

BRIEF REPORT

Psychological helpline in response to the COVID-19 pandemic in the Dominican Republic

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Abstract

The global health emergency due to COVID-19 is a disruptive event that has had various effects on mental health. Given this emergency, the Dominican Republic intervened to mitigate the negative impact of the pandemic, considering the physical isolation decreed in the country. In this context, the Autonomous University of Santo Domingo and the School of Psychology designed the *UASD COVID-19 Psychological Helpline*. The objective of this article is to describe the development, implementation and evaluation of a programme of psychological first aid. The programme aimed to attenuate the impact of morbidity and mortality due to mental health issues associated with the COVID-19 pandemic through mobile technology. There were 62 psychologists involved and trained to provide care, and a protocol was developed, implemented, monitored and evaluated. Over the course of four months, the programme assisted 497 people. The average age of the participants was 32 years, and 73% were women. The reasons for contacting the helpline included anxiety, stress, depression, domestic violence, suicidal behaviours and other behavioural problems. Following the intervention, most users reported feeling satisfied and having improved emotions. The first psychological aid in the country developed through telephone and chat messaging was an optimal resource since face-to-face interaction was not possible. It also reached more people and reduced the attention gap.

KEYWORDS

crisis intervention, pandemic, psychological first aid, psychosocial intervention, telephone helpline

1 | INTRODUCTION

On 31 December 2019, the World Health Organization (WHO) received notification of several cases of pneumonia from Wuhan, China. Later, on 30 January 2020, the outbreak of the novel coronavirus 2019-nCoV (COVID-19) was declared a public health emergency of international concern (World Health Organization, 2020a, 2020b). On 28 February 2020, the Ministry of Public Health of the Dominican Republic reported the first cases of COVID-19 (Ministry

of Public Health, Dominican Republic, 2020). From 16 March, as in other countries, the government applied measures for social distancing and policies for citizen security, including the closure of educational, labour and leisure activities (Ministry of the Presidency, 2020). The Dominican Republic has not had drastic measures involving confinement and social distancing. Being a country with cultural activities that invite the masses and involve the social and emotional closeness of the people, the fear and dismay of the population was immediately noticeable.

A crisis such as a health emergency, as in this pandemic, produces conditions for emotional instability in people as a result of exposure to high levels of stress (Pan American Health Organization, 2006a). Studies report that in an emergency or disaster situation there can be a notorious increase in mental illness. Twenty-two per cent of people who have been affected by a disaster suffer from depression, anxiety or post-traumatic stress (World Health Organization, 2019). Studies conducted during the pandemic suggest that important mental health implications are expected in the population, and that these may be long lasting, especially for those affected by the quarantine situation (Brooks et al., 2020). Furthermore, there have been warnings of the increase of domestic violence and the exposure of children, adolescents and women to being victims of abuse and aggression (UNICEF, 2018). This emergency needed interventions to mitigate the negative impact of the pandemic on the lives of this unprotected population.

Mental health professionals in the country already had experiences with interventions in emergency and disaster situations (Ministry of Public Health & Social Assistance, Dominican Republic, 2010). However, it became a challenge to develop intervention strategies in the new context of the COVID-19 pandemic. The confinement entailed the impossibility of intervening face to face, so interventions needed to be oriented at a distance, using remote communication through technology.

To understand the context, the Dominican Republic has limited mental healthcare resources (World Health Organization, Pan American Health Organization, & Ministry of Public Health, 2008). The model of care has focused on the care of people with serious mental disorders in large hospitals in the city, with the modality of hospitalisation and outpatient consultation, with a low capacity for care in the community and for those with psychosocial problems. Attention to child and adolescent mental health is much scarcer, with only three large hospitals in two provinces of the country serving children and adolescents, with limited capacity. Users of mental health services report significant barriers to access, such as limited time to attend consultations, difficulties in economic resources for transportation, the purchase of medications and difficulties in scheduling appointments (Caplan, Little, et al., 2018).

The country does not have national community research or surveys on morbidity due to mental disorders; studies of prevalence by demand in health services (Ministry of Public Health, 2019) are also limited. However, the National Epidemiological Surveillance System records that the most reported mental health issues are anxiety attacks, depression crises and alcoholism. Of concern is the steady increase in cases of suicide among adolescents and young people (Luciano et al., 2019).

In the pandemic, mental health services were closed, and only emergency services in major hospitals were open. There was no structure in place in the country to respond to mental health needs in health emergencies.

The authors of this project have experience in the development of app-based mental health programmes, but intervention via the Internet or using mobile or residential telephony had not previously

Implications for Practice and Policy

- The *UASD COVID-19 Psychological Helpline* was a mental health support service developed as a rapid, efficient and timely response to the challenges that the COVID-19 pandemic imposed on the mental health of the Dominican population. The service was provided virtually and using telecommunications, facilitating the provision and access to psychological first aid services. It became a national model of digital public health intervention that demonstrates the usefulness of digital media and the need to move towards sustainable types of mental health support.
- This therapeutic modality has a cost-benefit that helps to reduce the gap in mental health care.
- The model improves the monitoring of health actions and outcomes and, above all, brings the service closer to those at greater psychosocial risk in the community. This closeness is vital because it includes populations highly vulnerable to violence and abuse such as children, adolescents and women.

been implemented at a large scale by psychologists and therapists in the Dominican Republic. Therefore, this was a challenge for psychologists and therapists who wanted to develop an intervention at the national level. The development of medical health interventions based on technology is very low in the Dominican Republic; however, professionals identified some conditions that could facilitate the acceptability of the use of technological tools for health and mental health treatments. The first was to review international experiences of using a psychological helpline in an emergency, and the opportunities associated with the implementation (Hillers Rodríguez & Rey Bruguera, 2006; Jiang et al., 2020).

The Dominican Republic has a connectivity rate of 79.95%, equating to 8,354,051 people with Internet accounts (Dominican Telecommunications Institute [INDOTEL], 2020b). Nonetheless, there are significant gaps in Internet access given that 83% of the highest socioeconomic stratum (quintile 5) have Internet access compared to 3.7% and 10.4% of poor households (quintile 1 and 2, respectively) (Dominican Telecommunications Institute [INDOTEL], 2020a).

Studies indicate that people recognise digital mental health interventions as convenient, private and affordable (Caplan, Sosa Lovera, et al., 2018). For mental health personnel, traditional training focuses on face-to-face interactions, and there are not institutional programmes or interventions based on the use of mobile technology for mental health care. Nevertheless, research suggests that health personnel value the implementation of technology in mental health (Caplan, Sosa Lovera, et al., 2018).

Faced with this health situation, the School of Psychology at the Autonomous University of Santo Domingo (UASD) organised the

UASD COVID-19 Helpline Service to offer psychological first aid to the Dominican population. The objective of this paper is to describe the development, implementation and evaluation of this programme of care in psychological first aid. The programme was facilitated by technology and worked towards a goal: to reduce the impact of mental health morbidity and mortality due to the COVID-19 pandemic. This programme is the first national emergency helpline in the country.

2 | METHODOLOGY

On 16 March, the government declared nationwide quarantine, and on 21 March, the *UASD COVID-19 Helpline* began operations as the first national mental health support resource. The helpline initially was only available to people linked to the University (students, professors and employees, more than 250 thousand people), but it became a national line for the entire Dominican Republic (10 million inhabitants). It had a team of 62 professionals of psychology, composed of part of the teaching team of the Autonomous University of Santo Domingo, divided into three work cohorts, available from Monday to Wednesday, from 7 a.m. to 11 p.m. This team was led by professionals from psychology and public health with experience in mental health interventions in emergency and disaster situations.

The programme's intervention protocol is based on the Five Steps of First Psychological Help of the Practical Protocol of Psychosocial Support in Disaster Situations of the Ministry of Public Health and Social Assistance (MISPAS) (Ministry of Public Health & Social Assistance, Dominican Republic, 2008); the Pan American Health Organization (PAHO)/WHO Practical Guide to Mental Health in Disaster Situations (Pan American Health Organization, 2006b); and the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Humanitarian Emergencies and Disasters (2007) (Inter-Agency Standing Committee [IASC], 2007).

The School of Psychology called on professors of psychology, psychiatry and other areas of health sciences who wished to join the helpline voluntarily. The training of the first cohort (36 professionals) was through presentations with audio, created using Microsoft PowerPoint software, and reading materials shared by emails and messaging in WhatsApp groups. The trainees also participated in virtual meetings through the Zoom platform for training on the protocol of action and the First Psychological Aid. The material focused on the characteristics of virtual interventions, recommendations, ethical aspects in psychological interventions in emergencies, and digital technology usage. Also, the training addressed the ways of registering for interventions and the route of action in situations of risk of mental health. Situations of risk entail the detection and referral for issues including psychiatric decompensation, violence, suicide attempts, depression crisis and anxiety crisis. In addition, exercises with case studies and a pre-test and post-test were included as a self-assessment to measure the change in knowledge.

For the formation of the second cohort, the university identified different psychology professionals, graduate students and other professors at the university from the health department who were interested in being part of the helpline. A selection was made through telephone interviews by a staff member in occupational psychology, who was also part of the management team of the helpline. Their eligibility relied on their professional profiles, their link with the university, the availability of support and voluntariness. In addition, the participants signed a contract for the confidentiality and security of information.

In the second cohort, online training took place through the Google Classroom platform for care professionals, with the same topics and activities as described above. Also, through the Zoom platform, professionals developed subjects synchronously and conducted trials of helpful interventions. This second group added a service for people with hearing disabilities, through the use of a professional expert in sign language available via WhatsApp video call to assist this population.

The psychologists used their mobile phones and Internet service to perform the intervention from home, besides contributing to the development of the intervention with their knowledge and time. Only three participants used mobile phones assigned from the UASD. In the other cases, the professionals used their personal phone numbers. All interventions were performed via calls to mobile phones, as well as video calls and messages through WhatsApp.

Each professional who attended to a case was asked to report the general aspects of the case in a data record on the Google Drive platform. The information gathered included date and time of service, province, the reason for calls, gender and age, referral made, and detection of a situation of psychological risk (decompensated psychiatric crisis, suicidal behaviour, violence, anxiety crisis, depression crisis).

As a way of safeguarding the mental health of participants, there were three working cohorts. The first cohort of 36 mental health professionals offered services from 21 March to 11 April 2020. The second cohort of 25 professionals provided services from 12 April to 23 May. At the end of this time, a third cohort was convened, consisting of 12 professionals who participated in the first and second cohorts and four new volunteers, from 24 May to 17 July.

A management team was responsible for the supervision, monitoring and evaluation of the reporting of the cases. They were also responsible of the compliance with the protocols of action, the analysis of the data and the generation of weekly bulletins. Constantly, through a WhatsApp group with the entire team and personal communication, the reported cases were followed up and support was offered to the staff on the correct procedure in each situation and the timely reporting of cases was reiterated.

At the end of each cohort, there was a closing meeting to debrief and provide emotional support for the staff. In addition, a specialist in Information and Communication Technology was involved to protect the telephone identity of the staff and reduce the likelihood of identity theft through the phone and WhatsApp.

TABLE 1 Distribution of age groups and gender of the people who received care

	Female		Male		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Children under 17	15	4	4	3	19	4
From 18 to 25 years old	127	35	35	26	162	33
From 26 to 35 years old	95	26	53	39	148	30
From 36 to 45 years old	53	15	29	21	82	16
From 46 to 55 years old	43	12	7	5	50	10
Over 55 years of age	28	8	8	6	36	7
Total	361	100	136	100	497	100

Each staff member obtained a certificate of recognition for their volunteer work on the *UASD COVID-19 Helpline*.

2.1 | Detection of risk situations

The care protocol called for the identification of risk situations. In these cases, professionals referred the users to the mental health services of the local public network.

The management team, coordinated with the National Department of Mental Health and the National Health Service, worked together to ensure the timely response to people identified as at risk.

2.2 | Promotion and dissemination of the helpline

The Department of Communications of the University designed a written advertisement containing the telephone numbers and schedules of the volunteers and short videos promoting the service with the support of volunteer publicists. These lists and videos were promoted by the social networks of the University and the Dominican College of Psychologists. In addition, promotion occurred through WhatsApp groups and personal social networks of participating psychologists, students and teachers, groups of psychologists and other communities. Journalistic notes reporting on the service of the helpline were prepared and disseminated by the national media.

2.3 | Feedback on the service provided

Within the protocol of action, the user was asked for authorisation to make a follow-up call. Within one week of receiving assistance through the helpline, a team of six psychologists made calls to the users who authorised the follow-up on their cases. These calls examined the compliance with the protocol, as well as the improvement of the individual intakes and the detection of risk situations at home. The Dominican College of Psychologists covered the cost of the Internet for these calls.

TABLE 2 Origin of calls to the helpline

Province	Frequency	Percentage
Santo Domingo	240	51
Santiago	45	9
San Cristobal	23	5
Barahona	11	2
Duarte	9	2
Other provinces	81	16
Internationals	78	16
Total	497	100

2.4 | Helpline assessment survey by care staff

The staff completed an assessment survey once the interventions in the Helpline had finished. The survey allowed the coordinating team to identify the opportunities for improvement of the helpline's processes, as well looking at the remote teaching of the staff.

3 | RESULTS

3.1 | Characteristics of the intervened population

During the four months of intervention, 497 people were assisted, with an average of eight interventions completed per day and 45 interventions completed per week, approximately. The average age of those receiving care was 32 years, with 73% of cases being women and 27% men. Fifty-four per cent of people who received assistance were from the National District and Santo Domingo; 14% of people called from abroad. The rest of the calls were from other provinces of the country (Tables 1 and 2).

3.2 | Characterisation of assistance provided

Eighty-three percent of the attention was called for the first time. The main reasons for the calls were because people had signs of

	Female		Male	
	Frequency	Percentage	Frequency	Percentage
Signs of anxiety	121	33	39	30
Signs of stress	76	30	25	83
Signs of depression	33	9	10	8
Domestic violence	35	10	3	2
Suicidal behaviour	25	7	11	8
Other mental health problems	50	14	14	11
Other physical health problems	25	7	30	23
Total	365		132	

TABLE 3 Reasons for attention by gender

TABLE 4 Assessment of the service by users

	Very good rating								Very bad rating	
	5		4		3		2		1	
	F	%	F	%	F	%	F	%	F	%
User believes that the psychologist paid attention to what they said	160	83	24	13	6	3	2	1	0	0
User believes that the psychologist showed interest in what they said	167	87	19	10	4	2	2	1	0	0
User believes that the recommendations given by psychologists were helpful	133	69	42	22	11	6	4	2	2	1
User considers that their emotions improved after the intervention	85	44	68	35	29	15	4	2	6	3

anxiety (32%), stress (20%), depression (9%), intrafamily violence (8%) and suicidal behaviours (7%). Other circumstances included behavioural management of sons and daughters at home, relationship/marital issues, problems with schoolwork and requesting information about COVID (24%).

There was a total of 162 cases (32.5%) of high-risk reported, some identified as anxiety crises, depression crises, suicidal ideation and attempt, and domestic violence.

The preferred means of communication was messaging by WhatsApp (47%), followed by calls from local mobile numbers (39%), and then WhatsApp calls (24%) (Table 3).

3.3 | Feedback on assistance provided

A total of 192 feedback and service assessment surveys were completed by people who had received care through the helpline. More than 80% of users felt that psychologists paid a lot of attention and interest. Eighty-one per cent of respondents considered the recommendations given as useful, and 79% noted that their symptoms improved after the telephone intervention.

Most people indicated they would call the Helpline again if they felt emotionally unwell (96%), and 97% said they would recommend it to other people (Table 4).

3.4 | Assessment of the intervention by the care staff

At the end of the operation of the helpline, a survey was carried out with the staff. Of the 46 people who responded to the survey regarding the training provided, the majority believed that the content was good (92%), the objectives of the training were met (98%), the material used was adequate (96%), and the medium used was good (96%).

Regarding the care provided, they felt that the protocol provided was easy to use (94%), it was easy to communicate with users (98%), and they valued the use of technology for mental health care positively (98%).

When asked about the aspects they considered facilitated care, they pointed out that the protocol was very helpful. Other aspects valued positively were the systematic recording of information, the personal well-being of knowing that another person was supported, and working from home without leaving behind work and home responsibilities. They emphasised that the most complex situation is not being able to follow-up with people since, in most cases, they needed medium- or long-term mental health care, where the psychological first aid was not enough.

In 57% of cases, the care staff believed that they improved their handling of technology after participating in the helpline. The

majority (87%) believed that they will use technology to continue their clinical practice (Table 5).

4 | DISCUSSION

The *UASD COVID-19 Helpline* was the first emotional support resource available to the entire Dominican population following the impact of the pandemic. The helpline supported a proportion of the population, but it was not enough for the whole country, as many people were never able to access mental health services. The same happened in other countries, where the rate of use of helplines was very low (Michaud et al., 2020).

However, some elements that could help the development of a mental health helpline in future health emergencies stand out. Strengths in the development of the helpline were the professional competencies in mental health care issues in emergencies and disasters, and the experiences of approaching digital mental health. These two competencies facilitated the development of the project.

Similarly, leadership and organisational skills of the team granted the development of the idea in a short time.

Access to electronic applications and resources that facilitated communication and teaching were of great help in the transmission of knowledge and the training of the team. However, better technological tools and more online training programmes could be used in the future.

The collaboration between the Faculty of Humanities and the Faculty of Health Sciences of the University and the Dominican College of Psychologists was a strength for the development of the interventions since the collaborative effort allowed the identification

of human resources, facilities for technological tools, promotion, dissemination services, and economic resources for the payment of part of the helpline service.

4.1 | Limitations

During the training, some challenges arose, such as the availability of technological resources for the development of the helpline and the vulnerability of the personal data of the team. Since professionals were using private numbers, they were exposed to threats such as the hacking of WhatsApp accounts.

There was also a barrier to access for people not having available minutes or Internet to access the service. In some situations, calls or chats were interrupted, and only staff who had funds available on their phone could return the call and continue the intervention.

Another limitation is that there was no specific protocol for support in situations of violence or care for people at risk of suicide.

Users identified situations of risk or that required a medium- or long-term intervention by mental health services that they could not access public services for, since the country was focusing hospital care on COVID-19 patients. Similarly, the helpline management team's efforts to establish collaboration with government entities were not successful.

The data registrations were stored in free-to-use software, where each provider could modify the forms. Each cohort had different forms. Each working group had updated data records, which limited the homogenisation of the variables and indicators. In turn, this impeded the process of organisation and cleaning of data and its subsequent analysis.

TABLE 5 Survey of assessment of the intervention by the helpline staff

	Very good rating								Very bad rating	
	5		4		3		2		1	
	F	%	F	%	F	%	F	%	F	%
Assessment of the content of the training	26	57	16	35	4	9	0	0	0	0
Assessment of the level of compliance with training objectives	33	72	12	26	1	2	0	0	0	0
Assessment of the materials used in the training	28	61	16	35	2	4	0	0	0	0
Assessment of the medium used for training	29	63	15	33	1	2	0	0	1	2
Ease of use of the care protocol	33	72	10	22	1	2	1	2	1	2
Ease of communication with users	35	76	10	22	1	2	0	0	0	0
Consideration of the use of technology in psychology	35	76	10	22	1	2	0	0	0	0

For the evaluation of the service, an analysis of the data could not be performed according to the demographic data of age, sex and locality, which could provide more insight into the responses service users.

5 | CONCLUSION

The UASD COVID-19 Psychological Helpline was a mental health support service developed as a rapid and timely response to the challenges that the COVID-19 pandemic imposed on the mental health of the Dominican population. The service was virtual and used telecommunications, facilitating the provision and access to psychological first-aid services. It became a national model of digital public health intervention that demonstrated the usefulness of digital media and the need to move towards sustainable types of mental health support. This is all the more important considering that a mental health service had never been developed in such a short time and with the use of digital technology in the country. This therapeutic modality has a cost-benefit that helps to reduce the gap in mental health care. The model improves the monitoring of health actions and outcomes and, above all, brings the service closer to those at greater psychosocial risk in the community. This closeness is vital because it includes populations highly vulnerable to violence and abuse such as children, adolescents and women.

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CONFLICT OF INTEREST

The authors of this article worked on the development of the Helpline described in this article and currently serve as directors and faculty of Psychology, Public Health, Bioethics, and Health Research, and declare no conflict of interest.

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