

Article

Telephone-Based Psychological Care During the 2020 Lockdown in Spain and Protocol for Data Collection

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ABSTRACT

Background: During the COVID-19 lockdown in 2020, the General Council of Psychology in Spain, together with the regional Official Colleges of Psychology, launched the Psychological Care Telephone Program (PCTP) to provide mental health services to the population. **Method:** The aim of the present study was to perform a descriptive analysis of the PCTP by analysing the data collected during the lockdown and at the 12-month follow-up, and to develop a brief protocol designed to standardise data collection procedures. **Results:** A total of 10,119 inbound telephone calls were made to the PCTP from March to May 2020, and 337 follow-up calls at 12 months. The most common reasons for contacting the PCTP were to consult for symptoms of anxiety (66.8%), depression (30.5%), and/or family problems (13.9%). At the 12-month follow-up, many users experienced anxiety (38%), depressive (35%), and panic (34%) symptoms. More than half of users reported using psychopharmacological medicines. **Conclusions:** This study demonstrates the need to offer the population telephone-based mental health consultations during times of crisis. It also shows the importance of systematising intervention and data collection procedures for future crises. We propose a data collection protocol for use with emergency telephone psychological assistance programmes.

Programa Telefónico de Atención Psicológica Durante el Confinamiento de 2020 en España y Protocolo de Recogida de Datos

RESUMEN

Antecedentes: Durante el confinamiento de 2020 por la COVID-19, el Consejo General de la Psicología junto con los Colegios Oficiales de la Psicología, lanzaron el Programa Telefónico de Atención Psicológica (PCTP) para atender a la salud mental de la población. **Método:** El objetivo del presente estudio fue realizar análisis descriptivos del PCTP con los datos recogidos durante el confinamiento y en el seguimiento a los 12 meses, y proponer un protocolo breve para unificar la recogida de datos. **Resultados:** Se analizaron 10,119 llamadas telefónicas realizadas al PCTP en el confinamiento de 2020, y 337 llamadas de seguimiento a los 12 meses. Los motivos llamados más frecuentes fueron los síntomas de ansiedad (66.8%), depresión (30.5%) y/o problemas familiares (13.9%). En el seguimiento a los 12 meses, los usuarios del PCTP presentaban síntomas de ansiedad (38%), depresión (35%) y pánico (34%); más de la mitad de los usuarios informaban del consumo de psicofármacos. **Conclusiones:** Este estudio destaca la necesidad de ofrecer atención telefónica a la salud mental de la población y sistematizar la intervención y la recogida de datos frente a futuras crisis. Proponemos un protocolo de recogida de datos para su uso en programas de asistencia psicológica telefónica de emergencias.

Palabras clave:

Atención psicológica
Teléfono de ayuda
Ansiedad
Depresión
Emergencias
Protocolo

During the pandemic caused by the SARS-CoV-2 virus, there was a substantial increase in demand for online and telephone-based psychological help and support services around the world. For example, one study collected data on eight million telephone calls in 19 countries, finding that calls to helplines increased by approximately 30% during the first wave of the pandemic, and 40%–81% of calls were made by first-time callers (Brühlhart et al., 2021). A study conducted in Australia found that demand increased among children and adolescents, most notably for online consultations (Batchelor et al., 2021). A study carried out in Ireland observed changes in callers' behaviour patterns before and during the COVID-19 crisis. That study found a notable increase in the mean duration of the calls made during the pandemic, with fewer brief calls (around 5 minutes in duration) and more calls lasting ≥ 30 minutes (Turkington et al., 2020). These data, considered as a whole, illustrate the impact of the pandemic on emotional wellbeing in the general population and its impact on support-seeking behaviour.

Another behavioural change in the demand for psychological help and support observed during the pandemic was a notable increase in users seeking help due to fear and loneliness (Brühlhart et al., 2021). The lockdown and the overwhelming demand for health care services affected not only patients with medical conditions but also mental health outpatients, with one study in China finding that nearly 71% had to postpone treatment (Gao et al., 2020). In a study conducted in Bangladesh, 80% of service users presented crisis-related anxiety and insomnia (Iqbal et al., 2021). There was also an increase in other mental health issues, including suicidal ideation/self-harm and family relationships; however, the most common reasons for consultation were concerns related to COVID-19 (Batchelor et al., 2021), with several studies reporting a significantly higher prevalence of symptoms (panic, anxiety, depressive) related to COVID-19 (Arora et al., 2022; Ravindran et al., 2020; Santabárbara et al., 2020; Santomauro et al., 2021). For instance, a study conducted in Spain found that worries about the risk of infection were associated with an increase in generalized anxiety in the Spanish population (Muñoz-Navarro et al., 2021). In Spain, 65% of the general population reported anxiety or depressive symptoms (Fullana et al., 2020). A study performed in Greece found that 23.3% of callers to a mental health helpline had suffered a panic attack in the prior 2 weeks (Peppou et al., 2021); moreover, although anxiety symptoms were more common than depressive symptoms, there was a greater prevalence of clinically-significant symptoms of depression versus anxiety (37% vs. 20.3%). In a study conducted in the United States by Gallagher et al. (2020), approximately one-third of callers met criteria for probable anxiety and depression, especially patients who were diagnosed with (or believed they were suffering from) COVID-19, and those with a close relative who became ill or died from COVID-19. The presence of significant perceived stress levels due to COVID-19 was a strong predictor of greater functional impairment, health anxiety, and symptoms of depression and anxiety. These data suggest that people with emotional disorders, particularly older and less well-educated individuals, were more vulnerable to the impact of the pandemic (Gao et al., 2020).

Spain was one of the European countries most affected by COVID-19 pandemic (Balmford et al., 2020). A state of alarm was declared in Spain on March 14, 2020 to control the spread

of the SARS-CoV-2 virus. Shortly thereafter, the Official Colleges of Psychology (COPs; in Spanish) in Spain launched the Psychological Care Telephone Program (PCTP) to offer free, telephoned-based counselling and psychological interventions during this period. This service was aimed mainly at people affected by COVID-19, including people who were possibly ill with COVID-19, relatives of the deceased, elderly living alone, people with disabilities and their families, or anyone whose psychological wellbeing was affected.

The PCTP was staffed by licensed psychologists. It received more than 30,000 telephone calls, demonstrating the rapid organizational capacity of the COPs to develop and implement this program throughout the country. This intervention could have been vital in mitigating the psychological impact of the pandemic, as studies have shown that psychological telephone assistance services can help people to cope with the emotional discomfort caused by the pandemic, as well as prevent long-term psychological problems (Ravindran et al., 2020; Turkington et al., 2020). Importantly, such services can provide a rapid response to emergency situations, such as suicidal ideation (Fernández-Montalvo et al., 2021). In this line, a study conducted in India showed that helplines are efficient interventions (Ravindran et al., 2020) and that most service users (90%) were satisfied with the care received, with most respondents stating that they would use the service again.

In this context, the aim of the present study was to perform a descriptive analysis of the PCTP by analysing the data collected during the lockdown period and at the 12-month follow-up. A second aim was to develop a brief protocol designed to standardise the data collection procedures for use in future emergencies.

Method

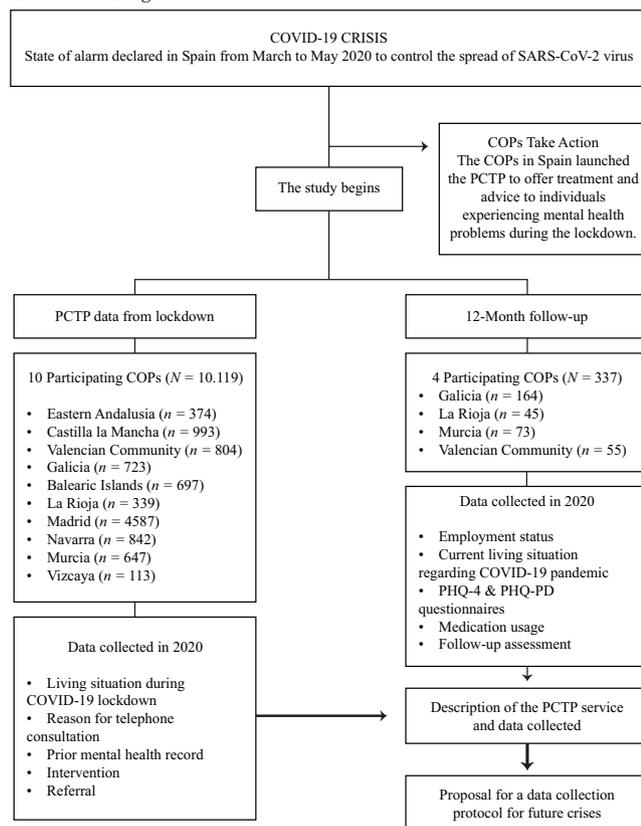
Participants

The PCTP was launched in March 2020 to offer telephone-based psychological care to individuals with mental health issues during the lockdown of the first wave of COVID-19. Spain has 17 autonomous communities (regions) with a total of 22 COPs. Working in collaboration, each of the COPs established a separate emergency telephone number available to anyone in Spain who needed professional help for a mental health issue. In most cases, the line was open 24 hours a day, 7 days a week. The PCTP were staffed by volunteers (all licensed psychologists), who were organised into shifts. In most cases, the calls were managed through telephony applications and software that diverted the calls to a software application installed on the volunteers' computers.

The crisis and emergency groups at each of the COPs prepared their own independent intervention guidelines to help orient the response with basic care guidelines. The volunteer teams were supervised by emergency area coordinators who were available to resolve doubts, report the need for follow-up, and to handle other aspects related to the intervention. The volunteer psychologists were instructed to make every effort to keep the intervention brief and specific (since it was a crisis intervention, not a psychotherapy consultation) to ensure that they could reach the largest possible number of people. After each call, the psychologists completed a report with descriptive data on the care provided.

From March to May 2021, we contacted representatives of the 22 COPs in Spain to invite them to participate in the present research project. A total of 10 COPs agreed to participate in the study. These included COPs in the following regions: Eastern Andalusia, Castilla la Mancha, Valencian Community, Galicia, Balearic Islands, La Rioja, Madrid, Navarra, Murcia, and Vizcaya. The total sample includes 10,119 calls. Of the 10 original COPs, four COPs (Galicia, Murcia, La Rioja, and the Valencian Community) participated in the follow-up assessment. Representatives of the participating COPs called the service users between April and July 2021 to administer the follow-up evaluation. The follow-up sample includes 337 calls. The study flow diagram is shown in Figure 1.

Figure 1
Method Flow Diagram



Instruments

PCTP Data From the Lockdown Period

Standardized, encrypted database with information on interventions made during calls to the PCTP during the 2020 lockdown period (March to May 2020).

12-Month Follow-Up

Follow-Up Survey. We created an ad hoc, telephone-based assessment procedure to collect data on the status of a sample of PCTP users at 12-months of follow-up. This interview assessed

living situation during COVID-19 lockdown, symptomatology (PHQ-4 and PHQ-PD), medication use, and a PCTP assessment of the care received.

Symptoms of Anxiety and Depression (PHQ-4). The PHQ-4 (Kroenke et al., 2009) was used to assess anxiety and depression symptoms. This scale is an ultra-brief screening composed of two items to assess depression (PHQ-2) and two items to assess anxiety (GAD-2) in the last 2 weeks on a 4-point Likert scale from 0 (not at all) to 3 (almost every day). Total PHQ-4 scores range from 0 to 12 points with a cut-off score point of ≥ 3 in each subscale. This questionnaire has shown adequate psychometric properties (sensitivity and specificity) as well as good internal consistency (PHQ-4, $\alpha = .83$; PHQ-2, $\alpha = .86$; and GAD-2, $\alpha = .76$; Cano-Vindel et al., 2018). The corresponding values for data in the present study were as follows: PHQ-4, $\alpha = .89$; PHQ-2, $\alpha = .89$; and GAD-2, $\alpha = .84$.

Panic Attacks (PHQ-PD). The PHQ-PD was used to assess the presence and frequency of panic attacks. This panic item assesses the presence of somatic symptomatology of panic attacks, “in the last 4 weeks, did you have an anxiety attack—sudden feeling of fear or panic?”, on a scale with two response categories no (0 points) and yes (1 point). Panic attack is considered to be present if the individual answers “yes”. This one-item scale presents good sensitivity and specificity (.83 and .66 respectively; Muñoz-Navarro et al., 2016).

Procedure

We asked the participating COPs to provide the data collected from the telephone consultations during the lockdown period (March to May 2020). These data were provided in a Microsoft Excel or Word file. The data were encrypted and any personal information that could identify the users of the service was removed. We standardised the information and created a database comprised of nine study variables: age, sex, reason for telephone consultation, previous calls (if any), living situation during COVID-19 lockdown, previous psychological clinical history, intervention performed, and referral information (if any).

The total sample included 10,119 calls, some of which were repeat service users. However, given the lack of a standardized information collection protocol, data are missing for many of the study variables. In some cases, no data were collected or recorded due to the emergency intervention. In addition, since the variables registered depended on the criteria defined by the individual COP and/or consulting psychologist, not all variables were available. However, we created a unified database based on the available data. In many cases, even though certain variables were not described on the intervention summary sheet, we were able to retrieve these data by reviewing the notes made by the intervening psychologist on the summary report. Consequently, in cases in which data for certain study variables were missing from the summary report, we performed a full text analysis of the psychologists’ reports, which allowed us to obtain the missing data for many variables. In some cases, the classification was simpler than in others. For example, for the variable “reason for telephone consultation”, we included the following as anxiety symptoms: “anxiety”, “fear”, “anguish”, “fear of contagion” or “worry”, and other less clear ones such as “uncertainty” or

“overload”. For “depressive symptoms”: “depression”, “sadness”, “low mood”, “hopelessness”, “guilt” or “loneliness”, and other less clear ones such as “not feeling anything”, “feeling of emptiness”, etc. Sometimes, reasons such as “overwhelmed”, “frustration”, “rage”, “anger”, “impotence”, “discomfort”, and “emotional exhaustion” were included as both anxiety and depression symptoms.

At the 12-month follow-up assessment, we determined the following data: sociodemographic variables, current living situation regarding COVID-19 pandemic, information about the service user’s current psychological status and status during the lockdown, medications, the users’ opinion of the PCTP and other psychological care services, evaluation of the psychological care received. In addition, we administered two questionnaires to assess anxiety and depression symptoms (PHQ-4) and panic attacks (PHQ-PD). Using these data, we developed a novel, brief data collection protocol, which we propose for future use to standardise data collection procedures for all COPs during emergencies (e.g. pandemic, earthquake, etc.). The data collection protocol proposal is shown in Table 2.

The study was conducted in accordance with the principles of the Declaration of Helsinki and following the Spanish Law on Data Protection (approved by the International Ethics Committee of the La Fe University and Polytechnic Hospital on 01/13/2021).

Data Analysis

Descriptive analyses were carried out with the available information from the 10,119 calls made during the 2020 lockdown to the PCTP. The users’ sociodemographic data are included, followed by a description of how callers fall into the above categories indicated in the results section.

Results

Sociodemographic Data

The present sample includes 10,119 telephone consultations made between March and May 2020. The caller’s sex was reported in 9,316 calls. Most consultations were made by women (71.2%). Age was recorded in 7,830 calls. Most calls ($n = 6,329$; 80.8%) were made by adults between 18 and 65 years old, while 18.1% ($n = 1,421$) were from people \geq age 66 and 1% ($n = 80$) of calls were made by young people (< 18 years). The mean (*SD*) age was 49.7 (16.27) years, ranging from 7 to 98 years. For the younger callers, in most cases the parents were the ones who initiated the call. For the analysis, we divided the sample into five age groups, as follows: < 18 years ($n = 80$; 1% of calls), age 18 to 35 ($n = 1,515$; 19.3%), age 36 to 50 ($n = 2,641$; 33.7%), age 51 to 65 ($n = 2,173$; 27.8%), and ≥ 66 ($n = 1,421$; 18.1%).

Living Situation During COVID-19 Lockdown

We obtained data on the COVID-19 living situation during the lockdown of the callers in 6,259 cases, distributed as follows: relative of a person who died of COVID-19 (11%), elderly person living alone (9.6%), person with disability (8.3%), possibly ill with

COVID-19 (8.4%), etc. Callers could be classified as experiencing more than one situation. Consequently, the 6,259 cases were classified into 7,107 different situations. Most of the calls were classified as “other” ($n = 3,081$; 43.4%), which refers to situations other than those directly related to COVID-19 (Table 1).

Reason for Telephone Consultation

The most common reason for the consultation was anxiety symptoms ($n = 6,761$; 66.8%), depressive symptoms ($n = 3,085$; 30.5%), and sleep disturbances ($n = 959$; 9.5%). Note that more than one reason could be assigned to a given call. For example, 31% of people with symptoms of anxiety also had symptoms of depression, and 11.3% had sleep problems. Similarly, 65.9% of people with depressive symptoms also had anxiety, 13.2% had sleep problems, and 6.8% suicidal ideation.

Other reasons for consultation were as follows: to request advice or counselling (on how to cope with the lockdown, communicate bad news, or manage cohabitation; $n = 859$; 8.5%), the grieving process ($n = 661$; 6.5%), gender violence ($n = 47$; 0.5%), family problems ($n = 1,411$; 13.9%), suicidal ideation ($n = 394$; 3.9%), substance use ($n = 124$; 1.2%), and other reasons ($n = 1,385$; 13.7%).

Prior Mental Health Record

We obtained data on the callers’ mental health record from 2,643 calls (26.1%). Note that callers could have a history of more than one disorder. In terms of severe mental disorders, 28.2% of the sample revealed to have received a previous a diagnostic of personality disorder and 28.7% bipolar disorder.

PCTP Service Demand

Of the 10,119 calls received, 25.2% ($n = 2,552$) of users had called PCTP on more than one occasion.

Intervention

Data on the specific intervention were available from 7,303 calls. To facilitate data analysis, we classified the intervention into three levels, as follows: 1) initial intervention ($n = 4,365$; 59.8%), which included emotional ventilation techniques, validation, active listening, etc.; 2) psychoeducation counselling ($n = 5,532$; 75.7%), which included initial evaluation, assessment of resources, emotional support, psychoeducation, self-care guidelines, referral, etc.; and 3) coping interventions ($n = 3,533$; 48.4%), which included cognitive-behaviour therapy (CBT) interventions and emotion management techniques, among others. In 35.8% ($n = 1,562$) of the registered interventions, all three levels of intervention were required.

Referral to Other Services

In 2,407 cases (23.7%), the caller was referred to another service, mainly to specialized care (27.4%), primary care (18.9%), or mental health/hospital services (17.2%).

Table 1
PCTP Data From the Lockdown Period and 12-Month Follow-Up

Theme	Subtheme	Frequency, <i>n</i> (%)	Theme	Subtheme	Frequency, <i>n</i> (%)	Theme	Subtheme	Frequency, <i>n</i> (%)	
Participating COPs	Eastern Andalusia	374 (3.7)	Reason for Telephone Consultation	Relative of a person with a disability or dementia	358 (5)	Prior Mental Health Record	Anxiety	692 (21.5)	
	Castilla la Mancha	993 (9.8)		Relative of COVID-19 patient	234 (3.3)		Depression	657 (20.4)	
	Valencian Community	804 (8)		Person with disability	590 (8.3)		Bereavement/grief	117 (3.6)	
	Galicia	723 (7.1)		Elderly living alone	685 (9.6)		OCD	97 (3)	
	Balearic Islands	697 (6.9)		Other	3081 (43.4)		Eating disorder	32 (1)	
	La Rioja	339 (3.4)		Anxiety symptoms	6761 (66.8)		Addictions	193 (6)	
	Madrid	4587 (45.3)		Depression symptoms	3085 (30.5)		Suicidal ideation	98 (3.1)	
	Navarra	842 (8.3)		Sleep disturbances	959 (9.5)		Severe mental disorder	623 (19.4)	
	Murcia	647 (6.4)		Ask for advice/counselling	859 (8.5)		Violence	100 (3.1)	
	Vizcaya	113 (1.1)		bereavement/grief	661 (6.5)		Does not specify which one	427(13.3)	
Living Situation During Lockdown	Sick of COVID-19	600 (8.4)	Substance use	Gender violence	47 (0.5)	PCTP Service Demand	Other disorders	178 (5.5)	
	Possibly ill with COVID-19	416 (5.9)		Family problems	1411 (13.9)		There were previous calls	2552 (25.2)	
	Living with sick people	236 (3.3)		Suicidal ideation	394 (3.9)		Intervention	Initial intervention	4365 (59.8)
	Working in contact with sick people	162 (2)		124 (1.2)	5532 (75.7)		Psychoeducation counselling intervention		
	Relative of deceased by COVID-19	745 (11)		Other	1385 (13.7)		Coping counselling intervention	3533 (48.4)	

Table 1
PCTP Data From the Lockdown Period and 12-Month Follow-Up (Continued)

Theme	Subtheme	Frequency, <i>n</i> (%)	Theme	Subtheme	Frequency, <i>n</i> (%)	Theme	Subtheme	Frequency, <i>n</i> (%)
Referral	Emergencies	167 (8)	Current Living Situation Regarding COVID-19	Unemployed (looking for a job)	46 (13.6)	PHQ-4	No contagion and healthy	162 (45.9)
	Police/civil guard	29 (1.4)		Unemployed (not looking for a job)	40 (11.9)		Vaccinated	180 (51)
	Information	289 (13.9)		Affected by employment regulation file	5 (11.9)		Other	7 (2)
	Social services	195 (9.3)		Sick leave (temporary)	18 (5.3)		Anxiety symptoms	128 (38)
	Primary care	394 (18.9)		Sick leave (permanent)	34 (10.1)		Depression symptoms	118 (35)
	Mental health/hospital	360 (17.2)		Retired	71 (21.1)		Panic symptoms	114 (34)
	Associations and support networks	81 (3.9)		Working in contact with sick people	4 (1)		Medication to sleep	169 (50.1)
	Specialized care	573 (27.4)		Relative of a person with a disability or dementia	29 (8.2)		Medication for anxiety	170 (50.4)
Participating COPs at the Follow-up	Galicia	164 (48.7)	Person with disability	20 (5.7)	Follow-up Assessment	Medication for depression	148 (43.9)	
	La Rioja	45 (13.3)	Elderly living alone	20 (5.7)		Very good	285 (84.6)	
	Murcia	73 (21.7)	Living with sick people	5 (1.4)		Good	51 (15.1)	
	Valencian Community	55 (16.3)	Relative of deceased by COVID-19	16 (5)		Bad	1 (0.3)	
Employment Status at Follow-up	Employee (full time)	102 (30.3)	Possibly ill with COVID-19	1 (0.3)				
	Employee (part time)	21 (6.2)	Got sick from COVID-19	33 (9.3)				

Note. OCD = obsessive compulsive disorder

12-Month Follow-Up Evaluation

We obtained follow-up data from 337 users, which was less than expected due to the large number of unanswered calls and repeated telephone numbers (many people had called the service on more than one occasion). The follow-up sample was mainly comprised of women (73.3%). Most patients (67%) were between the ages of 36 and 65, with 33.5% in each group (36–50 and 51 to 65). In terms of employment status, most people were inactive (63.5%), versus 36.5% active (Table 1).

Current Living Situation Regarding COVID-19 Pandemic

In the follow-up call, we assessed the user’s situation regarding COVID-19 pandemic. A large proportion were not infected and healthy (45.9%); however, 9.3% had developed COVID-19. In 8.2% of cases, the user reported a relative with disability or dementia. A percentage of 5.7% were elder people living alone. Users could be classified into more than one category.

Symptomatology

The PHQ-4 and PHQ-PD questionnaires were administered during the follow-up call. Using these screening tests, more than one-third of the 337 users presented symptoms of anxiety (38%), depression (35%), and/or panic attacks (34%) in the last 4 weeks. More than half of the users surveyed (*n* = 169; 50.1%) reported using sleeping pills. A large percentage of users were taking medication for anxiety (*n* = 170; 50.4%) and/or depression (*n* = 148; 43.9%).

PCTP Assessment

During the follow-up, users were asked to indicate how they felt during the lockdown period, with 55.2% and 30.6% describing this as *very bad* or *bad*, respectively; by contrast, only 5% and

0.9% reported feeling *good* or *very good*. To the question of *how are you feeling currently*, 8.6% and 21.4% responded *very bad* and *bad*, respectively, while 31.8% and 16% responded *well* and *very well*, respectively.

Most users (92.3%) considered the care received during the lockdown to be helpful or very helpful. More than half (53.7%) of users reported having received (or currently receiving) any psychological treatment (35.6% in the public system and 24.6% private). Most users (86.3%) were dissatisfied with the psychological treatment in the public system and most (78%) also indicated a need for better access to public psychological treatment. Nearly all of the users were appreciative of the follow-up call, with 99.7% rating it as *good* or *very good*.

Data Collection Protocol Proposal for Future Crises

During the course of carrying out this study, the need to develop a data collection protocol for telephone psychological care programs became evident. There is a clear need to develop standardised assessment criteria and data collection protocols for future crises and emergencies. Therefore, based on our experience in this project, we developed a protocol to facilitate and harmonize data collection processes, including the key variables that should be recorded. Given that data collection during a crisis can be highly challenging, we sought to develop a protocol that allows the psychologist to collect information in a flexible manner appropriate to the intervention. In other words, it should be quick and easy to record the data on those key variables by simply checking a box on a form (thus obviating the need to write down the data). In this way, the attending psychologist can select one or more of the options for each variable, leaving blank any options that do not apply. In this protocol, we included both the PHQ-4 and the PHQ-PD as rapid screening tools to detect symptoms of emotional disorders; nevertheless, the decision to administer those tools (or not) is up to the psychologist. The proposed tool is shown in Table 2.

Table 2
Data Collection Protocol Proposal for Future Crises

Sociodemographic Data	
Participating COP/ province	
Age	
Sex	
Current employment status	
Living Situation Regarding X Crisis	
Sick/ affected by X	<input type="checkbox"/>
Possibly ill with/ affected by X	<input type="checkbox"/>
Living with person sick/affected by X	<input type="checkbox"/>
Working in contact with person sick/affected by X	<input type="checkbox"/>
Relative of person who died of X	<input type="checkbox"/>
Relative of X patient	<input type="checkbox"/>
Relative of a person with disability or dementia	<input type="checkbox"/>
Person with disability	<input type="checkbox"/>
Elderly person living alone	<input type="checkbox"/>
Not infected and healthy/unaffected by X	<input type="checkbox"/>
Other	<input type="checkbox"/>

Table 2
Data Collection Protocol Proposal for Future Crises

Reason for Telephone Consultation		
	Anxiety symptoms	<input type="checkbox"/>
	Depression symptoms	<input type="checkbox"/>
	Sleep disturbances	<input type="checkbox"/>
	Asking for advice/counselling	<input type="checkbox"/>
	Bereavement/grief	<input type="checkbox"/>
	Gender violence	<input type="checkbox"/>
	Family problems	<input type="checkbox"/>
	Suicidal ideation	<input type="checkbox"/>
	Substance use	<input type="checkbox"/>
	Other	<input type="checkbox"/>
PHQ-4		
	Over the last 2 weeks how often have you been bothered by the following problems? Not at all/ several days/ more than half the days/ nearly every day	
	Feeling nervous, anxious or on edge	<input type="checkbox"/>
	Not being able to stop or control worrying	<input type="checkbox"/>
	Feeling down, depressed or hopeless	<input type="checkbox"/>
	Little interest or pleasure in doing things	<input type="checkbox"/>
PHQ-PD		
	Over the last 4 weeks have you had an anxiety attack or sudden feeling of fear or panic? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Prior Mental Health Record		
	Anxiety	<input type="checkbox"/>
	Depression	<input type="checkbox"/>
	Bereavement/Grief	<input type="checkbox"/>
	OCD	<input type="checkbox"/>
	Eating Disorder	<input type="checkbox"/>
	Addictions	<input type="checkbox"/>
	Suicidal ideation	<input type="checkbox"/>
	Severe mental disorder	<input type="checkbox"/>
	Violence	<input type="checkbox"/>
	Type not specified	<input type="checkbox"/>
	Other disorders	<input type="checkbox"/>
Medication Use		
	Medication to help sleep	<input type="checkbox"/>
	Medication for anxiety	<input type="checkbox"/>
	Medication for depression	<input type="checkbox"/>
	Other	<input type="checkbox"/>
PCTP Service Demand		
There were previous calls		
Intervention		
	Initial intervention	<input type="checkbox"/>
	Psychoeducation counselling intervention	<input type="checkbox"/>
	Coping counselling intervention	<input type="checkbox"/>
Referral		
	Emergencies	<input type="checkbox"/>
	Police/civil guard	<input type="checkbox"/>
	Information	<input type="checkbox"/>
	Social services	<input type="checkbox"/>
	Primary care	<input type="checkbox"/>
	Mental health/hospital	<input type="checkbox"/>
	Associations and support networks	<input type="checkbox"/>
	Specialized care	<input type="checkbox"/>

Note. More than one option can be selected for each variable

Discussion

A total of 10,119 inbound telephone calls were made to the PCTP from March to May 2020. The most common reasons for contacting the PCTP were to consult for symptoms of anxiety (66.8%), depression (30.5%), and/or family problems (13.9%). More than 25% of patients sought psychological support from this service on more than one occasion. At the 12-month follow-up assessment (337 telephone calls), we found high rates of anxiety (38%), depressive (35%), and panic (34%) symptoms. A substantial proportion of the users reported using sleeping pills (50.1%) and medications for anxiety (50.4%) or depression (43.9%). These findings highlight the need to improve telephone access to psychological treatment. Similarly, the finding of this study also underscore the need to systematize evaluation and intervention protocols in future crises, for which we propose a data collection protocol for an emergency psychological care telephone system.

Importantly, we found that 25% of the calls to the PCTP during the lockdown period were repeat calls. However, this figure is likely higher since incoming calls were answered by the first available psychologist, and unless the caller specifically indicated that this was a second call (or the call was answered by the same psychologist who also recognized the caller), there would be no way to know if they had called before. Considering that the service was organized into several shifts, it seems highly likely that the 25% figure for repeat calls was actually higher, but these data were not registered. In any case, we found that a considerable proportion of the sample (at least 25%) required more than one intervention. In addition, at the 12-month follow-up, the users presented symptoms of emotional disorders, with approximately one-third of patients reporting symptoms of anxiety, depression, and panic, even 12 months after the initial lockdown. Moreover, a high proportion of the service users were taking psychotropic drugs for sleep-related issues (50.1%), anxiety (50.4%), and depression (43.9%) at the 12-month follow-up.

Our findings with regards to the proportion of users with emotional symptoms are consistent with previous reports on the prevalence of emotional disorders during the pandemic. A recent meta-analysis found that approximately 25% of the general population experienced anxiety during the pandemic versus 7.3% in non-pandemic periods, indicating a three-fold increase in the prevalence of anxiety during the COVID-19 pandemic (Santabárbara et al., 2020). Another meta-analysis found that prevalence rates for anxiety and depression during the pandemic were 28% and 22%, respectively (Arora et al., 2022).

In the follow-up evaluation, most users (> 90%) considered the care received to be helpful or very helpful. A similar percentage of users stated that making the call was beneficial. These results are consistent with those reported by Sosa-Lovera et al. (2022), who evaluated a similar telephone psychological care service in the Dominican Republic. In that study, most users were satisfied with the service and noted that it improved their emotional state. According to those authors, the telecare format (chat and telephone) was the optimal option to reach more people given that face-to-face interaction was not possible.

A large proportion of users (> 86%) of the PCPT reported being dissatisfied with access to public psychological treatment in Spain, with more than three-fourths underscoring the need for

better access to treatment. Given this finding, it seems clear that a telephone-based service such as the PCTP would be beneficial to treat mental health issues in any future crises. Indeed, multiple studies have reached this same conclusion, as the pandemic has revealed a clear and urgent need to address mental health issues in the population and to strengthen mental health systems globally (Santomauro et al., 2021). To this end, strategies should be implemented to preserve the mental health and wellbeing of vulnerable groups (Santabárbara et al., 2020), and governments should strengthen mental health care by providing psychological interventions and assistance (Monreal-Bartolomé et al., 2022; Tian et al., 2020), especially to primary care services, where evidence-based treatments can be offered efficiently to address common mental health problems (Cano-Vindel et al., 2022; Munoz-Navarro et al., 2022). Our findings also suggest a need to increase resources for mental health problems in children and adolescents (Racine et al., 2021; Zhang et al., 2021), including programmes to detect mental health issues, and to offer treatment at universities and colleges (Deng et al., 2021). In this regard, the meta-analyses by Zhang et al. (2021) and Wang et al. (2022) both point out the need to design and implement prevention programs to address students' mental health. The COVID-19 pandemic and the restrictions imposed to control the spread of the virus have had—and still could have—a significant impact on mental health in the population. The relevant authorities must be aware of this and should strengthen mental health care services by implementing psychological support services to manage both the present situation and future emergencies in the medium and long term (Barguilla et al., 2020; Bäuerle et al., 2020; Mucci et al., 2020; Wang et al., 2020).

It seems clear that a standardized approach to data collection and analysis is needed for all COPs so that future telephone psychological care programmes all follow the same protocols and collect the same variables. Based on our findings and those of similar studies, it is evident that a telephone-based mental health service like the PCTP is essential. Without it, Spain would not be prepared for possible future crises. In this regard, we believe that the COPs in Spain are probably best prepared to manage this type of psychological care service. These organizations are the natural point of contact with mental health care professionals and thus capable of establishing these types of programmes. We believe it would be advisable to establish a PCTP that can be rapidly deployed should a similar crisis emerge in the future.

The present study has several limitations. The main limitation of this study is related to the objective of the PCTP, which was to offer emergency psychological care during the 2020 lockdown. In other words, this programme was designed to provide emergency care, not to collect detailed data. As a result, data collection was inconsistent, with missing variables in many cases, in part due to the time constraints of the brief telephone consultation. In addition, there was no standard protocol and thus the different COPs collected data for different variables (based on their own criteria). Consequently, in many cases, data were not collected for all of the study variables. Nevertheless, in most cases, the consulting psychologists collected more data (or different data) than requested, even though most of these professionals prioritized patient care over data collection, leading to missing data. To partially overcome this limitation, we performed a full-text analysis of the psychologists' reports in order

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Declaration of Interests

The authors declare no conflict of interest.

Data Availability Statement

Data available on request.

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to retrieve and categorize as much data as possible. However, the lack of a specific assessment instrument or questionnaire means that information on certain variables (e.g., the prevalence of some symptoms) could be imprecise. Another limitation is that we were unable to contact the entire sample of users during follow-up, for a range of different reasons (e.g., most telephone numbers were not registered or were incorrect, or there was no answer). Moreover, many telephone numbers were duplicated because the person had contacted the PCTP more than once. Another potential limitation is that our efforts to standardize and group the data could have biased the results. By contrast, the study has several important strengths, most notably the large sample size, which makes the results more robust. Another strength is that the study was conducted during a major crisis (COVID-19), and is one of a limited number of studies that assessed the impact of a telephone-based psychological care programme offered by licensed psychologists.

To conclude, this study presents data from more than 10,000 telephone consultations made during the COVID-19-related lockdown in Spain in the year 2020. The most common reasons for psychological consultation were symptoms of anxiety (66.8%), depression (30.5%), and family problems (13.9%). In addition, more than 25% of patients sought psychological support from this service on more than one occasion. At the 12-month follow-up, approximately one-third of patients had symptoms of anxiety, depression, or panic, and half were on sleeping pills and taking psychotropic drugs for anxiety or depression. These data highlight the need to improve telephone access to psychological treatment, especially in health and community public services, as well as the importance of systematizing evaluation and intervention protocols in future crises, for which we propose a data collection protocol for an emergency psychological care telephone system.

Author Contributions

María Carpallo-González: Conceptualization, Data Curation, Methodology, Writing – Original Draft. Ana M. Nuñez-Rubines: Investigation, Data Curation. **Joaquín T. Limonero:** Writing – Review & Editing. **Pablo Fernández-Berrocal:** Writing – Review & Editing. **Roger Muñoz-Navarro:** Funding Acquisition, Methodology, Project Administration, Supervision, Writing – Review & Editing.

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