The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

10 August 2020

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By email to: ashley.bloomfield@health.govt.nz

Tēnā koe Dr Bloomfield

Re: The Royal Australian and New Zealand College of Psychiatrists (RANZCP) - Response to COVID-19 pandemic

Thank you very much for attending the Council of Medical Colleges' hui on 28 May 2020 and providing an update on the health sector's response to the COVID-19 pandemic. It was pleasing to hear that Aotearoa's health system was able to work efficiently and collaboratively during the COVID-19 crisis. The RANZCP's Tu Te Akaaka Roa (New Zealand National Committee) believe that the leadership demonstrated by you and your team contributed to this outcome and as a result we are in a fortunate position compared with many other countries.

We understand that the Ministry of Health (the Ministry) is now preparing for ongoing work in the post COVID-19 phase and that the Ministry will evaluate its overall response to the pandemic.
The medical colleges were asked to provide feedback on their specific experiences of what worked well during the COVID-19 pandemic, where improvements could be made, and what initiatives they wanted implemented in a post-COVID environment.

Our observations during the COVID-19 situation are summarised below and we have also provided a brief commentary on working with some specific mental health and addiction populations during the pandemic.

Experiences of what worked well during the COVID-19 pandemic

- The health system in Aotearoa adapted quickly to change: some health providers and consumers struggled with new models of care but generally health providers were able to support the health system by working together and developing timely responses during the COVID-19 situation. The transition to telehealth went well but it had some limitations. (RANZCP will address these issues in a separate document evaluating telehealth.)
- Due to fewer admissions and people on the ward, psychiatrists reported they were able to work more intensively with inpatients, indicating it is easier to optimise best practice methods when there are good staff to patient ratios.
- Inter-staff communications seemed to be enhanced during the pandemic. Health providers joined virtual meetings and established good working relationships that resulted in greater connections across the sector.
- Anecdotal evidence suggests that DNAs (Did not attend) declined when psychiatrists were able to consult remotely with their patients/ consumers.
- Being able to send prescriptions via email from a valid DHB email address rather than outdated faxing/posting improved efficiencies and improved consumer satisfaction.

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Where improvements could be made

- While DHBs had a broad pandemic plan, much day to day detail (such as closing the entrance to an outpatient unit and screening patients prior to entry) was absent. Plans needed to be developed as the situation unfolded and delays in communication, up and down chains of authority, made for considerable uncertainty and stress for frontline staff.
- There were some concerns about the security of platforms such as Zoom for the communication of sensitive personal information during a video consultation.
  We will expand upon these issues in our feedback on telehealth, but we strongly advocate that the Ministry develops guidelines on the most appropriate telehealth platform. If telehealth is the 'new normal' then it would make sense for all health providers (across all areas of health) to use the same software/telehealth platform to make it easier for consumers to access services and engage with health providers. With this approach health providers and consumers would only need to be familiar with one platform and this may improve engagement and clinical outcomes.
- The RANZCP advocates for a round table discussion on equity issues associated with delivery of care during a pandemic. The COVID 19 situation exposed the inequities of delivering a model of care based on technology. Those with appropriate knowledge, skills and funds were able to access a well-developed remote health service, while others were left behind. It also became clear that not all consumers have equal access to adequate telehealth services in New Zealand.
  a. Cell phone coverage is poor in rural New Zealand and many towns and cities have very limited connectivity.
  b. Many consumers are unable to afford data and/or do not own or have access to smart phones. These consumers are unable to attend a video-enabled consultation delivering a comprehensive, clinically nuanced service compared with a telephone conversation.
  c. People with learning and language difficulties, intellectual or visual impairment or who are deaf or elderly, may struggle greatly to effectively use technology when face to face models of care are severely curtailed.
  d. People living rurally or in areas of high deprivation (where Māori and Pacific populations are over-represented) are often the most vulnerable populations, as they are exposed to adversity such as poor housing and live with co-morbid conditions. While they require the greatest level of health and social interventions, they often receive the least attention and the configurations in place around telehealth only amplified the current health inequities existing in New Zealand

Managing specific populations with mental health/ addiction issues during the pandemic

- **People with mental health and addiction issues presenting at Emergency Departments**

During a pandemic working with highly disorientated people due to psychosis or intoxication can be very challenging for those treating, supporting or coming in contact with them whilst in ED. Because these individuals are unlikely to understand the risk of contagion due to their clinical presentation, trying to gain compliance regarding COVID-19 restrictions was challenging. People who are dependent on alcohol and other drugs may present in withdrawal due to reduced access to alcohol or drugs and due to reduction in detoxification services provided by specialist alcohol and drug services. Health providers and supporting staff working in ED need to be adequately trained and equipped to provide appropriate health services to these individuals.

There were opportunities to work differently including the development of community hubs to deal with the increased mental health traffic and demand at the ED whereby some services were able to organise additional staff and security arrangements to divert traffic from ED. Unfortunately, these were temporary arrangements that despite working well, are not able to be resourced sustainably. Within the ED and the general hospital, there was increased prevalence of mental health distress among staff members across all disciplines whereby mental health staff were able to provide both formal and informal supports.

- **People in the care of the Department of Corrections**

During a pandemic, prisoners must have access to ongoing psychiatric assessments, even if this results in a shift toward telehealth as the primary channel of assessment. The Ministry, working with the Department of Corrections, should ensure prisoners have adequate technology available for telehealth consultations so psychiatric care can be effectively provided. When appropriate, seriously mentally ill prisoners should still be able to be admitted to inpatient facilities to treat their illnesses rather than left in prison. Hospitals are the best place to manage a seriously mentally ill person at risk of transmitting COVID-19.

The mental wellbeing of those in care of the justice system must be carefully managed, but more so during a pandemic. Many prisoners were not able to receive visitors or see their whānau. For Māori and other cultures, this is likely to impact on their psychological wellbeing as their iwi and hapū connections sustain them during their time in prison. During a pandemic it may be necessary to increase psychological support for prisoners to assist them to manage their social isolation.

We acknowledge in vast majority of situations prisoners will have to be managed within the prison setting. As we experienced during the pandemic the requirement of extensive social distancing measures will have particular implications for those most vulnerable in society, including prisoners. The risk of an outbreak of a pandemic within a prison and the potential harm that would arise from such an outbreak will be considerable. It is therefore important that evidence-based steps are taken to reduce such risk. Further, the pandemic poses risks to staff who may come into close contact with infected people and elevate their risk of infection. Prison staff and mental health staff working in the prison setting will need access to Personal Protective Equipment, and processes need to be established to ensure that their risk of infection is minimised.

- **Older people requiring care, including those with dementia**

COVID 19 had a disproportionate negative impact on older people**.** People reliant on regular support services (such as support staff coming into their home) started to experience a decrease in the mental wellbeing and an increased risk of no longer being able to cope.

Some older people became very anxious due to the risk of contagion and effects of COVID-19, being isolated from their whānau and support systems. In addition, many older people are not technologically savvy, and most apps are not designed for those who are visually or aurally impaired. These individuals require specialised support during a pandemic to keep them well to avoid admission into a DHB or an Aged Residential Care facility. After the lockdown was lifted a large portion of people retrospectively described the lockdown as a significantly stressful period and some described it as a precipitant for relapsing.

- **People requiring ECT (acute presentations)**

During the pandemic the DHBs prioritised healthcare focusing on supporting acute services and urgent care; including ECT. ECT was provided for severe, acute and life-threatening presentations, however, maintenance ECT was compromised with people ending up in a crisis situation due to not being able to access continuous care. As theatre and emergencies services were possibly going to be burdened by the potential pandemic cases, consumers requiring ECT during this period may have found it difficult to access services. DHBs need to keep ECT services available during a pandemic to ensure consumers do not relapse and deteriorate requiring greater interventions in the future.

- **People with addiction issues**

People living with addictions had specific needs during the lockdown and some of these were clinically challenging especially in rural areas. In particular initiating someone on opioid substitution treatment or managing someone with severe alcohol use disorder requiring alcohol detoxification. Assessing a consumer's psychological and physical issues when one is unable to see them face to face is associated with clinical risk. Working using tele-health for short periods is acceptable but clinical risk increases as time progresses**.** Addiction specialists would like to highlight them as issues that would require consideration if the health sector went into lockdown again.

- **Women giving birth during COVID Lockdown**

The lockdown had a negative impact on women's perinatal mental health. Women had limited contact with their midwives, birthed without the support of partners and family/whanau. As a result psychiatrists saw an increase in postpartum psychosis (both in Auckland and Christchurch). This phenomenon has also been reported overseas.

Emerging opportunities & implementation in a Post-COVID health system

- **Improving prescribing processes.** The ability to send prescriptions via email from a valid DHB email address worked well. The RANZCP advocates that this process is enhanced by developing a nationwide electronic medical record system allowing medical practitioners to generate scripts.

- **Improving electronic charting**. Electronic charting solutions for inpatients would also be very helpful in delivering optimal care during a pandemic. Rest homes use different electronic prescribing systems to the DHBs (1Chart and Medi-map for rest homes, and MedChart for most DHBs). Multiple systems make things inefficient and creates difficulties for clinicians and there is an increased risk of error. We seek the Ministry of Health's view on developing greater consistency in this area, such as guidelines or mandating the use of the same system across the various parts of the health system.

Updating the Mental Health (Compulsory Assessment and Treatment) Act 1992 so it can be implemented using telehealth approaches. The RANZCP is supportive of the Mental Health Act allowing a greater use of telehealth for patients with community treatment orders (when deemed appropriate by both parties). While there was some relaxing around working with various parts of Mental Health Act there was a need for more training to implement this well.

- **Implementing Consultation–Liaison Psychiatry to provide greater support across the health service during COVID and after COVID**

Consultation Liaison Psychiatry (CLP) connects medical services, mental health and addiction services, and secondary care service usually in a general hospital setting. The Consultation Liaison Psychiatry Team should be interdisciplinary, including medical, nursing, psychology and allied health professionals. The model fosters a culture of working together to address needs of people with continuing or complex, physical, mental and addiction needs, and by facilitating effective relationships across the DHB's services. CLP services typically assess and manage people in the ED, inpatient wards and outpatient clinics and through close collaboration enabling holistic care for mental and physical health needs. CLP services also have a teaching/skills-enhancement role for non-mental health clinicians by fostering a better understanding of mental health therefore destigmatising people with mental health needs. Allied to CLP, primary care liaison (PCL) in the community enables close mental health collaboration with general practitioners to ensure physical and mental health needs are addressed.

Implementing a CLP and PCL model may benefit the health system by improving the flow of patients/consumers within the hospital and community systems (e.g. developing referral and management pathways) and also help to allay any psychological issues (such as anxiety, depression, separation from loved ones) patients/ consumers may develop due to the pandemic. The RANZCP calls for the DHBs to implement CLP models to improve hospital efficiencies e.g. reduce hospital admissions and bed blockages in a post- COVID environment.
The adequate provision of CLP services during a pandemic needs to be a priority and, if anything, provision increased.

Prioritising health care in a post-COVID-19 environment

Prioritising health care in a post-COVID-19 environment requires a national conversation. As health services return to normal there should be clear national guidelines assisting health providers to manage the health needs of our population. The health system does not have the capacity to meet

everyone's health needs immediately, following a pandemic. There are likely to be tensions prioritising people with chronic vs acute presentations; people who had procedures cancelled due to COVID-19 vs those people who are presenting with new conditions. In addition, there are population groups, who may be forgotten as they are unable themselves to advocate for services and support they need e.g. people with dementia, intellectual disability or serious mental health and addiction conditions. Many consumers we work with have physical co-morbidities that if left unattended, could have an adverse impact on their health outcome. We are concerned that individual DHBs may have their own clinical priorities, where mental health issues are not seen as significantly important, resulting in our consumers not receiving equal access to services.

Closing remarks

The COVID-19 situation provided the health sector with a chance to reflect on the way we work and consider new approaches to health care. For example, clinicians were able to collaborate in developing solutions, such as using email prescriptions to increase efficiencies, and subsequently improve consumer's satisfaction with the health system. These types of innovations need to be built upon in the post-COVID world.

While COVID-19 remains with us there will be continuing uncertainties: the economic, social and psychological consequences of COVID-19 will ripple out across our society. Negative effects will be seen in people losing their jobs, economic recession and these non-health related impacts will have a major impact on mental wellbeing for the entire population and not just people with pre-existing mental illness or those impacted by the health consequences of Covid-19. Mental health and addiction services were already under pressure prior to COVID-19, but it seems likely demand will increase as many people having lost their work, independence and future will seek assistance in the coming months. We ask that the Ministry is mindful of this eventuality and ensures DHBs are adequately resourced to meet this challenge.

Thank you for an opportunity to provide feedback on our experiences during the COVID-19 situation. We look forward to working with the Ministry in the future. If you have any further questions regarding this letter please contact the New Zealand National Office - Tu Te Akaaka Roa. Ms Rose Matthews, National Manager, supports our mahi and may be contacted by email rosemary.matthews@ranzcp.org or by telephone on 04 472 7265.

Ngā mihi

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