Amrita COVID Mental Health Helpline

Abstract

Observing the rapid spread of COVID-19 across multiple countries, the Indian government prudently declared a lockdown on March 24, 2020. We anticipated that this safety and precautionary measure would also increase mental health issues among the population due to future uncertainties evoked by the situation. A group of volunteers from Amrita Vishwa Vidyapeetham in Kerala, India responded to these concerns by launching the Amrita Mental Health Helpline to serve people in distress. A telephonic network was established to function remotely, and a system was developed by which to triage more serious or urgent callers to higher level professionals. MSW students were trained extensively as Helpline Mental Health Workers. The helpline opened in April, 2020 primarily for those within Kerala, but people from other states and countries have also called. Within the first month we received 500+ calls of which more than 160 specifically pertained to mental health (MH) needs. The majority of MH callers reported distress related to such issues as the lock down itself, job loss and economic insecurity, medical needs, worry about family, interrupted medical treatments for chronic illnesses, abandonment by a spouse, delusional experiences, and loneliness. Callers have also reported feelings of anxiety and fear, sadness, delusional experiences, suicidal ideation, substance abuse struggles, anger, and relationship discord. Many callers were referred to higher level professionals for more ongoing support. Several callers expressed gratitude for the help they received from the Amrita Helpline.

Introduction

Never in the known documented history of the world have humans witnessed such a rapid, pervasive global spread of an extremely contagious, potentially lethal coronavirus. COVID-19 has brought not only a multitude of physical problems and deaths to the world, but given its many unknowns and initial misinformation from some international leaders, it has also gripped the world with emotional distress, fear, and anxiety. Globally, nearly every country virtually came to a standstill due to this microscopic virus, furthering the reach of anxiety to that of unemployment, economic losses, and food scarcity especially for those in remote, impoverished areas. Although serving a necessary purpose to minimize virus spread, lockdown measures have also increased mental health challenges. This includes familial distress, boredom, anger, and reported increases in child sexual abuse (Kamenetz, 2020) and domestic violence (Ratnam, 2020; WHO, 2020).

Observing the onset of the multi-country rapid spread of COVID-19 and its devastating effects in some nations, the Indian central government prudently declared an ambitious national lockdown

(LD) on March 24, 2020. This was an attempt to protect one of the world's most populated countries from massive and swift contagion, illness, and death. With this enforced safety and precautionary measure, however, we anticipated a rise in mental health issues. Earlier and less severe epidemics have precipitated psychological distress among people (Mak et al., 2009; Maunder et al., 2003; Wu et al, 2005), thus we anticipated the same during this pandemic. We expected to see anxiety about specific fears and needs such as fear of virus contagion to oneself and loved ones, food availability given loss of income (particularly among impoverished, marginalized groups), job availability and security, inability to maintain regular appointments with doctors, financial losses, relational and domestic issues, loneliness, and more. Even as those who could no longer work because of LD reported stress and anxiety, so did those forced to continue working at non-essential jobs without proper COVID-19 testing and precautionary measures. Hence, the simultaneous confluence of multiple high-level stressors would most certainly put many at risk for mental distress and disorders such as mood and anxiety disorders, psychotic disorders, suicidal ideation, and loneliness.

In response to these concerns we established the Amrita Helpline using a systematic approach that includes: a) structured training for assessment and referral of callers, b) A defined network of collaborative professional supports for callers needing further interventions, and c) a documentation system to maintain caller outcomes. The Helpline is a cooperative effort among a multidisciplinary group spanning three locations across Kerala, including Amrita Vishwa Vidyapeetham and MA MATH in Amritapuri, AIMS hospital in Kochi, and Amrita TV in Trivandrum. Helplines in response to crises have been shown to be highly effective in alleviating psychological stress and distress (Ben-Ari & Asaiza, 2003; Shor & Birnbaum 2012; Ekberg et al., 2014). The callers are assured of anonymity, confidentiality, a sincere listening person, support, information, and encouragement. For us, it was a way to provide immediate outreach to those in need during the COVID-19 crisis. It also became a rich field of learning for those who volunteered to serve on the Amrita Helpline, particularly Master in Social Work students.

Combining Learning with Serving - MSW Students Train to become Helpline Mental Health Counselors

Amrita's MSW students were studying a course about Mental and Physical Health (MPH) that began in December 2019, ironically the same month of the first recognition of the novel

coronavirus appearing in China. With the increasingly rapid virus spread worldwide, the course was simultaneously focusing on mental disorders and concepts related to Global Burden of Disease. COVID-19 became an obvious focus of course, including considering the mental disorders that would likely be precipitated by the pandemic.

Due to the pandemic, the University closed and began online classes, the central government declared a lockdown, and we established the Amrita COVID-19 Mental Health Helpline. Eight MSW students in the MPH course elected to join the Helpline as a continuation of their course that, for them, became an experiential, true-to-life fieldwork education. These students all expressed a strong desire to "do something" to help others during the pandemic rather than just sitting at home studying. What started as a structured classroom learning environment became an active, first-hand learning opportunity to understand how fear and anxiety can provoke mental disturbances, and how to help relieve such suffering.

MSW students received structured training and supervision from a Clinical Psychologist through online group meeting platforms, and through provided reading material to study. The students were taught skills in deep listening, brief psychosocial assessments, understanding a caller's needs, and working with callers to choose interventions to help alleviate emotional pain and distress. Having exposure to various forms of mental distress through the Helpline, this became a source of rich learning for students about depressive disorders, anxiety disorders, severe loneliness and social isolation, substance abuse issues, delusional and other psychotic disorders, suicidal ideation, marital discord and other life challenges. Ongoing supervision, training, and debriefing has augmented the learning experience. The MHCs were also prepared to address caller concerns about fake and misleading news, and to correct these (UN, 2020)

Methodology

The telephonic call center was set up with a single phone number to which the concerned people could call. The call center consists of landline phones and depending on the requirement the calls were forwarded to mobile phones of MSW students, psychologists, psychiatrists, and other doctors from the Call Center Help desk. This strategy had to be utilized as it was not possible to get everyone in the same space due to the lockdown. The calls were divided into three types:

1. General calls that consisted of requests for financial aid, scarcity of food and other general requirements but not related to mental health or general health.
2. Calls related to physical health were forwarded to on-site medical doctors.
3. Calls related to mental health were forwarded to the trained MHCs. Depending on their assessment, when necessary the calls were forwarded to higher-level mental health professionals (Psychologists and Psychiatrists).

A log was maintained to keep track of all the calls. With the help of a dashboard details of the calls were saved such as the incoming phone number, and the duration of the call. This helped to conduct proper follow ups and also to maintain a structured case study for all the calls.

Establish a multidisciplinary team of key collaborators

To establish a Helpline that would provide comfort, satisfaction, and encouragement to callers, we sought to create a multidisciplinary team of key collaborators in Kerala. This included personnel from Amrita Vishwa Vidyapeetham (University), Amritapuri, Amrita Institute for Medical Sciences hospital (AIMS) in Kochi, Amrita TV in Trivandrum, and the MA Math at Amritapuri (an international humanitarian institution). Amrita Vishwa Vidyapeetham contributors included researchers and faculty from Engineering, Biotechnology, Corporate Industry Relations, Social Work, Computer Science, and other University departments, and Masters of Social Work students, all from the Amritapuri Campus in Kerala. These combined institutions established a cohesive network to address both the logistical and technical details of the Helpline as well as the psychosocial/medical aspects. The main Call Center is at Amritapuri, MA Math. From here all calls are received and transferred to the appropriate persons based upon the nature of the call, as noted above. The Methodology for creating the Helpline is as follows.

Process Flow

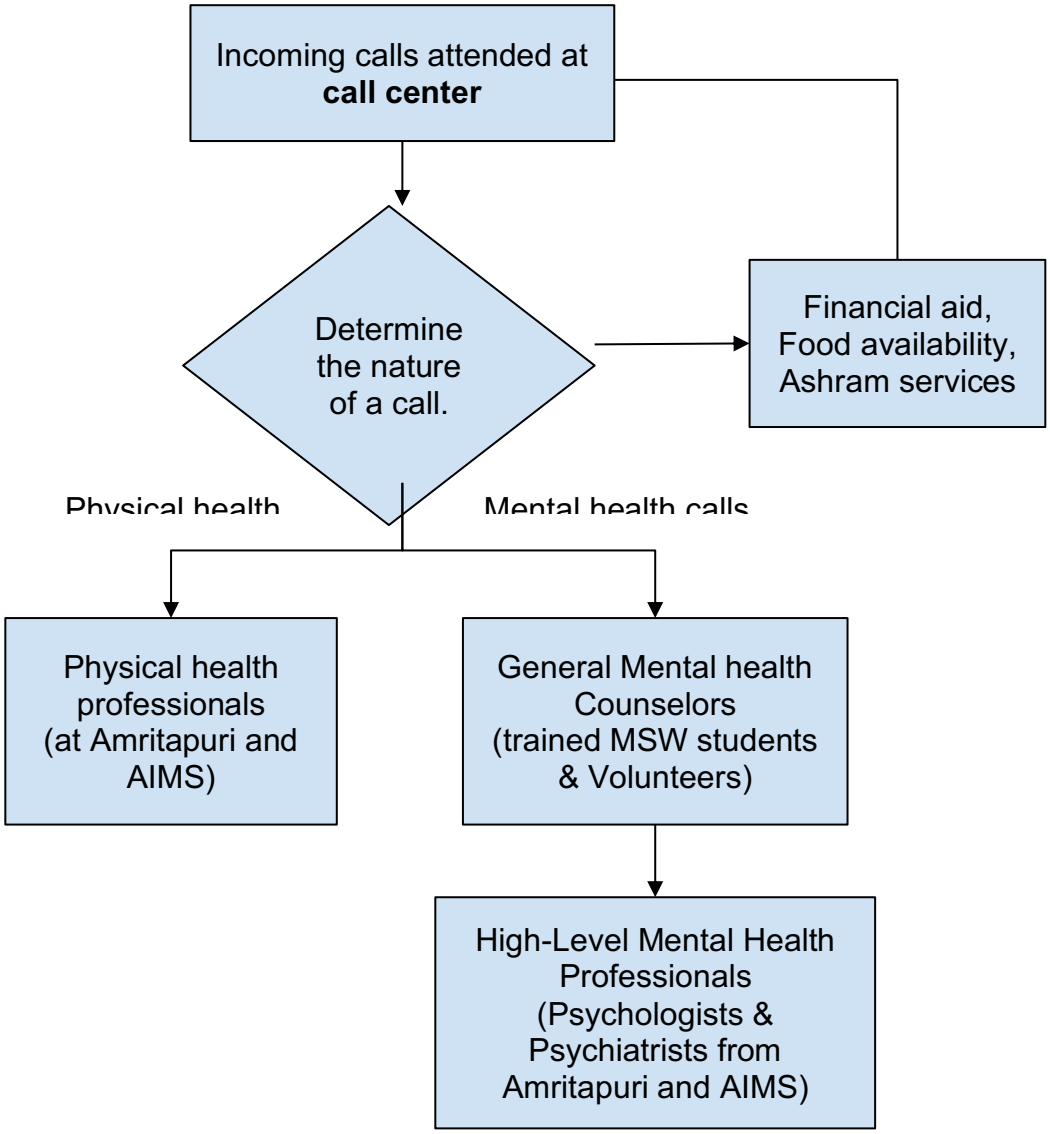

Figure 1 : The flowchart depicts the process followed at the mental health hotline

Establish Logistics Teams and Mental Health Teams

The **Logistics** Teams were compartmentalized into 5 areas, each with specific and unique functions. Each of these is described in more detail, and the Mental Health Team training is described later.

1. Technical team
2. Poster design and publication team
3. Communications managers
4. Call screening and diversion team
5. Data analysis team

1. Technical Team

The technical team dealt with all logistics which, because of the national lockdown (LD) in India, presented unusual challenges. They established a system that could be partially managed from the University location across a body of water (called the backwaters) approximately 1.5 miles from the MA Math grounds. The Helpline Call Center (with landlines) is located at MA Math. But the MHCs are located across four different districts in Kerala, so a remote system was configured to transfer callers to the MHCs via their mobile phones.

2. Call Center screening and transfer team

This team worked at the Call Center. The whole team includes three tiers of call volunteers: 1) Call Center volunteers (located at MA Math in the Call Center with landlines), 2) Mental Health Counselors (MHC) and when needed, medical doctors, and 3) higher level mental health professionals. Anticipating call of varying needs, at the first tier, the Call Center volunteers receive and screen the calls, and transfers them according to the appropriate volunteer based upon the nature of the call. Thus, a tight system was created for receiving and screening calls in order to divert them to either:

- ● Tier One: The Call Center phone team for financial-needs and other calls
- ● Tier Two: Our local ‘in-house- medical doctors for medical concerns
- ● Tier Three: The Mental Health team

Additionally, the Helpline includes an immediate referral system for those in need of more professional help with either a Medical doctor, Clinical Psychologist, or Psychiatrist. The Medical personnel have access to prescribing needed medications via a telemedicine unit.

3. Poster Design and Publication Team

Posters were designed, reviewed, and redesigned until the final accepted version was agreed upon. We wanted to invite particularly those with mental distress to call the line, but we also knew that the stigma related to mental health issues in India would prevent some from calling a Helpline that too prominently displayed itself as a 'Mental Health' Helpline. So several versions were created and the final one included the following words: "*Stressed by COVID-19?"* Beneath this are three words: "*Anxious, Afraid, Feeling low"*. These words were to convey that such feelings would be addressed by the line. The Helpline phone number is large, and just above this we finally did add, in smaller letters, "Mental health helpline."

4. Communications managers.

Communications Managers include a) Communication Coordinator/ liaison between Amrita Helpline Call Center and b) the AIMS (hospital) Communication Manager. These overseers assure that calls triaged from the Amrita Helpline to specific doctors at AIMS (Clinical Psychologists, Psychiatrists, and specialized medical doctors) reach the designated department seamlessly and that the calls are responded to quickly. They also ensure that the outcome of calls diverted to AIMS is documented and promptly sent back to the Helpline in an attempt to verify and conclude a completed call from initial answering of the call, directing it to the helpline volunteer, triage to higher professional if needed, to the final outcome. Thus, we wanted to be sure that no call would be left unattended, and that all callers would have the opportunity for intervention support appropriate to their expressed needs.

5. Data analytics team.

This team keeps track of all incoming calls in an organized system that documents the nature of the call, whether calls are being documented as needing further referrals, following up with the outcome of referrals, and overall seeing that each call completed a closed circuit from initial call to final outcome.

Mental Health Team

The Mental Health Counselors, consisting of MSW students and a few researchers at Amrita Vishwa Vidyapeetham, Amritapuri campus, were trained from start to finish on how to address calls. The training sessions included a 3-step process for addressing MH calls: 1) compassionate, reflective listening, 2) assessing symptoms and other issues, and 3) collaborating with the caller on stress management and self-care strategies that focus on a holistic triad approach of helping the person attend to self-care physically, mentally, and spiritually. Part of the caller assessment involves a Google Forms questionnaire on which to indicate the presence or absence of specific needs, complaints, symptoms, and other factors. The completed form is transferred to a spreadsheet that indicates numeric and written levels of the severity of primary mental health issues, contributing to the decision-making tree of whether a caller required further, or more urgent, help or not. Callers whose distress was of a nature more florid psychotic symptoms such as pressured and disorganized speech are listened to compassionately, and with their permission, are referred for a psychiatric evaluation and medication consultation.

Results

Every call to the Helpline is first screened by the Tier One Call Center volunteers who either resolved the call or send it to either MHCs or to onsite medical doctors (depending upon the nature of the call). Calls have been received from every district of Kerala with Trivandrum, Malappuram, Alleppey, and Ernakulam districts leading the list. Calls have been received from women and men of varied ages, religions, occupations, and languages across India and from other countries. The different categories of calls include seeking financial aid, mental health concerns, medication and physical health issues, and food availability. Of these, financial aid was the needed request from the 59% of the calls. Most callers, 57% have been male, to date (see Figure 2). Of callers who have identified their age, the youngest, to date, has been 20 and

the oldest near 80 (Figure 3).

Mental Health Concerns. People calling the Helpline report psychological symptoms such as depression, anxiety, delusions and other psychotic symptoms, suicidal ideation, substance abuse, loneliness, and more. They have expressed worry and concerns about loved ones living overseas, fear of virus contagion, infection and death, anger and agitation due to the lockdown, domestic problems (including domestic violence), concern about elders living alone, and persecutory delusions of others trying to harm them. A few adults reported struggling with recurring memories of childhood abuse. Others have been left by their spouse, and others, still, expressed strong suicidal ideation. All such calls were addressed by the MHCs. More serious calls were triaged to ongoing care with, as noted earlier, clinical psychologists or psychiatrists. For those resolved by the MHC volunteers, many callers expressed their appreciation for their help, and several called the Helpline again to thank the team.

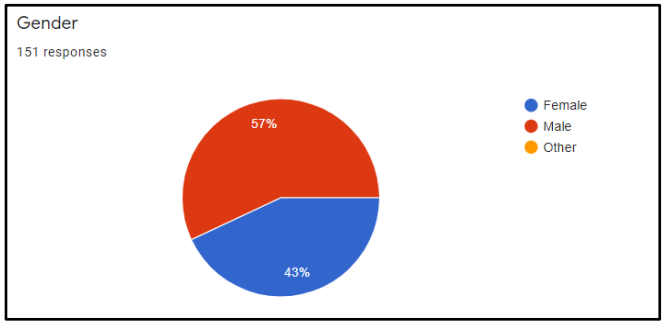

Figure 2. Gender differences in callers.

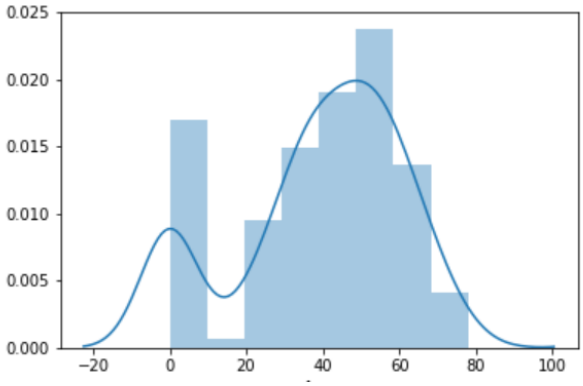

Figure 3: Age range & median

Mean: 39.245033; Median: 44

During the early assessment of callers, the MHCs noted the primary areas of concern that callers addressed. Some callers reported multiple areas of distress. This table applies only to calls that pertained to mental health concerns. The table indictes the most prominent areas of concern expressed.

Table 1. Problem Areas reported as the reason for mental health concern

Lock down	Jobless	Food Availability	Economic Issues	Medication Needs	Being Alone	Family Worries	Stigma
97	46	10	47	56	35	56	19

The MHC volunteers also noted the primary mental health concerns that surfaced during the interview (Table 2 below). As noted in the table, the majority of callers expressed anxiety, sadness, and fear. Those who reported other issues, such as loneliness and anger, were no less distressed, but fewer callers experiened those issues. Figure 4 provides a bar-graph image of the frequency distribution of these areas of concern.

Table 2. Symptoms Observed by the interviewer

Anxiety	Angry	Sad	Loneliness	Fear
104	26	105	35	79

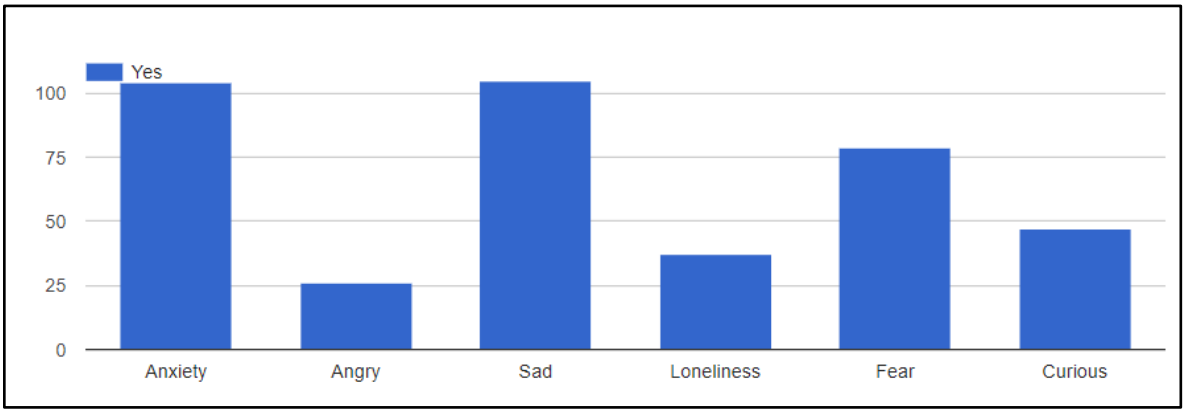

Figure 4. Graph showing the frequency distribution of areas of concern reported by callers.

Examples of Calls

Callers represented varied issues and reasons for calling as noted earlier. Whether they demonstrated anxiety, fear, depression, or delusional experiences, the reasons varied to some degree, and some were similar. Similarities usually were represented by a fear of COVID-19, fear of how long the lockdown would last, and for callers living alone, feelings of sadness, loneliness, and hopelessness were expressed. However, for this latter group, the callers were very responsive to the MHC interventions. Some called back later to express their appreciation.

A small percentage of callers expressed delusional symptoms, mostly of a persecutory nature. One in particular called several times over a 2 to 3 week period. She had not followed through with a psychiatric referral to AIMS that we made for her, and was not complying with medication instructions from an earlier psychiatric provider. Given her repeated calls to us, we worked hard to establish a positive relationship with her in spite of her highly pressured speech, disorganized thinking, and active delusions. But she began to trust us and eventually provided us with the phone number of her adult son who lives with her. Then we established a relationship with him, and eventually were able to convince him to contact AIMS psychiatry again. With patient encouragement from the Helpline team, the son did make the call to AIMS, and he and his mother successfully attended a psychiatric appointment there. She complied with their treatment intervention at that time. Of course, very few calls needed such constant attention to facilitate the caller getting the needed help, but it was a very happy moment for the team to see this woman finally get some relief from her fearful, tormenting delusions.

Below are more examples of calls we have received from callers of the Helpline. We have changed some of the personal details to preserve the anonymity of the caller.

1. A woman called who was highly tense about the COVID-19 pandemic. She was very afraid that she would get the disease. She was spending much time reading the newspaper, watching the news about the virus, and listening to neighbors who were also talking about it frequently. She reported having a particular chronic disease and heard that this illness put her at a much more at risk of getting the virus compared to others. All of these things exacerbated her feelings of anxiety. The MHC took time with this caller, and listened very

closely and sincerely to the woman's concerns, at times reflecting back the woman's meaning. The caller expressed feeling much relief just from that sincere listening. But the MHC continued, and worked with the caller to explore things the caller could do to reduce fear. The strategy was based upon daily attending to taking care of herself on the physical, mental, and spiritual levels at least in a small way each day. They discussed options such as getting exercise, eating well, resting, listening to her favorite music, brief meditation, and doing kind things for others to cultivate compassion for others (redirecting attention from her own fears). They also spoke of her spending less time watching news, and of cultivating courage. The counselor reviewed with the caller all of the precautions necessary to keep oneself and others safe from the virus. This and the other recommendations gave the woman a sense of having more control over protecting herself from the virus. The woman declined a referral offer for further support with higher level professionals, and expressed much gratitude, saying that the call was very helpful and that she would practice the recommendations.

2. The caller was a woman who was feeling very outcast and isolated. She wanted to speak with someone as she was falling into a depression. The caller admitted that not only during the pandemic was she feeling like an outcast, but that she had faced the same issue at other times in her life. The MHC reported that initially it was very difficult to help the caller, and it was a struggle to help the caller consider a path out of her loneliness. But eventually, with listening, understanding, strategizing, and encouraging, after some time the caller's attitude changed substantially from less despair to more balanced optimism. She shared her life stories and family difficulties. The MHC felt that basically, this caller very much needed to speak to someone and she was the one who was willing to maintain a sustained connection during the call. The call ended on a very positive note. But surprisingly, the woman called again after a few days and provided her feedback to our helpline members. She told the Helpline representative that she really wants to meet the MHC who had helped her when she visits the Ashram after the lockdown. Receiving such appreciation after a great effort gave the MHC much happiness.

3. A man called stating that he and his family had not eaten for the prior few days because of

no funds. They depend upon selling wood from the nearby forest for their daily wages, but the lockdown prevented work, so they lacked money to buy food. We asked if neighbours would help for the day, and whether he could contact the village sarpanch. Neither was a feasible option for him as he did not have a cordial relationship with anyone in the village, and did not have access to Sarpanch. We gave to him a state helpline number for this specific kind of help and asked him to call back at the end of the day if they did not receive any help, but he did not call back.

The following morning we followed up with the man. He explained that he could not get through to the state helpline as it was busy all day. But fortunately a family friend visited them the same day and gave them supplies for two days, thus he had not called us back. But he also shared his concern that after two days the family would be back in the same situation. He was given a Block Development Officer number for the Tehsil where the village belonged and asked to contact him directly for help. Later in the day the mn called back thanking us saying the Sarpanch delivered all the essential items for them to live through the lockdown.

Testimonials From the MSW Students

As noted earlier, the MSW students who underwent training to serve on the Amrita Helpline did so as a continuation of their course in Physical and Mental Health. After several weeks of responding to calls from the Helpline, they provided reflections about the experience working the Helpline. Here are a few examples.

- Before joining this Amrita Mental Health Helpline, I just only heard of people who are having psychiatric problems, but after working in this field I came to recognize how much difficulty people are going through. Learning something from a book is different from what we are experiencing in real life situations. Even though I have studied about anxiety disorders and heard about bipolar disorders, dealing with someone who is having that particular disorder is really different.

- The Amrita Helpline program offers a wide platform from which I can understand and learn how different emotions, ranging from simple to complex, can affect a person's complete state of well being. At the same time I played the role of a counselor, listener, and more than that, as a student in this learning platform. I was able to learn how I can promote social and emotional competency and build resilience in each caller, dealing with different psychological and physical and social issues. I am learning to understand the roots of distress, and to provide capacity building among the callers.

- As a social worker I have to say that the Amrita Helpline has contributed a good experience because it gives us the chance to interact with different people in the world. It helps to know more about different mental problems and their root causes among the people. It really helps to increase the confidence level in me. I am also learning about the after-effect of medicines in a person. This experience helped me to understand more about reflective listening.

- At first when I joined the mental health helpline as a volunteer, I had a feeling that I can't handle the emotions of people and it's going to be a tough task for me. But that feeling only lasted through the first two calls I received. After that, during the helpline hours I dealt with people with different mental and other kinds of problems. The day to day experience working on the helpline gave me the interest and the confidence to handle challenging situations in a friendly, empathetic, and consoling manner. It also taught me how to be a good listener. I feel very happy and sure that this experience will definitely be an asset for me in my career as a social worker.

- In the beginning, it was really tough for me to talk with people who were suffering from loneliness who had a lot of pain. In the first such call it was really difficult to ease their suffering. But with more experience I felt more confident working with the people, and more and more they spoke of how much relief they had as a result of our conversation. Even those with a lot of anxiety said how much confidence and relief they experienced from our work on the call. Even some who shared stories, I could see their strength and then helped them to see their own strength. Being one of the members of this helpline gave me so much of a sense of accomplishment about others' problems, especially those who are mentally down due to this

pandemic.

Overall, the Amrita Helpline has been an opportunity to provide an immediate source of support to those suffering through an unprecedented global crisis. It has provided a double benefit of optimal training opportunities for MSW students while also providing comfort, relief, information, and support to callers. The multidisciplinary team has added to the richness of this experience for us all, broadening perspectives and respect for those with varied skills brought to this project by all involved. We are grateful for this opportunity to offer some emotional support during a massive global crisis.

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