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A global needs assessment in times of a global crisis: world psychiatry response to the COVID-19 pandemic

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ABSTRACT

The COVID-19 pandemic has stunned the global community with marked social and psychological ramifications. There are key challenges for psychiatry which require urgent attention to ensure the mental health wellbeing for all – COVID-19 positive patients, healthcare professionals, first responders, people with psychiatric disorders, and the general population. This editorial outlines some of these challenges, research questions, and serves as a preliminary framework of what needs to be addressed. Mental healthcare should be an integral component of healthcare policy and practice toward COVID-19. Collaborative efforts from psychiatric organizations and their members are required to maximize appropriate clinical and educational interventions while minimizing stigma.

KEY WORDS

COVID-19, mental health, stigma, vulnerable populations, psychiatric guidelines, healthcare policy, medical disaster, infectious outbreaks, psychiatric organizations, education

The COVID-19 pandemic has stunned the global community, its reality only being accepted by the public with advice and subsequent legal enforcement of physical isolation to avoid contamination and transmission. The pandemic affects everyone, but some groups may be especially impacted, as is commonly the case where there are pre-existing health inequalities and social exclusion and stigma related to chronic conditions such as schizophrenia or depression or mental illnesses in general. Thus, those with pre-existing conditions are at risk, yet these are often assumed to mean diabetes, heart or lung disease, cancer, or immunocompromising disorders. Yet, people with mental illnesses already suffer higher rates of chronic medical conditions and have a shortened lifespan. People with mental illness also struggle with poverty, housing, access to education and employment, and social connection, especially if their illnesses are very disabling affecting communication and relational skills. Consequently, a pandemic may well be expected to affect them even more than non-psychiatrically ill patients. To illustrate: if they are inpatients, close proximity to others cannot be avoided; and if they live alone and isolated, they will not be easily able to ask for and secure additional supports, should they fall ill with COVID-19, especially as social care and support has in most countries been declining given the impact of austerity. Psychiatric patients should be considered an extremely vulnerable population in the COVID-19 pandemic. Incorporating psychiatric care and mental healthcare in general into the response to COVID-19 must thus be regarded a major public health imperative; any official response to a pandemic like COVID-19 without a psychiatric component would violate a government's prime duty: to ensure the health and safety of the society.

In the face of the COVID-19 pandemic, dissemination of knowledge, clinical care, and appreciation of our patients' perspective are key. This pandemic goes far beyond what medical

communities and societies around the globe in general imagined. We have to consult history books to get a glimpse of a global medical crisis comparable to what we are witnessing now: the Spanish flu (1918-1920) suddenly no longer is a footnote in high school students' textbooks but has become something to which each of us can relate. This pandemic of the past is now being used to alert society to the multitude of challenges posed by COVID-19.

From the vantage point of psychiatry, we see eight major challenges that need our urgent attention:

1. How does a pandemic like the current one impact people suffering from a psychiatric disorder including, but not limited to, symptom severity, relapses, need for increased frequency and intensity of mental healthcare? Will the COVID-19 pandemic peaking in the spring further exacerbate seasonal (spring) mania and suicidality?
2. Will a pandemic like COVID-19 trigger psychiatric illnesses in people who so far have been considered mentally healthy? Or in other words, can it lead to an increase in psychiatric morbidity and comorbidity in the general population?
3. How can psychiatrists and other mental health care professionals meaningfully address the potential impact on mental health of the population? In particular, how can a discipline that is based on a very close doctor-patient relationship uphold its standards of authenticity and empathy when both doctors and patients are considered a potential source of infection?
4. In our new world of social isolation, patients in need of care, even urgent care, are cancelling necessary appointments. How do we make telepsychiatry as meaningful, efficient and as effective as possible? Further, will such isolation lead to future psychiatric symptoms?

5. How can the mental health ramifications of the COVID-19 pandemic be communicated to other, non-psychiatrically trained health professionals? This also includes the impact on first responders (police, paramedics etc.) and health professionals (ER and ICU staff) working on the frontline of the fight against COVID-19.
6. How can we avoid and fight stigma and aggression and discrimination directed at people infected or presumed to be affected by COVID-19?
7. Are liaison psychiatrists, who frequently are requested to consult prior to neurologists, cognizant and prepared to address atypical neurologic and neuropsychiatric presentations associated with COVID-19? Integrated care is recommended amongst healthcare providers.
8. As healthcare systems focus on the direct medical effects of COVID-19 with reallocation of resources including personnel, both the quantity and quality of mental healthcare may be negatively impacted. This has long-term effects for the psychiatric and general populations, healthcare providers and first responders as disasters, high mortality infectious outbreaks, and this pandemic in particular will lead to significant levels of PTSD, especially if a period of quarantine is required [1, 2]. The current medical morbidity and mortality associated with COVID-19 must be dramatically addressed, but so too should the acute and chronic morbidity and even mortality from the development and/or worsening of PTSD and other psychiatric diagnoses.

We firmly believe that discussing these challenges is a task of global scope. This is not the time when national recommendations or guidelines alone will suffice but when international medical societies should rise to the occasion and offer evidence and advice. COVID-19 should not be an excuse for xenophobia but should be the basis for global public healthcare now and in

the future with sharing of knowledge, testing, and trials. It should also be a time when all international medical societies work together.

Key psychiatric research themes that might be endorsed and sponsored by large international psychiatric societies (e.g., Royal College of Psychiatrists, American Psychiatric Association, European Psychiatric Association, and World Psychiatric Association) include:

- a) perspectives of healthcare providers toward patients with COVID-19;
- b) perspectives of healthcare providers towards patients who come from, or are ancestrally associated with, countries with high COVID-19 infection rates;
- c) current and prospective levels of anxiety, depression, stress, PTSD, and functional status among healthcare providers;
- d) feasibility and efficacy of online education of non-psychiatrically trained health professionals regarding the psychological impact of COVID-19; and
- e) feasibility and efficacy of online education and training for healthcare providers to reduce stigma associated both with COVID-19 and mental health with emphasis on cultural themes and double stigma.

The same five research themes need to be posed to the general population and people with psychiatric disorders.

Whereas initial and prospective studies have addressed psychiatric impact of Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS) with emphasis on need for continuous psychiatric input to reduce immediate and long-term psychiatric morbidity when encountering high-mortality infectious outbreaks [3-8], there are only limited reports addressing the psychiatric impact of COVID-19 [9-11]. Findings from all

SARS, MERS, and even preliminary COVID-19 studies will assist in focusing responses to the challenges posed, though the dynamic implications of rapidly progressive COVID-19 statistics with global and prolonged lockdowns suggest that COVID-19 will have an even greater social and psychological impact than SARS and MERS. What is needed goes beyond research; “hands-on” psychiatric and mental healthcare clinical interventions are needed. International societies can work together to formulate intervention position statements to be shared with clinicians, patients and caregivers to help alleviate the degree of anxiety and depression both acutely and to address long-term sequelae.

Professional psychiatric organizations, including the American Psychiatric Association, the Royal College of Psychiatrists, the World Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry, have begun to provide resources to address some of the most ardent questions raised [12-15, see references for links]. National and international psychiatric organizations working together would lead to maximal guidance and further support for patients and healthcare providers.

Literature addresses the impact of disasters, though not pandemics, on survivors, patients, bereaved, society, medical personnel and first responders [1]. Yet with > 2 billion people in some form of lockdown, this is a medical disaster of global proportions with a still unknown trajectory. How do we meaningfully educate our medical colleagues and first responders that a pandemic like the current one has a major impact on the mental health of psychiatric patients, patients tested positive for COVID-19, the general population, first responders, and healthcare professionals? How do we ensure that mental healthcare is not only an integral component of healthcare policy but also applied practice toward COVID-19?

In a world of social media, we need to turn to our telepsychiatry experts to formulate best processes and messaging as well as to address social isolation. Suggested research will help develop more detailed and effective approaches. Social media can be supportive, but non-evidenced-based information on social media can be disruptive and harmful resulting in negative psychological effects.

Finally, with the advent of the COVID-19 pandemic, stigma and xenophobia have become major elements of the public discourse and a regrettable, but everyday reality. We have been witnessing increased antagonism toward specific groups with high infection rate that in turn has led to patients presenting with both enacted and felt stigma and associated increased anxiety and depression. Combining the stigma associated with mental illness with the stigma now shown toward certain COVID-positive patients may lead to double stigma, a barrier to psychiatric treatment adherence with resultant increased morbidity. Reducing stigma requires both national and international interventions.

In summary, to successfully address all these challenges and research themes in a manner that acknowledges the truly global nature and impact of the crisis we are witnessing, we see an urgent need for collaboration and consensus guidelines from psychiatric organizations and their members (task forces, treatment and education guidelines, multi-site /multi-country research, etc.). We must work together to maximize knowledge, always remembering that only with knowledge come the many solutions required for today and the future.

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K.R.K -- formulated this editorial

K.R.K. and T.G.S -- co-wrote the first draft

K.S.B and E.P -- both read the first draft and added critical comments

All authors approved the original submission

All authors helped to revise and approved the final version.

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