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ORIGINAL ARTICLE

Help-seeker expectations and outcomes of a crisis support service: Comparison of suicide-related and non-suicide-related contacts to lifeline Australia

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Abstract

Lifeline Australia aims to prevent suicide and support community members in personal crisis via the provision of free anonymous telephone, online chat and text message services. This study aimed to identify the expectations and outcomes of Lifeline help-seekers, including whether there are differences between suicide-related and non-suicide-related contacts. Help-seekers (N = 553) who had previously contacted Lifeline via telephone, online chat, or text message crisis services were recruited via social media and a link provided after Lifeline service use, who completed an online survey about their awareness, expectations and outcomes of Lifeline's services. The responses from help-seekers who self-reported suicide-related and non-suicide-related reasons for contact were compared. Participants were highly aware of Lifeline's services, particularly the phone service. The main expectations of all help-seekers were to feel heard and listened to, feel less upset and feel understood. There were 59.5% of the sample that reported suicidality as a reason for contact. Suicide-related contacts endorsed more reasons for contact than non-suicide-related contacts. Expectations of suicide-related help-seekers were greater, but they were less likely to report that their expectations were met. The high expectations and complexity of suicide-related contacts reveal the challenges in meeting the needs of this high-priority group, particularly within the context of the multiple demands on crisis support services.

KEYWORDS
crisis support, expectations, help-seeker, outcomes, service modality, suicide

1 | INTRODUCTION

Crisis support services fill a crucial gap in community mental health and support systems by providing highly accessible services that are usually free and anonymous to people experiencing any form of personal crisis (World Health Organisation, 2018). There are over 1000 crisis support services operating worldwide, with increasing reliance on these services each year, particularly for suicide prevention (Howe et al., 2014) and for support during national and international disasters, such as drought, fire, floods and the COVID-19 pandemic.

Suicide prevention is often a primary focus, so understanding the extent to which these services meet the needs of suicide-related contacts across the spectrum of risk from ideation to attempt, as well as the needs of non-suicide-related crisis help-seekers, is of utmost importance.

Telephone crisis services are the most common form of crisis support (World Health Organisation, 2018), although other modalities, like online chat and text messaging, have more recently been implemented. Research has shown the effectiveness of phone line support, with a systematic review by Hvidt et al. (2016) of 18 studies spanning 45 years, finding that telephone crisis lines have a beneficial impact on help-seekers' immediate and intermediate outcomes in terms of reducing levels of suicidality (suicidal thoughts and behaviours) and psychological distress. Another systematic review by Mazzer et al. (2020) of 31 studies examining the expectations and outcomes of crisis support service users found consistently positive outcomes across multiple modalities for help-seekers' emotional state, satisfaction and referral plans, although not surprisingly there was limited research for newer contact modalities. Helplines have been found to be particularly beneficial for young people, who are a population group of high need, and who were shown to seek help for a myriad of psychosocial concerns in another recent systematic review (Mathieu et al., 2020).

These reviews note that it was difficult to determine changes in suicidality attributed to crisis service use due to the lack of consistent methods employed, which ranged from telephone counsellors' subjective assessments to self-report ratings and coding by researchers. For example, in a series of studies comparing non-suicidal (Kalafat et al., 2007) and suicidal callers to eight US crisis hotline centres (Gould et al., 2007), at follow-up 12% of those classified as non-suicidal by counsellors' assessments of caller suicidality reported that they did have suicidal thoughts during or after the call. Having valid and reliable measurements of suicidality before/during/after the call remains a key challenge for research and practice. Self-report is important to prioritise person-centred experience, although reasons for contact are complex and help-seekers may not always have insight into what is driving their distress.

Australia's national crisis support service, Lifeline, provides free and anonymous 24-hour support to community members in immediate crisis (Lifeline Australia, 2021). Since its establishment in 1963, this charitable service has expanded to operate in 41 centres across Australia, with 3364 volunteers and paid crisis counsellors (Lifeline Australia, 2021). In line with technological advancements, Lifeline now delivers crisis support via online chat (since 2010) and text message services (since 2018), and these modalities have been found to play an important role in providing support for help-seekers who prefer methods other than the telephone and a growing preference by consumers to use the internet for help (Netbalance, 2014). In the 2019–2020 financial year, Lifeline reported servicing 989,192 telephone calls, 53,527 online chats and 39,680 text message conversations (Lifeline Australia, 2020a). There was a 25% increase in contacts across all modalities in 2020, which was attributed mostly to the mental health impacts of the COVID-19 pandemic, highlighting the vital role Lifeline plays in supporting the community during times of widespread crisis (Lifeline Australia, 2020b). Many of these were first-time callers, although the proportion of frequent callers was still high.

Lifeline's crisis support services are strongly associated with suicide prevention in the minds of the Australian public, with polling data showing that 91% of Australians relate Lifeline's branding with suicide prevention (Lifeline Australia, 2019). An earlier small-sample study of Lifeline telephone help-seekers revealed that 45% had a suicide plan at the time of contact and 38% had access to means to suicide (Turley, 2000). Furthermore, 58% of this sample reported prior engagement in suicidal behaviour, such as a suicide attempt, highlighting both past and present suicidality as a core service concern. During its implementation, the Lifeline Online Crisis Support Chat Service found high proportions of contacts (43%) expressing suicidal thoughts at the time of contact (Netbalance, 2014).

Nevertheless, help-seekers contact Lifeline for a wide range of crises and concerns, and Lifeline is promoted as a general crisis response service. For example, a survey of one Lifeline centre providing services to a call area of 455,000 people in regional Australia showed that 6% mentioned their main reason for contact was due to suicidality, compared to 29% for relationship issues, 21% for chronic mental or physical health problems, and 12% for another form of crisis (Perkins & Fanaian, 2004). Notably, two-thirds of respondents in this regional area reported they were using Lifeline as their only form of mental health support.

What is known about this topic

- Crisis support services play an important role in assisting help-seekers with crisis intervention and suicide prevention
- Research reporting on help-seeker expectations and outcomes is mostly limited to telephone services
- It is important to understand expectations and outcomes of help-seekers across various modalities

What this paper adds

- An online survey was conducted including a sample of help-seekers that have used telephone, online chat and text message modalities
- The most common help-seeker expectation was to feel heard and listened to, and help-seekers reported the service was best at achieving short-term outcomes
- Help-seekers were grouped into suicide-related and non-suicide-related contacts. Suicide-related contacts had more expectations of the service, but their expectations were less likely to be met

2 | THE CURRENT STUDY

Understanding expectations and outcomes for the broad range of crisis line help-seekers, and the extent to which there are unique

characteristics or needs for help-seekers with suicide-related reasons for contact, is imperative given the public health implications of not providing effective and immediate help that meets users' needs. This study aimed to understand expectations of Lifeline help-seekers. We investigated help-seekers': (1) reasons for contacting Lifeline; (2) awareness and use of the telephone, online chat and text message modalities; (3) expectations of Lifeline, in terms of what they hoped to receive and whether these expectations were met; and (4) perceived outcomes of contacting Lifeline, in terms of how they felt after contact, how satisfied they were, likelihood of future service use, and extent to which they thought Lifeline achieved immediate and longer-term outcomes for service users. We compared participants who reported that their own suicidality was a reason for help-seeking (whom we term 'suicide-related contacts') to participants who did not report that their own suicidality was a reason for contact (whom we term 'non-suicide-related contacts'). By revealing differences between help-seekers with suicide-related and non-suicide-related reasons for contacting Lifeline, we hope to inform crisis support services to better meet the needs of help-seekers experiencing any form of crisis, but particularly those at risk of suicide.

3 | METHOD

3.1 | Participants

Participants in the online survey were 553 Australian adults, aged 18 years or older, who had contacted Lifeline Australia via any of the following modalities: telephone, online chat, text message, or the Lifeline website. Almost three-quarters (73.6%) were female, and the mean age was 39.6 years (SD = 13.93, range = 18–77 years). A total of 1278 help-seekers initially responded to the survey, with 725 being excluded for the following reasons: no previous contact with any of Lifeline's modalities (n = 586), less than 60% survey completion (n = 126) and being under 18 years (n = 13).

3.2 | Procedure

A self-report survey was made available to participants via an anonymous online link over a 6-month period from December 2019 to June 2020. Recruitment occurred through convenience sampling via Lifeline's social media pages, including Facebook, Twitter and LinkedIn, and Lifeline Australia's official website. The survey was also shared through social media by Lifeline's Lived Experience Advisory Group and other mental health organisations' web pages, including Beyond Blue and SANE Australia. To increase the response rate from help-seekers who had last contacted Lifeline via the online chat and text message modalities, a survey link was included directly after service use during the second half of the data collection period. No incentives were given for participation.

The survey was hosted on the Qualtrics platform. Participants were first provided with information about the study and directed to the online questionnaire after providing consent. The questionnaire comprised 19 closed and one open-ended question, and eight demographic questions. The average completion time was 15.27 min (SD = 11.38). The study received ethics approval from the University's Human Research Ethics Committee (Project ID: 2295).

3.3 | Measures

The measures were developed in collaboration with Lifeline Australia based on past Lifeline surveys, service use data and consultation with Lifeline's Lived Experience Advisory Group, as no relevant standardised measures were identified (Mazzer et al., 2020). A previous survey of community members and their perspectives of Lifeline was also used as a basis for the survey questions (Ma et al., 2021).

Awareness and use of Lifeline. The questionnaire first assessed help-seekers' awareness of each of Lifeline's crisis support service modalities (telephone, online chat, text), their most recent contact modality, and time since most recent contact.

Reasons for contact. Help-seekers' reasons for previously contacting Lifeline were determined with 14 response options (participants could indicate multiple responses): immediate personal crisis; difficulty coping with events in my life; feeling isolated and lonely; feeling anxious or depressed; drug and/or alcohol problems; domestic violence; relationship issues; grief or bereavement; gambling; sexuality; worried about someone else and needed support and guidance on what to do; support after another's suicide death or attempt; feeling suicidal and follow-up support to stay safe and recover after a suicidal crisis (these last two were used to determine help-seekers with suicide-related reasons for contact, noting that this indicates that suicidality was present in a previous contact but not necessarily the most recent contact).

Expectations. To assess help-seekers' expectations of Lifeline, participants were asked whether they were hoping to receive or feel each of the following 17 expectations, indicated with a 'yes' or 'no' response: feel less upset; feel less alone; feel more confident; feel understood; receive information and referrals; receive safety advice or support to stay safe; feel heard and listened to; feel more hopeful; feel more connected to other people; learn strategies to cope; make a plan for how to improve things; feel less suicidal; feel less afraid; feel less anxious or depressed; feel happier; feel cared for and feel supported.

To measure whether these expectations were met, help-seekers were then asked, for each of the expectations that they endorsed, the extent to which they had experienced that expectation, indicated on a scale from 1 ('not at all') to 5 ('very much') after their contact with Lifeline. This method of measuring expectations was based on previous work conducted by Stace and Wyllie (2011) of the UK crisis support service, Samaritans.

Outcomes. Questions were also included to ask help-seekers about how they felt overall after their last contact with Lifeline (1 'worse' to 5 'better'), their satisfaction with the help received (1 'very dissatisfied' to 5 'very satisfied') and how likely they would be to

contact each of Lifeline's crisis support modalities in the future when experiencing a crisis (1 'very unlikely' to 5 'very likely').

Perceived outcomes of the extent to which Lifeline achieves immediate outcomes, such as a sense of relief or reduced distress, and longer-term outcomes, such as strategies to cope later, were assessed for each modality on a scale from 1 'not at all' to 5 'very much'.

Demographics. Age, gender, Indigenous status, sexual orientation, household structure, country of birth and main language spoken at home were asked. These demographics indicate population groups of specific interest for Lifeline.

3.4 | Analysis

Data were analysed using SPSS version 25.0 (IBM Corp, 2017). Descriptive statistics were calculated for each measure and reported as percentages (valid percentages are reported unless noted). Binary logistic regressions controlling for age and analysis of covariance using age as a covariate were used to compare key measures of expectations, satisfaction levels and outcomes between help-seekers with suicide-related and non-suicide-related reasons for contact. Age was included as a control because there was a significant age difference between the two help-seeker groups; no other demographic characteristics were significantly different after controlling for age (see Table 1). Significance was set at $p < 0.01$ to control for Type I errors and exclude trivial differences due to high power for most analyses.

4 | RESULTS

Suicidality was one of the main reasons for contacting Lifeline for 59.5% of the sample ($n = 329/553$), based on respondents

TABLE 1 Demographics of lifeline help-seeker participants

Demographic	Suicide-related $n = 329$	Non-suicide-related $n = 224$	Total $n = 553$	Difference p value [η^2]
Mean age (*SD*) ($n = 521$)	**36.73 (13.19)**	**43.99 (13.86)**	39.60 (13.93)	**<0.001 [0.066]**
Gender ($n = 425$)	%	%	%	0.663
Male	16.3	21.0	18.1	
Female	75.6	70.7	73.6	
Transgender	0.4	1.2	0.7	
Non-binary	3.5	1.8	2.8	
Other	2.7	3.6	3.1	
Prefer not to say	1.6	1.8	1.6	
Indigenous Status ($n = 400$)				0.417
Non-Indigenous	94.7	96.8	95.5	
Indigenous	5.3	3.2	4.5	
Sexual orientation ($n = 412$)				0.037
Straight/heterosexual	68.7	81.9	73.8	
Gay	2.4	2.5	2.4	
Lesbian	7.5	1.9	5.3	
Bisexual	11.9	3.8	8.7	
Other	5.2	3.8	4.6	
Prefer not to say	4.4	6.3	5.1	
Household ($n = 404$)				0.352
Person living alone	27.8	26.3	27.2	
Other	72.2	73.7	72.8	
Country of birth ($n = 417$)				
Australia	84.8	80.1	83.0	0.564
Overseas	15.2	19.9	17.0	
Language spoken at home ($n = 412$)				0.054
English only	92.4	87.6	90.5	
Other language	7.6	12.4	9.5	

Age difference determined by *t*-test. Other demographic differences determined using logistic regression controlling for age. Significant differences indicated in bold $p < 0.01$.

choosing 'feeling suicidal' and/or 'wanting support to stay safe after a suicidal crisis' as a reason they contacted Lifeline. Table 1 presents demographic characteristics and comparisons, showing that participants who had suicide-related contacts were significantly younger than those who were non-suicide-related contacts. When controlling for age, there were no other significant demographic differences found between suicide-related and non-suicide-related contacts.

4.1 | Awareness and use of modalities

Almost all participants were aware that Lifeline provides a telephone crisis support line (98.3%), nearly 90% were aware that it provides online chat, and about three-quarters were aware that Lifeline provides a text message service. There were no significant differences between the awareness of suicide-related and non-suicide-related contacts (Table 2). The most common modality for most recent contact was phone, followed by text and lastly online chat, with no significant differences between suicide-related and non-suicide-related contacts. While respondents most frequently indicated they had not previously used another modality, suicide-related contacts were significantly more likely to have previously also contacted by phone in addition to their most recent modality. In terms of recency of contact, help-seekers in both groups were most likely to have contacted either in the last week or more than 12 months ago, with no significant differences between groups.

4.2 | Reasons for contacting lifeline

The reasons for contacting Lifeline are presented in Table 3. On average, respondents reported about four reasons for contact, but suicide-related contacts reported twice as many reasons as participants who had non-suicidal related contact. The most common reasons endorsed across both groups were 'difficulty coping with events in their life', 'feeling anxious or depressed', 'feeling lonely' and 'immediate personal crisis'. Each of these reasons received significantly higher endorsements from suicide-related contacts. Endorsement of 'grief and bereavement' was also significantly higher for suicide-related contacts. Non-suicide-related help-seekers were significantly more likely to report being 'worried about someone else and needing guidance and support on what to do' as one of their reasons for contact, compared to non-suicide-related contacts.

TABLE 2 Awareness and use of lifeline modalities (%)

Measure	Suicide-related $n = 329$	Non-suicide-related $n = 224$	Total $n = 553$	Difference p value (odds ratio)
Awareness of modality %				
Phone ($n = 543$)	98.1	98.6	98.3	0.853
Online chat ($n = 514$)	89.4	87.3	88.5	0.551
Text ($n = 493$)	75.8	76.5	76.1	0.296
Most recent contact modality ($n = 553$) %				0.044
Phone	51.1	62.9	55.9	
Online chat	20.1	10.7	16.3	
Text	24.6	17.4	21.7	
Website	4.3	8.9	6.1	
Prior other contact modalities ($n = 545$) %				
None	41.5	56.4	47.5	0.021
Phone	**25.5**	**13.2**	20.6	**0.003 (2.073)**
Online chat	16.0	10.5	13.8	0.749
Text	6.5	5.9	6.2	0.967
Website	17.8	22.7	19.8	0.134
Time since last contact ($n = 542$) %				0.537
In last week	30.3	24.2	27.9	
In last month	11.3	8.4	10.1	
In last 3 months	14.4	12.1	13.5	
In last 6 months	10.7	10.7	10.7	
In last 12 months	11.6	9.8	10.9	
More than 12 months ago	21.7	34.9	26.9	

Notes: Differences determined by logistic regression controlling for age. Significant differences indicated in bold $p < 0.01$.

4.3 | Expectations of lifeline's services

Expectations are shown in Table 4, revealing that all expectations were quite commonly endorsed, and that there were few major differences between suicide-related and non-suicide-related contacts. The expectations almost universally endorsed by both types of help-seekers were 'feeling heard and listened to', 'feeling less upset', 'feel understood' and 'feel supported'. The vast majority also endorsed expectations to 'feel less anxious and depressed', 'less alone' and 'more hopeful'.

The largest difference between suicide-related and non-suicide-related help-seekers was, not surprisingly, an expectation to 'feel less suicidal', endorsed by almost 90% of those who were suicide-related contacts, compared to 36.7% of those who did not report feeling suicidal as a main reason for contact. Consistent with a higher expectation for feeling less suicidal, suicide-related contacts were significantly more likely to expect to 'receive safety advice or support to stay safe'. In comparison, non-suicide-related help-seekers were significantly more likely to endorse wanting to 'feel happier' and to 'make a plan for how to improve things'.

Whether help-seekers' expectations were met after their most recent contact with Lifeline is shown in Table 4. All means were around the mid-point of the scale from 1 'not at all' to 5 'very much'. For both groups of help-seekers, the best met expectation was 'feeling heard and listened to' and the least met was 'feeling happier'. There was a trend whereby suicide-related contacts reported their expectations were less well met compared with non-suicide-related contacts for all expectations, with these differences being significant for four of the 17 expectations (means in bold in Table 4): 'feel less alone', 'feel less suicidal', 'feel less afraid' and 'feel less anxious or depressed'.

4.4 | Outcomes

Table 5 outlines the main outcomes of interest for the current study. These show that non-suicide-related contacts who had 'felt less suicidal' as an expectation were more likely to have the expectation met compared with suicide-related contacts who had this outcome as an expectation. In terms of feeling better (or worse) after contacting Lifeline, help-seekers felt somewhat better on average, with non-suicide-related contacts feeling significantly better than suicide-related help-seekers. Help-seekers were mostly satisfied with their Lifeline contact, and there were no significant differences between suicide-related and non-suicide-related contacts (Table 5). There were 56.2% of suicide-related help-seekers and 64.1% of non-suicide-related help-seekers who were either very satisfied or satisfied with their contact.

There were no significant differences between suicide-related and non-suicide-related contacts in their likelihood of future service use by any of the modalities (Table 5), nor in likelihood of future use between modalities ($p = 0.148$). Overall, scores were around the scale mid-point showing that help-seekers were generally likely to contact Lifeline in future via each modality.

In terms of help-seekers' perceptions of the time frame of outcomes achieved by Lifeline for each modality, Table 5 shows a trend whereby non-suicide-related help-seekers had stronger perceived outcomes, but this difference only attained significance for longer-term outcomes for online chat. Immediate outcomes were more strongly anticipated for all modalities compared with longer-term outcomes ($p < 0.001$), and phone was the modality most strongly expected to achieve outcomes, followed by online chat, and lastly text message, for both immediate and longer-term outcomes (significant linear trend $p < 0.001$).

TABLE 3 Reasons for contacting lifeline (%)

Reason	Suicide-related $n = 329$	Non-suicide-related $n = 224$	Total $n = 553$	Difference p value (odds ratio)
Difficulty coping with events in my life	**78.1** ($n = 257$)	**62.5** ($n = 140$)	71.8 ($n = 397$)	**<0.001 (0.421)**
Feeling anxious or depressed	**78.1** ($n = 257$)	**53.1** ($n = 119$)	68.0 ($n = 376$)	**<0.001 (0.370)**
Feeling isolated and lonely	**62.9** ($n = 207$)	**42.4** ($n = 95$)	54.6 ($n = 302$)	**<0.001 (0.476)**
Immediate personal crisis	**69.6** ($n = 229$)	**30.4** ($n = 68$)	53.7 ($n = 297$)	**<0.001 (0.178)**
Grief or bereavement	**24.6** ($n = 81$)	**14.3** ($n = 32$)	20.4 ($n = 113$)	**0.006 (0.504)**
Relationship issues	16.4 ($n = 54$)	15.2 ($n = 34$)	15.9 ($n = 88$)	0.684
Worried about someone else and need support and guidance	**9.4** ($n = 31$)	**19.6** ($n = 44$)	13.6 ($n = 75$)	**0.002 (2.314)**
Domestic violence	12.5 ($n = 41$)	8.5 ($n = 19$)	10.8 ($n = 60$)	0.249
Drug and/or alcohol issues	10.3 ($n = 34$)	5.4 ($n = 12$)	8.3 ($n = 46$)	0.023
Support after another person's suicide death or attempt	7.9 ($n = 26$)	5.8 ($n = 13$)	7.1 ($n = 39$)	0.271
Sexuality issues	5.2 ($n = 17$)	2.2 ($n = 5$)	4.0 ($n = 22$)	0.150
Gambling issues	1.8 ($n = 6$)	1.3 ($n = 3$)	1.6 ($n = 9$)	0.545
Total number of reasons Mean (SD)	**5.20 (2.17)**	**2.56 (1.79)**	4.13 (2.40)	**<0.001**

Notes: Differences determined by logistic regression controlling for age. Significant differences indicated in bold $p < 0.01$.

TABLE 4 Expectations of lifeline (% endorsed) and mean ratings (scale 1–5) of expectations having been met by contacting lifeline

Expectation % endorsed *M(SD)* met	Suicide-related contact *n* = 329	Non-suicide-related *n* = 224	Total *n* = 553	Difference *p* value (odds ratio/ η^2)
Feel heard and listened to	94.8	93.5	94.3	0.335
	3.39 (1.51)	3.63 (1.54)	3.49 (1.52)	0.115
Feel less upset	92.4	93.5	92.8	0.683
	2.86 (1.38)	3.12 (1.41)	2.97 (1.40)	0.088
Feel understood	90.2	92.6	91.1	0.884
	3.12 (1.50)	3.40 (1.51)	3.23 (1.51)	0.040
Feel supported	90.2	91.1	90.5	0.438
	3.15 (1.49)	3.46 (1.53)	3.27 (1.51)	0.018
Feel less alone	84.1	76.4	81.0	0.043
	2.79 (1.41)	**3.23 (1.46)**	2.95 (1.45)	**0.006 (0.018)**
Feel less anxious or depressed	80.2 **2.52 (1.24)**	81.0 **2.88 (1.42)**	80.5 2.66 (1.32)	**0.007 (0.018)**
Feel more hopeful	74.9	81.9	77.7	0.242
	2.72 (1.40)	3.07 (1.45)	2.87 (1.43)	0.026
Feel cared for	69.8	72.3	70.8	0.792
	3.07 (1.48)	3.25 (1.50)	3.14 (1.49)	0.101
Feel less suicidal	**89.9**	**36.7**	69.0	**<0.001 (0.058)**
	2.77 (1.38)	**3.46 (1.57)**	2.91 (1.45)	**0.001 (0.034)**
Feel less afraid	61.7	59.2	60.7	0.248
	2.60 (1.37)	**2.97 (1.48)**	2.74 (1.42)	**0.007 (0.024)**
Learn strategies to cope	55.1	63.8	58.6	0.083
	2.50 (1.38)	2.82 (1.44)	2.64 (1.41)	0.026
Receive safety advice or support	**64.8** 3.00 (1.42)	**42.8** 3.17 (1.54)	56.1 3.06 (1.45)	**<0.001 (0.431)** 0.315
Make a plan for how to improve things	**49.1** 2.36 (1.35)	**62.0** 2.76 (1.48)	54.2 2.54 (1.42)	**0.023 (1.538)** 0.013
Feel happier	**47.7**	**64.0**	54.1	**0.001 (1.923)**
	2.47 (1.33)	2.73 (1.43)	2.59 (1.38)	0.111
Feel more confident	46.5	61.0	52.3	0.014
	2.59 (1.37)	2.97 (1.38)	2.76 (1.39)	0.061
Feel more connected to others	50.2 2.71 (1.41)	54.4 2.94 (1.48)	51.9 2.81 (1.44)	0.716 0.190
Receive information and referrals	37.0 2.69 (1.58)	48.1 2.88 (1.56)	41.5 2.78 (1.57)	0.043 0.297

Notes: Differences in % endorsing the expectations were determined by logistic regression controlling for age. Differences in mean rating of expectations being met were determined using analysis of covariance, with age as the covariate. Significant differences indicated in bold $p < 0.01$. Valid sample sizes excluding missing data reported as *n*. Ratings of whether each expectation was met was only asked of those who had endorsed that expectation initially.

5 | DISCUSSION

We examined expectations and outcomes from a large sample of adults who had sought help from Lifeline, via telephone, online chat and text messaging. Almost 60% of the sample reported reasons for contact that were related to their own suicidality. While the sample is not likely to be representative of Lifeline help-seekers, it confirms that suicide is a prime concern for many help-seekers, but that help is also sought by a substantial proportion of people for whom suicidality was not their main concern. Respondents with suicide-related reasons for contacting Lifeline were significantly younger, reflecting findings that suicide is the leading cause of death for younger Australians aged 15–44 years (Australian Institute of Health and Welfare, 2021),

Help-seekers' most common reasons for using Lifeline were feeling anxious or depressed, difficulty coping with events in life, immediate personal crisis, and feeling isolated and lonely, although it is important to note that answers were limited to the response options provided. The reasons reported are generally congruent with those revealed in a recent systematic review (Mazzer et al., 2020), which

TABLE 5 Mean outcome scores for help-seekers

Outcome	Suicide-related *M (SD)*	Non-suicide-related *M (SD)*	Total *M (SD)*	Difference *p* value [η^2]
Felt less suicidal (met expectation)	**2.77 (1.38)** *n* = 292	**3.46 (1.57)** *n* = 74	2.91 (1.45) *n* = 366	**0.001 [0.034]**
Felt better	**3.02 (1.37)** *n* = 322	**3.37 (1.44)** *n* = 210	3.14 (1.41) *n* = 532	**0.006 [0.015]**
Satisfaction	3.29 (1.52) *n* = 320	3.55 (1.54) *n* = 212	3.39 (1.53) *n* = 532	0.088
Likelihood of future use				
Phone	2.78 (1.64) *n* = 300	3.14 (1.66) *n* = 203	2.93 (1.66) *n* = 503	0.229
Online chat	2.82 (1.51) *n* = 284	2.84 (1.52) *n* = 183	2.83 (1.51) *n* = 467	0.204
Text	2.77 (1.55) *n* = 280	2.61 (1.59) *n* = 184	2.70 (1.57) *n* = 464	0.614
Perceived outcomes – immediate				
Phone	3.82 (1.37) *n* = 252	4.21 (1.20) *n* = 159	3.97 (1.32) *n* = 411	0.014
Online chat	3.42 (1.33) *n* = 243	3.70 (1.13) *n* = 154	3.53 (1.26) *n* = 397	0.062
Text	3.30 (1.37) *n* = 242	3.46 (1.25) *n* = 155	3.36 (1.33) *n* = 397	0.203
Perceived outcomes – longer-term				
Phone	3.15 (1.44) *n* = 248	3.60 (1.34) *n* = 155	3.32 (1.42) *n* = 403	0.012
Online chat	**2.90 (1.27)** *n* = 239	**3.30 (1.21)** *n* = 152	3.05 (1.26) *n* = 391	**0.005 [0.021]**
Text	2.82 (1.31) *n* = 238	3.16 (1.31) *n* = 154	2.95 (1.32) *n* = 392	0.015

Notes. Differences determined using analysis of covariance, with age as the covariate. Significant differences indicated in bold $p < 0.01$.

found interpersonal relationships, mental health, loneliness, work, school, abuse, suicide, and physical health issues were consistently reported reasons for service use in studies of crisis support services. However, the current study found an important distinction between the reasons provided by suicide-related and non-suicide-related contacts. People with suicide-related reasons were more likely to contact in relation to their own personal crises and feelings of emotional distress; whereas non-suicide-related help-seekers were more likely to contact Lifeline in relation to supporting others. This may not be surprising, but suggests that while the service response for suicide-related contacts needs to focus on their personal safety and distress, for non-suicide-related contacts the service response may need to address their capacity to appropriately support someone else, or manage their own well-being in the context of supporting someone else.

The most endorsed expectations for both suicide-related and non-suicide-related help-seekers were to feel heard and listened to, be understood, and feel supported. Emotionally, most help-seekers wanted to feel less upset, much more so than wanting to feel happier. It was evident that help-seekers wanted support whereby they felt listened to, less alone, and more hopeful. Instrumental support, including helping them to learn strategies to cope, make plans to improve things, or receive safety advice or support, were expectations for around half the help-seekers. The expectation to feel less suicidal was the main difference between suicide-related and non-suicide-related contacts, however, the more positively framed expectation to feel happier and the more long-term strategy of making a plan were favoured by non-suicide-related contacts. Both groups perceived Lifeline to be better at providing immediate outcomes such as reducing distress, compared with longer-term outcomes such as providing strategies to cope later. These findings align with Lifeline's support framework (CARE: Connect, Attend to Needs, Reaffirm and Empower), which focuses on reducing immediate distress and improving short-term outcomes. The CARE framework prioritises that above all else, help-seekers need to feel heard and connected, which was an expectation endorsed by almost all the help-seekers in the current study.

Suicide-related help-seekers generally felt that their expectations were met to a lesser extent than non-suicide-related help-seekers, particularly for feeling less suicidal, alone, anxious and depressed, and afraid. Suicide-related contacts reported twice as many reasons for seeking help and were more likely to endorse most of the reasons offered for contacting Lifeline, suggesting their needs are multiple and complex. While the one-off contact with crisis support from Lifeline may provide some level of immediate distress relief, suicidal callers are likely to have many ongoing issues to resolve. Consequently, identifying early in the contact whether a help-seeker is suicidal or not is important, not only to ensure their safety, but also to allow time to consider their multiple concerns and help provide them with some clarity on what their most pressing matters may be and how to address these. With so many presenting reasons, suicidal help-seekers may feel particularly overwhelmed by their concerns and, therefore, be unable to see their way forward. They may need support to understand that the crisis contact is primarily designed to address their immediate distress and risk, and that additional sources of support will be needed for their additional and complex underlying issues. These findings also strengthen the case for changing community (and policy maker) expectations that Lifeline alone is sufficient to support suicidal people, rather than being one component of a comprehensive suicide prevention strategy.

Overall, the phone modality was seen as more likely to have both immediate and longer-term outcomes, followed by chat and then text. This is likely to reflect the participants being most familiar with Lifeline's telephone services, as this is the longest established service, being available for almost 60 years. The chat service has been offered for just over 10 years, and the text message service for 4 years. While uptake of the newer modalities has risen rapidly, they are still novel for many people. Importantly, however, there were no differences between modalities in likelihood of future use. There is the potential that over time the text-based services will become more popular than the phone. In terms of innovation, these modalities are the most readily tailored and targeted to user needs through the implementation of computer-enhanced capabilities. Such changes will need to be carefully designed and implemented, however, by adopting user-centred approaches, as it is very clear from the current results that the main expectation of help-seekers is to feel heard and listened to.

6 | STRENGTHS AND LIMITATIONS

A major strength of this study is that it engaged a large sample of help-seekers and assessed key expectations and outcomes for a national crisis support service, identifying some distinct service needs for suicide-related and non-suicide-related help-seekers. Nevertheless, the results should be interpreted in light of the study's limitations. First, the sample is unlikely to be representative of Lifeline's help-seekers as it was a convenience sample of those who noticed the recruitment material and chose to take part. Consequently, the results may not generalise to the broad Lifeline user population, which is large and diverse. Furthermore, the measure indicating a suicide-related or non-suicide-related reason for contact did not measure the nature of suicidality—including how current or severe it was across the continuum of suicide risk. Level of suicide risk may be an important moderator and understanding people at imminent suicide risk is critical.

Similarly, ascertaining the reasons for contact is complex, as help-seekers may not always have clear insight into the causes or nature of their distress. This may be indicated by the finding that over one-third of non-suicide-related help-seekers had the expectation of feeling less suicidal, despite not indicating that 'feeling suicidal' was one of their reasons for seeking help. Alternatively, respondents who did not contact Lifeline primarily for suicide-related reasons, yet reported feeling less suicidal at the end of a call, may be contacting about immediate crisis issues in their lives and need support on a specific issue at that point in time, such as a relationship conflict, the loss of money, onset of mental illness symptoms, or distress over a situation. Suicidal ideation may sit underneath the immediate 'crisis', however, and this suicidal ideation may be reduced because the person is left feeling less distressed about the 'crisis issue'. It is also possible that this expectation reflects the general understanding that Lifeline has a focus on suicide prevention. The study also required participants to reflect on their past contact over a time period that was not defined; there was a wide range of prior contact times including over 12 months prior, and the cross-sectional nature of the study precludes drawing any causal conclusions. Attaining more proximal expectations and outcomes, with an indicator of suicide risk, prospectively from a representative sample of help-seekers, would substantially improve our understanding of help-seekers' needs.

7 | CONCLUSION

Crisis support services, like Lifeline Australia, serve an essential public health purpose, but are likely to be limited in their ability to address the many complex reasons that people contact for support and help-seekers' multiple expectations. The one-off nature of crisis contact is seen to be more suited to immediate outcomes, but longer-term expectations are also held. It is clear from our results that while suicide-related presentations are common, many people contact when suicide risk does not seem to be an issue. Suicide-related contacts to Lifeline appear to be more complex, and it is more difficult to meet these help-seekers' expectations. Consequently, ways to provide more tailored crisis support strategies could enhance the provision of services to be highly responsive and effective in assisting help-seekers in their time of need, whatever that need may be. The newer service modalities of online chat and text may provide opportunities for both greater user choice and more tailored help-seeker experiences, and it is notable that this study found no differences across modalities in likelihood of future use.

AUTHORS' CONTRIBUTIONS

MO lead data analysis and writing of the paper and contributed to study design. JM supervised MO and contributed to all aspects of design, analysis and writing. KM was involved in initial design and early supervision of MO. PB, KK, AW, BK, ML, RG and MG contributed to design and interpretation of analyses and reviewed drafts. DR lead the overall project and oversaw all aspects of the design, analysis and writing. All authors reviewed the final version.

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CONFLICT OF INTEREST

The authors report no conflicts of interest.

DATA AVAILABILITY STATEMENT

Original data are not publicly available due to ethics restrictions.

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