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ONLINE MENTAL HEALTH SERVICES PROVISION DURING COVID-19 PANDEMIC: PRACTITIONER'S LIVED EXPERIENCES IN THE GLOBAL SOUTH

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Abstract
The outbreak of the COVID-19 pandemic has necessitated sudden and radical changes in the mental health service delivery system, as strict physical distancing and lockdown measures were imposed in the early phases of the pandemic. With an unprecedented rise in consumption of mental health services, coupled with lockdown restrictions, practitioners were forced to transfer their face-to-face mental health services to online services. To understand the implications of this drastic change for mental health service delivery, and to improve the online care offerings, a case of a mental health practitioner who offer probono mental health services to diverse clientele in the African region and beyond is presented. Findings indicate that technological and usability problems pose a significant challenge, as do difficulties to establish rapport with clients. Moreover, not all mental health issues and treatment forms are equally amenable to online interaction. However, the practitioner was positive about the effectiveness of treatment, and reported flexibility, a lower threshold for contact, and lack of travel time as advantages. His most prominent needs concern better technological, organizational, and logistical support. In addition, current results inform future research on the improvement of e-mental health technologies.

Keywords: mental health; probono; physical distancing; COVID-19; e-mental health technologies

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Introduction

The Coronavirus Disease 2019 (COVID-19) pandemic, first emerged in Wuhan, China in December 2019 and spread globally in early 2020. Since then, the virus started to mutate causing a lot of distress and loss to humankind. A number of regulations were implemented to contain the spread of the disease and these included among others, lockdown, physical distancing, strict quarantine measures and isolation. Such measures have affected many people's various facets of lives. According to MacCartan et al. (2021), quarantine and other lockdown measures drastically changed people's daily lives with an elevation in levels of anxiety, depression, substance use, self-harm and suicide ideation. In support of this, Byrne et al. (2020), indicated that these preventive measures led to social isolation, stress and financial strain for many people which have been associated with adverse mental health outcomes. The COVID-19 threatened people's physical and mental health as well. According to Qiu et al. (2020), it has triggered various psychological problems such as anxiety, depression and panic disorder. In relation to this, Bao et al. (2020), notes that extensive outbreaks of infectious diseases like COVID-19, are usually connected to psychological distress and symptoms of mental illness. The pandemic situation also exacerbated existing mental health conditions like anxiety, depression, insomnia, alcohol and drug use (Bryne, 2020).

Background to the study

COVID-19 mainly presented as a physical health crisis however it has also proven to be a mental health crisis. Mental health refers to a state of psychological well-being in which people cope well with the many stressors of life, recognise their own potential, function productively and fruitfully as well as contribute meaningfully to their communities (WHO, 2020). According to the United Nations Policy Brief on Mental Health (2020), the mental health and wellbeing of entire societies was extremely affected by the pandemic which called for urgent attention. Many people from diverse backgrounds were reported to have experienced psychological distress. The same policy brief also notes that many people became distressed as a result of the immediate health impacts of the virus and physical isolation. During the pandemic era, many people dreaded the infection, dying and losing significant others. Some people got distressed because of the economic turmoil which threatened their jobs, others lost their jobs while others had salary cuts, and those in the informal sectors totally lost their sources of income. Such a

scenario predisposed many to mental strain. In addition to this, a lot of misinformation and rumours regarding the virus as well as uncertainty about the future also caused distress. According to Van Hoof (2020), the use of lockdowns and quarantine could be regarded as a big psychological experiment with a high likelihood of causing psychological problems in the future. This was supported also by the UN Policy Brief (2020), which states that there was a high likelihood of an upsurge in the number and severity of mental health problems. The rise in mental health conditions prompted many nations to adopt different mental health responses as a way of safeguarding humanity.

According to Torales et al. (2020), epidemics have got a detrimental effect on public mental health and in support of this, data from different national population surveys reflected a notable surge in mental health problems (Gonzalez-Sanguino et al., 2020; Jahanshahi et al., 2020; Shevlin et al., 2020). Unfortunately, mental health issues have not been given equal priority as physical health issues resulting in less prioritisation of mental health during the pandemic despite many people being affected psychologically. McCartan et al. (2021), pointed to the inequality in the allocation of funding towards health with mental health services receiving less funding than physical healthcare. According to the UN Policy Brief on Mental Health (2020), globally mental health has been robbed of significant investment with an average spend of only 2% of health budgets. Countries like Botswana, Sierra Leone, Ethiopia, Zambia and Zimbabwe developed health guidelines or Standard Operating Procedures (SOPs) in response to the COVID-19 pandemic but the guidelines excluded mental health or psychosocial support (Molebatsi, 2021). Mental health in Sub-Saharan Africa has been less prioritised during pandemics and has received little attention from the governments (Kidia et al., 2017; Ugochukwu et al., 2020). For instance, the Nigerian Mental Health Services Delivery Policy was yet to be effected into law by 2020 (Ugochukwu et al., 2020), in Zimbabwe the policy was last reviewed in 1996 (Kidia et al., 2017). Most governments focused on preventing COVID-19 infection and physical symptoms. Such a scenario has led to a delayed response towards the surge of mental health conditions caused by COVID-19.

The pandemic exacerbated the incidence of mental health conditions which was met with a reduction in the availability and breadth of mental health services thereby impacting negatively on people who had existing mental health issues and those who developed mental health conditions due to exposure to the pandemic. This surge in the need for mental health services was characterised by

a high demand for digital and telehealth service contact (Reay et al., 2020; Titov et al., 2020; Wind et al., 2020), and a reduction in the need for face-to-face services (Khoury & Karam, 2020), as some people were unwilling to report or seek help for mental health conditions in the midst of lockdowns (Doctors of the World, 2020). Online therapy started in the 1990s as internet became common and there is evidence that this medium has power and potential in providing therapies for mental health conditions however more research is need on remote deliverance of services and maximisation of engagement and effectiveness (Liesbeth, 2020). The earliest documentation of remote psychiatry was conducted at the University of Nebraska in 1965 where a two-circuit television system was utilised for educational and medical purposes (Chakrabarti, 2015). According to the UN Policy Brief (2020), digital and online services have the potential of alienating some already disadvantaged groups of people. McCartan et al. (2021), noted that the Director of Mental Health Europe, Claudia Marinetti, applauded the advent of mental health online professional care as a 'silver lining' in an environment where other options were not feasible. Other scholars, (Ray, Stevens, & Thirunavukarasu, 2020; Seifert, Cotton, & Xie, 2020) warned that digital technology has to be embraced with caution as it cannot eradicate the value of physical interactions required in delivering certain mental health aspects especially amongst digitally excluded groups.

In response to the increase in mental health conditions during the pandemic, different countries adopted various online mental health services. The use of telepsychiatry has been amplified through introduction of new teleconferencing applications like Microsoft Teams and Zoom to provide care continuity at the same time reducing the risk of virus transmission (Pereira-Sanchez et al., 2020). According to Barney et al. (2020), in San Francisco, physical mental health services were replaced with telemedicine which was highly embraced by young people. McCartan et al. (2021), noted that though this was a positive response it was met with barriers which included difficulty in maintaining privacy and confidentiality and limited clinical decision-making for professionals as they could not conduct physical examination and lacked access to laboratory data. In Qatar there was an introduction of telephone/video medical consultations which promoted video consultations with diverse specialists from the medical field. In Spain IT experts facilitated the access of electronic clinical records by mental health personnel as they work from home (Arango, 2020). Feijt et al. (2020), found out that many mental health practitioners in the Netherlands made

use of digital treatment tools with videoconference either through Skype, Zoom, etc. or secured applications in an online platform, telephone, chat sessions, e-mail and e-mental health modules.

Digital divide has been noticed in the populations expected to access e-mental health services. Young people have been regarded as overrepresented among users and callers to mental health hotlines but the elderly and others from low socioeconomic levels were underrepresented. In France, adolescents and early adults (under 25 years), have been reported to be the most frequent callers on mental health hotlines such as SOS Amitie, in Colombia there was a surge in youth-specific hotlines and services and nearly a third of callers to the COVID-19 mental health hotlines between April 2020 and March 2021 were young people within the age range of 15-29 years and in Ireland there was a 50% increase in demand for the services of a youth mental health charity 'Jigsaw' and an increase in the traffic to the e-mental health platform for the charity in the first half of the year 2020 (OECD, 2020). In the UK, 84 % of child and adolescent mental health services were delivered remotely in April 2020 (National Health Services Benchmarking Network, 2021) and in Australia, in June 2020 young people applauded the use of telehealth services which they described as appropriate for their needs (Headspace, 2020). On the other hand, adoption of e-mental health services has disadvantaged most elderly people globally. Older adults are excluded from digital services because they choose not to use internet, experience difficulties with network connectivity, lack necessary devices as well as technological experience hence fail to access mental health services online (Seirfet et al., 2020; Bryne, 2021). In addition, these older adults are mostly weak and usually offline and some are in long-term care facilities thus experience both social and digital exclusion. Pereira-Sanchez (2020), notes that patients belonging to lower socioeconomic groups might lack reliable internet access to facilitate the effective use of telepsychiatry. Digital exclusion has been reported to be influenced by income, language, literacy, culture and ethnicity thus according to Ray, Stevens, and Thirunavukarasu (2020), consequently in the United Kingdom, migrants living in vulnerable circumstances, Gypsy, Roma, traveller communities and homeless people become more vulnerable to adverse mental health outcomes due to digital divide.

Online mental health services during the COVID-19 pandemic have been reported to be effective but with some challenges. Young Minds (2021), stated that in the United Kingdom almost one-in-four of the young people with a history of

mental health needs, reported failing to access services even though they had searched for them due to barriers to access support online. The pandemic presented practitioners with extra challenges of conducting online mental health services which also require the experts to put into cognisance the context and consequences of the perpetuating pandemic. According to Liesbeth (2020), Feijt et al. (2020), online therapy raises issues of confidentiality as the client may be forced to receive the services in the presence of significant other which in some cases may jeopardise safeguarding of clients leading to exposure to domestic violence. Online therapy has also been regarded as an unexplored territory which may expose therapists to an additional sense of responsibility towards their clients but simultaneously lack the same means to address their clients' needs as they would during physical engagement and clients may also be reluctant to participate in remote therapy making the therapist helpless (Liesbeth, 2020). Other challenges included insufficient technological infrastructure especially poor internet connectivity for both clients and practitioners, clients' lack of required devices like smartphones and cameras, lack of organisational support for practitioners, inability to assess non-verbal cues as well as inability to engage in physical exercises like role plays or drawing (Feijt et al., 2020). Online mental health services have been found less suitable for some mental health conditions like when treating trauma, psychosis, severe anxiety, cognitive impairments, conducting family therapy, group therapy and child therapy. In relation to Sub-Saharan Africa (SSA), it has been noted that generally there is minimal utilisation of mental health services as many people resort to social resources and self-help methods when the symptoms are not severe. In addition, online and digital platforms utilised in high-income setting are a limited option in SSA due to poor internet access, low smartphone penetration and digital illiteracy. Therefore, it is more likely to benefit the populations in urban areas.

Despite the challenges mentioned above in relation to e-mental health services, literature has it that there are some perceived advantages associated with adopting it. Feijt et al. (2020), pointed out less travel time, flexibility of scheduling appointments, short and efficient sessions, high client satisfaction, less inhibited expressions from clients and less dependence of clients on therapists as some of the practical advantages of online mental health services.

As noted before, mental health has been given less priority than physical health globally and this has also been noted in Zimbabwe. The country's mental health act has last been updated long back pointing to the fact that it is now

outdated. In response to COVID-19, the country also prioritised physical health more than mental health. However, some mental health practitioners in Zimbabwe adapted online mental health services as a way of continuing care with their clients or addressing mental needs of those who were affected by the pandemic or those who had existing mental health conditions. It is against this background that the researchers opted to explore the experiences of mental health practitioners in an African setting, when they adopted digital means of delivering their services.

Objective

The researchers aimed to explore practitioners' experiences of online mental health service provision during the COVID-19 pandemic as a way of understanding the implications of such drastic changes to mental health service delivery. Using findings of this study the researchers suggested ways of improving online mental health care services.

Methods

Participants

The sample consisted of 1 practicing mental professional (male) working in Zimbabwe. Participant was identified through a WhatsApp group that offers mental health services and purposive sampling was used to select the participant from the social network.

Measures

A structured interview survey guide which consisted of both closed and open-ended questions regarding the practitioner's lived experiences on online mental health service provision during COVID-19 and after was utilised. The interview guide was pretested with some mental health experts who were offering online mental health services.

Procedure

Data was collected using an online interview guide and WhatsApp calling. Narrative interviews were audio-recorded and transcribed verbatim to prevent data loss and to preserve meaning so that nothing of importance would be overlooked (Tilley & Powick, 2002). Transcriptions were encrypted and saved on the researcher's personal computer for storage where no one, except the researchers had access to the transcripts.

Data analysis

The study used a narrative analysis (Polkinghorne, 1995) to analyse the actions, events and happenings in order to produce narratives. The raw interview data were synthesized into a coherent story of lived experiences.

Results

Entry into online mental health service delivery

I am a mental health practitioner (psychologist). I have more than ten years of experience in offering mental health services to many clients of diverse backgrounds. My modus operandi has been face-to-face counselling and psychotherapy session when all was well (before COVID-19). However, the coming of the COVID-19 pandemic changed the playground. The playing field has been made to be skewed. A great rift between me and my clients was permanently created. Before the pandemic, I had never offered my services using online means. To those clients who were far from my reach, I used to refer them to other colleagues near them.

The current situation left me with no option. It necessitated embracing online mental health service delivery with immediate effect. When I switched to online service delivery, I was not sure if this was going to be successful or not. Calls of distress from patients were coming through every minute. I anticipated some challenges that I thought were discouraging from starting it. However, as I started, challenges, joys and opportunities presented themselves along. I realized that no matter what, online means has become the new normal. I also anticipated some drawbacks that could totally discourage me from rendering my services.

Positive experiences and perceived advantages

Online mental health service delivery carries numerous advantages. Although I was hesitant from the beginning, I had positive experiences with online mental health service delivery. When I compare face to face to online service delivery, I realise greater convenience on my part as the therapist and also for the client. Once the client has booked the date and time, there is no travel time and scheduling appointments becomes more flexible. Moreover, due to costs associated with online discussions, sessions tend to be shorter and more efficient, because the conversations tend to focus more on the content. This alone tend to maintain a focused discussion without going around in circles.

I can confidently report that majority if not all of my clients are satisfied with online services so far. Online has worked and is still working sufficiently well and clients are satisfied. Some of my clients seem to benefit from the distance created by the online sessions. Face to face session has presented to me with challenges of inhibition and failure to disclose by some clients. However, in online services, some clients become less inhibited in their expressions, whereas others appear to become less dependent on me (the therapist). Following up on some homework I gave to clients, several of them have reported higher adherence to procedures and help. Furthermore, the lower threshold of mediated contact allows for short, more frequent moments of contact in-between regular sessions, affording a more intimate therapeutic relationship.

To add to the above, talking to clients from their home environment made me feel that transfer of skills was easier. This is unlike when meeting a client in office. Dealing with clients from their home environments facilitated them to quickly become auxiliary therapists. I realised the difference between face to face where clients would continue to present with lack of transferring skills in their environments.

Challenging issues and difficulties

Although online mental health service delivery presented me with the mentioned advantages, there are some insurmountable challenges. This type of service delivery was attacked on both ends of the rope. Challenges include insufficient technological infrastructure, particularly problems with the speed and stability of internet connection, at both the side of the client and the therapist. Internet instability would disrupt session and contributed to missing of appointments at booked times. Some clients lamented the high cost of data against the low incomes they were receiving during lockdown. Furthermore, some clients do not possess the technologically compatible devices, such as a smartphone or a laptop. Those with compatible devices lamented that their batteries were only 'fridges'. This means that their batteries did not last if there was no electricity. To add on to that, both the therapist and clients had challenges caused by power cuts.

Concerning the mediated nature of communication, lack of nonverbal signals that normally help to consolidate more information in face-to-face communication, such as gait, posture, hand movements and general appearance were missing. This made it more difficult to connect with a client or clearly communicate their intended message. It was even stronger when sessions were conducted by telephone, using audio only without video to back up.

Demonstrations made therapy more effective in certain situations. During the online sessions, I missed the ability to do exercises that require physical presence such as role play, breathing exercises or projective test sessions. However, trying to harness more efficient zoom sessions were more expensive on both the therapist and the clients. This limited such demonstrations and inversely affected the goal of therapy.

Online service delivery is more suitable to certain psychological problems than others. Online methods are limited and less suitable for trauma, family therapy, clients with psychotic symptoms, severe anxiety, and generally those who are vulnerable to crisis and a sudden exacerbation of symptoms like panic attack. Furthermore, sessions with children, groups, and clients with cognitive impairments are more challenging.

Online service delivery compromised a lot of ethical issues like consent and confidentiality. The client is at a rush to say out their issues and need to save on the cost. On the other hand, the therapist wants to establish basic ethical foundation at the outset of the discussion. Most of the times the home environment of the client failed to offer privacy and this compromised the nature and extent of disclosure.

Discussion

One of the findings of this study was that online mental health services provision proved to be convenient for both the therapist and the client. The reason being that booking and setting of appointments could be done remotely without any need for travelling and it was noted that it is more flexible to schedule appointments. The participant also reported that it's cheaper and less time-consuming than offering physical sessions which are long and less-focused. These findings concur with Liesbeth (2020), who cited that online therapy has proven to be a powerful medium which just needs further research to maximise engagement and effectiveness. In support of this, Claudia Marinetti, has been quoted by MaCartan et al. (2021), as having applauded the introduction of online mental health service provision as a sign of hope where other alternatives were not practicable. Feijt et al. (2020), also applauded the issues of flexibility in scheduling appointments as well as elimination of travel problems. However, the UN Policy Brief (2020), feared that digital and online services may alienate some disadvantaged groups of people.

Online sessions have also been found to be better than physical sessions as they reduce challenges of client inhibition and disclosure difficulties. The study found that clients welcomed the distance created by online sessions and they became less dependent on the therapist. Similar findings were reported by Feijt et al. (2020), who noted that online sessions resulted in high client satisfaction, less client inhibition and less dependence on therapist. However, Liesbeth (2020), states that the therapists lack the ability to address some of their clients' needs during online sessions in the manner they would do during physical engagements. Liesbeth, goes further and say some clients may be reluctant to participate in visual therapy which leaves the therapist helpless. Therefore, though virtual therapy has been seen as a positive it also poses challenges as the therapist does not get an opportunity to explore non-verbal cues from the clients which are very vital in assessments.

The participant of this study applauded the idea of interacting with clients within their home environments which he took as the best way of transferring skills where clients become auxiliary therapist. However, it was also found that in a negative way, the home environment infringes on ethical conduct, as in some cases there is no confidentiality and privacy which negatively affects client disclosure and consent. Online sessions also were reported to be rushed as the clients would be trying to save data and may be engaging in some activities at home. MacCartan et al. (2021), also note that virtual mental health sessions negatively impact on privacy and confidentiality issues and also limited professionals in clinical decision-making. In support of this, Liesbeth (2020), and Feijt et al. (2020), reiterated that online therapy raises confidentiality issues as in some cases the client may be forced to have sessions in the presence of significant others thus failing to safeguard the rights of the client. In certain circumstances, the client might be a victim of domestic violence which limits him or her to express issues freely as the perpetrator might be in the vicinity.

The major drawback that has been associated with remote mental health services was technological challenges. These challenges included insufficient or lack of technological devices to use for sessions, poor or erratic internet connectivity, high costs of data and power cuts. Such challenges disrupted sessions as sometimes either the therapist or the clients would miss out on scheduled appointments. In related studies it has been noted that challenges like lack of technological devices, difficulties with network connectivity and unwillingness to use internet for mental health sessions were experienced more by the elderly

(Seifert et al., 2021; Bryne, 2021). In addition, Pereira-Sanchez (2020), found that clients from lower socioeconomic groups lacked reliable internet access to facilitate the effective use of telepsychiatry. The same challenges were also noted for both therapists and clients (Feijt et al., 2020). This means that though e-mental health services have been introduced, their accessibility is marred by a number of challenges which require commitment from both individuals and nations as well as time to be addressed.

Conclusions

The use of online mental health services started around the 1990s however the need for such services was heightened by the emergence of the COVID-19 pandemic with its emphasis on human movement restrictions. Many mental health practitioners managed to switch from physical engagement to remote sessions but the progress has been greatly affected by technological challenges. Virtual mental health service provision has also exacerbated already existing inequalities amongst individuals from different socioeconomic levels as it has been highlighted that many from low socioeconomic societies could not afford such services. It also disadvantaged the elderly and other vulnerable groups of people who struggle in accessing virtual services.

Practical implications

As noted, that technological and ethical concerns pose great threats, there is need to improve on both the practitioner's side and the client's side. Availability of a stable internet connection, stable electricity supply, and proper devices on both therapist and client sides is essential. There is great need for a review of ethics to take into consideration online service provision.

Limitations and future research directions

The study was limited in relation to its research approach which is qualitative in nature however it gave the researchers an in-depth exploration of the practitioner's experiences. Future studies must expand this by utilising a mixed method approach to have a holistic understanding of the research issue.

It is also recommended that future researchers must try to explore the experiences of online mental health services from the clients' perspectives where they should involve clients from diverse backgrounds and orientations.

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