"*We Are Together*": Operating Protocol and Preliminary Evaluation of a Telephone Line for the Support of Healthcare Professionals During the Covid-19 Pandemic

Maria NK KARANIKOLA, PhD, MSc, BSN,[a] *Anna HATZIOANNOU, PhD (c), MSc, PMHN,*[b] *Virginia Sunday KOUTROUBAS, MSc (c), BA,*[c] *and Katerina KAIKOUSHI, PhD (c), MSc, PMHN*[d]

Objective: *The aim of the present article is to present the operating protocol of this helpline, as well as preliminary results of its evaluation.* ***Background:*** *The "We Are Together" telephone support helpline (TSH) was developed for the empowerment of healthcare professionals in view of the psychological distress associated with the Covid-19 pandemic.* ***Methods:*** *Based on a scoping literature review the steps for the development of the TSH included: (a) identification of the objectives of the TSH, (b) description of the basic concepts and the structure of the telephone call, (c) development of the operating tools of the TSH, (d) definition of criteria for the enrollment of mental health professionals, (e) development of an educational program for those staffing the TSH, (f) design of the monitoring and evaluation methods of the TSH. Preliminary evaluation of the helpline was based on descriptive statistics (volume and length of calls, demographic and vocational data of service users, cause of call, number of recalls).* ***Results:*** *During the first month of the helpline operation, only a limited number of calls was received. Only 20% of the service users were healthcare professionals, specifically emergency and critical care nurses, while the rest came from various backgrounds, including healthcare students, private sector employed citizens, unemployed, people with mental health issues, and the elderly. The majority of users were female.* ***Conclusion:*** *Additional measures to monitor and evaluate the effectiveness of the TSH regarding the psychological and mental health needs of its users are necessary.*

Keywords: Covid-19, pandemic, empowerment, critical care nurses, helpline, mental health

INTRODUCTION

Although data on COVID-19 and its implications for nurses are emerging, a number of empirical studies report on the health burden, physical and mental, imposed on healthcare professionals (HCP) working in the present pandemic conditions (Huang et al., 2020; Li et al., 2020; Shechter et al., 2020). In addition to the excess fatigue and anxiety, a percentage of clinicians have been exposed to the virus, as reported in a study in Chinese HCP (Huang et al., 2020). The International Council of Nurses has stated in May that at least 90,000 healthcare workers have been infected by the virus and more than 260 nurses have lost their lives, including critical care nurses (ICN, 2020). Specifically, 6% of global confirmed cases are healthcare workers; as a result, many of them have been asked to self-quarantine (Bielicki et al.,

[a]*Associate Professor, Mental Health Nursing, Cyprus University of Technology, Department of Nursing, 15, Vragadinou str-Limassol, 3041, Cyprus. E-mail: maria.karanikola@cut.ac.cy*

[b]*Mental Health Nurse- CBT Therapist, Cyprus Mental Health Services, 10, Triptolemou, flat 4, 1087, Nicosia, Cyprus*

[c]*Research Fellow, Cyprus University of Technology, Limassol, Cyprus*

[d]*Community Mental Health Nurse, Cyprus Mental Health Services, 54, Charalambou Mouskou, 5282, Famagusta, Cyprus*

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2020). Among them are nurses employed in Intensive Care Units (ICU) and emergency departments (ED).

The necessity to support critical care nurses to effectively cope with the physiological, psychological, and mental stress experienced during infectious disease outbreaks is well described (Adams & Walls, 2020; Maben & Bridges, 2020; Morganstein, 2020; Su et al., 2007). Concern over their family's safety, anxiety due to unfamiliar work environment and processes, limited work experience in infectious disease units, distress about the possibility to contract the disease, increased workload and subsequent long-term fatigue, as well as disappointment and depressive mood resulting from deteriorating status of those cared for, have been reported as the main stressors in critical care nurses during the Covid-19 pandemic (Shen et al., 2020). Despite this awareness, healthcare systems remain mostly unprepared to provide essential support to critical care nurses during the current, extremely stressful, pandemic situation (Montemurro, 2020).

Moreover, empirical studies in the general population, including critical care nurses, have described additional negative mental and psychological phenomena in people who were quarantined, such as symptoms of posttraumatic stress disorder, confusion, and anger (Brooks et al., 2018), while prolonged quarantine has also been associated with severe boredom, dysphoria, anxiety, and fear (Xiao et al., 2020). Other empirical studies in frontline HCP during the outbreak of Covid-19 have identified the main stressors during the pandemic; fear of infection, lack of medical and general supplies, insufficient and vague information, economic impact, social stigma, and lack of communication (Cai et al., 2020).

The present conditions have created a new reality for HCP in a professional, personal, and social aspect (Jackson et al., 2020). It is imperative and pressing that HCP should be able to cope with both the ever-increasing demands of the current professional situation of indefinite duration, as well as the burden on their personal and social lives (Greenberg et al., 2020). Several approaches aiming to alleviate HCP from Covid- 19-related distress have been developed, while the focus of various interventions is on promoting psychological and mental well-being (Shechter et al., 2020). Among the provided services, telephone helplines have been described, yet there is lack of data regarding their effectiveness or operating characteristics (Peppou et al., 2020).

The "WeAreTogether" telephone support helpline (TSH) was developed by the Nursing Department of the Cyprus University of Technology (CUT) for the empowerment of HCP, CUT students and personnel, in relation to the psychological distress associated with the Covid-19 pandemic.

AIM

The aim of the present article is to present (a) the development of the operating protocol of the "WeAreTogether" TSH for the empowerment of HCP during the Covid-19 pandemic in Cyprus, and (b) the preliminary evaluation results regarding the first month of the service operation.

METHODOLOGY OF THE TSH PROTOCOL DEVELOPMENT

The operating protocol of the TSH and the main objectives of the service were developed by the authors, taking into account relevant literature and anecdotal data regarding the needs of the target population during the pandemic in Cyprus. Specifically, a scoping review was applied to gather data on helplines and operating issues in the following database: EMBASE, MEDLINE, CINAHL, PsycINFO, Scopus, using "empowerment," "helpline," "support," "hotline," "telephone," "interventions," "protocol," "operati*" as key-terms. Predefined eligibility criteria (not reported herein) were applied according to scoping review guidelines (Levac et al., 2010).

Furthermore, an advisory group was established to support the development of the operating

protocol of the TSH and to critically revise its content and the objectives of the service. The advisory group encompassed (a) two academics in mental health, (b) two mental health nurses with advanced clinical experience, and (c) one academic in public mental health. All decisions were made by consensus and disagreements were resolved through discussion.

The steps that were followed for the development of the TSH included: (a) identification of the main objectives of the service and the target population of it, (b) description of the basic concepts and the structure of the telephone call, (c) development of the operating tools of the service according to a scoping review about records on psychological distress management (Levac et al., 2010), (d) definition of criteria for the enrollment of mental health professionals into the service (academic credentials, clinical experience), (e) development of an educational program for those staffing the TSH according to the objectives of the TSH and implementation of the operating tools, and (f) design of the monitoring and evaluation methods of the TSH.

RESULTS

Main Objectives of the TSH and Target Population

The target population of this service were HCP, CUT students and personnel. The main objectives of the TSH toward service users (SUs) were set as follows:

- Provision of support regarding management of negative emotions during the Covid-19 pandemic.
- Assessment of the emotional, mental, and psychological burden during the Covid-19 pandemic.
- Prevention of deterioration of the emotional, psychological, and mental burden during the Covid-19 pandemic.
- Short-term personalized counseling for distress during the Covid-19 pandemic.
- Referral to state mental health services or to the Student Welfare Service as needed.

Tools to Support Operation of the TSH

To support the operating framework of the TSH the following tools were developed:

- Policies and procedures regarding the operation of the TSH: (a) description of the basic concepts included in the operating protocol of the TSH (Table 1), and (b) scripted responses to SUs based on the content of the call (Structure of the Telephone Call, Table 2; Allan et al., 2014; Arullapan et al., 2018; da Silva et al., 2015; Iqbal et al., 2020; Watzke et al., 2017).
- An algorithm for the assessment of psychological distress and intervention (Table 3; Jackman & Prendergast, 2019; Perese, 2012; Rhoads & Murphy, 2015; Sadock et al., 2017; Wheeler, 2014).
- A guide for management of the psychological, emotional, and mental distress developed according to (a) a scoping literature review on HCP' distress during the Covid-19 pandemic (Blake et al., 2020; Brooks et al., 2018; Heath et al., 2020; Walton et al., 2020), (b) cognitive-behavioral techniques (Alkhawaldeh et al., 2020; Benhamou & Piedra, 2020), (c) previously effective stress management interventions applied during the Covid-19 pandemic (Shen et al. 2020), and (d) anecdotal data on the distressing experiences in midwives and emergency and critical care nurses employed in Covid-19 units in Cyprus (Karanikola, 2020).
- A stress self-management exercises list for the SUs (relaxation techniques, guided imagery, mindfulness exercises), based on their effectiveness (Chiesa & Serretti, 2009; de Vibe et al., 2013; Karaca & Şişman, 2019). This list included information encompassing a brief description of the objective and implementation steps of each exercise, as well as the link for a Youtube video. SUs were instructed to implement the most appropriate exercises to them, while support to follow the instructions was also provided when need.
- A guide for referral services.

TABLE 1. Description of the Basic Concepts of the "WeAreTogether" Telephone Support Line Operating Protocol

Concept	Description
Telephone support	Telephone support is defined as the service in which a mental health professional works with an individual or group of people over the phone, so that the user of the service (SU) can effectively cope with personal situations, problems, or crises in a single session which represents a short-term therapeutic relationship.
TSH	This term refers to a set of documented information given, and telephone intervention services provided, the main characteristics of which are active listening and supporting of those who call.
TSH "WeAre Together"	This refers to the present helpline, aiming to empower healthcare professionals regarding the psychological tension associated with the Covid-19 pandemic. It is provided nationally in Cyprus by the Cyprus University of Technology to nurses, midwives, and other healthcare professionals. The students and staff of the Cyprus University of Technology can also have access to this service. All provisions regarding the confidentiality and anonymity of communication regarding the SU shall be respected. The service provider (SP) reveals his/her professional status and name at the beginning of the conversation. The SU can call again to report progress or never call again.
SP	The SP is a mental healthcare professional who has been appointed as responsible for managing the telephone line and providing the services defined by its objectives. SP should be fully aware of the policy and objectives of the service and constantly strive for the proper handling of the SUs and their needs.
Information	The SP is expected to provide evidence-based information in response to the questions asked. The use of a subtle and friendly tone of voice is considered useful and beneficial. In the need for further investigation and discussion on the topic, a deeper conversation can take place. The SP must be able to provide more advanced information on the subject.
Coordinator	Coordinator of the TSH service refers to a mental healthcare professional responsible for the overall operation of the service, the management of challenging cases and the promotion of the service. The names and contact information of the scientific supervisor (MK), as well as of both coordinators (MK, AC) are clearly stated.
SU	A user of the service (SU) of the TSH "WeAreTogether" is the person who calls the line 25002900 with a specific service request, related to the objectives of the service.
Cost	All interventions are provided free of charge by the staff and research associates of the Department of Nursing of the CUT.
Confidentiality, ethical aspects and privacy	The Data Protection Act of Cyprus prohibits the use of information collected for a particular purpose to be used for other purposes. The consent of the user is necessary for any information exchanged during the TSH service to be disclosed. Documentation of data which may reveal the identity of the SUs is prohibited, unless SU consent to this.

- A documentation form, to enter data from each call (Appendix).

The Mental Health Professionals TSH Service Group

a) **coordination and scientific supervisors:**
   1. An Associate Professor in mental health nursing
   2. An Advanced Mental Health Nurse–Psychotherapist, PhD candidate in mental health nursing

b) **mental health professional support team:**
   1. Four Advanced Mental Health Nurses-PhD candidates in Mental Health Nursing
   2. Two Psychologists–Psychotherapists
   3. Two Mental Health Counselors
   4. Three graduate students of the MSc program in Psychiatric-Mental Health Nursing, providing services under supervision.

TSH Service Group Education

The mental health professionals team (service group) of the TSH were trained through a 6-hour interactive webinar on the operation of the service and the implementation of relevant tools via role playing techniques and response to actual incidents, drawn from the literature and clinical experience of the educators. Additional relevant literature was provided to all members of the service group to support the operation of the helpline. The webinar and educational material was provided by the coordinators of the TSH and two mental health nurses with clinical expertise in helpline services.

Basic Concepts

The description of the basic concepts which were included in the TSH operating protocol are presented in Table 1.

Structure of the Telephone Call

The structure of the response to the telephone call was also developed. Regardless of its duration (long or short), each call was expected to have a specific structure, with an initial, middle, and final phase. Each phase was expected to consist of identifiable stages and follow discrete rules, as described in Table 2.

Monitoring and Evaluation

Descriptive statistics (frequencies, means, standard deviations) were used for evaluating the TSH from 04/04/2020 until 04/05/2020. Specifically, the following data were recorded (TSH documentation form, Appendix): (a) age, gender, department of employment/ studying, years of professional experience/year of studying of the SUs, (b) duration of the call, return call (yes/no), brief description of call management.

TSH Evaluation Metrics

During the first month of the operation of "WeAreTogether" TSH, 15 calls were received. The mean call duration was 23 minutes and 44 seconds. The basic reasons for calling included: inability to cope with the stress caused by the Covid-19 pandemic; distress and fear of loneliness due to quarantine; fear of contamination; experiencing contamination and death of others; conflicts with partner or spouse; distress and fear of failure in exams and ineffective preparation of doctorate thesis coupled with lack of energy to start a project and follow it through; questioning personal opportunities for professional development, personal competence and personal value. The users that reached out for help on the "WeAreTogether" TSH came from various backgrounds including HCP, mainly from EDs and ICUs, healthcare students, private sector employees, unemployed, people with mental health issues and elderly people. Due to the policy of the helpline, cases that were not related to university staff, HCP, or students were offered an initial assessment, focused on the seriousness of the symptoms described, and were further referred to the appropriate routes of management (healthcare setting or other helpline)

Approximately 66.6% of the calls were made by females and 33.3% by males. Regarding

TABLE 2. Structure of the Telephone Call

Phases	Stages of the telephone call	SP's Response
Initial phase	**Stage 1: Establishing a relationship**	
	The service provider (SP) must provide the service from a place which allows him to focus on the narration/request of the SU. This requires an environment free of noise and external distractions. Taking written hand notes is advised. The SP should allow for the phone to ring two or three times, so that he/she has time to gather energy and focus on the SU, before answering the phone.	
	For many SUs, the way their call will be answered will also determine whether to go through with it. The use of the plural is advised for plural reason of politeness in the Greek language.	*"Telephone Support Line 'WeAreTogether,' this is X speaking to you (first name). How can we be of assistance to* you?" *"How can I call you? It doesn't have to be your real name if it makes you uncomfortable," "Do you feel comfortable talking the in singular or the plural?"*
	Confidentiality and anonymity are underlined at the beginning of the phone call.	*"I would like to point out that what will be discussed is confidential information and your anonymity will be maintained."*
	In case the present call is a return call, the SP has to offer the SU the option to speak to the SP of the first call at an arranged appointment.	*"Do you wish to continue with the same colleague or move on with me?" "We will arrange an appointment for you with my colleague."*
	The SPs may receive phone calls from users they know personally or professionally. In that case, the SP thanks the user for calling and keeps the SU contact information to be handled immediately by another colleague with the SU's consent.	*"Thank you for calling. I understand that you are facing a difficult situation but since we are acquainted, I must pass the call on to my colleague named X with the number Y to handle your call. Do you agree with this?"*
	Similarly, the SP may be uncomfortable with some SUs' narrative or cannot manage the call for some reason. In this case SP must reply accordingly, with respect.	*"What you share with me is important and requires more specialized intervention. Please wait on the line. You will be immediately contacted by the coordinator of the service with the Number Y."*
	Prank calls are common in telephone helpline services, especially on free of-charge helplines. In that case, the prank caller must be treated with respect. The coordinators must be informed.	*"Thank you for calling but you must have dialed the wrong number. Have a good day."*

(*Continued*)

TABLE 2. Structure of the Telephone Call (*Continued*)

Phases	Stages of the telephone call	SP's Response
Middle Phase	**Stage 1: Investigating the content of the phone call, as well as the emotional, psychological, and mental status of the SU**	
	This stage can often cover the main part of the phone call. The SP must be careful to "follow," rather than to lead or direct SUs. Many helpline users, when forming the number, have not yet organized their thoughts and clarified their needs or what they want to say.Undivided attention and positive reinforcement are necessary for the SP to understand what the SUs are going through and what they need from the service. The SP should continue to listen and respond in a way that helps SUs to clarify their condition, their needs, as well as their feelings about the situation. Open ended questions are used. The aim is to encourage SUs to voice their emotions.	*"How do you feel? What is happening? What are you going through right now?" "What is it that you need? etc. Talk to me more about your concerns,""What you are telling me is important. Would you like to expand on that?"*
	At this point, the SP has the opportunity to assess the extent to which the request or expectations of the SU are in line with the policy and objectives of the service and must accordingly continue the call, interrupt or refer the person to another service. The list of relevant services for referral must be used by the SP as needed.	*"I understand that what you are describing must be difficult for you, but from what you have shared with me I have come to the conclusion that this service is not designed for the needs you have at this stage. It may be more useful to call the service X").*
	It is important for the SPs to be aware of their personal limits, as well as the objectives and framework of the operation of the service, in order to distinguish whether the SU's request is manageable, or whether the SU should be referred to another service, or to the coordinators. At regular intervals, the SPs re-emphasize their support to the user, while it is necessary to express empathy toward SUs.	*"I am here to listen to you. Take as much time as you need" "I understand how difficult this is for you," "I understand why you feel that way."*
	The SPs must constantly check back their assumptions about what SUs say and be prepared to check back with the SUs whether they have made a proper assessment of their situation. Reflection is an appropriate technique for this purpose.	*"You sound overly concerned and tense. Have I understood correctly?"*
	SP must to listen carefully to the reactions of the SUs. To ensure the effectiveness of the service, the SPs should not make personal assumptions of what the SU is sharing, but use evidence-based reflection techniques. The use of these methods reduces misinterpretations, while the SUs feel that they are understood by their SP. At the same time, the SPs receive feedback from the SUs as to the extent of their understanding of their situation.	

(*Continued*)

TABLE 2. Structure of the Telephone Call (*Continued*)

Phases	Stages of the telephone call	SP's Response
	Stage 2: Investigating further psychological, emotional, and mental needs	
	This is the most vital stage of the middle phase according to the objectives of the service. In case SUs need further support, we proceed with the algorithm in Table 3 to clarify their needs. However, putting pressure on SUs to express themselves beyond limits is not advised.	*"Before we continue our conversation, I would like to ask you some questions that are important for us to provide you with the best possible support."*
	Stage 3: Preparing the user for the end of the communication	
	This stage is essential as the content of the communication is recapped, the extent to which the expectations of the SUs, up to that point, have been met, is clarified, and the objectives of the service have been successfully met. At this stage, the necessity for a referral is also reassessed. SPs must have the ability to distinguish between the actual need for a referral to a different service, and whether this is a strategy to protect themselves from the emotions evoked by the SUs, such as anger, disappointment, despair, etc. Similarly, it is vital for the coordinators to intervene in such situations based on the request from the SP, and be able to respond with respect and empathy towards them.	*"How do you feel now? Do you think that your expectations have been met? Is there something more that you would like to talk about?"*
	It is both understood and expected that problems in communication that could end up being described as unsuccessful interventions, will exist. Recognizing such cases can be challenging for both SUs and SPs. In such an event, SPs must respond to SUs with respect and honesty.	*"I am terribly sorry that your expectations and needs have not been met. I understand how difficult this can be for you. If you wish, I can inform you of other available support services."*
	Any information given to SUs must be comprehensive and complete, aiming to empower them to make their own decisions. Specifically, SPs must constantly self-assess the length to which they lead SUs toward one direction unless they are following TSH policy. This is applicable in the case of referral to another service due to (a) unsuitability of a SU's request (based on the objectives of the service), (b) the weight of the psychological burden expressed by the SU, (c) guidelines about protection against Covid-19. The TSH policy allows phone calls back to SUs only if (a) confidentiality is secured, and (b) there is consent from both parties.	
Final Phase	**Stage 1: Phone Call Termination**	
	The way in which the communication with SUs will end, often seals the effectiveness of the call and possibly enhances SUs' intention to call again.	*"Thank you for this call. If you need us do not hesitate to call us again."*

(*Continued*)

TABLE 2. Structure of the Telephone Call (*Continued*)

Phases	Stages of the telephone call	SP's Response
	A successful closure should include a summary (recap) of the conversation, accompanied with(a) acceptance and recognition of SU's feelings, (b) underlining of important pieces of information, and (c) confirmation that SUs have understood the information given to them.	
	Stage 2: The timeframe following the phone call	
	This stage is as important as the actual contact with SUs. SPs should take the time to review the whole call, assessing whether their response to the call was effective or not. Before proceeding to the next call it is proposed that the SPs take a reasonable break. Coordinators should be informed in case SPs feel that they have been emotionally overwhelmed and are unable to continue with the next one. Finally, SP must register the call in the documentation form found in the Appendix.	

female callers, 50% of them were aged 20 to 30 years and the rest were older. Approximately 20% of them called twice, while none of them was exposed to SARS-CoV-2. Twenty percent were critical care nurses and 20% were nursing students.

In relation to male callers, 40% had been exposed to SARS-CoV-2. Approximately 80% were over the age of 40, while 60% were elderly trying to cope with the pandemic stress and loneliness. Specifically, 20% had suffered Covid-19 along with their wives or had experienced loss of a relative or friend due to the pandemic. One out of five he male callers were ED nurses who were: reporting distress due to the repetitive Covid-19 tests; trying to cope with emotional stress due to the situation; having difficulty handling emotions and thoughts resulting from quarantine the following positive SARS-CoV-2 tests; strongly expressing the need for support. Callers from critical care were all female nurses, as were student callers. The metrics of the service are presented in Table 4.

DISCUSSION

We presented the operating protocol of a TSH for the empowerment of HCP, including healthcare science students, during the Covid-19 pandemic and the results of a preliminary evaluation. There are multiple helplines in Cyprus offering support to groups in need within the general population. The CUT is among the two universities in Cyprus, the other being Neapolis University of Paphos, that offer psychological support to HCP during the pandemic via a TSH. Thus, a strategy had to be developed to inform the public and HCP in particular of the service. Specifically, the helpline was promoted through the website of the CUT and social media. The coordinators of the helpline were invited in public and private television channels to present the service. Additionally, an announcement about the TSH was sent to the Cyprus Nurses and Midwives Association, Cyprus Nursing and Midwifery Council and the Ministry of Health. Furthermore, an email introducing the helpline was sent to CUT students and personnel. Despite efforts only a limited number of calls were received, during the first month of the operation of the TSH. This may be attributed to the fact that the TSH was introduced during the peak of the first wave of the pandemic. Indeed, Indeed previous empirical data from China (Chen et al., 2020) show that HCP do not seek psychological support during the peak of the pandemic,

TABLE 3. Algorithm for Assessing the Severity of the Emotional, Psychological, and Mental Burden

SP initial statement: ***"Before we continue our conversation, I would like to ask you some questions that are important for us to provide you with the best possible support."***

1. **How is your sleep over the last week? How many hours do you sleep on average? Is your sleep interrupted? Are you sleeping properly?**
   A. *If the service user (SU) answers positively to the last of the above questions, then we move on to the second question group without proposed interventions.*
   B. *If the SU suffers only from insomnia, it is recommended to try some of the behavioral relaxation exercises in a referral list (not presented here) and call back again in 2 days.*
   C. *If the SU has persistent sleep difficulties even if the SU's answers to the other of the above questions are negative, then the SU is referred to other relevant services included in a referral list (not presented here). Further assessment of neuro-mental/ neuro-biological functions is required.*
2. **In the last few weeks have you gained or lost weight of more than 5% of your total weight?**
   A. *If the SU responds positively, we ask for clarification and then we proceed to the third question without recommendations/ comments.*
   B. *If all other questions of the algorithm are answered negatively and weight changes are mild (less than 5%), proceed to discussing the advantages of physical activity and healthy diet during periods of stress.*
   C. *If weight changes are significant (greater than 5%), even if the user's answers to the other questions are negative, then proceed to a recommendation for referral to relevant services included in the referral list (not presented here). Further assessment of neuro-mental/ neuro-biological functions is required.*
3. **In the last 1–2 weeks have you had difficulty concentrating or doing what you usually do?**
   A. *If the SU answers positively, then ask for clarification on the type and extent of the difficulties and proceed to the fourth question without proposed interventions.*
   B. *If the SU answers positively only to this question and the problems do not cause a serious disturbance SU's his daily life then discuss with the SU the usefulness of mindfulness and consult the list for related exercises (not presented here).*
   C. *If the SU expresses inability to perform the daily roles even if the SU's answers to the other questions are negative then proceed to a recommendation for referral to relevant services. Further assessment of neuro-mental/ neuro-biological functions is required.*
4. **How often have you become emotional in the last week, how often do you cry or break out? (how many days a week/how many hours a day)**
   A. *If the SU is emotional/irritable for most hours of the day and most days of the week then ask for clarifications: **"How do you deal with it?" "How much does it affect you?"** Then proceed to the next question. At the end of the assessment recommend referral to relevant services . Further assessment of neuro-mental/ neuro-biological functions is required.*
   B. *If the SU reports mild melancholy but the answers to the all other questions are negative, please apply the guide for the management of psychological, emotional, and mental distress by healthcare professionals working in the Covid-19 pandemic* (not presented here; Karanikola, 2020).

(*Continued*)

TABLE 3. Algorithm for Assessing the Severity of the Emotional, Psychological, and Mental Burden (*Continued*)

5. **What are your plans for the future (immediate future and distant future)? What do you think of your life after the pandemic?**

A. *If the SU does not mention plans for the future, or reports despair, then continue with the question (with the appropriate adjustment):* ***"what makes you give such meaning to the events that are happening right now?"***

B. *Continue on to say:* ***"What you're telling me makes me realize that you need more support at this stage. A lot of times when we cannot take care of ourselves it's important that people who are trained for it to support us. I'll give you some phone contacts to reach out to as soon as we hang up the phone."***

C. *Give information/ Telephone numbers of the recommended referral services in the relevant list.*

D. *Ask the SU to contact you the next day to tell you if the lived up to the SU's expectations.*

E. *If the SU does not mention plans for the future, or reports despair, then definitely continue with the 6th question.*

6. **Have you thought about hurting or injuring yourself?**

A. *If the SU responds positively, then depending on the seriousness of the assessment you must choose one of the following:*

B. *Refer the person for further support (low risk- absence of self-injury risk factors) by saying* ***"What you're telling me makes me feel that you need more support at this stage even if you think you don't need it. Often when we can't take care of ourselves, it's important that people who are trained for it to support us."***

C. *Inform the coordinators to facilitate the referral process to public mental health services (high risk- presence of self-injury risk factors).*

instead, they focus on physiological needs, that is, warm food, drinks, access to SARS-Cov-2 testing, Personal Protective Equipment (PPE) and adequate breaks. Moreover, they seek reassurance about safety and well-being of their families (Chen et al., 2020). An additional explanation of the low response to the "WeAreTogether" TSH may be that the general population in Cyprus, including HCP, are not familiar with the use of helplines. This needs to be further explored and be considered in the design of future supportive interventions. Although there are several helplines in Cyprus, there are no data on their usage by the general population or their target populations. Moreover, one may also assume that the relatively low frequency of usage of this TSH by HCP could be associated with the rapid implementation a of total lockdown that protected the healthcare system from a surge of Covid-19 cases. Therefore, what was considered to be the first wave of the pandemic was characterized by a relatively short duration and controlled burden on the healthcare system. Yet, having in mind the second wave of the pandemic starting at the end of summer of 2020 as well as the government's strategic position to avoid total lockdowns, the burden of the healthcare system during the second half of 2020 is expected to be heavier and last longer. Thus, more prolonged exposure of HCP to the stressors related to Covid-19 is expected, and it is logical to assume that advanced services to support those at the frontline, including critical care nurses, will be needed. Based on this, healthcare systems must be prepared to provide advanced services, customized according to the needs of HCP and the lessons learned so far.

The pandemic has taken a toll on people's mental health (Pfefferbaum & North, 2020). It has enhanced stressors at all dimensions of life such

TABLE 4. Presentation of Call Metrics

Call	Age(years)	Sex	Work setting/Student's institution	Work experience/Year of study	Call duration	Repetitive call (Yes/No)	Service user's main need
1	Over 40	Female	Retired	-	10'	No	1. Information on how to return in Cyprus Republic and being provided her medication.
2	20–30	Female	Nursing student	4th	40"	No	1. Distress regarding semester exams.
3	Over 40	Male	Retired	-	10 '	No	1. Loneliness and need to communicate.
4	Over 40	Female	Retired	-	3'	No	1. Seeking help for a relative (granddaughter) with positive history of mental health problems who was isolated.
5	Over 40	Female	Unemployed	-	5 '	No	1. Need to be supported. 2. Loneliness and need to socialize with peers.
6	30–20	Female	Nurse	ICU nurse / 22	35 '	No	1. Inability to manage parental role. 2. Distress due to Covid-19 quarantine- isolation from her children.
7	Over 40	Male	Retired		5 '	No	1. To be informed about the service.
8	Over 40	Male	Retired		20 '	No	(Referral from another helpline 1. Management of anxiety symptoms. 2. Information on medication treatment of anxiety symptoms. 3. Inability to manage recent stressful events (job loss, COVID-19 diagnosis of him and his wife, death of a relative due to Covid-19).

(*Continued*)

TABLE 4. Presentation of Call Metrics (*Continued*)

Call	Age(years)	Sex	Work setting/Student's institution	Work experience/Year of study	Call duration	Repetitive call (Yes/No)	Service user's main need
9	30–40	Female	Unemployed		60 '	No	1. Inability to manage isolation due to Covid-19. 2. Inability to manage anxiety symptoms (vomiting, appetite changes [she lost 5 kg], phobias: fluctuation of the symptoms' intensity: highest intensity during evening time). 3. Difficulties fulfilling parental role.
10	Over 40	Male			15 '	No	1. Fear of confronting Covid-19 (called on behalf of a relative).
11	20–30	Female			5 '	No	1. Pursuit of free available psychotherapeutic services.
12	30–40	Male	Nurse	Surgical Department / 10 years of work experience	35 '	No	2. High distress due to repeated Covid-19 diagnostic tests 3. Distressing emotions and thoughts due to self–quarantine (positive Covid-19 diagnosis) 4. Need for support.
13	20–30	Female	National guard/MSc student in advance nurse practice	6 years /3° year	40 '	No	1) Interventions to manage distress. 2) Strengthening of the relationship with her partner. 3) Quality of the relationship bet her mother. 4) Writing of her dissertation and motivation issues 5) Opportunities forprofessional development. 6) Doubt of personal abilities/personal value.

(*Continued*)

TABLE 4. Presentation of Call Metrics (*Continued*)

Call	Age(years)	Sex	Work setting/Student's institution	Work experience/Year of study	Call duration	Repetitive call (Yes/No)	Service user's main need
14	30–40	Female	Director of a private company		37', 16"'	No	2. Inability to manage posttraumatic stress disorder symptoms related to workplace bullying experiences. 3. Inability to manage negative symptoms due to self- quarantined.
15	20–30	Female	National guard/MSc student in advance nurse practice	6 years of working experience MSc students (3° year)	30 '	Yes	Call by appointment. The following issues were which were discussed the day before were reviewed: 1) Addressing current tension. 2) Strengthening the relationship with her partner. 3) Quality of relationship with her mother. 4) Writing of her dissertation and motivation issuses. 5) Opportunities for professional development. 6) Personal competencies/personal value.
16	20–30	Female	Nursing student	Third year of studying	30'	No	Distress about studying in home during the quarantine and subsequent loss of privacy; how to effectively manage other family members distress.
17	20–30	Female	Nursing student	Third year of studying	20'	Yes	Distress about her sister's psychological problems and her denial to seek help.
18	20–30	Female	Nursing student	Third year of studying	22 '	Yes	Distress about being infected by the SARS-CoV-2 during clinical placement/ social contacting.

as personal, professional, social, and economic. The main reasons of distress described so far in the literature are related to the quarantine, contracting the virus, dealing with the death of a loved one, unemployment, social distancing, and loneliness and the possibility of facing death (Chew et al., 2020). These issues need to be addressed by supportive services, including helplines. Many people are experiencing depressive symptoms linked to the lack of strength to face everyday issues and problems that would in other circumstances be considered routine; people with mental health disorders find themselves alone and with no support (Salari et al., 2020). HCP need, too, constant support (Maben & Bridges, 2020). The World Health Organization has reported that countries must organize and implement immediate distress relief plans to alleviate the effects of the pandemic on people (WHO, 2020). Helplines combined with tele-counseling may be part of the solution. The impact of the pandemic is multifaceted and demands the involvement of mental health providers who will support the needs of the population (Li et al., 2020). Psychological PPE (P-PPE) is about empowering psychologically and mentally HCP through convenient and evidence-based interventions during pandemics (IHI, 2020). The focus of P-PPE is on decreasing distress and promoting psychological and mental well-being, peer support and optimal relationships in HCP. Relevant interventions are incorporated into everyday routine without adding to HCPs' workload. One example would be sharing successful recovery stories on a daily basis, or being able to actively express frustration and anxiety (Shen et al., 2020). Helplines, if formatted to meet the needs of critical care nurses, may be included in their P-PPE Such helplines could be from the work environment, and their use could be promoted by ICU managers.

The limitations of the present TSH protocol need to be taken into consideration for forthcoming revisions, as well as for the development of other helplines. The most important limitation of the present TSH regards its monitoring and evaluation (Helplines Partnership, 2015). Although data about volume and length of calls, demographics of the SUs, and so on were gathered (please see Appendix), the impact of the service on users was not assessed. Thus, under the pressure of the second wave of the Covid-19 pandemic, measures to quantify the effectiveness of the TSH need to be implemented and evaluated. One measure may include a structured short questionnaire about SU's satisfaction from the service provided, as well as a preservice and postservice brief assessment of the experienced distress by the SU (from 1 to 10). Also, a checklist filled-in by the SP could be used for this purpose. The aim is to be able to document on the impact the TSH has made on SUs. Additionally, measures to gather information on how to improve, and expand existing or develop new services in response to SUs' needs are deemed necessary in future helplines.

CONCLUSION

Research on the effects of Covid-19-related stressors and the quarantine on HCP suggests that there is a need for constant and specialized support. The Department of Nursing of the CUT developed and implemented the support helpline "WeAreTogether" for the provision of psychological support services to HCPs, students, and staff of the CUT. A set of procedures and algorithms were developed to support the service. Additional measures to evaluate its effectiveness in relation to meeting the psychological and mental health needs of its users are needed.

REFERENCES

Adams, J. G., & Walls, R. M. (2020). Supporting the health care workforce during the COVID-19 global epidemic. *JAMA*, *323*(15), 1439–1440. doi:10.1001/jama.2020.3972

Alkhawaldeh, J. M. A., Soh, K. L., Mukhtar, F. B. M., Peng, O. C., & Anshasi, H. A. (2020). Stress management interventions for intensive and critical care nurses: A systematic review. *Nursing in Critical Care*, *25*(2), 84–92. doi:10.1111/nicc.12489

Allan, J. L., Farquharson, B., Johnston, D. W., Jones, M. C., Choudhary, C. J., & Johnston, M. (2014). Stress in telephone helpline nurses is associated with failures of concentration, attention and memory, and with more conservative referral decisions. *British Journal of Psychology*, *105*(2), 200–213. doi:10.1111/bjop.1n.d

Arullapan, N., Chersich, M. F., Mashabane, N., Richter, M., Geffen, N., Veary, J., Jankelowitz, L., Scorgie, F., & Venter, W. D. F. (2018). Quality of counselling and support provided by the South African National AIDS Helpline: Content analysis of mystery client interviews. *South Africa Medical Journal*, *108*(7), 596–602. doi:10.7196/SAMJ.2018.v108i7.12543

Benhamou, K., & Piedra, A. (2020). CBT-informed interventions for essential workers during the COVID-19 Pandemic. *Journal of Contemporary Psychotherapy*, *18*, 1–9. doi:10.1007/s10879-020-09467-3

Bielicki, J. A., Duval, X., Gobat, N., Goossens, H., Koopmans, M., Tacconelli, E., & van der Werf, S. (2020). Monitoring approaches for healthcare workers during the COVID-19 pandemic. *The Lancet Infectious Diseases*, *20* (10) e261-e267. doi:10.1016/S1473-3099(20)30458-8

Blake, H., Bermingham, F., Johnson, G., & Tabner, A. (2020). Mitigating the psychological impact of COVID-19 on healthcare workers: A digital learning package. *International Journal of Environmental Research and Public Health*, *17*(9), 2997. doi:10.3390/ijerph17092997

Brooks, S. K., Dunn, R., Amlôt, R., Rubin, G. J., & Greenberg, N. (2018). A systematic, thematic review of social and occupational factors associated with psychological outcomes in healthcare employees during an infectious disease outbreak. *Journal of Occupational and Environmental Medicine*, *60*(3), 248–257. doi:10.1097/JOM.0000000000001235

Cai, H., Tu, B., Ma, J., Chen, L., Fu, L., Jiang, Y., & Zhuang, Q. (2020). Psychological impact and coping strategies of frontline medical staff in human between January and March 2020 during the outbreak of coronavirus disease 2019 (COVID-19) in Hubei, China. *Medical Science Monitoring*, *26*, e924171. doi:10.12659/MSM.924171

Chen, Q., Liang, M., Li, Y., Guo, J., Fei, D., Wang, L., He, L., Sheng, C., Cai, Y., Li, X., Wang, J., & Zhang, Z. (2020). Mental health care for medical staff in China during the COVID-19 outbreak. *The Lancet*, *7*(4), e15–e16. doi:10.1016/S2215-0366(20)30078-X

Chew, Q. H., Wei, K. C., Vasoo, S., Chua, H. C., & Sim, K. (2020). Narrative synthesis of psychological and coping responses towards emerging infectious disease outbreaks in the general population: Practical considerations for the COVID-19 pandemic. *Singapore Medical Journal*, *61*(7), 350–356. doi:10.11622/smedj.2020046

Chiesa, A., & Serretti, A. (2009). Mindfulness-based stress reduction for stress management in healthy people: A review and meta-analysis. *The Journal of Alternative and Complementary Medicine*, *15*(5), 593–600. doi:10.1089/acm.2008.0495

da Silva, J. A., Siegmund, G., & Bredemeier, J. (2015). Crisis interventions in online psychological counselling. *Trends in Psychiatry and Psychotherapy*, *37*(4), 171–182. doi:10.1590/2237-6089-2014-0026

de Vibe, M., Solhaug, I., Tyssen, R., Friborg, O., Rosenvinge, J. H., Sørlie, T., & Bjørndal, A. (2013). Mindfulness training for stress management: A randomised controlled study of medical and psychology students. *BMC Medical Education*, *13*, 107. doi:10.1186/1472-6920-13-107

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *The British Medical Journal*, *26*(368), m1211. doi:10.1136/bmj.m1211

Heath, C., Sommerfield, A., & von Ungern-Sternberg, B. S. (2020). Resilience strategies to manage psychological distress amongst healthcare workers during the COVID 19 pandemic: A narrative review. *Anaesthesia*, *75* (10) 1364-1371. doi:10.1111/anae.15180

Helplines Partnership. (2015). *Measuring outcomes for helplines*. Helplines Guidelines Partnership. www.helplines.org

Huang, J. Z., Han, M. F., Luo, T. D., Ren, A. K., & Zhou, X. P. (2020). Mental health survey of 230 medical staff in a tertiary infectious disease hospital for COVID-19. *Chinese Journal of Industrial Hygiene and Occupational Diseases*, *38*(3), 192–195.doi:10.1111/appy.12407.

Iqbal, Y., Jahan, R., Yesmin, S., Selim, A., & Siddique, S. N. (2020). COVID-19-related issues on tele-counseling helpline in Bangladesh. *Asia Pac Psychiatry*, e12407. doi: 10.1111/appy.12407.

Institute for Healthcare Improvement. (2020, August). *Why is "Psychological PPE" important for the health care workforce?* http://www.ihi.org/communities/blogs/why-is-psychological-ppe-important-for-the-health-careworkforce?utm_campaign=2020_TW_Test&utm_medium=Feature&_hsmi=94231218&_hsenc=p2ANqtz-9p7n7TpnMKD0DNJJaKWk1SBJeNkBKO8NU0N4HPYofIs1-YX3XbfwUddHq8wDGA7mvWEv_r60L6iyf9s2lX5TFmZ0cz-A&utm_content=Psychological_PPE&utm_source=hs_email

International Council of Nurses. (2020, May). *ICN calls for data on healthcare worker infection rates and deaths*. https://www.icn.ch/news/icn-calls-data-healthcare-worker-infection-rates-and-deaths

Jackman, K., & Prendergast, M. K. (2019). *Psychiatric case studies for advanced practice* (1st ed.). Wolters Kluwer.

Jackson, D., Bradbury-Jones, C., Baptiste, D., Gelling, L., Morin, K., Neville, S., & Smith, G. D. (2020). Life in the pandemic: Some reflections on nursing in the context of COVID 19. *Journal of Clinical Nursing*, *29*(13–14), 2041–2043. doi:10.1111/jocn.15257

Karaca, A., & Şişman, N. Y. (2019). Effects of a stress management training program with mindfulness-based stress reduction. *Journal of Nursing Education*, *58*(5), 273–280. doi:10.3928/01484834-20190422-05

Karanikola, N. K. M. (2020). Mitigating psychological, emotional, mental, and spiritual implications in healthcare professionals during the SARS-CoV-2 pandemic (Editorial). *Hellenic Journal of Nursing (Nosoleftiki)*, *59*(1), 9–16.

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: Advancing the methodology. *Implement Science*, *5*(69), 1–9. doi:10.1186/1748-5908-5-69

Li, Z., Ge, J., Yang, M., Feng, J., Qiao, M., jiang, R.,et al. (2020). Vicarious traumatization in the general public, members, and non-members of medical teams aiding in COVID-19 control. *Brain, Behavior, and Immunity*, *88*, 916–919. doi:10.1016/j.bbi.2020.03.007

Maben, J., & Bridges, J. (2020). Covid-19: Supporting nurses' psychological and mental health. *Journal of Clinical Nursing*, *29*, 2742–2750. doi:10.1111/jocn.15307

Montemurro, N. (2020). The emotional impact of COVID-19: From medical staff to common people. *Brain, Behavior, and Immunity*, *87*, 23–24. doi:10.1016/j.bbi.2020.03.032

Morganstein, J. (2020). *Coronavirus and mental health: Taking care of ourselves during infectious disease outbreaks*. https://www.psychiatry.org/news-room/apa-blogs/apa-blog/2020/02/coronavirus-andmental-health-taking-care-of-ourselves-during-infectious-disease-outbreaks

Peppou, L. E., Economou, M., Skali, T., & Papageorgiou, C. (2020). From economic crisis to the COVID-19 pandemic crisis: Evidence from a mental health helpline in Greece. *European Archives of Psychiatry and Clinical Neuroscience*, 2020 Jul 14, 1–3. doi:10.1007/s00406-020-01165-4

Perese, F. E. (2012). *Psychiatric advanced practice nursing: A biopsychosocial foundation for practice* (1st ed.). F.A. Davis Company

Pfefferbaum, B., & North, C. S. (2020). Mental health and the Covid-19 pandemic. *The New England Journal of Medicine*, *383*(6), 510–512. doi:10.1056/NEJMp2008017

Rhoads, J., & Murphy, P. (2015). *Clinical consult to psychiatric nursing for advanced practice* (1st ed.). Springer Publishing Company.

Sadock, J. B., Alcott Sadock, V., & Ruiz, P. (2017). *Kaplan & Sadock's comprehensive textbook of psychiatry*. Lippincott Williams and Wilkins.

Salari, N., Hosseinian-Far, A., Jalali, R., Vaisi-Raygani, A., Rasoulpoor, S., Mohammadi, M., Rasoulpoor, S., & Khaledi-Paveh, B. (2020). Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: A systematic review and meta-analysis. *Global Health*, *16*(1), 57. doi:10.1186/s12992-020-00589-w

Shechter, A., Diaz, F., Moise, N., Anstey, D. E., Ye, S., Agarwal, S., et al. (2020). Psychological distress, coping behaviors, and preferences for support among New York healthcare workers during the COVID-19 pandemic. *General Hospital Psychiatry*, *66*, 1–8. doi:10.1016/j.genhosppsych.2020.06.007

Shen, X., Zou, X., Zhong, X., Yan, J., & Li, L. (2020). Psychological stress of ICU nurses in the time of COVID-19. *Critical Care*, *24*, 200. doi:10.1186/s13054-020-02926-2

Su, T. P., Lien, T. C., Yang, C. Y., Su, Y. L., Wang, J. H., Tsai, S. L., & Yin, J. C. (2007). Prevalence of psychiatric morbidity and psychological adaptation of the nurses in a structured SARS caring unit during outbreak: A prospective and periodic assessment study in Taiwan. *Journal of Psychiatric Research*, *41* (1–2), 119–130. doi:10.1016/j.jpsychires.2005.12.006

Walton, M., Murray, E., & Christian, M. D. (2020). Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic. *European Heart Journal: Acute Cardiovascular Care*, *9*(3), 241–247. doi:10.1177/2048872620922795

Watzke, B., Haller, E., Steinmann, M., Heddaeus, D., Härter, M., König, H. H., Wegscheider, K., & Rosemann, T. (2017). Effectiveness and cost-effectiveness of telephone-based cognitive-behavioural therapy in primary care: Study protocol of TIDe - telephone intervention for depression. *BMC Psychiatry*, *17*(1), 263. doi:10.1186/s12888-017-1429-5

Wheeler, K. (2014). *Psychotherapy for the advanced practice psychiatric nurse. A how - to guide for evidence-based practice* (2nd ed.). Springer Publishing Company.

World Health Organization. (2020, March). *WHO releases guidelines to help countries maintain essential health services during the COVID-19 pandemic*. https://www.who.int/news-room/detail/30-03-2020-who-releases-guidelines-to-help-countries-maintain-essential-health-services-during-the-covid-19-pandemic

Xiao, H., Zhang, Y., Kong, D., Li, S., & Yang, N. (2020). Social capital and sleep quality in individuals who self-isolated for 14 days during the coronavirus disease 2019 (COVID-19) outbreak in January 2020 in China. *Medical Science Monitoring*, *26*, e923921. doi:10.12659/MSM.923921

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Appendix

Phone Call Documentation Form

Name of the service provider (SP):_____
Age of the service user (SU):
20–30 years old_____
30–40 years old_____
Over 40 years old_____
Department of Employment of the SU (for healthcare professionals)_____
Years of work experience of the SU:_____
***In case of a student, fill-in the following:**
Department of studies: _____
Year of studies: _____
Date/time of the phone call:_____
Duration of the phone call: _____
Return call? Yes_____ No_____
Management of the SU's needs (Write briefly what the user was asking for and how you managed it):_____