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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Ensuring mental health access for vulnerable populations in COVID era

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Severe acute respiratory syndrome coronavirus (SARS-CoV)-2, or COVID-19, is a novel RNA coronavirus that was identified in early January 2020 in Wuhan, China and soon spread to Italy, European countries, and the United States. COVID-19 has been responsible for over 350,000 deaths to date and disproportionately impacts vulnerable populations such as the elderly, ethnic minorities, severely mentally ill, and the homeless (Centers for Disease Contr, 2019). However, the impact of COVID-19 is beyond disease mortality alone. As estimates of mortality and morbidity continue to increase, isolation and lockdown are being prolonged, recreational opportunities are lessened, mental health problems are likely to continue to rise. A recent review of psychological sequelae among quarantined individuals and health care providers revealed elevated stress, depression, irritability, insomnia, fear, confusion, anger, frustration, boredom, and stigma associated with quarantine, some of which persisted after the quarantine was lifted. Risk factors included greater duration of confinement, having inadequate supplies, difficulty securing medical care and medications, and financial losses (Brooks et al., 2020).

Those with pre-existing mental health issues, including serious mental illnesses, are likely to be affected by relapse of their illness, disruption to services, isolation, possible exacerbation of symptoms in response to pandemic-related information, and behaviors as well as changes in mental health law (Panchal et al., 2020). When a person with a pre-existing mental health condition becomes infected with respiratory symptoms that may be COVID-19 related, an additional barrier is faced in accessing timely health services due to stigma and discrimination associated with their mental health illness. It is therefore critical to address barriers to care among individuals with pre-existing mental health problems, whose access to traditional outpatient treatment is limited due to national regulations to limit exposure and transmission of the virus (Holmes et al., 2020). Among the homeless population, there is fear of involuntary admission or imprisonment that may act as an additional barrier to mental health care (Holmes et al., 2020). Similarly, whereas it is of utmost importance for the elderly population to practice social distancing among other safety measures, these measures may limit interactions with caregivers and loved ones, thereby leading to increased loneliness and anxiety as well as exacerbating feelings of uncertainty and fear due to the pandemic (Panchal et al., 2020).

Before COVID-19, 47 million United States adults reported a mental illness in the past year, 11 million reported a serious mental illness, 17 million reported major depressive disorder and access to mental healthcare was limited (Panchal et al., 2020). Barriers to access include limited health insurance access, mental health professional shortage areas in every state across the United States, distance one must travel to a mental health provider, fragmented care, and societal stigma (Panchal et al., 2020). Gaps in mental health access are exacerbated in the COVID era because of social distancing guidelines, shelter in place guidelines, and increased mental health needs that strain available resources. Fortunately, technology-based approaches, namely clinical videoconferencing (or "telemedicine"), can be used to improve access to care and ensure that vulnerable populations receive the mental health services they need. The mental health field has used and evaluated telemedicine for decades (Richardson et al., 2009). The accumulated data from real-world program evaluations (Richardson et al., 2009) and randomized clinical trials clearly demonstrates the safety and effectiveness of telemedicine for the provision of evidence-based mental healthcare for a wide variety of severe psychiatric disorders and clinical populations, including rural and remote, elderly, immobile, and minority patients (Egede et al., 2015; Richardson et al., 2009). The data also show strong evidence of acceptability and satisfaction among patients (Richardson et al., 2009; Egede et al., 2018) and cost effectiveness for systems and providers (Egede et al., 2018; Richardson et al., 2009). Overall, strong evidence supports the use of telemedicine to provide evaluation, psychotherapy, medication management, case management, supportive counseling, psychoeducation, and professional supervision and training.

One challenge faced by the mental healthcare field in the U.S. has been slow implementation of telemedicine services, largely due to insurance billing restrictions and the patchwork of state licensing laws that forbid practitioners from serving patients across state lines. In recent years, only the Department of Defense and the Veterans' Affairs Healthcare System, both federal systems without such restrictions, have successfully provided substantial levels of mental health care via telemedicine. In the face of the coronavirus pandemic, long-standing restrictions in the U.S. have been temporarily waived and the door has been opened for people – patients, particularly vulnerable populations, providers, and administrators – to experience the transformational benefits of telemedicine. Going forward, it is imperative that we make permanent the emergency deregulation laws that have been enacted

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during the current crisis to continue to allow for telemedicine mental healthcare services so that we may expand clinical services to those most in need.

We also need coordinated programs modeled after disaster behavioral health initiatives, which can serve as a framework for the current crisis. First, improved case identification and access to evidence-based care is needed for individuals with serious mental illness or psychiatric disorders. Centralized services such as the Disaster Distress Helpline is a SAMHSA-administered national multilingual hotline that can be reached by telephone or text and provides counseling, support, referrals to local healthcare providers, and other support services. It was recently expanded to serve people affected by the pandemic. Vulnerable people should be given telehealth-based referral options to address access barriers such as stigma, transportation, and scheduling, particularly when capacity is thin locally. Second, a number of educational and self-help resources are already widely available to disaster-affected populations that have strong applicability to the current crisis. These include self-help apps and vast libraries of educational tip sheets that are based on the best available evidence, which can be useful as front-line interventions for individuals who serve in caregiving or community leadership roles. Ensuring that high-risk populations and those who serve them have ready access to these materials is a key priority. Third, stepped models of care may improve cost and sustainability and ensure that the most intensive interventions are available to those in greatest needed. Most individuals who develop distress after a disaster or crisis demonstrate resilience or natural recovery and do not require resources beyond basic assistance, education, and screening. Brief interventions that can be delivered by master's-trained clinicians and lend themselves well to telehealth formats can be made readily available, such as *Skills for Psychological Recovery,* which assists with coping skills, problem solving, social connections, and positive activity scheduling. Individuals with serious mental illness or psychiatric disorders should be stepped up to more intensive treatment alternatives.

In conclusion, COVID-19 disproportionately impacts vulnerable populations including the elderly, minorities, severely mentally ill, and the homeless. Access to mental health services has long been limited for many people, and access barriers and health disparities are likely exacerbated during this pandemic. Fortunately, a number of technology-based approaches can help to overcome barriers to ensure that vulnerable populations receive much needed care. However, we have been slow as a nation to adopt it because of insurance billing restrictions and state licensing laws. Therefore, it is time to make permanent the emergency deregulation laws enacted during the pandemic to continue to allow for telemental healthcare services. Psychiatrists, psychologists, and other mental healthcare providers are in short supply in many regions, but telemedicine will better allow for supply to gravitate toward areas of demand. Training masters level therapists to deploy this from centralized centers can be an effective strategy. Centralized systems, perhaps modeled after coordinated disaster response programs, are needed as we deal with the mental health sequalae of COVID-19.

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Declaration of competing interest

None.

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