



Comparison of the Effects of Telephone Suicide Prevention Help by Volunteers and Professional Paid Staff: Results from Studies in the USA and Quebec, Canada

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Research since the 1960s has consistently found that lay volunteers are better at helping suicidal callers than professionals. Yet, professional degrees are increasingly becoming requirements for helpline workers. In our first study, we conducted post hoc comparisons of U.S. helplines with all professional paid staff, all lay volunteers, and a mix of both, using silent monitoring and standardized assessments of 1,431 calls. The volunteer centers more often conducted risk assessments, had more empathy, were more respectful of callers, and had significantly better call outcome ratings. A second study of five Quebec suicide prevention centers used silent monitoring to compare telephone help in 1,206 calls answered by 90 volunteers and 39 paid staff. Results indicate no significant differences between the volunteers and paid employees on outcome variables. However, volunteers and paid staff with over 140 hours of call experience had significantly better outcomes. Unlike the United States, Quebec paid employees were not required to have advanced professional degrees. We conclude from these results and previous research that there is no justification for requiring that

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suicide prevention helpline workers be mental health professionals. In fact, the evidence to date indicates that professionals may be less effective in providing telephone help to suicidal individuals when compared to trained lay volunteers.

In this article we present data from two studies comparing telephone help for suicidal callers by volunteers with telephone help provided by paid staff and professionals. The objective of the studies was to critically assess the relative effectiveness of using volunteers and professional paid staff to work on telephone helplines.

Every day thousands of suicidal persons call suicide prevention centers and crisis helplines around the world. Mishara (2012) traced two parallel trends in the development of telephone helplines since the beginning of the 20th century: using lay volunteers and providing help by paid professionals. Recently, in some areas, volunteer helplines have been replaced by professionally staffed services. For example, the province of Quebec, Canada, had all-volunteer suicide prevention centers 30 years ago. Today, only two of the province's 28 centers use volunteers; the others have replaced volunteers with paid staff. Increasingly, jurisdictions have been passing legislation to require professional qualifications for helpline workers. For example, in 2014, new rules in the state of Iowa (Code section 228) require that only mental health professionals with a university degree be allowed to provide crisis services, thus threatening the survival of long-established nationally certified volunteer helplines.

Worldwide, the majority of telephone helplines in suicide prevention still use trained volunteers to answer calls, often following in the tradition of the Samaritan movement founded by the Rev. Chad Varah in 1953. Varah, a professional psychotherapist, abandoned his therapy practice to establish Samaritan volunteer helplines because he was convinced that nonprofessionals who have a natural ability to befriend persons in need can effectively help people in crisis and prevent suicides. Volunteer telephone helplines exist in over 60 countries around the world, and many are members of the

nonprofit organization, Befrienders Worldwide (www.befrienders.org). In the United States, volunteer centers often followed the model of the Suicide Prevention Center of Los Angeles (1966), which originally had all professional staff but replaced them with lay volunteers.

During the latter half of the 20th century, when volunteer helplines were developing, others established helplines run by paid professionals. Probably, the first professional helpline was in 1947 at the neuropsychiatric clinic of the University of Vienna (Trowell, 1979). At the present time, volunteer and professional-staffed helplines coexist in the United States and many other countries. In some instances, for example Suicide Action Montreal, in Quebec, Canada, centers that began using only volunteers later started to pay staff to work some of the time (e.g., to take the nightshifts for which it was difficult to recruit volunteers) and developed a mixed model of using both lay volunteers and paid staff.

From the mid-1960s to the mid-1980s, there was much research interest in understanding the comparative benefits of professionals and "paraprofessionals" or "lay helpers." The pioneering work by Carkhuff (1968) set the groundwork for several empirical investigations. In his review of research until the late 1960s, Carkhuff found evidence that lay persons could be trained to be more effective helpers than professionals. His review of the efficacy of treatment indicated that there was no evidence that having graduate school training has benefits for clients, and there was clear evidence that lay persons can influence significant positive changes in clients. He concluded that professional programs have failed to produce tangible evidence of their benefits for clients, while lay counselor programs have shown significant positive effects. He felt the advantages of lay counselors are due to their greater ability to

relate to the milieu of the distressed and to establish peer-like relationships, as well as their ability to be empathetic and to identify how clients can better function.

In 1979, Durlak published a seminal article in *Psychological Bulletin* in which he reviewed 42 studies comparing the effectiveness of professional and paraprofessional helpers with respect to outcome and adequacy of design of the studies. He concluded that the findings have been consistent and "provocative." Paraprofessionals have clinical outcomes that are equal to or significantly better than those obtained by professionals. This controversial paper concluded that professional mental health education, training, and experience do not appear to be necessary prerequisites for helping people. As could be expected, Durlak's conclusions were not appreciated by some professionals. Nietzel and Fisher (1981) criticized Durlak's review by pointing out methodological problems and what they felt were poorly designed studies.

A few years later, Hattie, Sharpley, and Rogers (1984) used meta-analytic procedures to make 154 comparisons from 39 studies of the effects of paraprofessional and professional helpers on clients. They concluded that clients treated by the paraprofessionals were more likely to achieve resolution of their problems than those who consulted professionals. One of the moderators was the experience of the helper and the duration of treatment. They concluded that "paraprofessionals are more effective than (or at least as effective as) professionals" (p. 536). They found that the more experienced the paraprofessional, the greater their effectiveness, and the more training they had, the more they were helpful to clients.

Studies of telephone helplines working in suicide prevention have invariably found that nonprofessionals have higher levels of "facilitative characteristics" (Hirsh, 1981; Knickerbocker & McGee, 1973). Hirsh (1981), after listening to 100 telephone interventions by professionals and volunteers, concluded that volunteers are more patient, kind, and reassuring. An often-cited study

by Knickerbocker and McGee (1973) compared nonprofessional volunteers with both professional trainees and professionals at a crisis center in Florida, rating them on empathy, warmth, and genuineness using standardized scales. Analyses of telephone conversations found that the lay volunteers scored significantly higher than professional trainees and professionals on warmth and were marginally higher ($p < .10$, but this would be significant if one-tailed tests were used) on empathy and overall qualities using the Truax scale (Truax & Carkhuff, 1967).

Overall, when one considers research to date comparing professionals with lay persons and volunteers, one must conclude that there is no evidence of an advantage for professional training. Research has found that volunteers and lay persons are at least as good as professionals, no matter how you assess their effectiveness, and generally, they come out ahead.

This article presents the results from two separate studies aimed at critically comparing telephone help provided by volunteers and professional paid employees. The first study involved post hoc analyses on data from a previous study of the effectiveness of the staff of telephone helplines in the United States in relation to intervention styles (Mishara et al., 2007a,b). We reexamined the outcome data, comparing centers with volunteers or professional staff.

The second study, conducted in Quebec, Canada, was specifically designed to compare the practices and outcomes by volunteers and paid staff in telephone helplines. This study was stimulated by a survey in Quebec conducted by the Centre for Research and Intervention on Suicide and Euthanasia (CRISE) at the University of Quebec at Montreal of organizations and individuals involved in suicide prevention. The survey asked respondents about what they felt were the most important questions that needed to be researched. A priority issue was whether there is a difference between the effectiveness of telephone help provided to suicidal callers by volunteers and paid "professional" staff.

We present the methodology and results from both studies, then conclude with a general discussion of the findings.

Some Definitions

Before proceeding, it is important to define volunteers, professionals, and paid staff. Organizations accept as volunteers people who are willing to work without pay; who meet certain selection criteria, such as being nonjudgemental, empathetic, or “good listeners”; and who successfully complete a training program. Training usually conforms to best practices defined by organizations, such as the American Association of Suicidology, that accredit helplines, and training includes a period of verification of skills while taking calls in which supervisors offer feedback and observe the quality of telephone help, before allowing the volunteers to answer calls on their own. Some volunteers have schooling in the social sciences and advanced professional degrees, but they are generally told that in their work on the phones they must put what they have learned in their professional training aside and use the techniques taught by the centers.

“Professionals” and “paid staff” are not necessarily interchangeable terms as centers vary as to whom they accept to pay for work on the lines. In Quebec, paid staff are generally only required to have a high school diploma, junior college (CEGEP), or bachelor’s degree, and they often have prior experience as helpline volunteers. However, in the United States, paid staff are generally professionals who have at least a master’s degree in psychology, counseling, or social work.

THE FIRST STUDY: POST HOC ANALYSES ON CALLS TO 14 TELEPHONE HELPLINES IN THE UNITED STATES

Methods and Procedure

The first study involved conducting post hoc analyses in which data previously

reported (Mishara et al., 2007a,b) were re-analyzed, comparing centers staffed with volunteers and professionals. A complete description of the methodology and the overall results of this study, including the relationship between the nature of help provided and the short-term effects on callers, may be found in two articles (Mishara et al., 2007a,b). The methodology involved remote silent monitoring of 2,611 calls to 14 U.S. helplines, in which two trained research assistants listened to all calls and rated both characteristics of the helper’s behaviors and the observed impact on callers, using standardized rating scales. Raters were blind to the characteristics of the helpers, and high interrater reliability was obtained in independent simultaneous observations of calls. The main analyses concerned 1,431 calls from persons in crisis situations, of which 40% involved suicidal ideation. They found that establishing a good initial contact, being empathetic, and having respect for callers were associated with better call outcomes and that a collaborative problem-solving approach resulted in more often helping callers in crisis, when compared to active listening.

To investigate differences between volunteers and paid staff, after completing this study, we contacted the 14 centers and asked each whether they used all volunteers to answer their calls, all professionals, or a mix of volunteers and professionals. When we monitored calls, we retained data allowing us to identify which centers were being monitored, but we kept no records allowing us to identify which person in the center answered the calls, and we originally had no knowledge of whether the helpers who answered the calls were volunteers or professionals. As we re-contacted centers only after completing the original study, we were not able to obtain any specific information about the characteristics of the individual helpers who answered the calls at the time the study was conducted, other than the staffing status of having the call answered by a center who had all volunteers, all professionals (with college or university degrees

in psychology, counseling, or social work), or a mix of professionals and volunteers.

Four of the centers had all professionals, with a total of 168 professional helpline workers participating in the study. Three centers with 131 helpline workers had a mix of professionals and volunteers, and only volunteers answered calls in seven centers with 493 helpers. In centers that used a mix of volunteers and paid staff, we could not identify which calls were being handled by whom, nor could we determine what percentage of calls to those centers were answered by volunteers and professionals.

One of the main findings we reported previously (Mishara et al., 2007a,b) was that suicide risk assessments and asking about suicide were not systematically conducted during crisis calls. This was despite the fact that all centers in that network were certified at the time by the American Association of Suicidology, which requires that all callers be asked whether or not they are considering suicide, and in the affirmative, a detailed risk assessment must be conducted. Since the publication of those findings, due to increased training and the development of national standards by the National Suicide Prevention Lifeline organization, there have been major improvements in risk assessment practices.

Results

The percentage of calls answered at centers with professionals, a mix of volunteers and professionals, and volunteers only, on several observed helper behaviors, are shown in Table 1. We found that the U.S. centers using all professional staff conducted suicide risk assessments, including asking about suicide intentions, in 47% of calls, compared to the centers using all volunteers who asked about suicide and conducted risk assessments in 64% of calls. The centers with a mix of professionals and volunteers asked in 51% of calls. Centers with professionals were less likely to identify callers as being suicidal, probably because they less frequently asked questions

to assess suicide risk. Overall, in calls that were answered by professional staff centers, suicidal callers were identified in 26% of the calls, compared to 24% for those with a mix of professionals and volunteers and 34% in the all volunteer centers.

Results of the Mishara et al. (2007a,b) study indicated that empathy and respect for callers were significantly related to positive changes in callers between the beginning and end of the calls. Our post hoc analyses found that centers with all professional staff were the group showing the highest number of calls with low empathy and low respect. The all volunteer centers least often had low levels of respect and empathy. The all volunteer centers had significantly higher (more positive) scores ($M = 105.09$, $SD = 19.40$) than the all professional and the mixed volunteer and professional centers ($M = 99.89$, $SD = 20.53$) on the Crisis Call Outcome Rating Scale (CCORS, Bonneson & Hartsough, 1987), which was used to assess the overall effectiveness of telephone help ($F = 6.68$, $df = 1, 1,226$, $p < .01$).

THE SECOND STUDY IN QUEBEC, CANADA, COMPARING TELEPHONE HELP BY VOLUNTEERS AND PAID STAFF

This study was specifically designed to compare telephone help provided by volunteers and paid staff in Quebec suicide prevention centers. As the overall results have not been previously published, the methodology is presented in greater detail.

Method

Participants and Procedure. Calls to five Quebec suicide prevention centers were monitored from a remote location without the helpers or callers knowing when or which calls were being monitored. Two of the centers had all volunteers, two had only paid staff, and one center had volunteers answering calls from 8 A.M. to midnight and paid staff answering calls from midnight to

TABLE 1

Comparison of 1,431 Calls Answered by U.S. Centers with All Professional Helpers, All Volunteers, and a Mix of Professionals and Volunteers

	Centers with Only Professionals (301 Calls)	Centers with Professionals and Volunteers (215 Calls)	Centers with Only Volunteers (915 Calls)
Conducted Suicide Risk Assessment	47%	51%	64%
Callers Identified as Suicidal	26%	24%	34%
Low Empathy Observed	47%	34%	27%
Low Respect for Caller Observed	17%	20%	15%

8 A.M. Monitoring of calls by supervisory personnel is part of the general practice in these centers. All helpers signed consent forms in which their anonymity was guaranteed.

A total of 129 helpers, 68% ($n = 89$) women and 32% men ($n = 40$), participated in the study. No telephone helpers declined to participate. The mean age of the helpers was 36.6 ($SD = 13.4$), and they had a mean of 142.2 hours ($SD = 172.7$) of experience in telephone intervention. The high standard deviation in helpers' hours of experience indicates there was quite a wide range, from new helpers who just began to answer calls to helpers with years of experience. However, helpers considered to still be in training were not monitored. This includes those who, at the end of their formal training, take calls with a supervisor sitting next to them until they are certified to take calls alone.

Of the 129 helpers, 90 (69.7%) were volunteers and 39 (30.3%) were paid staff. The average age of the volunteers was 33.0 years ($SD = 9.8$), which was significantly younger than the paid staff ($M = 39.1$; $SD = 13.1$; $t = 2.99$, $df = 127$, $p < .005$). Also, as might be expected, the paid staff had accumulated on average more hours of experience ($M = 158.8$, $SD = 155.3$) than the volunteers ($M = 100.9$, $SD = 132.9$; $t = 2.2$, $df = 127$, $p < .005$).

Research Assistants. Eleven research assistants monitored calls (8 women and 3

men), all with university education. They received a minimum of 21 hours of training including simulation monitoring, where near-total agreement on observations was obtained, and this was verified by independent monitoring of calls by two persons at the beginning and end of the monitoring period.

Callers. We report on the 1,206 calls which had suicidal content; of the 1,652 calls received during the monitoring, 434 (36%) were from men and 772 (64%) were from women. Overall, 548 were from callers who said they were considering suicide. Another 550 calls came from third parties; that is, persons who were in a relationship with a suicidal person and were calling concerning the suicidal individual. In addition, 108 calls were from persons who were bereaved by suicide. Of the calls monitored, 419 were answered by volunteers and 787 by paid staff.

At the end of calls, helpers were instructed to ask the callers whether we could call back as part of an evaluation study, and, if so, to ask for a phone number and time to call back approximately 1 week later. Only 205 callers were actually asked whether we could call them back, and of those asked, 146 (71.2%) accepted a call back. Of those 146, we were able to contact 105, 49 from calls handled by volunteers and 56 from calls handled by paid staff.

Instruments. The Helper Response Scale developed by Mishara and Daigle

(1997) involves coding every phrase uttered by the helper in one of 20 categories. In the present study, we assessed the scale's interrater reliability and obtained Kappas ranging from .78 to .86. We also rated suicide urgency on the 7-point scale used in Quebec at the time of the study, ranging from 1 (*thinking about suicide but with no plan, time frame, or method in mind*) to 7 (*decided to commit suicide in the next 24 hours with a specific method determined and available*).

At the end of the call, we assessed the overall call performance using CCORS (Bonneson and Hartsough, 1987). This 26-item scale has 16 items to indicate "successful" outcomes and 10 to indicate "unsuccessful" outcomes, rated from 1 (*strongly disagree*) to 7 (*strongly agree*). We also included the 14-item abridged version of the Ilfeld (1976) Psychological Symptom Index that was validated in Quebec by Prévaille, Boyer, Potvin, Perrault, and Légaré (1992). In addition, we used the Brasington Indication of Depression, which was assessed at the beginning and end of calls. In 126 calls that were independently coded by two observers, identical ratings occurred in 118 calls.

Results

Style of Intervention. The frequencies for the 20 categories of intervention styles may be seen in Table 2. The most common responses from helpers were acceptance, orientation/investigation, giving information, suggesting and advising, and clarification/interpretation. The high frequencies of asking questions and making suggestions indicate that overall, there is a mix of active listening techniques and more directive problem-solving approaches. Categories that are generally considered inappropriate in telephone interventions, including threats, threats to hang up, moralizing, and rejection, occurred infrequently (much less frequently than in our study of U.S. centers; Mishara et al., 2007b). These data were analyzed using the SPSS Quick Cluster method, and two clusters were identified. The first cluster was

characterized by more acceptance and approval, and described a "nondirective approach". The second "directive approach" cluster had more orientation/investigation (asking questions), more silence, reassurance, judgments, reflection, clarification, and interpretation, telling a personal experience and telling about the experience of others. The two clusters are very similar to the results found in the study by Mishara and Daigle (1997). We used the terms *nondirective* and *directive* to characterize the styles of intervention. Each intervention was classified according to one of the two styles with 262 classified as nondirective and 246 classified as directive.

There were no significant differences in intervention styles between paid staff and volunteers ($\chi^2 = 2.12$, $df = 1$, $p = ns$). Approximately half of volunteers (52.7%) and paid staff (46%) used the directive style; the others (47.3% of volunteers and 54% of paid staff) used the nondirective approach.

Overall Effects of Telephone Help. There was an overall significant decrease in the suicide urgency ratings from the beginning to the end of the call ($t = 6.05$, $df = 547$, $p < .001$, two-tailed test). However, the overall mean difference from 3.02 ($SD = 1.86$; on a 7-point scale) to 2.91 ($SD = 1.76$) at the end of the calls was modest. In 76% of the calls, there was no difference between the beginning and end of the call. However, when there was a change, it was much more frequently an improvement (16% of calls) and less frequently an increase in suicide urgency (7.8% of calls).

As the number of callers being asked to receive a follow-up call was limited, and may be an unrepresentative subsample of the calls, the results from the follow-up must be interpreted with caution. In the 104 instances where callers were called back to evaluate their call, 69.2% of callers were satisfied with the help they received and the remaining 31% were not. In each of the follow-ups, we verified whether the contract or agreement that was reached at the end of the call had been respected since the initial call. About 42.3% of callers did what they

TABLE 2*Sums and Percentages of Utilization on the Helper's Response List for all Calls to Quebec Centers*

Category	Total Number of Responses	Proportion of All Responses (%)
Silence	270	0.33
Incomplete Thought	73	0.09
Orientation/Investigation	19,511	23.58
Acceptance	33,162	40.08
Reassurance	2,324	2.81
Approval	876	1.06
Intentional Misinterpretation	5	0.01
Moralization	145	0.18
Rejection	67	0.08
Reflection	2,041	2.47
Information/Suggestion/Advice	11,503	13.90
Threat	7	0.01
Information/Suggestion/Advice Concerning the Call Format	1,347	1.63
Threatening to End Call Unless...	4	0.00
Clarification/Interpretation	10,484	12.67
In-Depth Interpretation	39	0.05
Sharing Personal Experience	159	0.19
Sharing a Third-Party Experience	16	0.02
Projection	28	0.03
Providing Information about Helper	681	0.82

said they would do to get help after the call. In 39 cases (40.2%), they did not do what they said they were going to do, and in 17.5% of calls, no specific contract or agreement on follow-up was reached.

Generally, women improved more frequently than men: 18.6% of calls from women had decreased suicidal urgency as compared to 11.8% of calls from men ($\chi^2 = 5.56$, $df = 2$, $p < .06$, two-tailed test). The CCORS scores were significantly higher in calls from women ($M = 106.3$, $SD = 20.9$) compared to men ($M = 98.0$, $SD = 17.2$; $t = 3.65$, $df = 309$, $p < .001$, two-tailed test). There were no significant gender differences in the probability of respecting the contract or agreement, nor were there significant differences in satisfaction ratings in the follow-up.

Volunteers Versus Paid Staff. There were no significant differences in changes in suicide urgency from the beginning to the end of the calls between calls answered by volunteers and paid staff, nor were there

significant differences in changes on the Psychological Symptom Index or the Brasington Indication of Depression. In the follow-up, there were no significant differences in whether or not a contract or agreement was respected; however, ratings of satisfaction with services were significantly higher when a paid staff member handled the call (78.6% satisfied with paid staff vs. 58.3% satisfied with volunteers; $\chi^2 = 4.97$, $df = 1$, $p < .026$, two-tailed test).

Differences According to Style of Intervention. There were no significant differences between nondirective and directive calls in terms of changes in suicide risk, CCORS scores, changes in the Psychological Symptom Index or the Brasington Indication of Depression, satisfaction with calls, making a contract or agreement, and respecting the contract or agreement.

Comparison of Experienced and Inexperienced Helpers. The mean number of hours of experience in telephone intervention after completing training was 142, and the med-

ian was 140. We compared those with less than 140 hours of experience with helpers with more experience. More experienced helpers were less likely to have an increase in suicide risk between the beginning and end of the call (5.4% vs. 12.2%) and more likely to have improvement in suicide urgency (16.8% vs. 14.7%; $\chi^2 = 8.08$, $df = 2$, $p < .02$, two-tailed test; $F = 4.037$, $df = 1$, $p < .045$). Those with more than 140 hours of experience had significantly higher CCORS ratings ($M = 105.1$, $SD = 19.4$) than those with less than 140 hours of experience ($M = 99.9$, $SD = 20.5$; $t = 2.25$, $df = 309$, $p < .025$, two-tailed test). When experienced helpers with over 140 hours answered the call, half the callers (50.1%) indicated that they respected the contract or agreement in the follow-up, compared to 31.1% when the call was answered by a helper with less than 140 hours of experience ($\chi^2 = 4.07$, $df = 1$, $p < .04$, two-tailed test; $F = 6.679$, $df = 1$, $p < .01$). However, there were no differences in satisfaction ratings in the follow-up for those with more or less experience. Overall, those with more experience were more likely to use a more nondirective style of intervention (55.2% vs. 45.1%, $\chi^2 = 4.70$, $df = 1$, $p < .03$, two-tailed test). When we examined volunteer–paid staff status as an independent variable in ANOVA tests comparing level of experience to each of the outcome measures, there were no significant differences associated with volunteer–paid status, nor were there any significant interactions between volunteer–paid status and level of experience.

DISCUSSION

The findings from the U.S. study concur with results from previous investigations, which found that volunteers were more empathetic and often have better outcomes than professionals. However, these are post hoc analyses in a study that was not designed to compare volunteers and professionals. It is possible that the centers

differ in ways other than the volunteer–professional status of their workers, including differences in the nature of the training and supervision they receive at each center. Nevertheless, most of the possible confounding variables one could identify would seem to favor the centers with professionals. One could assume that centers that can afford to hire professional staff would also have more resources for training and supervision of workers, thus favoring results that are contrary to what we have found. Our results concur with a large number of studies in the 1970s and 1980s in which the volunteers always came out better than professionals. Although congruent with previous research, our results would benefit from validation by more systematic studies in which other variables that might confound the results are taken into consideration.

In Quebec, there were no significant differences between volunteers and paid staff. This may be explained by the fact that, unlike centers in the United States, Quebec suicide prevention centers do not require advanced degrees from their paid staff. At the time of this study, most paid staff had a 2-year college (CEGEP) diploma or sometimes a bachelor's degree. However, they did not receive any specific intervention training in their undergraduate education. This differs from paid staff in the United States, who are generally required to have an graduate degree in an area such as psychology, counseling, or social work, where they are taught psychotherapy techniques.

The Quebec study indicates that helpers with more experience are more effective. This concurs with the Hattie et al. (1984) meta-analysis over 30 years ago, that found experience to be an important moderating factor. The implication of this finding is that it is important for centers to invest in retaining paid staff and keeping volunteers as long as possible rather than focusing on recruiting and training new personnel. We also found that women benefit more from telephone help than men. It

is important to develop and validate more effective approaches with men and to determine why men, who are much more at risk of dying by suicide, may benefit less from telephone help than women.

Unlike the results from our study of U.S. helpline centers (Mishara et al., 2007a, b), where we found that using a collaborative problem-solving approach was related to better call outcomes than a nondirective approach, no differences in the effectiveness of different intervention styles were found in the Quebec study. However, in the Quebec study, all interventions were relatively directive; even those with more nondirective characteristics could still generally be considered as using an active problem-solving approach. This differs from the study of U.S. centers, in which the “active listening” calls were characterized by mostly listening and reflecting, with relatively few questions or suggestions.

These two studies confirm over four decades of research results comparing lay volunteers with professionals: There are no indications that professional training is advantageous in providing telephone help to suicidal individuals. In fact, our U.S. study concurs with previous research indicating that lay volunteers do a better job of helping callers. The Quebec study, which found no significant advantages in paid staff, also did not identify disadvantages. However, the Quebec paid staff could not be considered “professionals” in the sense that they were not required to have professional psychotherapy training or graduate diplomas. In Quebec, paid staff receive the same training and supervision as volunteers.

We conclude from these results and the consistent pattern of findings in previous research that there is no justification for requiring that suicide prevention helpline

workers be mental health professionals. In fact, the evidence to date indicates that professionals may very well be less helpful and effective on the telephone with suicidal individuals and people in crisis, when compared to trained lay volunteers.

Further research is needed to better understand why professional diplomas, which are obtained after many years of specialized training, are not necessarily helpful. It would be useful to determine whether the explanations by Carkhuff (1968), that lay volunteers can better relate to the experiences of callers and that interacting as a peer is better than interacting in the role of an expert, can best explain the differences. It may also simply be that professional training focuses almost exclusively on face-to-face psychotherapy involving repeated contacts with a client, whose methods may be less helpful in an anonymous telephone intervention during a suicidal crisis. Or perhaps, people who apply for or are accepted in professional training programs have characteristics, such as good analytic skills, which may be antithetical to the empathetic emotional abilities that may be more useful in telephone help. It is also surprising, as a high percentage of suicidal callers have mental health problems, that specialized professional training in mental health does not appear to be an advantage in providing telephone help to suicidal individuals. A better understanding of these differences may have important implications for developing new curricula in professional training programs. Furthermore, as more services are provided over the Internet (Mishara & Kerkhof, 2013), we need to better understand what skills and training are best for providing help using the Internet and other new technologies.

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