Global Happiness Council
Thematic group: Vulnerable Populations

Policy Brief 2
Resilience in Turbulent Times
The COVID-19 pandemic has increased the demand for mental health services worldwide. Across regions and countries, governments and stakeholders, including health policy makers, hospital managers, and service providers have stepped up to extend physical and mental health services and transform mental health related legislation, regulation, financing, accountability, and workforce development to address COVID related mental health issues. This policy brief provides an overview of the policies, practices and interventions on how varied stakeholders have attempted to address the mental health concerns of vulnerable populations at individual, community, national and international level.

Keywords: COVID-19, pandemic, vulnerable populations, mental health policies, mental health services

**Introduction**

To address mental health needs, nations have been forced to adopt telehealth or remote delivery of mental health services in the midst of the pandemic, especially for the most vulnerable groups-- children and adolescents, women, elderly, persons living with a chronic disease and/or disability, healthcare and other frontline workers, refugees, asylum seekers and migrants, institutionalized persons and homeless people, and racial, ethnic, religious minorities including indigenous people. Digital platforms and artificial intelligence are being used for mental health screening and tracking in various subpopulations. The use of videoconferencing, online forums, smartphone application, text-messaging, and emails have been widely accepted in most circumstances for the delivery of mental health services and is experiencing exponential growth in utilization (Goldin, Maltseva, Scaccianoce & Brenes 2021). The application of telehealth platforms for remote consultations during COVID-19 for mental health services has been enabled by some legislative changes (Torous & Wykes 2020). Online and digital services have proven to be effective and efficient in terms of usage of scarce resources and maintenance of client connections in a time where social distancing has been endorsed (Goldin, Maltseva, Scaccianoce & Brenes 2021). This has driven many mental health professionals towards telespsychotherapy, relying on online consultations to provide continuity of care (Tohme, De Witte, Van Daele & Abi-Habib 2021). In this policy brief, we discuss some of the major policies, practices, and interventions developed to address mental health needs and challenges of vulnerable populations during the pandemic.

**Policies**

Recently, some governments have significantly changed health policies and regulations and passed executive orders and economic recovery bills to cater to the increasing mental health concerns of populations. As the pandemic hit in March 2019, WHO created the Department of Digital Health to assess digital technologies and support Member States in integrating and regulating them (WHO 2019). The CDC has put out mental health guidelines in the United States. In 2020, the American government signed an
Executive Order (EO) 13594, Saving Lives Through Increased Support for Mental and Behavioral Health Needs to improve mental and behavioral health of Americans through increased education, crisis intervention, follow-up and support services, and increased telehealth and online behavioral health services (Executive Order 2020). The American Psychiatric Association’s Serious Mental Illness Adviser Program (www.smiadviser.org) released a digital version of a psychiatric advance directive, called My Mental Health Crisis Plan (SMI Advisor 2020) (Kopelovich, Monroe-DeVita, Buck, Brenner, Moser, Jarshog, Harker & Chwastiak 2021). The Office for Civil Rights (OCR) announced the waiver of penalties embedded in the Health Insurance Portability and Accountability Act (HIPAA) against health care providers who serve their clients using “everyday communications technologies,” (Department of Health and Human Services 2020). The use of Tele-Mental Health for routine treatment was endorsed by the Office of Mental Health Memorandum (Smith 2020).

The NHS launched a mental health hotline as part of a relief effort to provide psychological support to those on the front line in the United Kingdom (National Health Service 2020). Since January, 2020, the National Health Commission of China have published the notification of principles for emergency psychological crisis intervention for the COVID-19 pandemic, the notice on establishing psychological assistance hotlines for the pandemic, and the guidelines for psychological assistance hotlines during the COVID-19 pandemic (Liu, Yang, Zhang, Xiang., Liu, Hu, & Zhang 2020).

The European Union (EU) has funded several projects to investigate the long-term behavioral and health effects of the COVID-19 crisis (i.e. Horizon 2020, SCI-PHE-CORONAVIRUS-2020-2C - Behavioral, social and economic impacts of the outbreak response). This is the case with RESPOND (Improving the PREparedness of Health Systems to Reduce Mental Health and Psychosocial Concerns resulting from the COVID-19 PaNDemic www.respond-project.eu/), an international study that brings together scientists from 13 universities and research centers from all over Europe. The RESPOND project aims to identify vulnerable groups that have been affected by the COVID-19 pandemic and to assess the impact on mental health and well-being (Ayuso-Mateos, Mediavilla, Rodriguez & Bravo 2021).

In May, 2020, the Africa Centres for Disease Control and Prevention issued guidance for mental health and psychosocial support during the COVID-19 pandemic to reduce stress, anxiety, stigma, and psychological disorders associated with COVID-19 (Adepoju 2020). One study indicates that 20 Eastern Mediterranean Region (EMR) Member States have mental health and psychosocial support (MHPSS) as integral components of national COVID-19 response plans and one-third have allocated additional funding (Eaton, Rahman, Gater, Saxena, Hammerich & Saeed 2020). The Arab MENA world digitally transformed the psychiatric services of many clinics and some hospitals into digital mental health systems (El Hayek, Nofal, Abdelrahman, Adra, Al Harthi, Al Shamli, AlNuaimi, Bensid, Cheaito, Emberish, Larnaout, Radwan, Slaih, Kobeissy & Bizri, 2020).
Data show that people experiencing unemployment and/or a partial loss of income during the pandemic are likely to have mental health issues. During the pandemic, numerous countries including the US have expanded their social policies. The rates of depression and anxiety among households that received supportive social policies, primarily those related to Medicaid, unemployment insurance, and suspended utility shut offs during the pandemic, had less mental health issues compared to the households without extended social policies (Donnelly & Farina 2021).

**Practices**

The mental health consequences of COVID-19 have affected individuals including children, elderly, healthcare workers, people living with chronic diseases and disabilities, and countries have adopted different mental health practices. Emergency psychological crisis treatment, hotline and online counseling services, online mental health course, outpatient consultation when needed, online application for mental health counseling, health education about adapting and responding to COVID-19, healthy lifestyle and physical exercise during isolation, and community empowerment has emerged to be among the coping practices (Lestari & Setyawan 2021). Telehealth, or more specifically tele mental health services, have been practically feasible and appropriate for the support of patients, family members, and health service providers during this pandemic (Smith, Thomas, Snoswell, Haydon, Mehrotra, Clemensen & Caffery 2020). Telehealth has enabled remote triaging of care and provided rapidly accessible information through technology – such as chatbots as seen in Singapore (Priya 2020) and online consultations as offered by Lebanese mental health professionals and others (Tohme, De Witte, Van Daele & Abi-Habib 2021).

Various States in the U.S. have developed their own emotional support text lines (for e.g. Call4Calm, a free-of-charge texting service made available by the Illinois Department of Human Services’ Mental Health Division to English and Spanish-speaking residents) (Halstead 2020). Telehealth services have been integrated into U.S. health care delivery systems as a strategy to improve mental health treatment as these systems sought ways to deliver care to people in their homes by decreasing costs and risk of infection (Goldin, Maltseva, Scaccianocce & Brenes 2021). Various mobile applications exist for providing ongoing care in the hospitals (Rosenbaum 2020).

In COVID units, the use of virtual groups and technology has allowed patients to engage in scheduled religious group activities. Mental health and wellness applications have been increasingly available for individual use with topics such as mindfulness, meditation and relaxation, cognitive behavioral skills, and grounding to reduce anxiety (Ward-Miller, Farley, Espinosa, Brous, Giorgi-Cipriano & Ferguson 2021).
Strategies on education and awareness have been made available for reducing tension between parents and children with special needs (Du, Dong, Wang, Yuan, Fu, Zhang, Liu, Zhang, Yin, Qin, Bouey, Zhao & Li 2020). Mental health interventions have been endorsed for elderly people as well, such as strengthening social support for those with low educational level, divorced, widowed, living alone, sleep disorders, and history of mental problems (Meng, Xu, Dai, Zhang, Liu & Yang 2020).

Positive coping styles have been reported to promote mental health among individuals, such as using positive reframing, acceptance, and humour (Gurvich, Thomas, Thomas, Hudaib, Sood, Fabiatos, Sutton, Isaacs, Arunogiri, Sharp, & Kulkarni 2020). Physical exercise, experiencing nature, and distraction with activities were associated with reduced depressive symptoms during the pandemic (Ebrahimi, Hoffart & Johnson 2021). The frequency of greenspace uses and the existence of green window views from within the home have been associated with increased levels of self-esteem, life satisfaction, and subjective happiness and decreased levels of depression, anxiety, and loneliness (Soga, Evans, Tsuchiya & Fukano 2021). Exercise is a protective factor for those living with mental disorders (Morrey, Roberts & Wichser 2020). Telerehabilitation programs like consultations, exercises, games, and therapy have shown positive outcomes such as improving patients’ functional abilities and mental health (Bhaskar, Bradley, Chattu, Adisesh, Nurtazina, Kyrykbayeva, Sakhamuri, Moguilner, Pandya, Schroeder, Banach & Ray 2020).

**Interventions**

Interventions at all levels have been developed, implemented and to some extent evaluated for sustainability. E-mental health interventions consisted of social media platforms, e-learning content, online resources and mobile applications (Drissi, Ouhbi, Marques, de la Torre Díez, Ghogho & Janati Idrissi 2021). There is good evidence on the usability, safety, acceptance/satisfaction, and effectiveness of eHealth interventions. Evidence on mHealth applications is also promising (Rauschenberg, Schick, Hirjak, Seidler, Paetzold, Apfelbacher, Riedel-Heller, & Reininghaus 2021). Digital mental health technologies played an important role in providing virtual mental health resources during the COVID-19 crisis (Torous, Jän Myrick, Rauseo-Ricupero, & Firth 2020). As COVID-19 outbreak started, the World Health Organization in Europe endorsed the usage of internet and mobile interventions to deliver psychological first aid and mental health problem-management messages (Kluge 2020). This section provides some examples of expansion of existing mental health services; development of promotional and educational interventions; and facilitation of training and capacity building of mental health professionals.

**Strengthening of existing mental health services and introduction of new provisions**
Governments strengthened their existing mental health services and introduced new provisions at the time of COVID-19. Various interventions at the individual, community, and city level have been adopted for the treatment and prevention of the mental health problems triggered by the COVID-19 pandemic.

For screening purposes, the COVID-19 Anxiety Scale (CAS), was developed to identify adults experiencing dysfunctional anxiety as a result of COVID-19 (Zhang, Wang, Yin, Zhao, Xue, Peng, Min, Tian, Leng, Du, Chang, Yang, Li, Shangguan, Yan, Dong, Han, Wang, Cosci & Wang 2020). Community mental health clinics across NYS redirected services to virtual platforms in March and April 2020 when COVID-19 cases were detected. NYS mental health clinics started providing 80%-90% of their services via online video telehealth or telephonic platforms (Smith, Sullivan & Druss 2021) during the first weeks of the pandemic. A task force in a large New York City hospital system was created to meet clinician basic daily needs (e.g., donated food, adequate PPE, offsite housing), to increase communication with frontline providers, and to develop psychosocial and mental health support options (Ripp Peccoralo & Charney 2020). Delivery of outpatient mental health services for individuals with serious mental illness (SMI) in the United States started offering remote and in-person care, integrated behavioral and physical healthcare, and increased collaborative decision-making related to long-acting injectable and clozapine use, modifying safety plans and psychiatric advance directives to include new technologies and broader support systems (Kopelovich, Monroe-DeVita, Buck, Brenner, Moser, Jarshkog, Harker & Chwastiaik 2021).

Telebehavioral health care (i.e synchronous interaction with a licensed mental health professional by telephone or secure video) has been further recognized as a solution to address geographical and health system barriers (Reilly, Zane, McCuddy, Souliard, Scarisbrick, Miller & Mahoney lli, J. 2020). UCLA/Duke University National Center for Child Traumatic Stress designed and implemented an extensive 3-tiered system of emotional support to best address the needs of the healthcare workers (Miotto, Sanford, Brymer, Bursch & Pynoos 2020).

China started providing various telemental health services during the pandemic like remote counseling, supervision, training, as well as psychoeducation through online platforms (e.g., hotline, WeChat, and Tencent QQ) (Ministry of Education The People’s Republic of China 2020). The popularisation of internet services and smartphones, and the emergence of fifth generation (5G) mobile networks, have enabled mental health professionals and health authorities to provide online mental health services during the outbreak (Thompkins, Goldblum, Lai, Hansell, Barclay & Brown 2020).

Internet-based data collection tools were used in Australia to strengthen mental health practice and policy during the pandemic (van Agteren, Bartholomaeus, Fassnacht, Iasiello, Ali, Lo & Kyrios 2020). In Africa, Ghana Health Service, with support from the Ministry of Health, established the COVID-19 Response Team to provide psychosocial support to deportees/returnees, international students, and travelers who must undergo
mandatory quarantine. The Ministry of Health directed counsellors to use Psychological First Aid as the standard intervention model, as noted in the Standard Operating Procedures for Counsellors and Psychologists providing Mental Health and Psychosocial Support for the COVID-19 response in Kenya. The Psychological Society of South Africa (PsySSA), a national membership organisation of psychology professionals consisting of psychologists, psychiatrists, anaesthesiologists and other health professionals formed the HealthCare Workers Care Network (HWCN) to support health care workers during the COVID-19 pandemic and beyond. It revised its telehealth policy to allow psychologists to provide online psychological services (Sodi, Modipane, Oppong Asante, Quarshie, Asatsa, Mutambara & Khombo 2021). The Portuguese Psychologists Association created a task force to assess and disseminate research projects in order to identify and monitor the population’s mental health unmet support care needs (Mendes-Santos, Andersson, Weiderpass & Santana 2020).

Studies show that videoconferencing and other digital technologies have improved literacy among the elderly with diagnosed mental health conditions (van Houwelingen, Ettema, Antonietti, & Kort 2018). Telemedicine has shown to prevent further decline in mental status and provide comfort to caregivers and family members of patients with neurological conditions (Bhaskar, Bradley, Chattu, Adisesh, Nurtazina, Kyrykbayeva, Sakhamuri, Moguilner, Pandya, Schroeder, Banach & Ray 2020). It has led to significant reduction in anxiety and depression levels among oncology patients and caregivers (Nemecek, Huber, Schur, Masel, Baumann, Hoeller, Watzke & Binder 2019).

Interventions to promote mental health and well-being

In addition to strengthening the existing mental health services, new interventions to address the rising demand of mental health care services were initiated during the pandemic. A digital learning package using Agile methodology was developed and evaluated within the first three weeks of the UK outbreak, which included evidence-based guidance, support and signposting relating to psychological wellbeing for all UK healthcare employees. The package was perceived to be usable, practical, low cost and low burden (Blake, Berringham, Johnson & Tabner 2020). Project Trust (PT), a 3-year-old program in the US, expanded its services to build a culturally sensitive online community and provide resources to pastors in African-American communities to aid them in conveying accurate public and mental health information about COVID-19 (Thompkins, Goldblum, Lai, Hansell, Barclay & Brown 2020).

A mobile application named ‘Muktonmon’ [open one’s mind] was developed to provide virtual mental health assistance using artificial intelligence (AI) based chat bot, videos and audios. The System Usability Scale (SUS) found this application to be useful in having a positive impact towards promoting mental health during the COVID-19 pandemic (Islam, Muhammad Nazrul et al. 2021). Another example is a mobile application called PTSD Coach (https://mobile.va.gov/app/ptsd-coach), a program based on cognitive behavioral therapy that offers PTSD symptom tracking and skills to cope with
common distress reactions such as anger, anxiety, hopelessness, and sleep problems was endorsed during COVID-19 (Wong, Pacella-LaBarbara, Ray, Ranney & Chang 2020). The feasibility testing of a mobile application-based psychosocial intervention for psychosis (TechCare-P) and a mobile application-based intervention for maternal depression (TechMotherCare) are underway in South Asia (Naeem, Husain, Husain & Javed 2020).

Digital mental healthcare services and resources have been developed in Canada, Iran, Malaysia, New Zealand, South Africa, and U.A.E among others. Online mental health care programs for healthcare workers were developed in Canada by medical and psychology associations (Wu, Styra & Gold 2020). In Iran, students of Shiraz Medical School created a social media platform that employed the Near Peer Mentoring method by having senior medical students instruct junior medical students in coping with the anxiety and stress caused by COVID-19 pandemic. Study results showed that 71% of participants believed the platform had a significant impact on helping them adjust faster to the situation (Rastegar Kazerooni, Amini, Tabari, & Moosavi 2020). During the pandemic, ultra-brief psychological interventions (UBPI) that were originally created in 2018 to empower healthcare providers with psychological skills was modified to suit the unique psychological demands of the pandemic. An initial evaluation of the handbook was conducted in a trial in 2020, with 25 hospital nurses in Malaysia and the nurses reported positive qualitative feedback regarding techniques presented in the handbook (Ping, Shoesmith, James, Nor Hadi, Yau & Lin 2020).

New Zealand developed the HABITs (Health Advances through Behavioral Intervention Technologies) ecosystem for young people, their families and health workers for digital mental healthcare (Merry, Cargo, Christie, Donkin, Hetrick, Fleming, Holt-Quick, Hopkins, Stasiak, & Warren 2020). The Psychological Society of South Africa developed resources to aid practitioners’ response to the pandemic and its mental health ramifications (Psychological Society of South Africa 2020). It also launched interventional services such as the Health Workers Network to offer short-term telephonic counselling to schools and offer voluntary services to victims and survivors of gender-based violence (Psychological Society of South Africa 2020a; Psychological Society of South Africa 2020b). Among many students, university students in the UAE found mobile mental health applications to be affordable, simple, convenient and effective (Drissi, Alhmoudi, Al Nuaimi, Alkhyeli, Alsalami & Ouhbi 2020).

The WHO has recognized the need to offer dignified treatment to the family members of lost patients in line with their beliefs (World Health Organization 2020a). Health and well-being leaders have emerged to optimize mental health and well-being through culture and resources available in the workplace and in communities (COVID-19: Resources for Employers and HERO Member Spotlights).
Interventions to train mental health professionals and build individual and institutional capacity

Medical professionals, trainees, and peer support specialists have had to learn how to use digital and mobile technologies for delivering care at a rapid pace during the COVID-19 pandemic. Training the workforce is an important intervention to allow building of the capacity to support increased access to care for the rising demand of mental health services, especially for vulnerable and hard-to-reach populations (Torous, Jän Myrick, Rauseo-Ricupero, & Firth 2020). The pandemic has required clinicians to learn and execute video conference systems, identify confidential space to conduct clinical practice within their homes, teach technology to their patients, and examine rapid changes to reimbursement practices to ensure that insurance companies would reimburse tele-health sessions (Gruber, Prinstein, Clark, Rottenberg, Abramowitz, Albano, Aldao, Borelli, Chung, Davila, Forbes, Gee, Hall, Hallion, Hinshaw, Hofmann, Hollon, Joormann, Kazdin, Klein, Weinstock et. al 2020). Various training programs and capacity building modules have been developed since the beginning of the COVID-19 pandemic.

Online mental health education with communication programs, such as WeChat, Weibo, and TikTok, has been widely used during the outbreak for medical staff and the public. In addition, several books on COVID-19 prevention, control, and mental health education have been published. Numerous books on COVID-19 and mental health have been published, including the “Guidelines for public psychological self-help and counselling of 2019-nCoV pneumonia”, published by the Chinese Association for Mental Health. Online psychological counselling services (eg, WeChat-based resources) have been widely established by mental health professionals in medical institutions, universities, and academic societies throughout China. In addition, several artificial intelligence (AI) programs have been put in use as interventions for psychological crises during the pandemic. For example, individuals at risk of suicide can be recognized by the AI program Tree Holes Rescue by monitoring and analyzing messages posted on Weibo, and alerting designated volunteers to act accordingly (Liu, Yang, Zhang, Xiang,, Liu, Hu, & Zhang 2020).

A multi-tier child and adolescent mental health (CAMH) intervention model using an online platform to train mental health professionals was developed in Nepal in 2020 (Dhonju, Kunwar, Karki, Devkota, Bista & Sah 2021). A training program called Digital Opportunities for Outcomes in Recovery Services (DOORS) was created for first-episode psychosis (FEP) patients and a chronic phase schizophrenia clubhouse to increase the utilization of smartphones to set reminders, download apps, join video calls, and connect with peers. (Hoffman, Wisniewski, Hays, Henson, Vaidyam, Hendel, Keshavan & Torous 2020). The National Mental Health Taskforce of Zimbabwe has been offering training for mental health cadres to be able to deal with issues on the ground (Sodi, Modipane, Oppong Asante, Quarshie, Asatsa, Mutambara & Khombo 2021).
Conclusions

Integration of mental health services with other health services and transformation of mental health related legislation, regulation, financing, accountability, and workforce development are vital for the prevention and treatment of mental health problems among vulnerable populations. Telemental health, online resources, advocacy and awareness, and educational interventions have emerged as necessary tools to address mental health needs and challenges of the general public and specific population groups. These interventions, including emergency psychological crisis treatment, hotline assistance, online counseling service, and outpatient consultation, have strengthened the communities’ mental health during the pandemic (Lestari & Setyawan 2021). Going forward, mental health related policies, practices, and interventions need to be evaluated and tailored to specific populations and settings for sustainability in the long term.
Policy Brief 2: Tackling the Crisis in Mental Health

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