

# The impact of COVID-19 on mental, neurological and substance use services:

results of a rapid assessment





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# Abbreviations

<b>AFR</b>	WHO African Region
<b>AMR</b>	WHO Region for the Americas
<b>EMR</b>	WHO Eastern Mediterranean Region
<b>EUR</b>	WHO European Region
<b>IASC</b>	Inter-Agency Standing Committee
<b>MHPSS</b>	Mental health and psychosocial support
<b>MNS</b>	Mental, neurological and substance use
<b>NCD</b>	Noncommunicable disease
<b>NGO</b>	Nongovernmental organization
<b>PPE</b>	Personal protective equipment
<b>SEAR</b>	WHO South-East Asia Region
<b>WB</b>	World Bank
<b>WHO</b>	World Health Organization
<b>WPR</b>	WHO Western Pacific Region

# Executive summary

The World Health Organization (WHO) has identified mental health as an integral component of the COVID-19 response. Its rapid assessment of service delivery for mental, neurological and substance use (MNS) disorders during the COVID-19 pandemic, on which this report is based, is the first attempt to measure the impact of the pandemic on such services at a global level. The data were collected through a web-based survey completed by mental health focal points at ministries of health between June and August 2020. The questionnaire covered the existence and funding of mental health and psychosocial support (MHPSS) plans, the presence and composition of MHPSS coordination platforms, the degree of continuation and causes of disruption of different MNS services, the approaches used to overcome these disruptions, and surveillance mechanisms and research on MNS data.

In total, 130 (67%) WHO Member States, across all WHO regions, submitted answers to the survey. Data were disaggregated by region, income group and stage of transmission of COVID-19.

The vast majority, 116 or 89% of responding countries, reported that MHPSS response is part of their national COVID-19 response plans. However, only 17% of these countries have ensured full additional funding for MHPSS covering all activities.

Two-thirds (65%) of responding countries have a multisectoral MHPSS coordination platform for COVID-19 response, and more than 65% of these countries include the ministries of health, social/family affairs and education and also nongovernmental organizations as part of these platforms.

Almost half (51%) of responding countries reported that ensuring the continuity of all MNS services was included in the list of essential health services in their national COVID-19 response plan, while 40% of countries reported the inclusion of some MNS services in the list of essential health services in their national response plan.

To understand government policies on access to a range of MNS services, the status of closure of existing services was checked across different categories and settings. A total of 10 types of services for MNS disorders were included, such as 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 services for MNS disorders at primary health care, residential, home and day care services at community level. No country reported a full closure of all services; but in only 7% of responding countries were all services fully open, with 93% of countries reported disruptions in one or more of their services for MNS disorders.

There were differences in the types of service affected by closure, with outpatient services in mental and general hospitals as well as community-based services predominantly more affected. For example, community-based services were more impacted compared with inpatient facilities, with full or partial closure in more than 40% of countries and home care and day care services reaching levels of full or partial closure in 60–70% of countries.

Countries were also asked to report on disruption (complete or partial) of delivery of specific MNS interventions. For the purpose of the survey, complete disruption was defined as more than 50% of users not served as usual, and partial disruption as between 5% and 50% of users not served as usual. One-third (33%) of responding countries reported complete or partial disruption across at least 75% of



specific MNS-related interventions/services. This level of disruption was the highest within countries in the community transmission stage of COVID-19 (44%).

An important finding is that some life-saving emergency and essential MNS services were reported as being disrupted; 35% of countries reported some disruption of management of emergency MNS manifestations (including status epilepticus, delirium and severe substance withdrawal syndromes) and 30% reported disruption in supply of medications for people with MNS disorders.

Prevention and promotion mental health services and programmes were most severely affected. Around three-quarters of school mental health or workplace mental health services were wholly or partially disrupted. Approximately only 30% of mental health services for children and adolescents or for older adults were available with no disruption, and fewer than 40% of antenatal or postnatal mental health services were not disrupted. Almost 60% of all psychotherapy and counselling services were reported as partially disrupted. Overdose prevention and management programmes and critical harm reduction services were disrupted in more than 50% of countries.

The main causes of disruption were identified as a decrease in outpatient volume due to patients not presenting, travel restrictions hindering access to health facilities for patients and a decrease in inpatient volume due to cancellation of elective care.

Community-based services and mental health prevention and promotion programmes, already limited in availability, are reported to be disrupted at a time when society needs them the most due to the adverse mental health impacts COVID-19.

Countries have responded to the disruption of MNS services in multiple ways. Some 70% of countries have responded by using telemedicine/teletherapy to replace in-person consultations (this included use of any remote contact, such as telephone or video conferencing). Other measures that were reported include helplines for MHPSS (68%) and specific measures for infection prevention and control in mental health services (65%). Training in basic psychosocial skills for health care providers working in COVID-19 treatment centres was the most common approach in low-income countries (60%). Generally speaking, however, interventions such as task sharing through building the capacity of general health workers seem to be underutilized in many countries (38%).

Slightly more than half of responding countries (53%) were reported to be collecting data on MNS disorders or manifestations in people with COVID-19, and two-thirds (66%) of countries reported ongoing or planned studies related to the impact of COVID-19 on mental health. A gap was identified in the areas of substance use and neurology research related to the pandemic.

This report provides key insights into the extent of disruption of MNS services and measures being adopted in response. Certain limitations should be kept in mind when examining the results of this rapid assessment; these include the limitations associated with self-reported data, particularly concerning judgements often being made by a single focal point.

The survey highlights the need to strengthen the monitoring of changes in service availability, delivery and utilization at country level, and to establish informed decision making on required adaptations and strategies for MNS services during the pandemic. WHO has published *Maintaining essential health services: operational guidance for the COVID-19 context (1)* which should be considered when making specific adaptations and considerations for safe delivery and restoration of MNS services, including emergency acute care and outpatient care guidance.

## Key messages

- **MHPSS is recognized by countries as an integral component of their COVID-19 response.** Almost all countries reported that MHPSS is part of their national COVID-19 response plans. Two-thirds of countries have a multisectoral MHPSS coordination platform for COVID-19 response; however, most countries are lacking additional funding for MHPSS response plans.
- **Disruption of essential MNS interventions/services are reported in many countries.** No country reported full closure of all MNS services, but a majority experienced some disruptions, including disruptions of essential, emergency and life-saving MNS services. Community-based outpatient services and prevention and promotion of mental health services, as well as services for specific age groups such as older adults and children, were among the most severely disrupted.
- **Learned lessons are emerging.** Countries are responding to the disruption of MNS services in multiple innovative ways, including telemedicine, teletherapy interventions, hotlines and training for health care providers. Notable differences in responses to disruptions were observed between high-income and low-income countries.
- **More data collection and research are required.** Almost half of responding countries are not collecting any data on MNS disorders or manifestations in people with COVID-19, and fewer than one-tenth of countries are researching COVID-19 effects on brain health.

# Introduction

Throughout the world, people are affected by MNS disorders, at staggering rates. In many contexts, appropriate and evidence-based treatment is lacking and people with mental health conditions experience severe human rights violations, discrimination and stigma. In conflict and other humanitarian settings, where mental health conditions are especially common, these issues are even more pronounced. Yet, despite this, investment in mental health remains extremely limited, characterized by a lack of resources and services and a large treatment gap, especially in resource-limited settings (2–4).

There are direct and indirect consequences of COVID-19 on mental health conditions, leading to increased demand for services. In addition, health systems around the world are challenged, leading to the disruption of delivery of essential services, especially for the most vulnerable populations. Major stressors such as the COVID-19 pandemic represent risk factors for the development, exacerbation and relapse of a range of MNS disorders. Furthermore, COVID-19 itself is associated with neurological and mental complications, such as delirium/encephalopathy, agitation, stroke, insomnia, loss of sense of taste and smell, anxiety, depression and Guillain-Barré syndrome (5–8).

Pre-existing MNS disorders increase the risk of becoming severely ill or of death, or of having long-term complications due to COVID-19 (9, 10). For example, people with dementia have a higher susceptibility to COVID-19 and higher rates of death associated with the disease (11–13). Many people are afraid of infection, of dying and of losing family members. People have been physically distanced from their social support networks, and many have lost those they love (14). Millions of people are facing economic turmoil, having lost or being at risk of losing their incomes and livelihoods (15). Many may be facing increased levels of alcohol and drug use or are engaging in addictive behaviours (16). There may be long-term mental or neurological consequences following COVID-19 infection, thus necessitating follow-up of patients and further research in this area (17–19).

The disruption of care for MNS disorders can be life-threatening, for example for treatment for epilepsy, unaddressed suicide risk, unmanaged opioid dependence leading to overdose, and severe alcohol withdrawal syndromes (20, 21). Additionally, not managing MNS disorders will hinder people's recovery from COVID-19 through the potential inability of those living with mental disorders (either before, during or after the pandemic) to work or being trapped in a cycle of poor mental health and poor reintegration into communities (22).

WHO has identified mental health as an integral component in COVID-19 response (1, 23). MHPSS should be treated as an integral and cross-cutting component in public health emergency responses as part of a range of pillars/domains, such as case management, risk communication and community engagement, the continuation of health services, coordination within countries, and operations (e.g. staff support). Mental health is an integral part of universal health coverage and is crucial to the overall recovery of individuals, communities and countries after emergencies.

Tracking access to health services during the pandemic is critical in order to achieve the optimal balance between fighting COVID-19 and maintaining these services. WHO's recent pulse survey on continuity of essential health services during the pandemic provides insights and perspectives on its impact on up to 25 essential health services in countries and how countries are adapting strategies to maintain essential services (24).

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<sup>1</sup> Mental health conditions include mental, neurological and substance use (MNS) disorders, suicide risk and associated psychosocial, cognitive and intellectual disabilities.

In order to further understand the impact of COVID-19 on service delivery for MNS disorders, a specific survey was sent to designated mental health focal points in ministries of health of all Member States across six WHO regions. This rapid assessment of service delivery is the first attempt to measure the impact of the COVID-19 pandemic on MNS services at a global level. The survey covered the existence and funding of MHPSS plans, the presence and composition of MHPSS coordination platforms, the degree of continuation and causes of disruption of different MNS services, the approaches used to overcome these disruptions, and surveillance mechanisms and research on MNS data.

The results of the survey provide an overview of the impact of COVID-19 on MNS services and understanding of the reasons for disruptions. This information will inform planning and response to mitigate the effects by countries and regions.

## Methodology

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 followed the template of a recent WHO survey on the impact of COVID-19 on noncommunicable disease (NCD) resources and services (25), but adapted its structure and scope to mental health. The survey was drafted in English and translated into Chinese, French, Portuguese, Russian and Spanish, and was launched in mid-June 2020.

Ministries of health were requested through WHO regional and country offices to appoint a focal point for completion of the survey. The focal point was encouraged to contact other experts in the country to obtain information relevant to answering the survey questions. Close contact with the focal points was maintained during their nomination and through submission of the questionnaire. WHO staff members in headquarters, regional and country offices were available to respond to enquiries, to provide additional guidance and to assist focal points in completing the survey questionnaire. In some regions and as requested, webinars were organized with focal points to provide further information on the survey and to respond to frequently asked questions. The survey was web-based, using the LimeSurvey platform, and countries were strongly encouraged to use this method for submission. A Microsoft Word version of the questionnaire was made available whenever requested. Box 1 provides the thematic areas and questions of the survey. The full questionnaire is available in Annex 1.

Responses were received between 15 June and 15 August 2020, though a handful of responses were accepted after this date (for the complete list of responding countries, see Annex 2). Fifty percent of responses were received during the month of July. When the WHO Secretariat received a completed questionnaire, the team reviewed it for incomplete and inconsistent answers. Respondents were re-contacted and asked for clarification and corrections as appropriate, to ensure data quality. Data from the national questionnaire were downloaded directly from the web-based platform into a spreadsheet and analysed using Statistical Package for the Social Sciences (SPSS) software.

## 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)?

The analysis presented in this report is based on unweighted country data. Data were analysed by WHO regions and by World Bank income groups (based on classifications as of July 2020). Countries are classified among income groups according to 2019 gross national income (GNI) per capita, calculated using the World Bank Atlas method (low-income, US\$ 1035 or less per capita; lower-middle-income, US\$ 1036–4045; upper-middle-income, US\$ 4046–12,535; and high-income, \$12 536 or more) (26).

Data were analysed also by the stage of COVID-19 transmission in responding countries (as of the middle timepoint of the survey on 15 July). COVID-19 transmission classification is based on a process of country self-reporting. Differing degrees of transmission may be present at the sub-national level; classifications are based on the highest category reported within a country. WHO has defined the following four transmission scenarios: No cases, countries with no cases; Sporadic cases, countries with one or more cases, imported or locally detected; Clusters of cases, countries experiencing cases, clustered in time, geographical location,

and/or by common exposure; Community transmission, countries experiencing larger outbreaks of local transmission, defined through an assessment of factors including, but not limited to large numbers of cases not linkable to transmission chains, large numbers of cases from sentinel laboratory surveillance or increasing positive tests through sentinel samples, multiple unrelated clusters in several areas of the country (27).

Certain limitations should be kept in mind when examining the results of this rapid assessment. Firstly, it is vital to acknowledge the limitations associated with self-reported data, particularly concerning judgements often being made by a single focal point. For some of the variables, it is not possible to compare self-reported responses with publicly available information due to the acute nature of the emergency and limited availability of data. While focal points were encouraged to consult with other stakeholders, especially other humanitarian responders, the extent to which a full range of consultation in each country has occurred is difficult to examine. Furthermore, this rapid assessment did not include other methods such as focus groups or interviews with key informants.

A further limitation is that most of the information provided relates to the country as a whole, thereby overlooking potentially significant variability within countries concerning, for example, rural versus urban areas or remote versus central parts of the country.

Additionally, the weakness of preexisting national information systems is another limitation. As per the *WHO Mental Health Atlas 2017*, only 37% of Member States regularly compile mental health-specific data covering at least the public sector. Additionally, 29% of WHO Member States compile mental health data as part of general health statistics (2). During the COVID-19 pandemic, we had to rely on preexisting information systems with their limitations to learn about the current impact on services.

While the best attempts have been made to obtain information from all countries on all variables, some countries could not provide data for some questions, and some countries could not participate in the exercise within the time allowed. The most common reason for not participating in the exercise or for sending incomplete data was that focal points were engaged in the acute emergency response, as communicated by some countries and WHO country and regional offices. Also, in some cases the situation was changing rapidly, or sometimes the data available were difficult for countries to use to report the information in the manner requested in the survey. This could lead to potential bias in interpreting data at group level, such as WHO regions or World Bank income groups. This survey will be an ongoing activity for WHO, to be repeated regularly and integrated with the pulse survey on continuity of essential health services during the COVID-19 pandemic (24).

# Results

In total, 130 (67%) WHO Member States responded to the survey between June and August 2020. Additional responses were obtained from 10 geographical territories. The current report includes the global analysis of data from Member States only. For a full list of responding countries, see Annex 2.

Overall, the survey had good representation across different income and geographical regions. The response rate varied between 50% and 90% across all WHO regions, with a high response rate in particular from countries in the Eastern Mediterranean, Americas and Western Pacific regions. The response rate across World Bank (WB) income categories was between 48% and 73% (Table 1).

**Table 1. Response rate by WHO region and World Bank income group**

		Total numbers of countries	Number of responding countries	Response rate
<b>WHO region</b>	<b>AFR</b>	47	28	60%
	<b>AMR</b>	35	29	83%
	<b>EMR</b>	21	19	90%
	<b>EUR</b>	53	26	49%
	<b>SEAR</b>	11	6	54%
	<b>WPR</b>	27	22	81%
<b>Income group</b>	<b>Low</b>	31	15	48%
	<b>Lower-middle</b>	46	33	72%
	<b>Upper-middle</b>	60	44	73%
	<b>High</b>	57	38	67%
<b>Total</b>		<b>194</b>	<b>130</b>	<b>67%</b>

AFR: WHO African Region; AMR: WHO Region for the Americas; EMR: WHO Eastern Mediterranean Region; EUR: WHO European Region; SEAR: WHO South-East Asia Region; WPR: WHO Western Pacific Region

## Mental health and psychosocial support

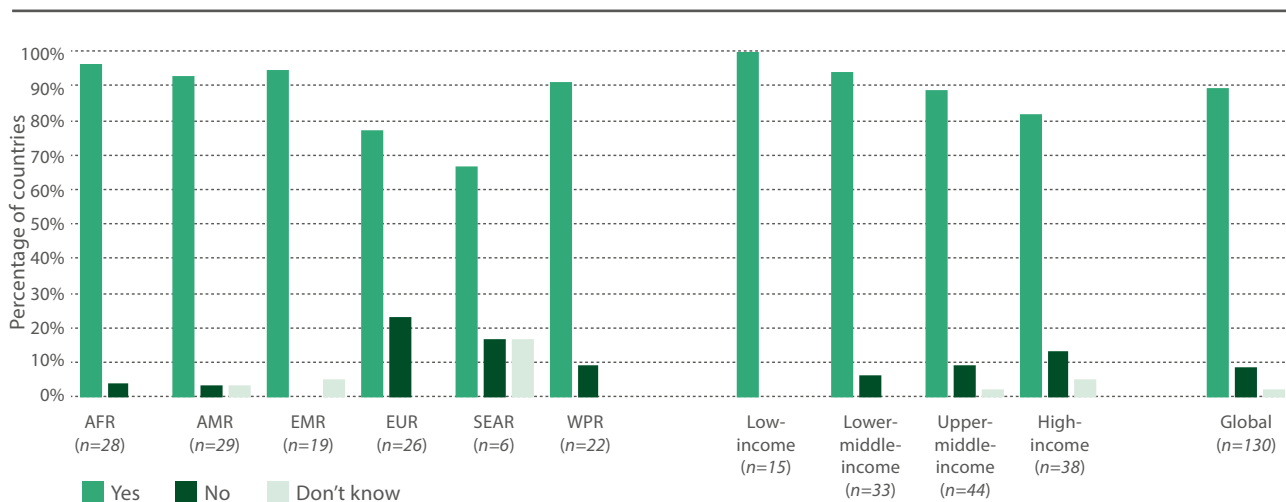
The composite term “mental health and psychosocial support” is used in the Inter-Agency Standing Committee (IASC) Guidelines in Emergency Settings to describe “any local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental health condition” (28). The global humanitarian system uses the term MHPSS to unite a broad range of actors responding to emergencies such as the COVID-19 pandemic, including those working in health, social, education and community settings, as well as to “underscore the need for diverse, complementary approaches in providing appropriate support” (29). MHPSS is a cross-cutting matter of relevance to all emergencies and all sectors. While there is a need to have focused interventions with specific objectives and target groups, MHPSS needs a “whole of society” and “whole of government” approach.

### MHPSS as part of COVID-19 response plans

A remarkable majority, 116 or 89% of the responding countries, reported that MHPSS response was part of their national COVID-19 response plans (Fig. 1). However, only 17% of these countries have fully ensured additional funding for MHPSS response in the government budget for these plans, while 47% responded that they had secured partial funding (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 plans.

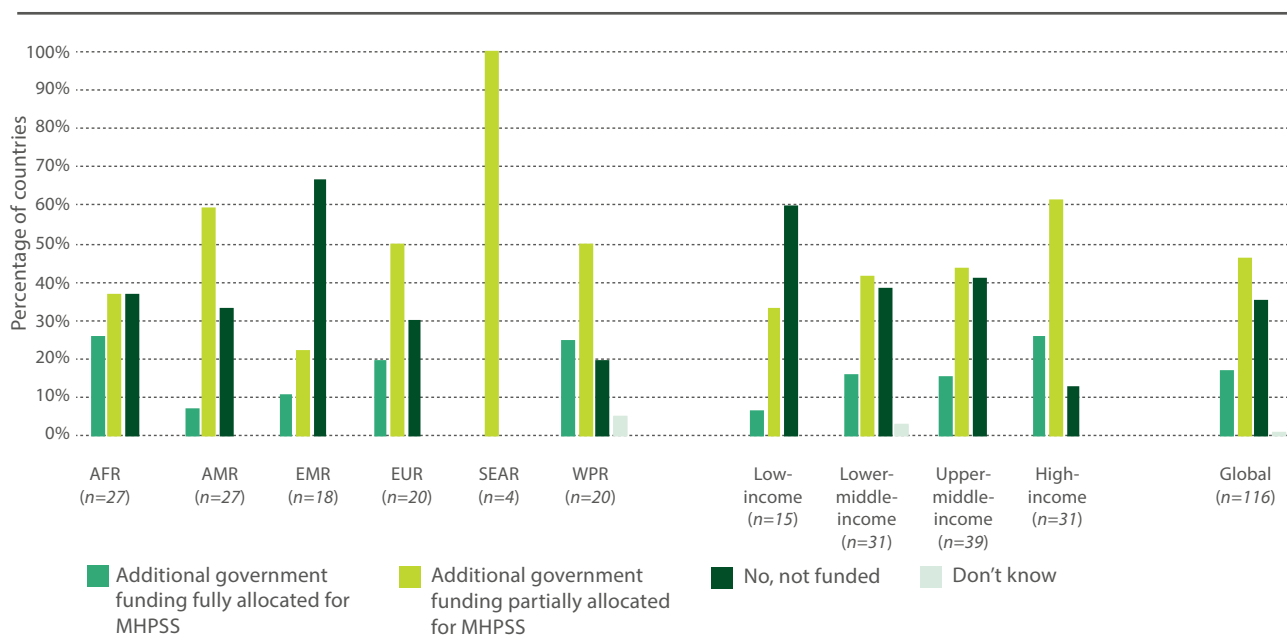
While it was encouraging to note that more lower-income countries have MHPSS as part of their national COVID-19 response plan, the level of funding of such plans, whether full or partial, was greater for higher-income groups. There is also regional variation in the integration of MHPSS into COVID-19 response plans. Regions with the largest number of preexisting humanitarian crises may be more familiar with the integration of MHPSS into their public health emergencies response, and these regions therefore show a higher number of countries reporting MHPSS being integrated into their COVID-19 response plans. At regional level, the Eastern Mediterranean and African regions show the highest percentage of countries reporting MHPSS integration in the response but with no additional funds allocated for this activity, followed very closely by the European and Americas regions (Fig. 1 and 2).

**Fig. 1. MHPSS as part of COVID-19 response plans, by WHO region and WB income group**





**Fig. 2. Funding for MHPSS as part of COVID-19 response plans, by WHO region and WB income group**

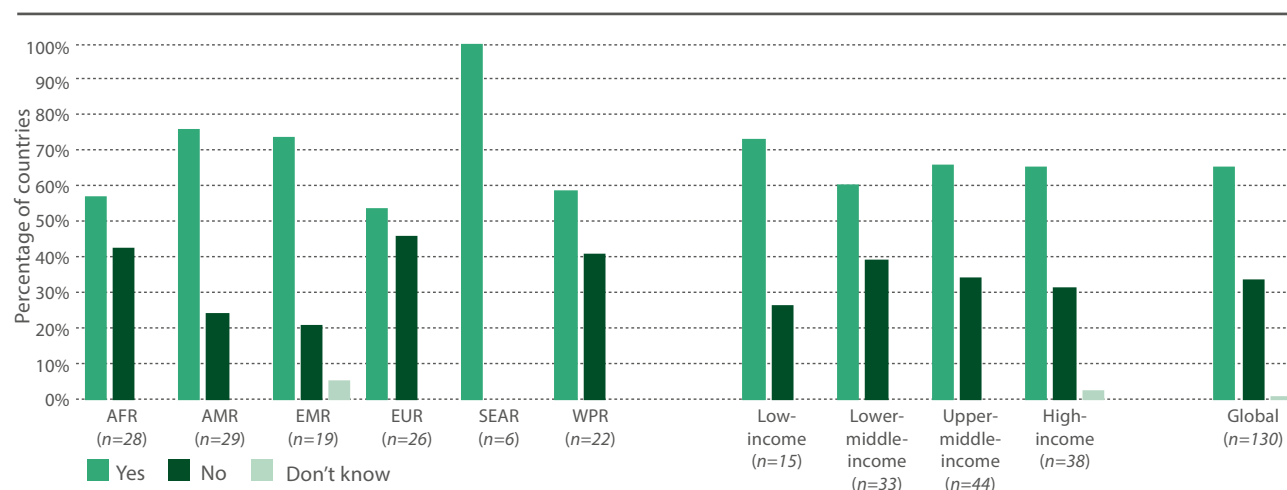


### MHPSS multisectoral coordination

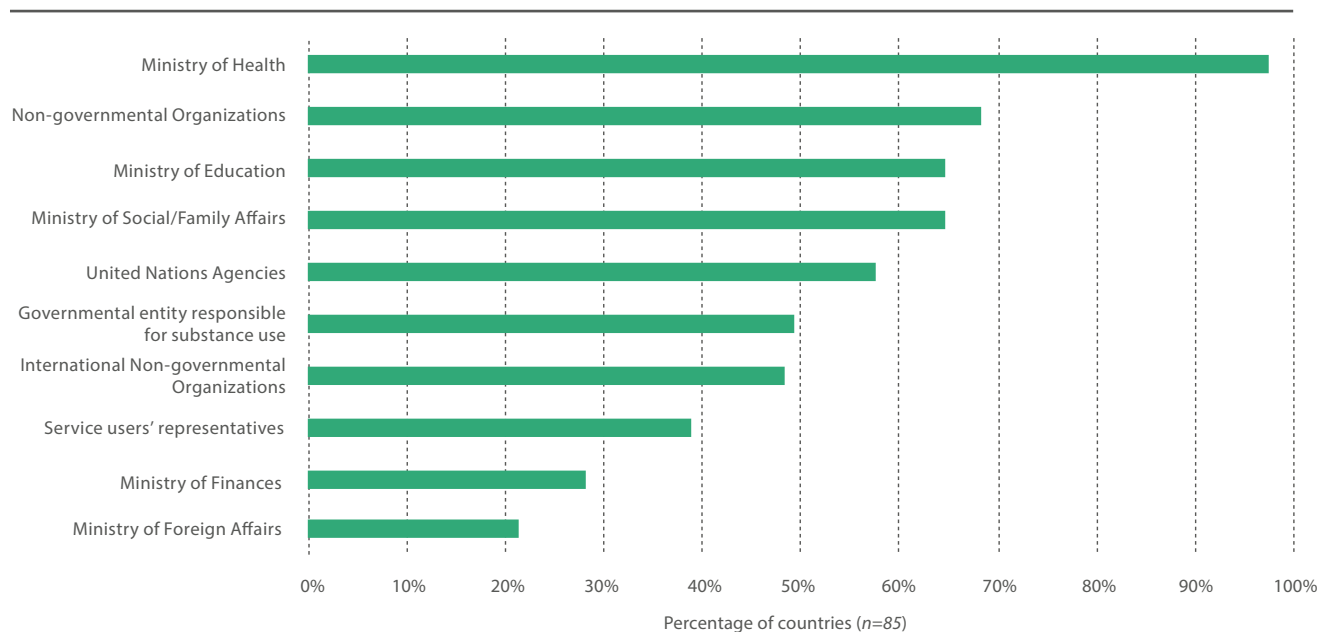
Two-thirds (65%) of responding countries have a multisectoral MHPSS coordination platform for COVID-19 response, with more than 50% across all regions and specifically more than 70% in the low-income group (Fig. 3). The ministry of health is a member of the MHPSS coordination platform in 98% of countries, while 65% of countries include ministries of social/family affairs and education, and 68% include nongovernmental organizations (NGOs) as members of the coordination platform. This positive finding shows the commitment of a number of relevant line ministries to MHPSS. However, in more than 50% of countries, entities responsible for substance use were not part of the MHPSS multisectoral coordination platform.

One-third (34%) of responding countries reported having no MHPSS coordination platform. This may reflect fragmentation of the MHPSS response in these countries, or a limited number of MHPSS multisectoral actors. 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 40% of these platforms and engagement with the ministry of finance in only 28% (Fig. 4).

**Fig. 3. MHPSS multisectoral coordination platform for COVID-19, by WHO region and WB income group**



**Fig. 4. Members of MHPSS multisectoral coordination platforms**



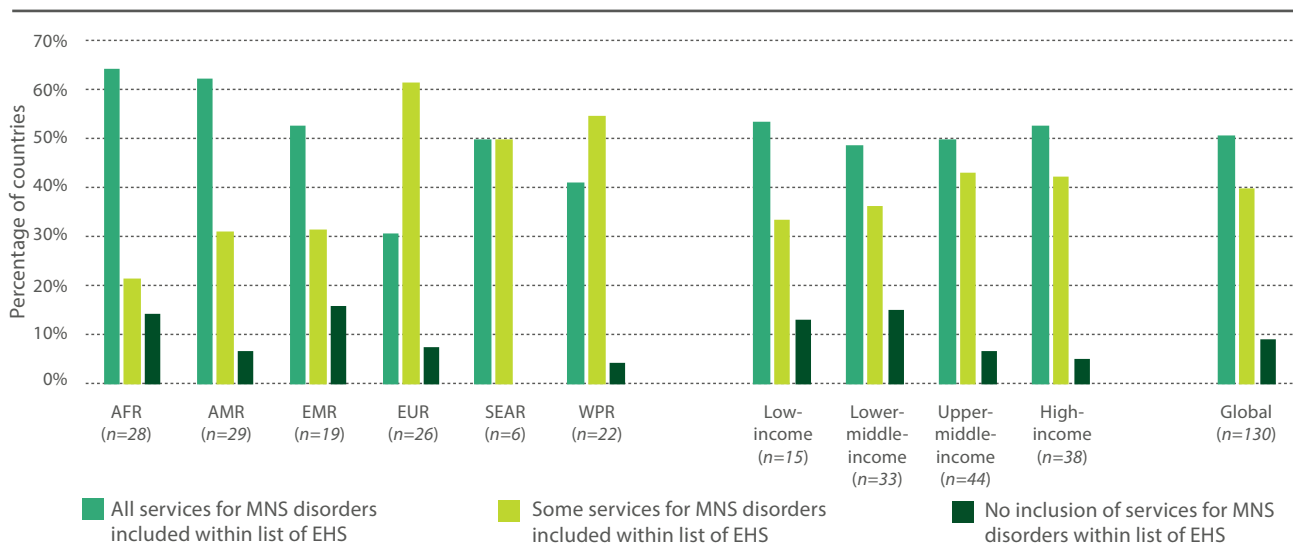
## Mental, neurological and substance use services during the COVID-19 pandemic

Despite the transition in many high-income countries towards psychiatric wards in general hospitals and the provision of community-based services, there are still a minimal number of facilities for community-based mental health care throughout the world, as evident from WHO Mental Health Atlas 2017 data (2). Even before the COVID-19 pandemic, levels of public expenditure on mental health were minimal in low- and middle-income countries. Government expenditure on mental health was less than US\$ 1 per capita in low- and lower-middle-income countries, whereas high-income countries spent more than US\$ 80 per capita. The majority of spending was going to mental hospitals, which serve a small proportion of those who need care. In low-income countries, the rate of mental health workers can be as low as two per 100 000 population, compared with more than 70 in high-income countries (2). During the COVID-19 pandemic, and at a time when MNS services are needed on a large scale, many countries are dealing with a challenging situation with scarce preexisting resources and investment in this area.

### Inclusion of services for MNS disorders in the list of essential health services

More than half (51%) of countries reported “inclusion of all services for MNS disorders in the list of essential health services” as part of their country’s response during COVID-19, while 40% of countries reported inclusion of some MNS services; 9% reported no inclusion of MNS services within essential health services. In the African, Eastern Mediterranean and European regions, services for MNS disorders are not included in the list of essential health services in approximately 10% of countries. The inclusion of MNS services in essential health services shows an apparent discrepancy across income groups, with no inclusion reported more frequently by Member States in the lower-income groups (Fig. 5). It is also important to note that mental health services are lacking across many settings in general.

**Fig. 5. Countries including services for MNS disorders in the list of essential health services, by WHO region and WB income group**



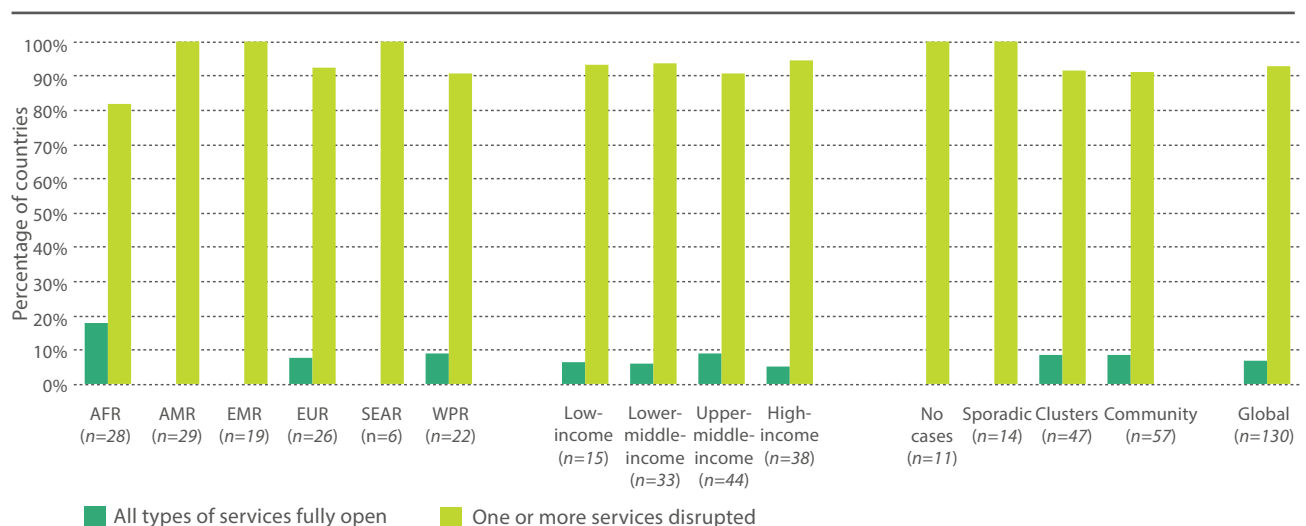
### Policies for access to essential services for MNS disorders

Countries were also 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. However, all services were fully open in just 7% of countries, while 93% of countries reported some disruption to their services for MNS disorders.

No country in the Americas, Eastern Mediterranean or South-East Asia regions reported having all services fully open (Fig. 6).

**Fig. 6. Status of services for MNS disorders, by WHO region, WB income group and COVID-19 transmission stage**



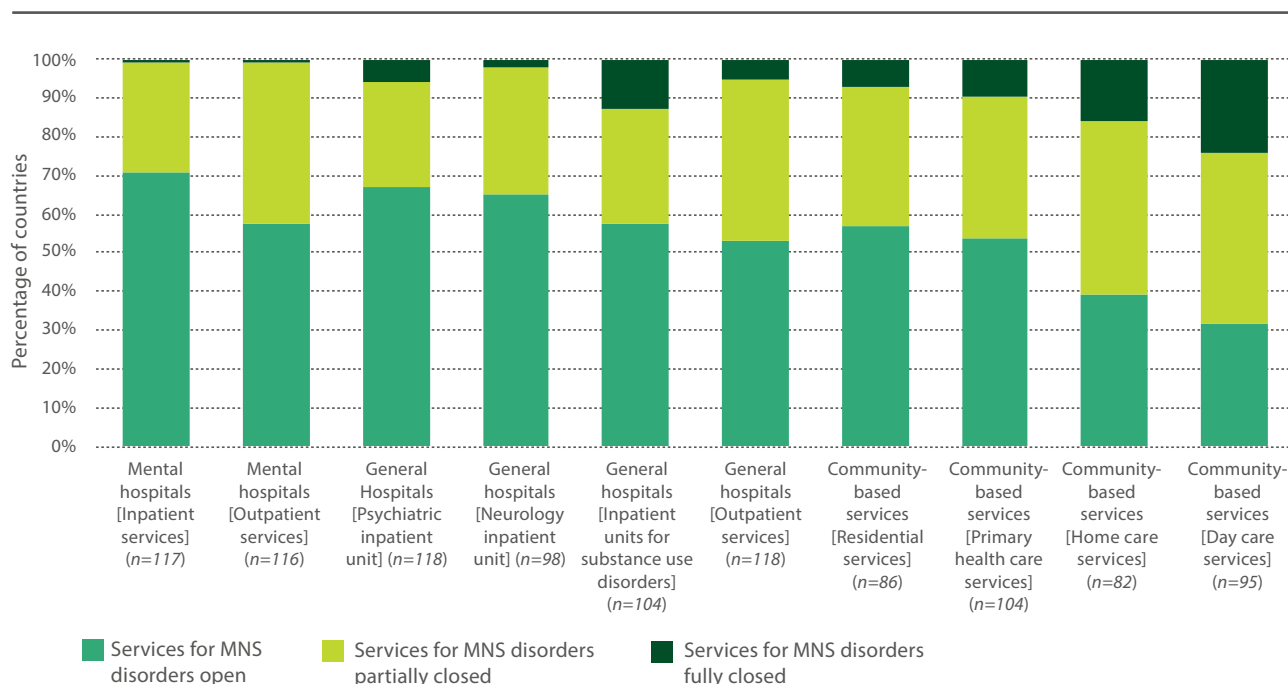
When looking at each of the 10 different categories of services, there were marked differences in the type of service affected by closure, with outpatient services in both mental and general hospitals as well as community-based services being in the main more affected (Fig. 7).

Around 70% of responding countries reported that inpatient services at mental hospitals and psychiatric units in general hospitals remained 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 more than 30% of countries. In contrast, inpatient services for substance use disorders were the most affected among all mental health inpatient services, with services fully closed in 12% of countries and partially closed in 30% of countries. These findings are consistent with the recent WHO survey on NCD services, which reported that access to inpatient NCD services was generally less affected compared with outpatient NCD services (25).

Approximately 60% of responding countries reported either partial or complete disruption of home or community outreach services (including social care services) for people with MNS disorders. For community-based services, only residential and primary health care services were open in more than 50% of countries, while day care services were open in just over 30% of countries.

Outpatient services in mental hospitals and general hospitals were fully open in fewer than 60% of responding countries, while they were fully closed in 1% of countries at mental hospitals and 4% at general hospitals. A similar finding was made in the recent WHO survey on NCD services, with 59% of countries reporting that access to outpatient services was restricted to some degree, including 4% reporting total closure (25).

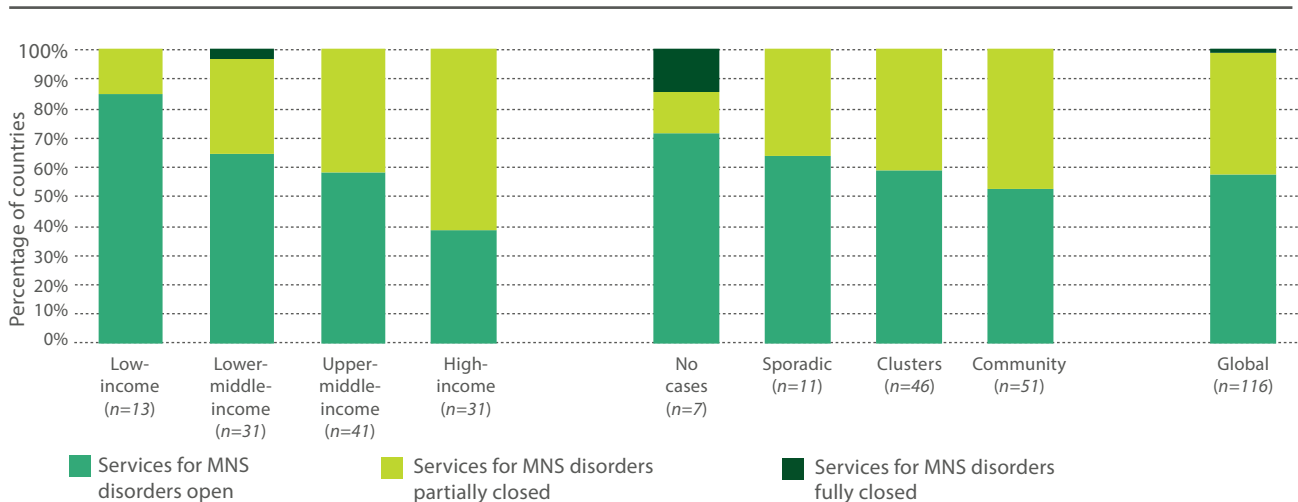
**Fig. 7. Policies for access to essential services for MNS disorders, by setting and categories of services**



Note: The difference in the denominator seen in Fig. 7 is due to the fact that in some countries these services are either non-existent or information is not available. Thus at mental health hospitals 10% of countries did not report on policies for inpatient services for MNS disorders and 11% for outpatient services; at general hospitals 9% of countries did not report on policies for psychiatric inpatient units, 24% for neurology inpatient units, 20% for inpatient units for substance use disorders and 9% for outpatient services; and at the community-based level 33% did not report on residential services, 20% on primary health care services, 37% on home care services and 27% on day care services.

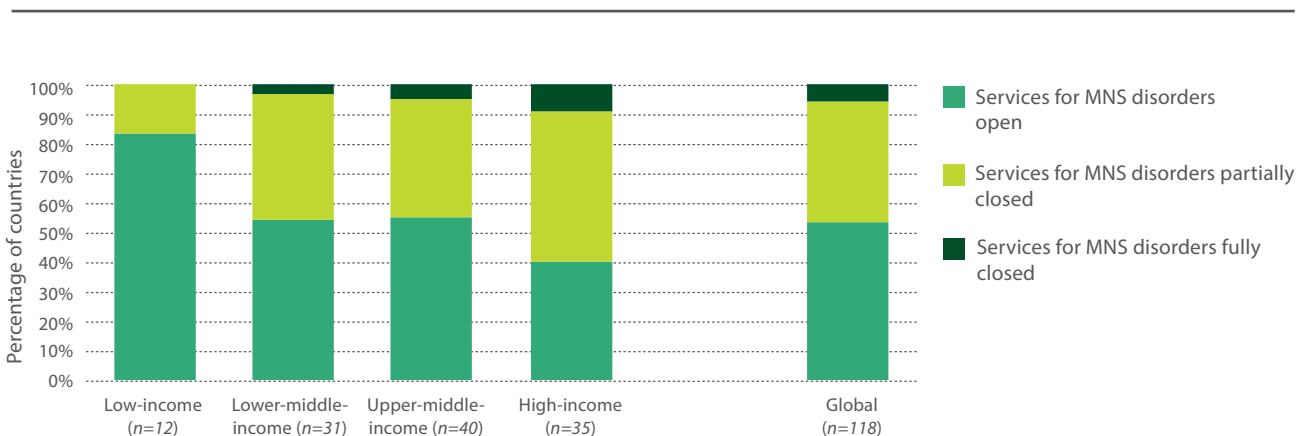
Disruptions in outpatient services at mental hospitals seem to be linked to the stage of transmission of the virus (27), with countries in the community stage showing the highest level of disruption, with services partially open in 47% of countries, around 40% within the clusters and sporadic stages, and fewer than 30% of outpatient services either fully closed or partially open in countries in the “no cases” group. Analysing the differences across income groups, outpatient services at mental hospitals were disrupted in a higher proportion of countries in the high-income group, with full closure or services partially open in more than 60% of them. In comparison, the figure was around 40% for upper- and lower-middle-income countries and 15% for the low-income group (Fig. 8).

**Fig. 8. Policies for access to outpatient services for MNS disorders at mental hospitals, by WB income group and COVID-19 transmission stage**



Disruptions in outpatient services at general hospitals were also more widespread in higher-income groups of countries, with services partially open in 17% of countries in the low-income group, around 45% in the lower- and upper-middle-income groups and 60% in the high-income group (Fig. 9).

**Fig. 9. Policies for access to outpatient services for MNS disorders at general hospitals, by WB income group**



The recent WHO pulse survey on continuity of essential health services included one overlapping item on treatment for mental health disorders, which were reported to be disrupted in 61% of countries, with 3% of those countries reporting severe/complete disruptions (24). The type of services for treatment of mental health disorders in this pulse survey, however, was not defined.

## Disruption of MNS-related interventions/services due to COVID-19

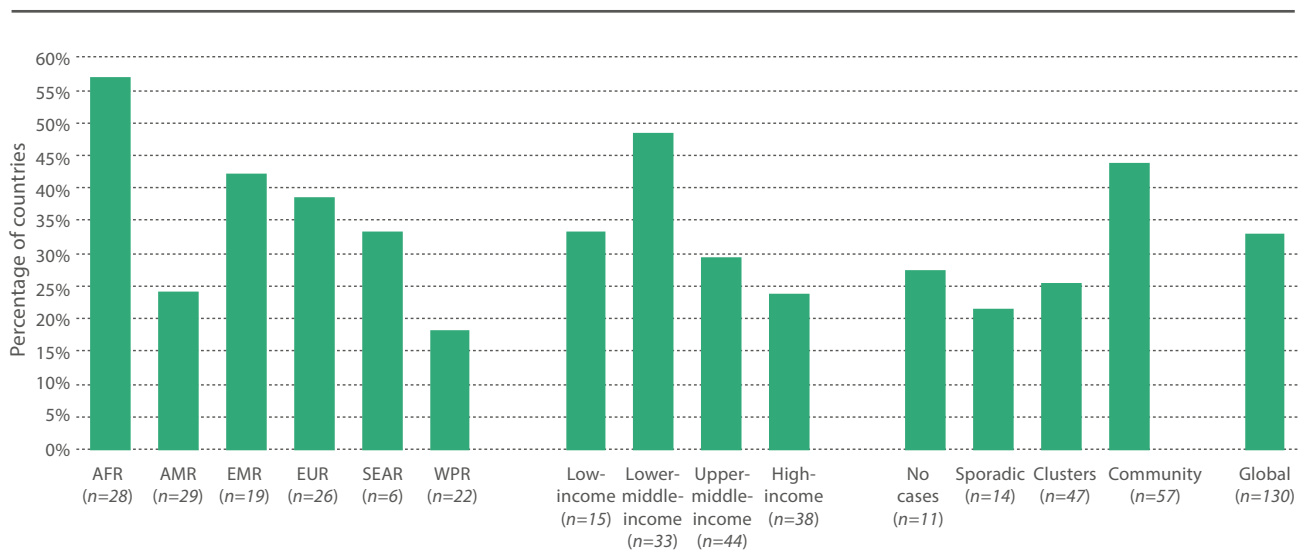
Countries were also asked about the level of disruption of 16 specific MNS-related interventions or services (Table 2), defining complete disruption as more than 50% of users not being served as usual and partial disruption as between 5% and 50% of users not being served as usual. We also looked at the level of disruption combined across the 16 specific MNS-related interventions/services. In the analysis, “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 2. 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 almost one-third (33%) of countries, at least 75% of MNS-related services were completely or partially disrupted. This percentage was higher in particular for the African region (57%), as well as for countries in the community stage of transmission. High-income countries showed a lower level of disruption at 24% compared with the other income groups (Fig. 10).

**Fig. 10. Disruption in at least 75% of MNS-related interventions/services, by WHO region, WB income group and COVID-19 transmission stage**



Importantly, some life-saving emergency and essential MNS services were reported as being disrupted: 35% of countries reported disruption of management of emergency MNS manifestations (including status epilepticus, delirium, severe substance withdrawal syndromes) and 30% reported disruption of medications for people with MNS disorders (Fig. 11).

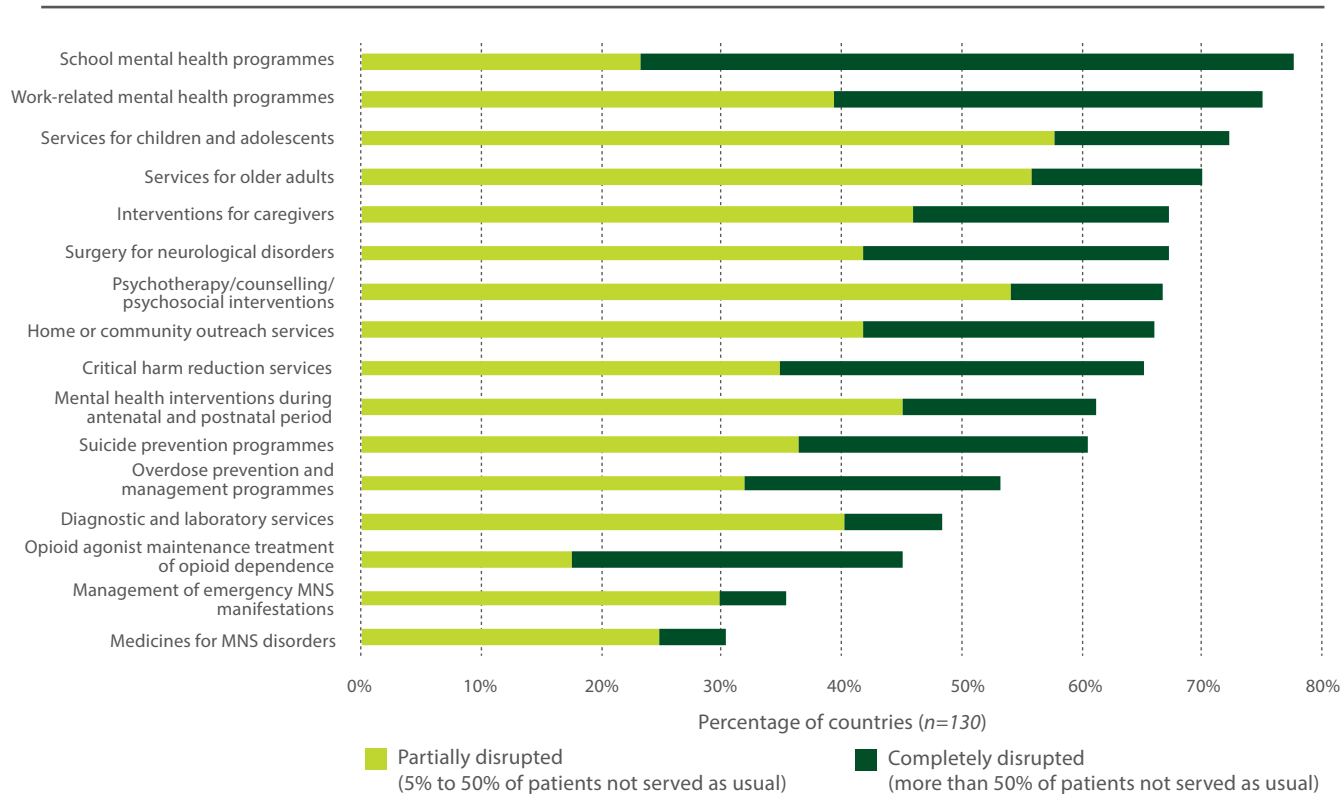
Prevention and promotion mental health services and programmes were most severely affected and disrupted. Around three-quarters of school mental health or workplace mental health services were fully or partially disrupted.

Other MNS-related interventions/services with complete disruption in more than 20% of countries were suicide prevention programmes (24%), home or community outreach services (24%) and interventions for caregivers (21%).

At a time when they are highly needed, mental health services for the most vulnerable were reported to be disrupted. Less than 30% of countries reported no disruption to children's and adolescent mental health services. In 70% of countries, MNS services for older adults were disrupted (56% partially disrupted, 14% completely disrupted). Fewer than 40% of antenatal or postnatal mental health services were not disrupted. Almost 60% of all psychotherapy and counselling services were reported as being partially disrupted.

Laboratory monitoring of some psychotropic medications, such as clozapine and lithium, is an essential part of management for severe mental health conditions. More than 40% of countries reported disruption of laboratory services at mental health facilities.

**Fig. 11. Disruptions of MNS-related interventions/services due to COVID-19**



Among interventions or services related to substance use, critical harm reduction services were completely disrupted in 30% of countries and partially disrupted in 35%; opioid agonist maintenance treatment of opioid dependence was completely disrupted in 27% of countries and partially disrupted in 18%; and overdose prevention and management programmes were completely disrupted in 21% of countries and partially disrupted in 32%.

One in three countries at least partially closed down neurology inpatient units during the pandemic (33% partially closed, 2% fully closed), with surgeries for neurological disorders disrupted in two-thirds of the countries (42% partially disrupted, 25% completely disrupted) and the management of emergency conditions such as status epilepticus being at least partly disrupted in one-third of countries (30% partially disrupted, 6% completely disrupted).

### Causes of disruptions in MNS-related interventions/services

The survey not only included questions on disruptions of MNS-related interventions and services but also on the main causes of the reported disruptions. The leading causes of disruption were a decrease in outpatient volume due to patients not presenting (62% of countries), travel restrictions hindering access to health facilities (54%) and a decrease in inpatient volume due to cancellation of elective care (47%) (Table 3). Indeed, the same main reasons for disruption were identified in the recent WHO pulse survey on continuity of essential health services, as a combination of demand factors on one side, such as patients not presenting to outpatient care or perceptions that government or public transport lockdowns were hindering access, and on the other side supply factors such as cancellation of elective care or redeployment of clinical staff to provide COVID-19 relief (24).

When data were disaggregated across income groups, travel restrictions were reported as the most common cause of disruption for 73% of low-income countries (Fig. 12). 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.



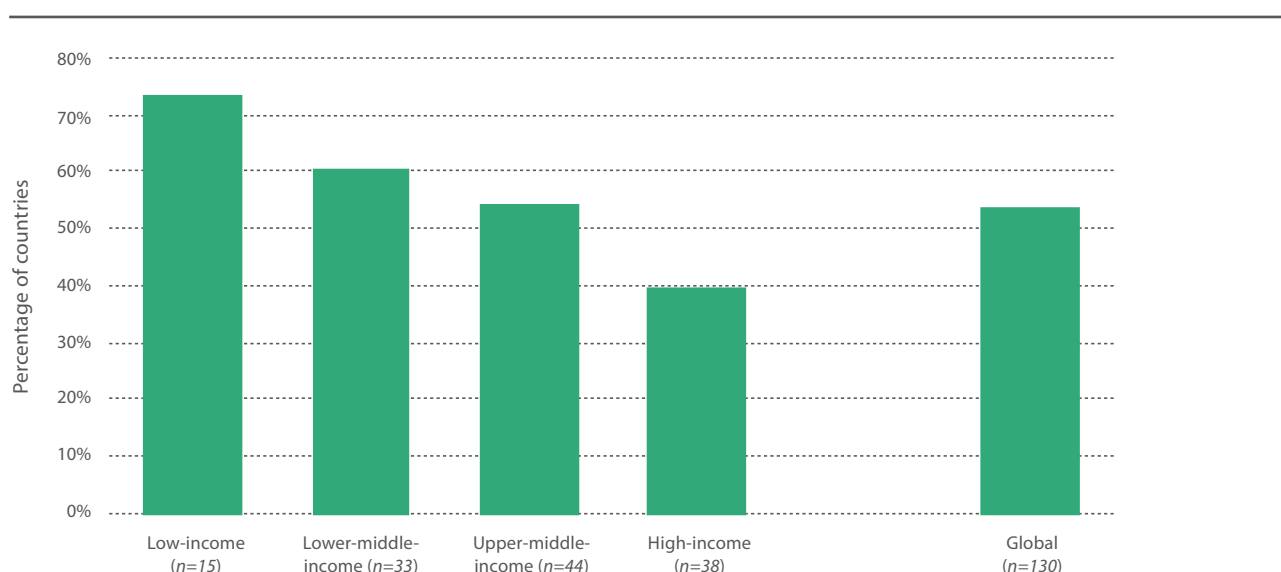
Repurposing of staff or of facilities was also reported as a cause of disruption. An insufficient number of health workers or redeployment of mental health care staff to support COVID-19 facilities seems to be the cause of service disruption in nearly 30% of countries, while in 19% of countries the cause was using mental health facilities as a COVID-19 quarantine or treatment facility.

In 28% of countries respondents reported insufficient supplies of personal protective equipment (PPE) available for health care providers to provide services at mental health facilities; this was reported most frequently in the African region (43% of countries), followed by the Western Pacific Region (36%) (Fig. 13). Additionally, limited supplies of health products were reported as a cause of disruption in 24% of countries.

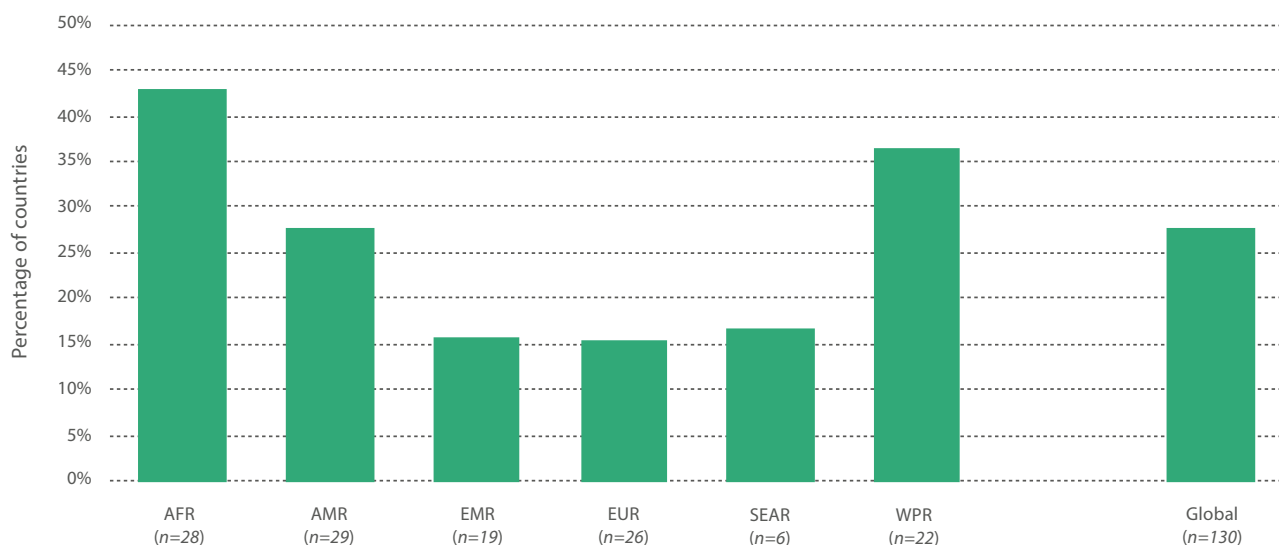
**Table 3. Leading causes of disruptions in MNS-related intervention/services**

Causes	Percentage of countries
Decrease in outpatient volume due to patients not presenting	62.3 %
Travel restrictions hindering access to the health facilities for patients	53.8 %
Decrease in inpatient volume due to cancellation of elective care	46.9 %
Closure of outpatient services as per health authority directive	33.8 %
Closure of outpatient disease specific consultation clinics	33.1 %
Clinical staff related to MNS disorders deployed to provide COVID-19 relief	31.5 %
Insufficient staff to provide services	31.5 %
Insufficient Personal Protective Equipment available for health care providers	27.7 %
Closure of population level programs	24.6 %
Unavailability of health products at health facilities	23.8 %
The clinical set up has been designated as COVID-19 care facility	19.2 %
Inpatient services/hospital beds not available	12.3 %

**Fig. 12. Travel restrictions hindering access to the health facilities by WB income groups**



**Fig. 13. Insufficient personal protective equipment available for health care providers to provide services by WHO regions**



### Approaches to overcome disruptions

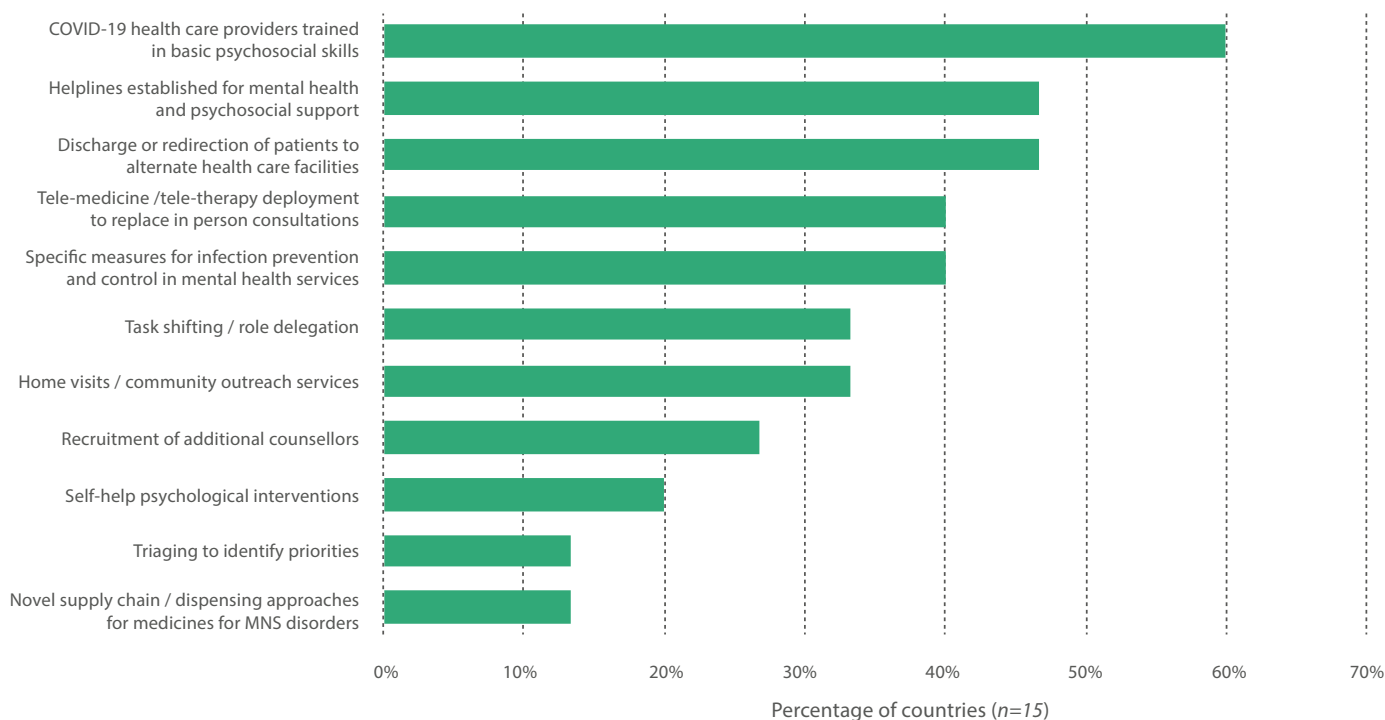
Countries responded via a checklist on approaches being used to overcome service disruptions for the management of MNS disorders and to provide mental health and psychosocial support. A country could check multiple options. Quite a few measures are being applied, with the most frequent approaches being telemedicine/teletherapy used to replace in-person consultations (70% of countries). This included use of any remote contact such as telephone or video conferencing. Other measures used included helplines for MHPSS (68%) and specific measures for infection prevention and control in mental health services (65%) (Table 4). These findings are consistent with the recent WHO pulse survey on continuity of essential health services, which also identified telemedicine among the most frequent approaches (24).

Across regions and income groups, MHPSS helplines, specific measures for infection prevention and control, and triaging to identify priorities were consistently used as the most common approaches for overcoming disruption; whereas training in basic psychosocial skills for health care providers working in COVID-19 treatment centres was the most frequently used approach among the low-income group, reported in 60% of countries (Fig. 14). The use of technology in overcoming service delivery disruptions varies by income group. While more than 80% of high-income countries reported deployment of telemedicine/teletherapy to replace in-person consultations, or the use of helplines, both modalities were used in fewer than 50% of low-income countries (Fig. 15). An overview of global figures indicates that interventions such as task shifting/role delegation or building the capacity of general health workers on basic psychosocial skills and community outreach seem to be underutilized as intervention modalities compared with remote support methods. Recruitment of additional counsellors and new dispensing approaches for medications were among the least reported approaches.

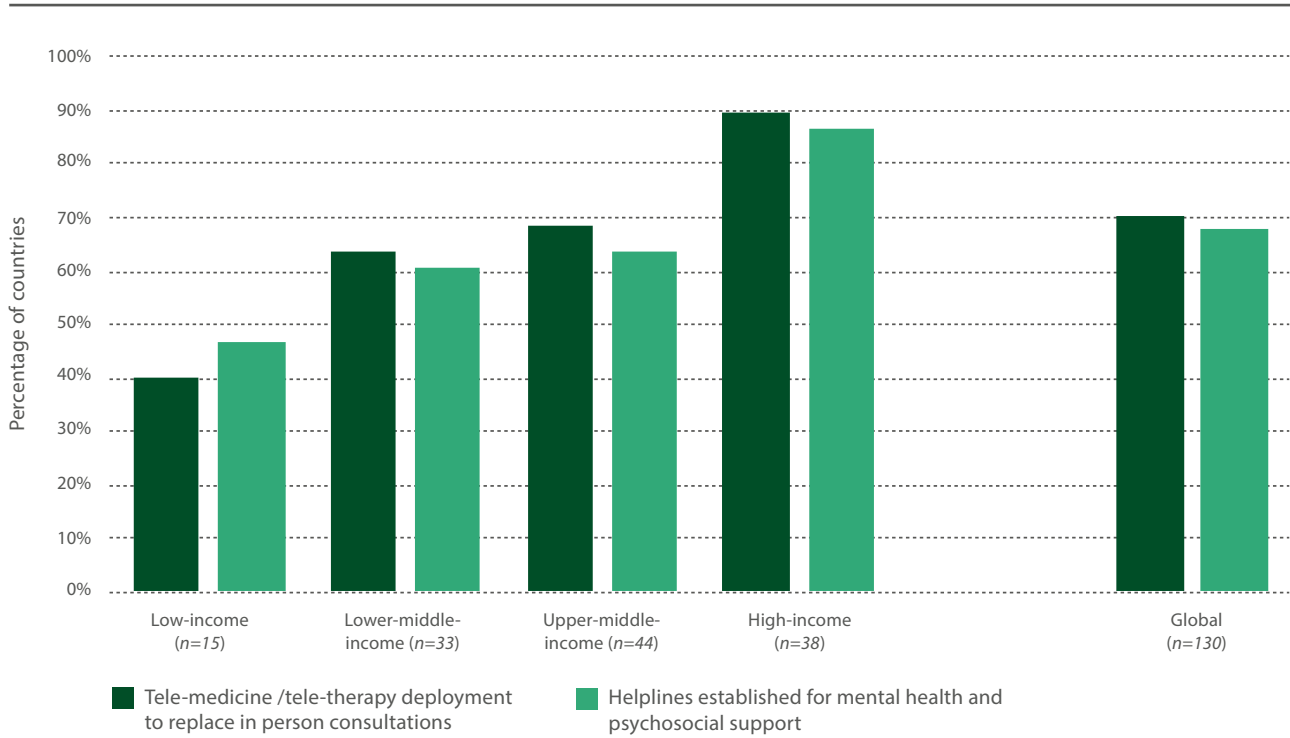
**Table 4. Approaches for overcoming disruptions in MNS-related intervention/services**

Approaches	Percentage of countries (n=130)
Tele-medicine /tele-therapy deployment to replace in person consultations	70.0
Helplines established for mental health and psychosocial support	67.7
Specific measures for infection prevention and control in mental health services	65.4
Self-help or digital format of psychological interventions	53.8
Triaging to identify priorities	49.2
COVID-19 health care providers trained in basic psychosocial skills	44.6
Discharge or redirection of patients to alternate health care facilities	44.6
Task shifting / role delegation	37.7
Home or community outreach services	33.1
Novel supply chain / dispensing approaches for medicines for MNS disorders	32.3
Recruitment of additional counsellors	20.8

**Fig. 14. Approaches for overcoming disruptions in MNS-related intervention/services among the WB low-income group**



**Fig. 15. Use of technology in overcoming service delivery disruptions, by WB income group**



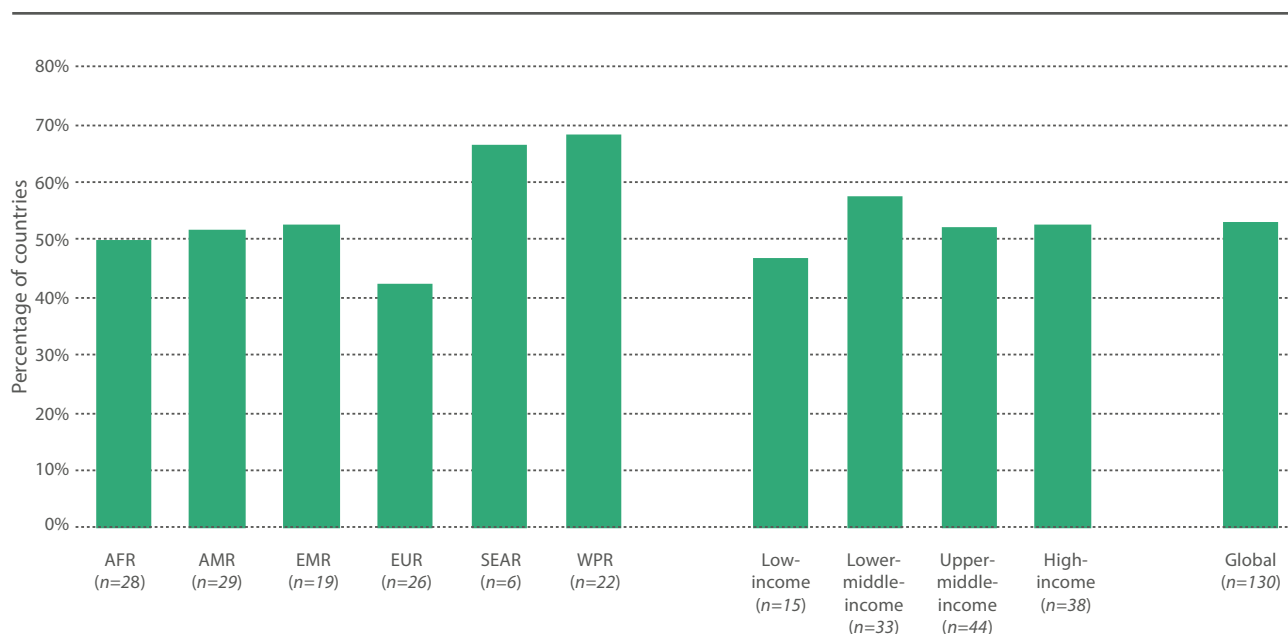
## Surveillance and research concerning MNS disorders during the COVID-19 pandemic

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 generation of new knowledge through research enables plans and actions to be based on evidence and best practice, and the availability of timely and relevant information or surveillance frameworks enables implemented actions to be monitored and improvements as well as gaps in service provision to be identified (30).

### Data collection on MNS disorders or manifestations

Data are needed to monitor trends and improve the quality of services during the pandemic through informed decision making. However, as shown by this survey, more than 40% of health ministries are not collecting any data on MNS disorders or manifestations in people with COVID-19. Across regions and income groups, more than 60% of countries in the South-East Asia and Western Pacific regions report collecting such data, while the proportion is less than 50% in low-income countries (Fig. 16).

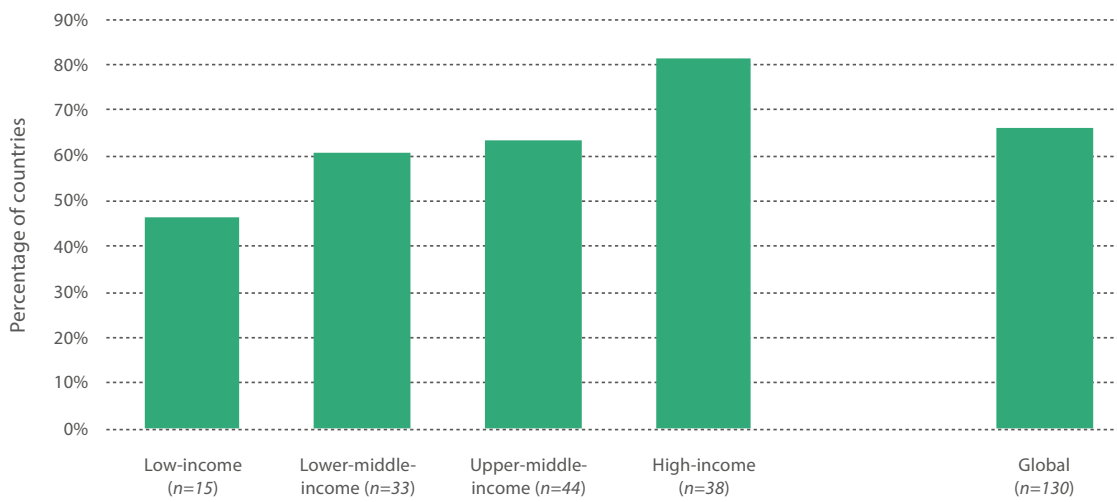
**Fig. 16. Data collection on MNS in Covid-19 patients, by WHO region and WB income group**



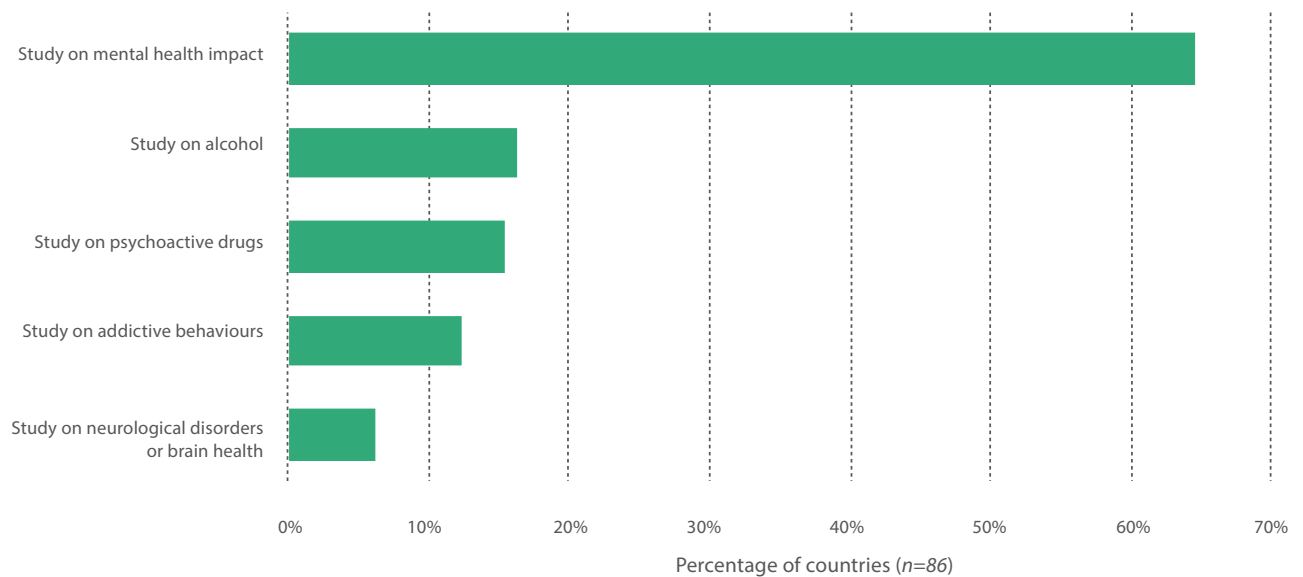
### Studies related to the impact of COVID-19 on mental health

Countries were also requested to report on any planned or ongoing study related to the impact of COVID-19 on mental health/brain health/substance use in the country, either by government or other stakeholders. In all, 66% of countries reported studies related to the impact of COVID-19 on mental health, brain health or substance use, with the most frequent type of study being on mental health impact (65% of countries). Across income groups, 80% of high-income countries reported carrying out studies on mental health impact. The number of countries globally conducting research on neurological or substance use was much lower (5% and 15% respectively) (Fig. 17 and 18).

**Fig. 17. Studies related to the impact of COVID-19 on MNS, by WB income group**



**Fig. 18. Type of study related to impact of COVID-19**



# Conclusion

This survey provides insights from mental health focal points within ministries of health on the extent of disruptions to services for mental, neurological and substance use disorders, and an indication of their experience in adopting strategies to mitigate the impact on service provision. There were differences in the type of services disrupted, with already scarce outpatient and community mental health services predominantly more affected. Mental health prevention and promotion programmes felt the most severe impacts at a time when countries need them the most. While acknowledging the limitations of such a survey, including the limitations of a self-reported questionnaire, the results, however, clearly indicate that mental health systems have been compromised at a time when they are likely needed most.

Innovative methods are being applied in many countries through teleservices and helplines; however, limited resources are a challenge to using these tools in lower-resource settings. Tools such as task sharing through building the capacity of general health workers seem to be underutilized. Although global advocacy for mental health inclusion in COVID-19 responses has resulted in better integration into plans, multisectoral coordination platforms and regular data collection, there is still a gap in the financial and human resources allocated to integrate mental health into the emergency response, which constitutes a significant challenge and a barrier to the continuity of services. The COVID-19 pandemic emphasizes the value of including MHPSS not only in response to emergencies and recovery, but also before emergencies through integrating measures into preparedness plans and efforts (31).

WHO's interim guidance *Maintaining essential health services: operational guidance for the COVID-19 context (1)* includes a section with specific adaptations and considerations for safe delivery of MNS services covering emergency acute care, outpatient care guidance and other contexts (see Annex 3). While many countries are implementing WHO-recommended strategies to mitigate disruptions to services, more information is needed to identify which approaches work in different settings during the different phases of the pandemic. Decisions about the nature and timing of adaptations to service delivery must be informed using accurate and timely data. As the pandemic is likely to ebb and flow over the coming months, real-time monitoring of changes in mental health service delivery and utilization is needed.

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# Annex 1 : Questionnaire



## **Rapid assessment of service delivery for Mental, Neurological and Substance Use Disorders during the COVID 19 Pandemic**

*Department of Mental Health and Substance Use*

*World Health Organization*

### **Introductory statement**

Dear colleague,

In the context of the COVID-19 pandemic response, we are reaching out to you to ask a small set of questions to quickly assess how essential services for mental, neurological and substance use (MNS) disorders are being impacted in your country by the current pandemic in order to help plan WHO support and technical tools which might be of value. We may reach out to you to seek any clarifications if needed. We will be using the aggregated data only for reporting purposes. Should we decide later to use examples or case studies that identify specific countries, we will contact you to request advance permission. Since these questions are intended to support a rapid situation assessment on these issues, we would be grateful to receive your responses by 30 June 2020. Please click on the link below to access the survey. Note that you may access the questionnaire as often as needed, saving your responses as you go. We believe that it will take you 20 minutes to respond to these questions.

Thank you in advance. For further information on WHO resources on Mental Health and COVID-19, visit: <https://www.who.int/teams/mental-health-and-substance-use/covid-19>

### **Information on those who completed the questions**

Who is the focal point who provided the responses?

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Organization: \_\_\_\_\_

Country: \_\_\_\_\_

Email: \_\_\_\_\_

## **POLICIES AND PLANS**

**1.** Is mental health and psychosocial support response part of national COVID-19 response plan?

- a. Yes*
- b. No*
- c. Don't know*

**1i.** If yes, is additional funding allocated for mental health and psychosocial support in the government budget for the COVID-19 response plan?

- a. Yes and 100 % funded*
- b. Yes but only partially funded*
- c. No, not funded*
- d. Don't know*

**2.** Do you have a multisectoral mental health and psychosocial coordination platform for COVID-19 response?

- a. Yes*
- b. No*
- c. Don't know*

**2i.** If yes, are the following Ministries and bodies part of the coordination platform?  
(Please check all boxes that apply)

- a. Ministry of Health*
- b. Ministry of Social/Family Affairs*
- c. Ministry of Education*
- d. Ministry of Finances*
- e. Ministry of Foreign Affairs*
- f. United Nations Agencies*
- g. Governmental entity responsible for substance use*
- h. International non-governmental Organizations*
- i. Non-governmental Organizations*
- j. Service users' representatives*

## **SERVICES**

**3.** Is ensuring continuity of services for mental, neurological and substance use (MNS) disorders included in the list of essential health services as part of your country's response during COVID-19?

- a. Yes, all*
- b. Yes, some*
- c. No/not yet*
- d. Don't know*

4. During the COVID-19 pandemic, what are the government policies for access to essential services for mental, neurological and substance use (MNS) disorders at primary, secondary and tertiary care levels?

Please answer for different categories of services for mental, neurological and substance use disorders. Please provide the response for national level policies.

SETTINGS	CATEGORIES OF SERVICES (Dropdown menus)			
MENTAL HOSPITALS	<u>Outpatient services</u> <input type="checkbox"/> <i>Outpatient services are open</i> <input type="checkbox"/> <i>Outpatient services are partially open</i> <input type="checkbox"/> <i>Outpatient services are closed</i> <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Not Applicable</i>	<u>Inpatient services</u> <input type="checkbox"/> <i>Inpatient services are open</i> <input type="checkbox"/> <i>Inpatient services are partially open (eg for emergencies only)</i> <input type="checkbox"/> <i>Inpatient services are closed</i> <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Not Applicable</i>		
GENERAL HOSPITALS	<u>Outpatient services for MNS disorders</u> <input type="checkbox"/> <i>Outpatient services for MNS disorders open</i> <input type="checkbox"/> <i>Outpatient services for MNS disorders partially open</i> <input type="checkbox"/> <i>Outpatient services for MNS disorders closed</i> <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Not Applicable</i>	<u>Psychiatric inpatient unit</u> <input type="checkbox"/> <i>Psychiatric inpatient unit open</i> <input type="checkbox"/> <i>Psychiatric inpatient unit partially open</i> <input type="checkbox"/> <i>Psychiatric inpatient unit closed</i> <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Not Applicable</i>	<u>Neurology inpatient unit</u> <input type="checkbox"/> <i>Neurology inpatient unit open</i> <input type="checkbox"/> <i>Neurology inpatient unit partially open</i> <input type="checkbox"/> <i>Neurology inpatient unit closed</i> <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Not Applicable</i>	<u>Inpatient units for substance use disorders</u> <input type="checkbox"/> <i>Inpatient units for substance use disorders open</i> <input type="checkbox"/> <i>Inpatient units for substance use disorders partially open</i> <input type="checkbox"/> <i>Inpatient units for substance use disorders closed</i> <input type="checkbox"/> <i>Don't know</i> <input type="checkbox"/> <i>Not Applicable</i>

COMMUNITY BASED SERVICES	<u>Day care services</u>	<u>Home care services</u>	<u>Services for MNS disorders in primary health care (PHC) services</u>	<u>Residential services (e.g. care homes)</u>
	<input type="checkbox"/> Day care services open	<input type="checkbox"/> Home care services open		<input type="checkbox"/> Residential services open
	<input type="checkbox"/> Day care services partially open	<input type="checkbox"/> Home care services partially open	<input type="checkbox"/> Services for MNS disorders in primary health care (PHC) services open	<input type="checkbox"/> Residential services partially open
	<input type="checkbox"/> Day care services closed	<input type="checkbox"/> Home care services closed	<input type="checkbox"/> Services for MNS disorders in primary health care (PHC) services partially open	<input type="checkbox"/> Residential services closed
	<input type="checkbox"/> Don't know	<input type="checkbox"/> Don't know	<input type="checkbox"/> Services for MNS disorders in primary health care (PHC) services closed	<input type="checkbox"/> Don't know
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Services for MNS disorders in primary health care (PHC) services open	<input type="checkbox"/> Not Applicable	
		<input type="checkbox"/> Services for MNS disorders in primary health care (PHC) services closed		
		<input type="checkbox"/> Don't know		
		<input type="checkbox"/> Not Applicable		

5. Which of the following interventions/services related to mental, neurological and substance use (MNS) disorders have been disrupted due to COVID-19?

Please check all that apply with their level of disruption

<b>Mental, neurological and substance use (MNS) disorders interventions/services</b>	<b>Completely disrupted</b> (more than 50% of clients not served as usual)	<b>Partially disrupted</b> (5% to 50% of clients not served as usual)	<b>Not disrupted</b> (less than 5% of clients not served as usual)
<i>a. Management of emergency MNS manifestations (including status epilepticus, delirium, severe substance withdrawal syndromes)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>b. Psychotherapy/counseling/psychosocial interventions for MNS disorders</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>c. Medicines for MNS disorders</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>d. Interventions for caregivers of people with MNS disorders</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>e. Home or community outreach services</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>(including social care services) for people with MNS disorders</i>			
<i>f. Mental health interventions during antenatal and postnatal period</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>g. Services for children and adolescents with mental health conditions or disabilities, including developmental disabilities</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>h. Services for older adults with mental health conditions or disabilities, including dementia</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>i. Diagnostic and laboratory services for people with MNS disorders</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>j. Surgery for neurological disorders (e.g. epilepsy)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>k. School mental health programme</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>l. Work-related mental health programme</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>m. Suicide prevention programme</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>n. Overdose prevention and management programs (e.g. naloxone distribution)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>o. Critical harm reduction services (e.g., needle exchange programs, outreach services)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>p. Opioid agonist maintenance treatment of opioid dependence (with methadone or buprenorphine)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. What are the main causes of this disruption(s)? (Please check all that apply)**

- a. Closure of outpatient services as per health authority directive*
- b. Closure of outpatient disease specific consultation clinics as per health authority directive*
- c. Closure of population level programs as per health authority directive*
- d. Decrease in outpatient volume due to patients not presenting*
- e. Decrease in inpatient volume due to cancellation of elective care*
- f. Inpatient services/hospital beds not available*
- g. Insufficient staff to provide services*
- h. Clinical staff related to mental, neurological and substance use disorders deployed to provide COVID-19 clinical management or emergency support*
- i. The clinical set up has been designated as COVID-19 care facility*
- j. Insufficient Personal Protective Equipment (PPE) available for health care providers to provide services*
- k. Unavailability/Stock out of essential medicines, medical diagnostics or other health products at health facilities*
- l. Travel restrictions hindering access to the health facilities for patients*
- m. Others (please specify what are the other causes of this disruption):*

7. What approaches are being used to overcome the service disruptions to the management of mental, neurological and substance use disorders and provide mental health and psychosocial support in health facilities? (Please check all that apply)

- a. *Tele-medicine /tele-therapy deployment to replace in-person consults*
- b. *Self-help or digital format of psychological interventions*
- c. *Task shifting / role delegation*
- d. *Novel supply chain and/or dispensing approaches through other channels for medicines for mental, neurological and substance use disorders*
- e. *Triaging to identify priorities*
- f. *Redirection of patients to alternate health care facilities or discharge to their homes/families*
- g. *Home or community outreach services*
- h. *Recruitment of additional counsellors*
- i. *Helplines established for mental health and psychosocial support*
- j. *Health care providers working in COVID-19 treatment centres trained in basic psychosocial skills*
- k. *Implementation of specific measures for infection prevention and control in mental health services*
- l. *Others (please describe what other approaches are being used):*

### **SURVEILLANCE**

8. Is the Ministry of Health collecting or collating data on mental, neurological and substance use disorders or manifestations in people with COVID-19?      a. *Yes*    b. *No*    c. *Don't know*

9. Is there a planned or ongoing study related to 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). Please check all that apply and provide details.

- a. *Yes, on mental health impact*
- b. *Yes, on neurological disorders or brain health*
- c. *Yes, on alcohol*
- d. *Yes, on psychoactive drugs*
- e. *Yes, on addictive behaviours*
- f. *No*
- g. *Don't know*

10. Please upload any files related to your mental health and COVID-19 response in your country that you would like to share. e.g Plan, Assessment or other materials: \_\_\_\_\_

# Annex 2

## List of responding countries and territories

### WHO Member States

Member State	WHO region	Responding focal point
Afghanistan	EMR	Bashir Ahmad Sarwari
Algeria	AFR	Mohamed Chakali
Andorra	EUR	Josep Romagosa Massana, Joan Escoter Blavi
Antigua and Barbuda	AMR	Teri-Ann Joseph
Argentina	AMR	Hugo Barrionuevo
Armenia	EUR	Armine Aghajanyan
Australia	WPR	Leila Jordan
Austria	EUR	Christina Dietscher
Bahamas	AMR	Phillip Swann
Bahrain	EMR	Eman Ahmed Haji
Bangladesh	SEAR	Helal Uddin Ahmed
Barbados	AMR	Brian MacLachlan
Belgium	EUR	Pol Gerits
Belize	AMR	Iveth Quintanilla
Benin	AFR	François Agossou
Bolivia (Plurinational State of)	AMR	Maria Guadalupe Gonzales Gonzales
Bosnia and Herzegovina	EUR	Drazenka Malicbegovic
Botswana	AFR	Moagi Gaborone
Brazil	AMR	Catarina Magalhães Dahl
Brunei Darussalam	WPR	Raidah Mohamed
Bulgaria	EUR	Hristo Hinkov
Burkina Faso	AFR	Marie Emmanuelle Zoure
Burundi	AFR	Jérôme Ndaruhutse
Cabo Verde	AFR	Aristides Delgado da Luz
Cambodia	WPR	Chhit Sophal
Cameroon	AFR	Justine Laure Menguene Mviena
Canada	AMR	Marie-Anik Gagné
Chile	AMR	Matías Irarrázaval
China	WPR	Fu Jun



Member State	WHO region	Responding focal point
Colombia	AMR	Nubia Esperanza Bautista Bautista
Congo	AFR	Rosalie Likibi-boho
Cook Islands	WPR	Evangelene Wong
Côte d'Ivoire	AFR	Anna-Corinne Bissouma
Cuba	AMR	Carmen Borrego Calzadilla
Czech Republic	EUR	Dita Protopopová
Denmark	EUR	Nicola Elisabeth Petersen
Dominican Republic	AMR	Alexandra Rodríguez
Ecuador	AMR	Ignacia Paez
Egypt	EMR	Eman Gaber
Equatorial Guinea	AFR	Ana Bella Ekiri Nguie
Eritrea	AFR	Theodros Tekeste
Ethiopia	AFR	Dereje Assefa Zewude
Fiji	WPR	Miliakere Nasorovakawalu
Finland	EUR	Helena Vorma
Germany	EUR	Thomas Stracke
Ghana	AFR	Akwasi Osei
Grenada	AMR	Meryl Roberts-Marryshow
Guinea	AFR	Kémo Soumaoro
Guyana	AMR	Util Richmond-Thomas
Honduras	AMR	Carolina Padilla Rivera
Hungary	EUR	Robert Wernigg
Indonesia	SEAR	Prianto Djatmiko
Iran (Islamic Republic of)	EMR	Ahmad Hajebi
Iraq	EMR	Emad Abdulrazaq Abdulghani
Ireland	EUR	Michael Murchan
Jamaica	AMR	Kevin Goulbourne
Japan	WPR	Takuro Kushima
Jordan	EMR	Fateen Janim
Kazakhstan	EUR	Negai Nikolai
Kenya	AFR	Simon Njuguna, Mercy Karanja
Kiribati	WPR	Arite Katherine Torote
Kuwait	EMR	Najah Mohammed Alenezi

Member State	WHO region	Responding focal point
Lao People's Democratic Republic	WPR	Bouathep Phoumin
Latvia	EUR	Ilze Straume
Lebanon	EMR	Rabih El Chammay
Liberia	AFR	Angie Tarr Nyakoon
Libya	EMR	Ali Abdalla Abdusamad
Lithuania	EUR	Jurgita Kinderiene
Madagascar	AFR	Glenn Torrencelli Edosoa
Malaysia	WPR	Nurashikin Bte Ibrahim
Maldives	SEAR	Aminath Shahuza
Mali	AFR	Cheickna Tounkara
Malta	EUR	Antonella Sammut
Marshall Islands	WPR	Marita Edwin
Mexico	AMR	Lorena Rodríguez Bores Ramírez
Monaco	EUR	Eric Voiglio
Mongolia	WPR	Khandarmaa Tseren-Ochir
Montenegro	EUR	Aleksandra Ražnatović
Morocco	EMR	Bouram Omar
Myanmar	SEAR	Tin Oo
Namibia	AFR	Magdalena Didalelwa
New Zealand	WPR	Barry Welsh
Nicaragua	AMR	Joaquín Antonio Escoto Galeano
Nigeria	AFR	Benjamin Aiwonodagbon
Niue	WPR	Sione Lima Mavaetangi
North Macedonia	EUR	Lence Miloseva
Norway	EUR	Anna Villa
Oman	EMR	Amira Al Raidan
Pakistan	EMR	Samra Mazhar
Panama	AMR	Jose Alberto Calderon
Papua New Guinea	WPR	Umadevi Ambihaipahar
Paraguay	AMR	Luis Armando Taboada Renna
Peru	AMR	Yuri Licinio Cutipe Cárdenas
Philippines	WPR	Frances Precilla Cuevas
Poland	EUR	Karolina Konarzewska

Member State	WHO region	Responding focal point
Qatar	EMR	Susan Clelland
Republic of Moldova	EUR	Jana Chihai
Russian Federation	EUR	Irina Borisovna Moroz
Saint Kitts and Nevis	AMR	Cherrilyn Warde Crawford
Saint Lucia	AMR	Alicia St Juste
Saudi Arabia	EMR	Eisha Mohammed Gaffas
Senegal	AFR	Jean Augustin Diegane Tine
Seychelles	AFR	Gina Michel
Sierra Leone	AFR	Kadiatu Savage
Singapore	WPR	Ong Lay Tin
Slovenia	EUR	Matej Vinko
Solomon Islands	WPR	Paul orotaloa
Somalia	EMR	Zeynab Ahmed Noor
South Africa	AFR	Ad Shiba
South Sudan	AFR	Joseph Mogga
Sri Lanka	SEAR	Rohan Rathnayake
Sudan	EMR	Zienat Sanhori
Suriname	AMR	Savora Omanette
Thailand	SEAR	Tanpisth
Togo	AFR	Kolou Dassa
Tonga	WPR	John Lee Taione
Trinidad and Tobago	AMR	Subrena Calvin-Smith
Tunisia	EMR	Fatma Charfi
Turkmenistan	EUR	Glory
Tuvalu	WPR	Katalina Filipino
Ukraine	EUR	Sergii Shum
United Arab Emirates	EMR	Muna Alkuwari
United States of America	AMR	Leandra Olson
Uruguay	AMR	Horacio Porciuncula
Vanuatu	WPR	Jimmy Obed
Venezuela (Bolivarian Republic of)	AMR	Lía Rodríguez Sánchez
Viet Nam	WPR	Tran Trung Ha

Member State	WHO region	Responding focal point
Yemen	EMR	Abdulquddos Abdulwahab Harmmal
Zambia	AFR	John Mayeya
Zimbabwe	AFR	SM. Chirisa

AFR: WHO African Region; AMR: WHO Region for the Americas; EMR: WHO Eastern Mediterranean Region; EUR: WHO European Region; SEAR: WHO South-East Asia Region; WPR: WHO Western Pacific Region.

## Areas and territories

Area or territory	WHO region	Responding focal point
Aruba	AMR	Chris Goedhart
Bermuda	AMR	Preston Swan
British Virgin Islands	AMR	Virginia Rubaine
Cayman Islands	AMR	Janett Flynn and Dympna Carten
Curaçao	AMR	Beulah Mercera
Hong Kong SAR (China)	WPR	Edmund Fong Ho Ching
Macao SAR (China)	WPR	Chi-Veng Ho
Northern Mariana Islands	WPR	Jesse R. Aguon
occupied Palestinian territory, including east Jerusalem	EMR	Samah Jabr
Turks and Caicos Islands	AMR	Alicia Malcolm

AFR: WHO African Region; AMR: WHO Region for the Americas; EMR: WHO Eastern Mediterranean Region; EUR: WHO European Region; SAR: Special Administrative Region; SEAR: WHO South-East Asia Region; WPR: WHO Western Pacific Region.

Note: Although care has been taken to include names of all contributors, information on any omissions or inaccuracies can be communicated to WHO Secretariat at [mhatlas@who.int](mailto:mhatlas@who.int).

# Annex 3

## Modifications for safe delivery of MNS services and considerations towards restoration of activities<sup>1</sup>

Programme activities	Modifications for safe delivery of service	Considerations for transition towards restoration of activities
Emergency/ acute care for MNS disorders in inpatient and outpatient settings	<p>Continue acute and emergency care for MNS disorders (e.g. imminent suicide risk, seizures, delirium, acute psychosis, acute mania, opioid overdose, severe and complicated substance withdrawal syndromes), and ensure that some inpatient care for MNS disorders remains available.</p> <p>Since neurological manifestations are associated with COVID-19 (e.g. delirium or encephalopathy, agitation, stroke, meningoencephalitis, impaired sense of smell or taste), ensure that all patients presenting with these manifestations are evaluated for COVID-19 as well as for other causes.</p>	
Treatment and care for MNS disorders in outpatient settings	<p>Prioritize face-to-face care for initial management of severe MNS disorders involving either severely impaired functioning or life-threatening situations.</p> <p>Establish clear protocols to ensure the availability of diagnostic and laboratory testing for key scenarios (e.g. to determine cause of delirium or interactions between medicines, blood level of lithium, white blood cell count for clozapine use, neuroimaging for stroke).</p> <p>Incorporate early recognition of and treatment for antenatal and postnatal MNS disorders into modified ANC and PNC protocols. See also Section 2.2.1.</p> <p>For people with substance use disorders, maintain critical harm reduction interventions and psychosocial services, including uninterrupted opioid agonist maintenance treatment and management of severe withdrawal syndromes.</p> <p>Reach out to frontline workers in all health facilities (including staff in long-term care homes) to offer access to mental health care and self-help materials.</p> <p>Introduce use of longer prescription periods involving either expanded take-home practices (e.g. for methadone or buprenorphine treatment, sustained release antiseizure medicines, or neuroleptic depot with informed consent) or periodic delivery of medicines to the home. Involve caregivers to ensure medicines are stored safely to reduce suicide risk.</p>	<p>Reinstate routine laboratory monitoring for people with MNS disorders on psychotropic medications on return to the clinic.</p> <p>Prepare for increased service use (beyond pre-pandemic levels) for a range of conditions, including depressive disorder, anxiety disorder, alcohol and drug use disorders, prolonged grief disorder, psychosis, posttraumatic stress disorder and self-harm and suicidality.</p> <p>Ensure that rehabilitation support is available for people with severe MNS disorders and associated psychosocial, intellectual and cognitive disabilities.</p>

Programme activities	Modifications for safe delivery of service	Considerations for transition towards restoration of activities
	<p>Digital health care or telemedicine can be introduced for:</p> <ul style="list-style-type: none"> <li>• follow-up visits;</li> <li>• psychological treatments, if functioning is not severely impaired;</li> <li>• caregivers of people with MNS disorders;</li> <li>• group psychosocial care (e.g. mutual-help groups).</li> </ul> <p>Redirect initial care for mild depression and anxiety to self-help (e.g. digital or written materials) (2).</p> <p>Enhance outreach care for isolated people with severe MNS disorders, as needed. Ensure home visits are maintained for specific situations (e.g. care of older adults with MNS disorders).</p> <p>Delay elective surgery for epilepsy and delay any psychometric assessments.</p>	
Care provided in specialized long-term inpatient care / residential facilities (e.g. mental hospitals, homes for people with dementia, alcohol and drug residential rehabilitation centres)	<p>Limit admissions to urgent cases. Perform COVID-19 testing prior to admission, ensuring that recommended quarantine protocols are followed with full IPC used for positive cases. Establish and enhance monitoring of complaint mechanisms for neglect or human rights violations. Enable remote family support if visiting is suspended. Use accessible formats and familiar communication channels to deliver information about IPC measures for people with psychosocial, intellectual or cognitive disabilities. Ensure that access to high-quality treatment and criteria for isolation are the same for people with MNS conditions as they are for others.</p>	
Cross-sectoral service delivery (schools, social services, criminal justice) for MNS disorders	<p>Enhance engagement with governmental and NGO actors to mobilize social and resources to support people with MNS disorders (e.g. at home, and in schools, care homes and prisons), and ensure that people with severe MNS disorders have access to services that address their basic needs.</p> <p>Modify school mental health services to be delivered through online platforms</p>	<p>Consider long-term effects of COVID-19 response on risk groups (pre-existing MNS disorders, older adults, women, young people, children); enhance cross-sectoral services.</p>

Programme activities	Modifications for safe delivery of service	Considerations for transition towards restoration of activities
Mental health promotion and prevention of MNS disorders	Provide access to information about positive coping methods.  Support nurturing learning environments for children and young people who are confined at home.  Support activities that help isolated older adults stay connected with others. older adults stay connected.	

ANC: antenatal care; IPC: infection prevention and control; MNS: mental, neurological and substance use; NGO: nongovernmental organization; PNC: postnatal care.

<sup>1</sup> Reproduced from section 2.2.3 of Maintaining essential health services: operational guidance for the COVID-19 context. Interim guidance (1).

1. Maintaining essential health services: operational guidance for the COVID-19 context. Interim guidance. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1>, accessed 2 October 2020).
2. Doing what matters in times of stress: an illustrated guide. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/331901>, accessed 2 October 2020).





World Health Organization  
Department of Mental Health and Substance Use  
20 avenue Appia  
1211 Geneva 27  
Switzerland

Email: [mhatlas@who.int](mailto:mhatlas@who.int)

[http://www.who.int/mental\\_health](http://www.who.int/mental_health)

<http://www.who.int/teams/mental-health-and-substance-use/covid-19>

