POPULATION MENTAL HEALTH TWO YEARS INTO THE COVID-19 PANDEMIC

RESPOND POLICY BRIEF
NOVEMBER 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, medium, and long term, as well as to understand which factors determine that risk. The RESPOND consortium is currently implementing potentially cost-effective programmes and conducting reviews of the scientific literature to help individuals in need. RESPOND is also focused on identifying effective strategies to improve health system preparedness in the event of a future pandemic. Four previous policy briefs have been published covering the topics of wellbeing, resilience, and mental health during the pandemic and the adaptation of mental services for vulnerable groups, among other topics. This policy brief focuses on recent findings related to the mental health consequences of the pandemic and what can be learnt from the policy response to inform future mental health policies during pandemics.

RECENT FINDINGS FROM STUDIES ON COVID-19 AND MENTAL HEALTH

- Overall, there has been a small increase in mental health symptom levels during the pandemic with some disproportionately affected vulnerable groups, although the evidence is mixed.
- Individuals who have been hospitalised for COVID-19 are at risk of having persistent mental health problems.
- Overall, the prevalence of domestic violence increased during the first stages of the pandemic.
- Additional financial support measures have been associated with better mental health during the COVID-19 pandemic.
- Healthcare workers have received inadequate mental health support and have persistent mental health problems.

KEY RECOMMENDATIONS TO SUPPORT MENTAL HEALTH AND WELLBEING DURING PANDEMICS

- Workplace mental health needs, specifically in healthcare settings, should be made a higher priority, along with crisis preparation and improved occupational health and working conditions.
- Early identification of population groups whose mental health may be most affected by a new pandemic or other major societal shock is essential to pandemic planning and rapid response.
- Structural collection of data from existing or future representative population surveys can assist governments and agencies to identify populations at risk during pandemics or other major crises.
- In order to prevent domestic violence, targeted screening of individuals that belong to high-risk groups, such as the economically disadvantaged or those with mental and substance use disorders is needed.
- Additional financial support to improve economic activity should be provided, given that it has been associated with better mental health during the COVID-19 pandemic.
- It is important not only to plan for future pandemics and other public health emergencies, but also to plan for continued recovery after these emergencies have ended.

INTRODUCTION

The COVID-19 pandemic has affected population mental health in a variety of ways: directly via the experience of illness and more indirectly via societal disruptions, such as social distancing and lockdown measures. The societal disruptions led to loneliness, work stress, and unemployment; and acute COVID and hospitalisation have been associated with increases in anxiety, depression, and cognitive impairment.

Overall, there has been a small increase in mental health problems from pre-pandemic to peri-pandemic time points according to a recent review of the subject.[1] This additional mental health burden is not only significant at the individual level, but also has far-reaching effects on the economy. In this RESPOND policy brief, we will outline new findings regarding the mental health burden of the pandemic among populations, including patients who were hospitalised and healthcare workers, and on increases in domestic violence.

Although the pandemic remains an acute global emergency,[2] most European countries have seen a transition to a less serious stage. At this stage, data are becoming more and more available on the effects of policy measures taken during the pandemic and whether or not mental health concerns were included in the decision making. The current policy brief will focus on the nature and impact of these policy responses.

MENTAL HEALTH TWO YEARS AFTER THE START OF THE PANDEMIC

Several reviews have consistently reported that across multiple studies and meta-analyses, there has been a small increase in self-reported mental health problems since the pandemic started. This finding is statistically significant, but highly heterogeneous in that not all groups have been impacted in the same way.[1,3]

Some groups may be disproportionately vulnerable to mental health problems associated with the pandemic, such as women, people with pre-existing medical conditions, adolescents and young adults, groups with low socio-economic status, and people who have experienced severe infection followed by post-COVID symptoms, also known as *long COVID*.[1] Others have seen a reduction in mental health problems. For example, psychotic symptoms seem to have decreased and suicide rates have remained stable or have even decreased in some countries.[4] Some of the results are therefore difficult to interpret as increased mental health in one group may mask problems in other groups.

Direct associations between symptoms such as depression and anxiety and the average number of daily COVID-19 cases have however been confirmed.[5] Mental health problems were particularly increased when based on elevated symptom levels on specific self-reports such as depression and anxiety, while the few longitudinal population-based studies with assessments of mental health disorders based on diagnostic psychiatric criteria and interviews are less consistent with several finding no increase from pre-pandemic to peri-pandemic time points. This discrepancy might be related to time-lag effects with disorders taking more time to develop or be picked up. The highest increase in mental health problems was seen during the first peak of the pandemic with smaller increases during the subsequent waves.[1]

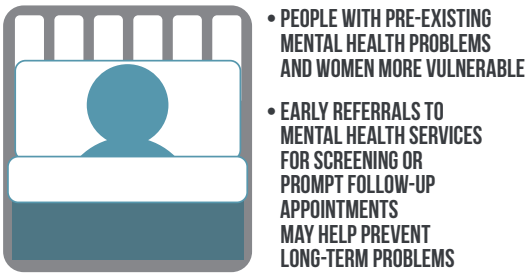
[1] Penninx, B., et al. (2022). Nature Medicine. https://doi.org/10.1038/s41591-022-02028-2
[2] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-policy-briefs
[3] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[4] Pirkis J., et al. (2022). EClinicalMedicine. 2022;51:101573. https://doi.org/10.1016/j.eclinm.2022.101573
[5] Jia, H. et al. (2021). MMWR Morb. Mortal. Wkly. Rep. 70, 1427–1432 (2021). http://dx.doi.org/10.15585/mmwr.mm7040e3

In addition to the psychosocial effects of the pandemic, such as fear of infection and dying, isolation, and unemployment, the neurobiological mechanisms at work in patients with severe COVID are increasingly coming into view. The most common neuropsychiatric symptoms among *long COVID* patients are sleep problems, fatigue, cognitive impairment, anxiety, post-traumatic stress, and depression.[1] However, at this stage, it is not yet clear to what extent these symptoms are unique to COVID-19 vs. other respiratory or inflammatory conditions. At present, there is no evidence-based intervention to specifically treat the neuropsychiatric effects of *long COVID*, so the best approach is to follow the same treatments as for other severe medical conditions and related mental health problems.[1]

MENTAL HEALTHCARE NEEDS AFTER COVID-19 HOSPITALISATION

Mental health problems following acute COVID and hospitalisation are commonly reported and are responsible for a large proportion of the associated burden of disability.[6] At a large hospital in Madrid, Spain, 14% of individuals who were hospitalised for COVID-19 still experienced mental health symptoms one year later, with anxiety, depression, and/or acute stress as the most commonly reported symptoms.[6]

This number, however, does not include informal consultations or consultations outside the national public health system and is therefore likely to be even higher consistent with the finding in China that one in four hospitalised COVID-19 patients had persistent anxiety and/or depression symptoms one year after being discharged from hospital.[6,7] Particularly vulnerable groups are women and patients with pre-existing mental health problems.[6]



These findings are highly relevant for mental healthcare planning and resource allocation both during the current pandemic and also for future health crises. In particular, early referrals for screening with mental health professionals and prompt follow-up appointments with patients' usual care providers may assist in preventing long-term mental health problems[6] and reducing the cost to the healthcare system in future crises.

SUSTAINED MENTAL HEALTH PROBLEMS AMONG HEALTHCARE WORKERS

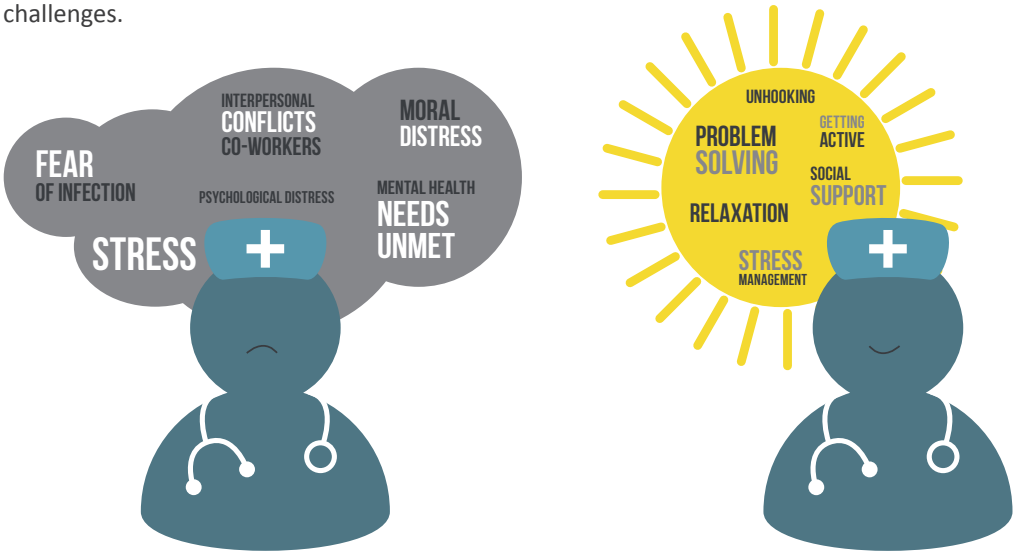
Healthcare workers have been particularly affected by mental health problems during the pandemic. In Spain, interviews conducted by RESPOND researchers revealed that most mental health needs in this group remained unmet in 2022.[8] The consequences of this finding are significant: high levels of depression, anxiety, acute and post-traumatic stress, and insomnia have led healthcare workers to experience exhaustion and to resign from work.[9]

While some additional mental health support was initially provided to healthcare workers in Spain, such as hotlines and ultra-brief stress management sessions, it was based on data from previous epidemics and not yet adapted to the given context.[8] As a result, healthcare workers have been overwhelmed by psychological distress, moral distress (i.e., distress arising from taking a decision that is different from what one considers ethically correct), interpersonal conflicts among colleagues, fear of infection, and stress caused by a lack of clear information on how to respond to the crisis.[8]

[6] Mediavilla, R., et al. (2022). Revista de Psiquiatría y Salud Mental - https://doi.org/10.1016/j.rpsm.2022.09.005
[7] Xue Zhang, B. S., et al. (2021). JAMA Netw Open, 4 (2021), p. e2127403. https://doi.org/10.1001/jamanetworkopen.2021.27403
[8] Mediavilla, R., et al. (2022). Frontiers in Public Health, 10:956403 - https://doi.org/10.3389/fpubh.2022.956403
[9] Borek, A. J., et al. (2022). PLOS ONE, 17:e0264906 - https://doi.org/10.1371/journal.pone.0264906

Healthcare workers expressed a widespread sense of disbelief at being overburdened yet not receiving adequate support.[8] They also felt that organisation leaders and policymakers did not share information adequately, promote occupational health, hire mental health specialists, or improve working conditions.[8]

Key public policy priorities are to increase training on infectious diseases and to improve occupational health and working conditions for healthcare workers. In addition, anti-stigma campaigns may be useful, as an association between discrimination and poor mental health among healthcare workers has been reported.[10] These recommendations are particularly important for protecting mental resilience and being better prepared for future European health challenges.



HEALTHCARE WORKERS: SUSTAINED MENTAL HEALTH PROBLEMS ONE YEAR AFTER & POSSIBLE SOLUTIONS

DOMESTIC VIOLENCE DURING AND AFTER THE COVID-19 PANDEMIC

The stay-at-home measures that many countries took to contain the COVID-19 pandemic created a potentially pressuring and perilous situation for people at risk or already facing domestic violence,[11,12] as they were confined with abusive family members in the context of uncertainty that the pandemic instigated. Moreover, the pandemic and the measures to contain it worsened known risk factors for domestic violence, such as financial hardship[13] and substance use.[14] These raised a heightened concern for domestic violence among the scientific community and the general public.

Initially, many studies showed an increase of domestic violence since the outbreak of COVID-19,[15] but others reported a decrease.[16] This mixed picture is explained by decreased help-seeking and limited access to services. In addition, the cases that were reported involved more frequent and more severe victimisation.[17]

[10] Mediavilla, R., et al. (2021). Revista de Psiquiatría y Salud Mental. https://doi.org/10.1016/j.rpsm.2021.06.001
[11] Mazza, M., et al. (2020). Psychiatry Research, 289. https://doi.org/10.1016/j.psychres.2020.113046
[12] Sacco, M. A., et al. (2020). The Medico-legal journal, 88(2), 71–73. https://doi.org/10.1016/j.psychres.2020.113046
[13] Gibbs, A., et al. (2018). PLoS ONE 13(10): e0204956. https://doi.org/10.1371/journal.pone.0204956
[14] Kadir Shahar, H., et al. (2020). BMC Public Health. 15;20(1):1550. https://doi.org/10.1186/s12889-020-09587-4
[15] Hsu, L. C., & Henke, A. (2022). Journal of family and economic issues, 43(2), 296–309. https://doi.org/10.1007/s11150-020-09526-7
[16] Sorenson, S. B., et al. (2021). Journal of interpersonal violence, 36(9-10), 4899–4915. https://doi.org/10.1177/0886260521997946
[17] Gosangi, B., et al. (2021). Radiology, 298(1), E38–E45. https://doi.org/10.1148/radiol.2020202866

The existing literature, which is at a preliminary stage, has estimated an overall 8% increase in domestic violence during the first stages of the pandemic, based on cases reported to health and legal services, mostly from the United States.[18] Regarding specific demographic subgroups, violence against adolescents[19] and children[20] increased respectively in the past two years, as well as against pregnant women (approximately by 5%).[21] The most common form of violence is psychological, and the least common is sexual.[22] As expected, higher rates of violence have been associated with financial difficulties,[23] substance use and pre-existing mental illness,[24] and concerns for childcare.[25]

As is apparent from the mixed prevalence rates based on different services, access to social and health services was hampered[26] and obstacles to help-seeking increased.[27] On top of that, provision of services became much more challenging for professionals.[28] However, there is not yet enough evidence on interventions delivered in the context of the pandemic.

A key priority in such emergency contexts is to do targeted screening for victimisation of individuals that belong to high-risk groups for domestic violence, such as the economically disadvantaged or those with mental and substance use disorders, so that the available resources are used efficiently. It is vital that screening is technically feasible remotely, while also maintaining safety and privacy, which are major concerns in domestic violence.

An important next step would be to facilitate remote delivery of interventions, and ideally scale them up by emphasising their most effective components. More research would help in identifying these components. These objectives are becoming increasingly relevant in light of the challenges Europe is currently facing, such as the energy and cost-of-living crisis. These challenges are pressuring financially strained households even further, and thus are very likely to heighten the risk of domestic violence even more, as financial difficulties are one of the most salient risk factors.

DOMESTIC VIOLENCE: HIGH RISK GROUPS NEED TARGETED SCREENING

PEOPLE DEALING WITH:

- FINANCIAL DIFFICULTIES
- SUBSTANCE ABUSE DISORDERS
- PRE-EXISTING MENTAL ILLNESS
- CONCERNS FOR CHILDCARE

[18] Piquero, A. R., et al. (2021). Journal of Criminal Justice (74) 101806. https://doi.org/10.1016/j.jcrimjus.2021.101806
[19] Meherali, S., et al. (2021). Int. J. Environ. Res. Public Health , 18, 13221. 10.3390/ijerph182413221
[20] Cappa, C. & Jijon, J. (2021). Child abuse & neglect 116, 105053. https://doi.org/10.1016/j.chiabu.2021.105053
[21] Huldani, H., et al. (2022). Women & health, 62(6). https://doi.org/10.1080/03630242.2022.2096755
[22] Bazyar, J., et al. (2021). Prehospital and disaster medicine 0(0):1–6. https://doi.org/10.1017/S1049023X21000789
[23] Lausi, G., et al. (2021). International journal of environmental research and public health, 18(12), 6204. https://doi.org/10.3390/ijerph18126204
[24] Langhinrichsen-Rohling, J., et al. (2022). Int. J. Environ. Res. Public Health, 19, 2608. https://doi.org/10.3390/ijerph19052608
[25] McNeill, A., et al. (2022). Journal of Family Violence. https://doi.org/10.1007/s10896-022-00386-6
[26] Mojahed, A., et al. (2021). Frontiers in Psychiatry, 12, 578150–578150. https://doi.org/10.3389/fpsyt.2021.578150
[27] Toccalino, D., et al. (2022). Archives of physical medicine and rehabilitation, 103(7), 1466–1476. https://doi.org/10.1016/j.apmr.2021.12.012
[28] Cabin, W. (2022). Home Health Care Management & Practice, 33(4), 305–313. https://doi.org/10.1177/1084822321992380

LESSONS LEARNT FROM THE INITIAL POLICY RESPONSE

Our work in RESPOND has sought to identify some of the lessons, both positive and negative that can be learnt from the initial policy response to the pandemic. These insights can also be important inputs to deliberations on the proposed new strategy for mental health in Europe that was announced by Commission President Ursula Von der Leyen in September 2022. More recently, Stella Kyriakides, Commissioner for Health and Food Safety commented that *"President von der Leyen spoke loud and clear for a comprehensive approach to mental health, involving all relevant EU funding actions and policies. An approach to boost mental health awareness across Europe, step up prevention, health promotion, improving access to mental healthcare services. A comprehensive approach with commitment and cooperation from all actors*".[29] This necessitates both better planning for future pandemics as well as the development of policy and practice to support individuals whose mental (and physical) health continues to be affected, in part because of the severe consequences experienced by a minority of individuals who experience *long COVID* (defined as having more than 12 weeks of symptoms).

As part of RESPOND, in-depth interviews were undertaken with a range of stakeholders including selected public health and mental health policymakers. They investigated the salience of mental health issues, the beliefs held by stakeholders and described how and when their interactions have affected the way mental health and wellbeing issues were taken on board during the COVID pandemic. In addition, RESPOND is also undertaking an online survey (known as a discrete choice experiment) looking at how policymakers and others weigh up the relative merits of policy actions to protect against the virus with their potential impacts on mental health and the economy.

Our analysis in the RESPOND project, looking at these data, plus our analysis of policy documentation and scientific literature suggests that mental health—understandably—was not a major consideration for many policymakers back in Spring 2020 when the pandemic first hit Europe hard. Nearly all European countries experienced restrictions on freedom of movement and social activities intended to suppress the spread of the virus, in order to not only limit onward transmission and therefore avoid deaths but also to avoid the complete break-down of the healthcare system. Some of these measures we now know had some consequences for mental health, but it should be stressed that not all of the population was affected negatively,[1] evidence continues to accumulate that a minority of the population experienced better mental health and wellbeing as a result of these measures. As the pandemic went on, policymakers more actively and explicitly began to take into account impacts on mental health when formulating policy, including for example, the balance between virus transmission and the educational and mental health benefits of reopening schools.[30]

A key weakness in pre-existing pandemic planning documents was a lack of any strong focus on mental health (e.g., the UK government's influenza pandemic preparedness documents).[31] As part of RESPOND we have created a mental health impact framework which considers the strength of the evidence on the impacts of different policy measures, including both their potential positives and negative impacts. Such a framework could inform plan development. For example, our RESPOND analysis indicates that during the first lockdown in 2020 an increase in the number of days spent outside was associated with decreases in depressive and anxiety symptoms and an increase in life satisfaction.[32]

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[29] Kyriakides, S. (2022). Video Keynote Speech by Commissioner Stella Kyriakides at the High-Level Conference on Mental Health, organised by the Czech Presidency. https://ec.europa.eu/commission/presscorner/detail/en/SPEECH_22_6742

[30] Lorant, V., et al. (2022). RESPOND Deliverable D3.3 – Report on strategies that stakeholders are prioritising, to mitigate and respond to the mental health challenges of the COVID-19 outbreak.

[31] https://www.gov.uk/government/publications/review-of-the-evidence-base-underpinning-the-uk-influenza-pandemic-preparedness-strategy

[32] Stock, S., et al. (2022). Sci Rep. 2022;12(1):10580. https://doi.org/10.1038/s41598-022-15004-0

Our analysis also highlighted the lack of access to readily updated population level measures of mental health during the early stages of the pandemic. Policymakers had to rely mainly on data on the number of contacts with mental health services; these data were not helpful, in part because they mainly focused on individuals with pre-existing mental health conditions, and secondly because there was a general public reluctance to come into contact with any health services early in the pandemic, for fear of being infected. We now know that the mental health of some sections of the population including young people, single parent families, those in insecure and poor accommodation and workers with temporary or no employment contract was more likely to be adversely affected than that of the population as a whole.[1,33, 34, 35]

At the start of the COVID-19 pandemic, there were concerns that rates of self-harm and suicide would increase as a result of the pandemic and pandemic response. In fact, this has not occurred. Detailed analysis of official public-sector sources and scientific literature from 33 countries worldwide, in fact found some evidence of lower-than-expected rates, and no association with the stringency of public health response measures.[4] One reason for this may be the high level of additional social welfare support seen in many countries. Longitudinal data now provide multiple evidence suggesting that income protection measures also were protective of mental health. Longitudinal data from more than 25,000 people of working age in the UK indicate that individuals who were eligible for the furlough scheme that covered up to 80% of salaries, had better mental health and wellbeing than individuals who became unemployed during the COVID pandemic.[35]

Going forward it is essential that plans consider the impacts on mental (and physical) health of public health measures that place restrictions on movement and our activities. Mitigation measures to help support mental health can then be developed as part of this plan; this for instance could include access to a range of telephone and online self-help services to help promote and protect the mental resilience of all. Policymakers might also for instance think about their public health messaging during a pandemic on the importance of taking exercise and spending some time in green spaces. Groups without easy access to green space may then be in need of additional support.

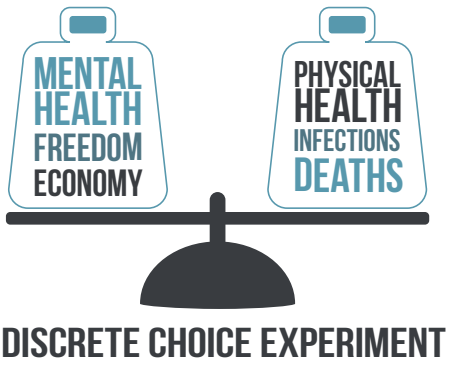
Earlier detection followed by provision of additional mental health support to groups that are vulnerable to increased mental health problems during the pandemic within the population is desirable. To do this it may be considered to put in place a 'radar' mechanism to identify these groups; for example through large-scale random sampling of the population on a longitudinal basis during times of public health (and also other crises, e.g., the energy price shock and cost of living crisis). One example of this is the rapidly created COVID Social Study in the UK which rapidly recruited more than 70,000 participants, collecting data on a bi-weekly basis for more than 2 years.[36] Other existing population panels such as the Dutch LISS panel[37] or the German SOEP panel[38] may also be used for this purpose. We would also suggest that these data need to be collected beyond the end of any crisis, as there can be time lags before mental health impacts are seen.

[33] Santomauro, D.F., et al. (2021). The Lancet. 2021;398(10312):1700-12. https://doi.org/10.1016/S0140-6736(21)02143-7
[34] Pedersen, M. T., et al. (2022). BMC Psychiatry. 2022;22(1):25. https://doi.org/10.1186/s12888-021-03655-8
[35] Wels, J., et al. Soc Sci Med. 2022;308:115226. https://doi.org/10.1016/j.socscimed.2022.115226
[36] Fancourt, D., Steptoe, A., Bradbury, A. (2022). Tracking the Psychological and Social Consequences of the COVID-19 Pandemic across the UK Population: Findings, Impact, and Recommendations from the COVID-19 Social Study (March 2020 – April 2022). London: UCL; 2022 September.
[37] https://www.website.lisspanel.nl
[38] https://www.eui.eu/Research/Library/ResearchGuides/Economics/Statistics/DataPortal/GSOEP

Additional support measures that reduce financial distress, as well as the fear of financial distress, can be an important tool/mitigation measure to be used during any public health crisis that impacts on economic activity. At the time of writing Europe is facing a major cost-of-living crisis, largely driven by the increase in the costs of energy due to the Ukraine conflict. Although a very different crisis to the pandemic, it has major public health concerns, and additional financial support may equally be protective to mental health.

Governmental finances are under considerable pressure at the moment; our work in RESPOND suggests that a proportionate universalistic approach[39] to address any future public health crisis is an option. This would mean ensuring that everyone receives some additional support, with further targeted support for individuals in most need. These individuals might be identified rapidly through the real-time large-scale surveillance mechanisms that focus on identification of psychological distress that we have noted.

Our interviews with policymakers also reinforce the message that there is also a longer term need for policymakers not to just plan for future pandemics and other public health shocks but also to plan for the long-term recovery of the population after these shocks have ended. Some governments have already developed long-term recovery plans, but these may now need further adaptation given that the economic situation in Europe has deteriorated rapidly since March 2022.



DISCRETE CHOICE EXPERIMENT

More generally as well, guidance documents on the promotion and protection of mental health need to be adapted to take account of changes in the way in which we lead our lives following the pandemic; for instance, new WHO guidelines on protecting mental health at work have been adapted to consider the likely permanent increase in the number of people working from home.[40]

MENTAL HEALTH SERVICE DELIVERY

In times of increased mental health burden, it is crucial to provide adequate mental healthcare. Disruptions in mental health service provision for anxiety, depression, and other mental health conditions during the pandemic could however not be prevented.[41] Reduced access to healthcare is particularly worrying for people with (severe) mental disorders who are at greater risk of poor health outcomes from COVID-19,[42] more often depend on regular outpatient services and prescriptions and more often suffer from (increased) socio-economic inequalities during the pandemic.[43]

[39] Marmot, M., et al. (2010). Fair Society, Healthy Lives. The Marmot Review. London.
[40] WHO guidelines on mental health at work. (2022). Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO. https://www.who.int/publications/i/item/9789240053052
[41] Mansfield, K. E., et al. (2021). Lancet Digit Health; 3: 4. https://doi.org/10.1016/S2589-7500(21)00017-0
[42] Vai, B., et al. (2021). Lancet Psychiatry; 8: 797-812. https://doi.org/10.1016/S2215-0366(21)00232-7
[43] Lee, H. & Singh, G. K. (2021). Monthly Trends in Access to Care and Mental Health Services by Household Income Level during the COVID-19 Pandemic, United States, April: December 2020. http://online.liebertpub.com/doi/10.1089/heq.2021.0036

Most mental health services during the pandemic have mainly responded to the COVID-19 restrictions by implementing technology-based mental healthcare. In a recent umbrella review of 38 systematic reviews, reduced access to outpatient mental healthcare and reduced admissions and earlier discharge from inpatient care were the most often reported disruptions. Practitioners and mental healthcare institutions mainly used synchronous tele-mental health tools such as videoconferencing, and to a lesser degree and later in the pandemic asynchronous tools were developed and implemented (e.g., guided web-applications) to enable continued access to mental healthcare for patients.[44]

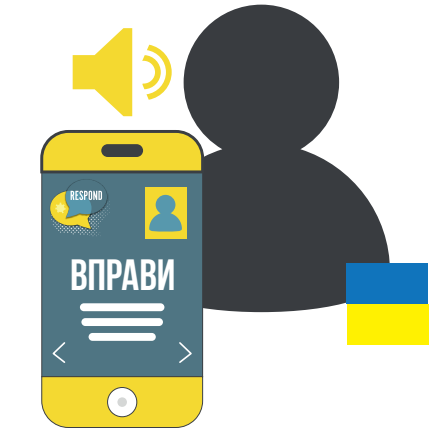
An implementation framework was used to structure the main barriers and facilitating factors of using remote mental healthcare tools during the pandemic. Among practitioners and patients, the most important facilitators of using tele-mental health tools were the improved scheduling, time efficiency, and treatment adherence. The main barriers to using digital mental health tools were poor technological literacy, particularly when pre-existing health inequalities existed, and beliefs about reduced therapeutic alliance particularly in case of severe mental disorders. On an organisational level, lack of support for technological implementation of digital mental health interventions due to inadequate IT infrastructure and lack of funding were factors that challenged the implementation of remote mental healthcare during the pandemic, as were limited confidentiality, other safety/security issues, and lack of privacy for the patient.

Reviews synthesised findings reflecting feasibility and acceptability and (cost-)effectiveness of tele- or virtual mental health interventions for common mental health disorders although many of these findings were biased and only few were based on quantitative findings from controlled trials.[45] Building an evidence-base of effectiveness of remotely delivered interventions is important for access, adoption, and scalability of mental healthcare in general and in future pandemics or other crises where face-to-face access to mental healthcare is difficult.

DWM NOW AVAILABLE IN UKRAINIAN

The “Doing What Matters in Times of Stress” Online Intervention has now been made publicly available in Ukrainian and English for use as part of the mental health and psychosocial response in humanitarian emergencies, particularly the current crisis in Ukraine: https://www.dwmatters.eu.

The DWM online intervention is a self-help intervention delivered through a mobile-supported website that can be used unguided, or offered with guidance where such a service exists. The intervention has been adapted from a stress management guide called “Doing What Matters in Times of Stress” (DWM) which is part of WHO’s evidence-based Self-Help Plus (SH+) stress management course. The original DWM guide was presented as a printed booklet divided into five chapters covering psychoeducation on stress and its causes, as well as five strategies from Acceptance and Commitment Therapy (ACT) for managing stress. While useful, the format and availability of the DWM guide only on the WHO website limited its usability for emergency responses.



[44] Witteveen, A. B., et al. (2022). Behaviour Research and Therapy, Volume 159, 2022, 104226. https://doi.org/10.1016/j.brat.2022.104226

[45] Hatami, H., et al. (2022). Int J Methods Psychiatr Res. 2022;31:e1924. https://doi.org/10.1002/mpr.1924

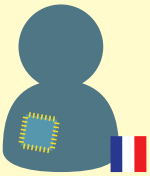
RESPOND partners consulted with the study's target groups to transform DWM into a mobile-friendly website, re-recorded audios and adapted some content to reflect barriers or stress triggers that might affect migrant groups and health and care workers across Europe. This included adding additional exercises to increase motivation to use the guide.

The public availability of the DWM Online Intervention means that people affected by adversity and experiencing high stress can access a stress management self-help tool which is consistent with WHO recommendations. There are plans to make this intervention available in additional languages relevant to the Ukraine response and other humanitarian emergencies over the coming months.

RECRUITMENT STRATEGIES VULNERABLE TARGET GROUPS

HEALTHCARE WORKERS

- PRIMARY CARE FACILITIES
- SPECIALISED CARE FACILITIES
- HOSPITALS
- INTERNAL HEALTHCARE SYSTEM COMMUNICATION CHANNELS
- SOCIAL MEDIA
- COLLEAGUES



PEOPLE IN UNSTABLE HOUSING:

- ACCOMMODATION CENTRES
- MENTAL HEALTH FACILITIES (FOR VULNERABLE PEOPLE)

POLISH LABOUR MIGRANTS:

- SOCIAL MEDIA
- GP'S AND NGO'S
- POLISH SUPERMARKETS
- MUNICIPALITIES
- WEBINARS
- LABOUR AGENCIES
- (LANGUAGE) SCHOOLS

MIGRANTS/REFUGEES/ASYLUM SEEKERS:

- NGO'S
- SUPPORTING ORGANISATIONS
- UNIVERSITY STUDENTS
- GENERAL POPULATION
- PUBLIC HEALTH SERVICES

NURSING HOME STAFF:

- NURSING HOMES
- HEALTHCARE PROFESSIONALS' ASSOCIATIONS AND POLICY AUTHORITIES
- SOCIAL MEDIA

RESPOND RESEARCH AT A GLANCE

RESPOND researchers are preparing to combine longitudinal datasets on COVID-19 mental health in multiple countries, which include pre-pandemic and peri-pandemic assessments. The datasets are currently being transformed locally at each study site, and once this phase is finalised, the harmonised datasets can be analysed.

The project has also investigated how stakeholders select different strategies to manage the effects of COVID-19 on health systems and the population.

This was done using a mixed-methods approach with qualitative interviews to explore the reasoning behind policy decisions as well as a discrete choice experiment which asked what trade-offs policy stakeholders were willing to make for mental health during the management of the pandemic.

A guided version of the DWM self-help smartphone app and PM+ (adapted to the context of the pandemic) are currently being tested among migrants, refugees, and other groups that have been strongly affected by the pandemic.

At all of the study sites, non-specialised helpers have been trained to guide participants in need of mental health support using the new adapted materials. The goal is to see how well the programmes reduce mental health symptoms in these vulnerable groups.

In France, Italy, the Netherlands, and Belgium, the studies are ongoing and participants are still being recruited. In Spain, the trial has been completed among healthcare workers and the data are currently being analysed. A protocol paper was also recently published.[46]

[46] Mediavilla, R., et al. Digital Health. 2022;8. https://doi.org/10.1177/20552076221129084

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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