
RESPOND

# DEVELOPING A VALIDATED FRAMEWORK FOR IMPROVING HEALTH SYSTEM PREPAREDNESS FOR DELIVERY OF MENTAL HEALTH

MAY 2024

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# Developing a validated framework for improving health system preparedness for delivery of mental health and psychosocial support during future pandemics

**Period covered by the report:** from December 1, 2022 to May 31, 2024

**Periodic report:** 3rd

# TABLE OF CONTENTS

# 1. EXECUTIVE SUMMARY

The COVID-19 pandemic has had a deep impact on the mental health and wellbeing in Europe. The mission of RESPOND is: 1) to identify critical resilience factors and specific vulnerable groups at risk of immediate and long-term adverse mental health impact of the COVID-19 pandemic; 2) To improve the resilience, wellbeing and mental health of frontline health and care workers and other vulnerable groups by implementing scalable World Health Organization (WHO) programmes, and 3) to steer future policy decisions by understanding and disentangling the effects of the COVID-19 pandemic and different public health containment and subsequently relaxation strategies on mental health and wellbeing in vulnerable groups across Europe's different health systems.

This briefing paper focuses on looking at the decision-making processes during the COVID crisis to tackle the pandemic and their impacts on mental health and wellbeing. Drawing on information from all work packages in RESPOND it looks at some of their flaws and strengths, with a view to identifying ways in which to improve the future response to many different types of potential health shocks, including the conflict and cost-of-living crises that are still being felt in Europe today. It should be noted that this is an interim version of the document. It will be further updated as other RESPOND outputs are finalised and become available.

What did we find? Decision making is complex at the best of times; it becomes even more challenging during a crisis, especially where there is much uncertainty both about how to respond, as well as on the magnitude and duration of impacts. Decisions have to be made in haste. We note the importance of the way in which the issues and relative benefits and adverse consequences of different strategies are communicated. We acknowledge that many decisions may have been different with the benefit of hindsight; decisions had to be undertaken, particularly in 2020 and early 2021 under conditions of extreme uncertainty, including great uncertainty over projected rates of mortality and viral transmission.

Our focus here is on identifying ways to ensure that important issues do not get overlooked during any public health crisis by having mechanisms in place to ensure that key factors, including mental health as well as physical health impacts, are always considered. The briefing paper therefore makes use of an existing framework looking at decision making processes in global health. It was originally developed to look at why some global health initiatives gain traction with policy makers, while others do not. The framework has four key dimensions: the strength of the actors involved in the initiative, the power of the ideas they use to portray the issue, the nature of the political contexts in which they operate, and characteristics of the issue itself.

The COVID pandemic in particular reveals the imbalance in power structures between policy makers and other actors in responding to a public health crisis. This also includes specific imbalances in power *within* scientific communities, with mental health expertise having had differing levels of input in different countries. The value of mental health can also be underestimated.

A number of steps can be taken to address these issues. We note that establishing various scientific advisory groups to provide input to the policy making process during a public health crisis is merited. However, **mental health expertise needs to be included within these groups** to enhance the likelihood that mental health is considered in a public health emergency. Another key issue that influences the role of mental health within policy making process is the *a priori* perception of psychological / mental health held by stakeholders. Similarly, it is also important to **strengthen public health emergency governance arrangements so that they fully involve mental health structures** as part of decision making groups. **Improving mental health literacy and having mechanisms in place to monitor mental health** can help identify when mitigations to counter adverse impacts on poor mental are needed; they can also help reduce the reluctance of some of the general population of seeking help, even in a public health crisis, for their mental health and wellbeing.

The importance of **collecting credible data on mental health, is absolutely critical to future preparedness**, as well as the immediate and ongoing response, to any public health crisis. This means focusing on measuring what matters in respect of mental health, as well as ensuring that it is feasible to collect. The pandemic has revealed how important it has been to **move beyond a focus on traditional indicators that are used for mental health**, namely specialist mental health service utilisation rates and a focus on rates of suicide and self-harm. During the pandemic, other measures of both positive and negative mental health, as well as factors that can influence mental health, such as levels of loneliness, have proved to be important in refining approaches to dealing with the COVID pandemic

It is also important to **rapidly search for and provide evidence on effective strategies to address any public health crisis**. Ideally this should be part of preparedness planning documents that consider multiple possible public health crises. However, the way in which this evidence is presented, as well as being updated, is very important. In the case of mental health, it is helpful **to formally employ rapid mental health impact assessments** when considering mitigation strategies, and to continue to update these over the duration of any crisis.

**Responses to public health strategies should be as flexible as possible** to address differential risk to mental health. Flexibility should be formulated on a clear and explicit reference to proportional universalism: services (or costs) should be delivered (or supported) at a scale or intensity proportional to needs. This in turn requires that the social determinants of mental health be included in the elaboration of policies and plans. Preparing for a future crisis should involve **providing a more flexible, fine-tuned strategy to avoid imposing too harsh a cost on those most vulnerable** to restrictive measures.

**Monitoring and surveillance data** is vital to identify these groups. They will vary depending on the nature of the public health emergency and the response. If adverse effects on mental health can be identified, even if they cannot be avoided, steps can then be taken to counter their impacts. The impact assessment framework also provides an accessible way of communicating the likelihood of positive and negative impacts, their magnitude and duration to decision makers. In the case of COVID, RESPOND has highlighted various groups including young people, those with precarious housing and/or employment as well as refugees.

A further key recommendation to inform decision making processes is to **objectively and independently evaluate the response to any previous public health crisis,** including the COVID pandemic to help ensure objective institutional memory. Such evaluations need to ensure that their **terms of reference include impacts on psychological health and wellbeing**. We have noted that future public health preparedness plans are being developed, however we also note that these do not appear to have much, if any, focus on mental health and wellbeing. Health is a holistic concept, involving both physical and mental health. **Mental health should be an integral consideration in these preparedness plans**.

# 2. BACKGROUND/CONTEXT

The COVID-19 pandemic was the greatest public health crisis of the 21st century. As of May 2024, globally 7.05 million deaths have been attributed to COVID, including 1.26 million in the EU, and 0.98 million in the eight RESPOND countries, ranging from 22,986 in the Netherlands to 232,112 in the UK (1). The mortality impact of COVID was very different across the RESPOND countries. The death rate per million people was much lower in the Netherlands at 1,309 per million people than in any of the other RESPOND countries, all of which had rates over 2,000 deaths per million people, with the highest rates seen in Italy at 3,337 and the UK with 3,438 deaths per million people attributed to COVID (1).

However, this is just the tip of the iceberg of impact. Many more people were hospitalised. Sadly, the impacts of the pandemic go well beyond individuals who contracted the disease and their families. COVID-19 initially triggered a wider health crisis: health systems had to deal with the pressures brought on by different waves of the pandemic, which reduced their ability to meet all routine demands for chronic and acute mental and physical care.

Economies came under great pressure, due to a combination of major sudden reductions in economic activity and major investment in COVID-related financial protection, as well as in public health measures. There have been substantial impacts on population mental health and wellbeing. While many factors will contribute to these differences in country experiences, the ways in which health systems have responded to this public health crisis are likely to have played a major role.

There is increasing evidence on the impacts, both negative and positive, that measures to address the pandemic, such as lockdowns, school closures, travel restrictions, home working, as well as the roll out of mass and some mandatory vaccination programmes, may have had for mental health. Other consequences include some periods of social unrest by a minority of populations who believed these measures to be unnecessary restrictions on civil liberties, as well because as the spread of misinformation on COVID. More information on these impacts is starting to emerge as governments review their performance during the pandemic.

While the COVID pandemic now has ended, with the condition perhaps becoming endemic but much more manageable, we are still left with longer term impacts, including impacts of long-COVID. Across the European Union it has been estimated (using UK Office for National Statistics Survey data) that 2.9% of the population (13 million people), were living with long-COVID in 2022. Some of these people are still experiencing severe side-effects. Not only is there increasing evidence on persistent debilitating effects of this condition, but it also has substantial economic costs. It has been estimated to have reduced labour force participation by 621,000-1,112,000 in 2022, due to lower productivity at work, more absenteeism, work hour cutback and withdrawal from the labour market(2).

In setting out the background and context, it would be remiss of this briefing paper not to also consider the profound additional challenges that Europe has had to face. There have been direct impacts from the Ukraine war which escalated in February 2022, including the need for European health care systems to provide psychological and physical health support to millions of refugees. The indirect impacts of the war have also included restrictions on the supply of energy, substantially increasing energy costs in Europe, driving many people into fuel poverty, or fear of fuel poverty. Inflationary pressures, due to macroeconomic conditions, have further compounded the situation, with costs of living rising at a greater rate than wages in many European countries between 2022 and early 2024.

While these additional challenges are unwelcome, some of the learnings about policy responses to the pandemic, such as the role of major financial support programmes, which helped protect mental health and reduce psychological distress, are very relevant to the ways in which these new crises are being handled. Thus, there are potentially important learnings from the way in which policy makers in different European countries responded to the challenge of COVID-19 that may be invaluable to addressing current crises. This briefing report looks in particular at the decision making

processes through the lens of response to the COVID crisis, looking at their flaws and strengths, with a view to identifying ways in which to improve future response to many different types of potential health shocks.

# 3. AIMS AND METHODS

The aim of this briefing paper is to bring together key learnings from the different work packages in RESPOND, making use of a validated framework on decision making processes, in order to make recommendations for the better future preparedness of health systems to deal with any crises likely to impact on mental health and wellbeing. Therefore, while RESPOND has specifically been focused on the response to the COVID-19 pandemic, in this briefing paper we recognise that future crises may take very different forms. Even during the lifetime of the RESPOND project Europe has had to deal with the many impacts of the war in Ukraine, including the impact that this conflict has had on energy costs in Europe (3, 4). Increasingly, Europeans are also having to contend with the mental health consequences of extreme weather events linked to climate change, such as the risk of flooding, drought and persistent very high temperatures (5, 6). The 2008/2009 global financial crisis is yet another different type of event that had many subsequent impacts on mental health and wellbeing(7, 8).

The information collected in this report draws on information collected from many different sources. This includes a range of policy briefs, reports and publications from across the RESPOND project, as well as outputs of other projects funded by the European Commission to examine the impacts and/or response of policy makers to the pandemic. It also draws on rapid appraisal reports and stakeholder analyses in work package 3. These made use of evidence and insights from policy documents, scientific advisory recommendations, behavioural-psychology informed public health communication strategies, variations in the timing and stringency of suppression and mitigation measures, print, social media, radio and broadcast media content analysis, as well as interviews with a range of stakeholders. This evidence has been iteratively refined to highlight key steps and infrastructure to help adequately prepare health systems to respond rapidly to any future pandemic or similar public health shocks. We also refer to a discrete choice experiment and survey that we have conducted with both the general public and European stakeholders, to uncover the core values guiding mitigation policies comparing the perspective of decision-makers with those of the general population.

Using an adapted version of an existing framework looking at factors impacting on the policy making process, we have drawn on these different evidence sources to highlight weakness and strengths in both the preparedness and response of health systems to the pandemic, in respect of the need to look at the mental health implications of the pandemic and pandemic suppression measures. While we focus on our eight RESPOND countries: the Netherlands, Belgium, France, Germany, Italy, Spain, Sweden and the UK, we also draw on material from other European countries and elsewhere, to look at some of these issues.

It should, however, be noted that, at the time of writing, some work within the RESPOND project is still being finalised. This briefing paper mainly draws on work from work packages 2, 3 and 4. This document will be updated as additional RESPOND outputs become available. This will include additional learnings around the implementation of remotely-delivered, stepped-care, and scalable interventions making use of well validated brief psychological interventions. Therefore, the conclusions drawn in this briefing paper should be treated as preliminary and will be updated.

# 4. FRAMEWORK ON DECISION MAKING

In looking at ways in which to strengthen preparedness for any public health emergency, including another pandemic, we have considered different potential analytical frameworks looking at policy decision making. Any framework on policy decision-making should start by acknowledging the high level of complexity of such an endeavour. Policy decision-making is multifaceted and involves a wealth of different actors which, at times, represent and advocate for different interests, and, therefore, try to influence the policy agenda according to what they consider to be the most appropriate course of actions, which would ultimately lead to the outcomes they are aiming at.

In moments of crisis, decision-makers are expected to make fast, high-stake decisions under considerable uncertainty and fast-changing scenarios. Additionally, what we have learnt from previous experiences show that there may be very narrow windows of opportunity for informed and effective decisions to be made. Decisions made, or avoided, at critical phases, particularly when a crisis starts to develop, may mitigate or amplify potential deleterious consequences and outcomes, which affect vulnerable population groups the hardest. Based on previous works on causal theories of the policy process (9), evidence-based policy agenda-setting (10) and political priority for global health initiatives (11), as well as on our own observation through consultations with relevant stakeholders, documentary analysis and other sources of evidence, we contend that a framework on policy decision-making must take into consideration different interwoven dimensions that play an important role in the political process.

We therefore have looked for an appropriate framework on policy decision making. There are many different frameworks and analytical approaches examining how decision making is made within and beyond health systems, including for decisions made within the context of health emergencies (12). In looking at the different frameworks we have adapted an existing framework that we believe can work with both the need to react to crises, as well as to more routine and long-term policy and practice planning. Originally developed to look at why some global health initiatives gain traction with policy makers, while others do not, the framework has four key dimensions: the strength of the actors involved in the initiative, the power of the ideas they use to portray the issue, the nature of the political contexts in which they operate, and characteristics of the issue itself (11).

Table 1 describes the four key dimensions and the 11 specific characteristics considered in this framework. It recognises the central importance of political and other actors in the way in which decisions are made, and the importance of the dynamics of interaction between these different actors. The extent to which these actors work cooperatively or competitively will also impact on the effectiveness of the policymaking process, as well as the perceptions among policy makers of the way in which these different actors, such as different scientific communities work together. Civil society organisations will also be important, as they both can shape and influence policy, as well as implement policy actions. During the pandemic the role of civil society groups focused on promoting mental health and wellbeing, and providing resources for this purpose were important.

The framework also recognises the central place of ideas and values held within policy making circles, as well as within society generally. When looking at mental health the way in which the concept is held by policy makers is likely to have an impact on the attention they place on the issue. As we will see later in this briefing paper, the perception that mental health may be perceived to be of less importance because it erroneously is not seen to have an impact on the risk of physical morbidity and mortality, can inform the frame of policy discourse and decision making. It is arguably why mental health continues to receive a relatively modest share of health care budgets across Europe. Equally, the perception of mental health by the public is also critical; although stigma around some mental health conditions, such as depression and anxiety in particular, may be reducing negative perceptions around mental health, including the view that it is a sign of underlying individual weakness rather than something that can be addressed through support, can also influence public attitudes towards any focus on mental health during a crisis.

The third dimension of the framework looks at the political context. In particular, it highlights the importance of effecting change during opportune time periods, when conditions can be most favourable. In the context of a public health crisis, there may be opportunities within the life cycle of the crisis, for changing policy direction based on initial learnings, and when it becomes easier to form coalitions around an idea. Global governance structures / and global coordination of actions also influence national and regional policy actions.

The fourth and final dimension of the policy framework concerns issue characteristics. Every public health crisis will have its own unique characteristics, as well as factors that will be common to many different crises. In all cases the way in which the impacts of crises can be measured will be critical to informing policy responses, including the mitigation of any unintended consequences of policy responses. Measures need to be feasible to collect, meaningful and capable of being delivered in a timely fashion. Too often measures actually used do not fully meet these criteria. There also needs to be a proper understanding of the magnitude of any public health crisis; in the case of the COVID pandemic that is not just about the rates of viral transmission and related deaths and morbidity, but also the wider impacts, including impacts on the economy and societal functioning. It is also about having a better understanding of which population subgroups may be more affected by any particular crisis.

Getting a better sense of the likely duration of any public health crisis is also important. Uncertainty is one of the key challenges that policy makers need to contend with. Finally, but by no means least, the way in which evidence on potential effective and cost effective actions to address any public health crisis are synthesised and conveyed to policy makers will also have an impact on policy response. This information needs to be conveyed in a way that recognises that actions are not perfect, they often have negative as well as positive impacts, and their effects may be felt unequally across society.

**Table 1. The four categories for the framework on determinants of political priority for global initiatives (11)**

| Theme | Description | Factors shaping political priority |
|---|---|---|
| Actor power | The strength of the individuals and organisations concerned with the issue | Policy community cohesion: the degree of coalescence among the network of individuals and organisations that are centrally involved with the issue at the global level |
| | | Leadership: the presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause |
| | | Guiding institutions: the effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative |
| | | Civil society mobilisation: the extent to which grassroots organisations have mobilised to press international and national political authorities to address the issue at the global level |
| Ideas | The ways in which those involved with the issue understand and portray it | Internal frame: the degree to which the policy community agrees on the definition of, causes of, and solutions to the problem |
| | | External frame: public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources |
| Political contexts | The environments in which actors operate | Policy windows: political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decisionmakers |
| | | Global governance structure: the degree to which norms and institutions operating in a sector provide a platform for effective collective action |
| Issue characteristics | Features of the problem | Credible indicators: clear measures that show the severity of the problem and that can be used to monitor progress |
| | | Severity: the size of the burden relative to other problems, as indicated by objective measures such as mortality levels |
| | | Effective interventions: the extent to which proposed means of addressing the problem are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive |

# 5. ADDRESSING THE MENTAL HEALTH IMPACTS OF A PUBLIC HEALTH CRISIS: AN OVERVIEW OF THE STRENGTHS AND WEAKNESS OF THE POLICY MAKING PROCESS

Table 2 provides a summary of some of the key learnings from RESPOND on effective and less effective aspects of policy making processes during the COVID-19 pandemic, with a particular focus on how these processes did or did not address psychological health concerns. We believe that many of these insights go beyond the COVID-19 pandemic and are relevant to other current and future public health crises that policy makers need to contend with. The following chapters of this briefing paper then look further at our insights for each theme in the policy framework, drawing on information from RESPOND work as well as other sources. For each of these dimensions we can note a number of strengths and weakness. Some of the strengths and weakness in the table also appear in multiple cells, because they can be associated with more than one dimension.

Many of these reflect differences in power structures between policy makers and other actors, including differences in power balances within scientific communities, with mental health expertise having different levels of input in different countries. Another key issue concerns the perception of the importance of mental health for different policy making actors and for the general public. We also have seen that investing in actions for early and relevant measurement of mental health impacts did make a difference to the extent to which pandemic suppression policies took account of mental health. We also note the importance of the way in which impacts are communicated and the relative benefits and adverse consequences of different strategies. Finally in all of these analysis, it is important to recognise that decisions would be different with the benefit of hindsight; decisions had to be undertaken, particularly in 2020 and early 2021, under conditions of extreme uncertainty, including great uncertainty over projected rates of mortality and viral transmission.

**Table 2. Summary of key strengths and weakness in policy maker response to pandemic and consideration given to mental health (11)**

| Factors shaping political priority | | Strengths | Weakness |
|---|---|---|---|
| **Overarching theme** | **Dimensions** | | |
| **Actor power** | Policy / scientific community cohesion | Establishing various scientific advisory groups to provide input to the policy making process. Well managed processes allow for discussion and disagreement to take place within these advisory groups, but then to reach a consensus on the advice to give to policy makers. This advice could highlight both the risks and benefits associated with different measures to address a public health issue. In this way the policy and scientific communities can be seen to avoid major public disagreements on strategy.<br><br>Important that an appropriate range of actors are included in advisory | Policy community divided over impacts of public health crises and various intervention strategies. This can have a negative impact on the credibility of expert input with policy makers. |

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| | | groups; must be multi-disciplinary and involve the most likely relevant expertise. Mental health as an issue is more likely to be considered in discussions if this different expertise includes mental health. | |
| | Leadership | Leadership structures for public health emergency that reflect the balance of administrative power within countries. This includes pre-existence of forums and other mechanisms for regional and national leaders to come together to discuss issues of mutual importance.<br><br>Having the right mix of people around the policy making table that can effectively convey critical information to key policy makers.<br><br>Importance of leading by example. Leaders themselves following restrictions enacted as part of suppression measures. | Lack of mechanisms for coordination of actions in countries with high levels of political and health system management devolution.<br><br>Convoluted policy making structures, impede the ability of evidence on the advantages and disadvantages of different public health responses to be conveyed to leaders. |
| | Guiding institutions | Institutions that had core links to policy makers, and with substantial human resource capacity could be more effective. Some public health institutions put an early focus on mental as well as physical health inputs. Guiding institutions also established credibility through communicating directly with the media as well as with policy makers. | Weak guiding institutions make it more difficult to obtain policy maker support for actions. This can relate to the capacities and skills of institutions and the role of the institution. |
| | Civil society mobilisation | Strong, independently funded civil society organisations that had a focus on both general mental health and representing people with lived experience of poor mental health, engaged in policy making processes. | A lack of strong well-funded and independent civil society organisations that had a focus on mental and psychological health |
| **Ideas** | Internal frame | Provision of evidence to policy makers on risk factors for poor mental health during pandemic and other previous crises, including information from real time monitoring initiatives.<br><br>Recognition of the importance of strategies that do not leave people | Limited mental health literacy in some political and broad scientific communities.<br>Continued negative perceptions of importance of mental health. |

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| | | behind; recognition of vulnerability due to poor mental health. | Incorrect perception that mental health has little impact on mortality. |
| | External frame | Increased awareness and changing perceptions of mental health as an issue during the pandemic, and also seen as an issue during the cost of living/energy crisis. This linked to publication of data on monitoring of mental health in crises.<br><br>Impacts of psychological distress discussed more by media; more awareness of psychological distress risk factors, including loneliness, risk of inter-personal violence, financial pressures for individuals with low job security.<br><br>Impacts on mental health of young people in particular became very visible. | Limited mental health literacy.<br>Continued negative public perceptions of poor mental health.<br>Perception that mental health does not have an impact on mortality.<br>Perception that high levels of psychological distress are 'normal' and not a high priority. |
| **Political contexts** | Policy windows | Uncertainty may be mitigated by having access to information on the policy responses to previous public health crises.<br><br>Important to also objectively and independently evaluate the response to previous public health crises to help ensure objective institutional memory.<br><br>During the pandemic there are numerous examples of how access to data on experience in previous waves led to policy change, e.g. on school closures.<br><br>Importance of data collection on mental health during and after a crisis. | Lack of real time monitoring of impacts of a crisis on mental health<br><br>Lack of subsequent evaluation of the impacts of mitigation measures during a public health crisis |
| | Global governance structure | Opportunity at international level to collaborate, collate and share data to help jointly develop emergency preparedness plans | Competing interests between different international actors |

| | | | |
|---|---|---|---|
| **Issue characteristics** | Credible indicators | Recognition of importance of monitoring population mental health during a public health crisis. Rapid development of approaches to collect data longitudinally through surveys using well accepted measures Using measures that capture positive as well as negative aspects of mental health | Lack of recognition of the relative importance of monitoring mental health at a time when focus on levels of mortality. Too much reliance on traditional proxy measures for mental health, e.g. service utilisation, self-harm and suicide. |
| | Magnitude of impacts | Access to effective monitoring data on mental health. Effective communication of data on mental health impacts | Focus on narrow mortality information on direct impact of a public health crisis, without providing information on other impacts. Underplaying impacts on mental health |
| | Effective interventions | Access to information on pre-existing evidence of effectiveness. Rapid modelling of cost effectiveness. Undertaking mental health impact assessments on strategies. | Lack of access or use of previously available evidence. No ongoing impact evaluation |

# 6. ACTOR POWER

## 6.1 POLICY COMMUNITY COHESION

Among the key themes that have emerged from our analysis is the value of establishing various scientific advisory groups to provide input to the policy making process. Well managed and transparent processes allow for discussion and disagreement to take place within these advisory groups, but then, ultimately, they can be organised so as to reach a consensus on the advice to give to policy makers. This advice could highlight both the risks and benefits associated with different measures to address a public health issue. In this way the policy and scientific communities can be seen to avoid major public disagreements on strategy. Another key facilitator is having an appropriate range of actors included in advisory groups; they need to be multi-disciplinary and involve the most likely relevant expertise. Mental health as an issue is more likely to be considered in discussions if this different expertise includes mental health.

A lack of policy community cohesion, including splits within the public health community over the nature and extent of any health crisis, including the COVID pandemic, can have a negative impact on the credibility of expert input with policy makers. This was observed in interviews with several stakeholders; another issue that we discuss later that hampered policy implementation around mental health in some settings included a lack of good, effective communication channels to link expert advice to the policy making process. This is really important to counter inaccurate information that may come from multiple sources, including various vested agencies as well as some elements of both traditional and social media.

**Challenges in policy community cohesion: an illustrative example from the UK**

Figure 1 depicts the myriad of actors potentially involved to different degrees in the complex decision-making and governance processes during the pandemic. Core decision-makers are surrounded by several different actors, or advocacy coalitions, who will try to influence the policy agenda in different, at times conflicting, directions. The way different actors, including core decision-makers, understand the nature of the crisis, its consequences, and potential ways to deal with it will be determined by their pre-conceived ideas, ideologies and interests. Therefore, it is fundamental to be aware that decision-making ultimately is a function of the interplay between different belief systems, and that, in the process, core decision-makers ultimately must arbitrate between conflicting interests or agendas and will, in turn, be influenced by their own belief systems. Considering the power imbalance that usually exists between different actors, some coalitions tend to be more influential than others in decision-making and agenda setting.

This draws on the wealth of evidence still emerging from the UK COVID-19 inquiry on policy making process in the four nations of the UK (most health and public health decision making is devolved to the four nations and indeed to sub-regions within those nations). In Figure 1, the circles represent different actors, or coalitions, which fed core decision-makers with information, evidence and advice on how to tackle the pandemic. Circles' colours represent different belief systems and their sizes and positions in relation to core decision-makers represent their relative weight in the power structure.

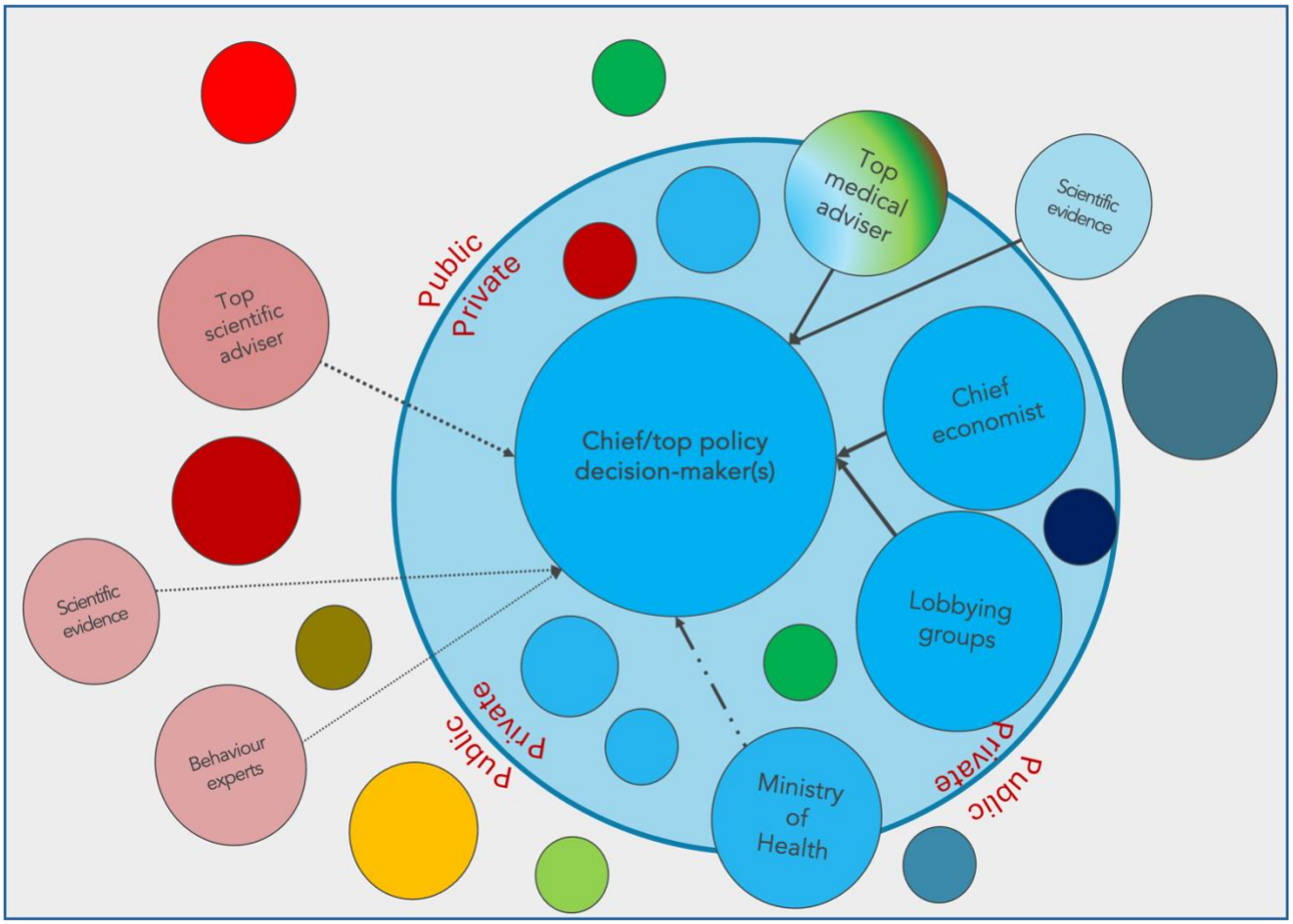
It is noteworthy that advice/evidence provided by certain groups, such as scientific experts, were made publicly through reports and meeting minutes, whereas other groups had more privileged access to the core decision-makers through private and confidential meetings. Some stakeholders advocating for the economic agenda, for example, held private meetings with core decision-makers to discuss some measures to support businesses which might have public health implications (e.g., easing of virus suppression measures) without apparent consultation with public health representatives.

One further lesson we learned which might be particularly important to the scientific community is that, at times, the same scientific evidence can be used by different actors to push the decision-making in different directions, by putting a different interpretation on this evidence. Therefore, if science is to have an opportunity to help inform decision-making, evidence ought to be framed and communicated in ways that are clear, transparent and explaining how the evidence can be interpreted and what the limitations are in interpretation.

Whereas scientific advisory groups should be diverse and multidisciplinary, scientific advisers should try and reach consensus before providing their recommendations, so to avoid ambiguities that might undermine the potency of science to influence the implementation of interventions and to achieve desirable outcomes. This, nonetheless, can be challenging, considering the complexity of multidisciplinary work and that the nature of any crisis may lead to the establishment of a *disciplinary hierarchy*, making it difficult for some disciplines to be properly listened to.

In a public health emergency caused by an infectious disease, biomedical models tend to be prioritised, leaving little room for potential psychosocial consequences to be considered. England's Chief Medical Officer Professor Sir Chris Whitty, the leading apolitical medical advisor to the Prime Minister and Ministerial Cabinet, speaking at the Royal College of Psychiatrists in 2021 stated that at the beginning of the pandemic that: "*The mental health elements of the lockdowns and public anxiety were often underplayed*" (13). Ignoring psychosocial aspects of the crisis, however, tend to undermine the efficacy of biomedical measures as psychosocial problems, such as loneliness and mental health impact of measures have been identified among potential barriers to compliance (14).

**Figure 1: Depiction of multiple actors and policy communities within the decision-making universe**




## 6.2 LEADERSHIP

Leadership structures for public health emergency ideally should reflect the balance of administrative power within countries. In devolved and federated countries in particular, this leadership process was helped by the pre-existence of forums and other mechanisms for regional and national leaders to come together to discuss issues of mutual importance. These forums could then be repurposed to discuss the public health emergency; moreover, the existence of these forums meant that leaders already might have some personal rapport with each other, even if they came from different political backgrounds and ideologies. For example, in Belgium, a National Security Council already existed and was successfully used to bring leaders from the different regions and the federal state together. Where such forums did not exist, there may have been greater levels of mutual distrust, with political differences leading to poorer communication strategies.

We noted that disjointed communication between leaders at national and regional level could be very problematic. Examples from some stakeholders interviewed highlight the importance of addressing this issue in future.

> *"there were quite a lot of tension [between] regional structures and [the] national structure [because national government] thought they could tell us what to do"*

> "*[regional and national structures should] work together [but] they [national structure] did not have the skills, the culture, or, will, they did not have the capacity [and] in many ways their attitude to working with people at local level was still quite arrogant top-down*"
>
> "*moved to a very top-down kind of position…….*[if] "*at the start of the pandemic it provided some structure and…gave direction, as the pandemic went on there was a lot of frustration that [local administrations] could not get on to do the things [they thought were] needed*."

Again, having the right mix of people around the policy making table can more effectively convey critical information to key policy makers. The role of special advisors/political appointees in government structures could be both positive and/or hamper effective leadership. These advisors had to filter information used in decision making, and it appears that they did not always have much knowledge or awareness of mental health concerns. It is also worth noting that one major consequence of any lack of transparency on how some decisions are made is that it can undermine trust in the leadership, which, in turn, can reduce compliance with interventions, among the public, and erode stakeholders' motivation to participate in, and to support the decision-making process.

Another important aspect of leadership that became very politically contentious in some countries, was the importance of leading by example. In particular, where leaders themselves did not always follow restrictions enacted as part of suppression measures, this sometimes gained substantial media attention, reducing confidence and trust in the decisions made by leaders.

## 6.3 GUIDING INSTITUTIONS

Institutions that had core links to policy makers, and with substantial human resource capacity could be more effective. Some public health institutions put an early focus on mental as well as physical health inputs. Guiding institutions also established credibility through communicating directly with the media as well as with policy makers. In contrast weak guiding institutions make it more difficult to obtain policy maker support for actions. This can relate to the capacities and skills of institutions and the role of the institution.

## 6.4 CIVIL SOCIETY MOBILISATION

We observed that countries having a tradition of strong, independently funded civil society organisations that had a focus on both general mental health and representing people with lived experience of poor mental health, often engaged with these organisations as part of the policy making processes. This did not necessarily mean that mental health became a higher priority, but it did make mental health more visible. High profile civil society organisations were also able to provide remote/online advice and other supports to the general population. This may also have helped mitigate some of the impacts of the pandemic, although we are not aware of robust data demonstrating this. Conversely a lack of strong well-funded and independent civil society organisations with a focus on mental and psychological health may have reduced the discussion of these topics in policy making deliberations. This weakness is not easy to change, particularly in countries where such civil society organisations are not prominent, but there is also potentially a role to be played by EU-wide organisations in this space that have skills in advocacy and policy communication to work with national level civil society organisations.

# 7. FRAMING OF IDEAS

## 7.1 INTERNAL FRAMING

A key issue that influences the policy making process is the *a priori* perceptions of psychological / mental health held by stakeholders. Objectively, funding levels for mental health across Europe are relatively low compared to the contribution of poor mental health to the burden of disease. This may be indicative of the view that mental health is in someway less important that physical health within health care systems.

There is evidence from many different countries that people with mental health needs may not receive the level of support from health care systems when they engage with these systems compared to people who are not perceived to have mental health needs (15). While the profile of mental health has risen awareness of the excess mortality risk associated with chronic mental disorders, including depression, which can be equivalent decades of life lost, even in high income European countries (16), it is still not well appreciated. This background may have been a factor in the low priority that appears to have been given to the mental health consequences of the pandemic and pandemic suppression measures in many jurisdictions.

Where policy makers were more aware of these issues, or they received advice from trusted key sources that were aware of these issues, mental health became more of a consideration. There has been more growing awareness of some psychological distress risk factors, including loneliness, risk of inter-personal violence, and financial pressures for individuals with low job security during the pandemic. This raises the issue of the importance of improving mental health literacy among policy making audiences, including those working in the physical health sector.

Ways to address this also include ensuring that evidence is provided to policy makers on risk factors for poor mental health, not only during the current crisis through real time monitoring (see also section 9.1 on measurement), but also looking back at experience with previous crises. A wealth of information exists, for example, on how financial insecurity can impact on psychological health which has been observed in many previous economic crises (17). It is also important to highlight the equity implications of strategies, what are the consequences for individuals that may be more vulnerable to mitigation measures, e.g. workers who have people-facing jobs in the retail and entertainment sectors.

## 7.2 EXTERNAL FRAMING

We need to recognise that, while mental health literacy has been improving, there remains a lot of ignorance and stigma surrounding mental health. The recent crises, both COVID-19 and the energy crises have arguably helped raise public awareness of the importance of mental health, so that these considerations should have more weight in future crisis planning, but it remains the case that more needs to be done to address poor mental health literacy and tackle discrimination. These are issues that go well beyond preparation for pandemics. It also includes strategies on mental health communication in the media. None of this is new or radical and it can take considerable time to maximise impact, but it still needs to be done. The long-term consequences, including for future crises, are also very important because they also impact on whether individuals experiencing psychological distress, for instance linked to a public health crisis, may because of their own negative perceptions of mental health be reluctant to seek help and support(18).

# 8. POLITICAL CONTEXTS

## 8.1 POLICY WINDOWS

The length of the COVID pandemic, and the nature of the pandemic, with a number of waves of the virus, broken up by periods the virus had less impact, also provided opportunities for policy makers to plan ahead. From various analyses, including our interviews with stakeholders, mental health became more of an issue throughout the crisis, in part because evidence became available (through new monitoring approaches) on the mental health impacts of the pandemic, as well as pandemic suppression measures. As the pandemic went on, our interviews indicate that policymakers more actively and explicitly did begin to take into account impacts on mental health when formulating policy, including for example, the balance between virus transmission and the educational and mental health benefits of reopening schools (19). Where data were more lacking, it may be argued that opportunities were missed to modify the response to public health crises.

A public health crisis can also provide an opportunity for evaluation of different policy tools that can then be used in future similar shocks. Currently there are many studies that are looking at the relationship between the psychological and other impacts of the pandemic and the availability of income support schemes. This research can only happen, and inform future policy actions, if appropriate data are collected. Uncertainty may also be mitigated by having access to information on the policy responses to previous public health crises. Ideally, data collection should also continue after crises are over for a period of time in order to look at longer term consequences.

Our interviews with policymakers also reinforce the message that there are also opportunities created by public health crises, not to just plan for future pandemics and other public health shocks, but also to plan for the long-term recovery of the population after these shocks have ended. In the UK, for example specific plans to address the mental health and wellbeing impacts of the pandemic were developed during the crisis. They include Scotland's Transition and Recovery Plan (20) and the strategy and the Mental Health and Wellbeing Recovery Plan published in England (21).More generally, guidance documents on the promotion and protection of mental health need to be adapted to take account of changes in the way in which we lead our lives following the pandemic; for instance, new WHO guidelines on protecting mental health at work have been adapted to consider the likely permanent increase in the number of people working from home (22).

## 8.2 INTERNATIONAL POLICY MAKING STRUCTURES

Previous work in RESPOND WP2 also indicates that the knowledge of the European public and policymakers regarding the mental health consequences of the pandemic, protective factors, and the efficacy of psychosocial and mental health interventions should be increased. Some of this could be done through international initiatives, including through EU agencies. The RESPOND consortium noted that any EU-wide emergency preparedness and response strategy should include response mechanisms for negative mental health impacts of cross-border health crises, for example, by providing psychosocial support resources (e.g., helplines, digital resources) for the general population and vulnerable groups.

Such a preparedness plan could also define criteria to ensure a sufficient supply of the EU population with (critical) mental health services during and after health emergencies. In addition to the European Parliament (e.g., by promoting the establishment of necessary funding programmes), different European and national actors could contribute to implementing these policy options, including the European Commission, the Member States, mental health organisations, as well as research groups and experts in the field of mental health. Again, data collected on the impacts

and consequences for mental health across countries could be used to inform such strategic plans, as well as look at the long-term impacts of a public health crisis.

# 9. ISSUE CHARACTERISTICS

## 9.1 CREDIBLE INDICATORS

RESPOND analyses have highlighted the lack of access to readily updated population-level measures of mental health during the early stages of the pandemic. There was sometimes a lack of recognition of the relative importance of monitoring mental health at a time when focus on levels of mortality. Measures were also very blunt; a traditional focus on measuring suicide and self-harm rates alone will be of limited use. Similarly, the same applies to service utilisation data. Policymakers had to rely mainly on data on the number of contacts with mental health services; these data were not helpful, in part because they mainly focused on individuals with pre-existing mental health conditions, and secondly because there was a general reluctance in the public to come into contact with any health services early in the pandemic, for fear of being infected. RESPOND reports indicate many higher risk population groups, including young people, single parent families, those in insecure and poor accommodation, as well as workers with temporary or no employment contract (23).

Policy makers need to have access to data on mental health impacts, if they are to factor this into their decision making. This means policy makers during a public health crisis need to work rapidly to ensure that either existing monitoring systems are adequate to address information needs, or if not, to determine what information is needed. In the case of mental health, this often means setting up new measurement systems, often through longitudinal surveys, to collect data on different dimensions of well-being. This means that measures should capture positive as well as negative aspects of mental health and psychological wellbeing.

Putting in place such systems, can in effect create a 'radar' mechanism that can help identify mental health consequences of any public health crisis and critically which segments of the population are most affected. For example, this could be done through large scale random sampling of the population on a longitudinal basis during times of public health (and also other crises, e.g., the energy price shock and cost of living crisis). One example of this was the rapidly created COVID Social Study in the UK which rapidly recruited more than 70,000 participants, collecting data on a bi-weekly basis for more than 2 years (24). These data need to continue to be collected beyond the end of any crisis, as there can be time lags before mental health impacts are seen.

## 9.2 UNDERSTANDING THE MAGNITUDE OF MENTAL HEALTH IMPACTS

A key theme throughout this briefing paper has been on the importance of effective communication, making use of mental health specific data. In some settings the potential mental health consequences of the pandemic were not very visible early in the COVID-19 pandemic. The magnitude of impacts, both of the pandemic on mental health and mental health mitigation measures, were sometimes hidden.

A good example of this concerns the attention given to the strengths and weakness of different models on the transmission and mortality risk associated with COVID. Adopting the precautionary principle, policymakers and their advisors tended to focus more on the worst case scenarios. There is nothing wrong with this approach, but as we have

learned in RESPOND scientific advisers best and worst-case scenarios were sometimes wrongly taken as predictive models. As a result, when the scenarios did not materialise, policymakers concluded that the models were wrong and, therefore, should not be taken into consideration. For example, when extremely high number of hospitalisations or deaths did not occur, likely due to suppression measures, policymakers sometimes concluded that the disease was not as severe and deadly as the evidence suggested and that, therefore, the same suppression measures that helped prevent deaths might not have been necessary. Perhaps what is even more relevant to our focus in RESPOND is that these scenarios typically did not look at possible mental and psychological impacts of the pandemic and suppression measures. Thus, the magnitude of the possible impacts on mental health were rarely discussed in these models; experts in mental health were not involved generally in model development, this was left to experts in epidemiology and infectious diseases.

A key message which applies regardless of the nature of a public health crisis is again to carefully consider how psychological as well as physical health impacts of the crisis can be modelled. We recognise understandably that immediate attention was focused on risks of excess mortality from the pandemic, but it is possible to also commission rapid modelling on other impacts. It can be erroneous to focus in any public health crisis on one key issue alone without considering other impacts, including on mental health.

Another key theme of this document is the need for effective communication. In both RESPOND work and external work looking at how scientific advisers working with governments in different countries, difficulties in communicating with policymakers were reported (25). The fact that scientific advisers complained that policymakers lacked a scientific background which would allow them to understand the evidence being presented (25) suggests that there is some important work to be done by researchers to improve communication, especially about concepts such as magnitude and relative versus absolute risk. It is also suggests a lack of knowledge in researchers of policy making processes. Knowledge exchange and communication processes are fundamental to translate scientific evidence in ways that it can be understood and taken on board by non-academic audiences, including policymakers and the general public (26).

Therefore, a great deal of attention ought to be given to communication strategies, including the communication content and terminology. Considering, for example, that risk perception is positively associated with compliance to suppression measures (27), we would contend that overemphasising a crisis as being restricted to vulnerable groups may undermine the general population's motivation to comply with measures. Particularly at the beginning of the Covid-19 pandemic, there tended to be an understanding that even suppression measures targeting non-vulnerable groups were actually aimed at protecting the vulnerable. In many countries, the main reason for adopting school closure was the understanding that, albeit being at low risk of severe symptoms, children were considered *Covid-19 super spreaders* and, therefore, a risk to the vulnerable, particularly to older people.

Such a justification on the implementation of measures that will impact the lives of both the vulnerable and the non-vulnerable may lead, among the latter, to a sense of unfairness that can both undermine compliance and amplify psychosocial consequences, such as psychological distress and mental health problems. Such narratives may also be misleading and result in excess morbidity and mortality that might otherwise be avoidable. This would be the case if the relevant authorities had made it clear from the very beginning that, although risks of severe illness and death were much greater in high risk groups, there was still some risk for other groups including young adults.

There are also specific issues on the language used for communication. Even though a key plank of any infectious disease contagion strategy is to maintain some element of *physical distancing* (28), this in many contexts, at least in Anglophone world, was somehow translated to the term *social distancing*. P*hysical distancing* would perhaps have been more desirable and might also have led to higher compliance. The reason is that the *social distancing* is semantically related to *social isolation* and *loneliness*, all of which bear a negative connotation and should, therefore, be avoided. Conversely, messages emphasising keeping appropriate *physical distance* as one of the most effective measures to suppress the spread of the virus would imply that people could still keep in touch with their loved ones, as long as doing it safely e.g.,

remotely, or at a safe distance. This may prevent feelings of self-isolation and loneliness that are detrimental to mental wellbeing and might undermine compliance.

### 9.2.1 CHALLENGES IN UNDERSTANDING MAGNITUDE OF RISKS TO MENTAL HEALTH AND WELLBEING

We highlight here some challenges in interpretation of the magnitude of risks to mental health and wellbeing. We know that the COVID-19 pandemic became rapidly a double-barrelled public health crisis. Not only were the populations at risk of COVID-19 infections, hospitalisations or deaths, but population mental health was affected directly or indirectly. However, the magnitude of this effect remains a debated issue (29-32). A meta-analysis of reviews concluded that the COVID-19 pandemic was associated with a heterogeneous, statistically significant but small increase in self-reported mental health problems (with effect sizes ranging from 7% to 27%) (32). Suppression policies also affected population mental health, with countries implementing more stringent policies displaying higher psychological distress (33)

Several longitudinal studies, which considered “pandemic fluctuations”, including variations in infection rates and responses like lockdowns, school closures, restrictions on social gatherings, and the longer-term repercussions on mental health, have produced inconsistent findings. For instance, a study on the psychological impact of the COVID-19 pandemic noted that while lockdowns had a modest yet notable effect on mental health symptoms in the general population, the authors stressed that the impact varied depending on contextual and individual factors (34).

Most studies identified an increase in psychological distress, depression (35-37), and anxiety at the onset of the outbreak compared to the pre-pandemic period (32, 38, 39), but this trend was not universally supported (40, 41). On the one hand, Gonzalez-Sanguino et al. (42) highlighted in their longitudinal study conducted in Spain that there was no statistical changes in anxiety and PTSD symptoms after 44 days of confinement. The authors showed that spiritual well-being, loneliness, and a younger age were the main predictors of the variance for depression and anxiety (42). On the other hand, in the United States, Breslau and colleagues concluded that an equal number of people experienced as much serious psychological distress over 30 days during the pandemic as they had done over an entire year before the pandemic (40).

In Belgium, Bruggeman and colleagues (43) highlighted that the proportion of participants with symptoms of anxiety and depression decreased during times of lower policy restrictions to almost the same level as in pre-COVID times (44). This study indicated that women, young people, people with poor social support, those having pre-existing psychological problems, and people who were exposed to the COVID-19 virus, had higher levels of both anxiety and depression. Mata and colleagues (45) pointed to an important increase in psychological distress indicators during the first months of the outbreak in Germany, followed by a subsequent stabilisation or slight decrease in symptoms. Another longitudinal study revealed that the timing of data collection, specifically during periods of high infection rates and the implementation of lockdown measures (hereafter referred to as the dynamic of the pandemic), accounted for 43% of the psychological distress variation (46). These results were also supported by several authors who highlighted fluctuations in psychological distress concerning the severity of the policy measures during the initial months of the pandemic (43, 47, 48).

**The role of intermediary mechanisms in explaining differences in magnitude**

One possible explanation for these inconsistencies would be that studies focused too much on the direct effects of the pandemic or of suppression measures and not enough on key intermediary mechanisms that were the product of the pandemic and the ensuing suppression measures. Here we highlight loneliness as a key intermediary mechanism. Ater all, not all the population experienced the pandemic in the same way. It varied depending on personal exposure to the risk of infection or risks of more severe health impact. The risk of hospitalisation and death, for example, was very much and linearly related to age and health status. In addition, homeworking, for example, which became very common had

an ambiguous effect on social ties: remote working provides more opportunity for socialising within the household but on the other hand it may decrease opportunities for socialising outside the household, in particular with work colleagues. An early study monitoring of the population mental health in Belgium in the first month following the lockdown showed that loneliness was the most important determinant of psychological distress(49).

A Spanish study also found that the feeling of loneliness increased in the first months of the lockdown, in particular for those being confined alone who felt increasingly being excluded(50), a decline which was also observed in a Dutch study(51). The Dutch study also found that social networks became smaller and more focused on stronger, family ties meanwhile weak ties disappeared (51). This detrimental effect was particularly pronounced for those living alone or having a disadvantaged socio-economic position. Thus, as governments diversified their restriction measures and implemented "social distancing" or "social bubbles", loneliness increased, leading to a deterioration of population mental health among those aged 50+ (52). The Belgian longitudinal study showed that loneliness was not only a key determinant of mental health, but explained an important share of the intra-individual variance of mental health between five waves of data collection (from March 2020 to November 2021) (49). Thus, loneliness turned out to be the key determinant of individual mental health "resilience" during the COVID19 pandemic. This then also emphasises the importance of measuring changes in loneliness as part of any public health crises which imposes restrictions on everyday functioning.

## 9.3 EFFECTIVE INTERVENTIONS

It is important to rapidly search for and provide evidence on effective strategies to address any public health crisis. Ideally this should be part of preparedness planning documents that consider multiple possible public health crises. However, the way in which this evidence is presented, as well as being updated, is very important. In the case of mental health, but this could also apply to other outcomes, we believe it is helpful to formally employ rapid impact assessments when considering mitigation strategies, and to continue to update these over the duration of any crisis.

In RESPOND we were able to use an impact assessment framework matrix developed by Public Health Wales (53), described in our previous rapid appraisal reports, to document the ongoing mental health consequences of selected pandemic policy response measures and mitigations across selected RESPOND countries. The framework identifies risk factors and determinants of mental health and wellbeing and considers how these may be affected by the pandemic and pandemic policy responses. It also looked at what is known on the effectiveness and consequences of different pandemic suppression strategies. It highlights direct impacts on mental health and wellbeing for the general population and for specific potential higher risk groups across the life course. It also provides a narrative on the likelihood that the positive or negative impact will happen as well as the magnitude of impact and the duration of impact.

We used this approach to look at six policy responses that are particularly important: school closures, restrictions on gatherings, stay at home instructions, measures to protect older people, as well as income support and debt relief. These policies were chosen because they affect a large share of the population (horizontal equity), they are likely to hit vulnerable groups harder (vertical equity), they were more strictly imposed where the COVID-19 pandemic was more severe and finally they strongly affect the social life and thus mental health status of individuals. The policies were tracked with Oxford COVID-19 Government Response Tracker (OGRT).

These are described further in our previous reports, but this impact assessment approach was helpful in identifying that strategies had differing positive and negative impacts on mental health for different segments of population groups. For instance, some children and adolescents benefited from the home learning environment, even though much of the evidence pointed towards adverse impacts on social development and mental health for many young people. Homeworking was associated with many positive impacts on wellbeing for many people, but only if the environment for

homeworking, for instance having sufficient space, was appropriate. Evidence continues to accumulate that a minority of the population experienced better mental health and wellbeing as a result of these measures (32).

We also identified measures that could be used to address many different crises through impact assessment. For example, additional support measures that reduce financial distress, as well as the fear of financial distress, can be important tools/mitigation measures to be used during any public health crisis that impacts on economic activity. Although the cost-of-living crisis is a very different crisis to the pandemic, it also has major public health concerns, and additional financial support may equally be protective to mental health. Although governmental finances are under considerable pressure at the moment; our work in RESPOND suggests that a proportionate universalistic approach to address any future public health crisis is an option. In crises that affect everyone, such as COVID and the energy crisis, then some provision of universal financial protection measures seems prudent. This would mean ensuring that everyone receives some additional support, with further targeted support for individuals in most need (54). These individuals might be identified rapidly through the real-time large-scale surveillance mechanisms that focus on identification of psychological distress that we have noted, as well as learning from previous economic and public health shocks helping to identify those in most need. Impact assessment can help provide this information in an understandable way to policy makers.

### 9.3.1 LEARNING FROM THE PAST

We have already alluded to the importance of learning from the past. A key weakness noted by interviewees of pre-existing pandemic planning documents was a lack of any strong focus on mental health. Going forward it is essential that plans consider the impacts on mental (and physical) health of public health measures that place restrictions on movement and our activities. Mitigation measures to help support mental health can then be developed as part of this plan; this for instance could include access to a range of telephone and online self-help services to help promote and protect the mental resilience of all.

Our review of documentation from the current and previous crisis indicates the importance of having access to objective and independent evaluations of the response to previous public health crises to help ensure objective institutional memory. Before the onset of the COVID-19 pandemic, different countries did take measures to prepare for future pandemic, with a review indicating that countries with prior experience in health crises, such as those in East Asia being better prepared for future pandemics (55). Our RESPOND D2.4 report noted that the Independent Panel for Pandemic Preparedness and Response established by the World Health Organisation (WHO) recommends an operational ecosystem for equitable access to medical countermeasures and sufficient financing for preparedness and response (56). It also recommends an independent, well-functioning and authoritative WHO, a high-level political council for pandemic threats, an improved international organisation against pandemic threats, a pandemic agreement and revised International Health Regulations, as well as ongoing monitoring. However, the panel report does not include any specific recommendations on how to mitigate against psychological impacts of pandemics.

Indeed, what appears to be more limited is existing learning on the mental health impact of many public health events, although there is a substantial evidence base on some of the impacts of economic crises for mental health. Unlike the example looking at suicide and self-harm, where there may be much to learn from past economic shocks, there may be fewer parallels with previous events. One option is to look at very early experience with the current pandemic in countries such as China, but is it possible to look at the psychological impacts of previous infectious disease outbreaks, such as SARS? A recent rapid review looked at the potential impact of infection outbreaks on the psychological state of long-term care staff identified six previous studies on this topic (57). Two of these were from RESPOND countries, Sweden and the UK, while another was from Australia, but all were very small-scale studies. All identified fear of illness and infection, workplace tension and stress as concerns. A larger study of nearly 400 residential care workers in Norway looked at the impacts of an MRSA outbreak (58). Although this study did not use validated instruments to assess

psychological health, fear and anxiety associated with being infected or becoming a carrier, as well as restrictions on social life because of infection were reported by more than 75% of survey participants.

Another important theme in interviews was also the toll that the pandemic has had on the mental health and wellbeing of policymakers and service planners, with respondents speaking of working non-stop for months at a time, and with little support in place for their own mental health. It is important that they also protect their own mental health and mental resilience. RESPOND is also looking at the impacts of stepped care brief psychological interventions to look at these issues. We will look at how this fits into the framework in an updated version of this report, but already we note that for some target population groups, the way in which intervention is delivered will have an impact on uptake. For example, health care professionals may prefer to only receive support from highly qualified health professionals(59, 60).

The emergence of powerful artificial intelligence means that it may also be possible to rapidly analyse the impacts of previous public health crises, including historical events where records are only available in written format. This could mean that it is possible, for instance, to look in more detail at the influenza pandemic in the early twentieth century to see if any lessons can be learnt, even a century later. It can also mean that vast amounts of data from the recent COVID pandemic may also be more rapidly processed for the same purposes. Other rapid ways of doing this include systematic reviews of previous responses to public health crises. For instance a recent review, identified common effective public health measures to address respiratory viral pandemics from experience dealing with influenza A H1N1, MERS and severe acute respiratory syndrome as well as COVID (61).

# 10. SUMMARY OF RECOMMENDATIONS

This briefing paper has looked at decision making processes during public health crises, looking in particular at RESPOND's work related to the COVID-19 pandemic.

**Actor power in decision making**

We note that establishing various scientific advisory groups to provide input to the policy making process during a public health crisis is merited. However, **mental health expertise needs to be included within these groups** to enhance the likelihood that mental health is considered in a public health emergency. If policy making processes are dominated solely by experts from a narrow beckground this is unlikely to lead to consideration of the broader consequences of any public health emergency crisis response. In the case of the COVID pandemic, the reponse was at risk of being dominated by virologists, something the advisory boards set up for COVID-19 struggled with (62, 63).

Our views are also supported by other insights. Based on interviews with 21 experts from five European countries, a study found that 'Integrating insights from various specialisms within a single board was also a challenge when individuals felt that their area of expertise should be a priority. Some participants felt that, at times, their colleagues overstepped their expertise, lacked openness towards other disciplines, or even questioned the expertise of their peers'(62).

**Framing of ideas**

Our anlaysis also indicates a need for more **campaigns to tackle the stigmatisation that surrounds the concepts of mental health and mental illness** (64). This influences perceptions of policy makers and the general public. However, as acknowledged by the OECD, only a handful of countries conduct periodic population surveys that include questions on such stigmatisation. Thus, the magnitude of stigmatisation and the effectiveness of campaigns remain unknown. In order to address this issue **it is important to regular collect information measuring the magnitude and extent of stigmatisation of mental illness**.

This will be important to take account of when emergency preparedness strategies need to develop information campaigns and encourage the whole population to take care of their mental health during a public health crisis. We have noted that people may be reluctance to seek help when experiencing distress and poor mental health because of negative attitudes to mental health (18); we also note that service utilisation may also be lower even when coming into contact with services (15). **Improving mental health literacy and having mechanisms in place to monitor mental health** also can help identify when mitigations to counter adverse impacts on poor mental are needed; they can also help reduce the reluctance of some of the general population of seeking help, even in a public health crisis, for their mental health and wellbeing.

The relatively modest attention paid to mental health during the pandemic, despite increased awareness of the importance of mental health in some countries, may also reflect the historical perception that mental health is less critical. We have noted that poor mental health is itself associated with a substantial excess mortality risk but this has long been overlooked. There is an underfunding of mental health care compared to non-mental health care in almost all OECD countries(65). Mental health care accounts for around 5% of total health care expenditures, while it represents 15% of the global burden of disease. Therefore, there is a long way to go. Although not directly linked to public health emergency planning, o**ur study also recommends moving towards the principle of parity regarding mental health and somatic health, and increasing funding for mental health care, as suggested by the OECD.**

**Political contexts**

It is also important to **strengthen public health emergency governance arrangements so that they fully involve mental health structures**. Initially, mental health was sidelined in decision-making processes, but over time, we have noted governments became more aware of this issue, and several countries developed plans including objectives related to the mental health of the population. Importantly these strategies are focused on population mental health, requiring actions across multiple sectors and not just focused on mental health care. These actors need to be involved in public health emergencing planning and response.

It is opportunity to take advantage of opportunities for adapt strategies and approaches as more evidebce becomes available. Additionally, different segments of the population may have different preferences or vulnerabilities, as evidenced by the rather high heterogeneity in choices. Instead of imposing a range of measures on all population segments, preparing for a future crisis should involve **providing a more flexible, fine-tuned strategy to avoid imposing too harsh a cost on those most vulnerable to restrictive measures**. This flexibility was one of the lessons of COVID-19, for example, when cities and rural areas faced different restrictive measures or when young people returned to school alternately. **Flexibility should be formulated on a clear and explicit reference to proportional universalism: services (or costs) should be delivered (or supported) at a scale or intensity proportional to needs.** This in turn requires that the social determinants of mental health be included in the elaboration of policies and plans. Again, the OECD suggest that few countries have mental health plans that consider different target groups according to gender, sexual orientation , ethnic minorities or social class.

We also note that mental health concerns had little influence on the initial design of political strategies to cope with the COVID-19 pandemic. An example is the "social distancing" or "social bubbles" restrictions implemented in many countries, which now have been shown to be detrimental to the mental health of many (but not all) people (52). In formulating decisions **there needs to be space to balance restrictive policies to protect and enhance the population's mental health, excluding measures with the least satisfactory cost/benefit balance**(66).

**Understanding the evidence base and magnitude of impact**

We have emphasised the importance on having credible measures on mental health that can inform policy making during any public health emergency. This **means having more sophisticated measures across multiple positive and negative dimensions of population mental health and wellbeing and not a reductionist focus solely on suicide/selfharm and mental health service utilisation.** These indicators were of limited use during the pandemic; meaasures of psychological wellbeing, and loneliness for example have proved more insightful. A toolkit of measures can be developed, but there will probably be a need to think specifically about what measures are most appropriate depending on the nature of the public health crisis. Moreover, surveys can be time consuming and might be affected by different participation biases. It is thus important to assess to what extent routine data could proxy the mental health status of the population in a dynamic way. For example, using regularly updated routine data on cinema ticket sales a a proxy for willingness to visit public spaces or on social activities as registered by online platforms.

This does not mean that decision-makers do not also need good routine data about mental health and mental health care to set priorities. Few countries have adequate data to track and analyse the performance of their mental health systems; data on continuity of care, for example, are lacking in almost all OECD countries, and almost half of these countries cannot measure the share of health expenditure for mental health(65). Similarly, **governments should measure population mental health dynamically, as illustrated by the numerous surveys conducted during the COVID-19 pandemic**.

While this report does not focus specifically on the nature of effective and cost effective interventions but rather on the ways in which the evidence base can be generated and conveyed to decision makers, we do note in RESPOND that **there will be differences in risks to mental health across the population. Again, monitoring and surveillance data are vital to identify these groups**. They will vary depending on the nature of the public health emergency and the response. In the case of COVID RESPOND has highlighted various groups including young people, those with precarious housing and/or employment as well as refugees. They are examples of groups that can experience high levels of mental distress and poor access to healthcare simultaneously and thus require better support during this period. There are other groups, who in theory, have more resource, but do need additional support. They include various emergency workers who have had to respond to the impact of the pandemic.

In order to collate information on effective and cost effective interventions we further recommend that **formal mental health impacts assessments should be conducted and updated during the course of any public health emergency**. It is important to consider mental health consequences when developing responses to public health emergencies. If adverse effects on mental health can be identified, even if they cannot be avoided, steps can then be taken to counter their impacts. The impact assessment framework also **provides an accessible way of communicating the likelihood of positive and negative impacts, their magnitude and duration to decision makers**.

A further key recommendation to inform decision making processes is to **objectively and independently evaluate the response to any previous public health crisis,** including the COVID pandemic to help ensure objective institutional memory. Such evaluations need to ensure that their **terms of reference include impacts on psychological health and wellbeing**. We have noted that future public health preparedness plans are being developed, however note that these do not appear to have much, if any, focus on mental health and wellbeing. Health is a holistic concept, involving both physical and mental health. The latter should be an integral consideration in these reports.

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