

PSYCHO-SOCIAL SUPPORT HELPLINES CALLS DURING THE FIRST YEAR OF THE COVID-19 PANDEMIC IN TURKEY TÜRKİYE'DEKİ COVID-19 PANDEMİSİNİN İLK YILINDA PSİKO- SOSYAL DESTEK HATLARI ÇAĞRILARI

Abstract

The necessary measures taken to limit the effects of the COVID-19 pandemic have had an unfortunate negative effect on the mental well-being of people across the world. The pandemic affected the service delivery of mental health services in Turkey. Unlike many countries, that made use of digital health services and of telephone helplines to respond to increased need for information and support, Turkey had no prior experience with national mental health helplines. It established a national-wide helpline in a short time and responded to calls for information and support. This study looks at the helpline establishment, support given, reasons for calls and referrals, for a period of 12 months. Top reasons for calls included COVID-19 infection or loss of relative, anxiety and need for information. The helplines were essential at the beginning of the pandemic to respond to the need for information and support.

Keywords Psycho-social support helplines, COVID-19 pandemic, Mental health, Psychiatric disorder

Özet

COVID-19 salgınının etkilerini sınırlamak için alınan gerekli önlemler, dünya genelinde insanların ruh sağlığı üzerinde olumsuz etkiler oluşturmuştur. Pandemi, Türkiye'de ruh sağlığı hizmetlerinin hizmet sunumunu etkilemiştir. Artan bilgi ve destek ihtiyacına yanıt vermek için dijital sağlık hizmetlerinden ve telefon yardım hatlarından yararlanan birçok ülkenin aksine, Türkiye'nin daha önce ulusal ruh sağlığı yardım hatları deneyimi bulunmamaktaydı. Türkiye'de kısa sürede ülke çapında bir yardım hattı kurularak bilgi ve destek çağrılarına cevap verilmiştir. Bu çalışmada, 12 aylık bir süre boyunca yardım hattının kurulması, verilen

Esra ALATAŞ¹,

Akfer KARAOĞLAN KAHILOGULLARI²,

Fatmagül ERTUGRUL³,

Altın MALAJ⁴,

Şebnem AVSAR KURNAZ⁵,

CORRESPONDENCE

1 Department of Mental Health, Ministry of Health,

Ankara, Turkey ORCID: 0000-0002-9629-7309

2 Department of Psychiatry, Health Sciences University

Ankara Diskapı YBEAH Training and Research Hospital,

Ankara, Turkey ORCID: 0000-0003-2247-9609

3 Department of Mental Health, Ministry of Health,

Ankara, Turkey ORCID: 0000-0003-1942-0411

4 WHO Country Office for Turkey, Ankara, Turkey ORCID:

0000-0002-5112-5183

5 WHO Country Office for Turkey, Ankara, Turkey ORCID:

0000-0002-4812-8420

6Corresponding Author, sebnem.avsar@gmail.com

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destek, arama ve yönlendirme nedenleri incelenmiştir. Çağruların en önemli nedenleri arasında COVID-19 enfeksiyonu veya akraba kaybı, kaygı ve bilgi ihtiyacı yer almıştır. Yardım hatları, pandeminin başlangıcında bilgi ve destek ihtiyacına yanıt vermek için çok önemliydi.

Anahtar kelimeler Psikososyal destek hatları, COVID-19 pandemisi, Ruh sağlığı, Psikiyatrik bozukluk

Introduction

The coronaviruses (CoV) are a large family of viruses that are commonly found in the community, such as common cold, and can cause more serious forms of infection, such as the Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) (Ksiazek et al., 2003; Drosten et al., 2003). The World Health Organization (WHO) Country Office in China reported the pneumonia cases with unknown aetiology in the Wuhan city of China on 31 December 2019. The factor was identified as a new coronavirus (2019-nCoV) that was not detected in humans before. Then, the name of the 2019-nCoV disease was approved as COVID-19 and named as SARS-CoV-2 due to its close similarity with the virus SARS CoV. The COVID-19 outbreak was declared as a pandemic by the WHO on 11 March 2020 (WHO, 2020). The first case in Turkey was reported on 10 March 2020. The Government took measures like flight bans or quarantine after international travels, isolation, and contract tracing within the same week. As of March 16th, all schools including universities were closed, social events including sports, movie theatres, night clubs, weddings were postponed, all legal courts proceedings were postponed, activities in crowded places including Friday worships were suspended. The mitigation strategy also included measures related to health system. People with chronic disorders began to receive their medicine through home delivery, care homes and hospitals were closed to the visitors. By March 20th all hospitals in the country, regardless of being private, foundation or government hospital, were declared pandemic response hospitals. Residents in medicine and dentistry were allowed to be repurposed in emergency by a presidential decree. These developments had a huge effect on elective medical services including mental health services. The country has a limited numbers of mental health professionals, mostly located at the secondary and tertiary care hospital, and some of these professionals were repurposed in COVID clinics, appointments were postponed or cancelled.

By March 22nd movements of people at 65 years old and older people and others with chronic diseases were restricted and they were asked not to leave their homes, go to parks and recreational areas. Flexible work hours, including telecommuting and rotational work were put in place. Hairdressers, barber shops and beautify salons were closed until further notice, restaurants and patisseries were allowed to offer only take out and

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food delivery services. Tables were removed from restaurants. Public transport vehicles were allowed to carry only half their capacity. By March 26th intercity travels were restricted and quarantines for villages and towns started. By April 3rd curfew for people under 20, and over 65 put into action. A 15-day ban on vehicles leaving or entering in 30 metropolitan provinces and mandatory use of face masks was announced on the same day. On April 10th a curfew for the whole country was announced and continued with gaps until June. The Government continued to revise the prevention measures according to the changes in the pandemic.

Pandemics and related measures like isolation and quarantine may have a negative effect on mental well-being of people (Dubey et al., 2020, Rodríguez-Rey et al., 2020). Fast spread of the virus, concerns about the capacity of health services, interruption of regular mental health services complicated the problem. Factors like unclarities on pandemic, difficulties in reaching vaccines, lack of specific treatment, high risk of contagion, isolation and financial problems related to pandemic commonly resulted with an anxiety about future, and feeling of despair, and stress reactions. Studies also have shown common and profound psychosocial impacts of the COVID-19 pandemic on mental health, such as stress-related symptoms, depression, and anxiety (Cao et al., 2020; Qiu et al., 2020). Long-continued anxiety or stress may cause physical functional disorders and further progression may lead to physical and mental disorders, such as anxiety disorders, depressive disorders, endocrine disorders and hypertension (Dong and Zheng, 2020; Shigemura et al., 2020).

Therefore, an urgent need to carry out mental health and psychosocial support services emerged immediately after start of the COVID-19 outbreak. Mental health and psychosocial support are defined by Interagency Standing Committee (IASC, 2020) as “all kinds of internal or external support aiming at protecting or supporting the psychosocial wellbeing and/or preventing or treating mental disorders”. Considering the pandemic prevention measures described above, face to face health service delivery including mental health services could not be continued. The health care delivery can be altered by telephone or video visits where in-person interventions are not possible. These alternative methods have the potential to decrease difficulties in access to care and improve outcomes among the vulnerable populations (McElroy et al, 2020). Several studies have found that telehealth offered an efficient and safe way for people to consult healthcare professionals for psychological issues (Elbeddini et al, 2020; Kirsch et al, 2015) Previous outbreak experiences showed that the telephone or video calls may be useful for mental health and psychosocial services delivery where face-to-face interviews are not possible. (Keshvardoost et al., 2020, Song et al., 2020, Miu et al., 2020).

Considering the quarantine measures, many countries adopted online mental health services such as hotlines and

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mobile application platforms during COVID 19 pandemic, (Wen Li et al., 2020; Brooks, et al., 2020). Before the COVID 19 pandemic, psychologists performed 7.07% of their clinical work through telecommunication technologies, whereas, during the pandemic, this number increased to 85.53%, (Pierce et al., 2020). As of 2019, 98% of adults in Turkey were using mobile phones while 67% of them were using internet (MOBISAD, 2020)

Within these conditions MoH decided to establish Psychosocial Support Helpline for COVID-19 Pandemic. The country did not have a nationwide psycho-social helpline experience before. The initiative aimed at screening and identifying the psychosocial problems of the callers, informing them on COVID-19, steps to be taken to keep and promote mental wellbeing in pandemic environment and possible solution alternatives for emerging problems; referring to the social care and health institutions based on the problems identified, provide basic psychosocial support.

This paper aims to describe development and implementation of the helpline as well as lessons learnt from this experience.

Methods

The study is planned as a cross-sectional descriptive study. Characteristics of calls between 18 March 2020 to 30 March 2021 and callers are evaluated.

There are no exclusion criteria in the study. Necessary approvals were taken from MoH and local ethical board. Data used in the study was not collected specifically for the study but retrieved from database of MoH. STATA 16 was used to analyse data. Analysis of the data by groups was done using bivariate analysis. Chi square tests were used to look for associations. Statistical significance was reported for p-values of 0.05 or less.

Establishment Process of the Helplines

Helplines were established in 81 provinces to ensure that persons access psychosocial support services within the three weeks after identification of first COVID-19 case in the country.

Voluntary mental health professionals working in healthy life centres and provincial health directorates were repurposed to work in helplines.

The staff did not have previous experience on working remotely, moreover some of the staff had limited training on psychotherapeutic interventions.

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Due to time restriction and lack of experienced qualified staff, a very structured guideline was prepared and shared with all staff to be used in the calls to ensure a standard operation in these lines. Guidelines were prepared by MoH, WHO, field mental health staff and academicians. The algorithms to be followed during the calls were supported by interview forms, scales for screening depression and anxiety, and information packages for frequently asked questions.

A short basic training supported the usage of guideline. The basic training package consisted of Psychological First Aid, operating procedures for the Helpline, including usage of assessment scales and forms, referral procedures, short information on institutions in referral list, COVID-19 prevention measures, tips to promote well-being for different age groups, screening and referral for possible cases of domestic violence, abuse and/or maltreatment, understanding needs of vulnerable groups (people with disabilities, elderly, children) and services for these groups. Training was delivered through distant learning platform of MoH and other online platforms like Zoom, WebEx and Microsoft Teams. The study guideline and the training also include information on suggestions to be shared during the interview.

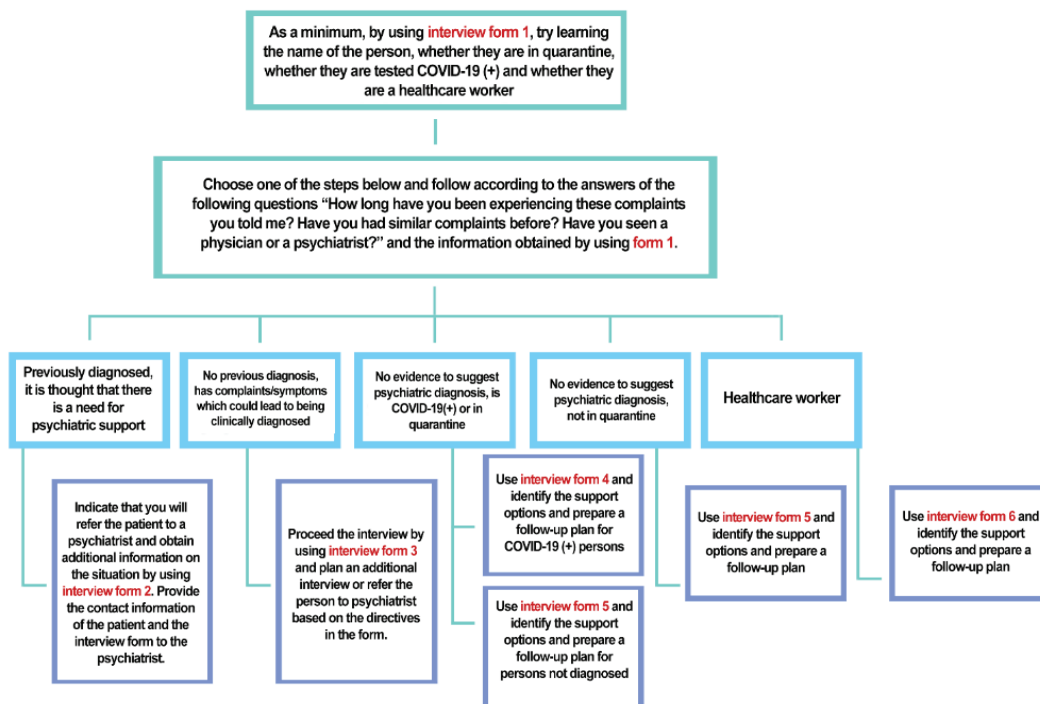
In parallel to the trainings a communication group was established by Ministry of Health to identify the problems in the implementation and support staff immediately.

Operational Process for the Helplines

The helplines served on 7/24 basis. Core interview algorithm used may be seen in Figure 1.

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Figure 1 The interview algorithm



Results

A total of 2,036 staff served in the Helplines. Most of the Helpline staff were psychologists. The other professional groups were social workers and child development specialists (Figure 2). 172 psychiatrists and 16 child and adolescent psychiatrists supported the helpline staff.

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Figure 2 Helpline staff according to the professions



A total of 49,736 calls were received between March 2020-March 2021 period. Sex of the person in need is recorded only in one third of the calls while age is recorded for two third of the calls. Of the callers for whom the gender was registered, 43.99% of callers were female while 56.01% were male. Mean duration for calls was 10.93 (± 0.05) minutes.

The calls are grouped according to age groups. Frequency of calls according to age group may be seen in Table 1.

Table 1 Distribution of service users according to age groups

Age-group	Calls	Percent	Cum.Percent
0-7 yrs	133	0.42	0.42
8-14 yrs	1100	3.45	3.87
15-18 yrs	1466	4.6	8.47
19-25 yrs	4634	14.54	23.01
26-40 yrs	10236	32.11	55.12
41-65 yrs	10624	33.33	88.45
65+ yrs	3682	11.55	100
Total	31875	100	100

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The most frequent reasons of calls were causes related to COVID-19 diagnosis, feeling anxious, information request about services and prevention measures related with COVID-19, support request for ongoing treatment of psychiatric disorders. Frequencies of the most common reasons may be seen in Table 2.

Table 2 Common reason for reaching out helplines

Reason for the call	Number of calls	Percentage in total calls
COVID-19 Diagnosis (have COVID-19 in self or a relative or loss of a loved one due to COVID-19)	38,324	77.1
Anxiety	21,551	43.3
Information requests about COVID-19 and prevention measures	5,387	10.8
Support for ongoing psychiatric disorder	2,267	4.6
Support request for basic needs	2,216	4.5
Difficulties in coping with stressors	1,930	3.9
Information and support request for people over 65	687	1.4
Information and support request for people with disabilities	445	0.9
Others	6816	13.7

As described in the methods section, helpline staff refer callers to the other services according to the needs identified in the call. A total of 6770 people were referred to other services. Of these 3741 people were referred to health services, 340 people were referred to the employment agency, 1617 people were referred to social support services and 1072 people were referred to protection services. 1365 people (2.7%) received psychoeducation without any need of referral to other services. Distribution of service users referred to the other services may be seen in Table 3.

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Table 3 Distribution of service users referred to the other services

Referred services	Number of calls	Percentage in total calls
Psychiatry clinics	1,611	3.2
Primary Health Services	574	1.2
COVID-19 Polyclinic	163	0.3
Mobile social support teams	1,009	2.0
Alcohol & Substance Use Treatment centers	28	0.1
Social support services	608	1.2
Employment agency	340	0.7
Centre for the Prevention and Monitoring of Violence	895	1.8
Child Advocacy Centre	177	0.4
Total	5405	10.8

A total of 38,284 people called for causes related to COVID-19 diagnosis. Of these 30,043 reported infections in themselves and 9,094 had COVID-19 infection in relatives. 295 of these callers also reported a loss of relative or a loved one.

When we looked at reasons of call between the callers with and without a COVID-19 diagnosis, we saw significant differences between groups (Table 4). COVID-19(+) callers reported more difficulties in coping with stressors and anxiety and they needed more support for ongoing psychiatric disorders compared with COVID (-) group. COVID (-) cases significantly requested more information and support for other needs.

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Table 4 Reasons of calls in people with and without COVID-19 diagnosis

Reason	COVID-19 (-) N=11,412		COVID-19 (+) N=38,324		Pearson Chi2	P-value
	Number	Percent	Number	Percent		
Support for ongoing psychiatric disorder	21	0.2	2,246	5.9	651	0.000
Difficulties in coping with stressors	382	3.3	1,548	4.0	11	0.001
Anxiety	780	6.8	20,771	54.2	8,000	0.000
Support request for needs	659	5.8	1,557	4.1	61	0.000
Information requests about COVID-19 and prevention measures	2,238	19.6	3,149	8.2	1,200	0.000
Information and support request for people over 65	678	5.9	9	0.0	2,300	0.000
Information and support request for people with disabilities	242	2.1	203	0.5	251	0.000
Others	1,622	14.2	1,463	3.8	1,600	0.000

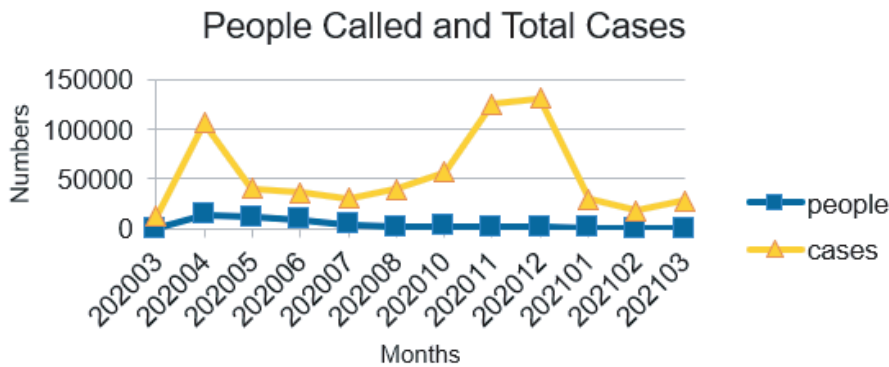
3,731 (7.5%) of the callers reported a chronic health problem. Frequency of chronic disorders in callers with a diagnosis of COVID-19 diagnosis was significantly higher than callers without a COVID 19 diagnosis (9.6% versus 0.5%, $p=0.000$)

Elective mental health services stopped during March-June 2020 period. Staff of CMHCs and some of other services tried to reach out their service users but these efforts could not cover majority of service users. Moreover, stress related to the pandemic may trigger mental health problems. Therefore, we checked if there is a relation between the number of calls and availability of services. Number of callers were highest in April and May period and began to decrease by June 2020 (Figure 2). Comparison between monthly calls and new cases reported monthly for COVID-19 shows that the number of people calling followed the number of cases only for the first phase of the pandemic (Mar-Jul 2020) but not in the second wave (peak) of the pandemic (Oct-Jan 2021). The number of persons calling and the new COVID-19 cases by month for all Turkey is displayed in

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the graph below.

Figure 3 The number of persons calling and the new COVID-19 cases by month



Number of callers per 10,000 population in different provinces was changing from 0.1/10,000 to 519.4/10,000. This variable was not related with the number of hotline staff in the province, size of province, or location of the province in the country.

Discussion

Almost concurrently with the global COVID-19 pandemic, MoH set-up a country-wide helpline system to deal with the increased need for information and assistance. The helpline was available to all the population of 81 provinces, with operators trained, guided, and supported by multidisciplinary teams. Despite of lack of previous expertise with similar helplines, the initiative supported a large number of callers with information, guidance, support and referral to other specialized services. The data collected for the first 13 months of the pandemic was fed into a central database, analyzed, and presented in this article.

Most callers were males in our study contrary to the literature (Du et al 2021). But since the helpline accepts calls for the needs of other people and only one third reported gender of person in need in calls, it is not possible to comment.

Most common reasons of call were having a COVID-19 positive test result and feeling anxious. This is in line with the in previous studies reporting anxiety as leading cause of calls (Brulhart et al 2021, Du et al 2021).

Support request for any ongoing psychiatric disorder was also common. Mental health services are disrupted almost in all countries during the COVID-19 pandemic (Chen et al 2021) and that was the case in Turkey. WHO reported that 70% of 130 member states adopted telemedicine interventions and 67% of them established

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helplines to overcome difficulties in providing face to face services (WHO 2020). Turkey did not have telemedicine implementation in the field of mental health before COVID-19 pandemic. Several universities, NGOs or private health care centers started services using telecommunication tools after the pandemic, but the helpline defined in this paper is the only initiative covering all country therefore large number of calls asking support for an ongoing psychiatric disorder (4.6% of calls) is understandable. No other articles were available in the published literature on helplines from other initiatives.

Helplines are good alternatives to continue services in difficult times such as COVID-19 pandemic, however it cannot cover the gap of the in-person services especially if the person needs specialized (Lestari et al 2021) or intensive care. The helpline staff needed to refer more than 10% of the callers to the other services, most common services used for referrals were psychiatry clinics, social support teams and centre for the prevention and monitoring of violence. Referral to other services as needed was unique and no other published articles has a similar feature (Berdullas et al 2020; Michaud et al 2020).

When we looked at the reasons of calls in COVID-19 (+) and COVID-19 (-) callers we saw that more than half of COVID-19 (+) cases experienced anxiety. Anxiety is one of the leading reasons for calling helplines (REF) but we did not see a comparison between COVID19 (+) callers and (-) callers in previous studies. Research on COVID-19 (+) cases showed high prevalence of anxiety disorders and anxiety symptoms (Taquet et al 2021, Michaud et al 2021), this finding supports our observations, but we also need to keep in mind that our results are not representing all COVID-19 cases and probably biased. COVID-19 (-) callers requested significantly more information and support for other needs. COVID-19 (+) cases might receive information about the disease and services as well as social support since COVID-19 contract tracing teams and the mobile social support teams were in touch with the COVID-19 (+) cases especially at the first months of pandemic. The country did not have a previous experience of nationwide mental health helpline. Therefore, we could not compare pre and post COVID-19 pandemic period. We observed significant high numbers during the first lockdown period. This is in line with the experiences reported by other countries (Scerri et al 2021). We did not observe an increase in the

period that the country went on partial lockdowns at the weekends in autumn 2021. This may be related with the partiality of the lockdowns in autumn period, the unclarity during the first lockdown or availability of face-to-face mental health services in Autumn 2021.

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The top three reasons for the calls were the COVID-19 infection or loss of relative, anxiety and need for information, confirming findings in the literature (Vindegaard and Bendros 2020). The demographic information of the callers could not always be recorded (age, gender, profession), but the rest of the records on reason for the call, call duration and referrals were complete. The data shows that the number of callers followed the number of new COVID-19 cases for the first wave of the pandemic, but not the second. This supports the conclusion that the helplines were essential at the beginning of the pandemic to respond to the need for information and support. As the pandemic entered into its second year, the number of calls plateaued, and it's not linked to the COVID-19 incidence. By now, enough information on the pandemic is available, and the restrictions on movement of people, curfews, working conditions, and other necessities have been lifted. The experience of setting up, operating, providing support at a national scale to the general population during a global pandemic could be useful in the future should similar events reoccur.

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