



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

measures are eased. Colombian municipalities have established crisis hotlines to provide mental health support and connect individuals to services. About 10% (180 000) of the Venezuelan migrants have Colombian health insurance, which allows up to ten sessions with a psychologist and the possibility of a referral to a psychiatrist. Expediting the care pathway to allow more refugees to be regularised and enrolled in the national health insurance program would be the most direct route for ensuring access to quality mental health services. There are also multiple intergovernmental and non-governmental organisations active in Colombia that provide MHPSS services. The Inter-Agency Standing Committee (IASC) uses a four-tiered intervention pyramid for organising and coordinating diverse services, ranging from population level provision of security and basic needs up to psychiatrist-delivered group or individual psychotherapy. IASC has adapted its model to COVID-19.

Coordination among responding organizations is needed to achieve comprehensive coverage. Proven approaches include: community outreach; screening for stressors and common mental disorders using validated instruments; and applying a stepped-care model to route migrants with symptom elevations into WHO-approved, evidence-based interventions provided by trained and supervised counsellors.⁴ Given the dearth of mental health professionals in low-income and middle-income countries, staffing can be extended by training para-professionals to deliver interventions (so-called task shifting or task sharing). Provisions should be made for referral and transport of migrants with severe symptoms or suicidal thoughts to emergency psychiatric evaluation. Intervention sessions should continue until symptoms decline to sub-syndromal levels.

For Venezuelans who remember their country before the 2000s, the complete metamorphosis from proud, functional, solvent democracy to disgraced, dysfunctional, bankrupt autocracy has been psychologically disorienting and disturbing. Millions who made the consequential

decision to migrate are experiencing severe psychological stressors, while the fearsome overlay of COVID-19 exacerbates risks for distress and disorder. Providing MHPSS for Venezuelan migrants in Colombia is a compelling need and a daunting challenge.

We declare no competing interests.

Zelde Espinel, Roberto Chaskel, Ryan C Berg, Hermes Jose Florez, Silvia L Gaviria, Oscar Bernal, Kim Berg, Carlos Muñoz, Marisa G Larkin, *James M Shultz
jshultz1@med.miami.edu

Department of Psychiatry and Behavioral Sciences (ZE) and Department of Public Health Sciences (HJF, JMS, MGL) and Miami Transplant Institute (CM), University of Miami Miller School of Medicine, Miami, FL 33136, USA; Department of Psychiatry, Hospital Militar Central, Bogotá, Colombia (RC); Department of Psychiatry, Universidad El Bosque, Bogotá, Colombia (RC); School of Medicine, Universidad de Los Andes, Bogotá, Colombia (RC); Latin America Studies Program, American Enterprise Institute, Washington DC, USA (RCB); Department of Psychiatry, Universidad CES, Medellín, Colombia (SLG); Department of Psychiatry, Universidad de Antioquia, Medellín, Colombia (SLG); Department of Government, Universidad de Los Andes, Bogotá, Colombia (OB); and Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA (KB)

- 1 Daniels JP. Venezuelan migrants "struggling to survive" amid COVID-19. *Lancet* 2020; **395**: 1023.
- 2 United Nations High Commissioner for Refugees. Refugee and migrant response plan 2020: for refugees and migrants from Venezuela. Jan 7, 2020. <https://data2.unhcr.org/en/documents/details/73277> (accessed May 12, 2020).
- 3 Shultz JM, Garfin DR, Espinel Z, et al. Internally displaced "victims of armed conflict" in Colombia: the trajectory and trauma signature of forced migration. *Curr Psychiatry Rep* 2014; **16**: 475.
- 4 Shultz JM, Verdelli H, Gómez Ceballos ÁM, et al. A pilot study of a stepped-care brief intervention to help psychologically-distressed women displaced by conflict in Bogotá, Colombia. *Glob Ment Health* 2019; **6**: e28.
- 5 Carroll H, Luzes M, Freier LF, Bird MD. The migration journey and mental health: Evidence from Venezuelan forced migration. *SSM Popul Health* 2020; **10**: 100551.
- 6 United Nations Security Council. Venezuela: overview of priority humanitarian views. March 2019. <https://undocs.org/S/2019/345> (accessed May 12, 2020).
- 7 Gómez Arvella CE. Venezuela's crisis reaches this point: the suicide rate exceeds the world average. July 3, 2018. <https://latinamericanpost.com/21905-venezuelas-crisis-reaches-this-point-the-suicide-rate-exceeds-the-world-average> (accessed May 12, 2020).
- 8 United Nations High Commissioner for Refugees. Protection monitoring Venezuela situation update 1 (January–June 2019). July 19, 2019. <https://reliefweb.int/report/ecuador/protection-monitoring-venezuela-situation-update-1-january-june-2019> (accessed May 12, 2020).
- 9 Tannen JN. Scholars explore the lasting effects of a crisis departure. April 2, 2020. <https://news.miami.edu/stories/2020/04/scholars-explore-the-lasting-effects-of-a-crisis-departure.html> (accessed May 12, 2020).
- 10 Grupo Interagencial sobre Flujos Migratorios Mixtos. Colombia: joint rapid needs assessment—COVID-19. May 6, 2020. <https://data2.unhcr.org/en/documents/details/76032> (accessed May 12, 2020).

Global mental health and COVID-19

The COVID-19 pandemic has disrupted the delivery of mental health services globally, particularly in many lower-income and middle-income countries (LMICs), where the substantial demands on mental health care

imposed by the pandemic are intersecting the already fragile and fragmented care systems. The global concern regarding the psychosocial consequences of COVID-19 has led major funding bodies and governments to



Published Online
June 2, 2020
[https://doi.org/10.1016/S2215-0366\(20\)30235-2](https://doi.org/10.1016/S2215-0366(20)30235-2)

increasingly call for proposals to address these effects. Although assessments of high-quality systematic data that address the immediate psychosocial problems of the pandemic are pertinent,¹ the generation of evidence that advances the objectives of global mental health within the context of the pandemic is also vital.²

In the past decade, global mental health researchers have made considerable progress in the development and testing of innovative approaches within mental health care. Trials have shown the clinical effectiveness and cost-effectiveness of mental health interventions, despite the large gaps in care for mental disorders globally.^{3,4} To address shortages in service delivery, the 2018 *Lancet* Commission on global mental health and sustainable development⁴ identified mental health as an essential component of universal health coverage. Among its key messages, the Commission re-emphasised the call to scale up mental health care and recognised the potential of digital health to increase access to mental health services.⁴ The case for repeating these key messages is compelling as mental health professionals devise urgent strategies to address the mental health consequences of COVID-19. How can we create notable actions from existing strategies in global mental health to improve coverage of mental health services in the coming months?

Two successful global mental health strategies are relevant to research on mental health services in the context of COVID-19. The first is task shifting—the use of trained lay health workers to deliver health care in non-specialist settings. With regard to the data on global care gaps for mental disorders, the situation is least favourable in LMICs.⁴ Task shifting has led to the success of many innovative mental health services, with evidence of promise in low-resource settings, despite several implementation challenges limiting their use.³ Increasing pressure on health systems resulting from COVID-19 highlights the need to re-examine task shifting, to further investigate how it can be widely implemented to improve the access and reach of mental health services. Task shifting can be used to address the urgent need to build a provider base in developing countries, given the flexible workforce it can provide for service delivery at the community level, within homes, schools, work places, and care centres.⁵ These settings can serve as service outlets for mental health promotion and awareness programmes, and for service provision

via community engagement with trained lay mental health providers.⁵ However, in implementing task shifting, important aspects are to build on past successes by recognising its limits as a system intervention,³ and give attention to implementation barriers to scale-up and sustain the use of successful approaches. Essentially, to optimise uptake of new or existing evidenced-based mental health innovations, adopting and adapting task-shifting strategies within health systems and implementation research frameworks will be necessary. Such approaches will allow targeted problems to be identified, studied, and addressed within some or all of the complex service levels within the six building blocks of the health system (service delivery, health workforce, information technology, medical products, financing, and governance and leadership), which will be crucial to wide-scale implementation and coverage.

The second strategy is the use of digital health technology to strengthen health systems. Widespread adoption of mobile phones in LMICs has led to their increasing use for health interventions. Although evidence supporting large-scale adoption of virtual interventions for mental health care in LMICs is sparse,⁶ and high-income countries (HICs) currently dominate digital innovations,¹ the COVID-19 pandemic has led to increasing global adoption of virtual care to reduce the risk of infection among health workers.⁷ Furthermore, despite several questions surrounding digital innovation, even in HICs, their potential to increase access and coverage in hard-to-reach areas calls for more research on their effectiveness in LMICs.⁶ Mobile phones can assist the delivery of quality services by facilitating access to training, supervision, and support among care providers, and making health records available remotely.⁶ A basic mobile phone function such as text messaging can have a range of uses, from delivering bulk health information on prevention and promotion programmes, to uses in supporting patient recovery even in cases of severe mental illness such as psychosis.⁸ Additionally, International Telecommunication Union reports have indicated high usage of mobile internet networks in LMICs (>91% 3G users and >78% Long Term Evolution or Worldwide Interoperability for Microwave Access network users), meaning online video calls and mobile phone applications can be used to support patient care in real time.⁹ The availability of internet data from mobile networks can also allow for follow-up care and empowerment of

For global statistics of the International Telecommunication Union see <https://www.itu.int/en/ITU-D/Statistics/Pages/stat/default.aspx>

patients and their families during the recovery process via various online platforms. Digital health care can be personalised to daily life^{1,8} by the direct delivery of psychological treatment to patients—an avenue that also addresses cost and stigma-related barriers to health care.⁵ From a research perspective, digital technology provides an efficient and cost-effective way to recruit patients and provide easy access to care, particularly in this time of physical distancing.¹ The high use of mobile phones in LMICs⁹ presents health-care planners and researchers with opportunities to develop or adapt virtual preventive and treatment interventions that have been successful in HICs, to minimise the mental health consequences of COVID-19. However, despite the incentives to increase uptake of digital health, an important caveat is the possible lack of access for vulnerable people needing health care. To address this limitation, the *Lancet* Commission on global mental health recommended adoption of digital interventions alongside traditional treatments, rather than as replacements.⁴

The psychosocial burden of COVID-19 will become increasingly evident in the coming months as the effects of social measures such as physical distancing, loneliness, death of friends and family members, and job losses manifest. Efforts to respond to these mental health needs present researchers with an important

opportunity to build on what we know and advance progress in achieving the mental health objectives of universal health coverage.

I declare no competing interests.

Lola Kola

lola_kola2004@yahoo.com

WHO Collaborating Centre for Research and Training in Mental Health, Neurosciences, and Drug and Alcohol Abuse, Department of Psychiatry, College of Medicine, University of Ibadan, Ibadan 200211, Nigeria; and Department of Sociology and Psychology, Faculty of Social Sciences, Lead City University, Ibadan

- Holmes EA, O'Connor RC, Perry VH, et al. Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *Lancet Psychiatry* 2020; **7**: 547–60.
- Saxena S, Belkin G. Knowledge gaps in implementing global mental health activities. *Glob Ment Health (Camb)* 2017; **4**: e23.
- Javadi D, Feldhaus I, Mancuso A, Ghaffar A. Applying systems thinking to task shifting for mental health using lay providers: a review of the evidence. *Glob Ment Health (Camb)* 2017; **4**: e14.
- Patel V, Saxena S, Lund C, et al. The *Lancet* Commission on global mental health and sustainable development. *Lancet* 2018; **392**: 1553–98.
- Kohrt BA, Asher L, Bhardwaj A, et al. The role of communities in mental health care in low-and middle-income countries: a meta-review of components and competencies. *Int J Environ Res Public Health* 2018; **15**: 1279.
- Naslund JA, Aschbrenner KA, Araya R, et al. Digital technology for treating and preventing mental disorders in low-income and middle-income countries: a narrative review of the literature. *Lancet Psychiatry* 2017; **4**: 486–500.
- Webster P. Virtual health care in the era of COVID-19. *Lancet* 2020; **395**: 1180–81.
- Ben-Zeev D, Buck B, Kopelovich S, Meller S. A technology-assisted life of recovery from psychosis. *NPJ Schizophr* 2019; **5**: 15.
- Kale N, Jacob I, Laux T, Kataria R, Jain Y, Gogia P. Managing major psychiatric illnesses through tele-consultation in a secondary care setting in rural India. *Ann Glob Health* 2016; **82**: 323–24.

Addressing the public mental health challenge of COVID-19



The rapid global spread of COVID-19 is having wide-ranging effects on population mental health, which are even greater for particular groups of individuals, including those with pre-existing mental disorder.^{1,2} Furthermore, increased COVID-19 infection and mortality would be predicted in individuals with a mental disorder,¹ given that their life expectancy is reduced by 7–25 years, mainly because of higher prevalence of physical ill health when compared with those who do not have a mental disorder.³

The COVID-19 pandemic presents a triple global public mental health challenge: (1) to prevent an associated increase in mental disorders and a reduction in mental wellbeing across populations; (2) to protect people with a mental disorder from COVID-19, and the associated consequences, given their increased vulnerability; and (3) to provide appropriate public mental health

interventions to health professionals and carers. This challenge is compounded by the inadequate population coverage of evidence-based public mental health interventions before COVID-19, even in high-income countries.^{3,4} Since the start of the COVID-19 pandemic, the provision of some of these mental health interventions has become more limited by quarantine and lockdown measures. Interventions to prevent, treat, and mitigate the effects of COVID-19 are likely to adversely affect mental health,⁵ particularly in those with or at a higher risk of mental disorder.^{1,3} However, a key opportunity exists to mitigate this challenge through early action to increase coverage of public mental health interventions.

Before COVID-19, 20% of the global disease burden was attributable to mental disorder.⁶ Factors contributing to the size of this burden include the

Published Online
June 9, 2020
[https://doi.org/10.1016/S2215-0366\(20\)30240-6](https://doi.org/10.1016/S2215-0366(20)30240-6)