New South Wales rural and remote communities’ perception of mental health telephone support services

Helen Le Gresley¹, Carlie Darling¹, Prasuna Reddy¹
¹Centre for Rural and Remote Mental Health, University of Newcastle

Introduction

Inequalities in the use of mental health services across Australia have been well established, specifically in relation to rural vs. urban communities (1, 2, 3). A range of factors have been identified as contributing to this inequity including physical access to appropriate mental health care services (1, 2, 4); social stigma (5); agrarian values (2); and affordability (6).

In an attempt to address some of these barriers, various telehealth and e-mental health services have been introduced, incorporating approaches such as telephone support/triage (5), internet based e-mental health resources (6), and service delivery (3,7). During the last 10 years these services have gained strategic momentum with the introduction of the Australian federal government’s Telephone Counselling, Self Help and Web based Support Program in 2006 (8). This program funded the development and implementation of 10 major projects undertaken by Australian Universities, and the non-government and private sectors, aimed at trialling e-mental health services across Australia.

Interestingly, of the estimated 30 services provided as part of these major projects, only three utilised telephone support as a method of delivery(8), with the majority focused on internet based approaches. Following a similar trend, future federal government initiatives (e.g. E-Mental Health Strategy for Australia) focus predominately on web based delivery (8). Given this emerging preference for more technologically advanced approaches, the role of telephone support in the wider e-mental health service delivery landscape is becoming unclear.

At a consumer level, the availability and use of telephone support appears to have grown, with estimates from Helplines Australia indicating a 30% increase in the number of support lines available since 1997 with over 4 million calls per year handled by their membership alone (9). In addition, the volume of calls reported by high profile lines continue to rise, with recent estimates indicating Lifeline receiving 36,000 callers per month (10); Beyond Blue 8,000 calls per month (11); and Kids Helpline 34,000 callers per month (12).

As these figures suggest, the number and consumer use of mental health support lines across Australia appears to be growing. However, there is limited and conflicting evidence about the perception and uptake of these services in rural and remote areas.

In 2008, the NSW Farmers Blueprint for Mental Health was published and included access to crisis lines as a strategy to provide timely mental health advice to farmers, their families and farming communities (13). This approach appears to be supported by Lifeline call data profiles (14,15) which suggest that the numbers of calls received from rural and metropolitan areas were proportional and the purpose of these calls consistent between geographical areas. Therefore it seems that the provision of mental health support to rural and remote communities via telephone has traction at both policy and consumer levels, by inclusion in a key rural mental health framework and rural usage statistics proportional in number and type to urban areas.

However, recent research published by the Rural Industries Research and Development Commission (16) concluded that telephone services as they were currently structured were not an appropriate solution for certain segments of rural and remote communities. The 110 farmers and fishers interviewed stated that their low uptake of these types of services was due to the lack of face to face contact and usability of such support. The participants indicated a preference for group based, face to face activities arranged by organisations they trusted would understand their needs, such as industry associations and community groups. Face to face delivery of mental health support has also been
highlighted as the preferred delivery method for rural and remote communities in other recent research (17, 18, 19).

Apart from a perceived preference for face to face support, it appears that the use of mental health telephone support is also influenced by consumer confusion regarding service availability. The NSW Farmers Blueprint highlighted that reducing confusion about which line was the most appropriate to call was critical, as each line appears to offer a somewhat different service and approach (13). This finding is supported in other research suggesting that the effectiveness of services in rural and remote communities is necessarily dependent on clearly defined target groups, and a conspicuous and unambiguous profile within the communities that they serve (4, 20, 21, 22).

Confusion regarding the type and breadth of mental health telephone support available to communities in rural areas has also been cited as an important issue for non-triage services, who tend to focus on counselling and self-management rather than direct referrals to public mental health services (4). Perceived service overlap from these more generic telephone counselling services could affect service utilisation, due to consumer confusion regarding the differences between the types of support available (4). This ambiguity may have been exacerbated by the recent tendency for many telephone support lines to adopt a hybrid model where support can be provided via e-mail, online chat and telephone, or any combination of these methods. While such an approach enables convenient access to communities and flexibility for those with limited access to mental health services (8), it may also overwhelm potential consumers if communication of the purpose and framework of support options is unclear.

Since the introduction of more sophisticated e-mental health support, there has been a paucity of literature exploring the perceived role of telephone support in Australian rural and remote communities. In order to address this, the current research seeks to explore knowledge and awareness of health telephone support services available in rural and remote communities. Additionally, perceptions regarding the type, level and nature of telephone support services required in these communities will be assessed.

**Methods**

A mixed methods survey was developed with items relating to knowledge, awareness and use of health/mental health telephone support services available; and perception of type, level and nature of telephone support services needed by rural and remote communities. The survey consisted of closed questions, rating scales and open ended questions and defined health telephone support services as telephone based support or advice lines, operated by government, not for profit or private organisations, with the aim of improving the health outcomes or capacity of individuals.

The survey was reviewed by employees of the Rural Adversity Mental Health Program (RAMHP) at the Centre for Rural and Remote Mental Health NSW, in addition to a group of ‘critical friends’ comprised of community members from rural NSW. Approval for this research was obtained from the University of Newcastle Human Research Ethics Committee (H 2012-0348).

RAMHP workers from each of the NSW Local Health Districts were used to identify community organisations and service networks in rural and remote communities who were able to assist with survey distribution. For the purposes of this research, rural and remote communities were defined using the Accessibility Remoteness Index of Australia (ARIA +) classification which classifies rural location on the basis of road distance from essential goods and services (23). ARIA + areas falling into the inner regional, outer regional and remote classifications were the focus of this research.

The Project Coordinator approached the identified organisations and networks and sought consent to distribute the survey. A link to the survey (including a participant information statement) was forwarded to consenting organisations and networks to distribute to suitable participants who had assented to future contact. In addition, the Project Coordinator contacted key organisations involved with rural and remote communities in NSW and sought their consent to distribute surveys to their membership.
In total, approximately 125 organisations/ networks were asked to act as survey distribution points, with 50 hard copies of the surveys sent to organisations who requested this on behalf of their members.

Demographic data were obtained on the respondents age, gender, employment (health professional or not) and place of residence (living on a farm or not). Basic descriptive statistics comprising of frequency and percentage counts were performed on the closed ended and rating scales items. $\chi^2$ tests were performed to determine the relationship between health professional status (yes/no) and awareness/understanding of mental health telephone support available, in addition to age and preferred communication channels. Open ended questions were analysed using the Grounded Approach (24). This analysis included an initial coding exercise; refining the codes through indexing, linking categories, memo writing and category integration; and producing final categories or themes that are fully saturated with central relationships between sub-codes.

**Results**

Surveys were submitted by 213 participants, with the majority of these on-line through SurveyMonkey (N= 195; 91.5%). As shown in Table 1, there were more female than male respondents, with the majority (66.2%) over the age of 45 years. Almost half of the respondents categorised themselves as health professionals and just over a quarter lived on a farm.

**Table 1   Demographic profile of survey respondents**

<table>
<thead>
<tr>
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<th>N</th>
<th>Valid percentage</th>
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<tbody>
<tr>
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<tr>
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<td>172</td>
<td>80.8</td>
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<tr>
<td><strong>Age (years)</strong></td>
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<tr>
<td>18-29</td>
<td>20</td>
<td>9.4</td>
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<tr>
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</tr>
<tr>
<td>No</td>
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<td>55.4</td>
</tr>
<tr>
<td><strong>Live on a farm</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>59</td>
<td>27.7</td>
</tr>
<tr>
<td>No</td>
<td>154</td>
<td>72.3</td>
</tr>
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</table>

**Awareness of health/ mental health telephone support**

A high proportion of respondents (N = 179, 82.5%) stated that they were aware of health related telephone support services available to communities in N.S.W. These levels of awareness did not differ significantly in relation to the demographic characteristics of status as a health professional or living on a farm (Table 1).

Of those respondents who stated that they were aware of health related telephone support services, 95% were able to spontaneously name at least one valid support line. In this spontaneous recollection, over 64 unique support lines were identified, with the most frequently cited (N > 5) shown in Figure 1. Of these spontaneously mentioned lines, 12 of the 13 shared a ‘mental health’ focus.
Prompted with the names of seven mental health telephone support lines, almost all respondents indicated that they had heard of the lines listed, with Lifeline, beyondblue and Kids Helpline the most recognised.

While the responses to the above items indicate relatively high levels of awareness of health/mental health support lines, only 20% of survey participants (N = 42) responded positively to the statement that ‘the availability of mental health telephone support services are widely advertised in the general community’.

The respondents generally acknowledged that they felt their awareness regarding mental health telephone support was not due to advertising but rather because of their interest and/or professional experience in the field of mental health.

“I think my knowledge as a health professional is probably above average so there are likely to be lots of people that aren’t aware of what is available.”

“I am aware of services available as a volunteer with aged care. I have never read or heard any local advertising of services. It is nearly impossible for anyone to find numbers in local telephone directories—let alone anyone under stress and needing to talk to someone.”

**Understanding of mental health telephone support available**

Although the respondents’ reported high levels of awareness of available mental health telephone support, they did not report the same confidence in their understanding of the availability of these services at a local community level.

Almost one-third of respondents (32%) disagreed with the statement that they had a good understanding of the mental health telephone support available in their community, however this was more prevalent in Non Health vs. Health professionals (42.3% vs. 18.9% \( \chi^2 (4) =20.89, p<0.01 \)).

A good understanding was perceived by respondents as being more than just the ability to list the names of mental health support lines but also having knowledge regarding the core purpose and operational characteristics of the services offered. Without such knowledge, the respondents suggested confusion tended to occur, thereby hampering their ability to make informed judgements about the services available.
“I don’t really know what the difference is between them all...there is a lack of understanding regarding what the service is and what they do... there needs to be a clear understanding for the client/family ringing what they will receive from the line they are calling and what will happen next, e.g. is it just a triage and referral line or does it provide counselling...will they call back or will someone else”

Sources of information for mental health telephone support
Respondents also identified a lack of awareness of services (79%), and confusion regarding the different types of support services available (71%), as the largest potential barriers to accessing mental health telephone support for rural and remote communities. To overcome these perceived barriers, adequate, informed promotion of mental health telephone support was deemed to be important, with television (58%), referral from a GP (52%) and radio (43%) selected as the best three options for promotion (see Figure 2).

Figure 2 Percentage response to best ways to promote mental health telephone support services

![Graph showing promotion methods]

Promotion method
Age did not appear to be associated with the suggested channels of promotion except for those who selected internet, with 88% of respondents aged 30–59 vs. 12% of respondents 60 years and over suggesting this as one of three best promotion options ($\chi^2 (3) = 10.88, p<0.01$).

Other suggested methods for promoting mental health telephone support services included promotional material such as pamphlets and magnets distributed via post and placed in visible areas such as pubs, sporting clubs, newsagencies, post offices; and expos/seminars held in the community.

Almost all comments regarding this item highlighted the need for ongoing promotion that is responsive to the local community, and maximises use of local assets and trusted sources of information.

“After recently moving to rural NSW and being employed by a Government Health organisation I now realise that the way to promote such services is very individualistic for each town but local papers and well informed GPs and community organisations are key.”

Quantity and quality of mental health telephone support services
Less than 20% of respondents felt that the current mental health telephone support services available to rural and remote communities in NSW were sufficient in number and adequate in type.
Table 2  Percentage agreeance with statements regarding number and type of mental health telephone support available

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree/agree</th>
<th>Unsure</th>
<th>Strongly disagree/disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of telephone support sufficient</td>
<td>19.7</td>
<td>37.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Type of telephone support adequate</td>
<td>15.5</td>
<td>38.9</td>
<td>45.6</td>
</tr>
</tbody>
</table>

The relatively high number of respondents who replied Unsure to these statements tended to express a lack of understanding regarding the services available that made it inappropriate for them to comment.

Those who did perceive that the number of services were sufficient tended to comment that more lines being introduced would add to the confusion felt by health professionals and consumers.

Key themes emerging from participants in relation to the adequacy of mental health telephone support included waiting times, availability of local responses and follow up, consistency of provision; and perceived barriers (e.g. call costs and ‘crisis’ focus).

The waiting times that respondents, or those known to them, had experienced when using mental health telephone support was raised a number of times when commenting on the adequacy of services.

“Rang [XYZ] about 4 years ago and got a recorded message they didn’t have enough staff to take my call. This put me off using telephone support”

“I have used [XYZ] when in a very desperate mental health situation ... and thought I was going mad at about 1 am and got a recorded message saying all lines are busy please hold on or if desperate call an ambulance. I held on for over 30 minutes and no one came on to talk and help me get through this... I can’t tell you how horrific this experience was and how excruciating it was that there was no one for me on the other end of the phone call”

“The one I used had an answering service and never rang me back. I ended up being admitted to a mental health facility 2 days later. I think this could have been avoided if I had had help that night or the next day.”

The availability of ‘on the ground’ local rural and remote mental health support services was raised as an important area for respondents. More specifically, respondents stressed that they did not want telephone support (or e-mental health support), to be delivered at the expense of face to face services. In addition, it was perceived that the effectiveness of mental health telephone services was dependent on the availability of suitable on the ground support to assist after contact was made over the phone. This perception was mostly articulated by health professionals.

“I think country people are generally more private and consequently find discussing intimate details like their emotional and psychological wellbeing difficult...Sometimes talking to phone services is not backed up by adequate community services and doesn’t translate to on the ground assistance so the helpfulness is only a bandaid”

“Telephone support is vital but someone very unwell will not be inclined to pick up the phone. Currently rural and remote areas are way under staffed and poorly funded with regard to mental health related illnesses and we need more funding for more health professionals and more mental health counsellors.”

“The focus needs to be moved from telephone support. Although I understand the difficulties in providing direct assistance to clients in rural and remote areas, funding for this area cannot and should not be skimmed on...I think in the name of cost cutting telephone services present a very poor option”
The need for people using mental health telephone support services to receive consistent and ‘joined up’ service provision that reduced the necessity to be directed from one service to another and retell their story, was also a major theme.

“Inability to get the same person each time you ring—you have to re-explain yourself each time—lack of trust built in a relationship”

“[XYZ] line appears to be a triage and referral to mental health services line but people don’t know that and so they contact [XYZ] line tell their story and are referred to mental health services. They are then assessed and tell their story again and are often referred to their GP at this point because they are not acute or in crisis enough. This is not good for the client who must feel very frustrated by this management as they go to the GP and have to tell their story again”

**Perceived barriers**

Two themes emerged relating to perceived barriers affecting the quality of mental health telephone support available to rural and remote communities in N.S.W., the cost of calls from mobile phones and a ‘crisis’ focus of mental health telephone service providers.

The cost of calling mental health telephone support from a mobile phone and the potential barrier this created in accessing services was a dominant theme, with concern particularly for young people.

“Important that people can still access these lines when they don’t have mobile phone credit especially for young people”

“Mobile phones are used by the low socio economic community and this is costly to access. By going to a 3rd party to use their phone also means divulging personal information to another person.”

“a lot of people are using mobile phones as their only means of contact. Mobile phone charges can become a barrier.”

Finally, a theme emerged around the need for mental health telephone services that promote both the ongoing development of mental health, as well as supporting people experiencing acute psychological distress or who are in ‘crisis’.

“We (rural and remote communities) need a dedicated line and not necessarily crisis. Tend to focus on crisis and mental illness and not about maintaining mental health”

“[XYZ] is promoted as a crisis line, I feel we need a local support line connected to mental health support. We need address the issues before it becomes a crisis”

“[XYZ] is known to be very dismissive of people with ‘non acute’ issues and I have experienced firsthand how this is a huge barrier to people requiring assistance”

“When are we going to start looking at mental wellbeing in a preventative situation rather than rehabilitation...assist people to accept mental wellbeing the same as physical wellbeing and work towards a total health lifestyle?”

**Dedicated support line**

Over three-quarters (78%) of respondents Agreed/Strongly Agreed (I think these should be capitalised to clarify they are variable names) that a dedicated rural support line was required. Thirty participants provided additional comments regarding their responses and from these the following themes emerged:

There are specific issues and challenges affecting people in rural areas, including the unique impact of farming on mental health and lack of access to face to face services. Being from a rural/remote area was viewed as a characteristic affecting mental health much the same as age, gender, ethnicity or being a war veteran.
“Issues are different in remote/regional areas and need people with that understanding and relevant training to be able to effectively assist”

“Rural and remote communities have different and additional health and mental health needs to our urban and suburban counterparts.”

A dedicated line may reduce the confusion regarding which line to call as people in rural/remote areas would identify more closely with the line’s purpose. However participants stated that the people working on the line would need to be familiar with the unique geography, needs and pressures of living in rural/remote NSW.

“one service that is very aware of the issues facing people in rural and remote areas that is well resourced with clinicians who can provide support for whole of life span issues and can provide counselling and support without having to send them through a number of different agencies”

Discussion
The survey responses suggest high levels of awareness, but comparatively lower levels of understanding, of the types of mental health telephone support that are available to rural and remote communities. The majority of the lines that were spontaneously mentioned were mental health related and this is possibly linked to the convenience sample.

Participant’s comments regarding understanding centred heavily on the confusion they felt regarding the core purpose and operational characteristics of the telephone support lines. Respondents perceived that this confusion could be acting as a barrier to service accessibility at the community level. This perception appears to be consistent with the literature (4,13) and is also acknowledged in the E-mental Health Strategy of Australia which is now focusing on an integrated marketing and communications plan to ensure that services are well sign posted, consistently badged and well known by potential consumers (8). Based on responses to this survey, it is suggested that communication plans should include an approach that utilises media channels such as TV and radio, in addition to information provision from trusted sources (e.g. GPs). Although these channels are reflective of the age demographic who responded to the survey.

Respondent’s also emphasised that for strategic initiatives such as the E-Mental Health Strategy to be successful, they require the flexibility to respond to the nuances of rural and remote communities and provide connected and consistent approaches. While linked delivery is addressed in the Strategy, none of the initiatives listed as receiving ongoing funding are specific to rural or remote communities.

Consistent with the literature, respondents expressed a preference for face to face mental health support (17,18,19) Generally telephone support alone was not perceived as an adequate stand-alone service, with the preferred approach described as ‘on the ground’, local follow up after initial telephone support has occurred. That is, there was an assumption that professional intervention would be required after initial telephone contact had occurred. This need for professional assistance following telephone support suggests that it may primarily be viewed as a gateway to further service delivery rather than a service or self-management tool in itself.

The perceived role of mental health telephone support as a gateway to further clinical intervention was also a source of concern for some respondents, who felt that mental health telephone support was synonymous with mental illness telephone support. These respondents felt there was too much emphasis, both in the delivery and marketing of these lines, focused on crisis and intervention and less on the promotion of well-being. This narrative also seems to be implicitly communicated in the E-Mental Health Strategy which states that “e-mental services are aimed at people experiencing mild to moderate symptoms of mental illness” (8), rather than being framed as a tool for enhancing the mental health capacity of all Australians. Likewise the NSW Mental Health Support Line is promoted as a service for people with “mental health problems” (25) and “connecting you with the right care” (26).
This predominant biomedical discourse connected to mental health may also explain why those lines that are not consistent with this discourse and do not overtly demonstrate that they will lead to further professional intervention, are more likely to be confusing to consumers and health professionals. The influence of this discourse in more widespread areas of our lives has led to an assumption that diagnosis and treatment will be available when we seek assistance. That is, increasingly individual consumers expect, whether consciously or not, to receive a medicalised experience when contacting services such as mental health telephone support lines (27).

One potential consequence of this assumption is that those consumers not wishing to engage in the biomedical discourse, that is, not consider themselves as unwell, may not access services which implicitly promote a medicalised approach. This is supported by research into the influence of rural stoicism on help seeking behaviour, which suggests that mental health services in rural and remote communities need to be framed and described in such a way as to alleviate any concerns about admitting and dealing with emotions and problems (2). This makes it even more important for those non-triage/ non-crisis lines to assert clear, unambiguous statements of purpose and market these purposes strategically to their target audiences. The extent to which the biomedical discourse influences the provision of, and communication about, mental health telephone support will be further explored as part of the key informant service provider interviews that form the second part of this research.

Additionally, as call charges from mobile phones were considered to be a potential barrier to accessing support lines, this should be examined in further research. Although Telstra recently introduced a Crisis Line Initiative to stop charges to 1800 helpline services from mobile phones (28), a similar scheme already in place by other telephone companies, this only applies to national helplines. Advocacy with mobile phone carriers to lift 1800 charges for state-wide services as part of the support fund for underprivileged customers may be a way forward, as these free-calls are only available for national calls and not included in disaster relief responses which particularly affect rural and remote communities.

There were some limitations to this study. As participants were recruited through their membership or contact with community organisations and service networks, and as such they were more likely to be socially included members of the community, it is possible they are not representative of the wider population. Many of the organisations who consented to distribute the survey were connected in some way to mental health and as such participants may have had greater awareness of mental health services available to rural and remote communities through this affiliation. Future research may seek to address similar research questions using a broader population sample.

In summary, while the respondents demonstrated relatively high levels of awareness of the availability of mental health telephone support services, their self-reported levels of understanding of support availability was relatively low, particularly in non-health professionals. It appears that a lack of detailed understanding of the purpose of mental health support lines, particularly those without a triage/ direct referral agenda, may be acting as a barrier to accessing services, as is the cost of calling from a mobile telephone. The biomedical discourse equating mental health support with mental illness support was evident in the respondent’s description of services available and was a source of concern for some respondents. This discourse will need to be directly challenged by support lines not operating in the crisis/ triage space if they are to gain traction with those callers dissuaded from using telephone support due to implicit, and at times explicit, overtones of illness and disorder.

References


