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.

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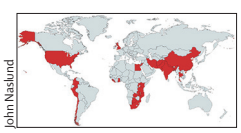
The NIMH global mental health research community and COVID-19



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The world faced substantial challenges in meeting the demands for mental health care, even before the emergence of coronavirus disease (COVID-19). With the havoc caused by the pandemic and the impending impact on economies, social structures, and health systems, a global mental health crisis is arising. The Director-General of the UN forecast this situation in a policy brief on May 13, 2020, stating, "The mental health and wellbeing of whole societies have been severely impacted by this crisis and are a priority to be addressed urgently."[1] Three critical actions were recommended: apply a whole-of-society approach to promote, protect, and care for mental health; ensure widespread availability of emergency mental health and psychosocial support; and support recovery from COVID-19 by developing mental health services for the future.

In a field that is chronically underfunded and ignored by most policy makers, especially in low-income and middle-income countries (LMICs), taking action is not easy. Upwards of 90% of people with mental health conditions receive no treatment in LMICs. As the COVID-19 pandemic unfolds, and given the likelihood of even fewer resources dedicated to mental health services, questions arise about whether it will be feasible to implement the UN's recommendations in the coming years.

Can the research community offer any rapid solutions? The National Institute of Mental Health (NIMH) supports a network of global research Hubs designed to address questions that arise as LMICs widely implement sustainable, evidence-based mental health services.[2] These so-called "NIMH Scale-Up Hubs" are interdisciplinary, with interest and expertise of the people involved in increasing the reach, accessibility, adoption, quality, costs, and effectiveness of mental health services, enhancing collaborative learning and development, building local capacity for implementation research, and establishing relationships with governmental, non-governmental, and community-based stakeholders. We present examples of replicable programmes that can support the UN's recommendations.

Hubs deploy creative strategies to engage entire communities in delivering evidence-based interventions through various platforms across the life course. In Pakistan, teachers are trained to recognise and manage emotional and behavioural problems in children attending primary and secondary schools through a specially developed online training programme integrated into the teachers' ongoing education platforms.[3] Teachers use an interactive chatbot to work with children in classroom settings, and become better equipped to prevent any emotional or behavioural problems from disrupting the children's education and wellbeing. In Uganda, parents are trained to work alongside community health workers to deliver a family group intervention to children with disruptive behaviours.[4] The intervention builds support for families by providing opportunities for caregivers and children to communicate in safe settings with other families who have shared experiences. In Sierra Leone, evidence-based group interventions for mental health are integrated into youth entrepreneurship programmes that offer war-affected young people opportunities for a livelihood and encourage development of local capacity.[5] The interventions combine elements from

cognitive behavioural and interpersonal therapies and are delivered by lay workers. In India, community-based interventions for suicide prevention are implemented among students and farmers, with community health workers who are trained to identify and refer vulnerable groups to local mental health services.[6] In Thailand, people involved in community-based care management are trained to help caregivers and people aged 60 years or older with behavioural and psychological symptoms of dementia.[7] Psychological, physical, and educational interventions are combined to increase the effectiveness of these interventions in improving the quality of life of older people and their caregivers.

Some Hubs focus on integrating digital technology into scalable models of service delivery. In India, digital technology is used to train community health workers to deliver a brief evidence-based psychological treatment over six to eight sessions for depression in primary care settings in a relatively deprived state in the country.[8] The low-cost training model replaces face-to-face training programmes requiring specialist trainers and costly logistical planning for delivery. In Colombia, screening and treatment for depression and unhealthy alcohol use computerised validated clinical assessments, a digital clinical decision support tool to guide providers in treatment choices, and a digital therapeutic application to promote behaviour change and wellness among patients.[9] In Mozambique, a brief electronic mental wellness tool helps community health workers, primary care providers, and mental health specialists to identify any mental disorder with accuracy. Additionally, the tool helps to provide standardised evidence-based interventions for severe and common mental disorders, alcohol and substance misuse, and suicide prevention through the use of digital therapeutic applications that are able to connect with electronic medical records.[10]

The Hubs rapidly responded to the COVID-19 crisis by adapting the above programmes to provide essential mental health and psychosocial support. Examples include developing modules to train teachers who are managing pandemic-related anxiety in school children in Pakistan, as well as taking measures to protect their own wellbeing. Technological innovations facilitating mental health delivery in Colombia have been mobilised and made freely available to assist with recovery efforts; furthermore, the Mozambican Ministry of Health has adopted and scaled up the technology as the new standard of care throughout the mental health system. In India, guidelines have been issued on the responsible reporting of suicides and other mental health concerns during COVID-19. In Malawi, a short telephone-based protocol is being used to identify suicide risk in community clinics, given that direct face-to-face contact is not possible. In India, Colombia, and Mozambique, digital tools are being deployed to manage stress, anxiety, and depression among frontline workers responding to patients with COVID-19.

Hubs present opportunities for mutual learning, in which frugal innovations forged out of necessity in LMICs can address racial and ethnic mental health disparities in high-income countries. For example, implementation strategies that have been developed and tested in Sierra Leone[5] are being adapted for a US-based initiative targeting mental health disparities in migrant communities by advancing new, family-based preventive interventions. These interventions are being given by refugees, for refugees, to reduce the risks of mental health problems associated with displacement, resettlement, family social and economic stress, experiences of racism, and poor access to care.

Collectively, the Hubs facilitate multidirectional learning, research capacity development, and, importantly, the design of novel implementation studies to advance scientific knowledge by examining the best strategies for scaling up mental health services in diverse settings, with all age groups, while addressing efficiency and cost-effectiveness. Much can be learnt from these successful collaborations to sustainably address immediate priorities and long-term strategies for mental health implementation research in LMICs, as well as in high-income countries, during and beyond COVID-19.

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