RESPOND

SUPPORTING MENTAL HEALTH OF VULNERABLE GROUPS DURING COVID-19:

EARLY FINDINGS AND RECOMMENDATIONS FROM THE RESPOND PROJECT

RESPOND POLICY BRIEF
MAY 2022

EXECUTIVE SUMMARY

RESPOND is an EU-funded research project running from 2020 to 2023. The project aims to identify which groups are most at risk for adverse mental health consequences due to the COVID-19 pandemic in the short, mid and long term, as well as to understand which factors determine that risk. The RESPOND consortium is currently adapting and implementing potentially cost-effective programmes and conducting reviews of the scientific literature to help individuals in need. It is also focused on identifying effective strategies to improve health system preparedness in the event of a future pandemic. Three previous policy briefs have been published covering the topics of wellbeing, resilience, and mental health during the pandemic and adapting mental services for vulnerable groups. This policy brief focuses primarily on recent reviews of early evidence from the pandemic on mental health and provides key recommendations from work completed under RESPOND.

RECENT FINDINGS

- In 2021, levels of depression and anxiety continued to be higher than pre-pandemic levels (as in 2020).
- There has been a general increase in loneliness during the pandemic.
- Data on suicide mortality in different countries is mixed: there is no clear indication of a change in rates due to the pandemic. However, the risk of suicidal behaviours among young people has increased.
- Exhaustion, loneliness, and COVID-19 diagnosis are associated with an increased risk for suicidal thoughts.
- Vaccine hesitancy is more frequent or pronounced in females, and in people with lower education levels, chronic mental disorders, loneliness, people who had a past COVID-19 diagnosis, people with agoraphobia, concerns about the unforeseen future effects of vaccines, and reporting general mistrust in vaccine benefits and safety.
- People with mental disorders are at increased risk of hospitalisation, severe illness, and death from COVID-19. Illness severity and mortality risk in people with mental disorders was greater among younger people.
- Adapted strategies such as tele-psychotherapy have been evaluated as (cost-) effective, convenient, and acceptable although findings are mixed depending on user characteristics and the quality of tele- or e-mental health services.
- There is evidence that physical activity may be therapeutic for people with mental health problems.
- Barriers to scale up e-mental health service delivery include: inadequate infrastructure, pre-existing inequalities (i.e. pre-pandemic inequalities, such as education and income), and low levels of technological literacy.

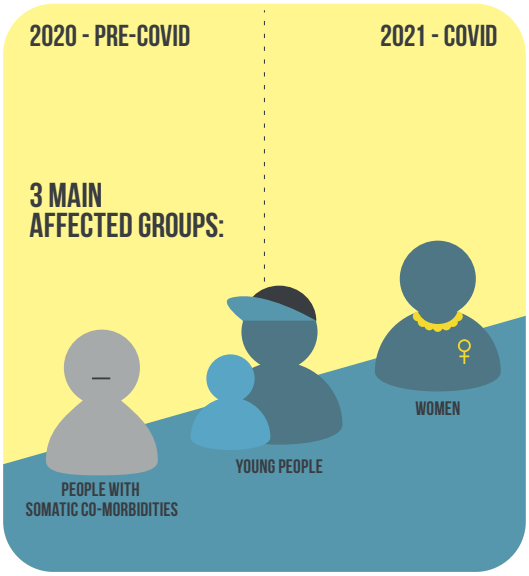
KEY RECOMMENDATIONS

- Further research on COVID-19 and mental health among specific at-risk populations and in low and middle-income countries should be conducted.
- Research to determine the effectiveness of adapted interventions to support wellbeing and resilience of diverse populations needs to be prioritised given the uncertainties of current or future pandemics.
- Suicide prevention (in emergency settings) is needed. This includes improvements in the following areas: restriction of the access to the means of suicide; ensuring the media do not sensationalise or otherwise mis-report on deaths by suicide; supporting the socio-emotional skills of young people, such as in school settings; identifying other at-risk groups; ensuring follow up with people who are affected by suicidal behaviours including in general health care and mental healthcare; and dissemination of information to the public (e.g. where to seek help and identify signs). Capacity building of gatekeepers in the community should also be enhanced.
- Further cultural adaptation and training of professionals is needed to support implementation of newly developed tele- and e-mental health interventions.
- Further investment in mental health services is needed to address the increased mental health need witnessed post-pandemic.
- Medical and paramedical staff involved in the care for COVID-infected people should identify people with pre-existing mental health disorders as a distinct risk group for greater risk of hospitalisation and death from COVID-19.

INTRODUCTION

The COVID-19 pandemic and its associated public health measures have led to a global increase in mental health problems. As previously reported, cases of major depressive disorder increased by 27.6% and cases of anxiety disorders increased by 25.6% in 2020.[1] These levels remained higher than pre-pandemic levels in 2021 in healthy individuals, while those with pre-existing mental health conditions have shown persistently high levels of symptoms (though not an increase).[2]

Worryingly, there are indications of an increased risk of suicidal behaviours among young people[3] and loneliness has increased in all groups.[4] The pandemic has also widened the mental health treatment gap.[5]



INCREASE IN DEPRESSION AND ANXIETY BY APPROX. 25%

These findings emphasise the need to scale up mental health services, both in general and more specifically as part of the response to public health emergencies; and for enhancing mental health promotion and prevention in community settings such as in education. These findings have now been published by the World Health Organisation (WHO) in a scientific brief on the evidence of the pandemic's impact on mental health, which was supported by members of the RESPOND consortium.

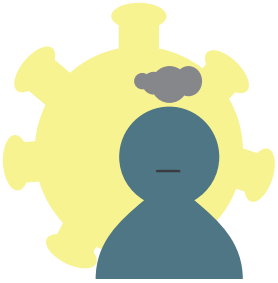
EFFECT OF THE PANDEMIC ON PEOPLE WITH MENTAL DISORDERS

People with mental disorders are affected by the pandemic in different ways than the general population. They are at increased risk of hospitalisation, severe illness, and death from contracting COVID-19 (though not more likely to become infected by it).[6] Younger people and those with more severe mental disorders have a higher risk of becoming severely ill and of dying as a result of COVID-19 infection.[7]

MORE COVID-19 WITH MENTAL DISORDERS

PEOPLE WITH PRE-EXISTING MENTAL DISORDERS HAVE AN INCREASED RISK OF:

1. GETTING COVID-19
2. BEING HOSPITALISED
3. MORTALITY



Health workers involved in the care of people with COVID-19, and in the care of people with psychiatric disorders, should be aware that people with mental disorders are a distinct risk group for an adverse course of COVID-19. Further investment in mental services is needed to address the increased mental health need witnessed post-pandemic and to help those with pre-existing mental health disorders.

[1] Santomauro, D. F. et al. (2021). The Lancet, 398(10312), 1700-1712.
[2] Kok, A. A. L. et al. (2022). Journal of Affective Disorders, Volume 305. https://doi.org/10.1016/j.jad.2022.02.056
[3] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[4] Kok, A. A. L. et al. (2022). Journal of Affective Disorders, Volume 305. https://doi.org/10.1016/j.jad.2022.02.056
[5] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[6] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[7] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.

MENTAL HEALTH SERVICE DELIVERY DURING THE PANDEMIC

In the initial stages of the pandemic, access to mental health services and contacts for anxiety, depression, and other mental health conditions were significantly reduced.[8,9] For example, as of May 1st, 2020, Hospital La Paz, one of the main general hospitals in Madrid (Spain), had seen roughly as many patients in 2020 as it did in the same period of 2019 (2019: 5,733; 2020: 5,755). Similarly, they registered almost the same number of follow-up appointments (2019: 30,073, 2020: 30,296). Community mental health centers had almost a thousand more follow-ups in 2020 (2019: 25,678; 2020: 26,790), even when in-person appointments had stopped a month before. This suggests that telephone follow-ups are compensating for the reduction of in-person contacts.[10]

Evidence collated from an umbrella review of 21 systematic reviews (published up to October 2021) commissioned by WHO[11], shows reduced access to in-person mental health services, in particular outpatient settings (e.g. consultations, therapy), and reduced admissions of psychiatric emergencies, earlier discharge, cancellations of (group) activities and more isolation in inpatient settings.[12,13] These barriers in accessing health services during the pandemic, may have put people with pre-existing mental health conditions at risk for worse outcomes.[14] Also marginalised populations (e.g. racial/ethnic minorities, (labour) migrants) were identified as being at increased risk for COVID-19 related disruption of access and utilisation of mental health care, while already disproportionately affected by COVID-19 in terms of morbidity and mortality and need for psychological support.[15]

Mental health care services largely adapted to the disruptions in mental health care provision by quickly scaling-up to remote delivery of mental health care services and interventions and by re-assigning resources (e.g. staff) to develop, often remotely-delivered, interventions for specifically impacted populations such as health care workers and (family of) severely affected COVID-19 patients. Particularly telephone or video-conferencing platforms were used for delivery of consultations, assessments, psychotherapy and follow-up in outpatient or community care. Although acceptability of tele-psychotherapy and internet-based psychotherapies was generally high, conversion rates of face-to-face to tele- and e-health applications in people with severe mental health disorders were lower in older patients and those needing a support person to facilitate virtual sessions, suggesting a need for support for some vulnerable groups to access e-health interventions.[16]

Most reported barriers of tele- and e-mental health interventions were inadequate infrastructure, pre-existing inequalities (i.e. pre-pandemic inequalities, such as education and income) and low levels of technological literacy for example in low- and middle-income countries. Professional barriers concerning the use of tele- or internet (guided) psychotherapy were concerns of not being able to establish therapeutic alliance or difficulty in conducting specific interventions such as exposure (where typically face-to-face contact has been the dominant delivery method).[17]

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[8] Mansfield, K. E. et al. (2021). The Lancet Digital Health, 3(4), e217–e230

[9] World Health Organization. (2021). Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS-continuity-survey-2021.1

[10] Mediavilla, R. et al. (2020). Psychiatry Res, 289 (2020), Article 113077

[11] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.

[12] Chiesa, V., Antony, G., Wismar, M., & Rechel, B. (2021). Journal of Public Health (Oxford, England), 43(3), e462–e481

[13] Raphael, J., Winter, R., & Berry, K. (2021). BJPsych Open, 7(2).

[14] Cabrera, M. A., Karamsetty, L., & Simpson, S. A. (2020). In Psychosomatics (Vol. 61, Issue 6, pp. 607–615).Psychosomatics; Fornaro, M. et al. (2021). In Journal of Affective Disorders (Vol. 295, pp. 740–751).

[15] Lemieux, A. J. et al. (2020). Victims and Offenders, 15(7–8), 1337–1360; Murphy, J. K. et al. (2021). International Journal for Equity in Health, 20(1), 21.

[16] Li, H. et al. (2021). In Psychiatric Quarterly; Selick, A. et al. (2021). In Disability and Health Journal (Vol. 14, Issue 4). Disabil Health J; Siegel, A. et al. (2021). Current Opinion in Psychiatry, 34(4), 434–443.

[17] Li, H. et al. (2021). In Psychiatric Quarterly; Selick, A. et al. (2021). In Disability and Health Journal (Vol. 14, Issue 4). Disabil Health J; Siegel, A. et al. (2021). Current Opinion in Psychiatry, 34(4), 434–443.

Flexibility in scheduling place and time of tele- or e-mental health care and the willingness and positive attitudes of users were facilitating the use and implementation of tele- and e-health services during the pandemic.[18] Adapted strategies such as tele-psychotherapy were often perceived to be (cost-) effective, convenient and acceptable although findings were mixed depending on patient characteristics and the quality of tele- or e-mental health services.[19] Conclusions of (cost-) effectiveness of tele- and e-health interventions mostly relied on appraisals of professionals themselves, rather than on comprehensive evaluation of the outcomes or on pre-COVID-19 effectiveness trials.[20] Also, the need for further cultural adaptation to specific populations and training of professionals to consolidate newly developed (tele- or e-) mental health interventions was stressed.[21] The review-findings synthesised in the umbrella review published by WHO[22] were based on primary studies and reports of the first half year of the pandemic, mostly from high-income countries and of a qualitative or observational nature with rather weak scientific methodology.[23]

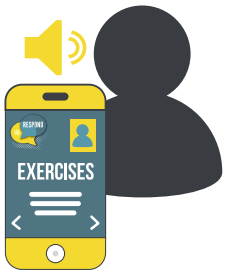
Based on the findings reviewed in the umbrella review, it was concluded that continuing research of scaling-up and implementation of tele- or e-mental health strategies and interventions or blended care is a promising solution to mitigate future disruptions of mental health care service delivery. It will be important to consider facilitators and barriers to their implementation to understand whether these interventions are feasible in relation to pandemic mitigation strategies, such as social distancing and confinement. Finally, research to determine the effectiveness of adapted interventions to support resilience of diverse populations, including healthcare workers, is a high priority given the uncertainties of current or future pandemics.

There is also evidence that physical activity may be therapeutic for people with mental health problems.[24] The affordable provision of opportunities to exercise in public, opportunities for physical activity in work settings[25], and a multidisciplinary and interprofessional approach can contribute to the prevention of mental and physical disorders and to promote the mental wellbeing of the population.

DIGITAL MENTAL HEALTH SERVICE DELIVERY

BARRIERS TO SCALING UP DIGITAL MENTAL HEALTH SERVICE DELIVERY:

- INADEQUATE INFRASTRUCTURE
- PRE-EXISTING INEQUALITIES
- LOW TECHNOLOGY LITERACY



[18] Li, H. et al. (2021). In Psychiatric Quarterly; Selick, A. et al. (2021). In Disability and Health Journal (Vol. 14, Issue 4). Disabil Health J; Siegel, A. et al. (2021). Current Opinion in Psychiatry, 34(4), 434–443; Murphy, J. K. et al. (2021). International Journal for Equity in Health, 20(1), 21.

[19] Selick, A. et al. (2021). In Disability and Health Journal (Vol. 14, Issue 4). Disabil Health J; Siegel, A. et al. (2021). Current Opinion in Psychiatry, 34(4), 434–443; Lemieux, A. J. et al. (2020). Victims and Offenders, 15(7–8), 1337–1360; Li, H. et al. (2021). In Psychiatric Quarterly; Yue, J. L. et al. (2020). In Psychological Medicine (Vol. 50, Issue 15, pp. 2498–2513).

[20] Cabrera, M. A., Karamsetty, L., & Simpson, S. A. (2020). In Psychosomatics (Vol. 61, Issue 6, pp. 607–615). Psychosomatics; Chiesa, V., Antony, G., Wismar, M., & Rechel, B. (2021). Journal of Public Health (Oxford, England), 43(3), e462–e481; Li, H. et al. (2021). In Psychiatric Quarterly.

[21] Li, H. et al. (2021). In Psychiatric Quarterly; Selick, A. et al. (2021). In Disability and Health Journal (Vol. 14, Issue 4). Disabil Health J; Siegel, A. et al. (2021). Current Opinion in Psychiatry, 34(4), 434–443; Soklaridis, S. et al. (2020). General Hospital Psychiatry, 66, 133–146.

[22] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.

[23] Baumgart, J. G. et al. (2021). International Journal of Environmental Research and Public Health, 18(15); Chiesa, V., Antony, G., Wismar, M., & Rechel, B. (2021). Journal of Public Health (Oxford, England), 43(3), e462–e481; Lemieux, A. J. et al. (2020). Victims and Offenders, 15(7–8), 1337–1360; Murphy, J. K. et al. (2021). International Journal for Equity in Health, 20(1), 21.

[24] World Health Organization (2020). WHO guidelines on physical activity and sedentary behaviour. https://www.who.int/publications/i/item/9789240015128

[25] World Health Organization (2020). WHO guidelines on physical activity and sedentary behaviour. https://www.who.int/publications/i/item/9789240015128

SUICIDAL BEHAVIOUR

Data on suicide mortality during the pandemic in different countries is mixed. There is no clear indication of a change in rates due to the pandemic. As previously reported, suicide rates did not increase during the first wave of the pandemic.[26] Until October 2020, rates decreased or remained stable, with some exceptions. These findings are mostly from high-income countries, as reliable evidence from lower resourced settings in Europe is lacking.[27] The mixed evidence could be attributed to differences across countries, the quality of suicide reporting, and urbanicity.[28] The data on gender and age group differences are mixed across countries too. However, data suggests the risk of suicidal behaviours among young people has increased.[29] Differences across demographic groups can therefore not be overlooked. Populations that appear at-risk are adolescents, young people, migrants, refugees[30], and in contradiction with pre-pandemic rates, women. Rates have fluctuated across the stages of the pandemic. Despite the absence of a clear increase in suicide rates, a Spanish study showed a higher suicide mortality risk in the general population from May 2020 onwards and similar time trends between the different stages of the pandemic and suicide mortality.[31] Other studies find that this relationship might be inverted.[32] Another crucial matter is the toll of suicide on burdened health systems. Overall, many (though not all) studies have reported a decrease in service use for acts of self-harm. However, a subgroup that was found to have increased service use is adolescent girls.[33] In general, the evidence on service use is mixed, except for some vulnerable groups.

SUICIDE

INCREASED RISK IN YOUNG WOMEN
SELF-HARM
EXHAUSTION
LONELINESS

Even when not resulting in suicide attempts, suicidal thoughts are highly distressing for individuals. Rates of self-reported suicidal thoughts were found by most studies to have increased. Women and young people appear to be more vulnerable. Factors associated with suicidal thoughts were: reduced social support, physical and mental fatigue, poor physical health, sleep problems, quarantine, loneliness and mental health difficulties.[34] Resilience, defined as maintaining strong mental health in the face of negative life events, is protective against suicidal thoughts.[35] The key message is that low social support and poor physical and mental health constitute a risk factor, especially for vulnerable groups.

[26] John et al. (2021). F1000 Research 9 (1097)
[27] Pirkis et al. (2021). The Lancet Psychiatry 8 (7). doi:10.1016/S2215-0366(21)00091-2
[28] Lopez-Morinigo (2021). Revista de Psyquiatria y Salud Mental (in press) https://doi.org/10.1016/j.rpsm.2022.02.002
[29] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[30] World Health Organization. (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.
[31] Torre-Luque et al (2022). Revista de Psyquiatria y Salud Mental (in press) https://doi.org/10.1016/j.rpsm.2022.01.003
[32] Lopez-Morinigo (2021). Revista de Psyquiatria y Salud Mental (in press) https://doi.org/10.1016/j.rpsm.2022.02.002
[33] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[34] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[35] Ayuso-Mateos et al (2021). Epidemiology and psychiatric sciences 30. https://doi.org/10.1017/S2045796021000408

Healthcare workers (HCWs) have been heavily affected by the pandemic, so it is important to investigate suicidal thoughts and behaviours among them. Higher-quality studies on the subject are still needed, but some factors have been found to be associated with increased suicidal thoughts and behaviours, namely poor working conditions, high physical and mental exhaustion,[36] and direct contact with COVID-19 patients.[37]

An epidemiological study focused on healthcare workers found that female and frontline HCWs were more prone to suicidal thoughts and that these thoughts were linked with lower resilience.[38] It is still unclear to what extent these thoughts are related to work-related stressors, but it already appears that triage decisions, lack of protective equipment and redeployment are linked with burdened mental health.[39] This is of concern since prior to the pandemic, health workers have been found to be disproportionately affected by suicidal behaviours compared to the general population.[40]

These findings suggest that workplace-based suicide prevention interventions for HCWs may be beneficial. Such interventions have shown some positive evidence for other occupations[41], and for medical interns.[42] However there is little evaluation of effective interventions in work-settings for this and other groups[43], yet available evidence indicates that efforts have largely focused on increasing awareness and ensuring employees are aware of resources to seek help when needed. More broadly, the WHO has already pointed out the need for suicide prevention in emergency settings and has highlighted the importance of the most effective suicide prevention interventions, which are: limiting the access to potential means of suicide, interacting with the media on responsible reporting, fostering the socio-emotional life skills of young people, and early identification of everyone affected by suicidal behaviours (which includes individuals themselves, and survivors including families/friends).[44]

Additionally, ensuring that countries are aware of their situations in terms of suicide prevention is a necessity including the identification of vulnerable groups, improving access to mental healthcare and dissemination of information so that people know where to seek help, enhancing the capacity building gatekeeping in the community and critically ensuring that health information systems for suicide are functional and up to date.

Suicide prevention interventions at all levels (e.g. public health initiatives, gatekeeper training and follow-up of people at risk) and their implementation should be adapted to the local context. It is essential that the training provided to people that deliver suicide prevention interventions is adapted to their social and cultural context and that the interventions are adapted based on the availability of resources and the context.

The method of communication should also be adapted to the target population; if available resources are scarce, it may be beneficial to adapt communications to the highest priority target populations to ensure interventions reach people who need them the most. Digital delivery is also an emerging direction for adaptation which may provide greater reach for some messaging. The WHO has developed several packages for suicide prevention that are available for adaptation.[45]

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[36] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[37] Farooq et al. (2021). Psychiatry research, 306 (114228). doi:10.1016/j.psychres.2021.114228
[38] Ortiz Calvo et al. (2021). Journal of Psychiatric Research https://doi.org/10.1016/S2215-0366(18)30509-1
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[41] Milner et al. (2015). Health Promotion International, 30, (1).
[42] Petrie et al. (2019). The LANCET Psychiatry, 6 (3), 225-234. https://doi.org/10.1016/S2215-0366(18)30509-1
[43] Milner et al. (2015). Health Promotion International, 30, (1).
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VACCINE WILLINGNESS AND HESITANCY

Individuals with mental disorders are at an increased risk of hospitalisation and mortality associated with COVID-19,[46] which is further increased in those who are unwilling to get vaccinated. However, vaccine willingness appears to be slightly lower in patients with mental illness.[47]

In order to understand which factors may be contributing to vaccine hesitancy, a recent study investigated attitudes toward COVID-19 vaccination in various groups. Increased age, worry symptoms, and obsessive-compulsive disorder were found to be associated with a higher willingness to get vaccinated.[48] By contrast, the following traits and conditions were associated with vaccine hesitancy: being female, lower education levels, chronic mental disorders, loneliness, COVID-19 diagnosis, agoraphobia, concerns about the unforeseen future effects of vaccines, and general mistrust in vaccine benefits and safety.[49]

In Spain, a recent study has investigated attitudes toward vaccines among healthcare workers. By March 2021, 79% of respondents had already received at least one dose. Among those, 2.3% were against it, i.e. they got vaccinated against their will (even though it was not mandatory in Spain). Two thirds of the 21% who were not yet vaccinated were willing to do so as soon as possible, while the other third was hesitant (31%) or against it (3%). Those who were hesitant often reported that they would decide depending on the specific vaccine. Most of those who were either hesitant or against it also thought that the vaccine had been developed too quickly.

VACCINE HESITANCY

- WOMEN
- LOWER EDUCATION
- CHRONIC MENTAL DISORDERS
- LONELINESS
- COVID-19 DIAGNOSIS
- AGORAPHOBIA
- CONCERNS ABOUT UNFORESEEN FUTURE EFFECTS OF VACCINES
- GENERAL MISTRUST IN VACCINE BENEFITS AND SAFETY

Overall, 75% of respondents thought that the vaccine would protect them, while 15% did not. This data was collected just a few weeks after the vaccination campaign for HCWs started in Spain. Although attitudes to the vaccine were generally positive, the lack of information or the feeling that it may have been released too quickly brought uncertainty and hesitancy, even among health professionals. Better adaptation of risk communications around vaccines is thus needed.

[46] Pan et al. (2022). Acta Psychiatrica Scandinavica, 145(4), 412-415. https://doi.org/10.1111/acps.13399
[47] Jefsen et al. (2021). Acta Neuropsychiatrica, 33(5), 273-276. https://doi.org/10.1017/neu.2021.15
[48] Pan et al. (2022). Acta Psychiatrica Scandinavica, 145(4), 412-415. https://doi.org/10.1111/acps.13399
[49] Pan et al. (2022). Acta Psychiatrica Scandinavica, 145(4), 412-415. https://doi.org/10.1111/acps.13399

ABOUT RESPOND

RESPOND stands for *PREparedness of health Systems to reduce mental health and Psychosocial concerns resulting from the COVID-19 paNDemic*. The project brings together a network of specialists in the areas of epidemiology, psychology, psychiatry, sociology, health systems research, political science, economic science, implementation science, policymaking, and dissemination and is coordinated by Prof. Marit Sijbrandij of the Department of Clinical, Neuro- and Developmental Psychology at the Faculty of Behavioural and Movement Sciences, Vrije Universiteit Amsterdam.

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