

Scaling Up Global Mental Health Services During the COVID-19 Pandemic and Beyond

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Every health care system requires an adequate health care workforce, service delivery, financial support, and information technology. During the COVID-19 pandemic, global health systems were ill prepared to address the rising prevalence of mental health problems, especially in low- and middle-income countries (LMICs), thereby increasing treatment gaps. To close these gaps globally, task shifting and

telepsychiatry should be made available and maximized, particularly in LMICs. Task shifting to nonspecialist health workers to improve essential mental health coverage and encourage efficient use of the available resources and technology has become the most viable strategy.

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Every health care system requires an adequate health care workforce, service delivery, financial support, and information technology to manage the required health care needs of the population. Research has shown an increase in the prevalence of mental health problems in the general population during the COVID-19 pandemic (1). The prevalence of psychological distress is estimated to have risen as high as 40.4% during the pandemic, with insomnia, anxiety, and depressive disorders accounting for the majority of diagnoses (1, 2). Patients with preexisting mental health conditions are also at an increased risk of relapse and of experiencing new episodes of illness as a result of the stress associated with the pandemic, its uncertainties, and the measures put in place to mitigate its spread. Low- and middle-income countries (LMICs) face a global shortage of human resources, and their health systems have not been adequately prepared to handle the increased demand for mental health care during the COVID-19 pandemic (3).

In this column, we highlight the state of mental health service delivery globally during the COVID-19 pandemic, discussing strategies (e.g., task shifting and digital health) to scale up mental health service delivery. At the onset of this pandemic, a group of early career psychiatrists from different countries was formed, assembled under the umbrella of the early career psychiatry section of the World Psychiatry Association, to provide information on mental

health services availability in their countries. Information was obtained from 15 countries (Brazil, Egypt, Ethiopia, Germany, Hungary, India, Iran, Italy, Kenya, Kosovo, Nigeria, Pakistan, Thailand, the United Kingdom, and the United States) representing low-, lower-middle-, middle-, and high-income countries (HICs). At the time of writing, the countries of all coauthors had experienced or were experiencing their first wave of the pandemic. Of note, countries in sub-Saharan Africa had reported relatively fewer positive cases and deaths.

HIGHLIGHTS

- During the COVID-19 pandemic, global health care systems were ill prepared to address the rising prevalence of mental health problems, particularly in low- and middle-income countries (LMICs), thereby increasing existing treatment gaps.
- To close these gaps, telepsychiatry and task shifting to nonspecialist health workers should be made available and increased everywhere, including in LMICs.
- Improving access to mental health care using these methods would decrease the treatment gap by meeting the mental health needs of disadvantaged communities and countries.

Rationale for Adopting Task Shifting During the Pandemic

Long before the COVID-19 pandemic, important gaps in the treatment of mental health care existed, especially in LMICs. These gaps have resulted from a combination of stigma, misinformation in the cultural context, and poor availability of financial and human resources for mental health. In addition to barriers in access to care, these countries face poor utilization of mental health services where services are available. Reports from various countries during the pandemic show an enormous gap in essential mental health care provision and access to mental health care. Mental health services were scaled down in most countries. LMICs did not have available mental health services tailored to at-risk populations or hard-to-reach groups, and the available mental health services were insufficient to meet the needs of the general population. Despite the global presence of public education on the mental health effect of the pandemic, public mental health screening was not offered by the governments of most countries. Community mental health was not available or was minimally available where present in most LMICs and was insufficient and not readily available in upper-middle-income countries. (Thailand and Kosovo had well-structured community mental health systems, which played an important role in relapse prevention for people living with mental illness and in monitoring child abuse and intimate partner violence.) The shortage of mental health workers prior to and during the pandemic was worsened by their deployment to COVID-19 treatment centers (3), creating difficulties in providing patient prescriptions or other treatment approaches. The increased demand in mental health care was due to the increased prevalence of common mental disorders. Additionally, mental health access inequities have existed in both LMICs and HICs, in the latter because of social inequalities. In these circumstances, task shifting to nonspecialist health workers to improve essential mental health coverage and encourage efficient use of the available resources has become a viable strategy.

Meeting Global Mental Health Needs With Task Shifting

Scaling up effective mental health services to meet the population's needs during the COVID-19 pandemic has been hampered by the stark scarcity in skilled human resources for health care and the inequities in mental health care access, especially in low-resource settings. Task shifting in mental health care can improve health care access in the face of limited human resources and can help decrease the large treatment gap and mental health inequities globally. Training of lay health workers and nonspecialist health care personnel at the primary and community health care level in low-resource settings should be a priority in order to provide access to essential mental health services in the general population and at-risk populations (4). Task shifting occurs through the "rational distribution of tasks among health workforce teams" from highly qualified health workers to those with less qualification or training or by creating new cadres with specific training, with the aim of efficiently using

available human resources for health care (5). If done right, task shifting can alleviate the reliance on mental health specialists who typically have been least available during the pandemic and can facilitate provision of some degree of mental health service delivery to those who normally do not have access to it. Shifting tasks to trained lay providers allows mental health specialists to attend to more serious mental health problems, improving mental health service delivery in LMICs where access to mental health services is widely unavailable (6). A Cochrane review found that task-shifting interventions in mental health strengthen and expand the health care workforce, increase access to services, and may improve clinical outcomes of depressive disorder, alcohol use disorder, and posttraumatic stress disorder (7). Task shifting would create a unique opportunity in LMICs to improve access to mental health care and the treatment received. The use of community health workers (CHWs) to achieve improved mental health access provides an additional opportunity to enhance mental health care education and promotion and decrease the stigma attached to mental illness. Education and promotion can be provided by CHWs, who are members of the community and are traditionally trusted by the local residents.

Integrating Mental Health Care Into Primary Health Care and Community Mental Health Services

There is a significant lack of mental health services available in primary and community health care in LMICs. Where specialist mental health services exist, they are insufficient to serve the general population. Psychiatrists should champion increasing the coverage of mental health care through shifting public mental health screening approaches, effective mental health interventions that use a stepped care approach (4), and mental health promotion to nonspecialist health workers at the primary and community health care levels. Mental health professionals should be tasked with designing programs and developing mental health screening and guidelines for intervention implementation that can be used by nonspecialist health workers at the primary and community health care level during the pandemic and beyond. Training of nonspecialist health care workers on these screening and intervention guidelines ahead of infectious disease outbreaks should be incorporated into the primary health care of LMICs and areas of health inequity in HICs. Regular supervision, monitoring, and evaluation of these services for quality assurance and efficient care provision during the outbreak should be a regular occurrence. Ideally, task shifting should deliver clinically effective interventions that decrease the burden of care and reduce inequity in health access in vulnerable populations (6).

Scaling Up Services With Digital Health Technology

Prior to the COVID-19 pandemic, the use of telepsychiatry in the delivery of mental health care was scarce (8). During the pandemic, some degree of telepsychiatry services became present in almost all countries. However, no standardized guidelines directed its application or objectives. Most LMICs have

low Internet penetration rates, and, as such, Internet-based health services would fail to meet demand. HICs had guidelines and protocols for telepsychiatry, but these were not designed to provide mental health care to underserved populations.

Telemedicine can be used to bridge the mental health access gap in LMICs and health access inequity in underserved and vulnerable populations in HICs. Goel et al. (9) developed a customizable telemedicine platform, OpenMRS, to enable task shifting to help bridge the health care access gap in LMICs. Yoo et al. (10) studied the role of telehealth in optimizing task shifting in health care delivery in underserved areas of a high-income country and found that it had a positive impact on improvement in access to and capacity of the clinics used.

There is, therefore, evidence that telepsychiatry can be beneficial in providing health care access via task shifting during infectious disease outbreaks, especially those that require physical distancing and movement restrictions, such as the COVID-19 pandemic. Telepsychiatry can be used to provide public mental health screening, appropriate referral to specialist care, public health promotions, counseling, and psychotherapy services and as such can improve mental health care access, reducing inequities. Telepsychiatry protocols can be used as a training guide in countries where it does not yet exist. Improving Internet access in LMICs, the major challenge for accessibility of telepsychiatry, should become a priority for policy makers in order to improve the infrastructures to enable adequate access to and provision of mental health care.

Through telepsychiatry, mental health care staff based in HICs could provide services remotely to LMICs by assessing patients directly (although this approach might raise some ethical issues concerning responsibility and duty of care). Alternatively, they could provide support to staff when needed, for example by training on the use of psychometric tools for earlier identification of mental health problems, collaboration on research projects, or provision of psychological support to staff in LMICs.

Global Mental Health Services During the COVID-19 Pandemic

Mental health service delivery did not seem to be a priority in low-income countries, whereas mental health services in middle-income countries were restricted to emergency services and inpatient care. The use of telepsychiatry services to cater to mental health outpatients and the longer prescription duration practiced in some HICs would improve access to mental health care in lower-income countries during the periods of lockdown.

Although telepsychiatry services were largely absent in lower-income countries, the gradual integration of these services in private mental health facilities in some middle-income countries could be a stepping-stone for providing widespread telepsychiatry services in LMICs to improve mental health coverage. The development of telepsychiatry protocols and

guidelines and the use of videoconferencing and mobile apps are necessary to kickstart the use of telepsychiatry services.

The pandemic has led to a general decrease in the use of community mental health services. These services have been substituted with telepsychiatry services, especially in HICs, which has allowed for the provision of mental health services to underserved populations. Public mental health screening of common psychiatric disorders during the pandemic was not conducted globally. However, countries such as India and Thailand were able to carry out these services using telepsychiatry and task shifting. The development of mental health screening apps, which were initiated in some HICs during the pandemic, could further improve mental health coverage.

Conclusions

The adaptation of mental health services during the COVID-19 outbreak has occurred in various ways across the globe. This variety seems to be reflective of the wealth of and different resources available in each country. Given that the outbreak is ongoing, all countries should reevaluate their policies to improve their psychiatric services with less risk exposure for their patients and the mental health care staff. To improve mental health coverage during the pandemic, we recommend that nongovernmental organizations in LMICs provide counseling and mental health screening services using telephone calls and mental health promotion using infographics on social and mainstream media, while government facilities provide essential psychiatric services. Resource-rich settings should integrate telepsychiatry with task shifting to improve mental health coverage to underserved populations. To manage population-wide psychiatric problems, which are currently higher than usual among the general and at-risk population, the incorporation of telepsychiatry services with task shifting to provide care at all levels of service delivery seems a viable option during these challenging times.

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REFERENCES

1. Rogers JP, Chesney E, Oliver D, et al: Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. *Lancet Psychiatry* 2020; 7:611–627
2. Liang L, Ren H, Cao R, et al: The Effect of COVID-19 on youth mental health. *Psychiatr Q* 2020; 91:841–852
3. Pereira-Sanchez V, Adiukwu F, El Hayek S, et al: COVID-19 effect on mental health: patients and workforce. *Lancet Psychiatry* 2020; 7:e29–e30
4. Adiukwu F, Orsolini L, Gashi Bytyçi D, et al: COVID-19 mental health care toolkit: an international collaborative effort by early career psychiatrists section. *Gen Psychiatr* 2020; 33:e100270
5. Task Shifting: Global Recommendations and Guidelines. Geneva, World Health Organization, 2008. <https://www.who.int/healthsystems/TTR-TaskShifting.pdf?ua=>
6. Orkin AM, McArthur A, Venugopal J, et al: Defining and measuring health equity in research on task shifting in high-income countries: a systematic review. *SSM Popul Health* 2019; 7:100366
7. van Ginneken N, Tharyan P, Lewin S, et al: Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries. *Cochrane Database Syst Rev* 2013; 2013:CD009149
8. Ramalho R, Adiukwu F, Gashi Bytyçi D, et al: Telepsychiatry and healthcare access inequities during the COVID-19 pandemic. *Asian J Psychiatr* 2020; 53:102234
9. Goel NA, Alam AA, Eggert EMR, et al: Design and development of a customizable telemedicine platform for improving access to healthcare for underserved populations. *Annu Int Conf IEEE Eng Med Biol Soc.* 2017; 2017:2658–2661
10. Yoo ER, Perumpail RB, Cholankeri G, et al: The role of e-health in optimizing task-shifting in the delivery of antiviral therapy for chronic hepatitis C. *Telemed J E Health.* 2017; 23: 870–873