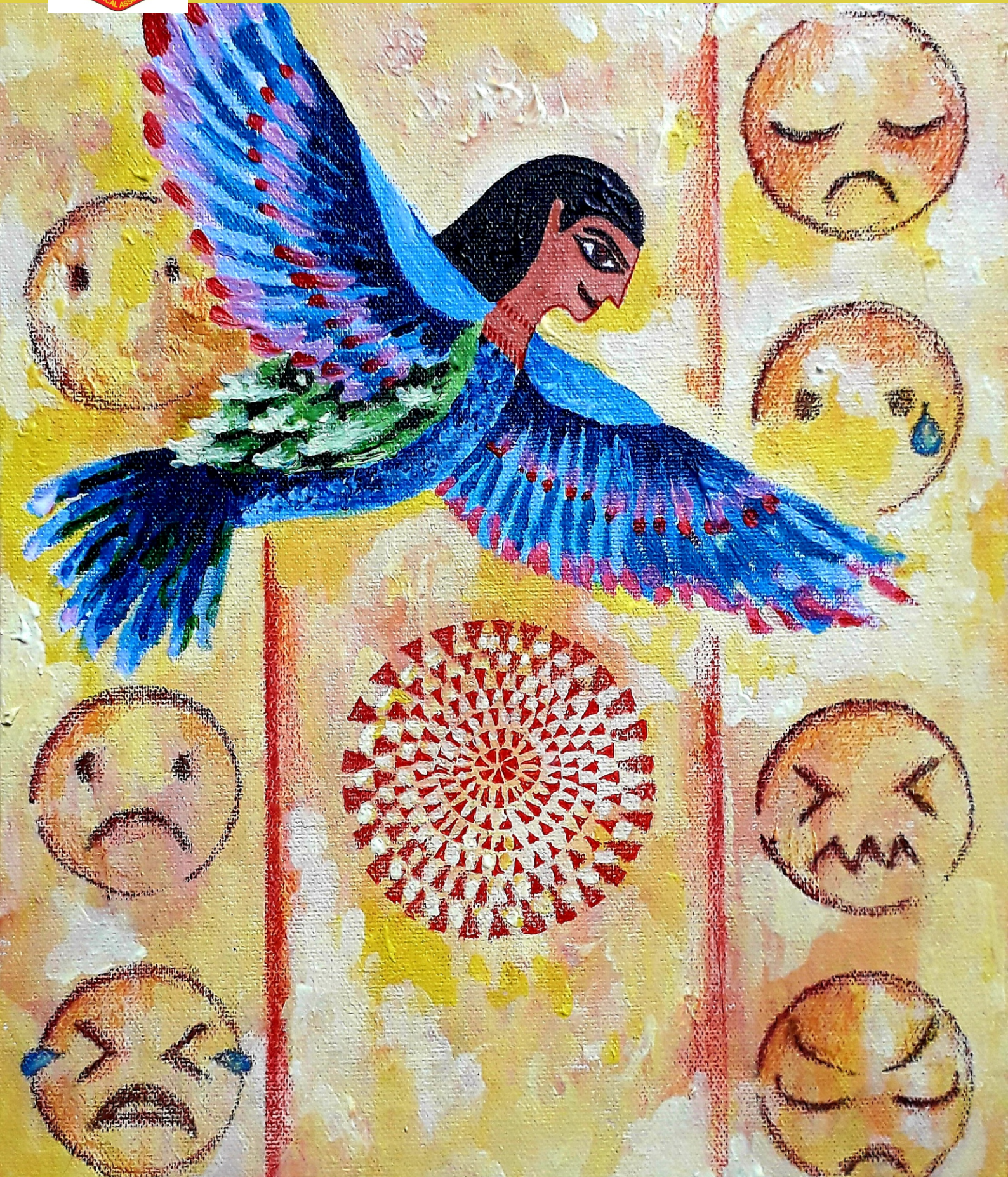




GUIDELINES FOR MANAGING MENTAL HEALTH ISSUES DURING COVID-19 PANDEMIC



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—Preface—

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22.06.2021
New Delhi

Dear Dr. Ranjan Bhattacharyya,

Greetings from Indian Medical Association Hqs., New Delhi.

As the National President of IMA, I am delighted to know IMA Bengal State Branch is releasing a booklet on "Guideline for Managing Mental Health Issues during COVID 19 pandemic". Covid-19 had impacts on the physical, mental, social, and financial aspects of day-to-day life for millions of people in this country. The community was gripped with fear, anxiety, and stress due to the lockdown, social isolation, disease burden, financial dip, and frightening WhatsApp messages.



The loss of loved and dear ones and the inability to pay the last ritual due to them by the family, has put irreparable stress on the family. The closure of regular public health care augmented many other non-communicable diseases too. The medical fraternity also had bearded the brunt of stressed out, physical and mental abuse, and the loss of many colleagues.

Though today we have controlled the disease per se due to the altruistic dedicated services of our fraternity from the front line, the post-covid-19 mental and physical complications are on the rise.

There are increasing reports of exaggeration of OCD, depression, suicide, anxiety psychosomatic disorders, and negativism are seen. The positive virtues of optimism, mindfulness, and resilience can be the tools to overcome mental stress.

It is not only the qualified psychiatrist but all the medical fraternity that shall be empowered with the basic skills and knowledge to combat these problems. With these in mind, I am happy to note the stalwarts in this field have made an easy understanding of proactive steps to combat the various disorders in a most coherent way.

I congratulate Dr. Ranjan Bhattacharyya and the team for this yeoman service and wish and hope this will reach all the doctors of this country and thereby the benefits shall be passed on to the common man in the society.

(Prof. Dr. J A Jayalal)
National President, IMA

Purity of Profession – Parity in Healthcare

All communications intended for headquarters office should be addressed to the Honorary Secretary General



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22.06.2021
New Delhi

Dear Dr. Ranjan Bhattacharyya,

I am very happy that IMA Bengal State Branch is releasing a booklet on "Guideline for managing Mental Health Issues during COVID 19 pandemic".

During these 18 months our war with COVID is very tireless and under constant pressure from all the sides. We have lost nearly 1500 doctors across India and still some are fighting with this dreaded disease. Many have affected physically as well as mentally and this booklet shall serve very important help to all the health care workers.

I congratulate Dr Ranjan Bhattacharyya and his co-authors in preparing this book.

It will be a great support and a soft copy should also be circulated to all.



Best regards.

J. M. Lele

Dr. Jayesh Lele

Honorary Secretary General, IMA

Purity of Profession – Parity in Healthcare

All communications intended for headquarters office should be addressed to the Honorary Secretary General

June 23, 2021

Ref: IMA Bengal/ 2021/013

To
Dr Ranjan Bhattacharyya (Editor)
Dr Anirban Dalui,
Dr Tamoghna Bandyopadhyay,
Dr Aratrika Sen (co-editors)



I am extremely happy to forward this booklet "**Guideline for managing Mental Health issues during COVID-19 pandemic**" which has been designed and written in a comprehensive manner which will surely be helpful to all doctors to understand and treat the mental health needs during this testing time.

The luminaries in this field from our state institutions as well as institutes of national importance have written these chapters in a very simple and lucid manner.

I would like to request all of you to forward this guideline to all medical professionals and members of Indian Medical Association for a wider circulation.

Long live IMA.

A handwritten signature in black ink, appearing to read 'Santanu Sen', with a horizontal line underneath.

Dr Santanu Sen, MP
Past National President, IMA
Hony State Secretary, IMA Bengal



MESSAGE

Dated:- 17.06.2021

Dear authors,

I am delighted to know that on behalf of IMA Bengal state a booklet on 'Guideline for managing mental health issues during COVID-19 pandemic ' illustrating different topics is going to be released shortly. The first case of novel coronavirus disease 2019 was diagnosed in December, 2019 which has spread across the world jeopardizing the global activity.

This unprecedented situation brought to institute the practice of physical distancing resulting in changes of natural behavioral patterns leading consequently to poor mental health and well being in both short and long terms accompanied by increases in depression, post traumatic stress disorders, mental and behavioral disorders, domestic violence, anxiety and loneliness which can not be bridged by digital technologies.

Pandemic is not only a medical phenomenon which also affects the individual and society at large causing disruption, stress, stigma, xenophobia etc. This restrictive measurements have affected undoubtedly in social and mental health of individuals.

I love it and it's very easy to help the book on its own journey. I also think the authors are mostly fantastic.

I hope to see more of your work in the future. Best wishes to you all.

Santosh Mandal
Dr. Santosh Kumar Mandal
President, IMA Bengal

To
Dr. Ranjan Bhattacharya. Editor.&
Hony. Asst. Secretary, IMA Bengal .

Prof. (Dr.) Debasis Bhattacharyya
MD, Ph.D, DNB

Director of Medical Education
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DME-Spl. Corresp./2021/ 71
Ref. No.

Dated : Kolkata, the 22nd June, 2021
Date.....

MESSAGE

It gives me immense pleasure to note that the IMA Bengal State Branch, would like to release a booklet on "Guideline for managing Mental Health Issues during COVID 19 pandemic".

One of the foremost concerns emerging from the different aspects of COVID-19 is its impact on mental health. The COVID-19 pandemic has disrupted every facet of our lives, most notably the social fabric which is an integral part of our health and happiness. Human beings are born social and spend a large part of their lives interacting with their relatives, colleagues, and friends. The lockdowns and restrictions imposed by governments across the world due to the pandemic have led to isolation, anxiety and depression among people, especially in high-risk groups. Fear of contracting the Coronavirus infection has affected mental health significantly. Additionally, restricted movements, like homeschooling of children, lack of social connections, unemployment and economic difficulties have not only impacted the day to day life of many people but also increased their stress levels.

Hope The IMA Bengal State Branch through this booklet will collectively develop guidelines for effective mental health management in general medical and specialized mental health care settings. This is timely and very much needed. This publication comprehensively covers mental health concerns of the general public, as well as those with psychiatric illness.

I express my best wishes and congratulate the Department of Psychiatry, Murshidabad Medical College & Hospital for coming together for this important initiative. I also express my sincere thanks to all the writers of this booklet.


22/06/2021
Prof. (Dr.) Debasis Bhattacharyya

*Dr Ranjan Bhattacharyya,
MD, DNB, MNAMS,
HOD, Psychiatry, Murshidabad Medical College & Hospital,
Asst Secretary, IMA Bengal, Direct Council Member,
Indian Psychiatric Society (2021-24).*



Dr. Ajoy Kumar Chakraborty
Director of Health Services
Department of Health & Family Welfare
Government of West Bengal

Ref. No.

Date :

FORWARD

It's my proud privilege to address the esteem publication of booklet on "**Guideline for managing Mental Health Issues during COVID-19 pandemic**" by Indian Medical Association, State branch, West Bengal.

The current outbreak of COVID-19 coronavirus infection among humans in Wuhan (China) and its spreading around the globe is heavily impacting on the global health and mental health. Despite all resources employed to counteract the spreading of the virus, additional global strategies are needed to handle the related mental health issues. This outbreak is leading to additional health problems such as stress, anxiety, depressive symptoms, insomnia, denial, anger and fear globally.

The total lockdown and social distancing were the only immediately available, best and ideal solution to the control COVID-19 pandemic initially. However, this is very challenging with added difficulty for larger sections of the society. Lockdown may lead to psychosocial difficulties for vulnerable population and consequently lead to stress, anxiety, frustration, boredom and depression and even suicidal idea and attempts. also highlighted the mental health needs of vulnerable groups.

All mental health sciences including Psychiatry can play a very important role in the comfort of COVID-19 infected individuals and their relatives, healthcare providers and society. We need to learn more about psychological and psychiatric features of COVID-19 from the perceptions of public and global mental health in order to cope up the present deteriorating situation caused by the SARS-CoV-2 pandemic.

In such a circumstance, I appreciate the tireless effort and enthusiasm of IMA , State branch to deliver the valuable aspects of managing mental health issues , discusses by esteem teaching faculties of Medical Collages of West Bengal ; AIIMS New Delhi ; PGIMER Chandigarh ; NIMHANS , Bengaluru, in such a concise form as ready reference.

Best Wishes.



Ajoy
24/6/21

Dr. Ajoy Kr Chakraborty
Director of Health Services
Dept. of Health & Family Welfare
Government of West Bengal
Swasthya Bhavan , Kolkata

Message

The COVID-19 pandemic has had a serious effects on mankind. Many of us are facing challenges that are stressful, overwhelming, and causing strong emotional disturbances in adults as well as children.

To contain the disease, we have taken some major public health actions, such as social distancing, but they are making us feel isolated and lonely and increase stress and anxiety. During the Coronavirus pandemic, panic attacks have taken on an additional layer of upset.



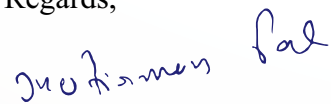
We have lost more than 750 doctors in this second wave due to Covid 19. Healthcare workers from all segments are now fatigued, depressed and stressed out.

In this time of crisis, Indian Medical Association, the largest body of Doctors in the world, is going to launch a book on Mental health issues during Covid 19 under the leadership of Dr. Ranjan Bhattacharyya, which is not only essential but also will help the people to combat the disease emotionally.

Hope this book will help people to cope up with mental health issues as well as rise as guiding one for treating physician.

Wish you all a good health.

Regards,



Prof Dr. Jyotirmoy Pal
Professor, Medicine, RGKMCH
Hony Secretary, JIMA
Dean, Indian College of Physicians



[Estd: 1947]

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Ref: IPS/20-22/0856 (COVID-19)

Dated: 23rd June, 2021

To,
Dr. Ranjan Bhattacharyya
 HOD, Psychiatry, Murshidabad Medical College & Hospital
 Asst. Secretary, IMA Bengal
 West Bengal.



Dear Dr. Bhattacharyya,

I appreciate the great initiative taken by IMA for focusing the mental health of the people with Covid-19. The Indian Psychiatric Society (IPS), the largest national body with more than 7000 active members across the states of the country, has been very aware and cognizant of the impact of the Covid-19 pandemic on the mental health of people. IPS is pro-actively helping this vulnerable population early on from the onset of the first wave of Corona Virus during March-April 2020 in India. IPS is offering volunteer services to the common public and also collaborating with IMA by way of expert resources to the health care workers, Covid warriors and front-line workers.

IPS has undergone many scientific surveys on mental health related to Covid crisis; published guidelines and journal supplement in managing Mental Health Issues during COVID-19 pandemic, prepared resource videos on mental health awareness; training materials and started short specialized training courses for the mental health professionals. IPS is collaborating with the World Psychiatric Association (WPA) as resource partner.

IPS getting lot many feedbacks from the society on COVID-19 that it is causing so much anxiety because the situation at work place is unprecedented and uncertain which further leading to psychiatric disorders. The members of IPS are working tirelessly on identifying needs and strengthening mental health services and aim to support everybody's mental health.

According to the present condition, with gradually subsiding second wave and an expected upcoming third wave, IPS seek collaboration with the Ministry at national and state level to deal with mental health issues of children in the new normal—that is online classes, lack of physical and outdoor activity, restriction of social contact; and more importantly —absence of a parent or parents or family member. These will lead to a huge gap in the normal development of the child and affect their upbringing in near future. It is thus very important that we reach out to these children, at this time of crisis, and hand hold them till these scars are somewhat better, and they can manage independently. We keep children and adolescents in our priority list amongst all other age groups.

IPS collaboratively joins hand with IMA to identify gaps and solutions to the mental health impacts of COVID-19.

Thanking you and best regards,

(Dr. Gautam Saha)
 President
 Indian Psychiatric Society

Society Registration No. 59 of 1948-1949



[Estd: 1947]

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Dated: 29th June, 2021

From the desk of Hon. General Secretary, Indian Psychiatric Society



To,
Dr Ranjan Bhattacharyya (Editor);
Dr Anirban, Dr Tamoghna & Dr Aratrika (Co-editors).

Dear Colleagues,

At the outset, I would like to congratulate the Team IMA Bengal for this noble initiative to publish the booklet on Mental Health guideline focussing on COVID 19 pandemic. I am very delighted specially to know that this will be published on the auspicious National Doctor's Day, the 1st July, 2021.

The life has been challenging all throughout and this pandemic has taught us many lessons. It's the resilience that counts at the end which enables an individual to bounce back amongst the adversities.

I wish all the success of this booklet based pictorial guideline. I am sure this version will assist all the frontline warriors to understand the impact of mental health issues during this COVID pandemic.

Long live Indian Medical Association.

Long live Indian Psychiatric Society.

(Dr. T.S. Sathyanarayana Rao)
Hon. General Secretary,
Indian Psychiatric Society

Society Registration No. 59 of 1948-1949

Message

Introduction to the Indian Medical Association's Handbook on “Guideline for managing Mental Health Issues during COVID 19 pandemic”

Globally the Mental Health Crisis will affect even more people than the Covid-19 virus has already infected! This Pandemic has highlighted the need for all to invest in their own Emotional Well-being as the most effective and best antidote to suffering Mental Health challenges.

From simple anxieties and low moods to full blown panic attacks, depression and suicides are on the rise among the young adults. The percentage of Medicos affected with these serious Mental Health problems is far higher than the general population. Creating and sustaining the Emotional Well-being of Medicos is the Vaccine against such suffering and anguish due to Mental Health problems!



The IMA started the National Initiative for Emotional Well-being of Medical Students and Doctors in India. The importance of sensitising and supporting our fellow doctors through emotional turmoil, burn-out, depression, addiction and suicidal thoughts arising out of mental health problems was understood by the IMA Leaders. Hence, they created this Standing Committee for Emotional Health in June 2018. Today this has become one of the most important initiatives of the IMA. Since it is work done by the doctors for the doctors and with the doctors, we gave it the short Title “Doctors4Doctors”

Doctors of all specialities and especially those working in Covid Care Units need to understand the impact of Covid on the Mental Health of their patients and the families of Covid patients as well. It is our duty to treat the patient as a whole and not just alleviate their physical suffering. Hence, sensitising all the doctors to these needs and giving them the necessary tools and skills needed to cope with these rising demands, is the purpose of this simple hand-book. A must read for all Medicos!

Let us all join hands to remove any stigma attached to mental health problems among our patients and our fraternity members. It is we as doctors who need to lead by example by asking for professional help in a timely manner for ourselves, our loved ones and our patients when we detect early warning signs of mental health challenges. We can do the most for our loved ones and our patients if we learn to take good care of our own physical, mental, emotional, social and spiritual well-being.

Stay safe, stay healthy and stay happy!

Dr. Nilima Kadambi
(MBBS, MS, Mch)

CHAIRPERSON, IMA National Committee for Emotional Health &
Emotional Well-being of Medical Students and Doctors in India

Message

It gives me immense pleasure to edit this guideline based booklet contributed by the luminaries in the field of psychiatry. Each chapter gives a bird's eye view of various emerging mental health issues during COVID 19 pandemic and practical points in managing them. I am indebted to Dr Santanu Sen, Hon'ble Member of Parliament, Immediate Past National President of IMA HQ & Hony State Secretary, IMA Bengal State Branch for giving me this responsibility which is much needed during this second peak of the pandemic.



There are 13 chapters contributed by 20 authors which have been included in this booklet. An attempt had been made to prepare this booklet with tables, figures and flowcharts which are clinically relevant. The eminent psychiatrists and faculties from the institutes of national importance e.g AIIMS, New Delhi; PGIMER, Chandigarh; NIMHANS, Bengaluru as well as the faculty members of the State Medical Colleges from West Bengal have contributed in this booklet.

I acknowledge the warmth, encouragement and prompt responses from our National President, Honorary General Secretary, State President, State Secretary of Indian Medical Association, Director of Medical Education, Director of Health Services, Government of West Bengal, National President of Indian Psychiatric Society, Dean of Indian College of Physicians, Hony Secretary, JIMA and Chairperson IMA Emotional Health and sending for forwarding this booklet with welcome messages and forwarding this to all doctors as a ready reckoner.

I have been assisted by my co-editors Dr Anirban Dalui, Dr Tamoghna Bandyopadhyay & Dr Aratrika Sen for the preparation of this booklet in near perfection.

Long live IMA

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COVID 19 and Psychiatric Issues

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INTRODUCTION : COVID 19 is an infectious disease caused by Severe Acute Respiratory Syndrome Coronavirus-2 (SARScov-2). The first case was detected in Wuhan province of China in November 2019.^[1] Since then, it is the reason behind the ongoing global pandemic.

Though it is predominantly a respiratory virus and spreads through droplet infection, however it can also cause neurological and gastrointestinal symptoms. The neuropsychiatric symptoms can be attributed to direct CNS invasion and as well as massive social disruption. The neuropsychiatric manifestations of COVID-19 have been summarized in Table 1.^[2,3]

TABLE 1: NEURO-PSYCHIATRIC MANIFESTATIONS OF COVID 19.

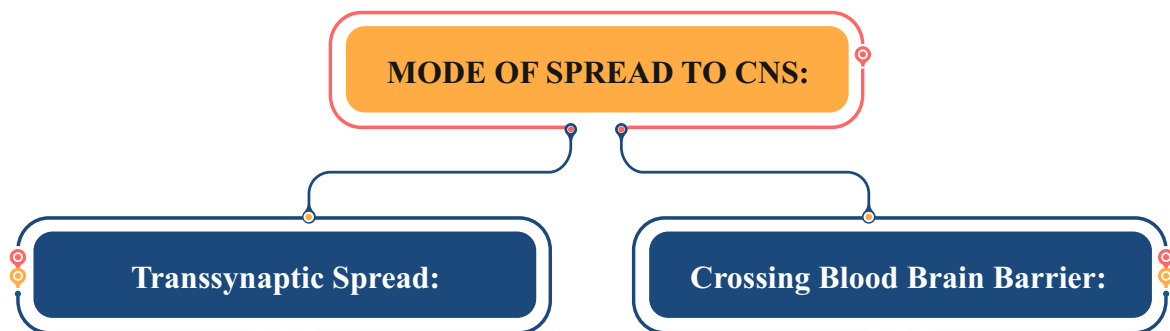
NEUROLOGICAL SYMPTOMS		PSYCHIATRIC SYMPTOMS	
CNS [86.3% INVOLVEMENT]	PNS [13.7% INVOLVEMENT]	ACUTE	CHRONIC
HEADACHE AND DIZZINESS	MUSCLE PAIN	ACUTE PSYCHOSIS	ANXIETY DISORDER
DELIRIUM AND ACUTE CONFUSIONAL STATE	DYSGUESIA AND ANOSMIA	MANIA	OCD
ENCEPHALITIS AND ENCEPHALOPATHIES	NEUROMUSCULAR DISORDERS	EXACERBATION OF SCHIZOPHRENIA	PTSD
ACUTE CEREBROVASCULAR EVENTS	GUILLAIN-BARRE SYNDROME	ACUTE STRESS REACTION	DEPRESSIVE DISORDER
EPILEPSY	PERIPHERAL NEUROPATHIES	SUICIDALITY	ADJUSTMENT DISORDER
NEURODEGENERATIVE DISORDERS	NERVE PLEXUS DISORDERS	PANIC ATTACK	EXACERBATION OF AUTISTIC TRAITS

MODE OF SPREAD TO CNS

SARS-CoV-2 is a neurotrophic virus that can gain direct entry into CNS. It has been now stipulated that the presence of ACE-2 receptors is essential for cellular entry of the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2). The spike proteins on the viral surface bind to the ACE-2 receptor on the host cells and enter the cells.^[4] In humans, multiple tissues express the ACE-2 receptors including the epithelium of the airway, lung parenchyma, renal cells, small intestine, vascular endothelium, and the CNS.^[5,6]

The process by which the virus spreads to the CNS is described in Figure 1.

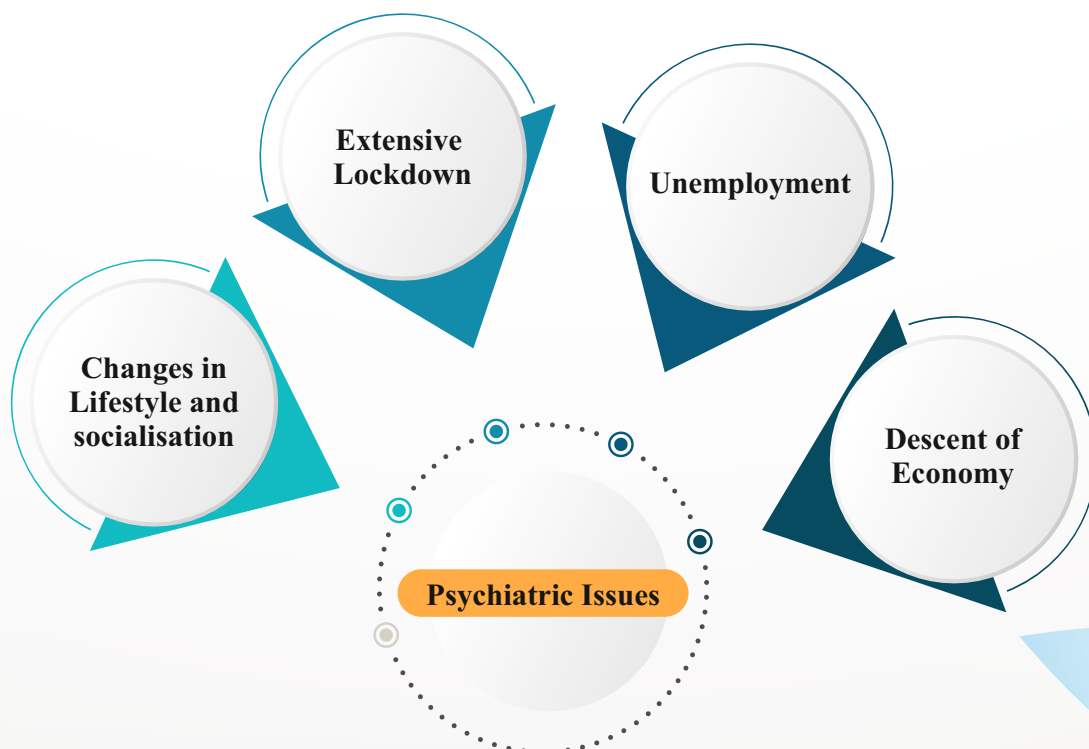
FIGURE 1: MODE OF CNS SPREAD OF SARS COV-2.



PSYCHOLOGICAL DISRUPTIONS

Various factors which are responsible for mental health breakdown have been summarized in Fig 2.^[7]

FIGURE 2: CAUSES OF PSYCHOLOGICAL DISRUPTIONS



MENTAL HEALTH OF FRONTLINE WORKER IN COVID 19

An online survey showed, out of 152 study participants, 34.9% were depressed and 39.5% and 32.9% were having anxiety and stress, respectively. Significant predictors for psychiatric morbidities were experience in health sector, duty hours, use of protective measures, and altruistic coping. Multivariable logistic regression showed most of the factors to be significantly associated with depression, anxiety, and stress level.^[8]

MENTAL HEALTH CONSIDERATIONS DURING COVID-19 PANDEMIC

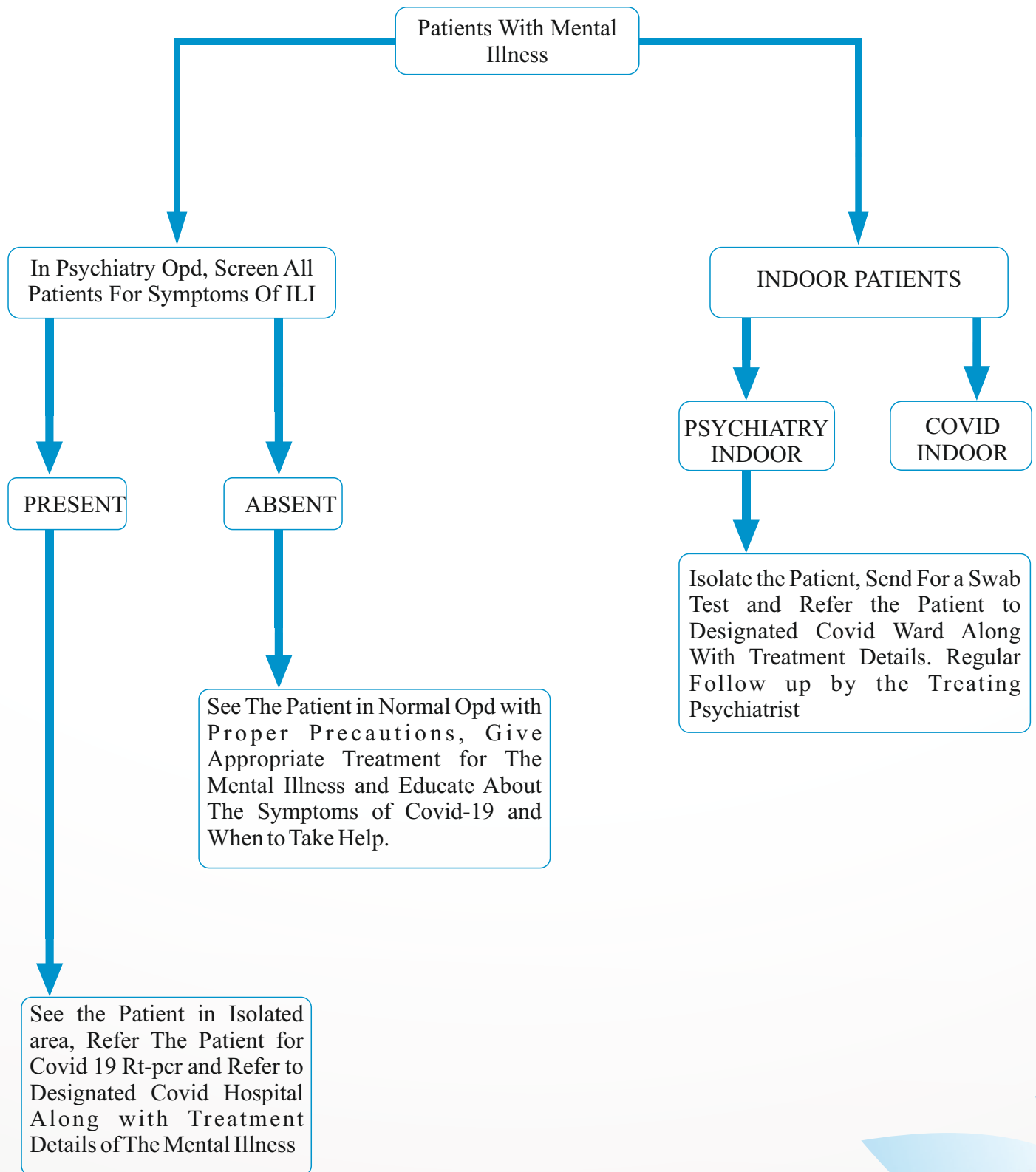
The mental health and psychosocial considerations of COVID 19 pandemic are summarized in Fig 3.

FIGURE 3: MENTAL HEALTH CONSIDERATIONS DURING COVID-19

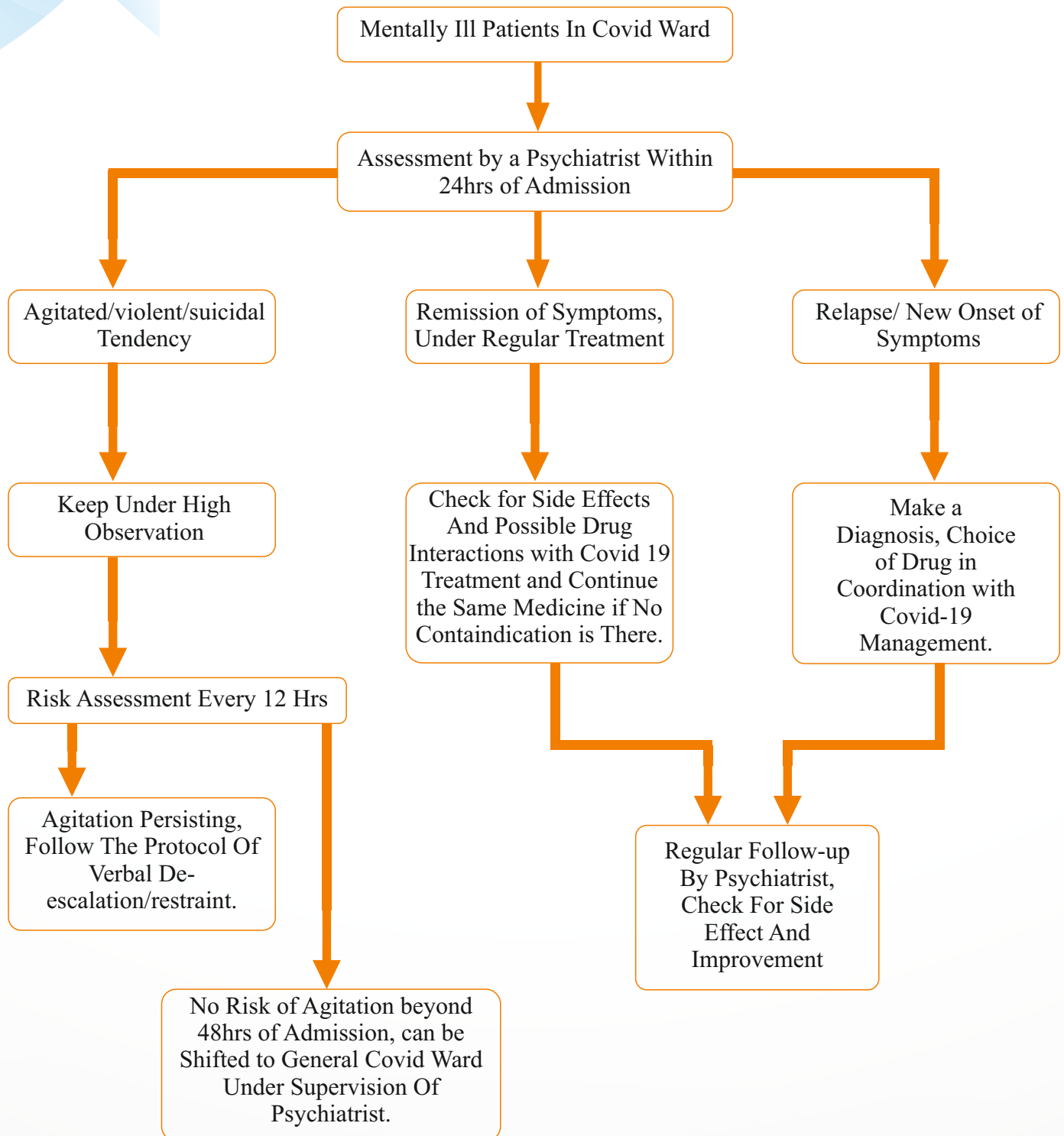


The general management of psychiatric patients have been summarized in Flowchart 1 & Flowchart 2. ^[9]

FLOWCHART 1: MANAGEMENT OF PSYCHIATRIC PATIENTS DEVELOPING COVID-19



FLOWCHART 2: MANAGEMENT OF MENTALLY ILL PATIENTS IN COVID WARD



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Depression in COVID-19: How to approach?

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Depression is a psychiatric disorder characterised by persistent low mood, anhedonia, increased fatiguability, depressive cognitions e.g., ideas of hopelessness, ideas of worthlessness, ideas of helplessness, ideas of sin/guilt/nihilism/catastrophe, suicidal ideas, low self-esteem, indecisiveness and altered sleep and appetite. The lifetime prevalence of depression has been estimated to be around 12 percent.

Corona Virus Disease (COVID)-19 is caused by SARS-CoV2 virus and has a been creating a havoc on mankind since early part of year 2020. Almost all the countries have been affected resulting in serious physical disability and innumerable deaths.

Depression has been found to be on rise because of the impact of pandemic and subsequent lockdown. The pandemic has resulted in job loss, unemployment, slowing of economy all resulting in increased poverty and hunger. Lockdown has forced people to change their daily routine, adapt to multiple adjustments both at workplace and home. With schools and colleges being closed it has also taken a toll on mental health of children by detaching them from teachers and friends. The uncertainty associated with the pandemic, lack of ICU beds, lack of oxygen, lack of emergency medicines, news of deaths of near and dear ones has compounded the psychological impact. Online surveys conducted among general population of West Bengal and India found that 24.7% and 10.5% respectively were suffering from depression during the pandemic.^[1,2] Another online survey during pandemic among children and adolescents found that near about one third of the children became irritable (35.3%), defiant/disobedient (38%), anxious (29.9%), and crying (32.7%) often which are symptoms of depression in children.^[3] People with depressive disorders are more vulnerable during such pandemic because they are more likely to pick up infections; accessing treatment can be more difficult for them; the emotional stress of COVID-19 and social isolation makes their pre-existing condition worse; quarantine may prevent them from accessing their usual treatments, such as going to therapy sessions or practicing certain lifestyle choice.

While assessing a person with depression, due importance should be given to detailed psychiatric history, medical history, family history, history of comorbid substance use disorders, and psychosocial stressors. Diagnosing depression in a patient with COVID-19 illness during acute stage or post-recovery can be quite challenging because of overlapping physical symptoms of both the conditions e.g., somatic pain complaints, fatigue, insomnia, loss of appetite etc. In such case emphasis must be given on cognitive symptoms of depression and patient's predominant mood. Pharmacological management include prescription of antidepressants e.g., selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). Mild and moderate depressive episode may require psychological intervention in the form of supportive psychotherapy or cognitive behaviour therapy (CBT) (Flowchart- 1). Some lifestyle modification techniques are also suggested (Box -1). In the context of COVID-19 illness one should remember that few of the medications used to treat COVID can cause prominent

mood symptoms e.g. ritonavir can cause abnormal dreams, emotional lability; azithromycin can cause psychotic depression; steroids can cause depression, mood lability; hydroxychloroquine and interferons can cause depression and suicidality.

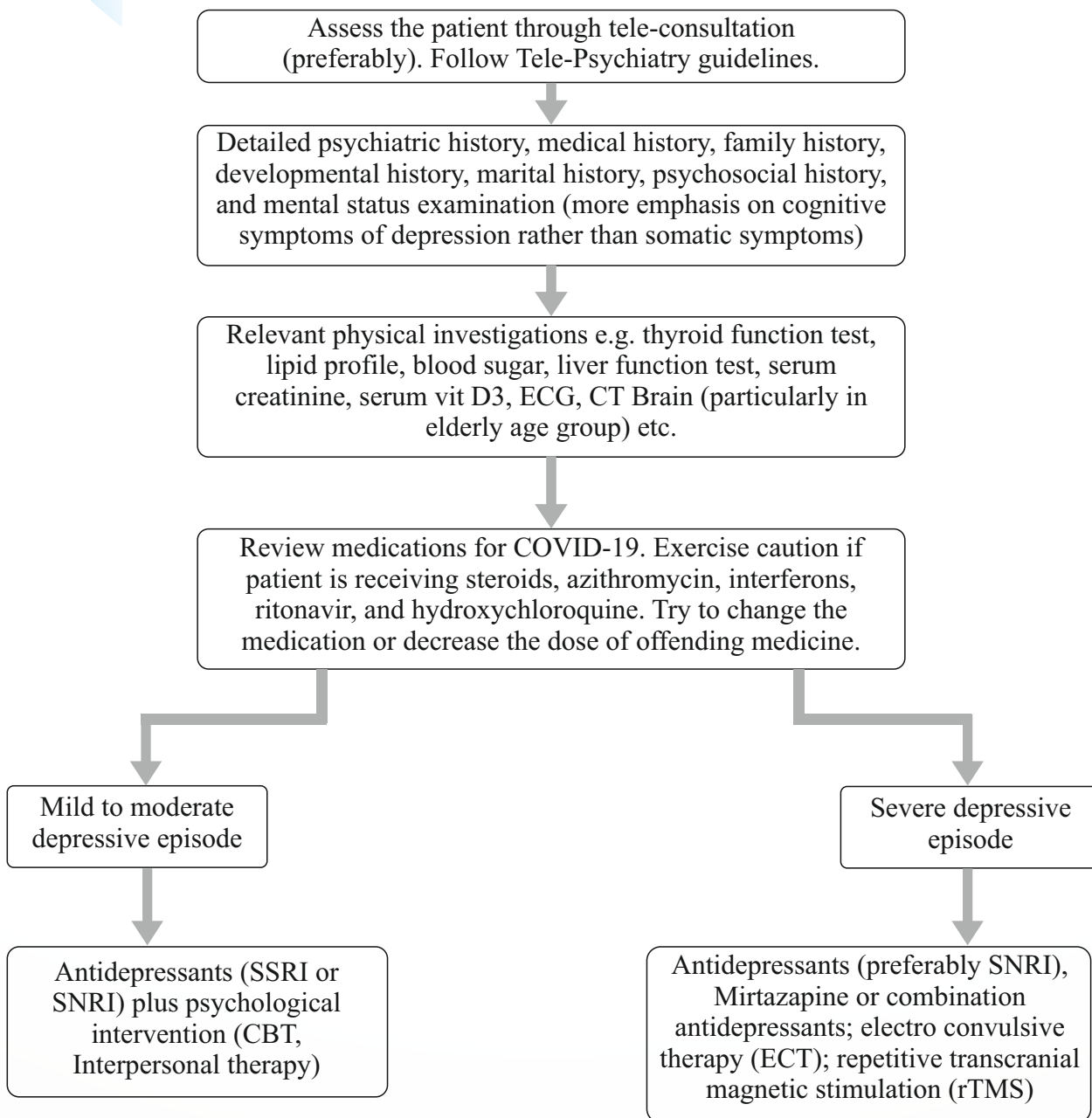
Box 1: Lifestyle modifications in the context of COVID-19 and depression

- Following a normal routine as much as possible
- Limiting time spent engaging with the news and social media
- Finding ways to be physically active
- Eating a healthful diet
- Trying to get enough sleep
- Avoiding alcohol and drugs
- Focusing on what you can control
- Maintaining social relationships

Box 2: Differential diagnosis of depression in COVID-19

- Substance withdrawal state (particularly cannabis)
- Depressive recurrence of recurrent depressive disorder
- Depressive recurrence of pre-existing bipolar disorder
- Brain fog in post-COVID patients
- COVID-19 related encephalopathy
- Hypothyroidism
- Vit D3 deficiency
- Dementia
- Parkinson's disease
- Small vessel disease of brain or macroangiopathic brain changes

Flow Chart 1: Management of depression during COVID-19 pandemic



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Managing OCD in COVID-19 pandemic

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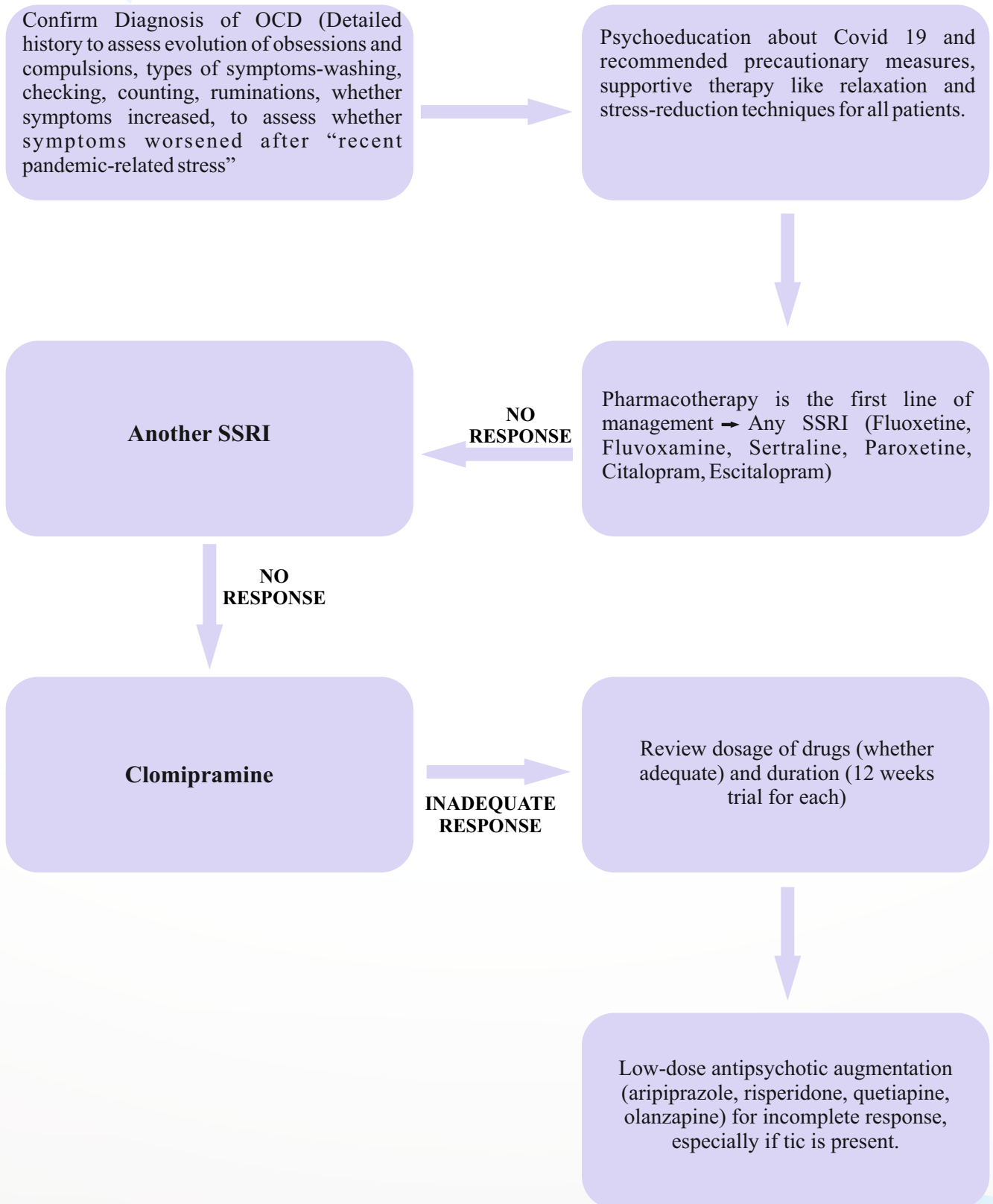
The fear and panic associated with COVID 19 pandemic along with restrictions imposed on normal lifestyle of the people has led to various psychological problems. It has also led to increase in common psychiatric problems like anxiety and depression apart from grief-related symptoms.^[1] An analysis of several studies revealed that the pandemic also caused worsening of symptoms of obsessive-compulsive disorder (OCD) in both adults and children, especially of contamination obsessions and cleaning compulsions.^[2]

Managing psychiatric disorders can be challenging due to difficulties in accessing the psychiatrist as well as inability to access medicines at times. However, the very nature of OCD poses a special challenge -the overzealous cleaning compulsions to reduce chances of “contamination” which had been considered as “excess” by the therapist suddenly seems “justified and appropriate”. To a patient with OCD, the whole world seems to be doing what they had been doing so long.

International College of Obsessive-Compulsive Spectrum Disorders (ICOCS) and the Obsessive-Compulsive and Related Disorders Research Network (OCRN) of the European College of Neuropsychopharmacology published a guideline for treatment of OCD during COVID 19.^[3] First of all, diagnosis must be confirmed. It is essential to differentiate worsening of OC symptoms from “exaggerated response to stressful events.” It is also essential to assess suicidal risk in every patient.

Due to risks associated with in vivo exposure and other logistic issues, pharmacotherapy has been recommended as the first line of management. Selective Serotonin Reuptake Inhibitors (SSRIs) like fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram and escitalopram are the typical first line of management which can proceed depending upon response in a sequential manner as shown in Fig.1. Thus, sequential SSRI trials followed by clomipramine and subsequent antipsychotic augmentation may be tried. There was preliminary evidence of efficacy of fluvoxamine in mild Covid 19 cases. In a double-blind, randomized placebo-controlled trial, adults with mild COVID-19 confirmed by SARS-CoV-2 polymerase chain reaction (PCR) assay within 7 days of symptom onset were randomized to receive fluvoxamine up to 100 mg three times daily or matching placebo for 15 days. None of the patients on fluvoxamine showed worsening of symptoms.^[4] However, this preliminary finding has no bearing so far on treatment algorithm of OCD. It is essential to ensure adequate availability of drugs and adherence to treatment. Treating team must provide psychoeducation with proper information regarding risks of COVID 19 and necessity to maintain restriction to news and information intake to 1 hour a day. Regarding the role of Exposure and Response Prevention(ERP), the mainstay of psychological management, in vivo exposure may have to be judiciously limited, or interrupted temporarily, while supportive modalities like relaxation and stress-reduction techniques should continue. This is essential to prevent the patient's condition from worsening suddenly. Activity scheduling is often helpful to keep the patient engaged. Supportive therapy of the caregivers should be offered whenever required. Finally, the basic precautions necessary for the pandemic like physical distancing, wearing masks and sanitization must be emphasized. The patient with OCD must be made to realize that he must muster his coping resources to withstand the pandemic wave with resilience.

FIGURE 1:



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Dealing with anxiety and stress of COVID-19 patients

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Introduction:

Patients with COVID-19 (symptomatic or asymptomatic) exhibit a high frequency of neuropsychiatric complications with highest being anxiety as a result of multiple biological-psycho-social risk factors.^[1] Biological risk factors include stress, resilience, genetics, gender, age, immune system, direct infection of the central nervous system (CNS) with SARS-CoV-2, comorbid psychiatric and general medical illnesses, ARDS and ICU stay. Anosmia and hypogeusia are COVID-19-specific anxiety risk factors. Knowledge of the anxiety risk factors is essential to focus on timely interventions, because anxiety may be a complication of and may exacerbate the COVID-19 course.

An inverse correlation exists between resilience and anxiety because of COVID-19. In COVID-19, important anxiety mechanism is neuro-inflammation resulting from activation of the immune system and an ensuing cytokine storm. The general approach to management of anxiety in COVID-19 should be compassionate, similar to that during trauma or disaster, with efforts focussed on instilling a sense of hope and resilience. In selecting pharmacological treatment of anxiety, the stress response and immune system effects should be the key. Anxiety disorders/symptoms require long-term follow up of at least one to six months after COVID-19.

“Worried Well”^[2]

They are healthy persons with less severe problems or those with intermittent concerns about their health and generally complain about symptoms about a particular potentially undiagnosed illness. They may wonder if these vague/non-specific symptoms represent the presence of a significant disease.

Management:

1. Do not turn them away or dismiss their problem.
2. Make them “feel understood” – first listen to their symptoms in detail and conduct a thorough physical examination.
3. Provide them with correct and authentic clinical information about COVID-19.
4. Point the discrepancy of the symptoms with which they present and symptoms of COVID-19 in a non-argumentative manner.
5. Acknowledge that their fears are understandable in the context of the pandemic's magnitude (Validation). This is a crucial aspect to establish a therapeutic alliance and gain trust.
6. Do not provide repeated reassurances or multiple referrals.
7. Relaxation techniques like deep breathing.
8. For subjects with significant anxiety and sleep disturbances, a short course of anti-anxiety drugs may be

considered if there are no other medical contraindications. (Alprazolam/Clonazepam/Etizolam 0.25-0.5mg OD/BD may be given for one week and tapered off.). However, efforts must be made to avoid medications and manage them only with education about COVID-19, reassurance, and support.^[3]

9. For severe and disabling anxiety unresolved with the above steps, consider referral to a psychiatrist for detailed assessment including consideration of long-term medications. For management of anxiety in adolescents and children please see chapter 6 by Malhotra and Ray.

Recommendations for pharmacology in anxiety and stress:^[4]

1. The risk and severity of drug–drug pharmacokinetic and pharmacodynamic interactions between COVID-19 medical treatments and psychotropic medications should always be assessed, (e.g., cardiovascular conditions increasing the risk of QTc prolongation).

2. In case of high-risk interactions, the combination should be avoided if possible. In case of moderate-risk interactions, dose adjustments, psychotropic medication withdrawal, or switch to a safer medication should be considered. In case of low-risk interactions, regular monitoring should be provided, with dose adjustments as clinically appropriate. In case of very low-risk interaction, regular monitoring is suggested.

3. The risk of respiratory impairment associated with benzodiazepines in the general population is debated, but might be particularly relevant in elderly patients with COVID-19 and pre-existing comorbidities (e.g., COPD). Benzodiazepines should be avoided or used short term (e.g., control of acute agitation), preferring those with shorter half-life and less sedating (e.g., etizolam, oxazepam, lorazepam). Although antidepressants are generally considered safe in terms of respiratory impairment, caution is advised.

4. An estimation of psychotropic-related risk of cardiovascular events should systematically take into account the following: (a) the intrinsic QTc-prolonging properties of psychotropic medications, their cumulative dose, and use in combination; (b) pharmacokinetic interactions possibly raising plasma levels of QTc-prolonging medications and pharmacodynamic interactions (e.g., co-treatments with antivirals, chloroquine, hydroxychloroquine, and opioids); and (c) pre-existing cardiovascular conditions (in particular, ischemic heart disease) and COVID-19-related cardiovascular conditions. Dose adjustment for low risk and switching/stopping for high risk interactions should be done. May take help of drug interaction checkers if in doubt.

5. Antipsychotics, benzodiazepines, and some mood stabilizers may be associated with an increased risk of secondary infections in people with COVID-19, and possibly with an unfavourable course of systemic infections. High risk for clozapine, carbamazepine, and oxcarbazepine. Call for psychiatry liaison services if the patient is on these; may stop or change.

6. In people with COVID-19, both antipsychotics and antidepressants might increase the risk of thromboembolism, particularly in the elderly. In people with COVID-19 taking heparin prophylaxis, antidepressants might increase the risk of bleeding, with a higher risk for serotonergic agents (i.e., SSRIs and SNRIs), especially in elderly patients. Regular monitoring is indicated.

7. In people with COVID-19 and known risk factors for delirium (e.g., old age, dementia, multiple comorbidities), the use of agents with anticholinergic properties (e.g., tricyclic antidepressants and paroxetine), benzodiazepines (particularly midazolam), and lithium should generally be avoided.

8. Adequate supportive psychosocial interventions are provided, including Tele-Psychiatry interventions – crisis-management/CBT/supportive psychotherapy/reassurance etc. For details about judicious use of psychotropics in COVID 19 please see chapter 10, Chatterjee et al.

Avoid these antidepressant/anti-anxiety combinations (unsafe profile):¹⁴

Fluoxetine/Paroxetine/Alprazolam/Midazolam/Quetiapine – Lopinavir/Ritonavir

Escitalopram/Citalopram – Chloroquine/Hydroxychloroquine/Azithromycin. Sertaline has the safest drug interaction pattern with these

Amitriptyline/Paroxetine/Alprazolam/Midazolam/Clonazepam – Darunavir/Covicistat

All Antidepressants and benzodiazepines are largely safe/low-risk – Tocilizumab and LMWH

Take-home points:

1. Management of anxiety is essential part of COVID-19 management.
2. Has a direct implication to the course and outcome – the relationship being bi-directional.
3. Early assessment is needed for better care.
4. Watch out for drug interactions, potential delirium, patients already on psychotropics.
5. Simple reassurance and other non-pharmacological methods can be applied. Call for psychiatrist if needed.
6. Follow up for anxiety is important and should be documented at discharge.

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Psychosis and delirium in persons with COVID-19 infection: Assessment & Management

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Psychosis in patients with COVID-19 can be new-onset or pre-existing. Simply speaking, psychosis is characterized by delusions and hallucinations. Additional symptoms which are often seen in patients with psychosis can include disorganized behavior, agitation, or marked psychomotor retardation. The psychotic symptoms in patients with COVID-19 can also be part of delirium, primarily characterized by disturbance in attention and awareness, which is acute onset, characterized by fluctuating course, accompanying other cognitive symptoms, sleep disturbance, delusions and hallucinations. The involvement of a psychiatrist (in person or through telepsychiatry) is essential for the management of all patients with COVID-19.

All the patients with COVID-19 should be initially screened for psychiatric disorders, including psychosis. While evaluating patients with psychosis, effort must be made to distinguish between pre-existing psychosis and new-onset psychosis (Figure-1 & 2). Another critical issue to be evaluated is the history of suicidal behavior and current suicidality. If a patient has pre-existing psychosis, exact details of ongoing medications, their interaction with medications to be used for management of COVID-19 should be considered. If there are no contraindications and the patient's clinical status reflects mild to moderate COVID-19, ongoing psychotropics should be continued. In patients with severe COVID-19 infection, efforts need to be made to continue the antipsychotics based on the assessment of the pros and cons of these medications. The most critical issues while using antipsychotics in patients with COVID-19 infection include drug interactions, current QTc interval, and impact of the ongoing medicines used to manage COVID-19 on the QTc interval. Another essential aspect is the evaluation of blood glucose levels, which are often deranged with steroids, and patients with concomitant use of antipsychotics and steroids may develop diabetic ketoacidosis. Preferably, if there are no contraindications, then the ongoing antipsychotic medication should be continued in patients with a primary psychotic disorder. A patient who presents with new-onset psychosis (maybe characterized by some of the following symptoms: fearfulness, accusing people of trying to harm them, reporting of seeing or hearing things which others cannot see or hear, voicing of insects crawling on their bed, marked fluctuations in symptoms, lability of mood, disturbance in attention, disorientation, forgetfulness, sleep disturbances, etc.), should be evaluated for delirium, organic psychosis, substance withdrawal or intoxication, medication-induced psychosis, and depression. In patients with new-onset symptoms, who have cognitive symptoms, fluctuating course, sleep disturbances, along with psychotic symptoms (especially visual and tactile hallucinations), a diagnosis of delirium should be considered as the first possibility. Delirium is understood as acute brain failure (in contrast to dementia-a chronic brain failure), which is always due to underlying medical illness(es), ongoing medication, and substance intoxication or withdrawal. It is also essential to understand that patients with delirium can have an intervening period of normalcy and usually show evening worsening of symptoms. Accordingly, all patients with delirium should be evaluated for underlying causes that need to be managed, be provided appropriate non-pharmacological treatment (frequent reorientation cues, ensuring adequate sleep, proper hydration, avoiding a frequent change of location of the bed, minimizing the change in staff, etc), and pharmacological management.

The pharmacological agents should only be used in patients who have severe agitation. The commonly used agents for the management of delirium include antipsychotics, melatonin, and dexmedetomidine. However, if a patient has delirium due to alcohol withdrawal, benzodiazepines (Lorazepam) should be used. Patients with alcohol withdrawal delirium should also be given thiamine. If a patient with new-onset psychosis does not have delirium, then the possibility of medication-induced psychosis or organic psychosis should be considered before considering an independent psychosis. Patients with new-onset psychosis should be managed with antipsychotics. All the patients started on antipsychotics should be carefully evaluated for QTc interval at the baseline and throughout the monitoring. Antipsychotics in patients with delirium should be stopped once the delirium clears. Similarly, the antipsychotics in patients with medication-induced or organic psychosis should receive these medications only if the patient is unmanageable or if the underlying cause cannot be immediately addressed. Once the underlying cause is taken care of, and psychosis is settled, the antipsychotic medications can be stopped shortly. In liaison with the psychiatrist, patients with primary psychotic disorders should be given antipsychotics beyond remission of symptoms.

Figure-1: Evaluation of a patient with psychotic symptoms

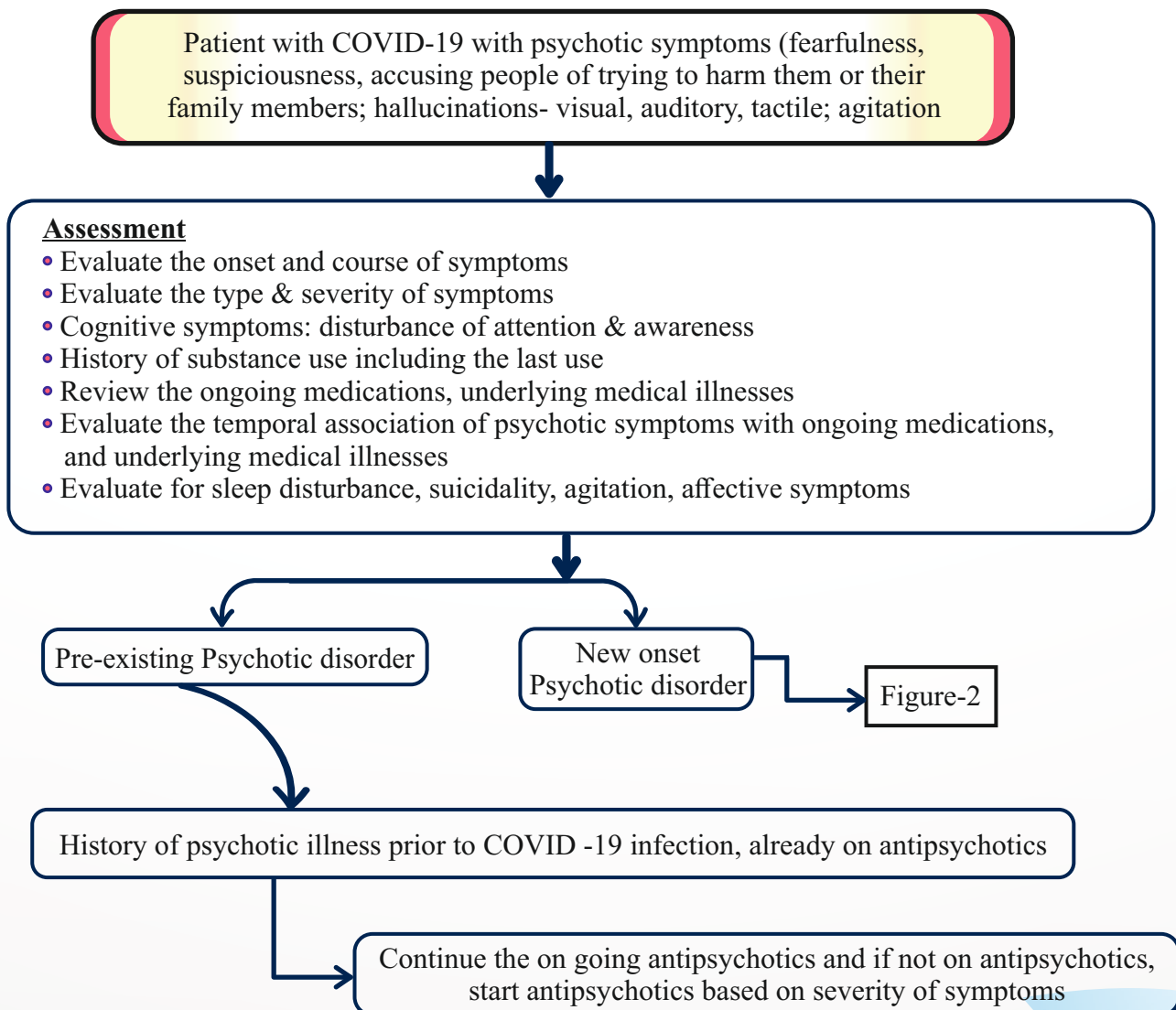
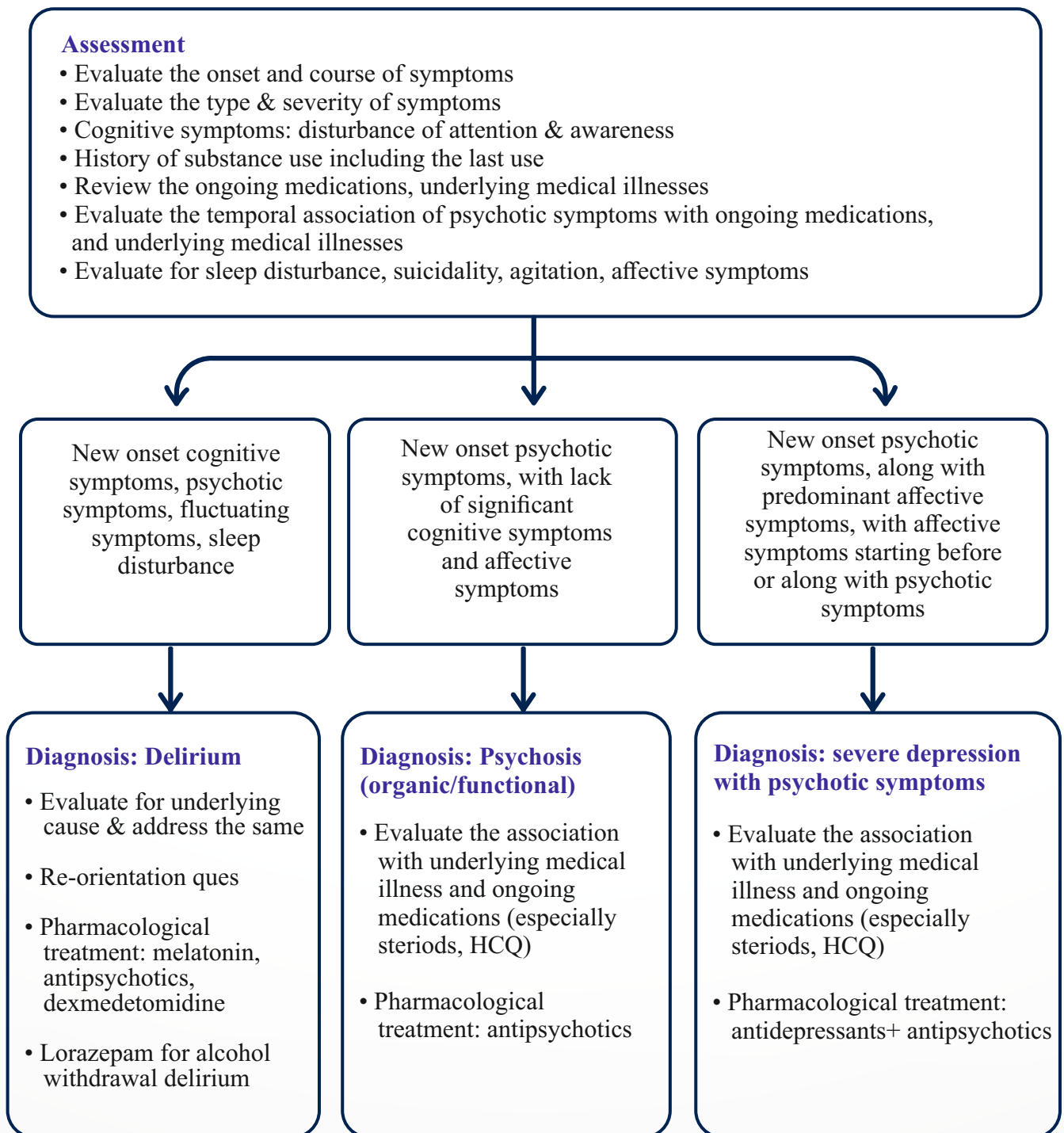


Figure-2: Evaluation of a patient with New onset psychotic symptoms in patients with COVID-19 infection



High-risk management in case of presence of suicidal behaviour
Monitor QTc interval, prior to starting antipsychotics and monitor the same

Psychosocial interventions for Children & Adolescents affected by COVID 19

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The world has been tormented by the outbreak of Covid 19 in the last over a year and a half. Children have been infected less frequently and less severely as compared to adults by this virus. However, the impact of the pandemic on children and adolescents is by no means less. Regular schools and routines got disrupted for most children throughout the world. ^[1,2] Online school and classes became a necessity which became almost like a double-edged sword.

Children can be affected by Covid in many different ways:

- A. The pandemic situation by itself disrupts normal life, thus creating anxiety, fear, uncertainty, and all children are affected by it.
- B. There are a large number of children who have one or more family members infected by Covid 19.
- C. Some children have been infected themselves.
- D. Many children have lost one or more of their family members to Covid.

A. Psychosocial Impact of Covid 19 on Children:

- 1. There is perpetual fear of them or any of their family members getting infected by the virus. This is more for those who are healthcare or frontline workers.
- 2. Fear of loss of near and dear ones, and in some situations grief and trauma due to loss of parents, sibs, or other family members.
- 3. Physical distance and separation from parents or caregivers on account of quarantine.
- 4. Loss of normal activities like interaction with the peer group, play, school, social exchange.
- 5. Disruption of studies and examination schedules causing uncertainty in career and future.
- 6. The negative impact of lost family income, jobs, the financial stress of parents.
- 7. Lack of physical space, pressures of work from home, online school, lack of support services leading to enhanced family stress, intolerance, that impact children negatively.
- 8. Unleashing of disharmony among parents, manifesting as abuse.
- 9. Excessive use of screens with a potential for screen addiction. ^[3]

The most important issue is that the world is in an inescapable state of mental trauma and turmoil. The only remedy is to learn to deal with the situation as best as possible. Parents need to be guided to handle children in a manner that will:

- a) Allay anxieties,
- b) Provide comfort,
- c) Set direction and goals,
- d) Acquire an understanding and cognitive appraisal of the situation

What should parents do:

- Explain to children in an age-appropriate language the nature of the disease Covid, what precautionary measures are necessary, and how to follow them.
- Encourage questions they ask. Answer their questions in an age-appropriate fashion. (Henceforth mentioned as 'psychoeducation').
- Spend time with them to address their insecurities, fears. Reassure them that all will be well.
- Maintain a regular daily routine
- Encourage physical activities even in the indoor space.
- Fix a family routine to do something together for at least half an hour every day.
- Allow some freedom and personal space for adolescents.
- Supervise overall activities, especially online.
- Maintain discipline about screen time and online activities. For example, no net after 10 pm is a good idea ("Night Net Curfew").
- Model by self-example. Parents themselves should follow the safety precautions and healthy habits of wearing a mask, washing hands, and social distancing.
- Encourage them to develop hobbies and co-curricular interests for relaxation,
- Give them age-appropriate responsibility.
- Control your own anxiety, fears, stress, and frustration.

What parents should not do:

- Don't panic or focus too much attention on unnecessary negative information.
- Do not get angry, frustrated, impatient with children.
- Do not exaggerate the negative impact of Covid.
- Do not cause conflict in the family and with children.
- Do not overdo the safety precautions and measures.

B. Children in whom family members are affected:

- Psychoeducation.
- Assure them it's mostly a temporary affair. But allow questions from him. Address those questions age-appropriately but do address.

C. Children who are infected themselves:

- Psychoeducation
- Try to keep the child with an already infected parent and explain it's purely a temporary measure. Allow enough play material to engage on his/her own.

D. Children who lost their near and dear ones:

- The deceased person's role in a child's life will determine the way the child will process the loss. If it is the child's primary caregiver like parents or another person with whom the child was very attached, then the child needs an alternative caregiver.
- Provide a safe haven, a warm caring environment.
- Allow the child to express feelings, thoughts. Listen to the child. Validate their concerns.
- Provide explanations in age-appropriate language.
- Support and focus on individual child's assets and strengths.

- Try to maintain a normal routine as much as possible.
- Consult a mental health professional if there are significant behavioural abnormalities that are potentially harmful such as impulsivity, depression, withdrawn behaviour, suicidal or other self-harm intent, refusal to speak or eat, etc.
- In extreme cases where a trusted caregiver can't be found, state CWC (Child Welfare Committee) must intervene.

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Geriatric Well-being During Covid 19

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The world is ageing, and one of the most important events of the 21st century is the ageing of world population. The population ageing is thought to be an achievement of civilization, the conquest of scientific discovery, but at the same time it has huge impact on the social, economic, and political changes of human society. Both developed as well as developing nations has to bear the brunt of the ageing, but the impact is greater on the developing nations including India.

The Covid 19 is a unique disease which has created havoc not only the physical health but also the psychosocial aspects of the elderly. India with a huge number of elderly populations has its own problems. Almost half of the elderly population suffers from different co-morbidities. And cognitive impairment also increases with ageing. Elderly population in India is a heterogenous population. There are different people with physical and cognitive impairment, with varying income patterns, variable social support systems and staying at rural, semi urban to urban localities. Many of the elderly are single and has lost one close relative in the pandemic. So, the impact of Covid is different among all these elderlies and they need different management plan. In the elderly covid can be related to mental health in three different ways.

1. Direct effect of covid on mental health.

There are known neuropsychiatric problems associated with Covid, Covid induced encephalopathy, Covid induced stroke, depression, anxiety disorder, post-traumatic stress disorder. The reason may be immunological reaction to the virus, rather than direct effect of virus.^[1]

2. Those who are already suffering from some mental disorder, how covid affects them.

The patients with serious mental illness are less likely to follow the safety protocols, and they are more vulnerable to exposure to Covid virus. Old age people who are already cognitively impaired are also difficult to manage during Covid times. Moreover, in our society where the medically co-morbid patients are usually being taken care by their spouses, this is more problematic.^[2]

3. The indirect psychosocial effects of covid on elderly mental health.

Here the loss of financial support, bereavement, loneliness due to lockdown all come into play.

Aetiologies of neuropsychiatric disorders

As we understand the different aetiology of different mental health problems so the approach to treatment will also be different.^[3]

Aetiologies of neuropsychiatric disorders

- Tissue hypoxia
- Desaturation
- Neuroinflammatory cytokines
- Loneliness
- Isolation
- Financial problems
- Bereavement
- Stress of not being able to visit near and dear ones.

One surprising feature is that elderly people are less negatively affected by covid. They have a higher resilience to Covid infection, and isolation. Wisdom may play a role.^[4]

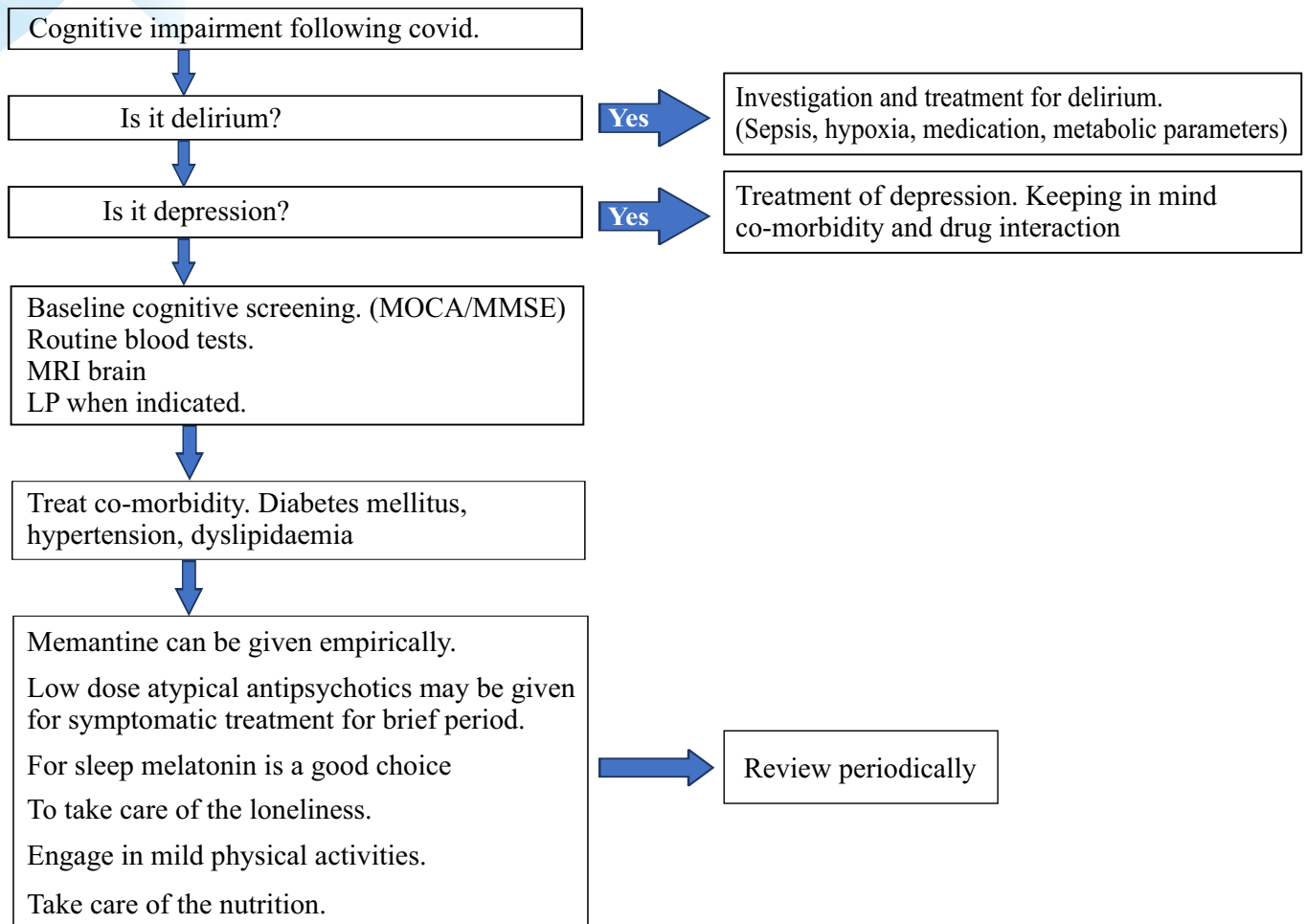
Cognitive impairment mainly affects the verbal learning and executive functions. The cognitive impairment is associated with D Dimer level and residual pulmonary dysfunction. So cerebral anoxia may be a reason which is responsible for impairment of cognition.^[5]

Some common strategies for taking care of mental health of the elderly.

- Nutrition and health care should be maintained.
- Keep them activated – daily routine, physical exercise.
- Relaxation/meditation
- Social connectedness
- To arrange for telemedicine
- Prevention from information overload and negative news

Cognitive impairment in elderly is a real problem. It may start after Covid, or premorbid cognitive impairment may be aggravated. It is too early to give accurate long-term outcome of cognitive impairment. But even mild covid may have negative impact on cognition. The treatment is empirical. No definite study on the treatment of cognitive impairment due to COVID-19 is there in the available literature..^[6]

FLOWCHART 1: APPROACH TO COGNITIVE IMPAIRMENT FOLLOWING COVID



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Challenges in Managing Substance Use Disorders during COVID 19 Pandemic

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The unprecedented COVID-19 pandemic is a significant challenge for almost all the aspects of human life including the delivery of health care services. In this context, people with Substance Use Disorders (SUD) are an especially vulnerable population.^[1]

People with SUDs are more at risk of suffering from medical co-morbidities which compounds their risk of experiencing a more severe COVID-19 disease, if infected.^[2] Apart from the pandemic (i.e., the infection and the resultant morbidity) itself, measures taken to respond to the pandemic such as isolation / quarantine / lockdown presents special challenges for people who use drugs (PWUD):

(a) Availability of alcohol or drugs is severely curtailed during the lockdown. Many users would experience craving (a distressing experience), and those suffering from dependence would experience withdrawal symptoms (which can be life-threatening in case of alcohol).^[3]

(b) Availability of, and access to the treatment and care services is also curtailed, posing challenges for both new and old patients alike.

(c) The healthcare resources may be diverted from addiction treatment to COVID-19 care further restricting the availability of services.

(d) Every physical interaction of a patient with a healthcare provider is associated with potential risk of exposure to COVID-19, which needs to be minimised.

In general, the response to these challenges must be based upon the two basic principles: (i) maintaining continuity of care to the extent possible, and (ii) minimizing the risk of infection for patients and healthcare personnel.

Managing SUDs during the pandemic: Clinical and Public health aspects

In general, treatment of SUDs during the pandemic times is NOT different from other times. Thus, the basic treatment approaches remain the same, and include:^[4]

- A compassionate, non-judgemental, and empathetic attitude towards patients
- Offering motivation enhancement and other psychosocial interventions, as indicated
- Offering pharmacotherapy which is the mainstay of treatment of SUDs. (Table 1)

Table 1: Important medications used in the pharmacotherapy of some common SUDs

<u>Condition</u>	<u>Medications used</u>	<u>Remarks</u>
Alcohol withdrawal	Benzodiazepines (diazepam, lorazepam etc.)	May be required in high doses. Careful monitoring is needed. Need to be tapered within few days.
	Thiamine (and other vitamins of B group)	May be required to be administered through parenteral route.
Alcohol dependence (for relapse prevention)	Disulfiram	Long term treatment. Can be prescribed to patients motivated for complete abstinence.
	Anti-craving agents (naltrexone, acamprostate, baclofen etc.)	Long term treatment. Usually do not adversely interact with alcohol.
Opioid withdrawal	Opioid Agonists (such as sublingual buprenorphine)	Not easily available with prescription. However, doctors & health settings can procure, prescribe, and dispense to patients. Need to be tapered within few days.
Opioid dependence (for relapse prevention)	Opioid Agonists (such as sublingual buprenorphine + naloxone)	Long term treatment. More effective than other treatment approaches.
	Opioid Antagonists (such as naltrexone)	Long term treatment. Poor compliance and retention.

A common myth about SUDs is that “treatment is possible only in the in-patient settings managed by specialist medical professionals (psychiatrists)”. The fact is, most cases of SUDs can be managed effectively in the outpatient clinics, even by the non-psychiatrists. However, the pandemic times would require following special considerations (for specialist, as well as for general healthcare settings):

1. Due to the higher, general level of stress in the society, there may be an increase in substance use (reflecting in more incidents of intoxication, overdose presenting to the healthcare settings).
2. Reduced access to substances and drugs may result in higher incidence of acute, severe withdrawal states (requiring urgent medical attention).
3. Patients who are on long-term medication and follow-up need to be protected from reducing the need of commute to the clinics for obtaining their medications or renewal of their prescription. Thus, in general, the prescriptions for such patients need to be more 'liberal' in the pandemic times (with prescribers exercising the due precautions and educating the patients). This includes more 'take-home' dispensing for medications which are otherwise dispensed as 'observed' treatment (such as buprenorphine and methadone).^[5]
4. To protect the healthcare personnel along with maintaining the continuity of care, tools offered by Information and Communication Technology (ICT) – the 'telepsychiatry' approach must be efficiently utilized. Unfortunately, most of the important medications required for treatment of SUDs remain out-of-purview of prescriptions using telepsychiatry, as per the prevailing guidelines in India.^[6] More advocacy with the policy makers is required in this context to bring about the desirable reforms.^[7]

Conclusion

Responsibility of all health professionals is considerably increased during the pandemic. SUDs are stigmatized and underserved health conditions even in best of the times. During pandemic, this crucial facet of healthcare delivery must not be overlooked, from both, the clinical as well as public health perspective.^[8]

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Post COVID fatigue syndrome and consequences thereof

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COVID-19 is an ongoing pandemic across the globe with many challenges. Beyond acute phase are new extension to its long-term sequel. Long COVID 19 syndrome, post COVID fatigue syndrome (CFS) and myalgia encephalomyelitis are all being used as diagnostic labels synonymously. This topic of Long COVID/CFS/ME is of paramount importance to public health care. Awareness, treatment, and recognition are the burning needs to empathize this condition and disseminate its awareness to medical professionals, patients, the public and the policy makers. We need to prepare and augment health care facilities for continued surveillance, research, and appropriate care. It warrants setting up dedicated, post COVID care, multi-disciplinary clinic, and rehabilitation centres for service delivery system across the nation. ^[1]

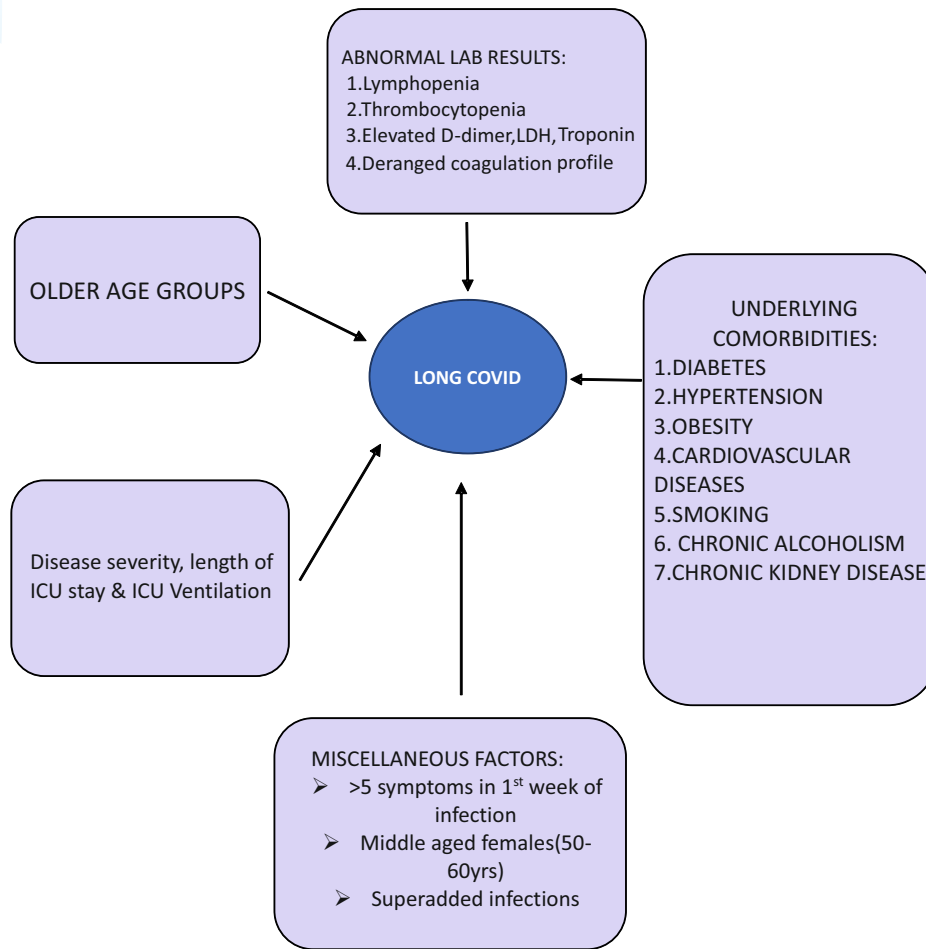
INTRODUCTION:

Back in April 2020, WHO became aware of an increasing number of people who had been ill with COVID 19 infection and were not improving even after several weeks (beyond four weeks). Most had debilitating fatigue, sometimes with continuing COVID 19 symptoms involving the lungs or heart, with loss of smell and taste in particular. More than a year on and we are now in a situation where some people are being given a diagnosis or a possible diagnosis of post COVID 19ME/CFS. Post COVID fatigue and post covid fatigue syndrome is observed across 10 to 12% of sufferers longer than 30days as per WHO reports.

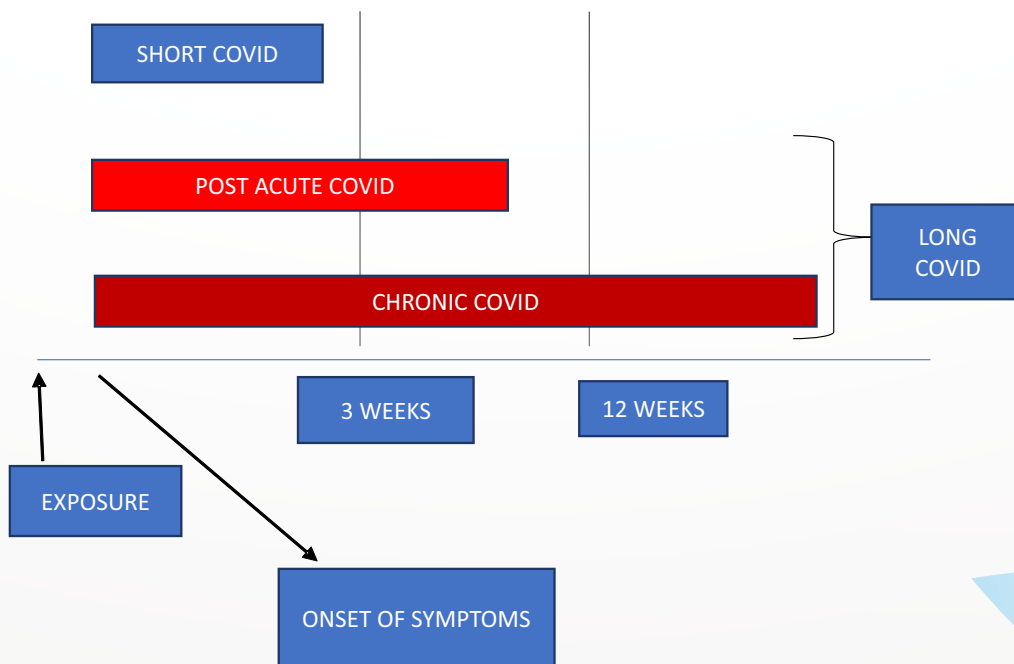
- Long COVID, post COVID fatigue and post COVID fatigue syndrome are all being used as diagnostic labels.
- Many have debilitating fatigue as a primary symptom.
- Some have respiratory, cardiac and other symptoms that are very similar to the acute infection symptoms. E.g., Breathlessness, palpitation, intermittent fever, headache, loss of taste and smell
- In cases where post COVID syndrome symptoms have persisted for more than three months and are considered with ME/CFS a diagnosis of post COVID ME/CFS should be considered.

The current status regarding Post COVID 19 FATIGUE, LONG COVID SYNDROME, Post COVID 19 ME/CFS: here we will deal with only one group out of four I.e. POST COVID 19 FATIGUE Syndrome. ^[2]

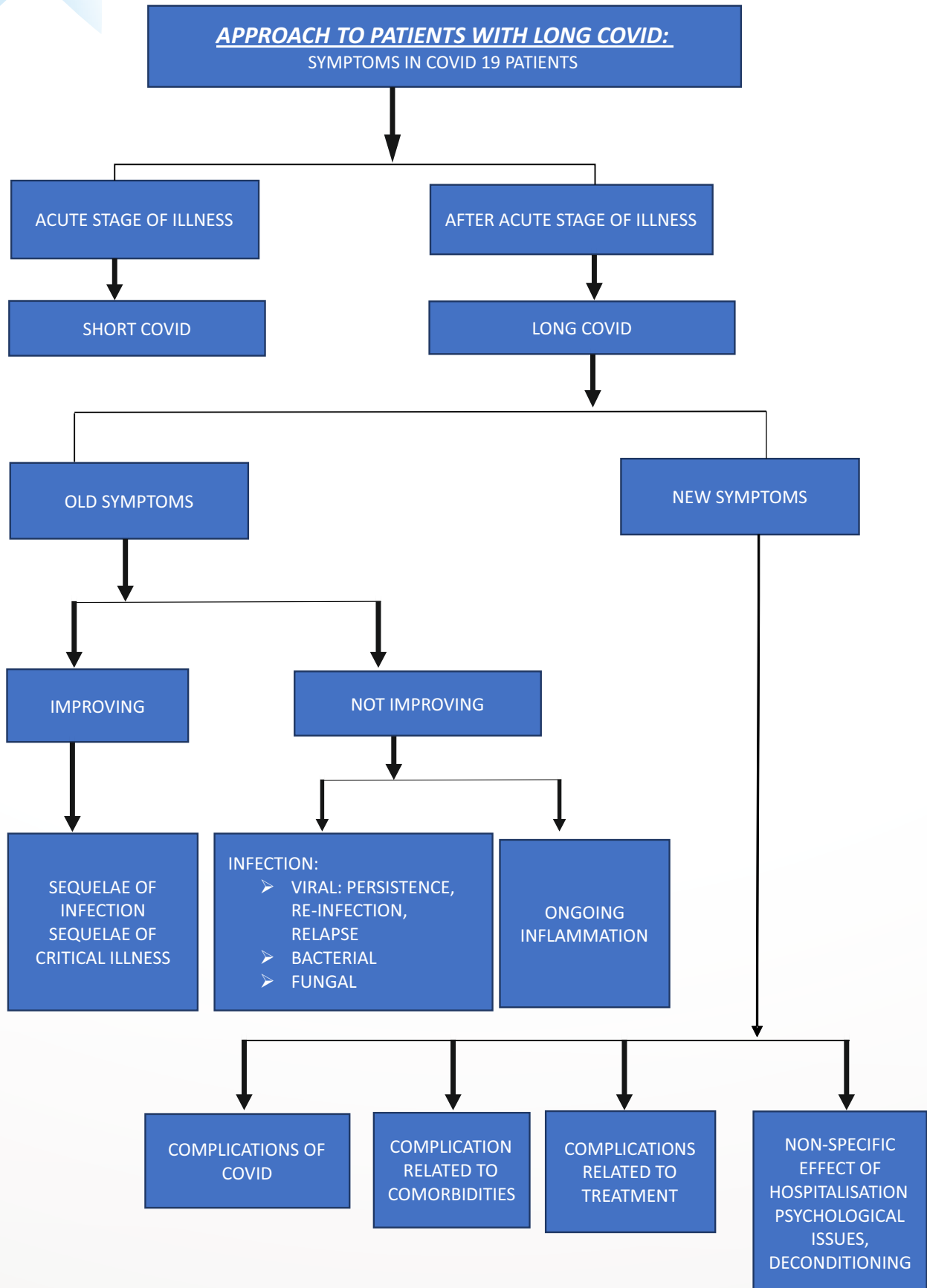
FLOWCHART 1: PREDICTORS/ RISK FACTORS FOR LONG COVID 19.



FLOWCHART 2: CLASSIFICATION OF LONG COVID 19.



FLOWCHART 3: APPROACH TO A PATIENT WITH LONG COVID.



FLOWCHART 4: VARIOUS PATHOPHYSIOLOGICAL MECHANISM OF LONG COVID.

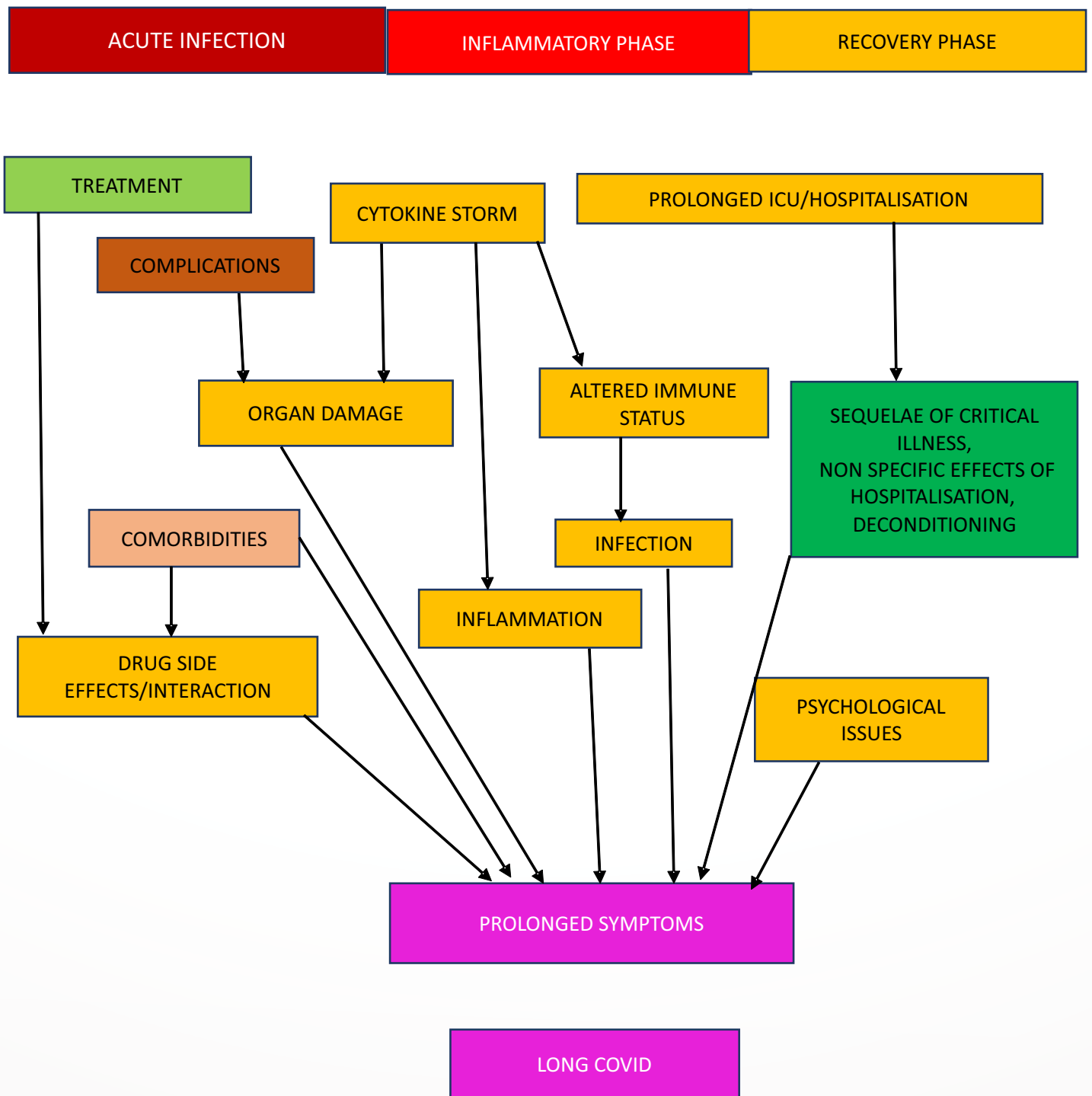


TABLE 1: POST COVID SYNDROME CATEGORIES

<u>POST COVID SYNDROME</u>	<u>PREDOMINANT CLINICAL FEATURES</u>	<u>REMARKS</u>
Post COVID Fatigue syndrome	Profound fatigue	Rule out causes like anaemia, hypothyroidism, electrolyte imbalance
Post covid cardio-respiratory syndrome:	Cough, low grade fever, shortness of breath, chest pain	Sudden increase in dyspnoea can be due to tension pneumothorax, pulmonary embolism, coronary artery disease or heart failure in patients recovered from COVID 19
Post COVID neuropsychiatric syndrome:	Headache, anosmia, neurocognitive difficulties, insomnia, depression, and other mental health conditions	In patients with acute onset neurological symptoms consider vasculitis, thrombosis, or demyelination. Post COVID psychological issues have to be addressed properly
Post COVID gastrointestinal syndrome	Abdominal discomfort, diarrhoea, constipation, vomiting	GI symptoms can be a sequela of disease. Various drugs used during acute COVID, especially Lopinavir/Ritonavir produces GI symptoms
Post COVID hepatobiliary syndrome:	Nausea, jaundice, deranged LFT	Drugs used in the treatment of COVID 19 like remdesivir, favipiravir, lopinavir/ritonavir and tocilizumab can cause hepatic impairment
Post COVID musculoskeletal syndrome	Muscle pains and weakness, arthralgia	May be due to disease, prolonged ICU care, neurological problems, myopathy, or electrolyte imbalance. Usually subside during follow up. Inflammatory arthralgias must be differentiated from other causes like RA, SLE

<u>POST COVID SYNDROME</u>	<u>PREDOMINANT CLINICAL FEATURES</u>	<u>REMARKS</u>
Post COVID thromboembolic syndrome:	Depending on the vascular territory of involvement, breathlessness in PE, chest pain in CAD and limb weakness and neurological deficits in CVA	Early diagnosis and treatment are lifesaving. Follow the standard treatment protocol
Post COVID Multisystem inflammatory syndrome/ post covid autoimmune syndrome	Fever, GI symptoms, rash chest pain, palpitations	Elevated levels of markers of inflammation
Post COVID genitourinary syndrome	Proteinuria, haematuria, kidney injury	Endothelial dysfunction, coagulopathy, complement activation, direct effect of virus on kidney, sepsis and multi organ dysfunction contribute to the development
Post COVID dermatological syndrome	Vesicular, maculopapular, urticarial or chilblain like lesions on the extremities (COVID Toes)	

GENERAL MANIFESTATIONS:

Persistence of some of the acute COVID 19 illness physical symptoms in milder form of the diseased, dyspnoea, fatigue, post exertions malaise, chest pain and cough, are the most common manifestation of the Long COVID 19 syndrome/CFS.^[3]

An online questionnaire-based study on 2113 post COVID 19 patients over 79days

- 0.7% (only) symptom free subjects are symptom free.
- Fatigue:87%
- Dyspnea:71%
- Loss of memory:34%
- Sleep disorder:30%
- Impairment of concentration28%
- Joint pain and myalgia:27%
- Cognitive abnormality [brain fog]: leading to decreased quality of life.

Derangement of laboratory parameters:

- D-dimer
- NT-pro BNP

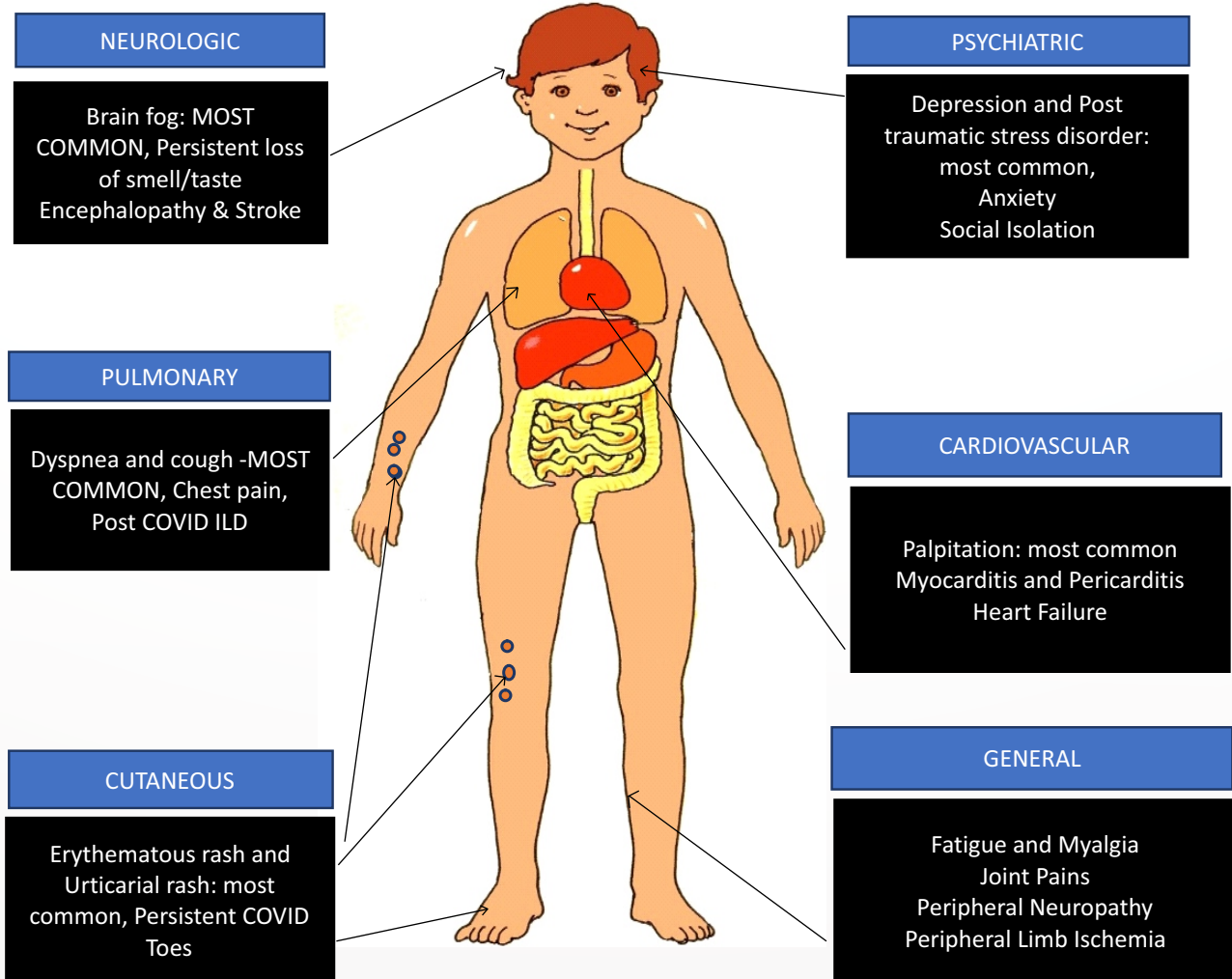
Both 20%

- CRP: 11%
- Serum ferritin: 8%
- Procalcitonin: 4%
- Interleukin 6: 3%

NEUROPSYCHIATRIC MANIFESTATIONS OF COVID-CFS /LONG COVID-19 SYNDROME

The impaired cognition, attention, concentration, and sleep disturbance are the commonly reported neuropsychiatric manifestations in the post recovery phase of COVID 19. The true incidental prevalence of the mental, emotional, and behavioural abnormalities in long COVID 19 subjects is yet to be explored. Hopkins and colleagues reported impaired attention span, mental processing speed, concentration, and memory impairment (working memory) at one year following post-acute respiratory syndrome. Dysexecutive syndrome, including the features of inattention, poorly organised motor tasks and disorientation (Brain fog) seen in Clinical Practice in Indian context.

FLOWCHART 5: LONG COVID 19: Common Manifestations:



MANAGEMENT OF LONG COVID 19 /CFS:

There are no consensus guidelines for long COVID 19 syndrome/CFS. The most important initial aspect of management of any form of significant post viral fatigue involves good old-fashioned convalescence. The aim is to make a gradual and flexible return to normal daily activities. In practice, one should have plenty of rest and relaxation during the immediate post infection stage. This should be combined with very gentle physical activity that is always within one's capabilities, having a good night sleep, eating a healthy diet, and avoiding stressful situations. It is advisable not to return to work, school, or domestic duties until well enough to do so. Adding yoga / meditation can help with recovery process. Post exertional malaise (PEM) or symptom exacerbation needs care. Four important basis: planning, prioritising, delegating, and explaining. Activity and energy management balance is important. Drug treatments and symptom relief- no specific drugs, vitamin D supplements, nutrition and fluid intake are good medicines for CFS and Brain Fog- Dual acting antidepressants like Desvenlafaxine, S-milnacipran, Duloxetine may have some role.^[4,5]

Multispeciality teams consisting of general physicians, microbiologist, radiologist, mental health professionals, rehabilitation care specialists and subspeciality expert – are needed for holistic management strategies.

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Judicious use of psychotropic drugs in COVID patients

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Considering that many patients with underlying psychiatric disorders may be infected with COVID-19, and that up to 25% of patients affected by COVID-19 were shown to experience a new onset of psychiatric manifestations (such as anxiety, depression, insomnia, obsessive-compulsive disorder, reactive psychosis, or post-traumatic stress disorder),^[1] concomitant use of psychotropic medications and COVID-19 therapies is highly probable. Additionally, intensive care support and COVID-19 therapies showing psychiatric side effects might be an additional risk factor for the onset of psychiatric symptoms and delirium, requiring adequate treatment with psychotropic agents.^[2]

Drug-drug Interaction:

In patients with COVID-19, the risks of drug–drug interactions involving psychotropic medications might be relevant.^[3]

1. The bioavailability and disposition of several psychotropic medications might be importantly affected by COVID-19-related systemic inflammation processes, impaired liver functioning, and abrupt smoking cessation.
2. Psychotropic medications and medical treatments can reciprocally affect each other's plasma levels by inducing or inhibiting cytochrome P450 (CYP) activity to an extent which is poorly understood and hardly predictable.
3. These combinations are at risk of pharmacodynamic interactions, and particularly QTc prolongation, immunity, and coagulation abnormalities.

Respiratory risk:

COVID-19 causes bilateral interstitial pneumonia and is associated with hypoxic respiratory distress, it can evolve to full-blown ARDS causing the major risk of mortality.^[4]

- Antidepressant use is not a risk factor, nor mood stabilizer. Antipsychotics especially highly sedative agents may theoretically cause respiratory depression but still there is no concerning evidence.
- In case of psychomotor agitation requiring rapid tranquilization with antipsychotics (e.g., hyperkinetic delirium), there are some risks for acute extrapyramidal symptoms (e.g., dystonia, with possible impaired swallowing and consequent risk of aspiration) and reduced mobility can notably worsen respiratory distress, which should be kept in mind. However, judicious use can easily avoid those complications.
- Although the risk of respiratory suppression with benzodiazepines is notably lower than barbiturates or other neuromuscular blocking agents, it may be relevantly high in people with acute respiratory distress and in the elderly. The risk of respiratory distress is related to the differential sedative properties of different agents, their half-life, and is usually dose-dependent. NICE guidelines states that in normal SpO₂ patients and patients without respiratory distress, low dose clonazepam is safely being used if necessary.

Cardiovascular risk:

People with COVID-19 may have heightened cardiovascular risk profile, including-

1. old age.
2. pre-existing comorbid cardiovascular diseases.
3. use of medical treatments with QTc-prolonging properties, often in combination (e.g., antivirals, chloroquine/hydroxychloroquine, and antibiotics)
4. a possible direct cardio toxic effects of the coronavirus; and
5. electrolyte alterations related to abnormal respiratory gas exchange.

The most important risk factors of severe arrhythmias, such as torsade de pointes, include the magnitude of QTc prolongation, pre-existing heart disease, female sex, bradycardia, hypokalemia, and other electrolyte abnormalities.^[5]

Common psychiatric medicine and Qtc prolongation	Risk, use cautiously	Safer alternatives
Antidepressants	TCA, High dose Citalopram, Venlafaxine	Sertraline, Escitalopram (Up to 10 to 15 mg)
Antipsychotics	Chlorpromazine, Ziprasidone, Quetiapine, Thioridazine	Risperidone, Olanzapine
Mood stabilizer	Lithium	Valproate

Risk of infections:

Systemic dysregulation of immunity and inflammation response is a key feature of COVID-19. The severity of inflammatory parameters (such as IL-6) has been associated with the fatality risk and immunosuppressive therapies may play a role in treatment and prevention of complications.

Antidepressants have been consistently shown to have anti-inflammatory properties, although little is known about their possible role in systemic infections. Antipsychotics have been associated with immunosuppressive properties, such as decreased pro-inflammatory cytokine levels, blood dyscrasias, and altered production of antibodies. The risk of neutropenia is about 1% for clozapine (3% in the elderly) and 0.1% for phenothiazines, while for other medications data are sparse.^[6]

Major practical summary

1. Steroid is mainstay treatment of COVID-19, and steroid induced psychotic symptoms are common. Steroid use coupled with ICU/ward stay can cause acute psychosis or confusional state. Low dose antipsychotics may be useful.
2. Ongoing lithium use should be monitored if creatinine clearance is low.
3. Valproate doses need to be reduced if LFT is de-arranged.
4. There is a risk of hyponatremia with antidepressant. The risk is more in geriatric patients. Escitalopram, Fluoxetine, Sertraline has higher risk; whereas desvenlafaxine and mirtazapine are safer alternatives.
5. QTc prolongation is common with psychotropic though it is not common. A regular ECG monitoring should be done, switch to safer alternative of QTc is more than 450ms in males and 470ms in females.
6. Antidepressants have been associated with altered coagulator profile. Antipsychotic and mood stabilizer the risk is low. Albeit some monitoring should be done.
7. Inhalational beta-agonist may cause tachycardia and other associated autonomic hyperactivity.
8. Delirium states to be monitored closely and all contributory factors should be excluded first. If patient is agitated, low dose antipsychotic-haloperidol, olanzapine-can be tried. Benzodiazepine can be used only, if necessary, in lowest possible dosage.
9. Antidepressants has added benefit of increasing immunity of patients. Fluvoxamine is under trial and reported to decrease the risk of having inpatient admission.
10. Fluoxetine, paroxetine and valproate are potent CYP inhibitors and when used with multiple medicines, dose modifications are necessary.
11. Clozapine and some FGAs can cause blood dyscrasias, neutropenia. Close monitoring is needed. Especially when a patient is on clozapine, he or she must be a case of treatment resistant schizophrenia and clozapine can only be decreased with back up of other alternatives.
12. Psychiatric diseases are as important as other illness and before decreasing any psychiatric medicines, specialist consultation should be done, always.

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Impact on the psychological health of relatives of patients who succumbed to COVID-19:

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Grief is a common reaction to loss and bereavement. COVID19 pandemic has led to different forms of loss and challenges to prevent or manage them. Difficulty to process the loss and persistent yearning for a prolonged period can be seen in people with complicated grief. Self-disclosure, supportive social networks, and cultural practices to facilitate mourning often protect against complicated grief. On the other hand, a difficult dying experience, and the inability to go through the mourning process may increase the risk of complicated grief.

COVID 19 pandemic has wreaked havoc in most parts of India, West Bengal was no exception. The state has already witnessed 14.3lakh people infected by the SARS-CoV-2, with an official mortality figure of more than 17000 people.^[1] In 2021, a disproportionately high number of excess deaths in India indicates many more people died possibly secondary to COVID.^[2,3] Many citizens of a resource-poor country like India were going through a period of suffering due to difficulties in accessing medical care and more specifically finding a hospital bed for themselves or their near and dear one. There was also an inadequate supply of oxygen and life-saving medicines. Like everywhere else in the world, family members were unable to meet their relatives admitted to a hospital for COVID19. Distress increased due to financial stress and consequent inability to afford medical treatment. Not being permitted to be at the bedside when the family members were very unwell, inability to say goodbye to loved ones before they die, unexpected deaths, multiple deaths in the family, poor social support due to imposed restriction, and stigma around COVID all caused immense psychological distress. All these significantly affected the family members living through multiple losses beyond death including that of companionship, intimacy, finances, and loss of social support and kinship. The 'bereavement guilt' was compounded by 'survivor' guilt and gave rise to prolonged unresolved complicated grief reactions in the family members of the deceased.^[4]

Management:

It is important to take protective measures to help people deal with their irreplaceable loss. Healthcare workers and

policymakers should be empathetic to the distress of the patients. The following measures may be of help to the family members to process their grief better.

Preparation:

Along with the preparation of the health infrastructure for future surges/waves of COVID, healthcare workers need to get trained to handle difficult communication with family members, including breaking bad news and language of communicating the information.^[5] It is important to involve family members in making decisions about the patient's treatment, update them about the course and possible prognosis regularly. This helps them to anticipate unfavorable outcomes of diseases and their complications and may help them to make more informed choices regarding the goals of care be it curative or palliative, based on realistic expectations about the outcome.

Use of technology:

In certain situations, a video chat through phone may offer an opportunity to the family members to keep in touch with the patient. This may facilitate family members to say goodbye to their loved ones. Following the death of the patient, telepsychiatry and bereavement calls from the treating team are likely to have some healing effect on the family members if this is well timed and done sensitively. This may give the family members to share their distress and validate their emotions. The contact established remotely between the family and the treating team of the deceased person may help to address the perception of feeling disowned by the doctors during this very difficult time.

Cultural issues:

Stigma is often a barrier in the expression of grief. It is important to mitigate stigma in the society around COVID through improving awareness and increasing community participation. Rituals around death, cremation, and burial often work as a culturally approved coping for a grieving family. Memorial services in the virtual platform have been proposed as a short-term alternative that may help family members to cope better.^[5]

Some measures can be taken by specific individuals going through bereavement due to unexpected and unacceptable losses secondary to COVID. Professionals can guide this process when family support is not forthcoming during the pandemic.

Expression of emotion:

The feeling of being lonely and isolated during the time of mourning is often very troubling. It is crucial to express the feelings about the loss and the possible painful experience around the death secondary to the COVID pandemic. People should be encouraged to share the experience with close family and friends over voice calls/video calls if physical face to face meeting of the extended family is not possible.

Dealing with the nature of death:

Deaths during a pandemic are difficult to accept and often deemed unfair. The feelings of loss of control and being let down can be disempowering. Not being able to be there during the event of death and/or cremation may lead to complicated grief. Sometimes a useful strategy to facilitate a psychological closure could be encouraging the family members to say a private goodbye through a prayer offering or writing a letter to the deceased person.

Taking care of oneself and surviving members:

It is important to take care of self and remain considerate toward other family members during the difficult time of grieving. The following practical suggestions may also help:

1. Do not skip meals even when not feeling the appetite.
2. To take regular medicines and health monitoring.
3. To sleep adequately, engage in regular exercise.
4. Distraction may help during the initial period.
5. To remain in contact with near ones, who can understand the grieving person's feelings.
6. To gradually re-engage in the usual activities.
7. To actively take care of the psychological health and take professional help if required.
8. To remember that grief is a normal reaction and permitting oneself to grieve.

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Guidelines on how to break bad news

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Introduction:

A medical news that seriously and adversely affects a patient and or a caregiver's overview of the future is 'bad news'. However, it has to be kept in mind that 'bad news' is 'bad news' but the presentation of the news in the time of crisis can decrease the sudden trauma to the person or family. When this news involves a death or a dying process which is so common in COVID 19 era, the consequence may bring shock, despair, loneliness, and anguish. Its impact arises from the gap between the reality and expectation of a medical situation which needs to be reduced by effective communication skills and empathy. ^[1]

❖ **Setting up a suitable communication:** In physical presence, it should be a quiet room, preferably outside the Covid 19 unit, with a proper introduction of self. If by a phone call, a video call is preferable without personal protective device on. While communicating over phone it is noteworthy that the physician should take care about to whom he/ she is talking and what the person is doing. It is essential to talk to an adult, not to a child or an elderly with a serious medical condition unless they are the only person in the family. If the person is driving a car or doing any work that may lead to an accident, then abstain from breaking the news at that point of time.

❖ Conversation to be started after a brief introduction of the doctor/ HCW, hospital, and the reason for the call. Preparing a script beforehand including patient's name, patient's medical evolution of the disease condition may come in handy.

❖ The concerned doctor or HCW should try to perceive the physical and psychological state and understanding of the patient's companion or the family members. Both in physical and video calling, give special emphasis on non-verbal gestures like crossing arms, deviation of look. Always try to be a good listener.

❖ Create an intimate atmosphere even on the smart phone screen. Try to assess how far the patient/family members know about the diagnosis, prognosis, and health status of the patient. Make yourself available to questions but also be aware of the limit.

❖ Simple language that is understandable to the patient/family members avoiding medical jargons should be used. Information should include patient's evolution, diagnosis and prognosis. Respect family's social, economic, and cultural limitations. In case of breaking death news, it is to be revealed in a very clear way that death has happened. Avoid euphemisms like 'passed away' and say died or dead.

❖ We should be empathetic to the family members/companion's emotions. In telecommunication particularly in Covid situation, there is often a lack of face-to-face conversation and socially acceptable funeral services. Bridge this shortfall by assuming an understanding and emotional tone. ^[2,3]

❖ In case there is an anger outburst, try not to react at this stage. Avoid prolonged conversation. Answer in small chunks of information. Check the understanding. If there is a denial, do not be combative and hostile, allow adequate time to adjust to the situation.

❖ Discuss the strategy and summary, infrastructural limitations of the institution, the nature of care etc. Ensure the belief that in any case, the patient will never be abandoned.

❖ Try to bridge common pitfalls like giving inadequate time, not allowing time to respond, false assurance of future, allowing denial to persist and removing all hopes.

* There are many existing protocols of breaking bad news like ABCDE, BREAKS, SPIKES etc. These are mainly used for breaking news regarding cancer and other serious medical illnesses.^{[4],[5],[6]}

ABCDE= **A**dvance preparation, **B**uild a therapeutic relationship, **C**ommunicate well, **D**eal with patient and family reactions, **E**ncourage and validate emotion,

BREAKS= **B**ackground, **R**apport, **E**xplore, **A**nnounce, **K**indling and **S**ummarize.

SPIKES= **S**etting up the interview, **P**erception of the family, **I**nvitation, **K**nowledge sharing, **E**motions (addressing emotions with empathy), **S**trategy and **S**ummary.

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Guidelines for communicating and breaking bad news at death over telephone for hospitalised COVID19 patients.

Perhaps nothing can prepare us for the death of a loved one. However, we can provide accurate and concise information to the family members after death in an empathic way.

1. It is preferable to have a designated hospital staff who would communicate with the patient's family members.
2. The call should be made from a designated number without incoming facility.
3. The call should be made to the next of kin as mentioned during hospital admission.
4. The caller should be a health professional (not necessarily a doctor) who is familiar with the medical details of the person. The staff should be able to communicate calmly and clearly.
5. The techniques of breaking bad news require skills in handling the conversation. Some of the essential elements of this are mentioned in the box.
6. It is stressful to be doing the task of death notification. The staff should have access to appropriate support.

Footnote: It would reduce the stress of family members if they are updated regularly by the hospital during the entire period of hospital stay of their loved ones. Many family members are themselves under quarantine or isolation and a telephone call will be acceptable form of communication. However, the above guidelines are only for breaking bad news at death over telephone.

12 Steps for breaking bad news via telephone during COVID.

1. You (staff) should prepare yourself and know the details that needs to be shared with the family.
2. After making the call introduce yourself by name and as a staff member of the hospital.
3. Check with the receiver the identity of the person who has picked up the call. It would be good to enquire if there are others at home for support.
4. Ask if this is a good time to speak.
5. Ask if they would like an update about the condition of patient X now (this is a question that is usually used to prime the person that there may be bad news).
6. Pause
7. Give the news in a clear way taking the name of the patient e.g., X was very sick and in spite of the best efforts, X had died at _ hours in the hospital.
8. Wait for the person receiving the call to respond. Speak slowly and do not rush.
9. Make empathic statements as 'I know this must be very upsetting.....'.
10. Mention that the next steps are being planned and that someone from the hospital will be in touch.
11. You are likely to be at the receiving end of an awkward conversation. You should be calm in handling the conversation.
12. Document the communication in the hospital records.

Prepared by Dr. Soumitra Shankar Datta

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Medical Teaching and Covid Pandemic: Mental Health issues of Medical Students

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The Coronavirus Disease 2019 (COVID-19) pandemic has caused an unprecedented disruption in medical education and healthcare systems worldwide. At the onset of the pandemic, most of the Universities proceeded to the decision to suspend clinical rotations as well as classroom lecture, and issued guidance for medical students to avoid activities involving direct patient contact, with many countries adopting similar strategies.¹

In this article, we explore the impact of the COVID-19 pandemic on the education and assessment of undergraduate medical students, the repercussions on their mental health and future career plans, while exploring their experience as 'frontline workers', along with the institutional responses to these challenges. We also focus on how this unique period could act as a catalyst for substantial changes and further implementation of the 'evidence-based' approach in medical education.

Online Education in Medical Teaching

This pandemic has already triggered the introduction of new methods of learning in education system and medical education is not an exception. In an effort not to distract the educational process, the academic institutions worldwide have accelerated the development of online learning environment.² Contact with patients is essential in educating medical students and they cannot only rely on books for medical knowledge and competency.³ Medical students face challenges that set them apart from most college students, since they can get infected during a bedside clinical session with a patient who is SARS-COV-2 positive, or they can serve as a vector, thus harming the patient and their colleagues including professors and doctors. Almost all students returned to their hometowns because of the lockdown, even medical conferences were postponed or cancelled altogether. Medical students and teachers explored new ways of learning/teaching and this led them to online learning. Online learning assumes various forms such as online classes, live web simulations, webcasting, and online chat rooms.

Challenges of Online Mode of Education

Online education mode in India coincides with the recently introduced competency-based medical education in the country which has embraced online education. This poses a new challenge for the institutions involved, the instructors or teachers, and the students since they must adapt quickly to the new mode of learning. Online education requires teachers to improve their competency in three major areas; pedagogy, technology, and content knowledge. Some of the challenges of online mode training in medical education are described in Table 1.⁴ Many universities have already taken initiatives to start web-based teaching using platforms such as Microsoft Teams and Zoom for teaching for medical students. E-learning has been shown to help foster self-learning and to be nearly as successful as traditional didactics. It has also been reported that many medical students find e-learning enjoyable. However, providing patient contact and clinical experience is still a challenge. Students can be invited into the virtual room to participate in history taking, observe virtual physical examination, be a part of decision-making, patient and family counseling, and planning of implementations of treatment plan. The completion of telehealth interactions that are supplemented by e-learning would help to create a new blended learning model that

still promotes patient involvement and would make the learning experience real, unlike sometimes the very impersonal and almost inauthentic e-learning experiences that exist in place of clinical rotations.^[4] Similarly, platforms such as VR4Health can be used to teach anatomy using 3D models of several human organs through virtual reality systems.^[5] Periodic assessment of the trainees and constructive feedbacks is equally important for progressive learning. Innovative methods such as real-time online assessment are needed.

Table 1: Challenges of online mode training in medical education

Lack of skills	Time management	Lack of infrastructure/ resources	Poor communication at various levels	The negative attitude	Student engagement
<ul style="list-style-type: none"> • Insufficient computer and/ or writing skills. • Lack of inter - departmental communication. 	<ul style="list-style-type: none"> • Mental and Physical fatigue for the teachers • Continuous Online classes/ webinars for teachers and students 	<ul style="list-style-type: none"> • Limited availability of digital resources • Poor network • financially disadvantaged students lacking smart devices 	<ul style="list-style-type: none"> • Lack of support from the institution • Lack of inter - departmental communication 	<ul style="list-style-type: none"> • Reluctance of learning new modalities • Concentration issues 	<ul style="list-style-type: none"> • Lack of motivation • Distracting environments in and around • Lack of interaction

Mental Health Issues of Medical Students

Psychological impact of COVID-19 on health care workers has been found significant. At the same time impact on the mental health of medical students are also significant. It is essential to safeguard the students from adverse psychological effects of the pandemic. According to Sridhar Mangalesh, 60.3% of Medical students were found to have mental health problems during this pandemic.^[5] The Covid 19 pandemic appears to negatively affect the mental health of the undergraduate medical students with the prevalence and levels of anxiety and stress being increased, and depression symptoms remaining unaltered.⁶

Medical students are experiencing increasing anxiety as COVID-19 gradually affects their physical, emotional, and mental well-being. Long-standing social distancing can have negative effects on mental health. Current pandemic can worsen already existing mental health conditions. Adapting to the new “normal” of medical education with lack of on-campus learning, absence of peer interactions, omission of direct patient care involvement and increasing barriers in professional identity formation as medical students struggle with finding their worth in health care is beyond challenging. Also with the death numbers increasing by the day and with news and social media flooded with COVID-19 discussions, it is hard to stay unaffected.⁷

The pandemic marked an end to normal day-to-day life. Ambiguity about the future, especially in relation to examinations, curriculum, promotion to the next semester, commencement of internship, competitive examinations, and finding employment, is likely to aggravate any preexisting mental health problems in the medical student, adding to the feelings of anxiety, and self-doubt.⁸

Medical schools are taking every effort to prevent their exposure to COVID-19. Mental health issues among medical students are also often unreported owing to stigma due to several factors, such as, fear of being evaluated

poorly by faculty members, diminished respect from peers, or being perceived as unable to handle responsibilities.^[9] As future health-care providers, medical students require early attention and support systems for their well-being during medical school.

Way out

- Medical colleges and faculty should continue to stay connected with students virtually. It will allow them to “connect” despite social distancing.⁵
- Exercise has been linked to positive mental health. One can engage in activities, which can be practiced at home such as yoga, meditation, running, and workouts to improve the physical and mental well-being.
- Counseling sessions/ discussions with stress on self-care such as getting adequate sleep and having healthy diet can play a key role.
- Keeping in touch with friends and family and avoiding negative coping methods such as alcohol and addiction are essential.
- Emphasis needs to be given on establishing a mental health support team with involvement of professionals for counseling and advice wherever necessary.
- Transparency and appropriate timely communication regarding the teaching program and assessment of the medical trainees may help in alleviating the anxiety related to their future training.

Recommendations

- Colleges could consider early graduation for their final year students to graduate their students early to bolster the physician task force for the pandemic; some schools have already taken this brave decision.
- With adequate availability of PPEs Medical Students should be allowed back in clinical rotations to learn valuable lessons in handling pandemic situations from frontline medical warriors. There are certain lessons in the curriculum that cannot be learned from textbooks.
- Schools should consider adding high-value, virtually deliverable, credit electives such as scientific writing, narrative writing, COVID-19 facts, biostatistics to continue student engagement in replacement of clinical experiences. Individualized career guidance to every student will be beneficial.

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GUIDELINES FOR MANAGING MENTAL HEALTH ISSUES DURING COVID-19 PANDEMIC

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