Summary of Research and Evaluation of Crisis Helplines

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Background

Telephone crisis line services have contributed significantly to community-based crisis support and suicide prevention since the 1950s. They have played a vital role in the early and subsequent development of suicide intervention knowledge and practice.

Internationally, these services are active in over 60 countries with well over 100,000 trained volunteers, supported by professional staff, to provide direct services to their communities (Scott, 2001; Bezencon, 2001; Domnish, 2001). The nature and range of these services has also been reviewed in Australia (Urbis Keys Young, 2002).

Following early research in the 1960s and 1970s (e.g. Litman, 1970, 1995; Sudak, Hall and Sawyer, 1970, 1995) published studies dwindled until research interest rekindled in the 1990s (e.g. Mishara and Daigle, 1992; Mishara and Daigle, 1997). Overviews of lessons learned from early evaluation studies began to lay foundations for future development (e.g. Farberow, Heilig and Litman, 1994; Mishara and Daigle, 2001).

The most comprehensive published studies have been conducted in association with two major North American projects (e.g. Mishara et al., 2007b; Kalafat, et al., 2007; Gould et al., 2007). These have provided genuine grounds for promise by demonstrating evidence of service benefit, while also highlighting needs for significant service improvement and development.

Findings from Crisis Line Research

Crisis line evaluation and research has focused on five key areas.

   i.   Impact of Crisis Centres in Communities – investigating whether the presence of suicide intervention crisis lines in communities has an impact on suicide rates;

  ii.   Service Promotion and Utilisation – evaluating the effectiveness of strategies designed to improve service utilisation;

 iii.   Service Reach – determining whether these services are attracting callers from a wide range of backgrounds who are in crisis and particularly those at risk of suicide;

 iv.   Crisis Supporter Processes – evaluating the alignment of service purpose, standards, training and helping style and their collective impact on caller outcomes, particularly in terms of relief from emotional distress and the development of coping capabilities with the caller;

  v.   Caller outcomes – measuring mission-aligned outcomes within and beyond the call for people in crisis and / or at risk of suicide.

Impact of Crisis Centres in Communities

This research has investigated whether reduced suicide rates occur in places where telephone counselling services are active.

A 1997 review by Lester identified fourteen such studies. Results have shown either slightly positive (Bagley, 1968) or neutral associations (Bridge et al, 1977; Jennings et al., 1978). Lester's (1993) own study found a 'consistent though weak' association between the presence of these Centers and reduced rates.

Goldney (1998) found the results of Lester's (1997) review 'unusually persuasive' given the methodological problems involved. Speculating on the therapeutic ingredient he noted that 'it may well be that the establishment of suicide prevention centers is perceived by the individual as an indication that the community cares, and that even though such contact may be anonymous, it provides hope to the individual' (p. 4).

However, the methodological problems in isolating and measuring the contribution of any intervention modality to reducing suicide rates are formidable. Accordingly, most research has focused on those who actually provide or received crisis line services.

Service Promotion and Utilisation – Crisis Lines

One measure of service effectiveness for crisis lines is their capacity to encourage service access for those in crisis, distress and / or at risk of suicide.

Jobes and colleagues (1996) investigated the aftermath of Kurt Cobain's suicide in his home town of Seattle. They found little evidence (one possible case) of copycat suicides. However, they reported a significant increase in calls to the city's Crisis Centre. They hypothesised that responsible media coverage and effective mobilisation of community resources channelled distressed, potentially suicidal, people toward help-seeking rather than expressing that distress through self-harm or suicide.

Lifeline's National Youth Suicide Prevention Project (YSPP) stimulated an increase of 64% in suicide calls from callers under 25. However, numbers receded toward the baseline once the project ended, highlighting the importance of sustaining momentum (Turley, et al., 2000a).

A subsequent report demonstrated that the Victorian Suicide Intervention Helpline increased the number of those calling about suicide from a baseline figure of 1300 in Lifeline's generalist service to a quarterly average of 3,309 during the 18-month field trial period – a gain of 150% (Turley, 2000b).

Increased *promotion* and *capacity* featured in both studies. Improved access expands prevention opportunities**.** *Community perceptions* also influenced service uptake. Consumers need to be aware that the service exists and also understand what it potentially offers them in relation to general and suicidal crises.

Service Reach – Callers at Risk of Suicide

A further area of research has sought to determine whether crisis lines are being accessed by persons in crisis who are at high risk of suicide.

In this regard, it is pertinent to note that Australian Newspoll data has found that more than 91% of Australians associate Lifeline with suicide prevention and the provision of support services. This high level of service recognition provides a strong foundation on which to build, provide and evaluate access solutions that enable help-seeking.

Lifeline combines broad population accessibility with the capacity to target groups and individuals known to be at high risk of suicide. Strategies to promote its availability to service providers as well as potential consumers can be implemented and evaluated. Service reach can also be assessed in terms of the range of backgrounds of callers so that the focus is on people who are in crisis and at risk, not necessarily only particular target groups, ie: that the service is perceived as and utilised by anyone.

Despite some scepticism (e.g. Lester, 1972), early follow-up studies indicated that crisis lines were attracting callers at significant risk of suicide (Litman, 1970, 1995; Sudak et al.,1970, 1995).

A Lifeline follow-up study of 72 young adults who had phoned about suicide reported similar findings. Results showed that 45% reported having a suicide plan at the time of the call and 38% had access to means that would implement the plan. Over half (58%) indicated that they had engaged in prior suicidal behaviour (Turley et al., 2000a). This last figure is particularly important, given that persons reporting prior suicidal behaviour have a risk of completed suicide that is over 30 times that of the general community (Jamison, 1999; Cooper, et al., 2005).

More recent North American research with much larger sample sizes has confirmed that that crisis lines are attracting callers facing significant crises, many of whom are at high risk of suicide (Mishara et al., 2007; Kalafat et al., 2007; Gould et al., 2007).

Gould and colleagues (2007) reported a detailed risk profile analysis for those who were suicidal. They found that over half had a suicide plan at the time of the call, while 8.1% had taken some action to harm or kill themselves immediately prior to the call. Over half (57.5%) reported prior suicide attempts and half of these had made multiple attempts. Overall, the risk profile is remarkably similar to that found in Lifeline's study (Turley, 2000a).

In sum, these services are attracting callers with a clear suicide risk profile. However, it does appear that women are more likely to call than men (e.g. Miller, 1984; Lifeline Australia call data) and there is an uneven distribution across various age-groups. More needs to be learned about how representative callers are of persons at risk of suicide to ensure that the reach of these services is comprehensive.

Crisis Supporter Processes – Effective Helping Styles

Research on crisis lines has also been conducted to determine which inputs and processes are associated with good outcomes.

Several early studies sought to determine whether Rogerian characteristics such as empathy, warmth and genuineness, presumed to faciliate good outcomes, were displayed by helpers (Rogers, 1957; Knickerbocker and McGee, 1973). Helpers' problem-solving skills were also evaluated (Slaikeu, 1983). Results were mixed, although there was some evidence that trained volunteers provided a comparable helping environment to clinical workers in crisis intervention (McGee and Jennings, 1973, 2002; Durlack and Roth, 1983). These studies focused more on practitioner capabilities than caller or client outcomes.

During the 1990s, Mishara and colleagues initiated a more comprehensive sequence of studies to determine which helper processes and helping styles were associated with good caller outcomes (Mishara and Daigle, 1992; Mishara and Daigle, 1997).

The most recent culmination of this work found that natural helper qualities such the capacity to communicate empathy and respect increased the likelihood of good outcomes (Mishara et al., 2007b). The learned capacity to provide support and make good contact was the most strongly related process to good outcomes. Examples include validation of feelings, giving moral support, reframing, talking about one's own experiences and offering to call back. Collaborative problem solving also helped account for positive caller outcomes. These factors demonstrate the importance of a 'positive helping relationship' being established with a caller, and therefore evidence of this relationship and its features should be a part of crisis line evaluation.

However, it is important to recognise that research by Mishara and colleagues also showed that while active listening encouraged more emotional expression (crying) it was not significantly related to positive outcomes. The nature of a 'positive helping relationship' is more complex than simply allowing a caller an opportunity for emotional expression.

Accordingly, this research examined the balance between directive and non-directive helping approaches originally conceptualised by Rogers (1942). Qualitative observer ratings found that a call-appropriate blend of these two approaches yielded the best outcomes.

Caller Outcomes

Several studies have documented specific caller benefits during and after crisis line contact. These include:

- Changes in the callers' crisis state or suicidality during the call;
- Resourcing for improved crisis management such as the development of action plans and the provision of referrals and
- Flow-on benefits after the call, as assessed in caller follow-up.

Reduced crisis state and suicidality

Kids Help Line research reported a significant reduction in suicidality and improvement in mental state from 100 young suicidal callers (King, Nurcombe, Bickman, Hides and Reid, 2003). Researchers readily acknowledged limitations of the study such as lack of case control or follow-up while noting that the very act of help-seeking may herald greater openness to finding alternatives to suicide. However, their research did provide promising indications of positive immediate impact for callers at risk.

Research with non-suicidal crisis callers found a significant reduction in their distress by the end of the call compared with baseline assessments of crisis state when the call started (Kalafat et al., 2007). Callers were significantly less confused, depressed, angry, anxious, helpless and overwhelmed and also less hopeless. Since amelioration of crisis state has been shown to contribute to improved crisis management, these results provide preliminary support for the crisis intervention value of these services.

Mishara and colleagues reported that while there was no significant change in observer ratings on many of the variables examined, changes that did occur were positive (Mishara et al., 2007). In particular, a majority were rated as less confused and more decided at the end of the call. Improvements in resourcefulness, hopefulness and confidence were also noted in many callers. However, about one in ten callers reported outcomes such as increased apprehension, sadness, hopelessness and confusion. This highlights the importance of attending to caller process during the call and the skills required to set and meet realistic goals when working with callers in crisis within a limited time frame.

Gould and colleagues (2007) measured changes in suicidal callers at the beginning and end of the call. They identified a significant reduction in suicidal status during the call on measures assessing intent to die, hopelessness and psychological pain. They found that these immediate outcomes were not modified by the risk profile.

A subset of callers were asked to reflect on their crisis contact when followed up within the next month. They identified the counsellors' warmth, willingness to listen, letting them talk and clarify options and patience as qualities that contributed to good

outcomes. Notably, 11.6% indicated that the call prevented them from killing or harming themselves.

Overall, there is promising evidence that crisis line contact does help alleviate distress and reduce immediate suicide risk in many callers. Variabilities in outcomes are likely to have been significantly impacted by inconsistencies in counsellor performance, highlighting improvements needed in training and service delivery.

Foundations for post-call crisis management

The development of action plans and provision of referral options are also important features of the call and are designed to enable coping and increase resourcefulness after the call has ended.

The study by Kalafat and colleagues (2007) on non-suicidal crises found that action plans were developed in nearly 6 in 10 callers and included such things as reaching out to a partner or friend or identifying relaxation activities. Two thirds of callers either received a new referral or were encouraged to reconnect with services previously accessed by them. Mental health care predominated in referrals provided.

Research with suicidal callers conducted by Gould's team (2007) initiated emergency interventions for one in every eight callers. Nearly half of the callers in the study were given new referrals while a further 10.7% were re-linked with their existing services. The researchers expressed concerns that these referral rates may have been lower than was warranted by information provided in the call and noted the need to improve referrals to mental health care in particular.

More recent research has suggested that telephone crisis lines can play a useful part in linking at risk callers to ongoing mental health care. In a study published in 2012, researchers Gould, Munfakh, Kleinmann and Lake report that of those callers who received referral information for mental health care, approximately 50% did utilise this information. Given that this study occurred in the USA, where barriers to health care because of lack of health insurance are significant, the result is possibly an under representation of what is possible through the activation of help seeking action during a telephone crisis line call.

Flow-on benefits

Beyond measuring immediate caller benefits during the call, researchers have also sought to determine the flow-on effects of crisis contact.

The Kalafat and Gould research teams therefore also conducted follow-ups two to four weeks after the call with a subset of the sample to identify whether alleviation of distress and reduced suicidality measured during the call was sustained. These follow-ups also invited callers to reflect, retrospectively, on the crisis call and enabled an assessment of callers' follow-up on action plans and referrals.

The non-suicidal crisis callers in the Kalafat study had positive recollections of the crisis contact, indicating that they felt heard by empathic helpers who also helped them to calm down and identify options relevant to their concerns. A further reduction in crisis state was found in these callers. Most of those who had developed action plans had followed through on them or implemented first steps, which was more promising than the lower follow-through on referrals. The researchers conjectured that, for some, the alleviation of distress in the crisis call and reduced the impetus for further help, although inappropriateness of referrals was also cited as an issue for some callers, highlighting the need for service improvement in this area.

Follow-up with suicidal callers conducted by Gould's team found further abatement of callers' psychological pain and hopelessness after the call in contrast to the intensity of their intent to die. Suicidal ideation persisted in the weeks following the call for 43% of callers while 3% made a suicide attempt. Thus, while some flow-on benefits were evident, continued vigilance and the deployment of follow-up strategies are indicated.

A caller's intent to die at the end of the call was the best predictor for the persistence of suicide risk after the call and the intensity of this intent did not significantly diminish in the follow-up period. This flags the importance of reviewing the caller's intent to die toward the end of the call as an indicator of elevated suicide risk that needs to be managed in the period immediately after the call.

Overall, these studies provide promising, if preliminary, evidence that the participating crisis lines did deliver outcomes consistent with their goals of providing crisis support and reducing immediate risk of suicide. They also demonstrate how research can identify areas that need addressing to increase helper competencies and enable service improvement.

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