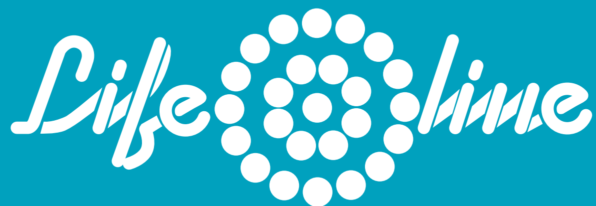
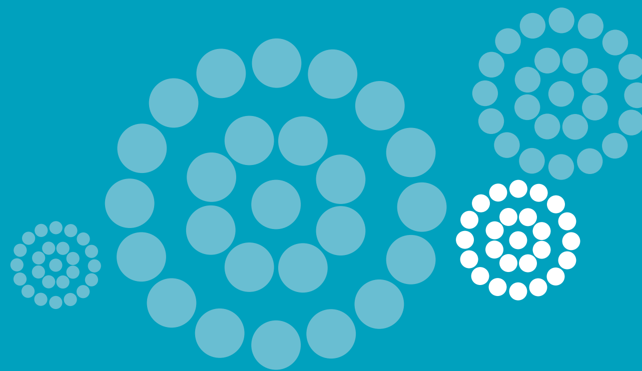




[Lifeline Calls]

Profile of Rural and Metropolitan Telephone Counselling Service Users

PROFILE/02 | MARCH / 2005

This is the second of three profiles that Lifeline is producing throughout 2004/05 that provides insight into the calls received by Lifeline's 24 hour telephone counselling service, with a particular emphasis on rural and regional areas. The purpose of the profiles is to provide insight into population well being, identify local and regional variations in caller needs and service usage and promote awareness of social trends and changing priorities.

The call statistic findings reported on in this profile are based on nationally accumulated data. It is important to highlight that local Lifeline Centres around Australia research and evaluate the calls their individual Centre receives. Regional research and findings into Lifeline calls varies from Centre to Centre.

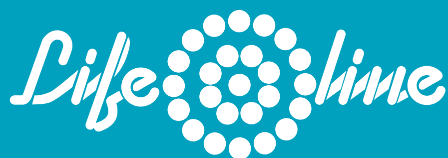
Introduction

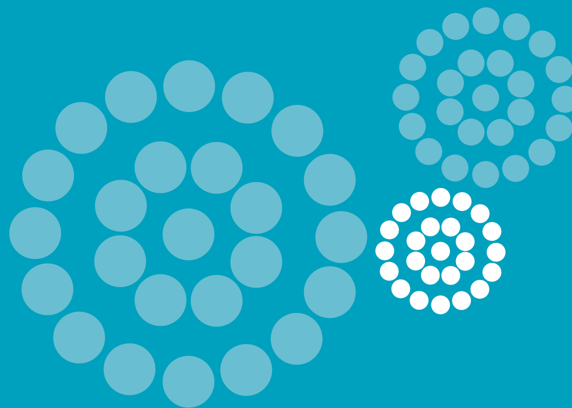
Mental health needs are a particular focus for counselling and information services such as Lifeline. The Australian Institute of Health and Welfare (2001) has estimated that the burden of mental disorders nationally in the Australian community represents 30% of the non-fatal disease burden. The implications for Australians living in rural and remote areas are significant. This profile equates to over one million people living in rural and remote Australia experiencing mental health problems. Although the prevalence of depression stands out, anxiety disorders and schizophrenia also feature strongly along with issues such as substance misuse. Co-morbidity, where people are dealing with more than one disorder, also presents challenges for those providing treatment and support.

Some of these mental health conditions are among the many personal and situational factors that can increase vulnerability to suicide – impacting life and safety. Rates of suicide are frequently higher in remote and rural areas than in metropolitan and in regional areas. Many factors may contribute to this pattern, including isolation from formal and informal resources and demographic profiles in some areas featuring groups such as young males, known to be associated with higher risk.

A consistent reported research finding is the decline in health status along a continuum as people move away from metropolitan centres to rural and remote locations (National Rural Health Alliance, 2003). People in rural and remote areas report higher incidences of cardio-vascular disease, preventable accidents, cancer, diabetes and mental disorders.

Further, changes to mental health treatments and care arrangements have resulted in a higher proportion of people with mental disorders living in the community. This presents both opportunities and challenges for people living with mental health conditions. It has also increased the importance of support for the families and carers of people with mental disorders. Australia has made significant progress under a succession of Commonwealth Mental Health Plans and initiatives such as the Better Outcomes projects. Groups such as *beyondblue* and SANE Australia are making major inroads into enhancing literacy around depression and other mental disorders. However, stigma is still a major barrier to seeking and providing care. Community awareness of mental health conditions and needs remains fragmentary and significant deficits in services remain. Several reports





have documented these concerns (Groom, Hickie and Davenport 2003; SANE 2003). In rural and remote areas additional factors, such as isolation, distance and the relative paucity of services exacerbate the situation of families and carers.

Early diagnosis and intervention are keys to effective management of mental health. Service deficiencies and the need for improved mental health education is a major issue in rural and remote Australia. Research has indicated that a range of rural health workers identified mental health services as one of the most significant deficiencies in rural and remote Australia (Hodgson & Jackson, 1997, Groom, Hickie and Davenport 2003). There is a shortage of mental health nurses, psychiatrists, psychologists and other mental health professionals (including Aboriginal mental health workers) in rural and remote communities. This lack of access to health practitioners has a major impact on the health and well-being of people living in rural and remote communities.

In 1996, it was reported that the rate of access to social workers was appreciably lower for residents in small rural centres and remote areas – 51% below the national average (ABS, 1996). The rate of access to clinical psychology drops significantly for residents in small rural centres (52% below the national average) and even further for those in remote areas (83% below the national average) (ABS, 1996).

Further, professional isolation, the lack of access to training, heavy workloads and limited resources, affect the recruitment and retention of mental health personnel to rural and remote areas. Access to after-hours mental health services is especially limited in many rural and remote areas.

Lifeline

Over the last 40 years, Lifeline's commitment to community-based services has positioned it well to respond to local and regional needs. In 2004, Lifeline has 60 locations from which services are offered, over half of which are in rural and regional areas[1]. The fact that its services are provided within a national accreditation framework and service delivery network adds further value. In addition, its national mental health information line *Lifeline's Just ask* is targeted specifically to rural and remote communities, providing accessible support by phone.

General information about Lifeline and the development of a framework for data collection, national Client Service Management Information System (CSMIS) was contained in Lifeline Calls No 1 (August 2004).

In 2003–04 Lifeline received over 500,000 calls to its 24-hour telephone counselling service. This report provides the first opportunity to analyse the information collected on a sample of these calls.

This profile compares calls from rural and remote communities with those from metropolitan areas. The sample for this analysis comprised a total of 88,872 calls from Lifeline centres across Australia during the October-December 2003. It should be emphasised that most of the analysis is based on the number of calls not callers (many callers access the service more than once for support – some frequently). This profile includes a detailed analysis of the call pattern and caller demographics and the needs of callers, including the specific needs of recurrent callers. Implications for policymakers and health care providers is also provided.

Over the next three years Lifeline will be embarking on an ambitious program to enhance its telephony system and improve service practices. This is called the Greater Access Program or GAP. With the support of the Commonwealth government, business and the community, many of the issues identified in this profile are addressed. In particular, there will be more effective strategies for working with recurrent callers and improved systems for data collection.

Profile of Rural and Metropolitan Telephone Counselling Service Users

Call Patterns

The average duration of calls calculated from this data was 21 minutes. This was consistent across both rural/remote and metropolitan callers. Within each 24-hour period call response rises to a high point around 10 pm each day. Over half of Lifeline's calls are taken after hours or on the weekends when other services are less accessible or closed. Overall, metropolitan call numbers were proportionally higher on the weekends while those for calls in rural/remote areas were proportionally higher during the week.

An analysis of the caller usage pattern revealed important differences between metropolitan and rural/remote callers. Callers from metropolitan areas had a pattern of longer term frequent service usage with one third (34.8%) having called Lifeline repeatedly for more than a year. These long-term callers are also likely to phone for support several times

1. This is based on the RRMA Classification – metropolitan (over 100,000), large rural (25,000 – 99,000), small rural (10,000 – 25,000) and less than 10,000 – remote.

a month (26.3%) or daily (24.6%). Only 14% of metropolitan calls were from first time callers. By contrast rural callers had a significantly higher proportion (20%) of first time callers. First-time callers most frequently called on a Monday. For the rest of the week, there were no significant differences between first-time callers and long-term callers. (Figure 1)

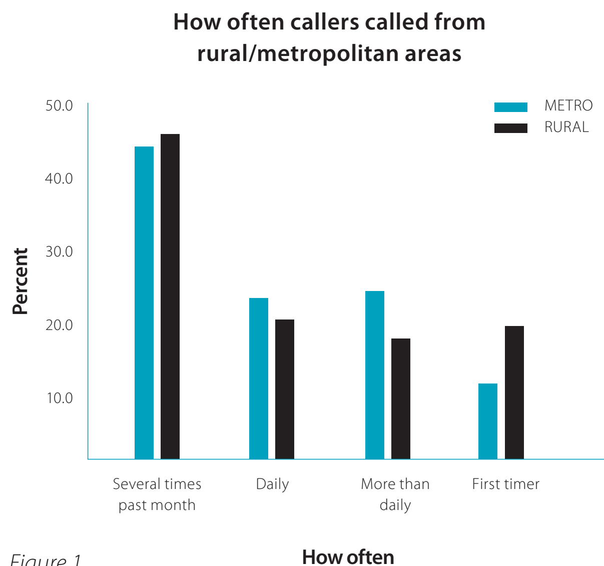


Figure 1

(N=19 583; Chi-squared, 346,776; df=3; p< .00)

Although these differences were evident, the numbers of calls received from rural and metropolitan areas were proportional to the population distribution. That is, people from rural and remote areas are calling Lifeline as frequently as people living in metropolitan areas. One of the implications of this finding is that callers across rural and metropolitan areas are gaining equitable access to Lifeline. The finding that a large number of calls are from callers who call weekly or daily appears to indicate that Lifeline is supporting a large population of long-term callers. The finding that a lot more first-time callers are from rural areas could suggest greater growth in Lifeline's caller population is coming from the rural/remote areas. This interpretation is supported by statements made by Lifeline, SANE and Kids Help Line indicating that callers from the rural population were on the increase (Gregor, 2004). It could also mean that first time rural callers "get through" to Lifeline more easily than metropolitan callers.

Who's calling Lifeline?

Calls to Lifeline were twice as likely to be from women. This was found to be a consistent pattern across rural/remote and metropolitan areas.

The highest number of calls, consistent across metropolitan and rural/remote areas, was received from people aged between 35 and 44 years. However, a broader analysis of age revealed differences between rural/remote and metropolitan callers (Figure 2). In rural and remote areas there was a higher proportion of callers in the age range from 45 to 64 years of age. By contrast, in metropolitan areas, the average age of callers was 43 years, 75% of callers were below 53 years, and there were a higher proportion of younger callers.

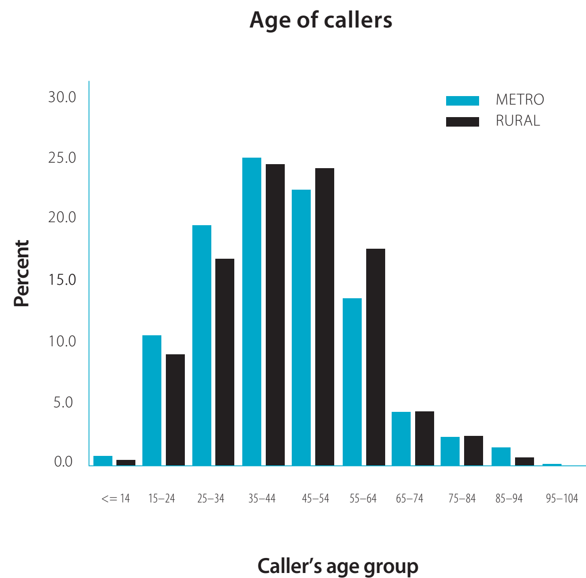


Figure 2

(N=17 095; Chi-squared, 105, 641; df=9; p< .00)

There are both similarities and differences in the relationship status of rural/remote and metropolitan callers. Similarly, in metropolitan and rural/remote areas, significantly more callers describe their relationship status as single. In metropolitan areas, 25.7% are not currently in a relationship, 18.3% are married or partnered and 15.5% are either separated or divorced. This pattern was also found to be consistent between metropolitan and rural/remote callers. However, it was found that a higher proportion of callers from metropolitan areas are single and a higher proportion of callers from rural/remote areas are married.

The majority of callers were calling in relation to themselves. Only 6.2% of callers called to seek help with a family member.

What were callers calling about?

Analysis of the focus of the calls revealed a similar pattern between rural/remote and metropolitan callers in prominent categories (Figure 3). Overall, the highest proportion of callers focused on issues relating to 'family and relationship challenges'. Within this category, relationship breakdown (24.2%) was the most frequently identified issue. The other response categories that made up a significant proportion of the sample were 'non-counselling calls' (21.2%, community services information is the main item), 'health and disability' (15.2%, mental health is the main item) and 'self and society' (12.35%, loneliness being the main item).

There were some significant differences between rural and metropolitan areas. Of most significance were differences in the categories 'practical help' and 'abuse, anger and violence' which were proportionally more prevalent in rural areas.

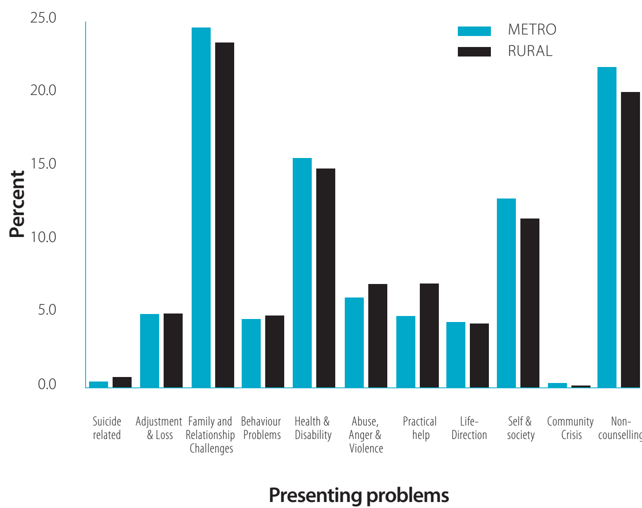


Figure 3

(N=88872; Chi-squared, 344.116; df=10; p<.00)

Within the prominent 'presenting problems' categories there were few significant differences recorded across rural and metropolitan samples. It was only in the category of 'practical help' that issues across rural and metropolitan samples differed whereas in metropolitan areas accommodation was the main concern (Figure 4). In rural/remote areas material aid and problems related to meals/shopping were of main concern.

The use of Lifeline for material aid in rural areas could reflect the high level of success Lifeline has in reaching farm family members and small businesses noted by Alston and Kent (2004) in their review of the social impacts of drought.

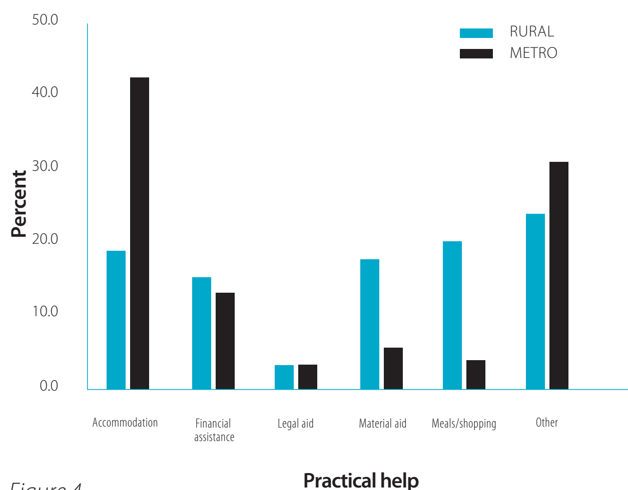


Figure 4

Those calling about 'life direction' tended to be significantly older in age, slightly more likely to be male, and equally likely to be from either metropolitan or rural/remote areas (Figure 5). Those calling about 'behaviour problems' were twice as likely to be male, younger in age and from a rural/remote area, those calling about 'community crisis' were significantly older and more likely male, though equally located in a metropolitan or rural/remote area.

There were significant gender differences in the call focus. Women callers more frequently focused on relationships. Male callers more frequently focused on mental health, self and society and behaviour problems.

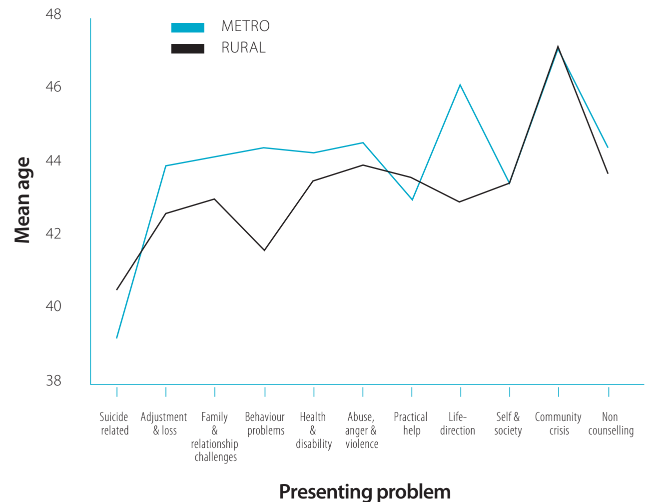


Figure 5

(Age/presenting problem: N=17 094; F=1.899; df=10; p<0.04)

Suicide-related calls

Every day, Lifeline receives over 30 calls about suicide. While these calls comprise a relatively small proportion of total calls (3.6% - n = 3280 in this sample) their importance in terms of addressing issues of life and safety can be critical. A significant proportion (58%) of people who phoned about their own suicide thoughts were from people who indicated they had engaged in suicidal behaviour previously. Self-poisoning (51.0%) and cutting (30.0%) were the most frequently reported self-harm methods within this group. Further, 43% of those who phoned about their suicide thoughts indicated that they had a suicide plan. This underscores the importance of the fact that these callers are accessing help, because prior suicidal behaviour is one of the stronger indicators of completed suicide and the presence of a suicide plan also flags elevated risk.

The age profile for people who phoned about suicide was similar to the overall sample. However, callers were equally male and female and more likely to be from rural/remote areas.

Lifeline is currently reviewing its systems for gathering data on these calls to ensure that the full spectrum of situations featuring suicide is captured and a clear picture of needs is developed. Gathering appropriate information guides the management of the call as well as yielding helpful data on Lifeline's suicide intervention role.

Referral Patterns

An analysis of the pattern of referrals made from Lifeline counsellors to callers revealed that a higher proportion of referrals for accommodation, material relief and mental health were provided for rural/remote callers (Figure 6). Overall, referrals for counselling were significantly higher (40%) than any other referral. This was consistent for both metropolitan and rural/remote areas.

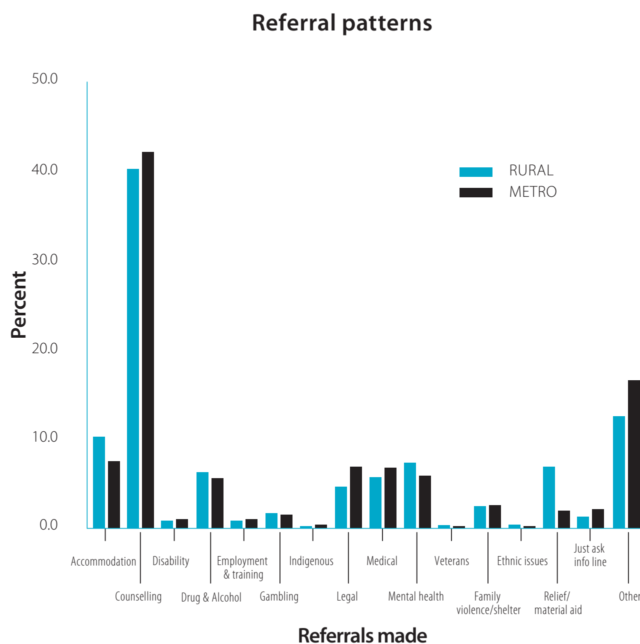


Figure 6

(N=5967; Chi-squared, 148,983; df=15; p< .00)

What is the mental health status of callers?

Lifeline counsellors know that mental health needs feature prominently in many calls and this perception has been supported by internal research in some Lifeline Centres. However, it is difficult to get reliable national data on the mental health status of Lifeline callers. Lifeline does not conduct formal assessments of mental status or disorder and many callers do not disclose mental health issues they may be dealing with.

One indicator of mental health came from callers (n = 6,794) who said that they were currently receiving treatment for a mental disorder – about 7% of the dataset. The most common mental health conditions were depression and schizophrenia. Male callers were more likely to be receiving treatment for schizophrenia and women callers were more likely to be receiving treatment for depression.

Rural callers made up 45.5% of this response set. When these responses across rural and metropolitan categories are compared with the total number of rural/metropolitan callers, a higher proportion of rural callers receiving treatment for a mental disorder 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 may support the idea that rural callers with mental health problems are more likely to depend on Lifeline as compared with callers from metropolitan areas.

Who are the first-time callers?

In an earlier section it was indicated that first-time callers are almost twice as likely to be from rural areas. A consideration of 'presenting problems' for first-time calls is a better indication of the kinds of problems Lifeline is dealing with as this sample is not affected by the number of calls an individual makes. Consistently across metropolitan and rural/remote callers, the focus of first-time callers was significantly different to other callers. Figure 7 illustrates first-time callers focused on relationship issues ('family and relationships challenges' 35.3%) and 'practical help' (14.1%). In comparison, a higher proportion of recurrent callers call about mental health issues ('health and disability', 28.2%) and loneliness ('self and society', 23.5%).

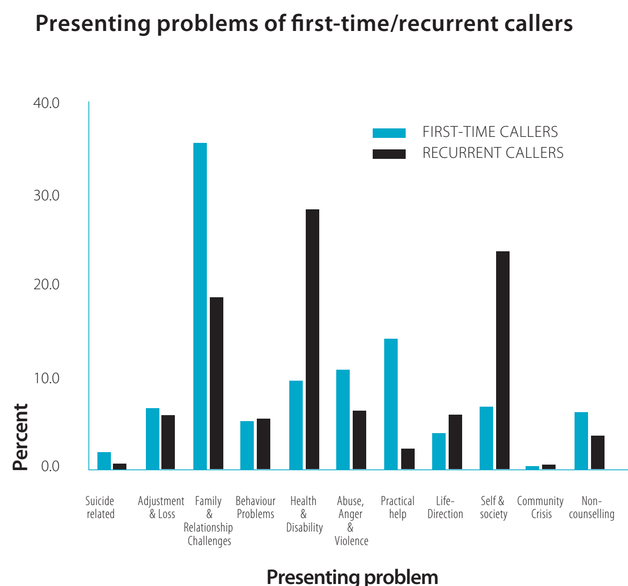


Figure 7

(N=19 583; Chi-squared, 2054; df=10; P< .00)

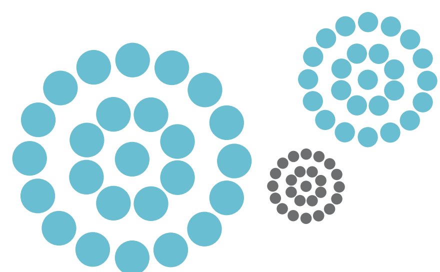


Figure 8 demonstrates within the first-time caller sample, the rural population displayed significantly greater needs in the area of practical help (19.1%) whereas metropolitan callers showed greater needs in the 'family and relationship' area (39.9%). 'Abuse, anger and violence' problems were experienced to the same degree in both rural and metropolitan first-time callers.

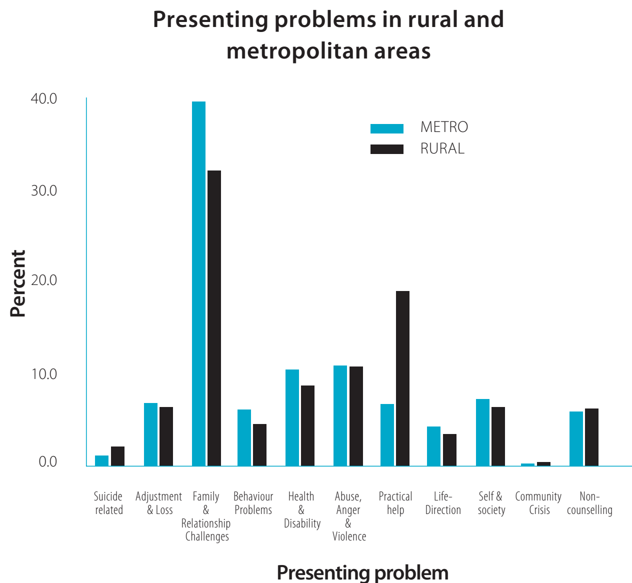


Figure 8

(N=2784;Chi-squared, 99.303; df=10; p< .00)

Only 7.8% of first-time callers reported having treatment for mental health issues (96% of these lived in metropolitan areas). Only 11% of first-time callers reported having experienced symptoms of mental health issues. 95% of these were from metropolitan areas. First-time callers tend to be younger, to call during normal business hours during the week and to call for longer than the average call. These findings suggest that first-time callers use Lifeline to resolve a 'once off' issue that is not necessarily directly linked to mental health. Alternatively, these findings suggest that first-time callers may be 'trying out' telephone counselling with a safe issue.

Who are the recurrent callers?

Recurrent callers are characterised as people who call the telephone counselling service either several times a month, daily or more than daily. These recurrent callers are significantly more likely to be calling about mental health issues and loneliness.

In a multiple response assessment of experiences in the past two weeks, recurrent callers frequently self-reported symptoms associated with depression (59%) and anxiety (45%). Recurrent callers were also more likely to report access to support, with 28% identifying their medical practitioner as their primary support person. This suggests that repeat callers may require more ongoing support. It also suggests that they may call Lifeline to obtain similar kinds of basic support. Furthermore, these findings may suggest that medical practitioners are providing information about Lifeline to their clients with mental health issues.

Are mental health callers receiving treatment from healthcare professionals?

Only 5.3% of calls indicated that callers were receiving care from a healthcare professional. Of these calls, 57.9% were receiving care from a Psychiatrist and 30.7% indicated they were receiving care from a General Practitioner. Only 7% indicated they had been seeing a Psychologist. This was consistent across recurrent and first-time callers.

Figure 9 illustrates a significantly higher proportion of rural calls indicated receiving care from a General Practitioner (35%). The Metropolitan calls indicated that a higher proportion of callers were under the care of a Psychiatrist (60.6%).

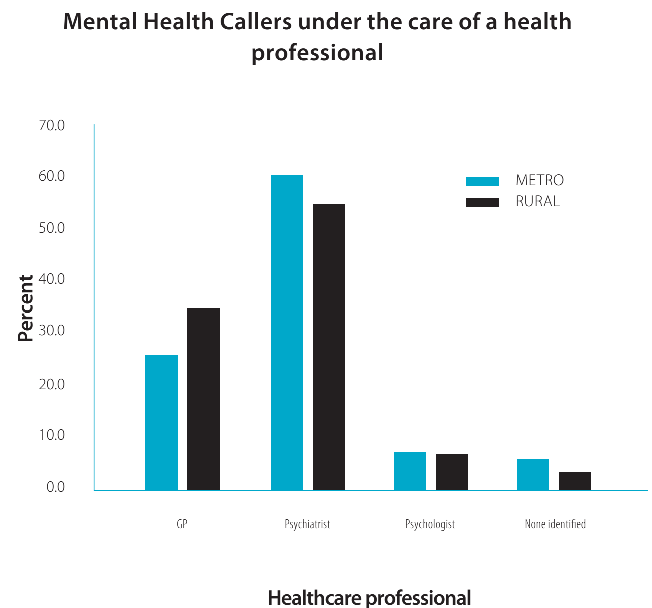


Figure 9

(N=4690; Chi-squared, 52.613; df=3; p<.00)

What service are telephone counsellors providing to mental health callers?

Information on the service provided to mental health callers was collected in a small percentage of calls (6.9%; N=6 169). The findings indicate that telephone counsellors provide significant primary prevention services, focused on reducing levels of distress and promoting coping strategies and adaptation. Counsellors reported providing 'emotional support' (82.2%), 'exploring coping strategies' (63.6%) and 'assessing for suicidal intent' (37.7%). Referral was provided to 11.1% of callers, with 3.0% being referred to Lifeline's mental health information and referral line.

Implications for Policymakers

There are several implications of these findings for policymakers across the areas of health and mental health and for all levels of government in providing services to people living in rural and remote communities.

Firstly, the findings clearly demonstrate the critical role of telephone counselling in the provision of services for people living in both rural and remote communities and metropolitan communities. This role consists of a mix of crisis management, social support, referral and early intervention in suicide and behaviour issues.

It confirms the importance of change initiatives planned as part of the GAP to better provide for the needs of recurrent callers and to enable crisis and first time callers to gain access to the service.

Secondly, the data demonstrates that the Lifeline telephone counselling service is accessible and valuable to people presenting with a broad spectrum of issues. These range from significant mental health issues to requirements for practical assistance, with relationship concerns being paramount.

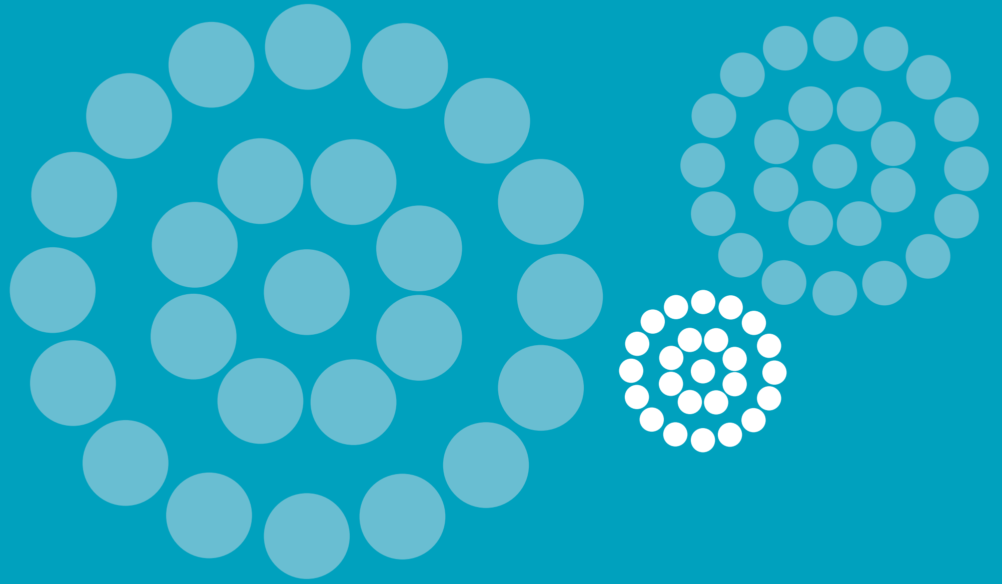
Lifeline provides a universal service that is available everywhere and to everyone. Most current health and mental health services provide a targeted service for particular areas or groups who meet specific criteria. Such services more narrowly target audiences and provide more limited access.

Further, the findings show that Lifeline counsellors have a critical role in providing emotional support to callers. As services struggle to balance scarce resources with increased service demands, they are less able to meet the essential outcome of providing emotional support to consumers. This research demonstrates a high community need, across both well-serviced metropolitan communities and service depleted rural and remote communities, for emotional support. Lifeline, though offering a highly accessible and universal service, has a critical role in primary prevention, providing emotional support to callers experiencing significant mental health issues and negotiating a community or personal crisis or who do not have access to support from other areas, such as family or partner.

Thirdly, the findings show a high rate of first time callers from rural and remote areas. This may indicate that people in rural and remote areas view telephone counselling as a valuable and accessible health service. It may also be a consequence of a lack of alternatives for people in rural and remote areas and underscore the greater need (particularly for a 24-hour service) and reduced access to mainstream services in rural and remote areas. This data shows that help line services are highly accessible in rural areas.

Further, the finding suggests that services developed in line with universal models of delivery may be more applicable in rural and remote areas. A universal model of service delivery is structured to provide a range of services to all in need. This would be especially suited to rural and remote areas where the Lifeline data demonstrates a range of needs, with callers experiencing significant mental health issues to relationship issues and loneliness.

The data suggests that rural and metropolitan callers make use of Lifeline differently. This may have policy implications for planning interventions to meet the needs of both caller groups, whilst managing resources effectively. For instance, it may prove effective to manage recurrent callers differently so that access for first-time callers is not compromised.



Conclusion

Overall, these findings provide strong support for the provision of universal health services, particularly in service-depleted areas such as rural and remote communities. Additionally, the range of callers and issues discussed, from significant mental health issues to the need for practical support and crisis negotiation, suggests that a multi-disciplinary team able to offer a range of services would best staff such services.

Lifeline acknowledges the support of the Commonwealth Department of Health and Ageing, Rural Health and Palliative care in the publication of this profile.

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People seeking counselling should phone 13 11 14 to access Lifeline's 24 hour telephone counselling service.