Viewpoint

How to Organize Mental Health Services in the Era of Unlockdown

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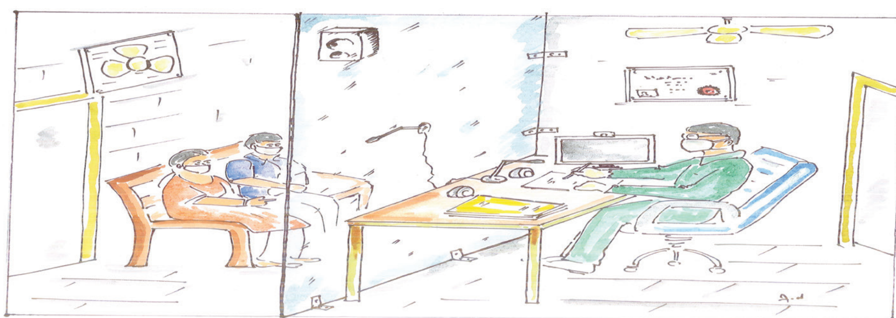
Lockdown across the world in response to the COVID-19 pandemic had led to several significant consequences such as a decline in the global economy, problems in providing essential services, the agony of the migrant population, and the difficulty in attending the emergency medical services.[1]

Of all these issues, the effects of the closure of routine medical services on patients and caregivers have been tremendous. The patients on regular psychiatric care (follow-up visits, psychotherapy services, periodic/scheduled brain stimulation services, etc.) or requiring mental health care have been significantly affected.[2–5] Moreover, at some places such as Massachusetts General Hospital, Boston, considering the increase in the need for inpatient care, new acute inpatient units have been opened to cater to patients who have psychiatric disorders. These patients with various psychiatric disorders have additionally got infected with COVID-19 that is medically not serious, to the extent of admitting the person in infectious disease units or intensive care units.[6]

Data from India also suggests that the COVID-19 pandemic and the lockdown have affected the mental health services significantly in both government and private sectors.[7,8] There are also reports of private-sector health care staff getting infected due to the continuation of medical services, and subsequently, some of the health care workers (HCWs) facing legal actions too.[9,10] Recently, reports have emerged from different parts of the country about HCWs working in various institutes catering to patients with COVID-19 having got infected with the virus.[11]



To overcome these issues, telemedicine and telepsychiatric services were started or resumed actively in many hospitals across the world.[12] Pre-existing guidelines were renewed and new telemedicine and telepsychiatric guidelines were formulated.[13–15] India's government too issued the Telemedicine Guidelines on the March 25, 2020, to ensure care to the needy patients.[14] However, there are many limitations of telemedicine services such as lack of the humane touch, being an indirect mode of communication, inability to carry out detailed physical examinations, difficulty in tele/internet connectivity in rural and difficult-to-access areas, lack of overall public acceptance, difficulty in diagnosing with accuracy and providing tele-psychotherapy services, issues related to confidentiality and security, etc.[14,16] Further, these may be out of reach for the poor and people who do not have a telephone.[17] Hence, in-person consultation will remain a preferred method of seeking professional help and need for inpatient care, and special treatment (e.g.,, electroconvulsive therapy, which will require

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direct contact with mental health professionals [MHPs]), cannot be underscored.

The recent studies on the impact of COVID-19 pandemic on mental health outcomes of the general public and HCWs suggest that there has been a significant rise in the mental health morbidity, mostly common mental disorders, across the world.[18–21] There is every possibility that MHPs would see an upsurge of the psychiatrically ill population shortly, that is, in the unlockdown phase, across the world. Further, at this moment, there is a steep rise in COVID-19 cases. It is said that there are many more undiagnosed asymptomatic or mildly symptomatic cases of COVID-19 for every diagnosed case.

In the post-lockdown/unlockdown phase, there is possibility of a flurry of new patients with psychiatric disorders and those experiencing a relapse of illness, coming for psychiatric consultations. Patients with mental illness have an added vulnerability to develop COVID-19 for several reasons such as difficulty following the infection control measures due to disturbed mental state, poor cognitive skills, and heightened risk due to the low immune response in chronically mentally ill persons.[22]

MHPs will be facing an ethical dilemma of whether to see or not to see patients, as the unlockdown progresses, in the background of a rising number of cases of COVID-19. If someone decides to see the patients physically, they run the risk of getting infected; if they do not see the patients, they will go through the ethical dilemma and guilt.

Because of this, there is an urgent need to reorganize the services to practice safely. The reorganization of the services has to keep the HCWs' and patients' safety into account. A few authors have tried to put forth the essential case management practices amidst the pandemic about tele-case management, preparing for surge capacity, discharge planning, transitions of care, ethical and legal obligations, etc.[23–25] Some of the authors have also discussed the necessity for expanding the roles and responsibilities of every specialty, ranging from pharmacy to public health, to reorganize the services back into the track.[26]

In India, most of the health sector, especially in the government sector, does not work on the appointment basis—the patients can walk into the hospital at their own will. The government hospital outpatient services may get crowded with the unlocking and reopening of the services. There would also be a lot of pressure for admission to the inpatient units. Hence, if appropriate planning is not done, the outpatient and the inpatient settings themselves can become hotspots for the spread of infection, all

TABLE 1.

Standard Procedures to Be Followed for Running the Mental Health Services

Outpatient services	
1.	Online appointment system, with no or minimal walk-in patients.
2.	For online appointments, verify the patient's identity based on government documents such as Aadhar card, voter ID, driving license, etc.
3.	Review the travel history.
4.	Review the history of COVID-19 in any family member and at workplace or neighborhood.
5.	Check the area from which the patient is coming, i.e., does it fall in the red, orange, or green zone.
6.	Review the medical history for comorbidity, i.e., the presence of various chronic physical illnesses.
7.	Does the patient have access to a smartphone for videoconferencing?
8.	If feasible, advise the patient to travel by their own conveyance.
9.	A day before the appointment, review the patient's health status for fever, cough, and respiratory symptoms (recent onset, worsening of pre-existing symptoms).
10.	At entry point, make arrangements for hand-washing and sanitizer for all persons entering health facility.
11.	Have infrared thermometers system to monitor the body temperature of the patients and their accompanying family members; avoid seeing patients with fever (i.e., temperature more than 37.5 °F).
12.	Use pulse oximeter at the entry point to evaluate the oxygen saturation.
13.	Maintain the waiting in such a way that social distancing can be managed.
14.	Manage the appointments in such a way that there is no or minimal waiting time.
15.	Online payment methods must be used to collect the fee to minimize the contact of patient/family with other HCWs.
16.	Review the previous treatment records and investigation reports in the softcopy format.
17.	If feasible, take the history on the phone by using the telecommunication modes, even though the patient is in the waiting area or nearby room, to minimize the direct contact time.
18.	If direct contact is to be done, maintain proper social distancing and keep a distance of 1–2 meters.
19.	Consultation in well-ventilated area/room instead of AC cabins.
20.	Alternatively, can use two rooms with glass partition: patient in one room and the therapist in another room, with both able to see each other physically, with the communication system in place so that they can listen to each other even by sitting in different rooms.
21.	Use proper masks while carrying out direct contact with the patients.
22.	Follow-up appointments to be made by teleconferencing.
23.	Avoid or minimize the visits of medical representatives.
24.	Inform the patient and the family about the changed functioning, with clear information about what you would be and would not be able to do.
25.	Frequent disinfection of waiting area/reception and cabins as per the recommendation.
26.	Avoid generation of aerosols: use vacuum cleaners and mopping, instead of using other cleaning measures such as brooms.

Inpatient services	
1.	Inpatient area should be separate from the outpatient area and preferably away from the latter, so that the number of visitors can be minimized.
2.	Reduce the number of patients to ensure social distancing; percentage reduction in an inpatient facility to be decided based on the number of isolation rooms available at the given facility.
3.	Minimize the number of caregivers/family members accompanying the patient during the inpatient stay.
4.	Avoid change of caregivers/family members during the inpatient stay.
5.	Minimize the number of visitors to the inpatient area.
6.	Screen all the patients for COVID-19 before admission.
7.	Inform the patient and the family about the risk of acquiring COVID-19 infection in the hospital.
8.	Minimize the number of HCWs at a given time to reduce the chances of infection and have a back-up team in case of crisis.
9.	Be vigilant about signs and symptoms of COVID-19 in your patients and their caregivers.
10.	Inform the patients and their caregivers about the signs and symptoms of COVID-19 and request them to report the same.
11.	Use pamphlets and display boards to convey the messages related to COVID-19.
12.	Psychoeducate the patients and the caregivers about social distancing, use of masks, hand hygiene, sanitizers, and restricted mobility in the inpatient setting.
13.	Avoid all kind of group activities in the ward area.
14.	The admission and discharge plan of patients should be organized so that there is minimum contact of old patients with new patients.
15.	Minimize the physical contact.
16.	Look for the feasibility of reviewing the health status of inpatients by teleconferencing.
17.	Have isolation rooms to accommodate the new patients during the initial few days and to accommodate patients who develop respiratory symptoms.
18.	Have isolation rooms for the staff, so that they can be kept there if they have symptoms of COVID-19.
19.	Have separate staff and inpatient facility for admitting medically fit COVID-19 positive cases.
20.	Rotate the staff to reduce the risk and spread of the infection.
21.	Maintain a close liaison with the other specialties and COVID team of the hospital.
22.	Arrange for back up of specialists and tie up with a physician in case of a medical emergency (related or not to COVID) to address the issue and for a seamless transfer of the patient to the required facility.
Consultation-liaison psychiatry (CLP) services	
1.	Try to provide the consultation online, if feasible.
2.	If it is not feasible to provide online consultation and the COVID-19 status of the seriously medically ill patient is not clear, use a proper mask (N95) to examine patients with respiratory symptoms.
3.	At the institutional level, rather than the whole CLP team examining the patient at the bedside, only one person can be at the bedside and others could examine and monitor the patient's status using teleconferencing.
4.	Liaison with the primary team to review the patient by teleconferencing.
Emergency services	
1.	Consider all patients to be a possible case with COVID-19 and take all precautions, such as proper face mask, face shield, gloves, gown, and other PPEs.
2.	All patients should undergo screening for COVID-19, for fever and other signs, and symptoms of COVID-19.
3.	Maintain social distancing and minimize the duration of direct physical contact.
4.	Review the treatment records electronically.
5.	Keep the patients in the emergency for a minimal duration.
6.	At discharge, make a plan to follow-up the patient by teleservices.
ECT services	
1.	Choose patients for ECT carefully.
2.	Document the indications for ECT.
3.	Avoid giving ECT on an outpatient basis as ECT procedure can involve aerosol generation and patients asymptomatic for COVID-19 may spread the infection to others.
4.	Screen the patient for signs and symptoms of COVID-19.
5.	Get a test for COVID-19, if there is suspicion of COVID-19.
6.	All medical personnel involved in the ECT procedure should don complete PPEs (including shoe covers, outer and inner gloves, gown, N-95 mask, surgical cap, goggles, and face shield).
7.	Have designated donning and doffing areas.
8.	Maintain social distancing in the waiting area, during the administration of ECT, and in the recovery area.
9.	Minimal number of professionals (such as one anesthetist, one psychiatrist, and 1–2 nursing staffs) to be involved at a given time.
10.	ECT staff should avoid mingling with patients in other medical wards.
11.	Discard the disposables after one use.
12.	Disinfect the reusable equipment after use for each patient.
13.	Ensure proper disposal of PPEs.
14.	Use aerosol box shields to better contain the spread of aerosols from the patient during the procedure.
15.	Hand hygiene needs to be strictly followed before and after every patient procedure.

HCWs: healthcare workers, ECT: electroconvulsive therapy, PPE: personal protective equipment.

TABLE 2.

Required Changes in the Role of HCWs, Administrators/Supervisors, Teachers/Trainers and Trainees

Norms for the staff	
1.	Check the body temperature daily at the time of reporting for work.
2.	Encourage the staff and students to report their health status before starting the work.
3.	The staff should disclose their travel history, which can include visiting the nearby city/town, epidemic area/red zone.
4.	Review the history of staff for recent duty in a COVID hospital/ward.
5.	Allay the anxiety of the HCWs.
6.	Encourage the HCWs in all levels to use the proper mask and other protective instruments, depending on their level of involvement with the patients and the procedures carried out.
7.	Avoid all kinds of in-person staff meetings and preferably use online platforms to carry out the meetings.
8.	Use psychological tests that can be administered by using smart devices.
9.	Ensure hand hygiene and social distancing norms at all office areas.
Roles of administrators/supervisors	
1.	Be a leader, rather than a boss.
2.	Take care of the mental health of yourself and your staff.
3.	Encourage self-reporting of symptoms—physical and psychological.
4.	Allay the anxiety of your team and ensure the safety of your staff.
5.	Provide adequate safety gears to your staff.
6.	Value your staff.
7.	Avoid job terminations due to financial crunch.
8.	Discuss things with your staff, rather than taking a unilateral decision.
9.	In case there is no other option than salary cut, make decisions in liaison with the staff, give an adequate explanation, and assure resuming typical salary with improvement in the situation.
10.	Always insist on teamwork rather than individual work.

HCWs: healthcare workers.

the HCWs working in a particular unit getting infected, leading to complete closure of the services.

All these require planning and reorganizing the services both in the government and the private sectors. Reorganization of the services will be required in the form of working with appointments, reduction in the number of patients attending the services, minimization of the waiting time, and explicit instruction to the patients and caregivers concerning what will and will not be provided in the changed scenario (**Table 1**). Similarly, changes would be required to reorganize the inpatient setting, consultation-liaison psychiatry services, emergency psychiatry services, electroconvulsive therapy services, brain stimulation techniques, etc. (**Table 1**). Besides the routine guidelines for the staff, the time of unlocking calls for developing specific norms for the staff of all the categories (**Table 2**). The standard procedures that may be followed have been listed in the given tables, which can be adapted in different types of facilities, keeping in mind the feasibility. The ground rules for providing the services should be following adequate safety and infection-control practices, limiting the number of appointments/patient inflow, ensuring proper training and supervision of staff, and caring for the staff and the students.

While the imminent risk of getting an infection is high for the HCWs, the proposed reorganization of services can be taken as a template to minimize the risks. However, this model can be regarded as dynamic, and it can be changed as per the changing scenario of COVID-19 spread (containment zones/buffer zones/red hot spot zones, etc.) and based on the infrastructure of the healthcare set-up.

Various other strategies based on the patient catchment area of the hospital can be followed/developed. These include different departments developing standard operating procedures based on the number of cases they used to see in the pre-COVID era. There can be a partnership among the government sector hospitals as well as between the government and private sectors, for helping out in segregation and providing care to COVID and non-COVID patients. Some designated centers can be earmarked for admitting suspected COVID patients. It is also likely that in the future, there may be a need for having separate COVID wards for patients with mental illnesses, which have to be managed jointly by people from other specialties and MHPs. Hence, in cities and towns where there is more than one mental healthcare facility, MHPs need to reorganize the services so that some of the centers provide care to patients without COVID-19 and other centers provide care to those with suspected or confirmed COVID-19. Once those suspected to have COVID-19 are cleared, they can be shifted to the place where people without COVID-19 are cared for. There is also a need to develop proper procedures and standard operating procedures for moving patients from one place to another. If these measures are not planned on time, we may soon see closure of services in some areas and HCWs getting infected. If such reorganization with a futuristic viewpoint to protect the people with mental disorders and MHPs is not undertaken, we may be heading for another disaster.

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