Auckland Manukau North Shore Waitakere

Evidence of the Effectiveness of Telephone Counselling Services

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YOUTHLINE
gsk GlaxoSmithKline

Contents

Introduction

In order to fully evaluate the effectiveness of Youthline it is necessary to consider the service as a whole – not as a phone counselling service only. It is important to note that the phone service is not a stand-alone intervention, but the 'front door' to a range of community and youth development initiatives and specialist youth services. The phone service is a youth-centred, accessible 'first point of contact' for young people, providing immediate support, information and referrals.

Youthline crosses many sectors and has a multiple range of initiatives that reflect current government strategies. These strategies have been determined through extensive community consultation and research. They include:

- Youth Development Strategy Aotearoa – Ministry of Youth Affairs
- Youth Suicide Prevention Strategy – Ministry of Youth Affairs
- Youth Health Action Plan – Ministry of Health
- Statement of Government Intentions for an Improved Community–Government Relationship – Office for the Community & Voluntary Sector
- New Directions – Child, Youth and Family
- Agenda for Children – Ministry of Social Development.

A multi-agency approach to implementing Youthline's 24/7 project would meet many of the objectives and goals outlined in the above strategies. This approach requires the support of the Ministry of Youth Affairs and the Ministry of Health.

It is valid to question the effectiveness of a phone counselling service in reducing suicide, however. As noted earlier, it is important that the wider Youthline service is considered when evaluating effectiveness. Quantification of the effectiveness of phone-based counselling is made difficult by the particular nature of these services, which are typically user-driven, confidential, limited in their coverage of time/regionality, and lacking funds for post-service research and assessment.

However, a recent report on the impact of phone counselling services on youth suicide, funded as part of the Australian National Youth Suicide Prevention Strategy, found:

> Telephone counselling services have a part to play, alongside other services, in enhancing identification and engagement of young people at risk, directing them to appropriate services, helping them through suicidal crises, and enhancing the continuity of care provided to individuals at risk. (Mitchell, 2000, p. 14)

In 2003 a report by The University of Queensland (King, Nurcombe, Bickman, Hides & Reid) evaluating the effectiveness of telephone counselling for suicide prevention also gave clear support for further development of hotline services. It found that significant decreases in suicidality and improvement in mental state occur during counselling sessions, suggesting a positive immediate impact. The authors of the report found that the results warranted continuing community support for hotline types of counselling services, in particular those targeting young people.

The following sections review the evidence supporting the Australian studies quoted above, along with other data on the effectiveness of youth-targeted telephone

counselling within wider community support systems and phone counselling services in general.

Evidence of demand for phone counselling services

At the simplest level, analysis of call data for Youthline readily identifies the demand, and implicitly the need, for the service, with some 232,000 calls made, of which Youthline counsellors were able to service only 20,000. Though a proportion of the total calls would have been accounted for by young people who eventually got through, the difference remains significant, and represents a need among youth for greater accessibility. This need has been reflected in Youthline's innovation of 24/7 response systems and new web-based and texting channels.

Data also indicates that ease of access to phone counselling may help overcome limitation in other channels, which may not deliver appropriate services and interventions. A critical review of the evidence by the Christchurch School of Medicine (Hider, 1998) states that '[a]pproximately four times more young people will attempt suicide but never receive medical care' (p. 16), and adds:

> More than 80% of the members of a bipolar consumer organisation all of whom had experienced the onset of their disease before 20 years of age, reported that they had waited for over a year before they had sought help and when they did contact a doctor, in over 75% of cases their condition was initially incorrectly diagnosed. (Lish et al., cited in Hider, 1998, p. 43)

Other assessments of the role of phone counselling

Throughout the 'developed' world telephone 'helplines' are part of the overall service mix to young people, and are supported by governments, professionals and the public.

In the UNICEF publication *Implementation Handbook for the Convention on the Rights of the Child* (Hodgkin & Newell, 1998), there is a child protection checklist, against which states can consider the adequacy of their child protection measures. The checklist identifies the need for states to establish and support confidential helplines providing advice and counselling for child victims of violence, abuse or neglect.

The Daphne Project grant programme, which funded this study, has signalled that the European Union considers children's access to independent, confidential help to be a central plank in the struggle to prevent the abuse of children. In Sweden, the Minister for Children recently explicitly exempted helplines from their new mandatory reporting framework for child abuse, arguing that children must have a confidential space.

The role of phone services is also discussed in a report of the United Kingdom's National Commission of Inquiry into the Prevention of Child Abuse (1996), which asserts that the most effective and important ways to prevent abuse are:

- listening to children
- accepting that children are the experts in their own lives
- encouraging and supporting children
- helping young people to notify a safe adult if they are experiencing abuse.

In 2001–2002 a study was conducted of subjects with obsessive compulsive disorder in the Manchester region of England (Lovell et al., 2006). The study compared the effectiveness of cognitive behaviour therapy delivered by telephone with face-to face therapy, and found the clinical outcome and levels of satisfaction to be equivalent. Importantly, the telephone sessions were found to take around 40% less of the therapist's time – an outcome with serious economic implications given the pressure on health services and funding. Another study by den Boer et al. (2005) found that there was a significant positive effect gained through the use of phone 'paraprofessionals', when compared with no treatment, when dealing with anxiety and depressive disorders. The authors also identified the need for further development and evaluation of programmes in this area, given the pressure on the 'established' mental health care system.

A United States study of the effectiveness of telephone hotlines in dealing with the callers' suicide state found a significant reduction in suicide status from the beginning to the end of the call (Gould, Kalafat, Harris Munfakh & Kleinman, 2007, p. 345). It also found a continuing decrease in callers' feelings of hopelessness and psychological pain when follow-up calls were made in the weeks following the initial contact, although a statistically significant number of callers continued to express suicidal ideation in the weeks following their initial call (p. 349). This led the researchers to recommend that telephone crisis services develop improved follow-up strategies and make more referrals to mental health services (p. 350).

Analysis of the 1-800 SUICIDE telephone network in the United States (Mishara et al., 2007a, pp. 303–304) identified a number of variables considered necessary for successful helpline intervention:

- supportive approach and good contact (moral support, offering to call back, reframing, talking about own experience)
- collaborative problem solving (questions on problem and resources, suggestions of ways to solve problem, questions about precipitating events, proposing no-harm contract, suggested plan for action, referrals)
- active listening (reformulation, reflection on feelings, questions about emotions, empowerment towards resources and plan of action)
- avoidance of negative style (things not to do, such as telling caller what to do, reading information, challenging, making value judgments).

The researchers (Mishara et al., 2007a; 2007b) identified a need for greater quality control of telephone helpline services to reinforce these variables, including the use of call monitoring for quality assurance, developing model training programmes, and the application of standards of good practice.

Evidence of impact of broader issues and need for community involvement

The Christchurch School of Medicine report mentioned earlier (Hider ,1998) also details the broader range of environmental factors that can be associated with suicide behaviour among young people, and these correlate with the typical areas of concern that lead young people to use phone counselling services. These factors include recent

loss, the end of a romantic relationship, interpersonal conflict, disciplinary procedures and general stress.

This need to consider multiple factors is consistent with Youthline's approach to phone counselling, which includes a range of intended outcomes rather than a single focus such as youth suicide prevention, and which involves the community in an integral way.

Dr Annette Beautrais comments in her review of the New Zealand Suicide Prevention Strategy (1998, p. 10) that '[e]ffective policies in the area of youth suicide prevention therefore need to focus upon the prevention, treatment, and management of psychiatric disorder in young people', and recommends programmes that promote a more holistic approach to positive mental health in young people. The report adds (p. 25) that 'the most effective approach to addressing suicide is to move away from models of suicide prevention and towards an approach which embraces youth mental health in a wider context'.

Importance of youth 'ownership' of the service

In the review of the evidence by Dr Annette Beautrais (1998), the importance of mental health services that are appropriate for young people is specifically highlighted: 'To be effective, youth health services need to be seen as being approachable, attractive and non-stigmatising' (p. 13).

Youthline is specifically intended to be an accessible and youth-appropriate conduit for young people needing emotional or mental health support. There is a body of evidence that youth must have an agency they identify as their own, which can bridge the gaps between young people and the help that state agencies can provide.

Youthline has identified that the specialism of services, be they driven by professions, government structures or issues, all contribute to the inaccessibility of services to young people in New Zealand. This finding has been supported in surveys conducted by Youthline and by Crown Public Health: young people will not on their own violation make contact with either the Child, Youth and Family agency or a mental health centre.

In the studies of Australia's Lifeline and Kids Help Line services (Rolfe & Turley, 1999; King et al., 2003) funded as part of National Youth Suicide Prevention Strategy, the project evaluators highlight the barriers to youth accessing the service due to the service being aimed at all ages: 'these findings need to be understood in the context of young people's frequent preference for peer rather than adult help'.

The telephone channel also fits well with youth culture and behaviour. Youthline and Crown Public Health surveys have shown that young people place a high value on the use of the telephone as a way of accessing help. Youthline has also been clearly identified as the one agency that many young people view as an avenue of support.

Evaluation of phone counselling services – the Australian experience

The Lifeline and Kids Help Line service studies referred to above (Rolfe & Turley, 1999; King et al., 2003) included measurement of outcomes for young people to evaluate the effectiveness of crisis interventions.

The Lifeline 3-month follow-up study used structured questionnaires over the phone. There was a drop-off in participation over time, and the method was limited by concerns about confidentiality and the appropriateness of inviting particular callers to participate. However, a total of 76 callers were eventually followed up at approximately 1 week, 5 weeks, and 12 weeks after the index call. Thirty young people completed all three follow-up interviews.

The Lifeline follow-up found that around 84% rated the service as either helpful or very helpful and satisfaction levels were sustained over the 3-month follow-up period.

However, critical comments included concern about the long delays sometimes experienced in getting through to Lifeline, which has also been an issue for Youthline in New Zealand.

The phone service was also effective in prompting action among callers in response to the advice given. The majority of respondents followed through with one or more of the referral options provided to them by the telephone counsellor, with the proportion that did so increasing over the course of the follow-up from two-thirds at week 1 to 90% at week 12. Ninety-three per cent of those who took action found the actions taken to be helpful.

A sizeable minority of respondents reported that the problem they had called about had either been resolved or shown improvement, increasing from 38% at week 1 to 46% by week 12. However, the problem had worsened for 21% of respondents by week 12 – indicating that situations are not always easily controlled and confirming the need for ongoing support and follow-up. In terms of suicidal ideation, at the initial call 88% of participants had current thoughts of suicide or self-harm. At the week 1 follow-up 60% of respondents reported still experiencing thoughts of suicide, and this did not decrease further over the 3-month follow-up period. Lifeline project staff and evaluators interpret this result as highlighting the importance of providing systematic follow-up in the form of professional help to individuals who contact telephone counselling services with a suicidal crisis.

Other mental health-related problems, as well as difficulties with psychiatric services, were prevalent as a current crisis or background issue. It is also notable that less than 40% of persons of 'concern' were thought to be accessing support. Many of those who were accessing support were likely to be receiving it from family or friends.

The study of the Kids Help Line service (aimed at children aged 5–18 years) focused on assessing staff development and training needs as a way to improve outcomes for callers. The analysis of call data also showed that the vast majority of callers using the service have issues peripheral – but nevertheless related – to mental health, including relationship, family, school, employment and financial issues, as well as substance use and self-concept issues.

Web counselling and telecounselling in Australia

In 2003 the Australian Government released the report of the independent national review of telecounselling and web counselling services.

In Australia, telecounselling is a large, diverse industry provided by 131 not-for-profit organisations and an unknown number of commercial organisations or individuals. The largest provider, Lifeline, consists of a federation of 42 centres, employing 5000 volunteers and providing 24-hour service 7 days a week. Web counselling (synchronous and asynchronous communication online or through email between a counsellor and a user) is a smaller, newer industry, with 17 not-for-profit agencies providing services that are mostly directed at youth.

Two key points emerged from the review. First, many Australians use telecounselling services, with two of the largest service providers answering a combined total of about 850,000 telephone calls annually.

A second finding was that mainstream healthcare professionals, including general practitioners, refer patients to web and telecounselling services, although these services are not a formal part of the healthcare system. More than 20% of web and telecounselling agencies estimated that at least half of their case load derived from referrals by healthcare providers.

For Lifeline, less than 25% of callers were first-time callers, and across all of the agencies that were surveyed nearly 40% of callers had called 20 times or more. Some of the many advantages identified by the review are the potential for geographical reach (particularly for rural users), accessibility, responsiveness, the provider's attention to evidence-based care and the provider's duty of care.

Before the web and telecounselling review, no one knew the extent, quality or standards of delivery of these services, or even who used them. We now know that these services are used frequently, both by the community and by healthcare agencies, and that they play a major role in managing vulnerable individuals with mental health problems.

Previously, telecounselling may have been seen as non-core – a poor cousin to mental health services. However, given the development of communication technology, consumer empowerment, and the infrastructure, workforce, and capacity in the web and telecounselling sector, it is now accepted that it plays a central role in delivering flexible, evidence-based, cost-effective help to the community.

Evidence of immediate positive impacts of phone counselling on suicidality and mental health

Notwithstanding the difficulties of studying outcomes given the confidential nature of helpline services, King et.al. (2003) identified direct mental health benefits and reduced suicidal ideation through the delivery of phone counselling sessions.

Their study of calls to the 24-hour Kids Help Line in Australia was funded by the Commonwealth Department of Health and Aged Care.

The team of researchers from The University of Queensland Department of Psychiatry and School of Mental Health undertook a naturalistic, uncontrolled evaluation of the short-term impact of counselling, using independent raters to measure callers' suicidality and mental state at the beginning and end of 100 taped counselling sessions.

Changes in suicidality and mental state were measured using a reliable rating scale specifically developed for the study and designed to give acceptable inter-rater reliability, adequate internal consistency, face validity, and sensitivity to change in suicidality. The study tested the significance of their data and showed there was a highly significant difference between suicide urgency scores from the beginning to the end of the call.

The researchers found that there was a substantial decrease in the proportion of cases rated as imminent risk by both raters from the beginning (47.5%) to the end (7%) of the call, and a substantial increase in the proportion of callers rated as no suicide urgency risk from the beginning (2%) to the end of the call (58.5%).

The researchers acknowledge the methodological limitations of the study, including the inability to follow up on participants. They also signal the possibility that callers were at the peak of crisis when making the call, so that their decision to call rather than to act on suicidal thoughts may have been an indicator of impending remission.

It was also noted that a substantial minority of callers (14%) remained suicidal at the end of the call. Policy allowing intervention that could breach confidentiality in emergency situations was in place. Callers are encouraged to contact the helpline again and Kids Help Line data suggests that 72% of all callers coded as presenting suicidal problems do in fact call back. In this study three-way referrals were initiated on 14 occasions.

Nevertheless, the results indicate that telephone counselling had a substantial and immediate impact on the suicidality of young people and provide empirical support for continuing community backing of such services, specifically those targeting young people.

Community participation to improve outcomes

All major reports on health promotion in the past two decades, including the Alma Ata Health for All by the Year 2000 Declaration, the Ottawa Charter for Health Promotion and the Jakarta Declaration have emphasised the importance of community participation to successful health promotion ventures (Baum et al., 2000). The Youth Suicide Prevention Strategy and Youth Development Strategy Aotearoa, administered by the Ministry of Youth Affairs, both list aims that are clearly activated in Youthline's model of service delivery, with community development processes at its core.

Core elements identified for a successful community development and youth development strategy include:

- promoting active participation of people in the community
- engaging the community to solve community issues and problems
- helping the community to understand society's impact on young people

- actively working to increase leadership capabilities of community members
- addressing and taking into account the needs of young people in our community
- strengthening links with other community agencies working with youth.

The following sections discuss evidence supporting the importance of community-based engagement in maximising the effectiveness of Youthline and phone counselling services generally.

Promoting active participation of people in the community

Studies have shown that when voluntary participation rates in communities increase, so too do levels of confidence and personal effectiveness (McClenaghan, 2000; Chinman & Wandersman, 1999). Furthermore, 'increasing levels of participation will reduce social exclusion and is likely to improve the overall quality of community life' (Baum et al., 2000, p. 414).

Youthline's approach to volunteer participation supports this community involvement in the services that Youthline offers, benefiting the volunteer and the community as well.

Engaging the community to solve community issues and problems

Engaging the community to solve community issues parallels the world view of many cultures, including Maori, where family/community are central to a person's identity. Therefore, this wider approach of involving the community needs to be followed.

It has been recognised in government policy that many of the issues that young people face need to be acknowledged and addressed at a community level. This means taking collective responsibility, rather than individuals struggling in isolation:

> It has been suggested that only interventions which are built upon notions of collective responsibility and emphasise the need for families and communities to work together are likely to be successful. (Aboriginal Corrections Policy Unit, cited in Singh & White, 2000, p. 55)

Helping the community to understand society's impact on young people

One of the major visions of the New Zealand government identified in the *Agenda for Children: Mahere Rautaki ma te Hunga Tamariki* discussion paper (Ministry of Social Development, 2001) is to change the way that children are viewed and establish their place in New Zealand society as respected citizens with valuable contributions to make. This is further expanded in the discussion document *Supporting the Positive Development of Young People in New Zealand* (Ministry of Youth Affairs, 2001), where one of the goals is to 'equip adults to better understand and effectively support young people' (p. 18). Youthline is an agency where young people are the focus and are central and valued. By involving the community the organisation plays a role in developing this vision and knowledge.

Working to increase capabilities of community members

Youthline volunteers gain more than just community acceptance and social inclusion – they also learn valuable transferable skills. Throughout their training, volunteers become confident and empowered and are trained to take on leadership roles. A principal reason for volunteers joining an organisation is to get valuable training and work experience, which can help in obtaining paid employment.

Addressing and taking into account the needs of young people in our community

The importance of young people having a sense of 'ownership' of youth services designed for them has already been discussed above. The involvement of young people in defining their community needs is important to ensure that the right mix of services is offered and this is integral to the approach taken by Youthline.

New Zealand's latest suicide prevention strategy encourages the participation of young people in all aspects of community life in its fourth principle, so that 'if young people can actively participate in their communities, they are more likely to have a sense of self-worth and purpose in life, and take responsibility for their actions' (Ministry of Youth Affairs, Ministry of Health & Te Puni Kokiri, 1998, p. 14).

Strengthening links with other community agencies working with young people

The role of phone counselling as a conduit to other help services underpins the need for strong links to the range of services available to help young people. 'Effective and comprehensive crisis work in a community includes establishing clear working agreements and referral procedures with all involved agencies' (Hoff & Adamowski, 1998, p. 170).

Youthline believes it is essential for youth and family-focused services to have strong community networks. It is proactive in developing the New Zealand Adolescent Association Network, and this philosophy is also reflected in Youthline's networking policy and procedures documentation. In many programmes, work is carried out in partnership with other groups in order to ensure that there is a collaborative model to help young people on the edge of our community. Cooperating and working in collaboration with other services is integral, and supports the New Zealand Public Health Strategy.

Other barriers to assessing phone counselling outcomes

In their evaluation of phone counselling services in Australia, Rolfe and Turley (1999) state that despite goodwill and good support for projects to assess outcomes of phone counselling, local centres were found to experience difficulties in stretching limited resources to cover both service delivery and evaluation requirements. They add:

> Perhaps the most important cultural barrier to evaluation within telephone counselling services derives from the long standing commitment of such services to the principle of complete confidentiality and anonymity for callers. Asking callers for information that is required to conduct follow-up, such as contact phone numbers is seen as directly contradictory to this principle.

The dynamic relationship between provider and user is unique to health-related services and could be discussed as an appropriate developmental response for young people. However, it means that the tools of research, categorising, counting and comparing are more difficult to employ. Notwithstanding existing data showing the unmet demand from youth for accessible phone counselling, the implementation of the proposed technology solution for Youthline will allow for further research and ongoing assessment to add to the body of evidence reviewed here.

Effects of different telephone intervention styles

In 1997, Mishara and Daigle published the findings of their study comparing different telephone intervention styles at two suicide prevention centres. To determine the relative effectiveness of telephone intervention styles with suicidal callers, researchers listened unobtrusively to 617 calls from suicidal persons at the two suicide prevention centres and categorised all 66,953 responses by the 110 volunteer helpers according to a reliable 20-category checklist, the *Helper's Response List*. This lists 20 possible techniques (verbal responses) that could be used in a telephone intervention with a suicidal caller.

Outcome measures showed observer evaluations of decreased depressive mood from the beginning to the end in 14% of calls, decreased suicidal urgency ratings from the beginning to the end in 27% of calls, and reaching a contract in 68% of calls, of which 54% of contracts were upheld according to follow-up data.

Within the context of relatively directive interventions, a greater proportion of 'Rogerian' non-directive responses were related to significant decreases in depression. Reduction in urgency and reaching a contract were related to greater use of Rogerian response categories only with non-chronic callers.

Only three out of the 617 calls were rated as increasing depression and only three individuals were known to have attempted suicide following their contact with the centre. It was concluded that the telephone interventions were helpful, particularly through initiating a process of resolving the caller's problems, and that the telephone interventions showed very few negative effects.

Recommendations for telephone counselling

In an article in the *Journal of Genetic Counselling*, Ormond et al. (2000) held that telephone counselling can provide a convenient, accessible and valuable source of information to the general public, healthcare providers and other professionals. Genetic counsellors routinely utilise the telephone in a number of different counselling encounters and results from this report are relevant to the Youthline service delivery.

The report found that telephone counselling provides a clinical service to the public and professionals that is convenient, accessible and educational, and which maximises the availability of resources.

It went on to say that telephone counselling can be seen as an adaptation of the skills required in a more traditional face-to-face consultation. While there are broad differences between counselling in the office and counselling on the telephone, telephone counselling brings both advantages and disadvantages to the counselling encounter. A major advantage of telephone counselling is its convenience for the caller. The telephone allows access to a wider section of the public who would not, for geographic or socioeconomic reasons, otherwise have access to counselling services. Moreover, the immediacy of the communication, whether needed or not, is usually identified by the caller as a benefit.

All communication methods use a combination of verbal, vocal and visual cues and involve variations in the number of communicators, their physical proximity, and the

immediacy of feedback. Because telephone counselling involves physical separation, one cannot rely on the physical and emotional cues (such as body language and facial expressions) that would normally be available in a 'face-to-face' counselling session. This loss of visual cues intensifies reliance on verbal and vocal cues and, as a result, counsellors must rely more on their listening and communications skills, including attention to specific wording and intonations.

Another major difference between the two scenarios is that clients may maintain more control throughout certain aspects of the telephone encounter. This is true in the timing of the call, the amount of noise and distractions, the pace of counselling, clients' agendas, and the amount of information they provide, including their name.

The report concludes that telephone counselling does provide a convenient, accessible and valuable source of reliable, accurate information for the general public and healthcare professionals. In spite of the differences from face-to-face counselling encounters, telephone counselling relies on the same knowledge base and counselling skills that the counsellor brings to any clinical setting. If the counsellor is able to establish rapport with the telephone client and accurately assess the client's problems and needs, he or she can offer reliable information and appropriate interventions to the client.

Evidence from two recent New Zealand surveys

18tracker survey 2003

In November 2003 an online survey was conducted by the youth marketing consultancy 18 to establish a snapshot of opinion reflecting young New Zealanders aged 15–29 as part of an ongoing youth insights research project.

Using an interactive website with an extensive database of young New Zealanders, the 18tracker.com survey sought opinions on a range of social and market-related issues. In all, 387 surveys were completed.

Youthline was the youth support service most known by the young people surveyed (97%) and over half the young people surveyed knew of the Youthline website.

When asked what types of services provide best support for young people, almost 70% preferred telephone helplines, followed by face-to-face counselling (61%).

The biggest barrier to respondents seeking help for a problem was embarrassment (72%), followed by confidentiality (almost 50%). This is most probably why telephone helplines were the preferred support, since both of these barriers are broken down by their use.

Youthline national schools survey 2005

In February 2005, 25 national schools were surveyed to evaluate whether Youthline's services are meeting the needs of today's young people and whether it is reaching its target audience.

A questionnaire consisting of eight questions was developed, each with a variety of answers to choose from. Twenty-five questionnaires were sent to the participating schools' guidance counsellor, requesting that they be completed by Year 11 (fifth form) students (aged 14–16 years old).

Nineteen schools responded (76% response rate), 13 of which were city schools and six of which were rural schools. Six were single-sex schools (three boys/three girls). In total, 447 students were surveyed.

Youthline was the youth support service most known by the young people surveyed (over three-quarters) and almost half the young people surveyed knew of the Youthline website.

When asked what types of services provide the best support for young people, telephone helplines were the preferred support for over half the young people surveyed, followed by face-to-face counselling.

Feelings of embarrassment might stop almost two-thirds of the young people surveyed from seeking help or advice and one-third were worried about confidentiality. As with the 18tracker survey, this underlines the importance of both these barriers being broken down through the use of telephone helplines.

Conclusion

Without a doubt, the evidence shows that telephone counselling provides a convenient, accessible and valuable source of support for the general public. Telephone counselling relies on the same knowledge base and counselling skills that the counsellor brings to any clinical setting. If the counsellor is able to establish rapport with the telephone client and accurately assess the client's problems and needs, he or she can offer the reliable information and appropriate interventions to meet the client's needs.

While in the past telecounselling may have been seen as a poor cousin to mental health services, given the development of communication technology, consumer empowerment, and the infrastructure, workforce, and capacity in the web and telecounselling sector, it is now seen as playing a critical role in delivering flexible, evidence-based, cost-effective help to the community.

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