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Some good news for psychiatry: resource allocation preferences of the public during the COVID-19 pandemic

The COVID-19 pandemic has put tremendous strain on health care systems all over the world and has particularly challenged mental health services. During the first wave of the pandemic, for reasons of both infection control and resource allocation, many mental health services have been downsized or even closed worldwide. A rapid assessment of 130 World Health Organization member states revealed that more than 60% of countries fully or partially closed community-based mental health services, and more than 40% fully or partially closed inpatient services for substance use disorders[1].

At the same time, it has been widely recognized that the pandemic increases the burden on people with mental illness and puts many healthy people at risk of developing mental health problems[2]. Maintaining adequate mental health services and adapting the way mental health care is delivered during the pandemic is thus of tremendous importance[3,4].

Previous population studies have shown that mental disorders enjoy low standing in the public opinion when it comes to allocation of financial resources[5,6], so there is reason to suspect that the current shortage of health care resources puts people with mental disorders at risk of structural discrimination. In this study, we examined how public priorities on health care spending have evolved from 2001 through 2011 to 2020.

From July to September 2020, a representative face-to-face survey was carried out among the adult population in Germany (N=1,200, response rate: 57%). The survey was a methodologically identical replication of surveys in 2001 (N=5,025, response rate: 65%) and 2011 (N=1,232, response rate: 64%)[7]. In 2020, respondents were asked: "In order to have sufficient resources for the care of patients with the coronavirus disease, it may become necessary to cut budgets for the care of people with other diseases. Please choose from the following list those three conditions where, in your opinion, it would by no means be acceptable to reduce funding for patient care" . They were then presented with a list of nine diseases, including physical conditions such as diabetes, rheumatism, cancer, AIDS and cardiovascular diseases, as well as mental disorders such as Alzheimer's disease, alcoholism, depression and schizophrenia. In 2001 and 2011, the question had been posed similarly, only with the first sentence being framed in more general terms: "There is an increasing shortage of financial resources within the health care system. Please choose from the following list…"

In 2020, depression ranked fourth – after cancer (84%), cardiovascular diseases (60%) and diabetes (41%) – among conditions for which funding should by no means be reduced, with 25% of the respondents selecting it to be spared from budget cuts. Its rise from the 8th position in 2001 and 6th position in 2011 mostly reflected two developments: a growing share of respondents indicating a funding preference for depression (up from 6% in 2001 and 21% in 2011), and a declining share of people giving priority to the funding of AIDS care, which started at 47% in 2001 and went down to 35% in 2011 and 20% in 2020.

Schizophrenia, although remaining on the 8th position in the list, was nevertheless chosen by 17% to be spared from financial cuts in 2020, about doubling its share from 9% in 2001 and 8% in 2011. Alcoholism, in contrast, remained firmly at the bottom of the list, chosen by 5% in 2001, 8% in 2011, and 6% in 2020.

Our results show that, under the unprecedented pressure of the coronavirus pandemic on our health care systems, resources for the treatment of people with mental disorders have solid support among the general public, at least in Germany. Probably, this reflects the extensive coverage of the mental health consequences of the pandemic both in the public media and medical journals[8], and possibly also the personal experience of psychological vulnerability during the crisis.

Comparing our recent survey with those from 2001 and 2011, there is evidence for a trend of growing support for mental health care funding, especially for the treatment of depression. It is striking, however, that alcoholism remains firmly excluded from this supportive public sentiment, despite evidence for an increased burden due to substance use during the pandemic[9].

Our findings are thus reassuring with respect to funding priorities for depression and schizophrenia, with little indication of public support for structural discrimination of people with these disorders. They are worrying, however, with regard to alcohol use disorders. Despite their high prevalence, considerable burden, and available treatment options, people with these latter conditions remain at particular danger to be neglected when competing for

treatment resources, even more so during the current pandemic.

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A prevalence assessment of prolonged grief disorder in Syrian refugees

Although many studies indicate the elevated rates of mental disorders in refugees[1], relatively little attention has been given to prolonged grief. This is surprising, considering that refugees commonly experience bereavement arising from war, torture, detention, or in the process of fleeing persecution[2].

There has been an increasing focus on problematic grief reactions in recent years, culminating in the new diagnosis of prolonged grief disorder (PGD) being introduced into the ICD-11[3]. PGD is defined as persistent yearning for the deceased, and associated emotional pain, difficulty in accepting the death, a sense of meaninglessness, bitterness about the death, and difficulty in engaging in new activities, persisting beyond six months after the death. The disorder is estimated to occur in 7% of bereaved people[4], but one population-based study of re-settled refugees reported an incidence of 15.8%[5].

There are no large-scale representative sampling studies of PGD in refugees directly affected by war. This is a serious omission in the evidence, because there are millions of refugees directly affected by war, conflict and persecution, and understanding the rates of PGD in this group would help shape better mental health policies to assist those experiencing bereavement. To fill this gap in current knowledge, this study aimed to determine the rate of PGD in a representative sample of adult Syrian refugee parents residing in a camp in Jordan.

Participants were recruited in the process of screening for eligibility for a trial testing the effectiveness of a psychological intervention (ACTRN12619001386123). The screening assessments included adult (>18 years) Syrian refugees who had at least one child residing in two villages in the Azraq Refugee Camp, which hosts approximately 35,000 Syrian refugees. Arabic-speaking interviewers approached each consecutive caravan in two villages in the camp between January 2019 and February 2020, and interviewed one randomly selected adult in the household. The interview included experience and timing of bereavement, cause of death, and relation to the deceased.

PGD was assessed using a 5-item interview that has been used in a previous survey following a major disaster[6], and is consistent with the ICD-11 definition. PGD was operationalized as satisfying the following criteria over the past month for a bereavement that had occurred at least six months earlier: a) yearning for the deceased at least "once a day"; b) at least two of the following three symptoms occurring "quite a lot": bitterness about the loss, difficulty accepting the loss, or feeling that life is meaningless; and c) endorsing functional impairment as a result of the grief. Additionally, psychological distress was assessed with the Kessler Psychological Distress Scale (K10), on which severe mental disorder was categorized as scores ≥30. Disability was evaluated using the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0), on which disability was defined as scores ≥17. The study was approved by the Institutional Review Board of the King Hussein Cancer Centre, Jordan.

We assessed 955 participants (67.3% females). Of these, 564 (59.1%) reported bereavement, with cause of death including war (26.5%), accident (8.3%), natural causes (64.6%) or other causes (2.6%). The deceased was a parent (32.2%), spouse (4.2%), child (5.7%) or relative/friend (57.9%).

Among those experiencing bereavement, 85 (15.1%) met criteria for PGD, which comprised 8.9% of the entire sample. In terms of the specific symptoms of PGD, 478 (84.8% of the bereaved sample) reported persistent yearning, 447 (79.3%) bitterness about the loss, 251 (44.5%) feeling meaningless, 167 (29.6%) difficulty accepting the death, and 149 (26.4%) impairment resulting from their grief.

There was no relationship between marital status, educational level, cause of death or relationship to the deceased and the likelihood of developing PGD. In terms of the association between PGD and ongoing problems, after controlling for cause of death, refugees with PGD were more likely to have a serious mental disorder (68.2% vs. 56.3%: OR=1.6, 95% CI: 1.0-2.6). PGD was not associated with greater disability.

These findings are significant as this is the first study reporting on the prevalence of PGD, by representative sampling, in a population of refugees directly affected by war. The percentage of 15.1% of bereaved refugees experiencing PGD is markedly higher than