of essential mental health and psychosocial services in development and humanitarian settings during the COVID-19 pandemic.

Humanitarian emergencies can be an effective impetus to strengthening community mental health care[10], as part of the overarching goal of universal health coverage. Strategies identified by the WHO will guide efforts to strengthen mental health care in countries recovering from COVID-19. These include: a) planning for long-term sustainability from the outset; b) addressing the population's broad mental health needs; c) respecting the central role of government; d) engaging national professional organizations; e) ensuring effective coordination across agencies; f) reviewing mental health plans and policies as part of reform; g) strengthening the mental health system as a whole; h) investing in health workers; i) using demonstration projects to raise funds for wider reform; and j) investing in advocacy to maintain momentum for change. This approach also links to the *WHO Special Initiative for Mental Health: Universal Health Coverage for Mental Health*[11], which will help improve access to mental health services.

Our approach to mental health is comprehensive – not only focusing on responding to the current crisis and recovery after the crisis, but also on preparedness and getting services ready in countries before the next emergency through supporting countries in establishing community based mental health services for everyone everywhere. Health for All means having strong health systems, and strong health systems are resilient health systems.

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# Psychiatry in the age of COVID-19

Within a few months, COVID-19 has sickened millions, killed more than 200,000, disrupted the lives of virtually everyone, and caused tremendous anxiety, trauma and grief. As psychiatrists, we are used to helping people who have suffered trauma and loss. Some of us have cared for survivors of disasters, but few have experienced a global pandemic that threatens all of our lives. None of us was prepared for this crisis, and we acknowledge that the observations and adaptations we are writing about here may not stand the test of time.

What do we know about the effects of pandemics on mental health and what can psychiatrists do to help? Studies from earlier outbreaks[1] suggest high rates of acute stress and anxiety among the public, patients and health care workers. A recent study of health care personnel in China found high rates of depression and anxiety, especially among those on the front lines[2]. In our own experience, we have seen increased stress in individuals with preexisting mental health or substance use disorders, who may be socially isolated and have reduced access to their usual treatment programs or support systems.

We have also noted new psychiatric symptoms in individuals experiencing stress, anxiety or grief as a result of the pandemic. Some are experiencing losses under traumatic circumstances, such as not being able to say goodbye to dying loved ones or the inability to offer proper burials. Physical distancing can help slow the spread of the virus, but we know the risks associated with social isolation. This can be particularly challenging for those who are elderly, poor, or without access to telephones or the Internet. Along with isolation, we may experience a loss of structure, increased time for anxious rumination, and limited opportunities for active coping.

Front-line health workers are experiencing severe stress and anxiety while caring for patients under difficult circumstances, battling a disease for which we have no cure, often with limited equipment. They are exhausted and doing their best, but patients keep dying. Clinicians also have to worry about their own health and the risk of bringing a deadly illness home to their families. These experiences may have long-lasting emotional and functional consequences[3].

Every one of us is at some risk for contracting this deadly virus, but there are those who are more vulnerable, and traditional social determinants of health still apply. Historic inequities driving chronic disease rates in people of color, poverty, and health literacy may play a role in differential rates of infection and death. Individuals whose livelihood and ability to obtain food and shelter have been diminished may suffer long-term consequences of this pandemic[4], and those with pre-existing mental health disorders may be at increased risk for developing post-traumatic stress disorder or suicidal ideation[5,6].

Our hospitals were among the first in the US to see patients with COVID-19. We have made a series of changes to our clinical programs and we are talking to our colleagues around the world to learn from each other and to support each other. We have rap-

idly moved our scheduled outpatient visits to telehealth care, going from doing almost no into-the-home telehealth to doing 90% of our visits in this manner. Telehealth allows our clinicians to safely work from home, where they can also care for family members such as children who are out of school.

Inpatient psychiatry is fundamentally different from inpatient medicine in that the care on psychiatry units takes place outside the room in a group and milieu setting, whereas the care on medical floors takes place inside the patient's room. This greatly increases the risk of COVID-19 spread between psychiatric patients and staff. We have developed protocols to screen all existing and new patients to our inpatient units for COVID-19 and we are conducting surveillance testing of staff who have been exposed.

Initial protocols called for movement of all COVID positive patients to designated medical units. However, the behavioral symptom severity of some geriatric patients and agitated younger patients required us to develop protocols for treating these patients on our psychiatry units, in sections designated as COVID hot zones, where we can maintain safe environments through the careful use of barriers and personal protective equipment. Because some freestanding psychiatric facilities struggle with caring for COVID patients, we plan to increase our inpatient bed capacity and we have streamlined the process for moving psychiatric patients out of the emergency room to make space for the anticipated surge in COVID patients. On our consultation-liaison services, we have sought to preserve personal protective equipment and limit staff exposure by employing modalities such as tele-video consultation.

In our organization, psychiatrists have not been asked to redeploy outside of behavioral health care settings thus far. Instead, we have focused on expanding our services to better assist our health care colleagues. Nearly 100 of our psychiatry faculty members are volunteering to provide mental health support to some 20,000 health care workers in our organization. We have also developed a psychiatric consultation service in which psychiatrists provide consultation to primary care providers and other health care professionals caring for patients with mental health or substance use problems anywhere in Washington State, an area that is four times the size of the Netherlands or roughly half of the size of Italy. Our calls come from primary care and community health clinics, jails, temporary field hospitals, recovery centers, and shelters.

Taking a moment to reflect on these changes, we are humbled and impressed by how all people have come together to rise to this challenge. After getting over the initial shock and fear, we have learned that as psychiatrists we can take care of our patients who are tremendously vulnerable right now, take on the care of new patients who are severely stressed and traumatized by this crisis, and provide important support to our health care colleagues on the front lines. We don't know yet what will come next and how long we will have to endure this crisis, but we are preparing for what will likely be a marathon rather than a sprint.

We are all learning a lot. We are learning about our tremendous interconnectedness on a local and even global level. We are seeing people being more tolerant with each other, more forgiving, and giving each other more latitude. We see people spending more time with their families, which can be good for some and stressful for others. We are learning what is truly essential and that a remarkable amount of work can be done from home, although this may not be as true for those who are poor or otherwise disadvantaged. We are finally learning the value of handwashing, even on mental health services where we have traditionally been poor at adopting this vital health practice. And we are noting that the planet must be smiling as we commute and pollute less. We hope that each of you is well and we invite you to share your lessons and your hopes with us as we look ahead together.

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