Profile of distress callers and service utilisation of tele-counselling among the population of Assam, India: an exploratory study during COVID-19

Abstract

Background: The coronavirus disease 2019 (COVID-19) pandemic has affected people globally by causing psychological, social, and economic chaos. The Assam Police, India started telephone helplines to address the psychological issues. **Aims:** To evaluate the sociodemographic profile of the distress callers, their psychosocial concerns, the interventions provided by the service provider, and whether the service users were satisfied with the intervention(s) or not. **Method:** It was a cross-sectional study done during the period of lockdown (7-24 April 2020). All the callers who called the helpline were screened for anxiety, depression, suicidal thoughts (when required), and the psychosocial issues which they were facing were explored. They were provided the psychological intervention(s) at the appropriate time, and they were asked to rate their experience at the end. **Results:** A total of 239 callers used the tele-counselling services. The majority of callers were male (79.1%). Most of the callers were between 19-35 years of age group (66.5%), married (52.5%), and graduates (31%). Two-thirds of the callers called to seek guidance for their own issues and one-third for their relatives or friends. Callers had anxiety (46%), depressive disorder (8.3%), and depressive symptoms not qualifying for depressive disorder (14%), and suicidal thoughts (5.44%). The commonest intervention provided to the callers was supportive (77.8%), followed by psychoeducation (30.5%), cognitive behaviour therapy (24.7%), relaxation (23.6%) and behaviour therapy (13.4%). Most of the callers utilised more than one type of therapy. Overall, most of the callers were satisfied and appreciated the tele-counselling services. **Conclusion:** The findings could help in formulating psychological interventions to improve the mental health of vulnerable groups in the post-COVID-19 period to reduce psychiatric morbidity and mortality.

Keywords: Anxiety. Depression. Suicide.

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INTRODUCTION

Assam reported its first case of the coronavirus disease 2019 (COVID-19) on 31 March 2020.[1] As of 13 July 2020, the number of confirmed cases is 16806 and 5873 active cases.[2] This pandemic has affected people psychologically globally. The direct effect includes fear and anxiety about getting infected, grief, and depression after getting infected or by losing someone due to the disease. Indirectly by the social and economic chaos caused by it.[3] In such circumstances, screening and treating the affected remotely will not only protect the mental healthcare workers but will also be economical by avoiding actual transportation costs and the use of personal protective equipment.[4] Considering the need for screening and intervention of the people who were on quarantine or were in hospitals after getting infected specifically, and for the public in general, the Assam Police, India with help from the Department of Psychiatry, Gauhati

Medical College Hospital (GMCH), Guwahati, Assam, started an initiative called "Proyax," which means "an effort".[5] The Assam Police provided helpline numbers through various platforms- Assam Police website, local print media, and social networking sites for the public. We assessed the psychosocial concerns and patterns of utilisation of tele-counselling by distress callers. The objective of this exploratory study was to evaluate the sociodemographic variables of the distress callers, their psychosocial concerns, the interventions provided by the service provider, and whether the service users were satisfied with the intervention(s) or not.

METHOD

We adopted a cross-sectional observational study, exploratory in design. The interview method was used to assess the callers' psychosocial concerns and patterns of use of the helplines facility provided to them. The sample was 239 callers who called the helpline numbers over 18 days (7 to 24 April 2020) during the period of lockdown. Data collection took place during the psychological counselling sessions provided to the callers of the psychological helplines. The data was collected in a format developed by the researchers. Sociodemographic information included gender, age, education, residential location, marital, and employment status. Past history of any physical or psychiatric illness, use of medication, and current treatment were also recorded. Anxiety and depression were established by a screening questionnaire which included questions "Do you feel sad most of the time?", "Have you lost pleasure in previously pleasurable activities?", " Do you wake up early in the morning, which was not the same before?" etc. The screening questionnaire included all the criteria as given in the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10)[6] for anxiety and depression. The distress callers were also assessed for any current suicidal thoughts. In the process of counselling, the major concerns for the calls were probed and addressed with various psychological interventions.

The data was collected by six counsellors who were qualified mental health professionals. They were provided six numbers by the Police Department of the Government of Assam to address the issues of the mental health of the crisis callers. Three numbers were active from morning 9 am till 3 pm (six hours), and the other three numbers were active from 3 to 9 pm (six hours). The helplines were active for 12 hours per day. As multiple therapists were involved, there was the possibility of differences in approaches. Efforts were undertaken to reduce this bias by uniformly following the Best Practice Guidelines for Telepsychology during Disasters (COVID-19 Pandemic)[7] that has been approved by the Committee on Mental Health formed by the Government of Assam. An expedited ethics approval was obtained from the chairman of the ethics committee of GMCH. All the callers provided explicit informed consent to record the responses for the research.

Statistical analysis

The sociodemographic data is presented as number (%). To establish the relation between sociodemographic variables and clinical variables, chi square test or Fisher exact test was used. The post hoc test was used with Bonferroni correction for p-value. Statistical analysis was performed using Statistical Package for the Social Sciences (SPSS) Statistics 25 (IBM SPSS Statistics, New York, United States).

RESULTS

Sociodemographic and clinical variables

Table 1 shows the sociodemographic and clinical variables. The callers came to know about the helpline numbers through newspapers, television, and radio (49.3%), social network (28.5%), relatives and friends (7.1%), and from Assam Police (14.6%). The majority of the callers were men (79.1%) aged between 19-35 years (66.5%), married (52.3%), and educated up to graduation (31%) belonging mostly from Central Assam (38.49%).

74.05% had called for their own issues, and 25.52% had called for help and guidance for their relatives or friends. There was a history of physical illnesses like hypertension, diabetes, respiratory illness, skin problems, thyroid, or other illnesses in 13.9% of the population, whereas 23.8% had a past history of psychiatric illness.

Reasons for call and clinical variables

Table 2 represents the data on the reasons/concerns of the crisis calls. Among the callers, 46% had anxiety issues and had morbid preoccupation about the lockdown and its effects on their lives. Around ten per cent had features of anxiety spectrum disorder, while 14% expressed feeling low, sad, and were fatigued. Depressive disorder was found in 8.3%, while suicidal ideation and death wish was found in 5.44% of the callers. Anxiety related to family conflicts and domestic problems were found in 2.5% of the callers, while around 34% of the calls were seeking for information regarding medicines, e-pass as they were stranded in places outside the state and districts.

No difference was seen in terms of reasons of call between callers with or without a pre-existing history of psychiatric illness except anxious/preoccupation about lockdown (finance), which was more in the group without pre-existing psychiatric illness group (p=0.012). Rest all reasons for the call were equally distributed between the two groups. It indicates that the whole population, irrespective of pre-existing psychiatric illness was affected equally psychologically during the lockdown period. Interestingly, regarding suicidal tendencies/thoughts, there was no difference between patients with pre-existing psychiatric illness versus those who did not have it. The reasons for the call were similar among callers with and without pre-existing physical illness (p>0.05 in case of all reasons of call).

Reasons for call and sociodemographic variables

Reasons for the call were similar across all age groups except that depression/loss/bereavement was statistically higher in the below 18 years age group. Anxious preoccupation about lockdown (finance) was more in men compared to women

Table 1: Sociodemographic and clinical variables

Parameter		Overall (N=239)	Psychological illness		Physical illness	
		(n, %)	Yes (n=57)	No (n=182)	Yes (n=33)	No (n=205)
Source of referral*	Newspaper/television/radio	118 (49.3)	23 (40.4)	95 (52.2)	18 (54.5)	99 (48.3)
	Social network	68 (28.5)	21(36.8)	47 (25.8)	7 (21.1)	61 (29.8)
	Relatives/friends	17 (7.1)	5 (8.8)	12 (6.6)	2 (6.1)	15 (7.3)
	Assam Police	35 (14.6)	8 (14)	27 (14.8)	6 (18.2)	29 (14.1)
Age (years)	0-18	4 (1.67)	1 (1.8)	3 (1.6)	0	4 (2)
	19-35	159 (66.5)	35 (61.4)	124 (68.1)	15 (45.5)	143 (69.8)
	36-55	62 (25.9)	19 (33.3)	43 (23.6)	10 (30.3)	52 (25.4)
	>55	14 (5.85)	2 (3.5)	12 (6.6)	8 (24.2)	6 (2.9)
Sex	Man	189 (79.07)	33 (57.9)	156 (85.7)	25 (75.8)	164 (80)
	Woman	50 (20.9)	24 (42.1)	26 (14.3)	8 (24.2)	41 (20)
Marital status	Single	112 (46.86)	30 (52.6)	82 (45)	14 (42.4)	98 (47.8)
	Married	125 (52.3)	25 (43.9)	100 (59.4)	18 (54.5)	106 (51.7)
	Divorced	1 (0.4)	1 (1.8)	0	0	1 (0.5)
	Widower	1 (0.4)	1 (1.8)	0	1 (3)	0
Education	Up to 10th standard	64 (26.77)	13 (22.8)	51 (28)	5 (15.2)	59 (28.8)
	12th standard	61 (25.52)	11 (19.3)	50 (27.5)	8 (24.2)	53 (25.9)
	Graduate	74 (30.96)	21 (36.8)	53 (29.1)	14 (42.4)	60 (29.3)
	Post-graduation and above	28 (11.71)	11 (19.3)	17 (9.3)	5 (15.2)	22 (10.7)
	Others	11 (4.6)		11 (6)	1 (3)	10 (4.9)
	Illiterate	1 (0.4)	1 (1.8)	0	0	1 (0.5)
Place#	Upper Assam	32 (13.38)	8 (14)	24 (13.2)	9 (27.3)	23 (11.2)
	Lower Assam	54 (22.59)	12 (21.1)	42 (23.1)	10 (30.3)	44 (21.5)
	Central Assam	92 (38.49)	28 (49.1)	64 (35.2)	10 (30.3)	82 (40)
	Outside Assam	42 (17.57)	4 (7)	38 (20.9)	3 (9.1)	39 (19)
	South Assam	17 (7.11)	3 (5.3)	14(7.7)	1 (3)	16 (17.8)
Status	Called for self	177 (74.05)	35 (61.4)	142 (78)	21 (63.6)	156 (76.1)
	Called for others	61 (25.52)	21 (36.8)	40 (22)	12 (36.4)	49 (23.9)

*n=238, #n=237

(50.3% vs. 30%, p=0.011), depression/loss/bereavement was more in women compared to their men counterpart (16% vs. 6.3%, p=0.042). Although the domestic issues were statistically higher in the marital status group compared to divorced and widower, however, the finding is limited by a limited number of samples in that respective group (n=one each).

Depression/loss/bereavement was significantly higher in the education category "graduate", "others (for information, e-pass, medicine)" was significantly higher in the education "up to 10th standard" category (p<.05). Anxiety disorder was significantly higher in professionals and students; however, it was significantly lower in the self-employed or business. The 'low feeling' was more in the professionals and students.

Interventions

Table 3 lists the interventions. Most of the participants received multiple psychological interventions, with 43.5% of the callers receiving a combination of two categories of intervention, a combination of three categories was received by 19.2%, and four or more category interventions were received by 3.8%. The commonest intervention being supportive (77.8%), followed by psychoeducation (30.5%), cognitive behaviour therapy (24.7%), relaxation (23.6%) and behaviour therapy (13.4%).

Outcome

Overall most of the callers were satisfied (49.8%) and appreciated (42.3%) the tele-counselling programme by Assam Police in collaboration with GMCH (Table 4).

Psychosocial interventions and outcome for emergency callers

There were 13 callers who had expressed death wish and contemplated suicide. The treating team (psychiatrists, police personnel, and hospitals) immediately had to be engaged for hospitalisation or immediate pharmacological management through the help of the caregivers. The callers were given supportive counselling. The family members were made aware of the current mindset of the callers, and

Table 2: Reasons for call and clinical variables

Parameter		Overall	Psychiatric illness				Physical illness			
		(N=239)	(n, %) Yes (n=57)	No (n=182)	p-value	OR (95% CI)	Yes (n=33)	No (n=205)	p-value	OR (95% CI)
Reason for call#	1	110 (46%)	18 (31.6)	92 (50.5)	0.012	2.215 (1.18-4.6)	17 (51.5)	93 (45.4)	0.511	0.782 (0.374-1.631)
	2	23 (9.6)	8 (14)	15 (8.2)	0.196	0.55 (0.22-1.37)	6 (18.2)	17 (8.3)	0.105	0.407 (0.148-1.122)
	3	34 (14.2)	7 (12.3)	27 (14.8)	0.630	1.244 (0.511-3.03)	5 (15.2)	29 (14.1)	0.794	0.923 (0.33-2.583)
	4	20 (8.3)	7 (12.3)	13 (7.1)	0.271	0.5 (0.2-1.4)	3 (9.1)	17 (8.3)	0.746	0.904 (0.25-3.273)
	5	13 (5.4)	6 (10.5)	7 (3.8)	0.086	0.34 (0.1-1.057)	4 (12.1)	9 (4.4)	0.088	0.33 (0.096-1.151)
	6	6 (2.5)	3 (5.3)	3 (1.6)	0.149	0.302 (0.059-1.538)	0	6 (2.9)	1.000	-
	7	81 (34)	21 (36.8)	60 (33)	0.059	0.843 (0.453-1.568)	10 (30.3)	71 (34.6)	0.626	1.219 (0.55-2.702)
2 reasons		53 (22.2)	15 (26.2)	38 (20.9)	0.389	0.739 (0.371-1.472)	10 (30.3)	43 (21)	0.232	0.61 (0.27-1.379)
3 or more reasons		2 (0.8)	0	2 (1.1)	1.00	1.011 (0.996-1.027)	2 (6.1)	0	0.19	-

#1=Anxious/preoccupation about lockdown (finance), 2=Anxiety disorder, 3=Low feeling/fatigue/boredom, 4=Depression/loss/bereavement, 5=Suicide and emergency calls, 6=Domestic issues, 7=Others (for information, e-pass, medicine) OR: Odds Ratio, CI: Confidence Interval

Table 3: Interventions

Parameter		Overall (n, %)	Reasons#								
			1	2	3	4	5	6	7	2 reasons	3 or more
Interventions	Psychoeducation	73 (30.5)	42 (38.2)	12 (52.2)	11 (32.4)	11 (55)	4 (30.8)	4 (66.7)	15 (18.5)	24 (45.3)	1 (50)
	Relaxation	47 (19.7)	26 (23.6)	8 (34.8)	11 (32.4)	6 (30)	3 (23.1)	1 (16.7)	6 (7.4)	13 (24.5)	1 (50)
	Supportive	186 (77.8)	83 (75.5)	19 (82.6)	18 (52.9)	11 (55)	11 (84.6)	5 (83.3)	74 (91.4)	41 (77.4)	1 (50)
	Behaviour therapy	32 (13.4)	19 (17.3)	4 (17.4)	13 (38.2)	5 (25)	0	2 (33.3)	3 (3.7)	12 (22.6)	1 (50)
	Cognitive behaviour therapy	59 (24.7)	28 (25.5)	8 (34.8)	21 (61.8)	10 (50)	2 (15.4)	2 (33.3)	7 (8.6)	18 (34)	1 (50)
2 interventions		104 (43.5)	53 (48.2)	17 (73.9)	25 (73.5)	15 (75)	6 (46.2)	6 (100)	19 (23.5)	35 (66)	1 (50)
3 interventions		46 (19.2)	27 (24.5)	9 (39.1)	13 (38.2)	7 (35)	1 (7.7)	2 (33.3)	4 (4.9)	16 (30.2)	1 (50)
4 or more interventions		9 (3.8)	9 (8.2)	2 (8.7)	1 (2.9)	1 (5)	0	0	1 (1.2)	4 (7.5)	1 (50)

#1=Anxious/preoccupation about lockdown (finance), 2=Anxiety disorder, 3=Low feeling/fatigue/boredom, 4=Depression/loss/bereavement, 5=Suicide and emergency calls, 6=Domestic issues, 7=Others (for information, e-pass, medicine)

24/7 vigilance was advised to the eight callers who had refused hospitalisation. They were given follow-up calls every alternate day for three sessions to review their mental health status. The significant issues were mostly conflicts in relationships between couples for earlier unresolved psychosocial issues, which got resurfaced during the lockdown period, financial issues, and job loss. They were advised for face-to-face therapy after the lockdown to which all of them accepted and committed, indicating favourable outcome of the interventions.

DISCUSSION

We tried assessing the profile of people using the tele-counselling service and the pattern of service utilisation. We found the majority of callers were male (79.1%). Most of the callers were between 19-35 years of age group (66.5%), married (52.5%), and graduates (31%). Two-thirds of the callers called to seek guidance for their own issues and one-third for their relatives or friends. The majority of callers had symptoms of anxiety (46%), depressive disorder (8.3%), and

Table 4: Outcome

Parameter		Feedback/outcome			
		Satisfied	**Appreciated**	**Written feedback**	**No feedback**
Overall		119 (49.8)	101 (42.3)	11 (4.6)	8 (3.3)
Interventions (n=239)	Psychoeducation	38 (52)	27 (37)	5 (6.8)	1 (1.4)
	Relaxation	20 (42.6)	21 (44.7)	0	5 (10.6)
	Supportive	86 (46.2)	81 (43.5)	3 (1.6)	7 (3.8)
	Behaviour therapy	17 (53.1)	11 (34.4)	4 (12.5)	0
	Cognitive behaviour therapy	24 (40.7)	27 (45.8)	5 (8.5)	1 (1.7)
2 interventions		49 (47.1)	44 (42.3)	7 (6.7)	1 (1)
3 or more interventions		19 (41.3)	20 (43.5)	4 (8.7)	1 (2.2)

depressive symptoms not qualifying for depressive disorder (14%), and some callers had suicidal thoughts (5.44%). We did not find past psychiatric illness had any major effect on current psychological status. The commonest intervention provided to the callers was supportive therapy (77.8%), followed by psychoeducation (30.5%), cognitive behaviour therapy (24.7%), relaxation (23.6%) and behaviour therapy (13.4%). Most of the callers utilised more than one type of therapy. Overall, most of the callers were satisfied and appreciated the tele-counselling services.

The world is in crisis. Once in any generation, one could witness a pandemic of this nature that has such a huge impact on the health and economy of all countries globally, and this is seen in the concerns of callers in the helplines. Report from China had shown active participation in online mental health support, indicating the interest and acceptance of this medium.[8,9] The same was seen in our state, who did not lag behind in seeking help in tele-mental health services, which is the beginning of a new way of access to healthcare.

One of the interesting findings of our study is that callers with past history of psychiatric illness were not showing any higher psychological symptoms as compared to those who did not have past history; the reason may be lack of knowledge[10] about the implication of getting infected or about the resultant social and economic consequences.

Tele-counselling is a novel practice in the state of Assam, India. The service users had reported comfort and expressed satisfaction in this process of intervention for their issues. Earlier studies reported that this kind of service is not only feasible but also appropriate for the overall support of patients, caregivers, as well as other frontline workers during any pandemic.[11] Tele-psychological counselling is an effective and affordable option. Another factor could be that the stigma is less as they would not have to come and meet the therapist in person for mental health issues; hence, the comfort.

It is also effective in different mental health problems.[12,13] We found among our callers while in the follow-up calls, their immediate issues and problems of which they were anxious and depressed had diminished with brief solution-focused and supportive work. Tele-psychotherapy provides individuals to be in a familiar environment (e.g. at home) and interact with the therapist who is also in his/her familiar environment, which results in a better alliance and therapeutic result.[14]

People in quarantine experiencing boredom, anxiety, depression, fear, and suicidal ideation as well as psychotic features for which time-bound behaviour therapy and emotion-focused psychotherapeutic interventions were opined for adaptation to the chronic stress during a pandemic.[15] The only concern as service providers is that the old system of accessing healthcare services physically may be so ingrained in our system that the benefit may not reach a majority of the population who needs care due to their ignorance of teleservices as a satisfactory option, hesitation to take help from someone with whom they had no previous interaction, poor knowledge and understanding of the technological advancement like video conferencing. This has also been reported in a 2019 survey.[16] The limitation of this survey is small sample size and convenient sampling. So, findings may not generalise but still holds importance because this is one of the first reports on tele-counselling in India.

Conclusion

Keeping in view the contagious potential of the virus and uncertainty about the treatment and prognosis, mental healthcare workers who are scarce can be kept safe with tele-counselling to deal with anxiety and depression of the affected individuals with various psychological intervention. The need for pharmacotherapy can be assessed during the tele-counselling sessions. This modality of intervention can be proved to be an effective way of providing mental healthcare in lower and middle-income countries (LAMIC) where resources are limited, even after the COVID-19 pandemic.

AUTHORS' CONTRIBUTION

Contributors

Conceptualisation, M.H., B.D., and A.B.; methodology, M.H., S.D., and P.S.; validation, M.H.; resources, B.D., D.H., and

A.B; data collection and curation, J.D., S.C., C.B., N.S., B.D., and M.H.; formal analysis, P.S., S.S.B., S.D., M.H., and B.D.; writing—original draft preparation, M.H., S.S.B., and A.B.; writing—review and editing, M.H., B.D., S.D., S.S.B., and A.B.; visualisation, P.S., M.H., and A.B.; supervision, M.H. and B.D.; project administration, M.H.. All authors have read and agreed to the published version of the manuscript. All authors have approved the final article.

Authorship

All authors have made substantial contributions to all of the following: (1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, (3) final approval of the version be submitted, and (4) agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

REFERENCES

1. Parashar U. Assam reports first case of coronavirus, carries out aggressive testing. Hindustan Times [Internet]. 2020 Mar 31 [cited 2020 Jul 8]. Available from: https://www.hindustantimes.com/india-news/assam-reports-first-case-of-coronavirus-carries-out-aggressive-testing/story-AFvN7xyUSqmfN3Kg5505dN.html
2. National Informatics Centre. Assam Covid-19 Dashboard [Internet]. 2020 Jul 13 [cited 2020 Jul 13]. Available from: https://covid19.assam.gov.in/
3. Wind TR, Rijkeboer M, Andersson G, Riper H. The COVID-19 pandemic: The 'black swan' for mental health care and a turning point for e-health. Internet Interv. 2020;20:100317.
4. Keshvardoost S, Bahaadinbeigy K, Fatehi F. Role of telehealth in the management of COVID-19: lessons learned from previous SARS, MERS, and Ebola outbreaks. Telemed J E Health. 2020;26:850-2.
5. Global Psychiatry: a LAMIC perspective. 'Proyax': mental health matters! [Internet]. 2020 Apr 17 [cited 2020 Jul 11]. Available from: https://globalpsychiatry.org/2020/04/17/proyax-mental-health-matters/
6. World Health Organization. The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research. Geneva: World Health Organization; 1992.
7. Hazarika M, Das B, Das S, Hazarika D. Best practice guidelines for telepsychology during disasters (COVID-19 pandemic). Guwahati: Society for Mental Health in LAMIC (SoMHiL); 2020.
8. Liu S, Yang L, Zhang C, Xiang Y-T, Liu Z, Hu S, *et al*. Online mental health services in China during the COVID-19 outbreak. Lancet Psychiatry. 2020;7:e17-8.
9. Ministry of Education of the People's Republic of China. Mental health service platform provides around-the-clock psychological support during COVID-19 outbreak - Ministry of Education of the People's Republic of China [Internet]. 2020 [cited 2020 Jul 11]. Available from: http://en.moe.gov.cn/news/press_releases/202003/t20200309_429190.html
10. Muruganandam P, Neelamegam S, Menon V, Alexander J, Chaturvedi SK. COVID-19 and severe mental illness: impact on patients and its relation with their awareness about COVID-19. Psychiatry Res. 2020;291:113265.
11. Smith AC, Thomas E, Snoswell CL, Haydon H, Mehrotra A, Clemensen J, *et al*. Telehealth for global emergencies: implications for coronavirus disease 2019 (COVID-19). J Telemed Telecare. 2020;26:309-13.
12. Dent L, Peters A, Kerr PL, Mochari-Greenberger H, Pande RL. Using telehealth to implement cognitive-behavioral therapy. Psychiatr Serv. 2018;69:370-3.
13. Bashshur RL, Shannon GW, Bashshur N, Yellowlees PM. The empirical evidence for telemedicine interventions in mental disorders. Telemed J E Health. 2016;22:87-113.
14. Watts S, Marchand A, Bouchard S, Gosselin P, Langlois F, Belleville G, *et al*. Telepsychotherapy for generalized anxiety disorder: impact on the working alliance. J Psychother Integr. 2020;30:208-25.
15. Xiang Y-T, Yang Y, Li W, Zhang L, Zhang Q, Cheung T, *et al*. Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. Lancet Psychiatry. 2020;7:228-9.
16. American Well. Telehealth Index: 2019 Consumer Survey. 2020.