Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Mental health insurance in India: lack of parity

India passed the Mental Healthcare Act on April 7, 2017,[1] which has been in effect since May 29, 2018. Section 21 (4) of the Act states "every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness."[1] But, in reality, this is not occurring. In 2018 and 2019, the Insurance Regulatory and Development Authority of India took no action to ensure that insurance companies included mental illness in their policies. The scenario started changing after the COVID-19 pandemic and subsequent lockdown in India, which exacerbated the incidence of mental disorder symptoms among the general population. In March 17, 2020, a Public Interest Litigation petition was filed in the Supreme Court of India by advocate Gaurav Bansal,[2] alleging violation of the Mental Healthcare Act 2017, as none of the insurance companies had complied with section 21 (4).

On April 19, 2021, a claimant filed a case against the National Insurance Company and the Insurance Regulatory and Development Authority in the High Court of Delhi,[3] for rejecting an insurance claim for expenses associated with hospitalisation with a diagnosis of schizoaffective disorder, because the policy excluded psychiatric disorders. The petitioner filed a complaint with the insurance ombudsman, after which the claim was again rejected due to an exclusion clause. The National Insurance Company argued that the policy covering mental illness was approved by the Insurance Regulatory and Development Authority on March 27, 2020, and the policy was launched on July 1, 2020, within the legal limit. So, there was a 2-year delay in the implementation of the Act. The petitioner had renewed her policy before the launch of the new policy covering mental illness, and the National Insurance Company rejected her claim on the grounds that she had to abide by terms provided in her health-care policy. The claim has been paid to the petitioner, because the Insurance Regulatory and Development Authority directed the National Insurance Company to make the payments of the claimant.

The apathy and aversion of Indian insurance companies towards mental illness is chronic and systemic. Insurance companies have been slow to include mental disorders in their policies. The non-settlement of claims for costs incurred due to mental illness and related court cases illustrate the stigma India displays to those with mental illness.

I declare no competing interests.

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COVID-19 vaccine uptake in patients with psychiatric disorders admitted to or residing in a university psychiatric hospital

People with psychiatric disorders, especially severe mental illness, have increased morbidity and mortality from COVID-19 infection; therefore, vaccination against COVID-19 should be prioritised for this vulnerable group,[1] which has been done in several countries (eg, Denmark, Germany, The Netherlands, and the UK).[2] There are growing concerns surrounding COVID-19 vaccine hesitancy in the general population.[3] Vaccine hesitancy might also affect people with psychiatric disorders; however, a study showed only slightly lower COVID-19 vaccination willingness in people with psychiatric disorders (84·8%) compared with the general population (89·5%).[4]

In a large university psychiatric hospital in Belgium, we assessed how many people accepted an offer to be vaccinated against COVID-19 in a targeted vaccination programme. From March 30, 2021, to July 19, 2021, patients older than 18 years admitted to or already residing in the hospital (including patients in daycare) were

	Patients
Mean age, years (SD)	49·31 (21·19)
Sex	
Female	676/1151 (58·7%)
Male	475/1151 (41·3%)
Diagnosis	
Cognitive disorder	113/1151 (9·8%)
Psychotic disorder	243/1151 (21·1%)
Bipolar disorder	77/1151 (6·7%)
Depressive disorder	159/1151 (13·8%)
Developmental disorder	17/1151 (1·5%)
Anxiety disorder	94/1151 (8·2%)
Personality disorder	134/1151 (11·6%)
Substance use disorder	62/1151 (5·4%)
Eating disorder	45/1151 (3·9%)
Adjustment disorder	142/1151 (12·3%)
Other	65/1151 (5·6%)
Vaccine status	
Fully	936/1151 (81·3%)
Partly	134/1151 (11·6%)
Refused	81/1151 (7·0%)
Vaccine type	
mRNA-1273 (Moderna)	590/1070 (55·1%)
BNT162b2 (Pfizer–BioNTech)	371/1070 (34·7%)
ChAdOx1 (Oxford–AstraZeneca)	94/1070 (8·8%)
Ad26.COV2.S (Johnson & Johnson)	14/1070 (1·3%)

Data are n/N (%), unless otherwise stated.

***Table*: Participant characteristics and vaccine information**

invited to be vaccinated against COVID-19. Participants were directly invited by the hospital staff or were already enrolled in the governmental vaccination programme to receive a COVID-19 vaccine. We recorded vaccine acceptance, vaccine type, and whether they were fully or partly vaccinated on July 19, 2021. In addition, we compared these results with the national vaccination uptake rates at the end of the same period.

1151 patients were offered COVID-19 vaccination, of whom 1070 (93%) accepted (table). Logistic regression did not show any effect of diagnosis on vaccination status. In the general population, by July 19, 2021, 88·9% of the adult population in Flanders, Belgium, had recieived their first vaccine dose, and 61·6% were fully vaccinated.

People with psychiatric disorders often receive less preventive health care. However, our findings suggest that COVID-19 vaccination rates in people with mental disorders admitted to or residing in a psychiatric hospital are just as high as in the general population with a targeted prevention programme. Our results corroborate those of previous studies showing that people with psychiatric disorders are just as willing to receive vaccination and that vaccination rates in this population can be increased by targeted prevention programmes.[4] Limitations of this study are the restriction to patients from a single residential setting and the generally high willingness for vaccination in Belgium. Vaccination willingness has been shown to be highly variable between countries.[5] In conclusion, vaccination rates in people with psychiatric disorders admitted to the hospital are high and they should therefore be offered the chance for COVID-19 vaccination.

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Taking the knee, mental health, and racism in sport

The booing of the England and Italian football teams when they took the knee before the final match of the 2020 UEFA European Football Championship and the online racist abuse of Black players subsequent to their performance in the match, just a week after the sentencing of a police officer in relation to the manslaughter of the former football player Dalian Atkinson, raises the connections between racism in sport and racism in society. These incidents also highlight the need for a transcultural model to recognise the inter-related experiences of racist abuse from fans and mental health in sport, particularly for members of the Professional Footballers Association. Reducing taking the knee to a political gesture encapsulates an attitude that Black footballers and athletes should not challenge racism and racial abuse whether inside or outside the stadium or online.

Unfortunately, current models of football and mental health in modern Britain do not address the connections between historical and discriminatory racialised processes,[1] how cultural values emerge, and their impact on mental health in relation to a diverse playing workforce. The current practices within Football Associations (the model of mentally healthy clubs) tend to replicate clinical models, with a focus on biomedical diagnostic categories, depression, anxiety, and obsessional disorder. As with the 2021 White Paper review of the Mental Health Act,[2] there is an absence of modern culturally relevant models, theories, and practices that help to understand racism as a mental health concern.

Few studies have looked at the interconnections between, mental health, sport, society, and racism. There has instead been a focus on elite White athletes, as revealed in Rice and colleagues' database analysis of 60 studies.[3] Studies of sport and mental health have not analysed how a culture of norms affects the psychological health of Black sporting communities.[4] To address racism and mental health in football and other sports is to move from a model that sees the individual as a subject of fear needing to be diagnosed[5] to a structural analysis of the way sport enables forms of abuse that, while rarely regarded as a mental health concern, might have a profound impact on the wellbeing of Black sportspeople.

Therefore, a model of mental health is urgently needed that is coproduced and racially and politically aware, in which the lived experiences of sportspeople shape the meaning of mental health. Such a model would look at the structural, cultural, and interpersonal factors rather than simply the psychological. It would not attempt to simply decolonialise Eurocentric models that might have demonised the Black athlete and the Black communities, but would advocate

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