HOW TO CITE THIS ARTICLE: Subramanian K, Vengadavaradan A, Chandrasekaran V, Manoharan P, Menon V. Diagnostic and therapeutic implications of borderline personality disorder on topical steroid dependence: A case report. *Indian J Psychol Med.* 2020;42(4): 396–398.

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ACCESS THIS ARTICLE ONLINE
Website: journals.sagepub.com/home/szj
DOI: 10.1177/0253717620934015

Tele-triaging: The Way Ahead for Tertiary Care Psychiatry in India Post-COVID-19

Sir,

The origin of the word "triage" is from the French word "trier." It was originally applied to a process of sorting, in the 18th century, by Baron Dominique Jean Larrey, who was the Surgeon-in-Chief to Napoleon's Imperial Guard. The original concept primarily focused on mass casualty situations in warfare. In the current practice, triaging is applied in disaster situations and emergency health care settings.[1] Health care triaging is practiced in the West, as their system works mostly based on a prior appointment with a general physician and by referral to the specialist. We outline the potential application of the principles of triage in tertiary care psychiatry practice in India, in the context and aftermath of the ongoing COVID-19 pandemic.

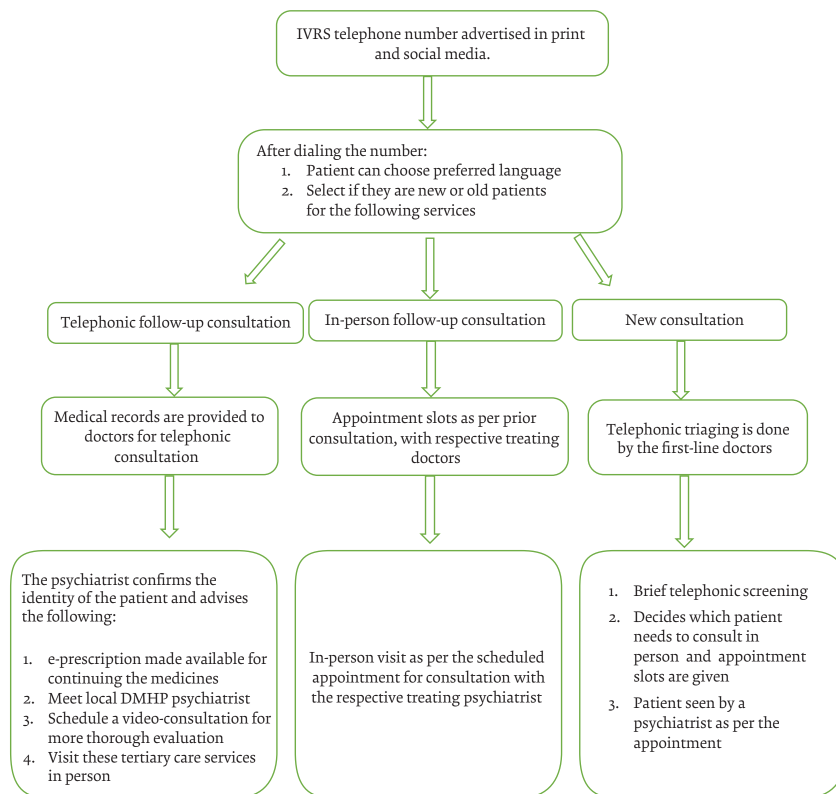
In India, patients have direct access to tertiary care psychiatry hospitals. Despite this, few centers offer tertiary care, and there exists a huge treatment gap of around 83%. The major reason for this gap is that there are only three psychiatrists per million population.[2] With the ongoing COVID-19 situation, recent surveys show that more than 80% of those polled perceived a need for mental health care,[3] which places a greater demand on the limited mental health care resources, over and above the existing treatment gap. Hence, tertiary care centers need to explore novel approaches to mental health care service provision, one such approach being tele-triaging. Tele-triaging would help the psychiatrist to make an informed decision about whether a patient requires tertiary care or can be effectively managed in a nearby facility. This is particularly important in the current context, where in-person hospital visits are best deferred to ensure physical distancing and more local access to health care has to be promoted to minimize travel. The three important factors on which the triage decision would depend are as follows: the person's need for specialist mental health services, the level of risk to the person and/or others, and the urgency of the response required from the tertiary mental health services.[4]

Tele-triaging has been recently initiated at our center. An integrated voice response system (IVRS) based follow-up service has been started for patients previously registered with the hospital, to register them for a telephone consultation with a qualified psychiatrist. The patient is then contacted by the qualified psychiatrist for a tele-assessment and is advised one of the following: continue the medications as prescribed with e-prescriptions being made available through the hospital information system, schedule a video consultation for a more thorough evaluation, meet the local psychiatrist at the district mental health center, or visit the tertiary care emergency services for immediate attention (**Figure 1**). Teleconsultation offers great privacy than in-person consultation and is likely to be more acceptable to patients who may not seek care from tertiary care centers on account of stigma. This system also reduces the travel costs for patients and makes it more feasible for a routine follow-up. The system is also devised to cater to the needs of a greater number of patients than what is currently being done. The advantage of this system is that it can cater even to people living in remote villages, as all it needs is access to a basic model mobile phone for contacting the center. Tele-triaging for new consultations is in the pipeline.

Mental health tele-triaging inherently carries some challenges, like knowledge about mental health emergencies, ethical and legal aspects of care, etc.[5] It, therefore, puts the onus on the experience of the mental health professionals. The following prerequisites should help in safe and appropriate decision making: adequate orientation to the triage role; proficiency in mental health assessment, including risk assessment; screening for problematic use of alcohol and other drugs, and the ability to assess the impact of a range of other health and social factors. In addition, communication and negotiation skills, access to well-developed algorithms for the assessment processes, knowledge of other services available in the local area and appropriate referral pathways, and a good understanding of the country's mental health legislations.[4]

With limited tertiary services in India, tele-triaging will help us reach out to more people and ration the resources to those that need them the most. This is the right time for introducing tele-triaging. With outpatient services being closed in most tertiary hospitals, IVRS based telemedicine was introduced by all institutions such as All India Institute of Medical Sciences, New Delhi; National Institute of Mental Health and Neurosciences, Bengaluru; and Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry, to provide continued service. The Board of Governors in supersession of the Medical Council of India rapidly approved the guidelines for telemedicine practice, to guide telemedicine-based services. With travel restrictions and physical distancing likely to persist due to the ongoing pandemic, tele-triaging is the way forward for tertiary care psychiatry in India. The tertiary mental health service providers across the country could streamline their services on

FIGURE 1.
IVRS FlowChart



these lines in order to be able to cater to the increasing demand and to reduce the gap in service provision. There is a pressing need to bring about several changes at the policy level and form guidelines for tele-triage in psychiatry practice.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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Submitted: **2 Jun. 2020**
Accepted: **9 Jun. 2020**
Published Online: **7 Jul. 2020**

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HOW TO CITE THIS ARTICLE: Reddy PV, Selvaraj S, Muralidharan K, Gangadhar BN. Tele-triaging: The way ahead for tertiary care psychiatry in India post COVID-19. *Indian J Psychol Med*. 2020;42(4): 398–399.

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Website: journals.sagepub.com/home/szj
DOI: 10.1177/0253717620937974