Singapore Med J 1998; Vol 39(11):488-490

Telephone Counselling in Psychiatry

I Perera, B K L Yeo, S M Ko, E H Kua

ABSTRACT

Aim of study: To study the description of callers using a telephone helpline to improve support to patients in between appointments.

Method: This includes creating a helpline in the department and getting psychiatrists, medical officers, psychologists and social workers trained to man this line during office hours. Information from callers were recorded and analysed using SPSS for MS Windows version 6.0.

Results: The callers were mainly females calling about personal problems, namely psychiatric symptoms and sleep difficulties. Half were given specialist appointments and one-fifth were discharged after telephone counselling.

Conclusions: Telephone counselling is useful in clarifying medical instructions and supporting psychiatric patients in between outpatient appointments.

Keywords: telephone counselling

INTRODUCTION

The use of telephone counselling has been in existence for many years. Although the original purpose was suicide prevention, it has gradually been extended to more general counselling for people with problems[1]. Issues of medical information, advice on illness, advice on medical service availability can be done via the telephone. When patients are seen in an emergency setting, often information is absorbed with great difficulty and this is understandable, considering that these patients and their families are often in a troubled state of mind when they receive such information. As a result, the advice often needs to be repeated and this may not always be possible in the acute emergency or clinic setting due to time constraints. It has been found that patients seen in clinics or casualty departments often need clarification of instructions they have received upon discharge[2].

There is public demand for medical advice over the phone in many countries[3,4]. This pertains not just to psychiatric issues but also other medical issues. For example, a study done in Pittsburg which looked at a crisis line for HIV counselling revealed recurrent themes of ignorance about HIV transmission, prejudice, misunderstandings about hospitals and anxiety about risk[5]. Therefore, the telephone can be used to educate the public about psychiatric illnesses and even dispel myths some people may have. Another use of the telephone line would be the telephone support groups where patients who cannot or choose not to attend support groups can engage with others over the phone. A study done on HIV-infected patients has shown how telephone support groups can improve their self-esteem and self-efficacy[6]. An additional advantage of telephone counselling is that the anonymity of the callers is maintained. The time limited hotline was found to be helpful in dealing with geriatric patients in Atlanta. Although the time spent per call was limited, all callers were referred to senior citizen's centres, meals on wheels programmes and special holiday activities. Volunteers were trained to ask specific questions, to use emergency protocol for suicidal callers and to utilise an interview format to identify problems[7]. The time limited hotline is useful as it can disseminate information with the minimum use of resources[8]. However, health service workers tend to regard phone calls as intrusive. For patients and staff alike, the very mention of a hotline conjures up images of unhelpful receptionists and impolite operators who interrupt the daily ward routine. Use of the phone also brings to mind being kept on hold for precious minutes or getting your line transferred many times. Despite these problems, the use of the telephone hotline is invaluable. This paper describes the experiences and results when a counselling hotline was created.

METHODS

A telephone counselling helpline was set up by the Department of Psychological Medicine, National University Hospital in 1994. This line is being manned by psychiatrists, medical officers, psychologists and social workers. The line is called a helpline because it functions from 9am – 5pm. Training was given to the medical staff. They were taught skills of talking to distressed, suicidal callers; how to empathise with callers, simple techniques of advising distressed callers and how to conclude a telephone conversation. Details of the callers are presented here. The information gathered from the consecutive callers included the caller's sex, presenting problem, the presumptive diagnosis of problems and disposal. The data collected was analysed using the SPSS for MS Windows Release 6.0.

Department of Psychological Medicine
National University Hospital
5 Lower Kent Ridge Road
Singapore 119074

I Perera, MBBS, M Med (Psych)
Registrar

B K L Yeo, MBBS, M Med (Psych)
Senior Lecturer

S M Ko, MBBS, M Med (Psych), FAMS
Senior Lecturer

E H Kua, MBBS, MD, FRCPsych
Head

Correspondence to:
Dr I Perera

Table I – Problems of stressline callers

Problem	Number	Percentage%
Psychiatric symptoms	36	16.9
Insomnia	34	16.5
General enquiries	33	16.5
Aggression/agitation	24	11.4
Miscellaneous	19	8.9
Interpersonal problems	17	8.1
Side-effect of drugs	17	8.0
Work-related problems	16	7.5
School-related problems	8	3.7
Sexual problems	7	2.8
Suicide	5	1.9
Total	212	100

RESULTS

The majority of callers were females (62.6%). Almost half the callers called about personal problems, while about 40% called about family members and 10% for others. The problems comprised mainly psychiatric symptoms of psychosis, anxiety and depression. School-related problems comprised about 3% of the calls. Insomnia was a fairly common reason for calling (16%) while simple enquiries took up 16% of the calls. Calls regarding suicide constituted 1.9% of the total number of calls (Table I).

About one-fifth (19.2%) were counselled and discharged. However, slightly more than half (54.2%) of the problems posed were more serious, involving psychiatric symptomatology which required follow-up visits. It must be borne in mind that the callers knew that the counselling centre was based in a psychiatric clinic in a general hospital. However, only 7% of the callers presented problems which warranted an emergency psychiatric consultation. Another 20% were referred to other agencies. More women called regarding interpersonal problems, suicide, insomnia, medication, aggression and agitation. The last two problems concerned their family members. More men called regarding work and sexual problems. The differences in numbers between the sexes were analysed using chi-squared test and none was significant.

DISCUSSION

The majority of the calls were related to psychiatric disorders which implies that by and large, the target population was reached. The rather high percentage of callers with physical problems points to a demand for hotlines targeted at medical problems. These problems when scrutinised, revealed that a sizeable number of callers enquired about psychiatric symptoms. This can be explained by the fact that this is a psychiatric helpline located in a general hospital.

Suicidal callers comprised 1.9% of the total number of callers. Using the suicide rate at 13 per 10^5, this figure is nineteen times the suicide rate in Singapore, but this is not surprising as the callers constituted a preselected population group with mainly psychiatric problems.

Most of the type of counselling offered focussed on crisis intervention[9] with the goal of assisting the patient in achieving a level of adaptation at least equal to that of their normal level of functioning. The method employed usually focussed on elements of problem-solving approaches[10] namely identifying the problem, thinking of alternate solutions, rehearsing each alternate solution and choosing one of the solutions.

The preponderance of females is not unusual as some studies of telephone hotlines yielded similar findings[11]. A study of a team crisis line reported that 68% of the callers were female[12] which compares favourably with the figure of 62% in this study. Some of the possible reasons for this are that utilising a helpline is easier than making a medical appointment for a busy housewife and mother. Also, increasingly more women have to juggle many roles as homemaker, wife, mother, career woman and carers of their physically or mentally ill family members.

In this age of cost effective health care, a telephone service that uses an interactive telephone system programme is of great use. Programmes using natural sounding digitised voices and touch tone recognition of caller's responses have been employed on a 24-hour basis. Subjects have found such programs useful especially if it is later followed up by a personalised call with homework assignments[13].

Another option to utilise manpower would be to use a main switchboard system whereby experienced operators redirect calls to appropriate staff including administrative staff if the call is on general enquiry matters eg. hospital cost, medisave, specialist referrals and appointments. This option is particularly relevant as 16.5% of the calls received were enquiries on medical services available. Another option is the multi-tier system where there are first line individuals who can pass complex calls to more specialised staff if required[14]. Frequent callers foster feelings of inadequacy in staff. This problem was encountered occasionally. Perhaps adjunctive correspondence to such patients would help by reducing burnout in staff and providing extra support to such patients[15]. Comprehensive training for telephone volunteers is essential for reducing the attrition rate. A well developed crisis centre devoted to suicide prevention can have a positive impact on the suicide rate within specific age groups. Certain health promotion modules have been found to be effective in training volunteers, reducing burnout and decreasing the suicide rate in some age groups[16].

The telephone helpline is useful in clarifying discharge instructions to patients and their relatives. It can be used to inform and educate patients on the adverse effects of medications and clarifying dosing schedules. All of these measures can increase patient compliance. In addition, the helpline is a cost effective method of providing support to patients in-between appointments. There is no consensus on whether

telephone counselling is efficacious. A review of telephone counselling services in New Zealand revealed that there is no convincing evidence that these services reduce the incidence of psychological disorder. However, these services help support patients with chronic disease or disability[17]. Another study in New Zealand was more optimistic. This study compared the perceptions of counsellors and callers by recontacting callers shortly after their initial call for help. The results indicated that the counsellors correctly identified 1 of the caller's 2 strongest feelings and 68% of the callers gave good ratings on helpfulness of the calls[18].

There are some limitations in using the telephone as a means of counselling patients. For instance, one phone interview is usually not sufficient to make a psychiatric diagnosis (if any). The reason for this is that other forms of assessment like observing appearance, behaviour and body language cannot be done. The telephone may not be sufficient for routine follow-up since the full psychiatric assessment cannot be done and this can lead to possible medico-legal problems. The people manning the helpline have different ethical and legal responsibilities to the callers as they are from different professions. For example, a social worker may counsel a patient but may not be able to make a psychiatric diagnosis which a psychiatrist would be better able to do.

REFERENCES

1. Hribersek E, Van de Voorde, Poppe H and Casselma J. Influence of the day of the week and the weather on people using a telephone support system. Br J Psych 1987; 150:189-92.
2. Jones J, Clark W, Bradford J, Dougherty J. Efficacy of a telephone follow-up system in the emergency department. J Emerg Med 1988; 6:249-54.
3. Eglestan CV, Kelly HC, Cope AR. Use of a telephone advice line in an accident and emergency department. Br J Psych 1994; 308:31.
4. Markland B, Bengtsson C, Blomkvist S, Furunes B, Cracke Herbst R, Silfverhielm B. Evaluation of the telephone advisory activity at Swedish Primary Health Care Centres. Fam Pract 1990; 7:184-9.
5. Polinko Paul, Bradley William, Molyneaux Bruce, Lukoff Carol et al. HIV in health care workers. Managing fear through a telephone information line. Social-work; 1995 Nov Vol 40 (6) 879-882.
6. Rounds K, Galinsky M, Despard MR. Evaluations of telephone support groups for persons with HIV disease. Special Issue: A festschrift in honour of Edwin J Thomas. Research on Social Work Practice; 1995 Oct Vol 5 (4) 442-59.
7. Loring, Marti T, Smith, Roger W, Thomas K. Utilization of a time limited holiday hotline by older adults. Gerontologist; 1994 Aug Vol 34 (4) 557-60.
8. Loring MT, Wimberley ET. The time limited hot line. Soc Work, 1993 May; 38(3):344-6.
9. Caplan G (1961). An approach to community mental health.
10. Goldfried MR, Goldfried AP (1975). Cognitive Change Methods in Helping People Change (ed FH Kagner and AP Goldstein) Pergamon Press, London.
11. Marcus AL, Woodworth MA, Strickland CJ. The cancer information service as a laboratory for research: the first 15 years. Monogr - Natl - Cancer - Inst. 1993; 14:67-79.
12. Boehn K, Chessare JB, Valko TP, Sager MS. Teen Line: A descriptive of a peer telephone listening service. Adolescence; 1991; Vol 26 (103):643-8.
13. Schneider SJ, Schwartz MD, Fast J. Computerised, telephone based stress management programme. Proc - Annu - Symp - Comput - Appl - Med - Care. 1993; 37-40.
14. Stark C, Christie P, Marr AC. How to do it: Run an emergency helpline. British Medical Journal 1994; 309:44-5.
15. Brunet AF, Lemay L, Belliveau G. Correspondence as adjunct to crisisline intervention in a suicide prevention centre. Crisis, 1994; 15(2):65-8, 76.
16. Frankish CJ. Crisis centres and their role i treatment. suicide prevention versus health promotion. Special Issue; Suicide assessment and intervention. Death-studies 1994; 18(4):327-9.
17. Hornblow AR. Does telephone counselling have preventive value? Aust N Z J Psychiatry 1986; 20(1):23-8.
18. Hornblow AR, Sloane HR. Evaluating the effectiveness of a telephone counselling service. Br J Psychiatry 1980; 137:377-8.