

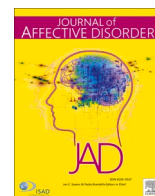


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Community mental health services: Access for acute psychiatric care during the COVID-19 lockdown



To the Editor

Australia's response to the COVID-19 pandemic is one of the most successful public health responses but such an approach is not without adverse psychological outcomes at population level. For example, in a recent Victorian survey, anxiety or depressive symptoms were reported by a third of respondents where as one-fifth reported suicidal thoughts (Czeisler et al., 2021). A relationship between duration of the lockdown and psychological problems have been reported (Brooks et al., 2020).

The COVID-19 pandemic has affected various aspects of mental health services (Byrne et al., 2021). Community mental health services experienced a greater impact of the pandemic such as closing of services in some places (Antoine et al., 2020) and implementation of changes to service provision, e.g., rescheduling non-urgent face to face appointments, introduction of telehealth, changes to home visits (Thompson et al., 2020). Despite the magnitude of changes at community mental health services, research on how the pandemic affected patient access for acute mental health care is largely restricted to emergency departments (EDs) (Ferrando et al., 2020) and psychiatric wards (Itrat et al., 2020). We found one study on community mental health setting that included crisis resolution team data on their broader study (Abbas et al., 2021). In this background, our study was aimed at comparing the total number of patients who accessed crisis treatment teams of North West Area Mental Health Service (NWAMHS) and their characteristics in the first six months of the lockdown in Melbourne and the control period.

This cross-sectional retrospective study was based at NWAMHS, a public mental health service of the North West Mental Health network of the Royal Melbourne Hospital, Melbourne, Victoria. NWAMHS catchment area includes cities of Hume and Moreland and the community mental health teams are located at two sites (Coburg and Broadmeadows). The crisis team previously known as the Crisis Assessment and Treatment team (CATT) is locally referred to as 'Brief Intervention Team' (BIT) and it is part of the broader community mental health service. The BIT consists of a multidisciplinary team (MDT) including medical (a consultant psychiatrist and a psychiatry registrar), psychiatric nurses and allied professional.

For this study, all patients who attended the crisis teams (BITs) during the lockdown period (16th March 2020 to 16th September 2020) and during the comparison period (16th March 2019 to 16th September 2019) were included. Electronic medical records and the State-wide database (CMI, Client Management Interface) were the data sources. We collected the number of patients who attended the BITs, socio-demographic and clinical variables as specified in Table 1. Psychiatric diagnoses were based on ICD-10-AM. This study was a part of a broader project on access to acute psychiatric care during the lockdown period and The Melbourne Health Human Research Ethics Committee approved

this study as a quality assurance project. Descriptive statistics and inferential statistics (Chi-Square test and independent *t*-test), with alpha (significance) level ≤ 0.05 , were done through SPSS Ver. 27.0 (IBM SPSS Statistics for Windows, Version 27.0. Armonk, NY: IBM Corp).

In terms of results, the total numbers of patients referred to the crisis team were more in the lockdown period ($n = 449$) than in the control period ($n = 423$) (6.1% increase). The mean age of patients in the lockdown period was significantly lower (40.96 ± 11.00 vs 38.95 ± 11.43) ($X^2 = 2.65$, $p = 0.008$). The proportion of age categories of 18–25 (3.5% vs 8.2%) and 26–35 (34.7% vs 37.1%) were higher in the lockdown period. The groups did not differ in gender, relationship status, primary language, educational background, employment, and accommodation status ($p > 0.05$). Compared to the control period, the lockdown period had patients who were significantly different with respect to their living arrangements ($X^2 = 15.8$, $p = 0.001$). Also, the lockdown period had higher proportions of patients with psychotic (21.9% vs 25.0%), anxiety (17.9% vs 31.0%) and personality disorders (8.0% vs 14.2%) but lower proportions of substance use (10.1% vs 6.7%) and mood disorders (21.2% vs 16.8%) ($X^2 = 63.5$; $p < 0.001$) (Table 1).

Our study found a marginal increase (6.1%) in the total number of patients during the lockdown period than the control period. We found increased rates of presentation among the age groups of 18–25 and 26–35 compared to the old age groups, a finding that agrees with a previous study that reported younger age as an important factor associated with anxiety and depression (Varma et al., 2021). We also observed that the lockdown period had a higher number of patients who were living with others (e.g., other family members and friends) than with partners/children. This finding could either mean that an increased rate of relationship problems and help seeking by individuals living with relationships other than spouse/children and/or more individuals lived with other relationship because of problems in intimate relationships. Increased psychopathology scores were observed among separated or divorced individuals during the pandemic (Nkire et al., 2021).

We found that a higher number of patients with psychotic disorders in the lockdown period similar to a previous study (Abbas et al., 2021). However, we noted a higher proportion of anxiety and personality disorders in the lockdown period unlike Abbas et al. (2021). The difference in the duration of study periods, i.e., 4 weeks in Abbas et al. vs 6 months in our study could account for the differences in psychiatric diagnoses. We also noted a reduction in presentations related to substance use which may be related to the reduced availability and accessibility to substances during the lockdown period.

Our study has limitations such as retrospective study design and inclusion of one psychiatric service. Research is needed on this topic to further characterise the nature of patients who accessed community mental health services for acute psychiatric care during the lockdown

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Table 1
Group differences in socio-demographic and clinical variables.

Variable	Group		X ² /t	p
	Control n (%)	Lockdown n (%)		
Age (in years) (mean ± SD)	40.96 + 11.00	38.95 + 11.43	2.65	0.008
Age categories (in years)				
18–25	15 (3.5)	37 (8.2)	12.01	0.017
26–35	148 (34.7)	167 (37.1)		
36–45	117 (27.5)	103 (22.9)		
46–55	94 (22.1)	101 (22.4)		
56–65	52 (12.2)	42 (9.3)		
Sex				
Male	198 (46.8)	206 (45.6)	0.13	0.7
Female	225 (53.2)	246 (54.4)		
Relationship status				
Single	162 (43.1)	191 (46.7)	1.83	0.4
Separated/widow/ divorced	122 (32.4)	115 (28.1)		
Married (including de facto)	92 (24.5)	103 (25.2)		
Primary language				
English	391 (92.9)	418 (93.1)	0.02	0.9
Non-english	30 (7.1)	31 (6.9)		
Education				
10 or below years	59 (22.5)	64 (24.1)	0.38	0.8
Years 11–12	99 (37.8)	103 (38.7)		
Tertiary/vocational	104 (39.7)	99 (37.2)		
Accommodation				
Crisis accommodation	5 (1.2)	3 (0.7)	9.4	0.2
No usual residence	6 (1.4)	1 (0.2)		
Supported accommodation	4 (1.0)	3 (0.7)		
Community residential	6 (1.4)	1 (0.2)		
Hostel accommodation	8 (1.9)	6 (1.3)		
Private accommodation	386 (91.9)	427 (95.5)		
Others	5 (1.2)	6 (1.3)		
Living situation				
Alone	113 (27.0)	119 (26.9)	15.8	0.001
With children	36 (8.6)	16 (3.6)		
With partner	131 (31.3)	118 (26.7)		
With others	138 (33.0)	189 (42.8)		
Employment				
Unemployment/pensioner	261 (63.5)	285 (64.0)	4.0	0.4
Student	20 (4.9)	17 (3.8)		
Home duties	17 (4.1)	31 (7.0)		
Employed	112 (27.3)	111 (24.9)		
Others	1 (0.2)	1 (0.2)		
Primary diagnosis				
Organic disorders	0 (0.0)	1 (0.2)	63.5	<0.001
Substance use disorders	43 (10.1)	28 (6.7)		
Psychotic disorders	93 (21.9)	104 (25.0)		
Mood disorders	90 (21.2)	70 (16.8)		
Anxiety disorders	76 (17.9)	129 (31.0)		
Personality disorders	34 (8.0)	59 (14.2)		
Others	89 (20.9)	25 (6.0)		

period. Such a knowledge will help to adjust and optimise psychiatric service delivery during the pandemic.

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CRediT authorship contribution statement

All authors have equally contributed to the study design and write up including the final draft of the manuscript. First and second authors were involved in data collection and analysis.

Conflict of interest

None to be declared.

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