Suicide lifeline call components and caller satisfaction

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Abstract

The need and use of the National Suicide Prevention Lifeline have been progressively growing over the last several years. Suicide lifelines and chat lines have a major role in risk management for individuals contemplating suicide, so the need for effective conversation tactics on the part of the crisis counselor is of paramount importance. The current study evaluated 75 individuals' satisfaction and perception of their conversation with the lifeline, via phone call or text. After answering "yes" to have called or texted the lifeline, participants were given several questions regarding their perception of individual components, including the introduction of a safety plan, as well as their overall satisfaction with the call on a zero to 100 scale. It was found that in both cases, if the counselor introduced a safety plan and walked the caller/texter through several of these questions, the caller/texter's overall satisfaction was higher than if the counselor did not provide such support. Understanding the efficacy of these conversations from the caller's point of view is helpful in knowing what crisis counselors should focus on in their calls to provide better service to those seeking out help.

Suicide lifeline call components and caller satisfaction

In the United States, suicide is the tenth leading cause of death, and is continuing to grow each year. In 2019 alone, there were over 47,000 deaths by suicide, and over one million people who attempted a suicide (AFSP, 2022). Over the past ten years, suicide rates among young adults ages fifteen to twenty-four have also been increasing substantially. (AFSP, 2022).

The National Suicide Prevention Lifeline is a suicide prevention resource consisting of a toll-free phone number in the United States that connects the caller to a trained suicide crisis counselor (AFSP, 2022). Between 2005 and 2015 the lifeline answered more than 5 million calls and answered over 2 million calls in 2020 alone (SPRC, 2022). One of the most effective parts of the Lifeline is the fact that it is easily accessible, as it is available 24 hours per day, 7 days per week, is free of cost, and is staffed by trained crisis professionals.

In addition to the national phone number to call, there is a number that people can use with SMS messaging ("text" or "chat") that has been available since 2013 (AFSP, 2022). This additional service is important since younger people are more likely to communicate via text than via phone call (Forgays et al., 2014). This text service has answered almost 7 million text conversations since 2013 with 20-25% of these conversations involving suicide (Crisis Trends, 2021). According to an article by Gould and colleagues (2021), data from 13,130 post-chat surveys showed that chatters were significantly and substantially less distressed at the end of the conversation with their counselor. This adds to the evidence that the option to text or chat with a counselor rather than call on the phone is more inclusive and makes Lifeline services available to everyone.

Both the Lifeline and chat line have used a number of different techniques and strategies to deliver their resources for those in need. One of these strategies is done by following the

Applied Suicide Intervention Skills Training (ASIST), which was created by Living Works in 1983 and has undergone several updates to keep it up to date with current standards and evidence. There are three major components to the ASIST model: Connecting with Suicide, Understanding Choices, and Assisting Life. One of the final and most important parts of ASIST is completing a safety plan within the "Assisting Life" portion of the framework (Living Works, 2021). The safety plan intervention was developed by Stanley and Brown (2012) and typically includes six or seven components: identifying individual warning signs for crisis, identifying internal coping strategies, identifying social supports to use as distraction, identifying social supports for help in a crisis, identifying mental health resources, making the environment safe (i.e., means safety), and, optionally, reasons for living. Though there are only a few studies evaluating its efficacy, the safety plan intervention has been shown to reduce suicide-related outcomes (Furgeson et al. 2021).

There is little evidence evaluating what call or chat (i.e., conversation) components are important for the caller's or texter's satisfaction with the conversation. Understanding what is associated with satisfaction is important because satisfaction with mental health services could be important for outcome (Bjørngaard et al. 2007) and likelihood of using services in the future (Fenton et al., 2012). Previous work has noted that certain user characteristics are associated with satisfaction (Gould et al. 2017), but we do not know which specific call/chat characteristics are associated with higher satisfaction.

Current Study

The current study evaluated the relationship between crisis line conversation components and caller or texter satisfaction with the conversation. *Hypothesis 1: Individuals would report overall higher satisfaction with the conversation if their crisis counselors included more*

conversation components. Hypothesis 2: Callers who were offered a safety plan would report greater satisfaction with the conversation.

Methods

Participants

Participants were from a larger randomized controlled trial examining way to increase the uptake of the lifeline. Participants were recruited from the Oklahoma State University Department of Psychology participant pool. All individuals who indicated that they called or texted the lifeline were included in this study. For the sample, 75 individuals called or texted the lifeline, with 47 of them calling and 28 texting. In our sample, seventy-two percent reported female sex at birth, 17% male, 4% intersex, and 7% chose not to respond. For gender 59% were female, 17% male, 7% non-binary, 7% transgender, 3% genderqueer, and 8% chose not to respond. For sexual orientation, 53% were heterosexual, 24% bisexual, 7% pansexual, 2% lesbian, 1% gay, and 8% chose not to respond. Regarding racial identity, 72% were white, 7% American Indian, 4% multiple races, 3% Black, 3% Asian, and 5% chose "other". For ethnicity, 15% of our sample identified as Hispanic/Latinx.

Measures

Gould and colleagues (2017) came up with questions that they asked callers following their conversation with the National Suicide Prevention Lifeline. These questions were used in this study, in a self-report fashion. In addition to the questions from Gould, additional clarifying questions were added, such as overall satisfaction with the call on a zero to 100 scale. The questions asked to participants aimed to get a sense of how the experience of calling or texting the lifeline went as a whole for them, as well specific parts of the call. These different parts included ringing the lifeline, wait time, being greeted, the conversation itself, and the conclusion

of the conversation. See *Table 1* for list of specific questions. These questions were used as an independent variable to compare to the dependent variable, their overall satisfaction with the call or chat on a zero to 100 scale. To create the dependent variable score of call or text components, the number of components endorsed was summed to get a total score of the crisis conversation components. This was then used to analyze with the independent zero to 100 scale of overall satisfaction.

In addition to perception questions, participants answered demographic questions such as age, sexual orientation, race, ethnicity, sex, and gender.

Procedures

After giving informed consent, participants completed all measures through Qualtrics, a widely used online survey platform. After completing the survey, participants were debriefed and compensated with partial course credit. All procedures were approved by the Oklahoma State University IRB.

Table 1

Questions asked regarding lifeline conversation

Question	n (%) endorsing
Did your counselor introduce you to a safety plan?	13 (17%)
Did you get offered a follow-up?	15 (20%)
Did you receive referrals for financial, food or healthcare assistance?	7 (9%)

Did you receive referrals for inpatient or outpatient mental health services?	14 (19%)
Did you discuss coping strategies?*	24 (32%)
Did you receive emotional support from your counselor?*	41 (55%)
Did you discuss social contacts or social settings as distractors?*	20 (27%)
Did you discuss social contacts to call for help?*	19 (25%)
Did you discuss past survival skills?*	14 (19%)
Did you discuss triggers for suicidality?*	14 (19%)
Did you discuss warning signs?*	15 (20%)
Did you explore reasons for living?*	24 (32%)
Did you discuss safe/no use of alcohol/drugs?*	11 (15%)

Did you discuss making your environment safe?*	15 (20%)
Did you explore reasons for dying?*	13 (17%)
Did you explore uncertainty for living and dying?*	17 (23%)

**Questions used from Gould et al. 2017*

Results

For Hypothesis 1 there was a statistically significant association between the total number of conversation components and satisfaction with the conversation for both those who called (n = 34), r = .496, p = .003, and those who texted (n = 10), r = .754, p = .012. In examining the relationship between a safety plan and satisfaction for Hypothesis 2, callers (n = 25) who reported receiving a safety plan (n = 11) also reported higher satisfaction with the call (M = 76, SD = 21) compared to those who did not report receiving a safety plan (n = 14, M = 55, SD = 20), $t(23) = 2.53$, p = .019. However, there was not a significant difference in satisfaction between texters (n = 22) who reported receiving a safety plan (n = 6, M = 72, SD = 30) compared to those who did not report receiving a safety plan (n = 16, M = 51, SD = 30), $t(20) = 1.43$, p = .167.

Discussion

This study investigated the relationship between components of a national lifeline crisis intervention conversation and the caller's or texter's satisfaction with the call or chat. With

Hypothesis 1, we found that the more conversation components that the counselor included was associated with a higher satisfaction. Similarly, with Hypothesis 2, if the counselor introduced a safety plan to the participant, the individuals reported higher overall satisfaction with the call/text conversation.

Safety plans have been shown to be efficacious for preventing suicidal behavior (Furgeson et al. 2021). Our results indicate that participants have higher satisfaction when they receive a safety plan. While we cannot be sure that the safety plan actually made the participants safer, it is possible that this is reflected in their higher reported satisfaction.

In addition, a higher perception of care from a crisis counselor has a positive impact on the individuals' desire to end their life (Gould et al. 2017). Though we did not measure perception of care, a higher number of conversation components may indicate a higher level of care. As the Suicide Prevention Lifeline grows in popularity, it is important for studies like these to understand the strengths and weaknesses surrounding the calls.

Implications for this research can be incorporated in a multitude of settings including, perhaps most notably, training procedures for crisis counselors. It is not unreasonable to deduce based on the percentage of participants that received safety plan guidance (17%) that a significant number of crisis counselors are unaware of, or simply unable to incorporate safety plans into their lifeline conversations. However, our results could be used to help increase confidence in safety plans and following protocols, since it seems like this leads to general higher satisfaction. In addition to professional training and development, this information can be used to educate the general public on effective communication surrounding suicide. Often the topic can be difficult for people to discuss but knowing best practices could prove to be effective for conversations surrounding suicide that come up in day-to-day life.

Understanding limitations to our study is also important. It is worth noting that this study did not directly ask if these questions reduced suicide risk, rather looked at the satisfaction with the conversation overall. This study was also cross-sectional, and it's possible that an unmeasured third variable (e.g., caller or counselor characteristics) is responsible for the relationship between conversation components and satisfaction. Lastly, our study was done with college-aged individuals and our results may not generalize to other age groups.

Despite limitations, this study has several strengths to consider. There is not a lot of safety plan-oriented data regarding satisfaction within a conversation from the caller/texter's point of view. Several studies look at perception of care from the counselor's point of view, but do not address the callers. Further, the questions asked to the callers get very detailed and address each safety plan component individually, giving data on which individual questions are the most effective from their point of view.

Overall, our study looked at how crisis counselors can create more favorable calls from the caller's perspective. Future directions for this could be getting a larger sample size and having a more diverse population. Our study added to the literature in several ways, emphasizing the importance of having effective, thorough, safety plan training for new crisis counselors, as well as educating the public on successful practices.

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