Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Tele mental health helplines during the COVID-19 pandemic: Do we need guidelines?

Swarndeep Singh, Rajesh Sagar *

Department of Psychiatry, All India Institute of Medical Sciences, Delhi, India

The COVID-19 pandemic and subsequent public health measures adopted to control its spread (e.g. social distancing, closure of schools/offices) have significant direct (e.g. fear of COVID-19 infection) and indirect (e.g. adverse socio-economic consequences, disruption of daily routines) negative impact on the mental health of the population (Rajkumar, 2020). This psychological distress commonly manifest as increased rates of depression, anxiety, post-traumatic disorder, insomnia, suicidal ideations, and/or harmful substance use behaviours in the general population (Salari et al., 2020; Singh et al., 2021). Further, the World Health Organization survey reported that the COVID-19 pandemic caused significant disruptions in the existing mental health services in about 93% countries worldwide (World Health Organization, 2020). Thus, telepsychiatry and telepsychology services have been recommended as a viable alternative for maintaining continuity of services and addressing mental health issues among people during the COVID-19 pandemic (Malathesh et al., 2020; Peppou et al., 2020). It allows delivery of services by experts remotely through telecommunication technology (telephonic or online-based communication) to people living in distant areas with no physical contact, minimizing the risk of spreading COVID-19 infection. Additionally, telephonic counselling services do not require access to internet or sophisticated digital devices, and would be able to cater a wider range of difficult to reach and vulnerable population groups who are more likely to experience greater levels of psychological distress during the COVID-19 pandemic (Joshi et al., 2021). This is also reflected in the increasing number of tele mental health helplines operating during the COVID-19 pandemic, with both scientific and media reports suggesting positive response towards telephonic counselling or psychotherapy services (IANS, 2020; Ravindran et al., 2020). However, almost all the studies assessing the effect of telepsychology services have included free-of-cost helplines manned by qualified clinical psychologists associated with government institutions or non-profit organizations till now (Hazarika et al., 2021; Joshi et al., 2021; Ravindran et al., 2020). Here, we discuss about potential concerns associated with the working of different tele mental helpline services during the COVID-19 pandemic, and provide suggestions for improvement and quality control of services provided by them.

Tele mental health helplines consists of a heterogeneous group of services depending upon the kind of support offered (e.g. general counselling, child helpline, or suicide prevention helpline etc.), time (i.e. 24 × 7 or certain fixed days and timing) and language (e.g. English/Hindi only, multiple regional languages) of operations, qualification of people handling distress calls (e.g. qualified clinical psychologists, social workers, or volunteers etc.), and free or paid services (Sharma, 2021). Thus, users should be made aware about the exact nature of tele helpline by sharing this information with them at the start of the conversation. This would help avoid confusion and reduce frustration among callers upon discovering these facts at a later stage (e.g. services being not available on weekend or late-night/early morning hours; being charged for the call by their service provider etc.). Second, though guidelines for providing tele psychotherapy or counselling by clinically psychologist and/or trained volunteers are available; these are neither specific nor mandatory or legally binding for tele helpline service providers in most countries including India (Department of Clinical Psychology, NIMHANS, 2020; Indian Association of Clinical Psychologists, 2020). Thus, there is a chance that inadequately trained or unqualified people are engaged in providing these services by some private-run tele helplines, which might end up making callers feel more distressed or helpless. Further, the available literature suggests that inadequately trained or unqualified service providers might be at a greater risk of being negatively affected themselves by attending several distress calls during the COVID-19 pandemic (Joshi et al., 2021). This might be due to their insufficient understanding of the hierarchy of different human needs during a disaster and their lack of expertise in being able to help the callers in distress adequately. Third, there is no available system for assessing the quality of services provided by most of the existing tele helplines or for accrediting helplines meeting certain minimum acceptable good practice standards of tele-psychotherapy. Fourth,

* Corresponding author.
E-mail address: rsagar29@gmail.com (R. Sagar).

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Table 1
Potential problems with services delivered via tele mental health helplines and recommendations to improve its quality and functioning.

Potential Problems	Proposed Recommendations
Lack of transparency about the services or support offered by tele helplines could lead to inadequate resolution of problems and/or increased frustration among callers.	Users should be made aware about the exact nature of tele helpline by sharing this information with them at the start of the conversation and/or disclosing it in the public domain (e.g. website, advertisement) to prevent any confusion or increased frustration among the callers. This should include kind of support provided (e.g. general counselling, child helpline, or suicide prevention helpline etc.), operational timings (i.e. 24 × 7 or certain fixed days and timing), medium of communication (e.g. English/Hindi only, multiple regional languages), qualification of people handling distress calls (e.g. qualified clinical psychologists, social workers, or volunteers etc.), and whether services are free or paid.
Inadequately trained or unqualified people might be engaged in providing tele mental health services in some helplines could negatively affect the mental health of both caller and the receiver (over a prolonged period).	Need for having guidelines on who all can provide mental health support via tele helplines. A creation of central database or online resource to direct callers to trained staff with necessary skills and resources to help people requiring different levels of mental health care or support could streamline the process of tele-referrals. For example, a woman reporting domestic and child abuse on a general helpline could be connected with a specialist equipped in dealing with such situations by the volunteer manning the helpline.
Sub-optimal handling of callers experiencing severe psychological distress which would require urgent intensive care or hospitalization. For example, a patient with severe suicidal ideation hanging up the call after revealing plan to die in near future, and without revealing any other contact details.	Often in these crisis situations there is a need to balance ethical issues related to the confidentiality, anonymity and autonomy of callers with their safety. There is a need to have consensus on how to best activate local support systems (mapping of local resources by mutual consensus or tracking the call location in certain situations) and provide emergency intervention. Also, developing a legal framework providing guidance on responsibilities of various stakeholders (e.g. tele helpline provider, local authorities like police etc.), and permissible violations of privacy done in the best interest of person in such crisis situations would also be helpful.
Lack of adequate quality check and control on the services provided by most of the existing tele mental health helplines.	A system for accrediting tele mental helplines meeting certain minimum acceptable good practice standards of tele-psychotherapy could be created. Further, information related to indicators of performance/ quality of tele helplines (e.g. number of calls handled on an average day or week, average duration of call, average waiting time for callers, number of callers successfully connected with a nearby health provider or emergency services, satisfaction feedback by clients, etc.) should be periodically audited by a responsible agency and/or displayed publicly for creating awareness among general people. There is also a need for development of short training courses for volunteers manning these tele helplines (preferably in online mode with an exit exam assessing basic knowledge and skills).
Lack of adequate evidence-base supporting the effectiveness of tele mental health helplines in improving long-term outcomes among the callers.	There is a need to conduct research about the quality of services offered by different tele helplines including those run by non-profit and private organizations. Also, the qualitative experiences of service users and long-term follow-up outcomes need to be systematically assessed to evaluate the effectiveness of different types of tele mental health helplines.

information or indicators related to the performance or quality of these tele helplines (e.g. number of calls handled on an average day or week, average duration of call, average waiting time for callers, number of callers successfully connected with a nearby health provider or emergency services, satisfaction feedback by clients, qualification or training of people involved in handling calls on tele helplines etc.) need to be audited by a responsible agency and/or displayed publicly for creating awareness among general people (MacDonald, 2015). There is a need to regulate the practice of tele-psychotherapy and promote greater transparency about the quality and nature of services provided by existing tele helplines. Lastly, the ethical issues dealing with confidentiality, anonymity and autonomy of callers in situations of severe psychological distress (e.g. informing legal services or police about a caller with imminent risk of suicide) requiring more intensive care or hospitalization also needs to be addressed in an appropriate manner, especially in the absence of any well-established rules or laws defining the responsibilities of tele mental health helplines in such situations (Mondal et al., 2020).

Table 1 summarizes some of the most relevant problems with the current tele mental health services, along with possible solutions to improve the quality and functioning of these helplines in the future. There is a need to conduct research about the quality of services offered by different tele helplines including those run by non-profit and private organizations. Also, the qualitative experiences of service users and follow-up outcomes need to be systematically assessed to evaluate the effectiveness of different types of tele mental health helplines. There is also a need for development of short training courses for volunteers manning these tele helplines (preferably in online mode with an exit exam assessing basic knowledge and skills), along with setting-up of mandatory practice standards or rules to comply with for all tele mental health helplines. The authors appreciate the positive role played by tele mental health helplines in addressing psychological distress among people during the COVID-19 pandemic; but would like to draw the attention of mental health professionals, policy makers, and other stakeholders towards the need for having a critical look at the quality of services offered by different kinds of tele mental health helplines, its short- and long- term impact on the mental health outcomes among callers and counsellors or volunteers, development of quality assurance mechanisms, and addressing ethical and safety concerns associated with tele-psychotherapy.

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Conflict of interest

The authors have no conflict of interest to declare.

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