



THE PSYCHOLOGICAL IMPACT OF COVID-19: BEHAVIORAL HEALTH'S VITAL ROLE IN THE RESPONSE AND RECOVERY

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Executive Summary

The increased burden of mental disorders during and after a disaster is well documented. Longitudinal studies suggest that post-disaster symptoms of mental health problems reach their peak in the year following the disaster and then improve, but for a substantial portion of the affected population symptoms may persist for years. The pandemic constitutes a traumatic event for families and health workers alike, making access to trauma-informed care more important than ever. Data has already demonstrated that communities of color, low income families and vulnerable populations are more negatively impacted than others, necessitating action to address the social determinants of health and health care inequities. Despite the need for behavioral health services as a result of the COVID-19 pandemic, access to and provision of such services are increasingly challenging given economic uncertainty. Despite an increased need for psychosocial support services, behavioral health organizations are experiencing significant losses in productivity as families cancel services over health concerns. Moreover, the nature of the pandemic calls for millions of Californians (and other residents of the U.S.) to comply with shelter-in-place orders which has resulted in behavioral health organizations radically adjusting their service delivery model from primarily face-to-face community-based services to telehealth. Decreased productivity coupled with a surge in business-related expenses to accommodate systemic change threaten the solvency of many behavioral health agencies and undercut their ability to provide critical mental health services during this unprecedented time. It is crucial to keep behavioral health organizations solvent as they are critical in the response to and recovery from COVID-19.

The Psychological Impact of COVID-19: Behavioral Health's Vital Role in the Response and Recovery

Background

The COVID-19 pandemic is an unprecedented threat to health systems and community well-being worldwide. As the novel coronavirus rapidly spreads across the globe, it has resulted in systemic crises that have in turn exacerbated existing healthcare challenges and presented immense adversities for people of all ages, races, ethnicities, and cultural backgrounds; however, the data clearly demonstrates the disproportionate impact on African American and Latino populations. From changes to daily routines, economic hardship, loss of community and social supports, illness and death of loved ones, and loss of rituals when a loved one has passed, the scope and breadth of the pandemic as it unfolds will continue to affect individuals, micro-, and macro-systems for years to come.

The Substance Abuse and Mental Health Services Administration (SAMHSA; 2014) defines trauma as “the effects of a single event, a series of events, and/or ongoing circumstances that are experienced or perceived as physically or emotionally harmful and/or life threatening.” As such, the current pandemic constitutes a potentially traumatic event for many families as it continues to spread throughout the world. While the psychological distress that accompanies potentially traumatic events like this one can have profound implications for mental health, everyone reacts differently to stressful situations. For many, resilience will prevail, and s/he will not necessarily develop mental health problems (Goldman & Galea, 2014). For a substantial portion of the population, however, the abrupt changes, upheaval, and uncertainties constitute traumatic events with significant repercussions (Benedek, Fullerton, & Ursano, 2007). In the current climate of uncertainty, more than ever, anxiety is flooding people’s lives as they worry about loved ones, health, finances, stability and the outlook of a future that is difficult to imagine.

Social determinants of health refer to economic, social, and societal conditions that can influence mental and physical health outcomes within a given population. Although mental health and behavioral health care disparities are seldom addressed in disaster response and disaster recovery (Davis, Wilson, Brock-Martin, Glover & Svendsen, 2010), research on social determinants of health indicate disruption of health care infrastructure disproportionately effects low-income families and vulnerable populations (Runkle, Brock-Martin, Karmaus, & Svendsen, 2012; Rabins, Kass, Rutkow, Vernick, & Hodge, 2011; Davis et al. 2010; Madrid, Sinclair, Bankston, Overholt, Brito, Domnitz, & Grant, 2008). For the 13 million Californians receiving Medi-Cal (California Health Care Almanac, 2019), we can anticipate that they will be negatively impacted beyond the average American family by virtue of their vulnerable status.

It is well documented that traumatic events can impair our ability to grasp or cope with the event(s) which can lead to a state of extreme confusion, panic, despair, anxiety, depression, stress, hopelessness, loneliness, and perhaps grief. Today, these feelings are all too common as we are reminded daily of the disruption to our lives (e.g., empty streets and restaurants, store shelves, constant barrage and newsflashes about the pandemic, etc.) and the potential loss of life or health we might experience as a result of COVID-19. Moreover, anxiety-related symptoms may be heightened for those with histories of trauma, as they may be re-experiencing intrusive distressing memories, flashbacks, nightmares, exhibit changes in thoughts and mood, and be easily startled. In addition to individuals (re)experiencing trauma on their own, the COVID-19 pandemic has

negatively impacted the entire globe which may result in collective trauma, psychological reactions to a traumatic event that affect entire communities (Hirschberger, 2018).

Previous pandemic research from both domestic and international outbreaks of influenza, the Ebola virus, and Severe Acute Respiratory Syndrome (SARS), as well as natural disasters (e.g., Hurricane Katrina) provide insight regarding how the COVID-19 pandemic may affect the mental health of the general population, particularly families and children. We know the consequences of those events have resulted in increased psychological distress, as well as post-traumatic stress (PTSD; Douglas, Douglas, Harrigan, & Douglas, 2009; Kamara, Walder, Duncan, Kabbedjik, Hughes, & Muana, 2017) and major depressive disorder (Maguen, Neria, Conoscenti, & Litz, 2009). While COVID-19 does not discriminate in whom it affects, we know there are vulnerable communities (e.g., Latino and African Americans) that have historically been neglected are more severely impacted than others. There is considerable evidence for several factors associated with greater risk of developing mental health problems after disasters including low socioeconomic status, belonging to an ethnic/racial minority, low social support, having children, prior mental health problems, female gender, and younger age.

While immediate attention is largely focused on the biomedical crisis of COVID-19, we cannot ignore the widespread societal mental health consequences of the pandemic. The Inter-Agency Standing Committee (IASC), the longest-standing and highest-level humanitarian coordination forum of the United Nations system, considers mental health and psychosocial support (MHPSS) services a fundamental aspect of emergency response, on par with basic sanitation and medical relief. MHPSS services are part of their basic response package to man-made and natural disasters, including pandemics (IASC, 2007). Consistent with the IASC, the World Health Organization (WHO) also considers MHPSS a fundamental aspect of their disaster relief packages.

Despite requests for more thorough consideration of mental health delivery in contexts affected by traumatic or distressing events, resources are predictably stretched thin or eliminated entirely. The nature of the novel coronavirus has led behavioral health organizations to rely heavily on advances on telehealth and digital medicine for behavioral health services, but their effectiveness is mixed or under-researched (Dugas et al 2020), particularly among families in poverty and vulnerable populations. As such, the population most consistently served by behavioral health organizations in the United States are the most disproportionately affected by a lack of consistent, evidence-based treatment.

Impact to Children, Adolescents, and Their Families

Children are a vulnerable segment of the population, as

DISRUPTED LIVES

“How do I do my job and be a teacher? My child has ADHD, I am a single parent, and I get paid hourly. I don’t even understand his math. I cannot do all of this!”

“They say to stay home, but I cannot afford to stay home. Please let me work and clean your house. I am not sick. I will use a mask. I will keep my distance. I cannot lose any more work. Please!”

“We don’t have space to do everything we need to do. My husband is running an IEP while my daughter is singing with her choir teacher with distance learning and I am trying to deal with a staff who is unraveling right in front of me because she is overwhelmed by everything around her.”

“No Senior Air Jam?! No prom?! Will we have a graduation ceremony? Will we be able to graduate if we don’t get credits? I already have a work contract at the college I’m supposed to go to. What’s going to happen?”

“How do you balance being a parent and teacher and still do your job which is on the line, and be a spouse?”

“For me, a good day is being able to get a cup of coffee and not having my kid spill it.”


they are dependent on others for their food, shelter, transportation, medical care, etc. Moreover, schools are an integral part of their everyday environment and are often taken for granted. Recent school closures have disrupted millions of students' and caregivers' daily functioning. Traditions that reflect achievement of certain milestones (e.g., prom, graduation, etc.) are no longer predictable events and caregivers are now assuming additional roles and responsibilities. Family stress levels are likely to increase when parents cannot work, children are at home, and loved ones are ill. If hospitalizations are required, it will lead to separations that will only exacerbate current stress levels. The experience of severe illness or witnessing the loss of loved ones to the disease in addition to cancellation of rituals and traditions that help children cope can further complicate the recovery process (Stevenson, Barrios, Cordell, Delozier, et. a, 2009). Subsequently, a high demand for community and behavioral health support can be anticipated.

Even prior to the COVID-19 pandemic, based on the large body of research dating back more than two decades has established that children who experience adverse childhood experiences (ACEs) not only are more likely to exhibit negative behaviors at school but are more likely to develop risky behaviors and face a host of negative health consequences over their lifetime, including reduced life expectancy. COVID-19 only compounds pre-existing conditions.

Impact on Health and Behavioral Health Workers

Behavioral health organizations serve a critical role in the recovery period of disasters. Not only do they provide critical mental health and psychosocial services, but direct-service providers are often the primary contact points for people before, during and after a pandemic perhaps because of their ability to deliver news in ways that mitigate anxiety and distress, especially among pediatric populations (Sprang & Silman, 2015). Beyond the burden of mental health problems incurred by those we serve, there is substantial evidence to suggest there will be lasting mental health and economic implications for our direct service staff. As such, we should not forget the needs of health care (including behavioral health) workers. Public health and public safety workers experience a broad range of health and mental health consequences as a result of work-related exposures to natural or man-made disasters. Benedek, et. al (2007) expands the definition of "first responders" and "public health workers" to include roles that augment the services of those traditionally included in definition (e.g., Police, firefighters, search and rescue personnel, and emergency and paramedical teams), including social workers.

Traumatic events are not limited to individuals who contract the virus and their family. There is a potential mental health sequela for responders and care providers (Greenberg, Wessely, Wykes, 2015; Benedek et. al. 2007). The psychosocial ramifications of natural disasters and pandemics are self-evident and widely described in both domestic and international settings (Raphael & Maguire, 2009; Neria, Nandi, & Galea, 2008; Neria, Galea, & Norris, 2009; Goldmann & Galea, 2014) for both individuals exposed to the potentially traumatic event as well as first responders. For example, Maunder, et. al (2003) reported negative mental health outcomes among service providers in the United States during SARS and significant long-terms stress in health-care workers that responded to the outbreak (Maunder, et. al, 2008). Bai, et al. (2004) reported quarantined health workers in Taiwan during the SARS outbreak reported PTSD symptoms and acute stress disorder, as well as workplace absenteeism, changes in work functioning, increased substance abuse, etc.



"I work in the ICU where the patients have tested positive for the coronavirus. I am so worried about passing it to my parents. I won't be able to live with myself if something happens to them because of me."

Long-Term Impact

Undoubtedly, history indicates there will be long-lasting effects of COVID-19. There is an established relationship between negative mental health outcomes and isolation/quarantine (Huremovic, 2019). In a review of studies comparing psychological outcomes for people quarantined with those not quarantined due to SARS, Brooks, et. al (2020) found that immediately after the quarantine period (9 days) ended, having been quarantined was the factor most predictive of symptoms of acute stress disorder and post-traumatic stress disorder three years later. Moreover, those quarantined were more likely to report exhaustion, detachment from others, irritability, insomnia, poor concentration, indecisiveness, deteriorating work performance – all symptoms of common mental health problems. While quarantines and isolation are critical strategies in suppressing the spread of the outbreak, there are negative psychological effects, including PTSD, confusion, and anger, primarily in adults (Brooks, Webster, Smith, Woodland, Wessely, Greenberg, & Rubin, 2020). In addition, rigorous longitudinal studies suggest high acute stress may indicate greater risk for subsequent health problems (Garfin, Thompson, & Holman, 2018).

Conclusion and Recommendation

Access to behavioral health services is critical as we endure the pandemic and deal with the aftermath. While a percentage of individuals will have their physical health affected by COVID-19, the psychological effects are pervasive and touch every single person and all levels of a system- from organizations and businesses to counties, states, countries, and the world. The current pandemic presents unprecedented challenges on many fronts. Longitudinal studies suggest that post-disaster symptoms of mental health problems reach their peak in the year following the disaster and then improve, but for a substantial portion, symptoms may persist for years. While most people will be resilient, for others, this crisis may result in trauma (individual or collective) or re-traumatization. There is an immediate need for behavioral health services to help people cope through the course of the pandemic and an on-going need to respond to the aftermath. Trauma is a pervasive public health issue. Maintaining the solvency of behavioral health organizations in this tumultuous time is critical to the overall health of our society.

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