Tidsskriftet
DEN NORSKE LEGEFORENING

Patient visits to a psychiatric casualty clinic during the initial phase of the COVID-19 pandemic

KORT RAPPORT

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BACKGROUND

We wished to investigate how the flow of patients to the Psychiatric Casualty Clinic in Oslo was affected during the acute phase of the COVID-19 pandemic.

MATERIAL AND METHOD

All patient records from the Psychiatric Casualty Clinic in Oslo from and including 13 March 2020 up to and including 1 April 2020 were compared with the patient records from the same period in 2019. Patient visits were registered as COVID-19-related when the patient came to the clinic for an issue linked to the pandemic.

RESULTS

The Psychiatric Casualty Clinic in Oslo had 105 patient visits in the period 13 March 2019–1 April 2019 and 63 in the same period for 2020 (–40 %). The number of admissions amounted to 16 in 2019 and 7 in 2020 (–56 %). The number of COVID-19-related consultations was 14/63 (22 %). There was a reduction in the number of patient visits for crisis reactions, from 28 in 2019 to 8 in 2020.

INTERPRETATION

The background for the decline in the flow of patients in the acute phase of the COVID-19 pandemic is most likely a complex one. We believe that patients primarily chose not to visit the clinic due to the risk of infection and the wish to avoid burdening the health services. With the reservation that our data are limited, it does not appear that increased access to psychiatric health services requiring physical attendance is indicated in the acute phase of a pandemic.

A pandemic can affect the population both somatically and psychologically. In England, 24 % of the population reported experiencing anxiety in connection with the swine flu in 2009 (1). We wished to investigate how the flow of patients to the Psychiatric Casualty Clinic in Oslo was affected during the acute phase of the COVID-19 pandemic.

Material and method

The Psychiatric Casualty Clinic is an emergency outpatient service under the direction of Oslo University Hospital. Located on the premises of the accident and emergency department in Oslo city centre, the clinic is open in the evenings and at weekends, and serves some one million residents in and around Oslo. Patients do not need a referral, but are triaged by nurses at the clinic reception prior to assessment by a psychiatrist or psychology specialist.

We compared patient records from the first 20 days following the Norwegian Government's announcement on 12 March 2020 of strict measures to control the COVID-19 pandemic with patient records from the same period in 2019 (from and including 13 March up to and including 1 April). We read and assessed all the records in the given time periods and made a discretionary assessment of the consultations based on the issue that the patients presented with and whether their condition had changed from 2019 to 2020. Patient visits were registered as COVID-19-related when the patient came to the clinic for an issue linked to the pandemic. ICD-10 diagnoses are used, but many patients are not given a specific diagnosis because one consultation does not provide enough information. We therefore categorised the conditions based on the issues that caused the patients to seek help from the clinic. The category of 'crisis reaction' includes a conflict in or break-up of a close relationship, work-related conflicts, or grief in connection with bereavement. The study was submitted to the data protection officer at Oslo University Hospital, who concluded that the study could be conducted without a formal evaluation.

Results

Compared with the same period in 2019, the number of patient visits to the Psychiatric Casualty Clinic declined from 105 in 2019 to 63 in 2020 during the first 20 days of the COVID-19 lockdown. This represents a reduction of 40 %. In addition, the number of psychiatric admissions declined from 16 to 7. The number of involuntary admissions remained relatively stable (7 in 2019, 6 in 2020).

Fourteen of the 63 consultations (22 %) concerned COVID-19-related issues. Seven patients had experienced more anxiety and uneasiness in connection with isolation and worries about infection. Among the seven other patients assessed as COVID-19-related, the reasons

they visited the clinic varied, such as distress that they were not receiving the same follow-up from the specialist health service as before, loneliness, increasingly obsessive thoughts, financial concerns, conflict and breakthrough psychosis. None of the patients had COVID-19 or had been in contact with others who had tested positive for the infection.

Table 1 shows the distribution of the reasons for patient visits/issues during the two time periods studied. While the number of patients with substance abuse problems and personality disorders was largely unchanged, there was a notable decline in the number of consultations for life crises and depression. We also observed a decrease in the number of consultations for psychosis, but this reduction was less pronounced. Moreover, the number of consultations related to suicide or self-harm declined from 38/105 (36 %) in 2019 to 15/63 (24 %) in 2020.

Table 1

Psychiatric issues resulting in patient visits to the Psychiatric Casualty Clinic in Oslo in the period 13 March–1 April in 2019 and 2020 (number).

Psychiatric issues	Time period 13 March–1 April 2019	Time period 13 March–1 April 2020
Crisis reaction	28	8
Substance abuse	22	20
Psychotic disorders (including bipolar disorder)	18	12
Depression	11	2
Anxiety (including post-traumatic stress disorder and obsessive-compulsive disorder (OCD))	10	8
Personality disorders	7	6
Non-specific mental disorder	7	7
Other	2	0
Total	105	63

Discussion

Altogether 40 % fewer patients sought help from the Psychiatric Casualty Clinic in Oslo from and including 13 March 2020 up to and including 1 April 2020 as compared with the same period in 2019. The number of consultations for substance abuse and personality disorders was mostly unchanged, while crisis and depression-related consultations declined significantly. The number of involuntary psychiatric admissions remained stable, while voluntary admissions decreased from nine in 2019 to one in 2020. We believe this could be related to the decline in consultations for life crises and depression.

In China, researchers have investigated psychological reactions during the initial phase of the COVID-19 outbreak. The study found that more than half of the respondents to a questionnaire had moderate to severe mental disorders, the most common one being anxiety (1). We cannot make a direct comparison between the conditions in Norway and China, but 7 of 14 patients with COVID-19-related disorders in our study were also assessed as having anxiety.

The accident and emergency department at St. Olavs Hospital reported a 39 % decline in the flow of patients in week 12 as compared with the corresponding week in the preceding year (2). It is interesting that their numbers and ours are so similar. The general public most likely believes that health facilities pose a high risk of infection, and they take the advice on social distancing seriously. The sight of health personnel in personal protective equipment collecting test samples from patients outside the hospital or in a tent contributes to this impression. People may have thought that the health services were overburdened and for this reason chose not to visit the clinic. We do not have data to support this view, and the

reasons for changes in help-seeking behaviours during a pandemic should be studied further. Nor can we rule out that the decline in the number of voluntary admissions may have been impacted by a higher threshold for patient admissions during the initial phase of the pandemic.

A literature review shows that quarantine in the short term can lead to depression, anxiety, anger and worry (3). These are normal reactions to quarantine. It is therefore important that the general public is informed about normal psychological crisis reactions during times of hardship, and this may prevent such reactions from being interpreted as mental illness. Providing sound information is a strategy that can also protect against long-term emotional distress and malaise (4).

In the book *Psychology of Pandemics* (5), Taylor writes that the extent of the psychological impact of a pandemic on the population is underestimated. Crisis reactions and depression in connection with bereavement, loss of employment and income, family conflicts, isolation and relocation are all to be expected, not only during the pandemic, but also in its aftermath.

The strength of this study is that the numbers stem from a randomly selected accident and emergency department setting that serves a relatively large population, which increases the study's validity. The weakness is that the amount of data is small, making it difficult to perform reliable statistical analyses.

Conclusion

With the reservation that our data are limited, it does not appear that increased access to psychiatric health services requiring physical attendance is indicated in the acute phase of a pandemic. This finding is interesting for acute care in the psychiatric health services and for accident and emergency departments.

MAIN FINDINGS

In the period 13 March 2020–1 April 2020, the flow of patients to the Psychiatric Casualty Clinic in Oslo declined by 40 % as compared with the same period in 2019.

In particular, patients with mild psychological conditions were less likely to visit the clinic.

Fourteen of 63 patients had psychological problems triggered by the COVID-19 pandemic; seven of them had anxiety.

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Published: 14 August 2020. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.20.0388
Received 28.4.2020, first revision submitted 8.6.2020, accepted 2.7.2020.