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The COVID-19 pandemic and its impact on mental health services: the provider perspective

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ABSTRACT

Background The impact of coronavirus disease 2019 on mental health of populations is in focus recently but few studies focus on service adaptations to ensure care provision for the mentally ill. In India, where community-based mental healthcare is led by non-government organizations (NGOs), this is a crucial time to gather evidence on how these organizations adapted to the challenges.

Methods We explored provider perspectives in an NGO providing mental health services to communities using in-depth interviews and a focus group discussion to understand the impact on services and adaptations during the COVID 19 pandemic.

Results Three elements of service provision were highlighted: established relationships with communities, responsiveness to the patient needs, and resilience in ensuring continuity. Responding to the end-to-end care needs of the clients and continual adaptations were vital for ensuring continued services. Telemedicine enabled expansion of service and clientele as well as efficiency, but there were issues of casualization of therapy and poor privacy.

Conclusions The study provides an understanding of adaptations to ensure continuity of care to mentally ill during disruptions. Insights from strategies are crucial to help plan for resilient community-based mental health care services.

Keywords communities, health services, mental health

Background

The coronavirus disease 2019 (COVID-19) pandemic has caused disruptions in services to mentally ill in many countries.[1] System adaptations included the use of telecommunication platforms, electronic prescriptions and the continued use of expired prescriptions[2,3] as well as facility-level strategies such as isolation and liaison psychiatry for patients diagnosed with COVID-19.[3–5] Among patients, social distancing and restriction of visitors were implemented, but enforcement was difficult especially with hygiene protocols.[3,6–8] In India, services were disrupted with the nationwide lockdown in March, 2020, and guidelines were released by the Government to move to tele-medicine.[9] The practice of tele-psychiatry has raised concerns involving patient dynamics, proper diagnosis and legal issues[10] but has been successful in some contexts.[11] Services to the rural and ageing population, which was always problematic, worsened during the pandemic.[5,12]

Mental health outreach services to communities and vulnerable populations in India have been pioneered by NGOs and these lessons were found to be particularly useful in the public mental healthcare system.[13] The insights from how these organizations adapted to the difficult circumstances during the pandemic may be useful in planning for resilient primary mental health services.[14] Our exploratory study was to gain insights from the perspective of the service providers of an NGO, the Schizophrenia Research Foundation (SCARF), based in Chennai, Tamil Nadu. The organization provides mental health care services for a range of mental disorders

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and also provides outreach services to the rural population. It is a training centre for psychiatry, psychology, psychiatric social work, and serves as a training partner for public mental health services.

There were three exploratory areas related to service provision: (i) the impact on mental health services during the pandemic, (ii) how the service providers adapted and responded to the challenges of providing service during the pandemic and the specific issues faced by the mentally ill and (iii) personal and professional learnings/insights gained in providing care to the vulnerable population groups during the pandemic.

Method

The cross-sectional qualitative descriptive study conducted between December 2020 and January 2021. In-depth Interviews (IDI) with ten service providers from the NGO were used to get an in depth understanding of individual practitioner's experience followed by a Focus Group Discussion (FGD) with a purposively selected subgroup of four of the IDI respondents to gain shared insights and aid reflection. Participants for the IDI were selected using purposive sampling from across the different types of services mapped initially from outpatient and in-patient clinical services, residential services, community outreach, psycho-social rehabilitation including family interventions, research and training. One of the interviews could not be scheduled as the participant could not give us an appointment during the data collection period. An interview guide aided the exploration of experiences in providing services on the three main themes through the months between February and December 2020. The interviews, lasting 50 to 80 minutes, were conducted in English or Tamil over telephone calls or video-conferencing, after obtaining oral consent. Participants for the FGD were chosen to represent management, clinical, rehabilitation and outreach/training. All interviews were recorded, transcribed, and coded by a single researcher using a codebook and verified by a second researcher. The transcripts were shared with the respondents for verification and corrections if any, were made. The data were categorized and analysed using QDA Miner. The analysis was thematic, based on a broad set of a-priori themes from the main research areas and emergent subthemes from data. Ethical clearance was obtained from IFMR Human Subjects Committee and SCARF Ethics committee.

Results

The respondents included: managers of clinical services, administrative staff, psychiatrists, social workers, psychologist, and researcher staff employed in community research projects Their work experience at the organization ranged from three to more than 20 years. Some respondents also played multiple roles, serving more than one department, with 2-3 of them taking on senior management positions, in addition to their other roles.

Impact of the pandemic and lockdown

In the two weeks of complete lockdown all services were affected, after which essential services related to care could be resumed. Non-essential like outreach, training, research and mass awareness programmes were partially resumed on digital platforms. From the service provider perspective, two areas of concern during the lockdown were the discontinuation of the medications dispensed from the centre, and the change in circumstances of the patients. In addition, the providers struggled with their own personal challenges in adjusting to the changed routines.

Access to consultations and medication

Access to all mental health care services was affected during the early lockdown because the patients could not physically access the centre's services due to restrictions. Obtaining psychotropic medications, a standard of care for patients with chronic mental illness, was challenging for most people. Patients who turned to local pharmacies faced trouble as not all neighbourhood pharmacies stocked the medications for mental disorders, and if they did, some pharmacists were reluctant to dispense them. There was no access to these services in smaller towns/districts as psychiatric care specialities were used for COVID-19 treatment. For some patients, especially in rural and district borders, restrictions on movement were particularly challenging.

> '*.. (Rural clients), get caught by the police who levied a penalty on them even if they said they were going to refill the medicines at SCARF, even if they showed the prescription. These are people who can't even afford medicines . . . it felt painful that we were helpless*' *(P6, male manager heading outreach efforts)*

The non-availability of medication resulted in a relapse of the conditions like schizophrenia or mood disorders, often necessitating in-patient care. However, the pandemic restricted admissions for because of concerns of possible spreading of COVID-19 to other patients in the facility.

> '*We stopped admission for few months. . . . I would have handled at least ten DESPERATE requests for admissions*' *(P4, female psychiatrist)*

Change in life situations and burden of care

The service providers had to also respond to multiple contextual issues faced by the families. Discharged and rehabilitated clients spoke about their concerns about missing vocational

activities and their social life at the centre. For the caregivers at home, the closure of the vocational centre and day-care led to an increased burden of care in addition to issues of job loss, pay cut and rise in debt.

'*Of course, we cannot give bread and butter for all 6000 patients. But we gave provisions for about 300 of them through various sources.*' *P6*

'*For them, talking to others, the 11 o clock tea, etc. are some routines they are so used to. Most of them keep in touch with us regularly, with case managers, doctors, etc. It was sad for them because this was their social life...*' *P4*

Personal impact on providers

The providers spoke about disrupted work-life balance, a feeling of being torn between providing appropriate quality of care while implementing the adaptations. Overflowing of the work into the personal space due to working from home meant that personal time was affected with extended work hours, reduced time with the family and reduced formal and informal interaction with colleagues.

'*After 4.30 used to be "my time". Now even at 10 p.m. I need to work-check if everything is ready as per requirement. I am more addicted to checking my phone-every 3–5 min because I don't want to miss anything...*' *(P5, middle-aged female administrative co-ordinator)*

'*There was loss with respect to my privacy and my family time. My children were there; my parents were listening when I was on the phone. My children would wonder why the person on the other end was crying so much*'. *(P2, middle-aged female rehabilitation coordinator/counsellor)*

There was also the perception of risk of contracting COVID-19 during travel or client interactions and passing it on to family members.

Adaptations and Challenges

The main objective of service delivery was to maintain continuity of care and at the same time minimize the risk of infection. Every service department operations, pharma/clinical services and non-pharma/counselling services, worked towards a set of adaptations and kept tackling challenges and modifying the adaptations. Much of this process was done through informal communication channels like WhatsApp groups, which proved useful for decision making, emotional support and load sharing.

The operations and management adaptations were intended for the following ongoing purposes: First, establishing standard safety protocols on the premises second, ensuring that staff and patients had requisite documentation to travel and third, introducing a rostering system that linked patients and the providers effectively either physically or through tele-consultation and ensuring services to a 24-hour helpline for the general public. The safety protocols included streamlining of movement of the patients, standard precautions like sanitization, temperature checks, masks and social distancing guidelines, which were adopted early and enforced. The documents required by staff and patients for movement demanded personnel to be constantly available to authenticate to the authorities.

'*Even if they had the cards/e-pass, police would still stop them and ask why they were going out . . . They would ask so many questions and in turn they would call me and hand over the phone to the police.*' *P5*

A dedicated helpline linked both the new and existing patients to the consultants and therapists. This helpline was also open to the public for distress calls and was displayed in media advertisements by the government. As the helpline was a 24-h service, it meant that the existing staff and the doctors had their working hours extended to deal with the volume of calls. The linking of services and documentation over the phone required the staff to solve problems particularly related to updating prescriptions and convincing authorities about the mental health needs of the clients.

'*Some of the clients who had travelled to other districts and got stuck there . . . I contacted their doctor on their behalf and passed on the prescription over WhatsApp.*' *(P3, middle aged female health worker)*

Within the in-patient centres, there was increased anxiety among the patients because of the media coverage on COVID-19. To assuage patient's anxieties and to maintain contact with families, staff used their own phones to set up video calls with family members, as many of the patients did not have smartphones. Isolation and quarantine measures were used to protect all in-patients and residential care staff.

For the outpatient services, a mix of tele-consultation and in-person consultation schedule was drawn up based on need. Case managers would complete case details on an initial phone call and document it in the electronic medical record system before confirming a consultation appointment. This reduced the time spent with the consultant at the clinic. Prescriptions were written out in the official prescription pads, signed, and a picture shared over WhatsApp, in line with the tele-consultation guidelines.

'*We usually used to take 1 h for a new patient for psychiatric consultation. In view of COVID-19, we addressed them in 15–20 min. After that, contact number will be taken and the case worker will call them back by audio or video call based on their convenience and then collect their detailed*

history and record it in [software]. During the subsequent visit, we will read the case history from [software] and also refer to our own notes' (P7, female psychiatrist)

Prescription sharing over WhatsApp also resulted in the consultant spending time over the phone, clarifying issues related to legibility, chemical names, brand names, prescription duration and alternatives to tackle supply issues with pharmacists

'*In fact, I had to talk to a pharmacist 2 weeks back, to honour a prescription that was already overdue, I had to explain that I would be meeting them only 2 weeks from now as the patient is held up somewhere else, requesting them to give medicines for 1 week or 10 days.' P4*

Use of telemedicine for rehabilitation, counselling, follow-up and review sessions had both advantages and shortcomings. While it was easier for the client and the provider to complete sessions without physically travelling to the clinic and this decreased the overall attrition, it became an additional burden for the counsellor to ensure that the client attended the calls and complied with their instructions remotely.

A proactive follow-up of patients and respect of patient choice for either virtual or face-to-face sessions were perceived to be crucial in ensuring the quality of care. Compliance and suitability were also better where family members could be synergized as effective co-therapists. For example, one patient was rehabilitated with the help of her 10-year-old child.

Some clients took the phone sessions rather casually, assuming it to be a friendly catch-up call rather than a tele-therapy session.

'*Some think it is just a normal call. If I ask why they didn't call they'll say that they thought we called just to ask "How are you doing? Are you taking medicine" and that they themselves would call me if there is any trouble...' (P10, female researcher/Trainer/case worker)*

Another issue with tele-therapy was lack of privacy with the whole family stuck at home; they simply could not talk freely.

'*Some people might say bonding has increased, but especially families who have alcoholic men at home, women and children have faced a lot of issues. These things people want to speak out but when the husband is around, how can they talk about the husband to someone over [the] phone?' P6*

Among the non-essential services, vocational rehabilitation and job placement continued over the phone. Job counselling and placement for recovering patients was particularly challenging as it required management of patient anxiety in resuming work while acknowledging employer expectations. For the public outreach programmes continuance was possible through an online platform, yet it affected the ability to have an effective two-way communication with government community health workers placed in various districts in rural areas.

'*Many people are not comfortable talking virtually. I am sitting and talking to you in a sound proof room, but that is not possible for everyone. Women in rural areas were not comfortable with gadgets.' P6*

Insights and reflections

Insight from the challenges and adaptations brought out three crucial elements in continuity and quality service delivery: relationships, responsiveness and resilience. The relationship between service providers and the patient-caregiver community was built over many years and strengthened through an existing system of educating patients and families. The providers felt that the impact of this psycho-education element was validated in patient compliance during the pandemic. Service providers' responsiveness to meet the end to end mental health care needs was reflected in their efforts to ensure that medication, counselling sessions, rehabilitation and job placements were available to each patient remotely, but also enabling safe physical access when needed. Provider commitment to care was based on their personal motivation, a perceived sense of fulfilment, and this was despite the long hours they had to put in and impact on their work-life balance. Some of the providers also had to deal with their own anxieties related to the pandemic, in addition to managing the extra workload. Open, adaptive and informal communication channels were found to be effective in dealing with personal, professional and pandemic-related challenges.

In terms of resilience, lessons from past calamities such as floods, tsunami and cyclones were found to be useful during the crisis. Providers' prior experience in implementing tele-psychiatry made implementation during the pandemic easier. Some of the challenges faced in service provision highlighted the importance of framing care policies and programmes for the mentally ill population within larger government/city disaster planning strategies, particularly, the need for including housing, transportation and medication for people with mental illnesses, and sensitizing enforcing authorities on the special needs of the mentally ill. To improve the resilience within services, training programmes for health workers including handling isolation, infection and relocation, and similar engagement for caregivers and families, was suggested.

Discussion

Main finding of this study

In this context, we document three crucial elements of service provision (i) the relationships with the communities,

(ii) responsiveness to the patient needs and (iii) resilience to ensure the continuity of services. Established relationships with the community was crucial in ensuring communication and trust during the crisis. Responding to the end-to-end care needs specific to chronic mental illness required that access was ensured for all services right from diagnosis to rehabilitation. And for this continual adaptations were required to ensure access to medication, tele-counselling, remote rehabilitation, and job-placements in strained livelihood conditions. Responding and adapting also required working across hierarchies, adapting newer communication strategies and overcoming personal concerns.

Telemedicine was useful to expand access to consultations, prescriptions and counselling to more clients, in a shorter period of time and with less effort. Challenges particularly to tele-counselling included lack of privacy, casualization of the exchange between service provider and patient, and absence of the social connect. Privacy issues may be of particular importance in planning for communities with space constraints. Planning for future disruptions should include patient and caregiver education regarding how to prepare for caregiving during times of disaster, and inclusion of care for the mentally ill in disaster planning by the government/city authorities.

What is already known on this topic

As the COVID-19 pandemic continues, there is a need to document strategies adopted by mental health systems to ensure continuity of care. This is crucial to enable planning strategies in the event of future disasters and also in building resilient systems. Facility level adaptations and use of telepsychiatry are reported in other settings.[3,4,7,8] Limitations to telemedicine in psychiatric counselling are noted in many contexts.[3,4,6,7,16]

What this study adds

There are few studies that focus on the service adaptations to ensure access care to mentally ill during the pandemic. The study describes the disruptions in mental healthcare services during the pandemic and how NGOs, who are important contributors to community mental health services in India, adapted to these challenges. Key elements to identified in ensuring are: Established relationship with the communities, responsiveness to the end-to-end needs of mentally ill, and resilience in learning from past crises while continually adapting to meet ground challenges. These may prove crucial elements for an effective primary mental healthcare response during future disruptions.[15]

Limitations of this study

The study helped provide an understanding from the provider perspective on the adaptations and evolution of strategies. Though limited to a single NGO and to providers, insights from a variety of services within mental healthcare was gleaned.

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