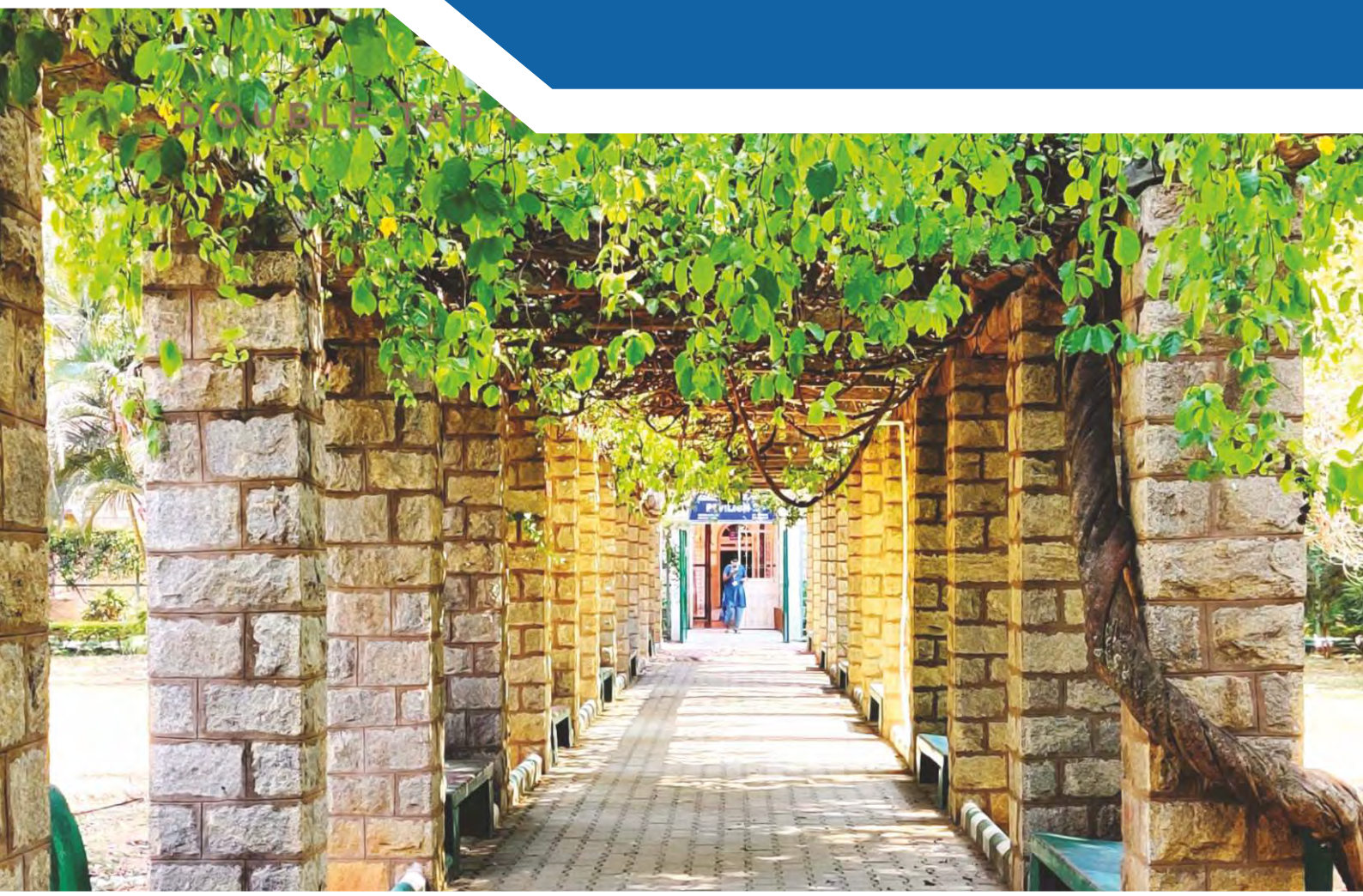
Mental Health in the times of COVID-19 Pandemic

Guidance for General Medical and Specialised Mental Health Care Settings



DEPARTMENT OF PSYCHIATRY

NATIONAL INSTITUTE OF MENTAL HEALTH & NEUROSCIENCES, BENGALURU, INDIA

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Guidance for General Medical and Specialised Mental Health Care Settings

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National Institute of Mental Health & Neurosciences

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MESSAGE

The National Institute of Mental Health and Neurosciences [NIMHANS] has been working with the Ministry of Health and Family Welfare, Government of India in effectively supporting the health care response to the COVID-19 pandemic in the country. One of the foremost concerns emerging from the different aspects of COVID-19 is its impact on mental health.

NIMHANS has responded quickly by setting up a task force in Mental Health on behalf of the Ministry; setting up a helpline; establishing a continuum of care service for patients with psychiatric, neurological and neurosurgical problems and strengthening telemedicine facilities to provide tele consultation to patients. Further, NIMHANS has been working with the Karnataka State Government to ensure psychiatric care and medications to patients on a continuing basis. Through the NIMHANS Digital Academy, thousands of doctors, counsellors, nurses and other professionals are being trained to provide psychosocial support in this crisis.

The Department of Psychiatry has collectively developed guidelines for effective mental health management in general medical and specialized mental health care settings. This is timely and very much needed. This publication comprehensively covers mental health concerns of the general public, as well as those with psychiatric illness. Beyond mental health care, it also addresses safety issues of psychiatrists and other mental health care providers.

While being aware that mental health concerns may keep changing in different phases of the pandemic, these guidelines will nevertheless continue to be relevant, though they may require modifications from time to time.

I congratulate the Department for coming together for this important initiative.

13th April, 2020

Dr B. N. Gangadhar
Director, NIMHANS

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Editorial Foreword

Mental health issues following the COVID-19 pandemic stem from **'normal' people being exposed to 'extraordinary situations'.** The presentations are myriad, and include emotional difficulties like anxiety, depression, biological effects like sleep, appetite disturbances as well as severe mental illness and substance misuse. For most, these symptoms are mild and transitory, but a minority may develop severe mental health issues that require additional mental health support. Children, elderly, pregnant women, people with pre-existing mental illness, people living alone and families of those who have died in the COVID-19 pandemic may belong to this group**.** Another important aspect is the psychological impact of the pandemic on the first response teams. The long hours working in potentially dangerous situations, with less than satisfactory personal protection equipment, make them particularly vulnerable. The widespread social and economic disruption of the pandemic has produced a psychosocial impact unheard of in modern times. All these have been further fuelled by information overloads of new generation media platforms that have relentlessly spread a mix of accurate as well as inaccurate information and even conspiracy theories which in turn have had a psychological impact on the community. The mental health and psychosocial impact of COVID-19 has thus been far-reaching.

All these have thrown an unprecedented challenge to mental health care across all settings in India. Given the likely magnitude of the pandemic and the patchy availability of specialist mental health care across the country, it has become necessary for all non-psychiatric health care professionals who often form the frontline of the health care response to provide 'whatever is possible'. Besides, the care of psychiatrically ill takes a back seat in pandemics. While this needs to be addressed, it is necessary that day-to-day psychiatric practice be recalibrated to ensure greater sensitivity regarding infection transmission.**This document is the collective effort of the Department of Psychiatry, NIMHANS and aims to provide the technical framework to meet these objectives.** *The document has two parts, the first, guidance for non-psychiatric medical professionals to address the immediate mental health needs of persons in the community and COVID-19 treatment centres. The second part provides recommendations for psychiatrists to ensure safety during their day to day practice, given the unprecedented infectious disease outbreak.* Professionals and frontline personnel accessing this document are likely to be overburdened and time-constrained and may be exploring answers in only one specific domain. Given this, each section is comprehensive in itself. This has however meant some degree of overlap across various sections. The sections are written in simple language to ensure understandability by personnel with varying mental health literacy. The sections focus on the immediate and short-term mental health impact of the pandemic. Though specific to mental health issues in COVID-19, all clinical aspects have been discussed in a

broad framework making it adaptable to any large infectious outbreak. This will also be available as a free online resource which may help mental health professionals working in low-resource settings across the world.

In preparing this document, the contributing authors with many years of clinical, training and research experience in psychiatry have quickly reviewed research, and all guidelines published to date by World Health Organisation (WHO), Inter-Agency Standing Committee (IASC), Centre of Disease Control and Prevention (CDC) and Government of India on the COVID-19 pandemic. They have incorporated these guidelines and adapted them to India's unique socio-cultural and relatively low-resourced public mental health settings. Senior faculty of the Department have independently reviewed to ensure sections are in concurrence with the broad objectives of the document.

1

The COVID-19 Pandemic and Mental Health – An Introduction

Currently, all of us are experiencing emotions, thoughts and situations we have never experienced before. It is not that there were no pandemics earlier. Pandemics, particularly plague outbreaks have been known since times immemorial. The Cholera pandemic followed by the flu pandemic were highlights of the nineteenth century. Another cholera epidemic and the "Spanish Flu", ravaged the world in the early part of the twentieth century. Subsequently, while there have been outbreaks of Asian flu, SARS, MERS, Ebola, etc, the pandemic of COVID-19 is on a completely different scale. It has shaken the entire world and created global panic. As COVID-19 initially creeps in and subsequently spreads at a galloping pace, it has been ravaging country after country. The pandemic has significant and variable psychological impacts in each country, depending on the stage of the pandemic.

At the time of this publication, in early April 2020, India is still at the stage of limited community spread and there is no idea how this pandemic will unfold. A large part of the psychological responses have so far been reactionary to what has happened in other countries in the world, fears of what might be in store in the times ahead and responses to the lockdown.

Spectrum of effects

The psychological effects of the pandemic are best understood in terms of psychiatric and psychological problems that were present before the pandemic and the pathoplastic effects of the pandemic on these problems; the responses to social isolation and lockdown; the psychological response to the diagnosis, public responses to those with symptoms suggestive of COVID-19 infection, as well as the aftermath of the infection.

In India, the first and foremost responses to the pandemic has been fear and a sense of clear and imminent danger. Fears have ranged from those based on facts to unfounded fears based on information/misinformation circulating in the media, particularly social media. At a time when change is the only constant (concerning advisories and precautions, as we move through different stages), the What to do? What not to do? questions are near-universal and give rise to worry and fear. Each of us responds differently to the barrage of information from global and local sources. This can lead to those who are the "worried well", those who develop distressful psychological symptoms and maladaptive coping with stress, and those who develop a mental disorder. The fears of contracting the illness are also frequent and range from misinterpreting every fever or cough as a COVID-19 infection, wanting a test done for reassurance even though there are strict guidelines for testing, to hoarding medications despite there not

being indications for their generalised use. Apart from the advisories regarding handwashing, doubts about whether or not to use a mask, what type of mask, what distances to maintain, what surfaces need disinfection with what? There are also real worries of job losses and economic slowdown during and following the pandemic. The list is endless and leads to a cycle of concern, worry, and distress. On the other extreme are also completely unworried or uncaring, who feel they are invincible and do not need to follow any advisory or precaution. This attitude can also lead to an endangerment to self and others.

Responses to social distancing and lockdown

The social distancing and lockdown have also led to several changes in day-to-day activities, redistribution of home chores, extensive working from home and greater time spent with those living together. Notwithstanding the importance of social distancing (although many prefer to use the term physical distancing), such a requirement has meant long separation from families (for those working away from their hometowns), financial stress and interpersonal strain. Reactions can range from boredom and moodiness to anger, irritation, and frustration. Another maladaptive coping is through the use of mind-altering substances. Uncertainty and a sense of loss of control are undoubtedly the pathogenic agents for anxiety, panic, and depression.

A more focused gaze

While one can view these reactions from a 'general' lens, it is equally important to consider the impact of the various phases of the pandemic on children, the elderly and pregnant women. The worries of adults can be transmitted to children and make them anxious and fearful. They can become very easily bored, angry and frustrated. Without an opportunity for outdoor play and socialisation, they may become increasingly engrossed in social media and online entertainment, which can make them even more socially isolated when they emerge out of this situation. Parents need to know means of keeping the children engaged, providing an opportunity to learn new skills at home, as well as encourage children to participate in activities, get them engaged in “edutainment” and hone their extra-curricular skills as well. Children with special needs may need innovative approaches to engage them and keep them active at home. For the elderly, they can feel further isolated and neglected, become more worried about their families, and increasingly worried about their health. They may not have the support systems to care for them, particularly in terms of their medical needs. This can aggravate into anxiety and depression. Pregnant mothers can have a host of concerns, from worries about whether or not to go for ante-natal examinations, worries about risks to the unborn child, worries about their contracting the infection and concerns about the future. Gender perspectives also need attention as times like this can amplify an abusive relationship and increase intimate partner violence.

In any of these situations, it is important to anticipate that stress, depression, and anxiety, if not effectively recognised and handled can transform into more severe distress, even leading to negative thoughts about the future, helplessness, hopelessness and suicidal thoughts and feelings.

Stigma

One has never imagined the stigma that might accompany COVID-19. There are several instances of people at risk, particularly health professionals being evicted from their premises by anxious landlords, people in quarantine being isolated from society, and cruel societal responses to people with a diagnosis of COVID-19, leading to people not disclosing symptoms and not seeking appropriate medical help.

Concerns for persons with mental illness

Persons with pre-existing mental illnesses and substance use are particularly disadvantaged during the lockdowns. For persons with mental illness or epilepsy, reduced access to medication can lead to relapse of symptoms, as can the compounded stress. For persons with substance use disorders, sudden withdrawal leading to seizures, delirium, agitation, and even suicide have been described.

Adapting to the changes

At this point, it is also important to emphasize that many people can handle this situation more constructively- by being calm or learning to stay calm, by busying themselves with simple daily activities, avoiding depressive or fear-inducing programmes on television or social media, connecting with others through telephone or digital means, cultivating or rediscovering old interests and hobbies and of course. For those employed, learning to work from home is a novel and challenging task for many. Discovering ways to calm the mind is another helpful strategy. For students, academic institutions are switching to digital modes of training, interaction, and assessment.

Anticipating situations of distress

As we advance deeper into the pandemic, mental health professionals also need to anticipate growing mental health problems. There can be psychological distress consequent to the diagnosis, guilt, worries about family and others as well as worries about recovering. For families separated from patients admitted with COVID-19 complications, the separation can be excruciatingly painful from a psychological viewpoint leading to worry, helplessness and frank depression. There will be situations when people have to face the unexpected instance of the death of a family member or be prepared for negative outcomes.

With the quickly growing knowledge of the impact of COVID-19, there are growing concerns about the possibility of direct neuropsychiatric consequences of COVID-19 infection, the interactions between psychotropic medications and those used to treat the infection, as well as drug interactions in patients with multi-morbidity. The modifications that might be required to deliver ECT and other physical methods of treatment in acutely symptomatic COVID-19 patients is yet another area that requires greater understanding.

Minding our own minds

One important group of professionals are health care professionals, who go through the same worries discussed earlier, but as the pandemic progresses, they will become more and more engaged in COVID-19 care. Worries about caring for such patients, adequacy of protection, taking infections to their families, long working hours, inadequate access to food, liquids and rest, and separation from families can lead to severe psychological distress among health professionals. Even for professions working in the community, the fears of risk and perceived or actual community aggression are realities that can cause tremendous anxiety. Listening to their anxieties, ensuring adequate protection, training health care professionals to provide appropriate care, supporting them and extending care to their families are important ways to help health professionals help others.

Adapting to changing knowledge and adopting newer approaches

Thus, we need to constantly update ourselves, as mental health specialists on the changing information concerning risk prevention, signs and symptoms, criteria and tests for diagnosis, safe management of the

psychiatrically ill patients with COVID-19 infection, in addition to providing psychological support to persons affected in a myriad of ways in the present situation.

Indeed COVID-19 has impacted the mental health of the entire community in one or another manner. This has created an unprecedented mental health challenge in the face of limited specialist resources. This also means that we need to think beyond conventional strategies. Frontline personnel need to be trained in simple and emerging evidence-based strategies of assessment and management. Presently, the remedial measures suggested for COVID-19 have only empirical evidence. We need to manage with what is available, but constantly update ourselves, almost daily. Simultaneously, we need to engage with non-psychiatric medical professionals to facilitate the psychiatric management of patients with COVID-19 infection and co-morbid physical illnesses. Digital-enabled learning and support for mental health issues need to be considered for all non-psychiatric medical professionals and frontline personnel. Online learning for are equally useful for regular updates for psychiatrists as well.

Despite the various disruptions in routine clinical practice, especially the regular outpatient services, this crisis has thrown up alternative and innovative approaches to offer psychosocial support and continuous care for patients with psychiatric problems or psychological distress. Online digital communication platforms have become a boon for follow-up contact with patients as well as to disseminate training to professionals working even in remote settings. The strengthened District Mental Health Program (DMHP) promises to deliver community care and ensure continuity of medications to prevent relapse.

Fresher challenges

Continuing challenges include the development of protocols for emergency care for suspected COVID-19 patients as well as positively diagnosed patients with appropriate precautions for the safety of the treating psychiatrist and other health personnel. The kind of modifications that might be required in the rapid tranquillisation of COVID-19 positive patients, modifications in interventions like ECT, TMS, tDCS require to be further examined, especially if this pandemic prolongs or lingers.

This guidance document brought out by the Department of Psychiatry at the National Institute of Mental Health and Neuro Sciences, India, attempt to address all these factors with the currently available knowledge to help psychiatrists, other mental health practitioners, non-psychiatric medical professionals, and other front-line personnel reach out in new and unconventional ways to provide support to troubled minds in the time of COVID-19.

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2

Note for Policy Makers

In the current situation, the policy makers are working on several policies related to prevention, treatment and containment of COVID-19. The pandemic has demonstrated beyond doubt that policy making is an acutely dynamic process during a crisis and the dissemination of information happens in real time. Advances in technology have made this task easier for policy makers. Despite the dynamic nature of policy making, the broad framework involves the established aspects of care during disasters and after.

One important aspect that the policy makers need to be "mindful" about is the mental health of people, certain areas that need attention currently are enumerated below:

For the community:

- The mental health professional associations and other related institutions should assemble experts with expertise in post-disaster psychological crisis intervention, to frame guidelines and provide technical guidance and emergency psychological crisis intervention under the coordination of the government's health authority

- Psychological crisis intervention should be integrated into the overall system of pandemic prevention and control, with the premise of reducing potential psychological damage caused by the pandemic and promoting social stability.

- Psychological crisis interventions for the high-risk population and mental health education for the general population must be planned and operationalized. Helplines are lifelines in such situations. A good control room with ready answers for FAQs is a must for running such helplines.

For persons with mental illness:

- The management and treatment of severe mental disorders should not be interrupted as far as possible and emergency care services must remain functional and be bolstered to handle additional influx of patients anticipated during the situation; the management and community care of at-home patients with severe mental disorders should be ensured through liaison existing community outreach programs, like the district mental health program (DMHP)

- The mentally ill patients may be highly susceptible, considering their poor awareness and poor general health condition. Institutions where severely mentally ill are admitted need to take measures such as:

    i) provide adequate medical supplies

    ii) educate these patients about basic preventive measures like hand sanitisation, maintaining physical distance

    iii) reduce visitors to the hospital

    iv) monitor temperature regularly

    v) avoid group interactive activities

    vi) create isolation wards for infected patients to be shifted

Alcohol policies:

- Substance use disorders treatment services need to continued uninterruptedly, there need to be community outreach programmes in which the mental health team can provide timely intervention to this group

Social concerns affecting mental health:

- Psychological intervention medical team can be formed as standalone team or be part of the general medical team attending to patients affected by the pandemic. The staff should consist of psychiatrists, with clinical psychologists and psychiatric nurses participating and the teams should formulate interventions plans separately for different groups eg:

    i) Confirmed cases who are hospitalised with severe symptoms

    ii) Suspected cases and close contacts of confirmed cases

    iii) Patients with mild symptoms who are in home quarantine

    iv) Health care personnel working with COVID 19 patients

    v) General public

- Understand the mental health status of various groups of the society affected by the pandemic. Timely identification of high-risk groups especially those with prior mental health issues, are essential to prevent extreme events such as suicide and other impulsive behaviours

- Interventions should be based on a comprehensive assessment of risk factors leading to psychological issues, including poor mental health before a crisis, bereavement, injury to self or family members, life threatening circumstances, panic, separation from family and low household income

Training for Mental Health Professionals (MHPs):

- The mental health team also need to be aware of the various schemes or policies the government has made in order to alleviate public anxiety about the pandemic and its economic impact

- Telepsychiatry services should be emphasized upon and policies should be framed for the same. Online training programmes in telepsychiatry for the mental health professionals across the country need to be conducted, keeping in mind the framework that professional bodies may have laid down

- Online training sessions for the mental health professionals across the country should be conducted regarding their role in this time of pandemic COVID-19

    - Documentation of all these activities is of paramount importance. Research should be an essential component of all planned public mental health interventions. This will ensure a better understanding about risk factors, patterns of help seeking, treatment outcomes and costs of health care, specifically to the Indian context.

Conclusion

Planning and policy making are critical to ensure program effectiveness. It is essential to ensure that mental health is integrated into the broad framework of COVID-19 health care response to ensure adequate and appropriate care to the many thousands who are psychologically disturbed following the pandemic.

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PART A

COVID-19
&
Mental Health
in
Community and General Hospital Settings

A1

Common Presentations of Psychological Disturbances Post COVID-19

COVID-19 pandemic is turning out to be a major stressor for most of humanity. Never has such an event affected so many individuals all across the globe. The initial focus is necessarily on the physical consequences of the infection per se. However, there is recognition that the significant psychological consequences emerging out of this catastrophe need to be addressed. These could be arising out of direct consequences of infection or of restrictive measures imposed to curtail the spread of infection or the socio-economic impact of the pandemic.

Some features are unique to psychological presentations related to disasters. First, the overlapping of psychological problems is very common. For example, anxious people may also have depression and drink alcohol to reduce anxiety and depression. Second, most people presenting with psychological disturbances are 'normal people' who have been overwhelmed by an extraordinary stressor. Third, a vast majority of people presenting with disaster-related psychological disturbances recover spontaneously over time or with brief psychological inputs. Therefore, these presentations do not necessarily always amount to a psychiatric diagnosis. However, descriptions of psychological disturbances in particular domains help frontline personnel communicate and ensure appropriate selection of intervention. This section describes the common psychological presentations of people exposed to the pandemic.

Case Studies

Scenario 1

Mr. X is a *35 years old bank clerk. His bank is busy and mostly caters to clients from abroad. Recently after the first few cases of COVID-19 were reported, he became a bit worried about the possibility of him getting infected but since he has received gloves and masks he is quite comfortable and carries out his work. The moment he comes home, he changes his clothes and washes his hands as prescribed. But when he listens to the news on TV, he worries for some time as to whether he would infect his mother who is 90 years old and living with him. These thoughts last for 10-15 minutes, but he can dismiss them and carry on with his routines.*

***Discussion**:* Mr. X only has occasional anxious thoughts with NO IMPAIRMENT IN HIS DAILY FUNCTIONING. Occasional psychological symptoms without any major impact on his life is NORMAL in the current scenario. He just requires reassurance that his concerns are understandable and that the safety precautions he has been taking are fine enough.

Scenario 2

Mr. Y a 40-year-old colleague of Mr. X, however, has become very anxious as he worries that he may get infected. The bank authorities have provided him sufficient personal protection equipment like masks and gloves, which he knows is sufficient protection. But, he is anxious and tense most of the time, feels panicky sometimes, and at home, he becomes angry for trivial reasons, his sleep is disturbed and he feels the food doesn't taste good. He continuously watches WhatsApp forwards and keeps checking the news on COVID-19 on the internet. He manages to do his work, but often goes only because of his wife's insistence.

Discussion: This is a common scenario that can occur in infectious outbreaks when people experience heightened anxiety but are still managing to carry on. This could possibly represent adjustment disorder.

These are emotional disturbances that arise in the context of a significant life change or a stressful life

Symptoms:

- Sadness of mood, anxiety or worry, fear of contracting an infection (or a combination of all these).
- Persistent preoccupation with illness worry.
- Inability to cope (giving up) and some degree of dysfunction.
- Sleep and Appetite disturbances.
- In adolescents, these symptoms might be associated with oppositional behaviour or truancy.

In most, symptoms remit after the stressor is removed. Some of these individuals with on-going issues might progress to a depressive episode or an anxiety disorder.

Mr. Y may benefit from the suggestions in the Section on “Allaying Anxiety of the Worried Well” and also with the techniques suggested in “Simple Psychological strategies to deal with common mental health concerns in the wake of COVID-19 -19”. Medications are only required rarely and if so, a short course of anti-anxiety drugs may be considered as discussed in the section on “Common And Safe To Use Psychotropics In COVID-19 – A Practical Guide For Non-Psychiatrists”.

Scenario 3

Mrs. N is a housemaid. Her husband lost his job in the textile shop as it closed down, after which she has become sad and withdrawn. She has reduced interaction with others including her neighbours to whom she was close to. She has become very slow in her work and feels tired almost all the time. She has made a lot of mistakes in her cooking and reports that she cannot remember things. When asked, she reports that she has become very sad and worried after her husband's job loss; now she is the only earning member. There are debts and she feels that she will not be able to repay. Her husband has also become more irritable and is drinking more. She feels hopeless and thinks of dying but feels she needs to go on at least because of her two young kids.

Discussion:

There are economic and social costs of pandemic and resultant shutdowns such as economic downturns, job and livelihood losses which can lead to significant mental health problems.

The symptoms that Mrs. N is reporting are suggestive of depression which is described below.

Depressive disorders: Depression can be an independent depressive disorder precipitated by COVID-19 or secondary to COVID-19 related stress and other related problems.

Symptoms

- Low mood
- Decreased or loss of capacity to enjoy things
- Decreased energy
- Marked tiredness after even minimum effort (not due to any medical cause including COVID-19)
- Reduction in activity or feeling restless
- Lowered attention/ concentration- complaints of poor memory
- Loss of self-esteem and self-confidence
- Ideas that one is worthless, or has done something wrong
- Feeling of helplessness (no help will be available), and that there is no hope for the future.
- **Death wishes, suicidal thoughts or attempts**
- Sleep and appetite disturbances

When subjects have most symptoms and are severely dysfunctional or have persistent thoughts of death, self-harm, and suicide, immediate referral to a mental health specialist has to be initiated.

The major stressor that Mrs. N is facing is how to solve her financial problems in the wake of COVID-19. She may benefit from problem-solving techniques in the section on "Simple Psychological strategies to deal with common mental health concerns in the wake of COVID-19". Medications may also be required because she seems to have fairly severe depression with death wishes. Please see the section on "Common And Safe To Use Psychotropics In COVID-19 – A Practical Guide For Non-Psychiatrists".

Scenario 4

Mrs. N's husband V, after losing his job has been drinking and smoking heavily. He has started borrowing money to drink and often picks up fights with his wife and beats his children after returning home late at night. Mrs. N has never seen her husband like this in the ten years of marriage and feels that he needs help.

Discussion

An increase in the use of substances is likely to follow the immediate aftermath of any disaster including COVID-19. The commonest substance use in India is alcohol and tobacco.

Substance Use Disorder (Alcohol/tobacco)

Individuals may use substances to overcome social isolation, as a way of pleasure-seeking or to reduce anxiety and depression. The most common and expected pattern is that of increased use with some dysfunction.

Harmful use may also occur which means there is damage to health due to alcohol or tobacco. In this case, harmful effects could be physical (e.g: liver/lung related issues) or mental (e.g: worsening of mental health issues like anxiety or depression). Continued use can lead to dependence or addiction, which is characterized by a strong desire to drink/smoke, difficulties in controlling the use, persistence of drinking despite harmful consequences, a higher importance given to use of substance than to other activities, increased tolerance, and a physical withdrawal state.

Frontline personnel may refer **to Sections on Management of Alcohol Use Disorder and Tobacco Use Disorder for management strategies for these common problems.**

Other Mental health presentations for Consideration

Anxiety disorders: Many forms of anxiety disorders are expected in the aftermath of COVID-19. The emergence of these symptoms can occur even during lockdown periods due to fear/ anticipation of an infection.

Generalized anxiety disorder:

It is characterized by excessive worrying and persistent free-floating anxiety (not restricted to any particular environmental circumstances).

Symptoms:

- Persistent nervousness, tension
- Restlessness or feeling on edge
- Irritability
- Muscles feeling tense and tight
- Poor concentration
- Sleep disturbances
- Physical symptoms such as excessive sweating, feeling light-headed, palpitations, dizziness and epigastric discomfort.

Panic disorder

It is characterized by recurrent unexpected attacks of severe anxiety (panic attacks) that reach a peak within a few minutes and last for a few more minutes. There is associated fear of having more attacks (anticipatory anxiety) or avoidance of triggers of panic attacks. **Many of these patients might feel that they are about to die or lose control or go mad, and will end up in a medical emergency setting.**

Phobias

There are also anxiety disorders that might emerge in certain well-defined situations. Most commonly certain people can excessively develop fear of crowds in the wake of COVID-19 (due to fear of infection). In certain cases, if there is excessive avoidance of crowds to the point of being house-bound it is called agoraphobia. In all these phobic states, anxiety symptoms are triggered only in particular situations, and are accompanied by strong avoidance of the situations that trigger fears.

Anxiety disorders can be treated with cognitive behaviour therapy or medications (antidepressants and/or benzodiazepines)

Obsessive-compulsive disorder (OCD)

OCD is also expected to increase in the aftermath of COVID-19. To ensure that subjects reduce transmission of infection, they have been bombarded with public health messages to wash repeatedly to

reduce contamination. Subjects with OCD also experience repetitive thoughts that they are contaminated (contamination obsessions) and wash repeatedly to reduce anxiety (compulsions). The subjects often recognise that these thoughts are senseless but cannot control them. Due to fear of contracting COVID-19 through fomite transmission, such a persistent fear is likely to predispose to severe OCD in some otherwise vulnerable individuals, and in these cases, washing can persist for many hours in a day, with significant distress and dysfunction.

Severe mental illness: The emergence of severe mental illness as a direct consequence of the pandemic is unlikely. However, in individuals already suffering from such conditions, there could be a relapse or worsening.

Common symptoms

- Unexplained irritability/aggressive behaviour
- Talking or smiling to self
- Suspiciousness
- Hearing voices when nobody is around (hallucination)
- False beliefs (delusions)
- Poor self-care

(Refer to Section on Severe Mental Illness for further details)

Conclusion

Psychological presentations post-COVID-19 are common. Identification of common symptoms is helpful to ensure that early intervention is provided.

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A2

Mental Health Assessment of COVID-19 Patient in Health Care & Community Settings

Introduction

COVID-19 pandemic has left in its wake an unprecedented challenge for mental health services across the world. With almost all affected, mental health service delivery to address the psychological consequences at the individual level has become near impossible. The existing health services is at its break point to control the spread and reduce mortality of COVID-19. Policy makers though aware of the mental health consequences are prioritizing capacity building of the health services and attempting to reduce the socio-economic hardships of communities following COVID-19. Front-line personnel including medical professionals however face the daunting task of dealing with the distress and trauma of individuals, families and communities on a daily basis. In addition, most have to deal with their own emotions and anxieties. The vast majority of frontline personnel have limited mental health competencies. This chapter is a frame-work for a simple mental health assessment by front-line personnel. The assessment may be integrated into the health care response or frontline response to the COVID-19 pandemic. A few theoretical concepts have been added to ensure a greater clarity for medical professionals.

Mental health issues noted in (biological) disaster zones including COVID-19 can be classified into an acute phase during the outbreak (approximately 2-6 months) and long-term phase after the control of the outbreak (>6 months). a) Acute Phase (during the outbreak) – Issues to be dealt with include immediate mental health impacts such as fear, denial, anxiety, insomnia, dissociative symptoms, depressive symptoms, suicidal ideas/attempts, substance withdrawal and relapse of pre-existing mental health problems. Besides, stress related issues of the health care providers and frontline personnel need to be addressed. b) Long-term phase (after the control of the outbreak) – Issues commonly presenting include grief, survivors guilt, depression, substance use, relapses of pre-existing mental illness, PTSD, and somatisation disorders. The major stressor during this period will be the direct and the indirect socio-economic impact of COVID-19. Along with the diagnosable mental health issues, the affected community also harbours a large number of the worried well. Mental health professionals should be aware of this phenomenon and restrain themselves from labelling this population with mental disorder

and treating them aggressively with medications (Please read the Section on Worried Well for more details). **In addition, all health care and frontline personnel should be aware that mental health issues post-covid-19 (or any disaster), represent emotional reactions of normal people in abnormal situations and for a majority these symptoms are self-limiting.**

The assessment of mental health issues in this section will focus on the psychological issues in the acute phase of the COVID-19 outbreak.

Case Finding

There are possibly three streams for case-detection/identification of mental health issues that need to be focussed in the acute phase of COVID-19.

1. Case Identification by front-line medical and non-medical personnel (including police officers, Members of Local Self Government, Community/health workers)

    - Points of entry into the country/state –Airport/Railway Station/State borders etc.

    - Home quarantine visits

    - Other Medical Emergencies

2. Case Identification by health care professionals (non-psychiatric)

    - Hospital quarantine/isolation

    - Routine out-patient assessment for other illness

3. Self-referral/Walk-ins to mental health professionals

4. Identification of frontline medical and non-medical personnel in need of help/support for stress management or burnout

5. Screening of the high-risk (vulnerable) population once Community Transmission is established

Who are the most Vulnerable?

- Children

- Senior citizens

- Pregnant women

- Persons with disability

- Homeless individuals, Poor social support & lower economic status
- Marginalised communities
- Life-threatening chronic medical conditions like cancer, chronic renal failure, liver diseases, asthma/COPD, immunocompromised patients
- History of severe mental illness and wandering mentally ill

How to assess?

There are many instruments for screening common mental disorders in disaster settings including PHQ-9 and GAD-7. A recently validated instrument for primary care attendees in India **(Screening Instrument of Clinical Schedule for Clinical Psychiatry Ver 2.3)** is being suggested for use. The instrument can be used by any frontline medical professional. The instrument has the advantage of being brief, hence saves time and and reduces the risk of prolonged exposure. It can also be used for telemedicine consultation.

The screening questions are as follows:

- ***Demographic Details***
- ***Would you like to share your concerns?***
- ***Please begin with these general enquiries!***

1	How is your sleep?	Normal / Disturbed
2	How is your appetite?	Normal / Disturbed
3	How is your interest in doing your daily work?	Normal / Disturbed

4	*In the past year, have you been drinking alcohol heavily or regularly?*	*YES / NO*	If YES to any, consider possibility of ***Alcohol Use Disorder*** *(Refer to Section on Alcohol Use Disorder for details/management)*
5	*In the past year, have you been having difficulty in falling asleep without alcohol?*	*YES / NO*	
6	*In the past year, have you been experiencing shaking of hands/body whenever you reduced the quantity of alcohol or stopped using it?*	*YES / NO*	
7	*Do you use Beedi/Cigarettes/Gutka or other tobacco productswithin one hour of getting up from bed in the early morning?*	*YES / NO*	If YES, consider possibility of ***Tobacco Use disorder*** *(Refer to Section on Tobacco Use disorder for details/management)*
8	*past few weeks, have you been experiencing sudden attack of fear or anxiety?*	*YES / NO*	If YES to any, consider possibility of ***Panic disorder(PD)*** *(Refer to Section on "Simple Psychological techniques" and "Safe Psychotropics in COVID-19 for management)*
9	*In the past few weeks, have these attacks been occurring spontaneously?*	*YES / NO*	
10	*In the past few months, have you been worrying excessively or getting anxious over infection or everyday problems or life circumstances?*	*YES / NO*	If YES to any, consider possibility of ***GeneralizedAnxiety Disorder (GAD)*** *Refer to Section on "Simple Psychological techniques" and "Safe Psychotropics in COVID-19 for management)*
11	*In the past few months, have you been finding it difficult to control or stop these worries?*	*YES / NO*	
Note: If 'YES' to any items from item 8 to 11 and they are primarily confined to or attributed to infection or fear of infection with Corona Virus, consider a possibility of either being "Worried Well" "Adjustment disorder" or "Acute Stress Reaction"and treat accordingly (see Section on simple psychological strategies/Worried Well). If symptoms are persistent and severe consider referral to a psychiatrist.			
12	*In the past few weeks, have you been feeling tired all the time?*	*YES / NO*	If YES to any, consider possibility of ***Depressive disorder****Refer to Section on "Simple Psychological techniques" and "Safe Psychotropics in COVID-19 for management)*
13	*In the past few weeks, have you lost interest or pleasure in your regular daily activities?*	*YES / NO*	
14	*In the past few weeks, have you been feeling sad / depressed?*	*YES / NO*	
15	*ASK the caregiver: In the past few weeks, have you found him to be unusually suspicious of others or reporting of hearing of voices or seeing visions?*	*YES / NO*	If YES to any, consider possibility of ***Psychotic Disorder*** -Referral to Psychiatrist
16	*In the past few weeks, did he/she have suicidal, self-harm or aggressive behaviour?*	*YES / NO*	*Referral to psychiatrist if required*

*(Only the screening questions pertaining to the immediate impact of COVID-19 has been included here. Somatisation and post-traumatic stress disorders (more likely during the long-term impact phase) which is a part of the original instrument (**Clinical Schedule for Clinical Psychiatry Ver 2.3)** have been excluded to ensure brevity).*

In addition, if time permits it's a good practice to also ask questions pertaining to-

* Pre-existing medical and mental illness

- Past treatment history
- Coping skills and strategies (if the test is positive)
- Family history of mental illness.

The primary focus of mental health interventions in the immediate aftermath of COVID-19 is to ensure safety, reduce distress and secondary stressors, enhance coping skills and promote recovery. The general principles of first-step management by non-psychiatric medical professionals are described in the relevant sections in this document.

Referral

If symptoms are severe and persistent or if there is an immediate risk of harm to self or others or features of relapse of pre-existing severe mental illness, the patient may require referral for specialist mental health assessment.

In this case,

- Check person's/family's desire or consent for referral
- Ensure written referral letter
- Information-sharing with mental health provider
- Keeping a written record of referral (if possible).

Additional Aspects

Human Resources Development: The COVID-19 outbreak threatens to weaken the already fragile mental health across the country. Considering the mammoth nature of the pandemic and available meagre resources, there is an immediate to address a mental health gap in trained personnel who will be able to make simple mental health assessments. Given the additional restrictions and risk of exposure, mental health workshops need to be held online for elected representatives of local self-government,

nurses, auxiliary staff, DMHP team members, physicians, school and college teachers, ASHA workers, lay-volunteers in early identification and referral. Strengthening and involving existing community resources will not only help in capacity building but also ensure greater community participation.

Conclusion

Psychological issues following the pandemic are likely to be common. Most affected will require only brief assessments and immediate support. This will require all front-line personnel to be competent in simple psychological assessment of the affected in the community and treatment settings of COVID-19.

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A3

Mental Health Issues of Home Quarantine

Quarantine is defined as the separation of people who have been exposed to a contagious disease to ascertain whether they become sick, thereby reducing the risk of them infecting others. **Isolation,** in contrast, is where a person diagnosed to have a contagious disease is separated from the general population to avoid transmission of the disease to healthy people.

Social distancing is another term that has acquired prominence recently in the context of the COVID-19 pandemic. **Social distancing** refers to certain measures taken to stop or slow down the spread of highly contagious diseases which include limiting large groups of people coming together, closing down public buildings such as schools, universities, canceling public events, etc. Presently governments across the world and in India are using a combination of these measures to stop the spread of the COVID-19 pandemic.

While considered essential under the present circumstances, quarantine can be a taxing and distressing experience for many. Based on studies from previous epidemics/ pandemics we shall identify some of the mental health concerns which people in quarantine face and propose solutions/remedial measures for the same. It must be acknowledged at the outset that we could not find any intervention studies which have examined the effectiveness of the various remedial measures. Rather, these measures are proposed based on the problems people in quarantine had faced in previous epidemics.

PROBLEM	WHAT CAN YOU DO AS A HEALTH CARE PROVIDER?
Duration of Quarantine	
Increasing the duration of quarantine can lead to increasing distress.	• You should always clearly inform the patient/public how many days the quarantine is expected to last. • Extensions of the quarantine period can be extremely frustrating. The rationale for the increase in the duration of quarantine to be explained, specifically ensuring that the anxieties of the patient have been addressed.
Inadequate and/or Confusing Information	
Multiple conflicting sources of information can lead to confusion and anxiety	• Provide as much information as possible in a simple and accessible manner. • Explaining the purpose of the quarantine increases the chance of people complying with the same. • Restrict news consumption to a reliable source – preferably a newspaper or a government website. • Discourage patients from continuously following a TV or online newsfeed as this can often lead to further fear and anxiety. • Warn patients regarding potential pieces of fake news circulating on social media and instant messaging apps such as WhatsApp • If possible, provide a point-of-contact number or helpline number in case a patient develops symptoms
Fear of Infection	
Fears about their health or fears of infecting others. Even minor physical symptoms can be misinterpreted as having the disease	• Provide adequate information about the disease. • Explain what symptoms are relatively innocuous. • Also, explain the danger signs patients need to watch out for. • Patients might have a lot of doubts and questions. Welcome them and answer them as best as time permits.

Frustration and Boredom	
Loss of routine, lack of social contact, sense of isolation from the rest of the world, etc. can produce significant distress	• Talking face-to-face on the phone or computer with family and friends can help • Encourage activation of patient's social network – remotely – over phone and computer • Ask patients to create and maintain a daily routine – this helps to create a sense of order even in changed circumstances • Encourage patients to engage in some activity – reading, music, gardening in own private plots, learning to cook something new, listening to music, learning something new, etc. • Encourage communication with other patients/people in a similar situation
Stigma	
Patients might face stigma from the community	• Again, explain the rationale for quarantining. • Public education
Finances	
Loss of work can lead to loss of pay, job loss, etc.	• To co-ordinate with a Social Worker or appropriate government agency • Make patients' aware of the various programs initiated by both Central and State Governments specifically following COVID-19
Unavailability of Supplies	
Inability to procure daily supplies can lead to anxiety	• With the help of Social Worker or appropriate government agency - coordination for provision of supplies. This should ideally occur in advance. • Ensure patients have enough supplies for their basic needs.

General Advice for Coping	
Altruism is better than compulsion	• Reinforcing the message that quarantine is helping to keep others safe, including those particularly vulnerable • Communicate to the quarantined patients that health authorities are genuinely grateful to them
Maintain a healthy lifestyle	• Get enough sleep, eat well and exercise/yoga • Avoid using alcohol or drugs to cope • Maintain a sense of hope and positive thinking • To write down things you are grateful for or that are going well
High prevalence of psychological distress in quarantined healthcare workers itself	• Address feelings of guilt that their absence from work increases the work for colleagues • Help them get support from hospital administration in facilitating their return to work
When to consult mental health professionals?	• Experiencing symptoms of extreme stress, undue anxiety, depression, ongoing trouble sleeping, inability to carry out daily routines, or an increase in alcohol or drug use

Counselling for home quarantined using telephone helplines and telepsychiatry

For subjects in home quarantine, supportive counselling can be provided by telephone helplines and telepsychiatry platforms. These have an important advantage over face to face counselling, as they provide specialist services, which can be accessed from the convenience of peoples' homes without endangering the health personnel and the larger community.

Conclusion

Quarantine, isolation and social distancing in the times of a raging pandemic can be psychologically distressing for many people. However, there are simple and effective actions that you can take as a health care provider. Key among them is providing information. As a health care provider, you would be seen as a reliable and trustworthy source of information. Explain the rationale of quarantining and social distancing. Promote reliable sources of information. Inform patients what symptoms to watch out for and what symptoms not to worry about. Encourage people to remain in touch with each other over virtual means. Address stigma. Finally, if you come across anyone having significant distress have them referred to a mental health professional.

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A4

Mental Health Issues in Hospital Quarantine/Isolation

Introduction

Quarantine is defined as restricting the movement of normal individuals who may have been exposed to infected people. The quarantine can also help limit the spread of communicable diseases like COVID-19. The quarantine can be done at home, hospital or community-based facilities. In contrast, isolation is the separation of people affected with illness/contagious disease from people who are not affected. In this chapter, we discuss mental health issues related to 'Hospital Quarantine and Isolation'.

Mental health issues during Hospital Quarantine

Quarantine is done for the larger interest of the community by curtailing the right of the individual. Quarantine can lead to physical, psychological, emotional and financial stress due to fear of contracting the illness, boredom, loneliness, loss of personal freedom, a new set of daily routine and lack of social togetherness. The mental health issues following the hospital quarantine period can be 1. New-onset mental health problems 2. Exacerbation of pre-existing mental health problems

New-onset mental health problems:

These include-

i. *Health-related anxiety:* By far this would be the most common condition that could arise during isolation. This can occur due to uncertainty of outcome, fear of turning positive on testing, and stigma. It can range from mild to severe. In severe cases, it can lead to panic attacks.

ii. *Depression and Anxiety:* Fear of contracting a severe and possibly life-threatening illness, isolation from the family, helplessness and guilt associated with behaviours which led to infection, is a source of infection to family and public, and not being able to perform duties, etc. can lead to depression and anxiety. Some people in quarantine may even harbour suicidal thoughts.

iii. *Low mood, fear, nervousness, irritability, anger, frustration, boredom, emotional exhaustion, feeling stressed, numbness, and insomnia:* Many quarantined persons may experience these problems which may or may not amount to a diagnosable mental health disorder, nonetheless, they need to be identified and addressed.

iv. *Substance Withdrawal:* Withdrawal from substances can occur due to non-availability and sudden stoppage from the substances especially alcohol.

v. *End-of-life crisis:* Thoughts of whether they have performed their duties adequately, fear of death, apprehension towards the family's reaction to one's death, guilt, etc. may haunt the person.

vi. *Acute stress reaction and post-traumatic stress disorder (PTSD):* Hospital quarantine can be a significant traumatic event resulting in acute stress disorder. People exposed to hospital quarantine have a higher risk of later development of PTSD.

vii. *Resilience:* A few may also report positive feelings. Resilience is known to occur not only in the persons infected but also in the community. Community's resilience help us in bouncing back from difficult times.

b) Exacerbation of pre-existing psychiatric conditions: Any pre-existing psychiatric conditions like psychosis, mood disorders, anxiety spectrum disorders, sleep disorders, etc can exacerbate during the quarantine. This can happen due to three reasons-

1. Illness related

2. Stopping ongoing psychotropic medications for reasons such as non-disclosure of mental illness, non-availability of medications, drug interactions and lack of access to mental health care providers.

3. Drug adverse effects: Drugs currently used to treat COVID-19 are known to cause psychiatric symptoms either in the form of emergence of new symptoms or exacerbation of existing symptoms. Some of the commonly reported psychiatric symptoms associated with the use of chloroquine, steroids, and antiretrovirals are psychosis, delirium, mood disorders, and cognitive disturbances.

Management

a) Validation– Acknowledge the feeling of boredom, loneliness, feeling sad, stressed, confused, loss of personal freedom and guilt

b) Keep quarantine as short as possible based on the knowledge of the incubation period. Avoid overcautious approach and avoid extension of quarantine. Stick to the recommended period. Extension of the quarantine period may lead to frustration and demoralisation.

c) Provide as much information as possible about the infection and rationale behind the quarantine. During quarantine, people may tend to misinterpret all physical symptoms as indicative of infection which may then lead to excessive health anxiety and other psychological issues. Therefore, the quarantined people must have an accurate and unambiguous information about the nature of the problem. Health professionals involved in caring for them may have to periodically reassure them.

d) Avoid speculation and break the chain of rumour during the hospital quarantine.

e) Screen for pre-existing medical, psychiatric and substance use disorder conditions. People with pre-existing mental health problems may be more vulnerable than others to develop psychological problems. Ensure treatment and continuity of care with the hospital for pre-existing medical and psychiatric conditions.

f) Provide facilities to the individual to remain physically active, continue or develop hobbies to be mentally active and ensure a balanced diet to keep themselves fit and calm.

g) Provide access to family and friends through mobile phones. The quarantined people need to maintain contact with others and have access to social networks to avoid boredom and loneliness.

h) Teach coping strategies to people who have psychological issues.

i) Ensure adequate supply of basic needs (food, water, medicines, etc.) and reinforce a sense of altruism.

j) Protect an individual's safety and privacy.

k) Use psychotropics sparingly as most people may do well with simple measures described above.

Counselling for patients with COVID-19 in hospital

The telepsychiatry platform may be considered appropriate for counselling those with COVID-19 who are in hospital quarantine. This will reduce the risk of contracting infection for health care personnel and prevent wastage of valuable personal protection equipment.

Conclusion

Understanding the mental health needs of people in hospital quarantine is important as its likely that many are likely to develop psychological issues that need early intervention.

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A5

COVID-19 Pandemic and Mental Health Issues in Children and Adolescents

Children

All of us, children included, are trying to make sense of the overwhelming uncertainty in front of us due to the global pandemic caused by the Coronavirus (COVID-19). Children and adolescents have already been at home – with schools being shut early – for over three weeks in several parts of India. Their regular schedules have been disrupted, with no clear idea of when they will be restored. Children are confined to the home and in some situations may be separated from the parent (s) because they are quarantined, or their parent (s) are quarantined. Children may experience a range of psychological issues such as anxiety, fear, worry, depression, difficulty sleeping, and loss of appetite. Quarantine and isolation may also lead to acute stress disorder, PTSD and grief in many children.

Children with various physical and mental disabilities – and especially mental health disorders – are more vulnerable during this trying time. The kind of therapeutic inputs that children with various disabilities may have been receiving may not be readily available now – various therapies, special schooling, psychotropic medication, etc. Social isolation may worsen the living situation of children in abusive environments as well as children with special needs. Economic hardships and the potential worsening of parental physical or psychological illnesses, including substance use disorders, may take a toll on all children. Children may even go through loss and grief at this time. Given this dire picture, what advice can health professionals give parents?

How can we help children cope in this difficult situation?

This guide is especially for parents of children.

1. Children are constantly exposed to information related to the pandemic in newspapers, TV news channels and social media. They may understandably have realistic and some exaggerated fears. They must be provided unambiguous and clear information regarding the pandemic in an age-appropriate language. The aim is to reassure them and reduce exaggerated threat perception. Children who wish to have access to information may be encouraged to look at reliable websites

such as the World Health Organisation (WHO), Centers for Disease Control (CDC) or the Ministry of Health and Family Welfare (MoHFW), Government of India.

2. Answer your children's queries but figure out a way of striking a balance. Too much information can cause panic and severe anxiety. Take your cues from the child.

3. Make sure that children are not excessively exposed to pandemic related information. Limit media exposure, especially if there is fear-mongering or exposure to alarming content. If the child hears or sees something upsetting, please put it in context for them. Avoid discussing the topic frequently in front of children.

4. Answer questions honestly. Don't dismiss their worries. Don't make false promises. For instance by saying, "what is there to worry?" or "nothing will happen". Talk about what the family will do should anyone fall ill.

5. Figure a new routine for the household and the child. This routine must include academic work, chores, play, interaction with peers and relatives over the phone or using other forms of technology as well as family time. Have a set time for meals and bedtime. It would be wonderful to also have some indoor exercise as part of this routine – for instance, yoga, stretches, skipping, etc. However, this routine need not be set in stone. The routine must be made collaboratively, including changes over time.

6. Family time can include games that parents may not have had time to play thus far. This is a good opportunity to reconnect with the family playing board games, cards, carrom, antakshari, etc.

7. Model calmness to the extent possible. You are their anxiety barometer. Don't transfer your anxiety on to children. Seek help if you are suffering from emotional issues.

8. Watch out for repetitive reassurance-seeking – a sign of distress in children. If there is significant distress, consider an evaluation by a mental health professional. Seek out the options available in your locality, or online.

9. If the child already has a mental illness, please reach out to your doctor via phone or email.

10. Use medicines sparingly and judiciously. However, continue any psychotropic medication the child is already prescribed at the prescribed dose unless otherwise recommended by your doctor. Please do not discontinue the medication abruptly.

11. Please find telemedicine resources, if possible, to start or continue psychotherapy or other therapies including speech therapy, special education

12. Find a way to take care of yourself – medically as well as psychologically. You are your family biggest pillar of support. "Me Time" is recommended. Share the burden of parenting, to the extent possible.

Given that children are likely to be bored and restless, given below are some resources for them to look through. It may be both educational and interesting. (Positive Parenting during the COVID-19 Pandemic with your Children. https://www.stmarysdubai.com/wp-content/uploads/2020/03/Positive-Parenting-during-the-COVID-19-Pandemic-with-your-Children-1.pdf).

Adolescents

Mental health issues discussed for children apply to most adolescents, hence many of the suggestions described above remain applicable to adolescents. But there are some age-specific issues, which need to taken into consideration by medical professionals and other frontline personnel while assessing adolescents.

General Considerations

Parents have to be aware of the normative developmental changes that occur during adolescence. Adolescents will have a better understanding of the COVID-19 related issues compared to children. Parents should engage in an open, non-judgemental communication with their adolescents rather than having assumptions like "you don't know anything","you will have to learn everything from parents"etc. Coping and Problem-solving skills of adolescents are better developed compared to children.

Adolescents and COVID-19

- Adolescents are likely to have preoccupation withthemselves, a sense of insecurity, mostly identify with their peer group and are often prone to risk-taking behaviours.
- Some adolescents may have feelings of being invincible and may take risks by not maintaining personal hygiene and social distancing.
- Others may be withdrawn, afraid of leaving home and worried about their health as well as that of their family members.
- They may also lose regular contact with friends because schools, colleges, and universities are closed. This may lead to feelings of boredom, loneliness, sadness, aggression, and irritability towards siblings and other family members.
- Few may start using Tobacco, Cannabis, Alcohol, etc. to handle their boredom, loneliness and emotional changes.
- The uncertainty about examinations and its impact on their career choices can exacerbate the stress due to the prevailing COVID-19 Pandemic.

What parents of adolescent kids need to do?

1. Parents should keenly observe for any emotional or behavioral changes in their adolescent kids. Sometimes these changes can be subtle.

2. Parents can play a vital role in ensuring that their adolescents maintain their mental health by listening to them, acknowledging their difficulties, clarifying their doubts, reassuring them, generating hope and providing emotional support in resolving issues

3. Excessive use of mobile and other devices can result in behavioural addiction. Parents have to negotiate with adolescents to ensure the limited use of gadgets and to discuss the inclusion of healthy non-gadget activities as a part of the daily routine.

4. Urgent professional help has to be sought if the behavioural and/or emotional changes last for more than two weeks if the changes are severe if there is a significant loss of sleep or appetite, if there is physical aggression towards others if the adolescent expresses death wishes or suicidal ideas or hopelessness or attempts self-harm and in case of any use of alcohol or other substances.

Conclusion

COVID-19 is too big a problem for a health professional or a parent to solve on their own. Since children and adolescents are at home with their parents, the following points are for parents. This advice can be dispensed to parents by health care professionals. For parents who are struggling with their daily needs, expecting them to structure their child's schedule may be impractical. Nonetheless, some of these principles may be used, where possible. Social distancing itself may be difficult given people's living situations. Parents' anxieties may have to be addressed. This is a difficult time for all with no easy answers but some of these simple strategies may help.

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A6

COVID-19 and Mental Health in Older Adults

Older adults are consistently reported to be more vulnerable to COVID-19. According to the Centre for disease control and Prevention (CDC), older adults with COVID-19 are more likely to be hospitalized (31-59%) and die of it (4-11%). This risk is much higher in older adults above the age of 85 years.

What makes older adults at a higher risk for mental health issues during the COVID-19 pandemic?

- Awareness that older adults have a higher risk for severe respiratory problems due to COVID-19 including the risk for hospitalization, the requirement of ventilatory support and a high mortality rate contributes to significant stress, anxiety, and other related mental health problems.

- Older adults are likely to experience more stress and difficulty in accessing essential services due to the restrictions enforced to maintain the social distancing to prevent the spread of COVID-19

- Older adults are less likely to have social contact using technology and social media which are useful for maintaining social contact despite the need for physical distancing.

- Social isolation is one of the important risk factors for mental health problems like depression and anxiety in older adults

- Older adults have higher chances of worsening of pre-existing medical and psychiatric illnesses because of difficulty in ensuring regular medication and routine health care due to COVID-19 related restrictions.

Mental health issues

- Sleeplessness, feeling anxious, boredom, panic attacks, nightmares, feeling of emptiness, fear of contracting COVID-19, fear of spreading the infection to others, health anxiety, feeling of imprisonment, anxiety related to uncertainty about future, anxiety about death and dying in

unnatural circumstances without access to other relatives are some of the psychological issues that can occur in older adults.

- Some of them may develop depression, anxiety disorders, hypochondriasis, post-traumatic stress disorder, substance abuse/withdrawal and related psychiatric disorders in these stressful situations.

Mental health issues in older adults with pre-existing mental illness

- The common mental illnesses in older adults are depression, delirium, and dementia. Older adults with a prior history of depression are at risk of relapse or worsening of depressive symptoms. This could be due to psychological stress, poor coping as well as difficulty in ensuring adherence to the routine treatment.

- Older adults are also at a higher risk of delirium or recurrence of delirium due to restrictions in mobility and decompensation of medical and psychological disorders.

- In older adults with pre-existing cognitive impairment, there are few unique challenges. Usually, older adults with cognitive impairment have behavioural problems. They have challenges in understanding the COVID-19 pandemic related preventive measures and related information. It is difficult for caregivers to restrict mobility in older adults with dementia. It is also difficult for older adults with dementia to be compliant with frequent hand cleaning, social distancing and use of the protective facial mask.

Unique scenario of Oldage homes and living alone

- Those living in oldage homes/residential set-ups or living alone are the most vulnerable population during this pandemic in terms of mental health. Oldage homes in India, which already have constraints in terms of staff and space will have challenges in implementing preventive measures.

- Mental health issues that can be expected in these settings are sleep disturbances, fear of contracting the virus, worry, and apprehension about the future and paranoia of other inmates.

Evaluation and management

- In the current scenario, people are advised to defer visiting hospitals/clinics for their scheduled appointment for minor issues. In this situation, there is a need for using other modes of communication with doctors and other health care professionals.

- The first step is increasing the awareness about mental health issues among the older adults and their family members via social media (Online programs, website, online forum, group email or messages)

- Utilising community health workers or trained social workers for the screening of older adults at oldage homes/assisted living facilities for mental health issues. This can be done through old age home staff using technology assistance to avoid exposure to the infection.

- To establish a helpline through which any older adult or family member can approach for minor mental health issues. The helpline can be managed by a specialist psychiatrist on rotation. Through this medium, there is a basic assessment of problems followed by a brief psychological intervention.

- Telemedicine can be used for consultations requiring more detailed psychiatric evaluation and prescription of medication (See Section on Telepsychiatry).

- Those with psychiatric emergencies like suicidal risk, severe agitation, catatonia, refusal of food or delirium would require personal evaluation in emergency settings with appropriate precautions related to COVID-19

Psychological interventions for mental health issues related to COVID-19

- Similar to other situations related to any disaster, most of the older adults are likely to have sub-syndromal mental health issues like anxiety and depressive symptoms related to the threat of COVID-19.

- This will require brief psychological and psychosocial intervention that can be delivered by any health care personnel, volunteers, etc with some guidance and training from mental health professionals (See Section on Simple Psychological Interventions).

- Older adults need reassurance that most of the mental health issues experienced in these situations are normal reactions to abnormal stress.

- They should also get appropriate information and clarification about various myths and false messages that are being spread through multiple unreliable sources.

- Guidance about maintaining a routine, physical exercise, Yoga, meditation, healthy diet, mental stimulation through home-based activities with appropriate safety precautions is essential.

- Brief relaxation exercises and supportive therapy can be done for those having severe psychological distress.

- Treatment by mental health professionals including medications and other interventions may be required for those with severe mental health disorders and emergencies.

Conclusion

It is necessary to bear in mind that older adults are more vulnerable both physically and psychologically to the COVID-19 pandemic. All stakeholders must work together to ensure their health and well-being.

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A7

Addressing Mental Health Issues among Pregnant and Postpartum Women during COVID-19

Introduction

Positive mental health is particularly important during pregnancy and postpartum. Currently, available literature has consistently shown an association between depression, anxiety during pregnancy and small for gestational age, low birth weight, and preterm delivery. During the postpartum period around 10-15% of women experience depression and anxiety. It has also been observed that postpartum depression is one of the reasons for poor bonding with their babies. In the current period of COVID-19 pandemic, even routine visits to health care facilities for antenatal care and infant immunization are likely to create a great sense of anxiety in mothers about their health and that of their unborn or newborn baby. It is thus a matter of priority to address these concerns to ensure positive mental health and early interventions for perinatal mental health issues.

Symptoms of anxiety and psychological distress during the perinatal period related to COVID-19

- Excessive worry about getting the infection even when all precautions are being taken and even after reassurance
- Lack of sleep because of anxiety
- Focusing excessively on social media messages about COVID-19
- Getting anxious about infection control procedures in family members
- Excessive worrying about missing work
- Feeling sad and angry because of isolation and not being able to meet family and friends
- Feeling nervous, anxious, or on edge
- Not being able to stop or control worrying

- Trouble relaxing
- Being so restless that it's hard to sit still
- Becoming easily annoyed or irritable
- Feeling afraid as if something awful might happen

Pregnant women and COVID-19 related worries

1. How can I prevent myself from getting the infection?
2. What will be the impact of the virus on my unborn baby?
3. Will my mother or husband be allowed to stay with me during delivery and later?
4. Will transportation be available if I go into labor?
5. Is it safe to go to the hospital for antenatal check-ups or scans?
6. Is excessive use of hand sanitizer safe during pregnancy?
7. Should I get tested for COVID-19?

Postpartum women and COVID-19 related anxiety and psychological distress

1. What if I get an infection, will I transmit it to my baby?
2. Is it safe to breast feed my baby?
3. Will my baby fall ill?
4. Is it safe to immunize my child?

General recommendation for pregnant women

- Remember that your mental health is as important as physical health for the adequate growth and development of your baby.
- Minimize watching, reading or listening to news about COVID-19 that causes you to feel anxious or distressed.
- Anxiety about the COVID-19 infection is normal at this time of pandemic and lockdown. But your mental health is important for the growth and development of your baby.
- Seek information only from trusted sources so that you can take practical steps to prepare your plans and protect yourself and your loved ones.

- Find opportunities to amplify positive and hopeful stories and positive images of local people who have experienced COVID-19. E.g. Stories of women who have had babies, persons who have recovered or who have supported a loved one and are willing to share their experience.

- Practice hand hygiene techniques frequently at home

- Exposure to COVID-19 can be prevented by following your doctor's advice. Most doctors are now discouraging women to come to the hospital and prefer advice over the phone. They will tell you how to get your scan and blood test done.

- Physical health during pregnancy can be sustained by maintaining an adequate diet which includes green leafy vegetables, protein, and carbohydrates.

- Continue Iron and Folic acid tablets prescribed by your doctor.

- Keep your contact only with persons near to you and who practice infection control.

- It is good to stay at your home and involve in pleasurable activities.

- Ask your doctor regarding sanitation practices at home.

- If you are concerned about your pregnancy, contact your ASHA (Mithanin/ JPHN) or ANM or obstetrician over the phone.

- If you are nearing your delivery, then keep your "Mother Card", emergency ambulance number ready.

- Please follow the instructions provided by your doctor regarding hospital visits.

- In case your doctor advises you to visit the hospital, then try not to touch any surface in the hospital.

Perinatal mental health of pregnant women under psychiatric care

A pregnant mother who has a preexisting mental health problem and is already under psychiatric care needs to take all the precautions as mentioned above. Besides, the following steps might help in reducing your concerns about your psychiatric condition as well as protect against exposure to the COVID-19 virus.

- Avoid hospital visits. If required, you can call your psychiatrist. In India, you can contact the NIMHANS Perinatal Mental Health Helpline Number (8105711277) or any local telephone helpline for mental health issues.

- Medications prescribed by the psychiatrist can be refilled at the local hospital or pharmacy.

- Not to stop psychiatric medications at any point in time without advice from your psychiatrist.

- If you are in the 3rd Trimester or nearing for your delivery, please contact your doctor/obstetrician and inform regarding the expected date of delivery.

- Do not stop your medication during the postpartum period without the advice of your psychiatrist. Your medications might need to be optimized during the postpartum period. You can call the helpline if you have any concerns.

Perinatal mental health of postpartum women under psychiatric care

Postpartum mothers who breastfeed their infants need to follow all the steps mentioned in the section on pregnant women. In addition to the above, the following steps might help you.

- Based on the available data, human breast milk is negative for the COVID-19 virus even if the mother had COVID-19.

- The benefit of breastfeeding outweighs any potential risk of transmission of the virus through breast milk

- For women wishing to breastfeed, the following precautions should be taken to limit viral spread to the baby:

    - Hand washing before touching the baby, breast pump or bottles

    - Try and avoid coughing or sneezing on your baby while feeding at the breast

    - Consider wearing a face mask while breastfeeding, if available

    - Follow recommendations for pump cleaning after each use

    - Consider asking someone who is well to feed expressed milk to the baby

- Call the NIMHANS Perinatal Mental Health Helpline Number (8105711277) or any local telephone helpline for mental health issues if you have any concerns about your mental health.

- Regarding the immunization of your infant, please talk to your pediatrician.

Role of partner and family

- It is important to support the pregnant and postpartum mothers during the COVID-19 pandemic and lockdown.

- Partner and family need to follow the social distancing as prescribed by the authority.

- Prepare yourself for an emergency hospital visit in case of emergency or delivery.

- It is important to keep the good mental health of you to help the mother in this situation.

· In case you need help regarding your mental health, you can visit our website E CONSULT @ COVID-19 available at http://vlc.nimhans.ac.in/?page_id=4045or consult any psychiatrist accessible to you.

· In case you need help regarding the mental health of your pregnant or postpartum partner, visit our website https://www.perinatalpsynimhans.org/

Conclusion

Addressing perinatal mental health issues is critically important for both the mother and the baby. Given the likelihood that mothers during the COVID-19 outbreak are likely to experience heightened distress, identifying and addressing these should be a high priority for health care providers.

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A8

Challenges Faced by People with Disability in a Pandemic

Pandemics, such as the current COVID 19 pandemic, fundamentally disrupt human existence, and affect persons with disability (PwD) disproportionately. Some PwDs might require help for basic activities of daily living (ADL) while others may be more independent but find it difficult to navigate new rules that a pandemic response demands. Their family caregivers also face more challenging situations – from the breakdown of a usual routine to increased facetime with their ward (due to lack of other activities to engage them) that a quarantine-like situation imposes on the family; worries about the financial and healthcare ramifications of any one of the family falling ill may be prominent concerns. Interpersonal issues between family members may experience a rise, and this may be complicated by the unavailability of a number of routine services to address them. In addition, essential caregivers may be unavailable to people with high support needs due to quarantine conditions.

PwDs are just as vulnerable to anxiety, apprehensions, sadness and grief, irritability, sleep disturbances and withdrawal as their non-disabled peers. These are common reactions, but they may be qualitatively or quantitatively different, depending on the type of disability and age of the PwD. Persons with intellectual and developmental disabilities, especially, may require assistance in understanding the current crisis and consequent disruptions to their routine lives. They will also require assistance in adhering to recommended hygiene measures. Caregivers may need to assist them in these and other activities. Whilst doing so, one should not compromise on hygiene measures themselves. Caregivers may find it difficult to effectively manage boredom experienced by PwDs; addressing their own anxieties while reassuring their loved ones may be more challenging.

Presentation of symptoms heralding the onset of a mental health condition may be different in those with developmental disorders. Sudden changes in sleep and appetite along with acute behavioural changes may be early warning signs for a worsening of a pre-existing condition, or the onset of a mental health disorder to be diagnosed. Persons with psychiatric disabilities, including those with anxiety and depressive disorders, may experience higher levels of stress and even panic during the situation.

PwDs need to deal with certain apprehensions and fears that a mental health professional (MHP) must be aware of. The thoughts and feelings unique to PwDs include

a. Thoughts of being a burden

b. Fear about their caregiver falling sick

c. Fear that they may be marginalized further during rationing of supplies or care

d. Sadness regarding feeling dependent on caregivers especially the elderly

e. Thoughts of being worthless, as people do not look up to them or expect them to contribute during difficult times

f. Thoughts of being left out of decision-making process

g. Worries about financial security

h. Worries about job security when things start to resume

Similar concerns may be expressed by caregivers, especially when there are fewer members to share care-giving duties with. Stigma (internal and external) may be exaggerated during pandemics. Other concerns may include limitations to information or healthcare access. professional caregiving access, and logistic issues. These concerns are enhanced when the prospect of quarantining looms, especially when such supports may not be available in general quarantine facilities.

Some issues which disproportionately affect PwDs are,

- Access to welfare benefits and emergency support (financial and non-financial)

- Access to essential supplies, and basic requirements such as potable water, food and sanitation

- Access for non-emergency healthcare needs such as blood transfusion among persons with blood disorders, review of medicine side effects/ symptom status

MHPs need to adapt to the available resources, needs and contexts, and use technology deftly in times of disasters. Service provision at such times must aim to ensure and maintain best possible health outcomes / status for which MHPs must take proactive steps; more so for PwDs.

Such steps can be categorized into 3 broad domains:

1. Continued access to healthcare and basic needs

- Ensuring delivery of necessary items to households or places where PwDs reside, especially where there are PwDs with high support needs, should form an important part of the disaster response, and mental health professionals should prioritise facilitating access to these with the help of various NGO or governmental organisations.

- Ensuring facilities available to a person with high support needs in the event of them falling ill, or their caregiver being quarantined due to COVID 19 are continued as much as possible. In such a situation, health professionals and frontline personnel may play crucial roles in guiding decision making and delivering interventions.

- Telemedicine may allow us to overcome access barriers during quarantine situations. Innovative service delivery ought to include provision of psychosocial interventions alongside prescriptions; strategies for home-based rehabilitation must be included.

2. Continued access and uptake of welfare provisions and or emergency supports

- Government agencies can aid the situation by pro-actively preserving and delivering benefits access in such a situation, such as advance payments of pensions and ensuring quick access to services. Continued service delivery may have beneficial impacts on reduction of post disaster morbidity and disability.

- Re-evaluate certification processes for PwDs to allow for more online or video-based assessments, in order to preserve access. Systems should adapt to include measures for ad hoc / temporary certifications so as to ensure adequate financial and non-financial supports. This is in consonance with sections 8 and 24 of RPWD act.

- Carer health is also imperative and should be proactively monitored by mental health professionals.

3. Access to information regarding health promotion / maintenance during a disaster

Accessibility during service provision must be ensured for PwDs with different needs via accessible electronic formats of information, accessible communication, and structural access. This can be addressed at multiple levels - MHPs can aid in disseminating safety and promotive health knowledge; specifically, they can help in tailoring information to PwDs' functional limitations.

How a psychosocial support provider (counsellor) may help:

1. Use techniques of active listening (in accessible formats, particularly for those with hearing impairment) to convey a message that he/she is interested in understanding the distress of the person

2. Acknowledge the distress and show empathy

3. Provide general mental health advice, which is common to persons without disabilities – these may be derived from programmes which are being run for the general public

4. Provide specific advice which is unique to the PwD in terms of his/her disability as well as context

Refer them to support groups if they exist and are accessible during the lockdown period, particularly groups which have online or phone-based supports were available.

Some recommendations to the system in terms of different disabilities are listed below,

Recommendation to the system:

1. General to all disabilities:

    a. All plans and programmes should be inclusive, with specific attention to the needs of and challenges faced by PwD. E.g.,

        i. Public communication and education materials should be accessible to PwD with different challenges

        ii. Quarantine facilities should be cognizant about challenges faced by PwD

        iii. Helplines should be accessible to persons with different disabilities

2. Specific:

    a. Developmental disabilities:

        i. Specific efforts should be taken to communicate the significance of the pandemic and measures to prevent infection

        ii. Specific activities should be planned to address boredom and disruption in daily routines

        iii. Mental healthcare helplines which address specific needs of PwDD/PwID may be set up

    b. Psychosocial disabilities (disability due to mental illness):

        i. Distress, anxiety and panic is likely to be higher in them. Helplines to address these should be set up

        ii. Measures should be taken to ensure continuity of medications in those who need them

    c. Hearing impairment:

        i. Masks make routine communication difficult. Alternatives including transparent masks should be considered by people communicating with PwHI

ii. Face-to-face communication may be reduced due to risk of infection – text-based communication should be preferred

iii. All mass communication should be made accessible for PwHI

d. Visual impairment:

i. As they may rely a lot on touch-based activities, measures of hand-hygiene should be facilitated specifically for them

ii. Specific stress should be given to sanitize assistive devices used by them

iii. The onus of social distancing should be on others, as PwVI cannot do that on his/her own

e. Locomotor impairment:

i. Accessible hand-hygiene facilities should be provided: accessible wash basins and/or liberal supply of hand-sanitizers

ii. Specific attentions should be given to sanitize assistive devices including canes, crutches, wheelchairs, handrails, particularly in public spaces

f. Blood disorders and neurological disorders: Extra support should be given by caregivers in accessing health services. Specific measures to prevent infection with coronavirus should be taken, as they may be more at-risk population.

Discrimination of PwDs in treatment protocols of COVID-19

One area in which requires more focus is the scrutinization of disaster protocols which may be discriminatory to persons with disability. PwDs have a higher chance of experiencing severe respiratory illness and suffering from additional co-morbidities. Emergency operation guidelines use for COVID-19 by certain states of the USA have designated persons with severe intellectual disability to be poor candidates for ventilatory support. The one used by the State of Alabama has emphasized that decisions should be guided by premorbid function and expected level of recovery rather than by diagnosis. This demonstrates the needs for mental health professionals to ensure that protocols in India preserve and protect the right of PwDs in line with international conventions and national laws.

Conclusion

PwDs may face multiple challenges during the COVID-19 pandemic. Policy makers and health care professionals should ensure continued delivery of vital services, help preserve access to benefits, and guide advocacy to preserve the rights of PwDs.

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A9

Psychological Issues of Frontline Personnel Combating COVID-19

COVID-19 presents the front-line of a new uncertain battle for the human race. Thousands of health care personnel, police and government officials are working round the clock to confront it head-on. While this has recently been highlighted across the world, little has been offered to ensure their mental health and well-being. Most people working in health care emergencies are likely to experience some stress. Some of them may experience distress to the point of not being able to carry on. They require help. It is critical to ensure that those in need are identified early and offered an appropriate intervention.

The commonest disabling mental health issue experienced by personnel in the front-line of any pandemic is “burnout”. Described classically as a triad of emotional exhaustion, depersonalization (loss of one's empathy, caring, and compassion), and a decreased sense of accomplishment. These may exist in varying degree or one symptom can predominate. Burnout can have a significant impact on competence and can impact health care delivery.

Risk factors for burnout

- Long working hours
- Worry about risk to self and family
- Concerns about inadequate personal protection materials
- Separation from family/loved ones
- *Pre-existing mental health & addiction issues*

How to prevent and combat burnout?

Self-care

All personnel in the front line should be made aware of the principles of self-care. Self-care includes those activities to promote our emotional, physical, relational, and spiritual/religious wellness. These include the following:

- Have a routine
- Ensure breaks and adequate sleep
- Keep in touch with relatives/friends
- Carry out some activities and hobbies unrelated to work
- Exercise regularly and have a healthy diet
- Practice relaxation exercises like yoga
- Religious activities (if you are a religious person)
- Make time for yourself and your family

In most emergencies the work schedule is hectic, and hence carrying out all activities may not be possible but team leaders should ensure that at the least, health workers get their breaks and facilitate regular contact with friends/family.

Team Leaders/Supervisors

To reduce the stress of the health care workers, team leaders are encouraged to:

- Focus on the long-term, ensure as much as training for their staff to fulfil roles
- Mix and match, ensure that juniors with limited experience work with their senior colleagues
- Ensure staff rotation from jobs of higher stress to lower stress and vice-versa
- Duty/shift breaks/holidays to be agreed within the team and ensured as far as possible
- Ensure good quality communication with accurate information updates
- Have regular team meetings even if its brief. It helps to develop a 'bond' and to also sort out issues that may emerge because of working in stressful situations

- Team meetings may also be used to discuss common mental health issues that arise out of working under difficult circumstances (stress, burnout, anxiety, fear, etc.) and simple steps for psychological 'self-care'

- In the event of unfortunate outcomes like death, ensure that the team has an opportunity to "debrief". In addition to the factual aspects related to the event, team members may be encouraged to share their emotions which may include guilt, anxiety, and distress.

- A flexible schedule may be considered for any person who has been directly impacted in some way or has an affected family member

- If a team member is experiencing mental health difficulties, provide for a 'buddy'. The 'buddy', can be a senior colleague/workmate, who may be expected to talk and listen and provide common sense suggestions for mental health care. They can also be asked to report back if things deteriorate. 'Buddy' should be made aware that all matters discussed are strictly confidential and to be shared only on a 'need to know' basis.

- All staff to be made aware of the nearest specialist mental health service and access to its services.

- Lastly, refer to any staff member who appears to have uncontrollable distress for assessment and intervention to the nearest specialist mental health service.

Indications for referral for mental health assessment

In most cases, mental health issues are self-limiting. But it is not uncommon for some personnel to show more severe and persistent mental health symptoms which may require immediate assessment and specialised intervention.

The common among them are:

- Expressing suicidal ideas

- Violent/aggressive behaviour

- Uncontrolled use of alcohol/drugs

- Crying or expressing uncontrollable distress

- Unexplained bizarre behaviour like talking or smiling to self

- Significant deterioration in occupational functioning

Specific Issues in Pandemics

Medical personnel in Quarantine

There is an increased risk of health-care workers themselves being infected or quarantined. In addition to stress-related to quarantine, most experience increased concern that their absence will create more understaffing issues. They may also experience guilt and fear that they may have infected their team, family and other patients. A sudden separation from their team also means an increased likelihood of experiencing more social isolation. It is essential that staff in quarantine feel supported by their immediate colleagues. Team leaders should ensure that staff under quarantine are kept in regular social contact.

Life and death decisions

Doctors and team heads working in the frontline of pandemics often have to make difficult and consequential choices. This may include issues related to withdrawal of care or differential allocation of sparse resources like ventilators and having to explain the decisions to affected families. Frontline personnel making these choices may be better served to discuss these decisions in a group or with colleagues. On occasions, professionals may be alone and if they are feeling overwhelmed, then discussing their emotions with a close friend or family may help. At all times, professionals must remain aware of the legal and ethical obligations of protecting patient confidentiality.

Stigma

Personnel working in hospitals in times of pandemic often experience stigmatising attitudes from the general public. Most may experience hurtful social distancing at their place of residence, local groceries or place of worship. Friends and relatives may show reluctance to interact with them. There have been instances of landlords denying residential accommodation to healthcare workers. In rare cases, there can be concerns about physical safety.

The organisational leadership should not be dismissive of these aspects and ensure the safety of their staff. They should encourage staff to remain connected to their friends/family through digital methods. Policymakers should implement local programs of “honouring front line personnel” and acknowledge their role using various media platforms. All staff should be sufficiently informed on means to access mental health and psychosocial support services if required.

Conclusion

Almost all frontline personnel in pandemics like COVID-19 are likely to experience stress to a certain degree. Steps need to be taken proactively to ensure that it remains in control. Personnel should practise 'self-care'. Team leaders should employ steps to minimize mental health difficulties. Administrators should be aware that the mental health support of personnel is an important part of the COVID-19 response. Most importantly, personnel requiring help should be identified and offered appropriate intervention to prevent negative consequences.

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A10

Allaying Anxiety of the Worried Well

The COVID-19 Pandemic is likely to evoke questions in the minds of a vast number of people across the globe due to its high degree of communicability and a greater fatality rate compared to many other flu-causing viruses. The condition does not have specific medications at present and there are no vaccines developed to date. The only methods to avoid contracting the illness are through hand-washing/hand sanitising, social distancing, etc. These measures would help to prevent the spread of infection to a great extent. However, many people would start "worrying" if they would contract the illness.

Case Study

A 60-year-old lady consults a physician with dry cough of one-month duration and no other symptoms. The physician explores other symptoms such as fever, breathing difficulty, etc. On examination, the respiratory system was found to be normal. The physician explains that this is probably an allergic dry cough and prescribes the required medications. However, the patient requests for the COVID-19 test to be done to confirm that she is not suffering from the deadly illness. She is worried that she might have contracted the illness and that she is at a higher risk of developing complications due to her advanced age. The physician tries to reassure her and explains that the nature of her symptoms does not warrant further investigations. The patient continues to express worries and appears overtly concerned about her health. The above person mentioned in the example may be considered to be suffering from a "worried well" condition. It is common to find several individuals worrying during pandemics.

Who are the "Worried Well" ?

They are healthy persons with less severe problems or those with intermittent concerns about their health. These individuals generally complain about symptoms about a particular potentially undiagnosed illness. They may wonder if these vague/non-specific symptoms represent the presence of a significant disease.

Worried Well – Issues for the public health system

- Overburden the already over-stretched health-services.
- Are at high risk of getting infected by repeatedly accessing the health services.
- Render it difficult for health-care workers to prioritise more seriously ill.
- Excessive and exaggerated worries frustrating to the treating physician.

How to manage the "Worried Well" in the COVID-19 clinic?

- Do not turn them away or dismiss their problem
- Make them "feel understood" – first listen to their symptoms in detail and conduct a thorough physical examination
- Provide them with correct and authentic clinical information about COVID-19
- Point the discrepancy of the symptoms with which they present and symptoms of COVID-19 in a non-argumentative manner
- Acknowledge that their fears are understandable in the context of the pandemic's magnitude (Validation). This is a crucial aspect to establish a therapeutic alliance and gain trust.
- Do not provide repeated reassurances or multiple referrals
- Relaxation (please refer to the section on Simple Psychological Therapies for details)
- For subjects with significant anxiety and sleep disturbances, a short course of anti-anxiety drugs may be considered if there are no other medical contraindications. (Alprazolam or Clonazepam 0.25-0.5mg OD/BD may be given for one week and tapered off.). However, efforts must be made to avoid medications and manage them only with education about COVID-19, reassurance, and support.

For severe and disabling anxiety unresolved with the above steps, consider referral to a psychiatrist for detailed assessment including consideration of long-term medications.

Conclusion

In a situation such as the COVID-19 pandemic, "worried-well" may be a paradox to the treating physicians and the health system in general. It is important that these people are understood and engaged with health-care professions so that their anxieties are addressed appropriately. They should also be empowered to be advocates of their health and well-being. Timely referral to psychiatrists for severe health anxiety should be considered.

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A11

Social Stigma with COVID-19

Social Stigma can occur in disease outbreaks when a specific disease is associated with any group of individuals. As a result, these people are likely to get labelled, stereotyped, stigmatized, bullied, racially discriminated and experience loss of their status. This can negatively affect them, their families and their relatives. The recent outbreak of COVID-19 has caused a lot of fear and panic about the disease. There is a lack of understanding and uncertainty regarding COVID-19. People have misconceptions that it has been associated with a certain group of individuals alone. The Social distancing that is advocated as a preventive measure to control the spread of COVID-19 can be misconstrued and easily manifest as social discrimination. The social stigma in India with COVID-19 has been currently based on racial profiling, infectious status, and occupation.

Racial Profiling

In the west, people of Chinese descent have been targeted as COVID-19 has been associated with China. In India, people from the North-east have been targeted. There are numerous media reports of north-east students being called as 'Coronavirus' and spat upon in public because they 'resemble people from China / South-east Asia'. Stigmatizing ideas are also being shown through social media. People from north-east who are being targeted include tourists, migrant workers and students. This has led to an increase in discriminatory behaviour both in public and in social media.

Health Professionals

Health professionals in the frontline of duty treating COVID-19 patients are now facing social stigma. Doctors and hospital support staff are now being distanced as people fear that they will get the infection from them. There are cases where health care professionals are being harassed by their landlords to vacate their homes and now are on the streets. Some of them are also victims of physical abuse for coming on the streets during the lockdown period of COVID-19.

People in quarantine or people with COVID-19

People with coronavirus infection or possible infection can get stigmatized by the words we use to describe them such as 'suspected case', 'victim' etc. These words can further induce fear, sadness and

make them feel unsupported. Similar stigma and discrimination could occur to those who have just recovered or returned from treatment of COVID-19. People in quarantine, all those who just have non-COVID-19 respiratory symptoms or infection and relatives of such individuals can all be subject to stigma and discrimination. The same can also occur to anyone who is in grief following the death of a loved one due to COVID-19.

Consequences of Stigma

- Preventing people from seeking help for COVID-19 when they need to
- Even if they have symptoms they tend to hide illness to avoid discrimination
- Families of medical professionals may pressurize them to quit jobs
- Demotivate frontline personnel from carrying out responsibilities

Stigma due to Covid-19, thus can pose a serious barrier to help seeking, that could lead to disease spread among the population.

What can be done?

- DO talk about the disease (COVID-19), But DO NOT use terms such as 'Wuhan virus/ Chinese virus etc'.

  SOCIAL DISTANCING is not to be confused with SOCIAL DISCRIMINATION. Its okay to stay safe by keeping a distance of 1-2 meters. Treat everyone as human with equal status and opportunity.

- DO talk about people with COVID-19, or people recovering from COVID-19, or people who may have COVID-19. DO NOT use 'COVID-19 or COVID-19 suspect'
- DO talk about people acquiring/contracting NOT people infecting/spreading the infection. This means that somehow, we may attach a deliberate intent of spreading the infection that can further induce stigma.
- DO TALK positively about the situation. DO NOT use terms such as infection resembles a plague or apocalypse or world is about to end etc. DO NOT share or repeat rumours.
- DO talk about the effectiveness of preventive measures and that for most people this is a disease that can be overcome. DO NOT dwell on the negatives or messages about the threat it poses.
- Correct misconceptions and do not encourage false propagation

- Encourage the importance of prevention and early screening

- Share sympathetic stories and narratives of struggle about those who have had COVID-19

- Communicate support and encouragement to frontline workers in this emergency (health care workers, doctors, volunteers, and community leaders)

Conclusion

Social stigma increases during infectious disease outbreaks and is often not given the emphasis required. Steps need to be taken at all levels to ensure that stigmatising behaviours are strongly discouraged. A failure to control stigma will impede and slow disease control response.

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A12

Handling Domestic Violence during Pandemics

Why is it necessary to address?

Pandemics like COVID have significant impact on individuals, families and countries. Persons not only have to deal with consequences of infection but also have to deal with measures taken to contain the infection like quarantines, social distancing and lockdowns. Individuals face issues related to health, finances and security concerns and these can impact their mental health and their relationships. Since there are curbs on the movement of the individuals, persons who are in abusive relationships face challenges as they are likely to be in close confined spaces with the perpetrators and may have difficulties in getting the timely help .

UN WOMEN have reported rates of increased violence against women and children more so girls in the COVID-19 times. Hence it is important to address this issue as it can lead to further crisis and probably secondary trauma

What happens to violence during pandemics /social isolation/lockdowns and why conflicts increase?

- Violence is likely to increase as the persons are likely to be in close confined spaces during the lockdowns
- Financial crisis due to lockdowns may lead to increased conflicts
- Substance related issues in the perpetrators
- Reduced opportunities to go out and seek help for violence
- Non availability of services for violence during the pandemic such as shelters or one stop centers and difficulty reaching them due to lockdowns

How can violence manifest?

Violence manifests in different forms like physical, emotional, sexual and often only physical violence gets highlighted.

- Psychological violence in the form of controlling behaviors like not providing financial support, not allowing to participate in health seeking behaviors, putting the person at risk for contracting the infection, not allowing the persons to use telephones or mobiles

- Emotional violence includes – name calling, threats of harm, rebuke, humiliating in front of others

- Physical violence in the forms of hitting, kicking, slapping and using weapons to cause physical harm

- Sexual violence in the form of non-consented sexual intercourse, not using or not allowing to use contraception and thereby increasing unwanted pregnancy as well as sexually transmitted infections.

- Pregnancy related violence

- Violence extending to older adults, children or pets

Simple Tips for families

- Encourage members to have separate times and together times

- Be aware when conflict is escalating so that they give each other emotional space

- Don't dwell on the small stuff

- Lower your expectations from each other so that quarrels are reduced

- Plan your day – Restart hobbies, exercises, work to reduce times for conflicts

Make available in health settings/public domain about violence and avenues to seek help – public information makes people more aware of their own conflicts

What can health professionals do? Suspect violence when they see persons with injuries (may be unexplained), unexplained physical symptoms or mental health consequences like anxiety, psychological distress, deliberate self-harm attempts.

Screening questions

The Questions need to be framed and asked in a sensitive manner. Please conduct the interview in safe place. Ensure confidentiality

1. Begin with the following statement- We generally ask about family life and relationships as they affect an individual's health

2. Have you been having facing any trouble in your close relationships?

3. Do you have any arguments/conflicts at home?

4. How are they generally resolved?

5. *Have you been subjected by anyone in in your close relationships to any form of ridicule, humiliation that has made you feel upset?*

6. *Have you been subjected by anyone in in your close relationships to any form of threats of harm, hitting, slapping or kicking that has made you feel upset?*

If answer is Yes, to questions 5 & 6 you can then ask

- Can you talk more about it?
- Allow the person to express their feelings
- Do not interrupt when they are expressing their concerns
- Validate their feelings
- Be non -judgmental

LIVES is a psychosocial approach that has been formulated by World Health Organization (WHO) that can be used as First aid for woman who are facing intimate partner violence or any other forms of domestic violence. This has been adapted in this chapter to address the immediate needs of any person who is exposed to domestic/intimate partner violence.

- LISTEN - Listen to the person closely, with empathy, and without judging.
- INQUIRE ABOUT NEEDS AND CONCERNS

  Assess and respond to various needs and concerns—emotional, physical, social and practical (e.g. childcare)

- VALIDATE

  Show that you understand and believe the person. Assure the person that he/she is not to blame.

- ENHANCE SAFETY

  Discuss a plan to protect the person from further harm if violence occurs again.

- SUPPORT

  Support the person by providing access to information, services and social support.

Issues in Discussing IPV in tele sessions with women

With the lock down and restriction, accessing health services is a challenge during the COVID times. Tele medicine and teleconsulting has been considered as an option of providing services to client

There are some concerns related to discussing violence during tele session

- Ensuring privacy is a challenge
- The perpetrator might to in the same space and there is possibility of escalation of violence
- The client might not be able to discuss the details of violence
- Health professionals may not be able to examine for injuries

So what can be done? Before asking, check with the person if someone is nearby, ask to respond only in yes or no. If the person says no one is around, give a code word that can be used when the person feels unsafe during the conversation or when someone is nearby- like the name of a fruit or vegetable. If there is an imminent threat of violence or continued violence, ask if the person has any support or can move to a neighbor/friend.

If there is an imminent danger of violence to the client, please direct them to contact the nearest police station (Police helpline Phone 1091) or Government of India (National commission for women-domestic violence help-line) (Phone No.181).

Conclusion

People in abusive relationships face challenges during lock-downs and restrictions in movements (as in COVID-19) as they are likely to be in close confined spaces with the perpetrators and may have difficulties in accessing help. Frontline personnel need to be aware and if required explore sensitively and offer timely support to the victims.

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A13

Management of Alcohol Use & Withdrawal Syndrome – In COVID-19 Treatment Settings

Introduction

Alcohol use and dependence are common in the community. In a majority of cases, people use alcohol in moderation but it is not uncommon to see people who have difficulty in controlling alcohol use. **Among them, those using alcohol hazardously (pattern of alcohol use that increases the risk of harmful consequences for the user) benefit from brief psychological interventions.** In many individuals with heavy daily use of alcohol, a sudden reduction or cessation of alcohol use can lead to the emergence of an alcohol withdrawal syndrome (AWS). **Therefore, in any COVID-19 treatment setting, when any patient reports a gradual increase in restlessness, tremors, and sleeplessness, it is important to ask for a history of alcohol use**. In a majority of cases, the withdrawal is mild and requires only supportive care. However, in a certain number of cases, there is a potential to develop life-threatening complications such as seizures and delirium.

This primer provides guidance for brief psychological interventions for hazardous alcohol use and identify and treat cases with both uncomplicated AWS and complicated AWS (seizures or delirium).

Brief Intervention for Individuals with hazardous alcohol use

In individuals using alcohol hazardously, brief interventions help to identify problems with alcohol use and bring about change in alcohol use behaviour. FRAMES is a typical example of a brief intervention for alcohol use. Brief interventions can be provided in 5-15 minutes over 1-4 sessions and have proven effectiveness for reduction of alcohol use.

- **Feedback of personal risk**

After clinical assessment and investigations, clearly inform the patient about his pattern of substance use and existing or potential harmful effects.

For eg: *"Your drinking is going to worsen your stomach pain"*

- **Responsibility**

Inform your patient that decision about making a change in substance use is their responsibility and choice solely.

For eg: *"Now it is up to you to take a decision on drinking"*

- **Advice**

As a doctor, give clear advice to reduce drinking and other drug use. Ask your patient to make a balance sheet. Ask about the advantages and disadvantages of drinking. Make the patient see that the disadvantages of using are much more than the advantages of using and the advantages of stopping are greater than the disadvantages of stopping. Clarify any worries or doubts the patient may have about stopping.

Balance sheet		
	Advantages	**Disadvantages**
If I continue drinking	I can forget worries I can escape responsibilities	I am having more family fights I am having health problems I am spending much more Everyone is looking down upon me My work is suffering I had an accident because of this My health is going to get worse if I continue
If I reduce drinking	My health will improve I will save money I will not injure or harm myself	I will find it difficult to pass time I will miss the pleasure of using I will lose friends
If I stop drinking	I can be like others I can get more respect My health will improve I will make more friends I will save money My family will be happy I will be able to work better	I may lose my friends I am afraid of withdrawal symptoms

- **Menu of alternate choices**

  - o Recognising and avoiding trigger situations (hunger, anger, tiredness, loneliness, peer pressure to use, seeing substances/users, being in situations previously associated with use)

  - o Planning ahead to limit drinking or use of the substance

- Learning to cope with everyday problems that encourage drinking or use of the substance
- Finding alternate sources of enjoyment
- Dealing with stress, anxiety and mood symptoms

- **Express empathy**

  Do not belittle or criticize. Do not refer to the person as an addict/alcoholic directly or to family members/while discussing with others. Acknowledge that substance dependence is a problem that can be difficult to overcome, but can be with some effort and help)

- **Self-efficacy**

  Encourage patient to be optimistic and to bring about the changes in drinking/substance use behaviour

Alcohol withdrawal (Uncomplicated)

If there is a pattern of daily drinking particularly with early morning drinking, the treating professional needs to assess for signs and symptoms of alcohol withdrawal.

Signs and Symptoms (Emerge within 6 to 12 hours after last drink and reduce by 7 to 10 days):

They include:

- Autonomic hyperactivity – Increased pulse rate and blood pressure, sweating
- Tremors – Fine or coarse (Depending on the severity of withdrawal)
- Insomnia
- Nausea or vomiting
- Psychomotor agitation
- Anxiety

Evaluation

- Ask for a history of alcohol use, specifically daily use/early morning drinking, recent pattern of use and last use of alcohol
- Ask the patient for symptoms of alcohol withdrawal and concomitant medical problems, especially head trauma, infections, gastro-intestinal bleed and hepatic disease and concomitant use of drugs

- Conduct a thorough physical and neurological examinations (hydration status, PICCLE, hepatosplenomegaly, focal neurological deficits)

- Investigations (when available)– Random Blood sugar, Liver function tests, Renal function tests, Hematology (MCV, Hb, TLC), ECG (>40yrs) and chest X-ray for all patients

Management

General Measures:

- Nutritious diet

- Correct dehydration & electrolyte disturbance (oral or iv)

- Thiamine (100 mg) or Multivitamin (Containing B complex vitamins) injection IM for seven days followed by oral supplementation (two to three tablets a day) for three months

- Proton pump inhibitors for 7 to 10 days

Specific Measures:

- Tab. Diazepam 40 to 60mg in divided doses to be tapered over 7 to 10 days (5 to 10 mg every 2 days)

OR

- Tab. Lorazepam 8 to 12mg in divided doses to be tapered over 7 to 10 days (1 to 2 mg every 2 days)

Example of a tapering regimen for Diazepam or Lorazepam in an individual with uncomplicated AWS

Diazepam 10mg 2-2-2 x 2 days	Lorazepam 2mg 1-1-1-2 x 2 days
1-1-2 x 2 days	1-1-2 x 2 days
1-0-2 x 2 days	1-0-2 x 2 days
0-0-2 x 2 days	0-0-2 x 2 days
0-0-1 x 2 days and STOP	0-0-1 x 2 days and STOP

Precautions (if in the community)

- Advise not to drive vehicles, work at heights or operate heavy machinery

- Advise not to use benzodiazepines and alcohol concomitantly

- Advise to stop medicines if the patient has excessive drowsiness and risk of falling down

- **Report to the hospital if the patient develops seizures or becomes confused or agitated despite treatment**

Alcohol Withdrawal Syndrome – Complicated

Signs and Symptoms

Presence of alcohol withdrawal signs and symptoms PLUS

- Seizures (Generalized tonic-clonic seizures semiology, peak occurrence of seizures 12-24 hours of stopping alcohol)

- Delirium Tremens (confusion, agitation, visual and auditory hallucinations, peak occurrence is 24-72 hours of stopping alcohol)

Evaluation

- Check for alcohol use pattern, past history of similar episodes, known medical comorbidities

- Look for and document other signs of alcohol withdrawal

- Physical and neurological examination – hydration status, external injuries, icterus, hepatosplenomegaly, pupillary reactions, extra-ocular movements, reflexes, gait, meningeal signs

- Check for orientation to time, place, person, consciousness, agitation, violence, delusions, hallucinations, mood changes and suicidal ideation, attention and memory deficits.

- Investigations: Electrolytes, Random Blood sugar, LFT, RFT, Hematology (MCV, Hb, TLC, Platelet count), ECG (>40yrs), Chest X-ray are mandatory.

- CT-Brain with contrast to be done if possible, to rule out other CNS causes of seizures or delirium when suspected.

Management

General Measures

- Keep NPO if the patient is confused or in altered sensorium

- Monitor Vitals frequently: Pulse, BP, RR and Temperature

- Maintain airway

- Secure IV access

- Check hydration status and replace with IV Fluids (if required)
- Correct electrolyte imbalances (Oral or IV)
- High dose multivitamin supplementation (B complex such as Optineuron or Neurobion) 15 ampoules in 500 ml of NS over 4 hours once a day for 7 days
- Proton pump inhibitors/Anti aspiration measures

Specific Measures

For acute control of seizures

- Give IV diazepam 5 to 10 mg OR IV Lorazepam 2 to 4 mg initially and repeat if necessary, at 10 to 15-minute intervals (inject slowly, taking at least 1 minute for each 5 mg given).
- Monitor for development of Delirium Tremens

For delirium tremens (Ideal Management)

- Should ideally be managed in ICU setup with cardio-respiratory monitoring
- Under monitoring by the clinician, IV Diazepam 5 to 10mg every 10 minutes or IV Lorazepam 2 to 4mg every 15 minutes is given until mild sedation is achieved.
- **If there is a failure to achieve mild sedation** even with a dose of 50mg of Diazepam or 10mg of Lorazepam within the first hour OR 200mg of Diazepam or 40mg of Lorazepam in 3 hours, it could be refractory delirium tremens; please refer to an intensivist.
- **If mild sedation is achieved:** Repeat doses of Oral/IV Diazepam or Oral/IV Lorazepam every 4 hours to maintain mild sedation for the next 5 to 7 days.

For delirium tremens (Lesser monitoring facilities and resource-poor setting)

- If LFT is normal, with regular vitals monitoring, Diazepam 10mg hourly oral to be given, till the patient is sedated and PR < 100/min. Average dose between 100 – 200mg may be required in some cases. Total dose required on Day 1 is calculated and given in divided doses from Day 2, tapered and stopped over 7 to 10 days.
- If AST and ALT > 3 times normal values, with regular vitals monitoring, Lorazepam 2mg hourly oral to be given, till the patient is sedated and PR < 100/min. Average doses between 16 – 24mg may be required in some cases. Total dose required on Day 1 is calculated and given in divided doses from Day 2, tapered and stopped over 7 to 10 days.

Precautions to be taken

- **DO NOT REPEAT DOSES OF DIAZEPAM OR LORAZEPAM IF PATIENT IS HEAVILY SEDATED/NOT AROUSABLE/COMATOSE**

- **AVOID USING ANTIPSYCHOTICS (SUCH AS HALOPERIDOL) BY PARENTERAL ROUTE AS FAR AS POSSIBLE SINCE IT INCREASES RISK FOR ARRHYTHMIAS IN DELIRIUM TREMENS**

Plan to refer to a specialist:

- Refractory seizures

- Delirium persisting after treatment with adequate benzodiazepines as instructed above

- Presence of more than one uncontrolled medical comorbidities (such as head injury, Diabetic Ketoacidosis, Hepatic Encephalopathy)

Conclusion

Alcohol use is common in India. Therefore, when patients present with restlessness and tremors, one of the possibilities to be considered is whether it represents alcohol withdrawal. AWS is eminently treatable and can be managed by physicians from different settings. Prompt identification and management of AWS can lead to a significant reduction in morbidity and mortality particularly in cases with seizures and delirium tremens. Treatment of choice for the management of AWS is **benzodiazepines** (Diazepam or Lorazepam are commonly used) and should be used in **adequate doses.** Multivitamin supplementation in appropriate doses is mandatory for all cases of AWS to reduce the risk of neurological complications. Referral to higher centres needs to be considered when there is a requirement of higher than recommended doses of benzodiazepines without resolution of symptoms or if there are multiple uncontrolled medical co-morbidities.

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A14

Management of Tobacco Use Disorder during the Pandemic of COVID-19

Introduction

Tobacco use is a significant public health problem. According to the Global Adult Tobacco Survey – 2, one in every three of our Indian population use one or other forms of tobacco. In the current global pandemic of COVID-19, it is reasonable to be concerned that compromised lung function or lung disease related to smoking history, such as chronic obstructive pulmonary disease (COPD), could put people at risk for serious complications of COVID-19. So abstinence from tobacco during this period might help in mitigating the serious complications from COVID-19.

Presentations of tobacco withdrawal syndrome in COVID-19 Scenario

1. In quarantined people who do not have access to tobacco, restlessness and agitation will interfere in compliance with the treatment strategies.

2. In the patients admitted in ICU, there will be a difficulty in clinical diagnosis whether the agitation and altered sensorium is a part of the underlying disease or a part of the tobacco withdrawal syndrome.

In this chapter, we are going to be focussing on the patients in the above-mentioned situations.

Management of tobacco dependence

The 5A's model is the management protocol for tobacco dependence can be used by health care providers to help a client with tobacco use in quarantine or self-isolation.

The 5A's stand for: Ask, Advise, Assess, Assist and Arrange for follow up.

Step I: Ask:

The health care provider should make it a part of their routine examination to ask every client the clinical history of tobacco use. the questions you should ask are as follows

1. What form/s of tobacco is/ are being used by the person? (Smoke/ Smokeless)

2. How much the person is using?

3. How regular the person is using?

4. What happens to the person physically and mentally, if he or she is not able to access tobacco due to any reason?

Look for withdrawal symptoms.

Withdrawal symptoms:

Develop within 2-4 hours of stopping to smoke

Symptoms:

- Intense urge for using tobacco
- Tingling sensations in the hands and feet
- Sweating
- Nausea and abdominal discomfort
- Headache
- Difficulty in focus / concentration
- Restlessness, Anxiety, Irritability, agitation and low mood, etc

5. How much time the person takes to smoke the first cigarette after getting up from bed? (If someone has to use the tobacco within half an hour of getting up from the bed, it is an indication of addiction/ dependence)

6. Use of any other substances especially alcohol

7. History of co-occurring mental illness

8. History suggestive of physical illness including diabetes, hypertension, chronic lung diseases, heart diseases, etc.

Step II: Advice

The health care provider should urge every client who uses tobacco to quit. The advice should be

1. Clear – Emphasizing the importance of quitting and reassuring the client that the health care provider can help

2. Strong

3. Personalized – During clinical history taking, identify the specific consequences of tobacco use relevant to the person and advice.

Step III: Assess:

Assess the motivation of the client to quit tobacco. Questions should be posed on current readiness such as, "Do you want to stop smoking?" and self-efficacy, "Do you think you can quit smoking successfully?"

If the answer to any of these questions is Unsure/No, motivational enhancement can be done using the 5R's step. But you can provide repeat the advice and tell the client to reach out for help whenever they are ready to quit tobacco, If the client is not ready repeat the advice whenever they reach out for help. If the answer to both the questions is 'Yes' proceed to the next two steps

The 5R's technique can help the health care provider to move through the 'Assess' step. The 5R's are

5R's	Strategy
Relevance	How is quitting relevant to the person's disease status or health of family
Risks	What are the risks of continued use of tobacco in the future in terms of medical illnesses?
Rewards	What improvements in health may be expected after quitting?
Roadblocks	What are the concerns regarding quitting? What are the pharmacological and psychological help available?
Repetiton	Client should be encouraged to quit in every visit

Step IV: Assist

a. Psychological measures

Develop a quit plan – Set a quit date ideally within 2 weeks, enlist the support of family and friends, anticipate challenges to the maintenance of abstinence, tobacco products should be discarded from the client's home and office space.

Practical counselling – Information about smoking and challenges in quitting should be discussed with the patient after taking his consent

High-risk situations (Eg - smell of tobacco smoke, seeing others smoking, tobacco products displayed in a shop) should be identified. Clients should plan to avoid these situations as far as possible. Psychological management of craving can be discussed. 5D's are often useful in the management of craving. They are

- **Delay** – Craving often appears in waves. When the peak of the wave comes client can tell himself he will delay the use of any cigarette. He can repeat in his mind about harmful effects of smoking or carry cards listing the same

- **Distract** – Client can use techniques such a counting backward in their mind or be engaged in a task they enjoy doing to shift focus

- **Drink water** – This is largely useful with alcohol

- **Deep breathing/Relaxation** – (Refer to the section on Simple Psychological Techniques for details)

- **Discuss** - Whenever craving comes to discuss with your family about our difficulties. This will serve the purpose of both getting their support and distracting yourself as well

Provision of support – Give positive feedback of the effort client is making, express empathy at the difficulty client faces especially w.r.t withdrawal symptoms and improve his confidence by encouraging to continue the measures he has been following to maintain abstinence.

Provide the client with resources he may read or information about quitlines.

Govt. of India has launched National Tobacco Quitline Services, can be contacted through the helpline number 1800-11-2356. The Govt. has also launched M-Cessation services for quitting tobacco where after giving a missed call to 011-22901701, you will receive a series of messages over the coming months.

The following URL may be shared with clients. The website is maintained by the National Health Portal

https://www.nhp.gov.in/quit-tobacco

b. Pharmacological Measures:

There are multiple pharmacological options available such as Nicotine Replacement Therapy (NRT), Varenicline, Bupropion and Nortriptyline. Use of NRT will be discussed below. Other pharmacological options are recommended to be used by specialists.

Nicotine Replacement Therapy:

There are different forms of NRT which are available in India. They are nicotine gums/lozenges and transdermal patches.

Nicotine Gum

Nicotine gum/lozenges are most commonly used for nicotine replacement therapy. The dose and strengths required are in Table 1.

The steps in using the Nicotine gum are

- Chew it slowly until you get the "pungent peppery taste" due to liberation of nicotine
- Place and rest between your cheek and gums "parked"
- When the taste fades repeat the first step. Repeat over 20-30 minutes
- Do not eat or drink or use removable dentures with the gum in the mouth; acidic beverages should be avoided 15 minutes (coffee, carbonated drinks) before using the gums

The possible side effects are headache, nausea, vomiting, heartburn, stomach discomfort, hiccups, and a sore jaw.

The steps in using nicotine lozenge/pastille are:

- Place the lozenge in your mouth, occasionally moving it side to side.
- Allow it to slowly dissolve (about 20-30 minutes) and try to minimize swallowing
- Do not chew or swallow the lozenge
- Don't eat or drink 15 minutes before or while you're using

Table 1. Nicotine Replacement therapy

	>20 cigarettes/day	<20 cigarettes/day
Gum/ lozenge	4mg/every 1-2 hours/Week 1-6 4mg/every 2-4 hours/Week 7-9 4mg/every 2-4 hours/Week 10-12	2mg/every 1-2 hours/Week 1-6 2mg/every 2-4 hours/Week 7-9 2mg/every 2-4 hours/Week 10-12
Patch	21mg/day	14mg/day

Nicotine Patches:

Nicotine patches are also used less commonly for replacement therapy. The doses recommended are in Table 1.

The steps in using the nicotine patch are:

- A single patch is worn each day
- Place the patch on different areas above the waist and below the neck each day
- Put the patch on a hairless spot
- If wearing the patch at night causes odd dreams, try sleeping without the patch.
- The patch should not be put in the same place again for at least 1 week.
- Should be removed during strenuous exercise to prevent excessive absorption.

Side effects of the skin patch are skin rash and allergy.

Nicotine replacement therapy should NOT be USED in patients in an ICU setting

Step V: Arrange – Follow up after 1 week and 1 month after the quit date. The provider should also consider referral to a specialist if there are difficulties. Clients should be congratulated on any success made in their attempts.

Additional Information on resources for Health Professionals

Health professionals can popularise the M-Cessation tobacco support that is available through the National Health Portal of the Government of India. By giving a missed call to 011-22907091, or by registering online at https://www.nhp.gov.in/quit-tobacco-about-programme_mtl, they can get a series of messages on the importance of quitting, dealing with withdrawal symptoms including craving and mood changes and making healthy lifestyle changes. Further, if they wish to speak to a tobacco cessation counsellor in a language of their choice, they can call the National Tobacco Quitline on 1800112356 for free counselling

Conclusion

Tobacco use is common among the Indian population. Given this frontline personnel may need to offer strategies to mitigate withdrawal from Tobacco for COVID-19 and suggest steps in quitting.

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WHO Toolkit for delivering brief tobacco interventions 5A's and 5R's https://apps.who.int/iris/bitstream/handle/10665/112835/9789241506953_eng.pdf;jsessionid=1DD11E3F7E80A9C193FA6569CBDF0539?sequence=1

A15

Management of Mental Health Issues in ICU patients with COVID-19 infection

Intensive care unit (ICU) settings, by their nature as well as the perceptions of individuals in the community, are deemed inherently to carry a high risk of mortality. Due to the same, individuals admitted to the ICU interpret various events occurring inside the ICU based on their circumstances as well as other persons concurrently admitted. These perceptions can sometimes lead to fear, despair or dreadfulness that alternate rapidly with optimism, the hope of recovery and comfort of being cared for. Generally, in the context of any illness, the family's presence and special attention paid by immediate family members contribute to restoring lost hopes. When a person is admitted in the ICU, they are separated from their family, their interaction with them is minimal to none.

A disruptive event causing uncertainty especially like an ongoing pandemic and the nature of COVID-19 isolation procedures destabilizes the emotional balance, generating feelings of insecurity, disbelief, helplessness, and hopelessness. This provides a fertile ground for a variety of psychiatric manifestations to develop, particularly in an ICU setting.

Whilst, patients infected with COVID-19 could manifest various psychiatric symptoms and disorders based on the stage of infection, this chapter focuses only on potential psychiatric issues that could be encountered in those receiving COVID-19 based ICU care.

Mechanical Ventilation

Mechanical ventilation is required in a small proportion of COVID-19 patients, given that the COVID-19 infection particularly targets the lungs and causes respiratory compromise. WEANING off mechanical ventilation is at times associated with acute and severe anxiety that could result in a delay in extubation and might mimic the inherent nature of infection resulting in respiratory distress leading to reintubation, prolonging the need for ventilatory support. Hence, an appropriate psychiatric medication that reduces anxiety (low dose antipsychotics- listed further in this chapter) is advisable. A plethora of psychiatric conditions are associated with mechanical ventilation including -

1. anxiety

2. sleep disturbance

3. depression

4. delirium

5. communication problems

6. pain

7. fear of being dependent on the machine for breathing

Delirium (also called ICU psychosis) - Patients admitted to the ICU are prone to developing delirium. Elderly individuals and people with decreased cognitive reserve such as those with preexisting dementia are at higher risk of developing delirium. It is usually multi-factorial and identifying the cause(s) is central to the management of delirium.

Symptoms that indicate the presence of possible delirium include the following:

1. inattention, confusion or disorganized thinking (talking irrelevantly or out of context/ not aware of time or place/ perplexity)

2. fluctuation in levels of consciousness (GCS score reductions/ changes) and altered psychomotor activity (restlessness/ agitation/ decreased motor activity)

3. rapid fluctuation in emotions (sudden unprovoked irritability, crying spells, laughter)

4. presence of auditory (hearing sounds/ voices of that are not present) and/or visual hallucinations (seeing objects/ persons not present).

If a COVID-19 infected patient becomes disruptive then, the management of such a disruptive behaviour is of utmost importance as it could result in a break in the isolation protocol and may place health care professionals at higher risk of exposure to infection. This may also place the neighbouring patients' life at risk by interfering with their treatment.

Prevention of ICU deliriumusing non-pharmacological behavioural interventions

Preventing the onset of ICU delirium has been proven to be a useful strategy. Even if delirium occurs despite these measures, it happens to be a milder severity and shorter duration.

These interventions typically include

1. Efforts to help in orientation

2. Enhance sensory efficacy (e.g., encouraging patient to use their glasses or hearing aids)

3. Promote sleep

4. Adequate and appropriate pain management

5. Preventing complications of immobility (bed sores)

6. Optimization of physiological parameters (e.g., electrolytes, hydration)

7. Foster physical therapy/early mobilization.

Management of delirium/ psychosis:

1. Identification and resolution of the primary cause for delirium is most effective and of prime importance. This includes evaluation and management of electrolyte, metabolic disturbances, substance use, polypharmacy (drug interactions/ toxicity), other infections, vascular causes, and traumatic injury.

2. When behavioural symptoms are disruptive or likely to interfere with treatment, the use of low dose antipsychotic medication is generally preferred for its short-term management. Among the antipsychotic medications, haloperidol is generally preferred over the other antipsychotics because of its availability in oral as well as injectable formulation, efficacy, safety because of lesser anti-cholinergic side effects and lesser propensity to cause sedation. The choice of medications depends on effectiveness and control; if one isn't working the other may be considered as an alternate.

    a. If a patient is in a position to take oral tablets, then oral haloperidol should be preferred over parenteral administration. A low dose of haloperidol (up to 2.5 to 5 mg up to twice a day) is generally adequate.

    b. Alternately Olanzapine 2.5 mg to 5mg in divided doses can be administered orally, which can be increased to 7.5mg or 10mg based on tolerability. Other options to be considered if there is history of seizures.

    c. Alternately, Quetiapine 25mg to 50 mg in divided can be administered orally

3. SIDE EFFECTS MONITORING: After administration of haloperidol, monitor for acute extra-pyramidal symptoms such as dystonia, parkinsonism, akathisia and other side effects like cardiac arrhythmias especially if the patient has hypokalemia and prolonged QTc.

4. Preliminary evidence suggests a role for hydroxychloroquine in the management of COVID-19 infection and with its potential adverse effect of QTc prolongation, cardiac arrhythmias the treating doctor should be cautious about concurrent use of hydroxychloroquine and parenteral haloperidol. This necessitates regular cardiac monitoring.

5. **RESPIRATORY DISTRESS AND RESPIRATORY FAILURE are fatal manifestations of COVID-19, hence ADMINISTRATION OF BENZODIAZEPINES SHOULD BE AVOIDED.** They may be used only when delirium is secondary to alcohol or sedative hypnotics withdrawal. In these cases, SHORT ACTING low dose oral benzodiazepines (e.g. Lorazepam 1mg to 2 mg) may be considered preferably with FULL VENTILATORY BACKUP.

Conclusion

Medical professionals should be aware of common psychiatric and behavioural manifestations of patients with COVID-19 in intensive care settings. Addressing these with simple pharmacological and non-pharmacological approaches is not only effective but also helps in reducing mortality and later morbidity.

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