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COVID-19 and mental health: How one pandemic can reveal another

Abstract  The COVID-19 pandemic disproportionately affected individuals with mental disorders, and revealed fundamental flaws in how vulnerable persons are treated in the context of such crises. Much of this difficulty may be attributed to ignorance of the prevalence, severity and economic burden associated with these conditions, as well as to enduring inequalities in how physical illness is treated in comparison to mental illness. As mental disorders are now the single greatest cause of disability, we have reached the point where the tremendous personal and societal costs associated with these conditions can no longer be ignored. Dramatic changes are needed to replace the slow, incremental efforts that most often characterize public health policy. Such changes can no longer wait for the national or international-level solutions that were once hoped, but they may be just as effective through the use of new technologies, grass-roots organization, and initiatives on a local scale.

In a very short period of time, the COVID-19 pandemic dramatically altered how individuals function, work and interact with others. Never before has society relied as much on new technologies and the internet to assure productivity and communication, and many of these changes are certain to last far beyond the current public health crisis. The pandemic has also taught us two very difficult but important lessons about mental health. The first is that individuals with mental disorders disproportionately bear the burden of such crises. In addition to being vulnerable due to their condition, the added travel restrictions, social distancing and home confinement — all necessary measures to control the pandemic — are fully opposite to what is commonly used in cognitive and behavioral therapies to effectively treat these disorders. A second lesson is that the majority of therapeutic progress needs to be made by patients when they are not with their clinician. It is at those moments, often when at home and alone, that patients need to remember to take their medications, to avoid risk factors and to perform adaptive behaviors or exercises. Many individuals with mental disorders were unprepared for such autonomy and self-help during confinement, and society was unprepared to reach out to them. For these reasons, the viral pandemic that is COVID-19 has also highlighted the existence of a chronic and major mental health crisis. Yet surprisingly, most people are still unaware of its magnitude or severity.

The impact of any disease or disorder can be measured by Disability Adjusted Life Years (DALYs), which represent the number of years lost due to ill-health, disability, or early death. It has been acknowledged for years that mental disorders are among the leading causes of disability worldwide when considering DALYs (Whiteford et al., 2013). This enormous societal burden is explained by both the high prevalence of these conditions as well as by the severe impairment they induce. Numerous large-scale epidemiologic investigations have demonstrated that major mental disorders such as schizophrenia, anxiety disorders, mood disorders, or substance dependence will affect large sec-
tions of the general population at some point over their life span (Compton et al., 2007; Kessler et al., 1997; Kessler et al., 1994; Merikangas et al., 2010; Regier et al., 1990). The epidemiologic studies with the highest rates (notably including the National Comorbidity Survey, or NCS) were also those that took steps to overcome biases leading to the under-reporting of disorder prevalence. In particular, this series of studies understood the limitations of door-to-door diagnostic assessment and the biases associated with structured diagnostic interviews. Concerning the former, many people with mental disorders may initially refuse participation when solicited by survey agents simply because they do not have the energy or desire to participate. After their initial refusal, the NCS asked a subset of these individuals to again participate while explaining why their initial refusal made them particularly important to include in the study and additional incentives were offered. A portion of those who initially refused to participate the first time finally agreed to participate, allowing the NCS to estimate the degree to which individuals who initially refuse participation may be more likely to suffer from a mental disorder and to adjust their estimates accordingly. The second bias these investigations overcame concerned the fact that structured diagnostic interviews for mental disorders typically last between 2 to 4 hours. Interviews are shorter (2 hours) if the individual does not endorse key “gate” questions for each disorder and therefore does not need to be administered follow-up questions. For example, if the individual responded “no” to the question “Have you ever in your life had at least one drink containing alcohol?”, then there is no need to ask further questions concerning drinking quantity, frequency or eventual symptoms of alcohol use disorder. The problem is that after about two hours of the interview, most participants start to understand that the more they say “yes” to such questions, the more questions are asked. So, they tend to start saying “no” in order to finish the interview more quickly. The NCS overcame this issue by asking all gate questions for each disorder at the very beginning of the interview, well before the participant learned the rule that positive responses lead to more questions. Once they had responded positively to those gate questions, all pertinent follow-up questions were eventually asked. Using both strategies for overcoming response biases and under-reporting, the lifetime rates of mental disorders are now estimated at just under 50% of the population. With one in every two individuals seeing diagnostic criteria for a mental disorder at some point, these results reveal the staggering magnitude of the mental health crisis. It also means that all of our families are affected in one way or another. It is important to note, however, that the general population is not experiencing more mental disorders than before: we are just becoming more accurate at estimating the full scope of this chronic and often ignored public health crisis.

Any form of illness also incurs economic burden. The most recent estimates indicate that the European Union spent 9.6% of its total GDP on health care (all diseases combined), but that almost half of these costs were dedicated specifically to the treatment of mental disorders (OECD/EU, 2018). Mental health expenditures in the United States are more difficult to quantify due to the complexity of its health care services, but conservative estimates for direct costs alone approximate one trillion dollars a year (Trautmann et al., 2016). It can be assumed that other areas of the world are also heavily burdened financially by these common forms of illness, despite considerable differences in investment in treatment or prevention efforts.

Editors of scientific journals such as JBCT are beginning to see increasing numbers of manuscripts addressing the mental health consequences of the COVID-19 pandemic. But the sad truth is that although the pandemic disproportionately affected persons with mental disorders, we have not yet fully realized what has happened. The crisis was always there, hidden by a lack of knowledge by politicians, public policy-makers, and indeed the general public, of what mental disorders are and what we are facing as a society. We are still far away from the point of treating mental disorders with the same degree of attention, financial investment and prevention strategies as is accorded to serious physical diseases. As of August 24th, 2020, COVID-19 had caused 800,000 deaths worldwide (World Health Organization, 2020a). This is precisely the same number of people who commit suicide every year (World Health Organization, 2020b). The difference is that COVID-19 will likely have an end, either through a vaccine or through eventual mass immunity. The mental health crisis may very well continue, with few dramatic improvements. It will not make the national news every evening. It will not be discussed on a daily basis. In brief, it will probably continue to be treated differently than any physical health threat of the same magnitude. If this makes you angry—and it should—there is no point waiting patiently for solutions to be put into place by someone else. If you are reading this editorial, it is probably because you are a mental health researcher or clinician, just like the entire JBCT editorial board. It can start very simply with us, from the bottom up. Ask ourselves simple questions, such as how we can expand our skills to reach out to those who are isolated? How can we continue to ensure human contact and clinical intervention under the worst-case lockdown scenarios? Could it involve mobile technologies, social media, neighborhood organizations, simple phone calls? How do we analyze a vulnerable person’s social support and material resources? How can we encourage our professional microcosms (the given hospital, clinic or university where we work) to coordinate broader initiatives in this direction? The COVID-19 pandemic left the world in a state of uncertainty and indeed anxiety. But it also shed light on essential problems affecting human kind as a whole, reminding us of our responsibilities and of the opportunities that can exist for lasting change.

Disclosure of interest

The author declares that he has no competing interest.

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