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Mental health among patients in a COVID-19-dedicated facility

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On 15 April 2020, as the coronavirus disease 2019 (COVID-19) pandemic tightened its grip in India and around the world, a 29-year-old woman died by suicide in a COVID-19 isolation ward of a tertiary care centre in Mumbai by hanging herself with a *dupatta* in the washroom a day after she tested positive for COVID-19. This was not the first such case. A man in Andhra Pradesh, fearing he had contracted COVID-19, quarantined himself away from his family, pelted stones on them when they approached him and later hanged himself from a tree.[1]

We newly minted interns were sitting in our COVID-19 screening clinic, pulling another 8-h shift, parched and hungry, when we heard the news of the suicide in our hospital. Initially we were shocked and in utter disbelief. Although we had witnessed deaths earlier as trainees and counselled the dying and consoled the bereaving, the young woman's death was a disheartening blow. We had expected patients to die from COVID, but not from the fear of COVID.

As worried patients thronged to our understaffed COVID screening clinic, we tried to push our thoughts aside. We asked patients their symptoms and comorbidities and their contact and travel history and then decided whether they had to be tested for COVID-19 or admitted for further management, all in <5 min. Stressed by the long patient queues, we barely managed to optimally counsel our patients. Sometimes all we could offer was to look them directly in the eyes and say, 'Don't worry, everything will be alright,' even when we didn't believe it ourselves.

We were as unfamiliar with a pandemic as they were. Sitting in suffocating personal protective equipment (PPE) for the first time and sanitizing our hands every 5 min, we worried about contracting the infection due to the high level of exposure and the risk of carrying it back to our families and friends. We discussed at length our moral responsibility to help the community, which was in direct conflict with our thoughts of self-preservation. Were we doing enough? Could the young woman have been saved? Were these moral dilemmas contributing to our moral injury?[2] As our anxieties intensified, it became difficult to be both the patient and the doctor.

In our next rotation, we worked in COVID care centres that hosted asymptomatic or mildly symptomatic patients. Yet to our surprise, better physical health did not translate into better mental health. Although the severity of the affliction contributes to worsened mental health,[3] even asymptomatic patients are at high risk. Despite repeated reassurances, they were anxious about their prognosis, date of discharge, chances of reinfection and transmitting it to others.

The patients in COVID-19 wards face a multitude of problems, including a lack of communication and social support due to the absence of family and friends, worrying about the health of their loved ones, financial strain, exposure to misleading information via social media, stigmatisation by the community and restricted interaction with physicians and nurses due to PPE. This leads to increased stress, anxiety and depression.[3–5]

In late April, as the government scrambled to augment its pandemic response, our hospital was converted to a 1600-bed COVID-dedicated facility, leading to the suspension of psychiatry outpatient departments (OPDs) and wards. This led to fragmentation of services for patients who regularly followed up at the institution at a time when they might need it the most, putting them at a high risk of exacerbation or relapse.[6]

In the isolation wards, patients were anchorless and anxious, some even refusing treatment or food. They were witnessing fellow patients in adjacent beds in an unfamiliar ward crying in agony, struggling to breathe, gasping for air, getting their chest compressed and tubes thrust down their throats by healthcare providers in 'spacesuits'. One man in his late 40s, not delirious, but agitated and abusive, claimed he had been 'stolen' by the government and his family 'was snatched away' and would hit himself repeatedly and refused any medical intervention. He was forcefully sedated and restrained to the bed, which became commonplace in all the wards. However, none of these patients received any psychiatric care. We did not expect the system to treat all our patients with the expensive drugs remdesivir and tocilizumab, but to deprive them of age-old psychiatric counselling displayed another level of structural apathy.

There was no provision of formal counselling to patients in screening OPDs or on admission unless referred to the psychiatry department, which was rare, as physicians managing them came from all kinds of specialities and did not have the training in identifying various psychiatric disorders. The trouble was only compounded by the skewed doctor:patient ratio with 1 doctor managing almost 15 patients at once (compared with the prior 1:8 ratio), leaving them hardly any time to focus on evaluating the mental state of each patient. Even if effective referral began, the demand was too high to be effectively managed by one psychiatrist on-call in each shift, as was the scenario.

Almost 50 days later, a critically ill COVID-19-negative patient in our hospital committed suicide in an eerily similar way as the young woman. This time we felt guilty, furious and hopeless. Could we, as an institution, have done something to prevent this? Could we, as individuals, have done something to prevent this? The answer we believe is a resounding yes.

There is an urgent need to address this mental health pandemic within the pandemic before we lose any more lives. We should start with reinstating the psychiatry department and engaging them in providing mental health care with regular counselling for patients and risk stratification. Recruitment of additional trained psychologists and psychiatrists to supplement the response and meet the demands is essential. Provision of various forms of entertainment such as TV/radio and group exercises such as yoga can help mitigate stress. Helplines staffed by experts can help reduce exposure, with in-person counselling for severe cases. Focusing on the development of 'soft skills' and recognising signs of common psychiatric disorders and providing psychological first aid is necessary among all healthcare providers. The administration needs to identify and try to circumvent the various means of suicide available to patients (e.g. conducting a ligature audit).

Mental health has long been ignored or taboo in India and around the world. This provides us an opportunity to take stock of our attitudes and practices and start looking at healthcare more holistically. It is time we start treating the ill and not just the illness.

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