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Letter to the Editor

Bridging the emergency psychiatry and telepsychiatry care: Will COVID-19 lead to evolution of another model?

Telepsychiatry is understood, as a subset of telemedicine, which involve providing a range of services including psychiatric evaluations, therapy, patient education and medication management through Telepsychiatry services (American Psychiatric Association, 2020; Chakrabarti, 2015). According to American Psychiatric Association, the term telepsychiatry should be limited to video conferencing (American Psychiatric Association and The American Telemedicine Association, 2018). The ongoing COVID-19 pandemic has brought the video-conferencing based Telepsychiatry services to the forefront. The Government of India (GOI) notified the Telemedicine guidelines on 25th of March, 2020 (Medical Council of India and Niti Aayog, 2020). This provided a boost to the Telepsychiatry services. According to the Telemedicine Guidelines, as issued by GOI, telemedicine services should be avoided for emergency care, when alternative in-person care is available. Emergency telemedicine consultation should be limited to first aid, life-saving measure, counseling and advice on referral (Medical Council of India and Niti Aayog, 2020). Further, these guidelines state that in all emergency cases, the registered medical practitioner (RMP) should notify the emergency to the patient and advise an in-person interaction at the earliest. However, during the Telepsychiatry consultation, the RMP is required to take adequate desired steps that could be life-saving. The RMP is also required to provide guidance and counseling.

It is seen that, during the ongoing pandemic, there has been an upsurge of mental health issues (Tandon, 2020a,b). However, due to lockdown various mental health services, such as inpatient, outpatient and other services have been reduced; there was an expansion of the Telepsychiatry services, both in the institutional set-ups and the private practice set-up across the country (Grover et al., 2020a,b). In psychiatry, one of the major emergencies is the suicidal behaviour of the person. Telemedicine guidelines have specifically not addressed this issue. Hence, psychiatrists are not clear, as to how to handle such a situation, while providing Telepsychiatry services and there are no clear-cut answers to the same. In general, it is suggested that, in case of emergency, the patient should be advice for in person consultation or should be advised to seek help at the local medical facility. Keeping the issue of suicidality, having two phone numbers of the patients (one of which is of the relative of the patient, preferably staying with the patient) at the time of registering the patient, and ensuring that someone is present with the person while providing Teleconsultation can help the psychiatrist in ensuring that the person is guided for the in-person consultation and first aid care is ensured.

An important aspect of medical practice is supervising or guiding other colleagues in providing care to the patient. This can involve patient to been seen by a local physician, who shows the patient to a specialist (in this case psychiatrist) through video-teleconferencing, during which patient is also independently assessed by the specialist sitting at the remote place. The specialist is able to make his independent impression about the patient's problem, advises the physician to carry out the physical examination as per the requirement, and advises for investigations. The patient is retained at the local health care facility and the patient is again reviewed by the specialist with the available investigation findings and treatment plan is formulated, which is executed by the physician seeing the patient locally. This ensures care at the local health care facility without having the patient to travel to long distances. In the western countries, emergency Telepsychiatry services have been growing steadily (Reinhardt et al., 2019). These services involve providing psychiatry services to various emergency set-ups through video-conferencing. For this, a psychiatrist at the remote location assesses the patient through video-conferencing, facilitated by the emergency physician. Based on the assessment, the advice is made for pharmacotherapy, discharge and admission to an inpatient facility. The emergency Telepsychiatry services are considered to be acceptable, feasible, possibly cost-effective, and leads to a reduction in waiting time in the emergency for the patient (Reinhardt et al., 2019).

At our centre, which is a tertiary care hospital, psychiatry services are provided to all the emergency set-ups (medical, surgical, pediatrics, trauma) by the consultation-liaison psychiatry team. This is a 3-tier system, in which the patient is assessed by a trainee psychiatrist, who is present in the emergency setting (rather than being on call). This has ensured increase in overall referrals from various emergency physicians (Grover et al., 2015). Once the emergency trainee resident assesses the patient, the patient is seen by a senior resident, who is a qualified psychiatrist, who carries out the further assessment. Finally, the patient is seen/discussed with the consultant and final treatment plan is made and patient is managed in the emergency setting for duration varying from 2 h to 72 h, with occasional patient kept in emergency for longer duration.

During the ongoing COVID-19 pandemic, the routine outpatient services have been substituted with the telepsychiatry services. Keeping the issue of suicidality in mind, we have tried to embed the emergency and telepsychiatry services (Fig. 1). Accordingly, if any patient seen at the telepsychiatry services requires an emergency care, patient and family are encouraged to attend the emergency services, where the team is already alerted about the patient's possible arrival. Once the patient arrives at the emergency, patient is evaluated by the emergency team, appropriate management is carried out and then patient is attached back to the telepsychiatry services. On the other hand, when a patient directly comes to the emergency, patient is assessed by the emergency team, and the patient is attached with the telepsychiatry services for further follow-up. This system of combining both the services has ensured that patients, seen in the telepsychiatry services, can assess the emergency in-person consultation and those directly seen in emergency are being seen through the telepsychiatry services ensure continuity of care. However,

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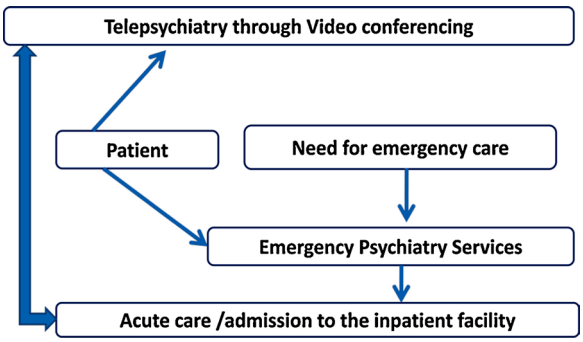

Fig. 1. Embedded Emergency and Telepsychiatry Model.

it is important to note that this may not be feasible across the country, but similar models, needs to be developed, where the patient can be seen by a local physician to provide emergency psychiatry care, under the supervision of the psychiatrist. This also requires modification of the telemedicine guidelines to incorporate the tele-supervision. If this modification is done, in long run, this can lead to evolution of a Tele-psychiatry model, where the patients at the remote rural places can be managed by the specialists with the help of local physician, without having to travel for long distances.

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The authors report no declarations of interest.

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