

# COVID-19 and population mental health: a systematic review

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## EXECUTIVE SUMMARY



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November 2022



Economic  
and Social  
Research Council

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## Funding & funder involvement

This review was undertaken by the EPPI Centre as a partner of the International Public Policy Observatory (IPPO) (<https://covidandsociety.com>) which is ESRC-funded.

## Conflicts of interest

There were no conflicts of interest in the writing of this report.

## Contributions

The opinions expressed in this publication are not necessarily those of the EPPI Centre or the funders. Responsibility for the views expressed remains solely with the authors.

This report should be cited as: Dickson K, Mendizabal-Espinosa R, Vigurs C, Meehan L, Draper A, Ko SY(J), Petros S, Nguyen C, Stansfield C (2022) *COVID-19 and population mental health*. London: EPPI Centre, UCL Social Research Institute, UCL Institute of Education, University College London.

## Acknowledgements

We would like to thank a number of student research assistants for volunteering their free time to contribute to all stages of this review while completing their studies: Aisling Draper, Celine Nguyen, Laura Meehan, and Sum Yue (Jessica) Ko. The research has benefitted greatly from their diligence and commitment to social science. We would also like to acknowledge the support of members of the Steering Board created to help with the project, namely Prof. Siobhan O'Neill, Prof. Ann John and Dr Polly Waite, as well as the members of the IPPO team Prof. Geoff Mulgan, Prof. Muiris MacCarthaigh, Ayden Wilson, and Sarah O'Meara, alongside initial discussions with Eleanor Williams. Our gratitude also extends to the EPPI Centre and their role in co-ordinating the International Public Policy Observatory: Dr Ian Shemilt, Prof. James Thomas and Prof. David Gough.

Cover design by: Lionel Openshaw

ISBN: 978-1-911605-35-5

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## EXECUTIVE SUMMARY

### BACKGROUND

The COVID-19 pandemic and related mitigation responses have impacted social, financial, and economic spheres globally. An increase in the incidence of mental health problems at population level has been reported against this backdrop, with studies suggesting that the prevalence of mental health problems during the COVID-19 pandemic is greater than pre-pandemic estimates (Nochaiwong et al., 2021). Population-level initiatives to mitigate the mental health problems arisen from the COVID-19 pandemic and other crises have been described in the literature but have not always been collated in a way that can directly inform policy decision-making (Kola, 2021). Consequently, policy calls to identify effective interventions to address poor mental health exacerbated by the pandemic continue to be made (Santomauro et al., 2021). However, identifying effective interventions and planning feasible and sustainable scale-up remains a challenge.

### REVIEW AIMS AND QUESTIONS:

To meet policy demand for collated evidence on population-level initiatives to mitigate the mental health problems arisen from the COVID-19 pandemic, IPPO is conducting a systematic review of international evidence to answer the following question:

***What are the most effective, scalable interventions to address widespread mental health issues that have surfaced during the COVID-19 pandemic?***

This will entail conducting a multi-component systematic review to answer review questions (RQ) on the:

- 1) nature and extent of mental health issues arising during covid-19, to inform the focus on
- 2) the effectiveness of population-level mental health interventions and
- 3) the factors potentially influencing scale-up of mental health interventions

Alongside this systematic review, the IPPO team has produced further materials to help policymakers better understand how governments have responded to the widespread mental health issues that have surfaced during the COVID-19 pandemic, and highlight key findings about the effectiveness and scalability of mental health and psychosocial interventions.

### REVIEW APPROACH AND SCOPE

Initial scoping for this review highlighted that an overview of reviews design was most appropriate for RQ1 and RQ2. Firstly, the IPPO map indicated that a number of systematic reviews on the prevalence of mental health issues had been published since the start of the pandemic, and secondly during initial screening for RQ2 and RQ3, we identified a number of systematic reviews focused on the effectiveness of mental health interventions delivered to whole populations. Using similar transparent methods to a systematic review, an overview of reviews also aims to make best use of existing research literature. For RQ3, process and contextual detail about the range of factors to consider when scaling-up interventions was more readily available in primary studies. To answer RQ1 we included systematic reviews published from 2021 that had critically appraised and statistically combined data on prevalence of, anxiety, depression, and PTSD in the general population. To answer RQ2, we also prioritised reviews that had conducted a risk of bias of included studies and evaluated the effectiveness of mental health and psychosocial interventions (MHPSS) on anxiety, depression and PTSD using meta-analysis. For RQ3 we included primary studies with data on scale up of MHPSS interventions. Further methodological details are provided in the technical report.

## KEY FINDINGS

### RQ1: What is the nature and extent of mental health issues in the general population?

Since 2021, a total of 19 reviews have provided pooled estimate of effects for anxiety (N=15), depression (N=14) and post-traumatic stress (N=6) amongst the general population.

- **Anxiety:** when comparing with pre-pandemic data two reviews found an **increase in anxiety**. Pooled prevalence varied between the remaining meta-analysis, ranging from 21.0% to 52.6%.
- **Depression:** when comparing with pre-pandemic data two reviews found a **moderate increase** in depression. The pooled prevalence of the remaining reviews ranged from 21.3% to 34.3%.
- **PTSD/PTSS** The pooled prevalence of post-traumatic stress in the general population ranged from 9% (CI: not reported) to 27% (95% CI: 20.0–35.6%).

### RQ2: Are population-level MHPSS interventions effective for reducing anxiety, depression and PTSD?

Seventeen reviews, nine investigating children and young people and eight investigating adults, were judged to be of high and medium quality and included findings from meta-analysis of outcome data. Overall, there is review-level evidence that psychological interventions, delivered at population-level, can have a positive impact on preventing and treating depression, anxiety, and PTSD. A summary of the findings is below:

#### Children and young people

- Reviews of **school-based interventions** report **evidence of positive effect** on:
  - CBT for the universal and targeted prevention of anxiety at primary schools
  - CBT and CBT with psychoeducation for universal prevention of anxiety and depression in secondary schools
  - Mindfulness/relaxation for universal prevention of anxiety in secondary schools
  - Cognitive-behavioural with IPT for universal prevention of depression in secondary schools
  - Third wave (e.g., acceptance and commitment therapy) for universal prevention of depression
  - Psychological therapies for indicated prevention of anxiety and depression in secondary schools
- **No evidence of difference** was found between intervention and control groups for
  - Universal or targeted prevention of depression in primary schools
  - Targeted prevention of anxiety or depression in secondary schools
- Reviews of **digital intervention** report **evidence of positive effect** on:
  - CBT-based interventions delivered via the internet, smartphone or mobile apps for treating depression and anxiety
- Reviews of **community-based interventions** report **evidence of positive effect** on
  - CBT for treating anxiety and depression
  - Psychotherapy for treating depression
  - A range of trauma-informed CBT and psychotherapeutic approaches for treating PTSD (see below).
- **No evidence of difference** was found between intervention and control groups for treatment of PTSD when delivering supportive counselling or family therapy

## Adults

- Reviews of **workplace interventions** report **evidence of positive effect** on:
  - Mindfulness training intervention for universal prevention of anxiety and depression.
  - Psychoeducation for universal prevention of depression
  - Cognitive behavioural interventions, and self-help interventions combined with exercise for indicated prevention of depression.
- Reviews of **digital intervention** report **evidence of positive effect** on:
  - CBT and ACT based smartphone apps for preventing and treating anxiety
  - Compositive psychological interventions for treatment of anxiety (e.g., mindfulness, iCBT, iACT)
  - Internet-based CBT for treatment of anxiety, depression and PTSD
- They also report **no evidence of difference** for
  - CBT and ACT based smartphone apps for treatment of PTSD when compared to control groups
- Reviews of **community-based interventions** report **evidence of positive effect** on:
  - Stress Control Programmes for preventing anxiety and depression
  - IAPT and CBT based psychological therapies for treating anxiety and depression

## RQ3: What factors potentially influencing scale-up of mental health interventions?

A total of 87 primary studies provided evidence on scaling up of mental health and psychosocial interventions. Scale parameters: (e.g., intended reach) included:

- **Transnational**: e.g. not being limited within physical or political spatial boundaries
- **System wide**: e.g., the integration of services, such as integrating new mental health care services into general health care systems or integrating services into primary care.
- **Place-based** e.g., within the boundaries of a community, nation or state or smaller place-based communities such as schools, universities, or workplaces.

The **factors** presented below suggest that **programmes may be more likely to achieve scale-up** if they:

- **Intervention characteristics**:
  - Increase access to services across time and place by digitising interventions and making them available online
  - Expand the workforce by task shifting or task sharing from specialists to non-specialists
  - Use technology and online provision to train non specialists and speed up workforce availability
  - Enable self-referral and make mental health interventions more open access
- **Resource related factors**:
  - Secure policy support and government funding for scaling by demonstrating evidence of impact
  - Identify when additional resource is needed for scale-up to support greater implementation success
  - Match service level to needs by identifying care pathways, signposting, or stepped care
  - Integrate mental health services into primary care to make more efficient use of resources
- **Working together**:
  - Employ effective leaders to gain lasting buy-in from stakeholders on scale-up of services
  - Include knowledgeable local champions to promote new services at set-up and maintenance
  - Gain the buy in of multi-stakeholders, including the implementors of programmes
- **Programme fidelity** (to ensure scale up happens as intended):
  - Provide training fidelity and knowledge transfer to provide skills for consistency in provision
  - Use guidelines, templates, manuals to provide a common shareable framework for delivery

- **Monitoring and Evaluation:**
  - Use benchmarks and indicators to measure progress against and support future investment
  - Include ongoing evaluation of the quality and feasibility of services and track scale-up progress
  - Standardize training and adopt recognised accreditation models to disseminate the programme more widely and implement best practice while seeking greater reach
- **Test the acceptability of an intervention prior to scale-up**
  - Assess acceptability to implementors to anticipate potential organisational changes needed
  - Assess acceptability to service users to ensure services are meeting needs and reach
- **Contextual factors:**
  - Engage with the socio-political context of programme implementation to assess and ensure fit
  - Consider cultural factors and adaptation needs by integrating local knowledge and practices with evidence-based programmes to contribute to contextually appropriate service delivery.
- **Combine supply side and demand side approaches**
  - Use resource mapping to identify population needs and service gaps.
  - Take proactive efforts to raise awareness of the programmes in the target community.
  - Minimising barriers to service use through campaigns to reduce stigma towards mental ill health

### Implications for policy and practice

- The evidence-base for the effectiveness of population-mental health and psychosocial interventions continues to gain traction. However, if effective mental health and psychosocial interventions are to be made available at population-level, they need to be scaled appropriately. Policy and practice support for scale-up is critical in this endeavour, and more so when scaling requires intervention, organisational and system-level changes. Government commitment in the form of policy initiatives and resource allocation is key to ensuring the sustainable impact of scaled intervention. Feasibility and cost-effectiveness analysis, prior to scale-up and throughout implementation, could also help inform the success of scale-up strategies.
- There is consistent evidence on the effectiveness of **community-based** population-level mental health services for treating symptoms of anxiety, depression and PTSD. Large-scale nationwide programmes, such as Increasing Access to Psychological Services (IAPT), which provides a stepped-care approach to maximise availability of services to need (e.g., low to high intensity CBT, counselling interpersonal therapy) is now very well established in England and Wales. The rollout of similar public mental health care in other regions would require significant government policy buy-in to enable and maintain any infrastructure changes needed. It would also require an investment in human resource to establish a trained and competent workforce and support and any organisational culture changes identified.
- The review-level evidence for **school-based** prevention interventions is mixed. While findings suggest that universal and targeted prevention can work to delay the onset or worsening of anxiety symptoms in primary schools, replication of results were not found for depression. Similarly, findings for interventions delivered in secondary schools suggested that CBT-based approaches work for universal prevention of anxiety and depression, but not targeted prevention. While there is evidence of effectiveness for indicated prevention in adolescents. To address this, it might be useful to consider taking a stepped care approach in schools. For example, providing universal prevention interventions for all students alongside targeted individualised support for children and young people with elevated symptoms. The school will continue to be a site in which to reach large numbers of children and young people, but more understanding of how interventions need to be tailored to meet their needs as they develop is required.

- There are a variety of effective universal and indicated **workplace prevention** interventions for depression and anxiety. Sustained, long-term investment in occupation-based mental health interventions by employers, ensuring they are both acceptable and accessible to employees, continues to be an important route when seeking to reach a large proportion of the adult population and support ongoing mental health efforts in light of the pandemic. The workplace also provides an opportunity to implement key scale up-strategies, such as: adopting effective leadership and deploying champions to promote mental health initiatives, engaging with multi-sectorial partners to provide on and off-site services (e.g., employee assistance programmes), using benchmarks and indicators to measure progress against and incorporating ongoing evaluation of the quality and feasibility of services to track effectiveness and scale-up progress.
- Although the evidence-base for the effectiveness of **digital and mobile app interventions** is currently modest, with greater effect sizes for internet-delivered interventions with professional input, the potential scale-up of specialist and non-specialist online psychological support and increasing transnational reach of mental health provision remains. Thus further consideration of the role of digital mental health, in the prevention and treatment of mental health symptoms as part of a stepped-care approach to service delivery is warranted. Online platforms also provide a resource efficient way to reach and train a workforce necessary for the delivery of mental health services, on and offline, including provision of supervision and cascading of best practice to ensure fidelity. This of course, is particularly salient in the context of COVID-19 and any future infectious disease crises, as many mental health services remain virtual as we continue to use a hybrid model of working.
- As highlighted, there is consistent evidence of improving intervention reach and scale-up of mental health services through **stepped care models** of provision. That is, where low intensity and brief interventions are offered as a first-line approach, with more intensive interventions made available for those with more severe needs. Taking a stepped care approach can be supported by **task-shifting**, where lower severity mental health needs can be shifted to non-specialists, (with referral to specialists at higher level of needs if required), enabling greater access to mental health services that would otherwise be the case if providers needed extensive training.
- However, in most scale-up scenarios, there will be a need to substantially enlarge the mental health workforce to scale interventions to effectively target large population with prevention needs and smaller populations of people who require more intensive treatments. This can be supported by **using guidelines, templates, manuals** to provide a common intervention framework and ensure intervention fidelity, as stated, by utilising digital platforms to support and train the workforce and speed up their availability.
- In the aftermath of COVID-19, the key to the scale up of mental health provision is being aware of and meeting demand needs. National and regional policy and practice initiatives can achieve scale-up by setting up strategic partnerships, with multi-stakeholders, which integrates local knowledge alongside knowledge of evidence-based mental health interventions. Doing so, can inform the maximisation of resources, how best to adapt interventions, and build a strong leadership team and trained workforce to implement services, as closely as intended to achieve intended reach. In the long-term, these mental health strategic partnerships can contribute knowledge on how to scale and deliver mental health programmes at population level and support best practice for similar initiatives in the future.

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**First produced in 2022 by:**

#### **International Public Policy Observatory**

**Department of Science, Technology, Engineering and Public Policy (STePP)  
Shropshire House (4th Floor), 11-20 Capper Street, London WC1E 6JA**

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ISBN: 978-1-911605-35-5

Design and editorial support by: Lionel Openshaw

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