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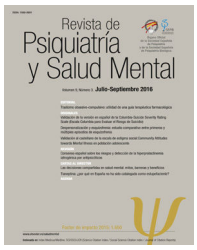

LETTER TO THE EDITOR

International Mental Health perspectives on the novel coronavirus SARS-CoV-2 pandemic

Perspectivas Internacionales en Salud Mental ante la pandemia por el nuevo coronavirus SARS-CoV-2

Dear Editor:

Different epidemics have taken place so far in the 21st century, caused by infectious diseases such as SARS (Severe Acute Respiratory Syndrome) or MERS (Respiratory Syndrome from the Middle East). Several studies have described an important psychological impact of these epidemics on the general population, patients, and health workers, proposing different measures to guarantee Mental Health and prevent the progression of psychopathology in these circumstances.[1,2] The emergence and rapid spread in Wuhan, China, of the novel SARS-CoV-2 coronavirus led to unprecedented measures such as the lockdown of Wuhan and millions of people in additional cities and provinces.[3] The enormous psychosocial impact of these actions, together with the background described, fueled the rapid emergence in China of various psychological assistance services based on Crisis Intervention procedures.[4] Subsequently, different approaches in Mental Health have been promoted in countries such as South Korea, Japan and Spain as the virus has spread internationally.[5,6]

In late 2019, the first cases of pneumonia of unknown cause were reported in Wuhan. The SARS-CoV-2 coronavirus was soon identified as the causative agent of the COVID-19 disease. It usually presents with fever, cough and dyspnea, presenting a mortality rate of approximately 2%.[7,8] On January 30, 2020 the WHO declared COVID-19 as an epidemic and PHEIC (Public Health Emergency of International Concern). On March 11 it was classified as a pandemic after its rapid international spread.

The Mental Health effects of the new epidemic are mostly unknown.[9] During the 2003 SARS epidemic, the affected patients in a Toronto hospital experienced fear, loneliness, anger, the psychological effects resulting from symptoms of infection and concern about quarantine and contagion. The fear of contagion stood out in the health workers. Stigmatization affected both patients and professionals.[10] Among emergency staff in Taiwan, 19.3% had significant symptoms of post-traumatic stress syndrome.[11] In the 2015 South Korean MERS epidemic, it was found that anxiety and anger symptoms predominated among isolated patients, especially in patients with a psychiatric history.[1] These epidemics, caused by other coronaviruses, may offer clues about the possible effects on Mental Health of COVID-19 in the general population, among patients and among health workers.

Among the general population, in a study carried out in China, more than half of the respondents reported a moderate–severe psychological impact, while 16.5% and 28.8% respectively reported moderate to severe depressive and anxious symptoms.[3] It has been noted that among subjects suffering from mental illness, the impact could be even greater.[12,13] Regarding patients diagnosed with COVID-19, it has been suggested that they may experience fear and distress from the potentially fatal consequences of infection and isolation. Furthermore, the symptoms of infection and the adverse effects of treatment, such as insomnia caused by corticosteroids, could worsen anxiety and psychological distress.[9] Health workers face challenges such as healthcare overflow, the risk of infection, exposure to family grief, and ethical and moral dilemmas.[14,15] A study in China found among them a high prevalence of symptoms of depression, anxiety and insomnia (50.4%, 44.6% and 34.0%, respectively). Women, nurses, and the most exposed workers reported more symptoms.[14] Taken together, these data raise concern about the psychological well-being of the health personnel involved.

The COVID-19 pandemic has also required the quarantine of multiple subjects exposed to the infection, with uncertain effects on their Mental Health. In a recent review on the effect of quarantine of some epidemics of this century (SARS, MERS, A/H1N1 flu and Ebola), a higher prevalence of psychological distress, affective symptoms (low mood or irritability) and post-traumatic stress are described, some of which could be long-lasting. Fear of contagion, lack of information, financial losses and stigma are some of the stressors associated with the quarantine, so measures are proposed aimed at improving communication or providing the necessary material means.[16]

Some general principles have been established for the intervention with patients and health workers such as: (a) psychological support by multidisciplinary teams, with clinical screening for anxiety, depression and suicidality;

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patients with psychiatric comorbidity should benefit from adequate follow-up; (b) accurate information to patients and health personnel; stay up to date and correct misinformation; (c) attention to symptoms such as insomnia as an early clinical marker; (d) efforts to overcome interpersonal isolation; (e) anticipate and counsel about stress reactions, teaching to recognize signs of distress and discussing strategies to reduce it. The responses of the majority of patients and health workers are adaptive to stress of this nature.[9,17,18]

Furthermore, specific measures have been implemented in different places. In China, a national guideline of psychological crisis intervention was published for COVID-19.[4] In Wuhan, the most affected location, psychological intervention teams were organized, consisting of experts in psychological interventions, psychiatrists and psychological assistance hotline teams. This approach is proving effective and has been implemented in other hospitals.[4] A free-access manual for psychological intervention and self-help was published in Sichuan province, with detailed recommendations for 11 different population groups (suspected patients, family members, doctors, etc.). 24-Hour psychological assistance hotlines were also set up there, and an online survey on the Mental Health status of patients and medical workers was organized to collect information and offer recommendations based on the score.[19] Structured Letter Therapy has also been proposed in China for quarantined patients.[20]

In South Korea, the *National Center for Disaster Trauma* has distributed leaflets reporting alarm symptoms (somatic symptoms, insomnia, anxiety, poor concentration, etc.) that require evaluation by Mental Health professionals, and offer indications (contact with close friends, focus on reliable information, maintaining pleasant activities) for quarantined individuals.[5]

In Japan, recent imperceptible-agent emergencies have increased fear associated with unseen agents such as infectious agents, and the spread of distress reactions or risky behaviors such as alcohol consumption is feared. It has been proposed to focus efforts on vulnerable populations: patients and their families, those of Chinese origin, vulnerable populations due to their psychiatric background and health workers.[6]

As for Spain, the rapid transmission of SARS-CoV-2 has prompted rapid setup by the Psychiatry services of units for the psychological care of patients and health professionals, both face to face and by telephone. The Spanish Psychiatric Society (SEP) has released Fact Sheets for the general population describing common reactions to infectious epidemics, as well as tips for dealing with isolation and quarantine.[21] Likewise, it has issued recommendations to guarantee the Mental Health of health workers.[15] Regarding outpatient care for psychiatric patients, telemedicine encounters have been extended, for which there are APA (*Best Practices in Videoconferencing-Based Telemental Health*) guidelines updated in March 2020.[22]

Definitely, given the high psychosocial impact of the SARS-CoV-2 coronavirus pandemic, it is necessary to continue with the implementation and development of Mental Health services in the health response to COVID-19. The description of internationally adopted strategies can guide their application in different health contexts.

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