Why people living with mental illnesses should have been prioritized earlier for COVID-19 vaccines

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Abstract

Researchers and advocates have argued that people living with severe mental illnesses are a vulnerable group and should be prioritized for COVID-19 vaccines. People living with severe mental illnesses, including substance use disorders, bear an elevated burden of intersecting risk factors related to the social determinants of health and medical comorbidities leading to greater COVID-19 morbidity and mortality. This increased risk is based on several intersecting factors, including the likelihood of living in unstable and crowded living conditions such as shelters, group homes, or institutions; unsafe working conditions; high rate of comorbidities; and marginalization and stigmatization. Nonetheless, many of the initial iterations of vaccine allocation frameworks internationally did not prioritize people living with severe mental illnesses. Moreover, people with severe mental illness who are long-stay inpatients in psychiatric institutions were left off of vaccine priority setting lists that included long-term care facilities and other congregate settings. In this commentary, we question why people living with severe mental illnesses – particularly those who are institutionalized – were not initially considered a priority for vaccine access given the supposed vulnerability. We describe how people are made vulnerable by intersecting aspects of systematic disadvantage such as stigma, poverty, and racism. We suggest that the lack of attention given to intersectional factors in vaccine prioritization compromises health equity for people living with mental health and substance use disorders. We end the commentary by suggesting how vaccine distribution and allocation could be more equitable by including people with lived experience of mental illness in designing and implementing vaccination strategies. Understanding how people with mental illnesses have experienced structural vulnerability and intersecting risk factors throughout the pandemic can help inform the creation of effective and ethical vaccine-related responses to the COVID-19 pandemic.

Background

As of May 31, 2021, almost 24 million doses of COVID-19 vaccines have been administered across Canada.[1] The National Advisory Committee on Immunization (NACI) reports to the Public Health Agency of Canada (PHAC) and sets the national standards for determining who ought to have priority for the vaccine within the national allocation framework. Part of NACI's task is to determine which groups should receive priority access to the vaccines. To make these decisions, the Advisory Committee uses a framework based on scientific evidence such as the burden of the disease and the characteristics of the vaccine and programmatic factors that include ethics, equity, feasibility, and acceptability.[2] The familiar bioethical principles of respect for persons and communities, beneficence and non-maleficence, justice, and trust make up the ethics portion of the framework.[2] Decisions about the just allocation of vaccine resources are fundamentally a matter of ethics: how should a scarce resource be distributed fairly and by what criteria? Within the NACI framework, decisions are made using an Equity Matrix that identifies 11 factors that may contribute to health inequality. Examples include pre-existing conditions, age, and socioeconomic status.[2] The PHAC has used the immunization guidance laid out in the NACI framework to determine the nation's vulnerable groups and designate three phases of COVID-19 vaccine distribution. While the NACI provides the national framework, vaccines are administered provincially, and the provinces and territories have created their own frameworks.

Many researchers have argued that people living with severe mental illnesses are a vulnerable group and should be prioritized for COVID-19 vaccines.[3-6] Nonetheless, many of the initial iterations of vaccine allocation frameworks internationally did not prioritize people living with mental illnesses or substance use disorders. Moreover, people with severe mental illness who are considered long-stay inpatients in psychiatric institutions – the hospital is their home – were left off of some provincial priority setting lists that included long-term care (LTC) facilities and other congregate

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settings. These inpatient settings were not considered congregate settings akin to LTC facilities, even though institutional settings can include shared spaces such as bedrooms, washrooms, eating areas, and environmental constraints, making it challenging to adhere to infection prevention and control (IPAC) protocols. While some inpatients in psychiatric hospitals and those living in congregate settings such as shelters were vaccinated during the initial phase, these were priority-setting decisions driven by local institutions and relentless community advocacy.

Phase two of Ontario's vaccine distribution plan extends eligibility to people with high-risk chronic conditions. People with diagnosed mental illness and substance use disorders are included in the third and final tier of those with chronic conditions. In this commentary, we question why people living with severe mental illnesses – particularly those institutionalized – were not initially considered a priority given the supposed vulnerability. We describe how people are made vulnerable by intersecting aspects of systematic disadvantage such as stigma, poverty, and racism. We suggest that the lack of attention given to intersectional factors in vaccine prioritization compromises health equity for people living with mental illnesses. Finally, we end by suggesting that people with lived experience of mental illness should be at the table informing how vaccines should be distributed to the population.

Mental illness and vulnerability

Several studies have found a link between pre-existing psychiatric disorders and increased risk for COVID-19 infection, hospitalization, morbidity, and mortality.[7-11] A recent meta-analysis investigating the relationship between COVID-19 and mental illness found that people with diagnosed mental disorders have a significantly increased risk of COVID-19 severity and mortality.[3] This increased risk is based on several interlocking factors, including socioeconomic factors such as unstable and crowded living conditions as in shelters, group homes, or institutions; unsafe working conditions; high rate of comorbidities; and, marginalization and stigmatization.[4-5] The stigmatization of severe mental illness is well-documented.[12] Experiences of social stigma and discrimination within the healthcare system and the general public may postpone or prevent individuals from accessing treatment when they are ill, resulting in detrimental health outcomes and more significant comorbidities.[12] People with mental illnesses face disproportionately greater health burdens such as the increased risk for physical diseases such as type 2 diabetes mellitus, respiratory and cardiovascular disease, and obesity, leading to a heightened risk of morbidity and mortality from COVID-19.[4] Additionally, high rates of tobacco use in this population may impact rates of infection.[13] Increased rates of poverty and unstable living conditions may make it more difficult for people with severe and persistent mental illnesses to follow public health guidelines such as frequent hand washing and practicing physical distancing.[14] Those living in congregate settings or within institutions, including hospitals and LTC homes, face high risks of infection.[13] Thus, people with mental illnesses bear a greater burden of intersecting risk factors related to the social determinants of health and medical risk factors.[5,15]

Nemani and colleagues conducted a retrospective cohort study in New York to understand the relationship between adults with diagnosed psychiatric disorders and COVID-19 mortality.[16] Researchers found that the highest risk of mortality was associated with a diagnosis of schizophrenia spectrum disorder. Individuals in this cohort had higher rates of mortality than those diagnosed with either mood or anxiety disorders. Across all of the demographic and medical risk factors examined in the study, schizophrenia spectrum disorder had the second strongest association with mortality following age.

Given the association between mental illness and COVID-19 morbidity and mortality, and the links between severe mental illness and structural inequality, many argued that people living with severe mental illnesses should be vaccinated during the first distribution stages.[4-5,17] These arguments are based primarily on the equity principle that suggests that allocation frameworks should assign equal respect for all persons: "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."[4] However, as we described, people living with mental illness – including those living in high-risk congregate settings – were initially left off of some priority vaccination schemes.[3,5] Furthermore, not all individuals have equal opportunities to receive mental health care, including assessment and diagnosis, thereby creating a further potential barrier to vaccine access. From an equity standpoint, the lack of a formal diagnosis should not prevent people with mental illness from being included in phase two of inoculation.

From vulnerable populations to being made vulnerable

The pandemic has worsened the population's mental health, even among those who did not experience mental illnesses before the start of the pandemic.[18-19] There have been documented increases in loneliness and social isolation over the past year, coupled with a lack of mental health resources.[20] Surveys of the public show a relationship between the pandemic and increased symptoms of depression, anxiety, and stress.[21] Rains and colleagues found that those who experience health challenges and social inequity have suffered the greatest hardships during the pandemic.[21] Structural racism is associated with poorer physical and mental health outcomes for Black, Asian, and Latinx populations.[22-25] A meta-analysis of 293 studies finds that individuals with racialized identities report more significant symptoms of depression, anxiety, and psychological stress.[23] These health inequities have been exacerbated during the pandemic.[22,24-25] In Ontario, the most racially and culturally diverse neighbourhoods report disproportionately higher rates of COVID-19 infection, and more severe outcomes (including hospitalization, admission to intensive care units, and death) compared to the province's more homogenous neighbourhoods.[26] The pandemic has both "magnified existing inequalities and created new ones."[27] Those who were already the most marginalized and deprived have suffered disproportionately.

A recent Lancet editorial suggests that people are being *made* vulnerable by the policies that are put in place to prevent the pandemic's spread; "lockdown policy can exacerbate health inequalities and the consequences need careful consideration to avoid reinforcing the vicious cycle between poverty and ill health."[28] Similarly, Ahman and colleagues argue that categories of vulnerability are not fixed; instead, they are continuously evolving based upon the systems and policies that create and reinforce them.[29] Vulnerability is not conceptualized as an inherent trait linked to some internal pathology for which individuals should be responsible. Instead, vulnerability is created by unjust systems and power relations and can thus be mitigated by

improving systems to be more equitable; this is what Bourgois and colleagues refer to as structural vulnerability.[30] Those who are made structurally vulnerable due to mental illness are not a stable category, but a group that continues to evolve with the pandemic.

Including those with lived and living experience in distribution strategy development

One way that systems could be made more equitable would be to include people with lived experience of mental illness in designing and implementing vaccination strategies. Engaging relevant stakeholders is suggested in the NACI guidelines for ensuring that distribution is equitable.[2] The experiences of people living with mental illness ought to be solicited, understood, and respected in pandemic responses.[28-29] The World Health Organization (WHO) promotes a people-centred approach to developing health care policy, where relevant stakeholders and service users are active participants.[31] Many mental health researchers and advocates agree that mental health service users should be involved in the development of policies and practices that impact their care.[32] Turk and colleagues argue that during the COVID-19 pandemic, policy responses should be co-produced by experts and stakeholders to enhance the equitable and transparent allocation of resources.[33] In order to ensure that the delivery of vaccines to people with mental illness is appropriate and equitable, the voices and perspectives of those with lived and living experience should be represented at the decision-making tables. Understanding how people with mental illnesses have experienced structural vulnerability and intersecting risk factors throughout the pandemic can help inform the creation of effective and ethical vaccine distribution strategies.

Mazereel and colleagues suggest that psychiatrists should reach out to their patients to invite them to be vaccinated; however, not all people with mental illnesses have access to a psychiatrist or a mental healthcare professional who is authorized to make a diagnosis.[5] Furthermore, some people may not conceptualize their lived experiences within a biomedical framework, thereby limiting their ability to access a vaccine in a timely matter for which they stand to benefit.

As the pandemic progresses, people continue to be made vulnerable by intersecting aspects of systematic disadvantage such as stigma, poverty, and racism and ongoing deprioritization in vaccine allocation criteria. There are exceptions, of course. For example, during Phase 2, the Centre for Addiction and Mental Health – Canada's largest mental health research hospital – included people diagnosed with a mental illness, substance use disorder, or dementia as a priority group for vaccination at its community clinic.[34] In order to improve health equity for people living with mental illnesses, initial provincial vaccine allocation frameworks should have prioritized these groups, including those with and without formal diagnoses. Finally, those with lived experience should be involved in designing strategies to ensure that people with mental illnesses have equitable access to these potentially life-saving vaccines.

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