



Department of Psychiatry and  
National Drug Dependence Treatment  
Centre, AIIMS, New Delhi



# COVID 19 Pandemic and Mental Health: Experiences of Organizing Services at a Tertiary Care Healthcare Institution

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# **COVID 19 Pandemic and Mental Health: Experiences of Organizing Services at a Tertiary Care Healthcare Institution**

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## **Foreword**

COVID-19 pandemic created unprecedented challenges for the healthcare sector worldwide. All India Institute of Medical Sciences (AIIMS), New Delhi set up a unique example of Covid care services by setting up two comprehensive Covid care facility, one at main AIIMS campus and another at its Jhajjar campus. The main hospital continued to provide general healthcare services and also provide support to the COVID care facilities. The Institute also took lead in developing telemedicine services in various medical and surgical disciplines. All infection control measures were followed by the Institute. Each department of the Institute had to deal with multiple challenges in terms of ensuring safety and continuity of services.

I congratulate the Department of Psychiatry & National Drug Dependence Treatment Centre (NDDTC), AIIMS, New Delhi for coming up with the monograph “Covid-19 pandemic and Mental Health: Experiences of Organising Services at a Mental Health Care Institution”. The monograph captures the activities and contributions of the department towards mental health care delivery at various fronts and experiences pertaining to reorganizing services in the wake of pandemic. The department has been providing consultation-liaison services for those admitted at AIIMS COVID care facility, in addition to contributing 40% of residents as well as faculty towards COVID duties. The department set up COVID safety processes and protocols across various settings for mental health and addiction services, such as out-patient and in-patient settings, emergency services, community outreach services along with establishment of telepsychiatry services in sync with the Institute guidelines and protocols. Several modifications were made in methods of teachings, academics and exam assessments amidst pandemic. The student mental health initiatives were planned for promotion of mental health of students and residents staying on campus to prevent social isolation.

I believe that this monograph will provide useful insights into experiences and narratives of the faculty members and residents of the department. The contributions of department of psychiatry and centre towards ensuring mental health care delivery and addiction services amidst pandemic are appreciable. I once again congratulate all those connected with these efforts.

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## Preface

Coronavirus disease-2019 (COVID-19), caused by the novel coronavirus (severe acute respiratory syndrome coronavirus-2 - SARS-CoV-2) was first detected in December 2019 at Wuhan city of central Hubei province of China and spread to many countries within a short span of time. On 11<sup>th</sup> March 2020, the World Health Organization (WHO) declared it as a pandemic. At that time, there were 118,000 cases in 114 countries and 4,291 people had lost their lives. Now ten months into the pandemic, on 16<sup>th</sup> January 2021, there have been 92,506,811 confirmed cases of COVID-19, including 2,001,773 deaths, impacting more than 210 countries and territories, as reported to the WHO. COVID-19 pandemic is an extraordinary event that the last three generations had not witnessed since the Spanish Flu of 1918; the suffering and casualty rates being very high and are comparable to the two world wars.

COVID 19 pandemic took over the health systems by surprise due to its high contagion capacity, continuously evolving understanding and therapeutic measures, lack of vaccine, and a large number of asymptomatic carriers in the community. There was intense media coverage and rapid spread of information on social media platforms due to availability of high-speed internet services through smart phones and other devices. It has spread rapidly and caused significant morbidity and mortality. For example, in India, on 24<sup>th</sup> March 2020, when the nationwide lockdown was implemented to check the spread of virus, total number of confirmed cases was 564 and there were just 10 deaths reported due to COVID-19, whereas, on 16<sup>th</sup> January 2021, the total number of confirmed cases was 10.6 million and deaths was 152,000. There has been a risk of high rates of infection in front line workers including health care workers due to its highly contagious nature. Many psychological symptoms like depression, anxiety, and stress are reported in general population, persons with COVID-19 and their families, those in quarantine as well as in the health-care and front-line workers. Socio-economic impact of lockdowns has been huge. The psychological disturbances are associated with multiple social phenomena like stigma for the affected persons and their contacts, marital or family conflicts due to many family members confined together at home over many days, loss of livelihood, withdrawal syndromes in the persons using psychoactive substances, not being able to get timely help in case of serious medical problems, effects on academic careers of the school or college going population, and so on. Many healthcare settings also had to close down the routine clinical care so as to divert resources for the COVID affected population. Due

to the lack of definitive treatment, preventive measures like frequent hand washing, respiratory etiquettes, physical distancing, mask, and self-isolation are important for controlling the spread of virus. Soon after the declaration of COVID-19 pandemic by the WHO, India went into complete lockdown from 24<sup>th</sup> March 2020 till 31<sup>st</sup> May 2020. The process of unlockdown took place in phases so as to open economy and other services.

The COVID-19 pandemic brought an unprecedented crisis for the community at large. From the early stages of pandemic, mental health was recognized as a crucial and integral component of a coordinated response to pandemic. Mental health as a field continues to face tremendous challenges in terms of increased stress and fear faced by the general population, new-onset mental health and psychosocial crisis amidst ongoing pandemic, and also service provision for follow-up patients. Right from the outset, the Department of Psychiatry & National Drug Dependence Treatment Centre (NDDTC) at the All India Institute of Medical Sciences (AIIMS), New Delhi - a tertiary care hospital and medical university in India, played an important role in dealing with COVID-19 pandemic. The department of psychiatry runs daily outpatient services, seven specialty clinics, community services at two centers, consultation liaison services and emergency care integrated with hospital emergency services. Annually on average it provides services to about 80, 000 persons in the outpatient department, 10, 000 persons in the community clinics, 1200 persons referred from other departments to consultation liaison team and 1000 persons in the main hospital emergency. Every year, about 300 inpatients are admitted in the psychiatry ward (a 32 bedded facility), located in the main hospital building. The academic responsibilities of the department include teaching and training medical and nursing undergraduates, 38 post graduates in psychiatry, post graduates from other departments on clinical rotation in psychiatry and PhD scholars in clinical psychology. The undergraduate teaching consists of 20 theory lectures and two clinical postings of 9 weeks, distributed in 4<sup>th</sup> - 5<sup>th</sup> and 6<sup>th</sup>-7<sup>th</sup> semesters. The department has been involved in interdepartmental collaborative and departmental research at the institute level. Many national and international agencies funded research projects are being carried out. COVID-19 pandemic impacted all these activities of the department.

The department of psychiatry and NDDTC at the AIIMS, New Delhi has been constantly working at various fronts, including out-patient care services, emergency services, in-patient services, consultation-liaison services, community outreach services and research pertaining to mental health in COVID-19. The Department also started teleconsultation service for the

patients using video calling and prescriptions were also issued as soft copies transmitted on WhatsApp and email. Patients with substance use disorders posed a unique challenge because most of the patients attending the hospital as well as the community outreach clinics were on maintenance medication dispensed from the hospital with many on daily dispensing regimen including methadone maintenance programme. These patients could not be managed by teleconsultation, since their medications could not be procured from outside counters. Hence we continued the follow up service at the NDDTC and its outreach clinics, but increased the duration of dispensing.

The department played a crucial role in public mental health care, including educational initiatives as well as print and audio-visual resource materials for the general population and vulnerable groups. In the process, several new capabilities, including tele-services were strengthened to deliver mental healthcare. Several new initiatives were planned for mental health of students and residents staying on campus to prevent social isolation. The department also built newer models of teachings, academics and assessments of the students as well as final examination amidst the pandemic. Over the year, 30-40% of residents at any given time and two faculty members were posted to the AIIMS COVID-care facilities at the National Cancer Institute, Jhajjar, Jai Prakash Narayan Trauma Centre and the Employee Health Service facility at new private ward, looking after patients with COVID-19. New learnings, experiences, skills and capacities have been acquired in various realms by faculty, residents and other healthcare professionals. Some of those experiences have remained uncaptured and undocumented.

In this monograph, we have compiled a collection of articles and writings about our experience of dealing with the pandemic. We discuss the new strategies and adjustments done to meet the challenges of COVID-19 so as to continue the basic functions of the department. In this monograph there are four sections:

- I. Academic papers and commentaries on various areas of service delivery/various services provided by the Department of Psychiatry and NDDTC during the pandemic. The learnings/teachings/challenges in the process of developing or delivery of services are included.
- II. Literary-academic-creative contributions rooted in COVID-19 theme. This section has writings from the residents and faculty members. This section has included any psychological-

philosophical insights of relevance to pandemic, personal-professional narratives and creative write-ups, poems, art/painting, humanistic story, irony/humor relevant to them

III. Published research (original, reviews, letters etc.) from the department and NDDTC with COVID-19 theme, reproduced with prior permission from journal editors

IV. Resource material related to COVID 19 developed by the department.

As we leap forward into next year, it is a useful exercise to reminisce and crystallize these learnings in the form of a monograph. We hope that the monograph shall serve as a 'holographic' reference for future with an aim to capture all activities, contributions and services rendered by department and NDDTC as well as experiences and narratives of faculty and residents for the period from onset of pandemic till year-end. This could serve as a model for continued functioning of a mental health services in a tertiary care set up in a pandemic situation in future.

Rakesh Kumar Chadda, Mamta Sood, Raman Deep



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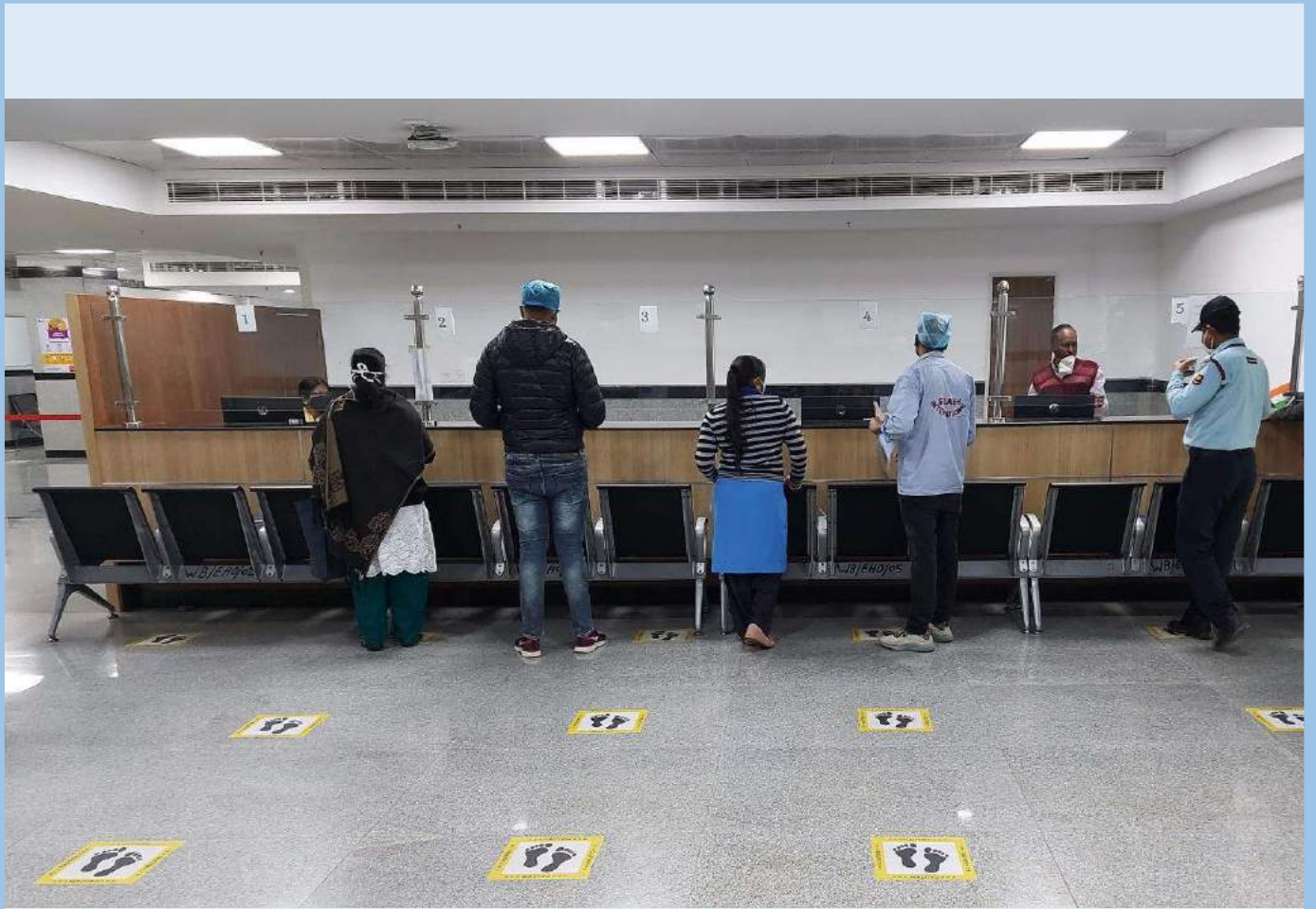
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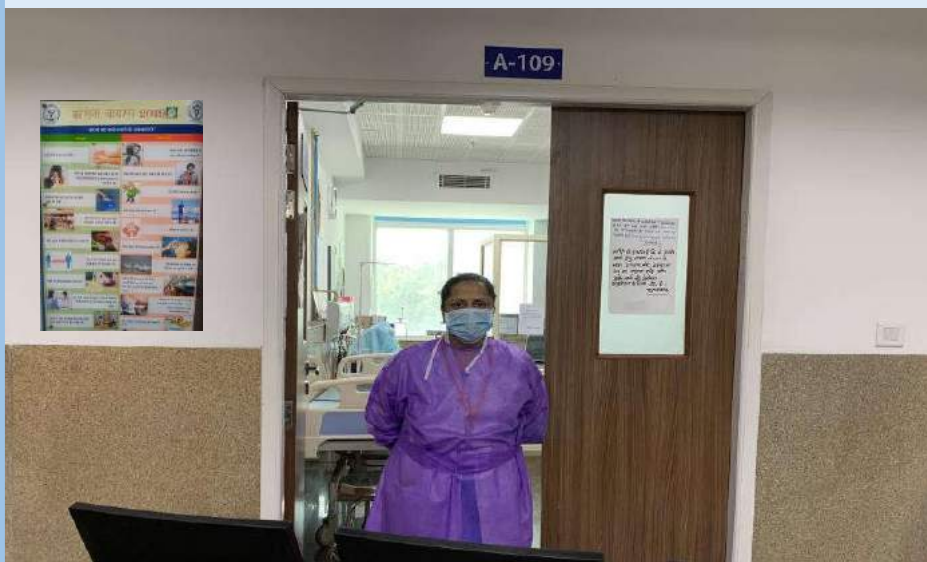
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# SECTION

## I

Services and Initiatives by Psychiatry  
Department & NDDTC during  
COVID 19 Pandemic

# 1

## **Mental Health Scene During COVID-19 Pandemic**

*Rakesh K Chadda*

COVID-19 pandemic has changed the way we would see the world. Even the mightiest nations, who held pride in their powers, health, and infrastructure, have not been able to cope with the situation despite having all the resources. The infection has had tremendous effects on the health infrastructure as well as economy of nations worldwide due to the steps taken for prevention of spread like lockdowns and social distancing undertaken. Mental health of the population, of both those infected by the COVID-19 as well as others, has been affected adversely in many ways due to multiple reasons. This paper discusses about how the department of psychiatry at our Institute dealt with the mental health issues as the COVID-19 pandemic spread since early 2020, with a specific focus on India as a representative of low- and middle-income countries. India's story of COVID-19 has been better than most of the Western world with India's strategies at dealing with the pandemic been more effective compared to the other countries despite having a much larger population and limited resources compared to the high-income countries.

### **Beginning of the pandemic and initial response**

Just to recapitulate, in December 2019, a cluster of cases of pneumonia of unknown origin were reported from the Wuhan city of China, which were identified to be caused by novel coronavirus (CoV), named as the 2019 novel coronavirus (2019-nCoV). The infection was highly contagious with spread by respiratory droplets. China publicly shared the genetic sequence of the COVID-19 on 12<sup>th</sup> January 2020. On 13<sup>th</sup> January 2020, a confirmed case was reported from Thailand. There was a rapid spread of the infection in the Wuhan city and around, and by 23<sup>rd</sup> January 2020, COVID-19 cases had been reported from Hong Kong, Macau and Taiwan. The infection rapidly spread to most of the countries in the next few months. The outbreak was declared a Public Health Emergency of International Concern by the World Health Organization (WHO) in January 2020, and was subsequently designated as a pandemic in March 2020. In India, the first case of COVID-19 was reported on January 30, 2020 in the state of Kerala. Till 15<sup>th</sup> January 2021, 92,779,627 confirmed cases of COVID-19 have been reported to the WHO with 1,990,398 deaths. Till mid-January 2021, India has reported 10,527,683 confirmed cases and 151,918 deaths. There has been a second wave of the COVID-19 pandemic in the USA and many other countries in Europe and South America in the last few months.

COVID-19 pandemic had tremendous adverse effects on the mental health of a wide strata of the population including those detected positive, their caregivers, healthcare workers and the general population due to fear of getting this severe potentially fatal illness. Persons already suffering from mental health problems were further affected due to not being able to access the mental health services. Preventive strategies of the lockdown, which led to closure of various



commercial and industrial establishments, as well as entertainment and tourism industry, led to economic shutdown and associated problems. Educational institutions were closed, and healthcare institutions had to divert their services to the COVID-19 specific healthcare facilities.

India declared a nationwide lockdown as a preventive strategy for spread of COVID-19 pandemic on 24<sup>th</sup> March 2020, which was extended in phases to 31<sup>st</sup> May 2020 and lifted back in a stepwise fashion over the next few months. Many general hospitals were converted partially or completely to COVID care facilities.

Our Institute, the All India Institute of Medical Sciences (AIIMS), New Delhi had started holding daily meetings of the Heads of the Departments, chaired by the Director for about a week prior to the lockdown in view of the worsening COVID-19 situation in the country. Thus, the Institute had been discussing the contingency plans to deal with the pandemic. As a first step for social distancing, the venue of the meeting was shifted from the Board Room to the main Auditorium. These early morning meetings held at the Auditorium continued for the rest of the year, which were important avenues of discussions and updates about policy decisions within institute. With the declaration of the lockdown at the national level, many contingency plans were brought in. These included challenges of meeting clinical responsibilities, teaching and providing care for the COVID 19 patients, as well as an advisory role at the national level.

As a first step, AIIMS, New Delhi started 24X7 National Telemedicine Service for doctors to resolve their queries about management of COVID-19, followed by telemedicine consultation for patients in different medical and surgical specialties, since regular outpatient services had been closed due to the lockdown. Round the clock emergency services continued throughout this period.

### **Response from the department of psychiatry and development of contingency plan**

Department of Psychiatry at the Institute had multiple challenges to meet in the background of the declaration of the pandemic, including clinical care for the patients in the psychiatry ward, looking for an alternative plan for the patients who were unable to get outpatient care due to closure of the services, teaching of postgraduate and undergraduate students, conducting the forthcoming examinations, mental health issues in the patients admitted in the hospital with COVID-19, and anxiety and stress in healthcare workers over risk of getting COVID-19 infection while providing care for patients with COVID-19.

A large part of the Institute's clinical setup was rearranged for COVID-19 specific services with the Institute's Trauma Centre and the AIIMS Jhajjar campus being converted to exclusive COVID-19 clinical services. Services of the Institute's Trauma Centre were shifted to the main hospital, with many departments including psychiatry requested to vacate their beds for the patients from the Trauma Centre. The bed strength of the hospital was also reduced by increasing the distance between the individual beds in various wards to maintain social distancing. Thus, in psychiatry, our bed strength was reduced from 32 to 18 beds with 12 out of 18 beds to be given to emergency and trauma patients. In addition, various departments

including psychiatry were requested to provide certain percentage of residents and faculty for COVID-19 services in the Institute.

Thus, the Department of Psychiatry (like other departments in the Institute) was to meet its main responsibility of providing mental health services besides providing general health care as well as make necessary modifications to meet the teaching responsibilities. To add to this, at any time, some of the clinical, teaching, and administrative staff were not able to reach the hospital due to lockdown or being quarantined due to getting COVID-19 infection or being a close contact of a person detected COVID-19 positive.

The subsequent paragraphs discuss author's first-hand experience at coordinating clinical and teaching services in Department of Psychiatry, AIIMS, New Delhi in the wake of the COVID-19 pandemic.

### *Clinical care in psychiatry*

The Department of Psychiatry at the Institute was able to begin the teleconsultation service within a week of closure of the psychiatry outpatient service. The department was provided with two dedicated smartphones for the purpose. In the beginning, teleconsultation services were provided to the follow up patients who had got an appointment for follow-up in the Psychiatry OPD at the Institute. Inpatient and consultation-liaison (CL) psychiatry services were continued as usual.

In the initial period of lockdown, there was also challenge of managing patients who had been admitted from the pre-COVID period, though we had stopped new admissions for few days prior to the declaration of the lockdown. New admissions were restricted to only emergency cases. Over a period of one week, we were able to discharge most of the patients admitted from the pre lockdown period. But over the next few weeks, we started getting more patients from emergency, which could not be refused admission. Then we had to request the hospital administration to reallocate the psychiatry ward beds to us which had been diverted to trauma care. The hospital administration agreed to our request and we got back our beds. However, it is important to state here that we continued with a strength of 18 beds (instead of the usual bed strength of 32) to maintain social distancing. It may be added that the substance use treatment services at the National Drug Dependence Treatment Centre (NDDTC), Ghaziabad and its three community outreach clinics continued uninterrupted. The inpatient services at the NDDTC had to be closed as a part of the AIIMS policy, since only emergency admissions were being done. The patients were given dispensing for longer periods so that they did not have to frequently visit the outpatient facilities. This was done to maintain social distancing at the clinical facilities.

CL psychiatry unit had an additional challenge of managing psychiatric referrals in the COVID wards, located in the Institute's Trauma Centre (around 1 km from the main AIIMS campus) and AIIMS Jhajjar campus (40 km from the main Institute campus). CL psychiatry team would make a daily visit to the COVID care facility at trauma hospital and attend to all psychiatry referrals. Psychiatric emergencies in the COVID inpatient services were often dealt by psychiatry residents, who had been diverted from the main hospital to the COVID pool.

### ***Teaching***

The first 10 days of the lockdown brought all teaching activities in the Institute as well as the Department to a halt, since all group activities had been banned due to the lockdown. Most of the undergraduate students were asked to return to their homes. The postgraduate teaching programme had been stopped. We started resuming our teaching programme gradually from the first week of April 2020 using online platform. We were able to complete our semester teaching schedule by extending its duration to May and June 2020. This was made possible since the summer vacations had been cancelled. The postgraduate teaching programme has been run in online mode till date. There are limitations in online mode like occasional connectivity issues, but it has offered a reasonable alternative. Similarly, we conducted our undergraduate teaching in online mode. The postgraduate examinations were another challenge. Since the physical OPDs were closed and inpatients were limited, there was limited or no clinical material for the postgraduate examinations. In addition, it was not easy to get external examiners. We were able to identify some external examiners, who consented for conducting the MD and DM examination by examining the candidates in person. We prepared case vignettes for the examinations by digging out material of clinical case conferences conducted over the last 10 years and were able to get a large cohort of long and short cases for the clinical examination. We also conducted mock examination of the MD and DM candidates using similar methodology to familiarize them to the new system. The final examinations were conducted with local external examiner joining physically and the outstation external examiner joining in online mode. The examinations were conducted satisfactorily. In the December 2020 examinations, we were able to get the patients, but both the external examiners for MD as well as DM examinations joined in online mode.

### ***Research***

Research is an integral part of various teaching and clinical departments of the Institute. The clinical research got stalled because the outpatient services were closed during the lockdown. Both MD and DM programme have also a requirement of a thesis/dissertation, which was also affected in the pandemic due to the lockdown. We used the approach of online assessments (wherever feasible) of the patients recruited earlier. For postgraduate and doctoral students and PhD scholars, the research protocols were reviewed and suitable modifications like reduction of the sample size or provision of online assessments were included. This helped the residents to meet the necessary requirement of finishing their thesis/dissertation in time and complete their training and appear in examinations.

### ***Community awareness activities***

The Department of Psychiatry and the NDDTC also prepared educational material for the healthcare workers, patients, caregivers, and doctors to deal with the mental health issues associated with the COVID-19 pandemic. In addition, the WHO's leaflets on COVID-19 and mental health were translated into various Indian languages (after taking permission from the WHO) and were displayed on the Institute's website. We also developed educational videos on dealing with various mental health issues related to the COVID-19 pandemic, which were

posted on the Institute's website as well as the Institute's YouTube channel. Faculty from the department also appeared in various educational programmes on COVID-19 and mental health on the national media.

### **Conclusion**

This paper summarizes various activities undertaken by the Department of Psychiatry and the NDDTC in the wake of the COVID-19 pandemic. The subsequent chapters describe in detail the steps taken in various directions by the Department of Psychiatry and the NDDTC. As of January 2021, the active cases in the country are in decline and recent launch of vaccination has generated hope. We look forward to the future with a cautious optimism along with preparedness for next waves, if any. The strategies developed during the pandemic are going to serve as a model to meet the challenges in future events of such a nature.

## **Outpatient Psychiatry Services During the Pandemic: An Experiential Account**

*Rohit Verma, Rakesh K Chadda*

### **Abstract**

The Corona Virus Disease 2019 (COVID-19) pandemic posed unique challenges for providing care to the psychiatry outpatient population across the country due to difficulty in adhering to respiratory etiquette and physical distancing norms by patients. Telepsychiatry was introduced as an alternative for the delivery of mental health services during the lockdown period. In order to reduce the risk and mitigate the COVID-19 outbreak in the outpatient services at our tertiary care psychiatry facility, preventive measures were put into place during the lockdown easing phase. We share our experiential account of risk mitigation strategies for resumption of psychiatry outpatient services after the lockdown started easing. While the strategy helped to ensure the overall continuity of mental health care, it had its own strengths and pitfalls. The model discussed here can be used in similar situations in future.

### **Introduction**

During the lockdown period of the COVID-19 pandemic, providing in-person mental health care services was a big challenge. Patients with mental disorders had difficulty in reaching health care services and faced difficulty in procuring medications due to a lack of prescription. The rapid advent of elaborate telemedicine services was a boon to health care sector and helped in providing services to the needy population. However, the felt need of physical consultation was prevalent as the telemedicine consultation has its own limitations and cannot completely replace didactic consultation.

As the lockdown eased, and the routine outpatient department (OPD) functioning was to be restored, there were new challenges to reduce the COVID-19 infection risk in the outpatient settings. Before we discuss further, it may be worthwhile to briefly discuss the services provided by the Department of Psychiatry, All India Institute of Medical Sciences (AIIMS), New Delhi.

### **Overview of clinical functioning of the department of psychiatry**

The Department of Psychiatry at AIIMS, New Delhi provides services at multiple places including inpatient and outpatient services at main AIIMS campus at New Delhi for mental health ailments, for substance use disorders at the National Drug Dependence Treatment Centre (NDDTC), Ghaziabad, and community outpatient services for mental health at the

Comprehensive Rural Health Services Project (CRHSP) Ballabgarh and for de-addiction at Sunder Nagari, Trilokpuri, Sarai Kale Khan and mobile methadone dispensing unit at Seemapuri. Emergency services are provided round the clock at main AIIMS campus at New Delhi. Psychiatry outpatient services at AIIMS, New Delhi are managed by are consultants, senior residents, junior residents and clinical psychologists, 6 days a week.

Psychiatry OPD was recently shifted along with other OPD services of the institute to the newly inaugurated New Rajkumari Amrit Kaur OPD Block at AIIMS when the unfortunate COVID-19 infection spread was reported worldwide and nationwide lockdown was declared. The modified electroconvulsive therapy (MECT) facility and the transcranial magnetic stimulation (TMS) facility were not shifted along with the OPD services and remained at the Old Rajkumari Amrit Kaur OPD Block, which continued providing services to patients during the lockdown itself due to the perceived need felt by the patients and clinicians alike.

### **Managing psychiatry outpatient services during the lockdown**

During the lockdown, telepsychiatry took over the OPD services as an alternative approach to reach patients and was welcomed by the patient population being served. This was started within a week of the closing of the routine outpatient care. Although telepsychiatry services fared well during the difficult times and provided the much-needed comfort to the needy population, requirements for in person consultation remained and was much awaited by the clinicians and the patient population. As the lockdown started easing, the need for initiating routine OPD services was stressed. From July 2020, as the OPD services resumed in a gradual roll-out manner with limited patient appointments allowed initially, various forms of modifications were made to the existing service provision from an infra-structural level to changes at service provider levels.

All patients were instructed to obtain an online appointment through the dedicated AIIMS web portal. Online appointments were available to limited new as well as follow-up patients. Patients had a choice to have an in-person appointment or a telephonic consultation. New patients did not have a choice of telephonic appointment. Those choosing in-person appointment at the OPD received a telephonic call prior to the appointment day to confirm the appointment and received a text on the short messenger service (SMS) platform at the registered phone number. On the day of the appointment, patient and one caregiver were allowed to enter the OPD premises through a specific gate. On entering the gate, all patients and family members/caregivers were screened by a COVID screening team comprising of doctors, nurses and supportive staff. The screening included reviewing history for possible COVID-19 infection symptoms, checking temperature, and physical examination wherever warranted to exclude COVID-19 associated physical signs. Those cleared by the screening personnel were tagged with a coloured wrist-band, and were provided N-95 masks and hand gloves, if they did not have any. Thereafter, they were provided with an empty card for receiving prescription from the respective clinician and asked to go to the respective OPDs while maintaining adequate distance from each other.

All OPD staff were provided an entry from a separate gate different from the common entry gate. Staff entry to the OPD rooms managed through a specified donning room where all OPD personnel were to wear their respective personal protective equipment (PPE) based on the World Health Organization (WHO) recommendations, which included N-95 masks, goggles, face shields, water-resistant gown, gloves, apron, shoe cover, hood, etc. The entire OPD staff including guards, sanitization workers, OPD orderlies, OPD counter and file maintenance staff, nursing staff, residents and faculties were provided with individual PPE distributed by the OPD sister-in-charge. All PPEs were to be discarded after finishing the OPD work which was done in the specified doffing room and disposed of by the respective garbage disposable units as per the standard hospital infection prevention and control guidelines.

An automatic sanitizer dispenser was installed at the Psychiatry OPD entry gate for the patients, family members and staff to sanitize hands on entering and as on need basis. The patient/family seating arrangement was done in such a way in the waiting area and in the service provider's (clinician's) room so as to maintain a gap of one seat between two adjacent persons. A glass fibre panel was erected between the patient and the clinician who were seated at a distance of about 8-10 feet from each other. A hand sanitizer was installed in each service provider's room so that they could frequently wash hands after physical examination of the patient or after handling patient documents. A small thin transverse slit was made in the glass panel to facilitate the handling of patient related documents and clinical prescription.

As the junior residents required longer time for case work-up of a patient, an innovative strategy was implemented to facilitate interviewing the patient for a long duration while maintaining physical distancing. The resident would sit in one room with the computer connected by a local area network (LAN), interview the patient and the informant sitting in the other room with an independent desktop making use of video and audio facilities. The psychologists also utilized a similar LAN setup for providing psychological assessments or therapies wherever feasible. Physical examination of the patient was conducted in a separately designated room taking adequate precautions.

Over the period, psychiatry OPD functioning have been gradually restored to the pre-lockdown functional state in a graded fashion with increasing number of patients, but safety protocol is being adhered to.

### **Manpower management**

As half the strength of residents in the Department was diverted to serving the COVID facilities in a rotational manner, the remaining half of the residents and faculties were divided into three near-equal teams of consultants and residents. This policy was framed to avoid the entire department service providers getting quarantined at the same time, since in the event of even one personnel getting infected, it would be difficult to segregate high-risk and low risk contacts, if everybody was in similar settings. In this arrangement, one team provided the OPD services and telemedicine services, second team managed the inpatient services and the consultation-liaison (C-L) services, and the third team managed the online academic activities with provision of work-from-home. The three teams managed the specified service delivery for a

week and then were rotated with another team over the next week. In this manner, the three teams alternated the service tasks appointed for a given team on a weekly exchange basis. Faculty from psychology and clinical psychologists were also divided into two teams and provided services on a weekly basis with initially one team providing services and other team providing online/telephonic consultations to COVID-19 facilities with work-from-home provision.

As the resumption of OPD services was gradually being rolled-out in a step-up phased manner, few service providers were enough for providing adequate clinical services utilizing the aforementioned infection preventive measures. New and follow-up cases were equally distributed amongst the senior residents and faculty in the OPD. Limited detailed case work-ups were allotted to junior residents for discussion in order to balance the clinical learning and exposure risk. Gradually as the lockdown eased further with more inflow of new and follow-up patient attendance in OPD, case work-up increased subsequently, and need arose for expanding the manpower.

### **Gradual resumption of services**

With time, it was observed that the weekly change of service providers made it difficult for continued care of the patients in a uniform manner. This was particularly true for inpatient facility and also inconvenient in OPD, as the appointment provided to the patient would many a times fall on a day other than that of his/her usual clinician care provider. The initiation of provision for MECT on an outpatient basis also created dearth of service providers at the facility, as previously it was only intended for admitted patients, wherein the team catering for the inpatient setting was managing the MECT on a weekly rotation. Also, while the online platform was found useful for continuance of academic activities, it was felt that the clinical teaching of the residents was getting hampered by the restrictive interaction with the faculty for case discussion in outpatient and inpatient settings.

In order to ensure uniform and continuous care by respective clinician, the teams were dissolved by late August 2020 and the pre-pandemic unit system was resumed with different units comprising of residents and faculty providing clinical services to the outpatient and inpatient settings. Emergency services were also taken care of by the units on their respective individual duty days. Separate postings were re-initiated for community clinic, MECT facility, TMS facility and C-L psychiatry services. Clinical psychology services were also resumed as in the pre lockdown period.

With the easing of lockdown and opening of the outpatient clinic, telepsychiatry has been continued as an alternate facility for follow up. Patients requiring in-person evaluation are advised to visit the outpatient clinic. Patients and family members with apprehension about getting COVID-19 infection and patients coming from distant areas and having difficulty in traveling still prefer to continue telepsychiatry services. The telepsychiatry service has been used only for follow up cases and has not been used to initiate treatment for new patients as per the national guidelines.



## **Conclusion**

An effective risk mitigation strategy was initiated to maintain the clinical services in the OPD during the lockdown easing period. The effectiveness of the strategy can be judged by the fact that no OPD personnel was found to be infected during the implementation period. While the strategy was effective in mitigating risk for service providers, it hampered adequate continuum of care to the needy personnel in the beginning due to logistics. This led to a change in strategy to a more patient focused approach and gradually the services were resumed with standard precautions.

# 3

## **Telepsychiatry Experience at AIIMS, New Delhi**

*Ragul Ganesh, Rohit Verma, Koushik Sinha Deb, Rakesh K Chadda*

COVID-19 pandemic has been a public health emergency with far reaching consequences on the mental well-being of the population. Its psychological impact has ranged from fear of acquiring infection and infecting others to isolation, financial strain and uncertainty about the future, which could trigger new psychiatric symptoms as well led to aggravation of the pre-existing mental illnesses.<sup>[1]</sup> COVID-19 pandemic has also created an unprecedented challenge for the delivery of mental health care across the world, more so in the low and middle income (LAMI) countries.<sup>[2]</sup> In the background of lockdown, travel restrictions and social isolation, telemedicine or more specifically telepsychiatry offered a very practical and useful alternative for the delivery of mental health services.<sup>[3]</sup> Telepsychiatry refers to the process of delivering mental health care services from distance by mental health professionals using information and communication technologies.<sup>[4]</sup> Thus, the mental health professionals could evaluate and manage the patients without exposing the service providers and patients to infection. As an extension, this would include offering advice to non-psychiatric clinicians on matters related to mental health issues.

The global public health response strategy of physical distancing and isolation for those who are at risk of infection have led to reduced access to support from family and friends resulting in deterioration of the social support systems, and further leading to worsening of anxiety and depressive symptoms.<sup>[5]</sup> During the COVID-19 pandemic, providing in-person mental health care service has been challenging. Patients with mental disorders have difficulty in reaching the health care services and face difficulty in procuring medications due to lack of prescription. Hence, there is risk of relapse due to non-availability of medications. Also, there is an emergent need to attend to the vulnerable population at risk of developing mental disorders during the time of pandemic.

As one of the strategies in mitigation of COVID-19, the Government of India announced nationwide lockdown on 24<sup>th</sup> March 2020. Most of the hospitals all over the country stopped the non-essential and routine services to adhere to physical distancing mandates. The Ministry of Health and Family Welfare, Government of India issued the Telemedicine Practice Guidelines-2020 on 25<sup>th</sup> March, 2020.<sup>[6]</sup> The release of Telemedicine Practice Guidelines enabled health care practitioners to adopt telehealth to manage the patients struggling to reach the hospitals due to nationwide lockdown. Healthcare institutions were encouraged to develop telemedicine services.

### **Telepsychiatry services for outpatients**

In the background of closure of the regular outpatient services due to the national lockdown, a decision was taken by the administration of our Institute (a tertiary care multidisciplinary 2500 bedded teaching hospital in North India) to start telemedicine services in different clinical disciplines.

The department of psychiatry in the institute was one of the first to start its regular telemedicine services on 30<sup>th</sup> March 2020. We developed a brief document on standard operative procedure (SOP) for providing teleconsultation services to patients with mental health problems with a purpose of following a uniform protocol in service. These guidelines were also put on the institute website. A dedicated team of senior and junior residents in psychiatry supervised by consultants provided mental health services to the patients already enrolled with the psychiatry outpatient service through teleconsultation. Three smartphone devices with dedicated mobile numbers were used for the provision of telepsychiatry services.

During the initial weeks of lockdown, the appointment lists of patients were prepared in liaison with the Institute's centralized appointment facility to avoid service interruption to those with scheduled appointment. The patients were contacted and enquired regarding their willingness for teleconsultation. Most of the patients showed interest and benefited from telepsychiatry services. In the subsequent weeks, text messages were sent to the registered mobile number of the patients, one day prior to the date of their scheduled appointment informing them about the availability of telepsychiatry consultation.

On the day of scheduled appointment, patients were called through dedicated telepsychiatry mobile devices. The patients were expected to use a simple mobile phone or a smart phone device. The psychiatrist calling the patient would assess the patient's current need and his/her technological capacity, especially about their access to internet and the kind of phone device available with them. If a patient had only calling and text message services, he/she and their caregiver were interviewed through audio call to assess the clinical status and digital prescriptions were sent through text messages. In patients with access to internet and familiar with simple technology, the latest prescriptions were obtained through online messenger applications like WhatsApp. They were then evaluated either through audio calling or video calling facility depending on their access to the applications and preference with WhatsApp video call, Face book video call, etc. By the third week, telepsychiatry services were further extended to all follow up patients enrolled with the clinical services of the hospital and the patients started enrolling for repeat teleconsultation. As patients got oriented towards the process of teleconsultation, they would be ready with the medical records and pictures of prescription at the time of being called for follow up. Some of the patients, who previously didn't have access to internet and smart phone device, used their family members' or other acquaintances' smart phones or internet to communicate with the psychiatrists in the subsequent teleconsultation. The patient's name and his/her unique health identification number were verified before the consultation. Emergency cases were called in-person to the emergency service of the hospital, and those having difficulty in travelling were advised to visit a local psychiatrist in their area of residence.

We were able to provide a total of 2401 telepsychiatry consultations during the period of four months of the closure of the regular outpatient services. This covered 64% of the total appointments including both previous booked appointments for physical consultation and follow up teleconsultations. The reasons for unsuccessful consultations included appointments without record of mobile numbers (n=142; 3.7%), appointments with wrong phone number or change of phone numbers (n=179; 4.8%), patients' number not reachable (n=540, 14.4%), or patient not picking the calls (n=480, 12.8%). Over the period, there was an improving trend in the number of successful teleconsultations from 51.4% (n= 910/1770) in April 2020 to 81.9% (n=480/586) in the month of July 2020. This could be due to improvement in patient's understanding about the process of teleconsultation.

With the easing of lockdown and opening of outpatient clinic, telepsychiatry has been continued as an alternate facility for follow up. Patients requiring in-person evaluation were advised to visit the outpatient clinic. Patients and family members with apprehension about getting COVID infection and patients coming from distant areas and having difficulty in travelling still prefer to continue telepsychiatry services. We would like to add that this service was used only for the follow up cases and was not used to initiate treatment for new patients as per the national guidelines.

When the regular outpatient services were started in late July 2020, we used another innovation of teleconsultation by redesigning our interview rooms in outpatient clinics to facilitate interviewing the patient for a long duration while maintaining physical distancing. The psychiatrist sitting in one room with the computer connected by local area network (LAN) would be interviewing the patient and the informant sitting in the other room with an independent desktop.

### **Learnings**

Department of Psychiatry at our Institute provides has catchment area spread over large parts of northern, eastern and western India with some patients needing to travel more than 12-24 hours to reach our facility. The approach used in the present experiment during COVID-19 has a potential to be used also in routine psychiatric care for patients coming from long distances at various places in India as in countries where patients have to travel long distances to seek a psychiatric consultation.

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# 4

## Psychiatry Inpatient Services During COVID-19 Pandemic

*Mamta Sood*

The news about COVID 19 had started circulating in the news and social media by February 2020. However, our routines related to clinical care, teaching and research activities at the Institute went on undisturbed. We had started talking about this new flu virus with faculty colleagues during lunch and “chai” in faculty canteen. When COVID 19 pandemic was declared by WHO on 11<sup>th</sup> Mar 2020, it still seemed like H1N1 influenza of 2009 that had fizzled out. However, news about ability of COVID 19 to cause extensive morbidity and mortality in Wuhan, China and Lombardy, Italy was pouring in. An idea that this was no ordinary flu started shaping up in my mind. Actions happened in quick succession and at the Institute, the preparations for dealing with the pandemic started. Two hundred and sixty bedded JPN Trauma Centre was declared as COVID hospital. Nation-wide lockdown was implemented on 24<sup>th</sup> March 2020. Multiple committees were formed which looked into the measures to be taken for dealing with COVID 19 pandemic.

We share our experiences of continuing psychiatry inpatient services during the pandemic in this article. In our hospital, psychiatry ward (C 1) is located on the first floor in the ward block of the main hospital building. It is an open ward and has 30 beds, two beds for child patients and two isolation rooms with attached bathrooms. About three hundred admissions are done annually, usually with a family member as a hospital policy. The ward is a hub of various kinds of activities: daily activities to maintain the ward and its routine, clinical care and rounds, day care activities, teaching activities and weekly case conference. On any day in the ward, there are patients and their caregivers, faculty, resident doctors, nursing staff, an occupational therapist, orderlies, cleaning personnel, guards and visitors along with medical and nursing undergraduates. Only one isolation room was available; other room was converted temporarily to pantry which was under repair.

We could identify three phases of actions in the period from 25<sup>th</sup> March to 31<sup>st</sup> December 2021. These were informed by evolving knowledge (mode of infection, incubation period, signs and symptoms, preventive measures, aetio-pathogenesis and treatment) about COVID 19<sup>1,2</sup>, literature on the issues related to COVID 19 infection in psychiatric inpatient facilities<sup>3</sup> and guidelines issued by the Institute from time to time. These guidelines were circulated among us by email and were also available on AIIMS website in the AIIMS COVID portal<sup>4</sup>.

***Phase I (Initial Phase):*** Psychiatry ward was designated as non-COVID ward. On 17<sup>th</sup> March, the first two beds of each general ward, including psychiatry, were earmarked for use by the hospital. On 31<sup>st</sup> March, 23 beds of psychiatry ward were reserved for surgical trauma patients as trauma centre now functioned as COVID hospital. The group activities conducted in the day care were stopped due to lack of enough space to ensure safe distance between patients. Stable

patients and those who could be managed at home were discharged. Routine admissions to the ward were temporarily stopped. The academic activity – case conference held every week in the ward, was shifted to online platform.

In the first week itself, a patient with bipolar disorder currently in manic episode, was admitted from emergency. He had stopped medications due to nonavailability. He was hospital staff. He had to be admitted alone as he did not have a family member staying with him. From the hospital administration, persons were arranged to stay with him round the clock. This admission started the process of brainstorming about preventing and identifying COVID 19 infection in the ward.

A multi-disciplinary team was built comprising of psychiatrists – in-charge inpatient services, nodal officer coordinating COVID 19 preparedness with hospital infection control team and a faculty, two senior residents; three nursing officers – two ward in-charges and a nursing officer and occupational therapist. The function of the team was to identify and implement measures to prevent COVID 19 infection in the ward. The group met in-person, as required and also maintained a WhatsApp group for coordination and periodic updates. In the first month of April, at Institute level, various guidelines were formulated. The most useful was a ready reckoner for hospital infection control practices related to COVID 19 formulated by the hospital infection control committee<sup>5</sup>.

Most of the actions were initiated simultaneously. These were:

- Making a checklist of symptoms of COVID 19 for use by residents and staff daily to screen for COVID 19 in the ward personnel and patients/caregivers
- Regular cleaning of the high and low touch surfaces in the ward
- Ensuring adequate supply of cleaning material, medicines and personal protective equipment (PPE) relevant for our setting
- Identification of facility for isolation where any new patient was kept for 5 days for observation of symptoms of COVID-19 infection
- Identification of areas for donning (occupational therapy room) and doffing (pantry that was under repair)
- Adequate management of bio-waste
- Ensuring attendance of ward staff of all categories in the infection control in the training courses arranged by the hospital administration
- Prompt sharing of information among the staff
- Posters (Hindi and English) for awareness about COVID 19 and preventive measures
- Minimizing influx of non-essential persons to the ward
- Provision of masks to unmasked patients/visitors/staff
- Putting sanitizer bottles at strategic places (not near the bed of patient)
- Referral system for COVID suspect or positive patient and caregiver/ward staff
- Advising not to eat and take tea in groups

- Making list of staff (both temporary and permanent) posted in the ward with their addresses and contact numbers for contact tracing in the eventuality of developing COVID 19 infection.

At any time, about 25-40% of the faculty and resident doctors were posted in the COVID areas. So, to conserve manpower and ensure continued availability in the event of infection in some of the team members, existing unit system operational in the ward was replaced by three teams. These three teams worked on the weekly rotations basis in the ward and looked after all the patients admitted in the ward.

On the allocated beds to surgery trauma, patients of other departments like gastroenterology, haematology, oncology, medicine and geriatric medicine were admitted from emergency. These patients needed intensive care. Our staff was overworked; this compromised their time and capacity to take care of patients with psychiatric disorders who also needed constant attention. Psychiatric patients admitted during this time were also serious, many of them suicidal, needing constant supervision and vigilance. Ward was full, no social distancing could be ensured and there was increased influx of people in the ward - many resident doctors, nursing staff and caregivers of these patients from other wards.

During this time, we temporarily converted our play therapy room into the duty room for residents from other wards so as to minimize overcrowding of our doctors' duty room. We had two COVID positive cases among the medical patients who were shifted out and fumigation of the cubicle was done. Also, there was fear of further spread of the infection in the ward as the patients from other wards also shared bathrooms (six in number, three each for males and females) that are common. Our major concern was that in case of spread of infection in the ward, as per guidelines, we may have to fumigate the whole ward and to transfer all our patients to other ward. Patients admitted in wards of other specialties can be shifted to any ward with standard facilities. For patients with psychiatric disorders, the ward has special provisions: no locks in bathrooms, round the clock guards, no rods, no strings or sharps of any kind, grilled windows, nurses counter clear of clutter or sharp objects, pipes and exhaust fans covered with iron cage and many such provisions to minimize the risk of suicide and violence. Therefore, any ward where our patients would be shifted, would have to be equipped with at least some of these measures. The hospital administration was requested and admissions of patients from other specialities were stopped in psychiatry ward. Also, in sync with the hospital policy, to maintain social distancing, number of patients to be admitted in the ward was reduced to half.

This phase lasted from 25<sup>th</sup> March to Jul 2020 included period of complete lockdown.

**Phase II (Maintenance Phase):** The protocols initiated in the first phase were continued. OPD services were started and the department reverted back to the pre-COVID unit system. This helped in ensuring better care as same team looked after the patient from admission to discharge.

Adequate resources such as PPE, sanitizers, cleaning supplies, training of the staff, medicines and other important resources were available from the hospital. Protocols for identifying patients with COVID 19 infection and referral were established. Any detection of new case in



the staff or residents led to contact tracing and their risk was determined by the nodal officer and was implemented.

To reduce the crowding of the resident doctors in one room, the isolation room was converted to additional duty room. However, there was still risk of new admissions being either asymptomatic COVID infection or positive taht could not be ruled out. About 5-6 months into the pandemic, the hospital guidelines were issued that all new admissions should be tested for COVID and only negative patients were to be admitted. That was a relief for the staff.

This phase lasted for about 5-6 months till December 2020. For most of this period, inpatient admissions have been through emergency. During this phase, although in the city as well as nation, infection rates rose to significant numbers yet knowledge about aetio-pathogenesis, effectiveness of preventive measures and treatment of COVID also improved.

***Phase III (Pre-normal phase):*** This is the current phase that started in January 2021. The number of cases of COVID19 have started to fall. Protocols initiated for continuing inpatient services have been maintained. As one enters the ward, the sight of observing masked faces, staff in PPEs, cleaning at regular intervals and other activities have become familiar. Day care activities have not resumed. The bed strength in the ward has been normalized to pre-COVID levels. Routine admissions (with COVID test) from the OPD services have also started. Case conference is still being held online. Nursing and medical undergraduates have pen posted to the ward for training.

From 25<sup>th</sup> March to 31<sup>st</sup> December 2020, bed strength in the ward was full. A total of 93 patients got admitted. Only 6 beds were available to us for initial four months and later 15 beds were available. During this duration, only four patients were detected to have COVID 19; two of them were transferred to COVID facility at JPN trauma centre and two were discharged.

Continuing inpatient services during COVID 19 pandemic has been a learning experience. The key learning points from this experience are: team approach, brainstorming about an important issue (foreseen or actual), open communication (including listening to, absorbing and respecting opinions) with everyone in the hierarchy, making persons from every cadre the stakeholders in ensuring implementation and compliance with the recommended guidelines, measures and protocols and pointing out whenever these are not adhered to.

The vaccine against the COVID 19 has arrived and is being given as per guidelines. We hope to enter a phase of new normal soon where all inpatient activities will resume. In this phase as with any other viral infection, any patient admitted suspected symptoms of COVID 19 - cough, fever, loss of smell and breathlessness will be tested and the preventive measures for COVID19 – hand hygiene wearing mask and maintaining social distance will continue.

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## **Mental Health Services for In-Patients at AIIMS COVID Care Facility**

*Bichitra Nanda Patra*

COVID-19 has resulted in large number of infections and deaths across nations and continents. Individuals who are infected with the virus can have psychological experiences such as concern about the outcome of their illness, stigma, amnesia or traumatic memories of severe illness. <sup>[1]</sup> In patients with no previous psychiatric history, a diagnosis of COVID-19 was associated with increased incidence of a first psychiatric diagnosis in the following 14 to 90 days compared with other health events. <sup>[2]</sup> In response to the large case load of COVID 19, reorganization of service provision has been done at All India Institute of Medical Sciences (AIIMS), New Delhi. Patients with COVID 19 and any other comorbidities are shifted to the trauma centre which has been functioning as the designated COVID care facility. As the psychiatric co-morbidities are high in patients with COVID 19, provision of psychiatric services are also arranged at the COVID care facility at AIIMS. Residents from all the departments are posted there for COVID duty. The residents from the department of psychiatry also look after the psychiatric patients who are admitted in the COVID care facility in addition to their usual COVID duty.

Apart from medical management by doctors, managing psychiatric patients required a great effort from the supporting staff/family members for the safety of the patient and others around, particularly for a suicidal and violent patient. As it was not possible to have an attendant with the patient in the COVID ward due to the risk of catching the infection, a brief orientation of the nurses, security personnel and residents of other department was done regarding the safety measures required for a patient with psychiatric illness. They were also informed about proper hand over or takeover of the duties when their shift ended to communicate the specific issues about a particular case. In the absence of psychiatry residents, giving a few more minutes of extra time by the non-psychiatry residents could alleviate the distress of the patients. A WhatsApp group was created between psychiatry residents and faculties designated for duty at COVID care facility. The ward and bed no. of patients requiring psychiatric interventions were communicated by the medical team. Then Senior Resident (SR) of psychiatry who had duty on that day communicated this to the psychiatry resident who was posted in the COVID duty at that particular duty hour. After that, the psychiatry resident assessed the patient, discusses with the SR/ faculty and then advised accordingly. The notes were also shared with concerned SR/faculty for verification or cross checking. Mostly the consultations are for delirium/agitation or suicidal ideations. In those cases, high risk management e.g. 24-hour vigilance and to ensure the safety of the patient was advised. In addition to above, if a patient was having the risk of harm to self or others, he/she was kept under supervision and monitoring.

There was a change of duty of medical and psychiatric team occurs after every 6 hours. So, to maintain the continuity of care, proper information sharing and briefing with the outgoing and incoming team was done. And primary responsibility was given to one psychiatry resident for

a particular patient irrespective of the duty hours. If the patient was already in follow up with the Department of Psychiatry at AIIMS, the clinical condition of the patient was discussed and supervised by the team treating before the admission in the COVID care facility. As family members play an important role in the care of patients with psychiatric illness in terms of providing history and being a party to clinical decisions, communication with them was facilitated by the dedicated communication team of COVID care facility. They had the contact number of the family members of the patients. Through them, the psychiatry team communicated with the patient's family member and also can obtain the old records through smartphones. This really helped a lot in managing psychiatric patients in the absence of family member staying with them. In one particular case, ECT was also administered in the COVID facility. The ECT was administered in the trauma center operation theatre (OT) after consultations and proper liaison with anesthesia and other relevant departments. This was a real challenging task on many levels. The discharge from the COVID care facility was decided by the medical team. Whether to discharge for home or transfer to psychiatry ward, depends on the clinical condition of the patient.

In COVID ward, managing a psychiatric patient without the presence of his/her family member is a difficult task. COVID duty in itself could be outside the "comfort zone" of a psychiatry resident as some of the duties e.g. ICU duties, writing death notes/death declaration are normally not done as frequently by a psychiatry resident.

Overall managing a psychiatry patient in COVID care centre is a great learning experiences in terms of team building, collaborative care and sharing of roles and responsibilities.

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# 6

## **Electroconvulsive Therapy during COVID-19 at AIIMS, New Delhi: Maintaining Service Feasibility and Accessibility**

*Rohit Verma*

The advent of COVID-19 pandemic has put the world in unprecedented times, with strategic removal of elective procedures from health care. Although, there is no clear consensus in medical field regarding the definition of an elective procedure, traditionally ECT has been considered an elective procedure. Surely, for some patients, ECT proves to be life-saving urgent treatment approach. While for others, it remains essential due to treatment ineffectiveness incurred with pharmacotherapy. In a select few, it has a place for maintenance treatment wherein no other strategy works well for the betterment of the patient. The need of the hour is to understand and apply the safe application of ECT for the needy individuals during these grim times.

The Department of Psychiatry at AIIMS, New Delhi has been performing ECTs under cover of anaesthesia over many decades now. With the sudden pandemic appearance and nationwide initial lockdown since 24<sup>th</sup> March 2020 by the Government of India, all non-essential and routine services were halted. The healthcare sector adapted utilizing telemedicine services as patients found it difficult to reach hospitals for treatment purpose. The Department of Psychiatry initiated the teleconsultation and telemedicine services from 30<sup>th</sup> March 2020 but the routine ECT services remained standstill. But as time of lockdown increased, the pressure for initiating ECT services was felt upon receiving repeated requests from the needy patients and their family members along with the need felt by the teleconsulting clinicians for select patients. Thus, after remaining at halt for about three months, ECT services were initially re-initiated for admitted patients from 26<sup>th</sup> June 2020 and with increasing pressure, the services were opened for outpatients too from August 2020. Apart from the usual measures kept to ensure safe delivery of ECT, additional steps were undertaken to ensure safety of services within the ongoing pandemic.

### **COVID testing**

The services were delivered thrice weekly (Monday, Wednesday & Friday) and all patients were required to be tested for COVID-19 infection with reverse transcriptase polymerase chain reaction (RT-PCR) tests within 72 hours of the ECT session apart from the usual screening procedures that are routinely performed before initiating ECT (e.g anaesthesia clearance, ophthalmological clearance for raised intra-cranial tension, laboratory investigations, etc.). The admitted patients posted for ECT were getting the tests done from the ward setting itself. Outpatients could not be tested too frequently for RT-PCR outside the hospital or through emergency services of AIIMS due to logistic issues or economic reasons, they were tested once a week with RT-PCR and for the remaining two sessions of the week with Rapid Antigen

Testing (RAT) kits available at the ECT facility after a collaboration with the Department of Biochemistry. After few weeks of rising incidences of false positivity, the practice of testing with RAT kits was discontinued in favor of cartridge-based nucleic acid amplification test (CBNAAT) tests done for the second session and RT-PCR done twice a week for the first and third session in a week.

### **Patient selection and ECT setting**

Careful selection of patients was done to weigh the risk vs benefits of transmission of COVID-19 infection during the procedure. The decision of administering ECT was taken independently by two psychiatrists. A thorough screening for COVID-19 associated symptoms was done at each ECT session visit. Dedicated rooms with adequate space for maintaining physical distancing for evaluation were upheld at the MEECT Facility, Old Rajkumari Amrit Kaur OPD Block, AIIMS. If a patient was confirmed COVID-19 positive then ECT was done only in imminently life-threatening condition with the patient being admitted at the special COVID-19 Centre established at Jai Prakash Narayan Apex Trauma Centre (JPNATC), AIIMS and the procedure performed in the operation theatre. While obtaining the consent for ECT, the possible risk of COVID-19 infection to the patient was informed to the patient and his/her caregivers.

### **Staff safety and precautions**

The ECT staff included two junior residents (psychiatric trainees), one senior resident (psychiatrist), one senior resident (anaesthesia), faculty (psychiatry and anaesthesia), two nurses, two attendants, two guards and sanitation workers. Apart from the usual staff members, intermittently depending upon the patient's status, a team of senior residents or faculty (anaesthesiologist, gynaecologist and paediatrician) would also join the session for maintaining patient safety such as in case of high-risk pregnancy status.

Complete personal protective equipment (PPE), consisting of shoe covers, outer and inner gloves, disposable gown, N-95 mask, surgical cap, goggles and face shield were donned by all medical personnel involved in ECT procedure. The patients too were given separate gowns for the procedure. Social distancing was maintained as much as possible in the waiting area as well as in the ECT administration and recovery area. Non-essential staff were avoided to be present in the procedure room. Even for COVID-19 asymptomatic patients, staff still took adequate precautions as the patient might turn out to be positive on next session. Designated places for donning and doffing PPE separately were made and the disposal of PPE of all persons was done together appropriately as per the ICMR guidelines.<sup>[1]</sup> All necessary anesthesia and ECT equipment such as electrodes, bag, mask with tubing, and suction cannula with catheter were discarded/disinfected with hypochlorite solution or 70% alcohol disinfectants.

The start and administration of ECT for inpatients and outpatients during the COVID-19 pandemic was informed by the ethical principle of beneficence. Guidelines and policies, many a times may become unpractical for use in certain scenarios. Fortunately, the Department of Psychiatry at AIIMS, New Delhi was able to provide the essential ECT services providing a ray of light in these unprecedented times of the pandemic benefitting the needy population.

Development of practicable guidelines made it possible to maintain feasible and accessible ECT services.

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## Experiences in Telepsychotherapy During COVID 19 Pandemic

*Vandana Choudhary*

During my training days as a psychotherapist, there was a brief chapter on telepsychotherapy in one of our course books, but somehow, I always envisioned it to be a more western concept, something far-fetched, which will take years in its effective implementation, something for which we are just not prepared for. The COVID-19 pandemic cleared those pre-conceptions or rather misconceptions almost within the first week itself.

As we witnessed the sudden upsurge of fear, anxiety, and stress symptoms both among those with a pre-existing condition and those after the disease outbreak, both clients and therapists were faced with a non-negotiable shift to either telepsychotherapy (TP) or nothing. Getting reminded of the old saying that “*some things are better learned from experiences than reading*”, I had to make a sudden and almost forced transition to TP. Although there were many like me for which TP looked futuristic, but since there were no existing specific training courses in India on conducting online therapy and orienting us to the ethical and legal aspects of it, I figured out soon that this journey would be a treacherous one. Soon, guidelines for conducting tele-psychotherapy services in India became available, which along with other useful readings on code of ethics and conduct by American Psychological Association and The British Psychological Society were of huge help. Further, since pandemic also brought an easy opportunity to assess learning through online medium, I did a five-day training course on the same. Though with all this background preparation, which at that time, appeared sufficient, I almost knew that the novelty associated with TP will present unique challenges, which I will learn only gradually.

As I began implementing my newly learned TP sessions, one of the first barriers was ensuring technical orientation for conducting the sessions. Many, though well-oriented to using the internet on social media platforms, were new to the general concept of TP or its specifics such as how to set up a session online, pre-requisites for conducting sessions, how to begin and how to end etc. So, I decided to include “*tele-grooming*” as a mandatory pre-session preparation for participating in therapy. Drawing the parallel from the concept of health hygiene where we have been regularly coached to ensure optimal health and prevent diseases, tele-grooming was all about grooming patients on the way technology works and its effective utilization for simulating in-person therapy sessions while maintaining cyber-security maximally. For this, a brief assessment on patients’ suitability to TP was done followed by education and training on technical competence, practice run sessions, orientation about ensuring cyber-security, preparation for technology failure and its resolution. This was usually followed by obtaining their verbal and written informed consent for TP which was important in letting a patient know that there are possible limitations to online care, need to contact the nearest available mental emergency in case of the emergency situation, and agreeing on maintaining confidentiality of online session (by using a secure line/connection, private space, warning against the recording of the session) along with asserting their right for withdrawing if uncomfortable. Though the process looked tedious to be followed initially but was really significant in practicing tele-hygiene and maintaining ethical standards of clinical practice in the online environment.



As I continued conducting sessions, my online practices matured, or rather I would say, I learned professionalism on webspaces as well. Patient's access was restricted to the inevitable presence of therapist on other social media platforms. As TP would include automatic intrusion into patient's and therapist's environmental background which were perceived as a breach of privacy, every effort was made at optimizing environmental pre-requisites for conducting sessions. I remember in my early TP session, where sessions were taken with my library in the background, few patients developed an interest in the book arranged on the shelves rather than the ongoing therapy session. Few even asked me out of curiosity to name the book or the author of the library. Soon I realized the need to introduce the virtual background to my therapy rooms. Since most of the apps are equipped with the facility to change the background graphics of choice and comfort, I started employing those to avoid the environmental discomfort or deal with privacy issues to a large extent. Further, communication and treatment via email and texting required maintaining the professional language. Use and lapse into more casual texting styles were avoided. Though, professional attire for the therapist was not mandatory but was helpful in the replication of the in-person therapy conditions online.

There were certainly many perceived benefits of conducting therapy online. Some of the most commonly applied techniques such as that of anger management, coping skills, emotion regulation worksheets could easily be exchanged with patients online. In addition to addressing concerns related to the diagnosed mental disorders, stress-related to the COVID-19 outbreak could also be incorporated. Documentation during a session using online tools was quite easy which was quite a helpful practice to follow-through. Session continuity could be easily maintained as the patient had to simply log in for session than traveling to hospitals and waiting for their turn in the in-person set-up. Therapy sessions were timed well and would follow a very structured beginning and end. Above all, many found TP very comforting as they remain in their own environment.

However, there were also many challenges related to the effective implementation of psychotherapeutic interventions when offered over the modality of telephone or digital platforms. For example, many of the behavioural experiments, interoceptive exposure exercises, or exposure and response prevention, which could otherwise be easily practiced in session, couldn't be delivered in the same way online and had to be explained in words only. Those with recent trauma due to adverse events in their life found it difficult to express emotions to the therapist on the virtual screen. The communication of emotions became even difficult when it was interrupted by network issues and hence could never simulate the therapy room situation. For many, the option of switching off the camera acted as an avoidance strategy in discussing distressing situations. Many of the concepts, process which required explanation on the paper were missing. For example, the cognitive case conceptualization model or panic circle couldn't be drawn on the screen. Though I used to either draw it on paper and present it online or draw it in the paint and send them on their email, certainly it wasn't as effective as it was when immediately done in sessions. The question of breach of privacy and confidentiality was always of concern. The virtual therapy room was quite susceptible to interruptions due to multiple factors that were beyond the control of the therapist such as the patient's home environment, sudden disruptions from other family members during the session, the possibility of the session being recorded by the patient without prior permission or mutual consent and the possibility of the session being tapped into by third party hackers.

Though the challenges are multiple, and I am still in the process of learning and accommodating telepsychotherapy hygiene in my practice, a larger benefit of TP in breaking the barriers of psychological support beyond therapy rooms cannot be ignored. TP swelled the outreach of psychological support many folds. I really found TP as one solution especially to those groups of people, who had many environmental barriers associated with getting connected/linked to a psychotherapist in a hospital set-

up. It's no longer a futuristic concept for me and I can foresee its enhanced applicability in coming times to shift to TP in extending the outreach of mental health services to those in need.

However, as the number of cases of COVID-19 has gone down recently with the promising arrival of vaccination, hospital is now running OPD services as before. For many patients, making a shift back to regular in-person visits is now seen as a challenge. It is leading to a huge number of requests for online sessions. I am sure it is going to take another few months for full resumption to in-person sessions; however TP may continue to find its applicability for a subset of individuals who cannot access the services on regular basis.

## **AIIMS Students Wellness Centre Initiatives During COVID-19 Pandemic**

*Pratap Sharan, Akanksha Gupta, Divyani Khurana, Aishwarya Raj,  
Anamika Sahu, Kalpana Singh*

For years, mental health has been an issue on medical campuses. Even before the COVID-19 pandemic, data sources showed a high prevalence of depression, anxiety, suicidality, and other concerns in medical student, resident and researcher populations. It is believed that a third of medical students, residents and researchers on campuses experience clinically significant emotional distress. However, less than 20% of those in need of services seek them. Preference for self-sufficiency and embarrassment (stigma) negatively impact the intention to seek help.

The COVID-19 pandemic impacted medical students, residents and researchers in overlapping but somewhat different ways. Closure of educational institutions and emergency distance-learning plans in the context of COVID-19 pandemic turned young people's routines and peer interactions upside down. Scholars feel stressed due to physical (social) distancing, stay-at-home policies, online classes, postponed practicals/bedsides/labs/OTs, fear of contagion, losses within the family, and uncertainty about the future. In many locations, large numbers of students were without reliable internet access. Some families were facing new or worsening financial hardship in the wake of the pandemic. Vulnerable student communities were disproportionately impacted. In addition, residents faced the risk of infection/quarantine/isolation, the discomfort of working with PPE kits for long hours, problems in communicating with patients, as well as morbidity and mortality, while on COVID duty. And they faced changing routines and overwork when not on COVID duty, because there were about half left to do all the routine work.

These stressors expectedly resulted in an increase in clinically significant distress (anxiety, depression, posttraumatic stress, grief, and loneliness) among scholars during the pandemic. Emphases on mental health interventions for students, residents and researchers were certainly relevant to these rapidly changing times.

### **Wellness perspective**

At the Students Wellness Services, we approached the mental health issues of scholars from a wellness perspective in the context of COVID-19 pandemic as it appeared more palatable to students and encouraged them to seek services as suggested by increase in Students Wellness Centre registration by over 250% compared to the previous year. In addition, the offered wellness interventions helped improve overall emotional well-being and fortify mental health.

**Table 1: AIIMS Student Wellness Activities during COVID 19**

Level	Activities
<b>Self-Help</b>	<ul style="list-style-type: none"> <li>• Online awareness lectures for students, residents and researchers</li> <li>• Online and In-person “Introductory Wellness Workshops” for students and residents (Mandatory)                             <ul style="list-style-type: none"> <li>○ The workshop covers a whole range of topics from lifestyle management (work-life balance, time management), mental health, suicide prevention, substance use related health, and prevention of sexual harassment on campus.</li> </ul> </li> <li>• Online Yoga and Meditation workshops for all scholars</li> <li>• Online Skills development workshops for volunteers                             <ul style="list-style-type: none"> <li>○ Stress Management: Covering a variety of topics to manage everyday stress, such as lifestyle management (sleep, exercise), time management, anger management, relaxation and mindfulness, self-compassion, self-confidence, and problem solving.</li> <li>○ Communication Skills: Covering topics like Verbal and nonverbal communication, Clinical communication and crisis management.</li> <li>○ Grief management workshops: Covering topics like bereavement and grief: dealing with unnatural death(s), dealing with suicide by public figures and dealing with death of patients.</li> </ul> </li> <li>• Language and Financial support (as per need)</li> </ul>
<b>Community Support</b>	<ul style="list-style-type: none"> <li>• Wellness Buddies Programme for peer support                             <ul style="list-style-type: none"> <li>○ Online Peer Support Training</li> <li>○ Online Awareness raising</li> </ul> </li> <li>• Mentoring for students by Faculty and AIIMSONIANS (Alumni Group)</li> <li>• Online Hobby Clubs (10): Art, Academic Support, Comedy, Chess, Cooking, Dance, Music, Photography, Quiz, Writing</li> <li>• Online “The White Coat and Other Stories” inspirational talk series</li> </ul>
<b>Students’ Wellness Centre (SWC)</b>	<ul style="list-style-type: none"> <li>• Counseling and psychotherapy (online and in person at 4 sites): Services extended to Sundays at one site</li> <li>• M(obile)-helpline (24X7)</li> <li>• E(mail)-helpline (24X7)</li> </ul>
<b>Department of Psychiatry</b>	<ul style="list-style-type: none"> <li>• Emergency support (24X7)</li> <li>• OPD, Ward (General, Private)</li> </ul>

### Telehealth

In the current pandemic with many students being off-campus and the need to maintain social distancing among the rest, online wellness programs were felt to be more relevant for reaching students, researchers and residents and attending to their wellness needs from a distance. Such modalities were attractive even to scholars whose reason for not seeking help include embarrassment, worry about harm to one's academic career, wanting to handle problems on one's own, and uncertainty about treatment efficacy. Whereas exclusive remote learning will

probably cease after the use of vaccination against corona virus becomes widespread; there may be longer lasting benefits for willingness to engage in wellness programs online.

### **Levels of care**

The Students Wellness activities were envisaged in four levels: Self-Help, Community Support, Occupational Health Unit for wellness protection, outreach, and integration (Students' Wellness Services), and Professional Services (Department of Psychiatry) for treatment and rehabilitation. (Table 1)

In addition to the above, the wellbeing of residents was supported through integration of mental health and psychosocial approaches during work assignments and isolation situations; and through engagement with community leaders to mitigate stigma and ostracization in their place of stay. Efforts were made to increase awareness of the prevalence of emotional distress at workplace, promoting positive coping strategies and reducing stigmatizing attitudes towards mental illness among health professionals. When residents' groups/departments approached SWC regarding burnout, focus groups meeting were conducted and steps suggested to mitigate the same through multiple levels of feedback and collaboration between residents, faculty and administration.

### **Conclusion**

Medical scholars experience high levels of stress that may compromise their overall wellbeing, and they are particularly stressed during the COVID-19 pandemic. Interestingly, wellness programs seemed to engender less stigma and were perceived as a more acceptable approach for meeting scholars' mental health needs. In the context of COVID-19, novel modalities of administering these programs were necessary, but they may continue to be beneficial even after the pandemic for increasing the reach of these programs.

## Coordinating Services for Healthcare Personnel with COVID-19

*Gagan Hans*

Healthcare workers (HCWs) are usually at an elevated risk of contracting COVID-19 infection as a consequence of working in high-risk environments. Initial estimates suggest that frontline healthcare workers could account for 10–20% of all diagnoses.<sup>[1,2]</sup> This can have a negative impact on the morale of the staff and affects the patient care in the time of crisis. Though strict infection control measures have been implemented, risk to the health care workers has increased exponentially as community transmission of the virus becomes more rampant. Thus, organising and coordinating medical services for the health care workers becomes important during pandemic.

Health administrators faced an unprecedented situation unforeseen in the modern medical history where services had to be organised for a pandemic considering the worst-case scenario. As the pandemic progressed and swept most parts of the world, acute shortages of the infrastructure and manpower were reported. This led to mounting fear in the subcontinent that such case scenario would be disastrous in the South East Asian countries. In the backdrop of all these developments, the provisions for the medical services for the patients and healthcare workers were developed.

Initially, the health care workers had anxiety about their role in the management of suspected and confirmed cases and whether they were adequately trained for the same. In addition, there were apprehensions regarding availability of the healthcare facilities on turning COVID-19 positive. The nature of work can lead to more chances of exposure to positive cases and need for quarantine. Thus, it became imperative that there should be a mechanism in place to address the health care issues of the healthcare workers to keep morale high.

Most public and private hospitals have some provisions for the treatment of the staff members and their family members. But the initial apprehension of the authorities in LMIC (Low- and Middle-Income Countries) was that all facilities would be quickly overwhelmed within a short span of time as happened in the western countries. The diagnosis of COVID-19 positive may be a cause of great distress in any individual and same can be generalised to healthcare personnel. A lack of established protocol or standard operating procedure (SOP) in the hospital may increase this distress immensely. Simple provisions like dedicated personnel for all COVID-19 related activities of the staff including facilitation of admission procedure, informing the infection control committee of the hospital, informing relevant authorities for making changes in the duty roster and doing the contact tracing makes the process relatively easy for the COVID-19 positive healthcare professional and also reduces the spread of the infection.

Similarly, a number of healthcare workers have to undergo quarantine based on their exposure to a suspected or confirmed COVID-19 positive case which can be institutional or domiciliary depending on the patient profile and magnitude of exposure. A history of quarantine in the health workers is most important predictor of developing acute stress disorder, low mood, anger, reporting exhaustion, anxiety, insomnia, irritability, poor concentration, decreased work performance, and reluctance to work or considering resignation.<sup>[3,4]</sup> Health care workers are also likely to be more concerned about spreading infection to others in the surroundings and family members.<sup>[5]</sup> Thus, there should be adequate provisions for the mental health services for the healthcare workers both in quarantine and treatment.

Owing to confinement in a much smaller spaces in institutional quarantine coupled with lack of a usual routine and reduced social contacts boredom, frustration and a sense of isolation may develop.<sup>[6,7]</sup> These symptoms may increase many folds if the quarantine facility lacks adequate sanitation, proper food, comfortable housing and access to internet for using their smartphones, tablets, computers and chargers.<sup>[8]</sup> Some predisposed individuals may also turn suicidal so a careful risk assessment may be needed before placing the individual under supervised quarantine.<sup>[9]</sup>

The organisation of the services for the health care professionals may also be dependent on the kind of settings they are currently employed. Whereas the services in the major public or private hospitals with adequate infrastructure and manpower may be relatively easy to organise, there may be difficulties at other levels. Organisational support has been found to be highly protective of wellbeing during infectious disease outbreak and staff should be supported in all possible ways to keep the morale high.<sup>[10]</sup> For individuals who are under quarantine or isolation in monitored facilities having access to reasonable amenities including a working internet connection with means to access it is a way of keeping in contact with the family members and significant others which can reduce the psychological impact of isolation.<sup>[11]</sup>

In conclusion, one of the key strategies to the successful organisation of the medical services for COVID-19 positive staff is the addressal of the apprehensions and concerns of the healthcare professionals along with provisions for satisfactory treatment. This will go a long way in keeping the morale of the healthcare professionals high who have been serving the humanity selflessly and despite all limitations since the onset of COVID-19 pandemic globally.

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## **National Drug Dependence Treatment Centre During COVID-19 Pandemic**

*Anju Dhawan*

The National Drug Dependence Treatment Centre (NDDTC), AIIMS is involved in provision of clinical services, academic activities as well as research. Several changes needed to be implemented in the provision of clinical services and academic activities at NDDTC in wake of COVID-19 pandemic.

### **Clinical services**

NDDTC has a 50 bedded ward, daily OPD and weekly speciality clinics that are run for special populations in the main centre besides three satellite community clinics located in different parts of NCT Delhi. The centre is located several kilometres away from the main building of All India Institute of Medical Sciences (AIIMS) with travelling time of about 1 hour from AIIMS. Most substance using persons are treated on outpatient basis at the centre and only some need inpatient treatment, which is usually elective. A small proportion of persons requiring emergency services due to medical comorbidity are managed at main AIIMS.

During the COVID-19 pandemic, elective admissions at main AIIMS were suspended for several months in order to handle the COVID-19 patient load. The inpatient services at NDDTC too were discontinued. However, outpatient services (OPD) continued throughout the lockdown period even though OPD services of many other departments at main AIIMS were closed. No new registrations were done in NDDTC OPD for a few months as also in main AIIMS. There was a reduction in the footfall at the centre though about hundred substance using patients continued to visit NDDTC OPD on any given day. The continuation of outpatient services at NDDTC was important as treatment of drug dependent patients involves provision of medication from the centre since many of the medicines (e.g. buprenorphine, disulfiram) are not available from pharmacies even with a prescription. The discontinuation of medication during lockdown would have posed a potential risk of disturbing the patients who were already stable on maintenance treatment for past several years. The continuation of dispensing of agonist maintenance medication was particularly important as its discontinuation is associated with increased risk of relapse to illicit use. <sup>[1]</sup>

COVID-19 created a unique and challenging situation for substance using patients,<sup>[2]</sup> especially during the lockdown as no public transport was available. But many patients continued follow up at the centre despite these challenges, often walking for hours on foot or cycling long distances to the centre. Some self-reported challenges faced by them included economic difficulties, loss of income and employment, difficulty in transportation and continued availability of illicit substances for those willing to make the effort to find it. <sup>[3]</sup>

Substance use is considered to be associated with an increased risk of acquiring COVID-19 infection.<sup>[4,5]</sup> The possible reasons include general neglect of health and hygiene, poor living conditions, over-crowding and difficulty in following the social distancing protocols, lack of access to resources among those using substances. Considering this, it was all the more important to follow adequate infection control measures at NDDTC.

The hospital infection control protocol of main AIIMS was followed at NDDTC as well. A hospital infection control committee (HICC) at NDDTC was constituted comprising faculty, ANS, residents, medical social service officer. A faculty was designated as the nodal officer for Hospital Infection Control. The infection control measures included adequate supply of hand sanitizers, screening patients for fever, social distancing and compulsory use of mask by the patients. Free masks were provided to those who did not come covering their face with masks. Patient inflow was modified to maintain safe distances between patients waiting for their turn. The OPD waiting area as well as the medicine dispensing area were marked to provide demarcation of spaces where patients could sit or stand while ensuring social distancing. OPD rooms were regularly sanitized and NDDTC staff who would potentially come in contact with patients were provided PPE that included gowns, masks, face shields, gloves, caps, hand sanitizers. Similar measures have also been reported by other addiction treatment centres in the country.<sup>[6]</sup>

Initially, an attempt was made to provide consultation by conducting on-site video conferencing with the patient and the doctor sitting in separate rooms within the center thus reducing or avoiding face to face interaction. However, since many of the patients are not familiar with digital technologies, this was a major handicap and had to be aborted. Eventually, structural changes like preparing glass cabins for doctors for interviewing patients across the glass partition with the help of microphone were made. As most patients did not use the masks properly (below nose or below chin placement being common) despite being educated about it, the glass partition helped maintain minimum risk of transmission. However, for patients who were familiar with the use of online platforms, in order to reduce the frequency of their physical visits to the centre, telephone calls and video conferencing were used for detailed assessment and for counselling sessions. It was also used to interview and counsel the family members as and when feasible.

Patients who are on buprenorphine maintenance treatment at NDDTC receive medicines on a daily dispensing basis for the initial 2-3 months and are then shifted to biweekly dispensing or weekly dispensing once they are stabilised. However, during the pandemic, a more flexible medication dispensing schedule had to be followed. Those on daily dispensing were shifted to take home dispensing. The period for take-home buprenorphine was enhanced to three weeks at a time. The available guidelines recommend flexible take-home dosing of Buprenorphine.<sup>[2,7]</sup> The frequency of dispensing of Naltrexone and Disulfiram was also reduced to once in two months instead of the usual monthly dispensing.

The clinical posting schedule of the resident doctors and faculty was modified. As about one third of the residents were posted in COVID duty at main AIIMS at any given point of time, the number of residents available was reduced. NDDTC has three units and the residents and

faculty reported to OPD only on their unit days (twice a week). This was primarily done so that in case of anyone getting infected with COVID, only one out of the three teams would need to be quarantined and services would continue uninterrupted.

However, despite all the precautions undertaken, a few staff members tested positive for COVID-19. All information about positive cases and their contact tracing was routed through the nodal faculty of HICC at NDDTC to the main AIIMS Hospital Infection Control Committee to ensure that the high-risk contacts among the staff were tested and adequately quarantined as early as possible.

### **Academic activities**

NDDTC runs a DM Addiction Psychiatry Programme and junior residents are posted here for a period of five months during their MD Psychiatry period. To ensure continuity in clinical training, OPD case work-ups and discussions were continued. Online virtual rounds were started for detailed case discussions that involved case presentation by a resident and discussion with all the unit team members including faculty and residents. The usual academic activities in the form of seminars continued uninterrupted during this entire period. As the wards had been closed down, there were no inpatients. Keeping this in mind, the thesis of some residents requiring inpatient sample had to be modified following discussion in faculty resident meeting.

The reorganization of clinical services and other activities was required amidst pandemic in order to ensure safety of patients and staff, while taking a flexible approach towards dispensing medications and ensuring continuity of treatment. For coming weeks, preparations are underway towards a gradual reopening and normalization of in-patient services from 1<sup>st</sup> March, 2021 at NDDTC, with necessary safety precautions.

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## **Delivering Addiction Treatment Services in Community Clinics During COVID-19 Pandemic – An Experiential Account**

*Ravindra Rao, Roshan Bhad*

### **Introduction**

Patients with substance use disorders (SUD) are a vulnerable population who face various complications in life either directly due to their substance use or due to various high-risk behaviours associated with their substance use. One of the important complications of substance use is lowered immunity and increased risk of acquiring infections either due to the direct effect of substance use or due to infections acquired due to substance use such as HIV.<sup>[1]</sup> These complications can make people with SUD vulnerable to COVID-19. Substance use is generally a group behaviour wherein people congregate together and consume drugs, which can increase the risk of transmission of COVID-19 from one individual to another.<sup>[2]</sup> Also, the lockdown imposed may reduce availability and accessibility of drugs leading to experience of withdrawals and craving in the users. Furthermore, it is well known that isolation is a stressful condition.<sup>[3]</sup> The stress due to lockdown may also affect substance using behaviour, including relapse to the psychoactive substance use. Thus, SUD and COVID-19 may share an adverse relationship.

Over the past year, limited literature has emerged on impact of COVID-19 pandemic on SUD. Existing literature shows that the COVID-19 pandemic has adversely impacted the treatment of SUD.<sup>[4-5]</sup> Many services related to addiction treatment were closed during pandemic. This included access to medicines, getting appointment for consultation with doctors or their therapists, or lack of access to other medicines (such as HIV or Hepatitis-C), social support and other services.<sup>[6-7]</sup> The lockdown imposed to curb the pandemic also imposed restrictions on movement of people to access many of these services even if these services were operational.

### **Community drug treatment clinics**

National Drug Dependence Treatment Centre (NDDTC) has been the pioneer in the field of Addiction Psychiatry in India and has been providing treatment for people with various SUD since 1980s.<sup>[8]</sup> NDDTC has been providing community-based treatment for SUD since the 1990s. Two of the three community drug treatment clinics are in operation for more than ten years now and cater to population residing within a defined catchment area. The community drug treatment clinics uses infrastructure available in the community to operate the clinics. The clinics are run daily by a team of nursing staff, while the doctor is available only twice a week. A menu of options, ranging from short-term treatment to long-term agonist maintenance

treatment is provided in the clinic. Both pharmacotherapy and psychosocial interventions are provided. Each clinic caters to hundreds of patients through these facilities.

The paper describes how community drug treatment clinics have provided services during COVID-19 pandemic to people with SUD. The paper describes the provision of addiction treatment services in one of the community clinics operating in East Delhi to describe how community drug treatment clinics have continued services during COVID-19 pandemic and lockdown.

The community clinic in East Delhi focuses exclusively on treatment of opioid use disorder (OUD). This community drug treatment clinic is in an urban impoverished area of East Delhi and provides short-term and long-term treatment of OUD. Most patients are on long-term Opioid Agonist Treatment (OAT) with methadone or buprenorphine. The clinic registers patients residing within a catchment area of 6–8 kilometres. The clinic provides low-threshold OAT services for patients with OUD. There is no waiting period for initiating treatment; treatment is provided free-of-cost. The patients used to visit the clinic daily to receive their OAT medicines. Since March 2019, the clinic also started dispensing methadone through a mobile van stationed at the periphery of the catchment area to reduce the travel distance for patients. Before the pandemic, the clinic, along with the mobile van, used to provide medicines to more than 500 patients on any given day. The medical and dispensing records have been digitized to ease record keeping and to ensure there is no duplication of dispensing of medicines from the clinic and the mobile van.

### **COVID-19 challenge for addiction treatment**

The Indian Government imposed a nationwide lockdown from 25 March 2020 onwards along with restrictions on travel to curb the spread of COVID-19.<sup>[9]</sup> The patients visiting the clinic were reluctant to travel to the clinic daily for getting their daily dose of OAT medicines due to the restrictions imposed on travel. The areas where the community clinic, and the mobile van were stationed also reported significant COVID-19 positivity in the general population. The staff involved in dispensing the medicines also feared getting infected with COVID-19. Daily visit of more than 500 patients to the clinic also led to crowding in the clinic premises and the mobile van. The overcrowding could have attracted adverse reactions from the local law enforcement authorities. Due to sealing of roads in adjoining areas, there were also difficulties for the van to reach its destination on some days.

All these challenges meant changing the strategy of operation of the clinic and dispensing medicines.

### **Addressing the COVID-19 challenges in community drug treatment clinics**

The first decision to address the challenges that was taken was to allow take-home doses of OAT medicines from the clinic and the mobile van. This had two-fold advantages. Firstly, the daily footfall to the clinic reduced resulting in lesser exposure of the staff and patients alike to COVID-19 due to decongestion. Secondly, the burden on patients to travel for their dose daily also reduced. Buprenorphine (BPN) is already dispensed as take-home in India using the BPN-

Naloxone formulation.<sup>[10]</sup> Hence, take-home dispensing of BPN was an easier decision, as NDDTC already had stocks of BPN-N, which was used in the community clinic as well <sup>7</sup>. However, in case of methadone, take-home dispensing was never practiced in India, though the narcotic laws of India do not explicitly forbid take-home dispensing of methadone. There was fear among the service providers of the possibility of diversion of methadone and chances of overdose. However, the decision to allow take-home dispensing of methadone was taken after considering the risk of spread of COVID-19 in the community. The duration of take-home doses differed based on the type of medicine and the dose the patient was on in the initial phase till July 2020. For BPN-N, the patients were allowed take-home for up to two weeks for those on lower doses, while for those on higher doses, take-home of up to one week was allowed. In case of methadone, for lower doses, the patients were allowed take-home for up to one week, while for those with higher daily dose, take-home was allowed for three days. Later, the duration of take-home doses was reduced to twice a week for both BPN-N and methadone (except those who are on higher doses who are given daily doses) once the lockdown was eased.

The take-home dosing helped in reducing the daily load on the clinic from a footfall of more than 500 patients to 130–150 patients per day. While the daily footfall has reduced, the number of patients who have received medicines from the clinic on any given day (including physical visits as well as those who have been given take-home) has increased. As the clinic and mobile van are located nearer to their residential areas, the patients did not find much difficulty in visiting the clinic even when the lockdown was imposed. The police allowed the patients to visit the clinic for their doses upon production of treatment records, as they were aware of the clinic's functioning.

The second challenge was to ensure safety of the healthcare staff working in the clinic. Due to less load on the clinic due to take-home dispensing, the daily strength of staff was reduced, and adequate personal protective equipment was provided. Functional changes in community clinic to reduce overcrowding was made, and the clinic was regularly sanitized. Face mask for the patients was made mandatory and an automatic sanitiser machine was installed at the entrance of the clinic for the patients to clean their hands before entering the clinic. Despite this, two healthcare staff from the clinic have tested positive for COVID-19, but they have recovered well and have resumed their duties.

Additionally, the clinic did away with the requirement of compulsory renewal of treatment by the doctor for dispensing of medicines during the lockdown period. This was done to ensure minimal time by the patient for their dose in the clinic or mobile van. From the second month, the clinic started allowing those who have dropped out of the treatment to restart their medicines. The assessment by the doctor and counsellor was done through teleconsultation online to avoid physical contact. The digitization of the records helped in ensuring minimal contact. The frequency of follow-up required was increased from once in 2–4 weeks to 6–8 weeks. Expectedly, the number of drop-out patients re-joining treatment increased greatly during the lockdown period, as the patients did not have enough money to spend on their drugs due to loss of work.

## Lessons learned and opportunities for the future

There are various lessons from our field experience which would benefit in ensuring continued treatment for patients with SUD. Our experience shows that locating treatment services closer to the residential areas of the patients, either through a static clinic or through mobile van, eases treatment access. Take-home doses of both BPN-N and methadone has helped in reducing the clinic load and difficulty in travel for patients. The impact of take-home doses of methadone on diversion and overdose needs to be carefully studied, though feedback from patients and informants suggest that diversion of methadone has been minimal. Using teleconsultation services and digitization of the records has helped in minimizing contact with papers that could potentially transmit COVID-19.

The pandemic has posed a great challenge for treatment continuity of OAT, but it has also taught us lessons which have been useful to tweak our practices in management of OAT.

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## **Coordinating Infection Control Initiatives in A Tertiary Mental Health Care Setting**

*Raman Deep*

After COVID-19 was declared as a pandemic, there was constitution of various committees and teams comprising of experts from various departments. The hospital infection control committee (HICC) is a multidisciplinary committee with faculty members from various disciplines (microbiology, anesthesia, pulmonary medicine, medicine, pediatrics, hospital administration etc) that works towards COVID-19 prevention and infection control activities within the institute. As part of institute's infection control efforts, each department was asked to designate a nodal officer in order to liaise with HICC for various activities pertaining to COVID-19 infection control.

As a faculty nodal officer for psychiatry department, my role was to act as a bridge between HICC team on one hand, and coordinate with departmental staff and employees on the other hand to ensure that infection control processes are being followed in accordance to standards laid out by HICC.

In order to orient nodal officers, a prompt meeting was called by HICC core members on 1<sup>st</sup> May 2021 in which objectives of the HICC as well as roles and responsibilities of nodal officer were discussed in detail, along with discussions on COVID-19 related processes within institute and types of PPEs and their appropriate use. It was an interactive session, which led to resolution of queries and gaining insights about prevention of COVID-19 within hospital settings. One has to remember that it was still early in lockdown and many guidelines or policies were still evolving. In that context, this meeting provided a sense of clarity on processes and policies to be followed.

In order to facilitate communication, a nodal officer's WhatsApp group was constituted with HICC core members and faculty nodal officers from each department, with an aim to share knowledge and access to resources. This was the go-to place for any new situations or dilemmas which arose. Such periodic interactions as well as group meetings (held both online and offline) continued over coming months, which gave an opportunity to interact and learn from each other's experiences as well as from HICC.

Following were the mandated roles and responsibilities as a faculty nodal officer towards COVID-19 prevention in the department:

- (i) coordination of infection control activities within department
- (ii) supervision of training aspects of health care workers
- (iii) supervision of disinfection and cleaning protocols being followed by staff;
- (iv) coordination with Nurses incharge for a daily monitoring of health status of staff

- (v) appropriate PPE use/availability through nurses incharge/stores; and
- (vi) formation of a team within department to periodically adhere to COVID-19 related infection control guidelines.
- (vii) contact tracing (CT) of confirmed positive staff within dept, with help of a dept team and coordinate towards testing of any symptomatic personnel

Measures were taken towards all these aspects with active involvement of members of the COVID-19 Infection Control Team (faculty members, SRs, nurses, staff). A previously published paper discusses many of the measures and initiatives taken by the members of the team for ward safety in more detail, which is also reproduced in this monograph <sup>[1]</sup>

Below is an overview of initiatives taken in the psychiatry department in the months after pandemic, with participation of all concerned.

### **Supervision of training aspects and creating awareness among health care workers**

- Periodic training sessions were offered by institute for healthcare workers especially in early months of pandemic. Those sessions dealt with basic safety aspects including appropriate use of PPE and general awareness about spread of COVID-19. Information pertaining to those sessions was disseminated to all concerned within department and it was encouraged to staff to attend those training sessions.
- Additionally, small group or one to one sessions were conducted by Nurses/occupational therapist, SRs and nodal officer for various personnel to make them aware about specific measures and extra cautions required in a psychiatric setting.
- Through nurses incharge, it was ensured that health care workers continued to have an updated information as well as access to new resources shared by HICC/Institute
- The salient points from institute guidelines were verbally discussed by Nurse Incharge/ANS with nursing officers along with addressing any queries and periodic supervisions for adherence. All nursing officers had previously taken online course for infection control offered by institute which generated certificate after completion.
- As temporary health attendants and security staff in the ward were changed every few days from one place to other in general hospital, it was requested to concerned authorities that their postings are not changed in and out from psychiatry wards. This ensured a consistency of training activities as well as reduced potential exposure from other wards in a general hospital setting.
- It was emphasized to all healthcare workers that there is a need to follow all precautions in both on-duty and off-duty hours with same rigor.
- Reinforcement or booster sessions were required to prevent laxity in the precautions.

### **Planning and coordination of Infection control measures**

The hospital infection control practices were provided in HICC 'ready reckoner' document which was used as reference to set up the practices. But some other practices had to be evolved in-house and put into place considering the unique needs of a psychiatric setting as a caution to minimize the risk of infection spread.

- *Adherence to disinfection protocols:* The sanitation staff was supervised by nurses incharge, especially about method of preparation of 1% sodium hypochlorite and minimum duration of contact (e.g. 20-30 min for eye goggles/face shield). Such daily supervision was needed in early months of pandemic so that inadvertant errors are not made and instructions are clear to all concerned personnel. It was advised to clean ward surfaces frequently using 1% sodium hypochlorite, every 4 to 6 hourly depending on whether surface is high-touch (e.g. door knobs) or low-touch surface (e.g. walls). A register was also maintained as a record for cleaning at regular intervals.
- *Adherence to bio-waste management protocols:* Supervision was done by nurses incharge/ANS that staff adheres to standard operating procedures for bio-waste management with regard to doffed PPE etc
- *Delineation of donning and doffing spaces:* Dedicated spaces were identified and marked for donning and doffing of PPEs. Informative posters on donning and doffing methods in a visual form were made available in the respective spaces.
- *Appropriate PPE use and its availability:* Institute guidelines recommended the use of level I PPE (N95 mask, gown, gloves and eye goggles) for all health care personnel in non-COVID wards. Additionally, it was conveyed to all residents/nurses etc to wear face shields for any close patient encounters such as sampling, injections etc. PPE stock was periodically indented with all necessary items to meet the demand. Requisition for necessary supplies was sent with a weekly estimate to MS office, with a renewal every week to adjust for rise in demands. Whenever there was an issue about availability of PPE, nodal officer was informed for coordinating it with duty officer/MS office.
- *Monitoring of daily health status of staff:* All staff reporting on duty was asked for new onset symptoms, and were advised to refrain from coming to duty in case they experience any symptoms. This was supervised on daily basis by nurses incharge which served to sensitize the staff to undergo testing rather than dismiss any mild symptoms. Symptomatic staff personnel were asked to report to EHS screening OPD.
- *Avoiding frequent change of security staff:* The security officer-in-charge was requested to retain the same set of security guards for at least first few months in psychiatry ward, not changing their postings on frequent basis. This could facilitate their on-site exposure/training in handling the psychiatric patients especially as extra precautions were required in view of pandemic.
- *Screening and sensitizing 'reliever' health attendants on rotation:* In a general hospital setting, there is often a mobility of employees from one to other areas of hospital and change of duties between medical and psychiatric wards as a 'reliever' on duty. New employees/relievers were sensitized about all standard practices and were closely supervised. A register was kept to document the asymptomatic status at the time of beginning shifts in psychiatry ward.
- *Sequential rather than collective lunches/teas:* At an institute level, collective lunches were prohibited for all healthcare workers and office staff. Same was emphasized at the departmental level to all office, ward and other staff. It was encouraged to take sequential lunch breaks as meal times involve taking off masks and increase the vulnerability of getting exposed. Similar precautions were also advised for tea/coffee breaks.

- *Adherence to universal precautions:* Universal precautions such as masks, distancing etc were emphasized periodically for all settings and personnel to minimize risk of transmission. The office staff in particular deals with visitors, inflow of paper and administrative work across clinical departments and other offices/sections at AIIMS. Staff was educated to sanitize hands each time after coming in contact with files, letters or any potential fomites delivered from other wards/offices.
- *Pre-admission COVID-19 test screening for all patients:* All patients who get admitted undergo a pre-admission COVID-19 test in AIIMS emergency, the result of which is usually available within 3-4 hours. This is being followed since the onset of pandemic till date. There is some likelihood of a false negative report, so all new admissions are kept at quite a distance from other beds or in a separate cubicle (if vacant) for initial few days. Patients with certain psychiatric emergencies (e.g. mania) are often potentially vulnerable to acquire infection. Some may be overactive, overfamiliar or dismiss any risk to self. They are less likely to adhere to basic safety measures such as hand hygiene, mask or distancing in the days prior to admission.
- *Safety initiatives for patients and their attendants in wards:* All admitted patients and their family members were required to wear a mask at all times in ward and practice social distancing and hand hygiene. If they did not have mask, the nursing personnel provided them with triple-layer surgical mask every day. Sanitizers could not be kept at bedside in view of suicidal patients who may sip or drink these as a means of self harm. Soaps/hand washes were used by all patients at periodic intervals. Educative posters were put up to display preventive measures for COVID-19. These posters were bi-lingual and visual for ease of understanding. The patients and their attendants were screened daily for any new-onset fever, cough or any other symptoms suggestive of COVID-19. This was done by the resident in charge & by nursing staff on duty. The distancing could be easily ensured between beds as admissions were less in the lockdown months. Though there is some increase in admissions in recent months, but even now only those with severe illnesses or other emergencies seek admission. In view of this, the distancing between adjacent occupied patient beds is being ensured at all times. The family attendant go out of ward for bringing their own food/tea etc. It was discussed that treating teams shall ensure that the number of such visits is kept to minimum and all necessary precautions are being followed when the attendants go outside ward.
- *Protocols for transfer and disinfection of the space after COVID-positivity in staff/patients* There were occasions when a particular patient or staff is confirmed to be positive upon testing. In case of patients, an immediate transfer to AIIMS COVID facility or discharge was initiated after coordinating with duty officer/hospital administration. The plan was finalized after discussing with family depending on patient's medical and psychiatric status. An immediate disinfection was initiated through nursing officers on duty for ward or through office staff for psychiatry department office spaces to call the disinfection personnel for respective areas of hospital.
- *Periodic supervision and routine monitoring through HIC checklist:* There has been a routine supervision of standard practices by the nurses incharge on a day to day basis. A hospital infection control (HIC) checklist was shared with nodal officers as a template

against which daily adherence to standard practices should be monitored. The nurses incharge were asked to use these checklists for daily supervision purposes. These covered a variety of items such as frequency of disinfection of surfaces, bed spacing, cleanliness of nursing counters, ward cubicles and duty rooms etc. A periodic supervision was done by Infection control team members to monitor the adherence and detecting any loopholes.

Often, issues would come from OPDs/wards in terms of test report interpretations (such as suspected false negative test or continued positive report etc) while deciding for admission or procedures such as MECT etc. In those scenarios, opinion was taken from faculty members of Infectious disease (ID)/Medicine or from members of HICC. Those issues also constituted new leanings for similar scenarios in future.

### **Contact tracing (CT) within department and liaison with central contact tracing team(CCCT)**

From institute perspective, this exercise was thought to be best carried out by respective departments, in order to share the work-load and build the capacity. Additionally, one is privy to more information about the movements and exposures of a positive staff/potential contacts within department. A constant guidance and feedback was available from the faculty members of CCCT.

The Contact Tracing was done in accordance with set guidelines shared by CCCT which laid out the role and processes to be followed after a positive test report.

- *Preparation of a list with entire staff details in department:* A list of all staff/personnel working at department was prepared in advance, including their names/telephones/residence, which was kept with nodal officer for coordination and filling of contact tracing forms, as and when required
- *Tracing the contacts and risk stratification:* After any resident/faculty/staff was confirmed to be COVID-positive, an exercise was undertaken to explore the potential contacts of the positive person, including nature and duration of contact. A time period of 48 hours prior to onset of first symptom (or in case of asymptomatic person, within 48 hours prior to test report) till current was taken for purpose of tracing contacts. Those who were deemed to fulfill the definition of contacts were thereafter stratified into high-and low-risk contacts as per pre-defined criteria, and accordingly advised for processes laid down by CCCT. Those who were classified as high risk contacts were advised for mandatory quarantine and testing on day 5-7 if asymptomatic or early if symptomatic. There would be occasions when a clear categorization into high vs low risk could not be made and such cases were discussed with CCCT members. Overall, an effort was made to maximize their safety and take an extra caution assuming a higher risk.
- *Managing the panic and providing relevant information to contacts/cases:* One important aspect which came bundled with the task of CT was the management of fear, anxiety and even panic among those who test positive and among those who were potentially exposed. After a staff member comes out to be positive, s/he was advised to contact the EHS helpline

or Infectious disease/Medicine faculty/SRs to discuss need for admission. The contacts would discuss their degree of risk, need for quarantine and testing at EHS OPD. Addressal of their queries (pertaining to their risk or type of leave etc) would often be necessary as many were not aware of exact procedures in early phases. For example: some high risk contacts would want to get tested immediately/next day of exposure itself, even if an early negative report is of no clinical relevance. Further, the process of preparing the timeline with a confirmed positive case/contacts regarding the type and nature of exposure often brings out a myriad of emotions ranging from regret/guilt to anxiety/fear and health concerns for self/others.

The process of CT also served as a feedback in some cases for potential gaps in the infection control activities which needed to be filled by setting up appropriate practices in that regard.

To conclude, the infection control initiatives in psychiatry department covered training and awareness building across various cadres of staff/personnel, planning as well as supervision of infection control activities aligned to institute guidelines/standard practices, tracing and stratification of contacts and problem-solving for any newer challenges faced. The pandemic has not ended yet, though even after that, the coronavirus infection is here to stay in some measure. Some of the COVID-19 safety practices inculcated during pandemic shall be helpful for infection control if carried forward as a routine practice in hospital settings.

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## **Infection Control Activities at Addiction Treatment Facility During COVID-19**

*Yatan Pal Singh Balhara*

In order to minimise the risk of transmission of the novel coronavirus infection among the patients, their care givers and the hospital staff employed at the National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi a series of measures have been taken since the beginning of the COVID- 19 pandemic. These measures are grounded in the principles of safe health care delivery in COVID – 19 times and are guided by the instructions from the administration and recommendations made by the Hospital Infection Control Committee (HICC), AIIMS, New Delhi.

The HICC is a multi disciplinary committee at the institute that offers guidance on prevention of transmission of the novel coronavirus infection and infection control throughout the institute. The committee developed resources targeted at the aforementioned aims. The centre has followed the recommendations made by the HICC. <sup>[1]</sup> Also, the instructions issued from the offices of the Director and the Medical Superintendent have been followed at the centre. This chapter offers an overview of the infection control activities taken at NDDTC during COVID-19.

The centre appointed a nodal officer for the infection control to coordinate with the HICC. The nodal officer was responsible for coordinating the novel coronavirus infection control activities at the centre; liaisoning with the HICC to address situations as they arise; liaisoning with nurses in charge and hospital stores to ensure adequate availability of appropriate PPE/ PPE items in different clinical areas; contributing to training and reorientation of all staff with respect to infection control practices, especially in context of COVID; and form a team to periodically assess adherence to the COVID-19 related infection control guidelines.

Additionally, the COVID- 19 Infection Control Committee was constituted at the centre. The committee comprised of faculty members, resident doctors, ANS, and Medical Social Services Officer (MSSO) from NDDTC. The committee was constituted in keeping with the recommendations by the HICC. The committee was responsible for taking various decisions with respect to infection control at the centre, implementation of these decisions and follow-up actions. The committee was also responsible for implementation of the recommendations made by the HICC.



The requirements for the PPE kits for the hospital staff posted in different areas of the centre was calculated and shared with the stores for procurement. The level of PPE requirement for different areas was as per the recommendations made by the HICC. Additionally, N95 masks were provided to all the healthcare workers involved in patient care. A fresh set of masks was issued after every twenty days.

All the healthcare staff were advised to implement standard infection control precautions including basic hand hygiene, use of personal protective equipment, respiratory etiquettes, and environmental disinfection. The staff at the centre was trained on prevention of infection transmission based on the HICC guidelines. The training of nursing, security, Sulabh, mess staff at the centre was carried out in small batches under supervision of ANS, MSSO, and senior resident doctors. The instructional videos on proper use of PPEs were also shared with all employees.

The clinical areas were periodically cleaned and sanitised using 1% Sodium Hypochlorite solution as recommended by the HICC. Alcohol based disinfectants were used to wipe down surfaces where the use of bleach was not suitable. The procedure for cleaning and disinfecting was as recommended by the HICC in the Infection Prevention and control Guidelines for 2019-nCoV (COVID- 19). Hand sanitisers were made available at various places in the clinical as well as the administrative zones.

Educational posters were posted at different places across the centre. These posters offered messages on hand washing and sanitising, social distancing, use of face mask, and common symptoms of the infection.

Everyone entering the centre premises was checked for body temperature. Also, it was ensured that everyone entering the premises covered their face with a mask/ cloth and kept it covered during their stay on the campus. Patients who are visiting the centre without masks were given masks at the entrance gate.

In order to ensure adequate physical distancing during the clinical care delivery indicators were painted all along the path followed by the patients to reach the OPD area from the entrance. These indicators guided the patients to ensure that they maintained adequate physical distance from each other. The patients considered to be high risk for the novel coronavirus infection were referred to nearest hospital in Ghaziabad providing COVID- 19 related services. Three such hospitals were identified. At the same time provisions were made to ensure that this interfered minimally with the treatment sought by the patient from the centre and alternate arrangements for dispensing of the medicines were made.

In case a staff member reported of a febrile illness or respiratory symptoms (cough, difficulty breathing, etc) they were advised to consult at the EHS OPD. In case any staff member tested positive for the novel coronavirus, the contact tracing was done as per the recommendations by the HICC. The details of all the contacts were shared with the central contact tracing team. The level of risk of exposure was ascertained and depending on the same the contacts of the index case were advised monitoring, isolation and home quarantine, testing for the infection, and admission to the COVID care facility at AIIMS. The high-risk contacts were advised to

EHS helpline for quarantine and testing. They needed to be tested after day five of exposure or if symptoms developed, whichever happens, earlier. The low-risk contacts could continue their duties with adherence to standard precautions like social distancing, hand hygiene, and use of mask/PPE as appropriate. They were advised to EHS helpline/OPD if any symptoms like cough, fever, shortness of breath are observed.

Besides these measures changes were made to the clinical duty roster of the faculty, residents, nurses, MSSO, security staff, sulabh staff, and other administrative and support staff at the centre. Additionally, changes were made to the medicine dispensing and follow up visits of the patients. Details of the same have not been mentioned here as they same are expected to be covered in other chapters of this monograph.

These measures continue to be in place at the centre. Additionally, the amendments shall be made going ahead as per the instructions from the administration and recommendations made by the HICC.

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## **Meeting the Challenge of Teaching During the COVID-19: Experiences from the Department of Psychiatry**

*Rakesh K Chadda, Raman Deep*

COVID-19 pandemic posed a major challenge in continuing teaching in medical schools. The medical schools in India have both undergraduate and postgraduate students. The undergraduate students are generally in big number varying from 50-300 depending on the capacity of the medical school. The postgraduate students are distributed across various preclinical, paraclinical and clinical disciplines, and are also involved in clinical and research work. In the initial period of the COVID-19 pandemic, a nationwide lockdown was declared in India like in many other countries. Most of the educational institutions suspended the academics during this period and hostels were also vacated as a preventive measure. These steps were taken as a part of social distancing measures. Since it was not possible to have regular teaching programme in physical mode, and the teaching and training of the students and postgraduate trainees was affected, it was decided to look into alternative options.

This paper discusses various approaches used to continue teaching of the undergraduate and postgraduate students in the Department of Psychiatry at the All India Institute of Medical Sciences (AIIMS), New Delhi.

### **Teaching and training activities amidst pandemic: approach and initiatives**

The Department of Psychiatry, AIIMS, New Delhi is involved in training of undergraduate and postgraduate students in psychiatry, doctoral level programme in addiction psychiatry, BSc Nursing and also has PhD programme. Postgraduate students also have to undertake a research project and write a thesis on the research project. All these trainings had been affected by the lockdown. About 33% to 40% of psychiatry residents at any point were posted outside department for COVID duties. Further, the regular clinical services in out-patient settings were suspended at the onset of lockdown, with a gradual, phase-wise re-opening; therefore, the clinical teaching as well as clinical research was affected. Thus, there was a need to take due measures in all of these directions, as listed below and discussed later:

- Regular teaching sessions of postgraduate and doctoral students
- Clinical teaching and training
- Thesis research projects
- Undergraduate teaching

### ***Regular teaching programme of postgraduate and doctoral students***

In the background of the COVID-19 pandemic, the Government of the National Capital Territory of Delhi closed all the educational institutions on 12th March 2020, initially for a

period till 31<sup>st</sup> March 2020.<sup>[1]</sup> This led to uncertainty over residents' academic programmes, with a close monitoring of an evolving situation. A ban was also declared on conferences or seminars with a gathering beyond 200 people from 13<sup>th</sup> March 2020, which was further strengthened to gathering of less than 50 people on 16<sup>th</sup> March 2020 and less than 20 people on 19<sup>th</sup> March 2020.<sup>[1]</sup>

The regular teaching programme of psychiatry department runs thrice a week in afternoons. It comprises of Monday Journal Clubs (JC) and Thesis presentations (MD/DM), Wednesday Seminars and Thursday Case Conferences. These are held at the seminar room on 4<sup>th</sup> floor of teaching block (or day care room, C-1 ward for Thursday case conference) with an audience comprising of Junior Residents, PhD scholars, Senior Residents as well as the members of the Faculty. Similarly, teaching programme at National Drug Dependence Treatment Centre (NDDTC) comprises of Journal Clubs/Seminars on Wednesdays and Fridays.

On 16<sup>th</sup> March 2020, the Journal Club was scheduled for the same afternoon, when news of ban on gatherings beyond 50 people began to pour in. Hence, it was decided to withhold teaching programmes with immediate effect to avoid any risk of infection. An e-mail intimation was sent to the entire department stating "*all academics stand cancelled w.e.f. today till further notice in view of health precautions related to COVID -19*". It was conveyed that residents may keep their thesis protocols or midterms ready, and if need be, those can be prioritized in a very small faculty group with adequate distancing. By 22<sup>nd</sup> March 2020, however, as situation escalated, that plan was deferred till further notice. Thereafter, national lockdown was announced from 24<sup>th</sup> March 2020<sup>[2]</sup>, followed by closure of out-patient services at the Institute.

Most of the departmental focus in initial few days shifted to COVID-19 preparedness, establishment of telepsychiatry services for follow-up patient care, and organizing awareness activities and developing resource materials for COVID-19 and mental health. Residents were actively involved in many of these activities.

In a faculty meeting held on 9<sup>th</sup> April 2020, it was decided that academics can be resumed via online mediums. A revised academic roster was prepared to resume thesis presentations, journal clubs and seminars beginning from mid-April 2020. The case conference roster was not taken out in view of limited case availability during initial phase of lockdown. Prior to COVID-19, online platforms such as Zoom, Webex, Google Meet etc. were never employed for departmental academics. Therefore, we anticipated some teething issues, mostly related to technical support, web connectivity and level of audience participation in web-based platforms.

The department booked slots at SET facility, AIIMS for afternoons (3 to 5 pm) to facilitate technical support to presenter/chairperson who initially used SET studio to broadcast their presentation, while the audience joined remotely via a shared link. However, within first few days itself, such technical assistance was not required as the web conferencing became a norm within and outside department. The teaching programmes began to be hosted in-house from the departmental account. Presenters could log in from their place of duty (such as ward room), chairperson's office or from their hostel premises, depending on internet availability and mutual convenience. The concerns about audience participation too went away pretty soon, as

there were proactive discussions after each seminar or journal article. The feature of web-chat facilitated written queries, often quickly resolved by others in audience, during the presentation itself in addition to verbal queries and comments at the end, with a smooth flow of discussions and interactions amongst residents and faculty. In fact, the social isolation brought by lockdown meant that the online academics also served as a means to see, hear and discuss with each other on various issues of academic interest.

The online teaching programmes adhered to the same format as physically attended programmes. The residents were asked to keep the cameras switched on during the academic discussions. There were occasions when a particular academic had to be postponed due to COVID-19 posting of the resident-presenter, since 40% of the residents were in COVID-19 postings. However, eventually these presentations could be rescheduled and presented till end of June 2020, as academic session was extended in view of cancellation of summer vacations of 2020 for institute faculty.

As we began with the fresh session (July- Nov 2020) in mid-July, the structure and mechanisms for teaching programme were already in place. Case Conferences could also be started in this session due to gradual lifting of lockdown and resumption of out-patient services. Though patient inflow was less than regular times, availability of suitable cases for case conferences was not problematic at least for residents posted in main psychiatry. COVID-19 postings, however, continued for nearly one-third of residents on a monthly rotation basis, who would have some difficulty selecting or following up a case for academic purposes. It was also encouraged that online medium may be used to take more detailed history and to conduct some aspects of mental state examination such as facial expression etc., which would be hindered by use of masks in face to face sessions. Most of the preparatory discussions with senior resident or faculty coordinator too moved onto online platforms, to avoid potential exposure from each other.

As of now, we are about to begin third teaching semester (Jan to May 2021) since the COVID-19 pandemic via the web platform. It has become the 'new normal' over last year, with nothing amiss except perhaps a cup of café tea circulated in seminar room. Academic discussions often stretch till after 5 pm on some occasions as before. The quantity and quality of teaching programmes could be maintained over the last year due to an active participation of entire department and centre.

### ***Clinical teaching and training***

While academic teaching programmes could be resumed within three weeks of lockdown, the clinical training took some time to gradually resume to normalcy. A steady flow and availability of cases is required for clinical training of residents. However, case availability was restricted in both out-patient and in-patient services for the first few months. On 24<sup>th</sup> March 2020, the out-patient services of institute temporarily closed in view of lockdown, and diversion of manpower and resources to COVID facilities. Only 6 out of 32 beds of C-1 ward were under psychiatry department in a temporary re-organization of ward beds across hospital after conversion of the Institute's trauma centre to COVID facility. In the first three months of

lockdown, there were also concerns about resident's clinical exposure especially for those who were in their third year with their examinations due in a few weeks.

However, the emergency or on-call duties continued as before for residents. The emergency services saw a rather increase in the number of psychiatry patients, mostly of delirium tremens or psychiatric exacerbations, in the first few weeks of lockdown. The referrals for patients admitted in general hospital wards were also attended by on-call residents through online/physical consults. Telepsychiatry services soon provided a new avenue for clinical exposure of residents and assisted in their clinical training. The tele-consults were attended by senior resident/s along with junior residents in discussions with consultant as per need. The junior residents regularly participated in follow-up assessments and management of telepsychiatry patients.

To sum up, emergency consults, consultation-liaison referrals, tele-consults and limited in-patient beds provided the means of clinical exposure and teaching of residents from onset of lockdown till initial three months (March end till mid- July 2020). Additionally, it is also noteworthy that residents in COVID duties would routinely come across cases with psychological and psychiatric issues at AIIMS-COVID facilities. This constituted a new form of clinical exposure and learning as residents were involved in their psychiatric care, in addition to COVID care.

By July 2020, the out-patient services gradually began to open in a phase-wise manner and psychiatry ward beds were also reverted back to psychiatry department. To begin with, residents were posted either exclusively to ward or to out-patient clinics with weekly rotations, to limit risk of infection spreading across multiple settings. The availability of personal protection equipment (PPE) was not an issue in either OPD or ward, and was donned by residents in all clinical interactions. In spite of that, there was some apprehension for need to strike a balance between safety of residents and their clinical interactions. The detailed work-ups typically take 1-2 hours per patient, which is a prolonged exposure in a closed space. Further, psychotic or manic patients may not cooperate in terms of wearing masks or maintaining distancing from the clinician. Therefore, to deal with this issue, it was decided to set up fully functional computer terminals with camera and microphone, across partitioned rooms in OPD, which could be used by junior residents to take history from patient and family, if required.

Gradually, as the processes were put in place, the functioning reverted back to unit system as before, with regular detailed work-ups and discussions with senior residents and faculty members of respective clinical unit. The senior resident teaching rounds, faculty ward rounds and OPD case discussions resumed as before. The telepsychiatry exposure also continued to augment resident's training. For many months now, there has been a constant increase in patient inflow which has been adequate for teaching and training activities of residents.

***Thesis Research projects***

The MD /DM thesis students have to complete and submit their thesis as a partial fulfilment towards the degree. The department had a variety of thesis projects going on at the time of declaration of pandemic, which ranged from those involving clinical assessments, family interviews, blood-based assessments and magnetic resonance(MR)-based assessments to those involving visits to community for data collection. With declaration of pandemic, the ongoing thesis work was affected in many ways, as below:

- (a) There was closure of routine OPDs for initial few months. Even after restriction was lifted off, the patients, who were stable or mildly ill, would not come for physical follow ups. The seriously ill or unmanageable patients would figure in exclusion criteria or would not consent or cooperate for thesis assessments.
- (b) Patients in telepsychiatry services reported anxieties in commuting by public transport and apprehensions about infection at hospital settings. Outstation patients feared travel across borders of the state amidst pandemic.
- (c) MR-based assessments posed a challenge as pre-COVID screen was required before patient could be taken up in scanner. In initial months of lockdown, MR testing was not freely available and convincing a healthy participant to undergo test for thesis purpose was a big hindrance
- (d) Thesis based in community setting (for example shelter home or school) too faced challenge as due to COVID restrictions, shelter home was no longer accessible or feasible, requiring a change of proposed protocol.

The junior residents who were due to submit their thesis in next few months were the most anxious of all, though pandemic affected almost all thesis projects in some way. The institute relaxed the time to submit the thesis by two months in view of COVID pandemic.

It was discussed within department that mere extension of submission time would not be enough. It was preempted that the proposed sample sizes would need to be cut down to a feasible number, and requisite changes would need to be made in selection criteria or study setting or methods as per requirement. Further, it was thought that such an exercise would be required at a departmental level, given that COVID pandemic is likely to continue in near future. A core faculty group was constituted to look into the issues and explore potential options with the guides and candidates. In August-end, a schedule was prepared for all MD/DM residents in department. All residents presented their thesis protocols briefly to the core faculty group, highlighting difficulties and potential solutions for approval. Modifications in the thesis protocols were discussed and deliberated upon by the faculty groups and approved subsequently. The residents and guides in such cases intimated the academic section as well as ethics committee about the changes to the protocol.

Such an exercise at the departmental level helped to allay the anxieties and concerns of the residents. Afterwards, with gradual resumption of transport and normalization of OPD services, the recruitment of thesis patients is being ensured, albeit with some efforts in terms of contacting and coordinating for patient appointment and entry into the premises.

### ***Undergraduate teaching***

The clinical postings for undergraduates in the department of psychiatry occur for a period of 9 weeks divided in two postings of 25 days and 40 days respectively between 5<sup>th</sup> and 8<sup>th</sup> semester, in addition to psychiatry exposure as part of community medicine posting at Centre for Community Medicine, and 20 hours of theory lectures by faculty.<sup>[3]</sup>

Prior to COVID 19 pandemic, the students in clinical psychiatry postings were exposed to case workups, discussions and clinical teaching sessions by senior residents/faculty. Such clinical exposure to cases was not feasible during the pandemic. The students stayed off-campus at their respective hometowns beginning from lockdown. The undergraduate teaching at the institute continued to be imparted primarily through online mediums.

In view of this, there was a need to substitute clinical postings with online sessions with faculty from the department. Therefore, a schedule was prepared between 9 am to 1 pm daily for teaching batches of MBBS students for the entire duration of their posting in psychiatry. A faculty member was assigned the topic for discussion for each day of the postings, with roster covering various members of faculty. It was also discussed that the sessions may be kept clinically oriented and interactive rather than didactic lecture. Faculty members often used case histories/case scenarios/mental state examination for purpose of demonstration and to stimulate discussion. These sessions would be held at online platforms, coordinated by the class representative. At the end of each batch posting, the online assessments were conducted by two faculty members. Such efforts within department have attempted to maximize the exposure of undergraduates to psychiatry to the extent possible, within constraints of COVID 19 pandemic.

To conclude, the pandemic posed several challenges in terms of teaching and training activities. However, these were resolved by finding the best suited alternatives and a gradual phase-wise approach to near-normalcy. Certain steps were taken to facilitate postgraduate thesis research in the wake of pandemic. The quantity and quality of teaching programmes for postgraduate and undergraduate students could be maintained due to an active participation of faculty from entire department and centre.

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## Conducting MD/DM Examinations During COVID-19

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The Department of Psychiatry, All India Institute of Medical Sciences (AIIMS), New Delhi is involved in training of MD (Psychiatry) as well as DM (addiction psychiatry) residents. The MD/DM examinations are routinely scheduled in the months of May and December each year, beginning with theory examinations in the first week followed by viva-voce or practical around middle of the month.

For the batch appearing in final examination, a mock practical/viva is held within department. It follows the same pattern as final practical examination viz. a long case, two short cases and grand viva. For the batch appearing in May exams, it is usually held in the last week of March. The postgraduate students usually get a month of preparatory leave prior to final examinations.

In March 2020, the external examiners had consented for the examinership and a schedule was made for mock examinations to be held at month-end. However, as pandemic situation evolved and national lockdown was imposed, doubts were cast about the final examinations. The institute passed a circular for postponement of MD/DM examinations as all efforts were geared towards the containment of infection within hospital and management of suspect/confirmed COVID cases. By April 2020, the exam-going residents went into their preparatory leave and had to continue studying amidst the panic and concerns around them. While some delay was anticipated, it seemed likely that examinations would take place in the same summer. On 21<sup>st</sup> April, 2020, it was intimated that MD/DM examinations may take place by May-end and to keep the preparations ready towards the same. The departments were advised to prepare case simulations or alternate methods of assessments to substitute for real-life patients. Within a week of that, fresh dates were announced for MD and DM examinations. The theory examination was to be conducted by institute in early June, while viva-voce to be held by department was scheduled for mid-June.

It kick-started the meetings within department to invite suggestions and inputs to conduct the practical examinations. This was an unparalleled situation with no prior guidance or experience. It was obvious that it might not be possible for the patients to be called for examinations due to infection related risk. The use of telepsychiatry or online medium was likely to create issues for candidates (due to technical connectivity at patient-end or patient's cooperation level) and selection of suitable cases for tele-medium was another huge challenge, especially as OPD was closed in the previous month. To add to the task, MD batch comprised of a total of 12 residents, for whom atleast 30-35 cases were required. Another option was to draft a number of mock histories for long and short cases, but those 'creative' case writings (especially for long cases) may not have been nuanced enough to mimic real-life psychopathologies. All such options were deliberated by internal examiners and faculty members, but none was found to be too pragmatic.

Finally, a suggestion came to make use of the departmental case conference write-ups, which would have rich details gathered from real-life patients, and often have several diagnostic and management issues. This idea was immediately agreeable to all concerned. Each faculty had chaired the case conferences and could contribute those write-ups to the pool. They were asked to look into their records for past several years, especially beyond the last three years. This exercise yielded a total of 50-60 cases, of which suitable ones were short-listed after excluding those which were unsuitable or too complicated for examination purposes.

Next hurdle was that these write-ups were very long, spanning 25-30 pages each with tedious details and loose ends. A small group of faculty members were entrusted with task of going through each of write-up and to edit those to be concise and incisive. Also, care was taken that 'impressions' of given thought samples etc. were not provided to candidates and no 'formulations' were included in the case write-ups. These write-ups needed to be truncated to half to one-third the original length for long cases, while for short cases, a focus was retained on any aspect of mental state examination. For neurology cases, a faculty member who is part of neuropsychiatry clinic was requested to arrange for similar write-ups of common neurology cases, with brief clinical summary and neurological findings. None of these write-ups was shared with anyone beyond a small group comprising only of faculty members in the department and centre.

In the weeks preceding their examination, examination going batch had appeared in online mock examination, conducted by various members of the faculty, but that did not exactly replicate the final examination viva. Considering that examination going residents may have some anxieties or doubts about the new format, a meeting was called with examination-going batch in order to explain the practical examination process to them and address any queries. It was explained that resident would get an hour with long case write-up (and 30 min with short case) to read and conceptualize it. During case presentation, they would make their impressions about psychopathology from the given information in history/MSE, discuss potential diagnosis, differentials and management plan. Residents were also advised about precautions to be kept in view of COVID-19 during the examinaion process.

External examiners had already consented to be part of examination; however, their consent was reaffirmed in view of pandemic situation. Local examiner could join physically, while those from out-station planned to join through video conferencing due to safety issues, travel restrictions and need for quarantine on reaching Delhi.

Other examination related arrangements were made in terms of ensuring supplies of sanitizers, masks and disinfection of the room surfaces. A large room was chosen for examination to ensure distancing. Computer terminals were readied with necessary accessories to facilitate video conference and high speed internet connectivity. Institute cafeteria usually extends buffet lunch for examiners, but this time around, packed lunch boxes were sent to the examination room. In usual examination, the theory answer sheets are sent in a sealed envelope to be checked; however, this time in view of COVID infection related issues, an online portal, created by the Institute's examination section, was used to access scanned theory sheets at examiner's' terminal.

Finally, the practical examinations proceeded in June, first for DM and then for MD examinations a week later. These MD/DM exams were first such examinations in history of department without physical presence of patients, who were substituted by case write-ups, and thus the candidates could be tested on diverse case scenarios. The information which is typically gathered from patient was provided to the candidates as case histories, but understanding that information, analyzing it and making clinical decisions was the prerogative of candidates as before. Practical examinations went smoothly and continued till late evenings. Everyone made a mental note of the new learnings and methods adopted to test the candidates, especially as not many medical colleges had conducted their examinations yet.

This model could substitute reasonably well for regular examination viva and was tested twice in MD/DM exams in a month, with positive feedbacks in each scenario. It was uncertain if the next examination would be conducted on same pattern or not. The OPD services resumed over the next few months as the lockdown was lifted gradually, therefore availability of cases was no longer an issue. The December 2020 session examination was conducted with physical presence of cases and families, as per usual pattern. Only new addition was a host of infection control and risk prevention measures, including PPE, which were put in place for clinical case interactions. This model of examination was later followed at many other medical colleges and by the National Board of Examinations in the country in their respective postgraduate examination in psychiatry.

To conclude, there was no precedent or guidance on the methods and materials which could be employed to test candidates in final examination amidst lockdown in June 2020. The academic case write-ups were mined from past several years and suitably edited to yield an exhaustive list of cases write-ups for clinical viva. Safe and feasible solutions were devised to conduct MD/DM examinations smoothly, which formed a new learning to deal with similar scenarios in future

## **Online Learning and Mental Health: Pandemic Crisis for Children and Adolescents**

*Rachna Bhargava*

The outbreak of COVID 19 pandemic brought the entire world to a standstill. In AIIMS too, all regular, non emergency clinical services were closed in early months of pandemic. In spite of the attempts to maintain continuity of therapy sessions, confusion prevailed. With increasing number of COVID 19 cases, patients were slowly shifted to a virtual platform. Closure of clinical services led to disappearance of follow-ups among children. It was only after few months when OPD skeletal services were resumed that children with acute needs started seeking appointments. The parents' and children shared their experiences since the lock down and its toll on their mental health.

The news of the closure of educational institutes was welcomed like a warm beam of golden sunshine by many children in schools and colleges. Over time, however, this became too harsh to bear and different concerns permeated in different age groups. It soon dawned on the students that the pandemic was here to stay as annual exams and then competitive entrance exams got repeatedly postponed. These young minds were now haunted by the uncertainties, fear and anxiety of COVID times. Finally, the exams were held despite the mingling fear and anxiety of the infection. The uncertainties and home isolation seemed to have impacted their level of drive and many children admitted to not being able to use this time to their advantage for preparation.

Online learning was the only option to maintain continuity for educational institutions. The whole world saw a shift to e-learning from traditional face to face learning. This was not the first time when conventional educational activities were suspended. During SARS coronavirus (SARS-CoV) and H1N1 Flu outbreak in 2009 too, educational activities had been impacted in many countries. <sup>[1]</sup> Literature is sparse regarding the effects and efficacy of online education.

<sup>[2]</sup>

Parents expressed that adolescents gradually became accustomed to online classes and some even found entertainment during classes via private chats. The schools subsequently opted for virtual platforms where they could block these interactions in order to maximize concentration. But, over time, the newness of the e-learning wore off. Educational institutions are also the focal points of social activities and interactions. School interactions including group learning, lesson-discussions, and outdoor activities are thoroughly missed in online learning for all age groups. Studies have observed that students who felt like they had friends and teachers who cared about them found classwork to be more interesting, were more engaged in school, and were more confident that they could complete their work. <sup>[3]</sup>

The videos are usually switched off for better connectivity. In the given scenario, unsurprisingly children felt bored during classes due to lack of connect with teachers and sometimes new students (as new session also means reshuffling of students in some schools). Parents perceive that it has made it harder for the kids to remain focused in the online classes. Though teachers are not to be blamed as e-teaching indeed makes it difficult for the teachers to connect individually and provide individualized feedback especially in classes with greater strengths.

The preventive measures (masks and social distancing) have further added to their plight. Adolescents do connect with friends on various virtual platforms. Schools too have attempted to maintain some extracurricular school activities (online) yet the monotony of the routine days and tasks over months have resulted in decreased concentration and dissipated enthusiasm.

The youngest group of school goers i.e those in primary classes have not remained unaffected. The excitement of free time and unavoidable dependency on net based recreational activities has paved way to irritability and friction with elders especially over extended screen time. Many parents who were working from home could help in the technicalities of joining the e-classes but it also meant more supervision. The classes are being held in staggered timing which disrupts the working parents' schedule and the children too are not able to get into the 'study mood'. The understanding of effective schedule and methods is of utmost importance to enhance motivation and well being.

There has been a plethora of articles on the psychological impact of the issues arising due to pandemic among adults all across the world but there has been relatively limited empirical evidence of the psychological impact among children. <sup>[4]</sup> Our research work that was being carried out among students of Delhi government schools had to be changed to online mode. This led us to stand witness to the harsh realities of 'digital divide'. Among the children contacted, nearly 89% had WhatsApp facilities, while others did not. However, poor net connectivity and lack of devices deprives them from having online classes. The lectures are 'sent' via WhatsApp and children only get access to mobile when their parents return home from work. Online learning can be effective in digitally advanced countries. <sup>[5]</sup> In India, where 66% of the population resides in villages, issues of access to fast, affordable and reliable internet connections hinders the process of online learning. Even among the families, where affordability does not pose a problem, the speed and stable connectivity still remains as a concern.

The end of lockdown has not brought any respite to these young sailors as they continue their voyage, mapping this unfathomed sea of e-learning.

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## Mental Health Research Initiatives During COVID-19

*Sujata Satapathy*

### Introduction

With the aim to contribute to global and Indian literature on COVID-19, few short-term research projects were taken up by Department of Psychiatry & NDDTC. The broad focus of these projects was to assess the mental health status of COVID-19 patients and health care professionals. Each of those projects had its unique set of objectives, sample profile, and methodology. There were many challenges involved in planning as well as conducting research with COVID 19 patients. The chapter provides an overview of COVID 19 research initiatives by the Department of Psychiatry & NDDTC, along with issues and challenges faced in the process.

### Themes of projects

Following Ethics Committee approval letters in May and June 2020, COVID 19 research projects were taken up as shown in Table 1. One of them was funded by AIIMS Intramural grant, others were non funded. Both offline and online method of data collection were used.

**Table 1: Research initiatives by Department of Psychiatry & NDDTC during COVID-19**

Research	Project Team	Project Duration	Status of the project /publications
A cross- sectional questionnaire-based study to assess anxiety among healthcare professionals in India due to COVID 19	Siddharth Sarkar, Pratap Sharan, Deepika Khakha Piyush Ranjan	3 months (non-funded)	Project completed/under preparation for publication
Psychological burden and coping in hospitalized active COVID 19 patients	Bichitra Nanda Patra, Rakesh K Chadda, AnjanTriksa	6 months (non-funded)	On going
Mental health screening, patients' satisfaction, and brief supportive tele-counseling for admitted and quarantined/isolated patients during COVID-19	Sujata Satapathy LT Wundavalli RK Chadda S Satpathy Sheetal Singh Angel R Singh Vijay P Barre	8 months (AIIMS Intramural fund)	1 paper accepted for publication in Indian Journal Clinical Psychology; 1 paper in revised review & 2 papers communicated

- The projects investigated the impact of COVID-19 on mental health of COVID -19 patients and healthcare professional.



- A part of one project also attempted to develop and implement a structured tele-counseling module for COVID-19 patients admitted at AIIMS (NCI, Jhajjar) and followed up these patients till three months from the day of discharge from the hospital.

### **Challenges in conducting COVID -19 research**

While the whole country was trying to understand COVID-19 and its havoc on mental health of the population and the professionals around the world were still estimating the magnitude and severity of such mental health impacts, the process of undertaking the research began at AIIMS. Amidst heightened fear, apprehension, and challenges for conducting research in a hospital set up, the department took up these initiatives. The project teams faced many challenges to start, proceed and complete the research within a short and stipulated time period. Sharing such experiences is worthwhile to provide guidance to other researchers initiating research in similar situations.

The challenges of gathering data from healthy participants in general population could be dealt with use of online/telephonic medium, however getting data from COVID-19 active patients or healthcare professionals who were working hard in spite of occupational threats was quite different. Few challenges experienced by the project team are mentioned below:

#### *Consent*

- Although verbal consent is usually not ethically sanctioned, special mention about this was sought while applying ethics clearance wherein the participants' consent for recording his/her consent was sought first followed by their consents for participating in the study. The participant information sheet (PIS) was read out in detail and their queries were answered before the interview/tele-interview
- The online consent in the Google forms was set in such a way the participants can proceed further only after consenting.
- Consent on hard copies was done in the usual method.

#### *Data Collection*

- As employing a project staff was not possible due to various reasons, the investigators had to collect data themselves while doing duties in COVID care facilities, therefore it was a tough task to complete.
- Repeated reminders were sent for filling in the online data. In addition, WhatsApp support groups were made for each batch that used to be admitted in NCI, Jhajjar and reminders to filling in the Google forms were sent periodically.
- For offline data collection, bringing the filled-in forms outside COVID area was not possible due to the risk of viral contamination through fomites. The data sheets used to be distributed by the staff posted in COVID duty area. The project team members used to visit the patients few times in order to motivate them to participate in the research. Hence, between May 2020 and August 2020, collection of hard copies of data sheets followed a rigorous process of disinfection at three stages, (a) each sheet and packets of bunches of data sheets when collected; (b) storage of these packets for 2-3 weeks to reduce fomite

contamination risk; and (c) COVID safety measures for self before and after opening the packets for data screening or entries. Therefore, the process was quite long for getting the committed sample size and the response rate was around 60-65% after exclusion and refusal for non-participation.

- Continuous coordination with the partnering departments was tedious.

#### *Data processing and analysis*

- In both funded and non-funded projects starting with data entries (particularly data from hard copies) to analyses, everything was done by the investigators themselves. Though, the entire experience was a good learning experience, it was taxing for the project team as OPD duties, academic and other activities began to normalize from June-July 2020 onwards.

### **COVID-19 specific unique experiences**

It was surprising to see that a majority of COVID-19 patients admitted in NCI Jhajhar between April 2020 and August 2020 were refusing the online form but consented for reporting on hard copies. We wanted to understand the reasons for 60% response rate and so when asked during three-months follow up, most of them viewed:

- That they wanted to give their opinion about the experience rather than answering fixed/close ended questions only. And that was primarily related to the fear and confusion about issues surrounding their COVID-19 isolation or management or discharge etc.
- A small proportion had fear that the digital recording of data might be shared in public platforms, therefore they did not want to send any information from their mobile and e-mail.
- Those who did not participate or fill-in the data (either online or hard copies) expressed views that “I won’t have benefitted anyway. Since I was upset and anxious at that time, I refused. If someone could have talked to me in detail about this, I would have participated”.

We understood that brief communication through PPE and that too infrequently while maintaining the adequate distance and lack of proper eye contact was not a desired method of engaging the patients in the research. Involving and engaging patients in research could be better with one-to one telephonic discussions with each patient giving adequate time and personal attention, so as to increase the response rate. Perhaps during the initial months due to the chaos, fear, stigma, other stressors etc., the patients required more active involvement (either telephonically or personally) of the research team with them. This could be India specific experience, however, needs to be verified from other researchers.

#### *Points to Think:*

- The validity of online data collection through the standardized scales which are validated in face to face sessions can be questionable. The reliability of information might be an issue

in online data collection. The chances of ticking buttons randomly without reading the items increases due to lack of physical proximity between the researchers and participants.

- The validity and reliability of off-line scale administration in COVID 19 setting without following the actual processes of scale administration may also be problematic as the risk of ticking random responses theoretically remains almost similar due to lack of one-to-one scale administration.

### **Challenges in telecounseling and supportive therapy**

- Except for two COVID specific psychoeducation sessions, it was difficult to follow a structured common tele-counseling or supportive therapy sessions for all consenting participants.
- Three to five problem- and coping skills- focused customized sessions with elective therapeutic techniques were held for all participants.
- Sessions were focused on a wide array of issues encompassing stigma and guilt about getting COVID -19, enhanced workload (both for females and males) and selfcare, establishing daily activity schedule, marital discord/abuse, parent-child conflicts, digital detox, identifying maladaptive coping strategies and adopting adaptive coping skills, existing mental illness symptoms in self and family members, and practical guidance to take online appointments in future for AIIMS OPD.
- We also conducted online family therapy sessions for some patients. This helped in better treatment outcomes in the patients registered with us.
- Dealing with some individuals who were not adhering to COVID-19 safety protocols (due to fixed ideas and rigidity) was difficult and guiding family to ensure this was time taking.
- It was time-consuming to restart from rapport building to history taking stage if the therapist changed (especially in case of short-term projects when a staff is appointed for only 3-4 months) and it was also difficult for the participants to build alliance.
- Patient's queries regarding the clinical information regarding their discharge and test reports, addressing co-morbid health issues, and communication with treating teams could not be dealt with due to administrative reasons.

### *Points to Think*

- The ethical and legal standing of recordings of tele-counseling sessions by any participant, particularly in case of sensitive issues such as domestic violence, marital conflicts, abusive parent-child relationship (particularly adolescents abusing parents verbally and emotionally), self-harm, and suicide ideation. There is a risk of misusing a small portion of session recording without the entire context.
- How long the consented recording of sessions by the researcher should be stored is not clear and specified. Moreover, it cannot be stored in a common duty mobile due to confidentiality issues. Whether it can be stored in a personal mobile is also questionable.
- The burnout issues among the health care professionals and the desired preventive mental health care were marginalized.

Research initiatives with COVID-19 patients was a new experience, which threw some challenges and left us with learnings and feedback for planning research in similar situations in future.

**Contribution Towards National Policies and Programs Related to  
Addiction Treatment Services During COVID-19 Pandemic:  
An Experiential Account**

*Atul Ambekar, Ravindra Rao, Alok Agrawal*

The unprecedented COVID19 pandemic is a significant challenge for functioning of almost all the aspects of human life including the delivery of health care services. People affected by Substance Use Disorders (SUD) are an especially vulnerable population to both – the COVID19 infection as well as the adverse impact of measures taken to respond to the pandemic (such as ‘lockdown’ or ‘isolation /quarantine’). <sup>[1]</sup>

In the early days of pandemic itself (March 2020), a nationwide lockdown was instituted in India which lasted with varying degrees of ‘reopening’ for many weeks to months. In terms of their impact on the practice of addiction psychiatry, the pandemic and the lockdown implied that:

- (a) People who use alcohol or drugs will find it difficult to procure the same. While many of them would experience craving (a distressing experience), those suffering from SUDs would experience withdrawal symptoms with potentially serious and life-threatening consequences.
- (b) People with SUDs who need treatment services (either as new treatment seekers or as already registered patients) will find it difficult to access the services.
- (c) The pandemic response (in the form of lockdown and the diversion of routine healthcare to COVID19 care) will seriously impede the efforts of SUD treatment service providers to continue providing the services, even with the best of the intentions.
- (d) Patients with SUDs as well as the staff of treatment services remain at risk of exposure to COVID19, which needs to be minimised.

Thus, taking these implications into account, we, the addiction psychiatry community recognized the challenge. We mounted a response based primarily on the twin principles of (i) maintaining continuity of care and (ii) preventing the infection among patients and health care providers. In this paper, we present some distinct examples of challenges faced and initiatives undertaken at advocacy with policymakers and/or contribution towards designing programmes and policies addressing concerns related to delivery of SUD treatment services in the context of the COVID19 pandemic.

**People who use alcohol: left ‘low’ and dry**

Soon as the lockdown was hastily announced with little warning and preparation-time, the first and foremost challenge presented itself by the abrupt restriction on the availability of alcohol. Predictably, this resulted in the sudden influx of cases of severe alcohol withdrawal symptoms

presenting to the health care facilities. Reports highlighting this issue were published in the scientific journals as well as the general news media, from various parts of the country. <sup>[2-3]</sup>

Recognizing the need to address this issue urgently, we immediately sprang to action and worked at the multiple fronts. Firstly, in order to provide scientifically accurate information to the general public, a variety of content was developed and disseminated. This included short-video clips containing messages for the general public on how to deal with alcohol craving and withdrawals. These video clips were hosted on the websites of AIIMS as well as Ministry of Health and Family Welfare (MOH&FW), Government of India.

Secondly, it was considered important to develop educational and capacity-building resources for the health-care professionals as well as the health administrators. Thus, advisories and guidelines in the form of brief documents, written in simple language, were developed, published and disseminated.<sup>[4]</sup> Since, besides the health sector (such as MOH&FW), the social welfare sector (the Ministry of Social Justice and Empowerment, MOSJE) is also an important stakeholder in the response to substance use problems in India, similar advisories were developed for MOSJE and the NGOs supported by the MOSJE.<sup>[5]</sup> Realizing the important role played by the health departments of state governments, we worked actively to assist the MOH&FW, Government of India in issuing an advisory to all the state governments on “Managing Drugs /Substances Withdrawal in the context of Lock-down as a response to COVID19 Pandemic”.<sup>[6]</sup> We ensured that this comprehensive advisory provided guidelines to state government on (a) Public health response to the risk of substances and drug withdrawals precipitated by non-availability; (b) Treatment of substances and drug withdrawal syndrome; (c) Role of medications in the treatment of substances and drug withdrawal; (d) Organizational issues in health care delivery and (e) Capacity building of health professionals. Thus, clinical as well public-health-system aspects of managing withdrawal syndrome were addressed through these guidelines.

However, we understood that it would not be enough to just advocate or recommend evidence-based treatment for SUDs. It was also equally necessary to enhance the capacities of health providers, enabling them to manage acute conditions (e.g. withdrawal syndromes) in the non-specialist health settings. Since the traditional models of capacity building (such as classroom-type training programs) were obviously not feasible in the midst of pandemic and lockdown, we worked on urgently developing online training programs for health professionals on SUDs. Short modules on management of alcohol use disorders and opioid use disorders (“primer courses”) were developed and made available free-of-cost, hosted on an especially launched, easily accessible website “NDDTC AIIMS Addiction Training” (<https://naat.co.in/all-courses/>). Information on this was widely circulated through the social media.

### **People on opioid agonist maintenance: no drugs, no medications, risk of Relapse**

The lockdown and other restrictions presented another serious challenge for those receiving long term maintenance treatment, such as Opioid Substitution Therapy (OST). The challenge in this case was twofold: maintaining the continuity of care and well as protecting the patients

and the staff from risk of exposure to COVID19. This was obviously a paradoxical situation since maintaining continuity of care would ordinarily mean frequent visits to clinics which would entail risk of exposure. As is well-known, opioid agonist treatment remains a challenge in India, with a major reason being restrictive policies.<sup>[7]</sup> In the government health sector, OST has been provided primarily under either the National AIDS Control Program (sublingual buprenorphine, as daily observed treatment) and the Drug De-addiction Program (through the Drug Treatment Clinic [DTC] scheme; methadone syrup as directly observed treatment and sublingual buprenorphine-naloxone as take-home). The restrictive dispensing policies governing OST medications have largely been based upon the concern for diversion. However, in the early days of pandemic itself it became clear that the extraordinary situation demanded that ensuring treatment compliance and protecting staff and patients from the risk of infection needs to be prioritised over the concerns about possible diversion of agonist medications. Thus, we decided to adopt more liberal approaches for dispensing of buprenorphine, buprenorphine-naloxone and methadone. For the DTC program, modified dispensing guidelines were developed and disseminated to all the hospitals in the month of March 2020. For the National AIDS Control Program, we worked closely with the policy makers and programme managers to develop appropriate guidelines for the OST centres functioning with NACO, MOH&FW. For the private sector OST clinics (as well as for all the psychiatrists in general), we worked with the Indian Psychiatric Society to urgently develop and publish ‘interim guidelines’ for OST.<sup>[8]</sup> As a result, stable patients on buprenorphine and buprenorphine-naloxone became eligible to receive these medications as take-home for up to two – four weeks in almost all the treatment settings. More importantly, for the first time, even stable patients on methadone were made eligible to receive methadone as take-home for up to one-week, a significant development which was covered even by the international media.<sup>[9]</sup> These guidelines were formulated and widely disseminated among the treatment providers through sharing guideline documents as well as through webinars. Adopting these reforms has minimized the need to commute frequently for the patients and reduce the burden on the health staff. In order to monitor the situation, in the early weeks after the guidelines were implemented, a system of frequent collection of data and information from the peripheral clinics was put in place. Early results from these programmatic reforms indicate that the patients and staff have welcomed these changes and contrary to the prevailing concerns, no reports of significant diversion and attendant adverse consequences have emerged so far.

### **Telepsychiatry: so close yet so far**

For facilitating health-care delivery, the concept and practice of telemedicine got an early boost in India through publication of the Telemedicine Practice Guidelines by the authorities.<sup>[10]</sup> Projected as an ‘Enabler of Healthcare Access and Affordability’, these guidelines were found not satisfactory for the purpose of delivery of mental health care services. Soon, specific guidelines catering to the needs of telepsychiatry were published and were received with enthusiasm by the psychiatry fraternity in India.<sup>[11]</sup> However, unfortunately the existing telepsychiatry guidelines remain rather restrictive for the purpose of providing treatment to patients with SUDs. Specifically, most of the medications required for the treatment of SUDs have been explicitly disallowed to be prescribed through telepsychiatry tools, under the current

guidelines. Recognizing this gap, we urgently advocated with the developers of the guidelines on suitable platforms including as an academic publication.<sup>[12]</sup> While the concerns expressed have been well-received, bringing about the needed reforms in the telepsychiatry guidelines remain an agenda for the immediate future. Thus, the advocacy must go on.

## Conclusion

It would be an understatement to term COVID19 pandemic as a crisis. However, this crisis was effectively used as an opportunity to mount a response by the addiction psychiatry community in India, specifically the team of faculty members at the NDDTC, AIIMS. This experience has taught us valuable lessons. In any crisis of this nature, while speed is of essence, the scientific rigour and the ethical considerations cannot be allowed to be sacrificed at the altar of swiftness of response. Thus, a careful analysis of risk-benefit ratio is important for every action being proposed and considered. It is also imperative to remain cognizant of the gap between design and implementation, as sometimes, a plan which appears feasible on paper, may not get translated into practice. Finally, any policy or action must be evaluated, not by the stated intention but by its outcome. Thus, a careful assessment of impact of these interventions in the medium to long-term would be essential.

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## Psychological Support Services at Airport

*Vandana Choudhary*

### **Background**

As our country was hit by the recently declared global pandemic COVID-19 in early march, India began its battle against the disaster in multiple ways. While the layout to manage the situation in the country was still on progress, it was realized soon by authorities that it was necessary to regulate the source of infection, which was largely assumed to be the passengers across world landing to India. Aviation services quickly took charge of the situation and declared suspension of all international flights as a step towards restricting the inflow of infected cases. Standard operating procedures were immediately launched to screen every passenger landing to India, categorizing them based on risk of infection and isolating them at home for low risk cases and in institutional quarantine centres for those with high risk or if tested positive for COVID-19. Huge manpower resources were being pooled by the government in ensuring the implementation of all the mandates. Quite soon, it was also realized that mental health forms an integral part of the intervention and their services would be essential in managing the uncertainty and the associated emotional concerns of the people. With this thought, Ministry of Health & Family Welfare deputed clinical psychologists to the Airport Health Services, Indira Gandhi International Airport, New Delhi from 20<sup>th</sup> March, 2020.

### **Let's take imaginary tour to the situation on day 1**

I always associated Delhi Airport with a feeling of organization, hospitality and calmness. Be it the massive artistic pieces engraved on the wall, or the large spaces through which you make your way to the flights with brewed coffee in hand. Everything is just so systematic and the staff members are cordial and passengers look at ease. And here comes the morning of 21<sup>st</sup> March 2020, where I got the first opportunity of being a corona warrior. Though I was full of patriotism in heart, and confidence on my clinical skills learnt so far, there was a husky voice inside me questioning everything I was going to do, clouding me with many silent fears. While I would shut the voice and overpower it with optimism and related preparation on every possible way, my concerned family members kept calling on the way to airport seeking endless reassurance on my safety. Thus, my psychological services began quite early on the way to airport, while helping each of them to manage their anxieties and be assured of my safety.

Certainly I didn't expect the same image of airport as outlined above. As I arrived on the airport, I tried to figure out amidst all the confusions and doubts about the locations and activities going on there. There were lot of security personnel everywhere which thankfully did a good job at providing roadmaps to locate the COVID-19 screening centres. As I moved in the centre, it felt like, as if path towards uncertainty unfolded itself. From my eyes, it was an absolute chaos where a huge crowd of more than 50 health professionals in 'hazmat suit' were performing various services with another queue of not less than 100 passengers waiting to be seen by them. I made a quick transition from being surprised at the

situation to gearing up to jump into the team. The superimposed anonymity of PPE, which was a new concept to me at that moment, just made it too complex to locate the supervisor of the centre, so that I could take charge of my duties. Somehow, I located my way to her, and as I introduced myself as clinical psychologist from AIIMS and ways in which I could help manage the panic and so on. I was quickly interrupted by a ten minute introduction to the methods of filling the COVID-19 screening form, manner of stamping people and few tips for educating people about maintaining health hygiene at quarantine centres. I was assigned a table with a fellow co-worker and instructed to begin the services. Though I still struggled to explain the coordinator and my fellow co-worker, that my services would be different here than medical professionals, it was soon hushed by passengers who knocked our table with an urgency to relieve them of screening formalities. For a moment, I went into autopilot mode, and kept performing the duties as instructed.

After about an hour or so, an old passenger picked up a huge fight with my fellow health professional, and then suffered a panic attack and started running out of breath, with trembling of his entire body and expressed immense worry on the situation. That is the time I left all that I was doing and immediately provided crisis management to help him deal with the situation. After the situation was under control, I reintroduced myself to the coordinator and reemphasized that I was a clinical psychologist sent by AIIMS, New Delhi to assist people in management of crisis. My role was acknowledged and hence I made my way through a separate table on psychological management of crisis. Soon I was joined by another mental health colleague from other hospital and we formed a psychological support team.

### **Nature of distress in passengers**

The conception of the distress began from the moment a passenger would land up on the airport, and was unexpectedly lined up for no less than three hours for undergoing COVID-19 screening. This was quite a tiresome process, especially for those arriving after long journey, rushing for urgent meetings/gatherings or for vulnerable population like elders, children, and those with various ailments and disabilities. As expected, food joints were heavily crowded and there were complaints here and there about the paucity of many essential resources and poor sanitation facilities. But beyond that, the most prominent anxiety was that of the results from screening patients which became dichotomously associated with two kinds of outcome: happiness, if someone was home quarantined, and despair, if they were categorised to be of medium to high risk and were institutionally quarantined. One could quite guess from their faces of what result was bestowed to each of them. The happy ones were leaving the airport with minor worries related to management of taxi, and arrangement for home quarantine. But those with institutional quarantine formed a distressed group at the corner of the airport awaiting to be told about the process for going ahead.

Certainly, not everyone was emotionally on the same page. A large group communicated anger over the situation. Unwilling to be quarantined, they had complaints about the way they were treated throughout. Within short time, anger became aggression and soon resulted in few outbursts. I have a clear image of a young girl who was screaming and shouting at the authorities and deciding to break all the glasses of the hall. The situation was so severe, that police had to be called to help manage the outburst. Some, especially few elderly ones, internalized the aggression and decided to self-starve themselves to death till authorities bent down to their demands on exception from institutional quarantine. And I witnessed a domino effect in the crowd such that each of these instances were kicking in series of similar aggressive episodes in others, whose initial reactions were mild. Overall, the situation was escalating at such a fast pace, that people had to be segregated from each other and individually called for the management.

Beneath anger, there was extreme degree of anxieties related to quarantine centres. A large number of people had misconceptions about quarantine centres and hence experienced mistrust over everything planned by the authorities. These misconceptions primarily circled around the theme that quarantine centres were jails or lacked essentials services like food and medicines with restrictions forced on everything. The next level anxiety was about the process of moving to these centres. People had numerous unanswered questions related to payment of cost per day of stay, type of room and facilities available and whether couples could be quarantined together, etc. Many people were not carrying enough cash to pay for the institutional stay and were not ready to move to the government arranged centres because of anticipated lack of facilities. Thus, even though intellectual awareness could be generated in many people on the same, emotional acceptance was rarely seen.

### **Dynamic role of the clinical psychologist**

The role of clinical psychologist was really broadened depending upon the variable range of services that were needed to be provided at the airport. Some of the broad areas of my work were:

#### ***Psychological first aid (PFA)***

As COVID-19 pandemic was also declared to be a national disaster for the country, psychological first aid (PFA) was among the most crucial service to be provided to the passengers. Inter-Agency Standing Committee of the World Health Organization (WHO) describes PFA a supportive humane response to a fellow human being who is suffering a major stressor and may need support. <sup>[1]</sup> Some of the major themes included in PFA are immediate assessment of needs/concerns, helping people to address basic needs, empathetic listening to people, comforting and calming down people and helping them connect to correct information, services and social support. The World Health Organization (WHO) has broadly classified these themes into three action principles. <sup>[2]</sup> These principles provide guidance for how to view and safely enter an emergency situation (LOOK) in order to understand the needs of affected people (LISTEN) and link them with the information and practical support they need (LINK). Their experiences of the situation were normalized, hope was fostered, and their self-efficacy to deal with the situation was promoted.

#### ***Psychoeducation on COVID-19 and life at quarantine centers***

Since most of the distress circled around the pandemic situation and the life at quarantine centers, psychoeducation was planned. Though in early March 2020, relatively very less was known about COVID-19, I did my homework well on reading all the official information shared on the COVID-19 and ensured to deliver it accurately to everyone. This was usually followed by discussing with people their expected stay in quarantine centers. At the beginning, I mostly assisted people in eliciting their fears associated with their stay. Misconceptions were identified and replaced with required factual information. They were further encouraged to ask as many questions as they wanted to know, till they felt they are well-informed about everything. Though I attempted to furnish them with most details available, there were many new and unknown questions to me as well. To answer them, I kept referring back to the person arranging for the stay at quarantine centers. A detailed psychoeducation plan was thus formulated, which included information about reasons for taking them to institutional quarantine than for home quarantine, duration of stay at the quarantine centre, check-up frequency and procedures, rules and regulations of the centre, and expected duration of stay. Further, a prototypical day at quarantine centre was introduced, which a passenger would lead at the centre, right from the morning to

the night. This helped in setting up the right expectations in the passengers about the new routine and adjustments that they would have to do in the new setup.

***Addressing concerns about well-being of the parted family members:***

Passengers had many concerns associated with ensuring well-being of the parted family members. The focus of intervention here was bringing acceptance of the situation so that realistic expectations could be set. It was also helpful for them to consider their visit as temporary and expect a quick reunion as their stay would be over in two weeks. Thus, the adjustment was for few days only. Additionally, they were explained that they could always make calls to their family members and assure themselves of how they were coping with the separation and the pandemic. If there were potential concerns, the family could help them or make arrangements for it over phone. Talking about this concern to fellow passengers also provided relief through shared support.

***Providing brief mental health training to the other health care professionals***

As days passed, we were progressively better at handling the situation. However, since the health care professionals who were involved in the initial screening changed every day, many had very limited idea of how to handle the crisis. Thus, need for a brief mental health sensitivity training was realized to benefit the way they were handling the crisis. To implement this, before fresh batch joined the desk each day, they were called at a silent place, and oriented about their required duties in 10 min by the manager. I started taking another 10 minutes on psychoeducating them about the kind of anxieties passenger had, broad communication skills that could be employed to address their concerns, some guidance notes on how panic reactions could be dealt with, and few tips on optimizing mental health while being quarantined. They were further asked to send all the identified people, who found situation too overwhelming, to me for counseling. This was the shortest training that I could do at that point, but it turned out to be quite helpful to the people in managing the crisis as well as ensuring their basic mental health.

**Challenges in delivering the psychological services**

While every attempt was taken to optimize the psychological support to people at the airport, there were few challenges which stayed back with me and really questioned the way counseling services are delivered. I have tried elaborating here two of the most prominent ones and the way I tackled them:

***Communicating effectively well while wearing PPE***

As mandated by the government, use of PPE and social distancing norm of at least 1 meter was essential to avoid any possible spread of infection. While the measure provided enough protection to safeguard the health of the professionals, it also posed unique challenges while delivering interactions, especially when a psychologist is deprived of opportunity to display any form of non-verbal communication for facilitating adaptation process. It was extremely difficult to appear concerned or show empathy, while I was entirely covered with PPE, and interacting from such a considerable distance. Often, I was echoing in my gear, my voice wasn't reaching to the people I was interacting with, and the fog on the goggles just blurred the expressions on people's faces and hence a visual feedback which is the very wheel of forwarding two-way communication was missing. Honestly, I was neither trained nor prepared for this kind of communication and it became quite challenging initially. But I had to do something about it,

since giving up was not an option. Some of the ways in which I tried to optimize the communication was:

- *Eye contact:* Since eyes and brows were the only visible part of the face in PPE, it carried comparatively huge importance in non-verbal communication. Keeping a steady eye contact was significant to convey that I was attending to the other person sincerely. However, caution was taken to ensure that at no point, it became too intrusive, especially if the other person was unwilling to make eye contact. The position and form of eyebrows was another device available to me for visual communication. For example, raised eyebrows indicated shock, fear, or disgust, eyebrows drawn together suggested anger or confusion, one eyebrow raised showed disbelief etc. It was thus crucial to maintain a straight position of the eyebrow, moving as per the eye contact with minimal shift in its position.
- *Hand gestures:* Hand gestures were peculiarly very useful while counseling. For example, raised fist, or a clenched fist, is widely discussed to be a symbol of solidarity, support, unity or strength, and thus were very frequently used to communicate strength and togetherness. However, caution was taken in ensuring that the used gesture bared no negative connotation for the passengers hailing from varied cultural background.
- *Paralinguistics:* It included the vocal part of the communication determined by factors such as tone and pitch of voice, and speed and volume at which communication is delivered. It is often suggested for counsellors to match the volume and tone of voice to the patient's speech, and avoid using too loud or too soft tone of speech. However, social distancing norms mandated considerable distance between psychologists and family members which made it difficult to speak at a matched pitch and tone with patient. I had to be loud at many points to get across the message clearly to the people. Since loudness could easily be confused with rudeness and dominance, I used to pre-inform them before beginning speech that "*I may speak loudly than usual during the entire conversation but that's only because I want to be audible enough to send you my message clearly while maintaining social distancing norms. I would encourage you to do the same to avoid any confusion*". While being loud, it was a useful practice to emphasize keywords from the speech which I certainly wanted the other person to retain. Key words were communicated effectively when spoken with a pause, in louder tone or were repeated one or two times for effective delivery.

### ***Managing self while being in a disaster: Importance of self-care***

Though I have been part of disaster management services earlier, this situation at airport was unique as I was one of the first one deputed for the psychological services, and the pandemic was still at its initial stages. Years of training at being a psychologist helped me to provide all the required services at the airport. I would want to acknowledge the fact that I was many times equally impacted by it and had bouts of my own anxieties and fears associated with being in the pandemic. The central theme of these anxieties was to minimize the change of getting infected. I took every possible precaution to ensure my safety. Yet certain fears were just too obvious and unavoidable. For example, I clearly remember, there was a news all around the media that Italy had a recent outbreak in COVID-19 cases. Just knowing that the plane from Italy had landed with passengers I had to work with, was a bit anxiety provoking for me. Though, my rational mind prepared me well to go through the situation but the upsurges from emotional mind were overwhelming to manage at times. The vicarious trauma and compassion fatigue soon also

used to impact me deeply. Since all this could have deleterious impact on my own mental health, I was determined to engage in adequate self-care. For example, I ensured that I took all meals on time while being on duty, sleep adequately each day, and expressed myself and engaged in frequent ventilation of emotions with people in my support network. These were little steps which went a long way in building the inner resilience to being an active mental health professional at the times of crisis.

Providing psychological services at airport in early days of pandemic was quite a new and challenging experience. Mental health services in such a situation range from psychological first aid for individuals in distress over quarantine, psychological interventions for their family members in addition to mental health trainings to other professionals. Several other challenges involve finding new ways to communicate through protective gear as well as overcoming one's own anxieties and fears.

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# SECTION

## II

Literary and Personal Narratives





(Photographs credit: Dr. Lakshmy, Dr. Nivedhitha, Dr. Nidhisha, Dr. Shubha, Dr. Rajababu, Dr. Ashwin, Dr. Pooja, Dr. Anuranjan, Dr. Manish, Dr. Rajvardhan, Dr. Anjali, Dr. Jatin, Dr. Romil, Dr. Rajan Mishra, Dr. Jaswant, Dr. Abhishek)

## Receiving Care for COVID-19: A Psychiatrist's Perspective

*Vaibhav Patil*

Following the infectious coronavirus disease 2019 (COVID-19) outbreak, more than 93 million cases and 20 lakh deaths have been reported worldwide till mid-January of 2020. Restructuring of health services along with redeployment of health care professionals from all disciplines to COVID-19 services has been in place since the outbreak. Though vaccine has been developed in less than a year, it will take time to discern its impact on controlling and managing the infection. Till that time, this public health crisis will continue to keep Health Care Workers (HCWs) under both physical and psychological pressure. HCWs are highly vulnerable to emotional distress, due to their risk of exposure to infection, concerns about infecting loved ones, longer working hours, shortage of protective equipment, discrimination, isolation etc. When HCWs get infected with COVID-19, it further amplifies their distress levels. I would like to share my such experience of undergoing psychological stress as a psychiatrist during the process of receiving care when I got infected with COVID-19.

While working in hospital, I was taking all the recommended safety precautions. The fear of getting infected was lesser than fear of transmitting it to the family members. I was taking cautions for regular and frequent hand hygiene, cleaning all the materials such as bag, mobile, pen, spectacles etc taken to hospital on daily basis. But somehow, even after taking precautions and without any known exposure to a case, I tested positive for COVID-19. The first thing which came to my mind was to protect my family from further exposure, for which I needed hospitalization in order to isolate myself. During that time it was difficult to get admission in view of high patient load. I was under isolation and treatment for next 17 days at AIIMS, during which my thoughts and concerns can be summarized under the following themes:

***Fear of getting sick:*** When you get tested positive for COVID-19, there is always fear of getting a serious health complication based on your experiences while being part of the treating team for COVID positive patients or family member/friend developing complications while on treatment. Media reports and available literature also increases apprehensions. A sense of uncertainty creates anxiety and panic, which affects the sleep, appetite and ability to cope with such stressful events. In the initial period, there is a denial for current situation but gradually one starts accepting the situation. Apprehension and worry increases significantly whenever there is appearance of any new symptom or when one develops side effects due to medication. Prior to getting COVID 19, I was part of various research projects which aimed at identifying psychological impact of COVID-19 on patients, healthcare workers or on patients with mental health issues. Once I tested positive for COVID 19, it made me realize the importance of mental health aspects even more than before. While under treatment I received adequate support and reassurance from treating team. They used to visit regularly and would explain about

investigation reports and usual course of disease on daily basis. My family, friends and colleagues supported me through regular communication and helped me to stay positive.

**Worries about family:** Staying away from family also separates a person from the support system during difficult times. Emotional support of family is important to relieve someone from psychological distress anxiety, mood symptoms. At the same time fear of exposing family members, particularly elderly, to infection creates guilt. Inability to take their responsibility or provide emergency care, if needed, during the isolation period may induce feelings of worthlessness. Thus, family is important protective factor for mental health but at the same time, concerns related to their health can also cause mental distress in the period of isolation. I received support and help from friends and colleagues in managing care for my nuclear family in difficult times.

**Stigma:** Novel nature of disease, highly infectious nature and unpredicted outcome, non-availability of treatment along with need for social distancing, social isolation and quarantine have contributed to fear and resulted into stigma. The fear of getting isolated from society due to stigma is highly prevalent in infected patients. This may in turn act as stressor for later development of mental health problem. By the time I got infected, stigma was not that much of an issue as people got aware of COVID-19 due to large number of cases in the vicinity.

**Impact of Isolation:** Humans are social animals. Social connection is important for physical and mental wellbeing. Though isolation is effective method of preventing spread of infection but restricting and cutting oneself from social ties for extended period may lead to significant decrease in quality of life and wellbeing as well as high level of stress. Elderly population or those staying alone are at higher risk of developing mental health issues. Restricting yourself in one room for prolonged periods may induce anxiety, boredom, frustration, sleep disturbances, mood symptoms. I kept myself occupied with work when my health improved. Physical exercises and breathing techniques helped me to improve my health. I maintained my contact through video calls, phone and emails which helped to reduce my sense of isolation and stay connected with my support system.

**Health issues post discharge:** Post COVID fatigue, tiredness, dry cough, sleep disturbances and intermittent anxiety symptoms continued for nearly a month after discharge. There may also be difficulty in concentrating at work due to health related issues. Thus psychological impact of COVID-19 may continue even after designated isolation period is over.

Getting admitted and receiving treatment at COVID-19 ward helped me to understand its psychological impact. COVID-19 patients are at high risk of developing mental health problems due various factors such as fear of disease complications, isolation, stigma etc. Pre-existing mental health issues further increases risk. Various psycho-social factors along with raised inflammatory markers may contribute together to increase prevalence of psychiatric issues in this population. Thus, patients should receive mental healthcare along with physical care from the start of treatment, particularly in highly vulnerable groups. There is need for active psychiatric team involvement in the treatment of such patients which is being followed at AIIMS, New Delhi.

## 21

**Staying Positive as A COVID-19 Positive Patient: As Experiential Voyage***Barre Vijay Prasad**“In times of crisis, people reach for meaning. Meaning is strength.**Our survival may depend on our seeking and finding it” [Viktor E. Frankl]*

With the declaration of COVID-19 as pandemic, there was a fear and panic all around the globe. However, the question was not to view from someone else’s point of view, but to introspect within self, which led me to ponder “*what if ‘me’?*” Almost any kind of interaction in the initial few days created a perceptible fear within me about getting infected. Working in the health sector posed additional risks and led to more worries. Over next few months, there was also a shift towards recoveries and availability of more treatment options. With time, I got to accept the situation and chose to retain the focus on performing my duty. With this, the initial fear gradually faded out.

Few months later, I began to have fever, cough etc for a day or two. There was no known exposure and I hoped that it is just a common flu. The bodyaches kicked in shortly and subsequent sampling led to a positive test report. When I received the call, I took a decision to get admitted to the hospital for initial few days. I went all alone to hospital, keeping hopes for recovery and discharge, with not much anxiety to begin with.

During initial part of stay at ward, at some level, I felt like a layman trying to deal with rising levels of anxiety, despair, inability to fall or maintain sleep. I felt other unfamiliar symptoms and physical discomforts. I constantly assured myself with positive reframing of thoughts. Some points which helped me stay positive in my brief stay at hospital include

***Focus on realistic risks:*** One can be try to focus on realistic risks associated with COVID 19 rather than panic with the news of casualties. My initial preparedness in this regard at the outbreak of COVID 19 helped me with this. It is unavoidable to think of worst possible case scenario, however one need to deal with the situation using problem solving approaches rather than emotion focused coping methods.

***Stay connected with family members and friends:*** With family staying away in another state, it is not easy to disclose the positive test report to them without making them unduly anxious. One has to choose whom to communicate with about the situation and in what manner. I did the same by first deciding on who can help in terms of giving emotional support and strength during this phase. Engaging in a simple telephonic conversation with a relative can be emotional ventilation and conversations with friends can also serve as a good distraction.

***Deep breathing exercises:*** Luckily, I did not have any lung or breathing issues, but preferred to practice and continued breathing exercises to stay fit.



***Diet:*** I also focused on nutritious food, fruit juices, hot soups and nuts to help with recovery.

***Keeping faith:*** It may be last, but not least to say that I have “faith in god” in my difficulties and joyful moments. My prayers were also my biggest coping strategy to stay positive.

**Discharge and Post COVID fatigue:**

In terms of care and service, I acknowledge my treating team for their constant support. My symptoms were mild and I could be discharged to spend rest of the isolation period at home. However, the post COVID phase can be a horrifying experience in some regards. I experienced symptoms such as dizziness and persisting headaches etc which interfered my functioning at work. I was unable to carry out my regular responsibilities for some days, till they resolved.

Summing up my experiences, I could stay positive with help of these strategies during my small voyage as a COVID-19 positive patient in pandemic.

# 22

## **Effect of COVID-19 Lockdown on Mental Health and Suggested Management Strategies**

*Rakesh Lal*

Fear, worry, and stress are normal responses to perceived or real threats. This is compounded when we are faced with uncertainty, conflicting information and no discernible end point. Hence it is not surprising that people are distressed in the context of the COVID-19 pandemic.

In addition to the fear of contracting the virus, one has to make significant changes in daily lives. Humans are essentially social animals. Social interaction is the key for happiness and survival. This has been affected because the most publicized and widely practiced method to restrict the spread of the virus is ‘social distancing’. Consequent impact on day to day life includes:

- Working from home
- Lack of physical contact with relatives, friends and colleagues
- Restriction in leisure time activities, involving socialization
- Temporary unemployment and loss of income
- Disruption of education etc.

Although response to stress is an individual phenomenon, it is modulated by social support, financial stability and physical and emotional health. It is quite possible that certain individuals may be under greater stress than others. These include

- Individuals at a higher risk of complications from COVID-19 including those suffering from physical and mental comorbidity.
- Extremes of age: the elderly and younger/teenage group.
- Sole earning members of the family, especially when faced with job loss.
- Health care workers and other personnel with public dealing having increased risk of exposure as part of their profession.
- Patients of substance use disorders
- Socially isolated persons including minorities
- Inadequate access to reliable information
- Homelessness.

### Suggested steps to minimize stress, anxiety and low mood

- *Identify low mood:* There may be subtle changes in routine including decreased or increased sleep and appetite, avoiding pleasurable pursuits and avoidance of contact over and above social distancing norms advised. Feelings of helplessness, hopelessness and worthlessness may be expressed. There is a general attitude of pessimism. If such features are identified an empathic listening and spending quality time by a significant other may be the only thing necessary. However, if there is a progressive worsening of symptoms, establishing contact with a mental health professional is advisable. There are some guidelines on how to minimize impact of stress due to COVID pandemic.
- *Knowledge is power:* One must be aware of necessary precautions and worrisome symptoms and should be informed of facilities available for quarantine, testing and treatment and costs involved.
- Some other useful strategies to minimize stress and anxiety can be summarized by the acronym **SAPSCOMM**.
  - **Stay Connected** (by virtual means): Humans thrive on relationships. Positive interactions are the essence of our happiness. There is perhaps no more important time for people to feel connected to and supported by others as when they face a serious illness or trauma.
  - **Avoid** faulty coping strategies like increased use of alcohol, tobacco and other drugs
  - **Proper** diet and rest and exercise keeping in mind guidelines for reduced exposure
  - **Stock** a supply of medicines for at least two weeks if taking long term medications for a coexisting illness.
  - Many **children** are being forced to stay indoors. Provide engaging age-appropriate activities for children, including activities for their learning.
  - **Keep older** relatives informed about the current situation. They should be made aware of positive events happening. They are vulnerable both physically and psychologically and need to be protected.
  - **Mental** health issues should not be ignored. The stigma associated with mental health problems may cause reluctance to seek support for both COVID-19 and mental health conditions. One needs to overcome this.
  - **Minimize** watching, reading or listening to news about COVID-19 that is distressful. One should seek information only from trusted sources and rely on facts, not rumours.

It should be emphasized that man is a creature of routine and this crisis has led to a major change and need to adjust. Add to it, the fear of uncertainty and worry about personal well being and that of the family and being bombarded with rumours and negative (breaking) news, there is a sense of helplessness. Financial distress further compounds the stress. Good psychological support is helpful and advice like 'be patient' although well meaning, may not be wholly acceptable to an individual who is in financial distress and needs immediate relief.

Common sense precautions need to be incorporated like social distancing, wearing of masks and washing of hands. Unnecessary exposure should be avoided. Working from home may not be an option for many but when such an option exists, it should be exercised. One should be aware of all available sources of help should the need arise. It should be amply clear that the majority of patients recover completely. Those at risk for a worse outcome include the very young and very old, those with pre-existing physical and mental illness, weak and debilitated persons and those addicted to some substance.

Finally, for those diagnosed as positive, there is an urgent need to decrease stigma. Rather than referring to them as COVID cases it is advisable to refer to such patients as those who have/are being treated or those recovering from COVID 19. After recovery he should be accepted and allowed to resume a normal socio-occupational life.

**Take home:** Do not live in fear so long as you are taking adequate precautions.



## 23

### ***'Silence Before the Storm to Calmness in Chaos': Experience of a Psychiatry Resident Trainee during the COVID-19 Pandemic***

*Ankita Chattopadhyay*

As I pen down this article after returning from my COVID duty, I look back to the year 2020 and the challenges it put forth to us. Who would have thought that our generation would also face a 'pandemic', which we previously read of only in our microbiology and community medicine books?

Well, for me, the year 2020 started off pretty well with successful thesis submission and a charged-up mind for preparation of the final MD examination. Fleeting news of a virus creating havoc in some countries were coming, but like the other epidemics till date, it was being expected to subside in some days. Our routine clinical services continued with the mere precaution of wearing a mask initially.

Life was still going smoothly with the ruminations about how to prepare for the upcoming exam. At some time, we were thinking of arranging group study and at other, thinking of going home for the study leave. Amidst all this, there would sometimes be a discomfort whenever I would hear about the effect of the virus in the various countries and rising number of cases in India as well. But hoping all this would end soon, I continued with my plans.

Panic started to build up by the mid of March when our consultants started to prime us that there might be a situation when some of us will be kept as reserve force for serving patients if others fall sick. Till this time, I was in denial that it wasn't that bad. But when roster started coming up with my colleagues being sent to serve patients suffering from COVID-19 infection in designated wards and ICUs, things started to appear serious.

It was one such evening of our group study in the hostel common room when the news of nation-wide lockdown came up. Growing up, I have heard my elders mentioning about the emergency situation in our country. But the practical experience of being in lockdown was quite overwhelming at the onset. The struggle that followed was never expected. Getting groceries for basic cooking became a task, with long queue outside shops and halted delivery of online stores. The hostel mess started closing with online food delivery options also becoming few and unsafe. Necessity being the mother of invention, I started trying and testing easy food recipes and ended up inventing something new, but edible at least. Our OPDs started closing, only admitting patients from the emergency. Academics were withheld for some time with gradual shift to online platforms later.

As we moved on to April, we were put on the reserve force of residents with no option of going home to study. The daily rumours of postponement of exam were very distressing, with uncertainty creeping into the mind and making it a task to sustain attention in anything I did.

Then midway through the month, the news came that our final exams have been postponed and we were called to ward for duty.

One part of me was happy to see human faces and immersing myself in patient care. It came as a good opportunity for me to revise my clinical skills before the examination. But then my speed of studying had slowed down. Nevertheless, I managed to keep on going with learning to cook better with my mother's homely food recipes and sharing pictures with her at the end of the day. The frequency of video calls to home increased, to suffice for the loneliness that had crept up inside me with the so called 'social or physical distancing' being practiced. I would be looking forward to the online academics where I would get the new learning as well as get to see some familiar faces of the department. The consultants would also ensure that we feel at home by holding resident- friendly meetings online from time to time.

Time slid into May, with me gradually adjusting to this new form of living. Physical group study changed to virtual study over the phone or online platforms. The hostel room became the only place to stay for the next month. Exams were announced to be held in June with still lack of clarity about the mode of examination. But one thing was clear, I had to ensure to try not to get infected with the virus, otherwise I would not be able to sit for the examination. I was amazed to see how I could slowly adjust to this small room round the clock with the only excursion of going to fetch water from the end of the corridor. There were days when I used to yearn for going out or to see people, but the fear of contracting the infection was much more. As the days of the examination started nearing, the frequency and duration of group study calls started increasing.

The uncertainty regarding examination increased further when it was informed to us that there would be no patients to examine this time and it would be through 'case vignettes'. On one hand it was reassuring that there would be less chance of contracting infection, but on the other hand, the uncertainty of how to present vignette started creeping up. But to our rescue, the faculty arranged a mock examination for us to prepare us with the new format. Needless to say, a huge effort was put by our department seniors and the faculty for preparing case vignettes individually for the twelve of us and helping us to understand the format. The mock examination indeed helped me understand my faults in the preparation and made me feel at ease with the new format.

As the examination started coming closer, the hypochondriacal thoughts started creeping up more. With minimal runny nose or a mild itch in the throat, I would make frantic calls to my parents who would then reassure me that I would be fine, but also instruct to be alert to any worsening of symptoms. Being alone in a room and having any such symptoms was not an easy task I must say. But thankfully, I managed to keep going.

The days of the examination finally arrived. The long queue of sanitization prior to the entrance of theory examination hall with the constant task of putting on mask in the hot summer afternoon kept on reminding me of the tough times we were in. However, I managed to write the papers with a small excursion of going to take the entrance examination of DM in Addiction Psychiatry of our institute in between the theory papers (my first outing in these months).

It was finally the turn for the practical examination. The usual anxious person in me had already started ruminating about the possibility of doing mistakes in the examination. At around 10 pm the previous night, my friend gave me the news that I have cleared the theory entrance test of the DM course. Mixed with excitement of the passing this test and the anxiety of the examination the next day, I could hardly sleep that night.

I would probably remember the practical examination day all my life. The day started with us introducing ourselves to the examiners, one of whom was examining us through online video portal (another new experience). One after the other, the case vignettes were given to us, for long case, short case and the neurology case. With the preparation in the mock examination, it was clear to us how to present the cases. The viva followed as usual with extra efforts being made by the examiners to make us comfortable with the examination process as well as to analyse our skill set thoroughly. Though initially I was anxious, this day also passed.

Though the exam had ended for our batch, the results were still pending, so couldn't sleep well that night too. Next day we were called to the department at the end of the examination. The wait for the results to be hinted upon was too nerve wracking. When the final hint came that we have passed the examination and as the seniors congratulated us, I was feeling relieved of being able to survive these months of uncertainty and restlessness and that my efforts in the past few stressful months finally paid off.

The happiness doubled up when I got to know that I could make my parents and teachers proud by scoring the highest marks in the examination as well. The journey which started with uncertainty certainly helped me grow as a person, explore my coping strategies and ultimately making memories for lifetime.

Well, that's my story of surviving through the toughest time of my junior residency amidst the COVID- 19 pandemic, in a time which changed our lives and put up various new challenges for us to survive through it. I hope this pandemic ends soon and we get to meet our near and dear ones freely and without any fear of spreading infection to them. Till then, stay safe, stay healthy everyone!

# 24

## First Night Duty in COVID Hospital

*Pooja Shakya*

During COVID 19 lock down, my journey was full of overcoming my existing fears and developing the new ones. I share the tale of such an eventful night when I encountered both of these. It was the mid-year summer month when lockdown was on its peak as threat of infection due to COVID 19 was there everywhere.

I was posted in intensive care unit (ICU) of JPN Trauma Centre, COVID hospital of All India Institute of Medical Sciences (AIIMS). I had finished my shift of day duties and shift of night duties had started. I had my first duty that night. Although I drive daily for about 15 kms to my work, I always had a fear of travelling alone during night hours considering the situation in Delhi. Being Delhiite, my fear was compounded by my knowledge of the rampant mis-happenings on the roads of Delhi. For my first night duty, I had no options other than to travel alone as no one could accompany me. My father is diabetic and, I was staying away from him so as not to infect him in case I caught infection during my duties in the COVID ward. That night, somehow, I gathered my courage and got into my car. I started driving with slow music in the background. My mind was full of multiple fearful thoughts. Every time I drove on the dark roads with zero traffic, my heart would skip a beat. Somehow, I continued driving the car and maintained a steady speed. In between I got scared when I saw some people on bike doing stunts on the straight highway. I tried my best to avoid them by slowly taking my car from the side and drove fast past them ignoring their comments. As I was getting closer to AIIMS, my fear started to decrease. I was feeling relieved that I was able to drive at 3 AM on Delhi roads. I was about to reach my destination. Suddenly a traffic police person came in front of my car gesturing to stop the car. This made me really suspicious and a bit scared also. I was confused whether to ignore him or listen to him. However, my moral values took over my fear and I stopped the car. As soon as I pulled the window glass down, he said “*oh sorry aap toh madam hain, mujhe laga koi bhaisahab honge toh aage tak chod dega*”. I immediately understood him and gave a sorry smile, rolled up the window and continued to drive. Soon in around 20 minutes I was there at my destination. I was happy about my safe journey but was also worried because I was late by about 10 minutes for my duty. I parked my car and rushed inside the hospital for donning.

After reaching the donning area, I tried my best to wear personal protective equipment (PPE) as calmly as possible to avoid the fogging and heat which usually develop inside PPE. After doing duties in PPE on several occasions, I had realized that nothing made me more restless than feeling nauseated inside the PPE due to lot of sweating. I donned the PPE at my best possible ease to avoid heat getting trapped inside it. In spite of my best efforts, I ended up sweating and having lot of fog on my own spectacles and on PPE goggles as well, resulting into minimal visibility. I reached the intensive care unit (ICU) where I was posted and started my duty with very low visibility only as I knew it would take 1-2 hours to get the fog cleared

from my spectacles and the goggles. Soon after initial 20-30 minutes of my duty in which I had taken samples for two COVID positive patients, I was told there was a call on 4<sup>th</sup> floor ICU for a patient having mental health issues.

As it was my 7-8th duty, I was already aware about the passage, so I started heading towards ICU on the 4th floor with the minimum visibility. I walked towards the lift, as stairs were not in use due to small barricades which might have been put to prevent contact of the post duty COVID doctors with other people. Due to very less visibility on that day, I was a bit hesitant in entering inside the lift. However, I thought that other person in the lift would help me in operating the buttons. I didn't think much and just stepped inside. The lift got closed before giving me any chance to revert back my decision on not finding anyone inside the lift. With minimum visibility available to me through goggles and specs, I tried to press few buttons in the lift and I felt that it was moving. However, I was not able to appreciate with surity whether it was moving or not which made me feel restless. It took only a few seconds of those moments to initiate panic inside me. The panic was growing faster on seeing no change in the lift position. I in fact, started doubting my position and proprioception sense and tried to console myself that lift must have been moving. By this time, my predicament of being alone in the non-moving and closed lift, the restlessness and panic got out of proportion. My heart started pounding faster, my hands were trying their best to perceive the touch of buttons on those steel walls of the lift but all was in vain. My mind was coming up with all negative thoughts making my anxiety to reach its peak. I was feeling so helpless in that moment as a blind person being trapped inside both - the PPE and the lift. My anxiety was so much that I didn't even realise, when did I start shouting and screaming at my loudest through the crevices formed by the lift door slider. In that moment there was a fraction of second when I thought "ok! This is it! Now there is no way out. I am going to collapse". But soon it was followed by another wave of strength and hope to fight again. With all the force which I had, I started banging the lift and thought at the same time "just tear the PPE and came out of it". I just wanted to be able to at least see the surroundings clearly. "I do not care about this corona virus which I must be having all over the surface of my PPE due to my visit to patients in previous ICU". In that situation, I realised that I was not as afraid of the deadly consequences of tearing my PPE and get infected as I was afraid of bearing this impending doom and process of panicking. I prepared my mind that "what if I got infected? At least I will be able to decrease this current intensity of panic and about to die feeling". The moment I thought of tearing the PPE, two persons who were staff opened the lift and saw me standing leaning beside the wall hopelessly. They reassured me and told that lift was open now and at the level of floor only (not in between) so I could move out. In that moment their words brought a sigh of relief to me. I stepped out of the lift, came back to my senses and bid thanks to them, after which they left soon as they were in hurry.

I also started moving slowly towards the ICU gate contemplating about millions of thoughts and emotions which I had encountered in a few minutes that I had spent trapped inside that lift. I thought that a few hours back, I was happy and relieved to overcome my fear of travelling alone on Delhi roads during midnight, but now just few hours later I had an encounter with a new fear.

After that incident, I never used the lift in Trauma Centre and preferred jumping over or squeezing from the sides of barricades and used stairs to whichever floor I had to go.

# 25

## The Story of Survival

*Bandita Abhijita*

Once I read a poem by Joy Harjo, “Perhaps the world will end at the kitchen table, while we are laughing and crying, eating of the last sweet bite.”

This didn’t ever make more sense than in early April 2020. After spending two long weeks at home, flustered with uncertainty, zoom fatigue and captivated by emptiness that I was not prepared for, one day, someone beacons ways of survival in the pandemic. It was then that I created a literary group in one of the social media platform.

Initial few days, I used to sit for hours in an effort to create. Of course, poetry does not change anything, but the least it does is offer some consolation. It heals in ways nothing else can. My heart felt so numb and I could barely feel my own words. For many hours into the nights, I kept staring at the blank corner of my mind and felt as if suddenly all words have fallen into abyss.

I watched members of the group write and tell their stories. I listened to numerous stories of anticipations and fears. I read them religiously. But I could not write a word other than few pointless blabbers. Gradually, I witnessed the transition of the group; how people shifted from complaining about the unjust and cruel world, from painting burns and scars to acceptance and appreciating the greater good. I listened to the stories of the teen now learning culinary, the brat who now sits with the old man reminiscing his life, the lone girl who takes in stray animals giving them home, the introvert who tends to plants like his own, the party guy connecting to people in virtual world. In reality, it did not matter whether these stories were imaginations or real, true or virtual. Those unreal things on papers activated my amygdala and cortex, bringing back sensations into the numbness and made me feel real emotions. I started imagining and created a new world. Being imaginative is crazy, they say, but who cares if it heals.

Together we joined letters and words until it became an angelic choir, strong enough and kind enough to heal all sorrows. We accepted the losses and practiced it. We practiced it daily. YES! We practiced losing faster: losing wants and hopes, losing plans and desires, losing sites and places meant to travel and countless names and faces of dear ones taken away by the virus. Above all, we lost the fear. That’s how we survived.

# 26

## A Shift on The Front

*Prabhat Mani Pandit*

It was the same month of June - hot and humid but this time in 2020, there was a new pandemic. Finally, it was my turn to work in the COVID ward. With the fluctuations in dopamine beneath the scalp, I marched towards the battle against the virus that the entire world was dealing with.

But wait! This time, I had to don new 'gears' before proceeding for my 'duty'. With scrub on and sanitized hands, I went inside the designated room and started to put on parts of my 'armour suit' – the gloves, cap, cover all, shoe cover scrub and had to sanitise my hands. With each newly added equipment, I looked at the instruction poster on the wall as well as the staff deployed there for guiding me. At that moment, I had two kinds of feelings simultaneously, on one hand I was donned for a battle (with COVID), on the other hand, I had stepped back to my childhood, I was learning everything all over again; even putting on clothes with help and guidance of others. As the steps came to end and got thumbs up, I walked through the door inside the ward.

With the change of duty even the questions I would ask the patient were different now. Being a resident in psychiatry for around one year, I had been accustomed to ask questions regarding mood, sleep, behaviour, thoughts, etc. But here I was asking "How are you today? Do you have fever, cough, breathing difficulties or any other?", knocking door to door. I had to be proactive regarding status of their vitals and physical symptoms. I would add notes in my paper regarding investigations required or medications to be added or issues to be discussed. I learned to work like a general practitioner. In the ward, I felt as if I had restarted my house job in the medicine ward or ICU during which my concern and focus would be on the breathing pattern of all patients.

I had started to get accustomed to my new role and routine in a new attire. But the interaction of the attire and environment was constantly challenging my work. As soon as the process of donning would be finished, I could feel the sweat rolling down the torso. Sometimes as I would approach the designated last floor for rounds, I would be completely drenched. I remember a particular day when I was feeling uneasiness from the start, but I continued with my shift expecting it to settle with time. As the time passed discomfort surpassed my threshold. I had to



rush to the doffing area. I could not interact with the patients, rather communicated with them with a gesture of phone call. Luckily, they understood and nodded their head. I tried not to be in a hurry and tried to doff out of my gear step wise following the doffing protocol. Alas, one doesn't have full control of the chemoreceptor trigger zone (CTZ) center and I vomited n my mask before I could even remove my mask. I had to make a few adjustments for doffing with help of staff deployed for the doffing area, as I had to open my mask in between for 4-5 minutes inside the washroom. I finished the remaining tasks for the day and went back to my room.

We were posted in the COVID ward for a month so I was aware that I had to return to duty the next day. But I never thought that the morning would start with palpitation and racing thoughts concerning the duty. I was apprehensive about going to duty due to the incident on the previous day. Of course, the relentlessness to learn and provide service was there but the anticipatory anxiety regarding duty was something that I had not experienced apart from initial days of my internship in paediatric wards.

As the usual routine continued, I had to return to duty the next day. But from the morning I would have palpitations and racing thoughts concerning oncoming duty. For many days after that, I felt like I was in the initial days of my clinical posting in paediatrics during internship. Those were the days when I used to have anticipatory anxiety before going to ward. In between these memories and experiences, I continued further and tried to play a tiny role on the front line.

## 27

**Posted in COVID Duty- A Memoir***Omar Afroz*

It was in the last week of May 2019, a time when the country and whole world were fighting hard to keep in check the rapidly rising number of COVID-19 cases, that I was posted for COVID duty at JPN Trauma Centre, AIIMS. Although it was already expected that eventually every one of us would be asked to work in COVID areas; yet when the roster came out with my name on it, I was filled with a strange feeling of solemnity. Now it would not just be about discussing COVID related literature with colleagues or taking necessary precautions while managing patients in the psychiatry ward. I, a junior resident (JR) in Psychiatry was going to be a frontline corona-warrior! Little did I know that the next one month was going to change my life forever.

The duty started on first June. I reached the Trauma Centre, which is around 2 Km from the hostel where I stay, using the shuttle van provided by the Institute. I had distinct memories of the building from my undergraduate days when I had casualty posting there for a week, but it was not the same anymore. Now it was an apex and dedicated COVID-19 Hospital of the Institute. While entering the building, I had a myriad of fearful thoughts. The fear was not just about being infected with this dreadful virus but was also about becoming a carrier and transmitting it to my near and dear ones, of failing to fulfill my responsibility as a frontline warrior, of becoming weak in the face of the daunting task that had been assigned to me. Brushing off these thoughts, I entered the donning area which was in the basement parking. A very friendly nursing officer handed me the scrubs, personal protective equipment (PPE) kit, shoes, and face-shield. Taking these, I went into the changing room. We had to leave everything behind before entering the COVID area. No clothes or personal items (including phones) were allowed and had to be kept in a locker facility. This fact coupled with the location of the place in the basement reminded me of that ominous inscription on the gate of hell described by the great poet Dante - *Lasciate ogne speranza, voi ch'intrate* ('Abandon all hope, ye who enter here'), I chuckled at this thought and after donning, entered the Trauma Centre 1 High Dependency Unit (TC1 HDU) on the first floor where I was posted along with an ophthalmology JR and an anesthesiology senior resident (SR) who was the leader of the team. The TC1 HDU had over 20 beds, all were occupied and our work included - taking samples, managing ventilators, checking the investigations, and putting progress notes.

The duty-shift was for six hours, but as it was summer and month of June in Delhi, it was very hot. Due to the PPE, in just half an hour into the duty, I was completely drenched in sweat. There was no solution for this massive sweating. During all my duties, I would be dehydrated. After each duty, first thing on the list would be to drink lots and lots of water. Sometimes, seeing the cold water in the large plastic jars kept for patients in the HDU would be very tempting and it would require a decent amount of self-restraint not to remove the PPE and happily gulp down the elixir of life.

It was during my first duty itself that I discovered the biggest hurdle in doing COVID duty - fogging. The visibility, already reduced by goggles and shield, would be further diminished by fogging to such an extent that even reading notes in the files would become extremely difficult. After the initial couple of hours of duty, finding blood vessels for taking samples would become an arduous task. In this condition, somehow, the six hours would pass. After doffing and bathing, I could breathe the fresh air under the sky again. Over the next few days during my duty shifts, I would try a lot of different things to prevent fogging - putting cotton beneath mask to absorb moisture, putting tape over mask to stop moisture from escaping, putting small amounts of soap on goggles, and various other tricks learnt from colleagues. The only successful method was using the anti-fog marker which made life easier.

Another peculiar phenomenon was the slow passage of time which was subjectively felt during the duties. Einstein has postulated that the rate at which time passes depends on the frame of reference, but that does not explain how those six hours of duty would seem to last for the time equivalent to 24 hours. This would be more prominent while sitting down, and for this reason I would try to keep myself busy as much as possible. During the duties, there would be continuous sounds of machines beeping, patients coughing, and the ambient noise of the staff. Apart from that, everyone would be busy at work and would not be able to have conversations frequently. In the subsequent days, even after using *mepilex* foam dressing, the pressure due to goggles and mask caused the bridge of my nose to be pigmented and scarred. I would have continuous pain even when not wearing the PPE. Some people also developed skin rashes due to the PPE and would have to deal with extreme irritation and itching during the duties. After every duty, we would all be tired completely and in between the shifts, all we could do was to rest and try to recover for the next one. The suffering of the patients would dishearten us further. The words of a patient almost moved me to tears when he asked that if he were to die, would his body be given to the relatives or would he not be united with them even at the end of his life.

Despite all these difficulties and hopelessness, we carried on and tried to do our best. As the renowned Urdu poet Ghalib has said in a couplet - *Ranj se khoogar hua insaan to mit jaata hai ranj, mushkilein mujh par padeen itni ke aasaan ho gayin* ('If man becomes habituated with suffering, the suffering ceases to exist. So many hardships came my way that they turned into ease.') In this battle between hope and despair, the strongest motivator for us were the patients. Whenever any patient improved and was transferred to a ward, it would fill us with delight and would serve as the catalyst of optimism for us. This hope would kick us into action and suddenly the fogging, the fatigue, the pain did not matter; all that mattered was to keep on fighting, to do whatever we could to save our patients.

The days went by. By the end of June, my month-long duty was also over. This posting had started with fear and despair but had turned into a source of pride and gave me a sense of fulfillment. When I went to work in the psychiatry ward, I missed my COVID duty days. I was full of hope however, that one day we will defeat this debilitating disease and emerge victorious, like we always have - together.

# 28

## Terror in Resonance

*Hemant Choudhary*

In 2019, they said somewhere in a piece of paper about some virus. Nobody cared. Almost. There were more interesting articles to hunt.

I'll take you down the timeline, a few months into 2020. Let's take a flight in the streets of any metropolitan that has garnered a name for itself. Would you be the eagle or the pigeon? Flutter those wings and stretch far and wide. Let the wind touch the fur. Let it blow you to your regal posture. Ride the wind. Take a look down. Wait. Stand still. Breathe. You don't have to look closely to see the writhing, wriggling mass of humans turning into a maze of hollow streets. It is almost as if they are making way for the hapless souls from the cluttered corridors of a hospital, smelling of what hospitals usually do, escaping from the frail bodies left after being used as fodder by a coronavirus, for greener pastures. And the months passed away. In mere months, this virus was turned into a celebrity that was seldom celebrated.

For me, as merely myself and not a representative of humans, coronavirus was something that was supposed to pass away. Fleeting. Like the sand in an hourglass. And it did, for a while. It was hard to imagine the implications of a supposedly "low mortality" COVID infection from the comfort of your sheets. There was this one instance where my friend inquired about some medications for a cough and fever. They were hesitant to go for a COVID test, worrying about all the hassle a positive report portends. I advised it nonetheless. I inquired about it the next day. From the entirety of the conversation, two words left a lasting impression on my mind. "He died". A simple set of words, isn't it? I can only imagine his thoughts echoing on the other side of the screen. "You knew it was out there. You stepped out. You knew the symptoms. You waited for the kiss of lady luck. You waited for too long. You, in your foolish ignorance, lost a loved one. You shall bear this boulder of guilt in this last Sisyphean task". I offered him support, with a tinge of sympathy. He gathered all the guilt around himself, like a thin blanket to combat the chilly night. It stretched thin. He's cold, still.

I have always wondered about a life without my senses. A life where you cannot make out the details of the sand grains from a pile across the road. A life without the soft sound of a flute, trickling down a couple of floors. A life deprived of some taste that could only be found in the sweets from the older part of the city. And at the end of such fantasies, I've found myself terrified. Most of us would. It is hard to imagine a life without the thick scent of a deodorant layered in your room. Harder still to miss out on the flavour of a sizzling brownie. I've almost imagined them as something invincible to the slippery slopes of luck. Something that is always there. That always will be. Till the end of times, when my world comes crashing down on my deathbed. No worlds crashed down in those two weeks of quarantine. No reapers patrolled the corners of my bed. Somewhere down the line, amid the fever and the solitude, I lost my smell. I couldn't smell the perfume, still wet on the wrist. The garbage cluttering in my quarantined

room reeked no more. In the back of my mind, I reminisced about the odours of old. I was missing out on a lot already. Food turned into bits and pieces of sweet, sour and salty. All the stale and mundane smell disappeared out of the blue.

I missed the scent of shampoo and soap, lingering over the skin till it feels fresh. Of oranges and gooseberries, the citrus taking over. Of the spirits in the hospital corridors. Of scented candles, burnt rope, open drains and crowded pubs. Of sweat and smoke and the sting of alcohol. Of perfumed necks, sweet sanitizers, charred skin and rotten bananas. The dull smell of grass, just before their blades are chopped. The smell of rain and its leftovers. And when the solitude bites at the back of your neck, for it does in the later half, the smell of wide avenues. A smell of freedom, lost with the years.

The year 2020 has brought lessons for all. For me, it has been a highlighter, the one with a bright yellow colour, of all the important things and beings lost in the nooks and crannies of a heart too busy with its pumping. Human life is a frail thing, far more so than we are ready to acknowledge.

Sit still, preferably on a Monday. Take a few breaths, not too deep. Stare blankly ahead or close those eyes, at will. Someday, somewhere, somehow, you'll realise that too many important things have been delayed for far too long in the name of the necessities of life. Once in a while, on a sunny day, perhaps your heart can skip a beat or two.

## 29

**COVID-19 Pandemic: An Emotional Pandemic**

*Anuranjan Vishwakarma*

What could be more disheartening than facing a pandemic that too when you are going to take most important examination of your life – the MD exam. After studying and studying for many months – alone, in groups, cramming some parts and leaving others, finally we passed the examination. But we couldn't even celebrate our success of passing. Just after finishing examination, when we were supposed to visit our homes, we were called for COVID ward duties. It was important to be part of the workforce handling pandemic. But I could not escape feelings of doom the day I entered into the COVID wards while being wrapped in a plastic gown – these feelings cannot be expressed in words. All the residents were trying hard to keep up the pace of their work and life through blurred and hazy goggles, finding four-leafed clove appeared to be easier task than finding a vein for sampling through hazy goggles. I and most of us have gone through very mixed emotional states during the pandemic. At times, I would be very happy and satisfied when I watched patients getting well and discharged. While at other times, it would be very disheartening to watch them die and being wrapped in white sheets. At that time when a teardrop rolled down our cheeks, we let it be confused with sweat. Being a psychiatrist, everyone in the COVID wards consulted us for getting their doubts cleared. But at times I faced difficulty as I did not know with whom to discuss doubts regarding the emotions I felt and thoughts I had. Every day it was same - to treat and handle COVID infected patients but, at the same time to avoid getting infected oneself. During this pandemic, unfortunately my whole family got infected and I was trapped due to lockdown. I could not go to home. I felt very helpless for doing nothing for them. With God's grace, they recovered with appropriate management. The one hope which kept me driving was that everyone was going through same emotional state, more or less. My other colleagues were also getting emotionally drained out. I hoped and prayed that by being together we had travelled so far, and together we would see the end of this pandemic.

## 30

**Medicos Bio-bubble: Resilience during COVID-19***Ragul Ganesh*

Innovative approaches were implemented to continue the normal activities in various fields during the COVID-19 pandemic. The concept of bio-bubble was introduced in sports during COVID-19. A bio-bubble is a secure environment isolated from the outside world to minimize the risk of COVID-19 infection. A bio-bubble aims to keep the individuals relatively safe from exposure to infection present outside the bubble. The individuals inside the bubble can meet, dine together, and watch movies but they are not permitted to meet families, friends, relatives outside the bio-secure environment. The person violating the bio-secure protocols when he visited a friend had to self-isolate themselves before returning to the bio-bubble. The bio-bubble was implemented worldwide in various sports leagues including cricket (Indian Premier League), football (English premier league), and Tennis (U.S Open), etc.

In our hostel wing, we had senior resident doctors from each department including psychiatry, medicine, ophthalmology, nephrology, pediatrics, critical care, medical oncology, and endocrinology. During the initial days of COVID lockdown, routine clinics were closed and resident doctors from various departments were posted in COVID duties. We had a complete lack of communication with many colleagues within our parent department. The resident doctors in our hostel wing formed a bio-bubble. We used masks and other personal protective equipment (PPE) outside our bio-secure wing. Inside the hostel wing, we met, watched movies, and sometimes ate together. We formed a bio-bubble much earlier before the introduction to sports. It helped us to share the burden we had due to extra COVID duties, to avoid isolation, to share knowledge in the management of patients with COVID-19 infection.

As we were treating COVID patients, we did not visit our families for months. Hence living in a bio-bubble had become a new normal. Initially, it was challenging, gradually the bonding and support shared among us helped in maintaining both the mental and physical health of every member inside the bio-secure environment. When bio-bubble was introduced in sports, most cricketers and footballers felt difficult to stay inside the bio-bubble for even 2-3 months. However, we were able to maintain that for more than six months along with our hectic clinical activities.

Academic seminar evolved into online webinars, conferences were conducted through the digital medium. We implemented the use of various technologies such as “Zoom”, “Google Meet”, “GoToMeeting”, “WhatsApp” and “telegram” in our day to day academic and casual meetings. We had an opportunity to coordinate with our seniors and professors to conduct virtual meetings and webinars. Many of us mentored undergraduate students and postgraduate residents in academic and other student wellness activities through different clubs created under “AIIMS e-Student wellness center”. The resilient positive adaptations shown by resident doctors in the context of significant adversities during the COVID-19 pandemic inspired each

other. Being inside the bubble did not hinder us from communicating and contributing to the benefit of those around us. We continued our clinical services as PPE armored warriors.

2020 – can be considered as a year of learning through adversity. But none of us were alone in this learning. We as medicos learned together, supported each other, and played as a team in the game against COVID just like any other sports during COVID-19, maintaining infection prevention protocols – The Bio Bubble.



# 31

## **Learnings from COVID-19 Pandemic**

*Jawahar Singh*

Working during COVID-19 pandemic and doing duties in COVID areas of the hospital was a long and continuous learning session for me. I learnt many new things which in routine practice of psychiatry are not frequently encountered. This included taking care of patients in COVID-19 intensive care unit (ICU) and those with multiple medical comorbidities. AIIMS administration had created teams of doctors from different specialities like medicine, surgery and other super specialities like cardiology, neurology etc. As part of the multi-speciality team, it gave me many opportunities to learn by interacting and working with our colleagues from different departments which usually does not happen. I learnt many lifesaving skills like intubation of patients, arterial blood gas (ABG) analysis, interpretation of X-rays and ECGs. This learning experience boosted my confidence and I could handle general medical illnesses in COVID patients which was missing in the early days of my posting there. I myself witnessed psychiatrists as part of primary team taking care of pneumonia in COVID-19 patients which was needed in the wake of rapidly increasing number of COVID-19 admitted cases. It reminded me of my internship days, but this time we were under the guidance and watch of physicians in case any help was needed. I also got opportunity to share psycho-social aspects of COVID-19 pandemic in general and specific to patients admitted in hospital and COVID ICU with my colleagues from other specialties.

Gradually everyone realised that many COVID-19 patients had mental health issues also like anxiety, panic attacks, depression, and fear associated with illness. There were many instances when my duty colleagues had difficulties in managing mental health issues, I was called to address these. My colleagues would also at times appreciate my communication skills specially with some of the patients who were difficult to handle. I think it was a learning experience for them also. Gradually we realised that if someone gets COVID-19 infection requiring quarantine at home or institutionalization, he/she should be provided mental health care as and when needed. The import of WHO definition of health – physical and mental health along with social wellbeing became clearer to me. I learnt that taking comprehensive care of the patients during pandemic can bring major change in patient outcomes and wellbeing at discharge.

In the initial part of COVID-19 pandemic, little was known about the illness, its complications and treatment. There was a period of uncertainty and there was lot of fear and distress of this rapidly spreading pandemic. The entire world went in to the state of lockdown which disrupted the normal lifestyle of people. Along with it, adhering to preventive behaviours for COVID-19 pandemic like social distancing, isolation or quarantine also added to the psychological distress. India is a densely populated country with limited mental health resources, it is difficult to provide professional mental health care to people in need. Gradually as world got better understanding of preventive measures, illness pattern, treatment modalities and good recovery rate, certainly it was a big relief for people. Additionally, availability and dissemination of

authentic information about COVID-19 increased the knowledge of the public. There were many cases of suicides in the early part of pandemic reportedly due to fear of being infected with COVID-19. I personally felt that increased awareness of the pandemic, better understanding of illness, treatment and integration of mental health services to best possible level have contributed to decrease in suicides in the later part of COVID-19 pandemic.

## 32

**Attending to A Psychiatry Consult: The Story of Amma in COVID Centre***Jaswant Jangra*

It was the last week of June 2020. MD examination result was declared for our batch. We did not have the customary hostel party. Instead, the celebrations were online, like many other events since lockdown. Many of us reactivated our Instagram and Facebook profiles to connect with the world. We felt free and relaxed after months of doubts and uncertainties. We were on cloud seven. Soon enough, the roster for our COVID duties came in which brought us back to reality. We were to begin our duties from 1<sup>st</sup> July 2020. We went through all videos on personal protective equipment (PPE) donning and also asked our seniors for guidance; still it took us nearly 30-40 minutes to don the PPE kit on day one of the ICU duty.

For a psychiatry resident, working in ICU can take some time to adjust. I first began with familiar tasks like checking vitals, taking blood samples, monitoring ABGs, progress notes writing and other kinds of documentation under supervision. Gradually, I learnt to adjust ventilator settings and manage seriously ill ICU patients. Most patients in general wards were medically stable. Psychiatry residents posted in COVID duties also attended to mental health issues for the patients admitted there.

One day, I received a call for an elderly lady admitted in general ward on sixth floor of AIIMS COVID centre. When I reached there, I was told by nursing staff that the lady had not eaten food and medications for past 2 days. She refused to talk and cooperate in examination. I was also told that a psychiatry consultation was taken a day before yesterday to rule out delirium or psychosis. I checked those notes. It was documented, “*Patient is oriented. No active psychopathology.*” I went to the patient’s bed and saw an old lady in her late seventies lying down. I said, “*namaskar, amma* (usually in north India, an elderly woman is addressed as *amma* to show respect)” to which she did not respond or reply. She avoided eye contact and kept on staring at the wall. I then asked her to follow a simple instruction - ‘show your tongue’ to test her comprehension to which she responded by pulling the blanket over her face. I went back to nursing counter and placed a call to her family using landline phone. This was the usual protocol to check for any relevant past history and gather more information. Her son answered the call and confirmed that his mother had no psychiatric issues in past. From his voice, I could make out that he was worried and concerned about his mother. He also told me that her mobile phone was unreachable and family was not able to talk to her for the last two days. I assured her son with an update on her health status in terms of COVID 19. As I was about to disconnect the call, he requested me if I could convey a message to his mother. I consented to that. He told me to convey to her “*hamari gai ne bachhdi ko janam diya hai* (our cow has delivered a female calf)”. This is considered to be a joyous news for families in rural North India. I was a little confused about this last message for her, but ended the call thinking that it could be used to initiate a conversation with her.

As I went back to patient's bedside, she again covered her face with blanket on seeing me. I conveyed message to her in clear voice through PPE, "I have talked to your son. He told me that your cow has delivered a female calf". She immediately removed blanket and sat upright. She said, albeit angrily, "Then discharge me, why have I been kept here?" I remained quiet at her outburst, but was internally pleased that she finally spoke after 2 days. She continued "It has been five days here. My son is not even working these days. How will he manage hospital bills? I have never needed any treatment in my life...all are strangers here and are unknown to me." By now, the nursing officer on duty had joined in the conversation as *amma* continued expressing worries and various concerns about her family, about her stay and about inability to use phone due to battery issues. She then pointed to nursing officer, complaining to her "I had tried to speak to you two days back, but that time you went away in another direction". The nursing officer explained to her calmly that there was another patient who needed immediate oxygen and she was going towards that bed when *amma* had called her. In the meanwhile, she took the mobile phone from *amma* while chatting with her and went to search for a mobile charger compatible with her phone set. I then explained to *amma* about this being a public hospital with no expenses as well as about her likely discharge in next couple of days. I also told her about workload of doctors and nurses in COVID facilities. Meanwhile, nursing officer came back with her mobile phone with charger, using which *amma* talked to her family immediately. With a smile of satisfaction, she quickly picked up the lunch *thali* (*a round plate used to eat food*) lying on her bedside table. She began eating it on her own, saying "*beta, mein to angootha tek hoon, mujhe yeh sab pata nahin tha* (*son, I am illiterate and use my thumb to sign, I did not know all this*)." My work was done. I wrote in my notes, "No psychiatric diagnosis. No active intervention needed".

Next day, no call came from 6<sup>th</sup> floor. After my shift ended, prior to doffing, I went to 6<sup>th</sup> floor to check upon her. The nursing officer smiled "*amma* is fully normal today" and quipped that my services were not needed. As I went near *amma*, she instantly recognized me and smiled. She did not know my name or face through PPE, but recognition was somehow immediate. She greeted me and shared the news of her negative report and likely discharge next day.

Next day I was on duty-off and was talking to a friend at the main gate of Trauma Centre COVID facility. I noticed from some distance that *amma* was outside the main gate with someone, possibly her son, hiring an autorickshaw. She looked well and active. Soon, the autorickshaw with *amma* inside, faded from my view, though not from my memories.

## 33

**A Tale about the Trials and Tribulations of a *Turbanator* during the COVID-19 Pandemic**

*Swarndeeep Singh*

The COVID-19 pandemic is arguably the worst public healthcare crisis faced by the vast majority of people alive today. I too had only read and heard about the havoc created by the Spanish flu pandemic about 100 years ago during our microbiology rotation in my MBBS days (undergraduate medical training), and always thought that the wonders of modern medicine will never let such an infectious disease pandemic run amok through human civilization again. However, I was proven wrong by the gradually increasing number of COVID-19 cases across different parts of the world; and the World Health Organization declaring it as the global pandemic on 11th March 2020, followed by the Government of India announcing a nationwide lockdown from 25th March 2020. As a medical doctor, I was uniquely placed to experience this global pandemic first-hand.

There had been widespread concerns expressed by the scientific community as well as the popular media about the lack of immunity against this novel Coronavirus among the entire world population, different possible routes of transmission causing widespread sickness among the people (droplet vs. droplet nuclei transmission, ability to spread infection by asymptomatic carriers), lack of any effective treatment, and unpredictable death sentence on getting the disease. Interestingly, this pandemic also brought into focus the mental health related aspects of human living; with critical discussions occurring about the harms of COVID-19 pandemic and the subsequent social distancing (prolonged isolation, quarantine, or staying-at-home) on mental health of the population and various ways to mitigate and manage the same. Myself, working as a psychiatrist at a tertiary level teaching hospital was also involved in working on some of these aspects. Apart from the clinical services (including starting of tele-psychiatry services), online teaching, and research work conducted during this time by me and my colleagues and faculty at the Department of Psychiatry, I was particularly amazed by the trope of calling medical doctors as “Corona Warriors” during this pandemic period.

Now, I do understand that the elaborate donning and doffing procedures for wearing the personal protective equipment (PPE), and the strict infection control protocol to be followed by the doctors while dealing with COVID-19 cases may give some people a feel of a knight wearing his armour before going into a war. However, what people don't realize is that the mindset of a warrior and a doctor is distinctly different. While a warrior (or soldier) is both physically and mentally trained to either kill the enemy or die trying to do so in a war; doctors have been trained to save lives of their patients and ensure their own safety at all times while doing so. Therein lies the first fallacy of this comparison. Further, this comparison ignores the individual rights and wishes of the person beneath the PPE to some extent. For example, a doctor with little or no training about how to manage COVID-19 patients was expected to treat them at the cost of their own lives, with many state governments and popular public opinion

supporting this notion about doctors having a mandatory duty to treat suspected or potential COVID-19 patients during this pandemic. The individual rights and freedoms enjoyed by the human beneath the white coat were subjugated to some extent while proscribing to this idea.

At my place of work like many others, doctors from all pre-clinical, para-clinical, and clinical specialities were posted in COVID care duties. Many of my colleagues have already described their good, bad, and ugly experiences with their COVID posting, and I am not going to repeat the same here. However, I would add on to it a few which might not have been experienced by many of them and touches upon the human side of doctors under the white coat. I am a turban wearing Sikh apart from practising as a doctor or psychiatrist. I was also posted for taking care of COVID-19 patients, and this led me to make two challenging choices. Firstly, in order to properly wear the PPE provided, I would have to forego wearing my turban. Secondly, to ensure adequate fit of the N-95 mask I would have to shave off my beard. Both of these things are a part of the Sikh religion, and have also been ingrained as a part of my identity growing up during by childhood and early adolescence. This was akin to the identity vs. confusion psychosocial conflict described in the Eriksonian psychosocial stages of personality development. Both of those choices shaped in major way my concept of self and social relationships developed during the early adolescent developmental period. Further, it is a way of linking oneself to a larger group based on the tenets derived from the teachings of the tenth Sikh Guru. I discussed about this with my few Sikh colleagues from other medical specialities who had been posted for COVID duty previously, and found solace in sharing their experiences and ways of dealing with the same. The D-day came and a bargain was made. I shifted to wearing a mini turban compatible with the PPE and kept working with what might be described as a less than adequate seal for a N-95 mask over my beard. Though, I did not feel like a COVID warrior, but the feeling of a triumph made by the *turbanator* (a colloquial term used to describe men who wear the turban with pride) did help me resolve my conflict during this COVID-19 pandemic.

# 34

## Crash Course to Wisdom

*Mahadev Singh Sen*

Just another day, but I wake up not so fresh,  
My pulse seems fast and my thoughts enmesh!

What's this thumping I feel in my chest?  
I remember mom telling me last night to take rest!

I check my temperature it's reaching a hundred,  
I so hope that my throat doesn't turn red!

As the day passes, I feel lethargy and malaise,  
I check temperature again, hoping it doesn't raise!

To my horror, it has reached one-not-one,  
And suddenly pain in my throat has begun!

Have I fallen prey to the new disease?  
Why do I start to feel pain in my knees?

I tell my mom and dad to stay away from me,  
I don't want to infect them; I don't want to infect them!

I don't want to be guilty of putting my family into danger,  
I suddenly turn to God to be my rescue ranger!

I rush out of home without saying a word,  
My eyes are wet, and speech gets slurred!

After reaching a distance I make them a call,  
"wash all utensils, clean everything.....clean all!"

They ask me "what happened? where have you gone,"  
"Just do what I tell you. For now, I'm better alone!"

I give my throat and nose swab for testing and I sleep in my car,  
While I await the results, every second seems like an hour!

The test results come out to be what I was fearing,  
Foolish me! I should have at least carried something warm for wearing!

Coz now I feel cold, and sad, and worried,

I feel guilty to go back home, for which I hurried!

I am told to get admitted and jot down my contacts.  
I say, "it's my parents and a house-help!"

"And a milkman whom I attacked with breath full of death,"  
and as I speak, I start to lose my breath!

My saturation is 90, they put oxygen pipes in my nose,  
I almost feel I'm going, and the end is coming close!

I fear what have I done to the innocent parents at home,  
After my duty hours, why didn't I stop to roam!

"What if I wore masks at home? What if I didn't go home at all?"  
I curse myself while shivering in that shawl!

I call my mom, "I'm infected with the deadly virus,"  
She pauses a minute and softly says "it's a joke... you're not serious!"

"Don't worry" I say to her, "I'll come back very soon"  
"You continue taking hot milk with a full turmeric spoon!"

I feel alone in this isolation ward counting every single day,  
My family is gonna get tested on the coming Friday!

They say, "two policemen came today and put a red sticker on our door".  
"It says, HOME UNDER QUARANTINE... and the sweeper stopped coming to our floor".

Everyday passed slowly and finally the Friday came,  
I realised I am not an atheist coz every day I prayed in God's name!

They're symptom free and the tests are negative,  
I too am shifted on a management that is conservative!

Two weeks got passed...ups and downs kept coming,  
I kept listening to the recovery tunes that my mom-dad were humming!

And now I'm home again after three long weeks of fear, faith and gratitude,  
Those three weeks made me 30 years wiser and yet 30 more years renewed!



# 35

## **COVID-19 Pandemic: A Psychiatrist's Anxiety**

*Nishtha Chawla*

For a minute I feel I'm fine. Yet another I am scared as hell,  
Who do I talk to? What should I do? I turn to the immortal!  
People dying of COVID, and hunger, and suicide,  
We come in front as their saviours; they call us the nation's pride!  
But who will understand our fear, our plight?  
We too have a family; and feel gloomy in this dim light!  
But we must pretend to be strong and fearless,  
We cannot show that we too feel the distress!  
"Hey! I'm a psychiatrist, how can I help you?"  
"Eat healthy, exercise, and meditate for a minute or two"  
"Don't feel alone, it's happening to everyone", as we tell our client,  
We are consoling our hearts too, that this fear will surely end!  
Counting our blessings is totally under our volition.  
But this racing heart sometimes surely doesn't listen!!

# 36

## Epidemic Within the Pandemic

*Bandita Abhijita*

No longer proud, No longer brave

She hides her identity

What if they throw her out

Like every other warrior

Because of fear of the deadly

Yet they caught her with rage

Staring at her half hidden *Steth*

After all she was tired from the night

Serving people dying

She forgot saving herself

From the ruthless souls

'STOP' she said as they near

But they didn't hear

For they must act to save their own

At this moment, she realised

She is no God, just some pounds of flesh and blood

The more bruised she is

The more human they are

As she was taken in the red light van

delirious, she dreams of home

The faraway home with her child

The home she was thrown out of  
Or the home with white sheets and drips  
Everything is merging in her thoughts  
She can't differentiate  
For she is no longer brave  
No longer animate

As the largest pandemic of its kind 'COVID 19' began to spread its claws to capture the world, another phenomenon in the form of 'attacks' over healthcare workers was witnessed across cities. In various incidents, people shouted abuses at healthcare professionals or threw them out of their rented houses due to misplaced fears of viral transmission. Such incidents took a toll on the morale of healthcare workers till appropriate intervention by authorities put an end to it.

# 37

## Locked Time

*Prabhat Mani Pandit*

Yes, time does slow down,  
Science can be wrong, sometimes...

When the clock clicked 11 at night,  
With a lamp in my hands to light my way,  
With rucksack on my back, I walked ahead on the road,  
Not knowing where I will stop next...

Long ago deprivation enforced me to come here,  
The same is enforcing me to return back there,  
Heard that people are keeping food for animals besides poles,  
But this so called human "I" couldn't find a single console...

Some told don't make movement as a virus might kill,  
Hunger might do that even before if I remain still,  
I decided to walk down without any fear,  
But how could I avoid the hunger's tear...

I walked irrespective of lathis on my back,  
Repeated checking enforced me to open my pack,  
They asked what would an empty bag refer,  
I answered my bag and stomach never differ...

How long should we work without fuel, limbs asked,  
Brain replied one more hour just do your task,  
Each minute now is a whole day,  
This stretch won't continue after food, I pray...

Yes, time does slow down,  
Science can be wrong, sometimes...

# **SECTION**

## **III**

Departmental Resource Materials on  
COVID 19 and Mental Health



## **ENSURING THE WELL-BEING OF HEALTH CARE PERSONNEL DURING COVID-19 PANDEMIC**

The extreme stresses, uncertainties, and health risks associated with pandemics such as COVID-19 require a special attention to the well-being and needs of healthcare personnel providing care to others.

Practising self-care and encouraging other health care workers to engage in self-care sustains the ability to care for patients in need. On the other hand, self-neglect is likely to be detrimental and impedes the ability to provide care to others as well.

### **CHALLENGES FACED BY HEALTH CARE PERSONNEL**

- **Increased patient care demands**

Many more patients present for care, most of them being severely or critically ill posing an increased demand on a healthcare system with limited manpower resources. This often poses increased work demands with longer shifts or no breaks, often working under stressful conditions.

- **Risk of acquiring infection**

Increased risk of contracting the infection during patient contact, and passing it along to one's family members or relatives.

- **Equipment related challenges**

The protective equipment can be uncomfortable to wear over extended hours, with limited mobility and scope for communication. Occasionally, shortages may occur for one or other protective equipment/s leading to anxieties related to exposure.

- **Emotionally challenging experiences**

Patient distress related to their condition can be increasingly difficult to manage for healthcare personnel, and can take a toll. The infection can lead to mortality in spite of best of efforts put in by health care personnel. Such experiences may be emotionally draining for the health care worker.

### **STRATEGIES FOR ENSURING SELF-CARE AND WELL-BEING**

- **Meet your basic needs on regular basis.**

Maintain a regular eating, drinking and sleep schedule, adjusted to your duty shifts. Neglecting the basic needs puts you at higher risk and may affect your ability to care for patients.

- **Take designated break times.**

Give yourself a rest from patient care. If possible, do something unrelated to medical care such as listening to a song or talking to a friend or simply doing deep breathing exercises. Remember that appropriate rest or relaxation leads to proper care of patients after your break is over.

- **Communication with your colleagues.**

Talk to your colleagues and extend as well as receive support from each another. Identify the problems or challenges being faced in delivery of health care, work on effective solutions to ease the burden of care, and exchange constructive ideas.

- **Remain connected with family and friends.**

Keep in touch with your family and close friends who form your support network outside the healthcare system. Sharing your feelings and staying connected with them may help in de-stressing you.

- **Stay updated on latest scientific information.**

Gather information from credible sources of information and keep yourself updated on daily basis. Participate in workplace discussions to stay informed of the latest status and guidelines.

- **Limit media exposure.**

A continuous stream of news and updates on social media platforms and variety of news outlets can eat into your time, increase your stress and may reduce your effectiveness. Try to monitor the unnecessary exposure to media, setting a strict time limit.

- **Gauge your mental or emotional health.**

Monitor yourself over time for any symptoms of excessive anxiety or depression or prolonged stress such as changes in mood, insomnia, intrusive memories, hopelessness etc. Talk to a friend, trusted colleague or seek professional help if needed.

- **Appreciate the ‘honour’ and ‘noble calling’ of your profession**

There may be times when it seems challenging to provide constant care for those in need. However, it may help to remember the noble calling of medical profession—taking care of those most in need, which might be reassuring and fulfilling. Give due honour to you and your colleagues’ services towards those in need.

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## **MANAGING THE PSYCHOLOGICAL EFFECTS OF QUARANTINE DURING COVID-19 PANDEMIC**

Quarantine is the separation and restriction of movement of individuals who have been exposed to a contagious disease to ascertain if they become sick and to reduce the risk of infecting others.

It can be done at home setting or at government-run facilities, or even as mass quarantine for residents in a particular region.

While quarantine is a necessary preventive measure, it could be associated with several psychological challenges for those quarantined as well as their families.

Below is a brief description of the psychological effects of quarantine, as well as strategies which can be used to ensure mental well-being of those quarantined:

### **PSYCHOLOGICAL STRESSORS RELATED TO QUARANTINE**

- **Frustration and boredom related to social isolation**

Quarantine involves absence of usual daily routines (e.g. regular work/job, shopping, going for walk etc.) and limited contact with others, which may cause monotony and boredom.

- **Fears about becoming sick and/or infecting others in family**

There may be apprehensions or worries related to one's physical health and risk of getting the illness, in addition to the fear of infecting others in the family who are caring for them. This may be particularly concerning for those with young children, pregnant women or those with elderly parents or relatives in family.

- **Worries about inadequate household supplies or medical care access**

This may include worries pertaining to essentials like food or kitchen supplies, availability of sanitizers or masks and limited access to routine medical care during the period of quarantine.

- **Lack of adequate or accurate information**

The lack of clear information or confusing information can lead to uncertainty and stress among those quarantined. Occasionally, various social platforms or internet sources may have conflicting information.

- **Stigma from others**

Those quarantined may face some stigma from neighbours or those around them which can manifest as being treated differently or with fear and suspicion or not being extended support from the community.

- **Financial loss and hardships**

This is important especially for those with lower incomes or those with daily or weekly wages contingent upon work, with not enough savings to cover the period of quarantine. The possibility of continued unemployment or economic losses in the coming weeks even after quarantine is an additional source of distress.

### **PSYCHOLOGICAL MANIFESTATIONS**

The psychological impact of quarantine might involve anxiety, low mood, irritability, emotional exhaustion, inability to sleep and other trauma or stress-related symptoms, which could outlast the period of quarantine in vulnerable people.



## PROMOTING PSYCHOLOGICAL WELL-BEING DURING QUARANTINE

- **Clear and accurate information provision**

People who are quarantined often have catastrophic appraisals of any minor symptom in self or family members, or may have misinformation about the reasons or duration of their quarantine. Accurate information from reliable sources communicated in a clear, easy to understand language would help to allay their anxieties.

- **Assurance for provision of essential supplies**

The quarantined households must be provided with enough supplies for their basic needs e.g. food, medications etc. Such coordination should occur at the earliest, with an assurance of continued supply for period of quarantine.

- **Facilitate communication with family and relatives**

Ensuring a telephonic contact or internet based communication with family members or relatives is a source of support for the quarantined individual and reduces feelings of isolation. It also conveys about the health status and safety of the individual, thereby reducing the worries and fears among the loved ones. Therefore, facilitating the quarantined individuals with mobile phone/charging devices, and WiFi internet access can cut down on unwarranted panic.

- **Build a structured daily routine**

Having a lot of unstructured time and boredom will lead to more stress and adverse psychological outcomes. People who are quarantined should be advised about maintaining a structured time table for themselves which may include fixed sleep-wake hours, working on a new hobby (e.g. music, cooking, reading, writing a poem or a daily journal), play cards or board games, telephonic interaction with loved ones etc.

- **Dedicated time for physical activity and relaxation**

It is important to ensure some dedicated time for physical activity or yoga, or exercise in any form. The duration of such exercise may vary from 15-45 minutes, depending on one's level of physical fitness and stamina. Additionally, it is also beneficial to engage in meditation or breathing exercises, which helps in reducing the stress.

- **Curtail the excessive exposure to 'infodemic' on social media platforms**

A constant stream of news reports coming from various social media platforms and other outlets can cause anyone to feel anxious or distressed. Try to seek news updates only from reliable sources like the Government media channels or newspapers, and only at specified times during the day. Avoid listening to sources with possible rumours or fake news that may make you feel anxious.

- **Health-care personnel caring for quarantined individuals must take care of themselves also**

Health care providers are also vulnerable to experiencing the psychological effects of quarantine, which is further compounded by the stress of caring for possibly exposed or suspected patients. It is important that health care providers must also ensure that their own needs (eating, sleeping, taking breaks at designated time, ensuring one's family's well-being etc) are met and that they plan ahead for the possibility that the healthcare provider may need to be quarantined separately from the family after a possible exposure.

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- World Health Organization: . <https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf>



## **CARING FOR PATIENTS' PSYCHOLOGICAL WELL-BEING DURING COVID-19 PANDEMIC: A GUIDE FOR PHYSICIANS**

During COVID-19 pandemic, physicians are likely to encounter patients who are experiencing various levels of emotional distress about the risk of infection and its impact on them, their families, and their communities.

Physicians should acknowledge this uncertainty and help patients understand the emotional component to their potential health concerns. In addition, physicians may follow the following recommendations to help promote patients' mental well-being:

- **Stay informed and updated.**

Obtain the latest, credible information from authentic public health resources, such as the Ministry of Health & Family Welfare, Government of India, World Health Organization or Centers for Disease Control and Prevention (CDC), in order to provide accurate, factual information to your patients.

- **Impart education to patients**

Physicians are on the front lines of medical care and are in a position to directly influence patient behaviours. Patient education regarding various key aspects of the COVID-19 infection may play a critical role in disease control as well as reduction of emotional distress. Patient education can include education about basic hygiene such as hand-washing, cough etiquette, social distancing and staying at home to discussions on prevention or early detection. Having proper education empowers the patients to make right decisions which go a long way to protect the families and communities.

- **Correct misconceptions.**

In this digitally connected era with a variety of social media platforms, misinformation and rumours can spread quickly, causing unnecessary panic. If patients share any inaccurate information related to the pandemic, correct their myths or misconceptions and advise them to visit reliable public health resources to gather information.

- **Limit excessive exposure to media platforms.**

Try to have a limited time set aside to check for news or updates pertaining to the pandemic. Constant, inflowing stream of information every few seconds or minutes is likely to result in emotional distress and undue anxieties. Use only certain trusted media sources to update yourself twice a day. Counsel your patients to avoid excessive exposure to news channels and social media updates.

- **Counsel about stress management.**

- Some degree of stress is common in the context of uncertain situations and health risks. To begin with, help your patients to normalize their anxieties ("Many of us are feeling stressed right now. It is understandable that you are stressed.")
- Teach patients to recognize the signs or indicators of emotional distress, such as insomnia, concentration problems, bodily symptoms, increased use of alcohol or tobacco etc. This will help them become more aware of their mental state.
- Discuss strategies to deal with emotional distress and to alleviate health-related anxieties, which can include anticipation and preparation, rehearsing the everyday preventive measures, maintaining a healthy lifestyle with proper diet, light exercise or meditation.
- Encourage development of new hobbies and activities to cope with social isolation

- **Refer for specialized mental health care**

If a patient is found to have severe emotional issues or suspected exacerbation of pre-existing psychiatric illness, it is better to refer to a specialist for further advice.

- **Take care of yourself and your family**

Physicians themselves are vulnerable to emotional distress during pandemics, which can be exacerbated by their own risk of acquiring infection while providing care to possibly exposed or suspected patients and/or passing the infection to their family members. It is important that physicians must take the necessary measures to ensure their own mental health and wellbeing (e.g. eating or sleeping adequately, taking breaks etc). Physicians must plan ahead for the possibility that they may need to be quarantined after a possible exposure

**References:**

- Centers for Disease Control and Prevention (CDC). <https://www.cdc.gov/>
- Center for the Study of Traumatic Stress. <https://www.cstsonline.org/resources/resource-master-list/coronavirus-and-emerging-infectious-disease-outbreaks-response>



## **TAKING CARE OF PATIENTS DURING COVID-19 PANDEMIC: A GUIDE FOR PSYCHIATRISTS**

The novel COVID-19 is quite contagious with a potential to flood the healthcare systems within a short span of time. No specific treatment or vaccine is available. Prevention is the best way to protect oneself which requires a lot of changes in one's lifestyle such as social distancing, frequent hand washing and curtailment of social contacts or visits to potentially crowded places.

This scenario often leads to emotional distress, even among those who have not been directly exposed to the disease.

Psychiatrists are likely to encounter patients who have increased emotional distress resulting from the pandemic's impact on themselves, their families and communities.

Common psychological and behavioural responses include

- Increased anxiety or fears related to health of self or loved ones
- Low or irritable mood
- Anger, increased conflicts with family
- Increased use of alcohol and tobacco
- Inability to sleep
- Concentration difficulties or impairments in daily performance
- A proportion of individuals will go on to develop syndromal disorders, such as depression, anxiety, or trauma-related disorders, that require formal treatment.

In working with these patients, the psychiatrists should follow these principles:

- ❖ Acknowledge their concerns and uncertainties about the pandemic,
- ❖ Share medical knowledge that is accurate and objective,
- ❖ Encourage steps to reduce distress and encourage healthy lifestyle and behaviours.

Psychiatrists can play important roles in supporting physicians and healthcare personnel, as well as extend help to the community based interventions that encourage healthy behaviours during the pandemic.

Following strategies can help psychiatrists support their patients during COVID- 19 pandemic:

- **Stay updated with latest information**  
Obtain the latest, credible information from authentic public health resources, such as the Ministry of Health & Family Welfare, Government of India, World Health Organization or Centers for Disease Control and Prevention (CDC), in order to provide accurate, factual information to your patients.
- **Correct misconceptions.**  
In this digitally connected era with a variety of social media platforms, misinformation and rumours can spread quickly, causing unnecessary panic. If patients share any inaccurate information related to the pandemic, correct their myths or misconceptions and advise them to visit reliable public health resources to gather information.
- **Limit excessive exposure to media platforms.**  
Try to have a limited time set aside to check for news or updates pertaining to the pandemic. Constant inflowing stream of information every few seconds or minutes is likely to result in emotional distress and undue anxieties. Use only certain trusted media sources to update yourself twice a day. Counsel your patients to avoid excessive exposure to news channels and social media updates.

- **Impart education**

Common psychological and behavioural responses to infectious pandemics along with interventions to manage the emotional distress and risky health behaviours must be shared. Education about basic hygiene such as hand-washing, cough etiquette, social distancing and staying at home must be reinforced. Having proper education empowers the patients to make right decisions.

- **Help them by acknowledging and identifying their stress reactions**

- Teach patients to recognize any alarming signs or indicators of emotional distress, such as insomnia, concentration problems, bodily symptoms, increased use of alcohol or tobacco etc. This will help them to monitor themselves and their family members.
- It is also beneficial to acknowledge that certain emotional and behavioural responses are part of an adaptive response to extraordinary stress
- Psychotherapy techniques such as those based on the stress-adaptation model might be helpful.

- **Discuss strategies for stress management**

- Plan and prepare ahead (e.g. ensuring medicine supplies for chronic health condition etc.)
- Embrace preventive measures (e.g. social distancing, hand hygiene) as part of new lifestyle
- Maintain sleep-wake schedule, with regular nutritious meals
- Engage in daily physical exercise, depending on one's fitness level and stamina
- Limit the use of alcohol or tobacco as a means to cope with stress.
- Share the worries and concerns with family and relatives
- Practice deep breathing, muscle relaxation or meditation
- Develop your hobbies and activities to structure the daily routine

- **Identify and support high-risk patients**

- Patients with pre-existing conditions e.g. those with severe anxiety, obsessive-compulsive behaviours, or those previously exposed to severe trauma or those with severe depression or psychosis may be particularly vulnerable during the pandemic.
- Ensure patients have prescription with an adequate supply of their maintenance medications
- Clinical contact using telepsychiatry services can help to address any emerging concerns, which may help to avoid exacerbations of symptoms.
- Patients who show alarming symptoms such as suicidality or aggression must be advised to visit emergency services and must be taken up for emergency evaluation

- **Take care of yourself and your family**

Psychiatrists themselves are vulnerable to emotional distress and they must take the necessary measures to ensure their own mental health and wellbeing (e.g. eating or sleeping adequately, taking necessary preventive measures etc.). Psychiatrists must plan ahead for the possibility of being quarantined away from one's family after a possible exposure to a confirmed patient.

**References:**

- Centers for Disease Control and Prevention (CDC). <https://www.cdc.gov/>
- Center for the Study of Traumatic Stress. <https://www.cstsonline.org/resources/resource-master-list/coronavirus-and-emerging-infectious-disease-outbreaks-response>
- American Psychiatric Association Coronavirus resources. <https://www.psychiatry.org/psychiatrists/covid-19-coronavirus>
- Xiang YT, Yang Y, Li W, et al. Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. *Lancet Psychiatry*. 2020;7(3):228-229.



## **MENTAL HEALTH CARE AND TREATMENT OPTIONS DURING COVID-19 PANDEMIC**

COVID-19 is a novel corona virus which is highly contagious and has been identified as responsible for the recent global pandemic. It is, therefore, essential that mental and behavioural healthcare facilities implement plans to protect patients, caregivers and staff from infection to the greatest extent possible.

During this period of COVID-19 pandemic, providing in-person mental health care service is associated with following risks and challenges.

- ❖ Risk of transmission during the gathering of patients in a confined space e.g. registration or out-patient waiting areas
- ❖ Physical contact with door knobs, chairs, benches etc at hospital
- ❖ Risk of exposure during travel e.g. public transport

At the same time, the mental health care needs may be more during the pandemic. Further, there is an increased risk of relapse of psychiatric illness due to an inability to visit the hospital and consequent non-availability of prescription advice. Also, there is an emergent need to address the vulnerable population at risk of developing mental disorder during the time of pandemic.

Following are some of the considerations aimed at reducing the likelihood of disease transmission, while providing for mental health care needs of patients.

- **Tele-psychiatry services**

It is the process of delivering mental health care services from a distance by mental health professionals using information and communication technologies. A mental health professional can provide a range of services including evaluation, therapy, patient education and medication management via a tele-consult (audio/video/text or email).

These services have the advantage of providing medical advice without exposing the patients, their families and service providers to risk of infection. Service provider can provide a digital copy of a signed prescription or e-Prescription to the patient via email or any messaging platform

As per Govt of India telemedicine guidelines released on March 25, 2020, a few limitations are placed on certain medicines depending upon the type and mode of tele-consultation, and certain categories of medications cannot be prescribed (Schedule X of Drugs and Cosmetic Act/Rules; Narcotic drugs as listed in NDPS Act,1985).

Patients who are stable or by and large maintaining well may be encouraged to take professional advice via tele-consultation services. Telepsychiatry is also suited for individuals with mild to moderate symptoms. In cases with severe or emergent symptoms with possible risk to self or others, the service provider must advise the patients and caregivers to visit the nearest casualty or emergency services.

- **Emergency psychiatric services**

The emergency psychiatric services are available round-the-clock which can be availed for patients who show a significant worsening of their symptoms, or who are unmanageable at home or those with suicidal risk or risk of violence towards others. Patients who are experiencing significant or distressing withdrawal symptoms associated with alcohol or other substance use are also a candidate for

emergency care. The psychiatrist on call can evaluate the patient, give appropriate advice, prescribe injectable and/or oral medication and observe the patient before deciding on subsequent management.

- **Inpatient facilities**

These may be reserved for those in whom symptoms pose an imminent risk. In these extraordinary times of risk of COVID19 transmission, it is preferable that in-patient treatment be utilized only for those with emergency situation, limited to minimum essential duration. Routine admissions may be postponed in view of risk of restricted space in general wards with lot of common or shared facilities. While admitting a patient from casualty, care should be taken to screen and test those who may have been exposed to a family member or relative with COVID-19, along with similar policies for caregivers and visitors to psychiatric ward.

- **Out-patient facilities**

As and when permitted to be open by govt orders, these may be availed for routine care especially if telepsychiatry services are not deemed to be adequate for particular mental health care needs e.g. for patients requiring prescription of schedule X drugs, or patients requiring physical examination or patients who have been advised on teleconsultation by their mental health professional to visit out-patient clinic for further management, etc.

General precautions and advice, including social distancing, wearing a mask, hand hygiene and cough etiquette must be followed strictly during a visit to out-patient treatment facility.

Reference:

- Telemedicine practice guidelines: <https://www.mohfw.gov.in/pdf/Telemedicine.pdf>





মানসিক চাপ বা স্ট্রেসের কারণে বাচ্চা ভিন্নধরনের প্রতিক্রিয়া দেখাতে পারে - যেমন অধিক কোলঘেঁষা হয়ে পড়া, বাচ্চাকে অধীর বা উদ্ভিগ্ন দেখানো, সবার থেকে আলাদা থাকতে চাওয়া, সহজে রেগে যাওয়া অথবা বিছানা ভিজিয়ে ফেলা ইত্যাদি।

আপনার বাচ্চার মানসিক চাপের প্রতি সহানুভূতিশীল হোন, তাদের সমস্যা দয়াকরে মনোযোগ দিয়ে শুনুন এবং প্রয়োজনে একটু অধিক ভালোবাসাও যত্ন নিন।

মুশকিল সময়ে আপনার বাচ্চার আপনার থেকে ভালোবাসা আর যত্নের দরকার।  
ওকে একটু বেশি সময় ও আগ্রহ নিয়ে আদর করুন।

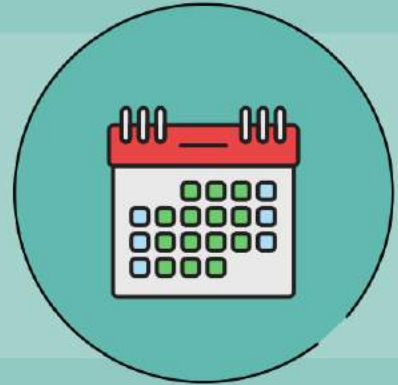
আপনার বাচ্চার কথা শান্তভাবে শুনুন আর প্রয়োজনে ওকে ওর সমস্যার বিষয়ে  
আশ্বস্ত করুন।

যদি সম্ভব হয় আপনার বাচ্চাকে খেলতে ও আরাম করতে সুযোগ করে দিন।



যথাসম্ভব চেষ্টা করুন বাচ্চাদেরকে তাদের পরিজনের কাছে রাখতে এবং যাতে  
করে মা বা কাছের মানুষের থেকে দূরে না রাখ হয়। যদি বাচ্চাকে দূরে রাখতেই  
হয় (উদাহরণস্বরূপ : হাসপাতালে ভর্তি করতে হল), সেক্ষেত্রে সবসময় চেষ্টা  
করতে হবে যে বাচ্চা নিয়মিত তার মা বা অন্যান্য পরিজনের সঙ্গে যোগাযোগে  
থাকে (উদাহরণস্বরূপ: মোবাইল ফোনের মাধ্যমে)।

চেষ্টা করুন বাচ্চাকে যথাসম্ভব তার প্রাত্যহিক রুটিনের মধ্যে রাখতে, আর তা  
যদি সম্ভব না হয় চেষ্টা করুন আপনার বাচ্চার জন্য নতুন রুটিন তৈরী করার  
যাতে সে পড়াশোনা, খেলাধুলো এবং আরাম করার যথেষ্ট সময় পায়।



চেষ্টা করুন যা ঘটেছে সে বিষয়ে আপনার বাচ্চাকে যথাসম্ভব সঠিক তথ্য দিতে,  
ওকে এও বলুন এখন কি ঘটেছে এবং আগে কি হতে চলেছে - আপনার বাচ্চার বয়স  
অনুযায়ী ওকে সংক্রমণ আটকানোর সঠিক এবং স্পষ্ট তথ্যগুলি বোঝানোর চেষ্টা  
করুন। (উদাহরণস্বরূপ আপনি বলতে পারেন, বাড়ির যে কেউ বা আপনার বাচ্চা  
অসুস্থ অনুভব করলে চিকিৎসার জন্য হাসপাতালে যেতে হতে পারে, যাতে করে  
সুস্থ হয়ে উঠতে পারে।)



# બાળકોને 2019-nCoV ફાટી નીકળવા દરમિયાન તણાવનો સામનો કરવામાં મદદ કરવી



બાળકો તણાવના સમયે વિવિધ રીતે પ્રતિક્રિયા આપી શકે છે જેમ કે (ઘરના લોકોને) વધુ વળગવું, બેચેન થવું, બધાથી દૂર થઈ જવું, ગુસ્સે થઈ જવું, વ્યાકુળ થઈ જવું, પલંગમાં પેશાબ થઈ જવો વગેરે.

તમારા બાળકની પ્રતિક્રિયાઓને સહાયક રીતે પ્રતિસાદ આપો, તેમની ચિંતાઓ સાંભળો અને તેમને વધારે પ્રેમ કરો અને વધુ ધ્યાન આપો.

બાળકોને મુશ્કેલ સમયમાં વચસ્કોના પ્રેમની જરૂર હોય છે. તેમને વધારે સમય અને ધ્યાન આપો.

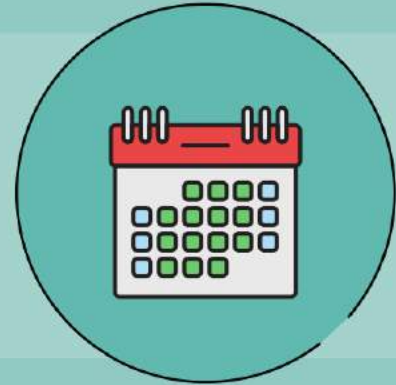
તમારા બાળકોને સાંભળવાનું, માયાથી વર્તવાનું અને તેમને ખાતરી આપવાનું ભૂલશો નહીં.

જો શક્ય હોય તો, બાળકોને રમત રમવાની અને આરામ કરવાની તકો આપો.



બાળકોને તેમના માતાપિતા અને પરિવારની નજીક રાખવાનો પ્રયાસ કરો અને શક્ય હોય ત્યાં સુધી બાળકો અને તેમના સંભાળ આપનારાઓને અલગ પાડવાનું ટાળો. જો અલગ થાય (દા.ત. હોસ્પિટલમાં દાખલ થવાથી) તો નિયમિત સંપર્ક (દા.ત. ફોન દ્વારા) રાખો અને વારંવાર ખાતરી આપો.

શક્ય હોય તેટલી નિયમિત દિનચર્યા અને અનુસૂચિ જાળવો અથવા નવા વાતાવરણમાં નવી (દિનચર્યા) બનાવવા માટે મદદ કરો કે જેમાં શાળા/ભણતર તેમ જ સલામત રીતે રમવા અને આરામ કરવાનો સમય પણ શામેલ હોય.



જે બન્યું છે તેના વિશે તથ્યો પ્રદાન કરો, હવે શું ચાલી રહ્યું છે તે સમજાવો અને તેઓને તેમની વચના આધારે સમજી શકે તેવા શબ્દોમાં આ રોગનો ચેપ લાગવાનું જોખમ કેવી રીતે ઘટાડવું તે વિશે સ્પષ્ટ માહિતી આપો.

આમાં આગળ શું થઈ શકે છે તે વિશેની માહિતી પણ ખાતરીદાયક રીતે આપો (દા.ત. કુટુંબના સભ્ય અને / અથવા બાળકને અસ્વસ્થ લાગે અને તે થોડા સમય માટે હોસ્પિટલમાં જઈ શકે છે કે જેથી ડોક્ટરો તેમને તંદુરસ્ત થવા માટે મદદ કરી શકે).

## Covid-19 बीमारी के समय में बच्चों को तनाव का सामना करने में मदद



बच्चे तनाव की प्रतिक्रिया में अलग-अलग तरीकों से व्यवहार कर सकते हैं जैसे ज़्यादा जुड़ कर रहना, चिंतित रहना, अलग रहना, क्रोधित या उत्तेजित होना, बिस्तर गीला करना इत्यादि।

अपने बच्चे की प्रतिक्रियाओं का सहानुभूति से जवाब दें, उनकी चिंताओं को सुनें और उन्हें अधिक प्यार एवं ध्यान दें।

बच्चों को कठिन समय में बड़ों के प्यार और ध्यान की आवश्यकता होती है। उन्हें अतिरिक्त समय और ध्यान दें।

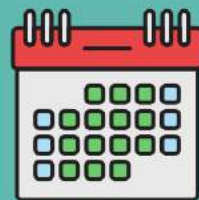
अपने बच्चों की बात ध्यान से सुनें, उनसे संवेदनापूर्ण बात करें और उन्हें आश्वासन दें।

यदि संभव हो, तो बच्चे के खेलने और आराम करने के लिए अवसर बनाएँ।



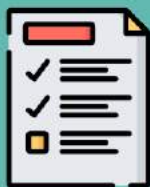
कोशिश करें कि बच्चों को उनके माता-पिता और परिवार के करीब रखें और जितना हो सके बच्चों और उनकी देखभाल करने वालों को अलग करने से बचें। यदि दोनों अलग होते हैं, (उदाहरण के लिए - अस्पताल में भर्ती होना) तो नियमित संपर्क (उदाहरण के लिए - फोन के माध्यम से) सुनिश्चित करें और आश्वासन देते रहें।

जितना संभव हो सके, नियमित दिनचर्या और कार्यक्रम रखें या नए वातावरण के अनुसार नई दिनचर्या बनाने में मदद करें, जिसमें स्कूल/पढ़ाई के साथ-साथ सुरक्षित रूप से खेलने और आराम करने के लिए समय भी शामिल हो।



जो कुछ हुआ है, उसके बारे में तथ्य बताएं, जो अभी चल रहा है उसके बारे में समझाएं और उन्हें इस बात की स्पष्ट जानकारी दें कि किस तरह से बीमारी से संक्रमण होने का अपना खतरा वे कम कर सकते हैं। बीमारी के बारे में उन शब्दों में बताया जाये कि अपनी उम्र के अनुसार वे समझ सकें।

इसमें आश्वस्त तरीके से बताया जाना भी शामिल है कि क्या हो सकता है (उदाहरण के लिए - परिवार के एक सदस्य और/या बच्चे को ठीक न महसूस हो और उन्हें कुछ समय के लिए अस्पताल भी जाना पड़ सकता है ताकि डॉक्टर उन्हें बेहतर महसूस करने में मदद कर सकें)।



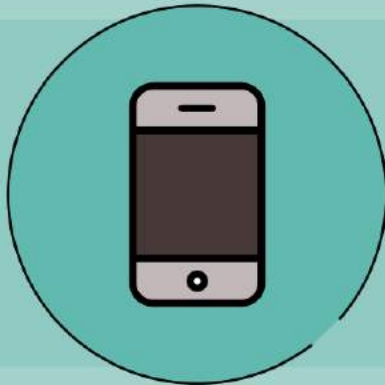


ପିଲାମାନେ ବିଭିନ୍ନ ଉପାୟରେ ଚାପ (ଷ୍ଟ୍ରେସ୍) ର ମୁକାବିଲା କରି ପାରନ୍ତି ଯେପରିକି ଜାଗୁଡ଼ି ଧରିବା, ଚିତ୍ରିତ ରହିବା, ପ୍ରତ୍ୟାହାର କରିବା, କ୍ରୋଧିତ କିମ୍ବା ଉତ୍ତେଜିତ ହବା, ବିଛଣା ରେ ପରିସ୍ରା କରିବା ଇତ୍ୟାଦି । ଏକ ସହାୟକ ଭାବେ ଆପଣଙ୍କ ପିଲାଙ୍କ ପ୍ରତିକ୍ରିୟାର ଉତ୍ତର ଦିଅନ୍ତୁ, ସେମାନଙ୍କର ଚିନ୍ତା ଶୁଣନ୍ତୁ ଏବଂ ତାଙ୍କୁ ଅଧିକ ପ୍ରେମ ଓ ଧ୍ୟାନ ଦିଅନ୍ତୁ ।

ପିଲାମାନେ କଠିନ ସମୟରେ ବୟସ୍କମାନଙ୍କ ପ୍ରେମ ଏବଂ ଧ୍ୟାନ ଆବଶ୍ୟକ କରନ୍ତି । ସେମାନଙ୍କୁ ଅଧିକ ଧ୍ୟାନ ଏବଂ ସମୟ ଦିଅନ୍ତୁ ।

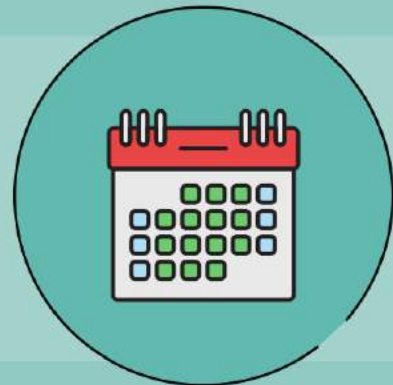
ମନେ କରି ନିଜ ପିଲାମାନଙ୍କ କଥା ଶୁଣନ୍ତୁ, ନରମ କଥା କୁହନ୍ତୁ ଏବଂ ତାଙ୍କୁ ଆଶ୍ୱାସନା ଦିଅନ୍ତୁ ।

ଯଦି ସମ୍ଭବ, ପିଲାମାନଙ୍କ ପାଇଁ ଖେଳିବା ଏବଂ ଆରାମ କରିବାର ସୁଯୋଗ ବନାନ୍ତୁ ।



ପିଲାମାନଙ୍କୁ ନିଜ ମାତାପିତା ଏବଂ ପରିବାରବର୍ଗଙ୍କ ନିକଟରେ ରଖିବାକୁ ଚେଷ୍ଟା କରନ୍ତୁ । ଯଥାସମ୍ଭବ ପିଲାମାନଙ୍କୁ ଏବଂ ତାଙ୍କ ଯତ୍ନ ନିଉଥିବା ଲୋକଙ୍କୁ ଅଲଗା କରନ୍ତୁ ନାହିଁ । ଅଲଗା ହବାର ପରିସ୍ଥିତିରେ (ଯଥା ହସ୍ପିଟାଲ୍ରେ ଭର୍ତ୍ତି ହବା ସମୟରେ) ନିୟମିତ ଯୋଗାଯୋଗ (ଯଥା ଫୋନ୍) ନିଶ୍ଚିତ କରନ୍ତୁ ଏବଂ ଆଶ୍ୱାସନା ଦିଅନ୍ତୁ ।

ଯଥାସମ୍ଭବ ନିୟମିତ ରୁଟିନ୍ ଏବଂ କାର୍ଯ୍ୟସୂଚୀ ଅନୁସରଣ କରନ୍ତୁ । ଅନ୍ୟଥା ବିଦ୍ୟାଳୟ/ ଅଧ୍ୟୟନ, ନିରାପଦରେ ଖେଳିବା ଏବଂ ଆରାମ କରିବା ପାଇଁ ଏକ ନୂତନ ପରିବେଶରେ ନୂତନ କାର୍ଯ୍ୟସୂଚୀ ବନେଇବାରେ ତାଙ୍କୁ ସାହାଯ୍ୟ କରନ୍ତୁ ।



ଯାହା ଘଟିଛି, ସେ ସମ୍ଭବରେ ତଥ୍ୟ ପ୍ରଦାନ କରନ୍ତୁ, ବର୍ତ୍ତମାନର ପରିସ୍ଥିତି ବିଷୟରେ ଅବଗତ କରାନ୍ତୁ ଏବଂ ବୟସ ଅନୁଯାୟୀ ସରଳ ଭାଷାରେ ଏହି ରୋଗରେ ଆକ୍ରାନ୍ତ ହବାର ଆଶଙ୍କା କିପରି ହ୍ରାସ କରାଯାଇପାରିବ, ସେ ବିଷୟରେ ସ୍ପଷ୍ଟ ସୂଚନା ଦିଅନ୍ତୁ ।

ଆଶ୍ୱାସନା ସହିତ କଣ ହୋଇପାରେ ସେ ବିଷୟରେ ଅବଗତ କରାନ୍ତୁ (ଯଥା ନିଜେ/ପରିବାରର କୌଣସି ସଦସ୍ୟ ଅସୁସ୍ଥ ହୋଇପାରନ୍ତି ଏବଂ କିଛି ସମୟ ପାଇଁ ହସ୍ପିଟାଲ୍ ଯିବାକୁ ପଡ଼ିପାରେ ଯାହା ଦ୍ୱାରା କି ତାଙ୍କରମାନେ ତାଙ୍କୁ ସୁସ୍ଥ କରିବାରେ ସାହାଯ୍ୟ କରିପାରିବେ) ।





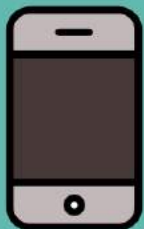
ਬੱਚੇ ਤਣਾਅ ਪ੍ਰਤੀ ਵੱਖੇ ਵੱਖਰੇ ਤਰੀਕਿਆਂ ਨਾਲ ਪ੍ਰਤੀਕ੍ਰਿਆ ਦੇ ਸਕਦੇ ਹਨ ਜਿਵੇਂ ਕਿ ਤੁਹਾਨੂੰ ਵਧੇਰੇ ਫੜੀ ਰੱਖਣਾ ਤੇ ਅਲੱਗ ਨਾ ਹੋਣ ਦੇਣਾ, ਚਿੰਤਤ ਹੋਣਾ, ਇਕੱਲਾ ਜਾਂ ਗੁਮਸੁਮ ਰਹਿਣਾ, ਗੁੱਸਾ ਹੋਣਾ, ਪਰੇਸ਼ਾਨ ਜਾਂ ਉਤੇਜਿਤ ਹੋਣਾ, ਬਿਸਤਰੇ ਨੂੰ ਗਿੱਲਾ ਕਰਨਾ, ਆਦਿ।

ਆਪਣੇ ਬੱਚੇ ਦੀ ਪ੍ਰਤੀਕ੍ਰਿਆ ਨੂੰ ਸਹਾਇਕ ਤਰੀਕੇ ਨਾਲ ਸੰਭਾਲੋ, ਉਨ੍ਹਾਂ ਦੀਆਂ ਚਿੰਤਾਵਾਂ ਨੂੰ ਸੁਣੋ, ਅਤੇ ਉਨ੍ਹਾਂ ਨੂੰ ਵਾਧੂ ਪਿਆਰ ਅਤੇ ਧਿਆਨ ਦਿਉ।

ਬੱਚਿਆਂ ਨੂੰ ਮੁਸ਼ਕਿਲ ਸਮੇਂ ਵਿੱਚ ਵੱਡੇ ਲੋਕਾਂ ਦੇ ਪਿਆਰ ਅਤੇ ਧਿਆਨ ਦੀ ਜ਼ਰੂਰਤ ਹੁੰਦੀ ਹੈ। ਉਨ੍ਹਾਂ ਨੂੰ ਵਧੇਰੇ ਸਮਾਂ ਅਤੇ ਧਿਆਨ ਦਿਉ।

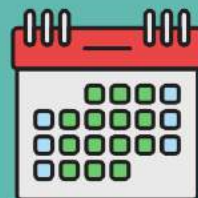
ਆਪਣੇ ਬੱਚਿਆਂ ਨੂੰ ਸੁਣਨਾ, ਪਿਆਰ ਨਾਲ ਬੋਲਣਾ ਅਤੇ ਉਨ੍ਹਾਂ ਨੂੰ ਭਰੋਸਾ ਦਿਵਾਉਣਾ ਯਾਦ ਰੱਖੋ।

ਜੇ ਸੰਭਵ ਹੋਵੇ, ਤਾਂ ਬੱਚੇ ਲਈ ਖੇਡਣ ਅਤੇ ਆਰਾਮ ਕਰਨ ਦੇ ਮੌਕੇ ਬਣਾਓ।



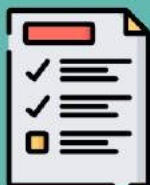
ਬੱਚਿਆਂ ਨੂੰ ਉਨ੍ਹਾਂ ਦੇ ਮਾਪਿਆਂ ਅਤੇ ਪਰਿਵਾਰ ਦੇ ਨੇੜੇ ਰੱਖੋ, ਅਤੇ ਜਿਥੋਂ ਤਕ ਹੋ ਸਕੇ, ਬੱਚਿਆਂ ਨੂੰ ਉਨ੍ਹਾਂ ਦੇ ਦੇਖਭਾਲ ਕਰਨ ਵਾਲਿਆਂ ਤੋਂ ਵੱਖ ਕਰਨ ਤੋਂ ਬੱਚੋ। ਜੇ ਵਿਛੋੜਾ ਹੁੰਦਾ ਹੈ (ਉਦਾਹਰਣ ਲਈ: ਹਸਪਤਾਲ ਦਾਖਲ ਹੋਣਾ), ਤਾਂ ਨਿਯਮਿਤ ਸੰਪਰਕ ਨੂੰ ਯਕੀਨੀ ਬਣਾਉ (ਉਦਾਹਰਣ ਲਈ: ਫੋਨ ਰਾਹੀਂ) ਅਤੇ ਭਰੋਸਾ ਦਿਵਾਉ।

ਜਿੰਨਾ ਸੰਭਵ ਹੋ ਸਕੇ, ਬੱਚਿਆਂ ਦਾ ਨਿਯਮਤ ਰੁਟੀਨ ਅਤੇ ਕਾਰਜ-ਕ੍ਰਮ ਜਾਰੀ ਰੱਖੋ ਜਾਂ ਨਵੇਂ ਵਾਤਾਵਰਣ ਵਿੱਚ ਨਵੇਂ ਕਾਰਜ-ਕ੍ਰਮ ਬਣਾਉਣ ਵਿੱਚ ਉਨ੍ਹਾਂ ਦੀ ਸਹਾਇਤਾ ਕਰੋ ਜਿਸ ਵਿੱਚ ਪੜ੍ਹਾਈ ਦੇ ਨਾਲ ਨਾਲ ਸੁਰੱਖਿਅਤ ਰੂਪ ਵਿੱਚ ਖੇਡਣ ਅਤੇ ਆਰਾਮ ਕਰਨ ਲਈ ਸਮਾਂ ਸ਼ਾਮਲ ਹੋਵੇ।



ਜੇ ਹੋ ਚੁਕਾ ਹੈ, ਉਸ ਬਾਰੇ ਤੱਥ ਪ੍ਰਦਾਨ ਕਰੋ, ਬੱਚਿਆਂ ਨੂੰ ਦੱਸੋ ਕਿ ਹੁਣ ਕੀ ਹੋ ਰਿਹਾ ਹੈ ਅਤੇ ਉਨ੍ਹਾਂ ਨੂੰ ਇਸ ਬਾਰੇ ਸਪਸ਼ਟ ਜਾਣਕਾਰੀ ਦਿਓ ਕਿ ਬਿਮਾਰੀ ਹੋਣ ਦੇ ਜੋਖਮ ਨੂੰ ਕਿਵੇਂ ਘਟਾਉਣਾ ਹੈ। ਇਹ ਜਾਣਕਾਰੀ ਉਹਨਾਂ ਸ਼ਬਦਾਂ ਵਿੱਚ ਦਿਓ ਜੋ ਉਹ ਆਪਣੀ ਉਮਰ ਦੇ ਆਧਾਰ ਤੇ ਸਮਝ ਸਕਦੇ ਹਨ।

ਇਸ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਵੀ ਭਰੋਸੇਮੰਦ ਤਰੀਕੇ ਨਾਲ ਪ੍ਰਦਾਨ ਕਰਨਾ ਸ਼ਾਮਲ ਹੈ ਕਿ, ਕੀ ਹੋ ਸਕਦਾ ਹੈ (ਉਦਾਹਰਣ ਲਈ: ਜੇ ਇੱਕ ਪਰਿਵਾਰਕ ਮੈਂਬਰ ਜਾਂ ਬੱਚਾ ਚੰਗਾ ਮਹਿਸੂਸ ਨਹੀਂ ਕਰ ਰਿਹਾ, ਤਾਂ ਕੁਝ ਸਮੇਂ ਲਈ ਹਸਪਤਾਲ ਜਾਣਾ ਪੈ ਸਕਦਾ ਹੈ ਤਾਂ ਕਿ ਡਾਕਟਰ ਉਨ੍ਹਾਂ ਨੂੰ ਬਿਹਤਰ ਕਰਨ ਵਿੱਚ ਸਹਾਇਤਾ ਕਰ ਸਕਣ)।





## கொரோனா பரவலின் போது மன அழுத்தத்தைச் சமாளிக்க குழந்தைகளுக்கு உதவும் வழிகள்



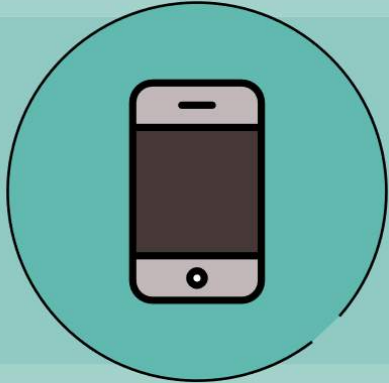
குழந்தைகள், மன அழுத்தம் வரும்போது - அதிகம் ஓட்டிக் கொள்வது, பதட்டம், எதிலும் ஈடுபாடு இல்லாமல் இருப்பது, கோபம், எரிச்சல், படுக்கையில் சிறுநீர் கழித்தல் போன்று வெவ்வேறு விதங்களில் நடந்து கொள்வார்கள்.

குழந்தைகள் அவ்வாறு நடந்து கொள்ளும்போது அவர்களிடம் அனுசரணையாகப் பேசி அவர்கள் மனக் குறைகளைக் கேட்டு அவர்களிடம் அதிக அன்பும், கவனிப்பும் காட்டுங்கள்.

இதுபோன்ற கடினமான நேரத்தில் பெரியவர்களின் அன்பும் கவனமும் குழந்தைகளுக்குத் தேவை. அவர்களுக்குக் கூடுதல் நேரத்தையும் கவனத்தையும் கொடுங்கள்.

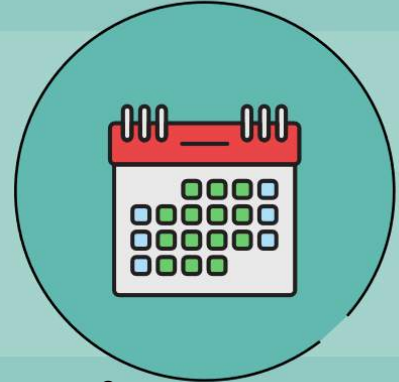
குழந்தைகளுக்கு செவிசாய்த்து, அன்பாக பேசி, நம்பிக்கையூட்ட வேண்டும் என்பதை நினைவில் கொள்ளுங்கள்

முடியுமானால், குழந்தைகள் விளையாடவும் ஓய்வெடுக்கவும் வாய்ப்புகளை ஏற்படுத்துங்கள்.



பெற்றோர் மற்றும் குடும்பத்தினருடன் குழந்தைகள் இருப்பது நல்லது. முடிந்தவரை, கவனிப்பவர்களிடம் இருந்து குழந்தைகளைப் பிரிக்காதீர்கள். ஒருவேளை, மருத்துவமனை சேர்க்கை போன்ற காரணங்களால் பிரிய நேர்ந்தால், தொலைபேசி மூலம் அடிக்கடி தொடர்புகொண்டு நம்பிக்கையூட்டுங்கள்.

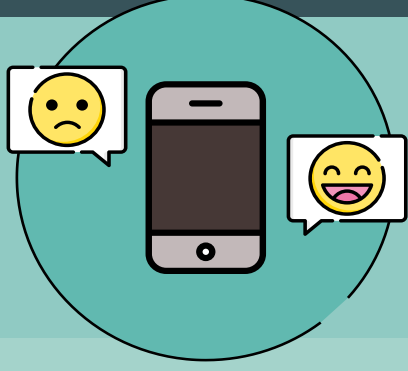
முடிந்தவரை குழந்தைகளின் வழக்கமான செயல்பாடுகளைப் பின்பற்றுங்கள். அல்லது புதிய செயல்பாடுகளைப் புதிய சூழலில் உருவாக்க உதவுங்கள். அதில் படிக்கவும், பாதுகாப்பாக விளையாடவும், ஓய்வெடுக்கவும் நேரம் ஒதுக்குங்கள்.



என்ன நடந்தது என்பது பற்றிய உண்மை விவரங்களைச் சொல்லுங்கள், தற்போது என்ன நடக்கிறது என்பதை விளக்குங்கள். எவ்வாறு நோய் தாக்காமல் தற்காத்துக் கொள்ள வேண்டும் என்பதை தெளிவாக அவர்களின் வயதிற்கேற்ப புரிய வையுங்கள்

நோய்த்தொற்று ஏற்பட்டால் என்ன நடக்கக்கூடும் என்பது பற்றிய தகவல்களை நம்பிக்கையூட்டும் விதத்தில் கூறுங்கள் (எ.கா: குடும்பத்தினருக்கோ குழந்தைக்கோ உடல் நலக்குறைவு ஏற்பட்டால் மருத்துவமனைக்குச் சென்று சிகிச்சை எடுத்துக் கொண்டு நலம் பெறலாம்).

# কোভিড-১৯ মহামারীর সময়ে আপনার মানসিক চাপের সাথে মানিয়ে নিতে শিখুন



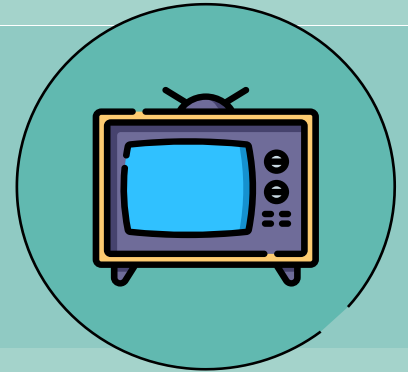
এই সংকটের সময়ে মানসিক চাপ, বিষন্নতা, বিভ্রান্তি, ভয় এবং সহজে রেগে যাওয়া অত্যন্ত সাধারণ বিষয়। আপনি যাদের বিশ্বাস করেন এমন বন্ধু-বান্ধব এবং পরিবার-পরিজনের সঙ্গে নিয়মিত যোগাযোগ রাখুন - অনেকেই এতে উপকৃত হন।

যদি আপনি বাড়িতে বদ্ধ থাকেন, অবশ্যই স্বাস্থ্যকর জীবনচর্চা পালন করুন - যেমন; নিয়মিত খাবার খান, ব্যায়াম করুন, ভালোভাবে ঘুম সম্পূর্ণ করুন, পরিবার-পরিজনের সাথে আনন্দে সময় কাটান ও বন্ধুদের সাথে ইমেল বা ফোনের মাধ্যমে যোগাযোগ রাখুন।



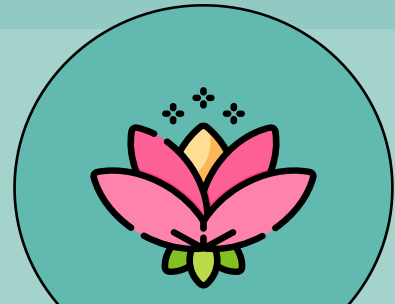
আপনার আবেগ রুখতে ধূমপান, মদ্যপান, বা অন্যান্য নেশার আশ্রয় না নেওয়াই ভালো। যদি অতিরিক্তভাবে মানসিকরূপে বিহ্বল হয়ে পড়েন - মানসিক স্বাস্থ্যবিদ বা কাউন্সেলরের পরামর্শ নিতে পারেন। নিজের থেকে বা পরিজনের সাহায্যে একটি সঠিক পরিকল্পনা রাখুন যে প্রয়োজনে শারীরিক বা মানসিক স্বাস্থ্যের অবনতি হলে কোথায় এবং কিভাবে সাহায্য নেবেন।

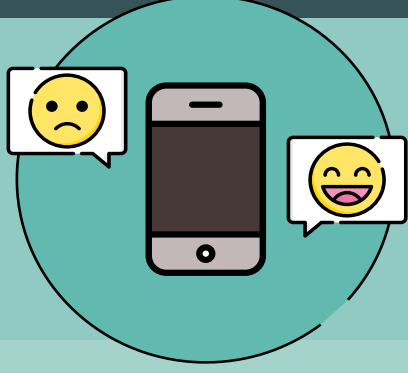
সঠিক তথ্যের সাথে পরিচিত থাকুন - যাতে করে আপনি, আপনার এবং আপনার পরিবারের সংক্রমণের ঝুঁকি কতটা তা আগেই অনুধাবন করে প্রয়োজনীয় সতর্কতা অবলম্বন করতে পারেন। চেষ্টা করুন বিশ্বাসযোগ্য তথ্যের মাধ্যম খুঁজে পেতে, যাকে ভরসা করা যায় - যেমন, বিশ্ব স্বাস্থ্য সংস্থার ওয়েবসাইট কিংবা আপনার দেশের বা রাজ্যের জনস্বাস্থ্য সংস্থার তথ্য।



আপনার আশঙ্কা আর উৎকণ্ঠা নাগালে রাখতে সেই সমস্ত সংবাদ সম্প্রচার কম দেখুন আর কম পড়ুন, যা আপনার উদ্বেগের কারণ হয়ে উঠতে পারে।

আপনার সেই সমস্ত দক্ষতাগুলির ওপর মনোনিবেশ করুন যা অতীতে আপনাকে আপনার জীবনের প্রতিকূলতাকে ছাপিয়ে উঠতে সাহায্য করেছে (উদাহরণস্বরূপ: ছবি আঁকা, গান গাওয়া, যোগব্যায়াম করা ইত্যাদি)।





કટોકટી દરમિયાન ઉદાસ થવું, તણાવ અને મૂંઝવણ થવી, ડર લાગવો અને ગુસ્સો આવવો સામાન્ય છે.

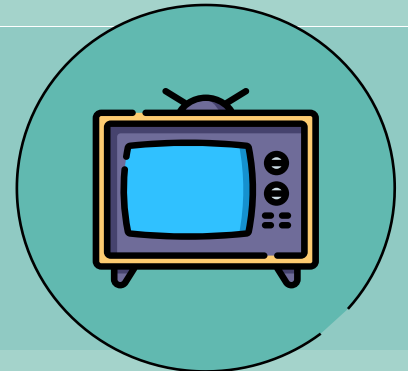
તમે વિશ્વાસ કરો છો તેવા લોકોની સાથે વાત કરવાથી મદદ મળી શકે છે. તમારા મિત્રો અને પરિવારનો સંપર્ક કરો.

જો તમારે ઘરે જ રહેવું પડે, તો તંદુરસ્ત જીવનશૈલી જાળવો જેમ કે યોગ્ય આહાર, નિયમિત ઊંઘ, કસરત અને પરિવાર ના લોકો સાથે તથા ફોન અને ઇમેઇલ દ્વારા મિત્રો અને બીજા સગા-સંબંધીઓ સાથે સામાજિક સંપર્ક વગેરે.



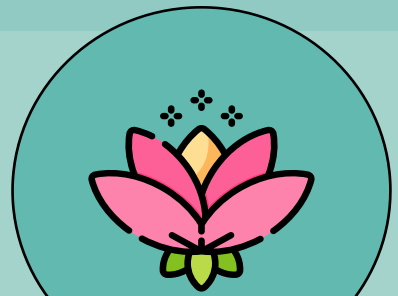
તમારી લાગણીઓ પર કાબુ લાવવા માટે ધૂમ્રપાન, શરાબ અથવા અન્ય નશીલા પદાર્થોનો પ્રયોગ કરશો નહીં. જો તમે વધુ વ્યાકુળ થઈ ગયા છો તો આરોગ્ય કાર્યકર અથવા સલાહકાર સાથે વાત કરો. જરૂરત પડવા પર શારીરિક અને માનસિક સ્વાસ્થ્ય જરૂરિયાતો માટે ક્યાં જવું અને કેવી રીતે મદદ લેવી તેની યોજના તૈયાર રાખો.

તથ્યો મેળવો. માહિતી એકત્રિત કરો કે જે તમને તમારા જોખમને ચોક્કસપણે નક્કી કરવામાં મદદ કરશે જેથી તમે વાજબી સાવચેતીઓ રાખી શકો. કોઈ વિશ્વસનીય સ્ત્રોત શોધો જેમ કે WHO વેબસાઇટ, સ્થાનીય અથવા રાજ્યની જાહેર આરોગ્ય સંસ્થા કે જેના પર વિશ્વાસ કરી શકાય.

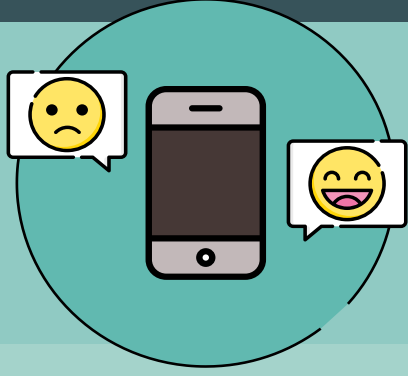


તમે અને તમારા કુટુંબીજનો મીડિયા કવરેજ કે જેને તમે અસ્વસ્થ માનો છો, તેને જોવા એન્ડ સાંભળવામાં ઓછામાં ઓછો સમય વિતાવો કે જેથી તમારી ચિંતા અને ઉત્તેજના ઘટે.

જે કુશળતાઓએ તમને પાછલા જીવનની મુશ્કેલીઓ દૂર કરવામાં ભૂતકાળમાં મદદ કરી છે તેનો ઉપયોગ આ ઉત્પાતના પડકારજનક સમય દરમિયાન તમારી લાગણીઓ પર કાબુ લાવવા માટે કરો.

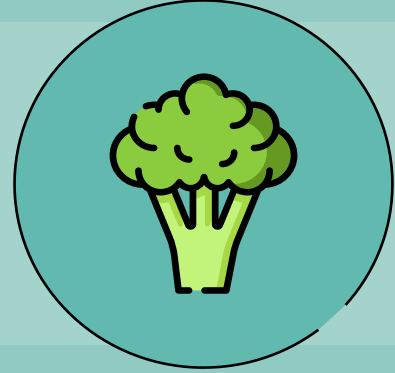






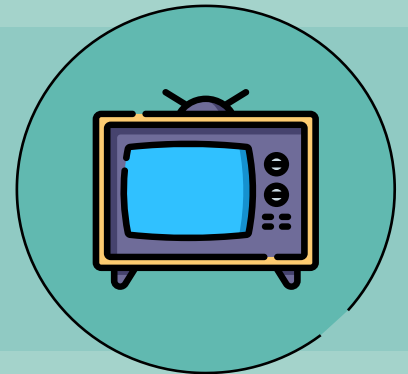
किसी संकट के समय उदासी, तनाव, परेशानी, डर या गुस्सा महसूस करना सामान्य है। जिन लोगों पर आप भरोसा करते हैं उनसे बात करने से आपको मदद मिल सकती है। अपने दोस्तों एवं परिवार से नियमित तौर पर संपर्क करें।

यदि आपका घर पर रहना आवश्यक है, तो एक स्वस्थ जीवनशैली बनाए रखें – जिसमें उचित आहार, नींद और व्यायाम शामिल हो। घर में प्रियजनों, अन्य परिवारजनों और दोस्तों के साथ ईमेल और फोन द्वारा सामाजिक संपर्क बनाए रखें।



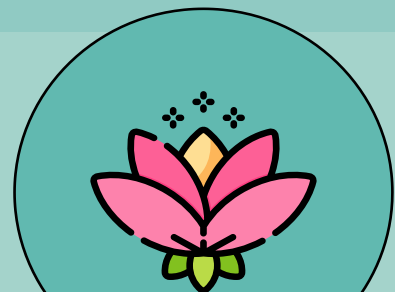
अपनी भावनाओं से निपटने के लिए धूम्रपान, शराब या अन्य नशों का उपयोग न करें। यदि आप घबराहट महसूस कर रहे हैं, तो नजदीकी स्वास्थ्य कार्यकर्ता या सलाहकार से बात करें। इसकी योजना बनाएं कि आवश्यकता पड़ने पर शारीरिक और मानसिक स्वास्थ्य के लिए मदद कहां से और कैसे लेनी है।

तथ्य इकट्ठे करें। ऐसी जानकारी इकट्ठा करें जो आपके जोखिम को सही ढंग से आंकने में आपकी सहायता करे ताकि आप उचित सावधानी बरत सकें। एक विश्वसनीय स्रोत खोजें जिस पर आप भरोसा कर सकते हैं जैसे कि डब्ल्यू एच ओ (WHO) वेबसाइट या, एक स्थानीय या सरकारी सार्वजनिक स्वास्थ्य संस्था।

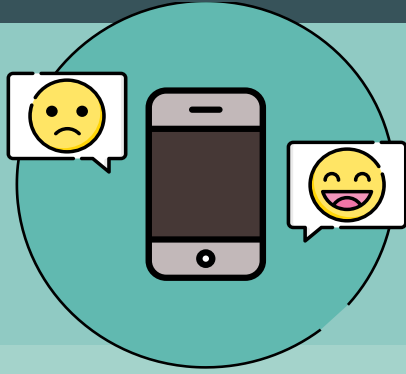


जो मीडिया कवरेज आपको परेशान कर दे, उसको देखने या सुनने में बिताए गए समय को कम करके आप और आपके परिवारजन चिंता और व्याकुलता को सीमित सकते हैं।

उन कौशलों का सहारा लें जिनका आपने अतीत में अपने जीवन की मुश्किलों से सामना करने में उपयोग किया है। इस प्रकोप के चुनौतीपूर्ण समय के दौरान अपनी भावनाओं को संभालने में मदद के लिए उन कौशलों का उपयोग करें।



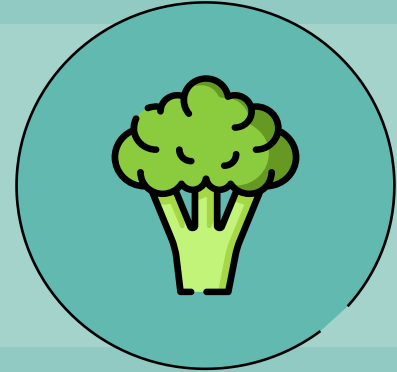




ସଙ୍କଟ ସମୟରେ ମନରେ ଦୁଃଖ, ଚାପ(ଷ୍ଟ୍ରେସ), ବିବାଦ, ଭୟ କିମ୍ବା କ୍ରୋଧ ଅନୁଭବ କରିବା ସ୍ୱାଭାବିକ ।

ବିଶ୍ୱସନୀୟ ଲୋକଙ୍କ ସହିତ କଥାବାର୍ତ୍ତା କରିବା ଆପଣଙ୍କୁ ସାହାଯ୍ୟ କରିପାରିବ । ନିଜ ବନ୍ଧୁ ଏବଂ ପରିବାରବର୍ଗଙ୍କ ସହିତ ଯୋଗାଯୋଗ କରନ୍ତୁ ।

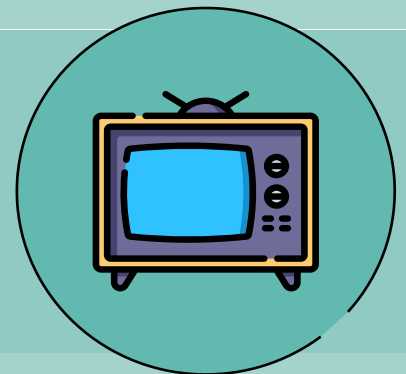
ଯଦି ନିର୍ଭୀତ ଭାବରେ ଘରେ ରହିବାକୁ ପଡୁଛି, ଏକ ସୁସ୍ଥ ଜୀବନଶୈଳୀ ବଜାୟ ରଖନ୍ତୁ ଯେପରିକି - ଉପଯୁକ୍ତ ଖାଦ୍ୟ, ନିଦ୍ରା, ବ୍ୟାୟାମ, ଘରେ ପ୍ରିୟଜନଙ୍କ ସହ ଏବଂ ବନ୍ଧୁ ଓ ପରିବାରବର୍ଗଙ୍କ ସହିତ ଇ-ମେଲ/ ଫୋନ୍ ମାଧ୍ୟମରେ ସାମାଜିକ ସମ୍ପର୍କ ରଖନ୍ତୁ ।



ନିଜ ଭାବନାକୁ ମୁକାବିଲା କରିବା ପାଇଁ ଧୂମପାନ, ମଦ୍ୟପାନ କିମ୍ବା ଅନ୍ୟ କୌଣସି ନିଶାଦ୍ରବ୍ୟ ବ୍ୟବହାର କରନ୍ତୁ ନାହିଁ ।

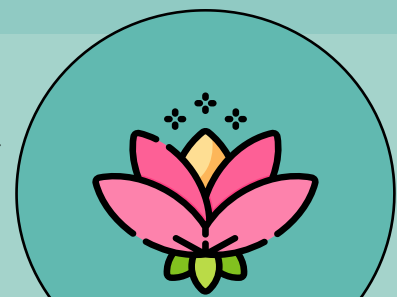
ଯଦି ଅତ୍ୟଧିକ ଚାପଗ୍ରସ୍ତ ଅନୁଭବ କରୁଛନ୍ତି, ସ୍ୱାସ୍ଥ୍ୟକର୍ମୀ କିମ୍ବା ପରାମର୍ଶଦାତାଙ୍କ ସହ ଯୋଗାଯୋଗ କରନ୍ତୁ । ଆବଶ୍ୟକ ସମୟରେ କେଉଁଠି ଏବଂ କିପରି ନିଜ ଶାରୀରିକ ଓ ମାନସିକ ସ୍ୱାସ୍ଥ୍ୟ ପାଇଁ ସାହାଯ୍ୟ ଖୋଜିବେ, ଏକ ସମ୍ପୂର୍ଣ୍ଣ ଯୋଜନା ପ୍ରସ୍ତୁତ କରନ୍ତୁ ।

ତଥ୍ୟଗୁଡ଼ିକ ପ୍ରାପ୍ତ କରନ୍ତୁ । ସମ୍ପୂର୍ଣ୍ଣ ସୂଚନା ସଂଗ୍ରହ କରନ୍ତୁ, ଯାହାକି ଆପଣଙ୍କୁ ବିପଦକୁ ସଠିକ ଭାବରେ ନିର୍ଣ୍ଣୟ କରିବାରେ ସାହାଯ୍ୟ କରିବ, ଯାହାଦ୍ୱାରା ଆପଣ ଯୁକ୍ତିଯୁକ୍ତ ସତର୍କତା ଅବଲମ୍ବନ କରିପାରିବେ । WHO ୱେବ୍‌ସାଇଟ୍, କୌଣସି ସ୍ଥାନୀୟ କିମ୍ବା ରାଜ୍ୟସ୍ତରୀୟ ପବ୍ଲିକ୍ ହେଲ୍ଥ୍ ଏଜେନ୍ସି ପରି ଏକ ବିଶ୍ୱାସଯୋଗ୍ୟ ଉତ୍ସ ଖୋଜନ୍ତୁ ।



ମିଡ଼ିଆ, ଯାହାକୁ ଦେଖି କିମ୍ବା ଶୁଣି ଆପଣ ତଥା ପରିବାରଗଣ ବିକ୍ରତ/ ଚିନ୍ତା ଅନୁଭବ କରୁଛନ୍ତି, ତାହାକୁ ସୀମିତ ରଖନ୍ତୁ ।

ଅତୀତରେ ପ୍ରତିକୂଳ ପରିସ୍ଥିତିରେ ବ୍ୟବହାର କରିଥିବା ପ୍ରତିଭା, ଯାହା ଆପଣଙ୍କୁ ପରିସ୍ଥିତିକୁ ପରିଚାଳନା କରିବାରେ ସାହାଯ୍ୟ କରିଥିଲା, ସେଗୁଡ଼ିକ ଏହି ବିଘ୍ନୋରଣର ତ୍ୟାଲେଞ୍ଜ୍ ସମୟରେ ନିଜର ଭାବନାକୁ ପରିଚାଳନା କରିବା ପାଇଁ ବ୍ୟବହାର କରନ୍ତୁ ।



# ਮਹਾਂਮਾਰੀ 2019-nCov ਦੇ ਦੌਰਾਨ ਮਾਨਸਿਕ ਤਣਾਅ ਦਾ ਮੁਕਾਬਲਾ ਕਿਵੇਂ ਕੀਤਾ ਜਾਵੇ।



ਕਿਸੇ ਸੰਕਟ ਦੇ ਸਮੇਂ ਉਦਾਸੀ, ਤਣਾਅ, ਉਲਝਣ, ਡਰ ਜਾਂ ਗੁੱਸਾ ਮਹਿਸੂਸ ਕਰਨਾ ਆਮ ਗੱਲ ਹੈ।

ਇਸ ਤੋਂ ਬਚਣ ਲਈ ਆਪਣੇ ਪਰਿਵਾਰ ਨਾਲ ਗੱਲਬਾਤ ਕਰੋ। ਦੋਸਤਾਂ ਅਤੇ ਰਿਸ਼ਤੇਦਾਰਾਂ ਨਾਲ ਸੰਪਰਕ ਬਣਾਈ ਰੱਖੋ।

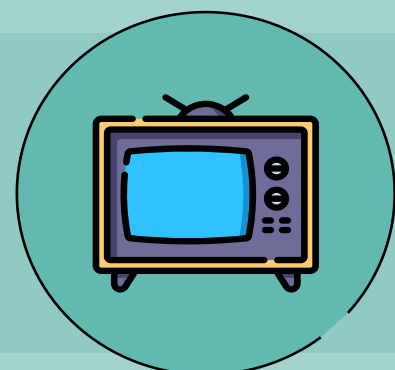
ਜੇ ਤੁਹਾਨੂੰ ਘਰੇ ਹੀ ਰਹਿਣਾ ਪਵੇ, ਤਾਂ ਇੱਕ ਸਿਹਤਮੰਦ ਜੀਵਨ ਸ਼ੈਲੀ ਬਣਾਈ ਰੱਖੋ - ਜਿਸ ਵਿੱਚ ਚੰਗੀ ਖੁਰਾਕ, ਨੀਂਦ, ਕਸਰਤ ਅਤੇ ਕਰੀਬੀ ਪਰਿਵਾਰ ਜਨਾਂ ਨਾਲ ਸੰਪਰਕ, ਅਤੇ ਰਿਸ਼ਤੇਦਾਰਾਂ ਜਾਂ ਦੋਸਤਾਂ ਨਾਲ ਫੋਨ ਅਤੇ ਈ-ਮੇਲ ਰਾਹੀਂ ਸੰਪਰਕ ਬਣਾਈ ਰੱਖਣਾ ਸ਼ਾਮਲ ਹੈ।



ਆਪਣੇ ਜਜ਼ਬਾਤਾਂ ਨਾਲ ਨਜਿੱਠਣ ਲਈ ਸਿਗਰਟ, ਸ਼ਰਾਬ ਜਾਂ ਹੋਰ ਨਸ਼ੀਲੇ ਪਦਾਰਥਾਂ ਦੀ ਵਰਤੋਂ ਨਾ ਕਰੋ। ਜੇਕਰ ਪਰਿਸ਼ਾਨੀਆਂ ਤੁਹਾਡੇ ਤੇ ਹਾਵੀ ਹੋ ਜਾਨ ਤਾਂ ਕਿਸੇ ਸਿਹਤ ਕਰਮਚਾਰੀ, ਸਲਾਹਕਾਰ ਜਾਂ ਕਾਉਂਸਲਰ ਨਾਲ ਗੱਲ ਕਰੋ।

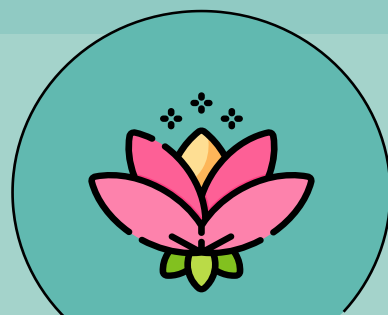
ਤੁਹਾਨੂੰ ਸ਼ਰੀਰਿਕ ਜਾਂ ਮਾਨਸਿਕ ਪਰੇਸ਼ਾਨੀ ਵਾਸਤੇ ਸਹਾਇਤਾ ਲਈ ਯੋਜਨਾ ਤਿਆਰ ਕਰਨੀ ਚਾਹੀਦੀ ਹੈ ਕਿ ਜਰੂਰਤ ਪੈਣ ਤੇ ਕਿੱਥੇ ਜਾਣਾ ਹੈ ਅਤੇ ਕਿਵੇਂ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨੀ ਹੈ।

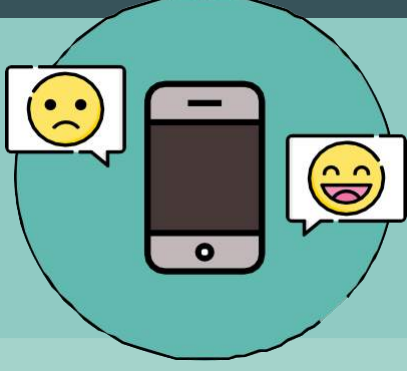
ਸਹੀ ਤੱਥ ਪ੍ਰਾਪਤ ਕਰੋ। ਉਹ ਜਾਣਕਾਰੀ ਇਕੱਠੀ ਕਰੋ ਜੋ ਤੁਹਾਡੇ ਜੋਖਮ ਨੂੰ ਨਿਰਧਾਰਤ ਕਰਨ ਵਿੱਚ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰੇਗੀ ਤਾਂ ਕਿ ਤੁਸੀਂ ਵਾਜਬ ਸਾਵਧਾਨੀਆਂ ਵਰਤ ਸਕੋ। ਇੱਕ ਭਰੋਸੇਮੰਦ ਸਰੋਤ ਲੱਭੋ ਜਿਵੇਂ ਕਿ W.H.O. ਦੀ ਵੈਬਸਾਈਟ ਜਾਂ, ਸਥਾਨਕ ਏਜੰਸੀ, ਰਾਜ ਜਾਂ ਕੇਂਦਰੀ ਸਿਹਤ ਵਿਭਾਗ।



ਚਿੰਤਾ-ਘਬਰਾਹਟ ਜਾਂ ਉਤੇਜਨਾ ਨੂੰ ਸੀਮਿਤ ਰੱਖਣ ਲਈ ਅਜਿਹੇ ਸੰਚਾਰ ਸਾਧਨਾਂ ਨੂੰ ਵੇਖਣ ਜਾਂ ਸੁਣਨ ਦਾ ਸਮੇਂ ਘਟਾਉ, ਜੋ ਕਿ ਤੁਹਾਨੂੰ ਅਤੇ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਨੂੰ ਪਰੇਸ਼ਾਨ ਕਰਨ ਵਾਲੇ ਲੱਗਦੇ ਹਨ।

ਇਸ ਮਹਾਂਮਾਰੀ ਦੇ ਮੁਸ਼ਕਿਲ ਸਮੇਂ ਦੌਰਾਨ ਆਪਣੇ ਜਜ਼ਬਾਤਾਂ ਨੂੰ ਸੰਭਾਲਣ ਲਈ ਉਹਨਾਂ ਤਰੀਕਿਆਂ ਦਾ ਪ੍ਰਯੋਗ ਕਰੋ ਜਿਨ੍ਹਾਂ ਨੇ ਤੁਹਾਨੂੰ ਅਤੀਤ ਵਿੱਚ ਜੀਵਨ ਦੀਆਂ ਹੋਰ ਮੁਸ਼ਕਿਲਾਂ ਦਾ ਸਾਮਨਾ ਕਰਨ ਵਿੱਚ ਸਹਾਇਤਾ ਕੀਤੀ ਸੀ।





நெருக்கடியான நேரத்தில் துக்கம், மன அழுத்தம், குழப்பம், பயம் அல்லது கோபம், போன்றவை தோன்றுவது இயல்பு.

நீங்கள் நம்பும் மனிதர்களிடம் பேசுவது உதவும். உங்கள் நண்பர்களையும் குடும்பத்தினரையும் தொடர்பு கொள்ளுங்கள்

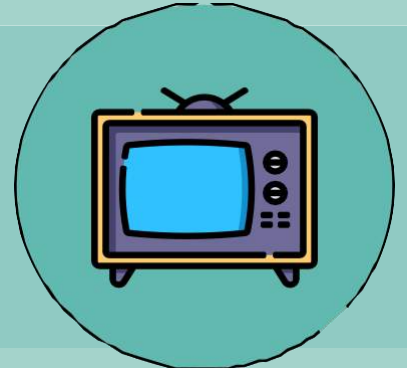
வீட்டில் தங்க வேண்டிய கட்டாயம் இருந்தால் - சரியான உணவு, தூக்கம், உடற்பயிற்சி மேற்கொள்ளுங்கள். வீட்டில் உள்ளவர்களுடன் உரையாடல், உறவினர்கள் மற்றும் நண்பர்களுடன் தொலைபேசி/மின்னஞ்சல் மூலமாகத் தொடர்பில் இருப்பது ஆகியவற்றையும் உள்ளடக்கிய ஆரோக்கியமான வாழ்க்கை முறையைக் கடைபிடியுங்கள்



உணர்ச்சிகளைச் சமாளிக்க உதவும் என்று நினைத்து புகைபிடிக்க வேண்டாம், மது மற்றும் வேறு போதைப் பொருள்களையும் பயன்படுத்த வேண்டாம்.

மனப் பிரச்சனைகளைச் சமாளிக்க முடியாவிட்டால், சுகாதார ஊழியருடனோ, மன நல ஆலோசகருடனோ பேசுங்கள். உடல் நல மற்றும் மன நலத் தேவைகளுக்கு எங்கே, எப்படி உதவி பெறுவது என்பது பற்றி முன் கூட்டியே திட்டமிடுங்கள்.

முறையான தெளிவான விவரங்களைப் பெறுங்கள். உங்களை நோய் தாக்கும் ஆபத்தைக் கண்டறிந்து, தேவையான முன்னெச்சரிக்கை எடுக்க உதவும் விவரங்களைத் தெரிந்து கொள்ளுங்கள். உலக சுகாதார அமைப்பின் வலைதளம் அல்லது அரசு சுகாதார அமைப்பு வெளியிடும் விவரம் போன்று நம்பத்தகுந்த ஆதாரங்களைப் பின்பற்றவும்.



உங்கள் மன அமைதியையும் உங்கள் குடும்பத்தினரின் மன அமைதியையும் கெடுக்கும் ஊடக நிகழ்ச்சிகளைப் பார்க்கும் நேரத்தைக் குறைப்பதன் மூலம், கவலையையும் பதட்டத்தையும் கட்டுப்படுத்தலாம்.

கடந்தகாலப் பிரச்சனைகளைச் சமாளிக்க உங்களுக்கு உதவிய திறன்களை நினைத்துக்கொள்ளுங்கள். அதைப் பயன் படுத்தி, சவால்கள் நிறைந்த இந்த கொரோனா பரவல் காலத்தில், உங்கள் உணர்ச்சிகளைச் சமாளிக்க வேண்டும்.

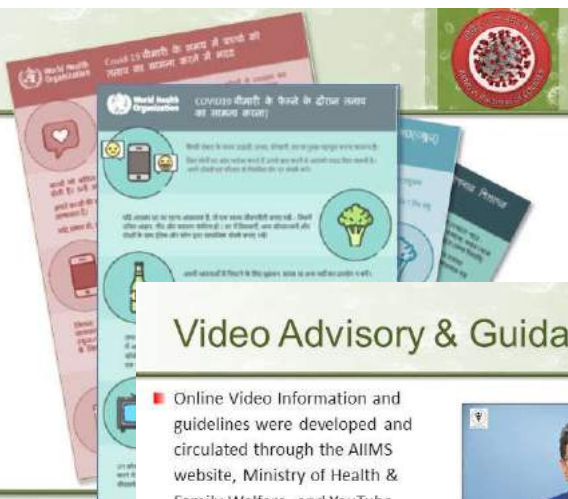




# Institute Day Poster Presentations

## Public Advisory

- Information leaflets on coping with stress during COVID-19 for Adults and Children
- Translated into 7 different Indian languages
- Uploaded on AIIMS Website
- Sent to national institutes for wider circulation



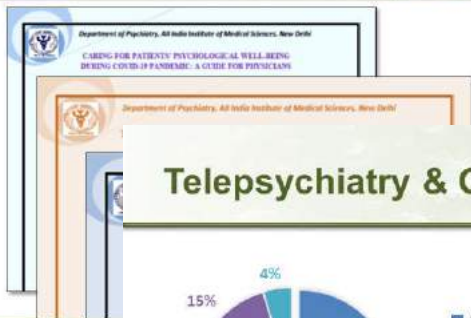
## Video Advisory & Guidance

- Online Video Information and guidelines were developed and circulated through the AIIMS website, Ministry of Health & Family Welfare, and YouTube Channel
- Topics covered
  - Stigma / Stress / Depression
  - Children, Elderly, Single youth



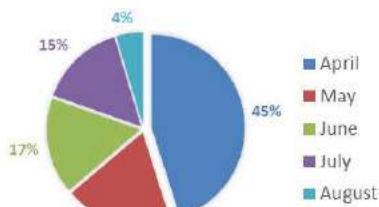
## Professional Advisory

- Evidence based guides for managing psychiatric issues
  - For General Physicians
  - For Psychiatrists
  - Quarantined persons
  - Health-care Personnel
  - Telemedicine



Department of Psychiatry, All India Institute of Medical Sciences, New Delhi

## Telepsychiatry & Clinical Services



### Psychiatric Disorders in COVID+ Patients

Psychiatric diagnosis (N=70)	n (%)
Suicidality	06 (8.6%)
Delirium	20 (28.6%)
Psychiatric Symptoms without Disorder	29 (41.3%)
Neurotic disorders (Depression, OCD, PTSD, Sleep disorders etc)	15 (21.4%)
Psychotic disorders	03 (4.3%)

## Infection Control & Digital Psychiatric Services



### For OPD Patients

- Brief face to face assessments
- Teleconsultation for long assessments
- Psychosocial intervention using teleconsultation

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## Research Findings on Mental Health Issues during COVID-19



### Mental Health Issues in Healthcare Professionals working during the COVID-19 Pandemic (N=348)

	Total	Doctors	Nurses
Depression	54.0%	54.5%	52.8%
Anxiety	44.3%	46.3%	39.6%
Somatic Symptoms	54.6%	50.4%	64.2%

Sood S, et al. 2020 (unpublished)

### Mental Health Issues in COVID+ Patients admitted to AIIMS during the COVID-19 Pandemic (N=641)

Condition	Incidence
Depression:	21.0%
Anxiety:	22.1%
Stressor	Lockdown

Satapathi S, et al. 2020 (unpublished)

65<sup>th</sup> Institute Day, 25<sup>th</sup> Sep 2020  
All India Institute of Medical Sciences, New Delhi

# SECTION

## IV

COVID 19 Publications from Psychiatry

Department & NDDTC

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## Organizing Mental Health and Psychosocial Support Services for COVID-19 at a Tertiary Care Center in India

### Abstract

Coronavirus disease 2019 (COVID-19) pandemic is associated with mental health consequences in patients diagnosed as having the disease, their contacts, healthcare workers, and also in the general community because of fear of getting the infection. Organizing mental health services in a big general hospital, especially in the background of diversion of many services including the workforce for pandemic-related services is a big challenge. The paper discusses the personal experience of the author in organizing mental health and psychosocial support services at a tertiary care teaching medical institution in India in the background of the COVID-19 pandemic. The services were targeted at the population visiting the hospital, healthcare workers, persons being quarantined, caregivers of patients with COVID-19 and the community in general. Some guidance notes were also developed for the physicians dealing with persons with COVID-19-related concerns and for psychiatrists in dealing with their patients. The strategy employed has a scope of being used at other similar institutions and also in similar situations arising in the future.

**Keywords:** *Coronavirus disease 2019, India, mental health, pandemic*

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### INTRODUCTION

Coronavirus disease 2019 (COVID-19) pandemic has engulfed most of the world since January 2020, having begun as a sporadic infection in the end-December 2019 in Wuhan, China. It appears no less than the Spanish Flu of 1918, which was also associated with worldwide mortalities. Due to high mortality, absence of an effective treatment and vaccine, limited knowledge about the virus, large number of symptomatic carriers, and very high contagious nature of the virus, COVID-19 has led to a kind of panic in communities all across the world. COVID-19 pandemic has come out with a major challenge to the healthcare services, health planners, public health experts, local governments, the World Health Organization (WHO) and other international bodies, due to its impact on health infrastructure and the economy. There have been increasing reports of persons with COVID-19 and related deaths, with the WHO reporting 3,679,499 confirmed cases

and 254,199 deaths till May 7, 2020.<sup>[1]</sup> India with a population of about 1.38 billion has reported 56,342 cases with 1886 deaths till May 8, 2020.<sup>[2]</sup> The low figures in India are a reflection of rapid control steps undertaken by the Government of India, such as social distancing, raising public awareness about respiratory hygiene, screening and quarantine of suspected contacts, followed by nationwide lockdown on March 24, 2020, which was extended in phases to May 31, 2020. COVID-19, by affecting all strata of population along with the lockdown, has got huge impact on the global economy, impacting the livelihood of large sections of the population. The illness is associated with a constant fear in the community of getting the illness along with economic hardships associated with the loss of livelihood.<sup>[3]</sup> The pandemic has also been associated with a massive reverse migration of people back from urban to rural areas because of closure of many industries in urban sector.

### CHALLENGE TO HEALTHCARE SERVICES

COVID-19 imposes a big challenge to the healthcare professionals with a very large number of asymptomatic carriers, high

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fatality, highly infectious nature of the virus, and absence of effective treatment and vaccine. The healthcare workers are also at a high risk of getting infected. The illness is associated with psychosocial stress reactions among the general public as well as the healthcare workers.<sup>[4,5]</sup> The illness has also been associated with communitywide fear in the background of the deadly nature of illness and socioeconomic impact of the countrywide lockdowns. The audiovisual and print media as well as the social media such as Facebook and WhatsApp have been completely dominated by (mis) information related to COVID-19. This is also associated with multiple social phenomena, such as stigma for the affected persons and their contacts, social effects of lockdown, including marital or family conflicts due to many family members confined together at home over many days, loss of livelihood, withdrawal syndromes in the persons using psychoactive substances, not being able to get timely help in case of serious medical problems, and effects on academic careers of the school- or college-going population.<sup>[3]</sup> Many healthcare settings also had to close down the general health services to divert resources for the COVID-affected population. The mental health professionals face a specific challenge in this scenario, especially to act on misconceptions and stigma among the public. The persons, who are detected COVID 19 positive, and their contacts have a number of mental health concerns including stress of being quarantined, which need to be tackled. Curtailment of general mental health services has adverse effects on persons with mental illness in the community. Similarly, concerns of healthcare professionals involved in the treatment of COVID-19 population due to their high risk of exposure need to be looked into.<sup>[6]</sup>

### MEETING THE CHALLENGE

This paper discusses the strategies used at a tertiary care teaching healthcare institute in India to deal with various mental health and psychosocial issues related to COVID-19. This could serve as a model for developing services and strategies at any healthcare institution in a pandemic situation across the world. Author works at a tertiary care multidisciplinary teaching hospital with bed strength of over 2500 beds. The institute hospital attends to around four million patients in its outpatient service and more than 250,000 inpatients annually.<sup>[7]</sup>

A number of contingency measures were taken up by the institute to control the spread of infection inside its hospital and campus, and also to develop the strategies at providing COVID-19-related services. Both the outpatient and inpatient settings in the hospital are at risk of spreading infection because of close contact. The outpatient service is often overcrowded, further increasing the risk of spread. In addition, the hospital was expected to develop the contingency measures for patients presenting with COVID-19 symptoms. As initial steps, the institute decided to close its outpatient service from March 24, 2020,

commensurate with the nationwide lockdown. In addition, attempts were made to discharge the admitted patients as they recovered. Three blocks in the hospital with a capacity of more than 500 (later increased to more than 1000) patients were reserved exclusively for COVID-19 services. Some percentage of clinical staff including from psychiatry was also diverted for the COVID-19-specific services.

### DEVELOPMENT OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES

Department of psychiatry at the institute was requested by the hospital administration to develop strategies at taking care of mental health issues related to COVID-19. The department also received a communication from the Ministry of Health and Family Welfare, Government of India, to develop public health education material on mental health issues related to the pandemic.

There were a number of issues to be dealt with including stress and worries communicated by the healthcare staff, stress levels in the general community secondary to the lockdown, patients with mental health problems in the community who were not able to access the services, and challenges faced by the mental health professionals and the physicians. COVID-19, because of its highly infectious nature, absence of an effective treatment or vaccine, high mortality, restriction on daily routines due to the lockdown, and other preventive measures such as social distancing, has a tremendous impact on mental well-being of the general population. Stress and fear are observed in healthcare workers posted for COVID-19-related services and in the persons who are advised isolation or quarantine due to coming in contact with a person detected COVID-19 positive. The person who tests COVID-19 positive suffers further emotional turmoil both as a result of getting a potentially fatal illness with no effective treatment and social stigma as a consequence of being kept under observation and isolation.<sup>[8]</sup> All these issues needed to be considered while developing educational material for COVID-19.

### DEVELOPMENT OF EDUCATIONAL MATERIAL FOR LAY PUBLIC

India is a multilingual and multicultural country with 22 official languages. The Government of India has developed educational material on COVID-19, focusing on the necessary precautions to be undertaken to protect oneself from getting the infection, concentrated mainly on respiratory and personal hygiene, consonant with various international guidelines. As already pointed out, COVID-19 has led to widespread anxiety, worries, and fears among the lay public of getting infected. This is also stigmatizing the persons who are detected COVID-19 positive even after they have recovered and also their family members. The lockdown, associated with restrictions on outdoor



activities, loss of livelihood, difficulty in accessing essential services, loss of recreational activities, and a general loss of freedom, has been associated with lot of stress.<sup>[3]</sup> For school- and college-going population, it is affecting their education, since all educational institutions are closed, some institutions have though started with online classes, which may, however, not be a satisfactory substitute. The WHO has recently come out with posters on “Coping with stress during the 2019-nCoV outbreak”<sup>[9]</sup> and “Helping children cope with stress during 2019-nCoV outbreak.”<sup>[10]</sup> We translated these posters into various Indian languages (Hindi, Punjabi, Gujarati, Marathi, Bengali, Kannada, Telugu, Tamil, Malayalam, Odia, and Manipuri), after taking due permission from the WHO. The translated versions were circulated among various social groups and also uploaded on our institute’s website. We also prepared many educational video clips targeting general public, children and adolescents, pregnant women, single men, single women and the elderly population, which were put on our institute’s website. Some of our colleagues also participated in health education programs on national television channels. We also provided services on mental health issues on the national helpline created by our institute.

### **PERSONS WITH MENTAL HEALTH PROBLEMS IN THE COMMUNITY**

Because of the lockdown, a large number of patients with mental health problems are unable to access mental health services. Those who are already on treatment are also facing difficulty in attending follow-up with the treatment facilities and are at risk of getting relapse, if they are not able to fill up their prescription.<sup>[11]</sup> We started tele-consultation service for our follow-up patients. The service was offered to the patients who had earlier taken appointments for follow-up with us. We dedicated three phones for tele-consultation. All the patients who had taken appointment for follow-up at our hospital were called by a psychiatrist to confirm about their current mental health status and need for a fresh prescription. In patients needing any modification, the patient was asked to send the old prescription electronically, and a fresh prescription was issued and sent electronically. During the month of April 2020, 1955 patients had taken follow-up appointments, but contact number was available for 1658 cases. We were able to provide service to 910 patients. Others could not be contacted for various reasons, such as call not picked up or the number not accessible. Thus, we were able to contact 46.5% of the patients who had taken a prior appointment and were able to deliver service. This experience serves as an example to introduce tele-consultation services in routine follow-up care in India and similar such settings in other places, wherever follow-up visits to the hospital can be avoided, especially in situations like a pandemic, or when

travel may not be feasible due to weather conditions. This can save time of travel as well as reduce overcrowding in hospitals, a very common problem in India and many other places. There is one limitation that tele-consultation may not be an advisable option in new patients.

### **TAKING CARE OF HEALTHCARE WORKERS**

The healthcare workers including doctors, nursing professionals and supportive staff, both those who are posted on COVID-19-related services as well as in other healthcare areas, face lot of stress and worries due to increased risk exposure.<sup>[12]</sup> This was further accentuated with the reports of many healthcare workers developing the infection as well as succumbing to it coming from different parts of the world. In India, there were also a few reports of the healthcare workers including the doctors being stigmatized, and facing stray events of violence in the community out of fear that they may spread the infection in the community due to being exposed to the virus during their clinical duties. This shows the kind of phobia the COVID-19 has spread in the community. Immediate curative steps had to be taken by the law enforcing agencies to prevent recurrence of such incidents.

We developed guidance notes for healthcare workers at our hospital giving general instructions about how to identify stress in them and to cope with it. In addition, the hospital administration also conducted periodic workshops on personal protection as well other precautions to be taken in care of patients and suspects of COVID-19, and for those being kept on quarantine. The healthcare workers also needed to be counseled about the precautions to be followed during clinical duties and while they were at home. Worries about spreading infection to the immediate family members further added to the stress. Our guidelines covered these areas. Focus was on basics of stress management and lifestyle modification. We also prepared short video clips on the subject which were put on social media and the institute’s website. A tele-helpline was also created for the in-house employees.

### **MENTAL HEALTH ISSUES IN THE PERSONS QUARANTINED OR PUT IN ISOLATION**

Individuals, who are put on isolation, go through lot of stress and anxiety for various reasons.<sup>[13]</sup> This includes persons who are COVID-19 positive and also their contacts, who have been put under quarantine. Considering that a small percentage of individuals may develop serious complications with risk of death, a positive report of COVID-19 is associated with lot of anxiety, worries, and despair. Similarly, the contacts also suffer similar type of predicament while waiting for the report. The phase of complete isolation with no face-to-face contact is very anxiety provoking, the only contact being with a person serving food for the day, who also comes with full protection kit. There have also been reports of suicides in few persons waiting for the report of the test. In this



background, we developed guidance notes both in English and Hindi using resource materials from the relevant literature, adapting it to local needs.

### **GUIDANCE FOR PHYSICIANS DEALING WITH PATIENTS/SUSPECTS WITH CORONAVIRUS DISEASE-19**

During COVID-19 pandemic, physicians are likely to encounter patients who are experiencing various levels of emotional distress about the risk of infection and its impact on them, their families, and the community. The physicians need to acknowledge this uncertainty and help patients understand the emotional component to their potential health concerns. The physicians can also take a lead in educating their clientele about the standard precautions such as respiratory hygiene, hand hygiene, and social distancing, and need to report to the relevant health services in case of development of the first warning signs of COVID19 in their patients.

The physicians also need to keep themselves updated with the latest information about the pandemic so as to be able to allay the fears and anxieties of their patients, as well as counsel them. It is also essential for physicians to follow full protection for themselves in clinical encounters, as being recommended by the local authorities.

### **GUIDANCE NOTES FOR MENTAL HEALTH PROFESSIONALS**

Patients with mental health problems are at additional risk of developing exacerbation in their illness due to the stress related to the COVID-19 pandemic along with the consequences of the lockdown, such as inability to access the services, difficulty in filling up of their prescriptions, and general restrictions on outdoor activities.<sup>[8]</sup> The new-onset cases are unable to access services. Patients with mental health problems would also have difficulty in following the social distancing and respiratory hygiene etiquettes such as use of mask. When admitted to a hospital, patients with mental health problems are likely to put themselves and their caregivers at extra risk of contracting infection because of their difficulty in following the usual safety precautions. If a person with psychotic disorder develops COVID-19 infection, maintaining isolation with the necessary precautions is a big challenge. Keeping all these issues, the guidelines were prepared for the mental health professionals. These included psychoeducating the patients with mental health problems, advising not to watch news on COVID-19 frequently, collecting information only from reliable sources such as websites of the Ministry of Health or the WHO, and to be regular in their medication. A strong emphasis was made on keeping a healthy lifestyle, stress management, and staying away from alcohol and drugs. It is believed that all these instructions would help in preventing relapse of an ongoing mental health problem.

### **CONCLUSION**

COVID-19 pandemic is a major challenge to the healthcare professionals, considering its highly infectious nature and

lack of an effective treatment and vaccine. There is a need to develop mental health and psychosocial support strategies aimed at general population as well as the healthcare workers. The strategies need to target multiple groups including the patients, their contacts, general population, healthcare workers, doctors and the mental health professionals. Author has shared his experiences at developing such services at a large tertiary care teaching hospital, which might be useful in developing similar services at other places in the face of similar crisis situations.

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### **Conflicts of interest**

There are no conflicts of interest.

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## Patients with Preexisting Mental Illness and Other Vulnerable Groups in the COVID-19 Pandemic

In the last few months, the whole world has been taken aback by the coronavirus disease 2019 (COVID-19) pandemic, which has probably played more havoc than even the two world wars by affecting most of the countries across almost all continents of the world. Because of its rapid spread across the world, the huge population it has affected, its highly infectious nature, and widespread transmission of the illness despite not a very high fatality rate, COVID-19 has brought a panic-like reaction in the whole world community.<sup>[1]</sup> The pandemic has been associated with psychosocial reactions and symptoms of stress, anxiety and depression in those detected positive as well as in their contacts and also the health-care workers. Due to the countrywide lockdowns in many countries as well as the diversion of health services from non-COVID to exclusive COVID care facilities, the pandemic has adversely affected the non-COVID health care. This has impacted the already-vulnerable population with preexisting mental illness or severe physical illnesses, whose continuation of care has been affected.<sup>[2]</sup>

The review by Khandelwal in this issue of the journal,<sup>[1]</sup> very succinctly discusses the psychosocial impact of the pandemic tracing its progress across the world, the initiatives taken up by the Government of India including the countrywide lockdown continuing for >10 weeks, diversion of the general health services to COVID-specific health services, creation of investigation facilities across the country, massive unemployment resulting from the closure of industries and businesses because of the lockdown, and the effects of the reverse

migration.<sup>[1]</sup> The lockdown with most of the population confined to closed doors in their respective houses because of the fear of getting the deadly infection; economic breakdown; and closure of all educational institutions and the entertainment industry as well as various avenues of the outdoor activities including parks, business malls, and markets, along with continuous streaming of news about the increasing number of cases and fatalities related to COVID-19, have all added to the stress reactions in the general population.

Stated as the fastest-moving global public health crisis in a century,<sup>[1]</sup> COVID-19 has brought the health systems across the world including those of the most advanced economies to a halt by its rapid and massive spread. India, fortunately, by clamping a countrywide lockdown, was able to slow down the progress of the infection, though the growth graph of the infection as well as the fatalities has been rising even after 10 weeks of the lockdown, which is now being lifted in a gradual manner.<sup>[3]</sup>

In the face of the pandemic leading to its devastating effects on the economic infrastructure, unemployment, community fear and panic, and psychosocial effects of lockdown and quarantine, persons with preexisting mental health problems and the other vulnerable population need specific attention from the state and the society as also stated in the article.<sup>[1]</sup>

Declaration of the national-level lockdown in India was meant for controlling the spread of infection, but its sudden declaration came out with many adverse consequences. Closure of industrial sector and business establishments led to a large population, working in such

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places, out of job and economic crisis. This group constituted a large section of population in big cities such as New Delhi, Mumbai, and others. Many of them in the absence of the availability of local transport left their houses and started moving toward their native places, leaving their abodes in the cities where they had lived for decades. Unfortunately, the state and the community were not able to make adequate arrangements or coordinate the needed support for this population in the cities.

The period of lockdown though helped the state health sector to organize its services for the COVID-19 pandemic, affected adversely the persons suffering from other illnesses including those with severe mental illnesses on treatment and those with serious physical illnesses such as cancer, cardiac, or illnesses of related nature. Persons with mental illnesses on treatment and those with substance use disorders on substitution treatment and with other illnesses including the life-threatening ones were not able to access the services, leading to multiple adverse consequences. The situation has not even been a healthy one in the advanced economies and countries such as the USA or most from Europe.

The National Disaster Management Authority of India, which had been dealing mostly with the natural disasters in India in the recent past, did not expect a biological disaster of this nature which has occurred. Similarly, India needs to increase its health budget, which stands at just about 1% of the gross domestic product, one of the lowest in the world. We need to go for universal coverage for health; an attempt for which has been made in the form of introduction of the Ayushman Bharat Schemes by the Government of India. Another important aspect that needs to be considered is the risk of law and order breaking down in the background of the economic hardships occurring as a result of the COVID-19 pandemic.

There was a response from the Union Government of India in the form of declaration of a financial package of Indian rupees 20 lakh crores (equivalent to 265 billion US dollars) along with support services organized by the state governments, the voluntary sector, and the community in general.<sup>[4]</sup> Many state governments, community organizations, as well as persons in individual capacity organized relief services, but the population affected was so large that a large section of the affected population was not able to get the needed relief. It is important to state here that the relief work needed is of mammoth nature, with bringing back of employment to so many people who lost jobs during the pandemic by resuming the business and industrial sector. Though the government has declared a reasonable financial package, it has to be used in a manner that it benefits those who need it the most.

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## Debating the Process, Impact, and Handling of Social and Health Determinants of the COVID-19 Pandemic

### The Impact

Between January 14 and January 20, 2020, when top Chinese officials secretly determined they were likely facing a pandemic from a new coronavirus, the city of Wuhan at the epicenter of the disease was busy hosting a mass banquet for tens of thousands of people; millions began traveling through for lunar New Year Celebrations. President Xi Jinping warned the public about a new virus on the 7<sup>th</sup> day, i.e., January 20. However, by that time, more than 3000 people had been infected and traveled to different parts of the world, according to internal documents obtained by The Associated Press and retrospective infection data.<sup>[1]</sup>

On March 18, a 35-year-old man, suspected of coronavirus infection, committed suicide at Safdarjung Hospital in Delhi. The 35-year-old deceased jumped off the seventh floor of Safdarjung Hospital, according to a PCR call received by the Delhi Police. He was admitted to Safdarjung Hospital at 9 pm on Wednesday only as a suspected coronavirus patient.<sup>[2]</sup>

On March 25, a 56-year-old man in Karnataka's Udupi district committed suicide by hanging. According to police, deceased left a suicide note saying that he had contracted the COVID-19 disease and asked his family to be safe. The police said, "According to the preliminary investigation, he had committed suicide after reading extensively about coronavirus on social media which led to excessive fear about the pandemic."<sup>[3]</sup>

A Chennai doctor, Simon Hercules, died of COVID-19 on April 19. He was denied even basic dignity at the time of his death as a mob attacked his friends and family with

sticks and rods when they were transporting his body to a burial ground.

This incident has, yet again, cast a worrying spotlight on the health and safety of our frontline soldiers in the collective fight against COVID-19.<sup>[4]</sup>

A 42-year-old man was arrested late Wednesday evening for allegedly assaulting two women resident doctors of Safdarjung Hospital after accusing them of "spreading" COVID-19 in Gautam Nagar area, South Delhi, said police.<sup>[5]</sup>

Manish Kumar who was employed in a factory says, "I am looking for any form of transport which takes me anywhere close to my destination. I am going to die soon anyway of hunger. There is no one here to even beg for food. Everyone's pockets are empty." Visual of hundreds of workers wearing gamchas, carrying heavy backpacks and wailing children, walking on national highways, boarding tractors, and jostling for space atop buses became defining images for days to come in India.<sup>[6]</sup>

A 12-year-old child recently shared that she felt very scared at home. "My parents are very stressed and they end up taking it out on me. They think it is not affecting me, but I am terrified most of the time. Stress is like polluted air, and we are all breathing it in."<sup>[7]</sup>

Sixteen migrant workers were mowed down by an empty freight train in Maharashtra's Aurangabad district in the early hours of May 8. While 14 of them died on the spot, two of them later succumbed to injuries. The workers, who were walking to Bhusawal from Jalna to board a "Shramik Special" train to return to Madhya Pradesh, were sleeping on the railway line extremely

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*tired after marathon walking for 40 km. Expressing grief over the incident, Prime Minister Narendra Modi tweeted, “Extremely anguished by the loss of lives due to the rail accident in Aurangabad, Maharashtra. Have spoken to Railway Minister Piyush Goyal and he is closely monitoring the situation. All possible assistance required is being provided.”<sup>[8]</sup>*

*As of July 18, 2020, there are 13,824,739 confirmed cases of COVID-19 (coronavirus infection disease, 2019) and 591,666 confirmed deaths worldwide as per the World Health Organization (WHO)’s dashboard.<sup>[9]</sup> India has confirmed 1,038,715 cases and 26,273 deaths so far.<sup>[10]</sup> India has been under lockdown since March 25, 2020, for 6 weeks (extended again with revised guidelines), and jury is still out whether to continue with lockdown or resume normal or truncated life activities.*

*The COVID-19 pandemic has been the fastest-moving global public health crisis in a century, causing significant mortality and morbidity and giving rise to daunting health and socioeconomic challenges. Governments are taking unprecedented measures to limit the spread of the virus, while health and social systems are struggling to cope with rising caseloads, supply-chain bottlenecks, movement restrictions, and economic strains. In humanitarian and fragile settings and low-income countries, where these systems are already weak, the pandemic is disrupting access to life-saving reproductive health services. It is also compounding existing gender and social inequalities.<sup>[11]</sup>*

## **Prelude**

On December 31, 2019, the WHO China Country Office was informed of cases of pneumonia of unknown etiology detected in Wuhan City, Hubei Province of China. China had kept it as a secret from the world. From December 31, 2019, through January 3, 2020, a total of 44 case-patients with pneumonia of unknown etiology were reported to the WHO by the national authorities in China. During this period, the causal agent was not identified. On January 11 and 12, 2020, the WHO received further detailed information from the National Health Commission of China that the outbreak was associated with exposures in one seafood market in Wuhan City. The Chinese authorities identified a new type of coronavirus, which was isolated on January 7, 2020. On January 12, 2020, China shared the genetic sequence of the novel coronavirus for countries to use in developing specific diagnostic kits.

When such cases were reported in other countries, the WHO declared this outbreak as a “Public Health Emergency of International Concern” on January 30, 2020, and raised the level of global risk to “very high” on February 28, 2020. Although the WHO had not declared COVID-19 to be pandemic by that time, it asked the countries to remain prepared. The WHO finally declared COVID-18 as “pandemic” on March 13 since its spread

crossed geographical boundaries affecting a large number of people.<sup>[12]</sup>

“We are fully prepared,” that is what the Hon’ble Health Minister of India is quoted to have said on March 2 or 3, 2020, on being asked by a news channel how well prepared India was, to tackle the possible spread of coronavirus.<sup>[13]</sup> By that time, that goes to India’s credit, India had already started country-wide screening, entry screening of all overseas passengers reporting at the national airports and seaports, and contact tracing.<sup>[14]</sup> It is worth highlighting that India initiated required preparedness and action at field level since January 17 itself, much before the advice from the WHO. Notwithstanding Health Minister’s assurance about India’s preparedness, there were doubts if we had really understood what it takes to get into a “fully prepared” state. Were thermal screening and travel advisory enough measures to contain an epidemic that soon would be a designated pandemic?

Coronavirus disease that made its surreptitious beginning in 2019 in human beings (that’s why nicknamed COVID-19) has taken the entire world by storm and within a few months driven the world gasping for breath. No one could fathom that even the affluent and developed countries would be caught unprepared and ill-equipped, leave-alone low and middle income countries (LAMIC) or poor countries. It is causing unprecedented morbidity and mortality cutting across all geographical boundaries, irrespective of gender, age, and socioeconomic status. Moreover, its spread and devastation have affected lives in a way no one has been able to imagine its magnitude and severity. The lockdown, which seems at this time the only strategy to contain the spread, has made a serious dent on people’s lives by affecting their physical and mental health, employment, earnings and income, livelihood, training and education, social inclusion, etc., In India, it has brought out never seen before problems such as reverse migration and assault on health workers.

There is now an urgent need to study and discuss the psychosocial aspect of this pandemic. Social determinants shape and govern our responses to not only health but also overall development of societies and nations. The social determinants are the conditions in which people are born, grow, live, work, and age.<sup>[15]</sup> These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen between various ethnic and socioeconomic groups. Access to health is not uniform in India; there has been a significant difference between rural versus urban, between low-socioeconomic versus high-economic groups, and between different cast systems and ethnic groups.

## How India Processed and Handled the COVID-19 Threat?

### Thermal screening at the airport

On January 17 itself, India began thermal screening for all the incoming travelers, though thermal screening is only a screening tool but not a diagnostic method to rule out the presence of flu-like illness. All incoming international passengers were required to have nontouch thermal screening for detecting high temperature, since it may be an early and easy symptom to detect. If any person was found to have high temperature, he/she was put in quarantine and had to undergo further testing. However, thermal screening is not a simple, fool-proof, or inexpensive method. First, it requires extensive training of the airport staff engaged in screening process.<sup>[16]</sup> They have to be, importantly, provided with proper personal protective equipment (PPE) since the airport staff comes in contact with a large number of incoming patients within a short time. They should know how to maintain a minimum distance of at least 1 m and yet keep the thermometer at a proper distance from the passenger to take the correct measurement of body temperature. The nontouch thermometers, infrared thermometers, should be of reliable quality so that it accurately measures what it purports to measure. There have been reports that the quality of available thermometers in the market has been quite variable.<sup>[17]</sup> There has been no clarity in technical specification of these thermometers; a defective equipment would defeat the purpose of entire exercise. Multiple scanners reviewed by this report on the same human body within a span of 30 min found temperature in a range of 87.0°F–97.5°F. Temperature screening alone, at exit or entry, may not be an effective way to stop international spread, since infected individuals may be in the incubation period, may not express apparent symptoms early on in the course of the disease, or may dissimulate fever through the use of antipyretics.<sup>[18]</sup> It has been reported in mass testing that up to 75% of positive cases may remain asymptomatic, but yet be infective to others. It may be more prudent to provide prevention recommendation messages to travelers and to collect health declarations at arrival, with travelers' contact details, to allow for a proper risk assessment and a possible contact tracing of incoming travelers.

### Countrywide lockdown

India had started responding to the COVID-19 threat in January 2020 itself by thermal screening, putting restriction to flights coming from countries with a large number of cases, suspected cases being put under quarantine, and issuing general advisory about social distancing, frequent hand wash, use of sanitizers, personal hygiene, etiquettes of coughing and sneezing, etc.

However, in view of the news coming from all over the world about its fast spread across geographical boundaries, and the virus of being highly infective nature, but

fortunately of low lethality, Hon'ble Prime Minister of India declared nationwide strictest lockdown in the history of India under the Disaster Management Act, 2005<sup>[19]</sup> for effective management of COVID-19 starting 25th March. COVID-19 had already been declared 'pandemic' by the WHO on 13th March. COVID-19 is the first pan-India biological disaster being handled by the legal and constitutional institutions of the country. A disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community's or society's ability to cope using its own resources.

The Central Government enjoys immense powers under this Act and can issue any directions to any authority anywhere in India to facilitate or assist in the disaster management.<sup>[20]</sup> Importantly, any such directions issued by the Central Government and National Disaster Management Authority (NDMA) must necessarily be followed the Union Ministries and State Governments.

The present national lockdown was imposed under this Act as per the Order dated March 24, 2020, of NDMA "to take measures for ensuring social distancing so as to prevent the spread of COVID-19." The Ministry of Home Affairs (MHA), being the Ministry having administrative control of disaster management, issued additional guidelines on the same day. This was to remain in force for 21 days. By this order, all activities including travel by any means, all commercial and private business establishments, industrial and manufacturing hubs, educational institutions, religious gatherings and congregations, all social and entertainment activities, and entire hospitality sector were to remain closed. There were notable exceptions for health services, essential services, defense and police personnel, ration shops, essential supplies such as milk, fruits, and vegetables. By its revised Order dated April 15, 2020, the MHA further extended the lockdown by another 3 weeks till May 3 with further relaxations made to ease the ground situation. Please refer to the MHA's Order for details (No. 40-3/2020-DM-I (A) dated April 15, 2020). This was further extended till May 17 vide MHA's Order number 40-3/2020-DM-I (A) dated May 1, 2020, with some relaxations on the movement of people, transport services, movement of goods, and opening of limited commercial activities. The lockdown had one further extension till May 31 with considerable relaxations, and more powers are being given to the states to take necessary actions regarding the extent of lockdown and opening of travel and commercial activities.

The COVID lockdown effectively halted people's movements and closed all avenues of income generation, but health services had no clear guidelines about what services to remain open and how to gear a hospital toward COVID preparation. How loss of income will impact the

laborers and daily-wagers would remain unfathomable as discussed below. As an economist has warned, “continued lockdown will mean a loss of 2 lakh crore every week, while the expenditure on ‘testing, tracing, isolating’ 1%–3% of population will cost 75 thousand crore a year.”<sup>[21]</sup>

### Testing for virus

One effective strategy to beat the spread of COVID virus is presumed to be quarantining of people with suspected or confirmed virus infection. It required screening by testing for the presence of virus in a body fluid (throat swab for COVID-19) in general population. India started testing, under the guidance of Indian Council of Medical Research (ICMR) with the objectives of containing the spread of COVID-19, and to provide reliable diagnosis to all individuals meeting the inclusion criteria for COVID infection. Initially, the strategy had been to test all the symptomatic cases of international travel, all symptomatic cases of confirmed laboratory cases, all symptomatic health workers, all hospitalized cases with severe acute respiratory symptoms, and asymptomatic high-risk contacts of confirmed cases. The ICMR had validated the Truenat Bet Cov test on Truelab Workstation as a screening test. All positive cases were needed to be reconfirmed by a separate confirmatory assay for SARS-CoV-2. Initially, only laboratories in the government setup were authorized to carry out the testing, and the capacity to test in the community had remained limited.<sup>[22]</sup> The daily count of positive cases in first few weeks had been low since we were able to test only limited number of cases due to constraints of trained workforce, kits, and number of laboratories. That was the main criticism by the experts, when the WHO had been saying, “test, test, and test.” It took a while before government agreed for private laboratories to begin testing with the ICMR providing guidance. As of the time of submission of this write-up, there were 885 government laboratories and 368 private laboratories engaged in various tests, viz., Real-Time RT PCR for COVID-19: 643 (government: 395 + private: 248), TrueNat Test for COVID-19: 507 (government: 453 + private: 54), and CBNAAT Test for COVID-19: 103 (government: 37 + private: 66).

As of July 18, 2020, India has tested 13,433,472 samples with daily testing of nearly 200,000 samples; there are 358,692 active cases, 653,750 recovered, and 26,273 deaths. On March 10, India had reported just 50 cases till then.

“Are we testing enough?” that has been a constant refrain from various experts in the media. There seemed to be two diametrically opposed positions on COVID-19 testing in India. On the one hand, the Indian government claimed that there were no problems with the testing process or the number. The evidence, according to the government, is the low positivity rate (ratio of positives to total persons tested) for India, which was 4.76. On the

other hand, critics of the government strategy pointed to the low testing rate (ratio of total persons tested to the total population) as the evidence of serious problems in India’s COVID-19 testing process.<sup>[23]</sup> According to Deepankar Basu, Associate Professor, Department of Economics, University of Massachusetts Amherst, writing for *The Week*, vide supra, “Low testing rate does not fully account for the low prevalence of COVID-19 in India, contrary to what critics might claim. But, India needs to keep ramping up testing. A rough number to use as a benchmark is a TPR of 2%, i.e., India needs to keep ramping up testing till its TPR falls to, and then stabilizes at, 2%. For this, India needs to carry out more than 16 million tests.” However, India has to strike a balance considering the finances, capacity, and geographical spread of the virus. In the beginning, when the government was scaling up the testing and had roped in private laboratories, it fixed up their charges as Rs. 4500/- per test. That is an expensive proposition for a country like India. In response to a PIL, the Supreme Court ordered the government to carry out the test free for all but did not clarify who would reimburse the private laboratories. Without a free test, it was a big question how India would scale up its testing strategy. On Government of India’s plea to the Court, the Supreme Court in its revised Order dated April 13 stated the government would reimburse the private laboratories up to 500 million tests through its flagship public health insurance scheme.<sup>[24]</sup> This again focuses on the poor funding of public health at just 1.3% of India’s GDP. The insurance cover is limited and largely unregulated. It is high time now that the public health receives major investments, and there is a proper policy framework for covering even the poor people under insurance schemes.

### Social distancing

A major strategy adopted the world over, and advised by the WHO too, to contain the spread of the virus has been social distancing or physical distancing, i.e., to maintain a distance of at least 1 m from other persons while in the public.<sup>[25]</sup> It also means not gathering in public and staying out of crowded and mass gatherings. COVID-19 spreads mainly among people who are in close contact for a prolonged period. Spread happens when an infected person coughs, sneezes, or talks and droplets from their mouth or nose is launched into the air and land in the mouths or noses of people nearby. The droplets can also be inhaled into the lungs. Recent studies indicate that people who are infected but do not have symptoms also play a role in the spread of COVID-19.<sup>[26]</sup>

#### *Advisory by the Ministry of Health and Family Welfare on social distancing<sup>[27]</sup>*

1. Closure of all educational establishments (schools, universities, etc.), gyms, museums, cultural and social centers, swimming pools, and theaters. Online education to be promoted
2. Possibility of postponing examinations may be explored



3. Encourage private sector organizations/employers to allow employees to work from home wherever feasible
4. Meetings, as far as feasible, shall be done through video conferences. Minimize or reschedule meetings involving large number of people unless necessary
5. Restaurants to ensure hand-washing protocol and proper cleanliness of frequently touched surfaces. Ensure physical distancing (minimum 1 m) between tables; encourage open air seating where practical with adequate distancing
6. Keep already planned weddings to a limited gathering, and postpone all nonessential social and cultural gatherings
7. Local authorities to have a dialog with organizers of sporting events and competitions involving large gatherings, and they may be advised to postpone such events
8. Local authorities to have a dialog with opinion leaders and religious leaders to regulate mass gatherings should ensure no overcrowding and at least 1 m distance between people
9. Local authorities to have meeting with traders associations and other stakeholders to regulate hours should exhibit Do's and Don'ts and take up a communication drive in market places such as sabzi mandi, anaj mandi, bus depots, railway stations, and post offices, where essential services are provided
10. All commercial activities must keep a distance of 1 m between customers
11. Nonessential travel should be avoided, i.e., buses, trains, and airplanes, to maximize social distancing in public transport besides ensuring regular and proper disinfection of surfaces
12. Hospitals to follow necessary protocols related with COVID-19 management as prescribed and restrict family/friends/children visiting patients in hospitals
13. Hygiene and physical distancing have to be maintained. Shaking hands and hugging as a matter of greeting are to be avoided
14. Special protective measures for delivery men/women working in online ordering services have to be considered.
15. Keep communities informed consistently and constantly.

India strictly followed the norms of social distancing to break the spread of virus and prevent community transmission. India succeeded in enforcing it to a large extent; however, there were clear violations not only by some individuals (marriage in a prominent politician's house, or birthday bash by another politician) but also by a religious group that led to spread in many parts of India where virus had not yet made its appearance till that time.

Dr. Shekhar Saxena, Former Director, Mental Health Division, WHO, prefers the term "physical distancing" rather than social distancing (emphasis added), "*We are all talking about social distancing. Actually, what we need is physical distancing, not social distancing – because*

*that conveys the wrong message. In fact, in this time of stress, we need more social togetherness; we need more social support than social isolation. You talk to people on the phone, on any other media, you support people in each other's difficulties and that is what the community needs to fight it together. Saying 'social distancing,' which means you are alone, increases your stress. International organizations and national authorities are all exercising 'social distancing' when actually, what they should be saying is physical distancing but social togetherness.*<sup>[28]</sup>"

It may be a question of semantics, and if the social distancing was considered inevitable, it still has potential of impacting mental health of people. Prolonged and forced isolation is likely to take its toll on one's ability to cope with tension and anxiety, and we are already noticing a spurt in cases presenting with anxiety-, depression-, and stress-induced mental health problems.<sup>[29]</sup> The impact is likely to be felt more by elderly, children, and people with disabilities. Another fallout of social distancing has been stigma; there are reports of local people shunning those who arrived home from other cities and shopkeepers refusing to engage with them.<sup>[30]</sup>

#### **Aarogya Setu app**

In its fight against the COVID-19, Government of India launched its Aarogya Setu app on April 2 this year.<sup>[31]</sup> Aarogya Setu, a GPS and Bluetooth enabled app, is a mobile app to track COVID-19 and is developed by the National Informatics Centre, Ministry of Electronics and Information Technology. With the launch of this app, the governments seeks to limit the spread of the COVID-19 cases in India via technology and artificial intelligence, as well as helps create self-awareness among the citizens with relevant information on the infection. Aarogya Setu has four sections.

1. Your status (tells the risk of getting COVID-19 for the user)
2. Self-assess (lets the user know the risk of being infected)
3. COVID-19 update (gives updates on local and national COVID-19 cases)
4. E-pass (if applied for E-pass, it will be available).

It tells the user how many COVID-19-positive cases are likely in a radius of 500 m, 1 km, 2 km, 5 km, and 10 km.

Very soon, this app became the fastest downloaded app in the world and by May 11 had 98 million users; 1.4 lakh people got alerted via Bluetooth tracing of their possibility of coming in the vicinity of an infected person. On April 29, the MHA vide its Order No. 40-3/2020-DM-I (A)<sup>[32]</sup> made it mandatory for all government and private sector employees to download this app on their phone. Gradually, it became obligatory for all people visiting hospitals, traveling by air, trains, and buses, and people living in containment zones.



As soon as the app was launched, there have been misgivings about its “true” purpose; it being a sophisticated surveillance app, its security issues, and fear of violation of privacy rights.<sup>[33]</sup> On May 12, Former Supreme Court Judge Justice B. N. Srikrishna termed the government’s push mandating the use of Aarogya Setu app “utterly illegal.” He said so far it is not backed by any law and questioned under what law, government was mandating it on anyone.<sup>[34]</sup> Although many countries have developed some kind of tracking apps and have encouraged their citizens to use this app to remain aware of their surroundings, India remains the only democracy that has made it mandatory.<sup>[35]</sup>

Notwithstanding above concerns, there are other reasons why the stated purpose of the app may be defeated. Epidemiologists reckon that for a contact tracing app to be successful, 60% of population should be using it.<sup>[36]</sup> There is a huge digital divide in India between urban versus rural areas and men versus women. In spite of a very high teledensity in India, smartphone use and availability of internet are a dismal (24%). Even in urban areas, it remains only 51%. By making the Aarogya Setu app mandatory for any kind of movement, it will make difficult for people, especially women, to access public services including health. While the app is being promoted as a tool to contain the spread of virus, our rates of COVID testing continue to remain low.

### Ministry of Finance

The Hon’ble Minister of Finance Nirmala Sitharaman announced the first package of Rs. 1.78 lakh crore to help mitigate the suffering of a large segment of India’s population. On May 12, the Hon’ble PM of India announced a total package of Rs. 20 lakh crore as a stimulus to the economy and to help the marginalized sections of the society, such as farmers, daily-wagers, construction workers, and street vendors. Since May 13, the Finance Minister announced five financial packages on each consecutive day. It was hailed as a massive package to the size of nearly 10% of India’s GDP and comparable to packages announced by leading economies of the world such as the USA and Japan.

“Seen against the scale of economic distress, and expectations raised by the Prime Minister’s announcement of a Rs. 20 lakh crore package, the measures announced by the Finance Minister over the past few days have been underwhelming,” says the Editorial in Indian Express dated May 18.<sup>[37]</sup> It further states, “A crisis of this magnitude needs to be tackled at multiple levels – relief for the most vulnerable, support to specific sectors, short-to-medium term measures to boost demand, and structural reforms. But, so far, the government’s response has centered around only providing some relief measures, extending liquidity to select sectors, and stating its intent to push through contentious pieces of reform.”

It is a foregone conclusion that the health crisis posed by the COVID-19 is likely to continue for a longer time than it was assumed earlier. During this time, people’s income and spending power must improve through a timely and aggressive economic and fiscal stimulus. It is essential to break the cycle of loss of income, poverty, starvation, and poor health and death for a large section of our population, that is, young.

### Telemedicine

Through a Gazette Notification from the Government of India, CG-DL-E (14052020)-219374; Notification no. MCI 211 (2)/2019(Ethics)/100659 detailed guidelines have been issued for the Registered Medical Practitioners to use telemedicine to assess and advise the needy patients.<sup>[38]</sup> It states, “Disasters and pandemics pose unique challenges to providing healthcare. Though telemedicine will not solve them all, it is well suited for scenarios in which medical practitioners can evaluate and manage patients. A telemedicine visit can be conducted without exposing staff to viruses/infections in the times of such outbreaks. Telemedicine practice can prevent the transmission of infectious diseases reducing the risks to both healthcare workers and patients. Unnecessary and avoidable exposure of the people involved in delivery of healthcare can be prevented using telemedicine as patients can be screened remotely. It can provide rapid access to medical practitioners who may not be immediately available in person. In addition, it makes available extra working hands to provide physical care at the respective health institutions. Thus, health systems that are invested in telemedicine are well positioned to ensure that patients with COVID-19 kind of issues receive the care they need. The government is committed to providing equal access to quality care to all and digital health is a critical enabler for the overall transformation of the health system. Hence, mainstreaming telemedicine in health systems will minimize inequity and barriers to access. India’s digital health policy advocates use of digital tools for improving the efficiency and outcome of the healthcare system and lays significant focus on the use of telemedicine services, especially in the Health and Wellness Centers at the grassroots level wherein a mid-level provider/health worker can connect the patients to the doctors through technology platforms in providing timely and best possible care.”

As per the data available as of December 2019, India’s mobile penetration stands at approximately 87%.<sup>[39]</sup> The rates in India for mobile phone use are among the lowest in the world. Hence, it is hoped that, given choice, people will come forward to take consultations over mobile calls or internet audio-video conferencing. The medical community also has to adapt itself to the new reality of telemedicine.

### Critical Analysis

Although there were initially some dissenting voices about the utility/futility of nationwide lockdown, now all public

health and epidemiology experts believe that lockdown was necessary to arrest the spread of virus. Although, by itself, lockdown does not eradicate the virus, it flattens the curve of new cases, impacting morbidity and mortality rates. India has managed to keep the COVID-19 threat under control till date, through proactive and preemptive interventions. The Hon'ble Health Minister expressed confidence, "We will continue to develop plans to flatten the curve and space out the occurrence of COVID-19 over a longer time period to enable our health systems to respond to the increased clinical workload."<sup>[40]</sup>

The time, thus gained, is then best utilized in preparing the country to gear up its health services: strategizing the response, mobilizing special COVID teams, optimizing virus testing in the community to see if there is any sign of community transmission (so far, it is believed that there is no community transmission in India), creating special COVID wards and hospital and ICUs, organizing availability of drugs, masks, PPE, and ventilators, and putting in place robust economic measures to look after the poor, vulnerable (street dwellers, homeless), daily-wagers, and large pool of unskilled and semiskilled labor force who would be deprived of their livelihood by shutting down of all commercial activities.

Since the lockdown due to COVID-19 has been enforced in the country, under the Disaster Management Act, 2005, it is prudent to understand certain terms to understand the social implications of a disaster like situation.

- i. Risk is likelihood or expectation of a loss
- ii. Hazard is a condition posing threat of harm
- iii. Vulnerability is the extent to which person and place are likely to be affected
- iv. Resources are the assets in place that will diminish the effect of hazard
- v. Social vulnerability refers to the demographic and socioeconomic factors that affect the resilience of the communities

Socially vulnerable are more likely to be adversely affected; they are more likely to become ill in face of a disaster and more likely to die because of no access to health services or other rescue measures. Effectively addressing social vulnerability<sup>[41]</sup> decreases human suffering and reduces post disaster expenditure on social services and public assistance.

Another set of factors one has to keep in mind is the social determinants of health<sup>[42,43]</sup> in measuring health outcomes, such as morbidity, mortality, life expectancy, health status, healthcare expenditure, and functional limitations.

Social determinants can be summarized as follows:

- i. Healthcare systems: health coverage, health providers, quality of care
- ii. Community and social context: social integration, social systems, community engagement, discrimination, stress

- iii. Food: availability of food, healthy options
- iv. Neighborhood and physical environment: housing, transportation, safety, parks, playground
- v. Education: Literacy, primary education, vocational training, higher education
- vi. Economic stability: employment, income, debt, population at the lower rung of income, and spending.

As the COVID-19 pandemic continues, social determinants of health such as occupation, income, food security, transportation, social support, and environment will prove to be increasingly significant as some populations, already compromised on these parameters, will be disproportionately affected by the pandemic.

Let us examine how various measures that the government has taken to control COVID-19 have impacted our health and social indices.

### Loss of livelihood

Dubbed as the strictest lockdown in the world, all commercial and industrial activities of any kind or size, construction, infrastructure development, and agriculture came to a grinding halt. The hardest hit was daily-wagers and self-employed unskilled laborers, farmers, and migrant workers, whose lives depended on their daily income, with no savings or reserves to fall back upon. According to the 2011 Census, the number of migrant workers under the category, "migrants for work/employment" was 41.42 million. It is the government's constitutional duty to ensure a safety net for the economically weaker sections of the society. The Preamble of the Constitution makes "Economic Justice" one of the founding goals of our polity. Article 21 recognizes that every person has a Fundamental Right to Life. The Supreme Court has reiterated several times that this Right includes the "Right to Livelihood," "Everyone has the right to life, liberty and the security of person. The right to life is undoubtedly the most fundamental of all rights. All other rights add quality to the life in question and depend on the pre-existence of life itself for their operation. As human rights can only attach to living beings, one might expect the right to life itself to be in some sense primary, since none of the other rights would have any value or utility without it."<sup>[44]</sup>

There is no doubt that, subsequent to the lockdown, a large section of India's population will slide down precipitously in their capacity to earn and will be forced into below the poverty line. Poverty will become a major risk factor for their survival. Poverty creates ill health because it forces people to live in environments that make them sick, without decent shelter, clean water or adequate sanitation, or access to healthcare.

Two days after the lockdown was announced, the Union Finance Minister Nirmala Sitharaman declared a package that aimed to provide, for the next 3 months, free food to the "poorest of the poor," some income support to farmers and unorganized sector workers, a Rs. 50 lakh medical

insurance cover for healthcare staff and a Rs. 500 transfer to women Jan Dhan account holders, Rs. 2000 transfer to the farmers, and increased rate of payment to the MNREGA workers. She also unveiled the Pradhan Mantri Garib Kalyan Yojana to provide free wheat, rice, and pulses to nearly 80 crore people across the country or two-thirds of the country's population. Finance Minister pegged the cost of the package at Rs. 1.70 lakh crore. Free gas cylinders would be provided to 8 crore poor families registered under Ujjwala for the next 3 months.

Several state governments including Delhi, Maharashtra, and Kerala were among those which announced measures such as free food, use of worker welfare funds, and minimum income.

Ostensibly, many experts and politicians are not happy with the financial package. It must be, nevertheless, understood that relief measures are never adequate. What must, however, be insured by the governments, both central and state, that these relief measures reach the targeted population on time and in full measure.

Loss of job and income will create a vicious cycle of poverty, homelessness, poor sanitation and environment, ill health, poor access to health, and premature death.

#### **Migration of migrant workforce**

The lockdown was enforced in the country at a 4-h notice. Overnight, all the labor force in cities such as Mumbai, Delhi, Ahmedabad, and many industrial towns became jobless. With no support coming from their adopted cities, no government plan in force for their travel, shelter, or food, and those having no wherewithal themselves to survive the lockdown period, a large number of migrants started on their homebound journey on foot with women, children, old parents, carrying nothing much (food or money) to subsist on their long and arduous journey. Their plight became evident by the heart-rending stories that started trickling in the print as well as electronic media. The most tragic incident has been that 16 people near Aurangabad (Maharashtra) who got run over by a goods train while they were resting and sleeping on the railway track after a day-long tiring walk in their quest to reach the safety of their homes in Madhya Pradesh.<sup>[45]</sup> For a long time, these visuals will define India's response to the COVID lockdown. Blamed for leaving their rented homes in defiance of the lockdown, hungry and cash strapped migrants struggled in packed shelter; those who managed to reach home were shunned by their own neighbors. What made it more ironical was the fact that vast majority of migrant labor force did not qualify for the welfare measures announced by the central or state governments. Sadly, a number of these people died en route their homes due to hunger, dehydration, and exhaustion. On March 31, the Supreme Court of India, giving its ruling on a PIL filed by advocates, asked the police and authorities to treat

migrant workers journeying home in fear of COVID-19 in a humane manner. "We expect those concerned to appreciate trepidations of the poor men, women, and children and treat them with kindness. The anxieties and fear of the migrants should be understood by police and other authorities. Considering the situation, we are of the opinion that state governments, union territories should endeavor to engage volunteers along with the police to supervise the welfare activities for the migrants," a Bench led by the Chief Justice of India, S. A. Bobde said.<sup>[46]</sup>

Those people who manage to reach their destinations braving all the odds will remain vulnerable for a long time for physical and mental morbidities, owing to the vicious cycle of poverty, poor health, and inability to access any kind of healthcare.<sup>[47]</sup>

This, never experienced situation in independent India before, should lead to major policy changes for the welfare of migrant laborers on long term for protecting them from falling into poverty, despair and distress, and chronic poor health. In the absence of long-term solutions to end their economic and health vulnerability, there is a real risk of their ending up into the trap of chronic deprivations.<sup>[48]</sup> Besides being in a huge number, they contribute significantly to the economy of the country. Many states depend on the remittance sent by these workers. Yet, they continue to live in hazardous and unhygienic environment, with no health insurance, and not being eligible for a number of welfare measures and compensation packages.

#### **Impact on children's health and development**

Children have been said to be less vulnerable to this pandemic, but their risk being among its biggest victims. While they have thankfully been largely spared from the direct health effects of COVID-19 – at least to date – the crisis is having a profound effect on their well-being.<sup>[49]</sup> All children are being affected, in particular, by the socioeconomic impacts and, in some cases, by mitigation measures that may inadvertently do more harm than good. The harmful effects of this pandemic could be lifelong. These are expected to be most damaging for children in the poorest countries and for those in already disadvantaged or vulnerable situations. A large number of children are likely to fall into poverty and ill health, with incomplete or no immunization, malnutrition, and risk to their survival. Because of their family's poverty as a consequence of pandemic, a large number of children will become homeless losing the security and safety of their homes. It will also seriously impact their learning curve.

*"Immunization acts as a protective shield, keeping families and communities safe. By vaccinating our children, we are also protecting the most vulnerable members of our community, including new-born babies. Only 65% of children in India receive full immunization during the 1<sup>st</sup> year of their life. This is unacceptable in a world where affordable,*



*life-saving vaccines exist*” (emphasis by authors).<sup>[50]</sup>

Despite the progress, infectious diseases continue to contribute to a significant proportion of child mortality and morbidity in India. Nearly one million children die before their fifth birthday in India. About one of every four of these deaths are caused by pneumonia and diarrhea – two leading infectious causes of child deaths worldwide, even though many of them can be saved by interventions, such as breastfeeding, immunization, and access to treatment.

It is pertinent to look at India’s record in taking care of its child population. There are 472 million children in India below the age of 18 constituting 39% of India’s population as per the 2011 Census of India.<sup>[51]</sup> 25% of these children (99 million) have not gone to school or have dropped out. Only 32% complete their school education age-appropriately. There are 10.13% of child laborers (between age 5 and 14 years) in India; as much as half of the child population in many parts of the country is engaged in labor, many of which are hazardous. The crime against children has been increasing every successive year as per the 2016 Report of the National Crime Record Bureau available (National Crime Record Bureau, 2019).<sup>[52]</sup> Number of suicides has been increasing in each successive year. A large number of street children are abusing a variety of addictive substances (Accidental and Suicides in India, 2014).<sup>[53]</sup>

India’s children are facing this pandemic from an already disadvantaged position. The poor development indices, health indices, and social indices related to children will get poorer and poorer over the years. The rich dividend India has been reaping of its young population in the world market will be seriously dented. It is high time India looks after its children in serious earnest.

### **Gender discrimination**

Women always face the consequences of disasters and pandemic in disproportionately higher number by the way of increased morbidity and mortality. They also remain at the periphery when it comes to receiving any welfare measures provided by the governments. The United Nations Population Fund<sup>[54]</sup> has estimated that there will be huge surge in unwanted pregnancies over the next 1 year, owing to nonavailability of contraceptive measures during the lockdown period. Similarly, the number of women facing domestic violence is set to rise.

The Delhi High Court Bench of Justices J. R. Midha and Jyoti Singh recently directed the Centre and the Delhi government to hold top-level meetings to deliberate on measures to curb domestic violence and protect the victims during the coronavirus lockdown. The April 18 Order came on a nongovernment organization (NGO)’s plea seeking measures to safeguard victims of domestic violence and child abuse amid the COVID-19 lockdown. The NGO, All India Council of Human Rights, Liberties and Social

Justice had claimed that there was increasing number of domestic violence incidents since the nation was put under lockdown and sought an urgent intervention by the court.<sup>[55]</sup>

Recently, the Jammu and Kashmir High Court too had taken a suo moto cognizance of domestic violence during COVID lockdown directing the state government to create special fund for the victims and creating safe spaces for their well-being.

An HT analysis<sup>[56]</sup> of cases recorded across the country reveals two important aspects. One, some states have reported a decline in complaints related to violence against women, while others have reported a spike in the calls received by helplines, indicating that the incidence of domestic violence during the lockdown depends upon the ability of victims to make complaints while they share domestic spaces with perpetrators. The Delhi Police recorded (by mid-April) nearly 2500 women calling emergency helpline numbers triggering the Emergency Response Support System of the state police; these calls were for abuse, domestic violence, and rape. It is quite possible that many victims could not make calls while their perpetrators were living in the same domestic spaces. It is also true that services of many shelter homes and NGO helplines have been seriously curtailed due to the lockdown and nonavailability of staff and volunteers.

Women, in India, continue to remain in a disadvantaged position, and in spite of the efforts of various sectors, the situation has been improving very slowly. All the efforts toward women empowerment have paid only lip service to their cause. They lag far behind in education and social, health, and economic parameters. There have been grave violations of their rights and dignity, and they are subjected to mental, physical, and sexual abuse, seriously impacting their ability to access opportunities. If India has to progress and aspires to be called as a civilized nation, it has to look after its girl child and women. It needs a long-term social, legal, and human rights-based approach for women to enjoy a healthy, safe, and dignified life, irrespective of any disaster or pandemic like situation.

### **People with preexisting morbidities**

In our anxiety and panic to contain the COVID-19 pandemic, we seem to have forgotten that, at any given time in a society, there will be a growing number of people living with multiple chronic diseases. It has been a consistent finding that people with multiple comorbidities represent 50% or more of the population.<sup>[57]</sup> Further, it has been estimated that 80% of the total deaths occurring in LAMIC countries are due to chronic multiple diseases.<sup>[57,58]</sup> It is evident that, at any given time, a substantial number of people in a society will require regular and long-term healthcare for noncommunicable diseases (NCDs) such as cardiovascular disorders, diabetes, mental health problems, cancer, and respiratory diseases. With COVID lockdown

coming into being, all these people have been tragically deprived of much needed healthcare. Nonavailability of much-needed care will push these patients toward increased morbidity and mortality.<sup>[59]</sup>

Immunization, antenatal checkups, and nutrition drives have been hit hard due to drafting of public health workers into governments' plan to contain the outbreak of COVID-19.

Responding to a PIL last month, the Bombay High Court asked the Maharashtra government and the central government not to ignore treatment of non-COVID patients.<sup>[60]</sup> According to a report from the National Health Authority, the private sector has a huge role to play in managing non-COVID patients, especially when the public sector is intensely involved in looking after COVID patients, and its hospitals and workforce from all fields to be deputed for COVID.<sup>[61]</sup> Normally also, private sector provides 70% care to the population;<sup>[62]</sup> at this time, it must rise to occasion to not turn away care of non-COVID patients. Neglecting care of non-COVID patients and other health services will prove to be a costly mistake in the long run. Sylaja *et al.* recently wrote for the Annals of New York Academy of Sciences (emphasis added), "*The stroke 'chain of survival' and care pathways in India have likely been affected in one way or the other because of the pandemic and lockdown. The shortfall of health insurance coverage and rehabilitative care centers ensures that most of the burden of illness is borne by out-of-pocket payment by patients and families. A large percentage of specialized health services, such as advanced stroke care, are provided by corporate hospitals. However, many of these centers are currently unable to extend care for stroke in persons suspected of having COVID-19, as COVID-19 care in India is mostly confined to designated hospitals under the state and central governments. Individuals from poorer sections of society and daily-wage workers are the worst affected owing to their already limited access to a healthcare facility. The priority has shifted from health to daily sustenance for economically weaker populations.*"<sup>[63]</sup>

Over the years, India has had a dubious distinction in controlling its burden of communicable diseases. However, the burden of NCDs has increased disproportionately. NCDs are characterized by their chronic course and are directly related to lifestyle and social determinants of health, viz., health and social systems, nutrition status of the society, physical environment, education, and economic stability. NCDs have become a major public health problem in India, accounting for 62% of the total burden of diseases and 53% of total deaths.<sup>[64]</sup> Cardiovascular disorders, respiratory diseases, diabetes, mental disorders, and cancer will continue to put a serious economic burden limiting society's ability to earn; they will also cause increase in out-of-pocket expenses by families, pushing them toward poverty.<sup>[65-67]</sup> If India has to control the burden of NCD, it has to make major investments in public health services

and social determinants of health. That will keep India ready to face any unexpected arrival of any epidemic or pandemic or a disaster.

### Vulnerable groups

In any society, poor and homeless people, people under lockup in the prisons, LGBT community, patients with severe mental illnesses, children, women, and old people are the most vulnerable groups during peace time and more so when faced with any disaster or social calamity. They remain the most neglected lot, and interventions and relief measures do not reach them. It is said that a civilized society is the one that takes care of its most marginalized sections of the society. By that yardstick, India has to traverse a long distance to be counted among civilized societies. In the current pandemic, it is feared that these groups will not reap benefits of economic or health measures, pushing them further toward the vicious cycle of poor health, poverty, and early death. This paper has already discussed the impact of COVID among children and women and to some extent on the groups, such as migrant workers, unskilled laborers, and farmers.

### Prisoners

There are close to five lakh prisoners in India. Mental disorders and infectious diseases are more prevalent in prisoners than in general population.<sup>[68,69]</sup> Prisoners are also at risk for increased mortality, suicides, self-harm, violence, and victimization. The contribution of prisons to illness outcome is unclear although shortcomings in treatment and aftercare provision contribute to adverse outcomes. Research has highlighted that women prisoners, older prisoners, and juveniles present with higher rates of many disorders than do other prisoners. The contribution of initiatives to improve the health of prisoners by reducing the burden of infectious and chronic diseases, suicide, other causes of premature mortality, and counteracting the cycle of reoffending should constitute a major exercise in improving the overall public health systems.<sup>[68]</sup> Reforms in the Indian prison system is long overdue as has been exemplified by the National Human Rights Commission of India time and again.<sup>[70]</sup> With public health funds and workforce being directed toward other areas during the pandemic, prison population will more likely than not suffer increased rates of morbidity and mortality.

### LGBT community

Another highly vulnerable group needing care and attention is the LGBT community. There are over 487,803 lakh transgender people in the country, according to the 2011 census of India. Prolonged nationwide lockdown to control COVID-19 outbreak has spelt trouble for the transgender community in India. With little savings and no social security benefits, this community has a massive challenge to deal with, due to depleting food supplies, and no cash reserves for any emergency. While several state governments

announced relief measures for the marginalized, only the Kerala government doled out temporary housing and food facilities for transgenders in the state.<sup>[71]</sup> Many in the LGBT community suffer from a compromised immune system and so are more prone to infections and respiratory problems and may also be suffering from HIV/AIDS. Because of the stigma, they will not access health services, where priority has shifted to contain COVID.<sup>[72]</sup> Meanwhile, the Delhi High Court declined to entertain a PIL on the protection of LGBT community during the lockdown.<sup>[73]</sup>

#### *Elderly population*

Elderly population. There has been specific health advisory for elderly in India<sup>[74]</sup> and globally.<sup>[75]</sup> The life expectancy is increasing in India year after year; currently it is 69.73 years. As per the census of 2011, there are 104 million people above the age of 60 years. What is peculiar of old age in India is that most of this population has multiple health problems and disabilities.<sup>[76]</sup> Even during normal times, this population does not have easy access to health services. In absence of dedicated public health system geared towards elderly population, this increasing section of society will be further put to hard times.

#### **Vulnerability of health workers**

The health workers remain vulnerable because they are directly exposed to a highly infective virus while looking after a COVID-positive patient.<sup>[77]</sup> They need specialized protective gear while working in the COVID wards and intensive care units (ICUs).<sup>[78,79]</sup> There were numerous complaints that the doctors and nurses were either not getting PPEs or getting the substandard ones. It took a few weeks before India got its act together to procure or produce its own PPE, masks, and other requisite equipment.<sup>[80-82]</sup> No wonder that so many of our doctors, nurses, and other workers got infected and a few perished.<sup>[83]</sup> However, the most disturbing trend that emerged during this pandemic was the frequent assaults on the health workers in different parts of the country.<sup>[84]</sup> These attacks became so frequent that the government had to bring out an ordinance to punish the assailants.<sup>[85]</sup> The sanitation workers, police personnel, and anyone who was involved in the COVID duty were victims of these vicious attacks. The doctors have been subjected to harassment and physical assault in India for a long time. As per the 2017 IMA study, as many as 75% of its members had faced violence related to their work, and some employed private security at their clinics.<sup>[86]</sup> However, the attacks now happened when these health workers, including doctors, nurses, and technicians, were assaulted by mobs when they were doing their assigned public health work in the community.<sup>[87]</sup> It cast a worrying spotlight on the safety and well-being of our frontline workers in nation's fight against COVID-19. Such instances became too frequent progressively, but the most shameful incident happened in Chennai, when a doctor, who had died of coronavirus, was denied even basic dignity at the time of his death as a mob

attacked his friends and family with sticks and rods when they were transporting his body to a burial ground.<sup>[88]</sup> It reminded the author of the famous couplet by Bahadur Shah Zafar that he composed while being incarcerated in Rangoon prison, "*kitna hai badnasib Zafar dafn ke liye, do gaj jameen bhi na mile, kuche yaar mei*" (how much unfortunate is Zafar, not even two yards of land in kuche yaar).

Health workers have also been trolled on the social media, barred from their rented accommodation, and driven out from the market place.

Ultimately, only when the IMA threatened to go on nation-wide protests, did the central government finally come up with an ordinance, wherein a guilty person could be punished by imprisonment up to 7 years, along with a fine of 5 lakh rupees.<sup>[89]</sup> Allaying all concerns of the medical fraternity regarding their security in the fight against the novel coronavirus, the Home Minister Shri Amit Shah assured members of the IMA that the government would leave no stone unturned in ensuring their well-being and security. Reflecting on the development, Prime Minister Narendra Modi said, "the Epidemic Diseases (Amendment) Ordinance, 2020 manifests our commitment to protect each and every healthcare worker who is bravely battling COVID-19 on the frontline. It will ensure safety of our professionals. There can be no compromise on their safety."<sup>[90]</sup>

Health is a fundamental human right, and by attacking and chasing away health workers, the citizens are sabotaging their own rights and depriving themselves of basic health care, which is worse since it is because of the risks the health workers are taking that the society can feel safe in both short term and/or long term.

#### **Health infrastructure**

The following information about India's health infrastructure and workforce is from the publication, National Health Profile-2019 of Central Bureau of Health Intelligence.<sup>[91]</sup>

Health infrastructure is an important indicator for understanding the healthcare delivery provisions and welfare mechanism in a country. Infrastructure has been described as the basic support for the delivery of public health activities. It also signifies the investments and priority accorded to create the infrastructure in public and private sectors. In the last three decades, India has progressed at a rapid pace to create its infrastructure. The number of medical colleges, dental colleges, nursing colleges, and paramedical staff has grown exponentially, yet the demand has far outstripped the supply.

There are now more than seven lakh hospital beds in the country. There is a huge rural-urban divide, with more than two-third beds located in urban areas. This should be kept in mind that rural population constitutes about 66% in India and has dismal health infrastructure.



Rao *et al.*<sup>[92]</sup> analyzed the June 2012 data of the National Sample Survey to produce the estimates of health workforce in India. Findings suggest that in 2011–2012, there were 2.5 million health workers in India; however, 56.4% of all health workers were unqualified. After adjusting for the qualification, the density of the health workers is estimated to be 9.1 per 10,000 of population. This is around one quarter of the WHO benchmark of 22.8 health workers per 10,000 population. Of all qualified workers, 77.4% were located in urban areas.

Despite a rapid surge in the number of medical and other health institutions to produce a large number of doctors and other health workers, the availability of workforce or health facilities per capita of population in India remains very poor and highly skewed. India spends only 1.3% of its GDP for its 1.3 billion population. The developed countries spend 10% or more of their GDP on health. The government claimed that the lockdown period has been gainfully utilized to ramp up health infrastructure by the way of organizing procurement of PPE and testing for the virus.<sup>[93]</sup> However, reports from across the cities indicate a health system in distress even after 70 days of lockdown as shortage of beds and healthcare workers prompts hospitals to turn away patients seeking testing and treatment for COVID as well as other illnesses.<sup>[94]</sup> However, the most tragic has been the death of an 8-month pregnant woman in an ambulance in Greater Noida after a frantic 13-h hospital hunt failed to find her a bed as over half-a-dozen facilities, including three government ones, denied her treatment on June 5.<sup>[95]</sup> The incident brought to force the issue of medical negligence and unavailability of care during the ongoing COVID-19 pandemic.

The National Human Rights Commission on Monday has issued a notice to the Uttar Pradesh government over media reports of medical apathy to the pregnant woman.

“Health infrastructure is creaking at this stage of the pandemic because of mismanagement, unprofessional planning, greed of private institutions, and unjustified fear. Health delivery in India is concentrated in urban areas and in metro cities. Majority of private hospitals in rural areas have either stopped giving services for COVID-19 patients or are extorting huge money. Therefore, patients are moving to bigger cities. ICUs with ventilator and available anesthetics or pulmonary medicine professionals are not available at even district-level hospitals,” said Dr. Jugal Kishore, a member of the government’s rapid response team on COVID-19 and Head, Department of Community Medicine, Safdarjung Hospital.<sup>[94]</sup>

### Public sector versus private sector

The COVID-19 remains a public health epidemic, yet the health services have been disrupted for various reasons. The private sector, which is a Rs. 2.4 lakh crore industry, accounts for 70% of total bed-strength, has 80% of total ventilators,

yet is looking after just 10% of entire COVID caseload. Private sector is shying away from providing even the routine non-COVID care, and so, it is the public hospitals, doctors, and nurses that are facing the real burden of COVID care.<sup>[96]</sup>

As per the Economic Survey of India, 2019–2020, India spends close to 1.3% of its GDP on health that includes expenditure on medical and public health, family welfare, sanitation, and water supply.<sup>[97]</sup> It does not look realistic if the country will be able to reach an expenditure of 2.5% of GDP by 2025 as envisaged in the National Health Policy of India-2017.<sup>[98]</sup>

India’s per capital expenditure on health is Rs. 4116, of which household’s out-of-pocket expenditure on health is Rs. 2494 per capita; that is, 60% of health expenses are borne out of pocket by people.<sup>[99]</sup> That is a huge amount for a country like India, where per capita income is already low, and health expenditure remains a major reason for pushing households to below the poverty line.

The Indian Constitution makes the provision of healthcare in India the responsibility of the state governments, rather than the central federal government. It makes every state responsible for “raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.”<sup>[98]</sup>

In practice, however, the private healthcare sector is responsible for the majority of healthcare in India, and most healthcare expenses are paid directly out of pocket by patients and their families, rather than through health insurance.<sup>[100-101]</sup> The government health policy has thus far largely encouraged private sector expansion in conjunction with well-designed but limited public health programs.

Over the years, India has neglected its public health sector by not opening enough hospitals, or equipping the existing ones with essential medical gadgets such as ventilators, or recruiting sufficient workforce. If one lesson we wish to learn now, is not to neglect the public health sector in India.

### Primary healthcare

The response strategy to the COVID and the degree of control and success that has been achieved in various states and union territories of India has not been uniform. Some states have succeeded in not only flattening the curve but also bending it downward. Their recovery rate and death rate are superior to national average. For example, Kerala which was the first state to report a positive case successfully arrested the progress of COVID; as on May 9, its total caseload has only been 503, cured or discharged 484, and only four deaths.<sup>[102-103]</sup> Similar are the stories from Tamil Nadu (only 40 deaths amongst 6009 cases), Telangana, or Andhra Pradesh.<sup>[104]</sup> However, states such as Maharashtra, Madhya Pradesh, or Rajasthan have not been so lucky in these numbers.<sup>[105]</sup> The major reason behind the success of former states has been the development

of primary healthcare and vigorous mapping of their population and data gathering and robust teams of health workers at all levels. Even as of July 19, 2020, death rates due to coronavirus have been low in Andhra Pradesh (1.13), Tamil Nadu (1.45), Kerala (0.34), and Telangana (0.93) as compared to the national figure of 2.48%.<sup>[14]</sup>

Primary healthcare should have remained the backbone of healthcare in India; however, it has been equated with providing healthcare to rural India, with no relevance to urban areas. With neglected development of our rural areas (economy, agriculture, housing, sanitation, and safe drinking water), primary healthcare has also been relegated to an insignificant spot.

After the Alma Ata Declaration, 1978, of “Health for All by 2000,” the Government of India commissioned a report, “Health for All—An Alternate Strategy” by the ICMR and Indian Council of Social and Scientific Research in 1980.<sup>[106]</sup> The Report concluded that to achieve “Health for All” by 2000, existing health services and workforce had to be increased substantially. It is not rocket science to analyze and conclude that we as a nation have failed miserably in improving our health indices over the years. While some states have health parameters comparable to the West, there are others which are worse off than our neighboring countries in the SAARC. The states, which have taken health of their citizens seriously, have been reaping rich dividends in terms of health in normal times as well as during disaster like situations.<sup>[107]</sup>

### Stigma

Stigma is a very disturbing response as has been seen in the past epidemics of infectious diseases.<sup>[108]</sup> It will certainly play a part in this pandemic also. Stigma is an evolutionary response, and humans are hard-wired to distance themselves from others who could infect us. This stigma may lead to social rejection, gossip, physical violence, denial of services, and poor access to healthcare. It may lead to exaggerated depressive symptoms, increased stress, and substance abuse. Unfortunately, stigma extends to people who are involved in looking after sick persons, such as family members and health workers, as is discussed below.

Deepa Rao *et al.*<sup>[109]</sup> discuss the impact of stigma, “*Stigma can aggravate disease processes and add numerous socioeconomic, psychosocial, and health burdens on people who hold marginalized identities or status, including reduced educational attainment, exposure to psychosocial stressors, and challenges in accessing healthcare. Behavioral scientists have studied the severe negative consequences of stigma for individuals coping with various health conditions and have learned that stigma can deter individuals from optimally engaging in treatment for their condition, which has serious impacts on morbidity and mortality. Strikingly, when disease morbidity and*

*mortality are low but the condition is highly stigmatized, the burden of stigma may exceed the burden of the disease in its impact on social, emotional, and work functioning, thus negatively affecting the overall quality of life. Researchers have long recognized that stigma operates on interpersonal, organizational, and structural levels, and as such, stigma is conceptualized as an inherently multi-level phenomenon*” (emphasis added).

However, the research in this area has shown that stigma may not be an inevitable response as is evident from social neuroscience research.<sup>[110]</sup> Strategies such as emphasizing “social distancing, and not social isolation,” education, inclusion, acceptance, dispelling stereotyping, and investing in wellness programs that help in promoting resilience, will go a long way in tackling this menace.

### Mental health

During disasters, disaster-like situation, or any upheaval in the society, including pandemics, mental health of people is seriously compromised. Scientific literature has been full of the effects of disasters, wars, and civil strife on the emotional health of affected population. According to the World Health Report, 2001, such situations take a heavy toll on the mental health of the people living in developing countries, where capacity to take care of these problems is extremely limited. Between a third and half of all the affected persons suffer from mental distress. Most common diagnoses made are anxiety, depression, and post traumatic stress disorder (PTSD). Besides, a large number of people continue to suffer multiple psychological symptoms for a long time.<sup>[111,112]</sup>

Migrants, refugee, and asylum seekers have an elevated need for mental healthcare but simultaneously have less access to it. Reasons for this gap include stigma and shame regarding mental illness, cultural beliefs, and lack of language proficiency, as well as financial constraints. Furthermore, real economic barriers and perceived social consequences could impede service seeking because migrants, refugees, and asylum seekers often lack health insurance.<sup>[46,113]</sup>

Prolonged isolation leads to frustration, stress, followed by symptoms of sleeplessness, loss of appetite, anxiety, depression, obsessions, loneliness and boredom, and an increased use of tobacco and alcohol. Although media in India has been regularly publishing about the impact of the COVID on mental health of people under lockdown, there are no precise data available to gauge its magnitude in the society. However, if previous studies are any indications, it is quite likely that more than 50% population will be having significant emotional and psychological problems to warrant some interventions. People with existing mental illnesses are further vulnerable due to nonavailability of health services and running out of their drug supply. The author has received numerous requests from his patients for help, since the local chemists had refused to honor



old prescriptions. It is likely that a number of patients with severe mental illnesses will see worsening of their symptoms or a frank relapse, if their drug compliance is interrupted for no fault of theirs. A way out had been suggested for providing teleconsultations,<sup>[114]</sup> but a large number of patients and many clinicians are not adequately equipped with the skills. Even, the guidelines from the government had lacked clarity earlier; fortunately, with the efforts of many institutions, revised guidelines have been made on employing “Telemedicine” to provide healthcare to people to improve accessibility of healthcare.<sup>[115]</sup> The issue of prescribing psychotropic drugs online still remains.

Ministry of Health and Family Welfare (MoHFW), as well as institutions such as All India Institute of Medical Sciences, New Delhi, National Institute of Mental Health and Neurosciences, Bengaluru, Institute of Human Behaviour and Allied Sciences, Delhi, and some others have put up guidelines and webinars on their websites advising people on how to look after their mental health during the COVID pandemic. However, a major limitation of such measures will be the digital divide between people who have access and who do not. Moreover, India has very low number of mental health professionals, mental health services, and hospital beds for its population (Mental Health Atlas);<sup>[116]</sup> the mental health gap remains as high as 75%. We are likely to see a huge surge of mental health problems for some time to come, resulting in increased rates of morbidity, mortality, and disability.

### Suicide

A disturbing trend, which began soon after measures such as quarantine and lockdown were enforced in India, was people committing suicide. A disturbing trend, which began soon after measures like quarantine and lockdown were enforced in India, was people committing suicide. At the time of writing this paper, suicide has been the leading cause of death in 338 non-corona deaths during lockdown.<sup>[117]</sup> People committed suicide due, ostensibly, to reasons like fear of infection, stigma, loneliness, hopelessness, alcohol withdrawal symptoms, and total income loss. It must be understood that like any other study on suicide, such figures are underestimates of actual number.

Kedia *et al.*,<sup>[118]</sup> reviewing the sudden spurt in suicides case during COVID-19, discuss various reasons for this, “The novel coronavirus (COVID-19) has caused the worst pandemic seen in the 21<sup>st</sup> century. In the last 5 months, it not only has caused significant health-related complications and morbidity but also has plunged the world into a lockdown and eventual economic crisis. Across the globe, the pandemic has sparked a number of suicides, even in individuals with no prior history of any psychiatric disorder or mental health complications. A plethora of studies have shown that natural calamities such as tsunami, or Spanish flu of 1918, economic upheavals such as the “Great

Depression” have spiked the suicide rates. The current suicides triggered by hopelessness, altruism, stigma, or uncertainty resonates with Durkheim’s sociological viewpoint, which speculated that, “when a society is disturbed by some painful crisis or by beneficent but abrupt transitions, it is momentarily incapable of exercising its moral influence; thence come the sudden rises in the curve of suicides. In the current pandemic, suicide is already becoming a pressing concern. Therefore, the prevention of suicide needs immediate consideration. We need to move beyond general mental health practices and pick strategies that are rooted in a more psychological and sociological understanding of the phenomenon.”

The strategy to prevent suicides and suicidal attempts in India must adopt public health measures.<sup>[119,120]</sup>

### National Disaster Management Authority

This pandemic has been compared to something like disaster. NDMA has given guidelines on managing mental health and psychosocial issues seen during or subsequent to a disaster.<sup>[121]</sup>

#### *Ten important components of the guidelines*

- i. Integration of psychosocial support and mental health services into various health programs, NMHP, DMHP and evolving of legal instruments necessary for the implementation of such policies under the guidance of National Subcommittee on Psychosocial Support and Mental Health Services constituted by the MoHFW
- ii. Development of skilled and competent human resource at all levels with the help of nodal institutions through standardized training practices
- iii. Mainstreaming the knowledge about preventive and mitigation strategies for adverse psychosocial effects of disasters into education system. Training of community-level workers, NGOs, and various professionals for providing psychosocial support and mental health services in the aftermath of disasters
- iv. Normalization of survivor’s psychological impact could be hastened by providing “Psychosocial First Aid.” Later, provision of psychosocial support during rehabilitation and rebuilding phase would be integrated into the overall community development interventions
- v. Research and development for effective intervention should focus on community needs, integration of professional referral system with existing community best practices, and vulnerability and epidemiological factors that compounded the psychosocial impact on any emergency
- vi. Systematic documentation, procedures to enhance community participation, elements of Psychosocial Support and Mental Health Services in deliverables such as relief, transportation, care of vulnerable groups,

- and psychosocial first aid supported by adequate infrastructure will be undertaken as planned objectives
- vii. Inclusion of Psychosocial Support and Mental Health Services in hospital disaster management planning, effective communication and networking, counseling session areas, pooling of resources among network of healthcare services, and identification of all the critical issues in state/district health disaster management planning
  - viii. Identification of designated institutions for training under Disaster Mental Health Programme and models of PublicPrivate Participation will be developed, tested, and practiced
  - ix. Long-term management of mental health interventions will be undertaken through standardized and structured need assessment tools followed by scientific studies and evaluation and development of specific intervention modules thereupon
  - x. Adoption of international best practices, provisions for special care to vulnerable groups, care to caregivers, role of Psychosocial Support and Mental Health Services.

### COVID-19 and civil society's response

In the aftermath of the lockdown, the Prime Minister reached out to the NGOs, to help the government during the lockdown by providing basic necessities to the underprivileged, supplying medical and protective gear, and assisting with awareness campaigns on social distancing.<sup>[122]</sup> Exactly a week later on April 6, NITI Aayog, the think-tank of the Union government, communicated with more than 92,000 NGOs, industry associations, and international organizations seeking their assistance in delivering services to the needy through cross-sectoral collaborations.<sup>[123]</sup>

Besides the public and private sectors, this is the third sector, the civil society, in any nation that fulfills a crucial role during peacetime, and in face of any crisis. They have skills and expertise and enjoy a tremendous goodwill across all sectors and segments. They can mobilize resources and are backed by a large, committed, and motivated force of volunteers. They assume a significant role in providing not only material support to the needy but also extend much-needed care and emotional support to the vulnerable during disasters. During the COVID-19, a large number of civil society organizations and NGOs have been coming to forefront to provide food to hungry, distribute protection kits to the hospitals and administration, and work as volunteers in hospitals and quarantine centers. NGOs have been providing services in those areas, where the efforts of public or private sectors are often lacking, for example, health, education, empowerment of under-privileged sections, enhancing skills, and earning potentials of communities living in remote areas of the country. In the last few years, a large number of NGOs were at the receiving ends from the government, and many

have shut the shop. It is high time that the intrinsic value of these organizations is appreciated and their strength is harnessed for much-needed succor that a large segment of our population will continue to desire.

### Inspiring Stories

There have been numerous instances of individuals rising to the occasion and help elders take care of their daily needs, allow house-help to stay home without fear of their wages being affected, organizations coming forward to manufacture personal protective equipment, provide meals from factory kitchens, and administration opening up stadia and public buildings to provide space for those who need shelter or isolation. Central banks have brought in massive policy measures to help tide over the crisis, and governments have provided the weaker sections of society with cash and food.

Instances of doing generous deeds during this crisis are too numerous to be enumerated comprehensively; however, together, they have re-established that society has a heart.

1. An act of kindness by a police inspector in Hyderabad is receiving plaudits from far and wide, including from the Himachal Pradesh Chief Minister. A few days ago, Inspector B. L. Lakshmi Narayana Reddy of Kukatpally Police Station under Cyberabad not only rescued a stranded man from Himachal Pradesh by admitting him to a hospital but also paid for his medical expenses. Lalit Kumar, a native of Hamirpur district in Himachal Pradesh, was stranded in Kukatpally and in need of an emergency operation<sup>[124]</sup>
2. Joining the fight to stem the rise of COVID-19 infections in the country, First Lady Savita Kovind on Wednesday stitched facemasks at Shakti Haat in the President's Estate. These masks will be distributed at various shelter homes of the Delhi Urban Shelter Improvement Board. The First Lady was seen covering her face with a red cloth mask while stitching the masks<sup>[125]</sup>
3. The Greater Chennai Corporation, which runs over 400 Amma Canteens in Chennai on Thursday, announced free food to people at all its eateries till the lockdown ends.<sup>[126]</sup> Local Administration Minister S. P. Velumani tweeted that the Chennai Corporation with the largest number of canteens in the city has made food free in all its 407 canteens until the end of the COVID-19 shutdown
4. An entrepreneur in Chhattisgarh, in association with a women's self-help group, has developed a hand sanitizer liquid with alcohol distilled from Mahua flowers as its main ingredient.<sup>[127]</sup> Hand sanitizers are currently in great demand because of their use to clean hands helps keep COVID-19 at bay. Yellow Mahua flowers are one of the major forest products during summer. They are also believed to have medicinal properties. "The idea to develop hand sanitizer from Mahua spirit came to me

when I could not obtain enough hand sanitizer liquid for the employees at my petrol pump,” said Samarth Jain, who runs a company in Jashpur that makes agricultural and herbal products

5. From their home in Bibwewadi, four sisters of a family are fighting coronavirus (COVID-19) on two frontlines – the hospital and the street.<sup>[128]</sup> Two are in the police force and two are nurses. “There is a high chance that one or all of us will get infected. That’s the nature of our job. To protect the rest of our family, we have sent our parents, younger brother, and children to our village in Satara. What pained me most was sending my two children – a 9-year-old son and a 2-year-old daughter – away with them,” says the eldest sister, who is aged 27 years and is a police Naik. She does not want her family’s identity to be published. “My daughter is too young to understand what is happening, so I have asked my relatives in the village to send me videos of her. I watch her skipping and playing in the videos and I don’t know when I will hold my children again. But, this is the time that the country needs healthcare officials and law-keepers, so we are on duty,” she says. The policewoman adds that “the educated and uneducated classes” were equally guilty of violating lockdown rules. “They should stay home for the sake of the elderly and children in their families,” adds the police Naik. After work, on the occasions when the sisters meet for dinner, they turn on the television. “We opt for an entertaining film and turn to news afterwards for updates on the coronavirus situation,” says one of the sisters.

### Corona Crisis: Its Present Ramifications and Future Portends

It is abundantly clear that the multiple crises unleashed by the COVID-19 pandemic are not going away any time soon.

Health and economic upheavals aside, a major humanitarian challenge is facing us. It has brought into sharp focus all that is wanting and apparent in our health systems, in our social inequalities, in our widely practiced discrimination, in widespread poverty, and in the continued stigma and superstition.

India became a nuclear power on May 18, 1974. It has been launching satellites into the space since 1975. It joined an elite space club when in 2008 it successfully put its Chandrayaan-I to orbit around the moon and in 2014 became the fourth country in the world to reach and orbit around the Mars. It has its own Missile technology. These are stories of India’s stupendous success in the field of science and technology. But have all such achievements made India a great civilized nation, when India’s health and social indices still leave a lot to desire?

India ranks 129 in the Human Development Index report released by the United Nations in 2019.<sup>[129]</sup> “For

countries like India, which have shown great success in reducing absolute poverty, we hope that the 2019 Human Development Report sheds light on inequalities and deprivations that go beyond income. How we tackle old and new inequalities, ranging from access to basic services such as housing, health, to things like access to quality university education, will be critical to whether we achieve the Sustainable Development Goals,” said Shoko Noda, UNDP India Resident Representative in an official release.<sup>[130]</sup>

India has been making heroic efforts to control the morbidity and mortality associated with the COVID-19 pandemic. Yet, the number of cases has been relentlessly increasing every day. The end is not in sight, the treatment protocols are still being evolved. Moreover, vaccine development and its market availability is a painstaking and slow process and will not be available to masses any time soon.

What has this pandemic brought into our consciousness is the plight of the poor, under-privileged, and marginalized sections of the society. A civilized country is not one that has skyscrapers, fast moving cars, instruments of modern warfare, or by its progress in science and technology; however, a society is considered civilized when it is judged by how well it looks after its disadvantaged citizens.

This now raging pandemic will too go away sooner or later, but it has seriously dented the fabric of Indian society. It has given its wake-up call. It would have served its purpose if we now focus on taking long-term measures to launch sustained programs to look after vast sections of the society and to achieve the development goals enunciated by the United Nations. That will empower our society to fight any disaster or pandemic with a measured response by not pushing any section of the society into desperation, now so very visible.

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NOTE: The data and views in this Debate are updated, and accurate, to the best of knowledge of the Author as of July 19, 2020.

# Mental Health Issues in Coronavirus Disease 2019 Pandemic: Evolving a Strategy

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## Abstract

Coronavirus disease 2019 (COVID-19) pandemic has become a global health emergency in a short span of time. Novel kind of the disease, highly infectious nature, rapid progress with serious medical complications and risk of death, and absence of effective treatment and vaccine have all added to a community fear. Need for social distancing, social isolation, and quarantine in contacts further contributes to the fear and also creates a stigma. Declaration of lockdown in many parts of the world to prevent spread of illness has been associated with socioeconomic consequences with great loss to the world economy as well unemployment in a large section of the population. All these factors impose a high risk of mental health problems like anxiety, fear, worries, sleep disturbances, depression, etc. in the general population, and also worsening of the existing symptoms in persons with existing mental illness. The impact of the pandemic on mental health is likely to be long lasting, and a great challenge to the mental health professionals and the policy makers. This paper discusses various strategies to effectively manage the mental health issues in the light of limited availability of mental health resources and restricted access to health services due to lockdown in low-resource settings.

## Keywords

- ▶ COVID-19
- ▶ mental health
- ▶ management
- ▶ lockdown

## Introduction

On March 11, 2020, the World Health Organization (WHO) declared the novel coronavirus disease 2019 (COVID-19) outbreak a global pandemic. It began as a cluster of cases of pneumonia in Wuhan, Hubei Province, China and started spreading alarmingly all over the world. By May 14, 2020, over 4,218,212 confirmed cases with 290,242 deaths across 216 countries had been reported.<sup>1</sup> The numbers in India stood at 78,003 cases with 2,549 deaths till the same date.<sup>2</sup> This rapidly spreading public health emergency has affected health, safety, and well-being of all at individual as well as community level. Novel nature of the virus, its rapid spread with high infectivity, lack of effective treatment, and unpredictable prognosis with restricted health infrastructure have led the local governments to impose nationwide lockdowns by many countries including India as a measure to prevent the chain of transmission. The lockdown resulted into

restriction of movements, limited availability of health services, shutting down of educational institutions and public transport along with ban on social gatherings. Agricultural and industrial sectors have been severely affected by the COVID-19 pandemic. This socioeconomic disruption has come with significant impact on the livelihoods of large strata of population, as there is high risk of unemployment and financial loss. Fear of illness, social isolation, and fear and misinformation spreading through social media along with uncertainty about the future have potential of adversely affecting the mental health of the population. Various studies have already demonstrated impact of infectious disease outbreak on mental health in the recent years.<sup>3,4</sup> The persons affected by the economic shutdown, persons with COVID-19 and their contacts, especially those being kept in quarantine and healthcare workers (HCWs) are at high risk of developing mental health issues. Though at present the primary focus is on physical health, neglecting mental health may have



deleterious effects in form of increase in anxiety and depressive symptoms, increased use of psychoactive substances, sleep disturbances, and so on. In fact, there have also been a few reports of suicidal attempts and completed suicides in persons being under quarantine or admitted with COVID-19 infection. Thus, the mental health professionals (MHPs) face several challenges in this background, and there is a need to evolve well-planned strategies to meet this challenge.

This paper discusses various strategies at individual as well as the community level to meet the mental health challenges being faced in background of the COVID-19 pandemic.

### Challenges for Mental Health during Coronavirus Disease 2019 Pandemic

COVID-19 has been spreading alarmingly across the globe with fatalities increasing day by day. Restrictions imposed through lockdown leading to financial instability have created a sense of panic in the general population. Social isolation, fear of contracting illness, unpredictability of disease with high morbidity and mortality, fear of unemployment, and sense of loss of control are among many factors contributing to the rise of mental health problems. Though it is early to study impact of COVID-19 systematically, mental health issues like anxiety, worries about self and family getting the infection, depression, sleep disturbance, symptoms of post-traumatic stress disorder, multiple pains, and feeling stressed have been reported in recent studies.<sup>5,6</sup> People with pre-existing mental illness are more likely to react to such stressful situations, leading to relapse or worsening of preexisting mental health condition. Lockdown, lack of public transport services, and limited access to health services have made difficult for people with mental disorders in maintaining their regular follow-up with the mental health services. Persons with chronic or severe physical illnesses are also facing similar issues leading to worsening of their illness and worries. Individuals infected by COVID-19 who are under isolation or treatment or those who have been quarantined may develop severe anxiety, worries, depression and stress reactions. Quarantine and isolation have also been reported to be associated with stigma and discrimination.<sup>7</sup>

There are also vulnerable groups like the elderly, pregnant ladies, children, migrant workers, unemployed people, and individuals with existing severe medical or psychiatric illnesses, who would need extra care. The HCWs are also at high risk of contracting disease particularly those who are involved in diagnosing or treating known or suspected COVID-19 patients. Fear of contracting illness and infecting loved ones along with threat to life, increased work hours, lack of adequate protective equipment, fear of discrimination or violence in society, and lack of effective treatment are important stressors for HCWs.<sup>8</sup> This may result into feelings of loneliness and helplessness, physical and mental fatigue, and depression or anxiety symptoms. Thus COVID-19 is a major challenge to mental health. The MHPs need to develop well-planned strategies at delivering mental health services to the affected population as well as strengthening stress coping abilities of the community to deal with the stress of

social isolation and economic crisis in the background of the lockdown. There is also a strong need to tackle the stigma and discrimination being faced by the persons infected by COVID-19 and their contacts even following recovery. The MHPs can also play an important role in managing stigma in the community.

### Strategies for Developing Mental Health Care Services during Coronavirus Disease 2019 Pandemic

COVID-19 pandemic is fast turning into a global mental health crisis and major international agencies have launched wide-ranging efforts to raise awareness about its mental health implications. WHO has been instrumental in highlighting specific mental health issues and assisting countries in formulating their response.<sup>9</sup> On May 13, 2020, the United Nations (UN) Secretary General emphasized mental health as essential component of COVID-19 response and launched its first policy brief on "COVID-19 and the need for action on mental health."<sup>10</sup> UN has urged the governments, the civil society, and the health authorities to collaborate and urgently address the mental health dimension of the pandemic. The policy document recommends three immediate actions for this purpose: (1) a whole-of-society approach for mental health promotion and protection, (2) widespread availability of emergency mental health and psychosocial support, and (3) building mental health services for the future to support recovery from the pandemic. Academic institutions and health and social-sector organizations across the world have become active in conducting research and disseminating useful information focusing on strategies to cushion the enormous psychological impact of the COVID-19. Various national governments including the Government of India have also been taking steps for integrating mental health and psychosocial support as part of management plan for the pandemic. There is no single prescribed policy for this unprecedented event in modern history, and the strategies would evolve gradually with the progress of the global pandemic. MHPs and policy makers need to join forces to develop a comprehensive and multidimensional response plan. Building capacity for promotive, preventive and curative aspects of mental health care for society at large with focus on vulnerable groups is need of the hour. The strategies would include raising community awareness about the problem, expanding mental health services, emotional support for the quarantined persons, and supporting and sensitizing the health professionals.

#### Raising Community Awareness

Effective public health communication is a crucial step in controlling the escalation of overwhelming anxiety and panic. Basic knowledge about the modes of disease transmission and preventive measure should be made available to the public. Mass media including print, audio-visual, and social media are useful in dissemination of such information and educating the population. MHPs can be involved in developing and delivering such public health

messages.<sup>11</sup> Factually, accurate information in a simple, concise and comprehensible language coming from reliable sources (political leadership, health professionals, popular personalities, etc.) plays an important role in conveying the message.<sup>1</sup> Equally important is countering the spread of misinformation and rumors by rapidly identifying malicious content, debunking myths, disseminating alerts, and counterarguments. Fear and anxiety due to COVID-19 infection can be addressed by unambiguous public messages from health authorities clearly describing prevention approaches, pathognomonic symptoms of COVID-19 infection, self-monitoring, and methods to swiftly access testing and medical help. In addition to the information about physical risks, public should also be educated about common psychological responses in such a situation and informed about methods of coping with stay at home restrictions (lockdown).<sup>12</sup> Sharing experiences of individuals, who have recovered from COVID-19 infection, can also help to alleviate anxiety in community. Positive mental health and stress reduction strategies are useful in building resilience among individuals to tide over period of crisis. Basic advice includes sleep hygiene, activity scheduling, exercising, maintaining social connections, relaxation techniques, avoiding substance use and limiting time watching news and on social media.<sup>12</sup>

Social adversities like financial strain, loss of employment and educational opportunities, social isolation, and related issues secondary to the pandemic that threaten to trigger psychological distress also need to be addressed by raising awareness about the available alternatives for help, which may include welfare measures from the government and pragmatic financial advice. Options of work from home, distance learning using media, virtual classes from the educational institutions, and also virtually connecting with family members and friends are some other alternatives which can help in reducing distress and anxieties in the lockdown atmosphere. Another subject for community awareness programs is reduction of stigma associated with the infection and against those at higher risk of getting infected.<sup>7,9,13</sup> Stigma reduction requires spreading the true facts, engagement of social influencers, amplifying the voices of people with lived experience of COVID-19 infection, honoring frontline care providers and promoting ethical journalism.<sup>14</sup> Along with health information targeting the general population, specific advice and information support should be made available for the particularly vulnerable groups including children, elderly, people with COVID-19 infection, quarantined individuals, HCWs, people with preexisting mental disorders and those facing severe psychosocial adversities (e.g., migrants, unemployed and those facing domestic violence). Both national and international agencies like the WHO, ministry of health and family welfare, health care institutions, and professional societies are regularly publishing relevant public information about how to tackle various psychosocial issues arising out of the pandemic. Such information is available both in print as well as digital media in various local languages and needs to be further disseminated so as to reach all strata of the population.

### Expanding Mental Health Services

COVID-19 pandemic has brought the issue of public mental health to the center of debate and offered a unique challenge for policymakers, academicians and clinicians globally. A major spike in psychological adversities and mental disorders is expected among general population and more so in the high-risk groups. In addition to lack of adequate human resource and infrastructure, risk of spread of infection has significantly disrupted the routine inpatient, outpatient, and community mental health services. Mental health systems across the world are quickly adapting to the situation by initiating and scaling up digital models of psychiatric assessments and consultations.<sup>15</sup> Various audio-visual communication platforms and models are being used globally and evaluated for their effectiveness during the pandemic. On March 25, 2020, the board of governors of the Medical Council of India announced “Telemedicine Practice Guidelines” providing a legal framework enabling medical practitioners to practice telemedicine in the country.<sup>16</sup> Subsequently, the All India Institute of Medical Sciences (AIIMS), New Delhi, started its telemedicine service for the follow-up patients. As a part of this service, the Department of Psychiatry, AIIMS, New Delhi, has also started telemedicine services. Given the uncertainty regarding the duration of pandemic, further innovative and sustainable models of telepsychiatry and telepsychotherapy services need to be developed and evaluated. Mobile application technology has also been used in past for many psychiatric disorders and has served as tools for health information, self-help, symptom monitoring, lifestyle modification, delivering psychotherapy and medication management.<sup>15</sup> Many such apps are available on Internet and their use has been advocated during the pandemic. MHPs can recommend appropriate apps to patients which can become an integral part of treatment in future. Adopting digital psychiatry and scaling-up will require investment of resources, collaboration with IT professionals, training of clinicians and quality improvement based on experience.<sup>15</sup> Legal, ethical, and patient safety issues also need to be addressed while implementing such models.

It needs to be pointed out here that telemedicine can benefit mainly in routine consultations, that is, managing patients with low-risk and mild-to-moderate symptoms. Patients with severe symptoms or with comorbid physical health issues will require in person outpatient visits and may even need inpatient admission. It is therefore advisable that strict screening of patients, physical distancing, and infection control protocols are established for emergency, inpatient, and outpatient psychiatric settings. Further precautions would be needed in procedures like repetitive transcranial magnetic stimulation, electroconvulsive therapy which will pose higher risk to the treatment team and require extra precautions and personal protective equipments (PPEs). MHPs will need to be educated and trained in appropriate use of PPEs and self-monitoring of symptoms. Psychiatrists will also need to understand potential interactions of psychotropic medication with COVID-19 illness and its treatment, and prepare guidelines for the treatment of mental health problems in COVID positive patients. Since hospital inpatient units often become

hotbeds of infection, it will be advisable to avoid inpatient admissions as much as possible and keep these reserved only for patients with life-threatening risk. The limitations placed on the hospital-based psychiatry system lay emphasis on development of community mental health. Reduction in inpatient admissions will require enhanced support for such patients in the community by creation of crisis intervention and home treatment teams as an alternative. Mental health workforce will need to be rapidly expanded to meet the rising demand, which can be done by increasing investment in community mental health. The National and District Mental Health Programs would need to be further strengthened to meet the challenge. As recommended by the UN and the WHO, mental health services would need to be integrated with COVID-19 response teams to improve access to a whole array of psychological and psychiatric services.<sup>10</sup>

### Support for the Quarantined Patients

MHPs have another important role in COVID-19 units and quarantine centers. COVID-19 positive and suspected patients display a range of stress reactions which may interfere with their medical management.<sup>7</sup> MHPs need to sensitize COVID-19 frontline HCWs about these issues and train them in communication skills to allay patient's anxiety, using screening tools for mental health problems, providing basic psychosocial support/counseling to patients and referring to a psychiatrist when needed.<sup>17</sup> Health authorities should be proactive in their approach to address the mental health needs of patients and suspects to avoid untoward incidents. Quarantine centers and COVID-19 wards need to be equipped with patient education material about COVID-19 and mental health literature about managing stress and uncertainty. Structured daily routine, basic amenities, physical exercise, recreation facilities and encouraging virtual connectedness with family helps people cope with the quarantine.<sup>7,17</sup> Various information technology-based models of providing mental health support to this population are currently being tested across the globe. Initial reports are encouraging and further research is needed to consolidate the findings and build sustainable models.

### Supporting and Sensitizing Health Professionals

A large proportion of country's health care work force including doctors, nurses and paramedical staff are involved in provision of COVID-19 related services. They are experiencing significant psychological distress due to multiple factors and need to be sensitized and supported about need of caring for their own mental health. Studies are being done at national and international level to identify HCWs' needs, and to evaluate various psychological interventions to support them during this period. Health system leaders and hospital administrators need to understand the needs of the HCWs and create a positive work environment.<sup>18</sup> These systemic interventions include adequate provision of PPEs, training in infection control, supervision and clinical protocols, adequate rest and sleep time, freedom of expression, motivation and boosting morale, opportunities to contact family members and availability of psychological help.<sup>17,18</sup> MHPs have a

key role in coordinating with COVID-19 response teams to screen HCWs for mental health problems, addressing their specific concerns, providing psychological support, teaching coping and self-care skills, problem-solving, ventilation and reassurance depending on the context of consultation.<sup>17</sup> Dedicated confidential mental health helplines for health professionals providing access to both clinical psychologists and psychiatrists need to be made available.

## Conclusion

COVID-19 pandemic is spreading alarmingly and has affected health, well-being and financial stability of the general population all over the world with significant impact on mental health. There is a need to raise awareness about its mental health implications and make strategies to manage the mental health issues. Effective public health communication in simple, concise, and comprehensible language coming from reliable sources may help to alleviate panic and anxiety in public. Mental health issues in persons being quarantined and in COVID-19 patients need to be taken care of. HCWs also face lot of stress while caring for the COVID-19 patient and need emotional support. IT-based technologies can be of great help in delivery of the mental health care. There is a need to strengthen the mental health system in view of various challenges and demand posed by COVID-19 pandemic

### Conflict of Interest

None declared.

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# COVID-19 Pandemic and the Mental Health of Health Care Workers: Awareness to Action

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## Abstract

The enormity of the coronavirus disease-2019 (COVID-19) pandemic has overwhelmed most health services and has placed health care service providers under unprecedented stress. The rapidity of spread, uncertain clinical course, and unavailability of effective treatment make clinical decisions cognitively demanding. Extended work hours inside uncomfortable protective gears, improper hydration, with conflictual health systems and patients at work; and social stigma and isolation after it ends, have created an unending downward spiral of mental health in care providers. Care providers are at increased risk of developing mental health problems in form of burnout, stress reactions, anxiety, depression, and post trauma stress. Concerted strategies for managing the mental health of care providers are urgently needed at individual and systems level. A plethora of strategies, developed from previous experience of crisis management, need to be made available to care providers through accessible mediums of delivery. This paper explores the mental health problems encountered by health care personnel and examines various strategies which need to be implemented to manage them.

## Keywords

- ▶ mental health
- ▶ COVID-19
- ▶ health care worker
- ▶ depression
- ▶ stress
- ▶ management

## Introduction

Coronavirus disease-2019 (COVID-19), caused by the novel coronavirus (severe acute respiratory syndrome coronavirus-2 [SARS-CoV-2])<sup>1</sup> has emerged as the most significant global health crisis of our times. The outbreak was declared a Public Health Emergency of International Concern in January 2020, and was subsequently designated as a pandemic in March 2020.<sup>2</sup> In just 144 days since the first reported case in Wuhan, COVID-19 infected 4,993,470 persons globally and claimed more than 327,738 lives.<sup>3</sup> The World Health Organization as on May 22, 2020 projected a daily new infection of around 103,211 persons/d with around 4,477 deaths per day. In India, the first case of COVID-19 was reported on January 30, 2020 in the state of Kerala. The Ministry of Health and Family Welfare, Government of India reported a total of 124,462 cases and 3,583 deaths in the country as of May 25, 2020 with the number growing fast.<sup>4</sup> A nationwide lockdown was initiated in the country on March 24, 2020, which was extended in phases due to rising number of cases, and was partially lifted after May 31, 2020. With surge in cases and hospitalizations, health care workers (HCWs) around the

world have been thrust into the position of frontline personnel in the war of survival. The role of HCWs in such times of unprecedented crisis is challenging and is fraught with both physical and mental health consequences.<sup>5</sup>

The psychological impacts of COVID-19 are many and the HCWs are not immune to it.<sup>6-8</sup> The increase in working hours, inability to meet family and friends, fear of transmitting the infection to family members, unfavorable working conditions in areas with limited resources, overenthusiastic reporting by media and projecting HCWs as COVID warriors, and paradoxical societal stigma, all contribute to the emergence of various mental health problems. Over the past few months, mental health problems faced by HCWs have been increasingly highlighted by health professionals themselves,<sup>5</sup> with an associated upsurge of research communications in scientific journals. There is an urgent need for identification and management of mental health issues in the HCWs through support, counselling, and psychotherapeutic strategies as and when required. This paper discusses about identification and management of common mental issues faced by HCWs involved in management of patients with COVID-19.



## Mental Health Issues in Health Care Workers

Global crisis situations are likely to adversely impact a large section of the general population due to the associated stress, uncertainty, and fear. Infectious disease outbreaks in the past including severe acute respiratory syndrome (SARS) epidemic and H1N1 pandemic were associated with reports of stress, anxiety, depression, burnout, post-traumatic stress disorder (PTSD), and other mental health issues in HCWs.<sup>7,9,10</sup> Occurrence of mental health problems in medical staff, including doctors and nurses posted in COVID duty, has been reported uniformly across developed as well as resource constrained countries.<sup>11-15</sup> Mental health disturbances varying from subthreshold (36.9%), mild (34.4%), and moderate (22.4%) to severe (6.2%) level as assessed on the Patient Health Questionnaire have been reported in the HCWs in Wuhan.<sup>16</sup> Another study from China reported that about half of the HCWs had symptoms of depression, 30% experienced insomnia, 45% had anxiety, and more than 70% reported distress due to COVID-19.<sup>17</sup> Socio-demographic factors like age, gender, place, and department of work and psychological factors like poor social support were associated with depressive and anxiety symptoms as well as with increased reporting of stress and insomnia.<sup>6</sup> A multinational and multicentric study, which also had 3 centers from India, reported that though the rates of depressive and anxiety symptoms were similar to other studies, 5.3% of the subjects screened positive for moderate to very severe depression, and 8.7% had moderate to extremely severe anxiety. Headache (32.3%) was the commonest physical symptoms reported, and physical symptoms experienced in the preceding month were predictive of subsequent depression, anxiety, or PTSD.<sup>11</sup> Another study from Singapore reported of lower scores on Depression, Anxiety, and Stress Scale and Impact of Events Scale-Revised in HCWs during the current pandemic as compared with previous SARS epidemic, citing increased mental preparedness and stringent infection control measures after Singapore's SARS experience as possible reason.<sup>15</sup> The current pandemic is both a challenge as well as an opportunity for working on not only the development of clinical expertise but also on psychological preparedness of the HCWs. Steps need to be taken for timely assessment of the HCWs so that help can be offered for the mental health issues that they face.

## Stressors Contributing to Psychological Distress

The emotional distress experienced by HCWs remains multifactorial in causation. Disaster mental health research conducted in the past and present has highlighted various factors which contribute to nonspecific symptoms of psychological distress as well as psychiatric disorders in the workforce. Factors related to work, finances, social support, personal predilection and resilience often combine to determine the expression of symptoms.

## Work-Related Stressors

The rapidly changing face of the pandemic is a challenging task to deal with for clinicians as well as researchers. The unpredictability of the nature of the virus and its mutations, variability of the clinical course in patients, and lack of any curative treatment options make all clinical decisions a judgment call, cognitively stressing decision makers.<sup>18</sup> Awareness about the lack of any definite and effective treatment can lead to therapeutic nihilism. Multiple and rapidly changing guidelines have resulted in an information explosion that clinicians need to assimilate rapidly into clinical practice. Coupled with the increase in working hours and expansion of workload due to increasing critically ill patients, clinicians face the moral dilemma of choosing between knowledge or service. Non-availability of adequate resources including personal protective equipments (PPEs), ventilators, and crucial equipments, in even the most resourceful health systems, force HCWs to take on additional roles of protesters and whistleblowers.<sup>19</sup> Apart from the fear of the possible patient to HCW infection, workforce shortage and death of coworkers can quickly erode the moral of the whole unit.<sup>20</sup> Difficulty in dealing with patients not willing to opt for quarantine, or not following prevention protocols and using masks leads to increased workplace conflicts. Patient anger due to genuine infrastructural shortcomings are often borne by HCWs as they remain the proximate representative of the system.<sup>21</sup> Prolonged work hours and post-duty-quarantine protocols have ramifications beyond workplace stress. Worry about family members and inability to fulfil family role obligations due to work is a source of concern. A survey conducted on HCWs in China revealed that once the medical staff initiated their COVID-19 duties, their primary reason of worry was the fear of transmitting the virus to family members rather than getting infected themselves.<sup>22</sup>

## Inadequate Social Support

HCWs often need to stay away from their friends and families, due to the fear of transmission to family members. Strict physical distancing measures, that need to be followed at work, deprive HCWs of their workplace social and human interactions that help reducing stress.<sup>23</sup> In an already stressful environment, HCWs feel isolated and lonely on work and off work. The impact of poor social support on mental health and self-efficacy of HCWs has been highlighted by multiple authors.<sup>24</sup> HCWs have repeatedly reported their physical health to be poor, with sleep deprivation, headache due to rebreathing, dehydration due to thermal build-up in PPEs, and fatigue due to inability to eat in PPEs. Inadequate access to adequate psychological help has led to aggravation of mental health issues in HCWs.<sup>16</sup>

## Stigma, Hostility, and Media Response

The lack of adequate awareness and knowledge amongst general public about the pandemic has led to stigmatizing attitudes and outright hostility toward the HCWs. Doctors have been locked up in their houses, asked to vacate their rented accommodations, physically abused in markets, and

have been refused cremation in death in India. Media has highlighted events of mass assault on HCWs during contact tracing efforts. Globally, HCWs have been pelted with eggs (Mexico), attacked with bleach (Philippines), spit upon and harassed (United States and Australia).<sup>21</sup>

Though various attempts are being made by the Government, organizations, and media platforms to increase awareness, the incidents of general public expressing anger and aggression toward HCWs continue to happen. A constant media scrutiny, media sensationalism and lack of follow-up reporting create an environment of permissiveness for violence against HCWs. In contrast, overenthusiastic reporting, projecting the staff as frontline heroes and saviors, lead to unnatural patient and societal expectation, pressurizing HCWs. All these factors have the potential to contribute to psychological distress.

#### **Inadequate Communication and Associated Guilt**

As the patient load has increased, the average time an HCW spends on a patient has decreased. Use of masks and PPE make it difficult to have a good and satisfying communication with the patients. Many times, the HCW has to work in ways which is not pertaining to the usual standards. The staff also needs to ensure that relatives and friends of patients are not exposed to the virus which requires following specific protocols on not allowing family members to meet patients, and see or collect the body after death. Breaking the bad news of death may not be properly handled as in usual situations and often information is given to family members telephonically. HCW may sometimes feel guilty for the same which can further lead to mental health concerns. The feeling of guilt can also arise in HCWs who have been quarantined after exposure or belong to a special population like pregnant females, who may feel guilty of not being able to help at the frontline.<sup>13</sup>

### **Commonly Encountered Mental Health Issues**

The pandemic has an alarming impact on the mental health of general public and HCWs. Prolonged periods of shouldering the burden have raised concerns about the psychological impact on the medical personnel involved in providing care. Some of the common mental health issues encountered are discussed as below:

#### **Burnout**

Burnout has been described as a triad of decreased sense of accomplishment, depersonalization characterized by lack of compassion and empathy, and emotional exhaustion.<sup>22</sup> It does not fall under the category of any specific psychiatric disorder but has a significant impact on the work efficiency and competency and can further lead to development of psychiatric symptoms and illness. Medical staff experiencing burnout may opt for quitting their jobs or may not be able to function adequately. The overall quality of life may get compromised. It is important that burnout be identified early, so that steps can be taken to manage it.

#### **Moral Injury**

Moral injury is not a psychiatric disorder but a term that has been borrowed from military. Any action that goes against one's moral or ethical values can result in moral injury. The parallel examples in medical staff in comparison to situations faced by military personnel can be multiple. These may include choosing between two critically ill patients who require attention at the same time, following circulated protocols which one may personally not believe to be based on one's clinical experience or making treatment decisions which do not turn out to be fruitful in terms of saving life of patients. HCWs who face this problem may be prone to develop negative emotions and negative cognition. They may feel guilty or ashamed of either committing or omitting an action and feel stressed. Some HCWs may emerge stronger after being confronted by challenging situations, with strengthening of their psychological resilience and self-esteem, often referred to as post traumatic growth.<sup>25</sup>

#### **Acute Stress Reactions**

The HCWs are exposed to various stressors as has been discussed previously in this paper. The stressors can lead to transient stress reactions which might resolve in a period varying from few hours to 2 to 3 days. Affective, cognitive, physical, and autonomic signs of anxiety are common presenting symptoms of acute stress reaction.

#### **Anxiety**

HCWs may develop anxiety and fear due to various risk factors including those related to work and lack of adequate support.<sup>20</sup> The anxiety experienced can have cognitive, behavioral and physical component. Cognitive symptoms include constant worries, decreased attention, and concentration and fearful anticipation of extreme or worse outcomes. Physical symptoms include signs of autonomic arousal like palpitations, dryness of mouth, epigastric discomfort, tremors, headache, or aching muscles, etc. Behavioral component includes avoidance behavior, irritability and restlessness. The symptoms of anxiety may arise for the first time during the times of crisis or there can be an exacerbation of pre-existing psychiatric condition. Medical HCWs have been reported to experience an increased prevalence of anxiety, insomnia and depression.<sup>26</sup>

#### **Depression**

Depressive symptoms are also common in the HCWs involved in delivering services to COVID-19 patients.<sup>8,25,26</sup> There can be an exacerbation of symptoms in those already suffering from psychiatric disorders. Common symptoms of depression include disturbed sleep and appetite, low mood, decreased interest in previously pleasurable activities, poor attention and concentration and easy fatigability. An inability to help the patient in the crisis may also lead to ideas of guilt, shame, or self-harm.<sup>25</sup> There can also be cognitive component of feeling helpless, hopeless, and worthless.<sup>27</sup> When the symptoms are many and florid and distressing, interfering in functioning, a diagnosis of depressive episode

can be made. The problem needs to be adequately addressed by timely pharmacological and psychological interventions.

### Substance Use Disorders

Tobacco and alcohol are among the commonly used psychoactive substances. There can be an increase in difficulties faced by those using or dependent on these substances. Tobacco use is quite prevalent in HCWs with a recent systematic review and meta-analysis reporting a pooled prevalence of 21%.<sup>28</sup> Studies on alcohol use and dependence in HCWs are limited. Some studies have reported hazardous or harmful drinking in approximately 4 to 6% of the HCWs.<sup>29</sup> With the lockdown in place, restrictions in procurement and work-related factors like longer duty hours and use of PPE can act as barriers in the use of these addictive substances. This can lead to minor withdrawal symptoms like irritability and restlessness in tobacco users and symptoms like nausea, vomiting, poor sleep, irritability, craving, fine tremors and signs of autonomic hyperactivity in those taking alcohol. For those consuming these substances in a dependent manner, the withdrawal can be severe resulting in coarse tremors, seizures, and delirium tremens which would require emergency management.

### Post-Traumatic Stress Disorder

Besides the commonly encountered mental health issues, there is a possibility of development of PTSD later in those involved in COVID-19 duties. The projections come from past experiences with SARS and Middle East respiratory syndrome (MERS) outbreak.<sup>9</sup> Based on previous research, some researchers expect that with increasing deaths and other risk factors leading to psychological trauma, the rates of PTSD may rise above 10% in the current pandemic.<sup>9,11,30</sup> Moral injury in the form of a perceived inability to help the patient may also contribute to the development of PTSD.

### Other Psychiatric Symptoms

A higher prevalence of insomnia, anxiety, depression, somatization and obsessive-compulsive symptoms has been reported in medical health workers as compared with non-medical health workers in a study from China. The authors also reported that those who had risk of coming in contact with COVID-19 positive patients had a greater risk of developing obsessive compulsive symptoms. Presence of a comorbid organic disease was a risk factor associated with insomnia, depression, and obsessive-compulsive symptoms in nonmedical health workers.<sup>26</sup>

### Managing Mental Health Issues

HCWs caring for patients with COVID-19 experience significant psychological distress and mental health issues which need to be addressed.<sup>31</sup> There is a growing need to prepare the HCWs for the mental health crisis and build up their resilience. The mental health problems can be dealt both at an individual level as well as at the level of team leaders and organization.

### Management at Individual Level

At an individual level, HCWs can involve themselves in various activities that help in promoting their mental health. Some general guiding principles include maintaining a regular routine, adequate sleep and regular food intake. A schedule of regular physical exercise, deep breathing exercises, meditation, yoga, or religious activities depending on individual preferences can help the individual HCW in decreasing levels of distress and burnout. One needs to stay in touch with family and friends through phone or social networking platforms and discuss and share one's worries and feelings with them including talking about things which one finds pleasurable, other than work.<sup>32</sup>

Messages to the HCWs, as outlined below, are helpful.

- Ensure that the loved ones are fine by talking to them rather than overthinking about the situation.
- Take pride in the work you are doing and try to rationalize your fears about getting infected and the risk of transmitting infection to your family members.
- Avoid using negative coping strategies like use of tobacco, alcohol and other drugs.
- Take breaks in between from COVID-19 news and rely only on authentic sources.
- Everyone in the battle with the pandemic experiences these problems and one is not alone. But at the same time, be aware of your condition and if the distress is interfering with your social and occupational functioning, do not hesitate in seeking expert opinion and help.

### Management at the Level of Team Leaders

The team leaders have a challenging role to play when handling crisis situations. But looking at the positive aspect of this, they emerge stronger and more confident after they have adequately handled the situation. The leaders need to be open for a bidirectional conversation with health care personnel working under their leadership.<sup>10</sup> They need to empower their staff and be humble and provide them accurate information. Leaders can encourage staff to share their concerns and fears with them, so that both can work collectively to explore possible solutions. Adequate training of staff and matching them to the roles based on their work experience is essential. Equally essential is staff rotation from high stress to low stress jobs.<sup>31</sup> They can ensure that early support is provided, and confidentiality is maintained. If there is need for expert help or detailed assessment, the HCWs can be referred to mental health experts for the same. Ensure that information of available help options is available with the staff. The HCWs should be given adequate breaks from the COVID-19 duties.

Availability of support from family and colleagues, validating and appreciating the contributions made by staff, and providing a supportive environment are likely to have positive impact on the mental health of HCW.<sup>33</sup> System of buddies as in armed forces can be helpful. A buddy can be a colleague, senior, or any other staff who may be expected to provide support, monitor stress and maintain confidentiality.<sup>34</sup> It is also essential that the team leader uses this opportunity to



learn and create a meaningful narrative after the crisis is over, so that the resilience is built up. Aftercare also needs to be ensured by continuing monitoring of staff for emerging new symptoms or the continuing symptoms.

### Management at Organizational Level

Organizations need to ensure that work-related stressors are adequately managed like ensuring availability of PPE, providing transport and resolving accommodation difficulties faced by staff, equitable distribution of resources, and being available to address the concerns of staff and boost their morale. The organizations can hold meetings with team leaders to stay updated about the concerns of staff. Focus should not only be on providing help for mental health problems as they emerge, but also on preventing their occurrence.

### Specialized Psychological Support

If the mental health issues do not resolve on their own and the complaints are more pervasive and persistent and lead to disturbed functioning or compromised quality of life, special intervention should be provided. This includes referral to a mental health professional, conducting a detailed assessment and tailoring the treatment, if required, to the needs of the individual. Common indications requiring referral include risk of harm to self or others, onset of psychotic symptoms, and excessive consumption of substance of abuse. Nicotine replacement therapy can be offered for tobacco dependence. Pharmacotherapy and psychotherapy can be offered to the affected person, depending on the needs and preference.

### Conclusion

As we continue our battle with COVID-19, we need to focus on the mental health of our HCWs who are working at the forefront. Mental health problems are expected to arise, and adequate support needs to be provided to combat it. The role of mental health professionals in this fight is both crucial and challenging as they cater to the increasing psychological support needs of HCWs with limited resources in terms of trained staff available throughout the country. A concerted effort for service provision at both individual and organizational level needs to be achieved quickly. Utilization of technology infrastructure to create accessible and flexible service delivery, and a plethora of strategies need to be utilized to provide the greatest benefit to the largest possible numbers.<sup>35</sup> The focus should be on mental health promotion and prevention as well as early identification and management of these mental health issues.

#### Conflict of Interest

None declared.

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## Social and Psychological Consequences of “Quarantine”: A Systematic Review and Application to India

### Abstract

**Background:** Quarantine has been used as a public health measure to contain the spread of communicable diseases. Its use in the current COVID-19 pandemic is based on experience from the past while handling other coronavirus infections. **Objectives:** The aim of this study is to synthesize the available literature focusing on the psychological and social consequences of quarantine. **Materials and Methods:** PubMed search for original research articles published in peer-reviewed journals in the English language was done. Studies focusing on psychological or social impact on quarantine were included. In view of the current pandemic being caused by coronavirus, studies were limited to the outbreak causing coronavirus diseases. **Results:** Psychological problems most commonly reported were anxiety, depression, acute, and posttraumatic stress disorder. Various other emotional problems, loneliness, anger, frustration, and psychosomatic problems were also reported. Quarantined individuals experience stigma and isolation. The literature on the purpose of quarantine, and referral pathways to obtain help and care seemed lacking. Literature from India and other low- and middle-income countries was scarce. **Conclusion:** There is a need to address the psychosocial issues emerging from the experience of quarantine. Mental health workers can play an important role in managing them, but it would require collaboration and good organizational support. More studies from developing countries can be planned in future.

**Keywords:** COVID-19, Middle East Respiratory Syndrome, psychological, quarantine, severe acute respiratory syndrome, social

### Introduction

The world today is facing a global health crisis. In December 2019, the Wuhan city of China witnessed the initial outbreak of COVID-19 disease. The outbreak was declared a public health emergency of international concern in January 2020, and a pandemic in March 2020, by the World Health Organization.<sup>[1]</sup> Preventive measures such as frequent hand washing, maintaining good cough hygiene practices, and physical distancing have been stressed upon.<sup>[2]</sup> The government of India responded to the pandemic by announcing a nationwide lockdown, which was implemented in four phases extending from March 25 to May 31, 2020. Currently, the country is in the Unlock phase extending from June 1, 2020 to July 31, 2020, where restrictions are being lifted in a graded manner, and re-initiation of activities outside the containment zones in phased manner has begun.<sup>[3]</sup> The pandemic has

significantly impacted the mental health of people, as well as of those working at the front line, like health-care workers.<sup>[4,5]</sup>

Coronaviruses are a large family of viruses, which cause respiratory and intestinal infections in humans and animals.<sup>[6]</sup> Illness caused in humans can range from mild flu-like symptoms to deadly outbreaks, including severe acute respiratory syndrome (SARS, 2002-2003) and middle east respiratory syndrome (MERS, 2012).<sup>[7]</sup> The strategy of quarantine is centuries old, and with the continuous re-emergence of infectious diseases, it has emerged as a powerful public health response. Quarantine measures focus on restricting movements and separating people, potentially exposed to a contagious disease, to ensure that the risk of these people infecting others gets reduced.<sup>[8]</sup> The strategy is beneficial for containing the infection, but the benefits need to be weighed against the impact it has on the psychological and social well-being

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of individuals. It leads to negative psychological impact, including anger and post-traumatic stress symptoms, and thus, adequate support and care need to be provided.<sup>[9]</sup> Looking at the other side of it, if strict quarantine measures are not followed, and infection is allowed to spread, people may feel stressed.

This review was planned with the objective of evaluating the available literature on the social and psychological impact of quarantine. This public health measure has been previously used in a wide range of communicable diseases, including plague, measles, and Ebola virus disease.<sup>[9,10]</sup> To restrict our focus on diseases with a similar causative agent, we have reviewed the available literature on coronavirus disease outbreaks.

## Materials and Methods

### Search strategy

The search strategy for this review was designed, and an electronic search for published literature was done using PubMed. Search items used were related to psychosocial impact (“psych\*” OR “anxiety” OR “depression” OR “emotion” OR “substance abuse” OR “alcohol” OR “tobacco” OR “social stigma”), quarantine (“quarantine” OR “social isolation”) and coronavirus infection (“SARS” OR “MERS” OR “COVID-19”). The search items were used in combinations (“psych\*” OR “anxiety” OR “depression” OR “emotion” OR “substance abuse” OR “alcohol” OR “tobacco” OR “social stigma”), quarantine (“quarantine” OR “social isolation”) AND (“quarantine” OR “social isolation”) AND (“SARS” OR “MERS” OR “COVID-19”).

### Study selection

Studies were included using the following selection criteria.

Inclusion criteria for selecting studies for this review:

- Studies that assess the psychological and/or social impact (including problems such as anxiety, depression, substance use, emotional problems or social stigma) of quarantine due to any outbreak causing coronavirus disease including SARS, MERS, and COVID-19
- Primary research studies, published in the English language and in peer-reviewed journals from November 2002 to June 6, 2020, were included.

Exclusion criteria:

- Studies evaluating the psychological or social impact of lockdown or isolation (separation of sick infected people from others)<sup>[8]</sup>
- Studies that included coronavirus infected patients as participants
- Studies assessing the psychological or social impact of other communicable diseases requiring quarantine such as Plague, H1N1 influenza, or Ebola virus disease
- Studies that evaluate outcomes other than psychosocial issues like quality of life

- Case studies, opinion papers, editorials and review articles.

The initial search yielded 131 papers. Four additional studies were obtained from references of included studies. Of these 117 were full-text articles and 107 were in the English language. Titles and abstracts of all the selected articles were screened. A total of 107 titles and abstracts were screened, of which 73 were excluded as they did not meet the selection criteria. Out of the 34 full-text articles screened, 13 were further excluded because psychological parameters were not assessed ( $n = 7$ ), quarantine was not actually implemented ( $n = 5$ ) and the articles were not primary research articles ( $n = 2$ ). Figure 1 shows the screening process. Finally, a total of 20 articles were selected for the current review.

## Results

Thirteen studies were focused on SARS outbreak, 4 on MERS and 3 on COVID-19. Details of studies are provided in Table 1.

Only one study was conducted in India (on children and adolescents).<sup>[25]</sup> Participants in the majority of the studies were country residents or health-care workers. Two studies included patients on hemodialysis as participants, who were quarantined after a patient or staff working in the hospital became positive for MERS.<sup>[14,18]</sup> Some studies did not specify the exact quarantine duration.<sup>[12,19,21-22,24,29-30]</sup> The quarantine period ranged from a minimum of 2 days

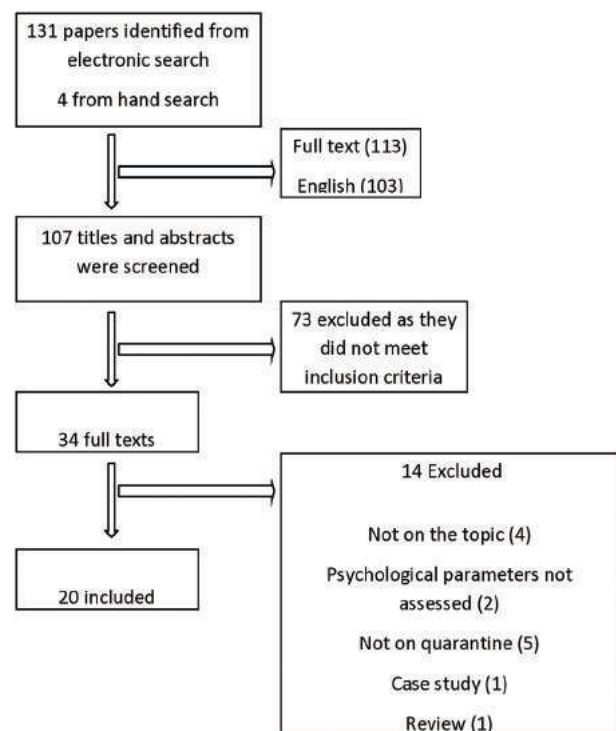


Figure 1: Screening process

**Table 1: Studies included in the systematic review**

Authors (year)	Country	Type of corona virus outbreak	Participants (age)	Assessment measures	Study design
Maunder <i>et al.</i> (2003) <sup>[11]</sup>	Canada	SARS	Around 100 HCW quarantined after exposure various events, 6 came out positive Age not specified	Semi-structured interview	Qualitative
Blendon <i>et al.</i> (2004) <sup>[12]</sup>	Canada	SARS	501 residents	Telephonic survey	Cross-sectional
DiGiovanni <i>et al.</i> (2004) <sup>[13]</sup>	Canada	SARS	1509 residents of Toronto	Telephonic interviews Focus groups Structured interviews	Mixed methods
Hawryluck <i>et al.</i> (2004) <sup>[14]</sup>	Canada	SARS	129 residents (>18 years)	IES-R CES-D	Cross-sectional
Robertson <i>et al.</i> (2004) <sup>[15]</sup>	Canada	SARS	10 HCW	Semi-structured Interview	Qualitative
Cava <i>et al.</i> (2005) <sup>[16]</sup>	Canada	SARS	21 residents	Interview	Qualitative
Marjanovic <i>et al.</i> (2007) <sup>[17]</sup>	Canada	SARS	333 nursing staff	MBI-GS STAXI-2 Study-specific questions for assessing avoidance behavior	Cross-sectional
Reynolds <i>et al.</i> (2008) <sup>[18]</sup>	Canada	SARS	1057 residents ( $\geq 18$ years)	IES-R	Cross-sectional
Mihashi <i>et al.</i> (2009) <sup>[19]</sup>	China	SARS	187 printing company workers	GHQ-30	Retrospective
Wu <i>et al.</i> (2009) <sup>[20]</sup>	China	SARS	549 hospital employees ( $\leq 35$ to $> 51$ years)	IES-R Chinese version	Cross-sectional
Liu <i>et al.</i> (2012) <sup>[21]</sup>	China	SARS	549 hospital staff	CES-D IES-R	Cross-sectional
Lei <i>et al.</i> (2020) <sup>[22]</sup>	China	COVID-19	1593 residents of southwest China ( $\geq 18$ years)	SAS SDS	Cross-sectional
Sun <i>et al.</i> (2020) <sup>[23]</sup>	China	COVID-19	442 HCW ( $\geq 18$ years)	IES	Cross-sectional
Lee <i>et al.</i> (2005) <sup>[24]</sup>	Hong Kong	SARS	Survey of 903 residents 2 SARS negative residents were interviewed (15-80 years)	Focus groups Self-report questionnaire	Mixed methods
Saurabh and Ranjan (2020) <sup>[25]</sup>	India	COVID-19	121 children and adolescents Comparable group of 131 children and adolescents (9-18 years)	Interview using preformed questionnaire	Cross-sectional
Jeong <i>et al.</i> (2016) <sup>[26]</sup>	South Korea	MERS	1656 residents	GAD-7 STAXI-2	Longitudinal
Yoon <i>et al.</i> (2016) <sup>[27]</sup>	South Korea	MERS	6231 residents	Questions specific for assessing psychological impact	Psychological evaluation at community mental health centers
Lee <i>et al.</i> (2018) <sup>[28]</sup>	South Korea	MERS	359 hospital practitioners on duty during MERS outbreak ( $> 20$ years) and 73 patients admitted for hemodialysis ( $61.3 \pm 13.03$ years)	IES-R Korean version was applied to practitioners during hospital shutdown and again after 1 month MINI (abbreviated self-rated Korean version) and HADS were applied to patients	Mixed methods
Cho <i>et al.</i> (2020) <sup>[29]</sup>	South Korea	MERS	89 patients who received hemodialysis	IES-R-K	Cross-sectional

Contd....



Table 1: Contd...

Authors (year)	Country	Type of corona virus outbreak	Participants (age)	Assessment measures	Study design
Bai <i>et al.</i> (2004) <sup>[30]</sup>	Taiwan	SARS	338 hospital staff	Stress reactions questionnaire based on acute stress disorder criteria (DSM IV)	Cross-sectional

CES-D=Center for Epidemiologic Studies-Depression Scale, GAD-7=Generalized Anxiety Disorder 7-item scale, GHQ-30=30-item General Health Questionnaire, HADS=Hospital Anxiety and Depression Scale, HCW=Health care worker, IES-R=Impact of Event Scale-Revised, IES-R-K=Impact of Event Scale-Revised, Korean version, MBI-GS=Maslach Burnout Inventory-General Survey, MERS=Middle east respiratory syndrome, MINI=Mini International Neuropsychiatric Interview, SARS=Severe acute respiratory syndrome, SAS=Self-rating anxiety scale, SDS=Self-rating depression scale, STAXI=State-Trait Anger Expression Inventory, DSM=Diagnostic and Statistical Manual of Mental Disorders

to a maximum of 1 month.<sup>[16,18,25]</sup> Participants were either home or hospital quarantined. Some studies also assessed the factors which contributed to the development of psychosocial issues in quarantined participants. Some of these factors have been mentioned, but have not been fully covered as it was not part of the objective of the current review. One is directed to another recent review, which specifies the various factors contributing to psychological distress.<sup>[9]</sup> Three studies compared quarantined participants with those who did not experience quarantine.<sup>[21,27,29]</sup>

#### Psychological and social impact of quarantine

The qualitative studies were conducted to identify the common themes based on experiences of quarantined individuals.<sup>[13,19,23,26,30]</sup>

#### Adaptation issues and stigma

Emotional difficulties and difficulty in communicating with family members were reported by the majority of the participants in a telephonic survey.<sup>[12]</sup> In a descriptive study conducted to study the impact of quarantine on residents of Toronto, Canada, after the SARS outbreak, 21 residents were interviewed using a semi-structured interview.<sup>[16]</sup> All of them described four sequential stages in their narrative. Life prior to quarantine, getting to know about it, experiencing it and life post quarantine. Uncertainty (fear of health of self or loved ones, unpredictable course of the disease and its impact on daily life), isolation (feeling stigmatized, separated, lonely and bored) and coping (support from others and self-reliance) were the three sub-themes described by participants that intersected the data.<sup>[13]</sup> Psychological difficulties experienced by people quarantined during MERS outbreak was assessed in another study.<sup>[27]</sup> The two key questions asked were about feeling depressed/hopeless or losing interest in life. Around 19.3% of the people reported of feeling depressed and having other emotional problems, and about 350 participants required continued services.<sup>[27]</sup> In another study, around 50% of the participants attributed their symptoms to strict quarantine. Shorter quarantine period predicted lesser avoidance behaviour ( $\beta = 0.23$ ,  $P < 0.001$ ) and lesser anger ( $\beta = 0.14$ ,  $P < 0.008$ ) but did not predict emotional distress.<sup>[11]</sup>

In Hong Kong, residents reported feeling stigmatized in various forms like being rejected, marginalized, or insulted in various domains of their life's including occupational and social functioning.<sup>[24]</sup> Psychological distress due to stigma was noted with respondents reporting high levels of irritability, sleep problems, and somatic complaints like chest pain.<sup>[24]</sup>

HCW reported a constant conflict between their professional, altruistic roles and the negative emotions associated with the risk of them transmitting the infection to family members.<sup>[11]</sup> They felt stigmatized, which highlights the need of providing them with stress management and coping strategies by experts.<sup>[15]</sup>

A study, which assessed both residents and HCW using qualitative methods found that stigmatization and social distancing were major contributors for perceived psychological distress experienced in the form of emotional problems including fear, sense of isolation, depression, anxiety, and boredom.<sup>[13]</sup> Five percent of the HCW thought of violating quarantine measures due to increased stress levels. Among the other HCW, 34% were "pretty stressed" but were not tempted to violate quarantine measures, and 11% were not stressed at all. The remaining reported psychological discomfort but were not overtly stressed. The presence of other members in the same household added to the stress. Coping measures reported by HCW were reading, watching television, and connecting with near and dear ones. The residents from the population survey reported of experiencing stigmatization, such that they avoided social events and gatherings.<sup>[13]</sup>

In the only study conducted in India, 121 children and adolescents in the age group of 9–18 years, placed in either home (30.57%) or community facility (77.68%) quarantine along with their parents formed the study group and about 131 children and adolescents from the neighborhood with same family background, who did not experience quarantine formed the comparison group.<sup>[25]</sup> Most of the participants did not comply with strict quarantine measures advised and the inability to go out to meet friends was the most common difficulty reported by majority (65.26%). Greater psychological distress was reported by quarantined

participants with feelings of helplessness (66.11%), worry (68.59%), and fear (61.98%) being the most common.<sup>[25]</sup>

### Impact of event

Most studies on quarantine have used the IES-R to measure traumatic stress. It is a self-report instrument and consists of 22 items, yielding a maximum score of 88. It has three subscale domains (intrusion, hyperarousal, and avoidance). Many studies have reported significant psychological distress in participants who were quarantined.<sup>[14,16,18,25,28]</sup>

In a study with the majority of HCW respondents (68%), with a median quarantine period of 10 days and 90% experiencing quarantine only once, mean IES-R scores were 15.2 ( $\pm 17.8$ ).<sup>[14]</sup> About 29% of the participants had an IES-R score greater than the cutoff of 20. However, no significant difference was noted between those in the home and work quarantine. HCW were more compliant with the quarantine measures.<sup>[14]</sup> Another study on HCW who experienced quarantine showed high total IES scores and avoidance dimension scores.<sup>[23]</sup> Quarantine experience was significantly associated with IES avoidance ( $Z = -2.674$ ,  $P = 0.008$ ), arousal ( $Z = -1.826$ ,  $P = 0.068$ ) and total IES scores ( $Z = -2.033$ ,  $P = 0.042$ ). The relationship between quarantine and IES score remained statistically significant in multivariate analysis ( $\beta = -4.958$ , standard error [SE] = 2.149,  $t = -2.308$ ,  $P = 0.021$ ).<sup>[23]</sup>

A study on hospital employees who were exposed to SARS in 2003 but were recruited in 2006,<sup>[20]</sup> showed that ten percent of employees had experienced post-traumatic symptoms at some point in the past 3 years with an IES-R score  $>20$ . A strong association was found between any quarantine and PTS symptoms with adjusted odds ratio (AOR) being (2.09 [1.00–4.37],  $P < 0.05$ ).<sup>[29]</sup> Participants quarantined for longer durations had greater mean IES-R scores, and the most common symptoms reported were anxiety, boredom, and anger.<sup>[14]</sup> Regression analysis showed that HCW status ( $\beta = 3.38$ ,  $P = 0.002$ ) and duration of quarantine ( $\beta = 0.40$ ,  $P = 0.012$ ) contributed to greater IES-R scores.<sup>[18]</sup>

The impact of quarantine was not restricted to HCW but affected the common people and patients with comorbidities as well.<sup>[14,18,25]</sup> A study in Canada recruited more than a thousand participants, who reported that they had experienced a quarantine period ranging from 2 to 30 days (median of 8.3 days) and were found to have a mean IES score of 8.9 (standard deviation 13.7).<sup>[18]</sup> Approximately 15% of the participants scored at least 20 on IES-R. Boredom (62.2%,  $n = 638$ , 95% confidence interval [CI] 59.2–65.2), isolation (60.6%,  $n = 622$ , 95% CI 57.6–63.6), and frustration (58.5%,  $n = 600$ , 95% CI 55.5–61.5) were the common feelings reported by participants.

Two studies assessed psychological distress in patients with prior comorbid kidney problems, undergoing hemodialysis

when MERS outbreak occurred.<sup>[14,18]</sup> One of the studies used IES-R-K to assess posttraumatic stress symptoms 12 months after the experience. In total, 17.9% of participants ( $n = 12$ ) reported posttraumatic stress symptoms exceeding the IES-R-K's cutoff point ( $\geq 18$ ). Quarantine duration was linearly associated with the IES-R-K score (standardized  $\beta$  coefficient =  $-0.272$ ,  $P = 0.026$ ). Scores in Avoidance, Emotional numbing and Dissociation subscale were higher in patients with longer isolation period.<sup>[29]</sup> In the other study conducted at the artificial kidney unit, university hospital at Gangdong, total IES-R scores were higher in HCW ( $T = 3.894$ ,  $P < 0.001$ ) who performed MERS task when outbreak occurred.<sup>[28]</sup> The staff had greater risk for posttraumatic stress disorder (PTSD) symptoms, and the sleep and numbness sub-scores were higher in HCW who were sent on home quarantine as compared to those who were not. Thus, the risk continued to rise even after the home quarantine.<sup>[28]</sup>

Stress reactions questionnaire was used to study the impact of quarantine due to the SARS outbreak in Taiwan.<sup>[30]</sup> The questionnaire was based on acute stress disorder criteria of DSM IV. Five percent of the staff out of 338 surveyed met the acute stress disorder criteria, and the most common factor related to it was being quarantined ( $\beta = 1.405$ , standard error [SE] = 0.647, OR = 4.077, 95% [CI] = 1.148–14.48) on multiple logistic regression.<sup>[30]</sup>

### Psychological distress, depression, and anxiety

Various tools have been used to study distress due to quarantine, for example, CES-D, a self-report, 20-item questionnaire was used to screen for depressive symptoms.<sup>[16,21]</sup> State anger was assessed using STAXI-2, and the emotional exhaustion subscale of MBI-GS was used to assess emotional exhaustion.<sup>[17,22]</sup> Self-rated, 20-item, screener SAS, was used in conjunction with self-rated 20-item SDS to discriminate anxiety from mood disorders in one study.<sup>[22]</sup> GHQ-30 was used to identify participants with psychological distress.<sup>[19]</sup>

A study utilizing GHQ-30 was conducted on 187 printing company workers after 7–8 months of the end of the SARS outbreak (in the recovery period).<sup>[19]</sup> Around 25% of respondents reported a score of  $>7$  (suggesting psychological distress) during the quarantine period and about 26% also reported a score of  $>7$  during the recovery period. Suggesting that for some, psychological distress improved in the recovery period, whereas in some new symptoms developed. About 16.6% (95% CI, 14.8%–18.4%) of the quarantined residents expressed feelings of anger on STAXI-2 and even after 4–6 months post quarantine, feelings of anger were still present in 6.4% of respondents (95% CI, 5.2%–7.6%).<sup>[26]</sup>

In a study on hospital employees in China, three groups were formed based on CES-D scores.<sup>[21]</sup> About 8.8% of respondents had a score  $>25$ , indicative of greater

depressive symptoms. The high CES-D score group had a greater percentage of quarantined individuals (60%) as compared to the low score group (~15%). When other factors were controlled for, being in quarantine was associated with higher odds of having a greater level of symptoms of depression (AOR) of 4.90 (95% CI, 2.19–10.99;  $P = 0.0001$ ) on multinomial logistic regression analysis even after 3 years. Greater symptom level for PTSD was significantly associated with greater symptom level of depression (AOR, 7.40; 95% CI, 2.83–19.36;  $P < 0.0001$ ).<sup>[21]</sup> Quarantine negatively impacted the psychological well-being with mean CES-D scores being ( $13.0 \pm 11.6$ ) and about 31% of participants having a CES-D score  $> 16$ .<sup>[14]</sup> In the study on nurses, a significant positive correlation was found between emotional exhaustion and duration of quarantine, anger, and avoidance behavior.<sup>[17]</sup>

A study compared participants who had experienced quarantine themselves and an unaffected group (whose friends/family member/neighbor/colleagues had experienced quarantine).<sup>[22]</sup> Anxiety (8.3%) and depression (14.6%) were prevalent in the entire sample. The prevalence rates of anxiety and depression (12.9%, 22.4%) was higher in the affected group as compared to the unaffected group (6.7%, 11.9%). Certain factors, like poor psychological support and frequent worries about acquiring the infection contributed to increased anxiety and depression.

GAD-7, a self-administered test, was used to assess participants for generalized anxiety disorder in a study conducted at South Korea. About 7.6% (95% CI, 6.3%–8.9%) of the residents showed anxiety symptoms on GAD-7, which persisted in about 3.0% (95% CI, 2.2%–3.9%) of the residents even after 4–6 months of quarantine.<sup>[26]</sup>

### Diagnoses

A study conducted during MERS outbreak developed a short, self-rated Korean version of MINI to screen for anxiety and depressive disorders. Depression and generalized anxiety disorder were reported, but the adjustment improved as the duration of hospital quarantine increased, probably because those admitted received more care and help from psychiatrists.<sup>[28]</sup>

### Discussion

This systematic review evaluates the psychological and social impact of quarantine. Emergence and re-emergence of infectious and communicable diseases have become global health problems, imposing challenges on the world in dealing with them. As these recurrences continue to occur, the public health sector has developed strategies such as isolation, quarantine, and contact tracing to control its spread. Undoubtedly, these measures are required for effective infection control and prevention of transmission and spread in the community. However quarantine can be

taxing in terms of the psychological and social impact. It is, therefore, essential that the risks and benefits of the process are explored systematically to help prepare for eventualities.

Many studies conducted focused group discussions, surveys, semi-structured and structured interviews to identify common themes that emerged from conversations with those who experienced quarantine. The residents reported emotional difficulties such as feeling anxious, irritable, and depressed.<sup>[12,15,19,30]</sup> Lack of proper communication, frustration, fear, boredom, sleep difficulties, somatic complaints, feeling helpless, and worried were the other common themes that emerged.<sup>[12,15,19,23,27]</sup> Some studies suggested that distress may be related to lack of adequate knowledge about disease,<sup>[12]</sup> and inconsistency in the case definitions (e.g., “suspect cases,” “probable cases”).<sup>[13]</sup> The study from India reported significantly greater psychological distress in the quarantined group as compared to the other group.<sup>[25]</sup>

HCW experienced more frustration, anger, and fear.<sup>[23,26]</sup> Additional problems reported by HCW were the unpredictable nature of the disease, not being provided with adequate knowledge and a strict working schedule.<sup>[20]</sup> The most common fear the HCW reported was that of infecting others in the family and close friends.<sup>[30]</sup> The findings are consistent with that of a recent review, which assessed for the psychological impact of quarantine.<sup>[9]</sup>

Stigma and a sense of feeling isolated were seen in both residents as well as HCW.<sup>[13,15,19,26]</sup> Stigma negatively impacts various domains of functioning, including academic, occupational, and social life leading to loss of social relationships.<sup>[24]</sup> Return to normalcy was delayed, and participants felt stigmatized and depressed even after the quarantine was over.<sup>[13,20]</sup>

Greater psychological distress in quarantined participants was evident on quantitative assessment as well, with most of the studies reporting greater IES-R scores for those experiencing quarantine.<sup>[14,16,18,25,28,29]</sup> HCW also reported stress symptoms, but an altruistic approach toward work helped the staff in dealing with these psychological symptoms.<sup>[20]</sup> HCW who performed tasks during acute stages of the infection were prone to develop PTSD symptoms that persisted.<sup>[18,25]</sup> Longer duration of quarantine had a greater impact on psychosocial adjustment.<sup>[16,25]</sup> The risk of developing PTSD was also found to be high in patients with comorbid kidney problems who were on dialysis and got exposed to MERS during the hospital stay.<sup>[28]</sup> A study reported the presence of acute stress disorder.<sup>[11,16,29]</sup>

The five studies which used different screening tools to assess psychological impact found that quarantined participants experience more anxiety, depression, anger, and emotional exhaustion.<sup>[17,20-22,24]</sup> Very few studies used structured diagnostic interviews.



Results of this review are consistent with studies conducted to assess the psychological impact of quarantine for other communicable diseases like Plague, Ebola, and H1N1 Influenza.<sup>[9]</sup> Those involved in direct management of infected cases exhibited higher levels of stress, anxiety, and sleep difficulties.<sup>[30]</sup>

Common limitations of the studies were selection bias due to the voluntary nature of surveys and variability in time of assessment and the duration of quarantine across studies.<sup>[11-13,18]</sup> Studies using a retrospective design would have recall bias as a limitation along with a lack of assessment of relevant psychological and medical problems that could have contributed to stress due to quarantine.<sup>[14,19]</sup> While some studies used validated scales for assessment, confirmatory diagnosis making requires the use of structured diagnostic interviews.<sup>[14]</sup> Lack of generalizability of findings and the possibility of the presence of preexisting psychiatric issues were also not reported.<sup>[18,29]</sup>

Research from India on the psychosocial impact of quarantine is limited. Experience from other countries that have faced and addressed the emerging psychosocial issues of quarantine can be capitalized, and further knowledge needs to be built up. In India, there is a diversity of communities and disparity in the educational and socioeconomic status across the country. This makes the implementation of public health measures like quarantine a challenging task. To add to the complexity is the finite nature of resources and the different types of problems faced by people in different sections of the society. Its imperative to address the concerns of people and provide them with adequate and evidence-based knowledge. Knowledge about the modes of transmission, nature of disease, effective preventive measures, and absence of a definite curative treatment can be provided in simple language.<sup>[9]</sup> It is equally important to make people aware about the purpose of quarantine as it helps in reducing unnecessary anxiety and in improving adherence. Addressing the issues of job loss and income loss can also help in reducing stress. Assurance and information about steps being taken by the government should also be easily accessible and available to people living even in remote areas of the country. There should be an effective collaboration between the hospitals, government, and public health, media, and communities at stake, with better team cohesion resulting from effective leadership.<sup>[11]</sup> Further studies can be planned to address these issues, keeping the socio-economic and cultural disparities prevailing in the country in mind.

Quarantine significantly impacts the psychosocial well-being of an individual, and so adequate support, needs to be provided to people to help them deal with it. People can be made aware of such problems arising as a consequence of quarantine and when they need to seek help. Mental health and psychosocial support should be made available and easily accessible. Telepsychiatry can

be used in these times of crisis, when compliance with strict quarantine measures may lead to immobility.<sup>[31]</sup> Frontline workers often encounter additional psychological problems and are often subjected to discrimination and stigmatization. Adequate support needs to be provided to them as well. People and HCW also need to be informed about the available referral pathways.<sup>[32]</sup> Training on improving coping strategies and techniques to handle stress are warranted.

In the current review, we did not come across studies on the impact of quarantine on people with problematic use of alcohol and drugs. Supplies may get affected during quarantine and can lead to withdrawals and occasional overdose.<sup>[33]</sup> Also, there were very few studies on the psychosocial impact of quarantine on children. Separation from parents and lack of companionship can be traumatic and can lead to a plethora of psychological problems.<sup>[34]</sup> Further studies can be planned to address these issues.

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#### Conflicts of interest

There are no conflicts of interest.

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## Intersectoral Activities in the Time of COVID-19

Intersectoral activities, as the name suggests, require involvement and integration of the mental health sector with public health, medicine, and various stakeholders. The infection that shook the world, COVID-19, not only is causing physical problems but is also causing a surge in mental health issues. It is a matter of concern that people are having “COVID stress” and related problems which is directly or indirectly leading to mental health issues. The motto “No health without mental health” stands true in this time also. Not only this but there may also be a surge in such cases even after the resolution of the problem. There is already concern in the rise in the demand of mental health professionals and a fear of how to meet such a demand. Most emergency departments are not well equipped to handle psychiatric emergencies, and economic burden is another concern. Such disasters disrupt normal lives and affect us in many ways. Such times require a strong leadership from government, and the functions include assessment of various risks to the society along with bringing together various specialized agencies to address those risks and damage control. Since the Declaration of Alma-Ata, the concept of intersectoral coordination for economic and social development of health in general has gained importance and the concept has been applied to mental health sectors as well. The authors have claimed that the intersectoral coordination is lacking in our country citing examples of many health policies related to infectious diseases, national health policy, etc., leading to poor management, unresolved issues, and direct and indirect economic burden.<sup>[1]</sup> Similar scenarios hold true for the mental health sector in India, and no importance is given to this aspect. Similarly,

the “National Disaster Management Guidelines on Psychosocial Support and Mental Health Services in Disasters” is not very forthcoming with the concept of intersectoral collaboration. Although in the National Mental Health Policy, the term “intersectoral collaboration” has been mentioned which focuses on sectors such as education, employment, housing, and social sector which includes private and nongovernmental sectors as well. However, observation from the field has pointed a rather incomplete implementation in the National Mental Health Programme that it was limited by “financial and human resource constraints, lack of community participation, ineffective training, poor nongovernmental organization (NGO)/ private partnership, and lack of a robust monitoring and evaluation (M and E) system.”<sup>[2]</sup>

Thus, “desperate times call for desperate measures,” such is the desperate situation we are going through at present and we need urgent desperate measures to tackle the current situation. Now is the opportunity for us to start building the future and come victorious.<sup>[3]</sup> As we know that there is a huge gap in the mental health services and severe deficiency in professionals, especially in a country like India, there needs to be a unique plan which caters to its need. There is a need to focus on developing special teams that not only consist of mental health professionals (incl. psychiatrists, psychiatric nurses, psychologists, and social workers) but also colleagues from other specialty including medicine, public health specialist, and stakeholders. The collaboration should be bi-dimensional, that is, on the one hand, there should be horizontal collaboration which includes different sectors related to health and administration at the same time; on

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the other hand, vertical collaboration that includes managing decisions from a joint committee which are smoothly carried out by those working in the field. The focus should start from the public and inclusion of preventive measures. The decisions should be made jointly or collaboratively, and the process should first start with frequent and productive meetings of representatives of various departments. It is important to ensure that every viewpoint is considered, and the ultimate decision taken should benefit the masses.<sup>[4]</sup> Active efforts should be made to keep the group together and avoid any topics or interests causing division. Sometimes, it may happen that the decisions may favor one group than the other; hence, caution must be taken to have the consent of all the parties involved in the decision-making.

While talking about horizontal collaboration, the task distribution should be done as per relevance, and inputs from all parties should be taken. The administrative action should include provision of a better and safe method of access to health care for everyone. This not only includes tele-psychiatry but also other initiatives such as online support groups, emergency services, strengthening of local community-based services, and addressing the basic needs of food and shelter. People from medical specialties who are already burdened by the caseload of COVID patients may have to bear even more because of the association between worsening mental health with degrading physical health. The medical outpatient departments are expected to be flooded with patients having health concerns, hypochondriasis, obsessions, anxiety, and depressive symptoms in the aftermath of the COVID-19 spread and the countrywide lockdown. A short-term training for general physicians and other medical specialists would be beneficial. Special inclusion of medical trainees and interns can also be a helping hand in some less-skilled tasks required in such times. Furthermore, a part of the general medical outpatient services as well as emergency can be tailored to people with mental health issues. These steps may benefit in early detection and ultimate lowering of the caseload.<sup>[5]</sup> The role of NGOs is also particularly important as mentioned in the guidelines laid by the National Disaster Management Authority. For the role of these NGOs, 11 points have been specifically mentioned ranging from damage assessment to social protection and planning recovery.<sup>[6]</sup> It is also very apparent that the role of private sector is variable yet fundamental. The private sector not only includes private medical professionals and establishments but also includes other nonstate-controlled organizations and companies. The functions can range from private-public partnerships, financial contributions as a part of corporate responsibility, help in research and analysis, etc.<sup>[7]</sup>

Vertical collaboration should include smooth execution of the plan from top to bottom. Then comes the need of the more severe psychiatric patients who may go through relapses and suffering additional new symptoms. The damage control can be done by urgent referral, sensitization

of general medical practitioners, family members, etc. These patients and their caregivers also face a dilemma of going to the emergency setting, getting treated, procuring medicines versus getting COVID infection, and getting stigmatized, especially those who are not in the vicinity of hospitals and related medical establishments. These dilemmas will probably lead to even more worsening of the clinical condition. Active collaborative efforts with community health workers, accredited social health activist workers, and some NGOs should be made. Involvement of pharmacists to procure and distribute medicines is also important especially when chronic illnesses would require people to procure medicines repeatedly and for longer duration. People with severe mental illness especially in rehabilitation facilities or halfway homes are more vulnerable to contract the virus. Along with this, there are several medical comorbidities in psychiatric patients such as obesity, hypertension, and diabetes, which may further complicate the clinical scenario and is a poor prognostic marker. The intervention at their places has to be intense so as to protect them. Any person living with mental disability should be a special focus from an administrative point of view as they are more vulnerable to abuse and concerns such as poverty, housing, and lack of medical care.<sup>[8]</sup>

The focus should be to keep the groups together and working with shared interest, values, and objectives. While sometimes it may be difficult to achieve the targets may be shifted, to more concrete steps, in order to have visible results and thereby being practical. Ultimately monitoring of the services delivered is a must and a vital part of sustaining the output of joint efforts which should be welcomed by the community. Monitoring and sustainability of the program also depends on the support of the government, which is also a key component.<sup>[4]</sup> We would like to conclude by stating that intersectoral collaboration is the backbone of program execution, and we need to focus on all the components in both dimensions so that we emerge successful.

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## Organizing Inpatient Services in a General Hospital in Times of COVID-19

### Abstract

COVID-19 is an unprecedented event and has affected patients with psychiatric disorders in multiple ways. Patients in inpatient settings are at high risk of exposure of getting COVID-19 infection. We reviewed the literature on the inpatient psychiatric facilities and measures regarding how to address COVID-19 in these settings. We then provide an experiential narrative of the strategies and improvisations to meet the challenges of COVID-19 so as to continue the inpatient services at a large public funded medical school and hospital in North India. Literature suggested that it is important to restrict hospitalization, expedite discharges, prohibit visit of the attendants, minimize group activities, provide psychological assistance, multidisciplinary teams to provide care, to tackle issue of stigma, have adequate means for practicing preventive measures, creating facility for isolation and have clear guidelines for diagnostic testing. The psychiatry ward in our hospital was designated non-COVID ward and substantial beds were reserved for surgical trauma patients. For organizing inpatient services, we created a multidisciplinary team. Some of the measures were institute-mandated, while others were intra-departmental measures to protect staff as well as patients in the psychiatry ward. It can be concluded that COVID-19 pandemic is still an evolving situation. The measures to prevent exposure to COVID-19 infection in the inpatient facilities continues to evolve as and when fresh challenges emerge.

**Keywords:** COVID-19, India, inpatient services, psychiatry

### Introduction

“I have no idea what’s awaiting me, or what will happen when this all ends. For the moment, I know this: There are sick people and they need curing.”

-Albert Camus, the Plague.

A new coronavirus originated in Wuhan China in December 2019 that caused coronavirus disease, also known as COVID-19. The World Health Organization (WHO) declared the COVID-19 outbreak a pandemic on March 11, 2020.<sup>[1]</sup> It is an unprecedented event that caught the world unaware and was described as an event that the last three generations had not witnessed since the Spanish Flu of 1918. A high contagion capacity that has resulted in its widespread, high R0, limited clarity on clinical features, pathophysiology and therapeutic measures, lack of vaccine, and large number of asymptomatic carriers in the community make this pandemic a force to reckon with. It has resulted in a large number of deaths across nations and continents. Availability of high-speed

internet services through smart phones and other devices, widespread use of platforms such as Facebook, WhatsApp, and Instagram and intense media coverage has resulted in rapid spread of information. As the number of cases increase in a region or a country, health-care systems start to get overwhelmed. This is compounded by risk of high rates of infection in front line health-care workers due to its highly contagious nature. Health-care workers and the population at large have many psychological symptoms such as depression, anxiety, and stress;<sup>[2,3]</sup> these are increased by the stigma attached to the diagnosis. Due to lack of definitive treatment, preventive measures such as regular hand washing, respiratory etiquettes, social distancing, wearing of mask, and self-isolation are important for controlling its spread. On June 6, 2020, as per the World Health Organization website, the number of confirmed cases were 6, 644, 011 with 391, 839 deaths<sup>[1]</sup> and in India, the total number of cases were 236, 657 with 6642 deaths.<sup>[4]</sup> Nationwide lockdown was

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started on March 24, 2020, which has been extended in phases at different regions in the country.

COVID-19 may affect persons with psychiatric illness in multiple ways. Psychological problems such as anxiety, depression, and stress caused by the pandemic may result in worsening or relapse of their psychiatric condition. Many patients and their caregivers travel long distances for follow-up care and medicines. Due to travel restrictions and non-availability of transport due to various degrees of lockdown, their follow-up care may get disrupted and they may not be able to get free medications available at certain public hospitals. Due to nonrenewal of prescription slips, they may not be able to replenish their medication stock even if they can afford to buy them. A high prevalence of physical comorbidities in these patients may complicate the management and prognosis of the infection.<sup>[5]</sup> Due to lack of insight and lack of awareness about risk of infection, poor personal care and functioning, negative and cognitive symptoms, the persons with psychiatric illness may not be able to adhere to preventive actions. The patients admitted to psychiatric facilities are at high risk of exposure due to multiple reasons. They may not be able to give an accurate account and chronology of symptoms. They may not be able to carry out preventive measures. In some of the psychiatric inpatient facilities, patients and staff may stay at close quarters due to limited space and resources. Usually, many group activities are also carried out in these facilities. There may be frequent turnover of the patients.

In India, the persons with psychiatric illnesses may seek treatment from psychiatric services in general hospitals, stand-alone psychiatric hospitals, psychiatric nursing homes, polyclinics, and office-based practices. Psychiatric services in general hospitals are major source of treatment seeking behavior. In addition, all medical schools have a psychiatry department and an inpatient facility. The patients requiring admission are admitted along with a family member to the inpatient services and are provided with comprehensive care, food, essential medicines, beds, bed linens, and basic recreation facilities.<sup>[6]</sup> There are many advantages of availing psychiatric services from general hospitals such as less stigma and involvement of family members. In the times of COVID-19 pandemic, availability of other specialists for care of physical ailments in the same premises and integration of emergency psychiatric services with hospital emergency services is of great help. However, amidst the pandemic situation, some of the aspects enhance the vulnerabilities for getting infection like space and manpower constraints, physical proximity to medical wards and casualty, frequent rotations of support staff and doctors across the various zones of hospital.

As per the National Mental Health Survey (2016),<sup>[7]</sup> the life time prevalence of any mental disorder in India is 13.7%, with a huge treatment gap of 70%–92%. Those were non-COVID times. Now in the time of COVID-19

when most of the health resources have been diverted to dealing with its management, meager resources available for marginalized populations such as persons with mental illness should be used judiciously.

This paper has been divided into two parts. In the first part, the literature is reviewed on the inpatient psychiatric facilities and the measures as to how to address the risk of COVID-19 in these settings. The second part is an experiential narrative of the authors in organizing and updating inpatient services in a large public funded medical institution and tertiary care hospital in North India.

## Review of Literature

### Methodology

We searched for published literature in English available in PubMed, Elsevier resource link on novel corona virus and Google scholar. We looked for articles in English, irrespective of the type of the article (included reviews, mini reviews, research article, correspondence, commentary, and short communication). We searched with the key words: COVID-19 OR CORONA VIRUS OR 2019 nCOV or SARS Cov2 AND Psychiatric hospital OR Psychiatric inpatient OR mental hospital OR psychiatric units OR Psychological OR psychosocial OR India OR low- and middle-income countries (LAMICs), in different combinations. Cross references of the articles on corona virus in psychiatric inpatients were also searched. We selected articles published till the 3<sup>rd</sup> week of May 2020. We also searched Google for any information on psychiatric illness and COVID-19. Two authors (M. S., B. P.) independently searched, short listed, and extracted data. When newer data become available, information shared in this review will need to be updated.

### COVID-19 and psychiatric inpatients

COVID-19 is significantly more infectious and pathogenic than seasonal flu, with an estimated case fatality rate of 0.5%–3% and approximately 5% of diagnosed patients requiring critical care. Disease severity is associated with advanced age and comorbidities.<sup>[8]</sup> With such a huge number of cases and deaths, the corona virus pandemic is expected to exert a high amount of pressure to the already strained health-care systems across the world and more severely in LAMIC like India.

Patients with serious mental illness, due to their unhealthy lifestyle and underlying medical illnesses, are more vulnerable to develop severe COVID-19 infection. Lack of proper living arrangement can raise the risk of infection and make it difficult to identify, follow-up, and treat those who are infected. Poor social support may limit opportunities to obtain help from friends and family members if individuals with serious mental illness catch the infection. Patients who are having impaired judgment will not be able to practice the appropriate preventive measures, for example,

wearing a mask, practicing hand hygiene, and maintaining social distance which are of utmost important to avoid the corona virus infection, especially in the absence of any vaccine and treatment for this infection. Taken together, these factors may lead to elevated infection rates and worse prognoses in the patients with mental illness.<sup>[9]</sup> In a general hospital, patients with medical illnesses, including patients with COVID-19 are also treated, which could potentially enhance the risk of exposure in these general hospital based psychiatric inpatient units.

During the pandemics, the major focus of the authorities remains around reporting on the disease related mortality rather than focusing on the mental health aspects. Furthermore, in some cases due to scarcity of hospital beds for COVID-19, the psychiatric beds are likely to be used for COVID-19 patients. For example, in Madrid, the number of psychiatric beds has been reduced by over 60%. The most large university hospitals do not have inpatient psychiatric units anymore, as almost all beds have been freed up for COVID-19 patients. Day hospitals, rehabilitation units, and vocational units for psychiatric patients have all been closed.<sup>[10]</sup> Due to increased number of patients with COVID-19, staff from psychiatric units are likely to work for the medicine/infectious diseases (IDs) department. In addition, a greater number of mental health professionals are engaged in providing psychosocial support to the frontline workers which can cause a shortage of workforce. Hence, an increased risk of infection to psychiatric patients coupled with reduced workforce can further complicate the situation. Some psychiatric hospitals also tend to refuse receiving new inpatients because of their poor medical conditions, which possibly can deteriorate their co-existing psychotic symptoms.<sup>[10]</sup>

Reports of corona virus infection of psychiatric patients started coming in February 2020. At the end of 1<sup>st</sup> week of February 2020, the China News Weekly reported that at least 50 inpatients with psychiatric disorders and 30 mental health professionals in a major psychiatric hospital in Wuhan, China, were diagnosed with the COVID-19.<sup>[2]</sup> The National Health Commission of China on February 18, 2020, reported that 323 patients with severe psychiatric disorders were diagnosed with COVID-19. The lack of clear information about COVID-19 outbreak in January 2020 and insufficient supplies of protective gear were the possible reasons. Moreover, patients in psychiatric hospitals often live in crowded conditions. They also participate in group activities which may increase patient-to-patient contact. Further, unhealthy lifestyle, side effects of psychotropic medications and poor physical health make them susceptible to COVID-19 and its complications. The lack of adequate training of the psychiatrists in the prevention and treatment of IDs could also have contributed to infection.<sup>[2]</sup> A COVID-19 outbreak in a South Korean inpatient psychiatric unit also infected 100 of its 102 patients and resulted in seven deaths; at the time

accounting for nearly half the COVID-19-related deaths in the country. Factors identified as having contributed to this outbreak were the lack of ventilation due to windows having been sealed shut to prevent suicides, and restrictions on the use of hand sanitizer due to fears that some patients would drink it.<sup>[11]</sup>

### **Review of measures to address COVID-19 in psychiatric inpatient settings**

To address the above-mentioned issues, some proactive measures have been suggested:

It is important to restrict hospitalization, expedite discharges, prohibit visits of the attendants, and provide psychological assistance. It has been suggested that an observation room outside the routine ward should be set up for isolation and observation for 14 days before formal hospitalization. Some even suggested to test all individuals for COVID-19 before entry into treatment facilities. Due to higher risk of transmission of infection, complete isolation of mental health centers has been recommended during the COVID-19 epidemic. Before admission, the symptoms suggestive of COVID-19 infection, travel history to (and from) high risk area must be enquired. Medical, nursing, logistics support, and canteen staff should limit their approaches to the hospital and have their temperature taken before entering and leaving the ward on a regular basis.<sup>[12]</sup>

The current policy and regulation issued by the government should highlight the needs of psychiatric patients and their families to provide mental health services. The provision for communication between psychiatric inpatients and their families should be considered by hospitals. The teams responsible for patient's psychological support and treatment should include not only psychiatrists and psychologists but also psychiatric nurses, social workers (psychiatric and medical), volunteers, and family members.<sup>[13]</sup>

The patients with mental illness should be supported by providing them accurate information about measures to reduce corona virus infection and when to seek medical help for the same. The educational material developed for general population should be tailored so that it is understandable and acceptable by the patients with mental illness. The risk of having dual stigma associated with infections and their mental health conditions should be kept in mind. Empowerment of mental health professionals and strengthening the mental health-care system are important. Mental health clinicians need to be trained to recognize the signs and symptoms of corona virus infection and develop knowledge about basic strategies to reduce the spread of disease. They also need support to maintain their own safety and well-being. In view of a smaller number of psychiatric facilities in LAMIC, plans should be developed for continuing operations particularly at the time of staff illness. Standard operating procedures should be developed



to identify and refer high risk patients and self-quarantine strategies for clinicians who develop symptoms of the illness. Adequate environmental protection including well-ventilated spaces, easy access to hand washing, and personal protective equipment (PPE) should be available. The mental health policies in the coming days should also be geared toward the welfare of the psychiatric patients.<sup>[9]</sup>

Other important measures like advocacy, mobilizing fund for research in this area, supporting own colleagues and the system have also been highlighted.<sup>[8]</sup> Strategies implemented at the Centre for Addiction and Mental Health in Toronto, Canada, modeled after a system developed during the 2003 SARS outbreak, involve designating different units to segregate patients with suspected infection, diagnosed infection, or absence of infection, and assignment to every inpatient psychiatrist of backup outpatient psychiatrists prepared to seamlessly assume care in the event that an inpatient psychiatrist becomes unable to work.<sup>[11]</sup>

A hospital from Italy reported that they had divided the hospital into COVID and non-COVID areas. The psychiatry ward is allocated to the non-COVID area and if any patient comes positive, he/she would be transferred to the COVID area and the patient would be managed by the consultation liaison psychiatry team. One seclusion room was designated in the COVID area and in the non-COVID psychiatric units for the violent patients.<sup>[14]</sup> Because some patients with COVID-19 can be contagious yet asymptomatic, especially in the initial days after infection, knowing who is infected requires timely diagnostic testing as well as when and how a patient was exposed and when symptoms began. This could be challenging in individuals with psychiatric disorders as some are unable to recall or are unaware of potential exposures and symptom onset.<sup>[15]</sup>

The group therapy sessions in the psychiatric unit should be changed. As the group therapy requires close contact, decisions to facilitate changes in group treatment may be needed, including limiting the number of individuals participating in a group and ensuring that physical distancing among individuals occurs. In addition, older patients with multiple medical comorbidities may be a “at risk” in group settings and need to discontinue and minimize group therapy during a pandemic<sup>[16]</sup>. A core leadership task force can be developed to address immediate operational concerns. This Task Force should include representation by clinical leaders in psychiatry, social work, clinical psychologists, and nursing, at minimum. The aim of a small core group would be to initiate and coordinate ongoing response efforts and to minimize sharing of misinformation. Furthermore, additional smaller workgroups can be created to work on staffing, COVID-19 precautions, operational issues, and other important contingency planning efforts.<sup>[16]</sup>

To restrict inpatient hospitalization, mental health home hospitalization care has been proposed as a substitute of inpatient hospitalization. This novel home-based approach

has two main modalities: Home intensive community teams for mild to moderately ill patients and home hospitalization teams for moderate to severely mental illness cases. Both seem promising and of clinical relevance during the COVID-19 pandemic. This approach has demonstrated their usefulness in reducing hospital psychiatric admissions for adult patients with moderate and severe mental illnesses, as well as in decreasing the risk for conventional psychiatric hospitalization of adolescents experiencing a psychiatric crisis.<sup>[17]</sup> The home care is also important for people with intellectual disabilities and/or autism and patients with severe mental disorders and poor functionality who live with older caregivers.<sup>[18]</sup>

### **Narrative Experience of Updating Inpatient Services at Our Hospital**

At All India Institute of Medical Sciences, New Delhi, psychiatry department is one of 42 departments. We have a 30 bedded inpatient ward facility with two beds for child psychiatric patients. This is located in the main building on first floor with dermatology ward as our neighbor. Immediately above is medicine ward and on the ground floor, is the main emergency of the hospital. The psychiatry ward is an open ward with a day care facility. The beds are laid out in “rig pattern,” with bedside trolley and a small bed for the family member which slides under the patient’s bed in daytime. There are two cubicles with bed capacity of 6 each and two isolation rooms with attached bathrooms. One of the isolation rooms was not available as it was under repair that was halted because of lockdown. There is gender-wise separation of wash rooms; three for each sex. In the middle of the ward is the nursing counter and the room. As per the Mental Health Care Act 2017, most of the admissions in the ward are independent admissions. Although every year, more than 80-85 thousand patients are seen in the outpatient services, only about 300 patients are admitted to the psychiatry ward for either management difficulties or sometimes for diagnostic clarification. Admission is usually done with a family member as a hospital policy. In the ward, there are faculty, resident doctors, nursing staff, an occupational therapist, orderlies, cleaning personnel, and guards. For the management of physical comorbidities, referrals are made to the specialists in the concerned department who examine, advise investigations, and management. The management is usually carried out in the psychiatry ward itself. If there is any need, the patients are temporarily shifted to the relevant ward and managed there. The planning to prepare the psychiatric in-patient unit in the face of COVID-19 pandemic began in March itself. Some of the measures were institute-mandated, while others were intradepartmental measures to protect staff as well as patients in the psychiatry ward. A team was built within the department, inclusive of a nodal officer, with an aim to brainstorm for specific measures for the ward and implement these

and to modify them, if necessary, for use in psychiatry ward. All authors in this write-up also serve as members of this COVID-19 preparedness team, and represent various cadres of health care professionals (psychiatrists, senior nursing personnel, and occupational therapist). Two senior residents (post-MD) were also included for the ward-related activities, with a scope to add new members kept open, as and when required. The team contributed regularly to awareness generation among ward staff, provision of informative display material in ward, ensuring indent and supplies for personal protection equipment and setting up various processes and procedures for the safety of patients and staff. The group met in-person, as required and also maintained a WhatsApp group for coordination and periodic updates.

Following is the narrative account of the various aspects, along with the trials and tribulations, of COVID-19 preparedness in the psychiatry ward. At the outset, it is acknowledged that in view of COVID-19 pandemic being an unprecedented and still an evolving situation, the learning curve also continues to evolve and may not have peaked yet.

#### *Initial actions*

Although in February and half of March, the news was pouring in the media about COVID-19 from some of the countries and sporadic cases in India, this had no impact on our services. However, in the second half of March, preparations to deal with the pandemic at our Institute started and in sync with nationwide complete lockdown on March 24, 2020, the outpatient services were stopped. At the Institute level, one of the large 260 bedded centers was designated as COVID hospital and a number of task forces and committees were constituted to handle the impending crisis.

- Psychiatry ward was designated as non-COVID ward
- As early as March 17, 2020, the first two beds of each general ward, including psychiatry, were earmarked for use by the hospital in preparation toward the pandemic. On March 31, 2020, 22 beds of psychiatry ward were reserved for surgical trauma patients, since trauma center was being prepared as COVID-19 facility
- Twenty-five percent of the faculty and the residents of the psychiatry department were posted for duty in COVID areas
- The group activities conducted in the day care were suspended immediately as there was not enough space to ensure safe distance between patients
- Discharges of in-patients who were stable and could be managed at home, were expedited. It also facilitated their timely travel back to their homes and native places especially for the outstation patients
- The routine admissions to psychiatric unit were temporarily stopped
- The telepsychiatry services were started by the department and any patient requiring emergency

help was asked to visit hospital casualty for further evaluation.

#### *Psychiatric emergencies*

These were attended to in the hospital casualty services and if required, admissions to psychiatry ward were also through it. There were many inherent challenges.

- The patients in casualty spend several hours to a day amidst other medically ill patients, often in a crowded environment. There was danger of exposure to our on-call residents. For consultation in emergency services, the hospital directives were that first telephonic consultations with the help of emergency doctor could be done. If at all, the patient needed in person examination, it was to be done in full PPE kit provided in emergency with donning and doffing to be done there only
- Patients with certain psychiatric emergencies (e.g., those with acute-onset psychosis or manic episode) are often potentially vulnerable to acquire infection and may not adhere to basic preventive measures such as hand hygiene, mask or distancing in the days prior to consultation due to impaired personal judgment and absence of insight. Some may even be overactive or over familiar to others in community, dismissing any risk to self. The patient may not be able to give reliable information pertaining to COVID-19 symptoms
- Some patients were brought to emergency by distant acquaintances or police personnel with their family or caregivers living in another state, with no travel possible during the lockdown. This led to clinical, psychosocial, and medicolegal issues in emergency situations
- Getting a reception order for unattended patients with psychiatric illnesses/homeless mentally ill persons who are brought to emergency can be a task in itself, since the majority of police workforce was diverted to COVID-19 duties. These problems were handled in liaison with the duty officer, usually a senior resident of hospital administration department who coordinated the conversations between various departments
- In addition, the residents on call were apprised of the reported association of new onset psychiatric symptoms, altered sensorium or deranged higher mental functions and COVID-19.<sup>[19,20]</sup> In these cases, consultation from ID team and if need be, neurologist was to be sought in the casualty itself.

#### *Psychiatry ward*

In the first week itself, a patient presented to emergency who needed to be admitted to the ward. Being an open ward with no separate cubicles and shared washrooms and spaces, it was difficult to isolate the patient and his/her attendant. Chances of his/her being asymptomatic carrier could also not be ruled out. However, routine testing for all new admissions was not advised at the institute level.

This admission started a chain of a few actions:

- A symptom checklist of COVID-19 was made. It was applied at the time of admission and on a daily basis by the resident in charge for both patients and attendants. This was documented in the clinical file and nursing notes
- There was a need to devise some kind of “isolation” for new admissions from casualty in anticipation of an incidentally detected COVID-19 suspect patient/symptomatic patient. It was decided to reserve one isolation room with attached bathroom and one cubicle of general ward for new admissions for the first 5 days, to observe and monitor them
- All potential emergency admissions would be mandatorily discussed with consultant/faculty member to decide on the critical need of admission
- Admissions of follow-up patients must be facilitated by psychiatrist-on-call in a manner which circumvents waiting time in casualty
- It was advised to clean all ward surfaces, which could serve as potential sources of infection, frequently using 1% sodium hypochlorite, every 4–6 hourly depending on whether surface is high-touch (e.g., door knobs) or low-touch surface (e.g., walls). A register was also maintained as a record for cleaning at regular intervals
- Family members/attendants of patients were advised to keep their visits outside the ward to minimum and were encouraged not to go outside repeatedly without a justifiable reason.

At institute level, the policies were modified with incoming of information as well as the need on ground. In the psychiatry ward, we also incorporated these suggestions:

- Prior to every new admission, place of residence was checked for its current status of containment zone. These zones were based on the risk profiling of the areas. Green zones were those where there were zero confirmed cases in the past 21 days. Red zone (hotspots) was defined by total number of active cases, doubling rate of confirmed cases, extent of testing and surveillance feedback. The areas which were neither in the red nor in the green zone were classified as orange zones.<sup>[21]</sup> If the patient/attendant was from red zone, the hospital ID team was consulted and need for testing addressed as per clinical discretion/policies was decided. Usually, such cases were carefully observed/monitored and not tested if asymptomatic, as per prevailing policy
- If any admitted patient was found to be symptomatic at any given time, referral to ID team for sampling and further action was done. The isolation was ensured
- Separate space was needed for donning and doffing of the PPE. To begin with, no suitable, non-clinical space could be found for use as doffing room. The nursing sister-in-charge of the ward had the much-needed idea to have a pantry under repair cleaned out, washed and

prepared to be used as doffing room

- All the persons in the ward, doctors, nurses, support staff, admitted patients, and their family members and visitors were instructed to wear a mask at all times in the ward and were instructed to practice social distancing and hand hygiene
- All staff reporting on duty was also asked for new onset symptoms from symptom checklist, and was advised to refrain from coming to ward in case they experience any symptoms.

In the last few weeks, further actions have been taken:

- A list of all staff and personnel working at ward, including their names/telephones/residence was made available with nodal officer for coordination and contact tracing, in the event any staff at psychiatry ward is confirmed to be COVID-positive
- Staff on relieving/rotating duty across various wards of the hospital were screened for any symptoms at the time of reporting on duty
- The staff was educated to sanitize hands after coming in contact with clinical files or administrative papers delivered to ward or any potential fomites
- Staff was advised not to have lunch or tea together, since eating/drinking requires taking off the mask, which could increase vulnerability. Therefore, lunch breaks should be taken in a sequential manner by all staff cadres in the ward. Collective lunches were prohibited
- Before discharge of patients, the treating team must check that the residence/locality where patient shall go back to after discharge from ward. For example, a patient planned for discharge from our ward could not go home when he found that his residence had been designated as containment zone. His ward stay was extended as a result for several days, with an option to move out to a suitable alternate place of his choice.

#### *Personal protection equipment*

The set of guidelines on the use of PPE for health-care personnel (HCP) and others evolved over weeks in the Institute, based on several national and international recommendations:

- Initially, the use of fluid resistant, three-ply/triple-layer mask was advised for HCP in non-COVID wards. Subsequently, the revised Institute guidelines recommended the use of N95 masks for health-care workers. Sanitation staff were additionally advised to wear heavy duty gloves for disinfection and health attendants were advised to wear gloves during the patient shifting. This was later upgraded to level I PPE (N95 mask, gown, gloves, and eye goggles) for all HCPs in non-COVID wards
- For patients and their attendants, to begin with, the use of medical masks was not recommended, which

later got revised to mandatory use of triple-layer mask for all patients and their attendants visiting hospital premises. If they did not wear any mask, the nursing personnel (or any designated person) would provide them with triple-layer surgical mask every day

- The stocks of PPE are being maintained by periodic indents on a weekly basis, with revision of estimates every week as per change in demands
- Staff was advised to adhere to standard operating procedures for bio-waste management, especially with regard to disposal of PPE.

#### *Information display, sensitization, and training*

These activities were started in the beginning and were reinforced at periodic intervals.

- All categories of health-care personnel underwent training sessions. For example, nursing officers were asked to take an online course for infection control offered by the institute which generated certificate after completion
- Sanitation staff was sensitized about the method of dilution of sodium hypochlorite and duration of contact (e.g., 20–30 min for eye goggles/face shield), in addition to training by sanitation supervisors/officers
- The staff at the entrance of the ward interacts with a variety of personnel visiting the ward (e.g., health attendants sent from other departments). They were sensitized about preventive measures such as not allowing anyone inside without a mask. Further, the need for carrying out these preventive measures was emphasized to them for both on-duty and off-duty hours, as many of them were staying in shared accommodations or crowded personal spaces
- Information was displayed in the form of posters educating about the preventive measures for COVID-19. The posters were in simple and easy to understand language
- Specific informative material on donning and doffing was made available in the respective spaces, in a visual format.

#### **Conclusion**

COVID-19 pandemic is an extraordinary event that has challenged mental health care systems worldwide. Inpatients in psychiatric facilities are at high risk of exposure due to multiple reasons. Literature suggested that it is important to restrict hospitalization, expedite discharges, prohibit visits of the attendants, minimize group activities, provide psychological assistance, multidisciplinary teams to provide care, to tackle issue of stigma, have adequate means for practicing preventive measures, creating a facility for isolation and have clear guidelines for diagnostic testing. We were able to implement institute-mandated and intradepartmental measures to protect staff as well as patients in psychiatry ward in a constantly evolving scenario. This could serve as a model for continued

functioning of a tertiary care teaching medical facility in a pandemic situation.

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#### **Conflicts of interest**

There are no conflicts of interest.

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## Impact of COVID-19 on Addiction Treatment Services

COVID-19 has impacted the treatment of substance use disorders to a considerable extent.

At our center, opioid substitution treatment (OST) is administered as daily-dispensing buprenorphine in the initial period, and then weekly take-home medication of buprenorphine–naloxone combination. As the lockdown was initiated in end-March 2020, there was a problem in the logistics related to OST. In the clinic setting, we could not initiate any new patients on OST and as the initial lockdown was for 3 weeks, we dispensed at least 3-week medication to others. Conversely, in our community setting, we gave medication for a week's time, as the patients enrolled in the community clinics resided nearby.

Due to the lockdown, patients found it difficult to commute to the treatment services, and the initial few weeks witnessed a drop in the number of patients coming for treatment. Yet, we had patients walking or cycling several kilometers to reach the treatment services as public transport was not available. While addiction treatment has several barriers of its own,<sup>[1]</sup> COVID-19 put forth added barriers for accessing treatment. Another challenge was ensuring that patients wore masks and adhered to social distancing when they came for treatment. Regulated entry of limited number of patients with temperature checks conducted by security personnel was ensured diligently. Stores prioritized the procurement of sanitizers and personal protective equipment. Doctors, nursing staff, sanitization staff, guards, and others rose to the occasion to provide care to the patients. There was a scare when a few personnel working at the center contracted COVID-19, but fortunately, it did not result in a localized outbreak.

Postlockdown and during the various phases of “unlock,” the current challenges include a severe impact in the training of postgraduates and super-specialists, gradually decreasing vigilance against COVID-19, and gradually increasing inflow of patients. Another pragmatic challenge that needs to be anticipated is dealing with the cases of COVID-19 in the inpatient setting. Whether the whole ward would need testing and isolation, or whether isolating a COVID-19 patient would suffice, would be the key question. Research, which was stalled till this point of time, would resume again, resulting in increasing patient–clinician

interaction. Consequently, ways of reducing the exposures during research endeavors would need to be sought out to minimize potential transmission of the infection.<sup>[2]</sup>

To conclude, from apprehension to preparation to tackling the pandemic, we move toward adaptation and re-normalization of the process of care in the field of addiction psychiatry.

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## Reflections for the Young Indian Minds

Though I have not yet been directly affected by the COVID-19 infection, yet its impact has infiltrated all spheres of my life. Living in a nuclear family set-up and being the mother of a teenage daughter initially brought reactions of concern for her: what if both parents got the COVID-19 infection, then who would take care of her? I could discern extreme psychological distress emanating from within her due to frequent spells of short temperedness and irritability in the initial phase of lockdown as the daily life of each family member became disrupted. I can still recall her anxiety writ face when being unable to log in for her unit test.

It additionally got me thinking about how this pandemic is affecting the development of children in this techno-world when we are already concerned with the rising cases of “Gaming Disorder” (ICD 11; DSM5) among adolescents (1.2%–5.9%)<sup>[1]</sup> and other related comorbidities. The literature search revealed that researchers have primarily focused on understanding mental health issues among the adult population during the pandemic. Though all countries are facing similar scenarios, there is a pressing need to understand the challenges faced by youngsters’, during and in post-pandemic era, within their respective cultural contexts; only a few empirical studies that have explored students’ mental health and well-being.<sup>[2,3]</sup> A similar scenario exists in India where the mental health of children has not been in the forefront, even though 41% of its population is <18 years of age.<sup>[4]</sup>

The lockdown in India was imposed along with the strict guidelines related to physical distancing, frequent hand washing, and wearing of masks. There was the closure of educational institutions, and children were encouraged to stay at home during these periods of curfew and staggered lockdown. Consequently, screen use became a norm due to physical distancing and online academics. A recent Indian study among college youth reported increase in gaming behavior in one-half of the students during the lockdown.<sup>[5]</sup> Despite this report, there exists a significant evidence-based gap regarding the relationship between gaming behavior and mental health issues in children and adolescents during the lockdown. This lacuna needs to be overcome as adults’

addictive behavioral and substance patterns are oft seen to have onset during adolescence.<sup>[1]</sup>

Interestingly, it is indeed a paradox where one is concerned about excess screen time and addictive risk, yet the same “vilified” technology is being utilized (and is seemingly helping) to mitigate the impact of social isolation. Adolescence is a period of increased need for peer interaction and acceptance, and social isolation may have far-reaching negative consequences on the brain and behaviour.<sup>[6]</sup> Digital technology through social media, video chatting, gaming, and blogging has mediated social contacts. Thus, this unprecedented situation calls for action for minimization of “digital divide” for this special age group, lest it may lead to long-term deprivation of the core activities of *education* and *socialization*. Educationists and policymakers are no doubt pivotal figures in planning and implementing innovative steps for this, but we too cannot absolve ourselves from the responsibility of balancing the emotional and social needs by collaborating with the policymakers. One certainly needs to undertake preventive measures to optimize stress, lest this boon becomes a bane.

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## About the Monograph

Over the course of pandemic, the Department of Psychiatry & National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi has been working at various fronts, including emergency services, in-patient and out-patient services, consultation-liaison, telepsychiatry, community outreach, public education and research on mental health related to COVID 19. The Department of Psychiatry & NDDTC contributed at least 30-40% of residents along with two faculty members towards postings at AIIMS COVID centres throughout the year. Amidst pandemic, newer models of teachings, academics and exam assessments were built. Initiatives were undertaken to prevent social isolation among undergraduate and postgraduate students.

In this monograph, we have compiled a collection of articles and writings to give an insight into learnings, experiences and capacities acquired in various realms. We hope that the monograph shall serve to capture the experiences of organizing services at the Department of Psychiatry and NDDTC, AIIMS, New Delhi.



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