspx

accept that they will rarely know the outcome of a call and that a considerable number of callers who present as being in the process of suicide will not actually be dying. Suicidality was seen by both callers and volunteers as sometimes a way of coping with a long term state or way of being. Expressions of 'being suicidal' were considered poor indicators of a caller's actual proximity to a suicide attempt. Suicidal impulses may be volatile and the correspondence weak between the words callers use to describe the thoughts and inner feelings and intentions which may be unclearly formulated, even to themselves [18, 19]. When in great despair or emotional pain, some callers claim that they are close to a suicide attempt despite not wanting to commit suicide at all. They may be distressed at the thought of committing suicide, and even perhaps be against suicide as a way of dealing with their pain, but will still be feeling as though they are close to making an attempt. Thus, the data (especially in emails) indicate an orientation to suicidal thoughts and behaviours as *not necessarily being about a desire to die*. For some callers, this may lead to difficulty with labels such as 'suicidal', as these labels do not allow for the 'grey area' of using such behaviours for ends other than death (e.g. as a reaction to severe emotional pain). Caller accounts vigorously conveyed the expressive and communicative nature of suicidal terminology (at least among those who contact Samaritans), and the rhetorical use of suicidal language to express misery and despair. Indeed, especially for long term and regular callers, it may be that the discourse of suicidality is to some extent *prompted* or maintained by contact with the Samaritans, especially if contact is of a long term or frequent nature: If Samaritans support the suicidal, and I am supported by Samaritans, then I am suicidal.

Respondents experiencing genuine fear and uncertainty about where their suicidal thoughts and impulses might lead discussed Samaritans as a valuable resource in helping them establish equilibrium and so avert the possibility of action they fundamentally did not want to take. These included some descriptions of how helpful contact with the volunteers is in terms of the organisation's core principle of providing an opportunity for the caller to reflect and explore options. However, these did not occur frequently, and throughout the data approximations to the 'good call' were rare. Callers who self-harmed were typically explicit that such actions were a coping strategy, entirely distinct in intent from suicidal behaviour, even if their behaviours included regular or repeated overdosing or 'threats' to kill themselves. In this context, the volunteers' treatment of self harm as equivalent, or a pre-cursor, to suicidal behaviour was perceived to be unhelpful.

Suicidality was discussed by callers as strongly related to mental health problems, either as a symptom or as a consequence, and always oriented to as an understood and accepted element of mental illness. Samaritans was described as important at times of mental distress, as suicidality was difficult for some callers to discuss with other services, due to the fear that such disclosures would prompt unwelcome intervention. This may have implications for the Samaritans practice of supporting interactions with statutory or voluntary organisations as callers may be in contact as they have already chosen Samaritans over these other services. Relationships in general were discussed as an important issue, and family and friends were discussed as both a cause for suicidal behaviour, and as a reason for not attempting suicide.

Mental health issues

A high proportion of both survey (47%) and interview respondents (77%) had experience of mental health problems. These were often given as a reason for making contact with Samaritans, particularly in the case of repeat or regular callers. Many callers clearly oriented to Samaritans as a mental health charity and regarded the ongoing support of those experiencing mental health problems of various kinds as a central to the support provided by the organisation. Callers tended to use Samaritans strategically and selectively as one among a range of informal and professional sources

of help. In this context the anonymity and confidentiality of Samaritans was particularly valued as an option which allowed callers to discuss issues (such as suicidal thoughts) which they did not wish to divulge to health professionals for fear of attracting unwelcome intervention. The 24/7 access allowed by Samaritans was also appreciated, and the availability of 'out of hours' support. Many respondents valued Samaritans' as an ongoing resource to help them deal with difficulties – sometimes episodic, sometimes chronic – that had no clear or likely means of resolution.

Volunteers recognised people with mental health problems as in need of on-going support. A few were involved with establishing partnerships and referral schemes with local services, in line with current policy [4]. More generally, however, volunteers did not view support for the mentally ill to fall within the remit of Samaritans or their personal competence, and were often ambivalent and uncertain about how to deal with callers experiencing mental health problems. Therefore, within these different stakeholders, there were conflicting positions as to whether regular callers with mental health problems were legitimate and welcome as Samaritans callers. This ambiguity is reflected in the accounts of both callers and volunteers as well as recent Samaritans policy documents and promotional material.

At an organisational level the association between mental illness and suicidal ideation is clearly recognised. It is less clear to what extent Samaritans positions itself as a mental health charity with a remit that extends to the varied needs of those with mental health problems, or how the experience of 'emotional despair or distress' is understood to relate to psychiatric disorder. How Samaritans understands the relationship between suicide and rational decision-making in those with clinically defined mental illnesses or the appropriateness of upholding their self-determination policy when dealing with this type of caller is not clearly articulated. The question arises as to how often, and in what circumstances, within our present social and clinical culture it is possible to be classified as sane and also suicidal. Also at issue here is whether upon contacting the organisation, the caller remains a 'person', or becomes a 'patient'.

Improving the service

Around forty percent of survey respondents offered suggestions as to how the Samaritans service could be improved or better tailored to meet their needs. The suggestions made were grouped into four main categories: recruitment and training of volunteers, interactional issues between caller and volunteer, practical issues to do with use of the service and the wider promotion of Samaritans. Such suggestions were mirrored in interview data, where both callers and volunteers had many points to offer on how the Samaritans service could be improved. This typically involved altering an existing aspect of the service, such as the policy on not providing advice. Some callers suggested improvements based on additions to the service or a return to previously offered services, such as liaising with other caregivers and support services or accompanying callers during medical consultations.

In relation to interactional issues callers proposed that volunteers could take a more proactive approach when handling calls, engage in a two-way interaction which involved being more sparing with the use of silence, and (especially in emails) a more empathic, personal and engaging 'tone' in the volunteer's response: in fact, better communication skills. Email callers expressed frustration about their call history not being read, volunteers inappropriately repeating questions (particularly regarding suicide) and issues relating to previous messages and the receipt of 'scripted' or 'standardised' rather than personal responses. Longer and faster responses were also requested by a substantial number of callers, especially those using the email facility. Most of the issues raised by the earlier report on the Samaritans email service remain live concerns for callers [17]. Callers thought these changes would allow volunteers to appear more human and

show genuine concern which would be more helpful, useful and make callers feel cared for. In turn this would make it easier for callers to open up and express their feelings. Many responses to how the service could be improved referred to 'giving advice' when this was requested by the caller. More information about the nature of service and what to expect when calling Samaritans would be helpful, especially in view of the reluctance many callers feel in making initial contact. Information in advance about the limits to the use of the service, and the nature of caller care plans would also be welcome. Callers suggested that volunteers should be prepared to signpost to other organisations, for example, by providing information, useful telephone numbers, and also undertake direct liaison and support with contacting other agencies and services.

Round the clock accessibility of Samaritans was strongly valued by callers. Suggestions for extending access included increasing the scope and hours of face to face visits, including 'drop in' sessions with other callers, and also reinstating (more generally) the previous 'assigned befriending' model of support in which volunteers would support callers through home visits and other activities outside the branch. Increasing the continuity of contact by assigning callers to individual, and sometimes preferred, volunteers was another option. Reducing the cost of calling was a further concern, and innovations such as Skype, web chat and instant messaging were suggested as positive innovations to the service, especially if the cost of phone and text calls could not be reduced.

Ways in which Samaritans could liaise more closely with other service and public agencies was a recurring theme across all data strands, although a few callers also expressed concerns that the organisation should be careful to retain its independence. Callers also suggested including people who have personal experience of mental illness in the training of new volunteers, and greater training of the volunteers about mental illness and self harm.

The quality of email responses was raised as a concern by volunteer respondents, and some discussed issues relating to the giving of advice to callers. Most volunteers remained centred on the listening service and their involvement with their local branch. However, a number of respondents were active and enthusiastic in exploring opportunities for extending the reach of Samaritans through partnership working and referral schemes with local agencies and professional services and saw this as a valuable means of extending Samaritans' service. Some volunteers would welcome the inclusion of information about mental health problems in training, while others would not. The most recurrent issue arising from discussions about improvements to the service with volunteers was that of volunteer training and development. Ways in which volunteers could progress and develop as Samaritans were discussed, such as improving ongoing training by recognising the varying needs and levels of experience of volunteers, introducing a more formal system of reviews for volunteers, and encouraging more 'listening in' to calls with the aim of providing feedback on a volunteer's performance. Reducing abusive and inappropriate use of the service by sexually demanding, regular and mentally ill callers and more effective preparation and training in how to deal with these were also issues for volunteers who pointed to improvements in these areas as means of attracting and retaining new volunteers in future.

Conclusion

The present study cannot contribute to the quest for evidence that Samaritans distinctive brand of emotional support contributes to reducing suicide. However, it has collected an unprecedented amount of empirical data as the basis of an analysis of the effectiveness of Samaritans from the perspective of those who use and deliver the service. The volunteers who took part in this study expressed a strong commitment to their role and to Samaritans mission, and gained a great deal from their experience of

volunteering. Callers expressed a high level of appreciation for the service and reported deriving considerable benefit from their contact with the volunteers. However, a substantial minority expressed disappointment with different aspects of their experience of contact. Some areas of mutual tension and dissatisfaction between caller and volunteer derive from different interpretations and understandings of the nature of service provided by Samaritans. Although the offer of support promises to be unconditional, in practice there are limits to entitlement and access. Active listening involves abstaining from making judgements and giving advice. However, these are regular features of contact between volunteers and callers. Many callers, including those who feel they have benefited greatly from volunteers' support fall outside the limits of service as defined by many volunteers. To date, the nature of caller needs and capacity to benefit from the service have been defined by Samaritans with reference to the organisation's mission and ideals and not by those who use the service. In practice, there is a great distance between the idealised representation of Samaritans promoted at this organisational level, and the more mundane reality experienced by volunteers and callers in the branches where only a small proportion of the volunteer's work involves support for those who are in great despair or suicidal. Many callers value the service as an ongoing source of support for difficulties that offer little scope for resolution. In practice, volunteers usually respond pragmatically and kindly and with tolerance, though this does not always happen. The present study sheds some light, not only on how callers assess the service currently provided by Samaritans, but also about what kind of provision they would value most in future. These findings point to a broader remit for the organisation and acceptance of the value many callers derive from ongoing support for issues and difficulties which stop far short of being suicidal. In focusing primarily on support for suicidal callers, Samaritans overlooks the considerable benefits the service provides for many people who need some help in dealing with the ongoing challenges of emotionally arduous and unhappy lives.

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Appendix I

Samaritans principles and practices

Volunteers have historically worked within the guidelines of the Samaritans' "Principles and Practices". These have now been replaced by the 'Nature of Service' Policies.

The Seven Principles:

- The primary aim of Samaritans is to be available at any hour of the day or night to befriend those passing through personal crises and in imminent danger of taking their own lives.
- The Samaritans seek to alleviate human misery, loneliness, and despair and depression by listening to and befriending those who feel that they have no-one else to turn to who would understand and accept them.
- A caller does not lose the freedom to make his own decisions, including the decision to take their own life, and is free to break contact at any time.
- The fact that a person has asked for the help of the Samaritans, together with everything he has said, is completely confidential within the organisation unless permission is freely given by the caller for all or a part of such information to be communicated to someone outside the organisation.
- A Samaritan volunteer is not permitted to accept confidence if a condition is made that not even the director should not be informed.
- Samaritan volunteers in befriending callers will also be invited to consider seeking professional help in such fields as medicine and social work, and material help from other agencies.
- Samaritan volunteers are forbidden to impose their own convictions or to influence callers in regards to politics, philosophy, or religion.

The Seven Practices:

- Samaritan volunteers are carefully selected and prepared by the local branch in which they are to serve.

- The Samaritans are available at all hours to callers, and may be contacted (anonymously if desired) by telephone, personal visit, or letter.

- When a caller is believed to be in danger of suicidal action, the Samaritan is particularly encouraged to ask the caller's permission for contact to be maintained during the crisis.

- Samaritans offer longer-term befriending of callers where appropriate while recognising the branch may from time to time have to set limits.

- Samaritans listen to those concerned about the welfare of another person, and, if satisfied that the third person is despairing, depressed or suicidal, may discreetly offer befriending.

- Callers normally know Samaritans only by a forename and contacts by callers made only through the branch centre.

- Samaritan branches are banded together in legally constituted association whose council of Management represents all the branches and reserves to itself the appointment of the person in charge of each branch.

Appendix II

Samaritans 'Nature of Service' Policies

24 Hour Availability

Callers can contact Samaritans by telephone, letter, email and minicom. The commitment to making these means of access available 24 hours a day will be maintained by all branches (except Festival and Correspondence Branches) covering the rota according to the number of active listening volunteers they have as members.

Callers can visit a branch for face-to-face support (except correspondence Branch). Each branch will advertise when they are available for face-to-face support.

All branches will negotiate and co-ordinate their availability with their Regional Representative.

Samaritans' aim is to ensure that telephone and minicom callers are not kept waiting for a response and that as many as possible get through first time.

The objective for distributing calls through the One Number is to cascade geographically by locality and region to try to ensure that no caller receives the engaged tone when a volunteer is available to take a call.

All branches (except Correspondence and Festival Branches) will have regionally agreed diversion plans.

Confidentiality

- All information relating to a caller is confidential to Samaritans unless:
- We have informed consent from a caller to pass on information
- We call an ambulance because a caller appears to be incapable of making rational decisions for him or herself.
- We receive a court order requiring us to divulge information.
- We are passed information about acts of terrorism or bomb warnings.
- A caller attacks or threatens volunteers.
- A caller deliberately prevents the service from being delivered to other callers.

Samaritans maintain confidentiality even after the death of a caller.

Honesty

Samaritans publicly state how information relating to callers is used

Callers are informed of what volunteers can and cannot offer.
Samaritans do not make recordings of calls but occasionally a colleague may listen in for training purposes and/or to offer support to the volunteer engaged with a caller.

All complaints will be investigated fully and sympathetically and callers will receive a full response in the shortest possible time.

Emotionally Supportive

Callers in need of Samaritans' service are accepted without prejudice and encouraged to talk or write about their feelings, acknowledge their emotions and explore options.

Volunteers use their listening skills, recognise the needs of callers and respond appropriately.

Volunteers will not impose their own convictions, or influence callers, in regards to politics, philosophy, or religion.

If a caller is at risk of suicide, or in despair, follow up contact is offered.

With a caller's permission, and after consultation with the person responsible for Caller Care, a group of volunteers may be assigned to a caller, to offer support through a period of distress.

If a caller is in need of other help, information may be passed on about other agencies (if held). With a caller's informed consent, and after consultation with the person responsible for Caller Care, a referral will be made on their behalf.

Samaritans also welcome appropriate referrals from other agencies or individuals.

Carefully Structured

Samaritans aim to offer a consistent service to callers. To support this aim, the care being offered is regularly reviewed and evaluated, to ensure it encourages callers to work towards managing their lives without dependency or attachment.

Samaritans volunteers are subject to a police records check (except in Ireland), selected and specially trained.

To ensure the safety and welfare of callers and volunteers, Samaritans' service is only available while volunteers are fully supported by a colleague and a leader.

If a volunteer deliberately prejudices the emotional or physical safety of callers, or the reputation of the Movement, this will be deemed as an act of serious misconduct for which they will be dismissed.

Samaritans strive to make the service as accessible as possible to those most in need and supports the Disability Discrimination and Equal Opportunities Acts. Samaritans reserve the right to end a call or withdraw the service if it is being used inappropriately.

Self-Determination

Callers remain responsible for their lives and do not lose the right to make decisions even if that decision is to take their own life.

Appendix III

Samaritans Vision, Mission and Values

The Vision

Samaritans Vision is that fewer people die by suicide.

The Mission

Samaritans work to achieve this Vision by making it our Mission to alleviate emotional distress and reduce the incidence of suicide feelings and suicidal behaviour.

We do this by:

- Being available 24 hours a day to provide emotional support for people who are experiencing feelings of emotional distress or despair, including those which may lead to suicide
- Reaching out to high risk groups and communities to reduce the risk of suicide
- Working in partnership with other organisations, agencies and experts
- Influencing public policy and raising awareness of the challenges of reducing suicide

The Values

Samaritans are committed to the following values:

- Listening, because exploring feelings alleviates distress and helps people to reach a better understanding of their situation and the options open to them
- Confidentiality, because if people feel safe, they are more likely to be open about their feelings
- People making their own decisions wherever possible, because we believe that people have the right to find their own solution and telling people what to do takes responsibility away from them
- Being non-judgemental, because we want people to be able to talk to us without fear of prejudice or rejection
- Human contact, because giving people time, undivided attention and empathy meets a fundamental emotional need and reduces distress and despair

(*Source*: http://www.samaritans.org/about_samaritans/governance_and_history/our_mission.aspx *Accessed 25.02.10*)

Appendix IV

The University of Nottingham

School of Nursing

An Evaluation of Samaritans Telephone, E-mail and SMS Services

Service Users Questionnaire

- ***Thank you very much for responding to this survey. Please note that it is only for people who have at some time used the service by e-mail, text or telephone***
- ***The information you provide will be treated with great care so that it remains anonymous and strictly confidential. It will only be used for the purposes of this project.***
- ***We are interested in finding out about all the issues covered in the questionnaire .However please feel free to leave any questions you do not want to answer.***
- ***We are very appreciative of the time and care it takes to complete this survey and hope the results will lead to a greater understanding of the needs of Samaritans service-users.***
- **To read more about the research please visit our website at www.nottingham.ac.uk/nursing/shelp**
- ***If you have any issues you would like to discuss prior to completing this, please phone Michelle on 011598230956 or +44(0)7825753816Or e-mail her at SHELP@nottingham.ac.uk***

I consent for the information I have given in the following questionnaire to be used only for the purposes of the Samaritans Helpline Evaluation and Research. I understand that all of my answers will be treated in the strictest of confidence and that this is an anonymous questionnaire.

Please tick here to say that you have read this ☐

How to complete this questionnaire

Please indicate your answer by placing an X in the appropriate box for each question below. If you select 'other' as an option, please specify what this is in the space provided.

Section A - A few Questions about you

1) Which age group do you belong to?

1	15 or under	
2	16-18	
3	19-24	
4	25-34	
5	35-44	
6	45-54	
7	55-64	
8	65-74	
9	75-84	
10	85 and over	

2) Are you male/female?

1	Male	
2	Female	

3) What is your ethnic origin?

1	White British English	
2	White British Scottish	
3	White British Welsh	
4	White British Irish	
5	Irish	
6	White and Asian	
7	White and black Caribbean	
8	White and black African	
9	Asian or Asian British	
10	Indian	
11	Pakistani	
12	Bangladeshi	
13	Black or Black British	
14	Caribbean	
15	African	
16	Chinese British	
17	Other (please specify)	

4) Please can you describe your marital status?

1	Married	
2	Divorced	
3	Separated	
4	Single	
5	Widowed	
6	Living with partner	

5) Do you live…?

1	Alone	
2	With spouse/partner	
3	With parents	
4	With spouse/partner and children	
5	With children	
6	With room-mates / in a shared house	
7	With extended family	
8	In residential care for elderly	
9	In care home for young people	
10	Prison	
11	In a hostel/ safe house	
12	In a hospice/hospital	
13	Other (please specify)	

6) Please can you tell us the first part of your postcode? Please indicate this in postcode format e.g. AA1 or AA12

7) Are you a UK resident?

1	Yes	
2	No	

8) Is your sexuality

1	Straight/Heterosexual	
2	Bisexual	
3	Gay/Lesbian	
4	Undecided	
5	Prefer not to say	

9) What is your current occupational status ?

1	Employed full time	
2	Employed part-time	
3	Self employed	
4	University Student	
5	College student	
6	Unemployed	
7	Unable to work due to health problems	
8	On maternity/parental leave	
9	Parenting/homemaker full time	
10	Retired	
11	Semi-retired	
12	Carer	
13	At school	
14 Other (please specify)		

10a) Do you have a disability?

1	Yes	
2	No	

10b)If you answered yes to Q10a) above, please give details.

Section B – The LAST TIME you contacted Samaritans
The following questions relate to the LAST TIME you contacted Samaritans.

1) When you last contacted Samaritans, was it by

1	Telephone	
2	E-mail	
3	Text message	
4	Postal letter service	
5	Visit	
6	Festival branch	

2a) What was the approximate date of your last contact?

Day	Month	Year

2b) What was the approximate time of your last contact?

Hour 24 hour clock please	Minute

3) Did you feel that your contact received a prompt response?

1	**Yes**	
2	**No**	

4) Why did you choose this method of contact as opposed to others?
Please select all answers that apply.

1	**It felt more anonymous**	
2	**It was cheaper**	
3	**I wanted to talk to someone**	
4	**It was easier to talk over the phone**	
5	**It was easier to write/text than talk**	
6	**I felt less embarrassed**	
7	**Other (please specify)**	

5) How did you feel about the length of the contact?

1	Too short	
2	About right	
3	Too Long	
4	Not sure	

<u>If you last contacted Samaritans by text or e-mail Please answer Q6 a) otherwise please go to Q7</u>

6a) How many messages did you recieve?

1	Number of text messages	
2	Number of e-mails:	

6b) Over what period of time? Please indicate the number of days OR weeks OR months

1	Number of days:	
2	Number of weeks	
3	Number of months	

7) How did you feel BEFORE the last time you made contact? Select as many answers as appropriate

1	In the process of suicide	
2	Suicidal	
3	Was self harming	
4	Wanted to self harm.	
5	In despair	
6	Very distressed	
7	Angry	
8	Anxious	
9	Out of control	
10	Not understood	
11	Lacking confidence	
12	Helpless	
13	Depressed	
14	Lonely	
15	Afraid	
16	Sad	
17	Worried	
18	Confused	
19	Hopeless	
20	Other (please specify)	

8) How did you feel AT THE END of the contact? For each of the feelings below, please put a cross over the circle that expresses how you felt after the contact.

Not Listened to	• • • • • • • • • •	Listened to
Suicidal	• • • • • • • • • •	Not suicidal
Alone	• • • • • • • • • •	Not Alone
Afraid	• • • • • • • • • •	Unafraid
Anxious	• • • • • • • • • •	Not Anxious
Unhappy	• • • • • • • • • •	Happy
No Confidence	• • • • • • • • • •	Confident
Not Understood	• • • • • • • • • •	Understood
Hopeless	• • • • • • • • • •	Hopeful
Depressed	• • • • • • • • • •	Not Depressed
Don’t Want to live	• • • • • • • • • •	Want to live
No Solution	• • • • • • • • • •	Solution
No advice	• • • • • • • • • •	Advice Given
Not Cared for	• • • • • • • • • •	Cared for
Not Supported	• • • • • • • • • •	Supported

9) How did you feel at the end of the contact compared to how you felt before the contact?
Please put a cross over the circle that expresses how you felt.

Worse • • • • • • • • • • Better

10a) How do you feel now compared to how you felt after your last contact?
Please put a cross over the circle that expresses how you feel now

Worse ● ● ● ● ● ● ● ● ● ● Better

10b) Please explain your answer to Q10a, if you can

11a) How much has your contact with Samaritans helped you?
Please put a cross over the circle to express whether your contact with Samaritans has made you feel better or worse.

Worse ● ● ● ● ● ● ● ● ● ● **Better**

11b) Please explain your answer in the box below, if you can.

12a) What was the MAIN ISSUE you were contacting Samaritans about? If so, was it.. (Please select one answer only)

1	Work issues	
2	Relationship problems	
3	Relationship breakdown	
4	Bereavement	
5	Family problems	
6	Gambling	
7	Drug/alcohol addiction	
8	Worries about someone else	
9	Being unable to have children	
10	Losing my job	
11	Sexuality	
12	Financial worries	
13	Post-natal depression	
14	Loneliness/ isolation	
15	Exams/ study	
16	Bullying	
17	Physical abuse	
18	Sexual abuse	
19	Emotional/psychological abuse	
20	Harming myself	
21	Sexual problems	
22	Mental health problems	
23	Illness/physical health problems	
24	Generally feeling sad or low	
25	Problems with friends	
26	Feeling anxious or worried all the time	
27	Overwork	

12b) Other -if you were calling about another or additional issues please explain.

13a) During this last contact, did the Samaritan ask you if you were feeling suicidal

1	Yes	
2	No-Please go to question 14a	
3	Can't remember	
4	Not sure	

13b) If yes, how did this make you feel? Please select as many as apply

1	Better	
2	It was a relief to talk about it	
3	It was good to explore the idea with someone	
4	I felt embarrassed	
5	I felt surprised	
6	I felt worse	
7	I'm not sure	
8	Other (Please specify)	

13c) Please explain your answer to 13b)

14a) In your last contact with the Samaritans, did you have contact with:

1	A man	
2	A woman	
3	Not sure	

14b) Were you comfortable communicating with a person of that gender?

1	Yes	
2	No	

14c) How easy was it communicating with a person of that gender?

1	Yes-very easy	
2	Yes- quite easy	
3	A bit difficult	
4	Very difficult	

15) At the time of your last contact with Samaritans were you in touch with any other services for help with the issue you contacted Samaritans about?

1	Yes-Please state which ones you are in touch with in the next question (16)	
2	No-Please go to question 17a)	

16) Of the other services you were in contact with, please indicate whether they were more, less or equally as helpful as Samaritans, and why.

Name of Service used - please specify	How helpful was this compared to Samaritans? Please circle answers	Please give your reason
	More **Equal** **Less**	
	More **Equal** **Less**	
	More **Equal** **Less**	
	More **Equal** **Less**	
	More **Equal** **Less**	

17 a) At the time of your last contact were you taking any medicine(s) for stress/ anxiety/depression or other mental health related problems?

1	**Yes-Please go to Q17b)**	
2	**No-Please go to Question 18**	

17b) If yes, what medicine(s) were you taking?

17c) How long had you been taking this medicine when you last contacted Samaritans? Please indicate the number of years OR months.

1	Number of years:	
2	Number of months:	

17d) Are you still taking this medicine?

Yes	
No	
My medication has changed	

18) Is this the only contact you have had with Samaritans?

Yes- Please go to Section C, Q4a)	
No- Please go to next question	

Section C - Now we would like you to tell us some more information about any EARLIER contacts you have had with Samaritans

1) Which Samaritans contacts have you used and how often?

Type of service (Please circle)	**Please indicate number of times used**	**How satisfied are you with the length of time for response generally?** (Please circle)	**How good did you find this service generally?** (Please circle)
Telephone helpline		Not satisfied Fairly satisfied Moderately satisfied Very satisfied Not sure/varies	Excellent Good Reasonable Bad Variable
Email Service		Not satisfied Fairly satisfied Moderately satisfied Very satisfied Not sure/varies	Excellent Good Reasonable Bad Variable
Text message service		Not satisfied Fairly satisfied Moderately satisfied Very satisfied Not sure/varies	Excellent Good Reasonable Bad Variable
Postal letter service		Not satisfied Fairly satisfied Moderately satisfied Very satisfied Not sure/varies	Excellent Good Reasonable Bad Variable
Visited a branch		Not satisfied Fairly satisfied Moderately satisfied Very satisfied Not sure/varies	Excellent Good Reasonable Bad Variable
Festival branch		Not satisfied Fairly satisfied Moderately satisfied Very satisfied Not sure/varies	Excellent Good Reasonable Bad Variable

2a) What kind of issues have you contacted Samaritans about on these occasions? (Please select all answers that apply)

1	Work issues	
2	Relationship problems	
3	Relationship breakdown	
4	Bereavement	
5	Family problems	
6	Worries about someone else	
7	Being unable to have children	
8	Losing my job	
10	Sexuality	
11	Financial worries	
12	Gambling	
13	Drug/alcohol addiction	
14	Post-natal depression	
15	Loneliness/ isolation	
16	Exams/ study	
17	Bullying	
18	Physical abuse	
19	Sexual abuse	
20	Emotional/psychological abuse	
21	Harming myself	
22	Sexual problems	
23	Mental health problems	
24	Illness/physical health problems	
25	Generally feeling sad or low	
26	Problems with friends	
27	Feeling anxious or worried all the time	
28	Overwork	
29	No specific cause	

2b) If you were contacting for another reason-please explain

3a) If you have contacted Samaritans on more than one occasion, has the service you received been consistent?

1	Yes	
2	No	
3	No answer	
4	Not Applicable	

3b) Please explain your answer to Q3a) above.

3c) Please indicate how helpful the contact with the Samaritans usually is by putting a cross on the appropriate dot on the line below.

No help at all ● ● ● ● ● ● ● ● ● ● Very helpful

4a) Before you first contacted Samaritans did you have any expectations of what would happen, or what this would be like?

1	Yes
2	No
3	Not Sure
4	Don't know
5	Can't Remember

4b) Please describe what your expectations were prior to contact.

4c) Did you find that the response you received from Samaritans was better or worse than you had expected?

Please put a cross over the circle that expresses your feeling

Worse ● ● ● ● ● ● ● ● ● ● Better

4d) Please can you explain your answer to Q4C) above

5a) Are you aware that Samaritans are a confidential service? (Meaning they don't keep details of caller's identity or share information outside Samaritans)

1	Yes go to	
2	No go to question 6a)	

5b) If yes, how important was this in your decision to contact them?

1	Very important	
2	Quite important	
3	Not important	

6a) Have you ever felt judged when in contact with a Samaritan? Please select one answer only.

1	Yes-every time	
2	Yes sometimes	
3	Not very often	
4	Not at all	
5	Only contacted once, did feel judged	
6	Only contacted once, didn't feel judged	

6b) Please can you explain your answer to Q 6a)

7a) Have you always felt listened to when in contact with Samaritans?

1	Yes-every time	
2	Yes sometimes	
3	Not very often	
4	Not at all	

7b) Please explain your answer to Q7a)

8) Have you ever encountered a language barrier when talking to a Samaritan?

1	Yes	
2	No	

9) Would you use Samaritans again if you needed to?

1	Yes	
2	No	
3	Not sure	

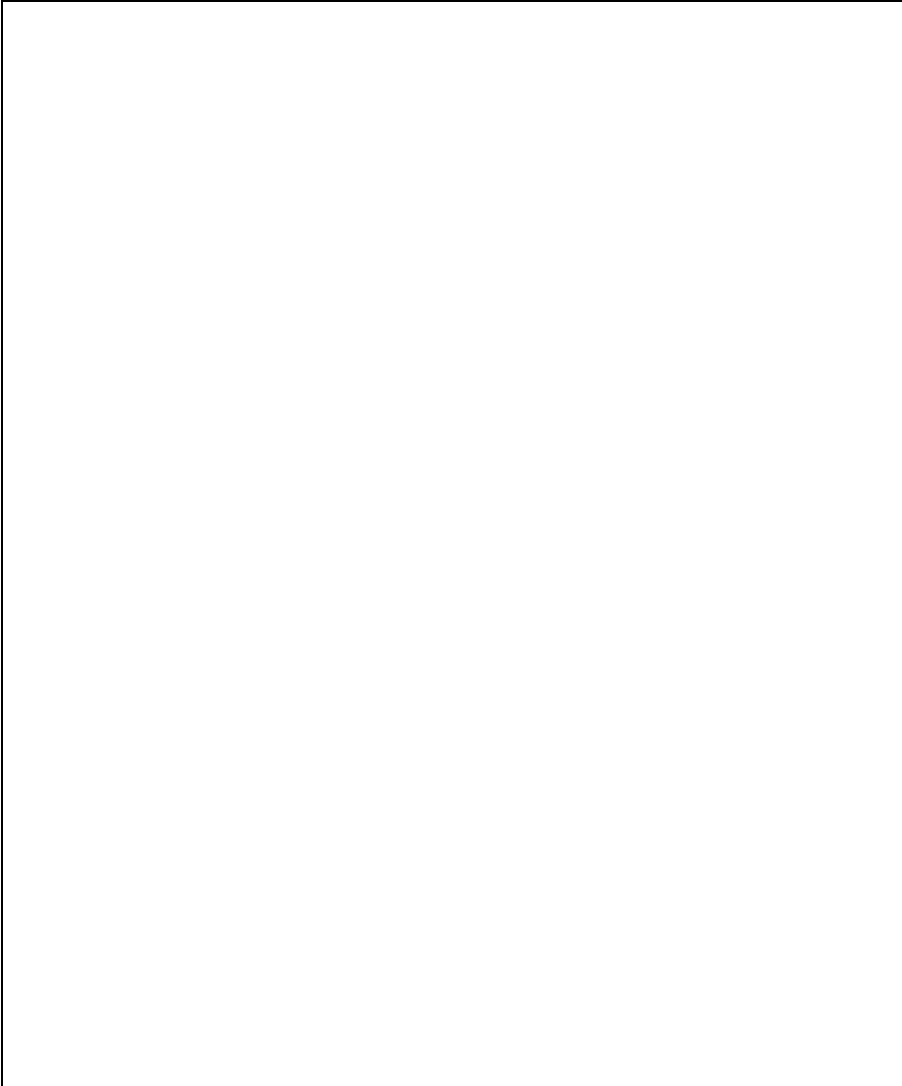
10) How did you become aware of Samaritans? Please select all answers that apply

1	Radio	
2	Newspaper/magazine	
3	Poster	
4	Online	
5	Word of Mouth	
6	Recommendation	
7	Telephone directory	
8	Meeting a Samaritan on the street	
9	Don’t know/can’t remember	

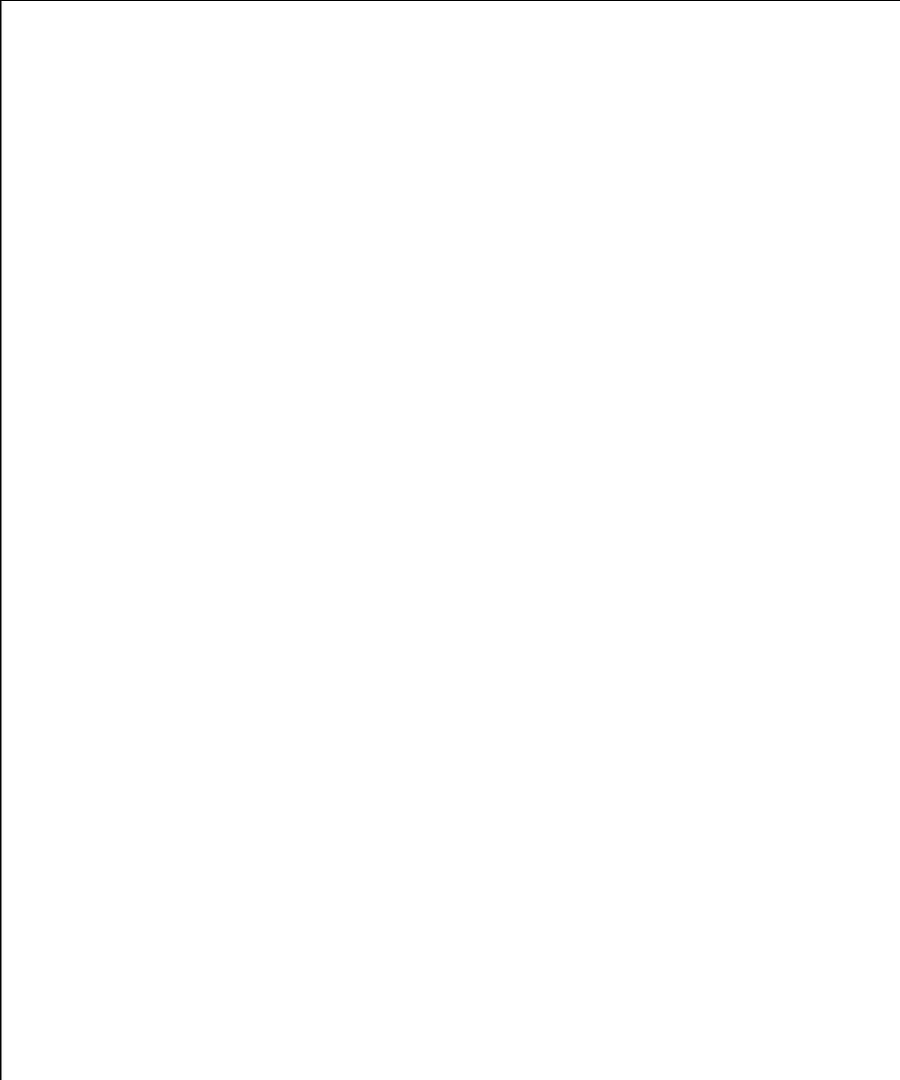
11a) Are there any ways in which you feel Samaritans could improve their service to provide more effective support for callers in the future?

1	Yes -please respond in the box below by saying how you think they could improve	
2	No	
3	Not Sure	

11b) Please indicate how the service could be improved



12) Please use this space to share any other comments or suggestions about your experience of contact with Samaritans.



Thank you very much for taking the time to complete this questionnaire.

Please return by freepost to

FREEPOST
RRUL-CYTL-HGJJ
University of Nottingham
NG7 2UH

Appendix V

Caller contact sheet

CALLER CONTACTS — The intention ***REMAINS*** to explore suicidal feelings at ***EVERY CONTACT***

Caller Name / No. First name of caller/anon. Write surnames as an initial e.g. Mrs. S. Only use full surname if absolutely necessary.	Contact Time		Method of Contact T=Telephone F=Face to face E=E-mail O=Other e.g. OB=Outside branch M=Minicom L=Letter	Gender M=Male F=Female U=Unknown	Nature of Contacts -3 = Concern for volunteer safety. Caller is abusive, violent & or threatening. -2 = Does not accept service. Unwilling to end contact even if on a time-restricting care plan. -1 = Not distressed. Chatting. Wants information. Not prepared to talk about feelings. Silent calls where no indication of feelings. 0 = Distressed but not expressing suicidal feelings. Able to cope with feelings. Upset but in control of actions. 1 = Caller indicates suicidal feelings. Caller may indicate suicidal feelings in an indirect way, but is still in control of action. Distressed and despairing. 2 = Suicidal feelings and plans. Overwhelming feelings of despair. Extreme distress. 3 = Suicide in progress. Caller might have self-harmed in a life threatening manner. Volunteer is concerned about caller safety.	X&N X = Not Explored N = No Answer	Follow-up O=Offered A=Accepted	Caller Age	Third Party Referral List source	Spare column (for Branch use)	COMMENTS Suggestions - what to record in comments column: ■ What were the reasons for calling? ■ Was a Caller Care Card made out? ■ Was caller a known regional or national caller? ■ Was it a Reverse Charge/Ring Back/Follow up call? ■ Was it a bomb warning - if so where are more detailed notes and was the procedure followed? ■ Was an ambulance called? Where can more details be found? ■ Were you particularly concerned about this call and why?	Day / Date / Page / Director	
	Start Time (24 hrs)	Duration	T F E O	M F U		X N	O A	Under 16, 16-24, 25-34, 35-60, 60+, Unknown				Volunteer Name / No.	Shift leader
Column 1	2	3	4 5 6 7	8 9 10	11	12 13	14 15	16 17 18 19 20 21	22	23	24	25	26
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								
			T F E		-3 -2 -1 0 1 2 3								

TOTALS	T	F	E	O	M	F	U	-3	-2	-1	0	1	2	3	X	N	O	A	-16	16-24	25-34	35-60	60+	U	3rd Party	Spare	TOTAL SNAP CALLS

SNAPS (✓) 10 20 30 40 50 60

Sign off. Caller Care ____________ Statistician ____________

Appendix VI

Survey data: additional tables

Table 1 Demographics of participants

Characteristic	Number (%)
Gender[76]	
Male	285 (22.1%)
Female	1002 (77.9%)
Age group[77]	
< 16	131 (10.1%)
16-24	470 (36.1%)
25-35	253 (19.4%)
36-44	188 (14.5%)
45-54	181 (13.9%)
55-64	67 (5.1%)
65-74	8 (0.6%)
75-84	1 (0.1%)
≥ 85	2 (0.2%)
Marital status[78]	
Married/Living with partner	299 (23.5%)
Divorced/Separated	152 (11.9%)
Single	792 (62.2%)
Widowed	30 (2.4%)
Living arrangements[79]	
Alone	266 (20.9%)
With spouse/partner	174 (13.7%)
With spouse/partner and children	104 (8.2%)
With children	68 (5.4%)
With room-mates/in a shared house	105 (8.3%)
With parents	459 (36.1%)
With extended family	26 (2.0%)
In residential care for elderly	1 (0.1%)
In care home for young people	3 (0.2%)
Prison	2 (0.2%)
In a hostel/safe house	4 (0.3%)
In a hospice/hospital	2 (0.2%)
Other	57 (4.5%)

[76] 1.7% missing data (n=22)

[77] 0.6 % missing data (n=8)

[78] 2.8% missing data (n=36)

[79] 2.9% missing data (n=38)

Table 1 Demographics of participants (cont.)

Characteristic	Number (%)
UK resident[80]	
Yes	869 (67.8%)
No	413 (32.2%)
Sexuality[81]	
Straight/Heterosexual	958 (76.2%)
Bisexual	116 (9.2%)
Gay/Lesbian	72 (5.7%)
Undecided	74 (5.9%)
Prefer not to say	37 (2.9%)
Current occupational status[82]	
Employed full time	296 (23.6%)
Employed part-time	100 (8.0%)
Self employed	38 (3.0%)
University student	133 (10.6%)
College student	119 (9.5%)
Unemployed	93 (7.4%)
Unable to work due to health problems	154 (12.3%)
On maternity/parental leave	4 (0.3%)
Parenting/homemaker full time	34 (2.7%)
Retired	27 (2.1%)
Semi-retired	9 (0.7%)
Carer	4 (0.3%)
At school	201 (16.0%)
Other	44 (3.5%)
Disability[83]	
No	967 (78.2%)
Yes	269 (21.8%)

[80] 2.1% missing data (n=27)

[81] 4% missing data (n=52)

[82] 4% missing data (n=53)

[83] 5.6% missing data (n=73)

Table 2 Details of last time of contact

Method of contact[84]	Number (%)
Telephone	420 (34.6%)
Email	723 (59.5%)
Text message	41 (3.4%)
Postal letter service	2 (0.2%)
Visit	26 (2.1%)
Festival branch	3 (0.2%)

Table 3 Comparison of methods of contact

	Method of contact used at last contact with Samaritans[85]						
	Telephone Number (%)	E-mail Number (%)	Text message Number (%)	Postal letter service Number (%)	Visit Number (%)	Festival branch Number (%)	Total (%)
Prompt response[86]							
Yes	388 (96.3%)	585 (84.8%)	27 (67.5%)	1 (50%)	23 (92%)	1 (33.3%)	1025 (88.1%)
No	15 (3.7%)	105 (15.2%)	13 (32.5%)	1 (50%)	2 (8%)	2 (66.7%)	138 (11.9%)
Length of contact[87]							
Too short	71 (17.4%)	118 (17.2%)	6 (16.2%)	0	3 (12.5%)	2 (66.7%)	200 (17.3%)
About right	285 (69.7%)	425 (62%)	24 (64.9%)	1 (100%)	18 (75%)	0	735 (65.0%)
Too long	5 (1.2%)	8 (1.2%)	1 (2.7%)	0	1 (4.2%)	0	15 (1.3%)
Not sure	48 (11.7%)	134 (19.6%)	6 (16.2%)	0	2 (8.3%)	1 (33.3%)	191 (16.5%)

[84] 7.2% missing data (n=94)

[85] Column percentages are presented in this table e.g. of those who used telephone as their method of contact, 388 (96.3%) respondents said the response was prompt.

[86] 11.2% missing data (n=146)

[87] 11.5% missing data (n=150)

Table 4: Recency of last contact

Recency of last contact[88]	Number (%)
< 1 month	460 (51.7%)
1 month	41 (4.6%)
2-3 months	52 (5.8%)
4-6 months	47 (5.3%)
7-12 months	195 (21.9%)
13 months to 4 years	69 (7.8%)
5-10 years	14 (1.6%)
>10 years	11 (1.2%)

[88] 32.1% missing data (n=420)

Table 5: Main reason for contact

Main reason for contacting Samaritans[89]	Number (%)
Work issues	18 (1.6%)
Relationship problems	79 (6.8%)
Relationship breakdown	88 (7.6%)
Bereavement	55(4.7%)
Family problems	75(6.5%)
Gambling	2 (0.2%)
Drug/alcohol addiction	11 (0.9%)
Worries about someone else	23 (2%)
Being unable to have children	1 (0.1%)
Losing my job	5 (0.4%)
Sexuality	12 (1%)
Financial worries	8 (0.7%)
Post-natal depression	1 (0.1%)
Loneliness/isolation	72 (6.2%)
Exams/study	13 (1.1%)
Bullying	10 (0.9%)
Physical abuse	5 (0.4%)
Sexual abuse	68 (5.9%)
Emotional/psychological abuse	27 (2.3%)
Harming myself	142 (12.3%)
Sexual problems	6 (0.5%)
Mental health problems	153 (13.2%)
Illness/physical health problems	21 (1.8%)
Generally feeling sad or low	75 (6.5%)
Problems with friends	5 (0.4%)
Feeling anxious or worried all the time	38 (3.3%)
Overwork	2 (0.2%)
Other	144 (12.4%)
Total	1159 (100%)

[89] 11.5% missing data (n=150)

Table 6: Feeling before last contact

Feelings	Number (%)[90]
In the process of suicide	113 (8.6%)
Suicidal	606 (46.3%)
Was self harming	300 (22.9%)
Wanted to self harm	380 (29%)
In despair	761 (58.1%)
Very distressed	839 (64.1%)
Angry	385 (29.4%)
Anxious	592 (45.2%)
Out of control	399 (30.5%)
Not understood	536 (40.9%)
Lacking confidence	547 (41.8%)
Helpless	694 (53%)
Depressed	894 (68.3%)
Lonely	813 (62.1%)
Afraid	561 (42.9%)
Sad	729 (55.7%)
Worried	588 (44.9%)
Confused	559 (42.7%)
Hopeless	669 (51.1%)
Other	88 (6.7%)

[90] Percentages do not add up to 100% since respondents could select more than one feeling to describe how they felt before their last contact with Samaritans

Table 7: Respondents reactions to being asked if feeling suicidal[91]

	Positive (Felt better/relieved to talk about it/good to explore idea) Number (%)		Negative (Felt worse) Number (%)		Embarrassed /surprised Number (%)		Not sure Number (%)		Total
Main reason for contacting Samaritans									
Health problems									
Self harm	58	(68.2%)	5	(5.9%)	29	(34.1%)	16	(18.8%)	85
Sexual problems	1	(100%)	0		0		0		1
Mental health problems	59	(62.1%)	8	(8.4%)	28	(29.5%)	20	(21.1%)	95
Illness/physical health problems	5	(35.7%)	2	(14.3%)	5	(35.7%)	5	(35.7%)	14
Feeling sad/low	11	(34.4%)	3	(9.4%)	11	(34.4%)	9	(28.1%)	32
Post-natal depression	0		0		0		1	(100%)	1
Problems with Family/Friends									
Family problems	19	(61.3%)	1	(3.2%)	7	(22.6%)	5	(16.1%)	31
Unable to have children	0		0		0		0		
Problems with friends	1	(33.3%)	0		1	(33.3%)	1	(33.3%)	3
Work/school problems									
Work issues	8	(66.7%)	0		1	(8.3%)	0		12
Losing my job	3	(100%)	0		0		0		3
Financial worries	2	(40%)	0		3	(60%)	0		5
Exams/study	2	(66.7%)	0		0		1	(33.3%)	3
Overwork	0		0		0		0		
Relationship problems									
Relationship problems	19	(59.4%)	3	(9.4%)	11	(34.4%)	4	(12.5%)	32
Relationship breakdown	36	(64.3%)	1	(1.8%)	16	(28.6%)	8	(14.3%)	56
Bereavement	19	(57.6%)	1	(3%)	7	(21.2%)	7	(21.2%)	33
Abuse									
Physical abuse	4	(100%)	0		2	(50%)	0		4
Sexual abuse	28	(60.9%)	4	(8.7%)	18	(39.1%)	7	(15.2%)	46
Emotional/psychological abuse	10	(58.8%)	3	(17.6%)	5	(29.4%)	4	(23.5%)	17
Bullying	1	(20%)	0		2	(40%)	1	(20%)	5

[91] Row percentages are presented in this table e.g. of those whose main reason for contacting Samaritans was because of self harming, 58 (68.2%) respondents felt positive about being asked whether they were feeling suicidal. Percentages do not add up to 100% since multiple feelings about being asked the question could be selected.

Table 8: Main reasons for past contact

Reason for contacting Samaritans	Number (%)[92]
Work issues	84 (14.2%)
Relationship problems	174 (29.3%)
Relationship breakdown	125 (21.1%)
Bereavement	113 (19.1%)
Family problems	239 (40.3%)
Worries about someone else	97 (16.4%)
Being unable to have children	13 (2.2%)
Losing my job	34 (5.7%)
Sexuality	53 (8.9%)
Financial worries	63 (10.6%)
Gambling	1 (0.2%)
Drug/alcohol addiction	50 (8.4%)
Post-natal depression	13 (2.2%)
Loneliness/isolation	329 (55.5%)
Exams/study	91 (15.3%)
Bullying	67 (11.3%)
Physical abuse	68 (11.5%)
Sexual abuse	127 (21.4%)
Emotional/psychological abuse	148 (25%)
Harming myself	302 (50.9%)
Sexual problems	28 (4.7%)
Mental health problems	279 (47%)
Illness/physical health problems	85 (14.3%)
Generally feeling sad or low	338 (57%)
Problems with friends	120 (20.2%)
Feeling anxious or worried all the time	280 (47.2%)
Overwork	45 (7.6%)
No specific cause	16 (2.7%)
Other	73 (12.3%)

[92] Percentages do not add up to 100% since respondents could select multiple reasons for contacting Samaritans in the past.

Table 9: Other services respondents were in contact with

Voluntary Organisations		
Name of Organisation	*Specialism*	*Number of callers in contact*
Alcoholics Anonymous	Alcohol addiction	1
Adsis	Alcohol & dependency	1
Aljeff	Addiction	1
Amber project (church army)	Self-harm	1
Aware	Depression	1
Befrienders	Suicide referral website	1
B-eat	Eating disorders	1
bipolar4all	Bipolar disorder	1
bodywhys	Eating disorders	1
Cancer support	Cancer	1
Childline	Young people	7
Citizens Advice Bureau	Legal & financial problems	1
Connexions	Young people	4
Cruse	Bereavement	1
Cura	Crisis pregnancy (Ireland)	1
D.A.R.E	Young people [Drugs, violence, gangs]	1
Depression alliance	Depression	2
Contact youth	Young people (USA)	1
Eighteen and under	Children, abuse & bullying	1
Focusline	Emotional support for mental health problems	1
Gay switchboard	Sexuality	1
Hand to hand	Poverty and injustice abroad	1
Harmless organisation	Self-harm	2
HARP	Homeless action resource project	1
Headway	Brain injury	1
Health in mind	Mental health	1
Helplines	Abuse, rape & violence	1
Homestart	Family support	1
Lifelink	Stress- part of North Glasgow Stress Centre	1
Maytree Centre	Suicide, crisis	1
MDF	Bipolar disorder	1
Mental Health Matters	USA based organisation	1
Mind	Mental health	8
Missing people	Runaways	1
National Perceptions Forum	For people who hear voices and other perceptions	1
National Self Harm Network	Self-harm	4
NERIL	Mental health support line working alongside statutory service in North Essex	1
Nightline	Students	1
NO PANIC	Panic, anxiety, phobias and OCD	1
npac	USA based support for nurses	1
OCD-UK	OCD	1

Papyrus	Prevention of young suicide	1
Penunbra	Supported accommodation for those with mental health problems	1
Postnatal helplines	Postnatal depression	1
Rape crisis	Rape	1
Recoveryourlife.com	Self-harm	2
Rethink	Severe mental health problems	1
SALT - Plymouth	Sexual abuse	1
SANDS	Bereavement	1
Saneline	Mental health	1
Shared Concern	Bullying	2
Suicide Hotline	Suicide	1
Sumithrayo	Suicide (Sri-Lanka)	1
Sure Start	Employment and education	1
Teenline	Teens helping teens	1
There4me	Young people (bullying, self-harm, abuse, drugs, exams)	2
Time2Talk	Young people (divorce)	1
To write love on her arms	Depression, addiction, self-injury and suicide	1
Victim support	Victims of crime	6
Voluntary carers association	Family carers (Ireland)	1
Womens Aid	Domestic violence	3
Youth2Youth	Young people	2
Other	Non-specified helpline	9
Statutory & Professional Services		
Access and liaison team		1
Ambulance		1
Counsellor / therapist		97
Crisis team		10
Complex needs service		1
Court		1
Deliberate self-harm team		1
Specialist doctor	e.g. Dietician, Gender clinic, Genito Urinary Clinic, Osteopath, Oncologist, Chiropractor	6
Drug rehab		1
Early Intervention team		1
Eating Disorders Service		2
GP		130
Health visitor		2
Home help team		1
Hospital		13
Nurse		3
Community mental health team/ CPN		86
Netdoc		1
NHS Direct		4
NHS Meriden Family Programme		1
Police		3

Psychiatrist/psychologist/ Psychotherapist		84
Probation service		1
Respite care		1
Social worker/ Social services		5
Support worker		2
Teacher/ school/ college		5
Alternative services		
Alternative therapist	Acupuncturist, Holistic healer, Hypnotherapist, Herbalist, Reflexologist, Shiatsu , Reiki	9
Church	e.g. Minister, Pastor, Priest, Church group	5
Friend or family member		7
Life coach		2
Occupational health	Workplace organisation	2
Yoga teacher		2

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