

doi:10.1192/bjb.2020.52

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Are UK care homes ready for the telemedicine revolution?

The restrictions implemented by coronavirus disease 2019 (COVID-19) have reawakened discussion surrounding the use of telemedicine in routine clinical practice.¹ Nursing home residents have emerged as a particularly vulnerable group, not only with respect to the virus itself, but to the effects of social distancing² and disruption to the services in place to support them. In working to stop the spread of COVID-19 within their facilities, many homes have found it difficult to sustain the non-pharmacological mainstays of management of delirium and behavioural and psychological symptoms of dementia.² Telemedicine, a proposed solution to these difficulties, has been demonstrated to be both valid and acceptable to patients with dementia and care home staff³ but it does not appear to be part of routine practice in the UK.⁴

We therefore aimed to determine nursing homes' capacity and enthusiasm for telepsychiatry assessments. Over a 2-week period in June 2020, we contacted senior staff at the 70 nursing and 'elderly mentally infirm' homes falling within the Belfast Health & Social Care catchment area and administered a short survey via telephone. Two questions; 'how would you rate your facilities' current capacity to participate in mental health assessments via video link?' and 'how interested would you be in establishing the capacity to participate in mental health assessments via video link?', were answered using a five-point Likert scale.

Participating nursing homes (56/70; 80%) reported that reliable WiFi connections and appropriate equipment (such as a tablet device, or desktop or laptop computer with webcam) were available in 41/56 (73%) and 40/56 (71%) facilities, respectively. Staff at 21/56 (38%) reported that they already felt they had the capacity to facilitate such consultations (answering '5' on the Likert scale); 16/56 (29%) felt they had little (5/56; 9%) or no capacity (11/56; 20%) to currently do so. Nursing home staff answering '3' (10/56; 18%) or '4' (9/56; 16%) on the Likert scale indicated some capacity to participate in remote consultations, although they felt they would not be able to do so on a routine basis. Respondents were 'very interested' in establishing capacity to use remote consultations in 44/56 (79%) of surveys.

Most nursing homes possess the appropriate equipment to facilitate telemedicine, and the majority (84%) demonstrate an enthusiasm for doing so. The failure to adopt telepsychiatry may therefore be more closely related to factors within mental health services, such as our access to appropriate equipment, than those within nursing homes. A survey of American psychiatrists working in nursing homes reported widespread support for telemedicine, but only 13% felt they had access to appropriate equipment.⁵ It would appear, however, that obstacles to telemedicine go beyond hardware; in spite of most

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respondents' access to equipment, we observed considerable variation in their perceived capacity to engage with remote consultations, perhaps suggesting a lack of comfort or familiarity with the medium. We suggest that before telemedicine becomes part of, as has been suggested, 'the new normal', that more detailed exploration is conducted regarding the attitudes and skills of professionals on both sides of the webcam.

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Declaration of interest

none.

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doi:10.1192/bjb.2020.93



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Attitudes of care staff towards video consultations

We read with interest the excellent article by Johns et al on video consultations in mental health services.¹ Such video consultations can also be used with key informants such as care staff. In our specialist mental health service for people with an intellectual disability (also known in UK health services

as learning disability) in Kent we have just completed a quality improvement project on attitudes towards video consultations among the staff in care settings.

We found that the majority of the care staff interviewed felt that video consultations would not have a negative impact on access to (67%) or on the quality of care (69%) provided by our mental health service for people with intellectual disability. Additionally, we asked care staff if they would consider using video consultations in place of face-to-face consultations beyond the time frame of the coronavirus disease 2019 (COVID-19) pandemic. Again, we found that the majority (66.7%) said they would.

Around a third of care staff stated that video consultations could be a good alternative to face-to-face appointments as they would allow them to still go ahead even if the service users declined to leave their accommodation. Other care staff explained that video consultations would allow clinicians to see the service users in their own environment and that they may make it easier to involve multiple healthcare professionals in an appointment. The most frequently cited benefit of video consultations was the potential to alleviate the worry and anxiety that some service users experience when going to a clinic appointment.

The attitudes towards video consultations among care staff were overall positive but they were not uniformly so. For example, it was mentioned that having a video consultation may mean that the service user is more likely to become distracted. Another respondent mentioned that for their service users, much of the information needed is derived from non-verbal communication and observed behaviour, which may be more difficult to assess over video. One carer stated that it would be too difficult to get their service user to cooperate with using the communication device.

These findings may be of particular significance in the world we face post-COVID-19 lock-down where individuals may experience increased anxiety associated with healthcare settings. The month of April 2020 saw a 48% fall in attendances to accident and emergency departments when compared with the previous year, and the fall was 72% for minor injury units and urgent care centres.² There may be some long-lasting public fear surrounding healthcare settings that disproportionately affects the most vulnerable patients and telepsychiatry may prove critical in reaching those individuals as well as the staff who care for them.

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Declaration of interest

None.

¹ Johns G, Tan J, Burhouse A, Ogonovsky M, Rees C, Ahuja A (2020). A visual step-by-step guide for clinicians to use video consultations in mental health services: NHS examples of real-time practice in times of normal and pandemic healthcare delivery. *BJPsych Bull* 8 Jun 2020 [Epub ahead of print]. Available from <https://doi.org/10.1192/bjb.2020.71>.

² The Health Foundation. *Visits to A&E Departments in England in April 2020 fell by 57% Compared to Last Year*. The Health Foundation, 2020.

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doi:10.1192/bjb.2020.91



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Safeguarding the physical health of people with severe mental disorders during the COVID-19 pandemic

The coronavirus disease 2019 (COVID-19) pandemic is putting unprecedented stress on global healthcare systems. Psychiatrists have also seen great changes to their day-to-day practice with a move towards telephone and video consultations alongside general practice and secondary care colleagues. As we move towards operating in these new ways for the foreseeable future, it is likely that COVID-19 will further exacerbate multilevel risk factors for excess mortality in people with severe mental disorders (usually understood to include people with psychosis, bipolar disorder or major depressive disorder).

People with SMD already have a 2–3 times higher premature mortality rate, accounting for a 10–20-year reduction in life expectancy, mediated through increased exposure to risk factors for non-communicable diseases, such as smoking, harmful use of alcohol, sedentary behaviour, iatrogenic effects of medications and inequitable access to healthcare services.¹ Those with SMD also often receive poor quality care, including health promotion and prevention, screening and treatment.

Individuals at higher risk for severe COVID-19 infection and mortality are people aged over 60; with underlying conditions such as obesity, hypertension, diabetes, cardiovascular disease, or chronic respiratory disease; and those who smoke.² For other infectious diseases, people with SMD are likely to be at increased risk of: (a) exposure to the disease; (b) accessing less effective healthcare; and (c) increased vulnerability for significant morbidity and mortality.¹

Although there are overlaps with pre-existing multilevel risk factors,³ there are some important differences. For individuals with SMD, disorder-specific factors of COVID-19 such as early symptoms being common and non-specific could delay diagnosis, and it is possible that people with SMD may be less able to self-monitor and raise concerns if their condition deteriorates. Furthermore, COVID-19 has the potential to mimic signs and symptoms seen in severe clozapine-associated complications, such as neutropenic sepsis and myocarditis, which can be difficult to clinically differentiate from severe COVID-19.² We anticipate that health-related behaviours, such as tobacco use and associated higher prevalence of underlying lung disease in the SMD population, will increase the risk of COVID-19 complications and deaths from pneumonia.

Individual vulnerabilities are exacerbated by health system factors such as absence of relevant shared guidelines for the management of COVID-19 from physical health and mental health bodies, diversion of resources from mental health