Review of Contemporary Philosophy
ISSN: 1841-5261, e-ISSN: 2471-089X
Vol 23 (2), 2024
Pp 6490 - 6498

Innovative Strategies in Mental Health Care Delivery during the COVID-19 Pandemic: The Roles of Pharmacy Services and Laboratory Diagnostics in Supporting Individuals with Serious Mental Illness

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Abstract

Background: The COVID-19 pandemic has significantly disrupted mental health services, particularly for individuals with serious mental illness (SMI). These disruptions have highlighted the need for innovative strategies to maintain continuity of care while minimizing health risks.

Methods: This review analyzes the adaptations in community mental health care during the pandemic, focusing on the roles of pharmacy and laboratory diagnostics in managing mental health disorders. A comprehensive literature search was conducted to gather evidence on the impacts of telehealth, medication management, and supportive resources in mental health rehabilitation.

Results: Findings indicate that telehealth services have been pivotal in ensuring access to mental health care during the pandemic, allowing for ongoing support despite physical distancing measures. The integration of pharmacy services has facilitated the continuity of psychotropic medications, while laboratory diagnostics have remained critical for monitoring treatment efficacy and potential side effects. Moreover, the involvement of family members and community resources has proven essential in fostering a supportive environment for patients.

Conclusion: The adaptations made in mental health care delivery during the COVID-19 pandemic underscore the importance of flexibility in treatment approaches. Collaboration among healthcare providers, pharmacists, and community resources is vital for enhancing patient outcomes. Future strategies should focus on sustaining these innovations to improve access and quality of care in mental health services.

Keywords: COVID-19, serious mental illness, telehealth, pharmacy services, mental health care.

Received: 17 October 2024 **Revised**: 29 November 2024 **Accepted:** 12 December 2024

1. Introduction

The ongoing COVID-19 epidemic has necessitated significant changes in the provision of outpatient mental health treatments for persons with severe mental illness (SMI) in the United States. Federal and state regulations restrict face-to-face interactions and explicitly instruct health institutions to minimize in-person contact. The alteration in care provision has significant public health ramifications, since persons accessing services via the public mental health system are more susceptible during public health emergencies (1). Various factors elevate the risk of infection and adverse outcomes in this demographic, including inequities in healthcare access, heightened susceptibility to COVID-19 stemming from social disparities (e.g., elevated poverty rates resulting in residential instability and food insecurity, significant unemployment rates), increased prevalence of medical conditions, and detrimental health behaviors (2). Furthermore, the pandemic intensifies the risk of adverse mental health consequences, which should be acknowledged as an important public health concern. As there is presently no vaccine or targeted treatment for COVID-19, health initiatives concentrate on prevention and screening, facilitating access to intensive services for individuals exhibiting severe symptoms, and ensuring the continuity of therapy for other chronic illnesses (3).

The pandemic poses a significant risk to the continuation of treatment for severe mental illness (SMI). It is imperative for community mental health facilities (CMHCs) to create strategies to guarantee the continuity of key services and sufficient stocks of psychotropic drugs. This article seeks to offer community-based mental health clinicians assisting clients with serious mental illness (SMI) with pragmatic advice for enhancing continuity of treatment amidst swiftly changing mandates and guidelines for healthcare practitioners.

2. Evolution of Healthcare during the COVID-19 Pandemic

Clients with serious mental illness (SMI) receiving services from Community Mental Health Centers (CMHC) outpatient and community teams may have persistently heightened risks of significant disabilities, emergency room visits, psychiatric inpatient stays, self-harming behaviors, arrest and imprisonment, food and water instability, and homelessness. In an epidemic of public health, it is essential to evaluate these risk variables with the individual's susceptibility to COVID-19 infection to ascertain the most effective approach to address their treatment requirements. The clinical team must evaluate the medical and mental risks and benefits for each individual client, incorporating input from the physician in charge as necessary, to determine if there is an urgent or essential requirement for in-person care and, if so, what adjustments to care delivery are required. Furthermore, natural encourages warm lines, and pandemic-compatible mental advance directives need to be established as the standard of treatment in the peri- and post-COVID period.

Clinics must evaluate a range of service delivery alternatives that cater to clients' requirements and preferences for treatment, in addition to their mental and medical risk profiles. These care delivery alternatives are not indistinguishable. Utilizing a diverse array of care delivery techniques concurrently may provide regular interaction while mitigating the danger of viral infection for both clients and staff. The spectrum encompasses community-based in-person care with suitable preventive therapies; clinic-based care in spacious rooms facilitating physical distance; clinic-based telehealth, wherein clients engage in telepsychiatry sessions within private clinic offices; clinic-based care conducted in standard offices adhering to local public health regulations; and telehealth interactions with clients at home or within the community. Care provided by clinics may be enhanced by training family members, creating connections to warm lines, and incorporating more e-mental health resources (4).

Although the majority of Community Mental Health Centers (CMHCs) may transition to telehealth services for many clients, a considerable subset will still need in-person assistance to address fundamental requirements or due to insufficient access to the required equipment or data plans for telehealth engagement. Telehealth may be modified to overcome technological or psychological obstacles. The customer may attend a telemedicine session in an isolated space, therefore reducing close interaction with

clinic personnel. Clients exhibiting cognitive disorganization or paranoia associated with technology or surveillance may be receptive to telephone interactions, which offer an efficient and familiar option for clients, and possess enhanced pragmatic advantages for Community Mental Health Centers (CMHCs) in states now eligible for equitable reimbursement for specific telephone experiences. Telephone interactions possess constraints that affect clinical treatment, as they may restrict medical observation, treatment engagement, evaluation, and interventions, so underscoring the need for additional therapeutic interactions.

During the pandemic, clinicians may need to briefly transition from skills training and rehabilitation initiatives to direct support for basic needs. Consequently, caregivers may need to collaborate with the client, natural encourages represented payees, faith-based groups, and social service agencies to identify resources, assemble care packages, and provide warm meals. Providers doing outreach appointments should refrain from entering houses, particularly in confined spaces or when other individuals are present, since maintaining physical distance may be compromised. Outreach teams ought to convene in well-ventilated locations external to the residence to visually evaluate the individual's condition, present as a familiar and reassuring social visit, model as well as reinforce appropriate behaviors, administer medications, and offer in-person demonstrations on utilizing smartphones or different gadgets for e-mental health engagement. Providers must be knowledgeable with and comply with local public health surveillance regulations for personal protective equipment (PPE) and physical distance during all in-person interactions.

Alongside a multimodal service delivery strategy, care should use all available clinic personnel, natural supports, and supplementary services in a comprehensive manner. Administrative personnel, such as receptionists, may conduct welfare phone calls to assess client well-being or facilitate educational sessions to prepare customers for telehealth appointments. Peer experts may maintain a crucial role in facilitating person-centered health control and coping strategies, providing coaching and consulting to enhance self-efficacy as well as self-advocacy, and addressing client needs via problem-solving. Peer specialists and case managers may assist in providing access to virtual spiritual, peer-based, recreational, and other groups to enable client connections. Therapists may temporarily substitute or supplement whole clinical sessions with telephone calls designed to instruct the client in the development, enhancement, and practice of certain behavioral skills to prevent a behavioral crisis.

3. Natural Resources as Clinical Team Extensions

Family members and caregivers may provide assistance to their loved ones suffering from mental illness, sometimes being accessible for more hours each day or week than the therapeutic team, particularly if they reside together. Providers must increasingly engage families as collaborators in care delivery. Providers may enhance services by allocating some of their efforts towards natural supports, such as skills imparted directly to particular consumers. Providers may collaborate with clients and families to organize their daily schedules, particularly for leisure activities and possibilities for social connection while maintaining physical distance. Although this imposes requirements on families, it may serve as a significant means of augmenting brief therapeutic sessions, especially for clients who are not participating in video or telephone consultations. Families may get additional help via cloud-based collaborative folders or additional assets including instructional and training resources (for example, manuals, clinical tip sheets for relatives) in order to enhance direct care. Moreover, most community behavioral health systems include assistance from trained family experts who possess life experiences with a relative suffering from mental illness, potentially accessible to families throughout this period.

Providers must assist in identifying and expanding alternative natural supports for clients without familial or other inherent support systems. While physical distance remains essential, virtual contacts and online networks are becoming vital. In contrast to hotlines or emergency lines, which cater to those facing psychiatric emergencies, warm lines provide a supportive alternative for those in distress seeking emotional assistance. The COVID-19 epidemic has resulted in an increase in the accessibility of warm lines, many of which are operated by peer support groups (5). Providers may consider organizing these

resources, assisting clients in entering phone numbers into their mobile devices, and disseminating them on organization websites or social media platforms.

4. Formulating a COVID-Compatible Mental Advance Order

Providers must collaborate with clients to revise safety measures and assist in the creation or modification of a psychiatric advance medical directive that incorporates contingency planning for pandemics. Advance directives specify an individual's preferences for medical services and treatments when they are unable to communicate their desires. Federal law mandates that institutions receiving CMS payments implement advance directives, including those pertaining to mental health disorders. Companion guidance materials are being developed to enhance engagement with both natural caregivers and providers in the creation and implementation of the psychiatric advance directive. Given the varying impacts of the COVID-19 epidemic on hospitals and crisis centers, patients should consider the treatment setting in their advance directives. It is essential to notify the client that some elements of their preliminary directive may not be feasible to implement, since conditions and resources are subject to change throughout this period. Providers should assist in resolving these circumstances to ensure optimal adherence to the individual's preferences as outlined in their mental advanced directive.

The advantages of virtual care are well demonstrated, as is its insufficient usage in public behavioral healthcare (6,7). Institutional and legislative obstacles to the widespread implementation of telepsychiatry and digital health treatments are now being addressed in response to emerging demands. Federal policy changes have shown a broad acknowledgment that the adaptable use of electronic medical records may be essential for sustaining continuous mental health care during the COVID-19 pandemic (8). The Office for Civil Rights (OCR) has declared it will waive penalties under the the Health Insurance Portability and Accountability Act (HIPAA) for health care providers utilizing "everyday communications technologies" to assist their clients (9), while acknowledging the tension between facilitating access to care and safeguarding patient rights (10).

Research indicates that telepsychiatry, conducted by telephone and videoconferencing, is both viable and satisfactory for patients with serious mental illness (SMI), potentially enhancing customer satisfaction (11,12). Studies on telepsychiatry treatment has often included meticulous execution planning, assistance, and assessment. The pressing need for rapid implementation of telehealth services has compelled healthcare locations around the US too hastily embrace new technologies, processes, job aids, and training for physicians who are concurrently managing critical clinical requirements. Clients may lack access to the necessary technology, software, or data plans for telepsychiatry. Both personnel and service customers may need many instructional sessions to get sufficient proficiency for autonomous use.

Mental health practitioners must optimize possibly constrained time for evaluation and treatment, since clients experiencing psychosis may struggle with prolonged sessions conducted by phone or video chat. Providers should strive to enhance the number of client interactions, perhaps decreasing their time (e.g., shifting from one weekly 30-minute session to two weekly 15-minute sessions). Increased visit frequency may provide enhanced opportunity to evaluate dynamic characteristics linked to heightened risks of functional impairment, victimization, drug use, self-harm, violence, and changes in housing or work status. Moreover, enhanced interaction with therapeutic team members facilitates greater social engagement during this phase of physical separation. Communicating and establishing trust by telephone is especially difficult for clients exhibiting substantial mental disorder and paranoia; hence, clinicians must adeptly integrate engagement, evaluation, and intervention techniques. Providers may encounter significant challenges in adequately assessing and engaging clients who have just registered in services via telehealth.

Conducting a comprehensive first examination and establishing a therapeutic rapport may be challenging by telephone. New clients may get significant advantages from an initial in-person contact, including a comprehensive intake evaluation and diagnostic interview, which may include physical observation and examination if warranted. Videoconferencing-based telemedicine is the second-best alternative for new customers, with telephone consultations serving as a temporary solution. Telehealth provides possibilities for environmental and interpersonal evaluations that are unavailable during in-person therapy sessions,

and this information may facilitate clients' functional recoveries. Key priorities for assessment and treatment for both new and existing clients include safety evaluation and management, psychological and pharmacological strategies for addressing psychiatric symptoms and concurrent substance use disorders, physical health assessment and management, and enhancing care through the integration of natural supports and the utilization of asynchronous digital health interventions.

Robust and efficient community-based mental health treatment is crucial to reduce emergency department visits and hospital psychiatric hospitalizations, which heighten the risk of COVID-19 exposure and further strain the healthcare system. Providers, in conjunction with clinic managers, the medical director, and/or the risk leadership team, should assess the risks and advantages of conducting in-person consultations with clients at heightened risk of possibly fatal self-injurious behavior or aggression towards others, as opposed to using telemedicine services. Clients who are unfamiliar to the clinical team, possess significant historical as well as clinical risk factors, or are newly indicating intentions to harm themselves or others should be emphasized for in-person care, with appropriate infection risk mitigation measures (PPE, physical distancing, etc.). Due to potential challenges in accessing hospital beds and a reduction in traditional clinic-based services, administrators may need to reassign certain outpatient clinical personnel to outreach and crisis response teams to improve capacity for both proactive and reactive client engagement, ensuring appropriate precautions for both clients and staff are maintained.

At the commencement of any telehealth and telephonic interactions, it is essential for the provider to acquire and record the client's phone number and present location. The phone number is essential for resolving technical issues, such as when a customer is unable to attend a videoconference or experiences disconnection. Providing a precise address is crucial to ensure emergency responders can accurately locate the client for a welfare check if needed. It is essential to formulate and revise safety plans to guarantee that all elements align with the constraints present in customers' local surroundings. If the client has a safety plan, it is important to provide simple access to the plan in various formats and to guarantee that all components of the plan are practical. Depending on the characteristics of suicidal or homicidal thoughts, distress tolerance will be most effective in facilitating the client's down-regulation until the acute crisis subsides (13). It is essential for providers to recognize triggers for suicidal impulses; instruct the client to observe emotional, cognitive, or physiological signals; and assist the client in devising alternative responses when first warning signs arise. Preferably, natural supports—especially those cohabitating with the client—will aid in recognizing early warning signals and facilitate compliance with the safety plan, contingent upon the client's consent for their involvement.

5. Fundamental Psychotherapeutic Approaches

Excessive concern, anxious avoidance, and sleeplessness are very frequent in persons experiencing mood and psychotic symptoms, serve as potential causative factors for mental illness, and are each amenable to therapeutic management (14). Moreover, inadequate self-esteem—characterized by detrimental self-perceptions and diminished self-efficacy—are recognized predictors of both sadness and schizophrenia (15,16). These significant objectives of in-person cognitive behavioral therapies for mood and psychotic disorders may also be accomplished via remote care. In times of anxiety and unpredictability clients may revert to previous maladaptive behaviors. As physicians and clients enhance their telehealth capabilities, their intervention tactics increasingly resemble in-person therapy (17). Throughout a national health crisis, the primary focus is to address lapses to avoid relapse, acute compensation, and risky behaviors.

6. Medical Administration

Community mental health practitioners often serve as the first contact with the healthcare system for clients with serious mental illness (SMI) and acted as first responders during the COVID-19 epidemic for several people. During this period, medical treatment should focus on COVID-19 infection prevention techniques, collaboration with medical professionals and public health for physical health condition management, facilitation of decreased smoking or cessation, pharmaceutical oversight, and laboratory monitoring.

Mental health practitioners must identify the symptoms and signs of COVID-19, educate clients about fundamental tools for symptom recognition, and convey public health guidelines in a manner that is understandable and actionable for clients. Materials intended for clients and the broader populace may need customization to accommodate insufficient medical knowledge (18-22) and to advocate for enhanced harm reduction techniques to decrease virus exposure. Providers may assist customers in addressing logistical obstacles to mitigating infection risks, perhaps selecting from many choices, each linked to certain hazards. Numerous social services and facilities upon which clients depend (for instance, clubhouses, pantry programs, hostels) may be temporarily inaccessible or pose an intolerable risk of infection. Treatment plans including clinic or pharmacy visits must explicitly include efforts to mitigate the risk of COVID-19 disease. Clients may find it more difficult to adopt risk mitigation methods owing to cognitive impairments, disruptive symptoms, and/or insufficient abilities to use or access essential resources. Consequently, teams must convert CDC instructions into specific behavioral examples and use several methods to visually demonstrate these actions. These may encompass illustrating proper handwashing techniques; individualized approaches to handwashing duration; utilization of disinfectants in the home, particularly in shared living situations; explicit instructions for maneuvering in public spaces, including spatial awareness of distances exceeding six feet; implementation and elimination of face masks; and adjusting interpersonal interactions with neighbors. Instruction may take place in person outside the house or be conducted by videoconference if telemedicine is feasible.

The team of mental health professionals should be conscious of each client's primary care provider or assist them in establishing treatment. Coordinating with primary care, communicating new respiratory signs, and advocating for examination and COVID-19 testing when warranted is essential. Clients exhibiting respiratory signs should be instructed to contact their primary care physician or the emergency room in advance, rather than arriving unannounced. Furthermore, collaboration with primary care providers and experts may be necessary to maintain the management of chronic medical diseases amid heightened system load and/or office closures, especially for disorders associated with a more severe course of coronavirus infection (23-26). Clients without housing, telecommunication devices, or computers will encounter specific obstacles in accessing their medical care requirements. Behavioral health practitioners doing outreach visits might be taught to evaluate vital signs. In some instances, resources have been designated for the acquisition of communication equipment and/or information plans for customers requiring assistance. County and state public health authorities provide advice on PPE guidelines for various contexts, facilitate access to COVID testing, and may provide quarantine locations for those who are homeless or lack enough room for isolation. Public health agencies should be notified when clients test positive for COVID-19, especially if the client may struggle to adhere to isolation protocols due to compromised insight or judgment. Public health may choose to use contact tracing and evaluate client contacts in a mental health facility, residential unit, or shelter.

7. Laboratory Surveillance

In standard pharmacotherapy, laboratory tests are often necessary to assess therapeutic drug concentrations, evaluate renal or hepatic function, and detect and monitor additional side effects, including unfavorable metabolic reactions. This surveillance may also be hindered during the COVID-19 epidemic, necessitating modifications to therapy. A client's laboratory may be closed or have limited hours, or they may encounter obstacles in accessing the lab. The psychiatrist provider and team must collaborate with the client to evaluate the dangers and benefits of every test for ongoing monitoring and assess the viability of alternative drugs that do not need monitoring.

The COVID-19 epidemic has profoundly influenced our healthcare system and global landscape. Community psychological clinics are exhibiting resilience in response to widespread trauma, and systems have the potential to undergo posttraumatic development as we start to recover from the epidemic. Numerous modifications undertaken to ensure care continuity throughout the epidemic may and need to be preserved—at least partially—after its conclusion. Experts anticipate ongoing expansion and utilization of technology in behavioral health care (27), suggesting that this innovative, adaptable, and technology-driven care model may enhance clients' functional recoveries (28) and potentially address mental healthcare

disparities among underserved and marginalized groups (29). This encompasses enhanced flexibility and creativity in care delivery, offering a range of remote and in-person options; improved integration of behavioral and physical healthcare for pre-existing conditions; tertiary prevention of infectious diseases due to heightened exposure risk and adverse health consequences; augmented collaboration and shared decision-making concerning long-acting injectables (LAI) and clozapine utilization; revision of safety strategies and psychiatric advance directives to incorporate emerging technologies and expanded support systems; increased incorporation of natural supports; and the integration of electronic health services to address primary and secondary psychiatric symptoms. To minimize human interaction, healthcare providers are swiftly transitioning to telehealth, motivated by newly established payment codes for telehealth services from the Centers for Medicaid and Medicare Services (30-35). CMHCs in states that have not opted to expand Medicaid may subsequently have restricted access to the recommended procedures and resources, potentially leading to increased rates of care interruption and/or worse clinical results throughout the pandemic response (36-38).

8. Conclusion

Providers as well as administrators have rapidly ascended a significant learning curve. Considering that experts anticipate recurring pandemics, healthcare providers and behavioral health administrators should develop decision trees to assess medical, psychological, and social risks for various CMHC clients, along with appropriate care delivery options that mitigate risks to the individual, the medical staff, and the public. The increased use of electronic mental health services may effectively meet both immediate demands during the COVID-19 pandemic and persistent requirements after its resolution. Politicians and clinical managers must address existing clinical deficiencies while also considering how COVID-related modifications may shape future sustainable processes, especially in the event of repeated outbreaks.

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استراتيجيات مبتكرة في تقديم خدمات الصحة النفسية خلال جائحة كوفيد-19: دور خدمات الصيدلة والتشخيص المخبري في دعم الأفراد المصابين باضطرابات نفسية خطيرة

الملخص

الخلفية :تسببت جائحة كوفيد-19 في اضطرابات كبيرة في خدمات الصحة النفسية، لا سيما للأفراد الذين يعانون من اضطرابات نفسية خطيرة (SMI).سلطت هذه الاضطرابات الضوء على الحاجة إلى استراتيجيات مبتكرة للحفاظ على استمرارية الرعاية مع تقليل المخاطر الصحية.

المنهجية :تحلل هذه المراجعة التعديلات التي طرأت على الرعاية المجتمعية للصحة النفسية أثناء الجائحة، مع التركيز على أدوار خدمات الصيدلة والتشخيص المخبري في إدارة الاضطرابات النفسية. تم إجراء بحث شامل في الأدبيات لجمع الأدلة حول تأثيرات التطبيب عن بُعد، وإدارة الأدوية، والموارد الداعمة في إعادة التأهيل النفسي.

النتائج :تشير النتائج إلى أن خدمات التطبيب عن بُعد كانت حاسمة في ضمان الوصول إلى خدمات الصحة النفسية أثناء الجائحة، مما سمح بتقديم الدعم المستمر على الرغم من تدابير التباعد الجسدي. ساهم دمج خدمات الصيدلة في ضمان استمرارية الأدوية النفسية، بينما ظل التشخيص المخبري أمرًا بالغ الأهمية لمراقبة فعالية العلاج وآثاره الجانبية المحتملة. علاوة على ذلك، أثبتت مشاركة أفراد الأسرة والموارد المجتمعية أهميتها في توفير بيئة داعمة للمرضى.

الخلاصة :تؤكد التعديلات التي طرأت على تقديم خدمات الصحة النفسية أثناء جائحة كوفيد-19 على أهمية المرونة في نهج العلاج. يعد التعاون بين مقدمي الرعاية الصحية والصيادلة والموارد المجتمعية أمرًا حيويًا لتحسين نتائج المرضى. يجب أن تركز الاستراتيجيات المستقبلية على استدامة هذه الابتكارات لتحسين الوصول وجودة الرعاية في خدمات الصحة النفسية.

الكلمات المفتاحية :كوفيد-19، اضطرابات نفسية خطيرة، التطبيب عن بُعد، خدمات الصيدلة، الرعاية النفسية.