



COVID-19 and Canadian Psychiatry

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The novel coronavirus disease 2019 (COVID-19) pandemic has dramatically altered the lives of Canadians on various levels. As of the end of October 2020, COVID-19 cases surpassed the 100,000 count in Canada, with regional differences in the burden of the pandemic. As a result of necessary public health measures, psychiatrists and psychiatry residents have had to quickly adapt both in the personal and professional domains to a global situation that is rife with uncertainty and upheaval. This will continue to have implications with regards to general psychiatric care, the psychiatry workforce, access to psychiatric services, public health policies, and research agendas.

Patients with psychiatric disorders are differentially affected by COVID-19. Emerging evidence suggests patients suffering from psychiatric illness experience

a distinct burden of the COVID-19 disease; several explanatory mechanisms have been posited to explain this association. First, both COVID-19 infection and psychiatric illness are associated with lower socioeconomic status and structural inequities. Second, patients with psychiatric illness experience many barriers to accessing health care as a result of stigma, reduced health literacy, or reduced ability to self-monitor for symptoms.^{1,2} They also may have greater difficulty observing public health measures, such as hand hygiene, physical distancing, or self-isolation, due to symptom domains (e.g., behavioural disorganization, impaired judgement, lack of insight) or lack of necessary resources (e.g., poor housing conditions, low social supports).^{3,4} Notably, within the inpatient psychiatric setting, greater infectious rates

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have been observed. It has been suggested that the design of the psychiatric inpatient units, wherein many spaces are shared and patients often interact in group activities, may render particularly challenging the implementation of COVID-19 infectious protocols.^{5,6} Further, many patients experience generally poorer health status due to lifestyle factors (e.g., smoking) and comorbid general medical conditions (e.g., diabetes mellitus, lung disease).² Some psychotropic medications may confer a theoretical immunosuppressant effect (e.g., clozapine).⁷ Finally, when patients with preexisting psychiatric illness become infected with COVID-19, they demonstrate a worsening of psychiatric symptoms and thus may warrant greater clinical attention.

Patients infected with COVID-19 are at risk of psychiatric sequelae. They may develop psychiatric symptoms both in the acute and post-acute phases of illness (e.g., post-traumatic stress and depressive symptoms).⁸ Many medications used to treat COVID-19, such as antivirals, may not only have psychiatric side effects but may also interact with commonly used psychotropic medications.⁹

In tandem, the pandemic has led to unprecedented levels of anxiety, uncertainty, and fear, with public health measures such as quarantine, physical distancing, and sheltering in place, contributing to increased levels of stress. In the first stage of the pandemic, there was a significant reduction in searches related to suicide, anxiety, and hopelessness; however, with prolonged public health measures and economic difficulties, there may be an increase in suicide rates, as was seen with the 2003 SARS epidemic in Hong Kong.¹⁰ As such, there is an anticipated mental health wave of the pandemic, wherein it is projected that portions of the population that might have previously been mentally healthy will suffer mental health sequelae. Already there is evidence within the general public of lower psychological well-being, as well as higher scores of self-reported post-traumatic symptoms, anxiety, and depression.^{8,11,12} Notably, children are felt to be vulnerable biologically and psychosocially to the impacts of the pandemic, with particular concern that measures may affect the development of prosocial skills longitudinally.¹³ Early evidence from a survey of youth in clinical and community samples suggests that, in addition to a perceived deterioration in mental health, there are substantial mental health service disruptions and unmet support needs.¹⁴

Taken together, this context has important implications for Canadian psychiatry across the domains of general psychiatric care, the psychiatric workforce, access to psychiatric services, public health policies, and research agendas.

Recommendations

General care for patients with psychiatric illness

- Psychiatrists represent important collaborators in the provision of high-quality care for patients infected with COVID-19, both in the acute and post-acute phases of the illness, as well as collaborators in the development of a pandemic response.
- COVID-19 testing efforts should involve targeted outreach to high-risk populations, including patients with psychiatric illness.
- Psychiatric care represents an important opportunity for public health promotion. Psychiatrists should aim to review up-to-date public health recommendations as part of routine care and psychoeducation with their patient population.
- There is evidence that chronic medical conditions are often not well managed in patients with psychiatric illness. During the pandemic, the care of chronic medical conditions has been delayed in general. Special consideration should be given to the risk that patients with psychiatric illness receive delayed care for chronic medical conditions during the pandemic, thereby increasing the risk of worsening medical conditions.
- Special consideration should be given to the geriatric psychiatry population. This population remains particularly vulnerable to complications from COVID-19 infection, yet they may face greater difficulties accessing telehealth services, compounding the risk of social isolation. Governments, institutions, and psychiatrists should pay special attention to this population's vulnerability in developing the pandemic response.
- Special consideration should be given to the child and adolescent psychiatry population. Although this population may experience milder symptoms and a lower fatality rate, secondary to COVID-19 infection, they may be more impacted psychosocially by public health measures during critical periods of development. However, this population may demonstrate greater acceptability of such service models as telepsychiatry and other forms of Internet-based care.¹⁵ Governments, institutions, pediatricians, and psychiatrists should give special attention to this population's vulnerability in responding to mental health needs both during and following the pandemic.
- Special consideration should be given to the forensic psychiatry population. This population remains

particularly vulnerable to COVID-19 infection, particularly within the setting of secure care, given the enclosed facilities, the requirement of high staff to patient ratio, and the behaviours of this group.¹⁶ Institutions and psychiatrists should consider these particularities in developing infectious protocols that are adapted to this population.

Psychiatric workforce

- Clinical facilities and institutions must ensure adequate access to necessary personal protective equipment and training for all staff providing psychiatric care.
- In the face of acute demand on the health care system, governments may seek to redeploy psychiatrists and psychiatry residents to other medical services for COVID-19 ‘relief care.’ Psychiatric services remain essential services as part of the pandemic response, and redeployment measures should reflect this. Psychiatrists should be able to provide the same level of services, as some are predicting a wave of increased demand on mental health services as a result of the COVID-19 pandemic.
- In Canada, psychiatrists are relatively older, compared to other medical specialties’ workforces.¹⁷ As such, many have had to limit clinical activities within hospital settings due to the personal risk of COVID-19 infection. Regulatory agencies, professional psychiatric associations, and residency training programs should collaborate to ensure workforce planning measures are put in place to respond to the pandemic’s anticipated impact on the psychiatry workforce. This may include temporary measures to adapt licensing requirements and advocacy surrounding the training needs of psychiatry residents, to ensure an adequate supply of new psychiatry graduates.
- Health care workers, who are currently front-line responders in this pandemic, have been found to be particularly at risk of psychological distress, depression, anxiety, and insomnia. Health care professionals are at greater risk of trauma and, therefore, post-traumatic stress disorder.⁴ Professional organizations and institutions should provide additional support for physicians, including psychiatrists, to ensure their well-being during a time of greater risk and burden. This can include, but should not be limited to, resources for stress management, peer support, and access to mental health supports.

Access to psychiatric services

- Telepsychiatry has been presented as a solution to mitigate the repercussions of physical distancing measures and isolation protocols, allowing for reduced person-to-person contact and therefore reduced propagation of the virus.^{18,19} Not all patients with psychiatric illness may have the financial resources nor digital literacy to effectively use telehealth platforms on an outpatient basis. Thus, institutions, governments, and psychiatrists must promote clinical practices that do not disproportionately disadvantage patients with limited access to telehealth.
- Electroconvulsive therapy (ECT) is highly effective in treatment-resistant psychiatric illnesses ranging from mood disorders to psychotic disorders. During the pandemic, elective procedures have been suspended as a means of health systems planning for pandemic response. However, ECT is considered an urgent and necessary treatment in some cases. As such, institutional administrators, anesthesiologists, and psychiatrists should work collaboratively to minimize the impact of public health measures on the continued provision of essential ECT treatments, as well as to develop a need-stratification model to ensure equitable use of this treatment modality in the face of more limited access. Other measures should also be considered when ECT is not available, such as, but not limited to, ketamine infusion and repetitive transcranial magnetic stimulation (rTMS).
- Psychiatrists should consider neuromodulation treatment protocols that reduce the risk of viral transmission (e.g., shorter duration of treatment, reduced frequency of in-person contact), while still ensuring safe and high-quality patient care. Psychiatrists and institutions should seek to ensure that treatment facilities used for neuromodulation promote safety precautions, including sanitation of equipment and adequate personal protective equipment.
- Inpatient psychiatric facilities should consider employing such technologies as videoconferencing and telehealth, to mitigate the impact of infectious protocols (e.g., discontinuation of visitors, isolation procedures) on the quality of psychiatric inpatient care.
- Adherence-promoting treatment strategies, such as long-acting injectable antipsychotics, should be preserved as essential clinical services, given their role in preventing relapse of psychiatric illnesses.

- Patients suffering from addictions may be at increased risk of relapse, substance use, overdose, withdrawal, reduced help seeking, disengagement, or non-adherence to treatment regimens in the face of greater anxiety, physical distancing, and social isolation experienced during the COVID-19 pandemic. Further, there may be reduced accessibility of outpatient addictions services and harm-reduction practices (e.g., safe injection sites).^{4,20} As such, institutions, governments, and psychiatrists must promote clinical practices and innovative service delivery models that continue to meet the needs of this high-risk patient population.
- The anticipated impact of the pandemic on mental health systems, in addition to the changes in mental health human resources, will require the proactive development of policies aimed at mitigating the impact of these factors on the capacity of Canadian mental health systems.

Public health policies

- Pandemic response plans must consider the mental health implications of the COVID-19 pandemic. Public health measures must balance both the risks and benefits to physical and mental domains of health for the general population, as well as more marginalized and at-risk populations, such as those with severe and persistent mental illness. Mental health expertise must be sought and consulted in the development of these policies.
- When patients with psychiatric illness do not conform to public health measures, such as quarantine, psychiatrists may be posed with the ethical and legal challenge of considering involuntary hospitalization to protect the public good or reporting the patient's behaviour to public health officials.¹⁶ Ethical and legal expertise should be sought to develop policies to guide psychiatrists in these situations and to ensure that clinical practice respects patient rights. Legislations under public health law can be considered in addition to mental health law when applicable.
- Those recovering from COVID-19 infection, including health care workers, may face stigma by the general public. Public health education initiatives should seek to combat this stigma.

Research agendas

- Research should seek to better elucidate the mechanisms through which patients with psychiatric illness experience a greater burden

of COVID-19 disease and identify specific public health interventions for this clinical population, such as regular screening.

- The current pandemic represents an unprecedented opportunity to evaluate the impact of the crisis response on the quality and value of mental health outcomes. Research should be conducted to understand this impact as a means of informing policy responses to future public health crises.

References

1. Yao H, Chen JH, Xu YF. Patients with mental health disorders in the COVID-19 epidemic. *Lancet Psychiatry* 2020;7(4):e21.
2. Moesmann Madsen M, Dines D, Hieronymus F. Optimizing psychiatric care during the COVID-19 pandemic. *Acta Psychiatr Scand* 2020;142(1):70–1.
3. Kozloff N, Mulsant BH, Stergiopoulos V, et al. The COVID-19 global pandemic: implications for people with schizophrenia and related disorders. *Schizophr Bull* 2020;46:752–7.
4. Vigo D, Patten S, Pajcar K, et al. Mental health of communities during the COVID-19 pandemic. *Can J Psychiatry* 2020;65:681–7.
5. Xiang YT, Zhao YJ, Liu ZH, et al. The COVID-19 outbreak and psychiatric hospitals in China: managing challenges through mental health service reform. *Int J Biol Sci* 2020;16:1741–4.
6. Strous RD, Gold A. Psychiatry and COVID-19: putting our best foot forward. *Br J Psychiatry* 2020;217(2):1–3.
7. Javelot H, Llorca PM, Meyer G, et al. Challenges for psychotropics in the context of the SARS-Cov-2 pandemic. *Encephale* 2020;46(3S):S116–S118.
8. Vindegaard N, Benros ME. COVID-19 pandemic and mental health consequences: systematic review of the current evidence. *Brain Behav Immun* 2020;89:531–42.
9. Zhang K, Zhou X, Liu H, et al. Treatment concerns for psychiatric symptoms in patients with COVID-19 with or without psychiatric disorders. *Br J Psychiatry* 2020;217:351.
10. Sinyor M, Spittal MJ, Niederkrotenthaler T. Changes in suicide and resilience-related Google searches during the early stages of the COVID-19 pandemic. *Can J Psychiatry* 2020;65:741–3.
11. Schmitz N, Holley P, Meng X, et al. COVID-19 and depressive symptoms: a community-based study in Quebec, Canada. *Can J Psychiatry* 2020;65:733–5.
12. Castelli L, Di Tella M, Benfante A, et al. The spread of COVID-19 in the Italian population: anxiety, depression, and posttraumatic stress symptoms. *Can J Psychiatry* 2020;65:731–2.
13. Di Nicola V, Daly N. Growing up in a pandemic: biomedical and psychosocial impacts of the COVID-19 crisis on children and families. *World Social Psychiatry* 2020;2:148–51.
14. Hawke LD, Barbic SP, Voineskos A, et al. Impacts of COVID-19 on youth mental health, substance use, and well-being: a rapid survey of clinical and community samples. *Can J Psychiatry* 2020;65:701–9.
15. Courtney D, Watson P, Battaglia M, et al. COVID-19 impacts on child and youth anxiety and depression: challenges and opportunities. *Can J Psychiatry* 2020;65:688–91.

16. Simpson AIF, Chatterjee S, Darby P, et al. Management of COVID-19 response in a secure forensic mental health setting. *Can J Psychiatry* 2020;65:695–700.
17. Royal College of Physicians and Surgeons of Canada. Royal College Medical Workforce Knowledgebase. Ottawa (ON): RCoPaSo; 2019.
18. Zhou X, Snoswell CL, Harding LE, et al. The role of telehealth in reducing the mental health burden from COVID-19. *Telemed J E Health* 2020;26:377–9.
19. Zhou L, Xie R, Yang X, et al. Feasibility and preliminary results of effectiveness of social media-based intervention on the psychological well-being of suspected COVID-19 cases during quarantine. *Can J Psychiatry* 2020;65:736–8.
20. Jaysinha R, Nairn S, Conrod P. A dangerous “cocktail”: the COVID-19 pandemic and the youth opioid crisis in North America: a response to Vigo et al. (2020). *Can J Psychiatry* 2020;65:692–4.