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Coronavirus outbreak from early career psychiatrists' viewpoint: What we have learned so far

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Abstract

Purpose: Since the World Health Organization declared the coronavirus outbreak a global pandemic several million cases and more than three million deaths have been already confirmed worldwide due to COVID-19.

Design and Methods: Early Career Psychiatrists from all over the world present an overview of what happened in their own countries and what they have learned so far by this experience in everyday clinical practice.

Practice Implication: We tried to take a real time picture of this unexpected situation, drawing useful hints for now and the future.

KEYWORDS

COVID-19, early career psychiatrists (ECPs), global health, mental health, perspective

1 | INTRODUCTION

By March 11, 2020 the World Health Organization declared the coronavirus outbreak a global pandemic.[1] Europe and the United States (USA) promptly became major hubs of this new disease which had previously hit Asia, and then has started spreading in Oceania, Latin America, and Africa.[2,3] Since vaccines for severe acute respiratory syndrome coronavirus 2 are not yet globally accessible, and there is not yet any effective treatment for the coronavirus disease 19 (COVID-19), prevention through physical distancing in the general population and isolation of cases remain the most effective measure to minimize its spread.[4,5]

The impact of this global crisis in our lives and clinical practice in psychiatry would only be fully understood in the future, but what have we learned so far?

1.1 | Australia

The events followed one after another quickly, with a rapid worsening of the spread of the virus, starting from the first official case, diagnosed on January 19, 2020, up to the first COVID-19 infection outbreak on a psychiatric inpatient unit in Australia, confirmed on April 24, 2020.[6] Therefore, Australia declared a Human Biosecurity Emergency on March 18, 2020, and our lives have been forever changed.[7] Schools, restaurants and many public facilities were closed, and citizens were encouraged to work from home and enforce social distancing to "flatten the curve." There was a palpable sense of anxiety in the community, and even more so in the medical community who were working in the frontline, with varied access to Personal Protection Equipment (PPE), due to sudden and unexpected increase in consumption.[8] Public and private hospitals canceled elective surgeries to direct resources towards COVID-19 related crisis presentations. Outpatient clinics across all specialties, if possible, converted to the use of telemedicine. Many ongoing non urgent reviews and allied health services were canceled, at a time where many patients' mental health was more vulnerable. Psychiatry was one of the last specialties that had its government telemedicine restriction lifted in the private sector, highlighting the chronic inequality of access to service people with mental health issues face compared with other illnesses. Inpatient mental health units were particularly vulnerable as many of the sterilization and social distancing measures had to be balanced with safety and risk considerations.[9]

1.2 | Brazil

Psychiatrists and trainees' routines have changed dramatically in Brazil since mid-March 2020. Although there was speculation about the virus arriving in the country since December 2019, it was in March 2020 when the first cases and deaths occurred.[10] Following several countries in Europe and Asia, most states and cities closed their borders and called for a voluntary physical distancing on March 16, 2020. Later, regulations on activities were enforced and even some cities ordered a lockdown.[11,12]

Most psychiatric outpatient services were closed or diminished their activity dramatically. Secondary care services, named Psychosocial Attention Centers, which are a fundamental part of the Psychosocial Attention Network, closed group activities and some of them suspended non-essential activities in most cities throughout the country. Activity in many psychiatric emergency units was also significantly reduced for reasons yet to be explained.[13]

In the biggest psychiatric hospital of Porto Alegre, Hospital Psiquiátrico São Pedro, all outpatient appointments were canceled, and all prescriptions were automatically renewed for at least two months. Psychotherapy sessions were rescheduled for online video conferences if the providers and patients agreed.[14]

The inpatient wards in this same hospital saw their staff reduced to the minimum necessary to work and the patients number cut by half. In mid-April 2020, after one confirmed case in one unit, it was decided that the hospital would dedicate one ward for suspected or confirmed COVID-19 cases and the staff received training in PPE use.[11,12]

Social isolation proved crucial in slowing the spread of the infection in Brazil, but as the cases grow exponentially every day in a second and far more severe wave, we fear we have not seen the worst of it and its toll in unassisted psychiatric patients will become unbearable.[15]

1.3 | Italy

Italy was the first European nation affected by the epidemic, and after having been for a long time leading the number of deaths in the old continent, after a year of pandemic it is still the second European country for the number of deaths from COVID-19 since its emergence.[3,16] The outbreak was initially located in Northern Italy, especially in Lombardy region, hitting weakly and lately the South.[17] Italy was also the first Western country to adopt a complete lockdown on March 9, 2020. This helped the slowing of the spread, but had also negative effects on the general population.[18,19]

Healthcare professionals are paying a high price, with at least 358 physicians,[20] 83 nurses (EcoDiBergamo.it,[21] and 30 pharmacists[22] already dead from COVID-19 in 1 year, from March 2020 to April 2021. The national health system was overwhelmed, and in response to this sudden "stress test," all available physicians, including recent graduates and non-specialists, were gathered throughout the country to assist. Many surgery and internal medicine units were quickly transformed into high-biocontainment COVID-19 units and all nonurgent activities have been canceled. Hospitals rapidly divided emergency and inpatient units into COVID-19 and non-COVID-19 areas, with different medical staff and located in separate areas of the hospitals.[23,24]

Moreover, all health care providers are still facing an exceptional workload and emotional burden. Many of them left their houses for the concern of infecting relatives. Some of them had developed anxiety, insomnia, fatigue and uncertainty.[25]

We expect a dramatic increase in the demand for psychiatry services together with further negative mental health consequences of quarantine and stress for patients with pre-existing psychiatric disorders and for the general population as well.[26,27] In this scenario, psychiatry practice has deeply changed, trying to adapt to the new challenges. Since in-person visits have been drastically reduced, a quick and terrific shift to telepsychiatry has been a given.[28]

1.4 | Japan

In Japan, the number of cases of COVID-19 was increasing slowly in February 2020. The government ordered a "self-restraint" request at the end of March 2020 in large cities.[29] But unfortunately, the disease rapidly spread, and more than 610,000 people have tested positive up to April 2021.[3] Facing this progression, the Prime Minister declared the state of emergency on April 7, 2020 to expand the public efforts to contain the spread.[30]

During the first months of pandemic, some emergency medical centers in large cities, such as Tokyo and Osaka did not have enough beds to admit new patients.[31] In addition, some general hospitals were finding it difficult to treat COVID-19 patients with acute and severe psychiatric symptoms. In some psychiatric hospitals, psychiatrists cooperated with physicians from nearby general

hospitals, but if their patients' respiratory symptoms worsen, they transferred them to emergency medical centers as soon as possible. Many medical workers were worried about the possibility of being infected or becoming asymptomatic carriers. In fact, a number of nosocomial infections have been reported, and PPE shortage was also a serious problem.[32]

Many people, including medical workers, have been feeling emotionally overwhelmed because of physical distancing. Although many psychiatric clinics offer telephone consultations, they are still open to meet both unstable and new patients. In this situation, some psychiatrists have been offering online training on coping skills. Furthermore, Japanese government has temporarily expanded telemedicine to include first visits providing a chance to spread and improve telepsychiatry as well.

1.5 | Nigeria

On February 27, 2020 the first case of COVID-19 was confirmed in Nigeria.[33] Although Nigerians were expecting it, it was hoped that it would take much longer to get into the country. As the memories of the Ebola crisis in Africa still lingered in our minds and some speculated that since the index case of COVID-19 was an expatriate, perhaps the tropics might confer some protection. Nonetheless, in April 2021, more than a year after, Nigerians witnessed a steady rise with more than 160,000 confirmed cases despite gross under-testing as the reality of community spread dawned on us.[34]

One of the effects on an existing derelict health care system is the infection of over 800 health workers with the virus since June 2020, and the death of over 20 doctors from the virus within a one week period in February 2021.[35,36] The mental health sector has not been excluded, considering the level of unpreparedness to handle a disease of such magnitude and peculiarities.

Indeed, increasingly more people infected with COVID-19 are experiencing forms of psychiatric disorders: both an increase in new cases of mental disorders and exacerbation of pre-existing mental illness, since patients cannot readily access their healthcare providers nor their usual medications.[37]

The challenges of the elusive nature of the virus, inadequate treatment materials and manpower are profound in Nigeria. To tackle these during the early phase of the pandemic, there has been a massive alteration in the traditional mode of healthcare delivery: adherence of precautionary measures; reduced physical contact; extended appointments; use of virtual media for consultation and academic activities.[38] Telepsychiatry platforms, which were initially discounted, are increasingly being employed. It is a long shot from the ideal but preparing us for what lies ahead: the innovation of more flexible healthcare delivery packages.

1.6 | Spain

Spain was the second European country hit by the coronavirus outbreak after Italy. The first case of COVID-19 in the country was confirmed on January 31, 2020, and despite the appeal by several Spanish researchers to institute a complete lockdown of the country, it was not until March 30 that the Spanish Prime Minister announced it.[39] After 10 days of total lockdown, 24 active medical doctors died from the disease.[40]

Trainees from all specialties in many hospitals all over the country have been redeployed into COVID-19 units as backup, losing months of their precious time of specialty training but providing incredible support to public hospitals. Some inpatient units of certain specialties (Gynecology, Psychiatry) were transferred to non-COVID-19 hospitals. Telepsychiatry via phone has been implemented for outpatient services.[41]

Disturbingly, access to PPE has been scarce in many hospitals. Ten days after the Spanish Government delivered hundreds of thousands of filtering face piece 2 masks, these were found faulty according to European regulations and had to be discarded leaving thousands of health workers exposed with inadequate material to COVID-19.[42]

1.7 | United States

By early March 2020, the USA public started to get seriously concerned about COVID-19. After weeks of hearing about a disease initially reported far away in China and seeing the early devastating effects in Europe, clusters of cases were observed on the West coast and in New York state.[43] Many feared that the USA, and particularly New York City, would soon become a major hub of spread and damage, and felt that some public authorities were not reacting diligently.

Within a few weeks, their worst fears became real: the USA began to record the highest numbers of cases and deaths globally and New York City became the epicenter of the Coronavirus pandemic. The overburden of hospital centers, especially in the public sector, was responded with injections of resources and a generous inflow of healthcare volunteers. Very soon, the morbidity, mortality, and financial toll of the pandemic reflected pre-existing structural disparities in healthcare access and outcomes, with people from racial and ethnic minorities and lower socioeconomic households being affected the worst.[44,45]

Amid the challenges of lockdown, psychiatry took soon advantage of the wide availability of internet technologies to expand the potential of remote healthcare. Early career psychiatrists (ECPs) not redeployed to general medical care of patients with COVID-19 were eager to lead this resurgence of telepsychiatry.[46] Despite the pandemic having been devastating across the whole country during the second half of 2020 and happening in a time of intense social unrest and political turmoil, the early availability of vaccines by late fall and its relatively quick rollout brought hope. Many if not most ECPs are now fully vaccinated and ready to serve even better their patients, healthcare colleagues, and the general population.

2 | CONCLUSION

The current COVID-19 pandemic scenario described by ECPs from different regions of the world points to similar challenges, as well as to specific serious problems. From the USA to Japan, from Brazil to Italy and Spain, from Nigeria to Australia, we are experiencing an unprecedented event that challenges our psychological capacity for adaptation.

Psychiatry will play a fundamental role to face the still unknown psychological sequelae that will arise in the post-pandemic period as well as during the crisis. However, as in no other moment in history, we can count on powerful tools of communication technologies so that mental health care can reach those who would otherwise not have the opportunity to relieve their suffering.

In conclusion, there are many lessons learnt from this experience so far: first, we perceive that telepsychiatry is needed and should be used more widely, especially for rural and remote areas; second, maintenance of mental health wellbeing should be a public health priority in times of pandemic, and part of the national disaster management plan; and finally, the importance of social connectedness to our well-being, as we remain apart to be together, and work towards the return to normal life, however it may look, whenever it may be.

2.1 | Implications for psychiatric nursing practice

We aimed to highlight ECPs' experiences and lessons learned across the world thus far and potentially applicable to psychiatric nursing practice and care in the context of COVID-19 pandemic. The experiences gathered in our paper show that the COVID-19 pandemic was a totally unexpected event that put a strain on the health systems of all nations and impacted psychiatric conditions in all countries. Therefore, the collection and exchange of how health care workers have and are still reacting in the face of this global challenge could provide strategies for adapting existing protocols and developing new guidelines for the management of psychiatric conditions and for psychiatric nursing practice aimed at improving the mental health assistance during the COVID-19 era.

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CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

AUTHOR CONTRIBUTIONS

Renatode Filippis, Joan Soler-Vidal, Andre Luiz Schuh Teixeira, and Alex Vicente Spadini, led the group discussion and manuscript drafting. Each author wrote his own country section. All the authors reviewed the manuscript and agreed on the final draft before submission.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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