March [ ], 2020

The Honorable Michael R. Pence
Vice President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Robert R. Redfield, MD
Director
Center for Disease Control and Prevention
1600 Clifton Rd.
Atlanta, GA 30329

Anthony S. Fauci, MD
Director
National Institutes of Allergy and Infectious Diseases
5601 Fishers Lane
Bethesda, MD 20892

Dear Vice President Pence, Secretary Azar, and Directors Redfield and Fauci,

As part of the United States Government's efforts to prepare our country for a possible Coronavirus (COVID-19) pandemic, the undersigned organizations urge you to fully address the cognitive and mental health dimensions of this unfolding public health crisis.

COVID-19 is already testing public health systems in countries around the world. If the virus spreads further in the U.S., as appears likely based on recent reports, it will put severe stress on our health care system. This stress will be exacerbated—and could become unmanageable—if federal, state, and local governments fail to acknowledge inherent cognitive biases,[1] which can turn reasonable fear into panic and hysteria. If such panic takes hold, our public health systems could be quickly overwhelmed, thus undermining response efforts to COVID-19.

The United States Government must communicate clear information based on science, taking great care to counter myths and falsehoods. For example, during the SARS epidemic, despite a survival rate of more than 80%, one community survey revealed that only a quarter of people in that community believed they would survive if they were infected.[2] To that end, research conducted after the SARS epidemic concluded that efforts to educate the public "must take into account background perceptions of risk and anxiety levels of the public at large."[3] Both SARS and H1N1 also demonstrated the importance of recognizing the cultural differences among communities and how these differences might impact their understanding and response to public health messages.

It is also critical that the United States Government counter any efforts to wrongly blame or associate COVID-19 with already marginalized groups. Such stigmatization and discrimination,

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[1] David Ropeik, "How our brains make coronavirus seem scarier than it is," *Washington Post*, January 31, 2020, https://www.washingtonpost.com/outlook/2020/01/31/how-our-brains-make-coronavirus-seem-scarier-than-it-is/.

[2] McAlonan GM, Lee AM, Cheung V, Wong JW, Chua SE, "Psychological morbidity related to the SARS outbreak in Hong Kong," *Psychological Medicine*, 2005 Mar;35(3)459-60, https://www.ncbi.nlm.nih.gov/pubmed/15841880.

[3] Leung GM, Lam TH, et al. "The impact of community psychological responses on outbreak control for severe acute respiratory syndrome in Hong Kong." *J Epidemiol Community Health*. 2003 Nov;57(11): 857-63, https://www.ncbi.nlm.nih.gov/pubmed/14600110/.

which can result in a misallocation of resources and people not stepping forward for needed treatment, will harm individuals in these groups and further undermine efforts to contain the disease. The "toxic mix of scientific ignorance and paranoia" has a long history, including in recent decades during the HIV/AIDS pandemic and outbreaks of SARS and Ebola.[4]

Finally, we urge the government to take steps to address the mental health consequences of COVID-19 during the current crisis and beyond. In a survey of Hong Kong residents about SARS, nearly two-thirds of respondents expressed helplessness, with nearly half saying their mental health had severely or moderately deteriorated because of the epidemic. Sixteen percent demonstrated posttraumatic symptoms.[5] Similar effects should be anticipated in the U.S. if COVID-19 begins to spread. Online mental health services and resources will be particularly critical given the possibility that significant populations may be quarantined or otherwise isolated in ways that could interrupt the availability of in-person services. Special attention should also be paid to older populations, those with development disabilities, and any other group with limited access to resources or who may be more likely to experience post-traumatic stress symptoms due to COVID-19.[6]

It is also important to consider the needs of those with existing mental health conditions who may have heightened psychological distress over COVID-19. With influenza H1N1, a review of electronic medical records found that children receiving mental health treatment and adults with neurotic and somatic symptom disorders appeared more likely to express moderate or severe concerns about H1N1.[7] While concerns may be legitimate, patients with severe psychological distress that harms their health and well-being should receive the services they need.

Your efforts are essential to saving lives and reducing the potential psychological harms associated with COVID-19. We stand ready to assist however we can at addressing the cognitive and mental health dimensions of this possible pandemic.

Sincerely,

The Kennedy Forum

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[4] Gregg Gonsalves and Peter Staley, "Panic, Paranoia, and Public Health — The AIDS Epidemic's Lessons for Ebola," December 18, 2014, *N Engl J Med* 2014; 371:2348-2349, https://www.nejm.org/doi/full/10.1056/NEJMp1413425.

[5] LauJT, Yang X, Pang E, Tsui HY, Wong E, Wing YK. SARS-related perceptions in Hong Kong. *Emerging Infectious Diseases*. 2005 Mar;11(3):417-424.

[6] Lee TM, Chi I, et al., "Ageing and psychological response during the post-SARS period," *Aging Mental Health*. 2006 May;10(3):303-11, https://www.ncbi.nlm.nih.gov/pubmed/16777659.

[7] Page LA, Seetharaman S, et al., "Using electronic patient records to assess the impact of swine flu (influenza H1N1) on mental health patients," *J Ment Health*. 2011 Feb;20(1):60-9. https://www.ncbi.nlm.nih.gov/pubmed/21271827.