

Lifeline Calls

Help-seeking behaviours in rural men

PROFILE/04 | SEPTEMBER 2007

Introduction

Lifeline is a network of 42 Centres located throughout metropolitan, rural and regional Australia. The Lifeline telephone counselling service is a 24-hour, 7-day a week telephone counselling service for the cost of a local call available to all Australians. Lifeline therefore has the opportunity to provide a unique insight into the counselling needs of Australians.

The purpose of this profile is to provide insight into whether men living in rural and remote Australia seek help when their levels of personal distress compromise health. The data collected and analysed for this report represents a national focus excluding Melbourne Victoria.

The outcome of associated Lifeline call data profiles (Cartwright & Hughson 2005) suggests that men do seek help in rural and remote Australia demonstrating also, the effectiveness of telephone counselling in promoting help seeking behaviour particularly amongst men in rural communities.

However, the impact on mental health of rurality and associated socio-economic factors are not clearly understood. As rural communities become smaller there has been a corresponding reduction in the provision of both general and specialist services including mental health services. Betts and Thornicroft (2) reported that mental health services are generally recognised as being less available in rural and remote areas, where access to qualified staff is often limited. There are fewer psychiatrists for rural and remote populations (3.3 and 1.8 per 100,000)

than for metropolitan populations (14.2 per 100,000). Consequently, the burden for mental health care increasingly falls on general practitioners (GP's), particularly where other specialist options for treatment are simply not available.

Additionally, there are well-documented issues for the recruitment and retention of GP's in rural and remote communities across Australia. Country medical practises are straining under the pressures of low numbers of GP's, high burnout rates, under-funded hospitals and a lack of specialists such as obstetricians, oncologists and psychiatrists. As a result people are forced to travel long distances to larger regional centres for primary medical care. This compromises patient care, particularly where there are mental health issues that require longer consultation times and frequent visits.

An important factor influencing access to mental health services is attitude towards help-seeking. Tudiver and Talbot (1999) argue that men do not seek general health care for a range of reasons, including a tendency to use indirect sources of help; the perception that seeking help will show their vulnerability; fear and denial; and difficulty relinquishing control.

Further, stigma has been shown to be a potent barrier to help-seeking for mental health problems (Judd, Cooper, Fraser & Davis, 2006), and it is assumed that stigma is worse in rural areas where communities are smaller, social networks are closely intertwined and privacy is reduced (Wrigley, Jackson, Judd, and Komiti 2005). This stigma has been found to be associated with erroneous beliefs about mental health problems. These beliefs are likely to have a direct effect on help-seeking behaviour, as in order to seek help they must first identify themselves as requiring help.

Introduction cont.

Several studies including (Fuller et al., 2000; Judd, Jackson, Komiti, Murray, Fraser, Grieve and Gomez, 2006) have suggested that attitudes of stoicism and self-reliance, prevalent in rural residents, make it difficult for people to acknowledge that they are experiencing problems and/or distress and then taking action to seek help.

Judd, Jackson, Komiti, Murray, Fraser, Grieve and Gomez, (2006) suggested that attitudes of stoicism and self-reliance are associated with beliefs that problems are to be endured and it is preferable to suffer in silence. It was also reported that in rural communities health is commonly defined as the ability to work or be productive in one's role, there are tendencies to rely more on family and friends than on health professionals and tendencies to assume greater self-responsibility for health problems.

Stoicism, defined as denial, suppression and control of emotions (Wagstaff et al, 1995) may influence help-seeking for mental health problems in two important ways. Firstly, individuals with such attitudes may report fewer mental health symptoms simply because they do not define such problems as illness. If this is the case, rural residents are likely to delay seeking help until symptoms are severe and disabling. This is also consistent with the rural definition of health as ability to work or be productive in one's role (Judd, Jackson, Komiti, Murray, Fraser, Grieve and Gomez, 2006). Secondly, while stoic individuals tend not to define problems as illnesses, they also may actively avoid situations where they will be encouraged to talk about their problems, thoughts and emotions.

Taken together, these agrarian values (Judd, Jackson, Komiti, Murray, Fraser, Grieve and Gomez, 2006) may influence both the definition of mental health problems and the probability of help-seeking and thus mitigate against early and effective help-seeking. The agrarian values are regarded by many as descriptors of "maleness", perhaps accentuated in rural men. Thus, help-seeking for mental health problems by men may be particularly affected by attitudinal factors.

This paper will investigate the help-seeking behaviours of men in rural communities through examining the data from those who sought help through the 24-hour Lifeline counselling service. Trends for rural and urban callers will be compared in terms of their reasons for seeking telephone counselling, any known mental health issues and their use of both general and specialist support and health services.

Demographic Information; Who is calling?

The information about rural men in Australia was drawn from 121,668 calls to the Lifeline telephone counselling centres across Australia during the period January to June 2006.

Overall, the male calls comprised 33.5% (N = 40 790) of all callers. Women were twice as likely (66.5%; N = 80 878) to call the telephone counselling service. An examination of rural calls revealed a similar profile: with rural women twice as likely (67%; N = 31 219) to seek support through telephone counselling than rural men (33%; N = 15 160). Overall, rural men represented 12.5% of all calls and rural women represented 25.7% of all calls.

The average age of both male and female calls was 45 years (26.5%). This was consistent across rural and urban localities. Lifeline generally receives a higher number of calls from men and women aged between 31 and 60 years, with a peak age between 41-50 years. Only 2.5% of rural men aged 11-21 and 9.0% of young men aged between 21-25 years contacted Lifeline during this period.

The relationship status of male calls revealed that 51% were not currently in a relationship, 28% had never married, 11% were divorced, and 12 % were separated. Only 11 % of rural male calls reported they were married or living in a de-facto relationship.

Reports of current living arrangements showed that 45% of male calls live alone and 20% of male calls live with their family.

The call pattern demonstrated a distinct difference between urban calls and rural calls. Callers from urban locations contacted Lifeline throughout the whole week including weekends. By contrast, callers from rural locations were during the weekdays, with much lower contact on the weekends. This quite distinct profile suggests that weekend activities may be ameliorating the reasons for initiating a call to Lifeline.

The call profile also demonstrated that rural men seek telephone counselling throughout the year. By contrast urban men called significantly more frequently in January. The most frequent call times for both rural and urban men are between 6 and 8pm in the evening, which is after close of business for most alternative counselling services.

Reasons for Calling

The reasons for calling are first documented using broad general categories. This is deduced through the content of the call and nominated by the telephone counsellor who takes the call. Overall the findings suggest that men and women seek counselling for different reasons.

Most men call about problems related to “family and relationship” (24%), “health and disability” (25%), and “self and community” (24%). Whilst the overall profiles of rural and urban-living men were similar, rural men called less often than urban-living men in relation to “self and community”. This contrasts with most women, both rural and urban-living, who call about issues related to “family and relationships” (38%) and self and community (22%).

In addition to the broad general categories, specific reasons for calling are elicited from callers. Across all calls, both men and women, the most significant specific issues called about were the mental health of the caller (12.8%; N = 15 516), family and partner challenges (12.5%; N = 15 263), loneliness (8.9%; N = 10 770), and relationship breakdown (6.0%; N = 7320).

Examination of the rural/urban call profile for calls from men revealed that these specific issues were consistent across locality. However there were differences between rural and urban calls within each issue, as shown in Table 1.

Table 1: Specific Call Issues: Rural and Urban Male Callers

SPECIFIC ISSUE	RURAL	URBAN
Mental Health of Caller	18.1% (N = 2751)	14.5% (N = 3728)
Loneliness	11.9% (N = 1806)	13.5% (N = 3456)
Family/Partner Challenges	8.6% (N = 1303)	8.0% (N = 2056)
Relationship Breakdown and Divorce	8.1% (N = 1231)	5.7% (N = 1455)

Mental Health Issues

Overall, 15 516 calls were made in relation to the mental health of the caller. Men (23.8%) were more likely to call for counselling with regards to mental health issues than women (18.5%). Rural calls were represented at a proportionally higher number than urban calls for both men and women. Rural men comprised 42% of the male calls related to the mental health of the caller. This represents a higher proportion of the mental health calls when compared to the general sample where 33.5% of all calls were from rural men. This suggests a greater need for mental health assistance for rural callers.

Depression was the most highly represented reason for calling for both rural and urban-living male calls. In comparing rural and urban-living male calls, proportionately more rural men reported depression (45%) than urban men (37%).

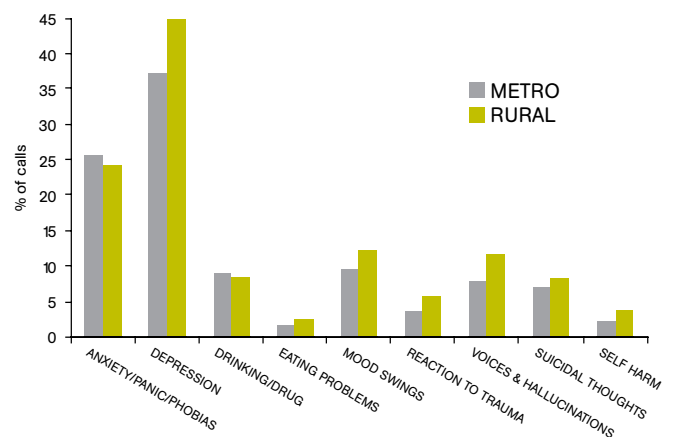
Anxiety related-issues were the second most highly represented reason for calling for both rural and urban male calls. Urban males (25%) called slightly more than rural men (24%) about issues to do with anxiety.

The other frequently reported reasons that rural men called Lifeline were in relation to mood swings (12%) and voices and hallucinations (11%). Urban men similarly reported that issues related to mood swings (9%) frequently initiated their contacting the service.

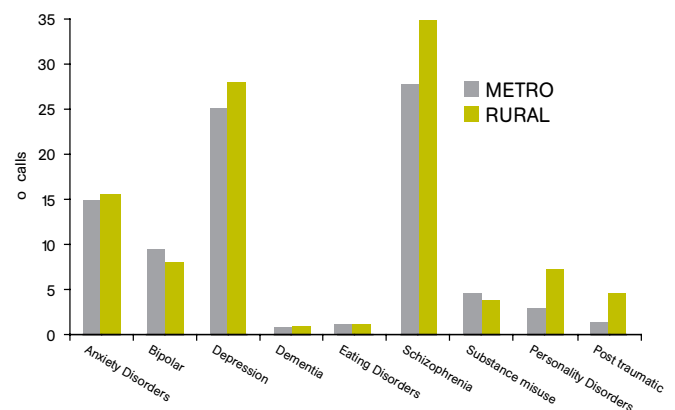
Table 2: Specific Mental Health Issues: Rural and Urban Male Callers

MENTAL HEALTH ISSUE	RURAL MEN	URBAN MEN
Depression	45%	37%
Anxiety	24%	25%
Mood Swings	12%	9%
Voices and Hallucinations	11%	7%

Graph 1: Reasons for Calling: Mental Health Issues



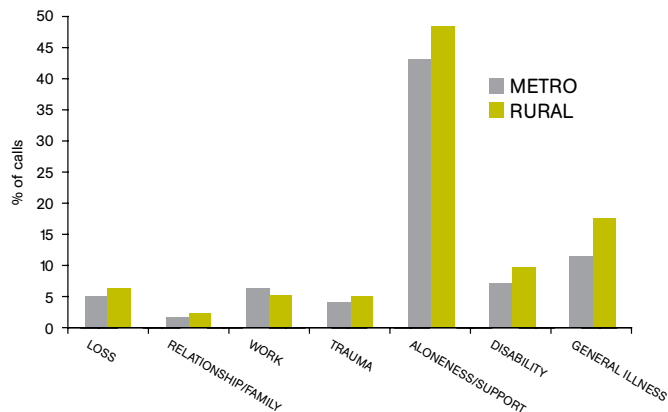
Graph 2: Caller Reported Diagnosed Mental Health Issue



Discussion

Rural men believed that their mental health issues were most likely related to loneliness and insufficient levels of support (47%) and general illness (17%). These were also the most prominent issues for urban-living men. It is important to note that, contrary to other reported research findings aloneness was found to be a greater issue for rural men than urban-living men.

Graph 3: Caller Reported: Issue Affecting Mental Health

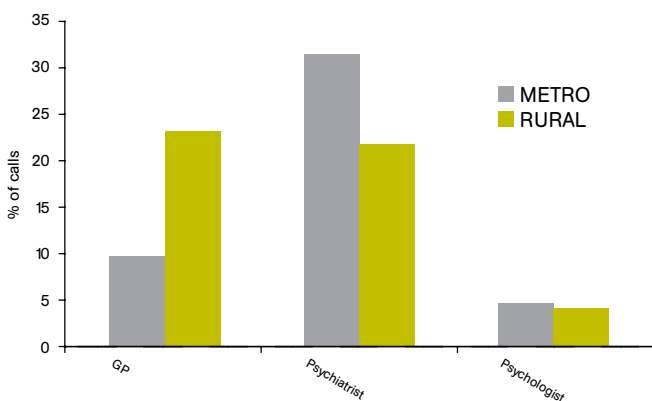


These findings suggest that remoteness per se may be a contributory risk factor for rural men who also find it difficult to establish support networks. The findings also underscore that psychosocial factors are more important determinants of mental illness than remoteness per se. This is consistent with previous research (Judd, 2006) that has demonstrated that individual-level psychosocial variables affect risk of affective and anxiety disorders.

Help-Seeking

Rural men (22%) rely much more on GP support than urban men (9%). By contrast more urban men rely on psychiatric treatment (31%) than rural men (20%). Of significance also is that 50% of male callers in both rural and urban populations did not identify that they were accessing professional support.

Graph 4: Caller Access to Professional Support (under the care of)



Men living in rural communities across Australia access the Lifeline 24-hour telephone counselling service half as frequently as women from rural communities. This gender profile is also consistent for men and women living in urban communities and suggests overall that women seek help twice as much as men. Tudiver and Talbot (1999) argue that men do not seek general health care for a range of reasons, including a tendency to use indirect sources of help; the perception that seeking help will show their vulnerability; fear and denial; and difficulty relinquishing control. Whilst several studies (Tudiver & Talbot, 1999; Judd, Cooper, Fraser & Davis, 2006) have shown that gender influences help seeking, the effect of gender may be a more potent factor in rural than in urban residents.

The finding that rural men and urban men must be considered within the broader context of service availability. As a proportion of population the data suggests that rural men access Lifeline at a much higher rate than urban men. It may be inferred from this finding that either the type of service, that is 24-hour anonymous and confidential, and/or the lack of appropriate alternative services accounts for this anomaly.

Despite the confidentiality of telephone counselling and the 24-hour, 7-day a week availability of the service, the call profile demonstrates that Lifeline receives less calls from adolescent and young men across both rural and urban communities (2.5% for age 11-21; 9.0% for age 21-25). This finding foreshadows an important service gap for rural adolescents and young men and is supported by Caldwell et al (2006), who found that only 11% of men aged 18-29 years with a mental health disorder in non-metropolitan areas had accessed professional help. Young men (the group with the highest suicide rates) had less contact with help professionals for mental health problems than both metropolitan young men and non-metropolitan young women with any mental health disorder. The Lifeline data demonstrates that few young males access the Lifeline telephone counselling service consistent with research findings by Rickwel et al (2005) that boys seem to seek less help from all sources across early to mid-adolescent years and view that they prefer to deal with issues themselves. It may also be that rural young people are contacting alternative, youth specific, services for their counselling support.

The most prevalent reasons provided by rural men for seeking telephone counselling through Lifeline were in relation to their mental health (18.1%), loneliness (11.9%), family/partner challenges (8.6%) and relationship breakdown and divorce (8.1%). This suggests that a high number of rural men receive support for their mental health issues through telephone counselling.

Of the mental health issues, the symptoms most frequently reported for rural men were depression (45%), anxiety (24%), mood swings (12%) and 'voices and hallucinations' (11%). The most frequently identified triggers for rural men calling in relation to mental health issues were loneliness and insufficient support (47%) and general illness (17%).

Discussion cont.

In a multiple response question, 9 955 responses (N = 6 794) were recorded for callers receiving treatment for a mental illness. Of these responses, 40% reported that they were currently receiving treatment for depression and 34.1% reported currently receiving treatment for schizophrenia. Significantly, male callers were more likely to be receiving treatment for schizophrenia and women callers were more likely to be receiving treatment for depression.

Rural calls made up 45.5% of the response set. When these responses across rural and metropolitan categories are compared with the total number of rural/metropolitan calls, a higher proportion of rural callers receiving treatment for a mental illness are making use of Lifeline. Here, 9.27% of rural callers (as opposed to 6.6% of the metropolitan sample) are receiving treatment for a mental illness. These findings tend to support the idea that rural callers with mental health problems are more likely to depend on Lifeline as compared to callers from metropolitan areas.

Together, these findings suggest issues related to the availability of and access to specialist mental health care in rural and remote Australia. In support of this, the report demonstrates that rural men rely heavily on their local GP (22%) for mental health treatment and support. This is significantly different from urban-living men who rely more on psychiatric treatment (31%). The finding demonstrated that rural men rely significantly more than urban men on their GP for mental health support. This finding is supported by Wrigley et al (2005), who found mental disorders to be more common among GP attendees in rural settings than in regional centres. Wrigley et al (2005) offered several interpretations for this finding. Firstly, the finding may suggest that rurality is a factor in the development of psychological disorders. Secondly, it could also reflect issues of service availability and accessibility. In many rural areas the only access to care for people with mental health problems is through their local GP. The significantly fewer GPs in small rural centres is well documented.

Alarming 50% of all men identified that at the time of calling Lifeline they had no other form of mental health support. Given the significance of the mental health issues identified, particularly the schizophrenia and depression, this is most concerning. It suggests that generic help lines such as Lifeline contribute significant support for many rural men with mental health issues.

These findings may also reflect stigma in relation to the self-identification of mental health issues. Research on stoicism in rural men further suggest that rural men may be particularly at risk of delaying seeking help until symptoms are severe and disabling. This is also consistent with the rural definition of health as ability to work or be productive in one's role (Judd, Jackson, Komiti, Murray, Fraser, Grieve and Gomez, 2006).

The significant number of rural men calling in relation to loneliness suggests that integrating social support with mental health literacy may benefit help seeking behaviours. Given the close risk of social isolation for a number of mental health problems including depression, interventions could also seek to address factors that have weakened rural

social networks. In the case of stoic individuals, in addition to improving mental health literacy, mental health services may also need to be framed in such a way as to alleviate concerns about admitting and dealing with emotions and problems.

In response to mental health literacy concerns, an awareness program titled Mental Health First Aid has been trailed and rolled out across Australia. This program trains members of the public in how to give initial help in mental health crisis situations and to support people with developing mental health problems (Jorm et al, 2004). Designed to develop community capacity to support those with mental health disorders in rural areas, the trial found a number of benefits, including greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with mental health professionals about treatment, and decreased social distance from people with mental health disorders.

Whilst such programs offer benefits in community mental health literacy this has yet to correlate with enhanced individual help-seeking. For example, mental health literacy may be a particular problem for young men in rural areas, who may be less likely to recognise or report symptoms of distress or know what can be done to help. While improving suicide prevention strategies for people already in contact with professional help is vitally important, mental health policy and services need also to better incorporate people who currently have little contact with the healthcare system.

Additionally, mental health literacy does not overcome the issue of a lack of available mental health practitioners. Support, regardless of its type and/or frequency, does not replace the need for mental health treatment from a specialist mental health provider.

Overall, the high rates of prevalence of mental health issues for rural men calling Lifeline, together with the identified issues of help seeking, and service availability suggest that the experience of Lifeline may just be the 'tip of an iceberg' in accessing the counselling needs of rural men across Australia.

Authors: Duncan Cartwright (PhD) & Sally Hughson (PhD)





References

1. Andrews, G., Hall, W., Teeson, M. & Henderson, S. (1999). *The National Survey of Mental Health and Well-Being: the mental health of Australians*. Canberra: Mental Health Branch, Commonwealth Department of Health and Aged Care.
2. Betts, V.T. & Thornicroft, G. (2001). *International mid-term review of the second National Mental Health Plan for Australia*. Canberra: Mental Health and Social Programs Branch, Australian Department of Health and Ageing.
3. Caldwell, T.M., Jorm, A.F., and Dear, K.B (2004) Depression; Reducing the burden. *Medical Journal of Australia*, Vol 181, No 7 p. 10-14.
4. Campbell, A, Manoff, T. & Caffrey, J. (2006). Rurality and mental health: An Australian primary care study. *Rural and Remote Health* 6: 595 (Online).
5. Cartwright, D. & Hughson, S. (2005) *Exploring Loneliness: The experiences of rural and metropolitan Australia Lifeline Calls* 3: 5.
6. Eckert, K.A., Wilkinson, D., Taylor, A.W., Stewart, S., Tucker, G.R. (2006). A population view of mental illness in South Australia: broader issues than location. *Rural and Remote Health* 6: 451 (Online).
7. Fuller, J., Edwards, J., Procter, N. & Moss, J. (2000). How definition of mental health problems can influence help seeking in rural and remote communities. *Australian Journal of Rural Health*, 8: 148-153.
8. Jorm, A.F., Kitchener, B.A., O'Kearney, R.O., & Dear, K.G. (2004). Mental health first aid training of the public in a rural area: a cluster randomised trial. *BMC Psychiatry*, 4: 33.
9. Judd, F.K. (2006). Progressing the agenda for mental health research. *Rural and Remote Health* 6: 615 (Online).
10. Judd, F., Cooper, A-M., Fraser, C. & Davis, J. (2006). Rural suicide – people or place effects? *Australian and New Zealand Journal of Psychiatry*, 40: 208-216.
11. Judd, F., Jackson, H., Komiti, A., Murray, G., Fraser, C., Grieve, A. & Gomez, R. (2006). Help-seeking by rural residents for mental health problems: the importance of agrarian values. *Australian and New Zealand Journal of Psychiatry*, 40: 769-776.
12. Page, A.N. & Fragar, L.J. (2002). Suicide in Australian farming, 1998-1997. *Australian and New Zealand Journal of Psychiatry*, 36: 81-85.
13. Rickwel, D., Deane, F.P, Wilson, C.J., & Ciarrochi, J. (2005) Young people's Help-Seeking for Mental Health Problems. *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 4:1-12
14. Sartore, G., Hoolahan, B., Tonna, A., Kelly, B. & Stain, H. (2005). Wisdom from the drought: Recommendations from a consultative conference. *Australian Journal of Rural Health*, 13: 315-320.
15. Tudiver, F and Talbot, Y. Why don't men seek help? Family Physicians' Perspectives on Help-seeking Behaviour in Men, *Journal of Family practice* 1999;48(1):47-52
16. Wagstaff, G.F. & Rowledge, A.M. (1995) Stoicism: it's relation to gender, attitudes towards poverty, and reactions to emotive material. *The Journal of Social Psychology*, 135: 181-184.
17. Wrigley, S., Jackson, H., Judd, F. & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry*, 39: 514-521.