The uses of mental health telephone counselling services for Chinese speaking people in New Zealand: demographics, presenting problems, outcome and evaluation of the calls

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ABSTRACT

Aim: This study aimed to investigate the call profiles of a Chinese-speaking mental health counselling helpline service in New Zealand (Chinese Lifeline provided by Lifeline Aotearoa) and to evaluate the calls and explore the possible factors influencing the outcome of the calls.

Method: A random sample of 151 answered calls was involved. Descriptive analysis with appropriate statistical tests was used to analyse the client profile and outcome data.

Results: The majority of the calls were made by female callers, aged between 21–60 both single and married. Top three presenting problems were: 1) mental health issues (82.1%); 2) family/partner relationship issues (47.0%) and 3) communication and related difficulties (45.0%). The majority of the calls (65%) ended after a clear decision in overcoming the issues made by the caller, with the help from the counsellor. Discussing mental health issues, grief and loss issues, and communication and related difficulties were shown to have influenced length of calls ($p<0.05$). Caller's age, frequency of calls, discussing relationship problems with family/partner, and physical problems were shown to have influenced the helpline counsellors' satisfaction of the helpfulness of the calls ($p<0.05$).

Conclusion: The service receives calls from callers with a wide range of demographics and a large variety of presenting issues. This study identified several important factors which influenced counsellors' satisfaction of the calls and the length of the calls.

In New Zealand, the Chinese population is on a constant increase. In the recent census in 2013, it was shown that Chinese people make up 3.8% of all New Zealand residents; the largest sub-ethnic group within the Asian ethnic group ('Asian' as defined by Statistics New Zealand in 1996.) in New Zealand.[1] Additionally, if we take into account the Chinese people who live in New Zealand without permanent residency (eg, international students), then the Chinese population or the Chinese speaking population would be even larger.

As Ho et al[2] pointed out, previous research findings have suggested that the mental health level among Asians does not differ significantly from those of the general population; there was also evidence of high rates of depression among Chinese older migrants. Furthermore, new or second generation Chinese migrants may face more emotional stresses and issues compared

to local people, such as issues related to cultural differences, language and communication issues, unemployment, traumatic experiences prior to migration, migration expectations not being met and regrets about coming to New Zealand.[2,3]

Since its establishment in 1993, Chinese Lifeline has provided confidential helpline services to people who would like to talk through their issues in Mandarin or Cantonese. The service has around 50–60 Chinese volunteer helpline counsellors. All of the counsellors need to have a counselling or related qualification or studying toward a degree in this area when they apply for the roles. When they are accepted, a six-week well-designed training program would be provided by Lifeline. It has several unique strengths compared to other mental health/emotional health services such as no language barriers and no cultural differences between the provider and the client.

Internationally, although there are a number of research studies in the field of Asian mental health issues, as Kumar et al[4] pointed out, most research focused on the Asian ethnic group in general and did not break it down to sub-ethnic groups (eg, Chinese). In New Zealand, literature on mental health issues around the Chinese population is even scarcer, and to the best extent of our knowledge we are not aware of any existing research that studied the client profile and presenting issues of a Chinese specific service in New Zealand. Thus, the aim of the current study is to investigate the demographic and presenting problems of the callers of a Chinese speaking counselling helpline service in New Zealand (Chinese Lifeline). It also aims to evaluate the calls using the length of the calls, and the counsellor's satisfaction of the calls, and explore the possible factors that influence these.

Methods

This study is a cross-sectional descriptive study. All call files of Chinese Lifeline that fell into the financial year (FY) 2013/4 (ie, 1 July 2013–30 June 2014) were obtained from Lifeline Aotearoa. There were several exclusion criteria: 1) the call was a test call; 2) wrong number; 3) a hoax call. Then a 20% random sample, stratified by the month of the calls, was pulled out from all the eligible calls in the FY 2013/4.

All the relevant call data were then entered into a standardised Excel database, which was set up for this study from the paper files. Data was carefully cleaned and validated before data analysis. Data was then analysed using SAS 9.3.

Descriptive analysis was used to analyse the client profile and the presenting problems. Chi-square tests were used to investigate the differences in the presenting problems among different demographic variables.

For the outcome and evaluation of the calls, three outcome variables were used: length of a call (up to 30 minutes vs. longer than 30 minutes), immediate outcomes of the calls and self-rated helpline counsellors' satisfaction on the helpfulness of a call (dissatisfied vs. satisfied; ie, whether the counsellor thought that the telephone counselling was helpful to the caller or not). The length of a call provides an indication of the efficiency of the service, while the immediate outcomes and the counsellors' satisfaction of a call gives an indication of the effectiveness of the service. Two separate binary multiple logistic regressions were undertaken to investigate factors associated with the length of calls being longer than 30 minutes and the helpline volunteers' satisfaction. The covariates were callers' demographic variables and the common presenting problems. Observations with missing data were excluded from the regression analyses. There were a few missing data of different variables which were excluded from all analysis.

Results

In total, there were 890 call files obtained from the call centre during the study period. Of these, 160 calls were excluded from the study due to the exclusion criteria. In the end there were 728 eligible calls for the study and the final sample size was 151 (ie, 20% random sample stratified by the month of the call).

Callers' demographics

Table 1 presents the callers' demographics and the main characteristic of the calls. The majority of the calls were made by female callers (90.5%). More than 40% of the calls were from young adults 21–30

years, 28% of the calls were made by callers from the 31–40 years age group and 23% of the calls were made by callers from the 41–60 years age group. In addition, most of the calls were made by either never-married singles (41%) or married people (43%). Frequent callers (classified as those who called more than 10 times per month for at least six months) made up just over one-third of the calls, while 27% of the calls were from first time callers.

Table 1: Callers' demographics and characteristic of the calls.

Demographic	n (%)
Gender (N=147)	
Male	14 (9.5)
Female	133 (90.5)
Age Group (N=126)	
20 or below	2 (1.6)
21–30	53 (42.1)
31–40	35 (27.8)
41–60	29 (23.0)
Over 60	7 (5.6)
Marital Status (N=118)	
Never married	48 (40.7)
Married	51 (43.2)
Separated	8 (6.8)
Divorced	4 (3.4)
Widow/widower	7 (5.9)
Type of callers (N=105)	
First time callers	28 (26.7)
Several times callers	40 (38.1)
Frequent callers	37 (35.2)

Presenting Problems

Reasons for calls have been classified into 13 categories as shown in Table 2. Top five presenting problems were: 1) mental health issues (82.1%; 95% CI [75.9%, 88.3%]); 2) family/partner relationship issues (47.0%; 95% CI [39.0%, 55.1%]); 3) communication and related difficulties (45.0%; 95% CI [37.0%,53.1%]); 4) peers/friends/employer/employee and other relationship issues (33.1%); and 5) work and education related concerns (26.5%). With the mental health and family/partner relationship issues, a more detailed account was captured by the counsellors. Overall, the most common mental health issues were "stress" (43.1%), "depression" (31.1%), "loneliness" (28.5%), and "anxiety" (27.2%). There was also 15.2% (n=23) of the calls where psychiatric/mental health issues (eg, bipolar, schizophrenia) were identified. With family/partner relationship issues, the biggest group was "issues with extended family and in-laws" (31.1%). The risk level for most callers' issues were low to moderate; however, there were occasional high risk calls (eg, suicide-related issues).

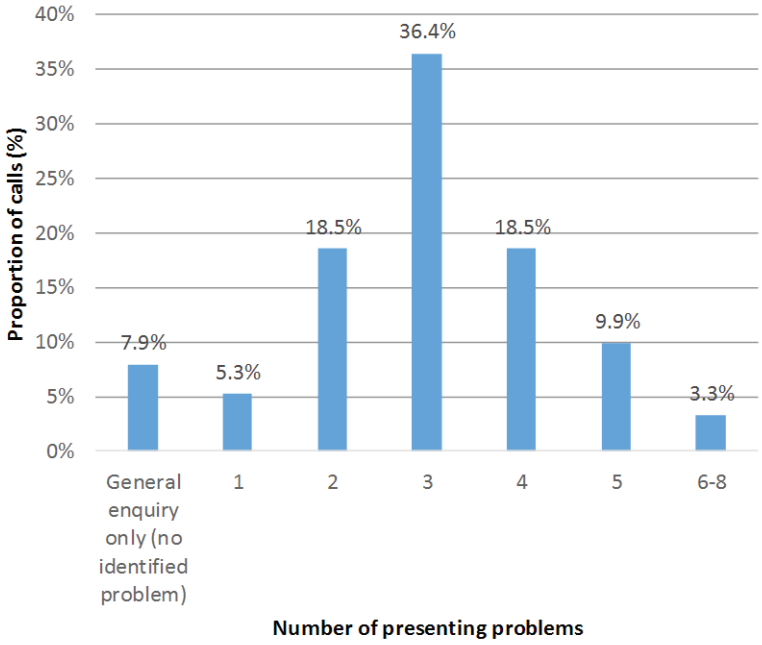
Only 7.9% (n=12) of the calls were general enquiry calls with no presenting problems identified (ie, non-counselling calls; see Figure 1). Furthermore, of the remaining 92.1% of counselling calls, only 5.3% (n=8) were of single presenting problem calls, and 86.7% were of multiple presenting problem calls. In fact, more than half of the calls (54.9%) were subjected to three to four presenting problems. Significant negative correlations were found between having family/partner relationship issues and having peers/friends/employer and other relationship issues ($r=-0.41$, $p<0.0001$), and significant positive correlations were found between having family/partner relationship issues and having mental health issues ($r=0.30$, $p=0.0002$).

In addition, the age groups of over 30 years were significantly more likely to have discussed family/partner relationship issues (65% vs. 33%, $p=0.0004$) and were significantly less likely to have discussed work and education related concerns than the age groups of 30 years or younger (19.7% vs. 41.8%; $p=0.007$). On the other hand, first time and several time callers were significantly more likely to have discussed grief and loss issues in the calls compared to frequent callers (34% vs. 8%, $p = 0.004$).

Table 2: Presenting problems of callers in descending order (N=151).

Presenting problem categories	**n (%)**
Mental health issues	124 (82.1)
Family/partner relationship issues	71 (47.0)
Communication and related difficulties	68 (45.0)
Peers/friends/employer and other relationship issues	50 (33.1)
Work and education related concerns	40 (26.5)
Grief and loss	34 (22.5)
Physical health concerns (eg, diabetes, obesity etc.)	29 (19.2)
General enquiries	29 (19.2)
Practical help/requests	19 (12.6)
Abuse and violence	8 (5.3)
Drug and alcohol and other addictions	3 (2.0)
Suicide related issues	2 (1.3)
Sexual health concerns	2 (1.3)
Details of Mental health issues	**Proportions of calls (%)**
Stress	43.1
Depression	31.1
Loneliness	28.5
Anxiety	27.2
Lack of confidence	22.5
Psychiatric/mental health problems	15.2
Self image	11.9
Phobia/fear	5.3
Disordered anger/violence	2.0
Details of Family/partner relationship issues	Proportion of calls (%)
Family (extended and in-laws)	31.1
Relationship breaking up	12.6
Marital/de facto	9.3
Parent/child	8.6
Romantic/emotional/sexual	7.3
Divorce/separation	6.6
Boy/girlfriend	5.3
Extramarital relationship	2.7
Single parent	0.7
Blended family	0.0
Former spouse	0.0
Adopted parent/child	0.0

Figure 1: Proportion of number of presenting problems identified in a call conversation (N=151).



Outcome and evaluation of the calls

Outcome of the calls

Counsellors were asked to record the immediate outcomes of the calls. Overall, the majority of the calls (n=92, 65%) ended after a clear decision in overcoming the issues was made by the caller, with help from the counsellor. Out of these, only five calls were transferred/referred to other mental health or counselling services (including the two suicide-related issues calls); whereas the rest of the callers came up with a detailed self-care plan. However, the remaining 35% of calls had no clear decisions made by the end of the calls; and the reasons were either because the calls were interrupted by somebody else from the caller's end and ended unexpectedly, or the caller did not feel like discussing the care plans at that moment in time.

Helpline counsellors' satisfaction of the helpfulness of the calls and associated factors

Helpline counsellors' satisfaction ratings with the effectiveness of the calls were captured in 141 out of the 151 calls in the sample. In total, they were satisfied with 109 (77.3%) of these calls. There were several factors identified, which influenced their satisfaction (see Table 3). In particular, the helpline counsellors were more likely to be satisfied with the helpfulness of the call if the caller's age was between 30 years or younger compared to if the caller was older than 30 years (p=0.002); and if the caller was a first time or several times caller, compared to if the caller was a frequent caller (p=0.02). They were less likely to be satisfied with their part of the call if relationship problems with people other than family/partner were discussed during the conversation (vs. if not) (p=0.008); and if physical problems were discussed during the conversation (vs. if not) (p=0.004).

Length of calls and factors associated with it

Overall, half of the calls were between 5–30 minutes (50.7%; n=73). There were 11.8% (n=17) of very short calls (ie, 0–5 minutes) and 10.4% (n=15) of very long calls which were over 60 minutes.

Table 4 presents the results of logistic regression of factors associated with length of calls being more than 30 minutes. Length of call was more likely to be longer than 30 minutes if mental health issues were discussed during the conversation (vs. if not) (p=0.04); and if grief and loss issues were discussed (vs. if not) (p=0.01). Length of call was less likely to be longer than 30 minutes if communication and related difficulties was discussed during the conversation (vs. if not) (p=0.01). On the other hand, callers' gender, age, frequency of contact and the existence of any other common presenting problems were not shown to significantly influence the length of a call (p>0.05 for each of these).

Table 3: Multiple logistic regression for factors associated with helpline counsellors' satisfactions with the helpfulness of the Chinese Lifeline calls (N=80).

Factors	OR (95% CI)	p-value
Gender		0.27
Female	Ref	
Male	7.55 (0.17,334.01)	
Age group		0.002
14–30 years	Ref	
30+ years	0.04 (0.003, 0.47)	
Frequency of contact		0.02
First/several times	Ref	
Frequent caller	0.08 (0.009, 0.77)	
Mental health issues		0.35
No	Ref	
Yes	0.31 (0.02, 3.97)	
Family/partner relationship issues		0.45
No	Ref	
Yes	0.46 (0.06, 3.40)	
Communication and related difficulties		0.10
No	Ref	
Yes	0.22 (0.03, 1.48)	
Grief and loss		0.16
No	Ref	
Yes	0.24 (0.03, 1.76)	
Physical health concerns		0.004
No	Ref	
Yes	0.03 (0.002, 0.46)	
Practical help/requests		0.06
No	Ref	
Yes	NA	

Discussion

Firstly, the results indicated that Chinese Lifeline is heavily dominated by female clients (90%). This finding is quite similar to the mainstream or English speaking helpline services. For example, in 2008, Lifeline Australia found that 76% of their callers were women,[5] and Coveney et al[6] found that 78% of the callers to a national suicide prevention helpline in UK were female. However, according to the Mental Health and Addiction: Service use 2011/12 data,[7] the overall age-standardised access rates to secondary mental health services was actually higher in males (3851.5 per 100,000 population) than females (3076.2 per 100,000 population) in New Zealand. For the Asian population, the access rate is quite similar between females (938.5 per 100,000

Table 4: Multiple logistic regression for factors associated with length of calls with Chinese Lifeline (N=88).

Factors	OR (95% CI)	p-value
Gender		0.69
Female	Ref	
Male	0.68 (0.11, 4.38)	
Age group		0.62
14–30 years	Ref	
30+ years	1.45 (0.35, 6.01)	
Frequency of contact		0.37
First/several times	Ref	
Frequent caller	0.51 (0.12, 2.25)	
Mental health issues		0.02
No	Ref	
Yes	12.79 (1.02, 160.73)	
Family/partner relationship issues		0.15
No	Ref	
Yes	3.21 (0.64, 16.02)	
Communication and related difficulties		0.007
No	Ref	
Yes	0.19 (0.05, 0.70)	
Grief and loss		0.007
No	Ref	
Yes	6.88 (1.48, 31.98)	
Physical health concerns		0.20
No	Ref	
Yes	0.33 (0.06, 1.89)	
Practical help/requests		0.40
No	Ref	
Yes	1.94 (0.41, 9.24)	

population) and males (969.0 per 100,000 populations). Further, in the most recent Mental Health Annual report, released by the Ministry of Health in 2014,[8] it highlighted that "approximately 3.3 times as many males as females died by suicide in 2011. Of those service users who died by suicide in 2011, 24 percent were female and 76 percent were male."[8] All of the data above suggests a need for males of any ethnic group to receive support from mental health services. However, males appear to be reluctant in approaching primary or community health services, such as counselling helplines, in the early stages of their presenting issues. As a result, these issues, if not dealt with, become more severe until they have to seek help from secondary health services, or in some cases, results in suicide attempts. For community helpline services, such as

Chinese Lifeline, the providers need to consider how to promote the service to males so that appropriate early interventions can be put in place, which is likely to reduce the need for secondary health services further down the track.

Secondly, our study shows that the callers of Chinese Lifeline often have multiple and complex issues with their lives. Mental health and family relationship issues are the top presenting problems and are likely to be present at the same time. Interestingly, compared to English speaking helpline services, Chinese lifeline has a much higher proportion of callers who are married (43.2%), while only 24% for Australia Lifeline.[5] Furthermore, McNeil found that people who are married experienced better mental health than all other marital status groups in Australia for both men and women.[9] However, the present study found that the most common problem with family/partner relationship issues of Chinese callers was, in fact, around extended family and in-laws, and most of these callers were married. This indicated that, compared to Europeans, Chinese people, and perhaps other Asian sub-ethnic groups, often face much more complicated family dynamics. Based on observations from the helpline services, and due to cultural reasons, many Chinese people live with their parents and other extended family members, even after getting married. Therefore, when problems arise within the family, it is often multi-dimensional, involving many people from different generations. As Chan and Parker pointed out, what is very important to the Chinese society is the collective sense of wellbeing, rather than an individual's.[10] Family (including extended and in-laws) is often considered the basic unit within a society. Especially given the service is for those people who would like to receive tele-counselling in Chinese, it is believed that the callers were more likely to be the first generation of immigrants who grew up in China and therefore tended to have more traditional beliefs and values. On the other hand, their children might have grown up in New Zealand and therefore were more embedded with western culture. Thus, it adds more complexity to the family issues of these Chinese families. The mental health service providers need to be fully aware of these cultural differences in order to provide appropriate and responsive cultural support.

Next, although the study showed that the helpline counsellors were satisfied with the calls most of the time, the study provides useful findings that are worth further investigation. The study indicated that the helpline counsellors may be less confident in dealing with callers who are over 30 years, frequent callers or if the presenting problems were related to relationship issues with people other than family/partner or physical health issues. More work should be undertaken in how to manage these cases more effectively. Recently, there have been quite a few research studies looking at regular/frequent callers.[11,12] However, most research focused on exploring the characteristics of frequent callers, rather than finding a solution in managing such callers more effectively.

Finally, the length of a call was more likely to be longer than 30 minutes if mental health issues or grief and loss were discussed. At Lifeline, the service sets the standard of ideal maximum call length to 20 minutes, the red flag length being 30 minutes or longer. This is the standard brief intervention timeframe used across helplines internationally, which increases efficiency and helps focus a call on the presenting issues. While it is important to make sure that the counsellors are able to guide the callers to focus on the present issues, it is also important to be aware that in Chinese cultures, people tend to avoid talking about mental health concerns. This is because the expression of emotions and any deviation from social norms are markers of incorrect social behaviour and could impact negatively on social harmony, hence stigmatised and shunned.[10,13] This meant that Chinese callers may find it difficult to express their true mental health issues in the first instance, but go around circles. Thus, it may be pertinent for the service to consider more flexibility in call length given the complex issues present within the Asian cultural context, especially where risk is present or complex mental health issues are involved.

There were a few limitations to this study. First, the study did not include any measurement of the effectiveness of the service from the callers' perspective because it was not collected as part of the practice. Also, given the service is strictly anonymous, it is not possible to send a survey to the

callers either. Second, some of the calls in the sample might come from the same people, so there might be some clustering effects. However, again due to the nature of the service, it is not possible to identify callers and thus interpretation of the findings should be based on calls rather than callers/individuals. With appropriate ethic approvals obtained, further research could be done to incorporate clients' satisfactions or client's self-ratings of effectiveness by inviting the callers to participate in a research study at the end of calls and also explore better management of the regular callers.

In conclusion, this is one of the first studies in New Zealand, or perhaps internationally, to investigate the client profile, presenting issues and evaluating the service of a Chinese-specific tele-counselling service in a Western country. The service receives calls predominately from female callers (which is very common in similar helpline services), with a wide range of other demographics and with a large variety of presenting issues. The majority of the calls ended with a definite decision made by the callers in solving their problems. Additionally, the helpline counsellors were satisfied with the helpfulness of the calls most of the time. There were several important factors which influenced the counsellors' satisfaction of the calls and the length of the calls. It is believed that the implications of this study should not be unique to Chinese Lifeline and it is generalisable to other similar Chinese-specific helpline services.

Competing interests:
Nil.

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