Another approach that has been shown to be ineffective, and indeed potentially harmful, is the use of psychological debriefing, or post-trauma counselling, delivered in the days after a traumatic event has occurred. Well-accepted PTSD management guidelines are clear in recommending against the use of such approaches[7]. This evidence is highly relevant during the current pandemic, when mental health professionals want to support their "front-line" physical health colleagues, or assist individuals recovering from serious COVID-19 infection. Whilst both aspirations are laudable, it is important to avoid causing harm.

On the other hand, there is strong evidence that training supervisors to implement supportive and empathetic communication techniques with their team members is highly beneficial to employees' post-trauma mental health and is associated with a reduction in their sickness absence[8]. Good evidence also exists that formal peer support programs can protect the mental health of trauma-exposed employees[9]. Furthermore, it may be useful to ensure that trauma-exposed staff are actively monitored, provided with time away from trauma-prone workplaces, and encouraged to engage in reflective practice protecting them against the onset of moral injury.

For people who do develop PTSD, there are some evidence-based treatments available. Whilst demand for these interventions is likely to be high, given the scale of the pandemic, it remains highly important that evidence-based approaches are utilized. Most evidence exists for trauma-focused cognitive behavioral psychotherapy and eye movement desensitization and reprocessing[6]. Most people will experience substantial improvement from 8 to 12 sessions of cognitive behavioral psychotherapy, although those with more complex presentations of PTSD are likely to require more prolonged treatment. For those who do not accept or respond to psychotherapy, antidepressant medications may help, and they may be especially useful for people who present a comorbid depressive disorder.

As with other mental health conditions, it is important that treatment for PTSD begins early on, before people lose their self-esteem, important relationships or employment, or develop other mental health disorders, including substance misuse. Given the likely increased global incidence of PTSD as a result of the pandemic, the routine use of the effective preventive measures and the dissemination of the evidence-based psychotherapies outlined above should be seen as a priority.

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Prioritizing COVID-19 vaccination for people with severe mental illness

In the global race for a safe and effective COVID-19 vaccination, there are still many challenges that need to be addressed. One of these is being the initial scarcity of doses and the associated ethical considerations as to whom they should be distributed first.

Recently, the National Academies of Sciences, Engineering, and Medicine have proposed an ethical framework for equitable allocation of COVID-19 vaccine in the US[1]. The World Health Organization, as well as several other entities, have produced similar frameworks. In the prioritization of vaccines, these frameworks endorse three universal ethical principles. A first principle concerns minimizing harm and maximizing benefit: an effective vaccine should reduce deaths, disease burden, and societal and economic disruption, and have a minimal side effect profile. The second principle advocates prioritizing populations that may experience disproportionately greater health burdens as a result of the COVID-19 pandemic: some groups are at higher risk of being infected with, dying of or having lasting sequelae of COVID-19, due to their age, profession, medical status or socioeconomic factors. The third principle relates to equal respect for every person, and requires that, in allocation and priority-setting, individuals are considered and treated as having equal dignity and worth. Individuals who, because of vulnerability or structural inequalities, would face barriers to accessing a vaccine, should be offered an equal opportunity to be vaccinated as compared to more privileged groups[2].

People of all ages with comorbid and underlying physical conditions, such as cardiovascular diseases, chronic obstructive pulmonary disease, type 2 diabetes mellitus, chronic kidney disease, obesity, immunodeficiency and cancer, are particularly vulnerable to morbidity and mortality due to COVID-19. The risk of premature death or severe morbidity in these patients is significant enough for the US National Academies of Sciences, Engineering, and Medicine to prioritize these patients in the allocation of vaccines[1].

Even without factoring COVID-19 into the calculation, people with severe mental illness, including schizophrenia, major depressive disorder and bipolar disorder, have a two to three times

higher mortality rate than the general population, resulting in a 10-20 years reduced life expectancy, that appears to be widening. This is mainly attributable to physical diseases. There exists a large body of evidence showing that these people are more likely to develop a wide variety of physical diseases, such as cardiovascular diseases, type 2 diabetes mellitus, and respiratory tract diseases[3]. The risk for obesity, which is an important associated factor for mortality in patients with COVID-19, can be more than four times higher in people with schizophrenia and about one and a half times higher in those with major depressive disorder or bipolar disorder, compared to the general population[3].

Recent studies have shown that people with severe mental illness are at a heightened risk of morbidity and mortality from COVID-19. We therefore argue that they should also be prioritized in vaccine allocation. A case-control study with over 61 million patients found that people who were recently diagnosed with schizophrenia, bipolar disorder, major depressive disorder or attention-deficit/hyperactivity disorder showed very high odds ratios (5.7 to 7.6) of being infected with COVID-19, as compared to patients without mental disorders, even after adjustment for age, gender, ethnicity and the aforementioned medical conditions. These people are also at increased risk for COVID-19 complications, as reflected in higher rates of hospitalization and death[4]. Other recent studies[5,6] have confirmed these data.

To put these findings into perspective with the example of the US: in 2017, there were an estimated 11.2 million adults aged 18 or older in the US with severe mental illness. Taking into account a mortality rate of 8.5% that has been found among COVID-19 patients recently diagnosed with a severe mental illness, this means that about 1 million of patients with severe mental illness in the US would die if all were affected by COVID-19.

Severe mental illness is known to be positively correlated with many environmental variables which are themselves risk factors for COVID-19 infection, such as socioeconomic deprivation, working in unsafe environments, living in overcrowded settings or being homeless, institutionalization and confinement. Furthermore, stigmatization, discrimination, erroneous beliefs and negative attitudes associated with severe mental illness, as well as system factors, act as barriers to the recognition and management of physical diseases in people with severe mental illness[7]. Finally, persons suffering from a severe mental illness have more difficulties in following and applying the confusing and constantly changing rules and obligations that are established in relation to the fight against COVID-19[4,8]. It thus becomes clear why severe mental illness is a major risk factor for COVID infection and negative COVID-19 related outcomes.

In light of this knowledge, and taking into account the second and third ethical principles that should guide vaccine allocation, we consider it paramount that persons with severe mental illness should also be prioritized to guarantee that they receive a COVID-19 vaccine during the first phase of its distribution. It is our responsibility as psychiatrists in this global health crisis to advocate for the needs of our patients with governments and public health policy bodies, as a position paper by the World Psychiatric Association recently stated[9]. In addition, public health bodies should develop and implement targeted programs to ensure that these patients and their health care providers are made aware of these increased risks as well as of the benefits of vaccination.

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A pandemic of social isolation?

On March 11, 2020 the World Health Organization declared COVID-19 infection a global pandemic, prompting closures and other restrictions across the world. A substantial proportion of the world population was suddenly homebound, giving us all a small glimpse into the experiences of the approximately 6% of US older adults who were already homebound. Further closures and restrictions have been implemented worldwide in relation to the second wave of the infection. This raises questions about the effects that social isolation may have on our mental and physical well-being.

Public health concerns about social isolation and loneliness were growing internationally even prior to the pandemic. In 2018, the UK appointed a Loneliness Minister and published a national strategy for tackling loneliness. In the US, the National Academies of Sciences, Engineering, and Medicine released, just two weeks prior to the declaration of the pandemic, an expert consensus report on the relevance of social isolation and loneliness in older adults for the health care system[1]. Nonetheless, social isolation and loneliness have generally been underrecognized and underappreciated relative to the evidence supporting their public health importance[2].

Evidence suggests that a significant portion of the population was already socially isolated, lonely, or both, prior to the pandemic[2]. Social isolation refers to objectively being alone, having few relationships or infrequent social contacts; whereas loneliness