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Frequent Callers to Lifeline

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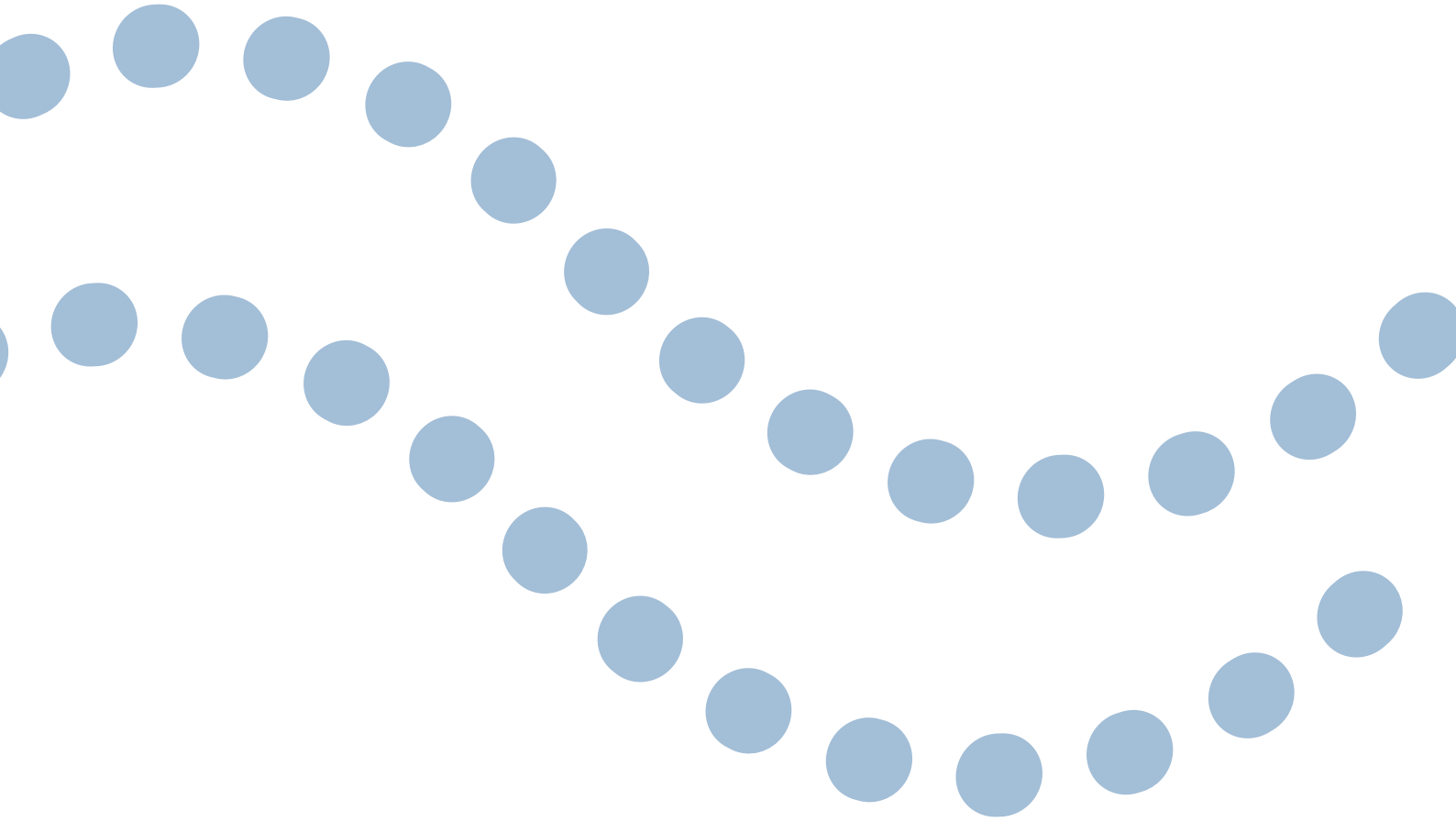

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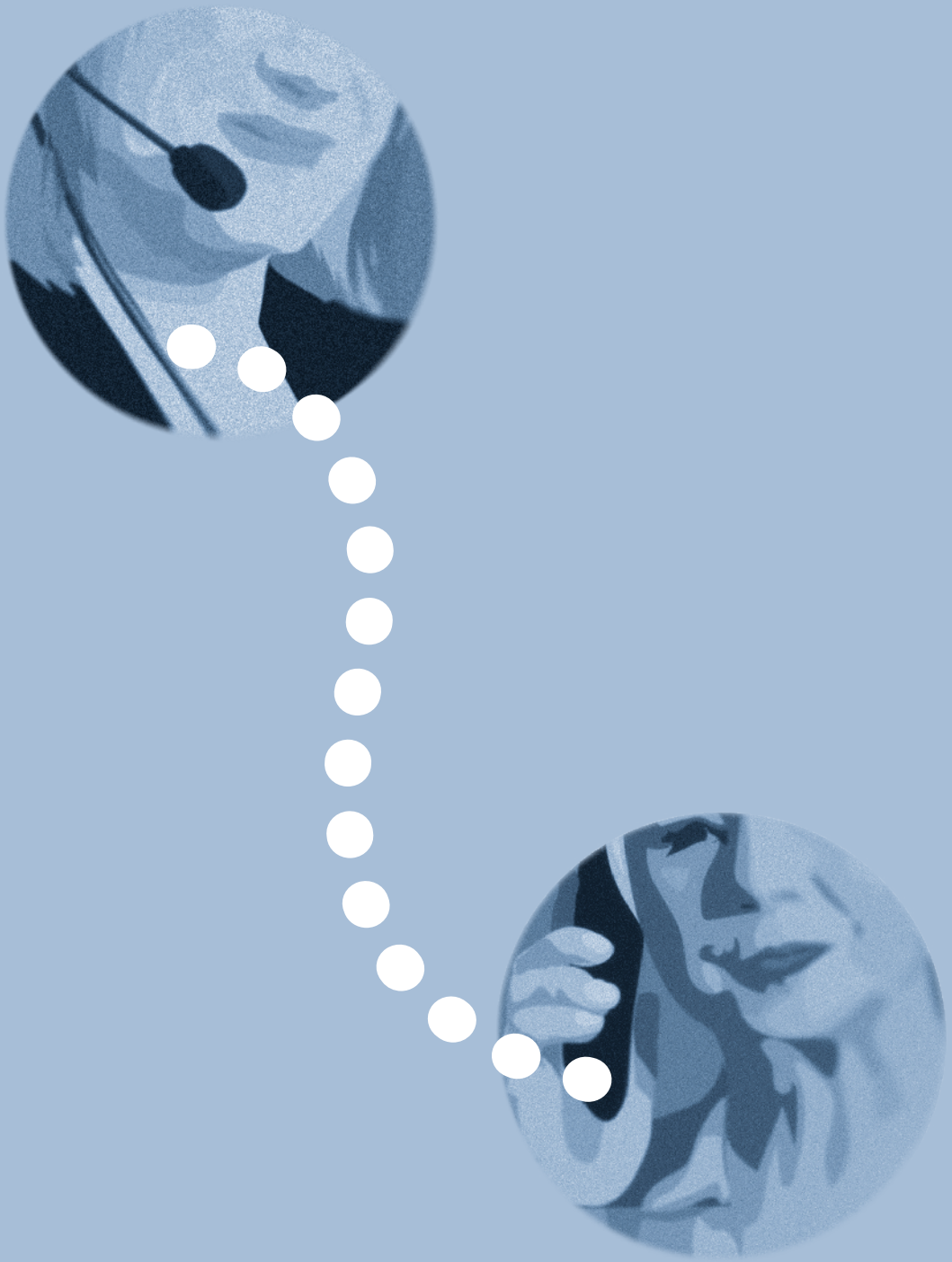


Executive summary

Lifeline provides access to crisis support, suicide prevention and mental health services. Key amongst these is its 13 11 14 telephone line, which offers 24-hour crisis support delivered by Telephone Crisis Supporters (TCSs). Assistance from services like Lifeline is intended as a one-off or time-limited intervention, but some people make numerous calls to these services, sometimes over a relatively short space of time and sometimes for prolonged periods. These 'frequent callers' present a challenge for Lifeline and other telephone helplines which aim to achieve the best outcomes for all callers but have to do so with finite resources. Responding to frequent calls from one caller may mean that several other callers cannot connect with the service, and may encourage a dependency on the service in frequent callers that is not in their best interests.

The Lifeline Research Foundation commissioned us to conduct a program of work designed to profile frequent callers and develop a service model that responds to their needs. The program of work included a literature review[1] and four empirical studies.[2–5] The empirical studies drew on data from different sources - (a) routinely collected Lifeline calls data;[4] (b) data from a purpose-designed survey/interview study with frequent callers to Lifeline;[5] (c) data from the Diagnosis, Management and Outcomes of Depression in Primary Care *(diamond)* study;[3]and (d) data from the National Survey of Mental Health and Wellbeing (NSMHWB).[2]

Several key findings stood out. Frequent callers are relatively few in number but they do account for a substantial proportion of calls. They have a heavy reliance on helplines, perhaps because they are isolated and have relatively few social supports. They are by no means just 'time wasters', however; they have high levels of need, as evidenced by the fact that they have major mental health problems (including anxiety, depression and suicidality) and are often in crisis. They also make use of other services for their mental health problems, including general practitioners (GPs), allied health professionals (e.g., psychologists), psychiatrists and emergency departments. The circumstances under which frequent callers

make use of telephone helplines vary, but current service models reinforce their calling behaviour.

These findings point to a potential model based on a number of principles, such as being responsive and non-judgemental, and offering flexibility and choice. The model involves several features, including offering frequent callers an integrated, tailored service in which they are allocated a dedicated and specially trained TCS, and given set times at which they can call to speak to this person. It also involves promoting better linkages between Lifeline and other services that provide mental health care, particularly GPs and other primary care providers.

We propose that the next step is to further refine the proposed model, testing the concept out with frequent callers and other key stakeholders. Once input from these stakeholders has been received and the model has been further refined, it should be tested in a controlled way via a randomised controlled trial. If the new model is shown to be both effective and cost-effective, then it would be ready for further roll-out.

Lifeline is not alone in struggling to deal with its frequent callers. Around the world, other telephone helplines face exactly the same issue. If Lifeline can implement a successful solution to responding to frequent callers, this will be ground-breaking. The model we propose here is based on the best available evidence, and we are confident that it (or a modified version of it) could provide the answer to how to meet the needs of frequent callers, as well as those of other callers, TCSs, and Lifeline's management.

1. Setting the context

Lifeline is a not-for-profit organisation that provides access to crisis support, suicide prevention and mental health services. Key amongst these is its 13 11 14 telephone line, which offers 24-hour crisis support. It also offers an online crisis support chat service (Crisis Chat) within a more restricted range of hours for people who are feeling overwhelmed and having difficulty coping, but may not feel comfortable speaking to someone over the phone. Both services are national, and both are staffed by highly-trained, dedicated volunteers. Both target people who may be experiencing mental health problems (e.g., depression or anxiety), have suffered abuse or trauma, be facing immediate stressors, or be feeling socially isolated. Both services have a particular emphasis on providing help for people who are at immediate risk of suicide.

Like other telephone helplines, Lifeline is designed to provide support to callers who are going through a crisis. A crisis is defined as a transient state of psychological disequilibrium during which a person's usual coping mechanisms are disrupted.[6,7] Lifeline aims to help callers to develop strategies to deal with the circumstances underpinning the crisis, and, where appropriate, suggest services that may offer more specialised, professional support. Its workers (known as Telephone Crisis Supporters, or TCSs) are trained to develop a rapport with callers, listening and responding to them in a way that is respectful and non-judgemental.

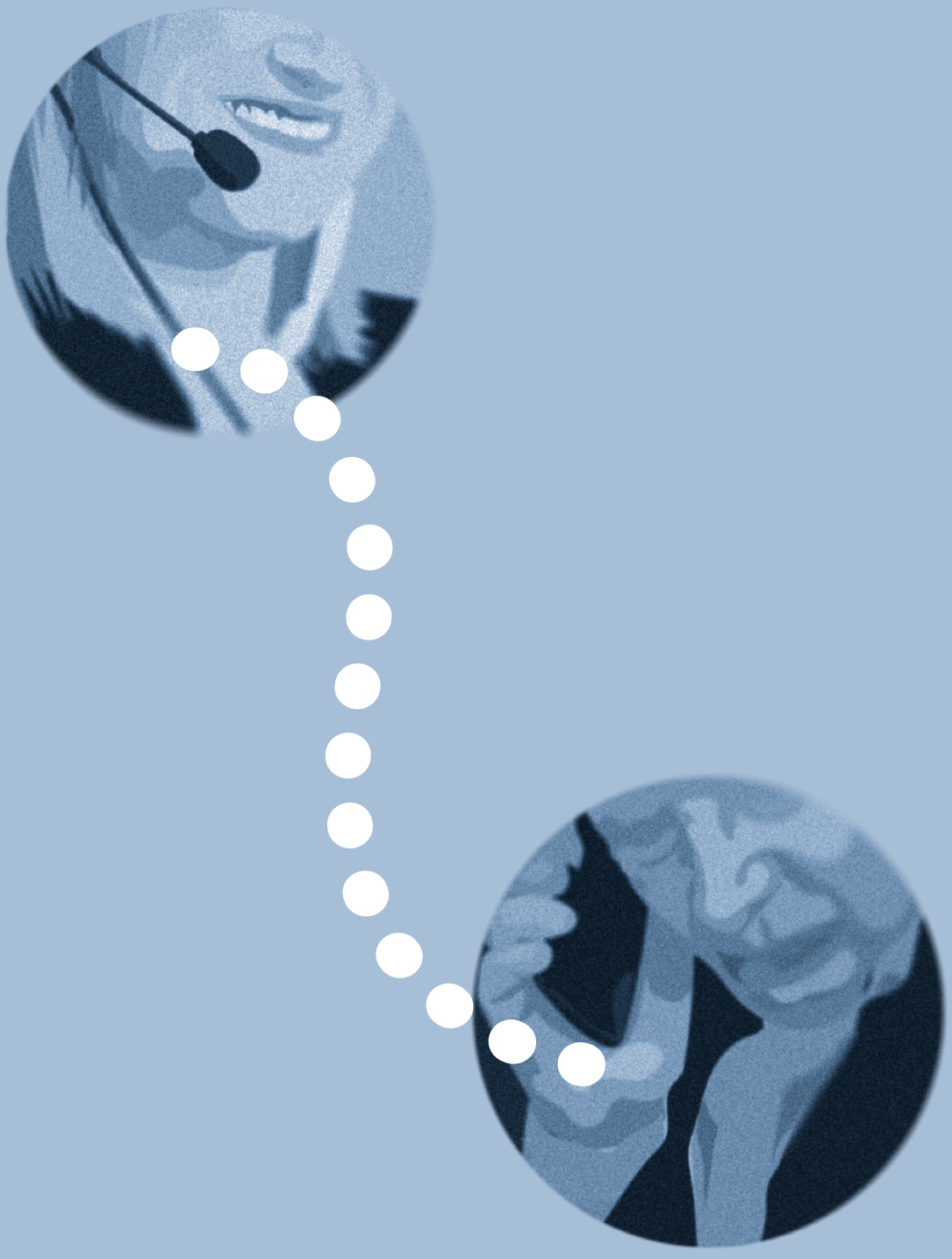
Assistance from services like Lifeline is intended as a one-off or time-limited intervention.[6] Some people, however, make numerous calls to telephone helplines, sometimes over a relatively short space of time and sometimes for prolonged periods. In this report, we refer to these callers as 'frequent callers', adopting this term from the telephone helpline literature.[8,9] They have also been described as 'chronic callers'[7,10–17] and 'repeat callers'.[18,19] Frequent callers present a challenge for Lifeline and other telephone helplines which aim to achieve the best outcome for all callers but have to do so with finite resources. Responding to frequent

calls from one caller may mean that several other callers cannot connect with the service. It may also encourage a dependency on the service in frequent callers that is not in their best interests.[20]

Lifeline has grappled with the issue of frequent callers for some time. In response to this, the Lifeline Research Foundation commissioned us to conduct a program of work designed to:

- Describe and develop the profile of frequent callers to Lifeline crisis support services; and
- Develop a service model that responds to frequent callers.

The program of work included a literature review[1] and four empirical studies,[2–5] each of which is reported elsewhere. This report summarises and synthesises the findings from the review and each of the studies, and uses these findings to inform a discussion about the principles and potential features of a service model that might free up resources for episodic and one-off callers while at the same time meeting the needs of frequent callers.



2. Furthering knowledge about frequent callers

Literature review

Our literature review allowed us to determine the extent of current international knowledge on frequent callers.[1] We searched Medline and ProQuest for articles relating to frequent callers to telephone helplines that were published between 1960 and 2012. We identified 21 articles that reported on 19 separate studies, 11 of which were call record audits,[7,11,14,17,20–27] five of which were follow-up surveys of callers,[6,28–32] and three of which were intervention studies.[10,18,33]

The published studies provided us with some insights into frequent callers. The studies suggested that frequent callers were more likely to be male and unmarried than other callers, but that, in the main, other key variables like age, mental health conditions or suicidality were unrelated to calling patterns. This led to suggestions about strategies that might meet the needs of frequent callers, including limiting the number and duration of calls permitted, assigning a specific TCS to the caller, implementing face-to-face contact, initiating contact with the caller rather than waiting for him or her to call, providing short-term anxiety and depression treatment programs over the phone, and creating individualised management plans. The first two strategies were found to show promise; the remainder are as yet untested.

These findings should be interpreted in the context of the limitations of the reviewed studies, which were quite significant. For example, the majority of the studies were conducted overseas, predominantly in the United States; only three were conducted in Australia. They used a variety of definitions of frequent callers,

most commonly using the very inclusive definition of 'more than one call', and not uncommonly failing to use a definition at all. Their samples were often small and/or unrepresentative, and only two compared frequent callers with other callers. Most of the studies were relatively dated; over two thirds were conducted before 2000. We concluded that more up-to-date, rigorous, country-specific work is needed in this area.

Empirical studies

Our empirical studies enabled us to consider frequent callers in the Australian context, and, in some cases, in the context of Lifeline specifically. The empirical studies drew on data from four different sources – (a) routinely collected Lifeline calls data;[4] (b) data from a purpose-designed survey/interview study with frequent callers to Lifeline;[5] (c) data from the Diagnosis, Management and Outcomes of Depression in Primary Care *(diamond)* study;[3] and (d) data from the National Survey of Mental Health and Wellbeing (NSMHWB).[2] The first two data sources were Lifeline-specific; the latter two provided additional perspectives on patterns of usage of telephone helplines more generally. The methods used in these studies are described in more detail below, as are the key findings that emerged from them.

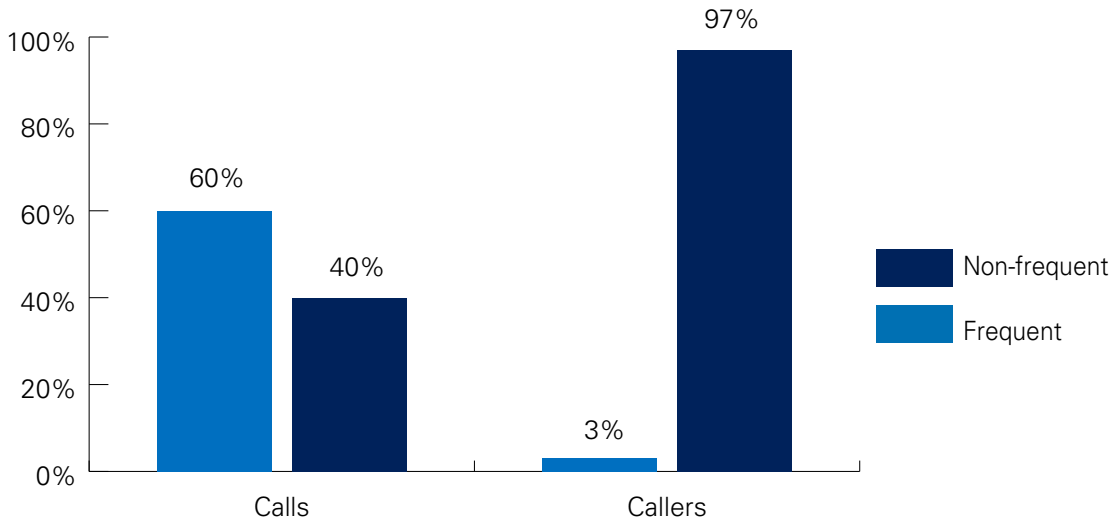
Routinely collected Lifeline calls data

Lifeline provided us with data on calls made to Lifeline between December 2011 and May 2013.[4] Although calls to Lifeline are anonymous, certain data are routinely captured for each call. These include phone number, call date and time, region of call origin, call duration, caller demographics and presenting issues, and call type (crisis versus non-crisis).

Before releasing the data to us, Lifeline encrypted the phone numbers associated with each call. We assumed that calls from the same (encrypted) number were made by the same person, and aggregated call level data up to the person level. This allowed us to look across time at calling patterns for individuals, and to identify frequent callers. We took Lifeline's rule of thumb of 20 calls per month as a guide, and scaled this up or down so that any individual who made 0.667 calls per day in any period longer than a week (4.7 calls in seven days, 20 calls in 30 days, 40 calls in 60 days, and so on) was regarded as a frequent caller.

In total, 850,344 calls were made to Lifeline during the study period. After excluding calls that were from blocked numbers, of very short or unknown duration, or in certain non-crisis categories (e.g., hang-up and unwelcome calls, donation enquiries and feedback calls), we were left with 411,725 calls in our analysis dataset. These calls were made by 98,174 individuals. Individuals who met the definition of being a frequent caller made up 3% of all callers (2,594) but made 60% of all calls (247,547) (see Figure 1). We identified a number of predictors of being a frequent caller, including being male or transgender, and never having been married. The odds of being a frequent caller increased with age until 55-64 years, and then declined. Suicidality, self-harm, mental health problems and issues related to crime, child protection and domestic violence were all associated with being a frequent caller.

Figure 1: Distribution of Lifeline calls and callers



Data from a purpose-designed survey/interview study with frequent callers to Lifeline

We worked with two New South Wales Lifeline centres (Harbour to Hawkesbury and Northern Beaches) to investigate the factors that influence callers' calling patterns, and the long term benefits of these calls.[5] Between February and July 2015, supervisors at these centres who had received specific training administered a brief survey to eligible crisis callers, at the conclusion of their call. The survey included a question about callers' calling behaviour in the past month. Those who indicated that they had contacted Lifeline only once were classified as one-off callers, those who said that they had done so between two and 19 times were regarded as episodic callers, and those who reported that they had done so 20 or more times were deemed to be frequent callers.

The survey ended with an invitation to participate in a more detailed interview. Those who accepted this invitation were later asked a set of broad, open-ended questions that explored their experiences with the support they had received from Lifeline in the previous 12 months, the reasons why they continued to call, and their use of other health services. The interviews were conducted by a member of our study team over the phone at a time convenient to the caller. We analysed data from the interviews using a thematic analysis methodology.

Recruitment occurred during 54 shifts at the two Lifeline centres. Approximately 900 callers were screened for eligibility, and 317 took part in the survey. Of these 317 participants, 69 (22%) self-identified as frequent callers. They were relatively evenly split in terms of gender (45% male, 55% female) and nearly two thirds (61%) were aged 45-65 years. When they were asked about what prompted their call to Lifeline on this occasion, the most common responses were: 'I regularly call Lifeline to let them know how I am feeling' (86%); 'I have been feeling very nervous, anxious or depressed' (68%); 'There was nobody else that I could talk to' (59%); and 'I was in an immediate crisis' (39%).

Of the 69 frequent callers who provided survey responses, 19 participated in an interview. Twelve participants (63%) were female and 11 (58%) were aged 45-65 years. Fifteen (79%) reported being unable to work, and 13 (68%) reported living alone. The interviews suggested that three distinct types of frequent callers exist: (a) addicted callers (who call out of habit and are unable to resist the urge to call); (b) support-seeking callers (who call looking for emotional support as they are unable to cope with constant life stressors); and (c) reactive callers (who call when they become unsettled by an external trigger). In addition, the interviews pointed to some themes that were common to all callers. These drove their frequent use of the service and included: positive reinforcement; social isolation; anonymity; and unrestricted access.

Data from the diamond study

The *diamond* study involves a sample of 789 patients with depressive symptoms who were recruited via 30 Victorian general practices in 2005 and have been interviewed annually since then.[34] We used data from the first year of follow-up, during which participants completed postal surveys at three month intervals (three, six, nine and 12 months).[3] The surveys asked participants to provide socio-demographic information, information about their mental and physical health, and information about their use of health and other services. Among the latter group of questions was one that asked how often participants had used telephone helplines for depression, stress or worries in the past three months. Those who indicated that they had done so once a week or more were regarded as frequent callers.

Data on telephone helpline use was available for 713 (90%) of *diamond* participants in the first year. In total, 16 participants (2%) reported frequent use of telephone helplines. Frequent use of telephone helplines was associated with being relatively young (18-34 years) and having difficulties managing on available income. It was also associated with several indicators of social isolation, including living alone and being bothered a lot by not having a confidant. Several physical health factors were also predictive of frequent use (e.g., having a chronic disease and/or self-rating of own health as poor or fair), as were a number of mental health factors (e.g., having anxiety, major depression, a likely personality disorder and/or suicidal thoughts, and/or using antipsychotic medication). Frequent use of telephone helplines was also associated with using certain health services (emergency departments) and providers (psychologists and psychiatrists). It was also associated with an increased likelihood of visits to more than one GP. In addition, frequent use was associated with greater levels of dissatisfaction with access to health services.

Data from the National Survey of Mental Health and Wellbeing (NSMHWB)

The NSMHWB was conducted in 2007 by the Australian Bureau of Statistics and collected data from a representative sample of 8,841 adults.[35] Respondents were interviewed in their homes, and asked a range of questions about their socio-demographic details, their mental health status, their levels of suicidality, and their use of a range of services. All NSMHWB respondents were asked 'Did you ever use a telephone counselling service (such as Lifeline) for problems with your mental health?' Those who answered 'yes' were then asked 'In the past 12 months, how many times did you use a telephone counselling service?'

In total, 90 respondents reported using telephone counselling services in the past 12 months. Forty seven per cent did so once (one-off callers) and 53% did so on repeat occasions (24% twice, 17% three to six times, and 12% seven or more times). We compared repeat callers with one-off callers and found that the former were more likely to have an anxiety disorder and to consult GPs and allied health professionals for mental health problems. They were also more likely to be unemployed.

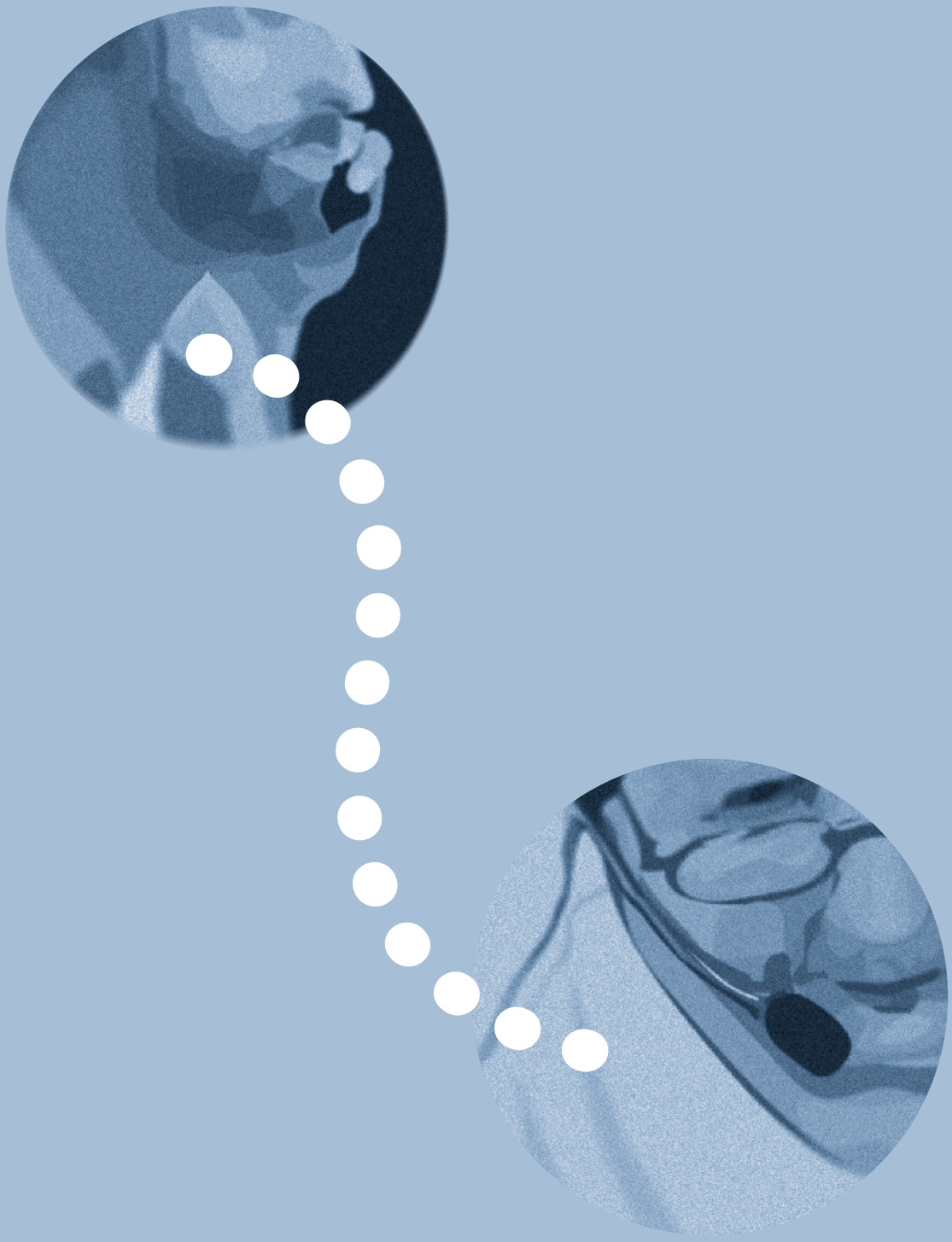
Summary

Our empirical studies add significantly to current knowledge about frequent callers to telephone helplines. Individually, most of them are larger in scale and more rigorous than their predecessors. They explicitly consider differences between frequent callers and one-off or episodic callers. They are also more relevant in terms of their currency and their being set in Australia. Collectively, they allow us to triangulate our findings and consider whether there are some findings that appear to be consistent across studies with different methodologies and data sources. They provide a similar picture of frequent callers, and thus give us confidence that the profile that we have identified is valid.

Several key findings stand out. Frequent callers are relatively few in number but they do account for a substantial proportion of calls. They have a heavy reliance on helplines, perhaps because they are isolated and have relatively few social supports. They are by no means just 'time wasters', however; they have high levels of need, as evidenced by the fact that they have major mental health problems (including anxiety, depression and suicidality) and are often in crisis. They also make use of other services for their mental health problems, including GPs, allied health professionals (e.g., psychologists), psychiatrists and

emergency departments. The circumstances under which frequent callers make use of telephone helplines vary, but current service models reinforce their calling behaviour.

Frequent callers' high levels of suicidality warrant additional comment here since Lifeline regards suicide prevention as its overarching mission. It is likely that there is a complex interplay between suicidality and some of the other characteristics of frequent callers. For example, some aspects of their suicidality are likely to relate to their circumstances and their struggles to cope or find meaningful support. These sorts of relationships are explained by O'Connor's Integrated Motivational-Volitional (IMV) model,[36] which suggests that the lead-up to suicidal behaviour involves three phases. In the pre-motivational phase, the scene is set by background factors like the person's environment and life events. In the motivational phase, suicidal ideas begin to form; the individual feels humiliated by his or her life circumstances, which leads to a sense of entrapment which, in turn, leads to thoughts of suicide and the intent to act upon them. These suicidal thoughts and intentions shift individuals to the third phase – the volitional phase – in which suicidal behaviour occurs. Importantly, the transitions within and between phases are influenced by mediators and moderators. This model points to opportunities for intervention – e.g., improving social problem-solving might act as a circuit-breaker in the humiliation-entrapment pathway, and positive future thinking might reduce the likelihood of suicidal intent developing.[36]



3. A potential model of service delivery for frequent callers

The findings from our empirical studies point to a potential model of service delivery that might better serve the needs of both frequent callers and callers who use Lifeline less regularly or often. The principles and features of the model are described below.

Principles of the proposed model

The proposed model is guided by the following principles:

- The model addresses a problem that is about behaviours (frequent calling) not individuals (frequent callers). The existence of these behaviours provides evidence that these callers' needs are not currently being met. These behaviours present a challenge for Lifeline but they can be 'turned around'. Those engaging in these behaviours may benefit from a different approach.
- The model is non-judgemental. It recognises that frequent callers have high levels of genuine need. They are experiencing complex mental and physical health problems, and a range of social issues and experience crises that may not be quickly resolved but instead may be more ongoing in nature and may be heightened by specific triggers or at times of stress and anxiety. They are isolated, but that this is not the sole reason for their calling patterns.
- The model recognises that individuals are different and therefore offers flexibility and choice. Some frequent callers will 'opt in' and take advantage of the new model, whereas others may prefer not to.

- The model articulates clear roles and responsibilities for frequent callers who do choose to use the new model of service delivery. It empowers frequent callers by involving them in early decisions about their ongoing care (e.g., goals) and commits them to calling at agreed times.
- The model acknowledges that frequent callers are accessing a range of other services in addition to Lifeline. It capitalises on this, and promotes collaboration between Lifeline and these services wherever possible and appropriate.

Features of the proposed model

The features of the model, and some of the conditions that would necessarily have to underpin them, are described in the following sections.

Dedicated and specially trained Telephone Crisis Supporters (TCSs)

Under the proposed model, a sub-group of TCSs would be dedicated to taking calls from frequent callers. They would receive additional training for this, over and above the normal training offered to TCSs. They would also have ongoing opportunities for continued professional development, one-to-one supervision sessions, debriefing, and peer support.

The training and other support offered to these TCSs would focus on equipping them to deal with mental health issues (particularly anxiety, depression and suicidality) and social issues (particularly loneliness and isolation), and on the overlap between these and physical health problems. It would also prepare these TCSs to deal with some of the complexities underpinning frequent callers' behaviour, including, for example, attachment issues.

The result would be that Lifeline would have a cadre of highly skilled TCSs with specific expertise in dealing with frequent callers. Their role would be akin to that of a mental health counsellor in other community settings. These TCSs would cover a significant number of shifts in any given week, and be available at times that frequent callers are particularly likely to call (e.g., at night).

Consideration might be given to whether these TCSs should be retained on a paid basis, rather than as volunteers, and whether individuals with some tertiary or

equivalent training in dealing with mental health issues might be preferred over lay people.

An integrated, tailored service

Frequent callers would be allocated to one of these specialised TCSs who would develop a rapport with them, establish rules about the timing and duration of their calls, and help them work towards clearly defined goals. The caller and the TCS would reach an agreement about how often the caller could use the service, the type of care he or she should expect to receive, and what to do in the case of an emergency. The TCSs would provide a more intensive, high level of counselling than the standard Lifeline service.

The TCSs would work with these callers to agree on well-articulated management plans, based on their history and presenting issues. Then, in accordance with these plans, they would assist them to develop strategies for dealing with their various mental health and social issues. They would also explore callers' relationships with Lifeline and guide them towards more adaptive relationships by modelling secure attachment behaviour,[33] setting defined boundaries, and articulating clear consequences of breaching these boundaries. They could potentially draw on a range of therapeutic approaches, but it is likely that some cognitive behavioural therapy (CBT)[34] and acceptance and commitment therapy (ACT)[35] principles would be at the core of these.

Calls would take the form of a series of sessions at which particular issues might be discussed or particular strategies might be taught. At each call, the TCS would ask the caller how things are going with issues that were discussed on the previous call, and would follow up with any homework tasks that might have been set. The TCS would acknowledge previous conversations but would guide the caller away from ruminative thought processes.

The model would also draw on newer technologies that might facilitate greater levels of care without being too resource intensive. By way of example, the common issue of loneliness might be addressed through a facilitated group that meets via a webinar platform to discuss topics related to general wellbeing. Similarly, symptoms of anxiety and depressed mood might be addressed via apps or interactive websites, of which there are many examples.[36] Of course, approaches drawing on newer technologies might not suit all callers.

Linkages to other services

The integrated, tailored service might be thought of as part of a stepped care process. Some callers might only use this service, whereas others might be assisted to 'step up' to other services, beginning with primary care and, where necessary, moving up to specialised mental health services. This would require good linkages between Lifeline and other elements of the service pathway.

The model recognises that frequent callers are likely to already be using a range of these other services, including GPs and mental health specialists. The model is not so much about creating new linkages as improving the quality of existing linkages, reducing the reliance on multiple providers (e.g., several GPs), and helping to foster consistent approaches. So, for example, there would be instances in which the TCS might work with the caller and his or her preferred GP to develop a shared care plan.

A seamless triage system

For the model to work, a seamless triage system would need to be put in place. Frequent callers would be identified by a variety of means (e.g., through Lifeline's telephony system 'flagging' their phone number, or through cues that they give when they introduce themselves). Once identified, they would be offered the opportunity to speak to one of the dedicated and specially trained TCSs. If they took up this opportunity, they would be put through to the TCS who would explain the service to them in more detail and invite them to make use of it. For those who chose to 'enrol' in the service, this would act as the first session.

Rules of engagement

The ongoing relationship between frequent callers and specific TCSs would require that callers relinquish their anonymity and give their names and contact details. The TCSs would also be required to give their names, although they might choose to use pseudonyms. This open use of names would foster rapport and trust, and would make for more 'normal' conversations. It would also be necessary for practical reasons, in order to ensure that the caller could always make contact with his or her allocated TCS.

As noted above, frequent callers making use of the integrated, tailored service would enter into an agreement with the TCS about the timing of their calls.

Effectively, they would be calling at agreed appointment times, some of which would be made available after business hours. Callers finding themselves in an acute crisis could call outside of these times, but would be diverted back to the regular Lifeline service. This arrangement would need to be explained to callers at the outset in a manner that did not encourage further frequent use of Lifeline, but empowered them to move towards a path of recovery. Further work is required to determine the optimal approach to restricting frequent callers' calls in this way, and it is likely that the solution will be different for different callers. One option, for example, might be to taper the calls over time, initially allowing callers to call daily, then two or three times per week, then weekly, then fortnightly, then monthly etc.

Although the caller would be paired with an individual TCS, the fact that there would be a critical mass of these specialised workers would mean that callers could potentially shift from one TCS to another if they felt that their needs could be better met by doing so. Equally, TCSs might refer callers to each other in order to better meet callers' needs, because it is likely that individual TCSs might develop expertise for dealing with particular types of frequent callers, and effectively become super-specialists.

Getting the balance right

The proposed model would need to be implemented in a way that ensures that it does not amplify frequent callers' reliance on Lifeline. It should be viewed as an intensive but time-limited service that helps frequent callers to move on with their lives. It should provide an opportunity for callers to develop a meaningful connection with a specific TCS without encouraging further dependency. It should also be seen as an alternative to their regular use of Lifeline, rather than as an adjunct to it, although, as noted above, it will be necessary to allow callers to make a standard call to Lifeline in the event of an emergency. The nomenclature around the model would also require careful thought; the name of the service would need to be non-stigmatising but also not one that might be seen to 'reward' frequent callers by offering them a specialised service.

4. Suggested next steps

We would suggest that the next step in the process of dealing with frequent callers is to further refine the proposed model, testing the concept out with key stakeholders. There may be elements that are missing, or existing elements that are seen as unworkable. These stakeholders should include frequent callers themselves, Lifeline TCSs, supervisors and managers, and representatives from primary care and specialist mental health services. Frequent callers would clearly have a view as to whether this sort of model would address their needs, and our survey/interview study suggests that they are very willing to participate in relevant information-gathering exercises. TCSs would provide valuable insights into the extent to which the model might alleviate some of the stresses associated with dealing with frequent callers, as well as views about whether the model might introduce new issues (e.g., by creating a parallel system of service delivery). Lifeline supervisors and managers would provide input from an organisational or systems perspective, and would be able to comment on whether the proposed model would be workable. Primary care providers (particularly GPs) and providers from the specialist mental health sector would have views on how best to formalise collaborative relationships.

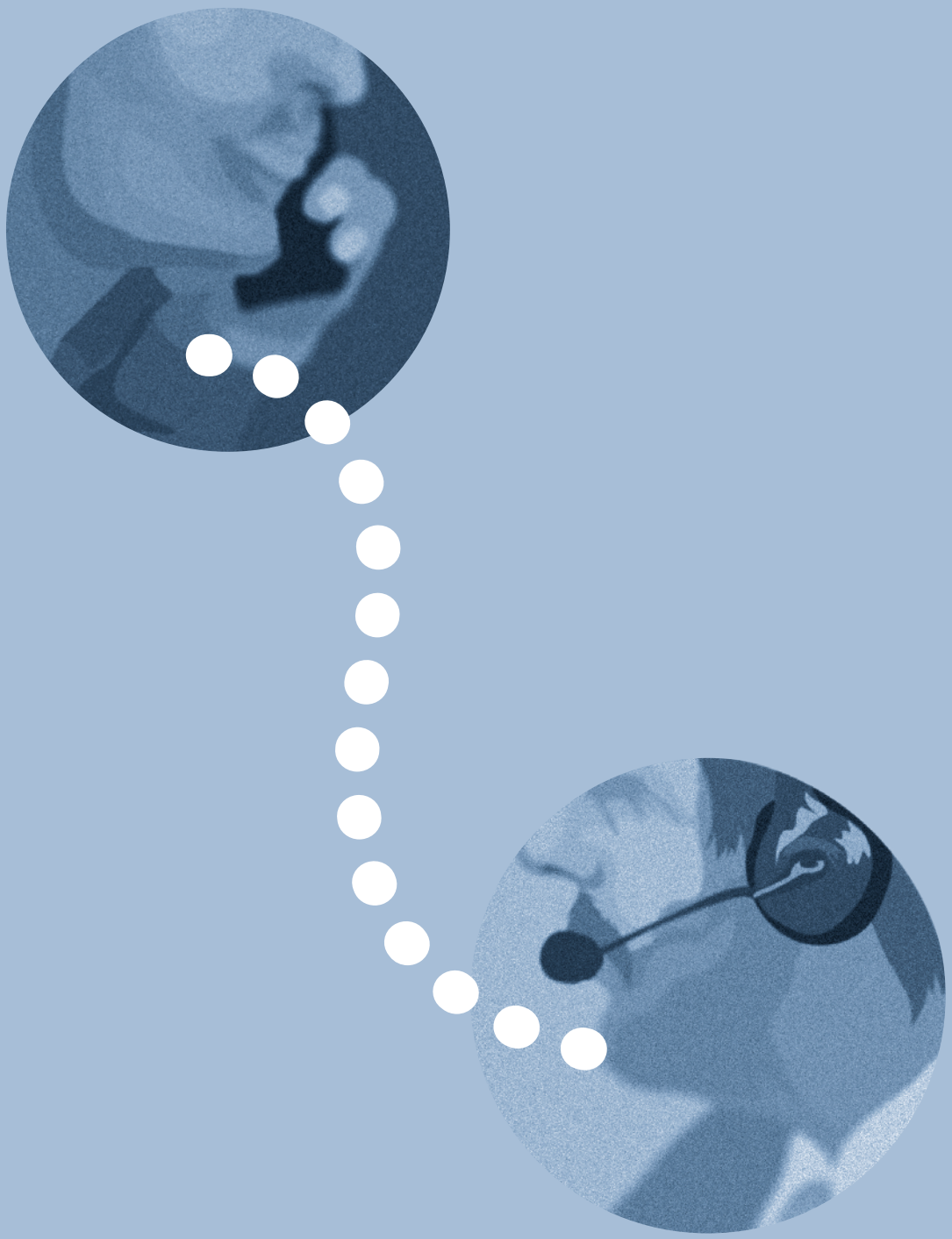
One approach to involving stakeholders in the model refinement process might be to use a co-design methodology.[41] This has been used in other areas of health and social care to reconfigure service systems to better address needs. It emphasises the experiences of stakeholders – particularly users – with the current system and the interactions that occur within it. It recognises that service users are not passive recipients of services but instead are integral to ideal models of care.

Once input from frequent callers and other stakeholders has been received and the model has been further refined, it should be tested in a controlled way. This is crucial because the model is not without risks; although it is intended to reduce the reliance of frequent callers on Lifeline and free up resources for other callers,

it is possible that it could have negative impacts. We would recommend piloting the model in a few Lifeline centres in the first instance, and evaluating it in a very rigorous way. Ideally, this would involve a randomised controlled trial in which frequent callers were randomly allocated to receive the tailored, integrated service or to receive usual care. The trial would consider both the effectiveness of the new service (i.e., its achievement of benefits for frequent callers) and its cost-effectiveness (i.e., weighing these benefits up against the cost of implementing the new service). Careful examination of unintended consequences would also be important. For example, it would be necessary to monitor the total number of calls made by frequent callers allocated to the new service to ensure that they were not in fact making greater use of Lifeline (i.e., using the new service and the regular service in tandem). In addition to focusing on outcomes, the trial should also monitor the processes associated with the new service (e.g., the way in which each of its elements is operationalised) and impacts (e.g., the effects the service has on Lifeline as a whole and its TCSs in particular).

Assuming that the trial shows that the tailored, integrated service is both effective and cost-effective, it would then be ready for further roll-out. Again, we would suggest that this implementation process should be carefully monitored, to guarantee that the service works smoothly across all Lifeline centres. Some 'tweaks' may be necessary to match the service to the local context. Opportunities should be taken to engage frequent callers and TCSs in providing feedback about the model, using structured approaches. There are precedents for this from elsewhere in health and social care, such as Patient Opinion Australia (https://www.patientopinion.org.au/).

Lifeline is not alone in struggling to deal with its frequent callers. Around the world, other telephone helplines face exactly the same issue. If Lifeline can implement a successful solution to responding to frequent callers, this will be ground-breaking. The model we propose here is based on the best available evidence, and we are confident that it (or a modified version of it) could provide the answer to how to meet the needs of frequent callers, as well as those of other callers, TCSs, and Lifeline's management.



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