Mental health in the age of COVID-19, a Mexican experience

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ABSTRACT

As of June 2020 the number of Coronavirus cases in Canada, Mexico, Central America and the Caribbean are just under 2.5 million infections and over 140,000 deaths. The health systems in half of the countries in the Americas and the rest of the world have faced the pandemic positioned from different perspectives. While Canada and the United States already had extensive experience in the practice of telemedicine, other countries such as Mexico and the Caribbean, doctors from both private and public sectors have been forced to start practicing medicine remotely. As a result there have been limitations such as poor access to technology, lack of privacy legislation, and difficulties with fee collection among many others. These situations must be taken in account to understand what is happening in the region. On the other hand, the need to continue providing medical attention is indisputable. We understand that COVID 19 besides other systems damages the CNS, patients present severe neuropsychiatric symptoms that range from headache, anosmia, ageusia, confusional state alteration of consciousness, toxic metabolic encephalopathies, encephalitis, seizures, cerebral vascular events, Guillain Barre-type demyelinating neuropathies, to the extent of conditions such as anxiety, acute stress disorder, post-traumatic stress disorder, depression, and eventually psychotic episodes. As time passes we try to differentiate the origin of the symptoms. We will learn which of these symptoms are a result of metabolic complications, which others are due to drug’s secondary effects and which ones are adaptive response. Therefor our contribution to the editorial supplements is given in two lines of analysis: disease physiopathology and ways to deliver treatment to the population.

Key words: COVID, mental health, telepsychiatry

INTRODUCTION

COVID-19 has affected the entire planet but has had serious effects in some countries. After only 7 months since the first outbreak in China, we know that the most affected countries are the United States (USA), Brazil, and India.

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However, among the twenty most affected countries, we found that six are in the Americas; among them, the USA is the leader in confirmed cases and deaths, followed by Canada, Peru, Chile, Colombia, and Mexico.

Currently, Mexico ranks 10th with more than 220,000 cases of positive infections. The position on this ranking could increase considering that every 23 days, infections are doubled.[3] Regarding the fatality rate, Mexico is ahead of Latin America, with 12% mortality rate compared to the
5% average in the rest of the world. México in ranked 5 among the 10 countries with the highest number of deaths, accounting for > 27,000 people.[1,3]

The higher number of deaths and infections has been a direct result of the various decisions and actions taken by each country. Unfortunately, even though Mexico entered the contagion phase, a little later than other countries like Italy and the United Kingdom, recommendations given by the WHO were not followed. As a result, we had a negative outcome.

It has been proposed as an aspect that influenced the increase of cases in our country was the Health Ministry’s decision to employ the sentinel epidemiology surveillance system, instead of active surveillance. The former approach does not obtain the most data in a systematic manner, but uses a selected sample of patients in relation to the course of contagion in a pandemic. This method usually does not serve as an accurate sample; moreover, it focuses on high-risk situations as a source of information for planning and decision-making.[4] The low sensitivity and the predicting value of this form of surveillance were questioned and did not allow accurate knowledge of the majority of the cases that would have been detected otherwise.

Consistent with this government position, very few tests for detecting COVID have been administered. In fact, of the 36 members of the OCDE, Mexico is the country with less testing done, with 0.4 tests/1000 citizens, whereas the average in other countries is 23 tests/1000 citizens.[1,5] This lack of case identification does not allow proper patient follow-up and tracking and tracing of potentially contacts exposed; as a result, it is very difficult to avoid the spread of the virus. Most likely, the high mortality rate is precisely the result of the number of undiagnosed patients and asymptomatic carriers such that those arriving gravely ill to the hospital are the only ones studied and confirmed.

In this adverse scenario where containment of the problem is unlikely to be part of the near future, we, the mental health professionals will face the 4th wave of the pandemic,[6] with increase of mental pathology, psychic trauma, economic problems, and burnout, as identified by an intensivist doctor Victor Tseng.

The need of care increased since the beginning due to the contingency as a result of severe anxiety in the population; after that, we identified neurological and neuropsychiatric complications of patients affected by coronavirus and with that a new area of research and clinical approaches had emerged. In addition, we are now facing complications as a result of the lack of primary and secondary patient care. The negative forecast will extend to the coming years where we will still notice the impact of the pandemic.

In this national context, Mexican psychiatrists have been participating in different activities and contributions. We have added efforts going forward offering support on several fronts. We have worked guiding and advising the population through the use of media such as radio, TV, and digital forums, giving emotional support and first psychological aid to health providers while keeping an open dialog with governmental authorities and nongovernmental organizations.

We would like to highlight two important concepts that we have been addressing nationally as we deal with the pandemic: first is the remote access to mental care services that allow us to provide protection and continuity of care, to the population at large, and follow-up to patients and second the analysis of the neuropsychiatric COVID phenomenon.

**TELEPSYCHIATRY**

In a matter of months, the lives of psychiatric patients and the lives of those not previously diagnosed have changed dramatically. At the same time, the way we practice psychiatry has changed around the world. In Mexico, practicing psychiatrists have had to adapt rather quickly in providing continuity of care to their existing patients and, more so, to make services available to new patients. As the second wave of the pandemic makes it appearance, we have already witnessing an increment in people seeking care and it is expected that this will keep on rising.

Telepsychiatry has become the most used tool to achieve this goal. The widespread availability of digital platforms has made it rather easy to provide services without exposing patients or providers to the spread of the virus. However, compared to countries like the USA and Canada, Mexico and other countries in Latin America do not have an established regulatory and legal framework to provide such services.

While these efforts are undoubtedly the way to go at this time, there are issues that will necessarily have to be addressed at a later time. The platforms that can secure privacy include informed consent, electronic prescription, electronic health records, measures to prevent malpractice risk increase, and safety measures that will protect suicidal and other kinds of at-risk patients. Sooner than later, we will return to in-person services, with proper protection measures (i.e., face covers and social distancing) and even telepsychiatry will remain, which will make a difference especially in low- and middle-income countries that did not have such access before the pandemic.[7,8]

In an effort to prevent burnout, the Mexican Psychiatric Association has launched telepsychiatric services at no charge to provide care for health-care personnel with psychological
first aid and psychiatric assessment and intervention. This intervention was implemented successfully in the past at the Universidad Nacional Autonoma de Mexico. The service was originally designed using standard outcome measures, as a first approach to explore and monitor the above-mentioned features.

NEUROPSYCHIATRIC DISEASES

The scope of central nervous system (CNS) diseases related to COVID-19 has been described according to the way in which they have emerged and reported worldwide. In order of frequency at a neurological level we find: headaches, anosmia and ageusia, disturbances in consciousness of the type of acute confusional states, metabolic encephalopathies, seizures, encephalitis, neurovascular injury and cerebral vascular disease, and demyelinating neuropathy like Guillain–Barré syndrome.[9]

The predominant psychiatry disorders are anxiety, acute stress disorder, posttraumatic stress disorder, depression, insomnia, and onset cases of psychotic and emotional disorders.[9,10] The coming months will be key in defining which disorders are the result of SARS-CoV virus, which are associated with metabolic complications and which are due to the adverse effects of medications.

CONCLUSIONS

While the impact in the millions of people affected by this pandemic is yet to be established, we should also take it as an opportunity to improve our competencies and, in this case, widen the opportunities to improve access to care, increase the availability of services, decrease stigma, and understand the viral effects in the CNS and peripheral nervous system.

Psychiatry should thrive as a result of this contingency, that will leave our society in greater need of care for an amount of time, yet to be determined.

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Conflicts of interest

There are no conflicts of interest.

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