Users' Perspectives on Crisis Helplines in Relation to Professional Mental Health Services

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Abstract: *Background:* Crisis helplines aim to provide a short-term intervention or guide users to professional mental health services, but many users return to helplines despite having professional mental health contacts. *Aims:* To contribute knowledge on users' perspectives on the role of crisis helplines in relation to their professional mental health contacts, we aimed to investigate how online helpline users describe such services. *Methods:* We used thematic analysis of 100 naturally occurring interactions from a Swedish online crisis helpline. *Results:* The users viewed the helpline as a safe space, a partner, or an alternative to bad professional services. Users oriented to ongoing helpline usage as crucial for their well-being while they described using professional mental health services to be able to stay alive. *Limitations:* The findings are limited to the nature of the different themes. *Conclusion:* The view on crisis helplines as a short-term intervention relies on an idealized view on crisis intervention that does not represent users' views. User control is at the core of the appeal of helplines, but it is also a key challenge for organizations and volunteers.

Keywords: crisis helplines, frequent users, user perspective, mental health promotion, suicide prevention

Crisis helplines have since the 1950s comprised an important resource in the wider set of suicide prevention services (Gould et al., 2021; Mishara et al., 2007; Mazzer et al., 2021). Trained volunteers, who provide peer support, often staff such services, while advice or interventions tend to be seen as tasks for professionals within health care or social services (Mishara et al., 2016; Pollock et al., 2010). With the rise of online support in suicide prevention, web-based crisis helplines have developed with the aim of providing low-threshold, short-term support (Mazzer et al., 2021; Sindahl et al., 2019; Westerlund & Krysinska, 2021). However, we know little about how users view crisis helplines in relation to their professional mental health contacts. Drawing on thematic analysis of online crisis helpline interactions, this study aimed to examine users' views on the helpline's role in relation to their contacts with professional mental health services.

These interactions come from Sweden's only crisis helpline, The Suicide Line, founded in 2012 by a nonprofit organization and staffed by volunteers. Like the UK Samaritans (see Mishara & Weisstub, 2010), the helpline's work is based on the idea that talking to another person can prevent suicide, but users are seen as ultimately responsible for their own decisions. The helpline explains this approach with the ideal of peer support (medmänskligt stöd, literal translation co-human support): Callers are considered experts while the call-taker is an anonymous friend who can assist the caller in exploring their situation (Iversen, 2021; Kevoe-Feldman & Iversen, 2022; see Pollock et al., 2012). Anonymity limits information about users, but volunteers' estimates show that the most common reasons for contacting the helpline is suicide thoughts (49%), sadness (41%), anxiety (24%), and loneliness (17%). Although the helpline's target group is persons in crisis, volunteers are instructed to offer all users *10 friendly minutes*.

Previous research into online chat and text services has shown positive results related to short-term improvement (Gould et al., 2021; Mazzer et al., 2021), while cautioning against conclusions about long-term suicide preventive effects (Westerlund & Krysinska, 2021; see Hvidt et al., 2016). In a study based on users' reports, Gould et al. (2021) showed that chatting could reduce experiences of distress and *feeling suicidal*. Other studies (Mokkenstorm et al., 2017, 2020; Sindahl et al., 2019) showed that service users' satisfaction and positive change during the contact were related to helpers'

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responsive approach, such as active listening. However, Westerlund and Krysinska (2021) noted that brief online sessions, even by a highly skilled and experienced volunteer, are not likely to stop or reverse the suicidal trajectory. The suicidal process is complex and develops over time (Wasserman, 2016), involving factors such as social conditions, mental health issues, and interpersonal dynamics (Sveticic & De Leo, 2012). Even after care, suicidal thoughts and behavior often persist (Kemp et al., 2021). In line with this, Sindahl et al. (2019) argue that crisis helplines should aim to reduce imminent risk of suicide and encourage the use of long-term counseling, which can address issues contributing to the onset and maintenance of suicidality.

The view of helplines – online and offline – as a short-term intervention that should provide a way into professional mental health services is present in many agenda statements of crisis helplines (Mazzer et al., 2021). However, research has shown that this goal is at odds with the way many people use crisis helplines, which is as a regular source of support (Pollock et al., 2012). In an evaluation of UK Samaritans (Pollock et al., 2010), volunteers reported user dependence on the helpline as a problem, which was actively discouraged. Frequent helpline users have been discussed for over 50 years as challenges to organizations' limited resources and volunteers' communicative strategies (Pirkis et al., 2016). Yet, research indicates that this group represents a major proportion of all users: Spittal et al. (2015) showed that three percent of the callers to telephone crisis lines produce 60% of the calls. Furthermore, Pirkis et al. (2016; see Pollock et al., 2010) showed that frequent callers tend to have substantial needs and use helplines together with other health and social care interventions. In fact, Bassilios et al. (2015) showed that the proportion of people with poorer mental health and people consulting various providers increase with call frequency. In addition, the group of frequent users may use helplines because they are dissatisfied with public welfare services (Middleton, Pirkis et al., 2016) or because they want to want to engage with volunteers on the basis of being a person rather than a patient (Pollock et al., 2010; see Mazzer et al., 2021). In interviews with self-identified frequent users, Middleton, Gunn et al. (2016) found that their reasons for returning were connected to their problems (e.g., persisting needs) as well as the response they received (e.g., availability) and their caller behavior (e.g., calling when triggered).

To address this gap between crisis helplines' ascription of users' needs and the needs many users themselves seem to identify, more knowledge is needed about users' perspectives on the role of helplines in relation to professional mental health services. This study contributes knowledge on this matter by analyzing how users referred to other services when chatting with volunteers. We show that rather than describing online chatting as a first step, users treated it as a safe space, a partner, or an alternative to professional mental health services. By unpacking these different professional care relations, we call for the need to rethink the role of crisis helplines in relation to the complexity of the suicidal process.

Materials and Methods

At the time of data collection, volunteers at the Suicide Line were trained in a 3-day workshop that covered information about suicide risk factors, suicide myths, and communication training, mainly in active listening and motivational interviewing (Ortiz, 2014). Volunteers were expected to listen and provide emotional support, but not give advice or practical help. In line with previous findings on volunteer behavior (e.g., Pollock et al., 2010; Kevoe-Feldman & Iversen, 2022), however, volunteers were often engaged in advice-related activities.

The dataset used in the study included 2,000 chats, randomly selected from an existing database including all chats received by the helpline between 2012 and 2016 (approximately 20,000 chats). To avoid an unbalanced sample, we randomly sampled 20 chats for each year (in total 100). For the current study, we excluded five chats with contacts on behalf of someone else. Accordingly, the analysis was based on 95 chats. In addition to chats, one of the authors (Iversen) conducted ethnographic research at the helpline, including participating in the volunteer training and discussing preliminary findings with experienced volunteers who participated with written informed consent. The study received ethics approval from the regional ethics committee in Uppsala [Dnr 2017/510].

The study used a phenomenological approach to data analysis, which means that we limited our analysis to the users' accounts, without taking a stance about their ontological underpinnings. Instead of assumptions about data, phenomenology focuses on people's lived experiences of different aspects in life, as described by themselves (McLeod, 2001). In the current study, this meant that we focused on the topic of professional contacts as initial analysis showed that this was a highly relevant theme for users. We used thematic analysis to identify recurrent and meaningful themes in the users' accounts (Braun & Clarke, 2006). In our close reading of the chats, users' accounts about professional mental health services appeared as a central theme, both in its occurrence (in 60 of 95 chats) and in the weight the users

placed on these services related to their reason for contacting the helpline.

Therefore, these 60 chats were further analyzed resulting in three subthemes related to the helpline's role in relation to professional mental health services (a safe space, a partner, an alternative), independently agreed upon by both authors. To systematically identify and sort different themes, we used the qualitative analysis tool NVivo (v.12 Plus). Although the same user's accounts often belonged to one of the themes, it is possible that the same user described different experiences of mental health services. We present the quotes with the anonymized reference number from the database. In the translation from Swedish to English, we have tried to retain misspellings and grammatical errors.

Results

Among the 60 chats where users described professional mental health contacts, 45 users explicitly described suicidal ideation and/or previous suicide attempts. Most users described being in contact with two or more professional mental health services. Having an ongoing mental health care contact, including medication, was the main type of professional service users described, for example with psychologists (N =30), psychiatrists (N =24), physicians (N =15), counselors (N =10), school personnel (N =9), and social workers (N =8). Users described being admitted to voluntary or involuntary inpatient care at hospitals (N = 5) and specialist centers (N = 4), as well as being subjected to emergency care interventions (N = 4). In the following sections, we explicate how users described their contacts with professional mental health services and the role of the crisis helpline as (1) a safe space alongside a working professional contact, (2) a partner in the struggle to pursue services that work, and (3) an alternative to *bad* professional services.

A Safe Space Alongside Professional Services

Several users described working professional services, where interventions had not resolved their suicidal thoughts or behaviors but helped with some aspect of their problems, such as therapy (ID7924; ID656) or medication promoting a more stable mood (ID709, ID6111, ID13185). The accounts of persisting needs, despite working professional contacts, may be related to the legitimacy of contacting the helpline. However, such accounts may also refer to how professional services and helplines can complement one another in a suicide preventive system, responding to different needs in a complex situation. For instance, users described professional help as stopping them from suicide, but not a remedy for their problems: "I'm admitted to the psych ward right now but if I wasn't, I wouldn't be alive today [. . .] I've got 'help' for adhd but the thing is, you can't conjure away adhd" (ID10222; ID2545). In these cases, the crisis helpline was treated as a safe service that users could return to in the face of ongoing mental health problems.

The users also turned to the helpline to get a service that they could not get from professionals. This user described being in a locked psychiatric ward where talking about their problems would lead to more restrictions:

> my situation isn't that good, I'm basically in a locked ward, there is personnel but I can't make myself talk to them no then they won't let me out at all, the more problems I'm expressing the longer time I get here [. . .] it might sound weird that I'm seeking someone to talk to at [the helpline] when I'm admitted but it doesn't work like that here. (ID5666)

Talking to someone at the helpline while being institutionalized was a way to share one's experiences without being subjected to risk assessment (ID21291). Moreover, the helpline worked as an outlet in relation to therapy that had yet to provide results: "I'm doing EMDR [eye movement desensitization and reprocessing] therapy, but haven't gotten that far. So I know I shouldn't take from your time, I apologize, but I don't dare telling anyone else how bad I feel" (ID7199). By apologizing, the user implied not being the target group of the helpline because they were already "doing therapy." Still, like the previous user, they oriented to the helpline as providing a safe space, where they could tell the volunteers things they would otherwise withhold. For these users, the anonymity provided by the helpline made it an important complement to care relations where professionals are required to manage risk.

Users also described previously working professional contacts, for example, regarding therapy (ID9487) or an eating disorder clinic (ID406), which helped partly or was terminated while the user's problems remained: "When I was in school, I talked to a psychologist, really liked her lot . . . but now there's no one I can trust" (ID1883). The accounts of not trusting professionals or being able to talk to them suggests that an important function of the helpline is related to providing users with control: a forum that users can contact when they need it, without it imposing restrictions based on their problems.

A Partner in the Struggle to Pursue and Trust Professional Services

Another central pattern in the users' accounts was their descriptions of struggling to get the right professional services. The users addressed volunteers as experts who could give advice on practical matters related to other services, such as when to call the emergency number and what would happen if they did (ID8979, ID10511). The users also approached volunteers as persons providing them with encouragement not to give up on themselves or services. Being misdiagnosed and misunderstood (ID6517, ID778, ID7980) was one experience, being seen as a "troublesome patient" (ID20988) was another. One user described the doctor's talk about therapy as "Just empty words so far" (ID7980) and another described a sense of giving up after having finally gotten an appointment:

> I was referred to the outpatient psychiatry care with guarantee to meet a doctor within 1 month and a psychologist within 8 months. I've finally gotten a doctor's appointment in three weeks after having nagged an reminded for 2 months+ [. . .] I'm so tired of constantly being forgotten in the care system and don't know if I can wait that long? (ID5948)

The sense of being *forgotten* is a contrast to being included in a working system that provides care for those in need. In these cases, the volunteers became partners who could encourage the users by telling them that they were on the right path and offer advice about how to endure the time before the professional meeting.

The users also described uncertainty in relation to their professional contacts and used the crisis helpline to voice their concerns about care (ID11402): "[The therapist] says it's working. that it can work out. but you know. I have so many difficulties. I really don't understand how she can believe it's going to work out." (ID13545). In this and similar accounts (ID17794, ID21411), users described, on the one hand, positive aspects of having someone who cares for their mental health and, on the other, their lack of trust that the professionals will be able to help them. In relation to users who described contact with professional mental health services in terms of a struggle and a matter of uncertainty, the crisis helpline seems to fill an important function as a forum for reflection and encouragement.

An Alternative to Bad Professional Services

A majority of the users ($N = 35$) who wrote about professional mental health services described them as insufficient, unhelpful, and sometimes even damaging. For instance, a user who described inpatient care after a suicide attempt referred to this contact as having made them feel even worse because of the caretakers' disrespectful approach (ID15472). A recurrent feature in these accounts was professionals not listening ("it feels like I'm talking to deaf ears" ID923) or not taking users seriously:

> [the counsellor] is unprofessional' cause when I got there and had cut myself and said that I wanted help to stop the behavior she said that I had cut too little for them to do something about it [. . .] so I'm not feeling safe with her and I've changed once but everyone seems to be like that at the whole place. (ID3024)

Like being told that one has "cut too little," advice, such as "take a deep breath" (ID13185), was described as provoking as it downplayed the severity of the user's situation. Other users described professional services in terms of a too limited scope, such as just using cognitive behavioral therapy (CBT) or just medication and restrictions in psychiatry. In such cases, the users referred to the helpline as offering a contact that responded to them as full human beings.

Another bad experience was giving up. This could involve discontinuity in care, with staff quitting ("Everyone always disappears", ID2365). It could also involve professionals trying various methods and "panicking" (ID725, ID5515, ID10020) when "nothing works" (ID7963). This user described having done their part but still being treated by professionals as an impossible case:

> They have prescribed medications, talked to me and asked what the problem is. I've told them everything. . . Then they say that they can't help me any longer. (ID621)

Users also described professionals as enemies ("idiots. . . stupid kinds. . . wiseacre. . .", "I truly hate the social workers they are as stupid as the cops. . .," ID10020, "I hate the psychiatry" ID16809, ID5844, ID10314, ID231). This view on professionals as the antagonists was also related to stories of lying to professionals (ID342): "I don't want to be locked up I guess thats what I think will happen [. . .] so now I've learned to lie to stop the coercion" (ID4220). This is reminiscent of the first theme where users described being selective about what to say to whom. The anonymity of the helpline is a unique feature in relation to other services in Swedish mental health promotion. This affords users with control, which they may otherwise lack.

Thus, in relation to inadequate, unhelpful, or damaging professional services, users treated the helpline as a place to communicate their hopelessness or to talk to someone who could provide support without having the power to

affect their lives. In such cases, they also sometimes treated the helpline as the last resort:

> I can start by saying that I'm here because this is my last resort. The psychiatric emergency does not admit me. [. . .] They're always assessing that I'm not feeling bad enough. Even though I was close to killing me last time. (ID5840)

As users criticized professional services, they addressed the volunteers at the helpline as offering an alternative response in taking the users seriously on their own terms. Users thus treated the helpline as a safe place in relation to working professional services, where they could describe their experiences without negative consequences. They also used the helpline for support in the pursuit of professional help. Finally, they used the helpline as an alternative to bad professional services.

Discussion

Recurrent in all three themes are the users' descriptions of serious and long-term problems, which affect numerous aspects of their lives. This resonates with previous research about the needs of helpline users, especially those who use helplines frequently (see Bassilios et al., 2015; Middleton, Gunn et al., 2016). Similarly, the way users describe being able to talk about things that they cannot raise with professionals is reminiscent of previous findings (see Middleton, Pirkis et al., 2016; Pollock et al., 2010). Thus, this study suggests that the ideal of a one-time crisis intervention or a first step in a suicide preventive system (see Sindahl et al., 2019; Westerlund & Krysinska, 2021) is at odds with users' views on crisis helplines (see Pollock et al., 2012). In addition, our thematic analysis of helpline chat data enables us to unpack the different ways in which people – chatting with volunteers – make sense of their use of support. We thereby respond to calls for differentiating between reasons for (frequent) helpline usage (Hvidt et al., 2016; see Middleton, Gunn et al., 2016).

A central aspect is users' control, most evident in how they treat the helpline as a safe place and an alternative but also in how they request advice and encouragement from nonexpert partners. For people with chronic mental health problems, the suicidal process can be lifelong: Thoughts about suicide occur with different intensity and can be absent at times but return in response to new difficulties (Middleton, Pirkis et al., 2016; Wasserman, 2016). In line with this, our findings show that many users describe crisis as a constant in their lives, to which professional services, with high thresholds, short time frames, or focus on particular symptoms, may not sufficiently or adequately respond. In this sense, frequent users can be seen as a resourceful group: They have found a crisis intervention that is continuous and easily accessible, either as a safe place, a partner, or an alternative (see Mazzer et al., 2021).

From an organizational point of view, the downside of users' control is misuse of the helpline: Frequent users are a challenge to limited resources, and both previous research and our ethnographic work indicate that user anonymity facilitates abuse toward volunteers (see Pollock et al., 2012). Previous efforts to deal with such problems, such as blocking users or developing care plans (e.g., Middleton, Gunn et al., 2016), are in opposition with unconditional acceptance (see Pollock et al., 2010) and user control. Although no solution to this problem is readily available, it is important to acknowledge that volunteers and organizations need resources for dealing with crisis as sometimes potentially involving user dependence. While frequent usage can contribute to users' problems (e.g., retelling of traumatic events; Middleton, Gunn et al., 2016), it may also resonate with needs of available social contact. Being prepared to offer every user 10 friendly minutes is a step in the direction of responding to those needs, but it may not be sufficient for callers who experience not being taken seriously, have given up on professional services, or deal with severe anxiety on a daily basis.

Limitations

Our study is qualitative, and the numbers are only used to provide transparency (see Braun & Clarke, 2006). Because of the anonymity of users, we do not know whether the same user appears repeatedly in different chats, which means that our findings need to be interpreted with caution. In addition, while our findings suggest that the helpline and professional services can meet different needs, the users' accounts of insufficient professional services can be related to displaying entitlement to contact the helpline. The findings are thus limited to showing various aspects of users' accounts of professional services in interactions with volunteers.

Conclusion

User control is at once a key challenge for crisis helplines and at the core of helplines' appeal and their usefulness in a suicide preventive system. Helplines face difficulties imposing boundaries that might ensure effective use of resources. On the other hand, users can

contact the helpline when they need and tell volunteers about suicidal ideation without having their lives further restricted.

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