Mental health and psychosocial support in a time of COVID-19

The authors' report on Ugandan experiences gives a glimpse of what it means to collaborate in times of adversity

Mental health relates to the thinking, feeling and behavioural part of life and influences the way individuals build relationships, cope with daily stress, overcome challenges and bounce back after facing setbacks. In everyday life, individuals need care and support from people around them on a daily basis. These people could be family members, teachers, health workers and community members. This support is referred to as psychosocial support. In normal life, mental health and the care and support the individual receives from the environment are in equilibrium, even unconsciously. COVID-19 causes disequilibrium in mental health and the environment leading to instability. Everyone to varying degrees experiences fear of infection, somatic concerns and worries about the pandemic consequences. Since the transmission mode is mainly by contact, measures to curb the spread of COVID-19 discourage social interactions and as such, people have been advised to stay home. In order to maintain a good mental health, one needs social support that heavily relies on social interactions.

Long periods of isolation coupled with loss of jobs and income can have adverse mental health consequences. If stresses are overwhelming or go on for a long time, it becomes traumatic. To work productively and fruitfully and to contribute to community, one needs routine, structure and opportunity. All these aspects of life are disrupted by the pandemic.

Given this background, different individuals with expertise in mental health under different organisations including World Health Organization (WHO), Ministry of Health (MoH), Butabika National Referral Mental Hospital, Makerere University, UNICEF, CDC as well as a number of local NGOs convened to develop a plan for the incorporation of mental health and psychosocial support (MHPSS) in the response against COVID-19. This collaboration became the MHPSS sub-pillar that fed into the overall national COVID-19 taskforce which itself consisted of eight major pillars namely: case management; infection prevention and control; surveillance; risk communication; logistics; laboratory; water and sanitation; and emergency medical services.

Figure 1 shows how MHPSS in COVID-19 linked with other pillars.

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Roles and issues

The MHPSS sub-pillar was designated several roles. The first was to identify the MHPSS issues in COVID-19 and provide leadership in designing intervention strategies in order to prevent transmission of COVID-19 infection. The second was to ensure the psychosocial health of responders especially health workers. Third was to offer MHPSS to those affected by or infected with COVID-19 whether in quarantine isolation centres, treatment units or in families and communities. Fourth was to provide ongoing mental health messaging and advocate continued mental healthcare around the country in order to minimise stigma. Fifth was to review national and international materials and literature and prepare MHPSS-related standard operating procedures and guidelines for the country. The sixth was to carry out research in MHPSS.

Mental health and psychosocial issues in COVID-19 were identified by the MHPSS team participating in initial regional preparedness assessment by the WHO in March. Pillar members visited isolation

Figure 1. MHPSS sub-pillar linkages

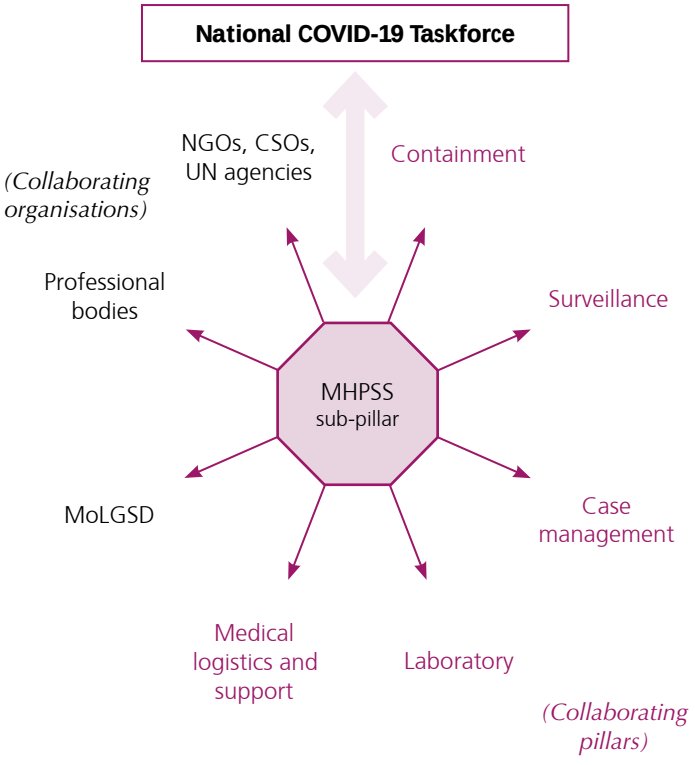


Table 1. Identified sources of stress in different categories

Quarantine	Presumptive in isolation	Confirmed CTU	Health workers	Security personnel	Community	Ministry of Health
Mode of admission	Waiting for results	Severe disease	Strict biosecurity measures	Inadequate PPE	Mass community infection	Limited resources
Stigma towards their contacts (usually close friends and family)	Mode of evacuation	Death	Inadequate PPE	Confusion over responsible Ministry	Stigma	Politics
Challenges securing basic needs		Vindictive-ness	Inexperience and inadequate drills		Tonsemberera campaign	Long working hours
Worries about the wellbeing of family members			Discomfort of PPE		Contradicting information and rumours	Tight deadlines, 'Action points'
Unclear information			Difficulties maintaining self-care		Un-employment	
			Desire to work despite poor pay/ moral injury		Broken social networks	
			No risk allowances			

Fear of getting infected, Fear of infecting others, Loneliness, Stigma, Attitude of a victim, Lack of basic needs, Routine disrupted

quarantine and Covid treatment units (CTUs) regularly to speak to individuals in isolation. They also attended different meetings for a including the national task-force pillar meetings as well as various community taskforces to gather information. An issues collection tool was developed that was used to document issues as they arose at different isolation centers and these were summarised for reporting at the various taskforce pillar meetings for action.

The team found that everyone, including heath workers, were experiencing fear of varying magnitudes and worries about COVID-19 and its consequences, so there was a need to address issues driving this fear including the lack of adequate personal protective equipment (PPE). In quarantine centers and CTUs there were very high levels of anxiety due to insufficient information and fears about the future. Other mental health problems such as depression, suicide ideation, substance withdrawal syndromes and seizures disorders and bipolar disorder relapses were also found and dealt with. There was very urgent need for MHPSS in these units to deal with all these acute and emerging MHPSS challenges.

In the regional centres mental health units were turned into CTUs as, in most cases, the mental health units were located far from the main hospital making them perfect for isolation away from the rest of the hospital units. Those with preexisting or constitutional vulnerabilities to psychiatric disorders including anxiety, depression, suicidal behaviours and substance use disorder were rendered especially vulnerable to symptom-worsening and relapses and therefore needed to have a place where mental health services could be provided. In most regional hospitals, alternative spaces were availed.

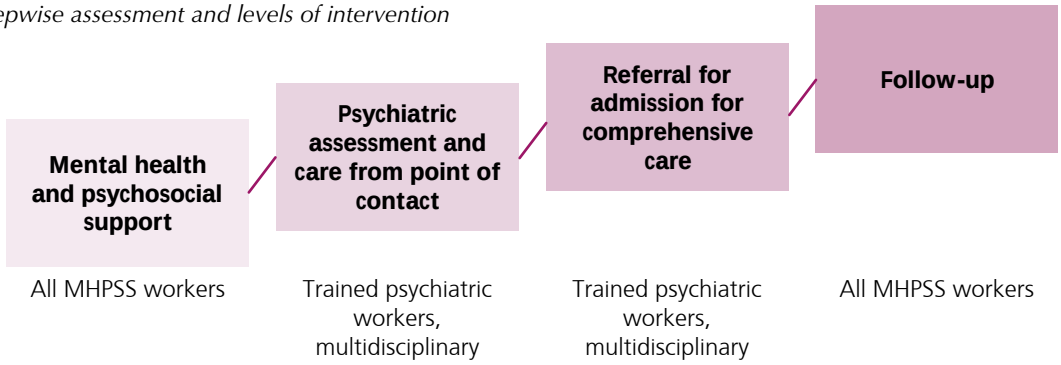
Table 1 highlights sources of stress among different categories of individuals as was identified by the MHPSS teams.

What did we do?

Initial deployment to avert a mental health crisis was organised and it involved mental health nurses and psychiatric clinical officers from Butabika National Referral Mental Hospital, who were quickly prepared and attached to Mulago and Entebbe hospitals which were the initially designated CTUs. These mental health workers had prior experience in providing MHPSS during the Ebola virus outbreak. At the same time, MoH engaged volunteers from the Uganda Counseling Association and deployed them in quarantine centres around Kampala. Social workers from Watoto church were trained to provide support to the 10 children who were under quarantine then. MHPSS sub-pillar members developed needs assessment tools for persons in quarantine and isolation centres in order to document needs and made periodic field visits to quarantine sites and treatment centres. Community engagement meetings were held with the Covid task force at various levels in order to identify needs or communicate them for action to be taken by the responsible people. Weekly mental health support was also provided to all frontline health workers to ensure they remained well as they worked in risky and stressful conditions. We employed the approach of 'normal reaction to abnormal situation' and therefore used stepwise assessment and intervention. Figure 2 shows the steps and levels of intervention.

The MHPSS team members integrated into the MoH COVID-19 regional support teams that included physicians, public health specialists and epidemiologists. The main aim of the regional teams was to support the

Figure 2. Stepwise assessment and levels of intervention



regions in prevention and control of COVID-19, and to facilitate regional and district response to the pandemic. A one-week training of regional MHPSS teams was conducted to address all aspects of COVID-19 prevention and treatment including mental health aspects.

Challenges

Although some regions embraced MHPSS as an important component of the COVID-19 response, we encountered others with unhelpful attitude towards MHPSS in the regions, including health managers. As a result, some of the trained mental health workers were not absorbed in the response teams. However, with continuous advocacy from the centre, this unhelpful attitude slowly changed.

Mental health units in the regions were turned into CTUs making continuation of mental health services for those who broke down or relapsed with severe mental disorders a challenge and rendering the mental health professionals in these units redundant. There was an increase in the number of new patients with severe mental illness as well as those with pre-existing mental illnesses who relapsed.

Because mental health is daily life, there is no magic bullet that is going to stop all the mental health issues at once and therefore new mental health issues keep coming up. For example, the individuals in isolation centres whose needs are not fulfilled or whose expectations are not met have posted their frustrations in the media. The media, on the other hand, with limited appreciation of mental health as everyday life quickly apportioned blame to the MoH and the MHPSS team.

The sensitisation campaigns such as the *Tonsemberera* promote social stigma rather than physical distancing. This could have made some people's mental health woes worse. MHPSS also found it a challenge to integrate MHPSS services in the community health service.

Last but not least, the number of experts who came together to offer leadership and their MHPSS expertise to the fight against COVID-19 became overburdened with work since they were already employees of other organisations like universities and hospitals. Balancing regular work with MHPSS COVID-19 response continues to be a challenge. However, as others have been trained, the experts have moved to a supervisory role.

Opportunities

Mental health has finally become a concern for many in Uganda and for this reason many are advocating increments in mental health financing and encouraging younger health professionals to join mental health courses.

COVID-19 has put to test our individual and community coping skills. This situation brings the opportunity to learn alternative ways of maintaining calm and happy. Because of the communal/collectivistic way of life, Ugandans, generally depend upon each other for their everyday coping and sustenance. However, this is slowly shifting to more individualistic living due to the need for social distancing. This is happening quickly without the development of necessary coping skills at the same rate. Many things that happen naturally such as holding hands, hugging, sitting close to each other, are no longer possible.

The 'new normal'

Mental health is everyday life yet with COVID-19, new challenges keep coming up at individual and community levels and yet coping mechanisms take time to build, However, there is hope for the 'New Normal' where individuals and the community may find a balance between preventive measures and maintenance of mental health.

MHPSS issues in COVID-19 are complex and could persist long after its physical threats have subsided. The surveillance of mental health issues and integration of their care in primary health care needs to be considered. Routine screening for common sequalae of a pandemic like COVID-19 including depression, anxiety, substance use disorders and abnormal grief reactions needs to be increased. Screening should go hand in hand with increase in service provision to handle large numbers and to ensure they have access to this within primary health care.

References

1. Pies RW. Care of the Soul in the Time of COVID-19. Psychiatric Times. May 13, 2020. Accessed August 21, 2020. https://www.psychiatrictimes.com/view/care-soul-time-COVID-19
2. CzeislerMÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep. 2020;69:1049-1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1
3. Pfefferbaum, B. and North, C.S., 2020. Mental health and the COVID-19 pandemic. New England Journal of Medicine.
4. Dr. Benedict Akimana& RebeccaCheropCOVID-19 impact on Mental Health in Low and Middle Income Countries: the case of Uganda
5. https://voxpopuli.ug/COVID-19-impact-on-mental-health-in-low-and-middle-income-countries-the-case-of-uganda