Field report

Stories from the Field: Mapping Innovation in Mental Health During the COVID-19 Pandemic

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Abstract

The COVID-19 pandemic has raised significant concerns for individual and population mental health. Physical health consequences of the virus, public health prevention measures and economic slowdown negatively impact mental health and pose challenges for the continuation of mental health services. To learn how healthcare workers responded to these difficulties, the Mental Health Innovation Network in collaboration with the World Health Organization Department of Mental Health and Substance Use launched a global call for stories from healthcare workers. Published submissions highlighted innovations and adaptations in mental health support, representing a range of geographical regions, resource settings and target populations. This article summarises key lessons learnt and recommendations from the project, including (1) promote access to basic needs, (2) prioritise care for vulnerable groups and people with severe mental health conditions, (3) support staff mental health, especially frontline health workers, (4) engage hard-to-reach groups through informal communication channels and collaboration with caregivers and (5) support central decision-making mechanisms and cross-sectoral coordination. Using case study examples from the submissions, this field report aims to inform and inspire mental health and psychosocial support providers striving to continue services during the pandemic.

Keywords: COVID-19, healthcare workers, innovation, mental health, MHPSS, mental health services, psychosocial support

Introduction

The COVID-19 pandemic has had disastrous effects on the world to date. Health systems globally have faced immense pressure with many countries struggling to respond to unprecedented demands. Many health systems have had to convert or repurpose some services in order to treat an increasing number of COVID-19 patients. Mental health services have not been exempted from the de-prioritisation of health areas considered less urgent.

The effects of large-scale crises on individual and population mental health and wellbeing are numerous and multifaceted. Examples from past pandemics show clear trends in increasing mental health needs as a result of outbreaks (Shultz et al., 2015; Tsang et al., 2004; Yip et al., 2010). Various parts of the world are reporting peaks in mental health needs, particularly linked to symptoms of depression and anxiety. Stress levels in many countries are extremely high according to large survey data (Jahanshahi et al., 2020; Kirzinger et al., 2020; Qiu et al., 2020)[1].

Multiple factors related to COVID-19 impact people's emotions and social support systems. Social isolation resulting from public health prevention measures is increasing and causing disruption in social support mechanisms. There is widespread fear of being infected and/or dying from the virus and fear of losing livelihoods. Those who have lost loved ones to the disease experience intense grief, often resulting in ambiguous loss or complex grief, for example, when they are unable to be present with the loved one before death.

In many countries, the pandemic has disproportionately affected marginalised racial and ethnic groups, exacerbating existing health disparities (CDC, 2020). Women and children are at increased risk of abuse and violence (UNDP, 2020), which can seriously impact brain health and development, especially in children and adolescents (UN, 2020b). Older adults and people with pre-existing health conditions are particularly prone to developing acute stress because of fear of health complications and dying

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from COVID-19 (UN, 2020c). The social isolation and reduced physical activity caused by lockdown measures are risk factors for cognitive decline in older adults, and underlying neurological conditions increase their need for hospitalisation (Garg et al., 2020).

Healthcare workers and first responders are among the most at risk of contracting the virus and developing mental health conditions with long working hours, often in busy and overstretched services with insufficient supplies of personal protective equipment (PPE). They are put in the position of making complex ethical choices, for example, deciding who receives life-saving resources and who does not. Given the fact that many patients with COVID-19 will die, the risk of dehumanisation of patients is high, potentially conflicting with healthcare workers' identity and values and significantly impacting their mental health and wellbeing.

A high burden of mental health problems among people who have experienced quarantine or isolation has also been reported (Hossain et al., 2020), with psychological effects including traumatic stress symptoms, confusion and anger (Brooks et al., 2020). Finally, people in humanitarian and lower resourced settings face harsh and crowded living conditions where physical distancing is nearly impossible, health and other services are weak and livelihood opportunities reduced, likely increasing the already high prevalence of mental health conditions in these populations.

Challenges for Mental Health and Social Care Services

This overview is not exhaustive, but highlights challenges faced by mental health and social care services in providing the support necessary to respond to rising needs. The pandemic has caused major disruptions in service provision (WHO, 2020), including:

(1) the repurposing of mental health infrastructure and staff to support the COVID-19 response,
(2) outpatient services receiving fewer visits, as people are afraid of contracting the virus in hospital settings,
(3) the challenge and risk of conducting face-to-face visits, forcing practitioners to shift to virtual consultations,
(4) the difficulty of conducting virtual consultations when many people do not have access to the technology required,
(5) heightened risk of infection in long-stay mental health facilities, including care homes and psychiatric hospitals,
(6) increased pressure on and reduced numbers of mental health workers due to COVID-19 infection, burnout and limited opportunities to practise self-care and
(7) lockdown measures preventing formal and informal social support groups from gathering, increasing social isolation for many people.

The Importance of Sharing Good Practices in Times of Crisis

Despite the many challenges, mental health practitioners are developing novel and innovative strategies to ensure the continuity of mental health services. During times of crisis, it is essential for practitioners around the world to learn from each other's experiences to maximise their resources and avoid reinventing the wheel when adapting services. Knowledge sharing platforms have a responsibility to collect high-quality experiences and lessons learnt, making them available widely and rapidly and promoting their uptake and adaptation around the world.

This article aims to share lessons learnt and recommendations from healthcare worker experiences of continuing mental health and psychosocial support (MHPSS) services during the pandemic. It highlights contributions from healthcare workers to a joint project, entitled "Stories from the field" by the Mental Health Innovation Network (MHIN) and the WHO Department of Mental Health and Substance Use. The project aimed to shed light on the adaptations made to MHPSS interventions around the world during an infectious disease outbreak to inform and inspire practitioners developing their own strategies to maintain services. Five key themes are presented with a case study for each offering practical examples from practitioners striving to keep mental health services running in the wake of COVID-19. These stories and more can be found on the MHIN website (bit.ly/MHSTORIES).

Lessons Learnt and Recommendations

Promote Access to Basic Needs

In addition to the health consequences of the virus, public health prevention measures have caused major economic and social difficulties. In particular, the closure of many businesses and a general economic slowdown have cost many people their jobs. Financial insecurity can be a major stressor impacting mental health. Limited access to food, water, shelter and basic healthcare exacerbates mental health conditions. Given under-resourced communities are disproportionally affected by the pandemic, enabling access to basic needs should be critical in supporting mental health.

The Inter-Agency Standing Committee (IASC) MHPSS Guidelines emphasise the importance of basic needs in the bottom layer of the intervention pyramid (IASC, 2007). The guidelines explain that MHPSS practitioners can facilitate access to basic needs by advocating for these services to be in place with responsible actors, documenting their impact on mental health and promoting services that are mindful of mental health and psychosocial wellbeing.

Many of the organisations that contributed to the call for stories did not have the capacity to respond to these needs directly. They facilitated responses by creating partnerships with other services and/or engaging community members. The mental health organisation Project Burans, for example, partnered with local police and community volunteers to distribute groceries and hygiene products in Uttarakhand, India (MHIN, 2020a). These communities, primarily comprised of daily wage earners, experienced high food insecurity prior to the pandemic. When lockdown was announced, they were not able to make money or

rely on savings to feed their families. Project Manager, Pooja Pillai, reported, "For them, it was difficult to actually imagine mental health and self-care and positive thinking when they do not know where their next meal is coming from."

To respond to this challenge, the organisation partnered with local police who had a list of families receiving government and donor provided essentials. Project Burans connected officials with community volunteers who distributed groceries and hygiene products, making sure the most vulnerable families were included. "We need to be able to listen to the actual needs of the community," continued Ms Pillai, "We are a mental health organisation . . . and our strength is in mental health services, but we realised the immediate need was actually food and to get essentials to the communities, so, tapping into existing networks and trying to sort as much of the other problems parallelly is also really important."

Healthcare practitioners repeatedly emphasised the importance of listening to community needs. By reaching out to existing networks and organisations that are already addressing basic needs, such as law enforcement, public school systems and religious groups, mental health organisations can act as liaisons between these services and their service users.

More stories on promoting access to basic needs include:
(1) BasicNeeds, Pakistan: Economic empowerment in under-resourced communities (Yasmeen, 2020)
(2) Enosh, Israel: Food basket distribution for people with psychosocial disabilities (David, 2020)
(3) The Royal, Canada: Ensuring families have access to regular meals (Haynes, 2020)
(4) Partners in Health, Sierra Leone: Coordinating with community leaders to find shelter for homeless people with mental health conditions (MHIN, 2020a)

Prioritise Care for Vulnerable and At-Risk Groups

As in most crises, the COVID-19 pandemic has limited the services that mental health practitioners can provide. It is important to use the little resources available in the most cost-effective ways, prioritising care for people most in need. In addition to people with pre-existing mental health conditions, vulnerable groups, such as older adults, people with pre-existing health conditions and children and women in potentially violent homes, should be prioritised. For example, the consequences of interrupting care for people with severe mental health conditions, especially if using medication, are likely to be profound. A significant challenge practitioners faced was the continuation of care for psychiatric inpatients while adhering to public health prevention measures.

St. Patrick's Mental Health Services is Ireland's main provider of specialised, inpatient and outpatient mental health care. Their hospital in Dublin provided care to hundreds of patients before the outbreak and had to adapt quickly to respond to changing circumstances (MHIN, 2020a). Visits were limited and performed under safe conditions, and prevention measures, such as physical distancing and the use of PPE, were strictly implemented. The organisation also implemented a new home care service, transferring inpatients who were willing and able to spend the lockdown period at home as a way to prevent disease spread.

"We looked very carefully into what we traditionally deliver to physical inpatients," shared Medical Director Dr Paul Fearon, "[This included] nursing input, ward rounds, multidisciplinary team meetings, an initial assessment and care plan [and] the prescribing of medication." St. Patrick's found ways to implement all of these aspects remotely. To prescribe medications, they contacted patients' local pharmacies and faxed prescriptions for new and repeat medications. They adapted projects using videoconferencing for cognitive behavioural therapy to expand telehealth to other services. The home care service now treats nearly 100 patients remotely as opposed to 150 inpatients before the pandemic. Beds are kept available in case anyone needs urgent hospitalisation. "I think it's very important for services to be proactive," concluded Dr. Fearon, "We know a lot about coronavirus in terms of . . . its transmission, and we know most of the things that we need to be doing. So when you marry that with what your services aims are, it is actually possible to come up with a strategy and a plan. Obviously, these plans need to be adapted in these times, and it's very important to remain agile in one's thinking and in one's imagination."

The resources employed in this example are not available in all settings. Many services contributing to the call for stories did not have the infrastructure to provide telehealth interventions with electronic medical records and prescriptions. Moreover, some practitioners reported difficulties in continuing psychotropic treatment because of border closures, movement restrictions and bans on plane travel. The practical approach, however, was the same – adapt, expand and support existing infrastructure whether in the form of human resources, such as community volunteers, or technology, such as telephone hotlines.

More stories on supporting vulnerable groups include:
(1) Jaya Mental Health, Nepal: Reaching remote rural communities during lockdown (Marçal-Grilo, 2020)
(2) Biella Local Health Unit, Italy: Supporting the mental health of people with chronic illness (Tempia, 2020)
(3) SPANS, Zimbabwe: Supporting prenatal and postnatal mental health (Muvhu, 2020)
(4) THRIVEGulu, Uganda: Mental health support for survivors of conflict and victims of gender-based violence (Hirsch, 2020)
(5) Trinidad and Tobago Association of Psychologists: Mental health support for Venezuelan migrants (Nakhid-Chatoor, 2020)

Support Staff Mental Health, Especially Frontline Health Workers

Healthcare workers of all kinds, especially frontline responders, are at greater risk of exposure to adverse circumstances and may experience stigma during an infectious disease outbreak. Service managers must prioritise

the mental health of their staff and implement policies that promote and protect their wellbeing. Mental health workers, in particular, are crucial not only for the continuation of mental health services for the general public, but also for providing emotional support to frontline workers.

One of the challenges reported by mental health practitioners included difficulty finding appropriate times for scheduling consultations with healthcare workers. Many were experiencing higher workloads, were often sleep deprived and needed to eat in between shifts. It was difficult to carry out face-to-face meetings because of the need to take off and put back on PPE and respect physical distancing measures. When shifting to telehealth, some staff reported reluctance due to concerns about confidentiality and difficulties or discomfort using technology.

To address these challenges, practitioners developed various strategies for more accessible and effective services. For example, Miri General Hospital is a public tertiary hospital in Sarawak, Malaysia with a psychiatric ward and a COVID-19 ward (Adam, 2020; MHIN, 2020c). Strategies to support staff included individual and group sessions and daily mental health tips via group chats. They also created a "Rest N' Go" lounge with drinks, food, a washroom and a place to rest. Interestingly, staff began requesting an activity book created for patients in the COVID wards. The workbook included information on COVID-19, ward procedures and quarantine centres, mental health tips, such as breathing exercises and muscle relaxation techniques, along with activities, including Sudoku and colouring. One programme that proved particularly effective was a buddy system to prevent burnout among top and middle management. "For example, my head of department and me are buddies," explained MHPSS Team Leader, Dr Raja Lope Adam. "We share information and work together well. In case I need rest, she can run the department and also the MHPSS team. And vice versa if she needs rest, I can run the department and MHPSS team." This system was also useful when staff needed to quarantine and was later implemented in other departments.

Many services implemented multiple and creative interventions to support staff. These included logistical changes, such as flexible working hours and travel reimbursements, as well as supportive spaces, such as rooms to relax with recreational activities. Practitioners noted greater uptake with interventions other than traditional individual or group counselling. Providing more options allowed staff to choose which ones worked best for them.

More stories on supporting staff mental health include:

(1) Emilia-Romagna Public Health System, Italy: Holistic integration of MHPSS (Marini, 2020)
(2) Interactive Research & Development, Pakistan: Peer support and relaxation spaces for frontline workers (MHIN, 2020c)
(3) NHS Crisis Team, London: Flexible working hours, reimbursement for travel and accommodation and activities to boost team morale (MHIN, 2020c)
(4) Curicó Organisational Development Unit, Chile: Short videos, field workshops and online training to support healthcare worker mental health (MHIN, 2020c)

Engage Hard-to-Reach Groups Through Informal Communication Channels and Collaboration with Caregivers

Engaging hard-to-reach groups was a major challenge reported by practitioners. These included children, older adults, ethnic minorities and migrants and refugees, among others. While technology allows for instant communication with large numbers of people, many have limited or no access to internet or phone communication. They may live in segregated and isolated communities (e.g. migrants and refugees), may not speak dominant languages in which public health messages are disseminated or may have sensory (visual or hearing) or cognitive disabilities. Over 1.6 million children are out of school due to the pandemic (UNDESA, 2020), many of whom do not have computers, tablets or phones to continue receiving emotional and developmental support. If poor access to technology is not taken into consideration, large parts of the population will be excluded from services and health promotion messages.

While working with older adults, Andrea Alvarado, a clinical psychologist from Ecuador, collaborated with caregivers to help service users access an intervention delivered via Facebook and WhatsApp (Alvarado, 2020; MHIN, 2020b). Based on psychological support, psychoeducation, psychological first aid (PFA) and cognitive stimulation techniques, the intervention aimed to mitigate the negative psychological effects of lockdown and isolation. To address the challenges of low social media use by older adults along with limited hearing, vision, manual dexterity, mobility and the notion that electronic devices are overly complex, Ms Alvarado established relationships with family members from the start. Their role was to teach the technological aspects and help them integrate technology into the new routine of COVID, she explained. Eventually, participants gained the autonomy and self-confidence to follow the intervention alone. Family members also benefited and appreciated seeing positive changes in their loved ones.

To facilitate remote support, mental health services can engage family members as intermediaries and build technology training into interventions. Caregivers may appreciate and benefit from interventions as well, however, it is essential to address their mental health needs in addition to those of service users.

More stories on innovations in remote support include:

(1) Minds At Play, India: Delivering a school-based programme for children in low-resource communities via WhatsApp (Kapoor, 2020)
(2) Cape Mental Health, South Africa: Collaborating with family members to implement home activities for children with severe and profound intellectual disability (du Toit, 2020)

(3) Centre for Mental Health Law and Policy, India: Sharing short videos via WhatsApp that adapted international guidelines to Indian contexts in local languages (MHIN, 2020b)
(4) Carers Worldwide, India, Nepal and Bangladesh: Remote support for unpaid family carers (Nicholson, 2020)

Support Central Decision-Making Mechanisms and Cross-Sectoral Coordination to Ensure Coherent and Holistic Interventions

Although in many contexts there may be a lack of actors providing mental healthcare, in others there may be difficulties due to existing services working in an uncoordinated manner. This is unfortunately very common and can lead to certain population needs not being addressed, duplication of services and dysfunctional referral mechanisms.

Cross-sectoral partnerships are often key in providing more holistic care and allowing access to people who may not have had it otherwise. A multistakeholder collaboration in Nairobi, Kenya facilitated the coordination and expansion of community services in a very short timeframe (Amin, 2020). "We all agreed that our community would be the worst hit if early precautions were not taken," reported mental health practitioner, Habiba Amin. "Hundreds of thousands of people gather five times a day for prayer at the mosques, and physical distance and no-touch policies are hard to understand for many."

The Muslim Psychologists and Counsellors Association, the Council of Imams, the Kenya Association of Muslim Medical Professionals and community leaders worked together to identify urgent needs, gaps, concerns and available resources. Local imams contributed to prevention and promotion efforts by including awareness-raising messages about the virus in their daily sermons. Procedures were developed so that COVID-19 burials were in line with Muslim jurisprudence. Mental health professionals created and managed a PFA hotline, and the community raised money and held drives for food and medications. "It was amazing to see how everyone was interlinked, how mental health mattered, and how culture and religion played a role in determining the success of response measures," shared Ms Amin.

Often coordinating multiple stakeholder groups is a challenge, and leadership is required in order to make efficient decisions and mitigate the negative impacts of a crisis. Strong leadership, namely within central government bodies, can be pivotal in developing clear response plans, coordinating diverse stakeholders and aligning multiple interventions. In Lebanon, for example, the National Mental Health Programme of the Ministry of Health developed a National COVID-19 Response Plan in collaboration with the WHO and UNICEF, which proved to be fundamental in creating a coherent and holistic response (El Chammay, 2020).

Collaboration and coordination with diverse stakeholder groups can ensure mental health responses are developed holistically, taking into account cultural considerations. In response to disrupted services, lobbying decision-making bodies to keep programmes running can ensure continuity of care and increase sustainability of reforms enacted during the pandemic.

More stories on cross-sectoral coordination and central decision-making include:
(1) Kovler Child Trauma Center, USA: Partnering with public schools to provide tablets for refugee children (MHIN, 2020b)
(2) Supporting refugee mental health, USA: Collaborating with religious leaders to spread public health and mental health messages among Somali refugee communities (Gray & Abdi, 2020)
(3) Hospital Universitario de la Princesa, Spain: Mental health care declared an "essential service" by the local health authority, ensuring the continuation of inpatient care when psychiatric wards were repurposed (Ayuso-Mateos, 2020)

Discussion

Despite taking place in very different contexts, these stories share similarities in the ways mental health practitioners approached challenges in response to the pandemic. Organisations listened to communities, paying close attention to the immediate needs of service users. They adapted and expanded existing infrastructure and resources, making interventions as simple and accessible as possible. In instances where organisations lacked capacity, they partnered with community groups, law enforcement, school systems and other actors to solve problems.

As emphasised in the WHO's publication, 'Building Back Better: Sustainable Mental Health Care After Emergencies' (WHO, 2013), plans to integrate emergency response into sustainable mental health systems need to be made early on in any crisis, ideally with mental health already incorporated into advanced planning. The challenges faced in the beginning of the pandemic highlighted gaps and needs in mental health services and existing delivery mechanisms. As we continue to adapt and strengthen services, we must consider how best to sustain successful innovations. Building new approaches into existing systems enables services to be proactive rather than reactive in future emergencies.

Significantly reforming existing systems can be challenging without political prioritisation. Like many emergencies, the COVID-19 pandemic has put mental health on the map. The socio-economic impact of the crisis has made emotional and social problems more prominent in public discourse and created a sense of urgency. Mental health actors should use this opportunity to come together and advocate for increased investment in progressive mental health service reform and integration across other sectors.

Certain efforts are already underway. The United Nations Secretary General published a Policy Brief on COVID-19 and the Need for Action on Mental Health in May 2020 (UN, 2020a). Its main recommendations include (i)

applying a whole-of-society approach, (ii) ensuring widespread availability of emergency MHPSS and (iii) supporting recovery from COVID-19 by building mental health services for the future. Mental health organisations can apply international best practice guidelines to their local contexts as evidenced in the experiences highlighted in this article and the wider 'Stories from the field' project.

Quickly and widely sharing adaptations to these unprecedented challenges is vital to avoid duplicating efforts. One programme's approach to a problem may help guide solutions in other contexts. We encourage readers to view the other blog posts, videos and webinars on the MHIN website, and for mental health services to continue finding ways to share their journeys through this crisis. Joining the MHIN is one way mental health organisations can exchange knowledge with each other during this time. MHIN continues to post contributions from network members and highlights their work via social media.

Conclusion

This article outlines the effects of the COVID-19 pandemic on mental health and wellbeing and documents important opportunities to learn from global responses. The stories reported represent individual instances of innovation and may not be appropriate in all contexts. They offer insight, however, into what can be done in the direst of circumstances and can inspire and inform practitioners to develop novel strategies ensuring the continuation of care. The contexts that necessitated these innovations are not unique to COVID-19, but are part of a long-term lack of resources and de-prioritisation of mental health. More needs to be done by countries to prioritise mental health and allocate a proportionate amount of resources to reflect the high levels of disability and social and economic costs associated with these conditions. The innovations in this article show that when such action is taken, wellbeing can be protected, resilience enhanced and support continued even in the most challenging of times.

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[1]Note that reported levels tend to be underestimated, partly due to the stigma associated with mental health conditions.