Comment on "Mental health: why it still matters in the midst of a pandemic"

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After the World Health Organization declared COVID-19 disease a pandemic, the number of confirmed cases has progressively increased to more than 1,600,000, including 95,000 deaths, which has led to the implementation of quarantine and isolation strategies worldwide. However, approaches highly focused on COVID-19 infection control may tend to ignore the psychosocial consequences of the outbreak. As da Silva et al. recently stated, the stress experienced by patients, healthcare personnel and communities could increase the possibility of anxiety, depressive, and stress-related disorders, which could add an underestimated additional risk during the epidemic.[1]

However, we think that some Latin American countries might face particular challenges. As the COVID-19 epidemic advances, our fragile health systems already face a high internal (regional) migration, an increase in measles cases, intense transmission of dengue and recent outbreaks of zika and chikungunya. Unlike temperate zones, the co-circulation of these viruses in tropical countries could affect diagnostic capacity and worsen the epidemiological situation. In areas with adverse geographical and sanitary conditions, the risks are further increased. For example, some remote areas of Colombia have fewer than 0.5 hospital beds per 1,000 inhabitants, much less than the national average of neighboring countries. These areas are inhabited by approximately nine million victims of a 50-plus year armed conflict. The Colombian National Mental Health Survey revealed that people who resided near armed conflict events had a higher prevalence of mental problems and disorders.[2] Notably, self-declared Amerindians also had higher rates of poverty, displacement due to violence, and mental disorders associated with acculturation.[3]

During the pandemic, numerous successful interventions involving technological tools have been reported around the globe.[4] However, the wide urban/rural gap and an internet access rate around 50% in many countries could be a barrier to web-based mental health services. Therefore, locally adapted responses to the COVID-19 pandemic must consider their impact on the mental health of vulnerable communities, emphasizing the strengthening of primary care and the role of social leaders. Critical situations like this pandemic will make the longstanding social inequities of our continent more evident. Amartya Sen aptly said that the fundamental requirement for enjoying better community mental health implies establishing high degrees of justice, equality, and social capital.[5]

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Supporting people with severe mental health conditions during the COVID-19 pandemic: considerations for low- and middle-income countries using telehealth case management

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The coronavirus disease 2019 (COVID-19) pandemic is a global challenge to humankind. Such disasters might

disproportionally affect patients with severe mental health conditions from low- and middle-income countries, who might need modifications to their care.[1] Here we present data on the feasibility of implementing intensive telehealth case management to fight the COVID-19 pandemic in a Community Psychosocial Center in Brazil.

Mitigating the risks of human physical contact is a difficult task in mental health community centers because minimizing physical contact implies reducing face-to-face patient interactions, a key component of mental health treatment. Although too many visits might unnecessarily increase the risk of COVID-19 exposure, too few visits might also increase the risk of destabilization, particularly for severe cases, resulting in crowded emergency services. To achieve that optimal balance, we tested the feasibility of implementing a telehealth intensive care management system.

The service currently delivers health services to 154 patients who attend the service on a regular basis, 61% male, with an average age of 38.8 (standard deviation = 13.6). Most patients have used the service for less than a year (66%), 22% between 2-5 years and 12% more than 5-years. The most frequent diagnoses include: psychosis (54%), intellectual disability (20%), bipolar (16%), and other mental health conditions (11%). Before launching the telehealth program, 48% attended the community center daily or at least 3 times a week, while the remaining 52% used the service biweekly/weekly/monthly. A total of 21% used depot formulations.

At the beginning of the telehealth program (March 23rd, 2020), patient care was divided among seven case managers. Phone contact was possible for 61% of patients, with 29% being advised face-to-face through regular service attendance. We were unable to contact around 7% of service users despite significant effort. Currently, all patients are telemonitored weekly or biweekly to investigate signs of psychiatric instability. We are also monitoring respiratory symptoms and fever, reinforcing the importance of hand washing and restricting physical contact.

Case managers classify patients as "stable" or "unstable" based on current changes in behavior. All stable cases are being asked to stay home. Unstable cases are being asked to visit the service for face-to-face consultations in addition to frequent systematic telemonitoring. Patients in the COVID-19 risk group (over 60 and with any chronic condition; 24%) who use depot medications are being visited at home for treatment. Increased food insecurity was detected, and all patients with basic food needs (50%) received donations, which were organized by the service. All group activities have been canceled. All actions and information about dynamic changes in patient status are coordinated with an online spreadsheet (https://figshare.com/s/826f200d872e35ea67f1). This spreadsheet is kept on a local server and information is kept private and secured by password.

Intensive case management via telehealth is a feasible strategy that can be used in mental health community centers in low- and middle-income countries and could mitigate the exacerbated risks of psychiatric instability from stress related to COVID-19 in this vulnerable population.

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Melatonin and cocaine: role of mitochondria, immunity, and gut microbiome

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I read with interest the recent article by Barbosa-Méndez & Salazar-Juárez on the role of melatonin in regulating the circadian effects of cocaine-induced locomotor activity in rodents.[1] These authors also showed melatonin to decrease cocaine-induced locomotor activity at different times of the day and propose that it could be a readily available, safe and cheap treatment option in the management of cocaine addiction. Future research in a couple of areas should better clarify melatonin's effects and treatment utility.

Many of the effects of cocaine are mediated by alterations in mitochondrial function. Recent work suggest that mitochondria are circadian-regulated, with the effects of