Addressing mental health needs: an integral part of COVID-19 response

COVID-19 is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). While governments around the world are acting to contain and end this pandemic, the strain on health, social and economic systems in all countries is unprecedented.

Not only is the COVID-19 pandemic a threat to physical health; it also affects mental health. During a crisis it is natural for individuals to feel fear, sadness and anxiety. Indeed, fear from the virus is spreading even faster than the virus itself. In the current crisis, people can be fearful about becoming ill and dying, losing livelihoods and loved ones, and being socially excluded and separated from families and caregivers. People who test positive for COVID-19 have to cope with anxiety about their condition, physical discomfort, separation from loved ones, isolation, and possibly stigma.

Many people in the world are suffering from loss of livelihoods and opportunities. Those who have loved ones affected by COVID-19 are facing worry and separation. Some people turn to alcohol, drugs or potentially addictive behaviours such as gaming and gambling. Domestic violence has increased. Finally, people experiencing the death of a family member due to COVID-19 may not have the opportunity to be physically present in their last moments, or to hold funerals according to their cultural tradition, which may disrupt the grieving process[1].

Frontline workers, particularly health staff, are playing a crucial role in fighting the pandemic and saving lives. They are under exceptional stress, facing increased workloads, and are being confronted with great suffering and high mortality rates. Some are being forced into triage situations that can cause ethical quandaries with traumatic impact. Their stress is compounded by their risk of being infected, as many facilities lack sufficient personal protective equipment. Sadly, social stigma towards those working with people with COVID-19 has been reported, while what they need is everybody's support[2].

Adversity is not only a potent risk factor for short-term mental health problems as mentioned above, but also for mental and behavioural disorders, such as depression, post-traumatic stress disorder and alcohol use disorder[3]. During the 2003 SARS outbreak in Asia, affected people experienced high levels of traumatic stress. People who had been quarantined, or who worked in high-risk locations such as SARS wards, or who had friends or close relatives who contracted SARS, were much more likely to have mental health problems[4]. It is clear that mental health systems in all countries need to be strengthened to deal with the impact of COVID-19.

There are reports from countries and in the scientific literature that COVID-19 illness is increasingly associated with mental and neurological manifestations, including delirium, as well as anxiety, sleep disorders, and depression[5]. In addition, COVID-19 is likely to exacerbate pre-existing mental health, neurological and substance use disorders, while limiting access for those in need of services. In many countries, community mental health services have stopped functioning. Yet, over 20% of adults over 60 years have underlying mental or neurological conditions, which represent a large proportion of people with severe COVID-19 illness. Long-term care facilities for people with mental health conditions (e.g., mental hospitals and homes for people with dementia) are places where infections can be especially difficult to control. Care and protecting human rights of residents at such facilities must be part of any public health emergency response[6].

Addressing mental health in public health emergencies is vital. Both are critical to the movement for universal health coverage. As expressed through the dictum "No health without mental health", poor mental health is associated with reduced adherence to physical health interventions[7]. A psychosocial lens helps in improving any emergency programming, including public health ones. In such emergencies, psychological factors in the affected population play a key role in their readiness to comply with public health measures. Any success in addressing people's anxiety and distress will make it easier for people to have the will and capacity to follow relevant guidance by public health authorities.

At the World Health Organization (WHO), the Department of Mental Health and Substance Use is working with different pillars of the COVID-19 response within the Organization to develop public messages and promote the integration of mental health and psychosocial support (MHPSS) into the COVID-19 response effort. MHPSS is a cross-cutting area of work across all sectors in all emergencies, and a cross-cutting area of work within health, and within public health emergencies response. The WHO is also the co-chair of the Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, a collaboration between WHO, other United Nations agencies, the Red Cross and Red Crescent movement, and international non-governmental organizations working in humanitarian settings.

The WHO, together with partners, has provided MHPSS guidance and awareness-raising messaging, which have been translated into more than 30 languages and are being disseminated widely. This includes, for example, the *IASC Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak*[8] and the *WHO Guidance on Mental Health and Psychosocial Considerations during the COVID-19 Outbreak*[1], as part of risk communication and community engagement technical guidance for the COVID-19 response.

Additionally, a wide range of materials are being prepared by the WHO and partners, including specific messages on coping for vulnerable people, including children[9] and older adults, clinical guidance on mental and neurological manifestations of COVID-19, adaptation of existing WHO mental health and psychosocial tools for COVID-19 context, and continuation and adaptation

of essential mental health and psychosocial services in development and humanitarian settings during the COVID-19 pandemic.

Humanitarian emergencies can be an effective impetus to strengthening community mental health care[10], as part of the overarching goal of universal health coverage. Strategies identified by the WHO will guide efforts to strengthen mental health care in countries recovering from COVID-19. These include: a) planning for long-term sustainability from the outset; b) addressing the population's broad mental health needs; c) respecting the central role of government; d) engaging national professional organizations; e) ensuring effective coordination across agencies; f) reviewing mental health plans and policies as part of reform; g) strengthening the mental health system as a whole; h) investing in health workers; i) using demonstration projects to raise funds for wider reform; and j) investing in advocacy to maintain momentum for change. This approach also links to the *WHO Special Initiative for Mental Health: Universal Health Coverage for Mental Health*[11], which will help improve access to mental health services.

Our approach to mental health is comprehensive – not only focusing on responding to the current crisis and recovery after the crisis, but also on preparedness and getting services ready in countries before the next emergency through supporting countries in establishing community based mental health services for everyone everywhere. Health for All means having strong health systems, and strong health systems are resilient health systems.

Tedros Adhanom Ghebreyesus
Director-General, World Health Organization

1. World Health Organization. Mental health and psychosocial considerations during the COVID-19 outbreak. Geneva: World Health Organization, 2020.
2. International Federation of Red Cross and Red Crescent Societies, UNICEF, WHO. Social stigma associated with COVID-19. A guide to preventing and addressing social stigma. Geneva: International Federation of Red Cross and Red Crescent Societies, 2020.
3. Dohrenwend B. J Health Soc Behav 2000;4:1-19.
4. Wu PFY. Can J Psychiatry 2009;54:302-11.
5. Carvalho PMM, Moreira MM, de Oliveira MNA et al. Psychiatry Res 2020; 286:112902.
6. World Health Organization. Interim guidance infection prevention and control guidance for long-term care facilities in the context of COVID-19. Geneva: World Health Organization, 2020.
7. Prince M, Patel V, Saxena S et al. Lancet 2007;370:859-77.
8. Inter-agency Standing Committee. Interim briefing note addressing mental health and psychosocial aspects of COVID-19 outbreak. Geneva: Inter-agency Standing Committee, 2020.
9. Inter-agency Standing Committee. My hero is you, story book for children on COVID-19. Geneva: Inter-agency Standing Committee, 2020.
10. World Health Organization. Building back better: sustainable mental health care after emergencies. Geneva: World Health Organization, 2013.
11. World Health Organization. The WHO special initiative for mental health (2019-2023): universal health coverage for mental health. Geneva: World Health Organization, 2020.

DOI:10.1002/wps.20768

Psychiatry in the age of COVID-19

Within a few months, COVID-19 has sickened millions, killed more than 200,000, disrupted the lives of virtually everyone, and caused tremendous anxiety, trauma and grief. As psychiatrists, we are used to helping people who have suffered trauma and loss. Some of us have cared for survivors of disasters, but few have experienced a global pandemic that threatens all of our lives. None of us was prepared for this crisis, and we acknowledge that the observations and adaptations we are writing about here may not stand the test of time.

What do we know about the effects of pandemics on mental health and what can psychiatrists do to help? Studies from earlier outbreaks[1] suggest high rates of acute stress and anxiety among the public, patients and health care workers. A recent study of health care personnel in China found high rates of depression and anxiety, especially among those on the front lines[2]. In our own experience, we have seen increased stress in individuals with preexisting mental health or substance use disorders, who may be socially isolated and have reduced access to their usual treatment programs or support systems.

We have also noted new psychiatric symptoms in individuals experiencing stress, anxiety or grief as a result of the pandemic. Some are experiencing losses under traumatic circumstances, such as not being able to say goodbye to dying loved ones or the inability to offer proper burials. Physical distancing can help slow the spread of the virus, but we know the risks associated with social isolation. This can be particularly challenging for those who are elderly, poor, or without access to telephones or the Internet. Along with isolation, we may experience a loss of structure, increased time for anxious rumination, and limited opportunities for active coping.

Front-line health workers are experiencing severe stress and anxiety while caring for patients under difficult circumstances, battling a disease for which we have no cure, often with limited equipment. They are exhausted and doing their best, but patients keep dying. Clinicians also have to worry about their own health and the risk of bringing a deadly illness home to their families. These experiences may have long-lasting emotional and functional consequences[3].

Every one of us is at some risk for contracting this deadly virus, but there are those who are more vulnerable, and traditional social determinants of health still apply. Historic inequities driving chronic disease rates in people of color, poverty, and health literacy may play a role in differential rates of infection and death. Individuals whose livelihood and ability to obtain food and shelter have been diminished may suffer long-term consequences of this pandemic[4], and those with pre-existing mental health disorders may be at increased risk for developing post-traumatic stress disorder or suicidal ideation[5,6].

Our hospitals were among the first in the US to see patients with COVID-19. We have made a series of changes to our clinical programs and we are talking to our colleagues around the world to learn from each other and to support each other. We have rap-