COVID-19 Exposes the Cracks in Our Already Fragile Mental Health System

See also Morabia, p. 923, Tarantola et al., p. 925, and the *AJPH* COVID-19 section, pp. 939–977.

The coronavirus pandemic has caused enormous concern among many people. Every morning, we are met with an increasing deluge of dire news about the most recent number of people to contract COVID-19 and to die from it, decreases in the stock market, and countries implementing broad travel restrictions and stay-at-home orders.[1,2] The current state of affairs is having a negative effect on the mental well-being of our country's residents. It also highlights the policy gaps in our current system that inhibit the vital conditions for well-being and resiliency.[3] Although the primary focus has rightfully been on stopping the spread of COVID-19, we should also quickly prepare to address the mental toll the pandemic is taking on individuals and communities across the country.

Those involved in past emergency responses have cited the elevation of anxiety among the general public as well as the heightening of symptoms among those who have a preexisting mental health or substance use disorder diagnosis. The former health commissioner of Boston (J. A.), who led the city's health response during the months after 9/11, reported the city's need for mental health professionals who could offer counseling and make referrals to those who called the city hotline. Similar needs arose with the H1N1 outbreak and the Haitian earthquake.

The current state of affairs could exacerbate the conditions of those seeking or receiving mental health care, and current regulations may further impede access to care. Right now, 112 million Americans live in mental health professional shortage areas, and roughly 50% of those who do receive care have to travel more than one hour round trip.[4,5] Increasing the number of mental health workers, putting them in the right places, and training them to work in these settings will remain a challenge for the foreseeable future. To augment onsite services, mental health telecare services are being used in primary care settings, nursing homes, and correctional facilities, where it may be difficult to find a local clinician. Sadly, these efforts have been stymied by a lack of access to technology, financial mechanisms to support delivery, and underenforcement of mental health parity laws, which affect all access to mental health services. Should an individual need to self-quarantine, or if a clinician restricts the hours of access to medications, as with treatment of an opioid use disorder, this could add yet another problem, making access and consultation to clinicians even more burdensome.[6]

Recently, the Substance Use and Mental Health Services Administration issued guidance for opioid treatment programs regarding COVID-19.[7] The guidance refers providers to their state opioid treatment authority to develop and implement a disaster plan to address various contingencies, including continuing medication-assisted treatment.[7] Although it is commendable of federal leadership to issue such guidelines quickly, pushing the decision down to states could create a patchwork of policies that could enable the easy continuation of treatment in one state while creating complications in others. Complicating this, the guidance came shortly before an inspector general report finding that the Substance Abuse and Mental Health Services Administration's oversight of opioid treatment programs did not comply with some federal requirements (https://bit.ly/33Ib2k3).

The elevated need for mental health services also exacerbates the already problematic gaps in culturally and linguistically appropriate care (https://bit.ly/39iadQ3). The mental health workforce, particularly for highly trained providers such as psychologists, is less diverse than is the general population (https://bit.ly/39j06dy). In past emergencies, these inadequacies meant unequal access to care, made even more complicated by lower rates of insurance coverage among the same populations (https://bit.ly/3br1vAt). There are even greater complications for immigrants who fear that seeking care might risk their immigration status (https://bit.ly/2xmG58P).

For many, the fear of getting ill is not new but has been aggravated by the novel coronavirus. According to the Bureau of Labor Statistics, 71% of private industry workers have paid sick leave benefits, but on average receive seven paid sick days (https://bit.ly/2WIw9Bl). For those exposed to COVID-19, self-quarantine and social distancing can be recommended for 14 days, creating a possible shortfall. Anyone who cannot afford to take time off sick is faced with a Faustian choice that can create tremendous stress: should they continue to work while sick to make ends meet, or should they take the necessary time to recover—even if that means they might be unable to pay rent or buy enough food for their family.

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Furthermore, many older adults, caregivers, and individuals with chronic medical conditions who are at higher risk of serious complications from COVID-19 are facing the double uncertainty of a new disease with many unknown variables and the unknown duration of this danger. Nursing homes and long-term care facilities, which have emerged as the highest risk areas, are taking prudent measures to address these dangers by limiting visitors and increasing screenings (https://bit.ly/3bsx8cG). Older adults who already suffer from social isolation may have even greater isolation as they are discouraged from traveling or attending events with large numbers of people.

Issues of loneliness and isolation are serious concerns across the entire population, but especially for older adults. Rates of loneliness are at an all-time high, and the impact of loneliness on our health is profound (https://bit.ly/33Jw5Tj). We must not overlook ways to address loneliness and isolation in the time of a pandemic. Alongside loneliness, underlying mental health and substance misuse needs require thoughtful attention to evidence-based solutions as well as technological advances that connect even the most isolated people to care and caregivers (https://bit.ly/2Jk8YFf).

Disruptions to everyday life have been widespread. Many college students returned from spring break only to be notified that they must leave their dorms and that any summer plans they had, like studying aboard or work–study programs, are up in the air (https://wapo.st/2QJPAWi). K–12 students are also experiencing cancellations or postponements of school plays and fieldtrips, and, in some areas, they are experiencing school closures (https://bit.ly/2xkzD2i, https://bit.ly/2UBOkpn). Although these decisions have been made to ensure the safety of students, policymakers should also prepare to address any mental health ailments that may result (https://bit.ly/39oDp8c). Mental health resources for both children and adults have been developed by the Centers for Disease Control and Prevention and should be reviewed by all parties (https://bit.ly/39hwQ7f, https://bit.ly/33KVCLK).

We have reached the tipping point at which the phenomena surrounding COVID-19 have affected most people in some way. The time has arrived to bolster supports for our fellow Americans. On March 6, the president signed into law a bill to fund response efforts to mitigate the spread of COVID-19 (https://bit.ly/3dtfwiW). Following this, the Congress passed the Families First Coronavirus Response Act, which includes provisions for free coronavirus testing, paid emergency sick leave, enhanced unemployment insurance, and increased funding for Medicaid (https://bit.ly/2UgjaFi).

Conversations about future legislative efforts to address the effects of COVID-19 continue. Any future legislation to address COVID-19 should include social policies that alleviate many of Americans' current concerns. These include establishing clear contingencies for those in need of or currently receiving mental health care, including expanding mental health teleservices, strengthening the integration of mental and physical health services, and incorporating mental health first aid and supports into broader recovery strategies. They also include expanding immediate crisis supports such as the Disaster Distress Helpline and National Suicide Prevention Lifeline. In an evolving situation with many unknown factors, we should focus on proven policies that, if implemented right now, will address present and future fears. We don't have time to waste. AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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