

# Mental health policy reactions during the first year of the COVID-19 pandemic in two worst-hit WHO European countries: a narrative review and lessons for the aftermath of mental health care.

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## Abstract

**Introduction:** The COVID-19 pandemic has been challenging the health care systems and public wellbeing unprecedentedly. The United Kingdom and Turkiye were the countries worst hit by the pandemic in the World Health Organization European region.

**Purpose:** This review investigated the mental health policies in these countries which draw a contrasting pattern of mental health care, sociodemographic background, and income level. Following the investigation, we recommended the possible directions to be pursued by European policymakers

**Methodology:** The documents were picked from the health policy sections from the websites of international organizations (European Parliament, OECD, WHO, UN), online data and policy reports of national ministerial bodies, and general web search. Later, the papers were reviewed and the author identified the main concepts of the responses to discuss after policy review. The study was designed as a review; therefore, no statistical framework was conducted.

**Results:** Identified concepts were as follows: a) continuing service provision for people with mental health conditions, b) digital mental health care interventions, c) building psychological resilience for citizens.

**Conclusions:** A strategy only focusing on treating mental health conditions will not be sustainable during the post-pandemic era. It is essential to address mental health in all policies to foster a strong mental health care system.

## Keywords

Mental health care; COVID-19; mental health policy; mental health; public health.

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## Introduction

The COVID-19 pandemic has been challenging the regional and global health care systems unprecedentedly since it started more than two years ago. Mental health care systems and public well-being have also been taken a toll

due to the pandemic-related regulations and socio-economic era (Racine et al., 2021).

Psychological well-being is strongly connected to various personal, interpersonal and economic elements such as financial situation, employment status, physical well-being, and sufficient human interaction (Kaplan et al., 2008; Santini et al., 2020; Romash, 2020; Romash et al., 2022). These elements have been affected drastically during the

pandemic. Consequently, according to the Organisation for Economic Co-operation and Development (OECD), the prevalence of anxiety and depressive disorders increased in many countries in 2020 (OECD, 2021b). This increase can be considered as response to an unexpected disaster; nonetheless, the long and medium-term effects of the pandemic are likely to become detrimental to public mental health.

Due to the aforementioned concerns, the governments immediately mobilised their mental health policy strategies against the rapidly progressing pandemic. As anticipated, many studies hitherto showed that both the pandemic and public health measures provoked distress amongst various populations (*Mental Health and COVID-19*, 2022; Racine et al., 2021).

According to the World Health Organization (WHO) data, The United Kingdom (UK) and Turkiye were two of the countries worst hit by the pandemic in the WHO European region during the first year of the pandemic (*WHO Coronavirus*

(*COVID-19 Dashboard*, 2021). The tsunami effect of this disaster has been felt almost in every part of the world, yet the populations of these countries became more susceptible in terms of having insufficient healthcare and lack of support for their well-being.

**A snapshot of pre-COVID conditions and COVID-related fiscal and lockdown policies in Turkiye and the UK**

The pandemic hit hard the healthcare systems all around the world, regardless of the income levels of the countries. This section provides data about the pre-pandemic conditions and COVID-related measures of the two countries.

In 2017, the gross domestic product (GDP) level per capita was equal to 10,591 US Dollars (\$) in Turkiye whereas it was \$40,361 in the UK. The UK spent 9,8% of its GDP (\$4,070) on its health care sector, whereas Turkiye managed to allocate 4,2% of its GDP (\$1,227) (Table 1).

**Table 1:** Summary of Health and Financial Profiles of Turkiye and the United Kingdom

Country	Population size	Income level	GDP per capita (US\$)	Health care spending per capita (USD)
Turkey	83,429,607	Upper middle-income	10,591	1,227 (4,2 % of GDP)
The United Kingdom	66,836,327	High-income	40,361	4,070 (9,8 % of GDP)

GDP-Gross domestic product,  
US \$- the United States Dollar

Source: World Bank data (*Data for Turkiye, United Kingdom | Data*, 2017; *World Bank Country and Lending Groups – World Bank Data Help Desk*, 2021), OECD Health at Glance 2019 (*Health at a Glance | OECD iLibrary*, 2019)

The two countries had national mental health strategies before the pandemic. The UK spent 179,5 the Great British Pound Sterling (GBP) in terms of the total mental health expenditure per capita; however, this data was not available for Turkiye (Table 2).

The density of high-trained mental health workforce per population in Turkiye was low: 1,64

for psychiatrists and 2,54 for psychologists. On the other hand, the UK had higher numbers of this workforce than Turkiye, 11 for psychiatrists and 9 for psychologists. However, not aligned with their workforce capacity, the burden of mental health conditions was higher in Turkiye than in the UK; 3,433 and 2,115, respectively (Table 2).

**Table 2:** Mental health profiles in the two countries

Country	The burden of mental health disorders (Disability-adjusted life years per 100,000 population)	Deinstitutionalization policy	Psychiatrists per 100,000 population	Psychologists per 100,000 population	Other care settings	Total mental health expenditure per capita
Turkey	3,433	Unavailable	1,64	2,54	-Ambulatory service (limited) -Community care	Not reported
The United Kingdom	2,115 (82)	+	11 (83)	9 (83)	-Ambulatory service -Community care -Primary care integration	179,5 GBP (84)*

EUR- Euro, GBP- the British Pound Sterling,

\*Data calculated from the numbers found in the sources

Source: WHO Mental Health Atlas 2017 (*Mental Health Atlas 2017*, 2018)

Restriction measurements and fiscal support schemes were similar in the countries. However, financial allocation differed saliently between two countries. For example, while the UK spent 32% of its GDP to support its population financially, Turkiye allocated only roughly 12% of its GDP for the same purpose. Moreover, 0,3% of Turkiye's GDP (\$2 billion) was spent on the healthcare

sector as a response to the pandemic. This amount was \$145 billion in the UK, equal to 5,3% of its GDP.

Both countries reacted the pandemic with travel restrictions, nation-wide curfews, and transition to teleworking. However, while the UK permitted solo physical activities during confinements; these activities were not excluded from the regulations in Turkiye (Table 3).

**Table 3:** COVID-related measures in the two countries

	Turkey	The UK
Lockdown measure	- Nation-wide - Total and partial confinement	- Nation-wide - Total and partial confinement - Permit for solo physical activities
Fiscal support	- Direct and indirect support for the enterprises and workers (~12% of GDP) - Budget increase for health care system 2 Billion (0,3% of GDP) - Firing ban and short-time work schemes	- Direct and indirect support for the enterprises and workers (~32% of GDP) - Budget increase for health care system 145 Billion (5,3% of GDP) - Job search help for unemployed group
Other	- Travel restrictions - Curfews - Implementation of telecommuting	- Travel restrictions - Curfews - Implementation of telecommuting

GDP: Gross domestic product

Source: IMF (*Fiscal Policies Database*, 2021; *Policy Responses to COVID19*, 2021)

In 2016, a return on investment study carried out with 36 countries estimated that every \$1 invested in mental health gives a \$4 return (Jorm et al., 2016). Despite this evidence, the budget allocated for mental health systems has always been notoriously low to respond to the needs (World Health Assembly, 2012).

## Purpose

This review investigated the mental health-related policies in the two European countries worst hit by the pandemic, two countries that also draw a contrasting pattern of mental health care systems, sociodemographic background, and income level. Following this, the paper recommended possible directions to be pursued by the European policymakers to foster mental health care.

It is undeniable that this study cannot cover all the struggles we face; nonetheless, it will address the major issues. These directions are also controversial topics that belong to the contemporary history of mental healthcare and would likely to steer the future of it.

## Methodology

The documents were picked from the health policy sections from the websites of international organizations (European Parliament, OECD, WHO, UN), online data and policy reports of national ministerial bodies, and general web search. English and Turkish sources were included in this review; “policy”, “mental health”, “pandemic”, “COVID-19”, “ruh sağlığı”, “pandemi”, “politika”, and their variations were used in the general web search process.

The documents were reviewed and the author identified the main concepts of the responses to discuss after policy review. These concepts were as follows: a) continuing service provision for people with mental health conditions, b) digital mental health care interventions, c) building psychological resilience for citizens. The study was designed as a review; therefore, no statistical framework was conducted.

## Review and Discussion

### Mental health policies in Türkiye and UK

#### Türkiye

Türkiye's first case emerged relatively later than those in other European countries; however, case numbers accelerated gradually, and the country still tackles several waves of the pandemic (*Türkiye Confirms First Case of Coronavirus*, 2020).

During the initial year of the pandemic, the Public Health Directorate issued guidelines to limit

the transmission of the virus while maintaining health care safely (*COVID-19 Rehberi [The COVID-19 Guideline]*, 2020). These guidelines included the reorganisation and adaptation of psychiatric facilities to the situation. Consequently, a decrease in inpatient and outpatient psychiatric capacities was observed (Başar, 2020). The Ministry also arranged telemedicine settings, including psychological support lines for those who could not visit health care facilities due to the acute COVID-19 infection (*Dr. E-Pulse: Video Call Platform*, 2020). The Ministry of Health additionally published recommendations for video consultation techniques. However, these were not implemented effectively in public hospitals because of insufficient infrastructure and supply (*COVID-19 Health System Response Monitor: Türkiye*, 2021).

The Turkish Psychiatric Association (TPA) provided hotlines for health care workers who combat the pandemic in the frontline (*Türkiye Psikiyatri Derneği Sağlık Çalışanlarına Destek Hattı Açıldı! | TÜRKİYE PSİKİYATRİ DERNEĞİ*, 2020). Similarly, the Turkish Ministry of Health also set up regional psychosocial support call centres for the general population and health care workforce (*81 İl Psikososyal Destek Hat Bilgileri [Psychosocial Support Line Informations for 81 Cities]*, 2020).

TPA continued to establish comprehensive recommendation papers for health care workers, the mental health workforce, and several vulnerable groups during the pandemic ('COVID-19 Resources', 2021). These papers addressed the critical points on mental health care delivery, telepsychiatry, treatment of mental conditions with COVID-19 infection, and psychological self-care techniques (*COVID-19 ve Ruh Sağlığı | TÜRKİYE PSİKİYATRİ DERNEĞİ*, 2020). Some of these recommendations were translated to Arabic or Kurdish to protect minorities' well-being ('COVID-19 Resource Centre', 2020).

#### The UK

The UK had to face multiple lockdowns and waves, which had deteriorating effects on the psychological state of its population.

Due to the re-purposing of the National Health Service (NHS) beds to COVID-19 care and the worsening mental health state of the population, psychiatric inpatient clinics suffered from bed shortages and sometimes overwhelming occupancy (James, 2021). The increased demand on mental health care were conveyed to ambulatory and community care settings (*The Impact of COVID-19 on Mental Health Trusts in the NHS*, 2020). On the other hand, mental health funding saw an increase that helped maintain the 24/7 helpline services, the closure of the outdated mental health dormitories, and launching physical screening programs for vulnerable groups

(COVID-19 Health System Response Monitor: United Kingdom, 2021).

Several organisations such as the Royal College of Psychiatrists (RCPsych), and the British Psychological Society prepared mental health and COVID-19 sections that target psychological resilience, the well-being of NHS staff, digital interventions, ethical issues, and the problems and solutions about the management of mental health settings (*Covid-19 Resources - The British Psychological Society*, 2021; *Responding to COVID-19 | Royal College of Psychiatrists*, 2021). Additionally, major voluntary organisations such as Mind, and the Mental Health UK shared their tips on protecting mental health (*Coronavirus - Looking after Your Mental Wellbeing*, 2020; *Covid-19 and Your Mental Health*, 2020). The NHS itself also provided novel care approaches, guidances that depict the pandemic's psychological effects, and possible behavioural prevention methods for vulnerable groups (such as young people, ethnic minorities, people with long COVID) or those with mental health conditions (*Guidance for Parents and Carers on Supporting Children and Young People's Mental Health and Wellbeing during the Coronavirus (COVID-19) Pandemic*, 2021; *Guidance for the Public on the Mental Health and Wellbeing Aspects of Coronavirus (COVID-19)*, 2021).

The pre-existing psychological support lines and groups of voluntary organisations continued to provide service ('Mental Health Helplines and Services during COVID-19', 2021). The NHS, Public Health England (PHE), RCPsych, Mental Health at Work and Frontline19 launched psychological support lines, counselling and therapy services for the NHS staff (*Frontline19*, 2020; *NHS England» Health and Wellbeing Programmes*, 2020; 'Our Frontline', 2020; *Psychiatrists' Support Service (PSS) | Royal College of Psychiatrists*, 2020).

Vis-à-vis mental health care was replaced with video or telephone consultations; however, physical appointments were also provided for those who need them. The NHS and the RCPsych issued guidelines for structuring the fundamentals of telemedicine (*COVID-19 - Working in Secondary and Specialist Mental Health Settings| Royal College of Psychiatrists*, 2020; *Digital - COVID-19 Guidance for Clinicians | Royal College of Psychiatrists*, 2020; *IAPT Guide for Delivering Treatment Remotely during the Coronavirus Pandemic*, 2020).

In March 2021, the government released an action plan that involves a multi-disciplinary recovery approach for mental health care and public well-being (*COVID-19 Mental Health and Wellbeing Recovery Action Plan*, 2021).

Since the early era of the pandemic, the PHE has been monitoring public mental health reactions and well-being with surveillance reports, academic research compilations, and evaluating

the frequency of telesupport service use (*COVID-19 Mental Health and Wellbeing Surveillance*, 2020). In addition, several vocational organs and universities also launched independent surveys or studies to evaluate public mental health and the psychological effects of the COVID-19 infection (*COVID-19 Surveys and Research | Royal College of Psychiatrists*, 2021).

### **The future of mental health care**

There is not a *one-and-only* mental health care approach which could be applied to every country because of such differences in the level of resources, cultural diversities or socioeconomic structure (Knapp et al., 2007). However, as the current situation helped draw attention and funding to mental health, the pandemic could positively transform this field instead of adding insult to injury.

The mental health interventions taken by these countries can be summarised in three concepts: a) continuing service provision for people with mental health conditions, b) digital mental health care interventions, c) building psychological resilience.

### **Continuing service provision for people with mental health conditions**

People with mental health conditions suffered from service disruptions during the pandemic. According to a WHO survey in 2020, more than 90% of the European countries reported that essential mental health services had taken a toll. Globally speaking, this rate was above 90% for the middle or high-income countries ('The Impact of COVID-19 on Mental, Neurological and Substance Use Services: Results of a Rapid Assessment', 2020).

Traditional mental health services are often criticised because of their inhumane and ostracising structure (Cohen & Minas, 2017). For many years, Western European countries have been designing a stepped-care approach that improves multi-disciplinary approach including social care and mental health organisations instead of institutionalisation. The fruits of these reforms can be seen in the example of the UK. Both countries had to reduce their psychiatric inpatient and outpatient bed capacity during the pandemic; however, the community and ambulatory care systems in the UK attempted to manage this deficit with collateral wellbeing and social care organisations. These settings aid various vulnerable groups such as adolescents, people with suicidal thoughts, severe mental health conditions or in isolated settings (*NHS England» Crisis and Acute Mental Health Services*, 2021). Despite the leveraging role of these organisations, the UK still suffered from shortages and insufficient care delivery (Campbell

& editor, 2019). Looking at the current picture, it can be argued that more funding will be needed to face the tertiary psychological effects of the pandemic.

The pandemic could hold a role as an accelerating factor for funding deinstitutionalised care. However, various WHO European countries still tend to spend most of their mental health budgets to traditional institutions (World Health Organization, 2009). These facilities do not possess evidence-based interventions compared to other integrated models of mental health care (Eaton et al., 2011). Community-based intervention models seem to be both effective and self-financing on bringing mental health care (Knapp et al., 2011). The demand for the treatment for mental health is likely to increase in the near future, and this single-layered system alone is no suitable to shoulder the forthcoming turbulence (*COVID-19 Mental Health and Wellbeing Recovery Action Plan*, 2021). An easily accessible, multi-disciplinary and stigma-free care environment could break this vicious cycle and engage more users in prospect. There is a need for novel national mental health strategy plans taking post-COVID concerns into account for WHO European region countries.

Specialised outpatient facilities have also taken a hit during the pandemic. This hit led to digitalisation in mental health care as much as applicable; on the other hand, countries like Turkiye (lower amount of qualified mental health workers, means of providing multi-disciplinary approach, and allocated budget for mental health) have become vulnerable in terms of providing sufficient outpatient care. It should also be noted that primary care integrated referral system and mental health integrated primary care are absent in Turkiye, and specialized facilities are the central pillar for any type of treatment ranging from mild depression to severe schizophrenia (Table 2). Therefore, mid- and long-term policies which aim to prevent congestions in outpatient settings must be considered before facing the long consequences of the pandemic.

Particularly for Turkiye and countries with similar profiles, it is vital to identify risk factors and plan cost-effective intervention and prevention methods to minimize specialized care saturation. It is known that mental health care in primary settings is more reachable by the population (Yeung et al., 2004). Cost-effectiveness and clinical-effectiveness studies also demonstrate these settings are applicable and sustainable (Mens et al., 2018; Rost et al., 2004). Turkiye and alike countries might not have sufficient workforce resource to fully integrate mental healthcare provision to primary care; however, prevention strategies such as increasing awareness between primary healthcare workers might help overcome the overwhelming demand on specialised care for easily treatable psychiatric conditions.

### ***Digital mental health care interventions***

The digitalization of medicine had already begun before the pandemic. Nonetheless, its pace skyrocketed with regards to a mandatory need (OECD/European Union, 2020). The elements of psychiatric care such as psychological therapies, consultations or evaluations also quickly adapted to the situation.

The prosperity of digital therapies and smartphone apps carries a double-edged position while it also facilitates populations to reach treatment. Firstly, this expanding marketplace could become a nest for unapproved methods (Terry & Gunter, 2018). For instance, a study from 2019 showed that top-mental health apps tend to use scientific language to evoke population, without the lack of adequate evidence on their effectiveness (Larsen et al., 2019). Moreover, the rate of free iPhone anxiety-targeted apps built with evidence-based approaches was found to be very low (Kertz et al., 2017). Secondly, the care provided by these apps was found to be lacking from emotional support, distracting from real life, and yielding misinterpretations in care seekers about themselves (Estrada Martinez De Alva et al., 2015). Hence, it is crucial to strengthen these interventions with convenient research studies and combine them with face-to-face methods when needed.

Ethical issues regarding data safety, transparency or patient confidentiality are other main concerns reported by healthcare workers (Stoll et al., 2020). These concerns are bilateral in carer taker and care seeker relationship, and government and vocational organs should act collaboratively in order to regulate this area.

Telemedicine helped providing care in the UK; on the other hand, the lack of telemedicine settings in public hospitals in Turkiye pushed citizens to postpone their needs due to fear of transmission and decreased face-to-face appointment options. The gap between these two countries indicate that digital infrastructure of health care should be promoted and supported across the WHO European region.

### ***Building psychological resilience***

The two countries attempted to mitigate the immediate psychological shock of the pandemic in varying degrees by enhancing pre-existing infrastructures or implementing novel strategies. Albeit, medium- and long-term effects of the pandemic will continue to challenge mental health wellbeing and related areas. Public or individual well-being are bound to many social determinants, and stakeholders need to follow a multi-systemic, multi-disciplinary pathway in order to protect both individual and public wellbeing (World Health Organization and Calouste Gulbenkian Foundation, 2014). Mental health distress could

metamorphise to mental health conditions, if not acted thoroughly.

Turkiye and the UK implemented several measures in order to protect economic stability. However, many studies in contemporary history showed that economic shocks are likely to trigger their detrimental psychological effects during tertiary phase. These shocks impact mental health in the long term due to economic instability, job loss, uncertainty and other factors (McDaid, 2017; Paul & Moser, 2009). It should be therefore kept in mind that even when the pandemic settles, time-delayed economic effects will cause challenging consequences in public mental health. This becomes extremely important when the current economic instability and increased cost of living within the European Union are considered (*EA and EU Economic Snapshot - OECD, 2022*). European policymakers should take into account that the monitorisation of suicide rates, levels of depression, anxiety, or substance use is particularly essential in vulnerable economic settings.

A study from the Netherlands shows that people without mental health conditions had a greater negative impact on their mental well-being than those with pre-existing mental health conditions during the first year of the pandemic (Pan et al., 2021). The most affected groups consisted of ethnic or racial minorities, women, people with low-income, students, young or elderly people (OECD, 2021a, 2021b; Saladino et al., 2020; Tai et al., 2021). This deteriorating effect was also present in the English population demonstrated by the surveillance reports of the Public Health England (Public Health England, 2020b, 2020a). Such reports and studies indicate that governments should strengthen their hands to protect general and vulnerable populations. Key organisations such as independent bodies, local governments or initiatives have already been promoting self-help techniques, peer support groups, psychological first aid teams or hotlines in Western countries. In other WHO European countries, where these organisations are absent or less active, the deficit can be filled by using key community members as pillars. Micro- or meso-level actors could stem from backgrounds such as religious leaders, union members, managers, school teachers or local authorities, as the studies show that these actors are extremely beneficial in community-based mental healthcare (*The Community Mental Health Framework for Adults and Older Adults, 2019*). According to a study, religious/spiritual advisors were seen by 35% of treatment-seeking Asian Americans with a lifetime mental disorder (John & Williams, 2013). Another study from the United States also indicated that at least 57,3% of respondents with mental health disorders first contacted professionals not working in mental health area (Wang et al., 2003). Training the actors from these settings could help monitor,

identify, or control mental distress levels effectively whereas preventing unnecessary specialised or primary care consultations.

A Eurofund report from 2017 showed that remote workers tend to spend more time on work than those in offices, possibly due to uncertain working hours (Eurofound and the International Labour Office, 2017). This impact could become a risk for working population as the pandemic catalysed the shift to teleworking rapidly (European Commission, 2020). According to the OECD data, the high prevalence of mental health conditions among the working-age population is linked to the high economic cost of mental health conditions (OECD, 2020). Countries with middle- or high-income, namely most Western countries, should regularly monitor the mental consequences of teleworking in terms of increased loneliness, isolation and burn-out.

The need to address migration-related mental health issues is increasing as the world has been seeing the highest numbers of human migration in the latest years (Jennings, 2011). Unsurprisingly, the pandemic and migration carry the same devastating effects: loneliness, feeling of isolation, discrimination (for instance, racist accusations about the origin of COVID-19) (Banerjee & Rai, 2020; Fernández et al., 2017). Therefore, the countries with a higher density of refugee or immigrated population, notably Western European countries or countries that have land frontiers with war territories, should particularly pay attention to these adverse psychological effects which could stem from the combination of immigration and the pandemic (Foad et al., 2015).

## Conclusions

The concepts mentioned above and recommendations reflect the future directions for mental health policies. Uniquely, they entail a cross-sectoral structure, namely the "*mental health in all policies*" approach, which includes areas such as technology, healthcare, labour, and economy (*Mental Health In All Policies » Mental Health and Wellbeing, 2013*). A public health strategy ignoring these areas and only focusing on treating mental health conditions will not be sustainable in delivering healthcare during the post-pandemic era. As the pandemic and its consequences reshape our society, it is essential to address these issues to protect and foster a multi-level mental healthcare system.

## Conflict of interest

The author declares that she has no conflicts of interest.

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