

Life Lines

Evaluation of mental health helplines



mental
health
foundation

Acknowledgements

Mental Health Helplines Partnership (**mhhp**) commissioned this project.

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Foreword

Mental Health Helplines Partnership (**mhhp**) is the membership body for organisations that provide helpline and related support for mental health and emotional wellbeing needs. Together, **mhhp** and its members work to improve accessibility, capacity and quality of services to offer better choice for users within a framework of sound governance. We welcome this research, which reflects the efforts of our members and the views of helpline workers, callers and professionals. Work of this nature has a crucial part to play in the continued development of mental health services.

Helplines have an important role supporting people with mental health and emotional needs, together with their carers, families, friends and the professionals treating them. Helplines complement the provision of mental health services, particularly when integrated within care plans. They are also accessible to individuals without a diagnosis and those who find it hard to engage with mainstream services.

This report evaluates the effectiveness of mental health helplines and how they are perceived by stakeholders, including helpline staff and volunteers, health professionals, and the people that call helplines.

Mental health helplines have a major role to play delivering the key objectives within the mental health strategy “No health without mental health”. They offer some of the most cost effective and accessible provision available by being contactable outside the operating hours of other services. This can reduce the impact on the statutory system, and provide people with choice and the means to contribute to and manage their own health and wellbeing.

It is important that the role of helplines is recognised within commissioning structures generally and that funding bodies, including emerging Clinical Commissioning Groups, acknowledge the need for them to be adequately resourced to maintain and expand their important work. In so doing reliance on other more costly services can be reduced. A particular priority is ensuring that callers in all geographic areas are able to benefit from out-of-hours support and that services providing specialist help on a national basis are recognised within the localised funding model.

Liz Felton
Chair, Mental Health Helplines Partnership

Background

There are many mental health helplines offering services for people who may experience mental health problems, their families, carers, and professionals. Some helplines offer general information or signposting, others provide support for specific issues, or work in affiliation with statutory mental health services. Mental health helplines usually aim to offer confidential or anonymous support, out-of-hours support, crisis resolution, or specialist advice.

This evaluation was commissioned by Mental Health Helplines Partnership (**mhhp**) with the aim to find out the effectiveness of mental health helpline services. **mhhp** is the umbrella body for telephone helplines offering services to people with mental health needs. It comprises about fifty mental health helpline providers, and aims to support and improve the quality of their member helplines.

Method

Four groups of stakeholders were selected for data collection:

- (a) Twenty-six staff¹ interviews were conducted with helpline workers and managerial staff of nine **mhhp** helplines.
- (b) A survey was sent out to 51 General Practitioners (GPs) via the National Opinion Poll Service to find out their views of helplines.
- (c) Twenty-three Community Mental Health Teams (CMHTs) took part and interviews were conducted with mental health nurses, community psychiatric nurses, team managers, intake workers, social workers, CMHT administrators and consultant psychiatrists.
- (d) A total of 139 callers were included in the evaluation; 63 respondents used **mhhp** helplines taking part in the evaluation, and 76 respondents used other helplines.

Results

Most helplines received in excess of 1000 calls per month, and the majority of calls lasted between 5–30 minutes. Helpline staff were highly motivated and felt that the helplines were of vital importance to the callers, and callers had benefited from being able to call a helpline. Staff generally believed that resources and capacity were the main pressing issues for helplines, as many calls could not be answered straight away, or individual calls needed to be limited to daily allowance. Managing callers' expectations about what the helpline is able to offer within its resources was highlighted as a key issue.

Most of the GPs surveyed (73%) were aware of mental health helplines, and over half felt helplines were a useful service and could prevent crises. However, concerns were expressed by some GPs about the evidence of the benefits of helplines and helpline staff expertise; a lack of awareness about such services amongst health professionals was also mentioned. Nevertheless, helplines were seen to have the potential to provide an additional tool for GPs, and to deliver a cost-effective means of support out-of-hours. In addition, over half of GPs would consider commissioning helplines in the future.

CMHTs viewed helplines' role as providing support for patients when other mental health services are not available, and offering help to someone in a crisis. They viewed helplines as complementary to secondary mental health services, as helplines could reduce the burden on those services. A large majority (87%) had recommended helplines to their patients, and received positive feedback (69%). Some CMHT members were using helplines themselves to access information for their patients; some felt that the usefulness of helplines depended on staff training.

1. 'Staff' is used throughout this report to denote paid staff and voluntary staff working for helplines.

Callers engaged with mental health helplines for a variety of reasons, and this depended on the type of service offered. A large proportion (60%) was currently receiving some sort of support for mental health (e.g. contact with a health professional), and 78% had a mental health diagnosis. The largest proportion of callers had called either once (39%), or over ten times (20%), suggesting that callers seek either one-off information, or else are likely to be regular callers. Callers appreciated that helplines were open out-of-hours, and were often confidential or anonymous. Many callers took further action following their call, such as talking to a health professional, or family and friends. The greatest proportion of callers contacted the helpline late at night (32%), or in the evening (22%), suggesting that the need for access to support often does not suit traditional working hours.

Almost all callers felt that the helpline had helped them; they felt listened to, and valued the safe space to talk. The majority of callers (79%) were satisfied or somewhat satisfied with the helplines' response, and most reported that helpline staff had understood or somewhat understood their concerns (81%). Some callers, however, noted that they would have preferred to speak to a worker with more expertise or experience. Nevertheless, the majority (69%) felt that contacting the helpline had enabled them or somewhat enabled them to cope better, and reported feeling supported, less anxious, less alone, better informed, and more in control.

About a third of callers had used additional services, such as email and texting, but the majority (66%) did not feel such services were useful to them. The most popular service was the phone service itself, followed by email and text.

Most callers were satisfied with helpline services and did not feel that they needed significant improvements. Nonetheless, callers wished helplines could operate more regularly, be open more days, and have longer opening hours. Callers would welcome helplines having greater capacity to minimise waiting times, as well as offering free phone numbers. Callers would also appreciate staff to provide specialist advice. Some felt that staff could be better trained, and helplines could provide better continuity in their service. Callers felt that more transparency about the purpose of individual helpline services would be helpful. Greater joined-up working within the mental health field, with better lines of communication between all types of services, was also recommended.

Conclusions

Participants in this evaluation were generally very positive about the services that mental health helplines provide. GPs and CMHTs saw the potential for helplines to play a role in supporting people with mental health problems, or people seeking information. Callers were very positive about helplines and their services, and especially appreciated that helplines operate out-of-hours, and many are anonymous and confidential. Most callers reported very positive outcomes as a result of calling a helpline. Contacting a health professional was the most commonly reported action after calling a helpline, suggesting that mental health helplines can be used for improving engagement with health professionals and provide specialist support.

A challenge for helplines was meeting the demand of callers. Managing callers' expectations about what the helpline is able to offer within its resources was an issue raised by helpline staff. However, most callers were satisfied with the outcome of their call.

Although there are resource implications, participants emphasised that helpline promotion was important, along with clear explanations of the services helplines provide. Health care professionals have to be aware of helplines in order to be able to promote them to their patients.

Helplines fill a niche within the mental health service provision, which does not appear to be filled elsewhere, but there are concerns that they may be used to replace regular mental health provision.

Helplines can form a part of an overall care package, and potentially reduce the use of more expensive services, but should not replace other services.

The evidence from this evaluation also suggests that mental health helplines are helping to meet some of the key objectives of the Government's mental health strategy (HM Government, 2011). For example, the finding that many callers found helplines as a strong source of support helps to meet the objective that more people with mental health problems will recover; being able to ring a helpline outside other services' normal working hours meets the objective that care and support, wherever it takes place, should offer access on a timely basis and help to give people choice and control; the benefits that people feel about being able to speak to someone in a confidential, safe and non-judgemental way meet the objective that fewer people will experience stigma and discrimination.

Recommendations

- In order to manage callers' expectations, helplines should promote their purpose with a clearer message of the services they provide.
- Apart from the promotion to the general public, helplines should increase awareness of their services among (a) primary care workers, including GPs, so that they can refer their patients to helplines; and (b) specialist mental health services staff, so that helplines could be integrated into overall mental health care.
- mhhp should consider issuing a regularly updated comprehensive guide to current mental health helplines.
- mhhp should establish minimum training requirements for helpline staff and volunteers, which would give health professionals more confidence in their expertise, and in turn could help secure future funding of helplines.
- Future funders of helplines, whether they are Local Authorities, NHS Trusts or Clinical Commissioning Groups, should take into account their contribution to individual and community wellbeing, and ensure they are available as part of the whole package of services offered to the public.
- Given the increasing economic and social burden of poor mental health, further research should be undertaken into the cost-effectiveness of mental health helplines services.

This study was commissioned by Mental Health Helplines Partnership (**mhhp**) to ascertain the effectiveness of mental health helplines. **mhhp** is the umbrella body for organisations offering helpline services to people with mental health needs. It includes about fifty mental health helpline providers nationally. **mhhp** aims to improve capacity, quality, choice, access and governance in the helpline sector for the benefit of callers. This report documents the findings from helpline staff², volunteers, callers, Community Mental Health Teams and GPs.

Originally, helplines were telephone services offering help to those that called; the most well-known examples include the Samaritans and Childline. Helplines were established as far back as the 1950s (in the case of the Samaritans) and grew in number and variety as the use of domestic telephones increased and major developments in telecommunications were made.

There are many mental health helplines for people who may experience mental illness, families, carers and professionals. Some helplines offer general services for anyone experiencing mental health difficulties, some offer support for specific issues such as anxiety or eating disorders, and some others are aimed at particular client groups (e.g. the gay community). Helplines may operate regionally or nationally, and may be run by charities, local authorities, membership organisations or NHS trusts.

Helplines vary in scope, some offer advice and information around particular issues; others provide listening services and act as a contact point for anyone who calls. As new technology has developed some

helplines have added multimedia components to their basic telephone service. These additional services may include text messaging, email or live web chat. The most common aims of mental health helplines are to provide the following:

- Confidential or anonymous support
- Out-of-hours support
- Crisis resolution
- Specialist advice

There is limited published literature on the effectiveness of mental health telephone helplines in the UK, therefore this report includes international literature where relevant.

Confidential or anonymous support

Anonymity and confidentiality make helplines accessible to those who might not otherwise seek help for their mental health problems. Most helplines offer a service that is confidential and give callers the option to remain anonymous. This confidentiality may be broken (if possible) during certain circumstances where there is risk of the caller self-harming or harming others. However, anonymous helplines cannot identify participants (unless the caller has volunteered this information earlier in the call), so breaking confidentiality is not always possible.

Anonymous and confidential services can offer callers a sense of security (Christogiorgos et al., 2010) and reduce callers' fears that they may be ridiculed or abused while they are in a vulnerable position (Rosenbaum and Calhoun, 1977). This is important when people are afraid or worried about seeking help and advice on difficult and sensitive issues. Having the option to remain anonymous can

2. 'Staff' is used throughout this report to denote paid staff and voluntary staff working for helplines.

reduce the psychological barriers that may prevent people from seeking help (Lazter and Gilat, 2005), and can make seeking help appear less threatening, as well as minimising the risk of the caller suffering from the stigma or loss of social status (real or perceived) that could result from accessing other mental health services (Rosenbaum and Calhoun, 1977).

Out-of-hours support

Traditional mental health services may have limited opening hours; helplines can operate outside of these boundaries. Some helplines offer support for people during the evening, some helplines offer 24-hour support. This can fill a void in the support available to those living with mental health problems, and can assist with loneliness, symptom management, and the process of recovery (Dalgin et al, 2011).

Users of one confidential telephone advice line and sign posting service for people experiencing low mood, depression or anxiety reported that they particularly appreciated being able to talk to someone when other services were not available (Sheehy et al, 2006).

Helplines can also support those with mental health problems in between psychiatric appointments. An evaluation of two helplines in the UK found them to be a valuable listening space providing emotional support especially out of office hours (Rethink, 2003). Regular callers reported that the helplines were providing support when they were feeling depressed or anxious, or at risk of self-harm.

A helpline set up within a hospital department in Singapore provided support for patients in-between outpatient appointments. The counselling focused on crisis intervention and problem solving, and was found to be useful in clarifying medical instructions, which can help increase patient compliance with treatment (Perera et al., 1998).

Crisis resolution

Crisis helplines aim to prevent harmful outcomes for callers by reducing their crisis and/or suicidal states and identifying coping strategies. Crisis helplines can provide financially and geographically accessible services (Gould and Kalafat, 2009). An urgent telephone consultation service for self-harm patients may result in reduced requirements for other health care services (Evans et al, 2000).

Research supports the association of stressful life events with suicide (Runeson, 1990; Brent et al. , 1993; Gould et al., 1996). Suicide is usually contemplated with psychological ambivalence; survivors of suicide attempts often report that the wish to die coexisted with wishes to be rescued and saved (Shaffer et al., 1988). This can result in a 'cry for help', which can be addressed by those with special training (Litman et al., 1965). Crisis services may provide relief to an individual who is in the 'final common pathway to suicide' by providing the opportunity for immediate support at these critical times (Shaffer et al., 1988).

An evaluation of telephone crisis services/helplines across eight centres found that suicidal individuals often reached out to telephone crisis services. Callers reported reductions in suicidal feelings during the course of the telephone session with continuing decreases in hopelessness and psychological pain in the following weeks (Kalafat et al. 2007b).

Callers themselves believe that helplines can help in prevention of self-harm and suicide (Rethink, 2003; Jianlin, 1995). After calling a helpline, callers have reported reductions in crisis states, feelings of hopelessness (Kalafat et al., 2007a), and feelings of isolation (Dalgin et al., 2011). In response to a hypothetical question "If someone you knew was suicidal, what you do first?", young people were more likely to call a suicide helpline than an emergency line, or go to an emergency room (Larkin et al., 2011).

In addition, a study of a telephone support and assessment intervention for elderly people at risk of suicide in Italy found significantly fewer suicides among elderly service users who used the telephone support (De Leo et al., 2002).

Specialist advice

Mental health helplines can increase contact of service users with other health professionals, support patients in-between psychiatric appointments and, in some cases, clarify issues regarding medication. Helplines can be effective in identifying mental illness and increasing psychiatric referral and treatment (Poschman et al., 2006). Across eight helpline centres, one third of callers who had been provided with mental health referrals had followed up with the referral within three weeks of the initial call (Kalafat et al., 2007a). For example, programmes that link psychiatric services with perinatal care can be effective in identifying women with psychiatric illness, increasing psychiatric referral and treatment, and decreasing maternal depressive symptoms.

Information provided by psychiatric medication helplines can result in changes to callers' treatment and increase contact with healthcare professionals (Olubanke et al., 2009). One study investigated the outcomes of information received by callers to a psychiatric medication helpline. Almost half of callers reported changes to their medication after consulting with the helpline, and over half contacted a mental health professional afterwards.

An evaluation of a Scottish confidential telephone advice line and signposting service for people experiencing low mood and depression reported mixed views about the advice, information and contacts that callers were given. However, the majority felt it had made a great difference to their lives (Sheehy et al., 2006). On the other hand, a study of a helpline for children struggling with emotional problems showed that children experienced a

reduced severity of their problems and a higher sense of wellbeing after consulting the telephone and online service (Fukkink and Hermanns, 2009).

Helpline staff

Different helpline worker behaviours and intervention characteristics have been shown to affect the outcomes of calls made to helplines. Expressing empathy and respect, and providing a supportive approach, good contact and collaborative problem solving were related to positive call outcomes in a study of fourteen different helplines (Mishara et al., 2007). A study of student helpline volunteers found that most volunteers display certain personality characteristics associated with good counselling skills, such as agreeableness and empathy, even before they received any training. It was noted that there was no evidence to suggest that individuals are motivated to volunteer by their own mental health difficulties (Vollm et al., 2009).

Furthermore, helpline staff members in the U.S. have been found to be accurate in their judgements of risk of suicide-related behaviour in youth (Karver et al. 2010). However, another study of several community telephone helpline services found very low levels of effectiveness on a series of measures, highlighting difficulties faced by helpline workers compared to those in conventional counselling situations (Page & Matheson, 1982).

This evaluation aims to explore how helplines work, and how they are perceived by stakeholders, including the staff and volunteers working at the helpline, professionals working in mental health or primary care who may refer to helplines or receive referrals from helplines, and the people that call the helplines.

Participants and method

mhhp approached helplines within their membership for help with the evaluation. Fourteen helplines expressed an interest and were referred to the Mental Health Foundation (the Foundation) research team. The evaluation team contacted these helplines to provide preliminary data on their services. Thirteen of the fourteen helplines provided data on their services. The majority of participating helplines used **mhhp**'s virtual call centre, a system which helpline services can connect to and track call statistics (i.e. total number of calls, call duration, number of calls connected, caller location etc.).

The evaluation team also consulted with Anxiety UK which had collected caller feedback to evaluate their helpline. Knowledge gleaned from this initial consultation and helpline preliminary data fed directly back into the development of the framework for how the research would be conducted.

A mixture of quantitative and qualitative methods was used. Of the potentially large number of stakeholders, four groups were selected for the evaluation: (1) helpline staff, (2) general practitioners (GPs), (3) community mental health teams (CMHTs), and (4) callers.

1. Helpline staff

Nine helplines agreed to continue participating in the evaluation: five provide a national service (Anxiety UK, Beat, CALM (Campaign Against Living Miserably), Mind infoline and Young Minds) and four provide a local service (Nightlink, City of York Mental Health Support Line, Brighter Futures and Mindline Somerset). The research team arranged staff and volunteer interviews for the consultation.

The consultation consisted of a screening survey conducted over the phone or in person with helpline staff about the role of the individual helplines, their aim and remit. Twenty-six staff interviews were carried out across all helplines. A mixture of helpline workers who operated on the line and management staff were sought for interviews.

2. GPs

We aimed to gauge GPs' views of helplines; their function, referral to helplines and reasons for referral. A survey was sent out using the National Opinion Poll World Health's 'GP Net' Service. A total of 51 GP responses were collected.

3. CMHTs

A database of CMHTs across the nine English regions was compiled (East Anglia, East Midlands, London, North East, North West, South East, South West, West Midlands, Yorkshire & Humberside). The database included 477 teams, though this was not exhaustive. A random sample of 40 was generated, with 5 CMHTs from each region. Teams were contacted by telephone. A total of 23 CMHTs participated. One member from each CMHT responded to a brief interview. Respondents represented varied roles within the teams, including mental health nurses, community psychiatric nurses, team managers, intake workers, social workers, CMHT administrators, and consultant psychiatrists.

4. Callers

Due to the nature of the services helplines provide, reaching callers was challenging; many called the helplines anonymously or were protected by confidentiality agreements. In order to reach the maximum number of callers, methods of data collection during this phase were informed by consultation with helpline staff. This process enabled the evaluation team to maximise the number of potential caller responses, without deterring them from future contact with their chosen helpline service. Following the consultation with helpline staff, callers could participate in the following ways:

- An online survey advertised by the Foundation, and promoted through participating helplines;
- Helpline staff discussing the evaluation with callers and referring them to the survey, or to the evaluation team;
- Paper versions of the survey sent by helplines to callers (for two helplines).

A total of 197 people responded to the evaluation invitation. Of these, 82% (n=162) had contacted a mental health helpline, 18% (n=35) had not used helpline services. The largest proportion responded via the online survey (87%, n=172); a further 11% (n=21) of respondents completed the postal survey, and 2% (n=4) of helpline callers were interviewed by telephone.

Of the 139 callers that specified the name of the helpline they had contacted, 63 responses related to helplines taking part in the **mhhp** evaluation (see Table 1 below for numbers per helpline). For the 76 respondents reporting from other

helplines, the most frequently reported helplines were the Samaritans (n=37), local crisis and out-of-hours helplines offered through Community Mental Health Teams (CHMTs; n=14), and SANE (n=9).

A small number of respondents did not use helpline services, they cited the following reasons; limited awareness of mental health helplines, not needing to, difficulty initiating contact due to being “too nervous to speak to someone on the phone” (C#189). Some expressed a reluctance to use helpline services due to the perceived stigma attached, and were “worried about how they might be perceived” (C#35).

Table 1: Numbers of callers responding to evaluation, by each participating helpline.

Name of helpline	Number of Responses	% of Responses
Helplines outside of mhhp membership	76	55%
Brighter Futures	17	12%
Mind infoline	12	9%
YoungMinds	9	6%
Anxiety UK	7	5%
CALM	5	4%
Mindline Somerset	5	4%
Beat	4	3%
City of York	3	2%
Nightlink	1	1%

1. Helpline characteristics

The tables below provide information on helpline characteristics, caller volume, call duration and repeat callers for each helpline. As Table 2 shows, five of the nine helplines provide a national service and four provide a local service. Nearly all operate within a charity framework, with the exception of the City of York Mental Health Support Line, Nightlink, and Brighter Futures. The City of York Mental Health Support Line is council owned, whilst Brighter Futures and Nightlink are both social enterprises. Two helplines outsource their helpline services to helpline service providers. Funding sources varied and included a larger charity, charitable trusts, local Primary Care Trusts (PCTs), Local Authority (LA), Department of Education, grant making bodies, or a combination. Four of the helplines operated Freephone lines, some operated local tariff rates, and some used non-geographical number such as 0844 or 0845, with variable rates.

The helplines differed in terms of the type of services they offer; three of the helplines provide a support or listening service, and three provide a support and information service. The remainder provide a combination of services, including: advice and support; listening, information and support; and advice and information. Four of the helplines said that callers' identities were anonymous, and two said that the caller identities were known (the City of York Mental Health Support Line operates a sharing policy with York Mental Health Services and staff are aware of callers' identities, feeding back information to a person's care team).

Helplines varied in terms of the target client group; three catered for specific groups (people with anxiety, men with suicidal feelings, eating disorders), four catered for callers with general mental health needs, one for support with emotional wellbeing, and another for parents of those affected by mental health problems. Most helplines promoted their services, only two did not, and one required a referral to use their service. Six of the helplines offered services in addition to the traditional telephone service. Typically this was email, though some of the helplines also offer Internet Messaging Services (IMS), Livechat, text, message boards, a call-back system or in one case a postal service.

Helplines had a mixed staffing structure; three helplines had only paid staff, whilst the remainder were staffed by both paid staff and volunteers. Eight helplines gave details of the training that staff receive; two provide in-house training, two offer a 2–3 day training course, one a two-week induction period, one a month of theory training in addition to four days practical training, one offers 1–2 months training, and one helpline offered 8 weeks of coaching.

To provide context to the information and results in Table 2, the following paragraphs outline the aims and staff structure of the helplines participating in the evaluation:

Anxiety UK is a national charity that provides relief and support to those living with anxiety disorders. It provides information, support and understanding through a range of self-help services which include a national helpline, access to talking therapies, a community of support, and, a peer mentoring service (in Manchester).

The Anxiety UK helpline is staffed by volunteers with personal experience of anxiety.

Beat is a national charity which provides helplines, online support and access to a network of nationwide self-help groups for adults and young people with eating disorders. Beat offers an adult helpline open to anyone who needs support and information relating to eating disorders, including sufferers, carers and professionals. A youth helpline is offered to anyone 25 or under and also provides a text service.

Brighter Futures is a social enterprise which provides support, housing and employment services to vulnerable individuals in the Staffordshire area. Brighter Futures provide a local helpline service offering emotional support for people who are concerned about their mental health, or the mental wellbeing of someone they know, as well as a weekend ring-out service to those who already use mental health services who may need regular, on-going support.

Campaign Against Living Miserably (CALM) is a national charity targeting young men in order to reduce the high suicide rate among those aged under 35. Though it is aimed at young men, it is available to anyone who needs help or support regardless of age, gender or geographic location. It offers a helpline service, magazine, and an online community. CALM offers two 'CALMzones' (London and Merseyside); areas where CALM works with local Primary Care Trusts to signpost young men in their area.

City of York Mental Health Support Line is a local helpline which covers the Selby and York Primary Care Trust area. It provides support and information to those 18 years or older who experience mental health problems. The helpline is also available to carers and supporters. The helpline is integrated within York mental health care services; callers are typically known to staff along with some of their medical history. The helpline uses a referral system and

a caller display system. Information is shared amongst professionals involved in callers' care.

Mind infoline is one of two confidential mental health information services the charity Mind provides. It is a national helpline that offers information on a range of topics including: mental distress, where to seek help, drug and alternative treatments, and advocacy. Staff have the ability to signpost callers to services in their local area, send printed information to individuals in unmarked envelopes, or direct callers to relevant online materials.

Mindline Somerset is part of Mind in Taunton and West Somerset. It is a local helpline which operates in the evenings from 8pm–midnight Wednesday, Friday, Saturday and Sunday. It is a listening and support service for anyone who is experiencing emotional distress. Mindline Somerset operates a system whereby callers contacting the service outside of operating hours can be transferred to Mind infoline, Working Advocacy in North Devon (WAND), or the Samaritans.

Nightlink is a local helpline and text service offering support to those aged over 18 in Cornwall and the Isles of Scilly. Nightline provides a telephone listening service, emotional support and personal empowerment to those in emotional distress. The helpline also provides for those supporting people in emotional distress.

YoungMinds is a national charity which aims to improve the emotional wellbeing and mental health of children and young people. It provides a free parents' helpline available to parents and carers who are concerned about the emotional or behavioural problems of a child or young person up to the age of 25. The telephone service is also supported by a specialist 'call-back' service, email and online support. Callers referred for call-back are contacted by a mental health professional for practical advice and guidance.

Table 2: comparison of helpline characteristics

Helpline type	Anxiety UK	Beat	Brighter Futures	Campaign Against Living Miserably (CALM)	City of York Council Mental Health Support Line	Mind infoline	Mindline Somerset	Nightlink	YoungMinds
Area remit	National	National	Local	National	Local	National	Local	Local	National
Clients targeted	People with anxiety	People affected by eating disorders	People affected by emotional wellbeing	Men with suicidal feelings	Over 18s, mental health need	Legal advice (mental health)	Mental health need	Mental health need	Parents of children with mental health needs
Opening hours	9.30-17.30 (Mon-Fri)	Adults: 10:30-20:30 (M-F), 13:00-16:40 (Sat) Youth: 16:30-20:30 (M-F), 13:00-16:30 (Sat)	19:00-02:00 (M-F), 14:00-02:00 (S, Su)	17:00-00:00 (Sat-Tue)	24 hour, 7 days	09:00-18:00 (M-F)	20:00-00:00 (Wed, Fri-Sun)	17:00-00:00, 7 days	09:30-16:00 (Mon-Fri)
Call tariff	0844	Mainly 0845	Freephone	Freephone	Local rate	Local rate	Local rate	Freephone	Freephone
Promoted	Yes, actively	Yes, targeted	Yes, dedicated post	Yes, targeted	Yes, without number (referral only)	Not actively	Yes, targeted	Not actively	Yes, targeted
Number of staff	1	5	5 FT equivalent	7	8	4	Not known	5	5

Number of volunteers	20	26	N/A	0	0	0	20	13	15
Funding stream	Anxiety UK: memberships, service-user activities, fundraising activities	Grant making bodies, PCT	PCTs and Local Authorities	Charitable Trust	Council	Local Authority	Local PCT	Department of Education, Charitable Trust	
Type of organisation	Charity	Charity	Social Enterprise	Charity	Council owned	Charity	Social enterprise	Charity	
Caller identification	Anonymous	Anonymous	Confidential*	Anonymous	Known	Confidential	Anonymous	Anonymous	Confidential*
Additional services	Instant Messaging Service, Livechat, email, text	E-mail, message board, live chat, text, call back	E-mail	None	None	E-mail, postal service	Texts	Email	
Office based / home based	Office	Office and home based		Home	Office	Office	Home	Office	
Staff training	2-3 day training course	In-house, induction, 8 weeks training, mentoring	8 weeks coaching, in support work, City & Guilds Level 2 Certificate for Mental Health Helpline Workers		2 week induction	1-2 months	In-house 3 self study modules, 2 days group training, ongoing 'online' training for 6 months	1 month theory, 4 days practical	
Languages	English/ Language Line	Language line		Language Line	English/ Language Line	Translation service offered		Language Line	

*Helpline staff ask for some personal details from callers, either to provide a call back service, send information through the post or refer back to care team involved

Table 3 shows the average number of calls to each helpline per month. Each helpline receives a large volume of calls monthly, with most receiving over 1000 calls per month. In the case of Mind infoline, this number exceeds 3000 calls per month. Just over half of calls to the helpline appear to be connected to helpline staff. Brighter Futures, however, reports the highest number of calls connected to helpline workers, with 74% of calls connected.

Table 3: Comparison of helpline call statistics

	Anxiety UK	Campaign Against Living Miserably (CALM)	City of York Mental Health Line	Nightlink	Mindline Somerset	Young Minds	Beat	Brighter Futures	Mind infoline
Number of calls to helpline (Average per month)	1129	1916	1350	1165	395	582	1190	1564	3489
Number of calls connected to helpline (Average per month)	650	821	795	580	152	-	619	1163	2117
% calls connected to helpline	58%	43%	59%	50%	41%	-	52%	74%	61%

Table 4 shows that the largest numbers of calls last less than five minutes. This could be expected, as a large proportion of these calls may not be connected to helpline workers. Some callers, inevitably, will be unable to connect to helpline staff immediately (due to high demand for services, etc.) and will instead receive a busy signal, or else an answerphone message detailing the subsequent action they should take. Connected calls typically last between 5–30 minutes; some helplines impose a time restriction in order to regulate the service and meet caller demand. Stricter time limits are in place for helplines that offer an information or advice type service where the aim of the helpline is to signpost callers to other services (Mind infoline, YoungMinds). Only a very small proportion of calls exceed 30 minutes in duration, and even fewer an hour or more.

Table 4: Call duration for each helpline

	Anxiety UK* Jan-June 2011 (n=6772)	CALM 1 June- 19 July 2011 (n=3075)	Nightlink* Jan-June 2011 (n=6768)	Mindline Somerset* 1 Aug- 22 Dec 2010 (n=1822)	Beat* March 2010- March 2011 (n=14282)	Brighter Futures Jan-June 2011 (n=6606)	Mind infoline Jan-June 2011 (n=7296)
<5 mins	67%	80%	63%	69%	0.2%	40%	63%
5–10 mins	14%	8%	6%	5%	11%		33%
10–20 mins	13%	5%	17%	9%	14%	26%	5–15 mins
20–30 mins	4%	3%	13%	6%	5%	33%	1% 15–30 mins
30–60 mins	2%	3%	0.1%	11%	3%	1%	0.01%
>1 hour	0.1%	1%	–	0.5%	0.2%	–	

*Please note, percentages may not add up to 100% due to rounding

Table 5 illustrates that the proportion of repeat callers for each helpline varies according to helpline type, with those offering information and advice services (such as YoungMinds, Beat, Anxiety UK) least likely to receive significant numbers of repeat calls. Helplines offering support and listening services that are affiliated with local statutory services (such as Brighter Futures) received the highest number of repeat callers, as could be expected, with individual callers' details already known to the helpline service.

Table 5: Proportion of repeat callers by helpline

	Anxiety UK Jan-June 2011 No. of callers (n=2746)	CALM 1 June- 19 July 2011 (n=461)	Nightlink* Jan-June 2011 (n=196)	YoungMinds January-June 2011	Beat March 2010- March 2011 (n=6013)	Brighter Futures Jan-June 2011 (record new callers only)
% new callers	69%	63%	50%	99%	72%	6%
% repeat callers	31%	37%	50%	0.5%	28%	94%
Highest volume caller over specified time period	309 times	844 times	447 times	-	178 times	-

Some data were collected on peak call times. Five helplines submitted information on call volume by time of day. These data show no consistent patterns across the helplines; Anxiety UK and YoungMinds show an even spread across their opening hours, with a slight peak in the morning. The City of York line peaks in late morning and early evening, with a decreased caller volume over the middle of the day. The two evening helplines that provided data (Mindline Somerset and Nightlink) show high call volume between 8:00pm and 11:00pm; Nightlink is open from 5:00pm but has significantly fewer callers until 8:00pm compared to later hours.

2. Views of helpline staff

Helpline staff reported that callers can feel worried, anxious or distressed at the beginning of the call, and that new callers may seem apprehensive. Nearly all staff said that they felt callers had benefited from calling the helpline by the end of the call. The callers were said to feel more comfortable, reassured, less isolated and less lonely. One staff member noted the problems of call interruption; ending a call upon using daily time allowance. For most helplines, callers have a limit for how long they can be on the line each day. However, if a caller phones in a crisis the helpline staff do not simply terminate the call when they exceed the maximum call duration. One staff member also mentioned that callers may release feelings that were hitherto concealed, so managing expectations from the outset was necessary, including the possible limitations of call duration.

Helpline staff and volunteers' motivations vary. Most reported wanting to help other people. A significant proportion of volunteers wanted to gain experience, usually in psychology or social care related subjects. Some volunteers had used helplines in the past and wanted to contribute to something that has helped them. Most of the volunteers

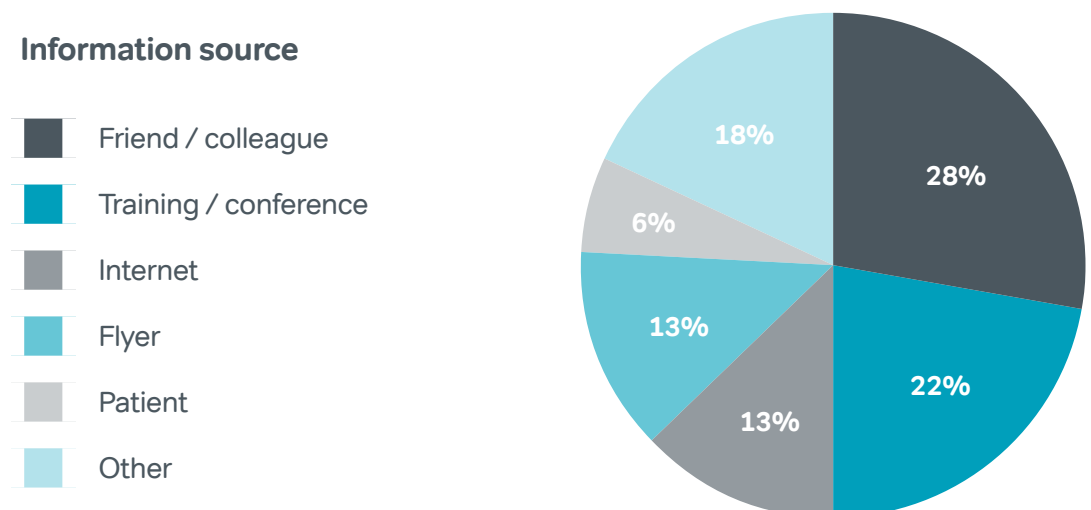
reported having experience of volunteering in other places, for example, other charities.

3. Views of GPs

Of the 51 GPs who responded to the survey, 73% (n=37) reported that they were aware of mental health helplines. When asked which mental health helplines they were aware of, the most frequently reported were those provided by national charities, such as the Samaritans (n=26), or Mind (n=17). Local statutory services were also named by GPs, including a number of local crisis intervention teams and NHS mental health trusts (n=7). In addition to those offering mental health support and advice, a number of more specialist helplines were named. These included helplines offering support specifically related to alcohol and addiction (n=5), bereavement (n=4), domestic violence (n=1), dementia (n=1), as well as those providing services for children and young people (n=5).

Figure 1 shows how GPs become aware of helpline services, listing a variety of sources. The most common way was through a friend or colleague, although many also found out through training or conferences. Significantly fewer GPs found out about them through their patients.

Figure 1. How GPs find out about helpline services



Fewer than half (43%) of GPs responding to the survey reported advertising mental health helpline services in their practice, in the form of posters or leaflets. Of those GPs who responded that they were aware of mental health helplines, 54% advertised mental health helpline services in their GP practice. When asked about the usefulness of mental health helplines, just over half (55%) of GPs responded that they felt helplines were a useful service, 39% (n=20) of GPs felt that helplines may be a useful service, and 6% (n=3) were unsure.

Overall, 59% (n=30) of GPs had recommended helpline services to a patient (76% of those GPs who were aware of helpline services). For those GPs who had not recommended mental health helpline services to patients, the majority of GPs answered that this was due to a lack of awareness (n=9), or lack of information regarding such services (n=5).

When asked if any of their patients use mental health helplines, only 37% (n=19) of GPs were aware of their patients using these services; the majority (53%) did not know the answer, with 10% of GPs answering no. For those who were aware of their patients using mental health helplines, 79% reported that they had received positive feedback regarding these services, 10.5% had received negative feedback, and a further 10.5% of GPs had received mixed feedback on helpline services.

Mental health helplines were seen to provide an 'additional tool' for GPs lacking resources, and could help reduce workloads in primary care. Mental health helplines were also considered to provide a cost-effective means of support, reducing the cost of referrals. Some GPs thought that helplines provided support and reassurance during hours when other mental health services may not be available.

“I find them useful – for several reasons – encouraging self-reliance in my patients, share the load

of listening, give an additional resource when time is limited. Mainly I find they save me time.” (GP#13)

“They are a very useful resource, especially for out-of-hour’s care, when routine mental health services are not available. It gives the patient someone to speak to when otherwise they would be on their own, and often this is the most difficult time for them. It can help avert crises.” (GP#90)

“They provide anonymous help at a time that is immediate (i.e. day or night) and experience of the operator.” (GP#102)

Mental health helplines were seen to enhance patient autonomy, providing a flexible and accessible information and support service that could be accessed from the patient’s own home.

“Offers an option to those with agoraphobia or those in full-time work.” (GP#108)

“Ease of contact for patients when they are distressed or need a good source of support and signposting. Patients don’t feel alone and stigmatised with mental illness.” (GP#109)

“May help reduce GP/out-of-hours/casualty department attendance. Enable self-care and improve patient care.” (GP#42)

However, concerns were expressed by some GPs about the effectiveness of mental health helplines. GPs commented that they would need to see further evidence of the benefits of helplines. Some commented that helpline staff may not have the necessary expertise.

“If there was evidence they were cost-effective and delivered better health outcomes.” (GP#50)

“There is a place for them so long as they do not turn into a redirect service as many people consider NHS Direct to be.” (GP#14)

“They must be manned at all times with people that are qualified in the mental health field. Helplines must give patients enough time to explain their problems.” (GP#37)

In relation to commissioning helpline services, 55% (n=28) of GPs reported that they may consider commissioning them in the future, with 35% (n=18) reporting that they would commission. Only 10% (n=5) said they would not commission them in the future, but a number of these GPs highlighted their location as a factor in this decision (with those practicing in Scotland unable to commission healthcare services). The majority felt that mental health helpline services were useful to patients. Some felt that there would be an increased need for such services in the future:

“More need may arise due to economic and health effects of recession and worklessness.” (GP#36)

4. Views of workers of Community Mental Health Teams (CMHTs)

All respondents had some awareness of mental health helpline services, and most were familiar with the Samaritans (16/23). Some CMHTs were acquainted with their area’s local mental health helpline services including their own crisis lines (13/23). CMHTs learned about mental health helplines through work (33%), the internet (21%), or flyers (9%), ‘other’ sources (33%) included direct experience of using services, information from the TV, or partnerships with other charities that run helpline services.

CMHTs recognised helplines’ role in providing support for patients when services cannot. They acknowledged that listening services improve wellbeing for someone in a crisis. They viewed helplines as complementary to secondary mental health services, and could reduce the burden on staff in mental health services.

More than half (16/23) of CMHTs reported they advertised or promoted mental health helplines. Many said they displayed leaflets or posters in their reception area, as well as providing crisis cards with helpline numbers on them.

When asked about the usefulness of mental health helplines, nearly all (21/23) CMHTs felt they were a useful service. Most staff from CMHTs (n=20; 87%) had recommended mental health helplines to their patients. One CMHT stated they put helpline numbers on patients’ contingency plans. They also felt that helplines were a source of out-of-hours help, or for those who struggle with face-to-face services. Some CMHT members described using helplines themselves for accessing general information for their patients. Two felt that the usefulness of helplines depended on staff training and qualifications. One team manager believed if a patient was receiving CMHT care they had no need for a helpline service.

When asked if any of their patients use mental health helplines, 65% (15/23) of CMHTs said their patients did use such services, 30% of teams did not know. For those teams aware of patients using mental health helplines, 69% (11/16) said patients’ feedback was positive, only one CMHT reported negative patient feedback with regards to difficulties with helpline accessibility. Three CMHTs (19%) said patients gave mixed feedback about helpline services, stating while they believed helplines were a good thing, they were not able to provide the help they needed or there was not enough time given for the call.

5. Views of callers

The majority of callers that specified the name of a helpline (n=129) had contacted a national helpline (61%, n=79); the remainder had contacted a local helpline (39%, n=50).

The majority (70%, n=113) of the 162 respondents to the survey (that had contacted a mental health helpline) disclosed their gender. The majority were female (90%, n=102). This did however vary across helplines. CALM, for example, explicitly targets male callers, though it does accept calls from anyone who is experiencing emotional and mental distress, including a rising number of female callers. One hundred and eleven of the 162 helpline callers that had contacted a mental health helpline disclosed their ethnicity, the majority were White British (79%, n=88), or White European (12%, n=13). One hundred and thirteen callers disclosed their age, figure 2 shows that the greatest number of callers were aged between 30-59 years (75%, n=84).

One hundred and twenty callers answered the question as to whether they had a mental health diagnosis. Over three quarters of respondents had received a mental health diagnosis (78%, n=94), 17% (n=20)

had not received a diagnosis, and the remainder (n=6) were unsure. Of respondents with a mental health diagnosis, the most frequently cited were depression (n=39), anxiety (n=18), personality disorder (n=18), post-traumatic stress disorder (n=10), eating disorder (n=10) and bipolar disorder (n=9). Other diagnoses included generalized anxiety disorder (n=7), dissociative disorder (n=3), obsessive compulsive disorder (n=2), social anxiety disorder (n=2), post-natal depression (n=2), seasonal affective disorder (n=1), psychotic depression (n=1), agoraphobia (n=1), body dysmorphic disorder (n=1), gender identity disorder (n=1) and schizophrenia (n=1).

Of those callers that answered the question regarding mental health support (n=121), over half (60%, n=72) were currently receiving support for their mental health. Health professionals were the most frequently reported source of support, including a consultant psychiatrist (n=18), GP (n=15) or a community psychiatric nurse (CPN; n=13). Others reported that they were receiving some kind of talking therapy (n=19), taking medication (n=11), or receiving support from their CMHT (n=10). A smaller number of callers reported that they were

Figure 2: Age of helpline callers

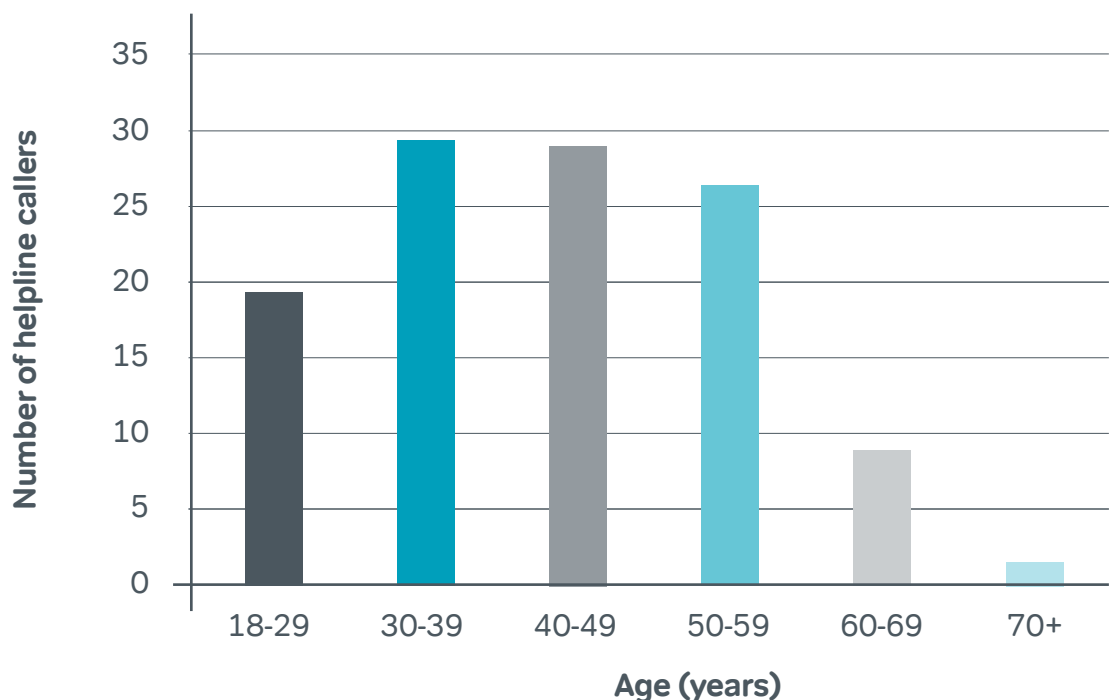
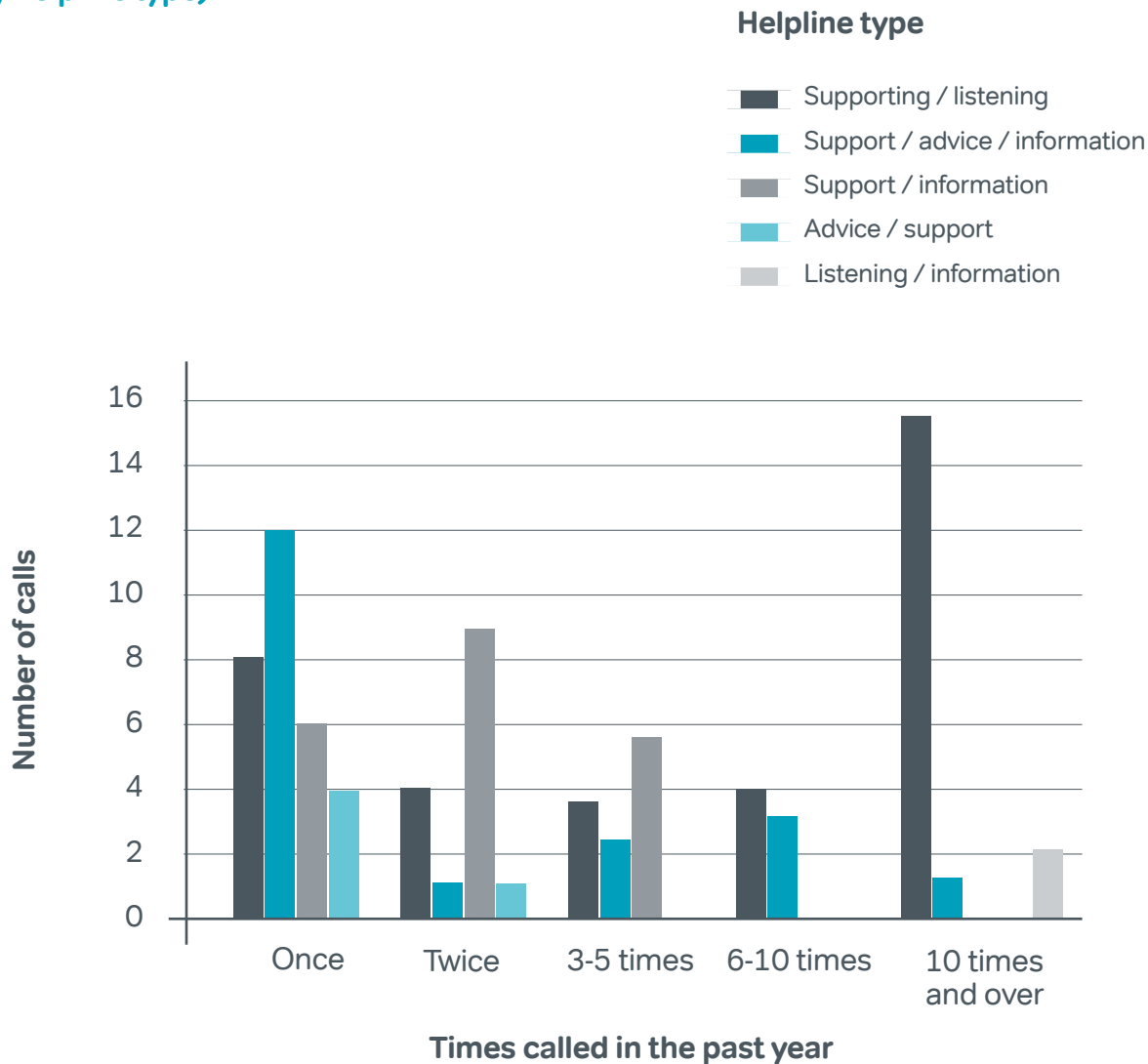


Figure 3: Number of times callers called the helpline in the past year (by helpline type)



seeing a support worker (n=6), were supported by friends and family (n=5), seeing a psychologist (n=5), receiving support from voluntary services (n=3), attending a mental health resource centre (n=3), attending day care services (n=3), seeing a social worker (n=3), care coordinator (n=2), occupational therapist (n=2), crisis team (n=2) or called a helpline (n=2). Two callers to the Brighter Futures helpline were either living in Brighter Futures supported accommodation, or accessing the project Safer Space Network (a weekend safe space for those in crisis or distress). The remainder (1 for each) reported the following types of support: mental health officer, alternative therapies, peer support worker, CAMHS (Child and Adolescent Mental Health Services), early intervention team, art group.

Of the 136 respondents who specified how they heard about helplines, the

greatest proportion said though the internet (35%, n=48), a health professional (24%, n=33), through the helpline’s promotional materials (19%, n=26), or word of mouth (10%, n=14). A further 11% (n=15) of callers specified other sources; these included other helplines and the workplace.

Callers to helplines were most likely to be calling on their own behalf, with 86% (n=119) of the 138 responses to this question indicating such. The remainder reported calling on behalf of a friend or family member (12%, n=16), or for information for work purposes (2%, n=3).

When asked the number of times they had called the helpline over the past year, the largest proportion of callers had called either once (39%, n=41), or over ten times (20%, n=21); suggesting that callers were most likely to be calling for one-off

information, or else they were likely to be regular callers. The number of repeat calls varies according to type of service provided by the helpline, as seen in Figure 3 below. Those calling a support/listening helpline were likely to ring more than ten times (n=15), or just once (n=8) which indicates that people either fall into two categories, one off callers or regular callers. Callers who used helplines offering support/advice/information (n=19) were likely to call less often, with the largest proportion (n=12) calling once.

When callers were asked if they had called other helplines in the past year, the majority had not (70%, n=89). Only 30% (n=38) of callers reported calling an additional helpline(s) in the past year, with the largest number calling the Samaritans (n=20).

One hundred and sixteen callers reported the time of day at which they were most likely to call. There were differences between the time of day (e.g. mornings, afternoons, evening, late at night or any time of day). The greatest proportion of callers rang late at night (32%, n=37) or in the evening (22%, n=25). Twenty-nine callers (25%) reported that they would call the helpline 'any time of day', with slightly fewer likely to call in the mornings (9%, n=10), or afternoons (13%, n=15). Responses were, however, doubtless influenced by helplines' operating hours. The majority of callers (72% of 80) surveyed did not call the helpline during particular times of the year, but callers who did phone during

particular times of the year cited anniversaries, holidays and specific seasons (autumn and winter) of the year as reasons for needing to phone more than usual.

Callers were asked to recall the first time they called their helpline service; the largest proportion, almost a quarter (23%), said that they first rang the helpline over five years ago, 22% said they called between 3–5 years ago and 14% said they phoned for the first time within the past 6 months (from February 2012).

Access to helplines

Of those responding regarding access to helpline services (n=101), most callers reported that helpline services were accessible; 64% (n=65) of callers said that they would get through to a helpline representative straightaway. A further 27% (n=27) reported that they did not get through straightaway, and were instead directed to an answerphone message, or received a busy signal (9%, n=9). Average caller reported waiting times are given in Table 6.

Most callers would call again if they did not get through (58%, n=66). When asked how many calls they had to make before they got through to a helpline worker, 89 callers responded. The majority reported that they would connect to a helpline worker on their first (62%, n=55) or second attempt (20%, n=18). Smaller numbers reported that they had to call between 3–5 times (11%, n=10) or 5 times or more (7%, n=6) before they got through.

Table 6: Time taken for call to be answered by a helpline worker

Time to answer call	Frequency	%
1–2 minutes	34	48%
2–5 minutes	21	30%
5–10 minutes	6	9%
10 minutes or more	10	14%

Answerphone messages deterred some callers from the service, though others found it easier to leave an answerphone message and have a preferred worker call back. One of the helplines, Brighter Futures, operates a call-back service which several callers use. It allows callers to request staff to phone them back at a specific time or day, or to receive a call at a pre-arranged time each week.

“Sometimes I get through straightaway but I don’t like answer machines so I’ll either try again later or not bother.” (Caller 9)

“The line was busy in the morning, so I called back at lunchtime and got through.” (Caller 20)

“I find it difficult if I have decided to phone and then find that I cannot get through.”(Caller 15)

“I have difficulty phoning out. I leave a message on the answerphone when I know no-one will answer, asking for a female to telephone me back, usually around 1.00am in the morning.” (Caller 3)

“I don’t phone them much because I find it difficult, so to help me, it has been arranged for them to phone me to check that I’m ok...” (Caller 99)

“They call me at pre-arranged times at weekends.” (Caller 196)

Only a small number of respondents (13%, n=15) said they would call another helpline if they could not get through to their preferred helpline, with the Samaritans being the most common choice:

“If I don’t get someone I like speaking with, I may call Samaritans or Rethink Focusline.” (Caller 42)

Vulnerable callers struggling with emotional and mental health needs felt that helplines were available to them when they were needed. Callers were reassured by the fact that some helplines operate under a policy of confidentiality or anonymity, which may otherwise have acted as a deterrent to contacting services.

“...suffering depression in the middle of the night when NHS help not available.” (Caller28)

“suicidal thoughts/wanted someone to try and sense to in the middle of the night when no-one else was around. Because I didn’t want to go to A&E to be shouted at, because I had no-one else to turn to. Because I thought that they might be able shed some light on my situation and suggest something the GP may have missed or didn’t know about.” (Caller128)

“I have no-one to talk to about how I’m feeling after hours when my social worker or support worker have gone home.” (Caller 9)

It is evident from the responses of many callers that the Government’s public sector cuts have left an impact on their lives, particularly with regards to access to services. The disappearance of some services has meant that, for those that still exist there is a greater demand placed on them with less resource. Vulnerable callers struggling with emotional and mental health needs felt that helplines were largely available to them when they needed it and that they were a strong source of support.

“Gives me a support that I would not otherwise have access to. I do not talk to family and friends about these issues...” (Caller 24)

“...It also makes you realise that help is available but that the government help structure in place is far too little, far too late. My son was told that there was a 3 month waiting list to see a counsellor; he saw the same consultant privately next day at a cost to me of £200 for a 20 min session!! I paid for many sessions, doing without things my family desperately needed...” (Caller 161)

“It doesn’t cost me anything to talk and be heard, unlike paying for a counselling service (I know helplines aren’t always offering a counselling service). I don’t have to phone every week or even ever

again if I don't want to; I feel more in control.” (Caller 131)

“It's a lifeline to support outside normal hours.” (Caller 11)

Reasons for calling

Callers engaged with member helplines for a variety of reasons, and this depended on the type of service the helpline offered. Some helplines gave information to callers about services, for example, where they could go to get help with mental health needs, or learn about prescription medications. Callers may feel more comfortable to discuss medication with helpline staff than with GPs or psychiatrists. One caller to Mind infoline said they rang because they were having trouble speaking with their GP. A few callers were also looking for more information about their legal rights as someone with a diagnosed mental illness. Callers to YoungMinds or Beat may ring seeking parenting guidance for their child's mental health needs.

“I wanted to find some information regarding medication I'd been prescribed by my psychiatrist for anxiety.” (Caller 139)

“Wanted to know about mental health services in my area.” (Caller 127)

“I called the helpline to ask for advice as to what my legal rights were in relation to disclosure of my mental health illness in a new job.” (Caller 92)

“I wanted to know what I could do to help and support my son, unfortunately I was told by every medical person that unless he was suicidal they couldn't MAKE him get help.” (Caller 161)

“How to help my daughter with a suspected eating disorder.” (Caller 197)

For member helplines providing listening services and emotional support, the level of support needed ranged from calling for 'a chat', wanting to feel listened to or understood, being isolated, and

needing extensive support for mental illnesses. Several callers to Brighter Futures sought support related to the burden of caring for family members with mental health problems.

“[I ring the helpline] just to chat and talk about what happened during the day.” (Caller 21)

“Just felt down wanted someone to talk to.” (Caller 162)

“Gives me the chance to talk to someone when I need to 'get things off my chest', get some information, and feel listened to...” (Caller 5)

“I wanted someone to talk to because I was depressed and suicidal.” (Caller 53)

“For support. Someone to talk to who understands my mental health problems.” (Caller 3)

“For support in dealing with my son who has mental health issues, self-harmed and made suicide attempts.” (Caller 5)

The majority of callers of other helplines (such as the Samaritans, SANE and local lines referred to by CMHTs) phoned because they were experiencing suicidal thoughts. Many reported feeling overwhelmed, distressed and unable to cope with life. Callers to the Samaritans described staff as providing a listening ear when they felt there was nobody else that they could talk to.

“I was feeling very low in mood, isolated, desperately wanting some help, yet didn't know what to ask for.” (Caller 151)

“I was feeling really low and upset and didn't feel that I could speak to anyone close to me.” (Caller 194)

“I wanted to kill myself and I just needed to talk to somebody about how badly I felt.” (Caller 61)

Experiences with calls

The majority callers were satisfied with the helpline's response, with 60% (n=69) being satisfied and 19%

(n=22) somewhat satisfied; only 22% (n=25) not being satisfied. Most felt that staff listened to their concerns (65%, n=75), only 16% (n=19) reported that they did not feel listened to. Most callers reported that helpline staff had understood their concerns (53%, n=62), 28% (n=32) felt that staff had 'somewhat' understood their concerns, but 19% (n=22) felt that staff had not fully understood. Of the 116 callers who responded to the question regarding adequacy of information and advice that they received, just over half (56%, n=65) felt that it met their expectations. Some callers specified that they would have preferred to speak to a worker with more expertise or experience.

“I usually feel real empathy, more than when I’ve had counselling.”(Caller 53)

“Reassurance. It gives me another way of thinking about my situation. Reminds me that I am in recovery and that the feelings are normal.” (Caller 170)

“The people there do a really good job and the most important thing is they are human and were prepared to listen even when I didn’t know what to say.” (Caller 53)

“I have never had such thorough information and advice or felt so assured and given that this is the single most important thing I have ever called a helpline about that is really saying something.” (Caller 109)

“Gives ideas and other places to go for help that you may not know or have thought of...” (Caller 20)

“I didn’t feel that understanding was the main part of the intervention, I felt the fact that he was actually listening to me was helpful.” (Caller 194)

“The person on the other end of the line didn’t seem to be knowledgeable about severe mental health issues and didn’t know anything about prescribed medications. I got the impression

he/she had no medical training whatsoever and wasn’t a trained counsellor with psychiatric expertise.” (Caller 139)

“I was given the phone number for something that didn’t exist anymore and went round in circles.” (Caller 79)

Outcomes of calls

Before calling a helpline, callers described feeling a range of negative emotions such as anxiety, anger, fear, desperation, depression or frustration. A quarter of callers (25% of 106) felt either anxiety or panic. When callers were asked about how the helpline helped them, almost all responded with positive comments. Callers felt that helplines offered a safe place to talk about their problems and, more importantly, that helpline workers listened to their problems. Many callers expressed appreciation for the non-judgemental manner of many helplines.

“Gives people a life-line and lets them know that they are not alone.” (Caller 161)

“I know it’s there everyday and that reassures me even if I don’t have to call them.” (Caller 10)

“I live by wearing a mask for my family, especially my 18 year old daughter. During my phone call I can let down barriers and discuss how I really feel and can be honest.” (Caller 12)

“Breaks my isolation and distress that I do not feel I can openly share with people I have a relationship with.” (Caller 186)

“I felt heard and understood, my distress validated by someone agreeing that my experiences were very difficult.” (Caller 146)

A total of 114 callers responded to the question regarding the ability to cope with issues following contact with a helpline. Just under half of respondents (44%, n=50) felt that contacting the helpline had enabled them to cope better with the issues raised. A smaller proportion (25%, n=29) reported that the helpline

had 'somewhat' enabled them to cope better, whilst 31% (n=35) felt that contacting the helpline had not helped them in this respect. Callers reported feeling 'calmer', 'uplifted', 'relaxed', 'supported' and 'less alone'. A few callers felt they were 'better informed' or had gained more knowledge as a result of calling the helpline. Callers also expressed feeling 'more in control' and having a better ability to 'focus'. Several expressed feeling 'relief' that there was someone on the other end of the line who was listening. Many felt that calling a helpline service enabled them to cope better with isolation, particularly when distressed.

"Helps enormously talking to someone, when you're struggling, feel so alone, in the blackest of places. Just an excellent service." (Caller 3)

"I know it's kept me alive." (Caller 18)

"1. Supports me. 2. Very understanding. 3. Help to reduce my anxiety/stress. 4. Gives me time to offload, talk about my difficulties, without being judged...I would be lost without this service.." (Caller 3)

"They reassure me. Never criticise, always helpful. They make me feel I am the only one they have spoken to. [I] never feel rushed, gives me hope." (Caller 13)

"It enables me to call at a time that suits me and to talk to someone in confidence. I know I am never likely to meet that person or maybe never speak to them again. It enables me to offload anxiety or discuss worries with someone who is non-judgemental and may be able to offer a different perspective." (Caller 131)

"Empathy, dignity, respect – because most of the staff who work on the phones have either personal or other experience of what I am experiencing. Basically they treat me like a valued human being." (Caller 25)

Callers also said that helplines were able to give them advice and

information and helped them to figure out what services were available to them. Callers also felt helplines provided a different perspective on a situation that they themselves had not realised.

"Reassurance. Gives me another way of thinking about my situation. Reminds me that I am in recovery and that the feelings are normal." (Caller 170)

"Gives information directly linked to problem and (I) can ask questions to clarify." (Caller 29)

"Gives ideas and other places to go for help that you may not know or have thought of..." (Caller 20)

One caller from Brighter Futures felt the helpline filled a gap in service provision which overlooked carers of individuals with mental illness.

"Let's me know there [are] some people out there trying to help carers of mentally ill people, which can be an exhausting task." (Caller 7)

A few callers, however, felt less optimistic after calling the helpline. Several reported feeling 'frustrated' at the end of a call. Some described a range of negative emotions such as feeling 'exhausted', 'worthless,' 'suicidal,' 'anxious':

"I get the feeling of dread because after the call I am back on my own. I do get frightened." (Caller 3)

When asked about whether they took further action following calling the helpline; 52 callers said that they had spoken to a health professional, 27 had spoken to family and friends. Smaller numbers took up therapy (n=21), made lifestyle changes (14), or took no action (n=21). Some further comments are shown below:

"I advised the school of the true problem which I had not before, bought a few self-help books for self and daughter." (Caller 169)

"Referred to books, signed up to the Beat message boards, and got more information from the site." (Caller 197)

“Wrote a concise report to share with Adult Social Workers and other professionals to detail why the current nearest relative was relevant...went to court and completed the displacement process. All of this I only had the sketchiest idea about before speaking to the Mind specialists.” (Caller 109)

Use of additional helpline services

Many helplines also offer additional services apart from the helpline itself. Other sources of additional support included a call-back service, online message boards and fora, email, chat rooms, and social networking sites such as Facebook. One particular caller to the Beat helpline created a support group as a result of meeting others in a similar situation on the organisation’s message boards. Helpline callers were asked if they had a preference for additional services offered by helplines, other than the telephone helpline. The most popular was the phone service itself (n=20), followed by email (n=18) and text (n=11).

A minority of callers reported using these additional helpline services (including text, email and chat rooms). Of the 115 that responded to this question, only 34% (n=39) had made use of such services. The most frequently used were email (n=24) and chat rooms (n=13). Only 8 callers reported using text-based services. Ninety-three people responded to the question regarding usefulness of additional helpline services. The majority of callers felt that additional services were not useful to them (n=61, 66%). Others reported that additional services such as email and message boards could be useful, as they may be easier to access under some circumstances than phone services, or could be used more discretely. Others felt that message boards were of limited use due to subjectivity of those participating, lack of activity, or the risk of bullying.

“Sometimes on holiday I get very anxious home or abroad, and by email I can get the reassurance I need.” (Caller 13)

“If your daughter is in the same room it’s difficult to have a phone conversation. It’s easier to discuss on message boards/email – discretely. Helplines [phone] are good as well though, just depends on if you need more privacy.” (Caller 197)

“Find the Mind Facebook site and the ‘elephant in the room’ Facebook site absolutely brilliant. Also have a good response by email however I was sent round in circles and was told the nearest Mind to me couldn’t help as was out of my area.” (Caller 79)

“Forum is not visited by enough people – have only received one reply to query posted in September, from admin to say welcome but no advice.” (Caller 169)

“Message boards and chat rooms are full of people who think they are experts from their own experience and can get very obsessed with putting their own view across. Sometimes there are people who are there just to make fun of people or bully them.”(Caller 53)

Improving helplines

Most callers were satisfied with the level of service from helplines and did not feel that they needed significant changes for improvement. Across helplines, callers wished they operated more regularly and hoped helplines could be open for more days during the week and for longer hours. Callers also wanted helplines to have greater capacity in order to minimise waiting times.

When asked about what would encourage callers to use helplines, callers responded that they would appreciate staff offering specialist advice. A few callers felt that staff could be better trained on how to handle calls, and could provide better continuity in their service.

“More specialist advice, both from trained medical professionals and long-term patients with detailed knowledge and understanding of mental health issues.” (Caller 27)

“More specialist advice. Better trained staff...”(Caller 58)

“...more medical advice.” (Caller 10)

Callers also highlighted how inaccessibility could deter people from using helplines. They wanted longer opening hours, more phone lines to get through to a helpline worker, as well as phone numbers being free to call. Callers felt that helplines would benefit from more publicity, as well as from more transparency about the aims of individual helpline services.

“Clear information about purpose.” (Caller 29)

“More awareness, more publicity. When [I] first heard about Mindline ...I wasn't sure what they were about. People might assume certain things as helpline service not really clear about what they do and for whom.” (Caller 18)

“If I knew about all the different types of helpline services available, I would use them more often...” (Caller 92)

“I had no idea that Mind offered such specialist advice. I wonder if it could be better promoted, it took a day of digging around before I found out about it.” (Caller 109)

Some callers highlighted the need for more joined-up working within the mental health arena, with better lines of communication between all types of services (both voluntary and statutory), as well as better promotion of various services available, and mental health helplines in particular.

“I wish everyone would talk more to each other in the mental health arena and keep on communicating to other bodies and promoting their existence/services, ask service users for input to changes in services provided and for their opinion on service delivery, leaflets etc.” (Caller 143)

“If helplines could be more coordinated it would be helpful, to make it easier for people to know where to turn for support,

particularly young people. There are a lot of different numbers out there for different issues, and sometimes they aren't all aware of each other.” (Caller 145)

“It would be useful to have a directory of helplines that are still in operation (some have had to close because of lack of funding)...not everyone wants to go to their GP.” (Caller 131)

“There isn't enough info out there about these helplines – I'm quite knowledgeable about mental health services, and yet didn't know a lot of these existed! There should be more active promoting in the community of the helplines through GP services, CMHTs, councils, libraries, etc.” (Caller 100)

Although there was some negative feedback from callers, it was limited.

“I found calling this helpline was totally unhelpful. I wouldn't advise others in the same position to use it.” (Caller 139)

“Sent me round in circles.” (Caller 79)

“Sometimes grounds me, at other times nothing.” (Caller 104)

A significant proportion of callers (70%, n=72) felt that the helpline did not provide for specific needs such as language and religion. Callers were asked to specify their particular needs, but only a limited number responded. Fifty-nine callers responded regarding their specific needs, such as language preference, religious background, or communication requirements. Two callers specified a preference for a female telephone operator, whilst another caller expressed a preference for religion based support.

“As a child sexual abuse survivor they are sensitive to my needs to not wish to talk to a male phone operative.” (Caller 25)

“I am a Christian and so my faith is of great help – if there was a Christian available then I would probably ring more.” (Caller 1)

The mental health strategy, No Health without Mental Health (HM Government, 2011) includes mhhp as a good practice example of “collaborative working to provide a more professional, comprehensive and personalised service for people”. This evaluation shows that helplines play an important role in supporting people who are at risk of developing mental health problems, people at the early stages of common mental health problems, or those seeking information, advice or support. Their anonymous and confidential nature provides a less stigmatising way of seeking mental health support.

Helpline services ranged from information provision, listening services and emotional support, to support for mental illnesses, and support in a crisis when feeling distressed, suicidal and unable to cope with life. Participants in this study were generally positive about the services that mental health helplines provide. GPs and CMHTs saw the potential for helplines to play a role in supporting people with mental health problems, or people seeking information. Callers were very positive about helplines and their role and services. As a result of calling a helpline, callers reported feeling better, supported, less anxious, less alone, better informed, more in control, feeling relief, and being able to cope. Callers especially appreciated that helplines operate outside normal hours, and many are anonymous and confidential. They can call and ask questions or discuss their problems and not feel judged or stigmatised.

The helplines that are not anonymous are usually integrated into other mental health services.

As a large majority of callers (60%) were receiving some sort of mental health support, and 78% had a mental health diagnosis, this suggests that helplines can play an important role in providing specialist advice. As suggested by the literature, mental health helplines can be used for improving engagement with health professionals and provide support between appointments. Our findings support this view, as the most commonly reported action after calling a helpline was contacting a health professional.

A challenge for helplines is meeting the demand of callers. In order to manage the demand on the helplines, staff have to try to manage callers' expectation not only with regard to the services offered, but also

concerning call duration. Data from this evaluation suggest that most helpline calls were brief (i.e. less than 30 minutes), and callers were satisfied with the outcome of their call. For the helplines providing a call back service, when callers did not get through to a helpline worker and left their number, calls were returned within a short period of time. These results indicate significant successes for the helplines.

It is important to manage callers' expectations about what the helpline is able to achieve within its resources. Some callers may expect expert medical advice or an ability to deal with complex psychiatric problems. The helpline may not have adequate resources or expertise to handle such queries, but should be able to signpost callers to the appropriate services. One limitation is that helplines may be seen as a psychiatric service in their own right, rather than as a complementary service to support people with mental health needs. Most of the respondents in this evaluation said that helplines filled a niche, but there were concerns that they may be used to replace regular mental health support.

Traditional telephone helpline services were unquestionably the most popular means of support; the low uptake of additional services, such as texts, emails, and chat rooms, was surprising, considering we live in the so-called 'digital age'. Although some callers liked emailing or texting, so that, for example, they could still be in the same room with other people, it is likely that these types of services are more relevant to a younger population. Also, few callers responded to the 'specific needs' aspect of helpline provision. Callers were invited to specify their particular needs (e.g. language, religion), but only a limited number responded. More research is required to elucidate the needs of helplines' target audiences.

Some GPs in this evaluation said that they were not aware of helplines, and therefore could not promote them to patients. Callers stressed that helpline promotion was important, along with

clear explanations of the services helplines provide (e.g. specific services, issues addressed, target group).

Promoting helplines can have advantages and disadvantages, as helplines need to manage call volume, and at present they cannot deal with all calls due to resource and capacity limitations. A better promoted helpline would be required to answer even more calls which will have resource implications.

Training of helpline staff was raised as an important issue, both by GPs and by callers. As there is no set minimum standard of training, some GPs expressed concerns about the expertise of helpline staff. Some callers also felt that they would like more specialist advice and staff could be better trained. However, this is a question of helpline resources, or it could be partly addressed by clarifying information about the purpose of the helpline.

Although anonymity and confidentiality make helplines accessible to those who might not otherwise seek help, these present difficulties in attempts to evaluate the effectiveness of helplines. The limitations of the current study therefore include some methodological issues, such as recruitment of callers and the potential bias of the sample. Nevertheless, the results provide evidence of the usefulness of mental health helpline services as reported by callers themselves.

Usage of helplines is varied but they occupy a niche within the mental health service provision. This niche does not appear to be filled elsewhere. It is important to bear in mind that, while helplines should not simply replace other services, they can form an essential part of an overall care package, particularly supplementing statutory services at times when they are not available. A good example is the Brighter Futures helpline, which is affiliated with local statutory services and callers are known to the helpline.

The evidence from this evaluation also suggests that mental health helplines are helping to meet some of the key objectives of the Government's mental health strategy (HM Government, 2011). For example, the finding that many callers found helplines a strong source of support helps to meet the objective that more people with mental health problems will recover. Being able to ring a helpline outside other services' normal working hours meets the objective that care and support, wherever it takes place, should offer access on a timely basis and help to give people choice and control, as mentioned by GPs and callers in this study. The benefits that people feel about being able to speak to someone in confidential, safe and non-judgemental way meet the objective that fewer people will experience stigma and discrimination. This is the case especially for some people with mental health problems who face additional difficulties or do not have the confidence to access traditional services.

Mental health helplines can provide a simple, low cost way of helping to manage mental health issues in the community. The evidence suggests that helpline services used in primary or specialist care settings could reduce the use of more expensive services, e.g. by preventing a crisis. In the light of the NHS reforms coming into place in 2013, the organisations that run mental health helplines will need to ensure that they establish contact with local commissioners to make the case for continued, or even increased, funding. New Health and Wellbeing Boards, Directors of Public Health and Clinical Commissioning Groups need to understand that levels of common mental disorders, such as anxiety and depression, are particularly high during the current recession, and that commissioning helpline services is a necessary and effective investment.

Recommendations

- In order to manage callers' expectations, helplines should promote their purpose with a clearer message of the services they provide.
- Apart from the promotion to the general public, helplines should increase awareness of their services among (a) primary care workers, including GPs, so that they can refer their patients to helplines; and (b) specialist mental health services staff, so that helplines could be integrated into overall mental health care.
- mhhp should consider issuing a regularly updated comprehensive guide to current mental health helplines.
- mhhp should establish minimum training requirements for helpline staff and volunteers, which would give health professionals more confidence in their expertise, and in turn could help secure future funding of helplines.
- Future funders of helplines, whether they are Local Authorities, NHS Trusts or Clinical Commissioning Groups, should take into account their contribution to individual and community wellbeing, and ensure they are available as part of the whole package of services offered to the public.
- Given the increasing economic and social burden of poor mental health, further research should be undertaken into the cost-effectiveness of mental health helplines services.

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