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The New Way of the World

By Sheila Cooperman, MD, CPS President

"It has been heartening to see the widespread explosion of the use of telepsychiatry with many clinical settings using this tool for sessions, consultations and meetings."

This is my final column as President of the Connecticut Psychiatric Society. I will say that I am sad about what has happened in the world at this time. We will be forever changed. Some aspects of life may return as before the pandemic but I believe many of the simple things of daily life will not. The pandemic has highlighted what the JAMA article I described in my last column detailed. Prior to COVID-19, the life expectancy of Americans has decreased due to heart disease, lung disease, obesity, conditions related to excessive alcohol use and opiate overdoses. This is intertwined with the lack of coordination and universal healthcare coverage in our health care system. I question whether we can call it a system given its inefficiency and disparity in the care of the most vulnerable. The pandemic has illuminated these issues like a neon sign.

Certainly, we as Psychiatrists can take advantage of this challenge to provide support to the public, our patients, and our colleagues. It has been heartening to see the widespread explosion of the use of telepsychiatry with many clinical settings using this tool for sessions, consultations and meetings. Systems that do not have patients with computers are using telephone sessions. Some psychiatrists have been surprised to find that their patients are talking more and making better use of their sessions with this change. Other groups are using tablets to go out into the community while the psychiatrist stays in the office to consult on a larger number of patients rather than go to each intervention in order to improve access.

The DEA has relaxed how patients with Opiate Use Disorders can access Buprenorphine without a face-to-face interview and Methadone patients are eligible for more take-home doses. These changes in federal regulations for telemedicine and the management of Opiate Use Disorders have been life saving as others around them struggle with COVID-19.

The pandemic has pushed us into adapting to new ways of providing access that will be important to maintain as our workforce diminishes and the need for care increases. What I do not want psychiatry to completely lose is the value of the in person, face-to-face interaction that we have enjoyed throughout our careers. There is a loss of important information in our global assessment of patients when we do not share the room with them. What is the detail of their gait,

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Covid-19's Silver Lining?

By Sohrab Zahedi, MD

"Psychiatrists are no stranger to social isolation."

Psychiatrists are no stranger to social isolation. Stigma is only the beginning. Our patients are often marginalized. Our units are locked and separated from the rest of the hospital. Seclusion is standard of care for agitated patients. Hospitalized psychiatric patients do not leave or transfer. They discharge or elope. Psychiatry, while better accepted, remains a stepchild in the medical family. CL psychiatry is a sub-specialty which helps us "liaison" with others within the house of medicine. The battle for the equal treatment of mental and physical illness is ongoing. And lastly, isolation from greater society is the harsh reality of imprisonment, a common course for the majority of severely mentally ill Americans.

In the best of times, psychiatrists face daily challenges of biological, social, & psychological nature in treating their patients; often while working alone, away from other physicians. Most of us don't attend conjoined grand- or tumor rounds. We are removed from curbside or hallway discussions with colleagues. During a viral pandemic? Stay tuned as that story has yet to be told, but what is clear is that things are even more isolated. Telemedicine is particularly amenable to the practice of psychiatry. But try interviewing a paranoid patient via a smartphone or a computer screen. Better yet, try explaining isolation to a COVID-19 positive patient who has long held that others are persecuting him.

And yet, what COVID-19 has brought on is exposure to colleagues from across the world. Society has turned to physicians to provide answers. Drs. Birx and Fauci, unknown to most a few weeks ago, are regular fixtures of the White House's task force and press conferences. For weeks, the nation has looked for their insights with great anticipation. Beyond our shores, one finds the legend of Dr. Li, the ophthalmol-

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The Benefits of Using Telepsychiatry Beyond the Covid-19 Pandemic

By Melissa Welby, MD

It took a pandemic to bring telepsychiatry into the forefront and change some people's perception that remote care is suboptimal to treatment delivered in the office. For physicians who were not raised with cell phones and video chatting, the idea of having an appointment with a patient over the computer is often met with skepticism. But in the face of COVID-19, many psychiatrists (and patients) have been forced outside their comfort zones and have had to crash learn the ins and outs of providing remote care. As we eventually return to the "old days" of being able to see people in person, physicians will need to decide what role, if any, telepsychiatry will play in their practice.

Although psychiatrists have been ahead of most other medical specialties that incorporate telemedicine, in general, it has been an underutilized modality (radiologists and dermatologists were other early adopters). Barriers to its use have been continued confusion about what it is and how to do it (it's like learning a new language!), how it benefits physicians and patients, and a lack of awareness of telemedicine best practices. Many public payer and private insurers have been reluctant to reimburse it.

Sometimes people forget that even before COVID-19, we weren't strangers to providing remote delivery of care. Many of us spend hours of unbillable time each day talking on the phone to patients or consulting with colleagues. Telemedicine offers an opportunity to both improve the efficiency of care, enhance access, and capture reimbursement.

Here are some ongoing benefits of telepsychiatry:

It's convenient!

People already struggle against stigma, access to care issues, and the fact that mental health needs are often put low on the priority list until they cannot be ignored. They don't need additional barriers to stand in their way of treatment. Telepsychiatry allows parents with young kids (or a newborn) to schedule appointments around naptimes without the need to lug their kids into the office with them. Employed individuals can go to their car at lunchtime for a remote appoint-

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Editorial: CPS Priorities and Strategies AC (After COVID-19)

By Steven Madonick, MD, CPS President-Elect

Crisis crystalizes needs and goals and motivates us far more quickly and clearly than routine. There are two priorities for Connecticut Psychiatry that have emerged from the coronavirus pandemic that will be important in the year to come and that present great opportunities for expanding the method and quality of support and services that we provide.

The first priority is to continue to expand the use of technology to support and treat our patients and communicate with colleagues. Telepsychiatry was proposed for many uses prior to the pandemic but it was only properly funded and supported in Connecticut during this emergency. This has led to a safe, flexible way of providing quality treatment when travel is not possible. It has allowed many professional practices and institutions to continue to support their patients during this crisis. Ongoing telepsychiatry will be crucial to our patients' achieving greater access to treatment in the future.

The second priority for Connecticut Psychiatry that emerges from the coronavirus crisis is greater attention to the physical health of our patients through integrated care. People with comorbid medical conditions are extremely vulnerable to the coronavirus. Given the extremely high prevalence of such conditions among our patients with serious mental illness, they are much more vulnerable than others to have severe symptoms or death upon infection with coronavirus. High rates of COVID-19 infection had been documented at long-term psychiatric hospitals in New York. In fact, we have long known of the far shorter life expectancy and greater morbidity among our patients with serious mental illness. We should not waste this crisis and must redouble our efforts at integrated care to emphasize prevention and treatment of medical co-morbidities in our patients.

Previous efforts to promote telepsychiatry and integrated care have had mixed results. Thus, our approach must evolve. Large payers like the Department of Social Services, the Centers for Medicare and Medicaid Services and private insurance companies usually mandate specific approaches to the administration of programs in exchange for their funding. This approach has often fallen short, lacking the innovation necessary to promote these changes. We'll continue to work with these organizations, but we must ally ourselves with smaller and more flexible patrons that will encourage the necessary innovation and change. Some sources of this additional support

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"We should not waste this crisis and must redouble our efforts at integrated care to emphasize prevention and treatment of medical co-morbidities in our patients."

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Resident Column: Layers

By Amanda Calhoun, MD, MPH, PGY-1
Yale Psychiatry Resident, Albert J. Solnit track

I am a psychiatrist in training. I am also an activist in training. I will never have the luxury of "just focusing on the medicine." If I did, it would be like looking the other way, ignoring a crucial layer of my life.

I grew up watching my parents advocate for my brother, who has severe autism, all the time. Mom and Dad, an inpatient clinical pharmacist and child/adolescent psychiatrist, were fortunate to even have the language to discuss the complexities of my brother's medications. They provided pushback against psychiatrists who slumped behind their computers at my brother's appointments, diving immediately into discussions about dosage increases, without looking up from their screens once. Mom placed calls of concern to the staff at his residential home, who failed to notice that my brother was dressed in old, ratty clothing, despite having newly bought apparel.

But on top of that layer, on top of the constant battle that only those with disabled family members can truly understand, there was another layer.

I remember a White couple, who lived down the street from my brother's residential home, threating to press legal charges against him. A group of boys were tampering with streetlights. The couple asserted that they "saw one who looked like my brother," which is code for: one of the boys looked Black. I remember my mother, very calmly and shrewdly, saying "My son is extremely autistic. He doesn't have any friends. I wish that was him whom you saw." The couple was quiet after that. Now, as a psychiatry trainee, I am doing my best to model my parent's poised, yet vigilant, activism, but sometimes, I have trouble.

One day, I was interviewing one of my patients. He was a complex kid, in all realms of the biopsychosocial model. Extremely intelligent and self-motivated, but badly in need of an advocate. He was a ward of the state with a DCF worker who seemed overworked and exhausted. But, there was another layer.

"Another patient called me a nigger today. He kept chanting it," he said softly, hanging his head in embarrassment.

The pieces fell into place. I learned that staff were present, but watched the scenario happen with no intervention. No one said anything to the patient tormenting mine. No one came to my patient to ask if he was okay after being repeatedly called such a historically loaded, traumatizing word. My blood began to boil. "So basically, no one did ANYTHING?!" I questioned thunderously. I quickly lowered my voice and glanced at my attending. Another layer. As a Black woman, I can never appear too passionate or too unhappy, because this quickly can and has been misconstrued as me being an "angry Black woman." As a minority and as a woman, we must always be aware of our stereotypes. "It's okay," insisted my patient, attempting to comfort me. "People chant nigger at my school too," he whispered.

I felt powerless, just like my patient. My idea to hold a staff meeting was politely declined. I told my colleague, who had just arrived for their night shift, what happened. We went together to check in with my patient and to apologize for what he endured. I wrote some emails to leadership, hoping to change how racism is responded to in the future. But, it makes me wonder, what if I hadn't been there? What if I hadn't had the energy to advocate for him, as my parents have for my brother? And even more importantly, what is happening to Black boys out there and why aren't we doing a better job of protecting them?

"I am a psychiatrist in training. I am also an activist in training."

The COVID-19 Disaster and Mental Health

By Shaukat A. Khan, MD

COVID-19 is the viral infection caused by novel coronavirus. As of the day of writing this article, 2,261,425 people worldwide have been infected with the virus, with total of 154,734 deaths. In America, the total number of infected people is 710,272 with a death toll of 37,175. Currently, the number active cases in the U.S. is 609,587 and the prediction is that there will be more than 60,000 deaths by August 2020. It was initially thought that the death rate from this disease to be about 2-3%, but if we calculate from the numbers above, the death rate is actually running between 5-7% . Earlier corona virus infections, such as Severe Acute Respiratory Syndrome (SARS) in 2002 and Middle East Respiratory Syndrome (MERS) in 2012 and had death toll of 10% and 34% respectively. The novel coronavirus disease started in China's Wuhan province in December of 2019. It possibly originated from a wet animal market via animal to human transmission. It was subsequently transmitted by person to person transmission via droplet or fomite and became a world-wide pandemic with 210 countries affected by it. The WHO has named it COVID-19 to avoid

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Legislative Report

By Jacquelyn T. Coleman, CAE, CPS Executive Director

"...May 6 is expected to pass without another session taking place."

I imagine most enjoy the promise of spring and the longer duration of sunshine that the season brings. Even this year, nature will take its course.

But April has for many years been my least favorite month of the year. The reason is that April is probably the most feverishly active time of the legislative year. For non-legislators, most hearings are over, and it's a time of waiting and worrying. Did all that testimony make an impact? Have we contacted enough members of the Committee? Will the bill get out of committee, or in other cases, is that bad bill really dead? In April, on my way to the Capitol, I drive by the glorious spring blooms and the rapidly greening landscape with a feeling of anxiety, if not dread.

Not so this year. The Capitol closed down on March 11 for what was to be a two-week cleaning period. That was extended to April 23, and everyone expects it to be extended again. The Constitutionally mandated adjournment date of May 6 is expected to pass without another session taking place. As a result, there will probably be a special session to consider budget matters and a stimulus package. That will be a free-for-all. Chaos is expected and we will have to watch very carefully.

After watching the debacle of trying a simple telephone conference for a Bond Commission a week or two ago, I think it's very unlikely there will be any remote session meetings of Committees. I believe the legislative leaders would have to allow it; individual committee chairs couldn't do it on their own.

Will the legislature ever operate remotely? That was unthinkable just a few months ago. I think it is conceivable, but a great deal of thought would be required. It won't happen this year. Politics is a people process, especially at the Senate and House District level. So much goes on at the Legislative Office Building in face-to-face conversations and the process will look very different without that.

So, what did CPS experience this year legislatively? Drs. Cooperman and Madonick gave excellent testimony of coverage for medication assisted treatment (MAT) and allowing shorter than 90-day prescriptions upon prescriber order. Dr. Cooperman spoke at a press conference with the Senate and House chairs of the Insurance Committee, Senator Lesser and Representative Scanlon. We had momentum.

On March 10, the Insurance Committee approved the MAT bill. They were hoping to preserve their option of taking up the bill along with others when the session recommenced. It's likely dead for this year as there is no plan to resurrect the current legislative session in its entirety as a special session. Other bills we were following were modifications to the red flag law and a proposal for outpatient commitment.

Legislators will be running for office this year, and the lack of legislative activity leaves them with very little to show for the year. I wonder if that lack of activity is going to be exploited by their potential opponents?

So perhaps this April hasn't been as stressful in the legislative arena, although there has been plenty of other stress to go around.

News from the APA

APA Urges Additional Access to Mental Health Services Over Phone During COVID-19 Pandemic

WASHINGTON, D.C. – In the face of the COVID-19 pandemic, increasing numbers of Americans are accessing their care through telehealth, and the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services has loosened requirements so that people receiving Medicaid and Medicare can use this vital link to health care. However, many of the most vulnerable patients, especially the serious mentally ill and elderly, are still facing obstacles to this care because they lack the required video technology or live in areas without reliable broadband access.

The American Psychiatric Association (APA) sent a letter to CMS to request that they loosen the video requirement for telepsychiatry to allow patients with older phones that do not have a camera, or who do not have internet access, to receive individual therapy and medication management with their physician.

"We have heard from many psychiatrists whose patients are only able to call into appointments, because they don't have access to online technology," said APA President Bruce Schwartz, M.D. "Even if we can't physically see our patients, we can provide medication management and psychotherapy. We must be able to provide care to our patients in a way that respects current guidelines on social distancing. Now is the time for CMS to revise the rule so that all people with serious mental illness and substance use disorders can access the vital care they need."

"We commend the great steps that CMS has taken thus far to ensure everyone can access the care they need during this pandemic," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "Our recommendation will ensure that those patients who still rely on older technology can access vital psychiatric services."

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Using Telepsychiatry Beyond the Pandemic

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ment. Providing flexible care can make it so people can be seen more regularly.

For some people, travel and wait times can take two (or more) hours to get to and from an appointment. This time burden disproportionately affects lower-income and minority patients. In one study, the total time was 25-28% longer for racial/ethnic minorities and unemployed individuals. The excess time burden can be a disincentive to seeking care. Transportation, whether public or private, is a major barrier, especially to lower income patients.

Improved reimbursement

Physicians can convert unbillable phone calls into billable time. For example, instead of calling to discuss lab results (or making someone come to the office to go over something that can be done remotely), a telepsychiatry appointment can be set up. Patients don't need to wait until their scheduled appointment to have their treatment adjusted, and physicians don't need to have these conversations (that often last as long as an appointment) and not be reimbursed.

Greater access to specialists

Technology expands the reach of physicians, allowing patients at a distance to access specialists. Sure, we have to be mindful of licensing restrictions when patients are out of state, but even in a small place like Connecticut, there is an uneven distribution of psychiatrists. Think about the struggles of patients unable to access Suboxone treatment because of the dearth of physicians prescribing it in their area. Why do we make our vulnerable populations work so hard to get care when we have options that work and make it easier?

Bonus: No more rescheduling for snow days and reduced no-shows!

One of my favorite benefits of offering remote visits, I no longer have to reschedule a full day of patients when it snows. Sure, some patients may choose to reschedule, but the majority are happy to hold a remote appointment and not have to wait for a new time.

Also, when a patient is late for their appointment, I reach out to them to see if they are on their way. If it turns out they have forgotten, I see them remotely.

Moving forward

Telemedicine is a tool that allows physicians to provide individualized and flexible care for patients. When used correctly, and in line with telemedicine best practices, it's an effective alternative to in-person appointments and can eliminate certain obstacles to accessing treatment. I am hopeful that by the time this virus passes, more physicians will feel comfortable providing remote care, confident of its benefits, and won't reflexively revert to the "old way of doing things."

Keep in mind, once this state of emergency passes, many of the telemedicine laws and requirements that have been temporarily waived will likely go back into effect. Make sure to familiarize yourself with these. Now that the world sees how useful telemedicine is, hopefully, the laws and insurance reimbursements will quickly and favorably evolve.

Moving forward, will you incorporate telemedicine services into your practice?

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how did they dress, what is the smell, how do they interact spontaneously.

It has taken a great deal of work for many of us to change our manner of working in order to adjust to this crisis. We have focused on how to "do" the care in a different way and that has been an important beginning. I do think it is important for each of us to examine how we feel about these changes.

When I was a Resident in Boston, one of our readings was Erich Lindemann's "Symptomatology and Management of Acute Grief." As the pandemic has continued, I kept having the themes from the article cross my mind and thought they would be worth sharing here. The background of the article is what Dr. Lindemann learned from the victims and family members of the Cocoanut Grove fire in Boston in November 1942. The club was at twice its capacity with one revolving door exit. A fire broke out, people ran for the only exit, 492 people died and hundreds more were injured. He described a syndrome of acute grief with "sensations of somatic distress occurring in waves lasting from twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, a need for sighing and an empty feeling in the abdomen, lack of muscular power, and an intense subjective distress described as tension or mental pain." He went on to state that grief when properly managed may help prevent prolonged and serious consequences. I see us as needing to work through this crisis by accepting these changes in our personal and professional lives so that we can better help ourselves and our patients.

"It is a nice time to belong to the tribe of physicians."

Silver Lining
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ogist who sounded the alarm on Coronavirus as it ravaged Wuhan, China, and eventually took his life. More locally, pick any news outlet and you will see a guest physician providing an opining on the latest clinical discoveries or the state of clinical knowledge. Long after this morass has been navigated, the memory of their contributions and input will remain. Among my personal favorites, are Drs. Bauchner and Mehta. The former hosts a JAMA Network podcast, which has become akin to a well-informed passenger who accompanies me in all my car rides. The latter is a young social media juggernaut whose "Physician Side Gigs" group on Facebook has made her a staunch physician advocate with a massive following. She has used her platform to shine a light on issues related to lack of PPEs or administrative blowback against outspoken physicians on the frontlines.

Looking to the future, as we race to find a remedy for COVID-19, be it a vaccine or drugs, it is a fact that other heroes within the house of medicine will soon emerge. While it is unlikely that psychiatrists' level of isolation will improve, we can look forward to our colleagues being celebrated by the news media and becoming known to the rest of us. It is a nice time to belong to the tribe of physicians.

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include donors, patients who can pay out of pocket, venture capitalists, purveyors of social impact bonds, psychiatrists and our physician colleagues. This support will be more flexible and will be aligned with the progress that psychiatrists and our patients have desired for some time. We need to broaden and modernize our approach to progress in important aspects of our field.

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disparaging China as its source.

SARS-CoV-2, the novel corona virus that causes COVID-19, comes from the same family of RNA viruses as SARS and MERS virus. The coronaviruses are named for the crown-like protein spikes on their surfaces. The coronavirus binds with the target receptors on human cells using these proteins. It has four main subgroups: alpha, beta, gamma, and delta. Although all coronaviruses have the spike proteins, because of the genetic mutations, in the novel coronavirus, it is a more compact structure which allows it to bind with the angiotensin converting enzyme II (ACE2) receptors on the surface of the human cells more strongly to better infect the cells and spread faster. It is highly contagious.

The initial symptoms of coronavirus infection include fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell (CDC). It may cause fulminant pneumonitis pneumonia, leading to acute respiratory distress syndrome and respiratory failure. However, comorbidities such as cardiovascular disease and diabetes are associated with increased fatality; according to initial reports from China, 10% of hospitalized patients with coronavirus had diabetes mellitus, while 10.5% of fatal cases occurred in patients with cardiovascular disease (China CDC Weekly, 2020: 2:113-122).

The novel coronavirus has a longer incubation period of 1-14 days, with an average of 5 days. It has longer infectious time and spreads the disease even when the infected persons are asymptomatic. Previous coronavirus infections had shorter incubation periods and were not contagious when the patients were asymptomatic. About 10-20% of the patients with COVID-19 require hospitalization, 5% of whom end up in intensive care units and may require ventilator support. The patients who require ventilator support have a 20% survival rate.

COVID-19 has significant mental health implications. As psychiatrists, we need to be aware of these consequences of pandemic disease. The impact may be greatest on the patients who are affected by the disease or have recovered from it, but it also affects the general population who suffer great uncertainty and fear that they could be next victims of COVID-19. National anxiety as manifested by unprecedented media coverage also adds to this fear. Immediate family members of the persons affected by COVID-19 may need to render help to the infected person and at the same time maintain social distance and avoid their own infection. The population in general is practicing "social distancing" for their own safety and as recommended by public health officials and sometimes mandated by government authorities.

The term itself is misleading and in fact people are maintaining "physical distance." They are staying at home, avoiding large gatherings, and staying at least six feet from others. While these public safety measures should be followed by everyone for their own safety and safety of others, such practices have consequences. Human beings are social animals. Consensual physical touch and close personal interactions release endorphins, serotonin, and oxytocin that can bring happiness, and reduce pain and stress. At a time when we need more closeness and support from each other, we are asked to maintain distance albeit for good reason.

Many businesses, deemed non-essential, have closed and furloughed numerous employees. COVID-19 may cause an unem-

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ployment rate that rivals that of the great depression of 1930s that reached 32%. Loss of family members from COVID-19, disruption of usual lifestyle, daily routine, business, employment, financial security, and access to community and religious support may lead to grief, anxiety, and even depression. According to recent report published in APA newsletter (Psychiatric News, March 2020), about 48% of Americans are anxious about getting coronavirus and 40% are worried about becoming seriously ill. In a survey by the APA, 36% believe COVID-19 has serious implication on mental health and 59% believe it has a serious impact on everyday life.

The COVID-19 pandemic is a disaster. The definition of disaster offered by WHO is as follows: a "severe ecological and psychosocial disruption which greatly exceeds the coping capacity of the affected community." There are different types of disasters based on their causes. Disaster may be caused by natural occurrences, or "acts of God" (e.g., earthquakes, hurricanes, floods); man-made accidents or technological malfunctions (e.g., aircraft crash or power plant explosion); or willful human acts (e.g., atrocities or terrorism). Natural disasters are becoming more frequent, which can be attributed to various factors, including changes in climate and geopolitical situations. Some experts even suggest that climate change might have contributed to the current COVID-19 pandemic. SARS-CoV-2 is closely related to a virus found in bats. The need for more natural resources has forced humans to encroach on the various natural habitats and increasingly expose themselves to unknown pathogens.

It is generally accepted that there are phases of response and recovery after a disaster hits a community, those are:

- Impact Phase: first 24-48 hours of acute phase (hours to days)
- Acute Phase: extends up to 2 months after the event
- Post-Acute Phase: approximately 2 months and beyond (weeks to months or years).

The primary focus of this article with be on the Impact and Acute Phases. Appropriate preparation for disaster should begin before a disaster hits a community (pre-disaster phase). The mental health intervention should begin as soon as possible, preferably, in the acute phase and should continue in the post-acute phase and beyond. In many ways, current disaster is not a typical disaster as described above. The Impact Phase of this disaster is ongoing as new communities continue to be hit by infection. The uniqueness of this novel virus infection also warrants unconventional interventions.

Long-term effects of exposure to disaster may cause or contribute to many psychiatric disorders. Immediately after a disaster, however, the psychological effect may be manifested by various symptoms. These may include acute stress, anxiety, depressed mood, sleep disturbances, mood lability, transient cognitive deficits (e.g. dissociation, concentration and memory problems), behavioral disturbances (e.g. agitation), psychosis (e.g., delusions and hallucinations), and medically unexplained physical symptoms (MUPS).

Following the current corona virus outbreak, the APA survey found 24% of responders have trouble concentrating on "other things," 19% have difficulties in sleep, and 8% have reported increased alcohol and substance use. The symptoms of pre-existing psychiatric conditions may also be exacerbated. Clinicians have already noticed increase in anxiety and depressive symptoms. Patients are experiencing more social anxiety and becoming fearful of leaving home (agoraphobia). This time is especially difficult for the patients who are suffering from obsessive compulsive disorder (OCD). Patients who are fearful of germs often have significantly increased (and validated) fears as well as increased compulsive cleaning behaviors. Paranoia is also often exacerbated under these circumstances. There will be a significant increase in suicidal behaviors.

Although mandated lockdown or self-quarantine has created an opportunity for the family members to be together, it has brought the disruption of the structure and routine in typical family and social situations. An APA survey has shown a 12% increase in conflict between partners and loved ones. These conflicts are expected to increase as more people live in close quarters, unemployment continues, and economic hardship deepens. There has been an increase in domestic violence as shelter-in-places continues. Surveillance for child abuse is also disrupted by school closing.

Disaster response preparation should include measures for prevention and for early intervention. Disaster mental health uses the principles of "preventive medicine." This principle has "relief centered post-disaster management to a holistic, multidimensional, integrated community-based approach of health promotion, disaster prevention, preparedness and mitigation." In the aftermath of disaster, the response is in the Acute Phase. After the needs assessment, the Acute Phase response includes ensuring safety, reducing symptom burden, reducing anxiety and distress and improving functioning. A key goal is to enhance resilience and prevent the long-term effects of trauma. As the current COVID-19 pandemic has created a complicated disaster situation, the Impact and Acute Phases are not distinguishable and disaster responses should be

"In a survey by the APA, 36% believe COVID-19 has serious implication on mental health…"

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modified. Nevertheless, the response should be started as soon as possible and continue as long as needed.

The Acute Phase intervention begins with the assessment of needs. In a typical disaster, the immediate needs assessment includes identifying the survivors who need immediate treatment of acute medical or psychiatric conditions and then the need for ongoing medical and psychiatric care. Other important needs to be assessed include hydration, food, shelter, safety, family and community support, and spiritual care. The International Federation of Red Cross and Red Crescent Societies (IFRC) recommend three forms of needs assessment: rapid assessment, detailed assessment, and continued assessment. The American Red Cross uses PsySTART for Triage System for disaster victims, which is a very useful tool for initial assessment.

The Acute Phase mental health intervention can be psychological or pharmacological. In the acute disaster setting, pharmacological treatment is directed at the symptoms rather than syndromes or specific psychiatric illnesses. For example, there is no U.S. Food and Drug Administration (FDA) approved medication for acute stress disorder (ASD), a common psychiatric condition in the context of disaster. Standard clinical practice is to prescribe various psychotropic medications for "off-label" use to treat anxiety, insomnia and agitation as in emergency psychiatry or primary care settings.

Acute Phase psychological intervention should be empathetic, supportive, practical, and short-term, with goals for enhancing resilience, and addressing impairment and acute mental health issues and symptoms. The individual and group psychotherapies for disaster victims include supportive psychotherapy, grief counselling, anxiety management, cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT) and eye movement desensitization and reprocessing (EMDR). The therapy with the greatest evidence base is cognitive behavioral therapy (CBT). CBT focuses on alleviating suffering by modifying maladaptive thoughts and behaviors associated with traumatic experiences. Specific techniques used for psychological intervention in CBT may include: coping skill training, problem solving, cognitive restructuring, goal setting, relaxation techniques, and relapse prevention strategies. Although it is still practiced, the critical incident stress debriefing (CISD), known simply as "debriefing," is no longer recommended as an intervention in the aftermath of disaster. Debriefing was found to be ineffective and some of its elements could be re-traumatizing. In CISD, normal responses to trauma are sometimes pathologized.

Members of consensus groups agree that the chaotic and stressful post-event environment may not be ideal for conducting the traditional psychotherapy. Also, the providers lack the energy and efforts needed to track clinical progress.

"Psychological First Aid" (PFA) is a very helpful tool, and all disaster responders should be familiar with it. It is used by responders to simply provide basic care, comfort, and support to those individuals who are experiencing disaster-related stress. PFA, currently used in the U.S., was developed by the National Child Traumatic Stress Network (NCTSN) and the National Center for PTSD (NCPTSD). PFA has received widespread acceptance, including adoption by the American Red Cross, public health agencies, and the military, as well as state and local governments. It has been translated into several different languages. PFA is an "evidence-informed" modular, flexible approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism.

PFA is designed to reduce the initial distress caused by traumatic events and foster short- and long-term adaptive functioning and coping. It is a set of early and practical responses, which can be started immediately in the aftermath of disaster on site, and then continued for several days or weeks. Many of these responses are not psychological in nature and are commonsense approaches related to meeting the basic needs such as physical safety. PFA also encourages calmness, connectedness, and security, with the goal of improving functioning and mental health coping.

The core actions and interventions of Psychological First Aid (PFA) are as follows:

- Initiating contact and engagement with victim in a non-intrusive, helpful and compassionate manner. All protocols for self-protection and protection of others need to be followed. One needs to be creative to initiate contact while maintaining physical distance.
- Ensuring immediate safety and physical and emotional comfort. In the context of the COVID-19 epidemic, safety from being infected by coronavirus is vital.
- Stabilizing anxious victims by using various techniques such as grounding, breathing exercises and mindfulness practice.
- Information gathering, primarily related to current needs and concerns. Overly detailed questions should be avoided. With COVID-19, having accurate information is important and it is also important to avoid misinformation.
- Offering practical assistance and giving realistic assurances.

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- Helping to establish connectedness with victim's primary support system, such as family members and friends, is very important while maintaining appropriate physical distance. Encourage using smart phones, computer, laptop, tablets and various programs installed in these devices to maintain connectivity.
- Teaching coping skills and fostering inner strength of the victims. Relaying accurate and timely information about the situation to reduce anticipatory anxiety and uncertainty.
- Establishing links with collaborative services, such as food banks, etc.

Providing care and support to the victims in the aftermath of a disaster can be satisfying for disaster responders, but it can also be physically and emotionally demanding. PFA providers should be mindful of their own care too. They should always maintain their own safety. One needs to follow well-known flight attendant instruction to "put your oxygen mask on first, before helping others." Providers of PFA should maintain supportive connections and "buddy up" with other providers and share emotional responses to the disaster work. They should take care of their own health issues, pay attention to adequate rest and nourishment, and find time for relaxation and recreation. Finally, they should know their own limits and say "no" when overwhelmed.

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