Impact of COVID-19 on mental health care for Veterans: improvise, adapt, and overcome

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Impact of COVID-19 on mental health care for Veterans: Improvise, adapt, and overcome

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INTRODUCTION

The ongoing COVID-19 coronavirus pandemic would, by most definitions, be considered a "crisis." While crises can be overwhelming and often expose vulnerabilities and gaps in our preparedness, they can also be seen as opportunities to quickly adapt, innovate, and learn. Leiden University professor Arjen Boin described a disaster as a "crisis gone bad."[1] Thus, the decisions and actions during crisis may avert disaster. The COVID-19 pandemic is having a broad impact on all aspects of society including health, education, the economy, and many fundamental freedoms.

We have chosen to focus on one important, but symbolic, example to demonstrate how this crisis poses a unique and real threat to the well-being of Veterans, and how that threat can be greatly mitigated through action. At a time when most are being asked to socially isolate[2] and avoid essential travel, it is difficult to determine where regular visits for mental health care fit in.

The emergent threat of a coronavirus pandemic significantly impacts the environment in which mental health care for Veterans and former service personnel is provided. The challenge of containing the spread of infection places a major demand on all health resources – and particularly general practices – because it is likely to further limit their capacity to respond to the health needs of Veterans. This is of considerable importance because of the centrality of general practitioners to the provision of care. Furthermore, the current situation limits the availability of face-to-face care delivery and access to mental health facilities due to the threat of COVID-19 infection.

A further concern is the impact of posttraumatic stress disorder (PTSD) on the resistance to infection within Veterans communities, given the known effects of traumatic stress on inflammatory responses and immunoreactivity.[3–5] Evidence indicates that anyone with PTSD, including Veterans, may be more vulnerable to severe infection,[3] in part due to medical comorbidities; however, just how significant an increased risk this poses in the current pandemic is unclear. Moreover, risk-taking behaviour is common in those with PTSD, and they may develop a fatalistic attitude to the future. Hence, there may be particular challenges in encouraging those suffering from PTSD to self-isolate. Furthermore, being in close proximity to family members without the ability to easily gain distance, take a break from one another, or stick to an exercise program, may increase the risk of aggressive behaviour toward others. Thus, reassuring Veterans their treatment will not be interrupted, and health practitioners will remain available – perhaps via technological means – may be comforting and reduce risk to themselves and family disruption.

The circumstances created by the COVID-19 pandemic require a reconsideration of how health care for Veterans and former service personnel might be organized. Significant thought should be given to how systems of support can improvise, adapt and overcome the issues outlined above during this challenging time.

SUGGESTED STEPS AND PROPOSED SUPPORTS

1. **Promoting increased use of telemedicine consultations:** Remote delivery of mental health services has the benefit of being able to provide ongoing care for those in isolation,[1] while protecting

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the workforce from the risk of infection. Assuming that the community and individuals are well connected (e.g., by telephone, internet, mobile phone), then existing service delivery models can be adapted. This should happen as a priority. Equally, telemedicine consultations can be used to assist in supporting other Veterans in the community who may be struggling with the emerging coronavirus risk.[6] The technology to deliver mental health services remotely already exists in many countries and individuals can be reached without violating social isolation protocols. For example, clinicians can reach out and conduct wellness checks on existing patients to ensure they fully understand the circumstances of the pandemic, have enough medication, and have the means and supplies to self-isolate.

2. **Seeking funding for telemedicine:** Respective governments and other funding agencies, should be approached to allow the delivery of counselling and psychological services without the normal restrictions on distance. There may be requirement for equipment, training, policy, and fee/billing structure/codes changes. Some nations may also require modifications to licence restrictions in the face of this pandemic.
3. **Providing alternatives to inpatient care:** In preparation for a time when psychiatric beds are available only by exception, more consideration should be given to developing home care programs. Due to demands on the health care system created by the COVID-19 pandemic, it is likely psychiatric beds will be diverted to those suffering from infection, and psychiatric hospitalization will be considered a last resort due to infection risk. Home care programs should include increasing monitoring and support of those who are at high risk of deteriorated mental health or suicide, who would normally be hospitalized. This may require considering alternative workforce models, as well as a triage system for access to inpatient care. The level of acuity for access to psychiatric inpatient beds has generally been less for Veterans than for other psychiatric patients. The pressure for hospital beds due to the coronavirus pandemic is likely to change this, and a management plan needs to be developed. Crisis resolution and home treatment are an established mechanism of care delivery.[7]
4. **Developing new communication strategies:** A communication strategy should be developed for the Veteran community to outline how COVID-19 may impact continued services, such as group and inpatient and outpatient mental health programs. The strategy may also include information about managing other social gatherings of Veterans, such as Australian and New Zealand Army Corps Day, Victory in Europe Day, Remembrance Day, and other military celebrations around the globe. Remotely delivered ceremonial activities may be an alternative to in-person gatherings and may assist in mitigating the distress caused by this issue.
5. **Monitoring and support for those already identified as at-risk:** Those already identified as being at-risk may need further support in the context of the COVID-19 pandemic. For instance, Veterans who live on meagre ill-health pensions or benefits may be less able to sustain themselves during a period of self-isolation. Consideration for how best to support such individuals should be treated as a special issue during coronavirus risk response. The development of a program for managing anxiety through exercise and relaxation strategies for those in isolation should be a priority. In addition, technology must be leveraged to disseminate these programs and, ideally, should be tailored to the Veteran context.
6. **Organizing support for health professionals:** COVID-19 risk is an issue acutely felt by health professionals. The need to provide advice and support must be addressed; however, it is unclear whether specific support is required for those involved in caring for Veterans over and above what is provided for other frontline healthcare professionals. As an example, if home visits are suggested as an alternative to hospitalization, then training, equipment and support will be required for mental health care workers providing the home visits. It is also possible that – in countries with ready access to lethal weapons – anxious, irritable, and scared Veterans may pose a risk to health professionals who carry out home visits.[8,9] These risks are in addition to the risk posed by the pandemic itself, and must be considered.[9]
7. **Investing in long-term impacts and suicide prevention:** The SARS epidemic was followed by an increased rate of suicide in those over the age of 65 years.[10,11] This arose as a result of the enduring effects of social isolation, which are shown to have the greatest impact on female suicides.[11] Suicides post-SARS epidemic were partly driven by the concerns of the elderly about being a burden on their families, as well as related anxieties faced during the height of the epidemic.[12] This would suggest that

Veterans over 65 years of age who are socially isolated, with high levels of distress and/or a known risk of suicide, should be targeted for practical provision of support such as grocery delivery and contact by Internet or phone. Support should be planned on a long-term basis and continue after the pandemic subsides, as risks do not greatly diminish.[11]

8. **Monitoring long-term impact on health workers:** The SARS and H1N1 epidemics were found to have significant adverse impacts on health workers, including increased rates of PTSD from dealing with patient suffering, death and personal risk.[13,14] It is important skilled health professionals provide support and advice for frontline workers of the COVID-19 pandemic. This is a role for older practitioners, who cannot afford to risk direct exposure to the coronavirus due to the potential mortality associated with age. Monitoring and provision of care for doctors and nurses working on the front lines should be planned as the pandemic recedes. Follow-up is particularly important for those who contract the virus, due to the high rates of PTSD found in those who recovered from similar infections.[15,16] Care should be taken to watch for long-term symptoms of fatigue and pain, which are a significant cause of morbidity,[17] and this highlights why planning for the care of infected health professionals should be a high priority.

CONCLUSION

Crisis is both a challenge and an opportunity to innovate and adapt. There are lessons to be learned from history and some projection required. The authors chose a vulnerable population (Veterans) for illustration, yet the principles are applicable to many groups. The steps outlined earlier are critical in the time of the current COVID-19 crisis and will remain so for some time after. When it comes time to scale down restrictions to care, it may afford an ideal opportunity to reappraise the value of traditional face-to-face based care.

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COMPETING INTERESTS

Neil Greenberg is the Royal College of Psychiatrists Lead for military and Veterans health and a trustee with two military charities.

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CONTRIBUTORS

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