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Research Article

Benefits of an Emotional Support Helpline in Primary Care Mental Health.

Experience of the 0-800-1920 COVID-19 helpline launched during the health emergency in Uruguay. From April to December 2020

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Abstract

This study describes the experiences of mental health professionals that staffed the 0-800-1920 Emotional Support Helpline launched during the health emergency declared in March 2020 by the Uruguayan Government as the result of the COVID-19 pandemic. The general objective of this study is to understand and analyse the benefits of the helpline in circumstances that had severe health and social implications. Also, to consider the value of the helpline as a first resource for primary level mental health systems, as well as its possible use once the pandemic is over. Health professionals volunteered for over-the-phone assistance and for the present study were interviewed and asked about the benefits of the helpline. The study is a testimony of the work done, and as such it hopes to encourage further qualitative, quantitative or mixed research in the future. The study covers the period from April to December 2020.

Keywords: *Mental Health; COVID 19; Pandemic; Helpline; Primary Care*

Introduction

Since the beginning of the pandemic, concerns have been raised about the effects and consequences it will have on the population´s mental health. Various authors [1,2] have pointed out the need for real-time monitoring of the population's mental health in order to develop effective interventions. "The impact on mental health is not short-term, instead it seems that it will continue for a long period after the pandemic ends" [3].

The extension and severity of the pandemic´s effects on the population´s health at all levels has added to the concept of a pandemic (an epidemic that extends to various regions or the entire planet) the notion of syndemic (Merrill Singer, 2009) to refer to COVID-19. A syndemic refers to two or more epidemics in a population that interact causing damage greater than the mere sum of the two. It takes into account the biological, social and environmental factors that promote the negative effects of their interaction. The nature of a syndemic demands different strategies to fight the disease since it requires the study not only of the virus transmission, but also the entire chain of its consequences, as well as the way in which they intertwine and enhance each other [4].

The first cases of COVID-19 in Uruguay were announced on March 13, 2020. On that date, the Uruguayan Government declared a national health emergency. It placed restrictions in education, public events, and commercial activities and cancelled others. Teleworking was encouraged in government offices and borders were closed, among other things.

The government asked the population to self-quarantine appealing to individual responsibility using the slogan "Stay at home". Compliance was high, possibly due to the amount of information available to the public about the critical situations and high rates of COVID infection seen in other countries going through their first wave.

A month into the pandemic, the government lifted some restrictions restrictions and some activities were allowed to resume progressively but they had to comply with rigorous protocols. This allowed health officials to keep the pandemic somewhat under control because it allowed a strict monitoring of the epidemiological thread of the cases that appeared in the form of outbreaks, which were tested and controlled. The total number of deaths from COVID-19 as of December 31, 2020 was 174, and the total number of infected amounted to 19,119 [5].

In the face of the pandemic which had severe health and social impact, the Uruguayan government set up the COVID-19 0-800-1920 helpline to provide emotional support to the entire population, which included users of both public and "Health Insurance System"[1] services.

Due to the urgency of the situation and the extensive time it takes to go through an open tendering process, qualified mental health professionals, psychologists and psychiatrists were encouraged to come forward and volunteer their time to provide over-the-phone assistance on a temporary basis, that is for as long as the crisis lasted.

Within fifteen days, 150 professionals got together and formed a group called "Voluntariado Juntos". The group was supported by the National Academy of Medicine (abbreviated ANM in Spanish) with one of its members acting as an advisor. They volunteered their time temporarily under the frame of the Administration of Public Health Services (abbreviated ASSE in Spanish) and the Ministry of Public Health, which provide administrative and technological support. Helpline was launched on April 14, 2020. Later on, institutions working in the area of mental health followed their footsteps with different initiatives related to telecare.

Background

A search was conducted in Google Scholar of over-the-phone mental health assistance provided during the COVID-19 pandemic from the start of the pandemic to date. Keywords such as "COVID helpline" and "Línea de ayuda telefónica COVID" were used in the search. No qualitative research studies were found based on the opinions of the professionals who answered the calls and their feedback as to the strengths and limitations of the helpline. Instead the research focused on user behavior and needs, as well as its impact on the mental health system and its future directions.

The studies found refer to the experience in India [6,7], Bangladesh [8], Malta [9], Ireland [10], Switzerland [11] and Greece [12]. Some consider the response to existing phone lines, others to lines that were set up at the start of the pandemic, for example in India, Bangladesh and Greece. Most focus on the first wave, except for in the case of Malta that takes into account the first and second waves.

Studies carried out during the year 2020 the year 2020 were reviewed. In all cases, there is an underlying need to measure the population´s psychological and social suffering during the pandemic, assuming that "mental health becomes a crisis in its own right" [8]. All of them agree on the importance of providing telephone assistance during the pandemic and afterwards.

As we reviewed the publications, we found similarities between the helplines set up in India and the line in Uruguay. A study was published [6] describing the setting up of a toll-free line that provides assistance in multiple languages in India. The line is the result of joint efforts between the government and non-governmental organizations that provide 1,328 professional mental health volunteers. The aim is to obtain state funding to ensure the helpline´s long-term sustainability.

[1]Semi-private health care providers in Uruguay.

One study in Uruguay that precedes ours was carried out by Bagattini, Dogmanas, Villalba and Bernardi [13] in collaboration with the Government's Honorary Scientific Advisory Group (abbreviated GACH in Spanish), titled "Attention in Mental Health and COVID- 19: Initial responses in in Uruguay". It includes preliminary quantitative data of the users of the 0-800-1920 line. Of a sample of 1,363 calls received during the first two months, 74% were female callers, 22% male and 2% LGBTQ+. The majority of the users were adults between 61 to 70 years, followed by individuals between 51 to 60 years and 41 to 50 years. Depending on the severity of the problem raised, there are 43% mild calls, 33% moderate, 11% severe, and 13% without data. According to the study, the majority of users were from the department of Montevideo (62%) followed by Canelones (12%). Assistance was provided to users from Administration of Public Health Services (abbreviated ASSE in Spanish) and Health Insurance System.

It is important to point out that Uruguay has a history of helplines staffed by people ready to provide assistance to anyone seeking support in areas such as suicide prevention (Linea Vida), gender based violence (Línea Violencia Basada en Género), food baskets (Linea de Apoyo INDA), homelessness (Linea de Atención a Personas en Situación de Calle), child and youth abuse (Linea Azul), elder abuse or mistreatment (Linea de Atención Adulto Mayores Víctimas de Abuso o Maltrato), and LGBTQ+ issues.

Description

The group "Voluntariado Juntos" included health professionals of different ages, coming from different academic institutions, with varied work experience, and different theoretical and technical backgrounds. The professionals formed small groups and worked under the supervision of more experienced colleagues.

A platform called "Circuit" was created, which allowed professionals to answer the incoming calls on their cell phones. Audio calls were used because they are easy to implement and guarantee that the caller remains anonymous. Video calls are better for diagnosing, but audio calls allow staff to provide immediate emotional support and the calls can be forwarded in cases that need additional assistance.

The program´s directives established calls with a maximum of 30 - 45 minutes per call. Depending on the severity of the case, they were classified in green, yellow and red codes.

A Green Code alert was applied when the professional considered that the caller had internal resources to deal with the situation with the help provided. If necessary, staff offered the possibility of calling back.

A Yellow Code alert applied when the professional recommended that the user be referred to other available helplines or other medical provider services.

A Red Code alert applied due to the severity of the situation. It required more time for the call (the duration of the call is extended to one hour or an hour and a half) in addition to direct intervention which could be contacting a family member or friend, calling 911 or 105 (Emergency Medical Care Line), in order to be treated or referred to the appropriate health provider.

After each call, the professional was required to fill out a form that included the user's socio demographic data, the reason for the call, and the severity of the case. The data was entered in the ASSE database, and the procedures had to comply with codes of practice for handling confidential information.

The supervisors held periodic online meetings with their respective groups, in addition to the one-on-one supervision required. Training was available for the professionals staffing the lines that included topics of interest such as addiction, suicide, crisis intervention, positive psychology and others.

There was a huge response on the part of the population. More than 8,100 calls [13] were received during the first two months. The high amount of incoming calls continued, reaching 29,400 in June 2021 [15]. The period covered in this study is from April to December 2020.

Objectives of the Study

The objective of this study is to provide a detailed description of the experience of the mental health professionals who staffed the 0-800-1920 helpline. Based on these testimonies, we focus on the role that a helpline can play during a pandemic and how it can become a resource for providing mental health services to the population once the pandemic is overcome.

First, we analyze directly the point of view of some of the professionals who participated and agreed to describe their experiences and answer questions. Second, we seek to understand indirectly, the point of view of helpline users, as described by the professionals interviewed. And finally, some aspects of the mental health system are inferred from the reports of professionals and users.

Two important questions are posed that trigger the analysis:

- Was the emotional support line 0-800-1920 useful during the health emergency?
- Is it a valid resource for providing primary care in mental health to the population once the pandemic is over?

Materials and Methods

A qualitative testimonial approach was considered the most suitable for this type of study. The sample consisted of interviews with 13 psychologists and psychiatrists who volunteered their time, and were chosen according to a convenience sampling criteria. They were chosen to best represent the group´s heterogeneity in terms of age, work experience, theoretical training, as well as university and post graduate study centers. Details of the sample are presented in annex 1.

An in-depth interview was used to obtain data, since "the information obtained in the interviews allows one to approach the interviewee's way of understanding reality" [16]. The interviews explore different aspects of the experience, focusing on the needs of the population, and exploring the experiences of professionals and users.

The study uses a phenomenological approach, from the point of view of the players: professionals, users and the helpline´s connection with the mental health system. According to Verd and Lozares, "Interlocution with key stakeholders is a way to obtain qualitative information of special value" [17]. The material collected in the interviews was analyzed taking into account themes, significant phrases, words and metaphors used. Some aspects of the content analysis are used. According to Glaser and Strauss (1999), the data collected was rearranged forming homogeneous sets or categories by grouping content that has similar meaning in order to reach conceptualizations that justify the grouping [18].

Interviews with volunteers were personal, anonymous, lasting between 50 and 60 minutes, The interviews were conducted by two interviewers using the Zoom platform. One conducted the interview and the other acted as an observer taking notes, recording the interview, and intervening when deemed necessary to clarify or add information, since later they were responsible for transcribing the interview. The interviews were carried out in a semi-structured way using the same general questions (Annex 2). In some interviews, during the call new questions other than the scripted can come up, enriching the dialogue with a snowball effect. The interviews were based on the idea that the initial question of a qualitative study is usually broad and open and tends to become more refined and specific as the investigation progresses and the problems of the area under investigation emerge [19].

An initial draft of this study was provided to all the professionals who appear as collaborators. The group was invited to discuss the study online in order to obtain valuable feedback, to confirm whether or not they felt represented by the final text, as well as opening the floor to further suggestions and modifications.

Ethical aspects

The professionals interviewed were invited by the authors to participate in this study as collaborators. Emails were sent out explaining the conditions. The collaborators were informed that the interviews would be recorded and that later the recordings would be deleted. During the interviews, measures were taken to protect the confidentiality of the information provided and the identity of users. Likewise, the confidentiality and anonymity of the interviewed was guaranteed as well as the right to withdraw from the interview. An affirmative answer to the email inviting health professionals to collaborate was considered the individual´s consent.

Results

Analysis of responses to interview questions

The data collected from responses was organized in the following way:

1. Volunteers´ motivation for collaboration and benefits obtained.
2. User's motive for calling was classified in Green Code, Yellow Code and Red Code. Different aspects are treated: the staff experience, emotional effects and benefits for users, technical resources used by the professionals, a typical case of crisis assistance, strengths and limitations of the different code.
3. Call content.
4. Contributions of the helpline to mental health. Difficulties encountered and suggestions.

Volunteer´s motivation for collaboration and benefits obtained

Most of the professionals stated that their reason for participating in the program was solidarity and a desire to collaborate in a time of crisis. They said their participation had brought them personal rewards, as well as changes and benefits to their professional practice.

Example of some of the comments follow:

- "Some colleagues told me about this, I loved the proposal and I decided to collaborate without hesitation. To contribute my grain of sand, to be there, help others, to provide human contact…"
- "I am here because of my fears. I was scared of getting sick, I had financial fears and I was worried also about my family and that something was going to happen to them. I felt all those things, but I was able to get through it. So, I said to myself that the only way for all of us to get through this crisis is by "rowing", moving this "boat" forward all together. Staffing the helpline was a way to help others move forward, and I am glad that I was able to do it".
- "I felt useful during all the calls, I felt self-satisfaction, at a time when everyone had fears, and we were feeling the pandemic, the confinement. It was a way to deal with it. I ended my day feeling that I had done something for someone".
- "When they showed me the schedule, I chose the time slots that needed the most help, and those were the moments where there was more demand, that´s when I would jump in and provide support".
- "This had a huge impact on us! I'm referring to the impact that all this had on my professional practice, incorporating new things."... "Before staffing the helpline, doing this kind of work online seemed impossible". 'I greatly underestimated the possibility of providing assistance online, and it turned out to be a very enriching experience".

Reasons for calling the helpline and benefits received

The reasons for calling the helpline were classified into three categories. Code Green, Code Yellow or Code Red calls depending on the severity of the situation Annex 3-2.

Code green calls

The majority of calls were classified as Code Green meaning that the staff believed the caller had the sufficient mental resources to resolve the situation with staff assistance and within the amount of time set for the call.

The professionals stated that interaction with callers was good and that caller attitude was positive. The professionals said this made them feel useful and, at the same time, that the emotional support line was fulfilling its goals.

Although most of the helpline staff had not received specific training or had little experience in providing over-the-phone assistance, they considered that their professional experience was sufficient to allow them to provide adequate assistance in cases of Code Green calls.

The reasons for calling were diverse: depression, anxiety, anguish, boredom, panic crisis, fear of contagion and infecting family members, job loss and economic uncertainty, difficulty in accessing medication and psychiatric support. Although less frequent, some calls were received from adolescents and youth who missed their friends and regular daily activities.

Within this category of calls, there was a great need to be heard. The majority of the callers were over 50 years of age, many women suffering depression, feeling lonely due to confinement, who missed their routines, bonding and affections.

The technical resources used for providing assistance were the following:

a. **Emotional support interventions:** Interventions such as empathetic listening, understanding, accompaniment, mirroring, emotional validation, affect regulation (i.e. calming, reassuring, containment) and the search for the user's ego strengths were provided by the professionals to help callers understand and manage their emotions. Many could be referred to as "affirmative" type interventions that remove any doubt that the user might have with regards to reality and re-establishing a feeling of identity [20]. Also relaxation and breathing techniques were used to reduce anxiety and get the user through panic attacks.

b. **Cognitive interventions:** The healthcare professionals provided users with accurate information about coronavirus, the care required, and other general information that the callers requested. Indications, clarification, psycho education and a change of perspective were also used. Summarizing the issues discussed also helped the callers put their thoughts in order. Suggestions were made of activities that could benefit the caller, reduce anxiety and regain control: "Come in contact with nature at home or in your garden, spend your time on manual tasks or things that you like to do, look into and analyze your anxiety, identify and adopt relaxation techniques from YouTube, try them and see which one works for you. Design a daily activity plan with healthy mental habits and processes that can replace the pathological ones. Take the attention off yourself and socialize as much as possible, help others, focus your attention on other people. Celebrate every success and persevere. Humor is also important for dismantling a concern".

Although there was no specific methodology or homogeneity in the techniques used because the professional staff came from different theoretical backgrounds, the following description of a Code Green call contains some elements that could be especially interesting when dealing with "crisis care".

"Personally, when I answered each call, I kept thinking that it was probably the only chance I had to help this person. Since I knew the line was originally for providing crisis care, I not only listened but also decided to be proactive. I had to do something to get through that moment of "emergency". My goal was to provide the person with tools to understand the origin of their current and future symptoms, although there were variable prognoses according to the "diagnosis". That is why I avoided, whenever possible, referrals to third parties that were unfamiliar to me. I recommended psychotherapy in several cases and reassured the users that the helpline would be available if needed in the future".

Acute attacks of anxiety, fear or panic

"They were the most frequent cases, so as time went by, I was able to improve my focus and better identify information that would best serve the callers".

"I didn´t set a time limit for the calls, so the sessions lasted as long as needed. I assumed that my responsibility ended when the "crisis" was over, that is when the person reached a certain level of understanding and assumed personal responsibility to deal with their mental state".

Some callers suffering an acute crisis had an understanding of what was happening to them since it had occurred in the past. Others, were experiencing the symptoms for the first time".

Steps to be followed

1. Deconstruct the emergency

"The aim is to project a more accurate view of the user's actual situation, to get the user to focus on something other than their imminent anxiety or their personal assessment of real danger.

Example: When I received a call from someone who was scared, they were crying or hyperventilating, and in a state of acute anxiety, my goal was to redirect their attention to situations of actual danger in order for them to differentiate between the fear of actual imminent danger and a personal, psychological perception of the danger that they were imagining. I asked questions that helped them reassess the threat they were perceiving such as "Are you in danger now?" or "Are you safe right now"?

The purpose of the questions was to help the caller re-evaluate their actual situation, decipher their "here and now", re-consider their perspective, to imagine actual dangers they could be facing and, at some point, realize that their mental state was often in many cases due to emotional factors and not the presence of actual danger. The result of assessing the situation was that the users generally felt relieved, realizing that despite their feelings of "anxiety, panic or fear", there was no actual danger. When the user says "No, I am not in danger" I can answer: "Well, I am glad".

Many times we asked the questions that were on the cards. Their purpose was to make the users refocus on other dangers they potentially could have been exposed to, but in reality were not. "Do you have any COVID symptoms right now?" Does anyone in your family have symptoms? They made the user focus on dangers or negative situations that exist but are not affecting them at the moment. It broadens the caller's perspective and reality, as well as turning their attention away from their own personal situation. It takes the focus away from current emotions and makes them aware of things that are not happening to them.

From then on everything seemed less of a burden, less scary and threatening to the user. Their reasoning was that the situation was actually not so bad if it could be worse. Only then did I realize that the caller was able to move away from a state of "emotional blindness" to a more "neutral state" where I could intervene. They became more receptive taking advantage of the help received as the only valuable opportunity.

I could then ask them to: "Calm down, breathe deep, rinse your face if you want, I'll wait for you, so we can talk about why you are feeling this way or what is happening to you". Always transmitting peace, willingness, a sense of non-urgency, and showing the user that the situation could be explained and understood, and therefore incorporated and overcome. Sometimes I would breathe with them until they were able to "self-control".

2. Cool down the crisis

Usually, the remaining amount of the time consisted of asking a few more questions such as when the caller first felt these symptoms. Sometimes the staff discovered situations of abuse behind the symptoms or that the symptoms were the consequence of behavior the caller adopted to avoid evils of less pathological burden than the consequences themselves.

An important aim was for the caller to achieve a certain level of understanding of what they were going through. The professional provided a brief but assertive psychological and neurological explanation of the anxiety-fear-panic process, explaining how our minds and thoughts work when processing uncertainty, potential threats and unprocessed traumatic emotions. The explanation included the amount of detail that the individual called for. It was always done in general terms and avoiding the particular. The professionals focused on cooling down the acute crisis, turning it into a well-known topic that could be discussed, and trying to include the explanation provided.

Many times this provoked multiple associations with other situations and an already more detached vision of how it started to gain ground in the user's mental health.

3. Rounding off/Closing: deactivating the crisis process

To conclude, the call always include references to the role of personal responsibility including the possibility of recognizing thoughts that come to mind before the crisis unleashed. Suggested modifications are activated, as well as the power of the caller to manage mental and emotional states, and behavior: "Get in the way of the process, deactivate it, don't allow it to grow, don't feed it" by taking actions to stop the process: take a shower, a walk, tidy up, or anything else. As a professional, I never left the solution for a second call or a call to someone else. I encouraged the power of "helping themselves to recover" and the possibility of resorting to psychotherapy or psychopharmacology available to assist recovery, but never as the only solution.

If I did not find a basis for the crisis during the interview, I would ask questions about chronicity, opening the door to recovery, and restoring the caller´s confidence in being able to achieve well-being and mental health.

The call ended when the person began to thank the professional, and they simply lost interest in any new suggestion, showing that the crisis was over and that they no concentrate on the subject.

Calls from a family context

Most of the calls were made from the caller´s home. They referred to personal problems or problems with their partner, children or family. For example in one call a woman said to her partner, "Come here, they are listening. Let's talk about what is happening to us".

Other calls sought guidance or an empathetic listener: "They asked me to put the pieces of the puzzle together... They had knocked on all the doors and they no longer knew where else to go" In five minutes they opened up and a lot. The callers got right to the point and trusted me. They opened up completely even though we never met!".

Calls from residences for seniors

Calls from seniors living in residences were very common. The protocols for visitors were very strict at the time, and their isolation intensified the feeling of loneliness of senior residents. "There was much loneliness… seniors wanting to talk, seeking human contact, someone who would accompany them, to talk to someone even if it was over the phone, they told me their story, their projects, and it was very moving. They were grateful and I felt that I had given that person what they needed at that time. That felt good".

ICUs and assistance to health professionals

In health institutions, there is constant need to provide support to professionals that work there as well as patients that are hospitalized.

"Not only do we receive calls from the general public, but also from doctors and nurses working in ICUs, requesting, in the middle of the work shift assistance for example for the containment of an acute patient who was hospitalized".

"I am a nurse working in an ICU. I have a patient who does not stop crying and I cannot stay with them all the time, I have many other patients, can you help the patient?".

"I am a doctor. I have a patient who is very depressed and I cannot calm them down. How can I help the patient? Can I tell you to call them directly?".

Crisis context with police intervention

"Once I received a call from a police officer who was answering a 911 call for help from someone who was suicidal. The officer was parked on the side of the road answering the call from a person who threatened to throw themselves in front of a bus or truck.

I am a police officer and I´m here with a person who is under the influence of alcohol and threatening to commit suicide. We are talking to this person, but we can't remain here. Can you help us?

The police officer passes the telephone to this person and after a while the officer asks again to see if it´s okay to leave.

"We can take him to an emergency or to the police station, but we can´t stay here".

Since the caller is contained, the decision is made that there is no imminent danger and assistance can continue over-the-phone until the caller feels relieved and decides to hang up".

Strengths of the line for code green calls

The strengths of the line were revealed when the professionals who provided the care, as well as the callers, considered that the care received was beneficial. The fact that the service was free of charge, available all the time, and easy to access were some of the benefits mentioned. Also, that a person could receive assistance without leaving their own home, that is was available at the right time, its immediacy, and knowing that someone would be ready to listen were also positive aspects.

"It is a very useful device. It is a space for containment and listening that has helped a lot. It allows us to deal with acute cases at the time that the person needs it. It takes more time to make an appointment, go to ASSE or the healthcare provider".

"There was a very good affinity, good rapport, the people with insight thought about the issues, they felt relieved, they were grateful".

"We always recommend consulting the healthcare provider afterwards, the line opens the way to further consultation that did not occur before".

"The emotion was running high on the surface, and it's a critical moment that can cause changes. The helpline is an opportunity to

intervene".

"People who call are really in need of help, so they value what you give them. They don't call for fun, although not all cases are serious or urgent. When they call, the professional listens so they´re not alone".

Limitations of the helpline's support in green code calls

The helpline's limitations occurred with regards to calls requiring follow-up work. Some professionals felt discomfort and frustration for not being able to do follow up on the user since it was not included in the original helpline protocol.

"In many cases, I was able to help doing practical or simple things which were for the callers a source of relief, and during the most critical moments, I was able to provide containment. However, the hard part came afterwards which was ensuring continuity, the where and how to continue working after all of that".

"I believe the helpline was not enough. I felt frustrated. People called for something more than someone who just listened, they wanted to bond with someone. Some cases were more complicated and I believe they needed something more, and that I could not provide what the person was looking for".

"It's a means of providing initial support". "It´s like a throwing a life jacket which is part of the rescue process, but it also needs the boat to back it up". "It is only one link in the chain".

"I felt it wasn´t much and was worried about what would happen next". "Something else was needed, one more link in the chain, in order not to leave the person alone and feeling as if they were being left behind". "I kept thinking... What happened with this person?".

Some callers who called more than once, were frustrated because they couldn´t talk to the same person. "There were also people who were very angry with the service because it was limited to only one call, or because they wanted to talk to a specific person". Other callers, however were aware of the protocol and didn´t mind talking to another professional. For example some elders living in residences called every night to talk to someone before falling asleep.

Sometimes there were problems with connectivity mostly during the first months of care, but that improved with the new platform. "If the call fails three times in a row, you lose the flow of the conversation, the desire to talk, you lose everything! If you are providing over-the-phone assistance, then you need a reliable platform that works well".

Yellow and red codes

They are calls from people who have pre-existing mental disorders which are worsening, individuals considering suicide in a situation with increased risk factors, suicide attempts, cases of domestic violence, or psychiatric decompensations.

Also considered within these yellow and red codes were serious somatic manifestations and calls from people in situations of extreme socioeconomic vulnerability. These types of calls were less in number but more difficult for the professionals to manage.

Strengths of the helpline in the yellow and red codes

One of the advantages of the helpline for users going through a crisis was that it was available 24 hours a day, 7 days a week.

"I received a call from a young woman who had taken more than the recommended amount of pills and called to say that she did not want to live any longer. When you get the call, you have no idea what you are going to find, you don't know anything about the person! And the person doesn't know anything about you either. You have to make the connection just by talking and listening because if you

don't there is no way that you will be able to intervene. In one case, I resorted to intuition and empathy to provide containment. It was the call that impacted me the most because they were on the verge of committing suicide, and they called the helpline. I asked her for phone numbers, called her relatives, and made sure she had a safety net available. I referred her to the Life line. She held on well. I called her back later, and she said that our initial talk had done her a lot of good, that she did not need to call the Life line, and that she was going to seek further assistance".

Another positive aspect of the helpline was the speed in which the users received a response, since our psychologists had access to emergency service lines such as the 105 (Emergency Medical Care Line) and 911.

Also, if the professionals needed help they could count on colleagues working at the same time or with a supervisor that could provide support. They could join efforts and build a network of containment and support in cases that were more difficult to manage.

"One of our colleagues said in the chat that she had a person on the line in risk of self-elimination. So we all helped out. While our colleague provided containment, I called 911. It was a very nice moment for the group. We felt that we could count on each other".

Limitations of the line in the yellow and red codes

The professionals staffing the helpline believed that its greatest limitation was the lack of follow-up, the need for greater fluidity in referrals, and the need for professional training in crisis management.

"Basic training is not enough..." "I felt like we were constantly putting out fires, and now, what´s going to happen next with what's left?... We put out fires".

"I felt useful in almost all of the cases, except for calls from users struggling economically or homeless, and didn´t have anyone to help them. I did not know where to send them...".

"They are like ships drifting in the sea that are hit by a storm. The line can help guide them through the storm".

"The most complicated cases were from callers with very important somatic manifestations. The caller needed a place to go, a referral to a psychiatrist or a health center. Everyone was overloaded".

"In yellow or red code cases, I believe the helpline should make 3 or 4 follow-up calls to make sure that the caller has been able to contact the appropriate services".

Call contents

According to the psychologists, the majority of the calls to the helpline were not directly related to COVID (fear of contagion, illness or death). Most of the calls were due to symptoms of depression, anxiety, anguish, loneliness, and boredom exacerbated by the context of the pandemic. This coincides with the data provided by Bagattini., *et al*. [12] Annex 3-1. According to the professionals interviewed, the calls showed that the pandemic context exacerbated feelings of loneliness, sadness, anxiety, anguish and depression, family and personal crises in users with greater mental fragility or social economic vulnerability.

Helpline contributions to the mental health system

1. Reveals difficulties in the mental health care of the population

All the volunteers found that the helpline was an important source for collecting data about the state of public mental health. The data collected and properly documented covered a wide range of health system topics. It showed aspects that are working well, and areas that need improvement.

It showed the difficulties that the general population encounters trying to access psychological care as well as the lack of resources available to the elderly whose situation often makes it harder for them to do the paperwork and move around to receive care even without a pandemic.

Another aspect that kept coming up was the high use of psychiatric medication of different age groups that lacked simultaneous indication of psychotherapy, many who needed it. There were difficulties in completing case follow-up work and coordinating different services.

According to some of the staff interviewed: "It was like a magnifying glass... we started seeing things" "We realized that people need to talk about their problems. They need someone to listen. There are people out there that need to hear a word, that want to be heard. They need a sign, something. Calls from seniors expressing how lonely they were was constant".

"COVID was what triggered the calls, but people were calling about things that have nothing to do with COVID" "The referral lines were often saturated".

"I was surprised with the amount of psychiatric medication that our population is using. It has become one of the main resources for treatment, despite the fact that it doesn´t necessarily provide the emotional support that the patient needs".

"There is no patient follow-up in cases handled by Public or Health Insurance providers, nor in cases that are referred to the judicial system". "The 105 lines are saturated and they only cover the capital city of Montevideo".

Likewise, the helpline revealed the difference in the level of health care available outside of the capital, Montevideo, comparison to the city itself. The professionals interviewed coincide with the statements made by Daniel Strozzi, an expert in family and community medicine and former head of the Northern Regional Federation of Doctors: "Today there is a lack of quality medical care in the interior of the country, above all in home health care services" [21].

2. Suggestions from professionals

The professionals agreed that the helpline was useful during the health emergency and argue that post-COVID it would be valuable to provide emotional support, accompaniment and a first contact with the health care system. They maintain that it´s a way to optimize government resources.

They propose evaluating the calls on a case-by-case basis and if necessary provide crisis care. The process would consist of various calls with the same professional who would follow the patient to ensure access to appropriate healthcare services with Public or Health Insurance provider.

For those professionals who were to work in this service, the basic training received in their bachelor degree would be complemented with specialized training in crisis intervention, and state and community mental health resources available to those in crisis.

The professionals stated that referrals by volunteer psychologists would be more efficient if they received information systematically

and had prior contact with the operators of the different helplines, institutions and mental health services. Information on how to proceed should be provided by each service in advance to optimize resources and services.

It would be important to have a manual or similar material available, with updated information on all the mental health resources available from government and civil organizations in different parts of the country and those that are free of charge.

"We would need to know what resources are available in the area and the work that is being done in order to do our referrals".

Discussion and Conclusion

According to responses to the first question, the emotional support 0-800-1920 helpline was a valuable resource during the health emergency. The professionals interviewed said it was an initial step in putting people on the path towards receiving mental health treatment. It took the place of a primary care resource that did not exist at the time.

This study covered the period from April to December 2020. At the beginning, fear of the unknown favored the population´s willingness to adopt preventive measures. The fear of COVID decreased as relative control of the pandemic was achieved. During 2020, the cases consisted of outbreaks that were tested and controlled, mostly because there were very few infections, so tracing the epidemiological thread of each outbreak was possible.

The data collected in the interviews could have been different if the interviews were conducted during the first half of 2021 due to the exponential growth of cases, the community circulation of the virus, and the great wave of infections and deaths that occurred during this time. ICU units were overloaded, and caregivers who worked in the first and second levels of ASSE, especially outside of Montevideo, were overburdened [22].

During the period studied, the health situation was relatively under control in terms of the number of infections and deaths. The importance of providing timely assistance to personal or family crisis situations was pointed out. The mental health issues of many callers was triggered or aggravated by the pandemic and its multiple social, work-related, and economic repercussions, however other reasons why individuals contacted the helpline were observed.

In view of the above, a helpline similar to the one analyzed in this study could be a valuable resource for post-COVID, since according to one volunteer there is a "vacuum" that exists in the primary care provided.

As far as the helpline´s role in prevention, the immediacy of the response was a very positive aspect, and also the fact that it could lead the way to future treatment.

According to Scerri., *et al*. [9], prevention includes the possibility of motivating the public to adhere to health promotion recommendations and education in healthy coping mechanisms.

As for the phone modality, there are differences in opinions among professionals as to the advantages of using audio calls over video calls. Some consider that an audio call is enough: "the voice is a great instrument" and that anonymity helps. Others believe that it´s important for professionals to have the information provided by the image, since not seeing the caller's face is an important limitation to diagnosis, although they recognize that the use of this technology implies a greater difficulty for elders and could also modify user attitudes.

In this regard, Scerri., *et al*. [9] points out that the challenge posed by not being present, such as reduced ability to gauge body language and to effectively respond to acute psychiatric emergencies over the phone. We do not have comparative information to indicate which way is more beneficial from the point of view of care, both for the user and for the professional.

Regarding the second question about whether it is a valid resource for providing mental health services to the population once the health emergency is overcome, there was consensus that it would be beneficial to keep the helpline operational as one of the first links between the population and the mental health system in support of prevention and psychoeducation.

The helpline could be considered "a special support measure for helpline users with mental disorders" since it minimizes the risk during the crisis, according to Romano., *et al* [23]. The need to provide training in this type of care to new professionals was highlighted. The helpline can have very positive results as a means to provide post-covid accompaniment for callers to work through a personal crises, with the current characteristics of a focal intervention.

All the data reviewed in the abovementioned countries coincide in the importance of monitoring the population's state. In Switzerland, Brülhart and Lalive [11 p.149] conclude that "more broadly, helpline data could be used to monitor societal suffering also in "normal" times" Holmes., *et al*. [1] argue that digital psychological interventions, have been identified as important means to support people at risk of mental illness at a time when face-to-face contact should be avoided. Telephone calls and messages allow to reach those with poorer digital resources. Turkington., *et al*. [10] point out the importance of examining help-seeking patterns and using crisis helplines so that services can respond accordingly and users can obtain additional support for mental health issues and suicide prevention. Peppou., *et al*. [12] state that mental health care lines have greater coverage than online services, because they are available to people in locations where internet access is not always readily available (i.e. rural areas in Uruguay).

With regards to monitoring the mental health needs in the general population, the variations and reasons for the calls could be quantified according to the different moments in the pandemic, which has already been indicated, crossing both variables: confinement, lifting of certain restrictions, worsening of the pandemic with increased infections and deaths, vaccination, saturation of 105 (Emergency Medical Care Line) etc.

In this study, the need to coordinate actions between the helpline and existing mental health services when required and in crisis counselling was observed (i.e. line 105 and other specific helplines mentioned). In cases that require a referral, the helpline is important but they need additional assistance. The helpline is a "lifejacket", but the system needs "rescue boats" for further support.

With regards to the availability of psychotherapy and psychiatric treatment, the data shows that many users are taking medication but they still feel a great need to talk about their concerns with a professional. One option would be to offer the users additional support, which would consist of three or four audio calls with the same professional in order to accompany them until they receive care from the corresponding health provider. This would be a way to prevent emotional problems that could be aggravated if they are not treated early.

This option would be in addition to short psychotherapies easily accessible to users from public and private care providers. It would be a way to optimize existing mental health resources and reduce medicalization. According to the professionals interviewed, there is a "gap" between the psychiatric care provided by the emergency services of public or private health insurance providers and the psychological or psychiatric care available in neighborhood health clinics. The helpline is also a way of contacting directly and immediately emergency services, through the helpline professionals in contact with them or through the 911 phone line.

Another benefit of the helpline is that it's a way to get feedback and the possibility of evaluating the mental health system. According to Scerri., *et al*. [9 p.6] "the helpline data was influenced by its advantage as a research method as it provides a more reliable gauge of the prevalence and monitoring of distress and is in real time, as calls are logged in daily. Additionally, the role of these helplines is expected to increase, and consequently, research relating to the utilisation of helplines is highly relevant". These authors also highlight the importance of developing assistance modalities supported by technology, considering that the pandemic has increased confidence in the digital world and its advantages.

The limitations of the methodology used are derived from having a small and non-representative sample of interviewees, which suggests the need to use complementary quantitative, qualitative or mixed methodologies that can expand and strengthen the observations included in this study. The lack of follow-up of the cases is also a limitation for obtaining a precise evaluation of the value of the service, since we only have the clinical view that the staff had during the call.

There are many lines that remain open for future research with appropriate methodology. It would be of interest to carry out an evaluation of the users to verify its usefulness and to create programs according to their needs.

Finally, we conclude that the helpline sends a message to the population about the state mental health system, that each individual has the possibility of being heard and guided by a professional in situations of anguish.

We believe that the helpline has undoubtedly benefits for the user, but it is a very valuable tool for the mental health system also for the early detection of critical situations, as well as identification of risk situations and monitoring of serious problems. In summary, to continue having the emotional support helpline available to the public beyond the pandemic would provide valuable information on the needs of the population, as well as evaluating whether or not the system is optimizing its resources, in order to improve care process.

Acknowledgment

We would like to thank all the professionals who volunteered their time to staff the 0-800-1920 helpline, since without each and every one of them this experience would not have been possible. We hope that they feel represented by the testimonies and opinions of their colleagues who have collaborated with this study. We hope that their work and commitment will serve as a stimulus for further research.

We thank the Directorate of Mental Health and Vulnerable Populations of ASSE and the Ministry of Public Health for the human and material resources assigned to sustain this program, and the dedication and support received at all times from the people in charge. Special thanks also to to Psychologists Irene Batista and Inés Caputto for their valuable comments and contributions.

Annex 1

Work experience

The professionals were classified into the following groups according to their years of work experience: From 1 to 5 years, 3 volunteers; from 5 to 10 years, 2 volunteers; from 10 to 20 years, 4 volunteers; more than 20 years 4 volunteers.

Vocational training

Various theoretical orientations were represented. Many of the professionals stated that they combine different orientations depending on the case or situation they are dealing with. The following currents were mentioned: Psychoanalysis, Cognitive Behavioral, Gestalt, Systemic Family Psychology, Neurolinguistic Programming, and others.

Complementary training or experience areas

Social work, Labor and Social Psychology, Dyadic Interventions, Psychoanalytic Focal Interventions, Medical Psychology, Addiction Psychology, Crisis intervention, Coaching, Mindfulness.

Study centers

Some volunteers are graduates from the School of Psychology of the University of the Republic (UDELAR) and others from the Catholic University of Uruguay (UCU). One is a graduate in Psychiatry from the School of Medicine of the University of the Republic (UDELAR).

Postgraduate degrees in: UDELAR Health Services, Master's degree at the University of Barcelona, Neuro-child Diploma at the University of Barcelona, Postgraduate degree in a private institute in Buenos Aires, Training courses in a private institute in the United States. Training in psychoanalysis and psychotherapy in the Uruguayan Psychoanalytic Association (APU), Uruguayan Association of Psychoanalytic Psychotherapy (Audepp), Clinica Uno, Prego Clinic and Cognitive Behavioral Training in the Uruguayan Society for Behavior Analysis and Modification (SUAMOC).

Annex 2

Questions for the interviews to the professionals of "volunteering together"

Previous personal data

Please answer the following questions briefly regarding training received.

1. Type of psychological orientation with which you identify and in which you have been trained. Years of training received.

2. Have you completed any postgraduate studies or specialization?

3. Years of experience and types of jobs before staffing the helpline.

Helpline work

1. Day and time you staffed the line.

2. Please describe some cases that have made you reflect more or that have impacted you the most and why.

3. Describe the cases in which you have felt most useful, at least one code green, yellow and red.

4. Describe one case in which you did not feel useful.

5. Did you ever learn how these situations were resolved after the call? Would you have wanted to know?

Thoughts

1. Based on your experience with the helpline, and once the pandemic is over, would a psychological support helpline to assist personal crises be useful for people to receive psychological help?

2. In that case, how many would be the minimum number of calls for a crisis situation?

3. With these calls that are framed as a single call, what is the type of emotional resonance or experience that occurs in each participant? What psychoanalytic theory would call the "transference" phenomenon that occurs.

4. What in your opinion are the advantages and limitations of this tool?

5. Was the training you received sufficient for this task, or would you need a specific one?

6. Do you have any final thoughts to contribute something else or to define the experience in a few words.

Annex 3

Reasons for calling

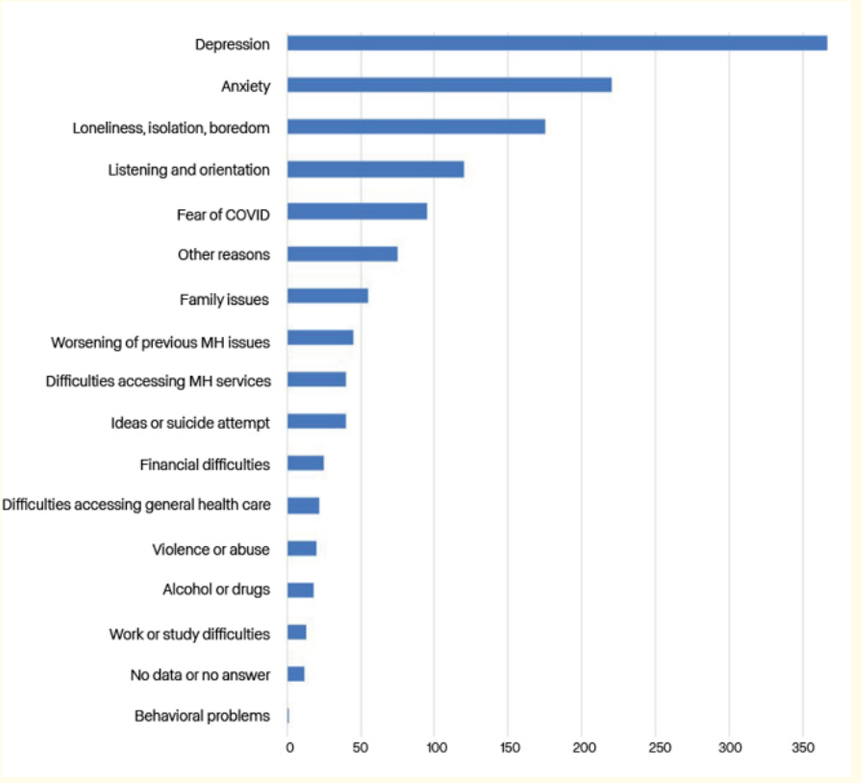

Figure 1

Number of calls

Calls according to severity of problems

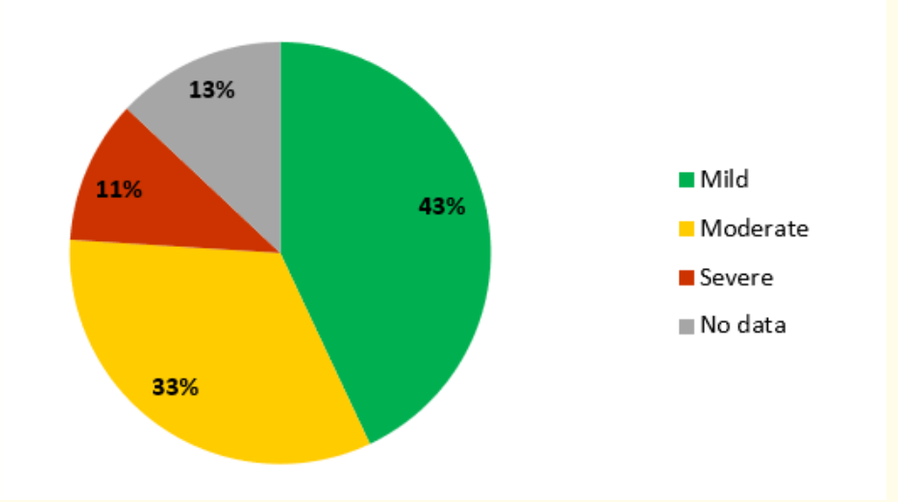

Figure 2

Source: ASSE's Statistics Unit for Mental Health and Vulnerable Population.

Graphics from the paper "Mental Health Assistance and Covid-19: Some initial answers from Uruguay" (Nicolás Bagattini, Denisse Dogmanas, Luis Villalba, Ricardo Bernardi).

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