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Lifeline Caller Response Times and Suicide Prevention

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Lifeline Caller Response Times and Suicide Prevention

The Australian Bureau of Statistics (2018) reports that 3,128 Australians died from intentional self-harm in 2017, a rise of 9.1% from 2016. Hence, there is mounting concern that Australia needs to find ways to reduce suicides' growing toll. Through its 13 11 14 telephone number, Lifeline provides Australia's largest (Spittal et al. 2015) and arguably most well-known national 24/7 telephone counselling service with a focus on adult suicide prevention. The paper aims to inform psychiatrists and others working with those at risk of suicide, to the access issue with Lifeline's 13 11 14 number and how this may have serious implications for the service delivery of suicide intervention.

The Lifeline telephone counselling service was introduced in Australia, over half a century ago, in 1963. The service was initiated by The Rev. Dr Alan Walker in response to the suicide death of a male known to him (Walker, 1967). Walker proposed that the telephone could be used to prevent an imminent suicide from occurring. This is still the primary role that Lifeline plays in the current suite of suicide prevention services that are available to Australians. The 2016-17 Lifeline Australia Report (Lifeline, 2017) notes that trained volunteers answered 789,761

calls, with 47 per cent of those answered within 90 seconds. While these are impressive statistics, they are nevertheless of only limited value because the report and the organisation's website make no mention of how long the other 53 per cent of callers waited for their calls to be answered.

Pirkis et al. (2016) reported that of the 884,000 calls to Lifeline in 2014, only 735,000 were answered. Thus, 149,000 calls appear to have gone unanswered in that year. The reader is reminded, here, that the genesis of the Lifeline service was inspired by the idea that the telephone could provide rapid access to counselling support that could then stop a person with suicidal thoughts acting on those thoughts. It is clear that current call response data that is publicly available does not allow stakeholders to determine maximum call waiting times, the average response time or how many calls are going unanswered. Therefore, based on available data, it is reasonable to conclude that more than half the calls to Lifeline Australia will take more than 90 seconds to answer, perhaps considerably longer, and that some calls will go unanswered.

One of the key reasons that calls to Lifeline Australia can take time to be answered, is the overwhelming number of calls the organisation receives each year. Clearly,

not all those calling are at imminent risk of suicide. However, non-suicide related calls may tie up the resource, so that when an urgent suicide call is made there may be no capacity to answer it in a timely fashion. With no process for triaging incoming calls, a suicidal caller may be waiting in a queue to talk to a counsellor behind callers with less urgent needs.

Currently, a caller to Lifeline's 13 11 14 number is greeted with a recorded message about the service, which begins by directing callers to ring 000 if life is in immediate danger for police or ambulance assistance, or alternatively, to choose from a menu to be connected to a counsellor or other staff member. Those who elect to 'speak to a counsellor now' are redirected to a second recording, which advises that the call has been placed in a queue and will be answered 'as soon as a counsellor is available'. No indication, however, is provided of how long they may have to wait for a counsellor or where they are in the queue of calls waiting to be answered. (Lifeline Australia 13 11 14 (telephone) accessed January 13, 2019).

The authors of this paper argue that 000 is not a suitable alternative to confidential counselling and directing suicidal callers to ring 000 ignores the crucial role that Lifeline counsellors play in talking suicidal callers out of their planned action. The first author of this paper was a Lifeline counsellor and trainer for a number of

years. It is his experience that Lifeline counsellors can work diligently, over a considerable time, perhaps an hour or more, to talk the suicidal person 'down' and guide her or him to reassess their circumstances and abandon the suicide plan for an alternative course of action. This is not something that an emergency services line is designed to do. With few other suicide services available to fill this vital gap in the service network, lives may be at stake. This matter of access is heightened, as callers to such services tend to be isolated from other forms of support (Pirkis et al., 2016), which might be utilised at such times. If socially isolated people do decide to call Lifeline at times of urgent need and then cannot reach a Lifeline counsellor within a reasonable time then they may perceive they are not worthy of support and/or see it as confirmation that death is their only option.

The authors believe that to reduce the rate of suicide in Australia a range of services that can respond rapidly to people in their time of need, is required. Further, we regard a 24/7 national telephone suicide service to be a vital part of this service network. However, if the caller experiencing suicide ideation cannot reach such services when required and there is no one else to call upon, suicide then may become a more likely outcome.

Many varied organisations including media organisations, health professionals and websites, routinely direct Australians to the 13 11 14 Lifeline counselling service but, we argue, this vital service may not be available for those with an urgent need, such as suicide intervention. The authors would like to see greater transparency regarding response times of such services, so that those referring people to these types of services and those in urgent need of suicide intervention are fully informed in this regard. If the current 13 11 14 telephone counselling service provided by Lifeline cannot guarantee timely access or some type of effective triage then there appears to be an urgent need to investigate alternatives, if we wish to reduce or contain the current suicide rate. The authors suggest that such a debate needs the input of health professionals with insight into suicide and its prevention. Given that a very high percentage of Australians now own mobile phones, the authors question if the full potential of the telephone to be used to intervene in imminent suicides, as envisaged by Rev. Dr Alan Walker, is being realised.

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The authors declare that there is no conflict of interest

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