## Psychiatry in Times of the Coronavirus Disease 2019 (COVID-19) Pandemic

Luykx, Jurjen J; Vinkers, Christiaan H; Tijdink, Joeri K

***published in***
JAMA Psychiatry
2020

***DOI (link to publisher)***
10.1001/jamapsychiatry.2020.1225

***document version***
Publisher's PDF, also known as Version of record

VIEWPOINT

# Psychiatry in Times of the Coronavirus Disease 2019 (COVID-19) Pandemic

## An Imperative for Psychiatrists to Act Now

**Jurjen J. Luykx, MD, PhD**
Department of Psychiatry, UMC Utrecht Brain Center, University Medical Center Utrecht, Utrecht University, Utrecht, the Netherlands; and Second Opinion Outpatient Clinic, GGNet Mental Health, Warnsveld, the Netherlands.

**Christiaan H. Vinkers, MD, PhD**
Department of Psychiatry, Amsterdam University Medical Center, Amsterdam, the Netherlands; and Department of Anatomy and Neurosciences, Amsterdam University Medical Center, Amsterdam, the Netherlands.

**Joeri K. Tijdink, MD, PhD**
Department of Medical Humanities, Amsterdam University Medical Center, Amsterdam, the Netherlands; and Department of Philosophy, Vrije Universiteit University, Amsterdam, the Netherlands.

**Corresponding Author:** Jurjen J. Luykx, MD, PhD, Department of Psychiatry, UMC Utrecht Brain Center, University Medical Center Utrecht, Utrecht University, Universiteitsweg 100, HP 4.205, 3584 CG Utrecht, the Netherlands (jluykx@umcutrecht.nl).

**The global effect** of coronavirus disease 2019 (COVID-19) is at an unprecedented large scale and changes rapidly, with lockdowns and other confinement measures at place in several countries. The undoubtedly widespread negative effects of the COVID-19 pandemic on mental health and mental health care do not mean that psychiatrists cannot diminish this effect. Here, we argue that psychiatrists can act now to help contain the current crisis.

Both the outbreak itself and the ensuing preventive measures are bound to severely affect mental health in those with and those without a history of mental illness and in health care workers. First, social isolation and the uncertainties around the virus may bring about depressive thoughts, despair, anxiety, and loneliness. Consequently, psychiatric symptoms in people without a history of mental illness may emerge and preexisting psychiatric conditions may worsen. Second, information about institutional prevention measures may be relatively hard to appraise and comply with by patients with cognitive impairment or acute psychiatric illness. The effect of COVID-19 on mental health and mental health care stands in contrast to the myriad measures a psychiatrist can take to diminish the effect of the pandemic on patients with psychiatric illness and the general population. Here, we argue that actions can be readily taken by psychiatrists themselves, creating an imperative for psychiatrists to act now. We envision 5 actions that carry the potential to reduce the effect of the COVID-19 pandemic within and outside the field of psychiatry.

First, we should adopt an active stance, both in outpatient and in inpatient settings. As in other fields of outpatient medicine, our focus should shift from elective to emergency consultations. Psychiatrists with currently less workload in elective care should reach out to colleagues working in emergency settings. In outpatient clinics, we should actively engage in teleconsultations, using webcams to facilitate observation. Using teleconsultations, we can contact close ones of patients and ensure they receive proper psychoeducation and engage over the internet with these patients. Thus, we ensure they aren't lost to follow-up or discontinue treatments. In addition, we should not lose sight of our colleagues working in emergency settings and dealing with unusually heavy workloads. Moreover, treatment adherence may be jeopardized as patients feel reluctant to fill their prescriptions. We should actively discuss possible new sources of nonadherence. Moreover, we should realize specific people and patients are susceptible to the psychological effect of the pandemic and to contracting and spreading the virus (eg, refugees and homeless). Furthermore, abstinence syndromes may be more commonly observed as access to illicit drugs becomes cumbersome.[1] Early recognition and treatment of such syndromes are essential. Vice versa, we should be wary of newly arising addictive behaviors, eg, addiction to gaming in people with less workload resulting from the recent millions of layoffs. Finally, psychiatrists working in inpatient settings should consider preparing for psychiatric patients who have tested positive for COVID-19 by creating specialized units for such patients.

Second, psychiatrists should help prevent further spreading of COVID-19 by patients vulnerable to mental illness. We should actively educate patients about the importance and possible consequences of social isolation. We should be available (online and by phone) to loved ones and health care workers dealing with those with COVID-19. We can help ensure institutional websites have appropriate contact information for such requests. For both patients and the general population, we should emphasize the availability of information about stressors of quarantine and ways to promote general well-being during quarantine.[2] Importantly, particular characteristics of psychiatric disorders put people at increased risk to not abide by quarantine measures. For instance, manic episodes often entail hazardous behavior, putting people at risk to contract and transmit the virus. Those with psychotic beliefs may find it hard to distinguish between fake and real news. As specific disorders come with specific risks, tailor-made measures should thus be implemented by caregivers familiar with patients' individual symptom profiles and social situations. Those measures will hopefully enable patients to openly speak about their adherence to quarantine measures and discuss ways to improve their adherence if needed.

Third, although it is unknown how long the current health care crisis will last, we should rethink current treatments. When medicine deliveries to pharmacies are jeopardized or pharmacies close due to lack of personnel, access to medication may be challenging. Compounds with long half-lives generally carry less severe adverse and rebound effects when (temporarily) discontinued. Thus, patients taking a relatively high-frequency intramuscular depot antipsychotic could be switched to less frequent formulations, eg, patients taking long-acting injectable paliperidone who have been stable for 4 months can be switched to 4 yearly injections. Additionally, we should be wary of current or possible future interactions with COVID-19 medication. A list from the University of Liverpool[3] indicates that in terms of interactions, olanzapine is one of the preferred antipsychotics; of benzodiazepines, lorazepam/lormetazepam, oxazepam, and temazepam (LLOT) are preferred; and with

regards to antidepressants, fluoxetine, fluvoxamine, and sertraline seem safest. Thus, medications with long half-lives and low risk of cardiac adverse effects may be preferred should (temporary) discontinuations arise due to medication shortages and limited access to pharmacies, eg, fluoxetine in new patients with anxiety or depression.

Fourth, psychiatrists should try to counteract and analyze the undesired effects of the current health care crisis on those with and without a mental illness history. Recently, the World Health Organization issued recommendations for citizens to prevent anxiety and stress in the current era.[4] Similar recommendations have been given to health care workers, eg, by the American Psychiatric Association.[5] Longer-term economic effects will put people at risk of poor mental health outcomes (including suicide). Preventive measures may include psychoeducational sessions and easy (online) access to mental health care in the working environment. Researchers working with prospective registries should consider analyzing the effects of the crisis on mental health outcomes to better predict the effects on mental health during future outbreaks.

Finally, webinars can foster educational sessions allowing psychiatry residents and medical students to continue developing their skills. Instead of canceling educational sessions, we should rethink them and prioritize issues and opportunities that are currently pressing, eg, teleconsultations, long-life medicines, suicide prevention, COVID-19 in the context of psychiatry, and abstinence syndromes. Such sessions can go from journal clubs to clinical case conferences discussing clinical dilemmas in psychiatry arising from the COVID-19 pandemic. In our experience, such lively webinar sessions with residents and staff also enable experienced psychiatrists to remain updated about diagnosis and treatment of COVID-19 as well as their implications for the field of psychiatry.

In the current COVID-19 crisis of uncertain duration and effect on society, rather than a wait-and-see approach, we recommend psychiatrists make active use of the several opportunities at hand to optimize care for people with and without a history of mental illness now. The above-mentioned actions may not only mitigate worsening mental health statistics (eg, incidence of psychiatric disorders and suicide) but also result in a lower frequency of COVID-19 transmissions from patients with psychiatric illness to others. At the same time, recommendations can easily become outdated, and therefore, psychiatrists should also feel free to speak out and advise colleagues on internet platforms and social media.


## ARTICLE INFORMATION

**Published Online:** May 27, 2020. doi:10.1001/jamapsychiatry.2020.1225

**Conflict of Interest Disclosures:** None reported.

**Additional Contributions:** Paul Naarding, MD, PhD (Department of Old Age Psychiatry, GGNet Mental Health, Warnsveld, the Netherlands), and Sisco van Veen, MD (Department of Medical Humanities, Amsterdam University Medical Center, Location VUmc, Amsterdam, the Netherlands), provided valuable feedback on the manuscript. Neither received compensation for their contribution.


## REFERENCES


1. Ritchie EC. What psychiatrists can do to prepare for the coming pandemic. Accessed April 21, 2020. https://www.medscape.com/viewarticle/926585

2. Center for the study of Traumatic Stress. Psychological effects of quarantine during the coronavirus outbreak: what healthcare providers need to know. Accessed April 21, 2020. https://www.cstsonline.org/assets/media/documents/CSTS_FS_Psychological_Effects_Quarantine_During_Coronavirus_Outbreak_Providers.pdf

3. Liverpool Drug Interaction Group. COVID-19 drug interactions. Accessed April 21, 2020. https://www.covid19-druginteractions.org/

4. World Health Organization. Mental health and psychosocial considerations during the COVID-19 outbreak. Accessed April 21, 2020. https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf?sfvrsn=6d3578af_2

5. American Psychiatric Association. COVID-19 and mental health: caring for the public and ourselves. Accessed April 21, 2020. https://education.psychiatry.org/Users/ProductDetails.aspx?ActivityID=7256&_ga=2.11521332.1024196078.1584823883-367123474.1584823883