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Brief Communication

Observation of telepsychiatry service in a teaching hospital of eastern Nepal during COVID-19 pandemic

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Abstract

Considering the geographical complexity and adversity, online communication and consultation are viable method in Nepal. The COVID-19 pandemic has accelerated the already starting trend of use of these technologies in medicine. In BPKIHS, telemedicine efforts were already initiated; lockdown rather warranted its maximum use. Here is an account of the observation made in telepsychiatry service provided by a consultant psychiatrist of its department of psychiatry. It is an institute-based observation noted for all the telepsychiatry consultations in 9 random duty days of the COVID-19 pandemic. Basic necessary information was noted down in a semi-structured proforma, like: socio-demographic, clinical information and advice provided.

There were 104 subjects; 73 follow-up and 31 new: 60 male and 44 female cases. Clients of multi-ethnic groups were the most from urban, then semi-urban and least from rural areas. More consultations were for young age-groups and from nearby districts of Sunsari. Mood, somatic (sleep), anxiety were the top presenting complaints and 8/104 clients had suicidal symptoms. Maximum follow-up cases were improving. The most common diagnoses were: Mood (Depression and Bipolar), Anxiety, Psychosis and Substance use disorders. Most common treatment advices included: Antidepressants, Antipsychotics, Benzodiazepines and Counseling/psycho-education. Telepsychiatry is a viable method of delivering service even during the pandemic.

More Information

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Nature of COVID-19 pandemic

The molecular, epidemiological and clinical features of SARS-CoV-2 have been gradually known. So far, it is evident that the nature of Corona virus disease 2019 (COVID-19) infection (mainly high transmission, mutation to new strains and consequent higher transmission and pathogenicity) resulted in rapid worldwide spread, morbidity and mortality [1]. Subsequent circumstances globally urged for a comprehensive approach with the balance of: protection of health, prevention of economic and social disruption, and respect of human rights [2].

Need of the hour

Some lessons learnt from the pandemic are general and others are local context based. Along with evolving facts about the virus and disease, the management strategies and policies are also forthcoming. The need of the hour, clear so far is breaking the chain of the infection through SMS IPC (Social distancing, mask, sanitization and infection prevention and control) measures and some local manners/customs like 'Namaste' in place of touching ways of greeting, intimacy or warmth [3]. In such a state of International Concern of Public Health, all including consumers (patients, students), providers (professionals, teachers, service institutes, government) and society (public) should bear extraordinary responsibility for the health, and prevention of the infection and other health issues [4]. Such a need of novelty, urgency and responsibility is there in health service setting and treatment strategies too [5,6].

Novel approach, policies and strategies

The method with social distancing and less touch, contact and aerosol generation as far as possible on one hand and on the other with a greatest possible respect to clients' individual needs (e.g. comorbidity, risks like old age), human-rights and dignity, would be the preference during the pandemic [6]. Current scenario compelled for various new strategies, modification in ongoing methods and replacement of ineffective and useless ways with effective ones. This need

was everywhere for all levels of prevention, i.e. primary prevention, treatment, rehabilitation. Novelty is warranted in service, research, academia of health sciences and other areas of human life and society. Various concepts, models and modes are already underway in this line [5-9].

Telepsychiatry: a novel strategy

Helpline telephone consultation [10,11]. and Tele-medicine/psychiatry services are novel methods [12]. Professional bodies have formulated guidelines regarding telemedicine [13] and telepsychiatry [14]. Wherever possible, available, useful and effective; these latest technology based innovations in treatment modality should receive the place and they are going to be increasing swiftly.

Telepsychiatry in Nepal and BPKIHS

Considering the geographical complexity and adversity, online communication and consultation, i.e. Telemedicine are viable method in Nepal. As in the country- Nepal [15], telemedicine efforts were already initiated in BPKIHS. The COVID-19 pandemic has accelerated the already starting trend of use of these technologies in medicine; lockdown rather warranted its maximum use [16].

BPKIHS started Helpline mobile phones for needy people to have free consultations with respective specialists when it closed OPDs in lockdown periods. This useful method was soon followed by Telemedicine/psychiatry service in the time of crisis and helplessness. In our telepsychiatry, we were providing service to 10-25 patients per day, 3 days in a week. Through virtual platforms (e.g. Google meet, Zoom etc.), we are having frequent virtual meetings regarding clinical care and academic activities. Academic activities/online classes are still heavily based on the virtual platforms.

Method and results

Telepsychiatry in our observation

Here, the author intends to depict an account of the observation made in the telepsychiatry service. It is an institute-based observation noted by a consultant psychiatrist of its department of psychiatry for all the telepsychiatry consultations in 9 random duty days of the COVID-19 pandemic. Basic necessary information was noted down in a semi-structured proforma, including: socio-demographic, clinical information and advice provided.

There were 104 cases; 73 follow-up and 31 new: 60 male and 44 female. Clients of multi-ethnic groups (main being Brahmin, Rai, Newars and Tarai ethnic castes) were the most from urban, then semi-urban and the least from rural areas. More consultations were for young age-groups and from nearby districts, i.e. Sunsari, Morang, Jhapa, Siraha though there were also for other age-groups and from far places of other provinces (Table 1).

Mood, somatic (sleep), anxiety were the top presenting complaints and 8/104 clients had suicidal symptoms. Maximum follow-up cases were improving, a few had ongoing either static or worsening symptoms (Figure 1).

The most common diagnoses were: Mood (Depression and Bipolar), Anxiety, Psychosis and Substance use disorders. Most common treatment advices included: Antidepressants, Antipsychotics, Benzodiazepines and Counseling/psycho-education (Table 2).

Discussion and conclusion

Reflection to our telepsychiatry observation

More Nepalese citizens live in villages. Geographic adversities, lack of roads and transport services, poverty and ignorance about the services along with minimal government priority and policy are some important reasons behind the huge mental health gap in Nepal. Access to the mental health services is still far from satisfaction in developing countries. These countries including Nepal struggle hard to provide even

Table 1: Case type, Gender, Age, District and Residence of Tele-psychiatry patients.

Category	S. No.	Variables	No. (%)	Category	S. No.	Variables	No. (%)
Case type	1	New	31 (29.81)	Age group	1	11-20	13 (12.5)
	2	Follow up	73 (70.19)		2	21-30	32 (30.77)
Gender	1	Female	44 (42.31)		3	31-40	26 (25.00)
	2	Male	60 (57.69)		4	41-50	13 (12.5)
Caste/ Ethnic group	1	Brahmin	30 (28.85)		5	51-60	16 (15.39)
	2	Chhetri	8 (7.69)		6	61-70	3 (2.89)
	3	Newar	15 (14.42)		7	≥ 71	1 (0.96)
	4	Rai	22 (21.15)	District	1	Sunsari	60 (57.69)
	5	Tamang	3 (2.89)		2	Morang	13 (12.5)
	6	Gurung	3 (2.89)		3	Jhapa	10 (9.62)
	7	Terai ethnic	15 (14.42)		4	Siraha	8 (7.69)
	8	Dalit	4 (3.85)		5	Dhanusha	3 (2.89)
	9	Muslim	2 (1.92)		6	Bhojpur	2 (1.92)
	10	Magar	1 (0.96)		7	Kavre	1 (0.96)
	11	Limbu	1 (0.96)		8	Dhankutta	4 (3.85)
Residence	1	Village	8 (7.69)		9	Saptari	2 (1.92)
	2	Semi-urban	29 (27.89)		10	Bharatpur	1 (0.96)
	3	City	67 (64.42)			Total subjects	104 (100.00)

Table 2: Psychiatric Diagnosis and Management advice in Tele-psychiatry service.

Category	S. No.	Variables	No. (%)	Category	S. No.	Variables	No. (%)
Diagnosis	1.	Organic mental	4 (3.85)	Diagnosis	5.	Anxiety	31 (29.81)
	1.1	SD	2 (1.92)		5.1.	Panic	7 (6.73)
	1.2	Headache	1 (0.96)		5.2.	OCD	4 (3.85)
	2.	SUD	5 (4.81)		6.	Stress related	2 (1.92)
	2.1	AUD	4 (3.85)		7.1	Dissociative	1 (0.96)
	2.2	Nicotine/ other	4 (3.85)		7.2	Somatoform	2 (1.92)
	3.	F20	11 (10.58)		8.	Mental retardation	1 (0.96)
	4.	Mood	69 (66.35)		9.	Drug side effect	2 (1.92)
	4.1	Depression	52 (50.00)		10.	DSH	8 (7.69)
	4.2	BPAD	15 (14.42)		11.	Other	2 (1.92)
	4.3	Other/Dysthymia	2 (1.92)		12.	Not adequate	1 (0.96)
Management	1.	Antipsychotic	48. (46.15)	Management	7.	Thyroid	2 (1.92)
	2.	TCA, SSRI, MAOI, other anti-depressant	75 (72.12)		8.	Vitamin supplement	5 (4.81)
	3.	Bzp, hypnotic	42 (40.39)		9.	Other	10 (9.62)
	4.	Lithium	9 (8.65)		10.	Psychological: Education	23 (22.12)
	5.	NaV/ CBZ, AE	9 (8.65)		11.	Refer	1 (0.96)
	6.	THP	1 (0.96)		12.	Bring in ER/OP	4 (3.85)

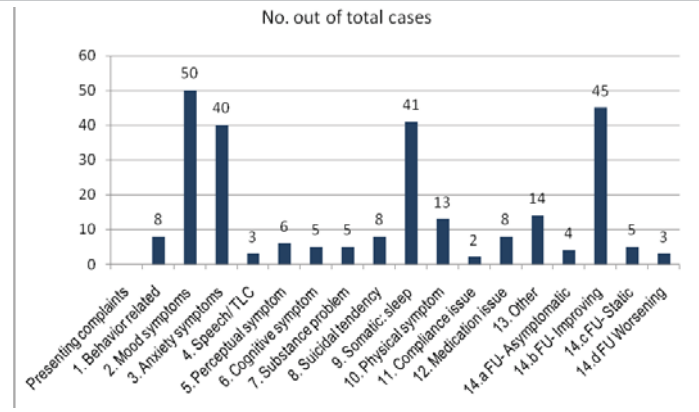

Figure 1: Presenting complaints in Telepsychiatry.

essential and basic, primary health care; even more during the pandemic. Nepal is a developing country with inadequate system, resource and monitoring mechanism; and was grossly unprepared for such a massive mayhem of the pandemic. There are new cases, emerging issues, with old cases of various health issues including mental, neurological and substance use (MNS) disorders. These clinical profiles of presenting complaints and diagnoses comply largely with the pictures seen in help line service of same setting [10,11]. Many with reactive states (sub-syndromal, less severe but distressing conditions like stress, stress situation), stress related disorders, mild depression etc. abound during the pandemic. Magnitude and burden of COVID per se is overwhelming. On the other hand, other health issues were not less which were somehow sidelined during the pandemic.

Many needy people were afraid of going to service while people with minor issues were exposed unnecessarily to the risk of COVID infection as reported in general in this tertiary care hospital set up [16]. Service facility, provider institutes, organizations, spread of information and adequate communication on part of the state/government and awareness, alert steps, help seeking through appropriate modes including novel methods (e.g. helplines, telemedicine) on part of clients would add to the better outcome in the pandemic as indicated by the literature of this short period. These novel strategies e.g. helplines, telemedicine/psychiatry were much talked off, discussed, and the protocols were developed throughout, e.g. Nepal (Nepal Medical Council) protocol for telephone or online consultations- telemedicine/ telepsychiatry.

Our observation too replicates that Telepsychiatry is a viable method of delivering service even during the pandemic (to address new and follow-up psychiatric cases). Hence, it should be extended and promoted in all the way possible for all the time.

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