COVID-19

The Impact of COVID-19 on Mental, Neurological and Substance Use Services in the Americas: Results of a Rapid Assessment

November 2020

PAHO Pan American Health Organization
World Health Organization Regional Office for the Americas
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INTRODUCTION

As of 2 November 2020, the Region of the Americas there have been 20,733,940 confirmed cases of COVID-19 and 642,995 associated deaths *(1)*. Since June 2020, the Region of the Americas has been at the epicenter of the COVID-19 pandemic. By 31 August 2020, six of the ten countries with the highest number of reported cases globally were located in the Americas, although currently trends are decreasing in terms of both cases and deaths *(2).*

The global COVID-19 pandemic is impacting people in a variety of ways. Faced with the challenging new realities of physical distancing, working from home, job insecurity, home-schooling of children, grief and loss, and a lack of physical contact with loved ones and friends, many are experiencing feelings of fear, anxiety, or sadness at some point in time.

Major stressors such as the COVID-19 pandemic represent risk factors for the development, exacerbation and relapse of a range of mental, neurological and substance use (MNS) disorders, particularly in the most vulnerable groups. National studies from the Region of the Americas, report increases in distress, depression, anxiety, and insomnia, among other conditions, as a result of the COVID-19 pandemic *(3-5).* Furthermore, COVID-19 infections are associated with neurological and mental complications *(6).*

Mental health systems, often under-resourced prior to the pandemic, have been further challenged with meeting the increased demand for essential mental health and psychosocial support (MHPSS) services brought on by the direct and indirect consequences of COVID-19.

In order to understand the impact of the pandemic on service delivery for MNS disorders, a survey developed by the World Health Organization (WHO) and implemented by the WHO and the Pan American Health Organization (PAHO), was sent to designated mental health focal points in ministries of health of all WHO Member States. The survey assessed the existence and funding of MHPSS plans, the presence and composition of MHPSS coordination platforms, the degree of continuity and causes of disruption of different MNS services, the approaches used to overcome these disruptions, and surveillance mechanisms and research on MNS data.

This report is based on the results of this survey, outlined in the recent WHO publication *The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment,* published on 5 October 2020. It uses data submitted by PAHO Member States in response to the survey to provide an overview of the impact of COVID-19 on MNS services in the Region of the Americas. This information will help to inform planning and responses to mitigate the effects of the pandemic by countries of the Region.

SURVEY METHODS

The WHO Department of Mental Health and Substance Use developed the survey "Rapid assessment of service delivery for Mental, Neurological and Substance Use Disorders during the COVID-19 Pandemic" in collaboration with the six WHO regional offices. The survey adapted the structure applied in the WHO Rapid assessment of service delivery for Noncommunicable Diseases during the COVID-19 pandemic to evaluate information needs for MNS disorders. In the Americas, the survey was applied in English, French, Portuguese, and Spanish.

Ministries of health were requested through WHO regional and country offices to appoint a focal point to complete the survey. The survey used the web-based LimeSurvey platform and countries were strongly encouraged to use this method for submission. An offline version of the questionnaire was also made available whenever requested. Box 1 provides the thematic areas and survey questions, and the complete questionnaire can be found in Annex 1 on page 23 of *The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment:* *https://www.who.int/publications/i/item/978924012455*.

Responses were received between 15 June and 15 August 2020. When a completed questionnaire was received, a quality assurance process was conducted to assess its completeness as well as inconsistences. Respondents were re-contacted and clarifications sought and corrections made as appropriate. Data from each country were downloaded directly from the web-based platform into a spreadsheet and analyzed using the Statistical Package for the Social Sciences (SPSS) software. The questionnaire information was aggregated for analyses, and where cases or case studies identifying specific countries were used, respondents were contacted to request appropriate permission.

BOX 1. Survey thematic areas and questions

Mental health and psychosocial support

Q1 Is MHPSS response part of the national COVID-19 response plan?

Q2 Do multisectoral MHPSS coordination platforms for COVID-19 exist?

Mental, neurological and substance use services during the COVID-19 pandemic

Q3 Is ensuring continuity of services for MNS disorders included in the list of essential health services as part of your country's response during COVID-19?

Q4 During the COVID-19 pandemic, what are the government policies for access to essential services for MNS disorders at primary, secondary and tertiary care levels?

Q5 Which of the following interventions/services related to MNS disorders have been disrupted due to COVID-19?

Q6 What are the leading causes of this disruption(s)?

Q7 What are the approaches used to overcome these disruptions?

Surveillance and research concerning MNS disorders during the COVID-19 pandemic

Q8 Is the ministry of health collecting or collating data on MNS disorders or manifestations in people with COVID-19?

Q9 Is there a planned or ongoing study related to the impact of COVID-19 on mental health/brain health/substance use in the country (by government or anyone else, whether stand-alone or as part of a broader survey)?

Certain limitations should be considered when examining the results of this rapid assessment. There are potential limitations with the data concerning judgements often being made by a single designated respondent. A further limitation is that the information provided may represent a country at the national level, while not capturing variability within countries.

RESULTS

Participating Countries

The survey was sent to 35 PAHO Member States. Of these, 29 countries (83.0%) responded: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Cuba, Dominican Republic, Ecuador, Grenada, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, St. Lucia, Suriname, Trinidad and Tobago, United States of America, Uruguay, and Venezuela. Additionally, four PAHO territories responded: Aruba, Bermuda, British Virgin Islands, Cayman Islands, and Curacao.

MHPSS AS PART OF COVID RESPONSE PLANS

A notable majority, 27 of 29 countries (93%) reported that MHPSS was part of their national COVID-19 response plans (Fig. 1). However, only 7% (2 of 29) of these countries ensured full funding for the MHPSS response in their government budgets for these plans, while 55% (16 of 29 countries) responded that they had secured partial funding, and 31% (9 countries) reported having no funding for MHPSS activities (Fig. 2). The lack of funding by countries is a major concern and may reflect the inability of these countries to implement their existing COVID-19 MHPSS components of national plans.

Figure 1. MHPPS as part of the COVID-19 response plans (n=29)

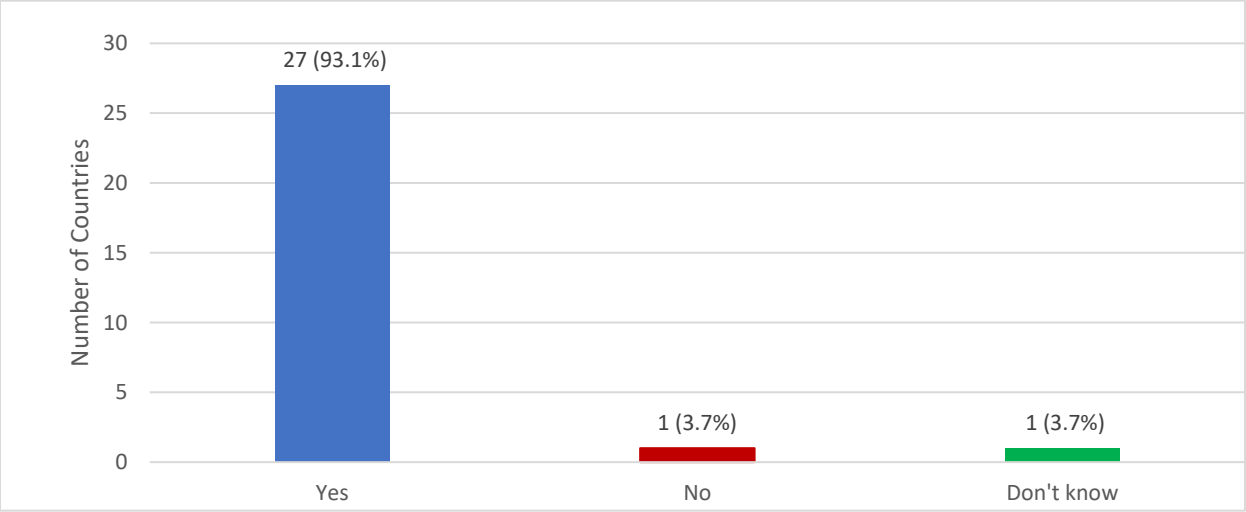
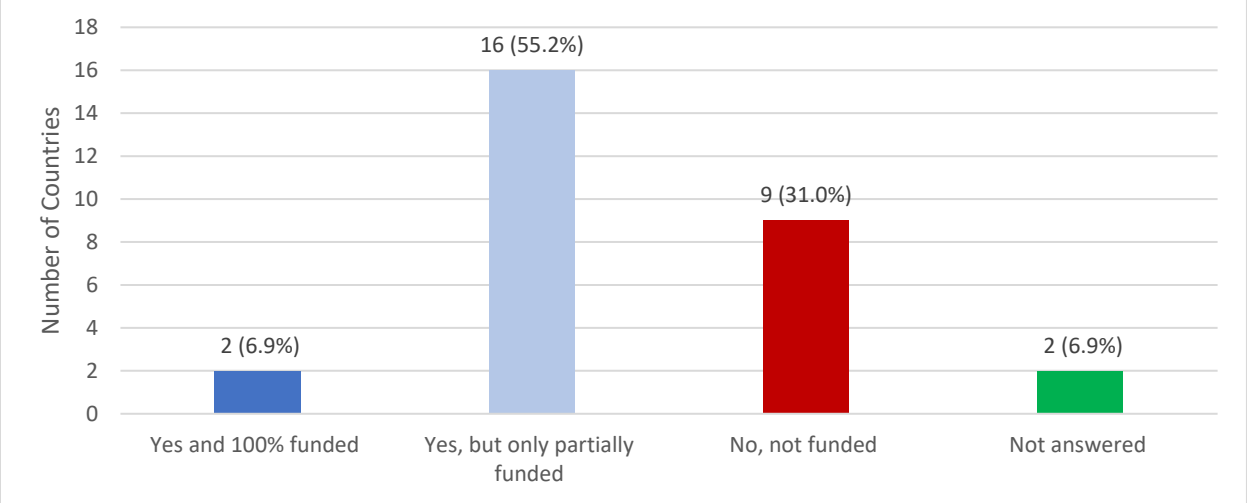


Figure 2. Funding for MHPSS as part of the COVID-19 response plans (n=29)

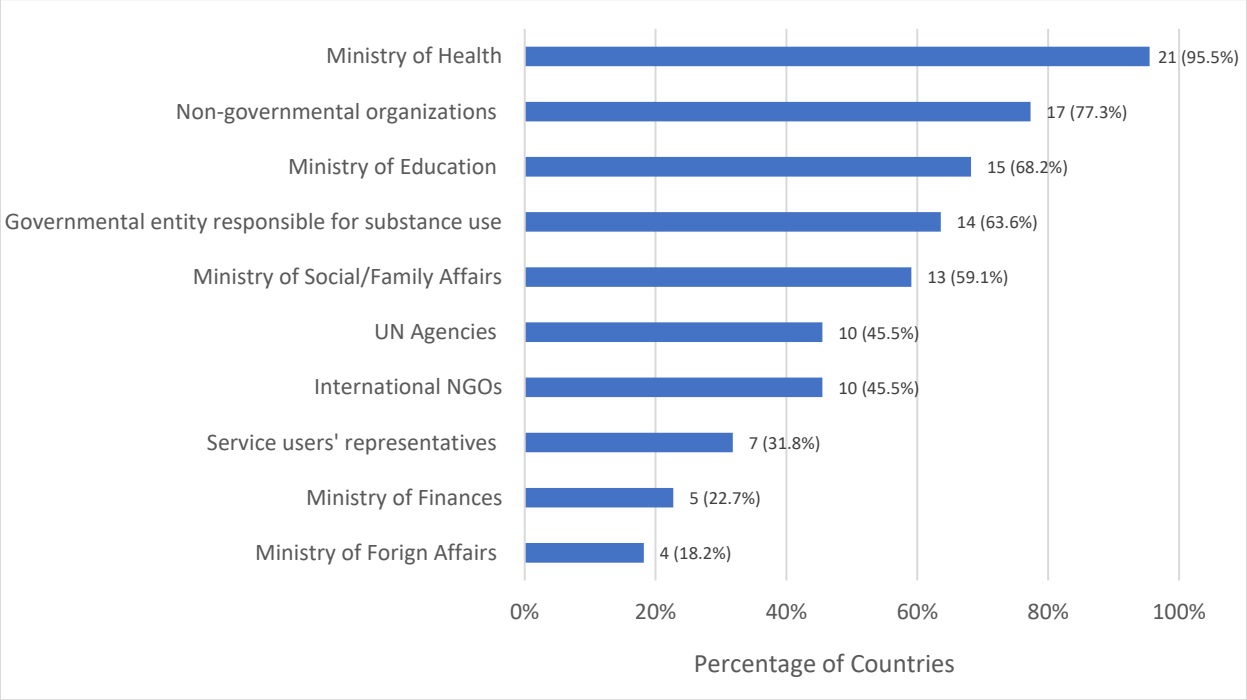


MHPSS MULTISECTORAL COORDINATION

Twenty two of 29 countries (76%) reported having a multisectoral MHPSS coordination platform for the COVID-19 response. Of 22 countries that reported on the members of their

MHPSS multisectoral coordination platform, 21 (95.5%) included the ministry of health, 17 (77.3%) included nongovernmental organizations (NGOs), and 15 (68.2%) included the ministry of education as members. This positive finding shows the commitment of a number of relevant line actors to MHPSS. Seven countries (24.2%) reported having no MHPSS coordination platform. This may reflect a lack of coordination of the MHPSS response in these countries, or a limited number of MHPSS multisectoral actors and/or approaches. While the results show a promising and widespread existence of MHPSS platforms in a majority of countries, the engagement of representatives of service user groups was reported in fewer than 7 (31.8%) country platforms and engagement with the ministry of finance in only 22.7% (5 countries) (Fig. 3).

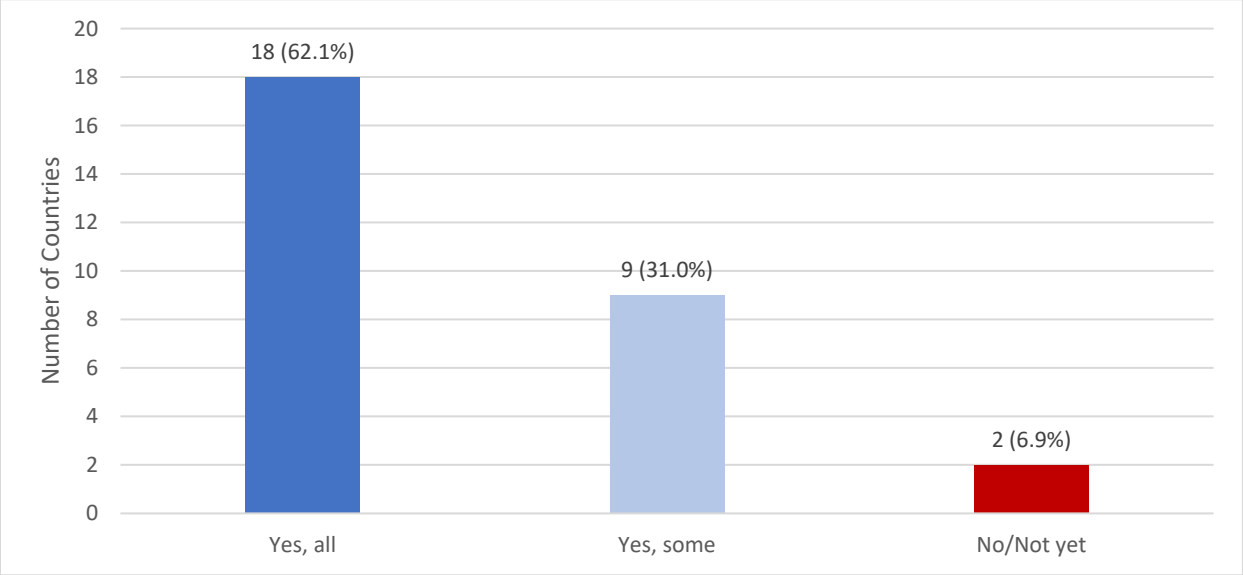
Figure 3. Members of MHPSS multisectoral coordination platforms (n=22)



INCLUSION OF MHPSS WITHIN THE LIST OF ESSENTIAL HEALTH SERVICES (EHS)

Of the 29 countries that responded to the survey, 18 (62.2%) reported the “inclusion of all services for MNS disorders in the list of essential health services” as part of their country’s response during the COVID-19 pandemic, while 9 (31%) countries reported inclusion of some MNS services; 2 (6.9%) reported no inclusion of MNS services within essential health services (Fig. 4).

Figure 4. Countries including services for MNS disorders in the list of essential health services (n=29)



POLICIES FOR ACCESS TO ESSENTIAL SERVICES FOR MNS DISORDERS

Countries were asked about national-level governmental policies on access to essential services for MNS disorders. These included 10 settings and categories of service for MNS disorders: inpatient and outpatient services at mental hospitals; outpatient services, inpatient psychiatric and neurological units as well as treatment of substance use disorders at general hospitals; and primary health care, residential, home and day care services at community level. In the analysis, countries were classified into three groups: (i) “all types of services fully open” when every existing service was reported as being fully open; (ii) “one or more services disrupted” when at least one of the 10 services examined was reported as being either fully or partially closed; and (iii) “all types of services fully closed” if all existing services were reported as being fully closed.

No country reported full closure of all 10 categories of service for MNS disorders as described above, nor did any country in the Region report having all services fully open. When looking at each of the 10 different categories of services, there were marked differences in the type of service affected by closure, with outpatient services in both mental and general hospitals as well as some types community-based services (specifically home care and day care services) being the ones most affected (Fig. 5).

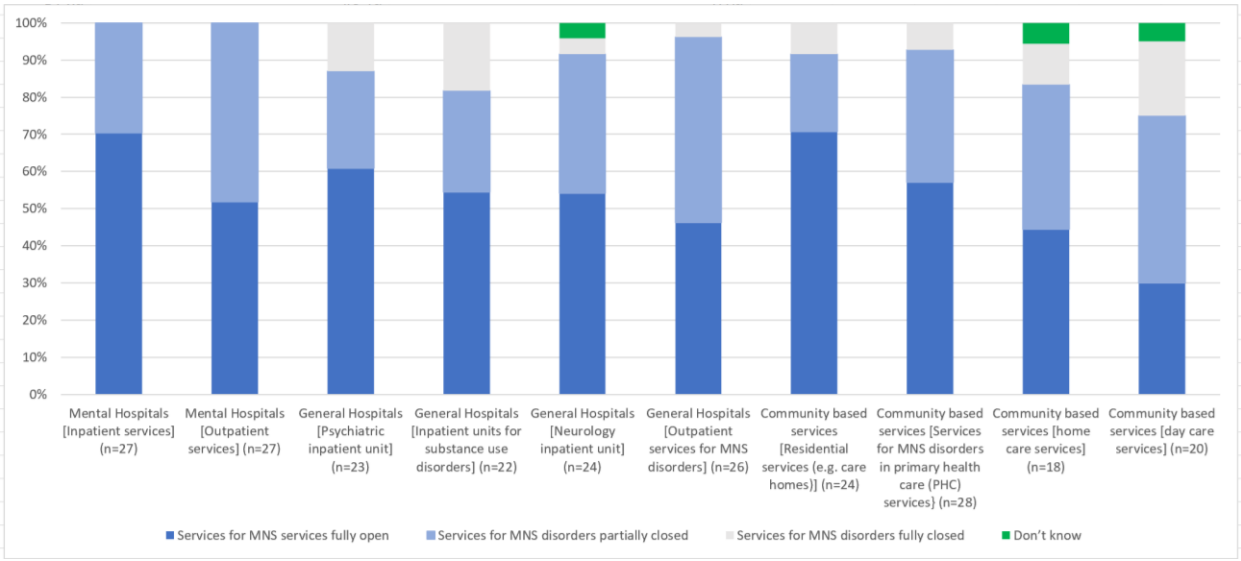
Nineteen of 27 (70.4%) countries reported that inpatient services at mental hospitals remained fully open, and 14 of 23 countries (60.9%) reported that psychiatric inpatient units in general hospitals were fully open. Neurology inpatient units, uniquely dealing with a wide range of life-saving interventions including for COVID-19 manifestations, were reported as being partially closed in 9 of 24 countries (37.5%). Inpatient services for substance use disorders were the

most affected among all mental health inpatient services, with services fully closed in 4 of 22 countries (18.2%) and partially closed in 6 of 22 countries (27.3%).

For community-based services, residential services were the least affected; they were reported open by 17 of 24 countries (70.8%). Day care was significantly disrupted, and was either partially or fully closed in 13 of 28 (65%) of countries that responded.

Outpatient services in mental hospitals and in general hospitals were fully open in 14 of 27 countries (51.9%) and 12 of 26 countries (46.2%) respectively, while outpatient services in mental hospitals were partially closed in 13 of 27 countries (48.1%) and outpatient services in general hospitals were partially closed in 13 of 26 countries (50%).

Figure 5. Policies for access to essential services for MNS disorders, by setting and categories of services



DISRUPTION OF MNS-RELATED INTERVENTIONS/SERVICES

Countries were also asked about the level of disruption of 16 specific MNS-related interventions or services (Table 1), defining complete disruption as more than 50% of users not being served as usual and partial disruption as between 5% and 50% of users not being served as usual. The level of disruption combined across the 16 specific MNS-related interventions/services was also determined; "disruption in at least 75% of MNS-related interventions/services" was defined as 12 to 16 of the specific MNS-related interventions or services being reported as either completely or partially disrupted.

Table 1. List of specific MNS-related interventions/services

a. Management of emergency MNS manifestations (including status epilepticus, delirium, severe substance withdrawal syndromes)
b. Psychotherapy/counselling/psychosocial interventions for MNS disorders
c. Medicines for MNS disorders
d. Psychosocial interventions for caregivers of people with MNS disorders
e. Home or community outreach services (including social care services) for people with MNS disorders
f. Mental health interventions during antenatal and postnatal period
g. Services for children and adolescents with mental health conditions or disabilities, including developmental disabilities
h. Services for older adults with mental health conditions or disabilities, including dementia
i. Diagnostic and laboratory services for people with MNS disorders
j. Surgery for neurological disorders (e.g. epilepsy)
k. School mental health programmes
l. Work-related mental health programmes
m. Suicide prevention programmes
n. Overdose prevention and management programmes (e.g. naloxone distribution)
o. Critical harm reduction services (e.g. needle exchange programmes, outreach services)
p. Opioid agonist maintenance treatment of opioid dependence (with methadone or buprenorphine)

In 7 of 28 (25%) countries, at least 75% of MNS-related services were reported as being completely or partially disrupted.

Importantly, some life-saving emergency and essential MNS services were reported as being disrupted. Eleven of 25 countries (44%) reported disruption in the management of MNS emergencies (including status epilepticus, delirium, severe substance withdrawal syndromes), and 11 of 27 countries (40.7%) reported disruption of medications for people with MNS disorders (Fig. 7). Mental health prevention and promotion services and programs were most severely affected and disrupted. 80% of countries (20 in 25) experienced complete or partial disruption of school mental health programs, and 80% (16 of 20 countries that responded) reported that workplace mental health services were completely or partially disrupted. Other MNS-related interventions/services with high rates of complete disruption were surgery for neurological disorders (31.8%, 7 of 22 countries) and critical harm reduction services (50%, 8 of 16 countries).

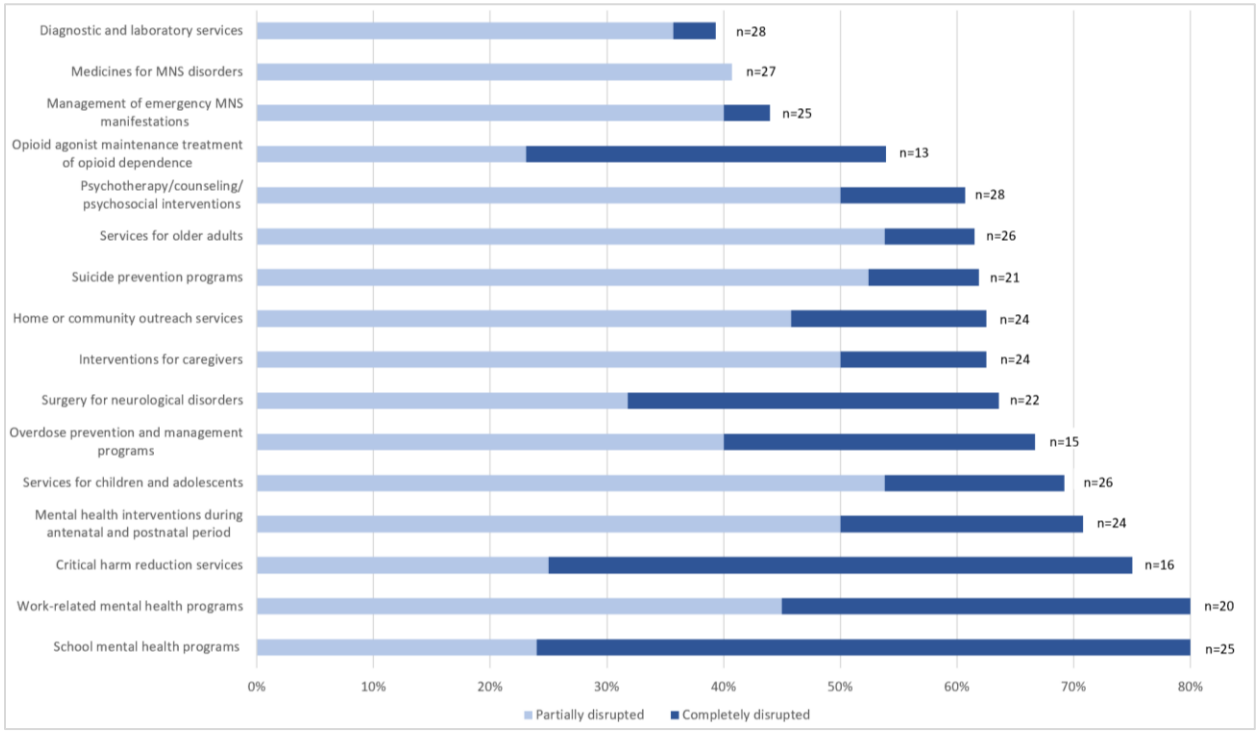
More than half of countries (17 of 28; 60.7%) reported that psychotherapy and counselling services were partially or completely disrupted, while 11 of 28 countries (39.3%) reported disruptions in diagnostic and laboratory services at mental health facilities. Laboratory

monitoring of some psychotropic medications, such as clozapine and lithium, is an essential part of management for severe mental health conditions.

At a time when they are highly needed, mental health services for the most vulnerable were reported to be disrupted. Mental health antenatal and postnatal interventions and services for children and adolescents with mental health conditions or disabilities, including developmental disabilities, were the most significantly impacted. Twelve of 24 countries (50%) reported that antenatal or postnatal mental health services were either partially or fully disrupted. Only around one quarter of countries (8 of 26; 27.6%) reported that MNS services for children and adolescents were not disrupted.

Among interventions or services related to substance use, opioid agonist maintenance treatment for opioid dependence was completely disrupted in 4 of 13 (30.8%) countries and partially disrupted in 3 (23.1%). In 15 countries that responded, overdose prevention and management programs were completely disrupted in 4 (26.7%) and partially disrupted in 6 (40%).

Figure 7. Disruptions of MNS-related interventions/services due to COVID-19



CAUSES OF DISRUPTIONS

The survey also included information about the main causes of the reported disruptions. Among the 29 countries that responded to the survey, the leading causes of service disruptions

were a decrease in outpatient attendance due to patients not presenting to health facilities (20 countries, 69%), travel restrictions hindering access to health facilities (14 countries, 48.3%) and a decrease in inpatient care due to cancellation of elective care (13 countries, 44.8%) (Table 2). Travel restrictions, together with limited availability and closure of community-based mental health services closer to where people live, can potentially lead to adverse outcomes for people with MNS disorders.

An insufficient number of staff to provide services was reported as a reason for service disruptions in 10 countries (34.5%), while the redeployment of mental health care staff to support COVID-19 facilities disrupted services in 8 countries (27.6%). In 5 countries (17.2%), disruptions resulted form the use of mental health facilities as COVID-19 quarantine or treatment facilities. Eight countries (27.6%), reported insufficient supplies of personal protective equipment (PPE) available to health care providers at mental health facilities. Additionally, limited supplies of health products were reported as a cause of service disruption in 8 countries (27.6%).

Table 2. Leading causes of disruptions in MNS-related interventions/services (n=29)

Causes	Percentage of Countries
Decrease in outpatient volume due to patients not presenting	69.0%
Travel restrictions hindering access to the health facilities for patients	48.3%
Decrease in inpatient volume due to cancellation of elective care	44.8%
Closure of outpatient disease specific consultation clinics as per health authority directive	41.4%
Closure of outpatient services as per health authority directive	37.9%
Insufficient staff to provide services	34.5%
Unavailability/Stock out of essential medicines, medical diagnostics or other health products at health facilities	27.6%
Insufficient Personal Protective Equipment (PPE) available for health care providers to provide services	27.6%
Clinical staff related to mental, neurological and substance use disorders deployed to provide COVID- 19 clinical management or emergency support	27.6%
Inpatient services/hospital beds not available	17.2%
The clinical set up has been designated as COVID-19 care facility	17.2%
Closure of population level programs as per health authority directive	13.8%

APPROACHES TO OVERCOME DISRUPTIONS

Countries responded via a checklist on approaches being used to overcome service disruptions for the management of MNS disorders and to provide mental health and psychosocial support, and responses could include multiple options. A number of measures were used to respond to service disruptions, with the most frequent approaches being telemedicine/teletherapy to replace in-person consultations in 24 of 29 countries that reported (82.8%). This included

remote contact using the telephone or video conferencing. Other measures included helplines for MHPSS, reported by 23 countries (79.3%) and specific measures for infection prevention and control in mental health services, reported by 21 countries (72.4%) (Table 3).

Interventions such as task shifting/role delegation, building the capacity of general health workers on basic psychosocial skills, and community outreach, seem to have been underutilized as intervention modalities compared with the use of remote support methods. Recruitment of additional counsellors and task shifting/role delegation are among the least reported approaches (reported by only 4 countries (13.8%) and 6 countries (20.7%) respectively).

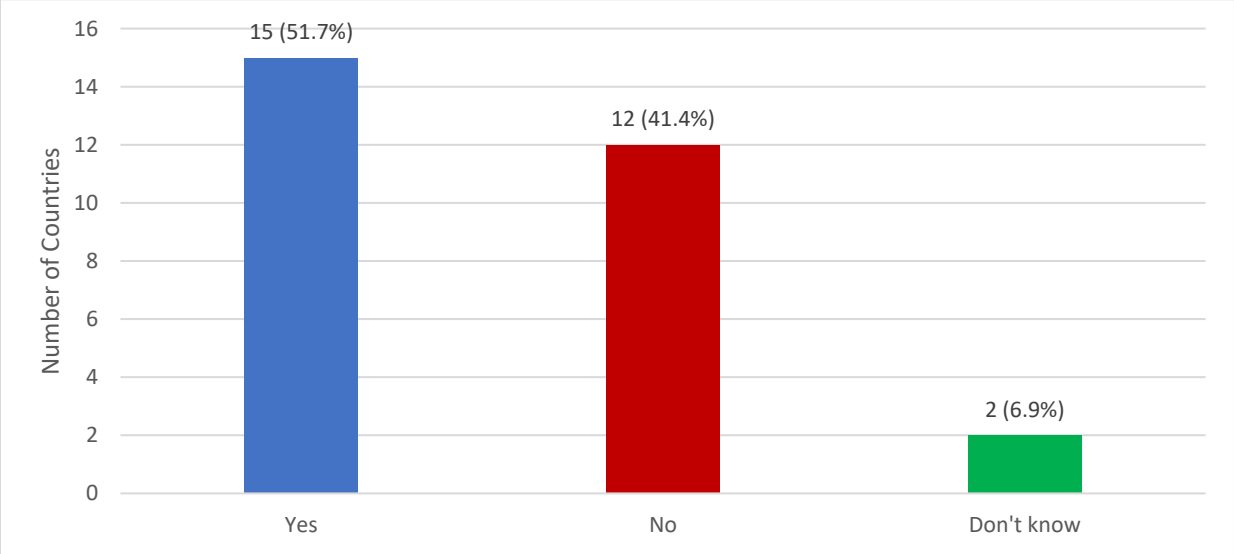
Table 3. Approaches for overcoming disruptions in MNS-related intervention/services (n=29)

Approaches	Percentage of Countries
Tele-medicine /tele-therapy deployment to replace in person consultations	82.8%
Helplines established for mental health and psychosocial support	79.3%
Implementation of specific measures for infection prevention and control in mental health services	72.4%
Health care providers working in COVID-19 treatment centres trained in basic psychosocial skills	62.1%
Self-help or digital format of psychological interventions	58.6%
Triaging to identify priorities	51.7%
Novel supply chain and/or dispensing approaches through other channels for medicines for mental, neurological and substance use disorders	34.5%
Home or community outreach services	31.0%
Redirection of patients to alternate health care facilities or discharge to their homes/families	31.0%
Task shifting / role delegation	20.7%
Recruitment of additional counsellors	13.8%

SURVEILLANCE AND RESEARCH CONCERNING MNS DISORDERS DURING THE COVID-19 PANDEMIC

Information, evidence and research are critical ingredients for appropriate mental health planning and response during any emergency, especially in novel situations such as the COVID-19 pandemic. The availability of timely and relevant information via surveillance frameworks and the generation of new knowledge through research, guide the development of evidence-based plans and actions and help to identify gaps in service provision and necessary improvements. Data collection on MNS disorders or manifestations is needed to monitor trends and improve the quality of services during the pandemic through informed decision making. Ministries of health in 15 of 29 countries (51.7%) reported that data were being collected on MNS disorders in people with COVID-19 (Fig. 8).

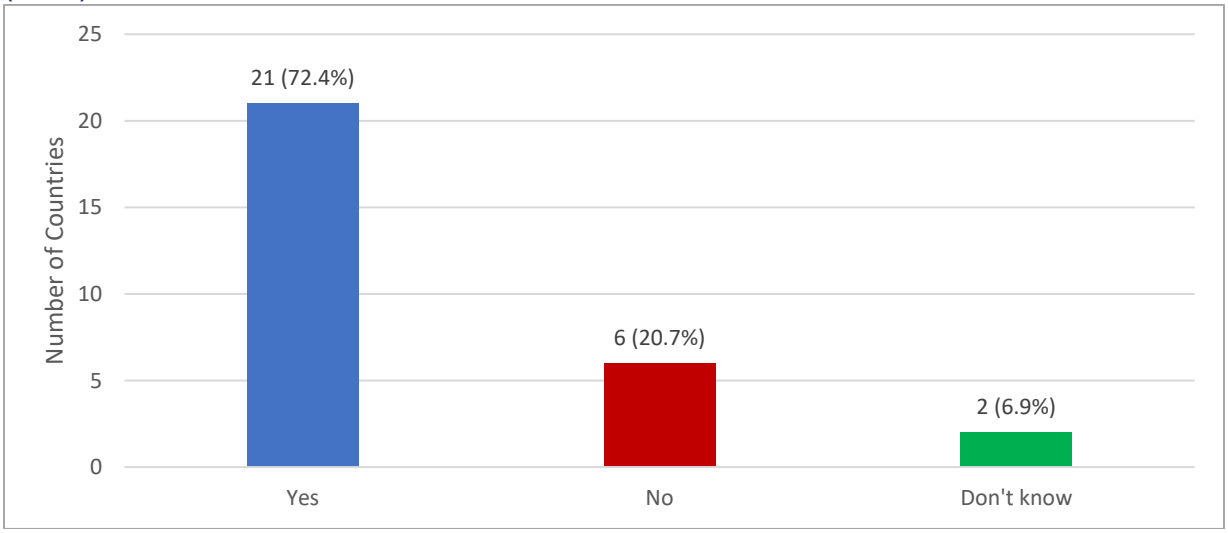
Figure 8. Ministry of Health collecting or collating data on mental, neurological and substance use disorders or manifestations in people with COVID-19 (n=29)



STUDIES RELATED TO IMPACT OF COVID-19

Countries were also requested to report on any planned or ongoing studies related to the impact of COVID-19 on mental health/brain health/substance use, either by the government or other stakeholders. Seventy two percent of countries (72.4%; 21 of 29) reported current studies related to the impact of COVID-19 on mental health, brain health or substance use (Fig. 9).

Figure 9. Studies related to impact of COVID-19 on mental health/brain health/substance use (n=29)



CONCLUSION

The results of this survey clearly indicate that COVID-19 has had a significant impact on MNS services in the Region of the Americas, while the types of MNS services and the degree to which they have been disrupted vary greatly. Most countries reported that outpatient services as well as community-based services (specifically home and day care services) were adversely affected to a significant degree. Additionally, MNS-related services/interventions serving vulnerable groups such as children and adolescents and pregnant women and new mothers, also experienced severe disruptions.

Importantly, the large majority of countries in the Americas incorporate MHPSS within their COVID-19 response plans; however, funding limitations and the lack of the necessary human resources remain a major barrier for most countries. And while most countries in the Region have a MHPSS multisectoral coordination platform for COVID-19, its membership often lacks the representation of service users as well as key government ministries, such as ministries of finance.

Countries are using innovative approaches such as telemedicine and helplines to meet the demand for MHPSS services during the COVID-19 pandemic. This survey illustrates that task sharing and home and community outreach services could be better utilized, and there is need for a more efficient use of scarce resources. Furthermore, almost half of all ministries of health in the Region are not collecting or collating data on MNS disorders or manifestations in people with COVID-19, an essential component of the MHPSS response to the pandemic. Comprehensive strengthening of mental health information systems is also a key step in creating strong and sustainable mental health systems for the future.

MHPSS is considered as a cornerstone in emergencies and has also been identified as an essential component within the public health response for the COVID-19 pandemic. MHPSS strategies and interventions should be the product of intersectoral coordination and based on evidence and a human rights approach. MHPSS Interventions during the COVID-19 pandemic should target the needs of different groups and ensure the inclusion of groups in vulnerable conditions. Services and communication on mental health must be adapted to the specific and diverse sociocultural contexts in our Region and take into account the high prevalence and burden of mental health conditions. Therefore, it is critical that immediate efforts are made to scale up the mental health services response to address the crisis of the pandemic and the post-pandemic period.

Finally, monitoring and evaluation of all MHPSS activities during the COVID-19 pandemic is crucial to maximize their effectiveness. For more information, please consult PAHO's *COVID-19 Recommended Interventions in Mental Health and Psychosocial Support (MHPSS) During the Pandemic*.[i]

[i] COVID-19 Recommended Interventions in Mental Health and Psychosocial Support (MHPSS) During the Pandemic. Washington, D.C.: Pan American Health Organization; 2020. Available at: https://iris.paho.org/handle/10665.2/52485

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