Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Remote consultations in the era of COVID-19 pandemic: Preliminary experience in a regional Australian public acute mental health care setting

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ABSTRACT

In the wake of the recent pandemic of Corona Virus Disease 2019 (COVID-19), with confirmed cases having crossed 750,000, health systems across the world are getting overwhelmed; making it strenuous to maintain essential health services. Several changes were implemented in our acute mental health care service using a collaborative approach to maintain a balance between preventive measures to 'flatten the curve' and to provide care to those who were in need. Mode of service delivery was changed predominantly to tele-medicine, amongst others. It was found to be a workable model, albeit further follow up will be required to better understand its viability and feasibility to withstand the COVID-19 cataclysm.

The Acute Care Team (ACT) in our regional public mental health service caters to a population of about 80,000. It is the primary public referral mental health service and point of access for people requiring acute mental health care in the region in business hours and for a larger health service catchment area of 110,000 square kilometers with a population of around 235,000 in the after-hours settings. A range of mental health professionals including a psychiatrist, psychiatric registrars, nurses, social workers and occupational therapists provide assessments, support and referral services to people who experience a gamut of mental health issues. Emergency Department (ED) crisis presentations form a sizeable proportion of referrals to ACT. The services are also accessed through a 24 h crisis number by consumers, family, carers, friends, general practitioners, and by other government and non-government services. Emergency face to face assessments, community and home-based acute and short term crisis care and referral to continuity of care services or primary care alternatives are routinely provided to patients. The Model of Service (MoS) is consistent with the relevant Statewide MoS.

In the wake of the recent pandemic of Corona Virus Disease 2019 (COVID-19), with confirmed cases having crossed 750,000 (World Health Organization Coronavirus disease, 2020), health systems across the world are getting overwhelmed; making it strenuous to maintain essential health services. Repercussions of this on mental health services may be construed as a likely drop in staff attendance and increasing demands of mentally ill persons, amongst other predicaments. Additionally fear of contracting the illness can lead to new onset psychiatric symptoms or exacerbation of pre-existing psychopathology leading to emergency presentations (Kavoor, 2020). Australia currently has 4245 confirmed cases with 20 deaths, of which 6 confirmed cases are in the health service catchment area serviced by this public mental health service (Australian COVID-19 health alert, 2020). Australia does not have widespread community transmission of COVID-19 at this stage but situations are rapidly changing and all areas of health sector are actively engaging in a national response (Australian Health Sector Emergency Response Plan for Novel Coronavirus, 2019).

It was noted that in the wake of this evolving health crisis, total staff numbers in the service reduced. Few of the referrals that came through were related to fear of contracting the infection, suicidality and mental health issues secondary to job loss in context of the pandemic, which has been recently envisaged by authors (Banerjee, 2020; Kavoor, 2020). However, the average number of patients 'open' to the service at one time has not increased or decreased significantly.

Screening questionnaire for COVID-19 was administered at the time of referral or initial triage. All pre-existing non-urgent appointments were reviewed for clinical and risk parameters and then amended and conducted over the telephone with consent of the patient. Where feasible, reviews were done using tele-medicine to outreach areas. Face to face assessments were limited to clinically high risk patients or those who requested this after the discussions on service infection control strategy. If any emergency arose during the telephone session, emergency arrangements were in place like contacting next of kin or ambulance. Specified clinic rooms were assigned for face to face

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consultations to limit exposure. All necessary precautions like physical distancing, hand hygiene, using antimicrobial wipes on surfaces and equipment before and after use, were adopted. Home-based acute care was temporarily suspended except for high risk cases or depot administration. Staff facilities were repositioned and reorganized to ensure adequate distance between each of the staff members. There are further adaptations being deliberated at the time this paper was written. Options of segregating psychiatric emergencies to a separate block, shift working by staff and work from home options are being progressed.

The rationale for the above strategies was to utilize a multipronged approach in addressing the emerging setbacks. Patients presenting to the acute care team were screened for COVID-19 and re-directed either to the emergency department or self-isolation where necessary, to limit the spread of virus to healthcare workers. Face to face assessments were limited to minimize patient exposure to public places /transport and hospital. It also aided in prioritizing a face to face review for high risk patients, limiting staff contact with patients, and preserving personal protective equipment (PPE) for essential front line personnel. Spread sheets were created identifying the current high risk patients, contacts and secondary contacts for all patients, capacity to travel to the service or needing transport or home visits, capacity to link to the service by tele-medicine options and crisis strategies were done. Specific consideration was given to patients on depots, clozapine and receiving ECT. Depot administration, where applicable, was carried out with necessary precautions to avoid relapse of serious mental illnesses. Singling out clinic rooms was a measure taken to enable tracing areas of exposure in case a suspected COVID-19 patient was being seen face to face in the service.

Most of the patients were accepting of the telephone consultation and those who worried about contracting the infection by exposure to hospital or health workers, preferred it over face to face consultations. Overall, switching the mode of service delivery from face-to-face to tele-medicine, to a great extent was possible and enabled us to be able to provide care and support to those who required it by minimizing the risk of exposure to patients and health workers. A collaborative approach was adopted to maintain a balance between preventive measures to 'flatten the curve' and to provide care to those who were in need. The above appears to be a workable model, albeit it lacks objective evidence at this point. Furthermore, online mental health services were briefly reviewed by Liu et al. (2020) who surmise that these services have helped facilitate the development of Chinese public emergency interventions. Given the uncertainty of what the future holds, further follow up is required to better understand the viability and feasibility of adaptation of this model to withstand the COVID-19 cataclysm.

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Declaration of Competing Interest

None.

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