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Review article

# Impact of the COVID-19 Pandemic on Mental Health Law in the State of Qatar

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## 1. Introduction

Accumulating evidence exploring the impact of the pandemic on mental health has been published as the Covid-19 pandemic has evolved and reflect how shock, anxiety, and fear of the early periods of the pandemic are giving way to depression and PTSD symptoms as the pandemic and its restrictions persist (Thombs et al., 2020; Vindegaard & Benros, 2020). The general findings have been those of increased psychiatric morbidity in general populations, psychiatric populations, and special groups like quarantined and isolated populations (Reagu et al., 2021; Salari, Hosseinian-Far, Jalali, et al., 2020).

Social distancing among general populations and isolation/quarantine for infected cases has been the mainstay of containment in the absence of treatment (World Health Organization 2020, Center for Disease Control and prevention 2020). However, this has been challenging and variable across the globe and has been affected by economic needs, political ideologies, and sometimes the nature of the populations like patients in mental health units (International Monetary Fund 2020, McMichael, 2020).

Individuals in mental health units have been specifically identified as a special population for whom the infection control measures, social distancing, and isolation can be challenging (Liu, Bao, Huang, Shi, & Lu, 2020). This population suffers from higher rates of underlying physical health illnesses, including respiratory illnesses and obesity which have been associated with higher risk of morbidity and mortality with Covid (Cormac, Ferriter, Benning, & Saul, 2005; De Hert et al., 2011; Jordan, Adab, & Cheng, 2020; Lawrence, Hancock, & Kisely, 2013). They can lack insight or cognitive capacity to appreciate the need for infection control measures and may fail to adhere to these measures on account of mental disorders or active mental illness symptoms (Zhu et al., 2020). They are longer-term residents within inpatients settings and are ambulatory making infection control more challenging. Sometimes they may need physical restraints for aggression and violence, which may place staff and other residents at risk of infection (Callaghan et al., 2020). In response some countries have passed emergency laws or made amendments to existing mental health legislation, where they exist, to allow for infection containment in these challenging circumstances (Brown, Ruck Keene, Hooper, & O'Brien, 2020; Sani et al., 2020; Stawicki et al., 2020). However, concerns have been raised over the inadequacy of the existing mental health legislations, including the emergency changes to deal with these unprecedented situations. Concerns have also been raised over the inadequacy of these legislations in protecting patient rights and safeguarding (Brown et al., 2020; Goldman et al., 2020; Kelly, Drogin, McSherry, & Donnelly, 2020; Stavert & McKay, 2020). It is pertinent to note that these concerns come from mental health legislation systems that are well established.

Here we present a view from Qatar as it grapples with the pandemic even as it is in the process of implementing the first standalone mental health legislation in the country.

## 2. Qatar a short country profile

Qatar is a small peninsular kingdom located in the Arabian Gulf. The country experienced rapid economic and social growth after the discovery of offshore gas in the 1970s and is now the wealthiest country in the world as measured by individual GDP (Ventura, 2021). The high income has driven a large-scale infrastructure development and has led to a massive influx of economic immigrants who now constitute around 90% of the resident population. For the vast majority of the residents, healthcare is delivered by the state funded hospitals through the Hamad Medical Corporation that offers heavily subsidised healthcare to all residents (Goodman, 2015).

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## 3. Qatar Mental Health Law; an introduction

Qatar passed its first dedicated mental health legislation by a royal decree in 2016 (Osman, 2016). It followed years of consultations with stakeholders within the state and from experts drawn from countries with established mental legislative systems. The passing of the Mental Health Law (MHL) was in line with the Qatar's national mental health strategy underlined by a strong state desire to reform its health services and mental health services (Abou-Saleh & Ibrahim, 2013). The MHL has been influenced by the mental health legislation of countries across the world, in addition to being guided by the Arab charter for human rights, and was developed closely with the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) guidance. (Abou-Saleh & Ibrahim, 2013, Sharkey, 2017, WHO 2005). Qatar is not the first country in this region to develop and implement mental health legislation although it is only one of the handful of countries in this region that have such standalone laws dedicated to mental health. Concerns have been raised over the alignment of WHO rights of the patients within the available mental health laws within these regional countries that have them (WHO 2019). Qatar, however, purposely attempted to develop legislation which was as much in line with the WHO as possible (Sharkey, 2017).

Although passed in 2016, the actual implementation has taken time, and at the time of writing this, the MHL is still not fully implemented. Training of the staff within mental health services has been completed, a detailed Code of Practice (CoP) has been published, and legal forms and administrative systems have been finalized in partnership with internationally established providers of mental health training (Qatar Tribune 2016). However, the wider training of other stakeholders has been slowed down because of the pandemic, and there have been delays in the appointments to the first Independent Competent Authority (ICA). According to its descriptions in the MHL and the CoP, the ICA will function somewhat along the lines of First-tier Tribunal system (Mental Health) as it exists in England and will be headed by an expert legal member and supported by a Psychiatrist independent from the Hamad Medical Corporation, representation from a member of the public and representation from human rights organization (Gov.UK 2008).

The MHL itself is a relatively short document consisting of 7 chapters divided into 35 articles and is accompanied by a more comprehensive CoP. Chapter 1 of the MHL starts with definitions and, for instance, it has an interesting take on the definition of mental disorder by how it relates it to the individual's social environment. It defines a psychological or mental disorder as a "*disorder in any of the psychological or mental functions to the extent that limits the individual's adaptation with their social environment. It does not include those who are solely presenting with a behavioral disorder. These disorders are classified according to the classification of psychiatry recognized by competent international organizations and bodies.*' While as the MHL does not make any distinctions based on the type of mental disorder, the CoP exhorts that care should be taken when applying the definition to individuals with learning disability and gives further guidance on this.

Chapter 2 focuses on setting out in general terms the rights of psychiatric patients and rights of the patient to standard care environments. These rights include, for instance, the right of the patient to his information, including treatment information, the right to an appropriate treating environment, and right to privacy and dignity. These are expanded upon in the CoP.

Chapter 3 describes the obligations on the hospital and treating clinicians when a patient voluntary accepts admission to the hospital and rights of the patient.

Chapter 4 sets out the various conditions including those pertaining to the nature of the disorder, nature and severity of risks, nature of the assessment, qualification of the clinician among others that have to be fulfilled before detaining a patient against their wishes, and the safeguards available to the patient and their relatives. It also lays out the role of the ICA as an organization with independent legal oversight in the correct implementation of the law. The CoP further elaborates that the ICA is responsible for ensuring that the human rights of people under the MHL are upheld and that provisions of the MHL are complied with by care providers. The CoP divides the main functions of the ICA into three domains; independent medical assessments, appeals against detention or compulsory community care and monitoring and reporting on the use of the MHL. CoP also notes that in some circumstances the ICA may act as the guardian for mental health patients.

Chapter 5 sets out the legislation related to forensic patients who are admitted under orders from the criminal justice system for treatment or assessment purposes. The patient rights except for home/community leaves and access to visits and phones remain the same as any other patient.

Chapter 6 sets out treatment rights for patients and the role of patient consent and capacity in care and treatment. The MHL also introduces the concept of capacity and defines it as, "*the patient's ability to understand the actions and information provided to them, and then make a decision depending on such realization.*" The CoP expands the concept further bringing this concept quite close in its principles to how it is understood in the Mental Capacity Act of England and Wales (Legislation.Gov.uk 2005).

It also deals with legislation around home and community leaves and community treatment orders.

Chapter 7 is devoted to describing penalties on healthcare providers for misapplication or misuse of the MHL like false detention, negligence and breaches of confidentiality.

## 4. Qatari Mental Health Law and the pandemic

The pandemic presented us with an unprecedented situation and the MHL faced its first biggest test right at the start of the implementation. We present here an overview of these challenges, some of which have been similar to what others have faced and some more unique. We believe that these challenges tested our MHL in a manner that are important in informing future developments of this legislation, its code of practice and its full implementation.

## 5. Established inpatient psychiatry units

Qatar reported high infection rates during the early part of the pandemic (Al Kuwari et al., 2020). Most of the mental healthcare and, all of the inpatient psychiatric care in Qatar, is provided by the state funded Hamad Medical Corporation. The main in-patient psychiatric unit provides 65 beds, and this is supplemented by additional step down and long term rehabilitation beds outside the main site. The number of acute beds at the main site have remained static despite the growing population and although there are changes underway (Abou-Saleh & Ibrahim, 2013; Sharkey, 2017).

The main challenge that faced the Qatar mental health services was whether the established in-patient psychiatry units could be utilized for admitting mental health patients with Covid infection along with non-infected patients. Admitting all patients, regardless of their infective status, would mean that non infected patients and staff would be at a serious risk of infection particularly given the severe limitation of this resource. The available strategies were either to discharge infected patients, isolate infected patients, or cohort patients with active infective status. Discharge could not be an option for patients requiring compulsory admission under the MHL. The existing limited structural infrastructure did not allow for isolation of the infected individuals for infection prevention while at the same time allowing sufficient space for therapeutic environment. Additionally, isolation for reasons other than directly related to mental health would be in direct contravention of patient rights of providing a therapeutic environment and liberty of movement as provided under the MHL and CoP.

Mental health services across the globe have written around the legal, logistical and ethical challenges facing them when faced with the

similar problem (Brown et al., 2020; Goldman et al., 2020; Kelly et al., 2020; Stavert & McKay, 2020). Services have chosen variously chosen isolation of infected patients within main in-patient units or cohorting of infected individuals together on separate units away from non-infected patients along with other infection control measures (Paletta, Yu, Li, & Sareen, 2021; Russ et al., 2021; Sverd et al., 2021). In view of the limitations of the in-patient mental health resource in Qatar, the mental health services worked with the State's Supreme Committee for Crisis Management and a decision was taken to keep the main psychiatry hospital a Covid free site (Qatar Government Communications Office 2020) and utilise cohorting as a means to managing Covid infection transmission.

Protocols were developed to screen the infection for any incoming admissions from the Emergency department or the community. Staff and visitor protocols were also developed to ensure keeping the site infection-free (Wadoo et al., 2020). It was understood that with cohorting of non-infected patients, the main in-patient site could function pretty much as business as usual, except the restrictions on allowing visitors and home leaves. Both these were considered significant sources of risk of infection. Families are an integral part of the therapeutic alliance and especially in the Arab world where they are historically and culturally often very intimately involved in decision making around admission, treatment, discharge, and community care (Fakhr El-Islam, 2008). The MHL and the CoP reflect this in making the family visits and home leaves as part of the patient rights which cannot be stopped unless clinically contraindicated on account of patient's mental health. The MHL and the CoP do not describe the frequency of the visits or home leaves but ties in the family visits and home leaves intimately to the treatment plan. The treatment plan here is understood to be mental health treatment and clearly infection control is not obviously so. Additionally, it follows that restricting home leaves and family visits can potentially negatively impact patient's mental health further making it difficult to justify these restrictions under the MHL. Attempts were made to facilitate this involvement remotely using technological support which were not always successful. We did not face any judicial challenge to these restrictions and so far, the families and patients have been mostly understanding of the need for infection control measures. However, it is possible a legal challenge that could have been, and still can be, mounted to test this out. It is possible that one of the reasons for lack of such a challenge so far has been that hitherto there is little awareness among the carers of the rights enshrined within the MHL.

## 6. Cohorting infected psychiatric patients at the designated psychiatry units at Covid sites

As a nationwide infection control measure, Qatar designated certain hospitals and residences across the country as "Covid sites". As part of cohorting strategy, these designated Covid in-patient sites included designated mental health inpatient units, staffed by mental health personnel (Masoodi et al., 2021). Psychiatric patients were admitted under both voluntary and involuntary conditions with a general understanding that such designation would allow for the criteria within the MHL and CoP to be fulfilled in that these units did not require for isolation of individual patients for infection control. However, it soon became apparent that it was difficult to provide for a proper therapeutic environment as prescribed by the MHL. These Covid designated psychiatric units were essentially medical wards that had been risk managed for psychiatric patients but offered little in terms of therapeutic activity spaces as needed by mental health patients. Additionally, the full range of multi-disciplinary involvement was not possible. This was due to limited multi-disciplinary staff availability on account of staff being stretched across multiple sites and strict infection control measures within these restricted environments.

Incidentally, this is an infection that does not require very prolonged periods of quarantine and after being declared clear of the infection, these patients were either discharged home or transferred to the main mental health facility. Again, the challenge of home leaves and visits by family remained and, if anything else, were even more restricted bringing up similar issues as described above.

There was an additional challenge that we faced and had not anticipated. This was the issue of patients not needing continued in-patient psychiatric admission but still requiring quarantine because of their infection status.

After discussion with the pandemic command committee, it was agreed that patients who no longer met the criteria for admission under the MHL but needed continued quarantine could be housed in the Covid designated psychiatric units on account of having developed a therapeutic relationship with the staff. It was further argued that these patients would be better able to tolerate the quarantine there as they were already familiar with the environment and the staff can pick up any change in mental state quicker.

However, it immediately became clear that the MHL could not be applied for this continued stay, particularly for patients who wanted to leave and no longer met the criteria for detention under the MHL. Although, so far, no judicial challenge has been presented and patients have been willing to stay sometimes needing encouragement but never force, we have two additional pieces of legislation and policy that are potentially available for this group of patients.

The Hamad Medical Corporation policies for clinician's refusal to discharge against medical advice (policy no CL7070) supported by corporate policies of capacity and informed consent (CL7226 and CL6109) can theoretically be utilized in these cases. However, these policies are designed for operation in emergency situations and only ever used for briefest of periods till further assessments are carried out. Further the existing policies do not come with any safeguarding measures that would cover a potentially extended stay. It was agreed that this policy was not appropriate to use in these cases should the need arise.

The second provision available is the emergency public health legislation on protection from infectious diseases which was amended in September 2020 (Amendment 2020). Patients who were deemed to be no longer detainable under MHL but still needed quarantine can be denied freedom of movement using this law and asked to stay in these hospitals or other quarantine sites. The wording of the legislation is general and allows for quite a bit of freedom, in the choice of sites for detention and leaves that designation, to the doctors (Amendment 2020). However, the policing of such detention is the role of police and law enforcement and not for healthcare staff. In these cases, the role of mental health staff in enforcing stay and maintaining a therapeutic environment is not clear or defined.

Additionally, the emergency legislation may work well for those with capacity and no underlying mental illnesses in non psychiatry sites. However, in patients with mental ill health or lacking capacity this becomes a big concern as these patients have no clear lines of appeal against detention and may not be capable of applying for such appeals. In addition, this prolonged detention itself may worsen the mental health of patients. So far, we have been managing this issue on an almost adhoc basis as the patients and families have not challenged the extended stays for infection control measures. Some States have passed emergency legislation specifically around Covid to manage these challenges (Brown et al., 2020; Sani et al., 2020; Stawicki et al., 2020).

## 7. Forensic patients

Rather unexpectedly, forensic patients have been relatively easier to manage so far as they come with judicial orders for admission and for the most part, they come tested negative from prison and court systems. However, even this arrangement was seriously challenged when a forensic patient with high risk of violence and absconding tested positive while on the main hospital site. Forensic patients in Qatar are housed on the only secure ward built to medium secure specifications. As alluded to, the designated Covid wards are barely sufficient to manage risk to

self and could not manage such type of patients. To manage this, we converted a part of the secure ward into a Covid positive site and managed this patient in isolation in this area using infection control protocols till he tested negative. MHL allows for isolation and segregation only for "*shortest periods of time*" and these can only be done when there is a clinically identified risk to self or others. CoP describes this as last resort for violence management after exhausting other techniques and therapeutic interventions. The segregation in this case lasted over two weeks and since the basis of the segregation was more complex than simply risk due to underlying mental health, we were not sure whether this restriction on movement would have stood up if challenged by the ICA.

Finally, although cohorting Covid positive psychiatric patients did allow for some creative management of infection control and provision of psychiatric care, this also meant more than usual patient transfers between teams and disruptions in continuity of care as the patients changed their clinical teams more often. The impact of these disruptions on patient outcomes has not yet been fully explored.

## 8. Out-patient and community services

Since the MHL is still in the process of its full implementation, at the time of writing this, there were no patients in Qatar on compulsory community treatment orders.

Regular community and out-patient care were managed through a combination of implementation of tele-health, out-patient attendance and community visits by staff utilising infection control measures. Patients were offered tele- health appointments unless indicated otherwise by their mental state or need for investigations for monitoring (Wadoo et al., 2020).

## 9. Conclusion

The Covid pandemic has brought along unique challenges in relation to mental health legislation around detention of patients within psychiatric units. Countries with established mental health legislation systems have found existing legislation falling short of providing adequate legislation and safeguards. Qatar was just setting out implementing its first mental health legislation focused on patient rights when the pandemic struck.

Qatar healthcare authorities believed that cohorting Covid positive patients would by-pass the challenges of deficiencies in the existing law but came across new challenges. The authors highlight these deficiencies as applied to the mental health legislation in Qatar and its interaction with exiting laws and policies. This pandemic has also highlighted the acute need for mental capacity legislation for patients with long term capacity issues and need for safeguarding protocols.

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## References

Abou-Saleh, M. T., & Ibrahim, M. A. (2013). Mental health law in Qatar. *International Psychiatry, 10*(4), 88–90.

Al Kuwari, H. M., Rahim, H. F. A., Abu-Raddad, L. J., Abou-Samra, A. B., Al Kanaani, Z., Al Khal, A., … Butt, A. A. (2020). Epidemiological investigation of the first 5685 cases of SARS-CoV-2 infection in Qatar, 28 February–18 April 2020. *BMJ Open, 10*(10), Article e040428.

Amendment (2020). Decree Law No. 17 of 1990 on Protection from Infectious Diseases. https://www.almeezan.qa/LawView.aspx?opt&LawID=2682&language=en. (Accessed 26th October2021).

Brown, C., Ruck Keene, A., Hooper, C. R., & O'Brien, A. (2020). Isolation of patients in psychiatric hospitals in the context of the COVID-19 pandemic: An ethical, legal, and practical challenge. *International Journal of Law and Psychiatry, 71*, 101572. https://doi.org/10.1016/j.ijlp.2020.101572

Callaghan, A. W., Chard, A. N., Arnold, P., Loveland, C., Hull, N., Saraiya, M., … Hills, S. L. (2020). Screening for SARS-CoV-2 infection within a psychiatric hospital and considerations for limiting transmission within residential psychiatric facilities—Wyoming, 2020. *Morbidity and Mortality Weekly Report, 69*(26), 825.

Center for Disease Control and prevention 2020 is: Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19), June 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html (Accessed 26th October 2021).

Cormac, I., Ferriter, M., Benning, R., & Saul, C. (2005). Physical health and health risk factors in a population of long-stay psychiatric patients. *Psychiatric Bulletin, 29*(1), 18–20.

De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D. A. N., Asai, I., & Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*(1), 52.

Fakhr El-Islam, M. (2008). Arab culture and mental health care. *Transcultural Psychiatry, 45*(4), 671–682.

Goldman, M. L., Druss, B. G., Horvitz-Lennon, M., Norquist, G. S., Kroeger Ptakowski, K., Brinkley, A., … Dixon, L. B. (2020). Mental health policy in the era of COVID-19. *Psychiatric Services, 71*(11), 1158–1162.

Goodman, A. (2015). The development of the Qatar healthcare system: A review of the literature. *International Journal of Clinical Medicine, 6*(03), 177.

Gov.uk, (2008). First-tier Tribunal (Mental Health). https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health. (Accessed 26th October 2021).

International Monetary Fund, (2020). Policy Responses to COVID-19. https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19. (Accessed 26th October 2021).

Jordan, R. E., Adab, P., & Cheng, K. (2020). Covid-19: Risk factors for severe disease and death. *BMJ, 2020*, 368. https://doi.org/10.1136/bmj.m1198 (Published 26 March 2020)

Kelly, B. D., Drogin, E., McSherry, B., & Donnelly, M. (2020). *Mental health, mental capacity, ethics and the law in the context of Covid-19 (coronavirus)*.

Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *Bmj*, 346.

Liu, J. J., Bao, Y., Huang, X., Shi, J., & Lu, L. (2020). Mental health considerations for children quarantined because of COVID-19. *The Lancet Child Adolescence Health, 4*(5), 347–349.

Masoodi, N., Abou-Samra, A. B., Bertollini, R., Halabi, A., Haidar, F., Al Anzi, N., & Butt, A. A. (2021). Steps and challenges in creating and managing quarantine capacity during a global emergency–Qatar's experience. *Journal of Infection and Public Health, 14*(5), 598–600.

McMichael, T. M. (2020). COVID-19 in a long-term care facility – King County, Washington, February 27–March 9, 2020. *MMWR. Morbidity and Mortality Weekly Report, 2020*(69), 339–342. https://doi.org/10.15585/mmwr.mm6912e1

Osman, M. (2016). *Law on Rights of Patients with Mental Illness*. The Peninsula Qatar. www.thepeninsulaqatar.com/article/24/11/2016/Law-on-rights-of-patients-with-mental-illness (Accessed, 10th May 2021).

Paletta, A., Yu, D., Li, D., & Sareen, J. (2021). COVID-19 pandemic inpatient bed allocation planning–a Canada-wide approach. *General Hospital Psychiatry, 69*, 126–128.

Reagu, S., Wadoo, O., Latoo, J., Nelson, D., Ouanes, S., Masoodi, N., … Alabdulla, M. (2021). Psychological impact of the COVID-19 pandemic within institutional quarantine and isolation centres and its sociodemographic correlates in Qatar: A cross-sectional study. *BMJ Open, 11*(1), Article e045794.

Russ, M. J., Parish, S. J., Mendelowitz, R., Mendoza, S., Arkow, S. D., Radosta, M., … Wilner, P. J. (2021). The Interface of COVID-19 and inpatient psychiatry: Our experience and lessons learned. *Journal of Psychiatric Practice, 27*(3), 172.

Salari, N., Hosseinian-Far, A., Jalali, R., et al. (2020). Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: A systematic review and meta-analysis. *Globalization and Health, 16*, 57. https://doi.org/10.1186/s12992-020-00589-w

Sani, G., Janiri, D., Di Nicola, M., Janiri, L., Ferretti, S., & Chieffo, D. (2020). Mental health during and after the COVID-19 emergency in Italy. *Psychiatry and Clinical Neurosciences, 74*(6), 372.

Sharkey, T. (2017). Mental health strategy and impact evaluation in Qatar. *BJPsych. International, 14*(1), 18–21. https://doi.org/10.1192/S2056474000001628

Stavert, J., & McKay, C. (2020). Scottish mental health and capacity law: The normal, pandemic and 'new normal'. *International Journal of Law and Psychiatry, 71*, 101593.

Stawicki, S. P., Jeanmonod, R., Miller, A. C., Paladino, L., Gaieski, D. F., Yaffee, A. Q., … Garg, M. (2020). The 2019-2020 novel coronavirus (severe acute respiratory syndrome coronavirus 2) pandemic: A joint American College of Academic International Medicine-World Academic Council of emergency medicine multidisciplinary COVID-19 working group consensus paper. *Journal of Global Infectious Diseases, 12*(2), 47–93. https://doi.org/10.4103/jgid.jgid_86_20

Sverd, S. S., Gardner, L. E., Cabassa, J. A., Schneider, M., Noone, R. H., Jahdi, M. H., … Gabbay, V. (2021). A Bronx tale: Exposure, containment and care on inpatient psychiatry units during COVID-19. *General Hospital Psychiatry, 69*, 121.

Thombs, B. D., Bonardi, O., Rice, D. B., Boruff, J. T., Azar, M., He, C., … Benedetti, A. (2020). Curating evidence on mental health during COVID-19: A living systematic review. *Journal of Psychosomatic Research, 133*, 110–113.

Ventura, L. (2021). Richest countries in the world 2020. *Global Finance Magazine* accessed 7 May 2021 www.gfmag.com/global-data/economic-data/richest-countries-in-the-world. Issue May 13, 2021. Online page..

Qatar Government Communications Office (2020). Supreme Committee for Crisis Management Press Conference on 8 June 2020. https://www.gco.gov.qa/en/briefing-room/supreme-committee-for-crisis-management-press-conference-on-8-june/ (Accessed 26th October 2021).

Qatar Tribune, (2016). MoPH, Maudsley International ink mental health partnership deal. https://www.qatar-tribune.com/news-details/id/9998. (Accessed 26th October2021).

Vindegaard, N., & Benros, M. E. (2020). COVID-19 pandemic and mental health consequences: Systematic review of the current evidence. *Brain, Behavior, and Immunity, 89*, 531–542.

Wadoo, O., Latoo, J., Reagu, S. M., Amro, R. A. A., Masoodi, N. A., & Alabdulla, M. (August 2020). Mental health during COVID-19 in Qatar gen. *Psychiatry, 33*(6), Article e100313.

World Health Organisation, (2005). WORLD HEALTH ORGANIZATION ASSESSMENT INSTRUMENT FOR MENTAL HEALTH SYSTEMS 2005. https://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf. (Accessed 26th October 2021).

World Health Organisation, (2019). Mental health atlas 2017: resources for mental health in the Eastern Mediterranean Region, 2019. http://www.emro.who.int/mnh/publications/mental-health-atlas.html. (Accessed 26th October 2021).

World Health Organisation, (2020). COVID-19 infection prevention and control : communication toolkit for long-term care facilities. https://www.who.int/westernpacific/internal-publications-detail/covid-19-infection-prevention-and-control-communication-toolkit-for-long-term-care-facilities. (Accessed 26th October 2021).

Zhu, Y., Chen, L., Ji, H., Xi, M., Fang, Y., & Li, Y. (2020). The risk and prevention of novel coronavirus pneumonia infections among inpatients in psychiatric hospitals. *Neuroscience Bulletin, 36*(3), 299–302.