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Title: The experiences of frequent users of crisis helplines: A
qualitative interview study

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Keywords: Crisis helplines; Health service use; Experience of care;
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PATIENT EDUCATION AND COUNSELING

CHECKLIST for the preparation of papers

Please **ensure** that your paper conforms to the following guidelines:

SPELLING

- ☒ In the manuscript US or UK usage should be followed but not a mixture of these.

AFFILIATIONS

- ☒ Forenames for all authors in the author list; no titles like prof., Dr., etc
- ☒ Affiliations must appear in English
- ☒ In the affiliations use USA and UK instead of United States and United Kingdom
- ☒ The following should be followed for all authors' affiliations: only Department, University, City and Country
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ABSTRACT

- ☒ Abstracts should be structured and have the following headings: Objectives; Methods; Results; Conclusions; Practice implications

MAIN TEXT

- ☒ All Original Articles must contain a first order heading section Discussion and conclusion and 3 second order headings 1) Discussion 2) Conclusion 3) Practice implications. Only within Discussion there may be subheadings.

REFERENCES

- ☒ Abbreviations for the names of journals in the reference list should follow Index Medicus (e.g. JAMA should read J Amer Med Assoc, BMJ should read Brit Med J). The abbreviation for Patient Education and Counseling is Patient Educ Couns
- ☒ Issue numbers and months must not be included in the reference list (only year, volume numbers and page range required)
- ☒ Page ranges in the reference list should appear as follows e.g. 310-5

☒ Titles of non English publications should be given in English language, between []

For further details see the extended guidelines

Wednesday, 8 June 2016

Dear Peter,

RE: The experiences of frequent users of crisis helplines: A qualitative interview study

Thank you for your careful consideration of the above resubmitted manuscript for publication in Patient Education and Counseling. We appreciate the time you have taken to review this paper and provide us with valuable feedback on how to further improve this manuscript. In particular, you have highlighted the need for clarification around the justification of the conceptual framework and the calling behaviour descriptions. We have carefully considered each of these points and now present what we believe is an improved version of this manuscript.

To assist with the Editorial process we have provided the following as attachments:

- A detailed response to your comments and where we have added text to the manuscript this is marked with grey italics; and,
- A revised manuscript with changes underlined.

Based on your feedback we have made several revisions to the manuscript. Firstly, we agree that the conceptual framework was unclear and have revised Figure 1 to better represent the content of the interviews. Based on these revisions we have also provided evidence in the text, using respondent quotations, to demonstrate how the three components prompting the frequent use of crisis helplines are interrelated. We have also revised the descriptions of each of the calling behaviours. All of these edits were made after reviewing the raw data and have been approved by all of the authors. We have thoroughly read the final manuscript to identify any further unclear statements or grammatical errors.

No data, patient information or other material of results closely related to the submitted paper have been published or are in press, submitted or nearly submitted.

On behalf of all the authors I thank you for reconsidering our manuscript for publication.

Yours sincerely,

Ms Aves Middleton

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The University of Melbourne

Summary of response to reviewers comments for “The experiences of frequent users of crisis helplines: A qualitative interview study.”

	Reviewer comments	Authors response
Editor	<p>Although the main categories of analysis are now better supported by data, the links you claim between the categories are not. You claim that <i>'These behaviours seemed to occur as an unintended consequence of the interaction between the factors motivating frequent users to call and the characteristics of the helpline service model'</i> but I do not think that you provide data to support such an interaction. It may be that you are just making an 'obvious' point - that the open and unrestricted access encouraged users to keep calling.</p> <p>A related part of the analysis that does not work convincingly is where you write that each type of calling behaviour was linked to people feeling better after their call. Because people in each group feel better, the finding does not seem to have any specific relevance in the context of the account of these different types of calling. Rather, you seem simply to be observing that, as you report elsewhere, people generally felt the service met their needs.</p> <p>If you can show that interactions in the <i>'conceptual framework'</i> do emerge from the data, it is fine to introduce it in Results. If not, it is better to introduce it in Discussion.</p> <p>In clarifying the analysis, the aims are exposed as not completely clear. It seems that you want to understand why people use the service so much (end of penultimate paragraph of introduction), which is a clear statement. But then you specify the aims as to explore reasons for, and experiences of, calling, which is a much more diffuse statement (there would be many aspects of experiences you could explore, in addition to</p>	<p>We have added the following paragraph at the start of the results before introducing the figure that demonstrates how these three categories are interrelated.</p> <p>“Frequent use was related to three interrelated components, namely; reasons for calling, service response and calling behaviours. Reasons for calling were closely related to the response they received from Lifeline, which one caller described as: <i>“well I do have a trauma history...when you talk to some counselling services they want you to stay a victim...whereas...Lifeline...talk to people about hard issues...they know how to...pull you out of that, and that...is what makes them so good to talk to, because you don’t feel like you’re a victim...they are very pragmatic and understanding”</i> [Caller 10; F; 25-44yo]. Such a response would then drive their calling behaviour because Lifeline <i>“were happy to talk to you even if you rang back several times within the day, and they’re still happy to talk to you...when you’re friends...get busy and...can’t talk...so I am a bit more reliant on Lifeline”</i> [Caller 16; F; 45-65yo]. The calling behaviours were also linked to their reason for calling, as demonstrated by: <i>“when I get upset or [have a] problem, that’s when I reach out”</i> [Caller 13; M; >65yo]. A conceptual framework illustrating how these components are interrelated is shown in Figure 1 and a description of each component is provided below.”</p> <p>In each of the calling behaviour descriptions we have removed any reference to callers feeling better after calling and instead have only described the factors prompting the behaviour and the regularity.</p> <p>We have now used data from the interviews to clearly show that frequent use was connected to three interrelated components and have therefore kept the conceptual framework in the results section.</p> <p>The aim of the study has been revised to: “...understand why some users call crisis helplines frequently”. Furthermore, the analysis and results have been revised to reflect this aim.</p>

those you describe here). Then, in Results, you seem to be aiming not only to understand reasons for calling but to describe patterns of calling. The paper needs a more coherent sense of its purpose.

A final point about analysis: '*Service characteristics*' is an 'a priori' and uninformative heading that does not do justice to what the respondents are telling you about 'what happens when they call' - which is how you introduce this component of the findings.

The heading of each of the emerging themes has been revised and now read as:

1. Reasons for calling
2. Response from Lifeline
3. Calling behaviours

Some statements are unclear:

- What do you mean by 'respondents had similar motivations for calling'. You did not say they shared all three motivations where you describe those motivations.
- **p3** '*lack of consistent variables between studies*' is awkward. Do you mean 'and differences in the variables studied'?
- **p6** The account of analysis is rather confusing because of reference to 3 overarching (but unspecified) themes and three categories of calling behaviours. The distinction between the '*conceptual framework*' and '*typology of calling behaviours*' is also unclear - isn't the latter part of the conceptual framework? The point links to the ambiguity in the aims.
- You refer to '*grouping*' respondents into '*categories*', but then in Results you report that many respondents were in more than one category, so it becomes somewhat unclear what these '*categories*' are categories of. Are they categories of behaviour or of respondents?
- **p9** '*nervous breakdowns*' is not a precise term. If you mean it as respondents' own language, it should be in inverted commas. Otherwise please define what you mean.
- **p13** '*Their calling pattern was not associated with a specific calling pattern*'!
- **p14** '*A qualitative approach was used to identify that respondents*' [note incorrect apostrophe] *called in an attempt to address their need for someone to talk to, their mental health issues and past and present negative life events.*' You didn't use a qualitative approach in order to

This sentence has now been removed.

Text has been changed to: "This has been attributed to differences in the way frequent users are defined and the variables investigated".

We have revised the text explaining how the analysis was conducted and removed reference to the typology of calling as this is part of the conceptual framework and introduced as the calling behaviours.

Reference to the typology of calling behaviours has been removed from the analysis so then this is no longer relevant.

This term is taken from the transcripts and has now been placed within inverted commas, made italic and referenced to the caller. [...and having a "*nervous breakdown*".

While revising the descriptions of the calling behaviours this text has been removed.

This sentence has been revised to read as follows: "Using a qualitative approach, we identified that frequent use was connected to three interrelated components."

<p>show that - the finding arose because you used such an approach.</p> <ul style="list-style-type: none"> ○ The subsequent sentence is also unclear. Do you need to write '<i>beneficial in meeting their</i>'? Wouldn't 'met' or 'helped to meet' be easier on the reader and closer to respondents' language? '<i>were able</i>' is wrong. Perhaps you mean 'they were able'. ○ p17 Section 4.3 becomes hard to follow because references to '<i>it</i>' and '<i>their</i>' become progressively harder to link to the relevant nouns. 	<p>This sentence now reads as: “Secondly, respondents indicated that the response they received from Lifeline helped to meet their short-term needs and the ability to call regularly without any restrictions.”</p> <p>This paragraph has been revised to: “‘There may be more efficient ways for crisis helpline providers to address the needs of frequent users while reducing the number of calls they make to the service. This may include offering a parallel telephone service to frequent users that includes a continuity of care component. Such a model of care would allow helpline staff to understand the calling behaviours of each frequent user and develop a personalised management plan. This would reduce the need for frequent users to repeat their story each time. However, there are a number of factors that need to be considered before such a model is implemented. Firstly, callers’ use of other healthcare services needs to be acknowledged so that the support offered by the helpline complements, rather than duplicates, any face-to-face care. The difference between these services would be that crisis helpline staff could address the calling behaviours of frequent users whereas face-to-face treatment could focus on their underlying social, mental and physical health issues. Secondly, processes need to be put in place to discourage any further dependency on the helpline. This could be done by focusing on the development of self-management techniques that assists frequent users to address their own issues in the long-term. This new model of care would need to be tested to see whether it has other unintended consequences before being introduced into routine practice.’”</p>
<p>There are some grammatical problems too:</p> <ul style="list-style-type: none"> ○ '<i>Respondents called seeking someone to talk to, assistance with mental health issues and negative life events</i>' - could read as respondents seeking negative life events. ○ Abstract conclusion: '<i>occurs</i>' = occur ○ p5 independent to = independent of ○ p11 - restricted TO 30 minutes ○ p12 TCS' = TCSs ○ 3.4.1 is duplicated ○ p14, 3.4.2 first line: the sentence is wrong. 'and was' perhaps should be 'which was' ○ p16 4.2, line 3. meets = meet 	<p>These grammatical problems have been changed as advised.</p> <p>The resubmitted version has also been proof-read to avoid any further grammatical problems.</p>

Highlights

- First study to investigate why some users call crisis helplines frequently.
- Frequent use was connected to three interrelated components.
- Frequent users described dependent, reactive or support-seeking calling behaviours.
- Frequent users may benefit from a model of care with greater continuity.

The experiences of frequent users of crisis helplines: A qualitative interview study

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Key words

Crisis helplines; Health service use; Experience of care; Qualitative research; Frequent callers

Abstract

Objective

To understand why some users call crisis helplines frequently.

Methods

Nineteen semi-structured telephone interviews were conducted with callers to Lifeline Australia who reported calling 20 times or more in the past month and provided informed consent. Interviews were audio-recorded and transcribed verbatim. Inductive thematic analysis was used to generate common themes. Approval was granted by The University of Melbourne Human Research Ethics Committee.

Results

Three overarching themes emerged from the data and included reasons for calling, service response and calling behaviours. Respondents called seeking someone to talk to, help with their mental health issues and assistance with negative life events. When they called, they found short-term benefits in the unrestricted support offered by the helpline. Over time they called about similar issues and described reactive, support-seeking and dependent calling behaviours.

Conclusion

Frequent users of crisis helplines call about ongoing issues. They have developed distinctive calling behaviours which appear to occur through an interaction between their reasons for calling and the response they receive from the helpline.

Practice implications

The ongoing nature of the issues prompting frequent users to call suggests that a service model that includes a continuity of care component may be more efficient in meeting their needs.

1. Introduction

Telephone helplines diversify the way people access healthcare [1]. Helplines reach a wide spectrum of the population [1, 2] and support people with cancer [3], smoking cessation [4] and acute crises such as suicidality [5]. Numerous helplines operate in Australia [6, 7] and crisis helplines account for the majority of them [8]. Crisis helplines provide anonymous 24-hour support to people experiencing an immediate crisis [8-10]. They are staffed by either volunteer or paid personnel who vary in their degree of professional training [11]. Lifeline is recognised as the national 24-hour crisis helpline in Australia and is staffed by trained Telephone Crisis Supporters (TCSs) [12]. Lifeline aims to support Australians in times of crisis and equip individuals and communities to be resilient and suicide-safe [13].

Lifeline's current model of care is based around providing short-term support [11, 14]. Each call is treated as a unique encounter [8]. However, a disproportionately high number of calls are from individuals seeking ongoing support [15]. A previous study found that 60% (or 247,547) of calls to Lifeline were from individuals who called 20 times or more in a month and represented 3% of all service users [16]. The high volume of calls made by frequent users creates the need to understand why these users continue to call. Frequent users of crisis helplines are neither unique, nor new, to Lifeline and were first recognised in an American study in the 1960s [17].

Previous studies used quantitative methods to investigate the differences among users of crisis helplines [16, 18-24]. These studies found that frequent users are more likely than non-frequent and non-users of crisis helplines to present with poor physical health, chronic disease, mental health issues and lack other social supports [11, 15, 16, 18, 19, 24]. The socio-demographic characteristics of frequent users vary between studies. This has been attributed to differences in the way frequent users are defined and the variables investigated [15]. However, several studies found that frequent users are more likely to be male [16, 19-

21, 23] and unmarried [16, 19, 20, 23]. They are also more likely than other users and non-users to visit health professionals, including general practitioners, psychiatrists, psychologists and present more often to the emergency department [18, 24]. Yet, frequent users are less satisfied with their current access to healthcare services [24]. These findings suggest that frequent users may be calling in search of a service that can better meet their needs. Further investigation is needed to understand whether this is the only reason driving the frequent use of crisis helplines.

The aim of this study was to understand why some users call crisis helplines frequently. This was investigated from the perspective of self-identified frequent users of Lifeline Australia.

2. Methods

2.1 Study setting and sampling

This study was part of a larger study investigating the experiences of, and outcomes for, callers to Lifeline. The larger study included a sample of 315 callers who completed a brief survey at the end of their call to Lifeline between February and July 2015 [25]. Callers were eligible to complete the survey if the TCS deemed them to be over 18 years of age, able to converse in English and not in an immediate crisis. Callers in an immediate crisis were excluded to ensure the safety of those who were vulnerable and distressed. All respondents who reported in the brief survey that they called Lifeline 20 times or more in the past month (considered frequent users according to Lifeline's current operational definition [16]) and provided their contact details were invited to this study. Ethics approval was granted by The University of Melbourne's Human Research Ethics Committee (ID: 1441987.2).

2.2 Data collection

Study data were collected and managed using REDCap electronic data capture tools at The University of Melbourne [26]. Respondents were contacted and interviewed between February and August 2015 by A.M., who is a trained and experienced research interviewer and independent of Lifeline. All eligible callers were contacted at least one day after completing the survey. Interested participants were sent a plain language statement, by post or email, at least one week prior to the interview. Before the start of the interview, the key requirements were read out by the interviewer and respondents provided informed verbal consent. All interviews were conducted over the telephone which allowed for a maximum number of respondents to be reached within the study period. Furthermore, respondents were already familiar with discussing their experiences over the phone as they were recruited from a telephone service. Interviews were audio recorded and transcribed verbatim by A.M.

Interviews were semi-structured and guided by an interview schedule (see Appendix). During the interview, respondents were asked what prompted their call to Lifeline, how they used the service and their experience of calling. They were also asked about their use of other helplines and healthcare services. These questions were specifically developed by the authors for the purpose of this study. All authors reviewed the first two interviews and decided no changes were required to the interview schedule.

Sixty-nine respondents completed the brief survey and reported frequent use [25]. Thirty-four of these respondents provided their contact details and were approached. Of these respondents, 19 were interviewed, eight could not be contacted after multiple attempts and seven declined participation. Reasons for non-participation included being too busy, no longer interested, and in one case having a long term brain injury. No differences were observed between the socio-demographic characteristics of respondents who were interviewed and those who declined participation. Interview duration ranged from 19 to 91 minutes, with an average of 38 minutes.

2.3 Analysis

Respondents' socio-demographic characteristics were analysed using STATA version 13 [27] and reported as frequencies. An inductive thematic analysis [28, 29] approach was used to understand why some users call crisis helplines frequently. Transcripts were anonymised and imported into QSR International's NVivo 11 Software [30]. Each transcript was analysed in its entirety and emerging themes were constantly compared across transcripts to ensure interpretation remained grounded in the data. Initially, A.M. coded five transcripts and discussed the emerging themes with J.G. They identified three overarching themes from the data and developed a conceptual framework. These themes centred on respondents' reasons for calling, the response they received from Lifeline and the calling behaviours they described. Using this framework, A.M. coded an additional five transcripts and found no new

themes. The other authors then reviewed the conceptual framework and independently applied it to the first five transcripts. Minor coding discrepancies were resolved through discussions among all authors. The conceptual framework was slightly revised and A.M. used this revised framework to recode all of the transcripts. All interviews were included in the analysis; there were no disconfirming cases.

3. Results

3.1 Characteristics of respondents

Table 1 presents the socio-demographic characteristics of the 19 respondents. Twelve respondents were female and 11 were between 45 and 65 years of age. Seventeen respondents reported English as their first language and 13 lived alone. No respondent reported being of Aboriginal and/or Torres Strait Islander origin. Only one respondent reported being employed with the remaining either unable to work (n=15) or unemployed (n=3).

<TABLE 1>

Respondents first called Lifeline about a legitimate issue, however, over time they found themselves calling frequently, as exemplified by the following quote: “[the] first time I called...was because it was the first time I had suicidal thoughts...when it started five years ago I would call them...once a month...I became dependent on them, like I can’t get better without calling them...[in] the last year...I’ve been calling...everyday, more often...three to five times a day” [Caller 07; Male (M); 18-25yo]. A few respondents had begun calling frequently in the last few months, whereas, the majority were calling frequently for over two years.

Frequent use was related to three interrelated components, namely; reasons for calling, service response and calling behaviours. Reasons for calling were closely related to the response they received from Lifeline, which one caller described as: “well I do have a trauma history...when you talk to some counselling services they want you to stay a victim...whereas...Lifeline...talk to people about hard issues...they know how to...pull you out of that, and that...is what makes them so good to talk to, because you don’t feel like you’re a victim...they are very pragmatic and understanding” [Caller 10; F; 25-44yo]. Such a response would then drive their calling behaviour because Lifeline “were happy to talk to you

even if you rang back several times within the day, and they're still happy to talk to you...when you're friends...get busy and...can't talk...so I am a bit more reliant on Lifeline" [Caller 16; F; 45-65yo]. The calling behaviours were also linked to their reason for calling, as demonstrated by: *"when I get upset or [have a] problem, that's when I reach out"* [Caller 13; M; >65yo]. A conceptual framework illustrating how these components are interrelated is shown in Figure 1 and a description of each component is provided below.

<FIGURE 1>

3.2 Reasons for calling

Respondents indicated that they called Lifeline seeking: someone to talk to, help with their mental health issues, and assistance with past and present negative life events. These reasons remained the same over time, with one respondent stating he "used to call...50 years ago...it was the same problem" [Caller 08; M; >65yo].

3.2.1 Someone to talk to

Over half of the respondents mentioned calling for social connection, advice and a listening ear. One respondent justified calling because she *"just wanted...somebody to talk to, somebody to help sort things out with"* [Caller 16; F; 45-65yo]. Often, respondents kept calling because they had *"no family support"* [Caller 15; F; 45-65yo] and there was *"no-one else to turn to"* [Caller 02; F; 25-44yo]. Lifeline provided an opportunity for human interaction, as exemplified by the following: *"I call Lifeline because I need a human connection"* [Caller 07; M; 18-34yo]. For many, Lifeline is their first point of contact when needing someone to talk to, with one caller stating: *"I just feel comfortable calling them first...I just sort of feel like it's a familiar friend I can call and count on that is always there"* [Caller 12; F; 45-65yo].

3.2.2 Help with mental health issues

Nearly all respondents reported calling because they experienced a mental health issue of varying severity. One caller explained, *“I call [Lifeline] for support because I have a mental illness”* [Caller 11; F; 24-44yo]; whereas, another caller commented that “if I didn’t have a mental illness I wouldn’t need to ring Lifeline” [Caller 13; M; >65yo]. Depression and anxiety were the most commonly reported mental health issues; however, schizophrenia, panic attacks and having a “nervous breakdown” were also mentioned by a few respondents.

Suicidality was another issue for many respondents, with one respondent stating, *“I was calling when I got suicidal...to get some help”* [Caller 19; F; 45-65yo]. For three of these respondents, they first called Lifeline *“because it was the first time [they] had suicidal thoughts”* [Caller 07; M; 18-24yo]. However, suicidality was not an issue for all respondents with four explicitly stating that they *“never had thoughts of suicide”* [Caller 03; F; 45-65yo] and *“would rather...they didn’t ask [about suicidal thoughts but]...wait for the caller to bring it up”* [Caller 05; M; 45-65yo].

3.2.3 Assistance with past and present negative life events

Respondents also called about past and present negative life events which included childhood abuse, domestic violence, loss of a loved one, separation from a partner and/or a major accident. Many of these events occurred several years ago but were still affecting the individual. For example, one male respondent aged over 65 stated that, he was *“not able to socialise in our society...because I came to this country at age of eight and... I was abused at school, verbally and physically by the other kids and it made it impossible for me to live a normal life”* [Caller 08]. For many respondents, the issues they called about were ongoing and one respondent stated that despite seeking help from a psychiatrist, she called Lifeline because she was *“still having difficulties with all of those issues...I mentioned initially”* [Caller 12; F; 45-65yo].

3.3 Response from Lifeline

In general, respondents preferred Lifeline over other helplines in Australia due to the response they received. A typical remark was: *“occasionally I would call [other helpline]...but I don’t call...anymore, I usually call Lifeline”* [Caller 01; F; 45-65yo]. This preference was attributed to the: provision of non-specific support, availability of the service and the variety of counsellors. However, this response only provided short-term benefits, with one caller stating “they give me about half an hour...that gives me a little bit of space...then I might wait two or three hours and phone again” [Caller 04; M; 45-65yo].

3.3.1. Non-specific support

Lifeline offered non-specific generalised support, which was unlike many other helplines that focused on specific issues. One caller described the difference as, *“I have [tried other helplines] but Lifeline is not as specific”* [Caller 10; F; 25-44yo]. Some callers were turned away from other helplines because they did not *“fit into the categories”* [Caller02; F; 25-44yo]. By contrast, the generalised support offered by Lifeline allowed callers to discuss anything that was on their mind without being turned away. This was important for one caller who reported, *“I don’t have anything specific I want to talk about”* [Caller01; F; 45-65yo]. However, other callers perceived that the counsellor did not see their issues as genuine and reported being told *“don’t waste our time; there’s other people in more need”* [Caller17; M; 45-65yo].

3.3.2. Availability

Over half of the respondents mentioned the importance of Lifeline always being available. The 24-hour operation of Lifeline meant they could *“pick up the phone and call any time of day or night”* [Caller12; F; 45-65yo]. If the line was busy, they would stay on hold until the call was answered. This was unlike other services where respondents had to *“keep dialling because they didn’t have a call waiting system”* [Caller19; F; 45-65yo]. One caller

summarised Lifeline's availability as, "*compared to a lot of other services...[Lifeline] is so easy to contact...get through to...their number's really easy to remember*" [Caller10; F; 25-44yo].

Despite being easy to contact, each call was usually restricted to 30-minutes. Many felt this was insufficient time to "*explain what's going on and express everything*" [Caller10; F; 25-44yo]. One caller felt that she "*can tell when they are trying to get me off the phone...when they are winding down the talk and I'd rather talk*" [Caller01; F; 45-65yo]. However, such restrictions were not of a major concern to respondents as they knew they could easily call back. In fact, respondents continued to call because the TCSs would "*tell [them] to call back whenever [they] want*" [Caller05; M; 45-65yo]. One respondent recently commenced calling frequently after a suggestion from one TCS: "*I was calling when I got suicidal...and a counsellor suggested...instead of waiting for it to culminate in feeling suicidal...if you can recognise the warning symptoms, ring up when you're feeling [down]*" [Caller19; F; 45-65yo].

3.3.3. Variety of counsellors

Having a variety of counsellors available was mentioned by nearly all respondents as an incentive to call frequently. A common remark was "*some of them [TCSs] are good, some...are downright rude*" [Caller03; F; 45-65yo]. A positive calling experience was reported when the TCS would "listen and give some advice" [Caller04; M; 45-65yo] as opposed to when they "just paused indefinitely...and not say anything" [Caller01; F; 45-65yo]. However, negative responses were uncommon in comparison to positive responses, with a typical comment about the ratio being: "*mostly I'd say 85% positive...there is about 15% of calls that I've had where it has been hopeless*" [Caller01; F; 45-65yo]. When respondents encountered a negative response, they would hang up and call back again hoping to find a different counsellor "*because [Lifeline] is Australia-wide, the chances of finding the*

same person again are very low” [Caller16; F; 45-65yo]. However, this also meant during each call they had *“to re-explain everything...[because] you’re speaking to someone different all the time”* [Caller10; F; 25-44yo].

Respondents also called looking for a TCS who *“forgot the rules...ask you how you’re feeling...tell you about themselves”* [Caller07; M; 18-24yo]. This was mentioned by half of the respondents when specifically asked how Lifeline could improve its service. They felt that rules made it difficult to build rapport with the TCSs, with one caller explaining: *“when you are having a two-way conversation it is nice to be two-ways”* [Caller05; M; 45-65yo]. Respondents also felt the TCS should *“have...a pseudo name...they don’t have to use their real name”* [Caller19; F; 45-65yo] so they can address them personally.

3.4 Calling behaviours

Respondents described three distinctive behaviours which drove their frequent calls and included reactive, support-seeking and dependent calling behaviours. Each of these behaviours were prompted by different reasons and varied in regularity.

3.4.1. Reactive behaviours

Nine respondents reported calling after an incident triggered feelings of anxiety and/or depression. This was categorised as a reactive calling behaviour and is exemplified by the following response: *“if I’ve got nothing that’s stressing me out...I’m not likely to ring...but...if I’ve got things that are stressing me out, or making my anxiety play up, then I’ll ring”* [Caller09; F; 25-44yo]. Reactive calling behaviour was directly related to events that were happening in their lives, which one caller described as: *“there’s no real pattern...if I’m around toxic environment it will be quite regularly, as much as 5 times a day...if I’m totally away from all the triggers...very little”* [Caller17; M; 45-65yo].

3.4.2. Support-seeking behaviours

Support-seeking calling behaviours were identified among nine respondents who would call when they needed emotional support. Five of these respondents also described a reactive calling behaviour at other times. The support-seeking calling behaviour was described by one respondent as calling *“to discuss my day or something because I’ve got no one else to...talk to”* [Caller19; F; 45-65yo]. Respondents reported a sense of “desperation...I just need someone to talk to that understands” [Caller13; M; >65yo]. Similar to the reactive calling behaviour, there was no distinctive calling pattern associated with the support-seeking behaviour; instead, respondents described *“there [are] long periods [I call] and then I stop because things are fine and then when things aren’t fine that’s when I keep [calling]”* [Caller14; F; 45-65yo].

3.4.3. Dependent behaviours

Dependent calling behaviour, described by six respondents was not related to a specific trigger. Instead, calling had become part of their daily routine. One respondent described this behaviour as: *“it’s like an addiction, that’s why I keep calling...part of my lifestyle...so I just keep calling...I don’t have anything to do, so I call Lifeline”* [Caller07; M; 18-34yo]. Respondents indicated that each time they called, their narrative was similar, often ruminating over a past event, with one caller reporting, *“I told her the exact same story a hundred times over”* [Caller04; M; 45-65yo]. Dependent behaviour was associated with daily calls to Lifeline regardless of life circumstances and a typical response was: *“well I just like ringing every night...I get bored and lonely cause I’ve got no-one else to talk to”* [Caller18; M; 25-44yo].

4. Discussion and Conclusion

4.1. Discussion

This is the first study to investigate why some users call crisis helplines frequently. Using a qualitative approach, we identified that frequent use was connected to three interrelated components. Firstly, respondents called seeking someone to talk to, help with their mental health, and assistance with past and present negative life events. Secondly, respondents indicated that the response they received from Lifeline helped to meet their short-term needs and the ability to call regularly without restrictions was favourably viewed. Thirdly, respondents described three distinctive calling behaviours which were classified as reactive, support-seeking and dependent. These calling behaviours appeared to develop over time and were closely related to respondents' reasons for calling and the response they received.

The current crisis helpline service model is designed to provide one-off support rather than ongoing support to individuals who experience chronic and complicated crises, even though these individuals make a large proportion of calls. Frequent users call about issues that are ongoing in their lives. However, the current model of care makes it difficult for crisis helpline staff to adequately address frequent users' needs in a single encounter. Furthermore, frequent users are sometimes dissatisfied with the response they receive and call back looking for a TCS with a different approach. This mismatch between the model of care offered by crisis helplines and the support frequent users are seeking suggests that they may benefit from more continuous care over a period of time.

The service model of crisis helplines also requires callers to retell their story each time they ring as prior encounters are not recognised. Repeating their story may frustrate frequent users with a reactive or support-seeking behaviour; however, this it also enables users with dependent calling behaviours to ruminate about past experiences which may

prolong their depression and anxiety [31]. A service model which reduces the need for frequent users to repeat their story during each encounter and includes a continuity of care component might lead to more efficient use of the service and offer benefits in building resilience in frequent users over time.

A major strength of this study was the use of interviews with self-identified frequent users of crisis helplines. No previous study has done this. The health issues experienced by respondents in this study were similar to those reported in previous quantitative studies [15, 16, 18, 24] and there were no differences in the demographics between frequent callers who agreed and declined to be interviewed, suggesting that our findings may be generalizable beyond our interview sample. Furthermore, respondents were heterogeneous in their experience of calling Lifeline.

Some limitations of this study are that callers were required to provide their contact details to be invited to this study. Callers who were in an immediate crisis or wished to maintain their anonymity were excluded from the study, which may have biased the results. We also relied on callers accurately reporting the number of times they called in the past month, thus excluding callers who may have under-reported their calls. Due to privacy, we were unable to verify respondents' self-reported calls with their actual call data.

4.2. Conclusion

Frequent users call crisis helplines about ongoing issues and find short-term benefits in the response they receive from the helpline. Over time frequent users develop reactive, support-seeking and dependent calling behaviours which appear to be interrelated to their reasons for calling and the response they receive. The ongoing nature of frequent users' issues suggests that a model of care that includes a continuity of care component may better suit their needs.

Over time this may lead to more efficient use of the helpline and improved mental health for frequent users.

4.3. Practice Implications

There may be more efficient ways for crisis helpline providers to address the needs of frequent users while reducing the number of calls they make to the service. This may include offering a parallel telephone service to frequent users that includes a continuity of care component. Such a model of care would allow helpline staff to understand the calling behaviours of each frequent user and develop a personalised management plan. This would reduce the need for frequent users to repeat their story each time. However, there are a number of factors that need to be considered before such a model is implemented. Firstly, callers' use of other healthcare services needs to be acknowledged so that the support offered by the helpline complements, rather than duplicates, any face-to-face care. The difference between these services would be that crisis helpline staff could address the calling behaviours of frequent users whereas face-to-face treatment could focus on their underlying social, mental and physical health issues. Secondly, processes need to be put in place to discourage any further dependency on the helpline. This could be done by focusing on the development of self-management techniques that assists frequent users to address their own issues in the long-term. This new model of care would need to be tested to see whether it has other unintended consequences before being introduced into routine practice.

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Conflicts of interest

No funding body had a role in the study design; the collection, analysis and interpretation of data; the writing of the manuscript; or the decision to submit the manuscript for publication.

Author contributions

J.P. and J.G. conceived the study and oversaw its successful completion. A.M. conducted the interviews with study participants and led the analysis. J.G., B.B. & J.P. provided input to the analysis. A.M. drafted this manuscript, with input from all other authors. All authors read and approved the final manuscript.

I confirm all personal identifiers have been removed or disguised so the persons described are not identifiable and cannot be identified through the details of the story.

Appendix

Interview Schedule

1. Can you tell me a bit about the circumstances under which you called Lifeline in the past few months?
2. What was happening for you that prompted your initial call?
3. If you called more than once, what made you continue to call?
4. What made you call Lifeline in particular?
5. Did you consider making contact with any other telephone services?
 - a. If not, why not?
 - b. If so, why did you call Lifeline as well?
6. Was the decision to call Lifeline entirely your own, or did someone else suggest it (e.g., a friend or a family member, a health professional)?
7. People call Lifeline in all sorts of different ways. Some people call only once and don't call again. Some people call more episodically, maybe making a few calls over a short period and then not calling again for some time. Still others call regularly and often, sometimes over a longer period. How would you describe your own calling patterns?
8. This might be a difficult question to answer, but can you explain why you have a particular calling pattern or why you call in the way you do?
9. What happens for you between calls?
10. What prompts you to call again?
11. How do you feel that Lifeline continues to provide you with support for your emotional wellbeing?
12. Some people see a range of health professionals for their emotional well being as well as calling Lifeline. Are you seeing any health professionals for your emotional well being?
13. Do you get different things from these health professionals compared with what you get from calling Lifeline?
14. How did you find the experience of calling Lifeline?
15. Did you find it easy to get through?
16. Did you feel as though the telephone crisis supporter listened to you?
17. Did he or she say things that were useful in helping you think through your issues and how you might deal with them?

18. Can you tell me more about the support you received from Lifeline?
19. What did you find helpful about the support provided by Lifeline?
20. How do you feel Lifeline could improve its service to meet the needs of callers like yourself?
21. How did you feel after calling Lifeline?
22. What, if any, action did you take after calling Lifeline?
23. What has happened for you since calling Lifeline?
24. I'm interested to know whether things have changed for you. Thinking back to what you told me about what prompted your initial call, would you say that things have got better, got worse or stayed the same?
25. If they've changed at all, would you attribute any of this change to Lifeline?
26. I've asked you a lot of questions, but I'm wondering if you might like to tell the story of your recent contact with Lifeline in your own words, taking me through from beginning to end. You can speak in general terms if that's easier for you.
27. Are there any other comments you'd like to make?

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Table 1: Socio-demographic characteristics of respondents (n=19)

	Respondents n (%)
Gender	
Male	7 (37)
Female	12 (63)
Age	
< 25 years	1 (5)
25 – 44 years	5 (26)
45 – 65 years	11 (58)
> 65 years	2 (11)
Employment	
Employed/studying	1 (5)
Not employed/not in paid employment	3 (16)
Unable to work due to sickness/disability	15 (79)
Lives alone	
Yes	14 (74)
No	5 (26)
English as first language	
Yes	17 (89)
No	2 (11)
Aboriginal or Torres Strait Islander Origin	
No	19 (100)

Figure 1: Conceptual framework depicting the interaction between the factors contributing to the frequent use of crisis helplines