

International Policy Guidance and Responses to COVID-19 Mental Health Recovery

Rapid Review, July 2020



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Executive Summary



This rapid review has been commissioned by the Mental Health and Capacity Unit of the Department of Health NI and funded by the Mental Health Foundation. The main aim is to identify, analyse and present evidence to inform the response to mental health needs arising and/or being exacerbated by the Covid-19 Pandemic and examine the international evidence beyond the UK and Ireland. This is a fast-moving landscape and it is anticipated that additional relevant reviews and articles will be identified as research, policy and practice develops.

The COVID-19 outbreak has negatively impacted people's physical health and mental health, generating stress and anxiety throughout the population. The introduction of quarantine and other behavioural preventive measures has affected people's usual activities, social connections, routines and livelihoods, increasing levels of loneliness, depression, alcohol and drug misuse, and self-harm or suicidal ideation.

We know that the pandemic has led to a sharp increase in mental health problems (Ammerman, Burke, Jacobucci, & McClure, 2020; Rossi et al., 2020; Troyer, Kohn, & Hong, 2020; Wang et al., 2020). The delivery of mental health services has changed considerably during the crisis, lockdown and social distancing measures have halted many face-to-face services and in-patient care. However, mental health services at a community-level, while also critically impacted, appear to have been able to adapt more quickly. Some of the services that have been most agile to respond have been those co-designed and co-produced by service users (Rodzinka, 2020).

This paper takes a snap-shot of how international governments, agencies and organisations are responding to the challenge of COVID-recovery in July 2020. It will aim to summarise the background and context to the crisis, identify some of the pre-COVID mental health inequalities and the psychological impact of COVID. It will give an outline of international COVID-recovery responses and planning, identify some of the key themes emerging from the literature, identify at risk populations and highlight some examples of innovation. While there is a specific focus on mental health, we will consider the wider context of the social determinants of health as one of the biggest challenges in transforming care.

There is a universal call for mental health services to be prioritised, invested in, and be at the forefront of every country's response to and recovery from COVID-19 (United Nations, 2020b). Taking urgent action may help prevent mental health problems and establish more effective support systems (Centre for Mental Health, 2020).



International organisations have issued policy statements and guidance about the priorities for promoting mental health recovery and responding to the additional pressures on healthcare provision as a direct result of the COVID-19 pandemic. At individual country-level, governments (such as Australia and New Zealand) have begun to outline considerations for mental health recovery as a result of the pandemic, developing action plans that build on experiences from previous pandemics and their psychological impact.

These plans are sensitive to their existing healthcare systems but apply learning from the emergency response to COVID-19 and identify opportunities to transform current care. Recurrent themes are emerging from these policy statements and draft recovery plans, reflecting some of the emergency responses created to maintain some level of continuity of care (see Table 1). Whether these changes to working will be sustained as lockdown continues to ease will be important to consider.

Beyond the immediate devastation that the pandemic has wrought on families, healthcare workers, the economy and livelihoods, commentators have started to think about the opportunities for change as a result of the innovative changes to service provision and the wider societal issues the impact of COVID-19 has further highlighted.

Key opportunities also have emerged from the community response that has been generated during this crisis. It is possible this could be harnessed to

promote a community-based healthcare model that is more sensitive and responsive to the needs of the local population. There are many examples of how communities have come together, extending care beyond traditional models of delivery but they have also highlighted some of the weaknesses in current provision.

We need to map and model what is available locally to understand local demand and build and strengthen a collaborative inter-agency response to meet these needs. The community response has also strengthened the role that lived experience and co-production must play in the design, delivery and monitoring of services.

Good quality data has to be the cornerstone of responsive and intelligent healthcare provision. Greater attention needs to be paid to the promotion and prevention of good mental health. Public health messaging that is clear, concise, trustworthy and accessible to marginalised groups is essential. Mental health and wellbeing has been pushed to the forefront of everyone's consciousness during this emergency, creating an unprecedented but perhaps time-limited opportunity to help to tackle some of the stigma surrounding mental health and promote early help-seeking.

Alternative routes of care and support have also emerged as a direct response to the crisis including a sharp increase in digital healthcare, self-help and information responses. Careful consideration is required to understand the benefits and limitations of this kind



of delivery before expanding. Although cost-effective and scalable it may not be right for everyone and has the potential to further exclude marginalised groups such as older people, or people experiencing homelessness. At risk populations should be routinely identified – communication and interventions must be developed and tailored for these groups, drawing on lived experience and good quality data.

The relationship between physical and mental health has to be seamless in the delivery of care.

Many people have adopted new routines and activities during quarantine and there is a big push for environmentally responsible approaches to reduce emissions and promote physical activity. Conversely, reported increases in alcohol and tobacco use during lockdown will have increased the risks to physical health in both the general population and mental health service users.

Making every contact count with individuals and promoting a holistic approach to mental and physical health is crucial in the current crisis and beyond.



Background and context



This rapid review has been commissioned by the Mental Health and Capacity Unit of the Department of Health NI and funded by the Mental Health Foundation. The main aim is to identify, analyse and present evidence to inform the response to mental health needs arising and/or being exacerbated by the Covid-19 Pandemic and examine the international evidence beyond the UK and Ireland. This is a fast-moving landscape and it is anticipated that additional relevant reviews and articles will be identified as research, policy and practice develops.

It is estimated that an additional 400-600 million people will be in poverty as a result of the crisis (Sumner, Hoy, & Ortiz-Juarez, 2020). While major economies have tried to mitigate the fiscal shock of COVID-19, with the use of measures including tax deferrals, income and loan subsidies, and debt repayment holidays it is widely anticipated that many organisations will not survive the impact of the pandemic and unemployment will rise significantly. Changes in consumer behaviour and the necessary move to online are expected to be sustained, exposing the high street to further stresses as people increasingly shop digitally.

The global economy is heading for the deepest recession since the Great Depression and the Organisation for Economic Co-operation and Development (OECD) has forecast that the UK economy is likely to suffer some of the worst COVID-19 damage globally with an estimated slump of 11.5% in GDP this year (OECD, 2020b).

Challenges for the UK will be significant. It has one of the world's highest COVID-related death tolls and the worst economic forecast of the developed nations (OECD, 2020b). There has been a stark relationship between deprivation and coronavirus – with the most deprived areas of England experiencing more than twice the death rate than the least deprived areas (Office for National Statistics, 2020b). There are considerable existing socio-economic, health and other inequalities likely to be compounded by the challenges ahead. In 2019, 30% of children in the UK were living in poverty (Child Poverty Action Group, 2019). The UK has high levels of income inequality compared to other developed countries (OECD, 2020a) and is ranked 21st in the Global Social Mobility Index (World Economic Forum, 2020), well behind most European countries.

The UK government has been criticised for failing to make progress on social mobility (in England) over the last seven years, accused that “there is no evidence that a strategy has been attempted” to implement a single co-ordinated cross-Whitehall plan. (Social Mobility Commission, 2020, p. 12). During the pandemic, navigation of the benefits system has been challenging for many without access to the internet or face-to-face support and a recent survey by Citizens Advice reported the five-week delay to new Universal Credit claims forced many families into hardship (Butler, 2020). New destitution and homelessness have been reported, particularly among those with no recourse to public funds.



Pre-COVID-19 mental health inequalities



The social determinants of mental health are well established (Allen, Balfour, Bell, & Marmot, 2014). Social inequality is a risk factor for mental ill health and those experiencing poverty and other inequities suffer disproportionately (Allen et al., 2014). Unemployment, precarious employment, employment conditions and low income are routinely linked to psychological distress (Amroussia, Gustafsson, & Mosquera; Han & Lee, 2015; Reibling et al., 2017). Neighbourhood deprivation has been associated with worse mental health, higher levels of psychiatric prescriptions

and higher risk of being hospitalised for mental disorders controlling for individual level socio-economic status (Crump, Sundquist, Sundquist, & Winkleby, 2011; Santiago, Wadsworth, & Stump, 2011; Sundquist & Ahlen, 2006). The impact of poverty on food insecurity and poor diet and nutrition have also been linked to poorer mental health (Carson, Blakley, Dunbar, & Lavery, 2020; Davidson & Leavey, 2010; Davison, Gondara, & Kaplan, 2017; Leung, Epel, Willett, Rimm, & Laraia, 2014; Martinez, Frongillo, Leung, & Ritchie, 2018).





Globally, mental health promotion, prevention and services have lacked significant investment with an average spend of only 2% of health budgets set aside for mental health (United Nations, 2020b). International development assistance for mental health is less than 1% of all development assistance for health despite the high prevalence of physical and mental comorbidity in diseases such as HIV/AIDS and TB (Gilbert, Patel, Farmer, & Lu, 2015).

Locally, 5.2% of the NI health budget was spent on the Mental Health Programme of Care by HSC Trusts in 2016-17 (not including spend on mental health services delivered by GPs or the PHA). Spend in the other UK nations was higher (in 2017-18, the mental health budget allocation was 13.3% in England, 11.4% in Wales, and in 2019-20, 7.6% in Scotland) (Northern Ireland Affairs Committee, 2019).

The Confidence and Supply Agreement between the Democratic Unionist Party and the Conservative Party pledged an additional £10 million a year over 5 years for mental health, however the Royal College of Psychiatrists stated in correspondence with Committee that due to the long-term underfunding of mental health services, this additional funding would not address the shortfall (Northern Ireland Affairs Committee, 2019).

At a local level, the Royal College of Psychiatrists (Lynch, 2018) identified a number of key projects that could help bring long-term savings to mental health care:

- Physical health monitoring for people with severe mental illness and eating disorders to reduce premature mortality and associated costs with cardiovascular disease and diabetes
- Early intervention in psychosis services to reduce acute admissions and morbidity
- Investment and planning in services for patients with Alcohol Related Brain Damage to prevent placements in dementia care/hospital treatment
- Establish multi-disciplinary integrated mental health liaison teams to service acute hospitals providing a 24-hour self-harm service, suicide prevention and substance misuse services to reduce SA morbidity
- Dementia home support teams
- Dedicated perinatal service
- Enhanced community services for patients with learning disabilities
- Enhancement of Addictions Teams

Impact of COVID-19 on mental health



A separate rapid review of the estimated mental health impact of COVID-19 in Northern Ireland has been completed (Mulholland, 2020). This review outlines the evidence from previous mass casualty events in Northern Ireland, identifies the direct and indirect impacts of COVID and how these may affect specific populations already known to services. It also considers the impact on 'at risk' groups and how service delivery may be affected. It sets out some of the considerations for treatment (prevention, early intervention and recovery) and identifies some of the research priorities moving forward. Some of the additional burdens created by the pandemic include:

Psychological impact

Research evidence from previous epidemics and the COVID-19 pandemic has highlighted the negative impact on mental health (Torales, O'Higgins, Castaldelli-Maia, & Ventriglio, 2020) and contemporaneous data from national population surveys have already identified a surge in mental health problems (González-Sanguino et al., 2020; Jahanshahi, Dinani, Madavani, Li, & Zhang, 2020; Mazza et al., 2020; Qiu et al., 2020; Shevlin et al., 2020).

A long-term increase in the number and severity of mental health problems is also anticipated (United Nations, 2020b). A reduction in the availability and breadth of mental health services has had an impact on both people with

existing mental health problems and those who are experiencing new or increased difficulties with their mental health during the pandemic. Demand for face-to-face services has significantly decreased for fear of infection, particularly among older people (Khoury & Karam, 2020). While there has been an increase in effective and scalable digital and online services, they are at risk of alienating illiterate, poor and older populations and such approaches may not meet all mental health needs (Doctors of the World, 2020; United Nations, 2020b).

There is evidence too that people were unsure whether they could report and seek help for mental health problems during the lockdown (Doctors of the World, 2020). The impact of social isolation, bereavement, and increase in negative coping skills or addictive behaviours may also have long-term consequences.

Children, school and child protection

School closures have led to different forms of exclusion for children. Child and adolescent friendship groups and peer networks have been disrupted. Children without digital access, physical space, or resources for other support are losing out on their education. Contact with other sources of support and help, both within and beyond the classroom, have meant that child protection concerns have not been identified or responded to in the same way. The Safeguarding



Board for Northern Ireland reported a significant decrease in child protection referrals in April 2020 (between 35-45%) and the Chief Social Worker for Northern Ireland, Sean Holland, said, “The takeaway message is referrals are down but we have no reason to believe that child abuse is also down” (Black, 2020). Food insecurity for children has increased due to lack of access to school meals.

There has been a sharp increase in internet searches relating to support for domestic violence (Poate, 2020), rises in reports of domestic violence and lockdown has led to many victims of domestic violence to shelter in place (Bradbury-Jones & Isham, 2020; Leslie & Wilson, 2020; Usher, Bhullar, Durkin, Gyamfi, & Jackson, 2020).

Dealing with healthcare backlog

Health and Social Care services will face additional pressures to deal with backlogs of postponed referrals and self-referrals during the pandemic. GPs are not seeing the usual number of people for routine health concerns and chronic disease management that they would expect to see under normal circumstances. Delayed diagnosis and management of disease, poor control of pre-existing long-term conditions, reduced opportunity for health promotion and disease prevention activities will all have had an impact. As a result, we can expect an increase in health inequalities already experienced by at risk groups.



COVID-19 mental health recovery planning



International policy responses

International policy guidance

Both the World Health Organization (WHO) and the United Nations (UN) have produced policy briefings on mental health recovery and professional bodies and third sector organisations have also generated policy responses and guidance (Centre for Mental Health, 2020; D'Arcy, 2020; IASC Reference Group MHPSS, 2020).

A growing number of fast-tracked journal articles are being published outlining priorities for meeting healthcare needs as a result of the pandemic.

The UN's policy brief on COVID-19 and the need for action on mental health calls for a 'whole-of-society' approach to promote, protect and care for mental health that includes widespread availability of emergency mental health and psychosocial support. It appeals for additional investment in mental health interventions that can be delivered remotely and uninterrupted in-person care for severe mental health conditions to ensure continuity of care.

The policy also identifies COVID recovery as an opportunity to reshape and transform mental health services as part of universal healthcare, centred around communities, services that consult and involve people with lived experience in the design, delivery and monitoring of care.

The World Health Organization's Inter-Agency Standing Committee (IASC) issued an interim briefing note on 'Addressing mental health and psychosocial aspects of the COVID-19 outbreak' in February 2020 (IASC Reference Group MHPSS, 2020). This gives specific guidance for mental health and psychosocial support in emergency settings in order to mobilise a broad range of agencies to respond. It recommends that multiple levels of interventions are integrated within outbreak response activities within a series of overarching principles that shape the guidance, including:

- Consideration of the wider context – what are the existing and ongoing issues within the community, who are the 'at risk' groups that may experience barriers to accessing information/receiving care.
- Strengthen Mental Health and Psychosocial Support (MHPSS) in the COVID-19 response – understanding and addressing mental health will be key to stopping transmission and help prevent long-term risk. This should include the integration of MHPSS within community strategies, outreach, contact tracing and in aftercare. MHPSS should be carried out within general health services and could be organised within pre-existing community structures such as schools, community centres, youth and senior centres.
- Co-ordination – MHPSS should be a cross-cutting issue across all sectors.



- Existing services – it is important to map existing MHPSS expertise and structures including private and public health, social welfare and education. This will help pool, mobilise and co-ordinate resources. Inter-agency/inter-sectoral referrals should be established or enhanced to ensure that at risk groups can access services quickly. Existing services should be adapted to new conditions such as mobile outreach units.
- Build on local care structures – national mental health, social care and welfare programmes, educational settings, local government and NGOs should play a role in the response. Where formal MHPSS services are missing, other sources of care should be identified to collaborate and work with e.g. families, social groups, religious groups where appropriate). These other sources of care should be supported with knowledge of COVID-19, MHPSS skills (e.g. Mental Health First Aid) and how and where to refer people who may need more specialist support.
- Protective environments – emphasise the strengths and resourcefulness of communities. Key psychosocial principles such as hope, safety, calm, social connectedness should be embedded across interventions.
- ‘Whole of society’ approach – meeting the needs of the whole population considering race/ethnicity, age, gender, etc. and promote activities relevant to all members of society such as self-care, providing support to people, and communicating clear and accurate information about COVID-19.
- Longer-term perspective – emergencies can lead to an influx of resources which can create an opportunity to strengthen long-term mental health, social care and social welfare.

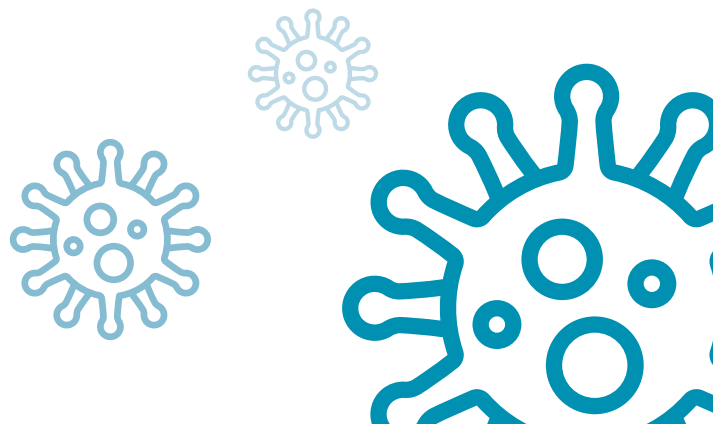
International co-operation

While some international efforts have been collectively made to find a vaccine and effective therapeutic responses to COVID-19, calls for international co-operation in mental health strategies have also been voiced.

The European Union has committed to publishing the EU strategy for mental health before the end of 2020 and this is expected to focus on ways of co-ordinating data collection and share best practice examples across the member nations rather than increase EU healthcare capability.

Country-level responses

Two countries that have had fewer deaths and been affected less by the pandemic have issued mental health response plans, Australia (Australian Government, 2020) and New Zealand (Ministry of Health, 2020). A number of countries have used a common framework to develop action plans, such as Lebanon and the MOPH-National Mental Health Programme (NMHP) with the WHO and UNICEF (Lebanese Republic Ministry of Public Health, 2020).





Australia

The Australian National Mental Health and Wellbeing Pandemic Response Plan (Australian Government, 2020) describes the Government's 'agile' response to the mental health needs exposed by COVID-19 that included a rapid expansion of digital services and telehealth delivery.

They scaled up community-based models of care, focused on better co-ordination between primary and acute care and increased the involvement of people with lived experience to inform the response. At risk groups were identified and social and economic needs were addressed e.g. finding housing for people experiencing homelessness.

They are mindful of retaining the positive learning from the emergency response and how this can be integrated and inform future care. However, the pandemic identified gaps in provision that needed urgent attention including the lack of rapid data collection and analysis to inform "targeted, timely and effective responses." (Australian Government, 2020, p. 3).

Key areas of improvement include:

- Rapid and responsive data collection including immediate monitoring and modelling of COVID impact on mental health
- Proactive outreach services to respond to new mental health concerns and for those who have disengaged with services





- Rapid access to assessment, treatment and support for individuals and their carers across the mental health spectrum
- Connected care pathways across and through the system including the traditional health system

The document sets out a series of principles and enablers to enact a nationally consistent, evidence-based plan that allows for 'local solutions' and ten key priority areas to address the response and recovery phases.

These include:

- Participation of consumers and carers with lived experience to lead, design and deliver responses
- Partnership and collaboration across health, other sectors and communities to maximize resources and deliver co-ordinated care
- An integrated approach to social and emotional wellbeing that understands mental health within a context of social determinants, environment and trauma
- Community-based approach to care
- Best practice sharing
- Flexible solutions that are outcome focused and relevant to local needs
- Equity and equality

A 'response' and 'recovery' phase is specified. The recovery phase includes the mid to long-term measures taken to respond to the psychosocial impacts of the virus and the transition to ongoing service system delivery.

During recovery, there are expected to be surges of mental health, substance use and suicide risk presentations around 3-6 months, 12-18 months, and up to 5 years post-response phase activity. The recovery phase may also include targeted measures to respond to any ongoing seasonal activity levels of the virus.

Plans for recovery and service need to support community-wide mental health and wellbeing in the mid to long term.

New Zealand

Currently, New Zealand is the only nation to produce a dedicated mental health recovery plan (Ministry of Health, 2020).

The plan details five areas of focus that consider the social determinants of health, the central role of communities and inter-agency collaboration to respond and aid recovery, and include practical measures that promote self-care, strengthen primary mental health and addiction care, promote collect good quality data and enhance specialist services (particularly for at risk populations).

These themes are evident in the growing literature and a fundamental recognition that mental health and healthcare more generally cannot improve without tackling the social determinants that create such health inequalities.



The five areas of focus are:

1. Collectively build the social and economic foundations for psychosocial wellbeing

- Address social and economic deprivation
- Consider mental wellbeing when developing policies, regulations and programmes
- Focus on equity and Te Tiriti o Waitangi
- Gather wellbeing data and evaluate impacts
- Partner with other agencies to support mental wellbeing

2. Empower community-led response and recovery

- Support tāngata whaiora (people seeking wellness) and their whanau (extended family or community of related families)
- Empower community-led solutions for mental wellbeing
- Support coordination of community-led initiatives
- Equip communities with skills to recognise and respond to mental distress, substance use and gambling harm issues
- Encourage communities to reimagine our future

3. Equip people to look after their own mental wellbeing

- Promote wellbeing, for all New Zealanders through national campaigns and resources, tailored to local needs
- Enable access and choice for practical self-help resources and tools

4. Strengthen primary mental health and addiction support in communities

- Increase access and choice of services for people with a range of mild to moderate mental wellbeing issues
- Support the expansion of primary services by and for Māori
- Provide support for groups of people with specific mental wellbeing needs
- Provide clear pathways for getting mental wellbeing support
- Support the delivery of primary and community mental health and addiction services and service continuity

5. Support specialist services

- Enhance specialist services
- Support Māori mental health and addiction services
- Provide support for specific groups of people
- Support the delivery of specialist mental health and addiction services and service continuity





Other countries have responded to emergency mental health needs during the pandemic and some of the resources put in place may be continued as part of a mental health recovery plan.

China

Online psychological services have been established in various settings across China's 31 provinces, providing free 24-hour care. Psychological self-help intervention including online CBT have been used and AI programmes have identified individuals at risk of suicide by monitoring and analysing messages posted on Weibo (the Chinese version of Twitter).

Online mental health education on social media (e.g. WeChat, Weibo and TikTok) has been used by the general public and mental health professionals (Liu et al., 2020).

WHO Central European Initiative (CEI)

A joint task force has been established by WHO/Europe and the CEI to respond to COVID-19 and co-ordination across the region during the transition phase as we emerge from the peak of infections. Some countries report better mental health outcomes than others, for example, preliminary results from a population survey conducted by the Finnish Institute for Health and Welfare found that the pandemic and associated restrictive measures had a smaller impact on the psychological well-being of the population than was originally feared (Lundqvist, 2020).

In France, people in some social care institutions have been locked in with concerns about limited levels of supervision and in Spain there are reports of psychiatric units securing people in their rooms depriving them of phone and internet access. In Belgium, almost all face-to-face therapies were cancelled and 60% of mental health service users in the Netherlands reported partial or entire suspension of their treatment, with 80% unable to access daily care (Rodzinka, 2020).

The Netherlands has established a single online portal aimed at promoting mental health under the responsibility of the ARQ Knowledge Centre Impact of Disasters and Crises (a part of the ARQ National Psychotrauma Center). The digital counter of the Information and Referral Centre (IVC) provides information for (healthcare) professionals and anyone who has questions about mental health during the time of the coronavirus. It also brings people into contact with different types of local and regional aid, care and service providers if necessary. The structure and content of the IVC COVID-19 is partly based on the experience of previous disasters and crises in the Netherlands.

The portal will be active for at least two years and content will be adapted as needs change. In addition to the development of guidelines and standards, ARQ Impact contributes to the development of measuring instruments (including a resilience monitor), vision documents (including a government-wide vision and strategy for the follow-up phase), online service centers for those affected (IVCs) and



implementation research (including monitor studies). It has access to a broad network within disaster response and crisis management at various levels including those with lived experience.

Eastern-Mediterranean Region

As a WHO grouping, many countries in this region have developed action plans to implement activities to address mental health and psychosocial support as part of their national response to COVID:

Afghanistan – has set up distant psychosocial counselling services through helplines and a website; they are developing awareness programmes that promote self-care in different groups including the general population, healthcare workers and children.

Egypt – has established a National Co-ordination Group to facilitate the coordination between different governmental departments and NGOs involved in the COVID-19 response. Distant psychosocial counselling services are provided through two helplines. One of the helplines runs 24/7, and provides brief psychosocial support by trained psychologists and psychiatrists.

A web-based psychological support service for healthcare personnel in quarantine hospitals has been established and expanded by appointing psychiatrists in all quarantine hospitals, to provide specialised psychological support to COVID-19 patients, healthcare personnel and people with mental health conditions.

Egypt has also developed guidance on the neuropsychiatric side effects of medications used for COVID-19 treatment.

Iran – the Islamic Republic of Iran has three helplines to provide information about frequently asked questions on the pandemic. It also has two helplines for mental health and psychosocial support services staffed by 450 trained clinical psychologists providing counselling, as well as answers to other questions as needed.

They are also in the process of developing national guidelines on the prevention of stress, anxiety and phobia related to COVID-19 in different groups, including the general population, healthcare workers, families of COVID-19 patients, children and other groups. It is also in the process of establishing regional call centres to provide psychological first aid and distant counselling to the public.

Iraq – Iraq is providing online training to frontline workers, including healthcare providers on mental health and psychosocial aspects of COVID-19, stress management, stigma, gender-based violence and psychological first aid. It is also providing mental health and psychosocial support services to people in isolation and quarantine. It is maintaining mental health services and the availability of psychotropic medications across primary health care centres, community health clinics and mental health units.

A number of NGOs in Iraq are providing distant psychosocial counselling services through multiple helplines.



Jordan – Jordan has established working groups to support the implementation of the response plan and to facilitate the coordination between all the sectors involved. They are providing distant psychosocial support services through two helplines. One of the 24/7 helplines and is staffed by a team of trained psychologists and psychiatrists, who also ensure effective access to psychotropic medications through the National Center for Mental Health, as well as referrals to specialised services, if further consultations are needed. Additionally, national and international NGOs in Jordan established similar services to support people.

Jordan is also highlighting mental health considerations in its national awareness campaign for COVID-19, and is disseminating orientation materials on the psychosocial aspects of COVID-19 through different social media. In its efforts to maintain continuity of mental health services during COVID-19, while challenged by strict lockdown measures, Jordan developed a mechanism for safe delivery of medications to patients in their homes. Healthcare volunteers deliver these medications.

Lebanon – Currently, Lebanon is providing mental health support to the public and sharing anti-stigma messages with them, as well as offering remote mental health support and consultations through video calls to people in quarantine hospitals. It also developed a patient leaflet on how to cope with stress and how to access the mental health support services currently in place. Additionally, Lebanon is providing training to healthcare personnel on: psychological first aid, emotional crisis

management, red flags for referral to mental health care, and tips for self-care.

It is also providing training to helpline operators across various sectors on the different aspects of mental health support during COVID-19. As part of the World Health Organization's MHPSS in Emergencies, the MOPH-National Mental Health Programme (NMHP), the Lebanese Government have developed an action plan based on local needs, the health system and national mental health strategy.

This is a dynamic document subject to revisions based on arising needs.

The document sets out four key goals:

1. Promote mental health and mitigate COVID-19 related stressors including stigma and discrimination against persons affected and health workers.
2. Provide mental health support to the persons in quarantine in the hospital or at home and their families.
3. Support the mental health of health workers and first responders in the response.
4. Ensure continuity of mental health care for persons using mental health services in line with IPC guidelines.

Palestine – Palestine has incorporated a mental health and psychosocial support component in its national response plan for #COVID19, despite various logistical and procedural challenges. It has also repurposed an existing helpline for psychosocial support. This helpline is supervised by specialised mental health professionals who can provide



psychological first aid and referral to specialised services to COVID positive people and their family members, particularly children. Palestine has also introduced remote mental health consultations and referrals via phone to ensure the continuity of access to mental health services and psychotropic medications through home deliveries.

Qatar – It developed a training package for healthcare staff to support them in managing their own stress during #COVID19, as well as support and understand the stress their patients and colleagues are facing during these times. Qatar is developing other training packages to support the public in general and people in quarantine.

The Ministry of Public Health and Worker's Welfare have launched an awareness campaign on its website. Qatar launched a new helpline to provide mental health and psychosocial support services during COVID-19. The helpline is operated by mental health professionals and they provide assessment and support to children and parents, adults, older people and frontline healthcare professionals.

Saudi Arabia – has established four psychosocial platforms that provide free online mental health consultations for COVID-19. They have launched an awareness campaign to address the mental health and wellbeing of the community. A second phase of the existing 'DA'EM (supporter) programme (a 24/7 web-based wellbeing and support programme that provides psychological and academic support to healthcare practitioners across the Kingdom and all Saudi practitioners who

are training abroad on scholarships) has been extended. The programme aims to reduce psychological pressures that health practitioners face in the fight against #COVID19 complemented with a hotline that provides mental health and psychosocial support for pressing psychological problems.

Tunisia – Tunisia established a Psychological Assistance Unit to support in identifying and managing psychiatric symptoms related to COVID-19 and confinement, and preventing relapse in people living with existing mental health conditions. This service also offers prevention and stress management for healthcare workers. They have also set up a toll-free helpline.

The helpline provides distant mental health consultations by 24O mental health professionals including psychiatrists, child psychiatrists and psychologists. Volunteer medical students and Tunisian Red Crescent psychologists also support the helpline and redirect victims of domestic violence to specialised NGOs.

Psychiatric patients are also redirected through this helpline to their service providers to avoid discontinuation of treatment or missing consultations. Two other helplines were established for healthcare workers, offering a stress management programme via video-consultation.

Yemen – An NGO, the Family Counselling and Development Foundation, is providing distant psychosocial counselling services through one helpline. This helpline runs for 12 hours per day and 6 days per week.



Key issues emerging from the literature



Tackling the social determinants of health

Funding – short-term fiscal stimulus packages

As already outlined, mental health services have had significant under-investment over decades. Adequate resourcing has been highlighted by various lobbies as key to promoting an effective and sustainable recovery. In the US, lawmakers from across Congress are urging for mental health funding to be prioritised within the next coronavirus stimulus package.

Senator Elizabeth Warren has led the call for the next coronavirus stimulus to include at least \$38.5 billion for behavioural health organisations which are at risk of closure, “The immediate and long-term effects of this cannot be overstated as millions of Americans rely on BHOs to address their mental health and substance use disorder treatment needs,” (The Hill, 2020).

Rethinking social welfare – Universal Basic Income or basic income guarantee?

The debate about a basic income guarantee has been put into sharp focus as a result of the pandemic. Countries including the US, Hong Kong, and Germany have provided one-off payments to families and government-guaranteed income subsidies and furlough schemes to support workers

incomes during lockdown have been implemented in many countries. Finland’s recent two-year universal income pilot gave 2000 unemployed people aged 25-58 £490 per month. Evidence reported better financial wellbeing, mental health and cognitive functioning and feeling more positive about the future compared to the control group, “The basic income recipients were more satisfied with their lives and experienced less mental strain than the control group” (Kangas, Jauhiainen, Simanainen, & Ylikännö, 2020).

Opportunities to strengthen new ways of living and working presented by the pandemic

Digital healthcare

The Director of Mental Health Europe, Claudia Marinetti, described the growth of mental health online professional care during the pandemic as the ‘silver lining’ in the absence of other options. Careful consideration is required to build a sustainable and accessible digital mental healthcare system to support and augment face-to-face care (ref).

While digital technology has exciting potential to transform services and increase capacity, it is clear that telemedicine cannot replace the importance of physical interactions to deliver certain aspects of healthcare, particularly with socially excluded or at risk groups.



Building stronger communities

Similarly, the galvanisation of communities to support the vulnerable has been evident throughout the pandemic – including huge responses to government appeals for volunteers (as in the Republic of Ireland and the UK) or the spontaneous action of local communities to provide practical and social support to those in need. While voluntary services cannot replace funded healthcare provision, these community responses have highlighted the importance of creating a sense of belonging and connection to an identity/place/community, central to helping increase social capital and empower communities. It has also emphasised how loneliness, isolation and social exclusion has significant negative impacts on mental health and wellbeing; the long-term impact of the social isolation associated with coronavirus yet to be fully understood.

A partnership of public services and local people maximising the assets of both, can be a source of reciprocity and mutual support into the future. Local institutions can play a key role. Experts by experience should be involved in the process, making sure that the information that is needed is available.

A plan to deal with future pandemics/threats should be prepared involving different stakeholders including community members. The capacity that communities have shown during the crisis could be the basis for reforming public services. Local community-based health partnerships should be supported based on evidence collected from capacity of decentralised health services

to manage and contain the pandemic. Community psychologists could support the development and management of community-based health partnerships. The European Association of Psychologists have stressed the importance of building a ‘community memory’ to help build resilience, be inclusive and establish learning to help respond to future challenges.

Co-production and lived experience

A common theme in both the immediate response to the emergency and planning for the medium- to long-term recovery is the importance of involving people with lived experience, their carers and family members in the design, delivery and monitoring of services. Each of policy and government responses have placed this as a central tenet of transforming care.

Improving data quality and modelling

This is key to understanding the problem, mapping services, and planning a comprehensive response to need. Many countries have already well-established health and social care monitoring systems that cut across different agencies (see for example, Norway and Finland). This is key to plan and respond to need and monitor effectiveness. Having capacity within health systems to conduct statistical modelling can only improve current delivery.

School-based interventions

It is important to restore children’s sense of security, emotional stability and opportunities for positive development (EPA, 2020) following the considerable



disruption to education, peer and family relationships as a result of lockdown. Many children with special educational needs and other disabilities have lost their support during this crisis – communities and schools will need to identify the additional support needs as they return to school.

Increase in physical activity

Levels of physical activity have increased in the general population during the pandemic as the government has reinforced public health messaging of the importance of physical activity to support good mental and physical wellbeing. Changes to promote greener commuting have been fast-tracked with expansions of cycle and walk schemes. Many people have also recognised the benefits of the reduction in pollution as a direct result of the containment of public transport and car journeys. How we build on this new habits could be crucial in supporting wellbeing. There is strong evidence of the benefits of physical activity to both prevent and treat mental ill health and COVID recovery presents a golden opportunity to reinforce this message and transform public transport.

Re-evaluating key workers and 're-productive work'

During the pandemic, work and economic opportunities for women have been impacted as the burden of child and family care has largely fallen to female family members. Similarly, calls for the re-evaluation of low paid key workers (who are disproportionately female) have been made; whether this recalibration will be sustained beyond the current crisis is unclear.

Focus on prevention, promotion and help-seeking

There has been a new and concentrated focus on self-care and self-help during the pandemic and greater promotion of prevention and early intervention for mental health support. This focus to upstream services could help reduce a spike in need for secondary/tertiary mental health services.

At risk populations

We know that mental health problems are not usually experienced in isolation and so the intersection with a range of other potential adversities does need to be considered.

Recent research conducted by the Mental Health Foundation has highlighted some of these complex issues in relation to COVID recovery (Mental Health Foundation, 2020a) and identified key at risk groups including people with disabilities, single parents, people with pre-existing mental health problems, victims of abuse and people living in poverty and unemployment.

There are also lessons from how COVID-19 has impacted 'at risk' and socially excluded populations that could help inform future healthcare delivery.

These groups also include refugees and people seeking asylum, undocumented migrants and people affected by trafficking or modern slavery. People experiencing homelessness, sex workers, people recently released from prison and the Roma and Travelling communities are also at increased risk.



Many of these groups had complex health needs prior to the pandemic and COVID has only restricted their access to healthcare and other essential services. COVID-19 has highlighted the health inequalities of these populations and meeting the health and social care needs of marginalised groups need to be cognisant of the difficulties delivering supportive care in times of crisis.

The WHO's Inter-Agency Standing Committee has produced helpful guidance to highlight ways to include marginalised and vulnerable people during the emergency but again, this learning is relevant to involve at risk populations beyond the pandemic (IASC, 2020).

Research conducted by Doctors of the World recorded service users' and health professionals' experiences of healthcare during the pandemic. This work identifies key issues that require consideration as the move to online health service delivery expands following COVID:

- Digital exclusion – people in excluded groups are often unable to access online information because of lack of affordability of broadband or mobile data. People can lack the required technology and/or the skills to access reliable and trustworthy information. Smart phones are not allowed in detention centres, some websites are blocked, prisoners have no access to the internet and there are low levels of digital literacy in the Roma and Traveller communities.

These experiences may also apply more generally to people experiencing poverty and older people for example. One staff member at Doctors of the

World commented, "The first thing that happened was that these support groups closed, and people lost their access to data. This has become a more urgent need than food." (Doctors of the World, 2020, p. 26).

- Different channels of communication – excluded groups often rely on different channels of communication through informal social networks and support groups – these were mostly ineffective during lockdown, leading to delays in information sharing. This highlights the importance of maintaining face to face and outreach work to ensure delivery to those most excluded.
- Barriers to following advice and guidance – although during the pandemic, specific guidance was issued to help avoid the spread of the virus, the difficulties associated with this has relevance for future mental health service delivery. People could be fearful of their immigration status, accommodation related barriers can make health guidance difficult to follow – shared kitchen and bathroom facilities, to need to leave home for economic reasons or to service addictions.

During the pandemic, there was evidence of a lack of belief about health messaging because of a lack of trust of the government, and by association, the NHS.

- The difficulties of recognising illness when people have a background of poor baseline health. In addition to this, finding food to live is more important than dealing with a physical health condition.



The report makes a series of recommendations to encourage people to access healthcare:

- Provide sufficient understandable information on the services available to them
- Support people to access services where there are practical barriers such as transport or digital exclusion
- All services are free at the point of access
- Basic survival needs or addictions are being addressed to enable healthcare to be prioritised
- Dealing with fear or lack of trust of health professionals, the NHS, fear of data being shared
- Make it easy to register with a GP

The role of face-to-face contact should also be a priority for some service users. It is harder for mental health services to offer effective alternatives to face-to-face consultations, therapy and support. One GP described the complexity of mental state assessments that can be challenging to conduct remotely, "How do you do this down the telephone; how do you deliver the support. You can do a lot of stabilisation work for someone's mental health, but it's difficult to move things forward; difficult to assess suicidal ideation without looking at their eyes; really tricky, really hard to gauge how safe a situation is; and as a clinician feel confident that you're leaving this person in a safe place. And [know whether] there is an adequate safety network around this person". (Doctors of the World, 2020).

Initiatives for excluded groups such as the 'Everyone in' hotels for people experiencing homelessness, have provided some opportunities for improved health and wellbeing because of their access to secure, stable accommodation with onsite support and access to technology.

COVID has affected many people's lives and highlighted some considerations for planning and working with at risk populations including:

Young people at risk of exclusion

- Importance of maintaining trusted keyworker relationships through regular communications
- Keeping connections with those who are digitally excluded and prioritising contact with these groups
- Consulting and sharing power with young people as equal partners in how services are designed and will change following COVID
- Government adopting language and communication that is culturally relevant for young people

Older people

- Important to communicate clear information and share simple facts in words older people with or without cognitive impairment can understand. Repeat the information whenever necessary.
- Medical needs of older adults need to continue to be met including uninterrupted access to essential medicines.
- Exploring how using technology to reduce social isolation can be used accessibly.



Workplace mental health

- Impact on healthcare and social workers – increased levels in anxiety and depression and PTSD. Locally, the Public Health Agency for Northern Ireland has produced a new framework to support the wellbeing needs of health and social care staff (Public Health Agency, 2020). Learning from other emergency events, it is expected that the psychological impact will be pervasive and long-lasting (Mulholland et al., 2020). The framework highlights the need for visible leadership, communication, access to physical safety measures, providing psychological care to patients and families. Wellbeing should be supported using a stepped care model and stresses the importance of human connection and pre-existing peer support. The framework uses the common phrase ‘it’s okay not to be okay’ highlighting the importance of normalizing the psychological responses to this unprecedented emergency.
- The importance of self-care and self-help has been widely promoted and many workplaces have begun to build on training such as Mental Health First Aid. It is important that wellbeing promotion is sustained post-emergency and continues to tackle some of the stigma about mental ill health.
- The social distancing measures are likely to extend for some time, many organisations will not be able to facilitate a return to office space and working from home will continue. It is important that workplaces consider the issues relating to social isolation and peer connection and support under these new working arrangements and promote work-life balance from the new ‘living from work’ rather than ‘working from home’.

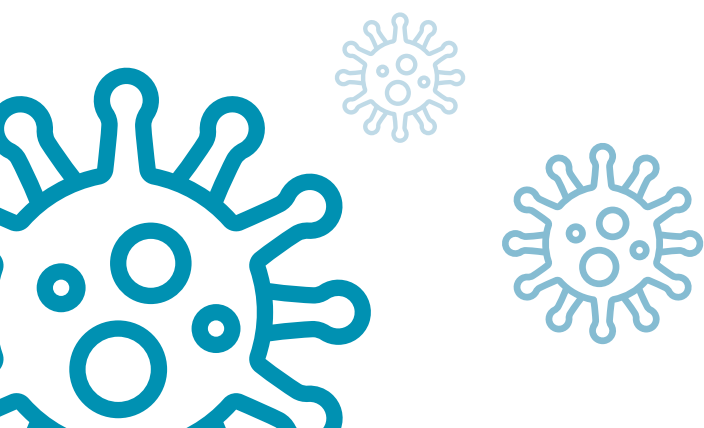


People with pre-existing mental ill-health

- Pre-existing mental health conditions are likely to have been exacerbated by COVID-19 as face-to-face services have been affected and continuity of care may have been disrupted. The additional stresses relating to the pandemic may also have led to a deterioration in their mental health. Relapse rates of pre-existing mental health problems have been common (Chatterjee, Barikar, & Mukherjee, 2020).
- People with conditions including OCD, especially those with checking, hoarding and washing compulsions are at higher risk.
- Depressive disorders can be exacerbated as daily routines and social rhythms have been disrupted, increasing stress levels (Chatterjee et al., 2020).
- Generalised anxiety disorder, chronic insomnia and risk of suicide may also have been affected (Dong & Bouey, 2020; Goyal, Chauhan, Chhikara, Gupta, & Singh, 2020).
- The economic impact and worry about the financial future can also have a detrimental affect (Zandifar & R., 2020).

Black and Minority Ethnic (BAME) Communities

- BAME communities have been disproportionately affected by COVID and are at increased risk of death (Aldridge et al., 2020; Pareek et al., 2020). Following the peak of the disease in April, 63% of fatalities in healthcare workers were from BAME communities, 94% of these were doctors, 71% nurses and 55% other healthcare workers (Kirby, 2020). Of the 6,574 patients in intensive care up to 30 April, one third were from non-white groups (Intensive Care National Audit and Research Centre, 2020). Chronic conditions such as diabetes, asthma, hypertension, kidney disease and obesity are more prevalent in African American and South Asian than white populations (Kirby, 2020; Tillin et al., 2013). These conditions have also been connected to higher mortality rates in COVID-19.
- Since the start of the pandemic, criticism has been levelled about the lack of quality ethnicity data that has resulted in poor health decisions.
- In Australia, steps have been taken to protect Indigenous Australians living in remote and rural locations. Strict travel limitations were introduced and an Aboriginal and Torres Strait Islander COVID-19 Advisory Group was established. Deaths in this population have been disproportionately lower than other ethnic groups. The medical advisor to the National Community Controlled Health Organisation, Jason Agostino, attributes this relative success to the Aboriginal and Torres Strait Islander people taking the lead to protect their





communities by adopting a 'whole of person' approach (Kirby, 2020).

- Ethnicity is a complex concept, not only relating to genetic composition but also formed by social constructs, cultural identity and traditions that can include certain patterns of lifestyle behaviours (Lee, 2008).
- Consideration must be given to the accessibility of public health and guidance including any language, formal or cultural or other barriers to effective dissemination within BAME communities (Welsh Government, 2020).
- The wider issue of the social determinants of health, and how racism and inequality affect the BAME community must be acknowledged in policy and practice.

People with disabilities

- People with disabilities have been disproportionately impacted due to attitudinal, environmental and institutional barriers that have been reinforced during COVID-19 (United Nations, 2020a).
- Many people with disabilities have been at higher risk of contracting the virus due to living environments and higher comorbidity of other underlying health conditions.
- Some immediate steps have been taken to mitigate against the virus. During the pandemic, some countries (including Spain and Switzerland) took the decision to move people from institutional living to return to live with their families where possible. The UN has highlighted the importance of ensuring that once people are

discharged into the community, they are supported appropriately through a range of networks and help reinforce deinstitutionalization strategies.

- In Canada, this has also meant that people with disabilities have been prioritised in testing and a range of preventative measures within institutional settings have been taken.
- Many countries (Mexico, New Zealand, Panama and Paraguay for example) have prioritised accessible communication including sign language interpretation, captioning and easy to read formats.
- Community networks have been established to support disabled people living in the community to assist with essential services and measures such as special shop opening hours for people with disabilities and their assistants.
- There have also been examples where quarantine and physical distancing measures have been altered to ensure people with disabilities can access support (Argentina, UK).
- The longer-term impact will also be experienced in these communities. Higher levels of anxiety have been reported in the disabled population compared to non-disabled people and average anxiety ratings during lockdown have remained significantly higher for those who are disabled compared with non-disabled (Office for National Statistics, 2020a).
- Regular routines continue to be disrupted. In Northern Ireland, many special schools and day centres have been closed since mid-March and an estimated 100,000 extra people



have taken on caring responsibilities since lockdown (BBC, 2020).

- People with disabilities are more likely to be unemployed or employed in the informal sector and face less economic protection than many other groups. A number of countries have responded to this increased risk by expanding social support systems (Bulgaria, Malta, and Lithuania for example), increasing benefits (Argentina, France and Peru) or offering tax relief (USA). It is important that people entitled to social security are protected and are offered support to access any benefits or financial compensation schemes available.
- Access to education has also been critically impacted and for many families access to equipment, accessible materials and online resources have not been available.

- Reporting and access to domestic violence services can also be particularly challenging for persons with disabilities (United Nations, 2020a). Hotlines should be accessible. Authorities in Peru have been proactive in making telephone contact with people during the pandemic but it is important that this approach of reaching out to people who may be isolated continues beyond the emergency. Awareness raising and training should be provided to promote the needs of vulnerable groups.

Lone parents

- Single parents are twice as likely to live in poverty than coupled households and more often in low or insecure employment made even more precarious during lockdown.





- Many single parent families will also have faced additional pressures during COVID. Relying on one income and without the support of another adult in the household to help with childcare arrangements will have been difficult for many families. Quarantine may have also heightened feelings of self-isolation.
- While many employers have promoted flexible working during the pandemic, support organisations such as Gingerbread have called for greater protection for single parent families including an increase in social security and suspension of the benefit cap, ending the five-week wait for Universal Credit and fast track single parent family applications (Gingerbread, 2020). There are also concerns about shortfalls in child maintenance as an economic fallout from COVID. Practical measures such as providing cash instead of free school meal vouchers and supporting employers to adopt flexible working arrangements including short-term reduction in workload or reduced hours should be promoted.

Parents of school-age children

- Many parents will have struggled with balancing childcare and work during lockdown including economic stress.
- The added difficulties of trying to manage and support their children's education may also have been stressful, particularly where a child has additional educational needs.
- Parents have also had the added strain of talking to their children about the virus and supporting their child(ren) to cope with exclusion and isolation from their peer group, school, teachers and extended family and how it is affecting their wellbeing. Anxieties about exams and transitions have also been heightened for many.
- Keeping children and young people safe online with the surge in activity and reliance on technology for not only school work but social connections will have also been a concern for many parents.
- Families need to be supported once children return to school and appropriate measures put in place to within education settings to help promote good mental health and access early support and intervention where required.

Unemployed people

- We are facing one of the biggest economic crises since the Great Depression and economic recovery is predicted to be lengthy affecting all areas of the economy (Nicola et al., 2020). Inequalities are also set to increase and unemployment is likely to stay high for some time.
- Unemployment is the economic variable most linked to unhappiness (Blanchflower, 2008; Clark & Oswald, 1994) and associated with poorer physical and mental health (Linn, Sandifer, & Stein, 1985).
- Citizens Advice reported recently that redundancy is the most searched item on their website and their benefits advice page has had 4.4 million views since late March 2020.
- In the UK, high levels of anxiety doubled when the economy went into hibernation at the end of March 2020 (Office for National Statistics, 2020a).



- A recent coronavirus study by the Mental Health Foundation found that 34% of UK adults surveyed and in full-time work were concerned about being made redundant, 20% of unemployed people had suicidal thoughts and feelings (Mental Health Foundation, 2020b).
- Young people leaving school and university may be particularly vulnerable to the long-term effects of the economic downturn. The UK Chancellor, Rishi Sunak's announcement of a kickstart scheme to subsidise six-month work placements for young people on Universal Credit has been welcomed but may not be adequate to stave off long-term unemployment. The Chancellor has also reacted to pressure to extend the furlough scheme to protect jobs but this can only go on for a limited period.

LGBT+

- LGBT community has faced additional risks as a result of COVID (LGBT Foundation, 2020).
- LGBT young people are at greater risk of homelessness.
- People from LGBT community are less likely to access healthcare when they need it and more likely to have higher risk factors such as tobacco use, sedentary behaviour and poorer nutrition. There are also higher levels of poor mental health and substance misuse in this population. Some mental health services have been suspended or reduced in some areas.
- There are additional COVID-related risks to this community including

higher levels of social isolation, lower levels of help seeking and for some trans and non-binary people, some medical services have been postponed as 'non-essential' treatment.

- One in ten LGBT people have faced domestic abuse, and this rises to 19% for trans people.
- Healthcare services should respond to the specific health risks and needs of the LGBT community and target resources and communications inclusively.

Victims of abuse

- We know that reported levels of domestic abuse have risen during the crisis across the globe. Forced coexistence, economic pressures and increased household tension have contributed to increased levels of domestic violence. The charity, Refuge, reported a 25% increase in calls and online requests since lockdown began (Social Care Institute for Excellence, 2020).
- Domestic violence has become less visible with fewer people visiting homes or seeing friends and family.
- Access to services has also been affected but many national organisations have responded quickly and have widely promoted guidance, continuing to provide services. Quarantine rules have been eased for those seeking refuge however as restrictions continue and with the ongoing economic stressors, it is important that victims of abuse are supported and have easy and quick access to services. The strong help-seeking message that has been conveyed should continue to be communicated widely.



Innovation



USA case study 1

'Our Tomorrows' is a rapid feedback loop for Kansas citizens to share their experiences of COVID-19 and the impact it has had on families. Stories are shared to a state-wide Story Bank hosted by the Kansas Children's Cabinet and Trust Fund.

State-level decision-makers and community organisations have access to the Story Bank and related analysis conducted by the Our Tomorrows team to develop interventions and provide a rapid response to virus-related developments. On a practical level, the Story Bank data has been used to identify repeated themes and patterns and potential opportunities to address local issues.

One example of how it has worked: a child care provider highlighted the problem of milk shortages because of grocery-store rationing, similar rationing within dairy production was leading to disposal of excess milk production – when the narrative reached state-level leadership, the demand/supply problem was quickly addressed through co-ordinated state action.

Qatar

Technology has been scaled up in Qatar to provide telephone/video medical consultations that allow patients to enter virtual consultations with their doctor with other specialists added where required. The system in turn can generate electronic sick leave.

This was a joint collaboration between the Ministry of Public Health and the TASMU Smart Qatar Program (part of the Ministry of Transport and Communications). 13 virtual clinics have been launched across primary care, secondary/tertiary care and 5 labourer compounds. The clinics include: geriatric memory clinics, urgent primary care, mobile doctor clinics for the specialist ambulatory department, mental health services for first responders, mental health clinics for children and adolescents, adults and older adults.

There are also specific virtual clinics for physiotherapy, diabetes education, endocrine/dietician and dental health.



USA case study 2

An Adolescent and Young Adult (AYA) clinic in San Francisco quickly responded to the COVID-19 emergency by replacing most in-person visits with telemedicine visits (Barney, Buckelew, Mesheriakova, & Raymond-Flesch, 2020). Telemedicine seemed acceptable to young people but several common barriers were identified across all clinical domains including the difficulty maintaining privacy and confidentiality. Using headphones, yes/no questions and 'chat' function enabled patients to type replies to questions. Lower socioeconomic status compounded privacy challenges because of crowded living conditions and some professionals felt their clinical decision-making was limited by not being able to complete a physical examination or have access to laboratory data.

Providers identified that medical management of mood disorders and maintenance of attention deficit hyperactivity medications were all easily facilitated via telemedicine however the management of medications for conditions typically managed by psychiatrists (e.g., antipsychotics, mood stabilizers, benzodiazepines) were a challenge. Mental health conditions that required ongoing medical monitoring (e.g. eating disorders and the need for regular anthropomorphic measurements) also required more planning. By working with hospital satellite clinics, local primary care providers, and therapists, patients and their families did not have the financial and time burdens of travel while minimising the potential transmission of COVID-19 between communities. Conversely, telemedicine created flexibility for some families, allowing increased parental participation in medical visits (e.g., among parents with separate households or for working parents). More research is required to assess how appropriate telemedicine is for young people. While many routine aspects of preventive care can be delivered, there is a lack of research or practice guidelines. Advancing technologies (e.g., wearables or smart phone accessories) and the shifting culture of adolescent medicine might overcome some of these challenges (Barney et al., 2020).

Spain

Madrid converted 60% of their mental health bed capacity to COVID wards, reducing the number of people attending A&E by 75%. Mental health services had to adapt quickly – where possible, people with severe conditions were moved to private clinics to ensure continuity of care. Local policy makers identified emergency psychiatry an essential service to continue outpatient services. Home visits were organised for the most serious cases. IT experts enabled mental health staff working from home to access electronic clinical records while maintaining confidentiality (Arango, 2020).



Summary and conclusions



The response to the emergency of COVID-19 has challenged and arguably permanently changed mental health services. This rapid review gives a snap shot of how the global community is trying to respond in a fast-changing environment. However services emerge from this crisis, many decision-makers are seeing this as an opportunity to make change creating the potential to positively transform mental health care.

There is consensus that this cannot be achieved without tackling the root causes of health inequalities and their social determinants. Grave economic stressors add considerable threats to increasing social inequality and poverty in NI. Data collection, modelling and sharing needs to be enhanced to better inform policy and service development. There are also opportunities to build on the more positive elements that have emerged in crisis.

These include the adaptability and flexibility of community-based care, the recognition of the importance of lived experience in the design, development and monitoring of services, improved interagency collaboration, the acceleration of the digitalisation of healthcare and the importance of connecting physical and mental health.

Appendix



Key themes	Additional risks	Additional opportunities
Addressing the social determinants of health	<ul style="list-style-type: none"> • Cuts to social services • Poor economic forecast • Mass unemployment 	<ul style="list-style-type: none"> • ‘Everyone in’ • Reduction in pollution • Increased levels of physical activity • Universal basic income • Significance of green and blue spaces in promoting wellbeing
Adequate investment	<ul style="list-style-type: none"> • Cuts to social services • Poor economic forecast • Mass unemployment 	<ul style="list-style-type: none"> • Emergency funding directed to mid- to long-term investment
Cross-sectoral collaboration and integration – psychosocial model of mental health	<ul style="list-style-type: none"> • Poor data and interagency collaboration 	<ul style="list-style-type: none"> • Making every contact count (universal screening measures for key touchpoints with public services) e.g. beyond healthcare including the police, education
Communication – reliable and trustworthy	<ul style="list-style-type: none"> • Fake news and misinformation 	<ul style="list-style-type: none"> • Strong public health messaging to promote adherence to safety measures • Also opportunity to reduce stigma around mental health
Community -based services	<ul style="list-style-type: none"> • Lack of joined-up services 	<ul style="list-style-type: none"> • Developing social and community capital • Local delivery • Extending care beyond traditional areas of responsibility • Harnessing community spirit – particularly seen in the countries hardest hit by the pandemic (Spain, Italy and the UK) • Mapping community services • Current momentum as result of pandemic



Key themes	Additional risks	Additional opportunities
Data collection and modelling	<ul style="list-style-type: none"> Poor data quality 	<ul style="list-style-type: none"> Identifying need Mapping services Monitoring care
Digital healthcare	<ul style="list-style-type: none"> Digital exclusion Inappropriate/ineffective for some conditions 	<ul style="list-style-type: none"> Cost-effective Scalable
Lived experience and co-production in design, delivery and monitoring	<ul style="list-style-type: none"> Tokenistic 	<ul style="list-style-type: none"> Bearing witness Participation/co-production – building resilience, using local community knowledge and networks, local ‘pop-up’ solutions
Mental health literacy & stigma		<ul style="list-style-type: none"> Experiencing distress is a normal reaction particularly during these circumstances – shared understanding
Opportunity to transform services		<ul style="list-style-type: none"> ‘Building Back Better’ Examples of innovation
Physical and mental health		<ul style="list-style-type: none"> Connecting mental and physical health Green transport solutions Sustaining new physical activity habits and routines Tackling co-morbidity

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