**Title:** Specialist call-handlers’ perspectives on providing help on a cancer helpline: a qualitative interview study

**Running head:** Call-handlers’ perspectives on providing help

**Abstract:**

Objective: To identify call-handlers’ key experiences of providing telephone help on a cancer helpline.

Methods: Semi-structured qualitative interviews with 30 call-handlers from three UK-based cancer helplines. Transcribed interview data were analysed thematically.

Results: Thematic analysis identified three themes: (1) call-handlers’ perceptions of their role on the helpline, (2) challenges of working on a helpline, and (3) the need for training/keeping up with competencies. Call-handlers reported satisfaction with their experience. However, there are tensions: whilst advice is formally not part of the remit of the helpline, in practice the boundary between giving advice and giving information can be blurred. No follow up with callers could be difficult, and experienced as a lost opportunity to help. Managing patient expectations could be challenging, and interviewees described particular difficulties with distressed callers. Training for the role was commonplace, but there was sometimes a desire for more opportunities.

Conclusion: There are challenges faced by helpline staff, and it can be difficult to manage callers’ distress and expectations of what they might get from a call experience. Recognising the skill and complexity of the call-handler role is important, as is meeting call-handlers’ support/training needs. Support is important to minimise the risk to their own emotional wellbeing.

Key words:

Cancer helpline; cancer information; psychosocial support; call-handlers’ perception; qualitative

**1. Introduction**

Existing research has demonstrated that there is an unmet need for cancer-specific support, psychological help and information for patients and survivors of cancer (Clinton-McHarg et al., 2014). Telephone helplines can help to meet this need, by providing a broadly accessible source of support for those affected by cancer (Chambers et al., 2012). Cancer-related helplines have been in operation for over three decades, (Klemm, Rempusheski, Jurkovitz, Kolm, and Zhang, 2014) and have several benefits: they provide support at a time convenient to the caller (Dean and Scanlon, 2007) and are not constrained by geographic location or transportation issues, thus rendering them widely accessible to many people (Ekberg et al., 2014) and they allow a degree of anonymity that can reduce the stigma of help-seeking (Stacey, Chambers, Jacobsen, and Dunn, 2008). As well as this, callers can discuss questions and concerns in a non-pressurised environment with someone outside of their treatment team (Dean and Scanlon, 2007).

The importance of helplines is recognised by the UK Department of Health, with over 1500 helplines in operation nationally (Ekberg et al., 2014). In the UK, helplines are now a core feature of the healthcare system. The Helpline Partnership’s online directory (previously the Telephone Helplines Association, established in the United Kingdom in 1980), including cancer helplines (<http://search.helplines.org/>), illustrates the number and scope of helplines in the UK. The growth of such helplines stems in part from reforms set out by the Department of Health (1998, 2003) to improve access to healthcare by harnessing information technology.

There is a large demand for cancer-related helplines, and given that the median survival time after diagnosis is increasing (Macmillan, 2017), demand for cancer-related helplines is likely to continue to grow. Although there is obvious need for these services, there is little knowledge about the experience of delivering cancer-related telephone help. There is some existing work examining the effectiveness of cancer helplines, (Clinton-McHarg et al., 2014) the demographics of helpline callers (Reid and Porter, 2011), their reasons for calling a helpline (Boudioni et al., 1999; Dean and Ahamed, 2011; Jefford et al., 2005; Klemm et al., 2014; Ledwick, 2012; Montazeri, Haghighat, Vahdani, Jarvandi, and Harirchi, 1999; Ross, 2007) and the content of helpline calls, (Shaw et al., 2013) but there is little in-depth qualitative research. A recent study explored the experiences of callers to cancer helplines, (Ekberg et al., 2014) but to our knowledge, there is no work focusing on the views of call-handlers on cancer helplines.

This paper explores call handlers’ views of their role and experiences of providing telephone based information, advice, and psychosocial support for callers who are people living with and/or affected by cancer (e.g. relative or friend).

**2. Methods**

Semi-structured face-to-face or telephone interviews were used to identify and explore participants’ experiences of working on cancer helplines and views on offering telephone help (*see Appendix 1*). One-to-one interviews were chosen because they provide an ideal way of eliciting rich information on individual experience. LD carried out the interviews (an experienced researcher trained in qualitative interviewing and she was closely supervised by GML, an experienced qualitative researcher). Participants were given the choice of a telephone or face-to-face interview to fit in with their work schedule. Open-ended questions were designed to meet the aims of the study and a review of existing literature within the field ensured relevant questions were added. Whilst guided, the interviews permitted flexibility for participants to raise issues that were important to them. Interviewees were free to indicate the relative importance of each topic (Green and Thorogood, 2009). Interviews were piloted (these were not used in the findings) with three call-handlers, before finalising the interview guide. Alterations to the interview guide were made in response to the data emerging from early interviews, allowing exploration of new or unexpected emerging themes/topics (Silverman, 2006). Each interview was audio-recorded and transcribed verbatim.

Dedicated cancer helplines were identified through a process of online searches, reference to online directories and through the Telephone Helplines Association (THA) (now Helplines Partnership) by advertising the research on their website. Each had a telephone helpline as well as additional services such as email support. In order to preserve anonymity these helplines are not named, nor the size of the helplines in terms of volume of calls. The three helplines selected for investigation were chosen because they differed in size of the organisation and whether they offered information and advice about all cancers or if they were one cancer specific (for more information on cancer helplines in the UK, see Leydon et al, 2016). The main criterion for participation was to be currently providing specialist cancer help on a helpline, call-handlers working on a cancer helpline in either a clinical capacity (e.g. specialist cancer nurse) or non-clinical capacity (e.g. frontline call-handlers) answering and providing information, guidance and support regarding cancer and cancer related issues. Figure 1 outlines the recruitment process: packs containing information about the study and how to participate were provided to the helplines to distribute. For two of the helplines ten participants were recruited from 30 packs (15 packs per helpline). Ten participants were recruited from the third helpline but it is unclear how many were distributed; therefore it is not known how many people saw them and declined to participate. Anyone who returned a form consenting to participate in the study was invited for interview at a time convenient to the participant and researcher. A fourth helpline was contacted but declined to be involved due to being short-staffed at the time (interviews took place between December 2010 and February 2011 – limitations related to this will be discussed). Participants were given a unique coded identification number in order to maintain confidentiality and anonymity. The Faculty of Medicine ethics committee at the University of Southampton approved the study, reference SOMSEC060.10.

Inductive thematic analysis (Braun and Clarke, 2006), assisted by NVivo 8 software, was used to analyse the data. Transcripts were read repeatedly and patterns and themes that consistently occurred within them were labelled with codes. Each code label referred to the theme content, and a full definition was provided for each theme. In order to test the consistency and validity of coding, the coding was checked by the team/doubled coded (LD, KE, CR, and overseen by GL). Data saturation was achieved when no new codes were being generated. The search for negative cases ensured final themes were not arrived at prematurely and the final thematic scheme could account for the corpus. Written field-notes and demographic information were collected to aid transparency of context and method, enhance analysis and give depth and validity to the interpretations made (Green and Thorogood, 2009).

**3. Results**

30 call-handlers, with various levels of experience (ranging from ten months to 16 years) and a range of men (n=7) and women (n=23) were interviewed from three helplines (see *Appendix* 2 for participant demographics).

Thematic analysis identified three themes (Table 1). Exemplary quotations are provided, together with the unique identifier of participants. Whilst demographic information was collected, analysis revealed no patterned differences according to these characteristics.

***3.1. Call-handler perceptions of the role of the helpline***

Interviews invited participants to discuss what call-handlers understood to be the aims of the helpline on which they worked. A number of aims were discussed and in particular the complex boundaries between information, advice, and psychosocial support and advice were explored.

***3.1.1. Different types of information need and provision***

Interviewees discussed different information needs of callers and described providing information in three key ways: a) as explanation, b) as support and c) providing facts.

Call-handlers described how callers often seemed to call the helpline for information that they have not been able to obtain from their healthcare practitioners, or for information they had forgotten to ask during their often time-constrained consultations.Interviewees’ accounts of information signalled an overlap between information giving and support.Many described how information and support could not easily be separated: they described giving information sensitively to ‘empower’ and support callers and to improve the caller’s day-to-day experience of living with cancer.

“I think giving information is a big part of – giving support – some people, if they are informed, they feel more supported and more in control” (CTOH2; H1).

Call-handlers discussed how some information giving seemed more ‘factual’, such as giving ‘facts and figures’ to callers and answering very focussed or specific questions, often of a medical nature about such topics as trial participation and typical treatment side effects.

“Sometimes the information is at your fingertips, so it might be something very practical like – how a trial is being worked, how it is randomised: sometimes it might be to do with treatment side-effects. So it can be quite factual in that sense” (CTOH1; H1).

Call handlers specifically highlighted the provision of information to family and friends as one of their key roles on their helpline.

Understanding how call-handlers provide information and what information provision means to them helps understand the role of the service being offered and the likely challenges therein.

***3.1.2. The role of support on a helpline***

Almost every call-handler interviewed described providing support as one of their main roles.

“I think that you expect advice and information if you ‘phone your bank or if you ‘phone anyone like that whereas it makes it unique to be able to provide emotional support for someone” (CTFL015; H3).

Some call-handlers also reported that simply allowing callers to talk things through was supportive. Call-handlers described supporting callers by making practical suggestions unlikely to come up in a consultation, and which might improve their day-to-day lives.

***3.1.3. The role of advice on a helpline***

Interviewees described their stance in regard to offering advice and touched on the overlap between advice, information and support. The call-handlers are able to provide *some* forms of advice such as signposting to other services; but they are not permitted to provide more specific forms of medical advice about the caller’s cancer diagnosis or treatment.

***3.1.3.1. Advice-giving on the helpline***

Overall, call-handlers conveyed great caution in their approach to advice. Notwithstanding, several call-handlers described giving advice as part of their role.

“That's often how people start: I'm ringing for advice – and I do worry at that point because often they might be ringing for medical advice, which we can't give” (CTOH1; H1).

In contrast, a few interviewees reported feeling very strongly that advice giving should be avoided, with one describing advice giving as unprofessional.

“I don't think it professionally right, ever, to give advice. You don't know that person – you haven't got enough information and it's not – you know – just not the right thing to do, professionally” (CTOH11; H2).

Not having enough personal information about individual callers provided a common underpinning rationale for avoiding advice giving.

***3.1.3.2. Advice overlapping with information and support***

Call-handlers also reported a blurring of clear boundaries between advice and information. They also described the importance of call-handler impartiality.

Although direct medical advice was generally considered to not be within their remit, they often signposted to support services or other agencies and organisations, and that could be considered advice. In particular, several call-handlers reported that they often recommend a caller visit their healthcare practitioner, considering that to be advice. It is debateable, however, that this definition would be accepted across the helplines sector as a whole. Many helplines view it as important to ensure that a vulnerable caller understands the options available to them, and this may include the option to access healthcare.

“We try and empower them to make decisions themselves, for example or – you know – talk through information so they can make their own decisions, that kind of thing” (CTOH12; H2).

“There needs to very clear remit and boundary for the service that you’re providing, and everyone who’s working on the helpline needs to understand what those boundaries are… and that can be a training issue” (CTOH5; H1).

***3.2. Challenges***

Challenges varied and ranged from knowledge related challenges to caller related challenges. The majority of the challenges were reported by all call-handlers, however there were some differences between call-handlers depending on whether they were working in a clinical or non-clinical capacity.

***3.2.1. The challenge of providing a service over the telephone***

When asked to describe key challenges, interviewees oriented to how difficult communicating by telephone can be. In particular, it was often hard to make sense of the information they were given over the telephone: it was described as more challenging because of a lack of visual / gestural cues between them and their interlocutor. However, a few call-handlers suggested anonymity could be a positive feature of their work, in that it helped callers to open up more.

“People want to speak to somebody completely detached from the situation, so not a relative or friend and not a health professional involved in their care, but somebody completely separate and so they have rung us in their time” (CTOH1; H1).

***3.2.3. Knowledge-related challenges***

More than half of the call-handlers interviewed described an unending need for ‘new’ or ‘updated knowledge’ as a challenge to providing information on the helpline. They described inevitable gaps in knowledge about treatments and clinical knowledge and the importance of staying up to date with the NHS. A few other knowledge-related challenges reported by call-handlers were related to accessing information for callers, and having different areas of specialised knowledge within the helpline team.

***3.2.4. Challenges – caller related***

All call handlers reported some level of challenge that was related to the nature of the callers themselves, and these varied from caller anger and caller distress, to ambiguity for the reason for the call. Call-handlers reported difficulties in engaging with callers who were angry at the NHS, health professionals or the charity, for example when they were not receiving the information they needed or had long waiting times.

Similarly, call-handlers discussed the difficulties of speaking with upset callers, describing some callers as distressed, aggressive or disagreeable. Some callers, in particular men, were viewed by a few call-handlers as not always wanting support. Other ‘repeat’ callers, especially those with mental health problems, or who were described as not showing signs of acting on help offered, were also discussed as challenging, which could lead to ‘circular’ calls.

“Some of the more anxious callers that maybe repeat calls – working out the best way to help them can be quite difficult – without getting trapped in a rather unhelpful circle” (CTOH2; H1).

Calls that dealt with poor prognosis or difficult pathways were also discussed: not knowing how to offer hope or support was a particular concern. A few call-handlers reported that callers’ expectations can be hard to meet and described finding it difficult not knowing whether support had been helpful at the end of the call.

“One example I have is a woman who er wanted me to give her a hypothetical prognosis but we deal in facts and information and when I wouldn’t do that she hung swore and hung the phone up on me so” (CTN023; H3)

***3.2.4.1 Ambiguity of caller reason for the call***

Call handlers described how calls could be difficult because of a lack of clarity of the primary concern of the caller.

“I think it can be difficult in work- in getting the caller to really define what it is that they are looking for rather than just saying they want support” (CTFL018; H3).

Some described key techniques they use to manage this challenge, including allowing the caller time to talk and asking callers open questions in an effort to unpack their concern(s).

“There won’t necessarily be a strategy, per se, however we do use helpline skills and communication skills like open questions, empathising, reflecting, that kind of thing” (CTOH12; H2)..

Several of the call-handlers described the challenge of receiving inappropriate, rude, or hoax calls.

***3.2.4.2. Gauging the success of a call***

Call-handlers reported that the success of calls was sometimes difficult to gauge, especially if there was no direct positive feedback from the caller, although it was sometimes possible to pick up on cues to work out whether the caller was satisfied.

Several call-handlers described the importance of *positive feedback from callers* in helping them to gauge whether a call had been successful. Call-handlers described successful calls as ones in which callers seemed to be calmer at the end of the call and more able to make sense of what they are going through, although how this would be judged was not clear. Several call-handlers described a successful call as one in which the *caller’s expressed needs have been clearly met* and an unsuccessful call was one where the caller’s needs could not be met, although a call could be viewed differently by caller and call-handler.

“A successful call I think would probably be one where (.) the caller comes away feeling supported and like they now kind of have the tools to support themselves” (CTFL011; H3).

“On the other hand, if you are on a call when someone says well, you're not really giving me what I want, that's a difficult one because in a way it might have been successful because I quite rightly haven't been able to answer their questions” (CTOH1; H1).

Call-handlers described the difficulty of having no follow up with callers, and discussed how having a more continuous relationship might be beneficial.

“We don't always get the feedback because – often we speak to people and we won’t speak to them again, although, clinically, we get continuation, with this job we don't, always” (CTOH1; H1).

***3.2.4.3. Ending calls and end of the day calls***

Interviewees described how they ended calls on the helpline, and how this could sometimes be challenging. Calls were described as generally coming to a natural end, although calls experienced as difficult were often more challenging to close. Call handlers described differing techniques for closing, such as asking if there is anything else, and pausing to permit callers to raise other concerns before closing. Finally, call-handlers described the challenges posed by end of the day calls when they had little time to offer the caller and too few call-handlers still working with whom they could debrief if the call turned out to be a difficult one.

“Yeah sometimes you’re just not in the right place yourself you know if it’s 4 o clock in the afternoon and you’ve been on the phones all day then you might take a call and at the end of it think gosh you know I really wasn’t at my best then and you know had it been first thing in the morning I might have responded very differently to that call” (CTN012; H3).

***3.1.4. Role limitations***

While discussing the limitations of their roles on the helpline, call-handlers also reported managing callers’ expectations as an important part of their job. Call-handlers described often feeling that callers had ‘unrealistic’ expectations about what the helpline could offer them. For example, some spoke of patients making requests for information about their particular ‘case’ of cancer, and some for requests about likely prognosis. Call handlers described the inappropriateness of attempting to answer such questions; in part driven by the practical hurdle of not having access to the individual’s case notes and the associated epistemic limits of what they could say. Call-handlers typically reported managing such situations by exploring caller expectations and the desired outcome of the call, thereby allowing them to explain what the helpline can and cannot do, or by offering to transfer a caller to a manager as well as knowing when to signpost to external agencies.

“A successful call I think would probably be one where (.) the caller comes away feeling supported and like they now kind of have the tools to support themselves” (CTFL011; H3).

***3.3. Training/keeping up with competencies******and organisational support***

Interviewees discussed initial training as well as their views on the need for, and the challenges of, completing on-going training.

***3.3.1. Satisfaction with initial and on-going training***

Several call-handlers described feeling confident and well supported following initial training, while others described training as being too basic.

“We did call listening that's quite a big part of the training erm and it's a really useful way of kind of hearing how other people do it because you pick up loads of different (.) kind of sty- styles of answering calls” (CTFL011; H3).

Initial training tended to be workshop-based learning focusing on key skills such as managing difficult calls. Several call-handlers mentioned they would have liked more communication skills training, although one individual felt training was possibly not needed due to the intuitive nature of what they do**.**

Satisfaction with on-going training was described by some call-handlers as being adequate and better than in previous jobs. Staff reported feeling supported and were keen to have continued training and support, recognising its importance for quality control and staff well-being. Interviewees described a range of approaches to on-going training and monitoring, and these are outlined in Table 2.

However, some call-handlers, especially the clinical call-handlers, discussed a need for more training in order to keep up to date with the cancer information policy landscape and literature. Call-handlers described the challenge of balancing their need for up to date knowledge with time spent on helpline calls.

“We get stuff sent through from the press, all the comments about cancer from our own organisation or elsewhere; if you read all of that, you wouldn’t actually do any of your job. So trying to keep up with what was in the papers that day” (CTOH1; H1).

All call-handlers described receiving regular appraisals. Approaches to monitoring included recording and listening back to their calls and supervision meetings.

Q8. “We do call recording and he listens to them and he gives us the opportunity to listen to our own calls – and everybody says how valuable it is, listening to their own calls and where they've gone wrong” (CTOH6; H1).

Interviewees described the purpose of monitoring as a vehicle for maintaining good standards within the organisation, supporting call-handlers to work well and to improve their call handling skills.

“It’s always been a very supportive environment because it’s so different to what you did before and because everyone knew how different it was there was that kind of fellow feeling of teamwork” (CTN008; H3).

***3.3.3*. *Talking to colleagues, debriefing and taking breaks after difficult calls***

In recognition of the potential for call-handler burnout and distress related to their work on helplines interviews explored how they managed difficult calls and supportive strategies they tried to employ. Call-handlers described being able to talk to colleagues after difficult calls and the importance of this mutual support.

“You can always find one of the nurse specialists outside or the helpline manager is around usually. There’s never a shortage of somebody that you can talk it through with” (CTOH7; H2).

In contrast, one call-handler highlighted the difficulty of supporting colleagues when they too might have had a tough call to deal with. In similar fashion to informal chats with colleagues call-handlers described the practice of debriefing at the beginning and end of the day, although this was not always possible.

“You also have got 15 minutes at the end of the day where one person covers the line and the rest of us debrief and that’s where we can take our calls” (CTOH11; H2).

Call-handlers described being able to take short breaks after difficult calls. However, some call-handlers described situations of not having enough time to recover after taking a difficult call before needing to answer another.

**4. Discussion**

***4.1 Discussion***

Qualitative semi-structured interviews with 30 call-handlers identified three key experiences associated with providing telephone help. These were: (1) call handlers’ perceptions of their role on the helpline; (2) challenges of working on a helpline; and (3) the need for training/keeping up with competencies. Working on a helpline was described as intense and some calls, particularly where the caller has wider mental health needs, were found to be challenging. Often callers’ medical problems cannot be separated from social and emotional issues they may be facing; staff therefore may need more training/support in managing psychosocial issues. Although the training varied slightly between each organisation, they typically offered generic skills training in the form of workshops and presentations rather than formal guidelines about call-handling for the service. Call-review whereby call-handlers calls are listened to with a supervisor in one to one supervisions also featured as a mechanism for on-going training and, in turn, quality control.

Many helplines set clear boundaries in their service provision as to whether they aim to specifically include the provision of advice in their service. Helplines that tend to categorise themselves as providing advice may be more likely to have clinical staff on the workforce, or be working in a specific advice provision field such as welfare rights. It was clear from this research that whilst advice was not within the scope of the helplines it was difficult to maintain a strict boundary between the activities of supporting and informing, and advice-giving. All call-handlers described support as one of their main roles on the helpline, emphasising the importance of listening to callers, acknowledging their experiences, and showing empathy (similar to call-handlers working on other helplines – see Hepburn & Potter (2007), and also Woods (2017) for a discussion of differing ways in which support is offered on a major helpline service). This perception of their role complements the perceptions of callers to cancer helplines. A previous study (Ekberg et al, 2014) that interviewed callers to cancer helplines found that callers’ key reason for using these helplines was to speak anonymously to someone about their cancer issues, while at the same time receiving reassurance, emotional support, and compassion. The findings from these two studies combined emphasise the importance of helplines for addressing the psychosocial needs of those affected by cancer, and how these needs are intrinsically intertwined with information or advice-seeking needs.

There were a number of challenges in working within a helpline setting discussed by call handlers. Callers can be distressed or angry at wider health system failures during calls. Staff are reliant on listening to the caller, and other communication features such as speed and tone of voice and they clearly do not have the benefit of the key para-linguistic communication features of body language, gestures and facial expressions to pick up on additional cues. Call handlers have no idea what problem a client will call with, the range of issues that can be covered is wide, they (typically) have no previous knowledge of callers (unless it is a call-back), and, once a call is closed, they have no on-going contact or mandate to follow-up (services are organised in such a way that repeat callers will seldom get to speak to the same call-handler). This, combined with boundaries created by not having access to key non-verbal communication, can limit call-handler’s ability to advise or to feel they can fully meet caller expectations. This is an important consideration for service delivery as callers have reported that the communication manner of the call-handler on the helpline is one of the vital elements of a call for a caller to feel like they had a successful call (Ekberg et al, 2014). It was also generally the case that managing caller’s expectations felt difficult. Finding ways to communicate with callers what they can and cannot do at the beginning of calls was described as one approach for managing this. It seemed, on the whole, that this approach was something call handlers learnt to do over time with experience. Still, with so many challenges outlined, the risk of vicarious trauma needs greater understanding and attention in the literature (Howe, 2015), especially with evidence suggesting call-handlers can indeed experience trauma vicariously (Golding, 2017). Call-handlers were keen to have continued training and support, recognising its importance for supporting them as well as ensuring sound quality control: staff had mixed views on the adequacy of support available. Recent survey research of 69 UK cancer helplines suggested that helpline organisations view training as an “on-going process”, although organisations did not elaborate further. Whilst 59.7% (n=40) of helplines reported availability of supervision and support for staff, 32.8% (n=22) of helplines did not have formal systems in place (Leydon et al, 2016).

Call-handlers’ perceived lack of control over outcomes has been reported elsewhere (Palmer, 2014) and the research reported here showed helpline staff described finding it difficult in some circumstances to know how successful a call has been. In this regard, they found clear feedback from callers useful, which resonates with recent work that analysed a sample of cancer helpline calls (Woods, Drew, Leydon, 2015). Authors identified a clear practice of call-handlers holding off closing calls until they had received a clear appreciation of the call from callers– i.e. they were in search of caller permission to close or some indication that their expectations had been met during the call.

***4.2. Conclusion and limitations***

Call-handlers were generally positive about their experiences of working in a helpline environment. There are many challenges that are likely to be encountered by call handlers working in the helpline sector, from ensuring their own welfare and supportive strategies are in place to managing call volume and caller expectations. These findings highlight the importance of helplines providing their staff with the support and resources required for them to provide this important service to callers without risking staff burn-out.

The time elapsed between the interviews and the reporting of findings potentially limits the relevance of key patterns identified in call-handler experiences and views in this interview study. However, there continues to be a lack of information on the perspectives of call-handlers in the United Kingdom and the important work they do. Moreover, there is no reason to believe that the motivations for being a call handler or the challenges faced have changed appreciably in the intervening period between data collection and publication. What we do know is financial challenges have increased (with less core government funding) for this sector and demand has continued to rise (The Helplines Partnership, 2011). Hence, speculatively, the challenges reported are likely to have intensified over time, rather than changed completely.

***4.3. Practice implications***

In line with previous survey research it is clear that “further research in partnership with helplines is required on how best to train and support staff” in this important work (Leydon et al. 2016). Moreover, a better understanding of what optimal call-handling looks like in order to design empirically based training is needed. As the sector continues to grow more support may be needed in order to ensure that staff do not face risks of negative impacts on their own emotional well-being. Call handlers in this study discussed the difficulties of long shifts on the helpline, as well as the draining and emotional nature of the work. Interviewees expressed a need for greater emotional support, and desire for more training to enhance their ability to maintain their clinical skills, to manage difficult calls, and ensure up to date information for their callers. Providing after-call support and on-going training to call-handlers have been suggested as valuable protective factors for the wellbeing of helpline staff (Howe, 2015). This might be happening across many helplines in the sector. Ultimately, this glimpse into the experiences of call-handler work highlights the skilled work of a cancer helpline and reinforces what we know from other literature about the essential role they can play for those affected by cancer.

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**Figure 1: Flow diagram showing process of recruitment for call-handler interviews.**

**Table 1: Themes and sub-themes**

|  |  |
| --- | --- |
| **Themes** | **Sub-themes** |
| 1. Roles: many but constrained | * 1. Different types of information need   2. Role: support   3. Role: advice   4. Limitations |
| 1. Challenges | * 1. Providing telephone support   2. Knowledge-related challenges   3. Support-related challenges   4. Caller-related challenges |
| 1. Training/keeping up with competencies | * 1. Initial training   2. On-going training   3. On-going professional development |

**Table 2: Training, monitoring and appraisal**

|  |  |
| --- | --- |
| **Training** | **Content of training** |
| Initial training | Practical aspects of the job, process of beginning to take calls themselves, and training received from outside organisations. |
| Keeping up to date | E.g. In house update days for new skills/services. |
| Communication skills | E.g. Views varied – some wanted more, while others felt it was a natural skill and initial training was adequate. |
| Study days from/with other organisations | E.g. Training was provided in–house and by other organisations with other helplines. |
| On-going professional development (appraisals and monitoring) | E.g. Informal and formal monitoring was common including regular appraisals. All staff saw the utility of this for quality control/staff support. |