Regular Article

AUSTRALASIAN PSYCHIATRY

Penumbra of the pandemic workplace for psychiatrists and trainees in Australia

Australasian Psychiatry
2022, Vol. 0(0) 1–3

DOI: 10.1177/10398562221109742
journals.sagepub.com/home/apy
SAGE

Jeffrey CL Looi Academic Unit of Psychiatry and Addiction Medicine, The Australian National University Medical School, Canberra Hospital, Canberra, ACT, Australia; Consortium of Australian-Academic Psychiatrists for Independent Policy and Research Analysis (CAPIPRA), Canberra, ACT, Australia

Paul A. Maguire Academic Unit of Psychiatry and Addiction Medicine, The Australian National University Medical School, Canberra Hospital, Canberra, ACT, Australia; Consortium of Australian-Academic Psychiatrists for Independent Policy and Research Analysis (CAPIPRA), Canberra, ACT, Australia

Tarun Bastiampillai Consortium of Australian-Academic Psychiatrists for Independent Policy and Research Analysis (CAPIPRA), Canberra, ACT, Australia; College of Medicine and Public Health, Flinders University, Adelaide, SA, Australia; Department of Psychiatry, Monash University, Clayton, VIC, Australia

Stephen Allison Consortium of Australian-Academic Psychiatrists for Independent Policy and Research Analysis (CAPIPRA), Canberra, ACT, Australia; College of Medicine and Public Health, Flinders University, Adelaide, SA, Australia

Abstract

Objective: A commentary on the workforce, infrastructure and health of psychiatrists and trainees providing psychiatric care during the COVID-19 pandemic in Australia.

Conclusions: The wide-ranging workplace, health system and societal changes necessitated by the SARS-CoV-2 virus have altered the practice and working lives of psychiatrists, trainees and other healthcare workers, as well as the general population. There have been workplace innovations, recalibrations and losses. There is a new baseline upon which to build better psychiatric services, as the pandemic's penumbra recedes.

Keywords: COVID-19 pandemic, psychiatrists, trainees, workforce, infrastructure

During the COVID-19 pandemic, there have been ongoing changes to psychiatric practice, the workforce and infrastructure, impacting upon healthcare workers (HCWs). We provide a commentary on each of these broad domains, and discuss these in terms of innovations, recalibrations, and losses. Our reflective focus is on sustainable psychiatric practice, by trainees and psychiatrists in Australia, during and beyond the pandemic.

Practice and workforce

Recalibrations

The population mental health effects of the COVID-19 pandemic have been relatively modest, with an initial rise in anxiety and depressive symptoms during lockdowns, followed generally by a return to baseline, while some increased youth and emergency presentations persist.[1] Lower intensity mental healthcare was provided by NGOs such as Lifeline.[1] However, there was a sustained need for the expertise of psychiatric services for treating complex and severe mental illness in public[2] and private practice.[3]

From 2016, the supply of psychiatrists has been reliant upon the entry of at least 150 overseas-trained psychiatrists per year.[4] The combination of travel restrictions, furloughs from exposure to COVID-19, as well as cessation of entry of international HCWs due to the border closures, exacerbated staff shortages that undermined healthcare capacity, with significant increases in workload (and exposure to associated occupational stress) for the remaining psychiatrists and trainees. Private psychiatrists expanded Medicare-reimbursed services by approximately 14% in 2020 compared to pre-pandemic 2019, through a combination of telehealth and face-to-face outpatient consultations,[5] while also maintaining private hospital care.[3] There remains a supply problem for psychiatrists and trainees. There is a need for appropriately identified,

Corresponding author:
Jeffrey CL Looi, Associate Professor & Head, Academic Unit of Psychiatry and Addiction Medicine, The Australian National University Medical School, Building 4, Level 2, Canberra Hospital, PO Box 11, Garran, ACT 2605, Australia.
Email: jeffrey.looi@anu.edu.au

supported and funded training positions, across the public and private sector, to recalibrate for these shortfalls. However, it is likely that recruitment of overseas psychiatrists will still be required, even when borders more fully open up.

Innovations

There was rapid adoption of telehealth necessitated by the public health measures. In private psychiatry, there was a sustained uptake of primarily telephone-telehealth for shorter appointments, and video-telehealth for longer consultations.[5] This led to the permanent approval of video-telehealth for private psychiatric outpatient consultations across the range of appointment lengths, as well as for initial assessments.[6] There was an accelerated uptake of telehealth for outpatient consultations in the public sector, although it is not always suitable for new patients, or patients with psychotic illnesses, and may be declined by some patients.[7] Research into patient and clinician reported outcomes of telehealth is needed, building on the demonstrated the efficacy of telehealth for mental healthcare.[8] While face-to-face consultation may be preferred, its future role remains unclear.

Due to physical distancing and travel restrictions, many HCWs, facilitated by telehealth consultation capacity and telework, began and continue, to work, part-time, from home. Telework, which has been defined as a subcategory of remote work where telecommunication replaces commuting to work, has been feasible since the early 1980s, and has become more widespread during the COVID-19 pandemic, with up to 50–60% of workers in the EU remote working.[9] Telework may have benefits (e.g., convenience) and risks (e.g., blurred work–life boundaries), mediated by a worker's family situation, housing and care-giving roles.[9]

Losses

The sustained provision of psychiatric care, with psychiatrist, trainee and HCW shortages during the COVID-19 pandemic, had negative impacts as well. Due to pandemic travel restrictions, many practitioners have not taken much leave, and this may partially explain increased private psychiatry services, as well as sustained levels of activity in public sector care.[2]

A meta-review of meta-analyses of global studies found an increased prevalence of anxiety, depression, post-traumatic stress disorder, insomnia, burnout, fear of infection, OCD, somatisation, and suicidal ideation/self-harm in HCWs.[10] Those at most risk were younger workers, females, nurses and frontline workers.[10] Another meta-review found the prevalence of psychophysiological stress was 38% for HCWs compared to 21% for the general public.[11] Lockdowns also had a small but significant effect on increasing anxiety and depression for the general population.[11]

Targeted interventions are recommended to support the mental health of practitioners, including psychiatrists and trainees.[10] HCWs 'soldiering-on' may impede sharing of distress and vulnerability, and inadvertently increase stigmatisation and mental health risks from not seeking care.[12]

In previous epidemics, professional and ethical values remained prominent motivators for HCWs, and more research is needed into interventions to improve morale and wellbeing.[12] However, there remains very limited practical evidence for specific psychological interventions,[13] self-guided interventions for anxiety and depression during social distancing,[14] wellbeing,[15] and related interventions that could be harnessed by psychiatrists and trainees.

The existential societal threat posed by the COVID-19 pandemic also affects HCWs. There were more severe pandemic outbreaks in the UK, US and Canada, together with HCW moral injury and distress, patient and HCW deaths. Extensive media coverage of the pandemic, including international impacts, may have negative impacts on the mental health of the population and HCWs, such as anxiety and depression; with recommendations to limit pandemic, and especially social, media exposure.[16]

For HCWs there are additional risks of collective moral injury (exposure to an injurious event such as observing, causing or failing to prevent adverse outcomes transgressing moral values and the resultant psychological distress)[17] from pandemic care burdens.[18] Pandemic-related moral injuries are superimposed on those that already due to under-resourcing of public psychiatric services.[17] Even in Australia, which has otherwise fared relatively well, persistent pandemic health impacts and service shortfalls may increase moral injury risks.

Infrastructure

Recalibrations

Public and private sector psychiatric services provided care for patients through the pandemic. However, the baseline levels of specialised mental health beds across public and private sector[19] remain low by world consensus standards.[20] Expansion of private hospital bed capacity has partially compensated for the decline in bed numbers for public sector services.[19] Steady emergency and specialised bed demands were within these limited resources.[2] However, sustainable expansion of specialised mental health beds, community and residential care services is necessary for future population growth.

Innovations

Telework has been rapidly adopted, to allow for the contingency of staff being in pandemic quarantine or furlough. For private practice, this involved the adoption of clinical practice management technology, including clinical information systems, cyber-secure videoconferencing for telehealth, as well as ergonomics, that might enable all staff to telework as needed.[21] Such innovations are also suitable for public practice.

Losses

There has been some pandemic contingency driven repurposing of specialised mental health beds in Australia. At least two deidentified examples of repurposing have occurred in Australia, e.g., the repurposing of a private

child and adolescent mental health unit by an adjacent child and adolescent public mental health service, and the repurposing of a specialised older persons mental health unit as a COVID-19 containment unit due to the relatively isolated airflow and medical supports, with older patients decanted to a general private medical-surgical ward. Whether such changes are temporary, occasional or permanent remain to be seen. Pandemic temporary re-purposing, while maintaining acute psychiatric inpatient care was possible because of reduced bed demand throughout 2020 and 2021, but may not be practicable in the future.

Recommendations for the pandemic penumbra

Psychiatrists, trainees and specialised mental health services need support for sustainable care delivery, through the pandemic and beyond:

1. Informed by the lessons of the pandemic, systemic planning across specialised mental health beds, community care and long-term residential supported care, as well as social and economic supports, is necessary for sustainable mental healthcare.
2. Ensuring that pandemic repurposing of specialised mental healthcare is contingent and temporary.
3. Appropriately identified, supported and funded training positions across the public and private sector to address workforce shortfalls highlighted by the pandemic.
4. Psychological support for frontline HCWs, including psychiatrists and trainees, based on epidemiological research, as well as on evidence-based psychological, wellbeing and social support interventions.
5. Telehealth is here to stay, and more research is needed into suitability and preferences for patients and clinicians, as well as patient- and clinician-reported outcome measures, to maximize its uptake and efficacy.
6. Research is needed to inform guidelines regarding, and technology for, safe and effective teleworking for HCWs, including psychiatrists and trainees.

The penumbra of the COVID-19 pandemic is an opportunity to recalibrate, adopt innovations and forestall losses through the creation of improved psychiatric services.

Declaration of conflicting interests

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

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Jeffrey CL Looi https://orcid.org/0000-0003-3351-6911
Stephen Allison https://orcid.org/0000-0002-9264-5310

References

1. AIHW. *COVID-19 impact on mental health*, 2022, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-impact-of-covid-19 (accessed 16 March 2022).
2. Allison S, Bastiampillai T, Looi JCL, et al. Real-world performance of Victorian hospitals during the COVID-19 lockdowns. *Australasian Psychiatry* 2022; 30: 239–242. DOI: 10.1177/10398562221079281
3. APHA. *PPHDRAS Annual Statistical Report for 2019-2020*, 2021, https://apha.org.au/for-industry/industry-resources/pphdras-annual-statistical-report-for-2019-2020/ (accessed 23 July 2021.
4. Department_of_Health. *Australia's Future Health Workforce – Psychiatry*. Canberra, ACT: Department of Health, 2016.
5. Looi JCL, Allison S, Bastiampillai T, et al. Telepsychiatry and face-to-face psychiatric consultations during the first year of the COVID-19 pandemic in Australia: patients being heard and seen. *Australasian Psychiatry* 2022; 30: 206–211. DOI: 10.1177/10398562211046301
6. Department_of_Health. *MBS Telehealth Services from January 2022*, 2022, http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth-Arrangements-Jan22 (accessed 4 April 2022).
7. Looi JC and Pring W. Private metropolitan telepsychiatry in Australia during Covid-19: current practice and future developments. *Australas Psychiatry* 2020; 28: 508–510. DOI: 10.1177/1039856220930675
8. Reay RE, Looi JC and Keightley P. Telehealth mental health services during COVID-19: summary of evidence and clinical practice. *Australas Psychiatry* 2020; 28: 514–516. DOI: 10.1177/1039856220943032
9. Lunde LK, Flovik L, Christensen JO, et al. The relationship between telework from home and employee health: a systematic review. *BMC Public Health* 2022; 22: 47–2022. DOI: 10.1186/s12889-021-12481-2
10. Chutiyami M, Cheong AMY, Salihu D, et al. COVID-19 Pandemic and Overall Mental Health of Healthcare Professionals Globally: A Meta-Review of Systematic Reviews. *Front Psychiatry* 2021; 12: 804525. DOI: 10.3389/fpsyt.2021.804525
11. de Sousa GM, Tavares VDO, de Meiroz Grilo MLP, et al. Mental Health in COVID-19 Pandemic: A Meta-Review of Prevalence Meta-Analyses. *Front Psychol* 2021; 12: 703838. DOI: 10.3389/fpsyg.2021.703838
12. Cabarkapa S, Nadjidai SE, Murgier J, et al. The psychological impact of COVID-19 and other viral epidemics on frontline healthcare workers and ways to address it: A rapid systematic review. *Brain Behav Immun Health* 2020; 8: 100144. DOI: 10.1016/j.bbih.2020.100144
13. Bertuzzi V, Semonella M, Bruno D, et al. Psychological Support Interventions for Healthcare Providers and Informal Caregivers during the COVID-19 Pandemic: A Systematic Review of the Literature. *Int J Environ Res Public Health* 2021; 18: 2021. DOI: 10.3390/ijerph18136939
14. Fischer R, Bortolini T, Karl JA, et al. Rapid Review and Meta-Meta-Analysis of Self-Guided Interventions to Address Anxiety, Depression, and Stress During COVID-19 Social Distancing. *Front Psychol* 2020; 11: 563876. DOI: 10.3389/fpsyg.2020.563876
15. Puyat JH, Ahmad H, Avina-Galindo AM, et al. A rapid review of home-based activities that can promote mental wellness during the COVID-19 pandemic. *PLoS One* 2020; 15: e0243125. DOI: 10.1371/journal.pone.0243125
16. Looi JCL, Allison S, Bastiampillai T, et al. Clinical update on managing media exposure and misinformation during COVID-19: recommendations for governments and healthcare professionals. *Australasian Psychiatry* 2021; 29: 22–25. DOI: 10.1177/1039856220963947
17. Maguire PA and Looi JCL. Moral injury and psychiatrists in public community mental health services. *Australasian Psychiatry* 2022; 30: 326–329. DOI: 10.1177/10398562211062464
18. Greenberg N, Docherty M, Gnanapragasam S, et al. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ* 2020; 368: m12112020. DOI: 10.1136/bmj.m1211
19. AIHW. *Mental health services in Australia - Specialised mental health beds and patient days*, 2022, https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/data (accessed 29 April 2022.
20. Mundt AP, Serri ER, Irarrazaval M, et al. Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process. *Mol Psychiatry* 2022; 27: 1873–1879. DOI: 10.1038/s41380-021-01435-0
21. Looi JCL, Atchison M, Matias M, et al. Sustainable operation of private psychiatric practice for pandemics. *Australas Psychiatry* 2022; 30: 275–276. DOI: 10.1177/10398562211052915