

Editorial

Emergency psychiatry during COVID-19 in developing countries



Psiquiatría de urgencia durante la COVID-19 en países en vías de desarrollo

Coronavirus Disease 19 (COVID-19) has come into sight as a public health threat in December 2019 and was declared a pandemic by the World Health Organization in March 2020.¹ People infected with COVID-19 present with diverse psychiatric problems because of the uncertainty of COVID-19. The COVID-19 pandemic has also lead to a rise in new cases of psychiatric conditions and exacerbation of pre-existing psychiatric illnesses. There has been a plethora of mental health and psychosocial problems found to be associated with COVID-19. The psychological repercussions of COVID-19 in the general population may last a long time as compared to the acute medical crisis.²

Emergency psychiatry services have been fundamentally affected all over the world, especially in developing countries. Few newer additional emergencies have arisen during this COVID-19 directly or indirectly related to it such as suicidal behavior and addiction-related issues. Existing emergencies have been hampered in several ways such due to COVID-19 and/or lockdown measures. Moreover, lockdown can affect the patients to visit the hospitals. Among psychiatric emergencies during COVID-19 and lockdown, there has been an increase in suicide and substance-related emergencies (mainly alcohol and opioids) in COVID-19.^{3,4} The abrupt rise in several suicide cases coincides with a rise in the number of confirmed cases of COVID-19 infection. The rise of suicide due to substance abuse disorders due to the COVID-19 pandemic is one major concern throughout the world especially in developing countries like India.³

The developing countries have lower intensive care units (ICU) support status, and during this COVID-19 pandemic the ICUs are occupied by COVID-19 patients. Therefore, the ICU supports psychiatric emergencies, i.e. neuroleptic malignant syndrome, serotonin syndrome, delirium, lithium toxicity, non-fatal hanging have been compromised certainly because of the COVID-19 ICUs are not permeable for the normal patients. Additionally, the hospital management in the developing countries are not in a condition to build separate ICUs for psychiatric patients. There is poor ICU support of patients with severe self-harm and non-fatal hanging especially in

developed countries, as ICU is already flooded with sick COVID-19 patients. The need for ICU beds for COVID-19 will exceed, even if self-isolation is done at 40%.⁵

A separate challenge appears when an admitted indoor patient of psychiatry is diagnosed with COVID-19. Many of psychiatric settings in developing countries do not have separate options for COVID-19 and non-COVID-19 patients. More complexities would arise when a COVID-19 patient needs rapid tranquilization or a patient on rapid tranquilization becomes COVID-19 positive as tranquilization needs close monitoring of the vitals. Starting the clozapine therapy, monitoring clozapine, lithium hampers significantly. American Association of Emergency Psychiatry pays special focus and attention to COVID-19 patients and health care staff with severe behavioral symptoms, timely detection and treatment of symptoms, liaison with psychiatric services, and minimizing staff hazard.⁶

At the services level, the core of the challenges arises, especially in developing countries. In response to the COVID-19 pandemic, several services have been closed because of cost curtailing, resulting in compromised emergency psychiatric services. Some hospitals are completely converted into COVID-19 dedicated centers, where non-COVID-19 patients are not allowed to visit and admit, which causes unexpected hamper. Duties of the physicians and nurses have been rationed, resulting in a reduced number of health care professionals and ultimately affects the emergency services.

Rapid tranquilization is adequate treatment for acutely agitated patients with COVID19, as it reduces the risk of spreading infection and harms to others. Benzodiazepine augmentation should be strictly monitored, as there is a risk of respiratory depression. Special focus should be given to drug-drug interaction between psychiatric drugs and drugs used for treating COVID-19, as some antivirals, antibiotics, and antimalarials can induce increased QTc interval and may augment prolongation by antipsychotics like clozapine and ziprasidone. Delirium can be one of the results of drug-drug interaction used for treating COVID-19.⁶

There is a dearth of published literature on the management of emergency neuropsychiatric conditions with adequate scientific data available. During the COVID-19 pandemic, prevention strategies should focus on reducing psychological distress associated with infection, individuals at risk at home (with or without quarantine). It needs a specific approach with strategies for hospital resource management, with special emphasis on innovative mental health interventions and guidance for family. The central health services authority should be aware about the psychiatric emergencies and relationship with the COVID-19. Certainly, these services should not be stopped, however could be renovated as per the availability of resources. At least there should have been regional coordination so that the services cannot be hampered. Besides, it is important to promote telemedicine or online mental health interventions for catering to vulnerable. The hospitals should be provided with adequate infrastructure and adequate staff to fight against the threat of decreased emergency care during COVID 19 pandemics.

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