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Mental health preparedness and response during the COVID-19 pandemic: from global to national implementation

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Globally, mental health disorders have claimed more than 14% of age-standardized years living with disability for three decades and have >10% prevalence in all geographical regions (GBD 2017, 2018). These findings substantiate an immediate need for strengthening mental health systems. Given large demands for mental health services, the mental health systems in low- and middle-income countries appear inadequate due to low public investment and limited health workforces which result in poor access to care.

High out-of-pocket payment is a key barrier to access to mental health services, leading to delayed treatment and poor mental health outcomes. Worldwide, the median mental health expenditure was as low as US$2.5 per capita, with a large variation across low-, middle- and high-income countries. Per capita spending on mental health was US$21.7 in the European region, which is 200 times higher than in African and South-East Asian regions (US$0.1). Low spending by governments on mental health services results in high levels of out-of-pocket payments; 43% of countries in the African region and 40% in the South-East Asia region reported that the costs of mental health services were mostly or entirely paid out-of-pocket [World Health Organization (WHO), 2018*a*].

Globally in 2018, the median numbers of mental health workers per 100 000 of the population was 9 but with a wide range: less than 2 in low-income countries and more than 70 in high-income countries (WHO, 2018*b*). Further, fewer than half of WHO Member States can produce and maintain mental health statistics such as prevalence, financing, health personnel and access to services. Over 65% of WHO Member States in low- and lower-middle income countries do not have or have non-functioning national authority responsible for mental health.

The COVID-19 pandemic is having profound mental health and psychological consequences on both the general population and health care workers. Death tolls and COVID-19 infections, as well as unintended consequences from public health and social measures notably social, physical distancing and isolation, have huge impact on human well-being and the economies of countries. Stresses from fear of infection, loss of loved ones, physical and mental isolation, job loss and income uncertainty have major mental consequences for people. Long working hours in providing COVID-19 services and in some cases with inadequate occupational protection, such as personal protection equipment for front-line health professionals, create additional stress and psychological consequences.

Mental health system challenges prior to and during COVID-19 pandemic

Prior to the pandemic

Mental health is arguably the most neglected area in terms of health funding. Many low- and middle-income countries have suffered from limited mental health service infrastructure and capacities. Common challenges facing mental health service provision include lack of financial resources, scarcity and limited competency among mental health workforce and care workers to provide quality mental health services, as well as the social stigmatization of patients and families experiencing mental health conditions (Eaton *et al.*, 2011; Keynejad *et al.*, 2021).

Further, there is a lack of mental health policies and legislation to support mental health system development, to integrate mental health services into essential health services, to ensure adequate access by the population and to protect the rights of mentally disabled persons. Possible reasons include lack of leadership, poor availability of data and information, and limited capacity to generate evidence to inform policies according to the national or sub-national context (Rathod *et al.*, 2017).

The Inter-Agency Standing Committee on Mental Health and Psychosocial Support in Emergency Settings developed guidelines through an inclusive process, with input from UN agencies, NGOs and Universities (IASC, 2007). These guidelines support countries to plan,

establish and coordinate a set of minimum multi-sectoral responses to protect, prevent and improve people's mental health and psychosocial well-being affected by an emergency. The guidelines, including two recent COVID-19-related publications (IASC, 2020*a*, 2020*b*), should be activated and fully applied in the COVID-19 situation. A study shows that community engagement, and good relationships between healthcare providers and the community are key to successful implementation and uptake of mental health and psychological support programmes in emergencies. Sufficient numbers of trained providers were essential to deliver the range of support in the constraint of resource-limited settings (Dickson and Bangpan, 2018). Collective efforts by all partners determined successful outcomes in a short time in the Gaza Strip, Palestine (Ubaid *et al.*, 2021).

During the pandemic

A systematic review of 136 articles showed that the short-term mental health consequences of COVID-19 are equally high across countries, and across demographic characteristics (Cénat *et al.*, 2021). The pandemic and its consequences, including from public health and social measures, affect the mental health of people from all walks of life, including patients and their family members, and health and care workers who provide public health and clinical services (Monica *et al.*, 2022). Those with vulnerability, in particular migrants, internal displaced persons, refugees, women and children, have experienced more social stressors resulting in higher anxiety and depression (Campo-Arias and Teresa De Mendieta, 2021). Other psychological impacts include insomnia and sleeping disorders, anxiety and suicide in the population and burn out among healthcare workers (Gilmore and Ward-Ciesielski, 2019; Magnavita *et al.*, 2021; Marvaldi *et al.*, 2021). Moreover, frontline workers who are exposed every day to infected patients are prone to higher-than-normal levels of perceived stress and fears of being infected and of transmitting infection to their own family members (Arora *et al.*, 2020).

While there is significant increasing demand for mental health services, these services seem to be the most negligible programmatic response to COVID-19. Disruptions of these services were reported from most countries. Out of 130 countries, 121 (93%) responded to the rapid survey by WHO and reported disruptions in one or more services for mental, neurological and substance use disorders. In addition, community-based outpatient services and mental health prevention and promotion services were among the most severely disrupted (WHO, 2020).

Mental health services during the pandemic tend to be a short-term reactive response, despite the fact of long-lasting mental health impacts on the population and a high incidence of depression, which increased by sevenfold during the pandemic (Bueno-Notivol *et al.*, 2021). Thus, additional attention should be given to catering to the long-term mental health needs emerging from the pandemic, while taking the opportunity of the pandemic to strengthen the mental health infrastructure.

The current global mental health action plan 2013–2020 does not incorporate actions required in the context of public health emergencies, (WHO, 2013). Neither does WHO's strategic preparedness and response plan for COVID-19 include strategies to address mental health needs from COVID-19 (WHO, 2021*a*). There is a need to fill these gaps either through the mental health action plan or the pandemic preparedness and response plan.

Global movement on mental health

At the 148th WHO Executive Board meeting (EB148) held in January 2021, Thailand proposed an agenda on 'Mental health preparedness and response for the COVID-19 pandemic' with an aim to include mental health services as an essential component in the preparedness and response to COVID-19. The Board considered and adopted a Decision on 'Promoting mental health preparedness and response for public health emergencies' which was co-sponsored by 47 WHO Member States (WHO, 2021*b*).

The Decision highlights the importance of mental health service provision with adequate resources by urging countries to: (a) develop and strengthen the timely and quality of the provision of the whole range of comprehensive and integrated mental health services and psychosocial support as components to achieving universal health coverage; and (b) allocate adequate funding for mental health, and to study the impact of COVID-19 on mental, neurological and substance use conditions and their consequences.

The Decision also requests WHO to: (a) provide technical support to countries to monitor changes and disruptions in mental health services, to promote and expand access to inclusive, integrated, evidence-based primary and community-based mental health services and psychosocial support; and (b) report on the implementation of this decision as part of the progress report on the implementation of the comprehensive mental health action plan 2013–2030.

During the EB148, many countries raised concerns and recommended actions to address the stigmatization and discrimination of COVID-19 patients and frontline workers, provide mental health support in particular through community-based approaches, and address the long-term impact of the pandemic on vulnerable populations.

Ways forward: opportunities and challenges to overcome

The adoption of the EB148 Decision on mental health provides key opportunities for countries and WHO to raise cross-sectoral awareness and reassure governments' firm commitment to strengthen national mental health systems. Based on the analysis of challenges, we propose four priority actions for strengthening mental health systems in a comprehensive manner, while taking the political window of opportunity opened as a result of the pandemic.

First, integrate mental health services into universal health coverage benefit packages and ensure adequate operating budgets. Comprehensive mental health services may cover screening, treatment, referral services and psychosocial support, in particular to high-risk groups such as COVID-19 survivors, orphans, those who lost their jobs, those who lost their loved ones and frontline health workers.

Second, strengthen supply-side capacity including community-based mental health infrastructure and human resources such as professional (specialists and non-specialists) and non-professional health workers. Mental health nurses are low-cost with high and sustainable impact, especially in resource-limited settings. Positive experiences are reported from high-income countries and other low- and middle-income countries on the contributions made by mental health nurses. Mental health nurses, although facing various challenges (Happel *et al.*, 2019), not only contribute to mental health but also to the physical health and well-being of patients (Heslop *et al.*, 2016; Lundström *et al.*, 2020). In-service training

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of nurses and general physicians can rapidly boost mental health system resilience for long-term responses as well as public health emergencies. Primary care facilities should be able to provide mental health services with proper referral support to higher levels of care.

Third, mental health service provision should be extended throughout the range of hospital- to community-based services in order to ensure continuity of care with referral backup and support for primary care workers. Moreover, promoting mental health literacy and awareness in the community not only enhances resilience to stress but also minimizes social stigmatization. During the pandemic, countries should capitalize and maximize the use of tele-medicine for psychological counselling services and online delivery of medicines (Arnone, 2020; Jobes *et al*., 2020; Kim *et al*., 2020; Madigan *et al*., 2020).

Finally, there is a need to strengthen the capacity of countries to produce evidence on effective mental health interventions based on country contexts and informed policy decisions; and monitor the long-term mental health and other psychological consequences of the pandemic.

This set of actions should be prioritized in line with country contexts and gap assessments, and WHO needs to ensure that work related to mental health is properly streamlined into universal health coverage.

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