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Impact of the COVID-19 Pandemic on Consultation-Liaison Psychiatry Services: An Exploratory Study From a Tertiary Care Center in North India

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ABSTRACT

Objective: The coronavirus disease 2019 (COVID-19) pandemic has affected all aspects of psychiatric care, including consultation-liaison psychiatry (CLP) services. The objective of this study was to assess the demographic and clinical profiles of psychiatric referrals made to CLP services during the pandemic period and compare to data during the same timeframe from the previous year at a tertiary care center in North India.

Methods: Data of patients referred for CLP consultation and seen by the CLP team in the medical-surgical wards wherein COVID-negative patients were admitted during the period of March 24, 2020, to October 11, 2020 (approximately 6.5 months, 201 days) were extracted from the CLP register (routinely maintained). These data were compared with that of the same timeframe from the previous year (March 24, 2019, to October 11, 2019).

Results: During 2020, a total of 562 patients were referred to CLP services, in contrast to 1,005 patients referred in 2019, suggesting a 44% reduction in the number of referrals made to CLP services. During 2020, CLP referral patients more often had metabolic/endocrine disorders, myocardial infarction, and peripheral vascular diseases and less often had chronic obstructive pulmonary disease/asthma and autoimmune disorders compared to 2019. Also, the number of referrals made to CLP services in 2020 for treatment of new disorders declined significantly ($P < .001$), whereas referrals for abnormal behavior/uncooperativeness ($P < .001$), self-harm attempts ($P = .007$), and other reasons (evaluation for organ transplant, sleep disturbances; $P = .029$) increased significantly. Further, significantly higher percentages of patients were diagnosed with delirium ($P = .03$) and depressive disorders ($P = .04$) in 2020 compared to 2019.

Conclusions: There was a significant increase in the number of psychiatric referrals for depressive disorders and self-harm attempts among admitted patients from medical-surgical units during the COVID period. These findings suggest that there is a need to modify CLP services to address the needs of patients referred to CLP services, especially during the COVID-19 pandemic.

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The coronavirus disease 2019 (COVID-19) pandemic has brought about several unprecedented events and had a significant negative impact on routine medical services across the world. Like other medical specialties, psychiatric services have also been adversely affected, leading to difficulties in providing care to people with psychiatric illnesses during lockdown periods.^{1–4} Due to lockdowns, routine psychiatric outpatient services were severely hampered, as were other subspecialties, such as child and adolescent psychiatry, addiction psychiatry, rehabilitation, and consultation-liaison psychiatry (CLP) services.^{4,5} The major impact on CLP services was due to the conversion of various medical-surgical wards to COVID wards and reduction in the number of inpatients with other physical ailments.⁶

However, CLP services have continued at many institutions with a change in focus to providing care to hospitalized patients with COVID-19 and mental health issues. Consultation-liaison psychiatrists have also been involved in providing psychological support to aggrieved family members of affected patients and mental health support and counseling to frontline health care workers.^{7–11} These services have been developed in addition to the routine CLP services. Key findings from the limited available literature about the impact of COVID-19 on CLP services suggest an increase in referrals for self-harm,¹² development of new CLP models for patients with COVID-19 infection,¹³ and integration of telepsychiatry services with CLP services for better patient management.¹⁴

Although, a few studies^{1,4,15,16} have evaluated the impact of the COVID-19 pandemic on inpatient and emergency services, little is understood about the impact of the pandemic on routine CLP services.^{6,12} Accordingly, this study aimed to assess the demographic and clinical profiles of psychiatric referrals made to CLP services during the pandemic period and compare with referral patterns during the same timeframe of the previous calendar year.

METHODS

This study was conducted in the Department of Psychiatry of the Postgraduate Institute of Medical Education and Research in Chandigarh, India, which is

Clinical Points

- The coronavirus disease 2019 (COVID-19) pandemic has affected the consultation-liaison psychiatry services, with significant reduction in number of referrals from other non-COVID wards.
- Psychiatric referrals for depressive disorders among patients admitted to medical-surgical units have increased during the COVID-19 pandemic.

a tertiary care hospital in North India. CLP services cater to patients admitted to different wards (medical, surgical, trauma, gynecology, pediatrics). CLP services in our department follow the “consultation” model in which calls can be made by specialists (faculty member, senior resident/registrar, and junior resident) from any department to request a psychiatric consultation for any inpatient under their care. The calls are made via telephone. Our consultation-liaison team is comprised of 2 to 3 trainee residents, a senior resident/registrar (qualified psychiatrist), and a consultant. The trainee resident makes the initial evaluation, and, subsequently, the patient is examined by the senior resident followed by the consultant. After initial evaluation, a treatment plan is formulated, which may constitute a request for further investigations, treatment with psychotropics and nonpharmacologic measures such as brief counseling sessions, and recommendations for consultations with other specialties for diagnostic clarification and management of symptoms. All psychiatric diagnoses are made per the *International Classification of Diseases*, Tenth Edition (ICD-10)¹⁷ criteria.

Besides documenting details of the patient's psychiatric issues in the main medical file, the CLP team maintains their own records of all patients, from the time of initial evaluation to discharge, which includes the sociodemographic profile, clinical details, diagnosis, and management. The CLP team maintains a register of all patients seen. The records are reviewed on a weekly basis for accuracy and completion.

Since the onset of the COVID-19 pandemic, patients requiring medical/surgical and other services have been admitted to different wards/intensive care units (ICUs) after a COVID RT-PCR (real-time polymerase chain reaction) negative result. Those with a positive result are admitted to designated COVID wards and ICUs of the hospital. Patients admitted to the COVID ward who require further medical care are shifted to the non-COVID area once they become COVID negative on RT-PCR. The retesting of such patients is usually done after 10 to 14 days of initial COVID-positive status.

For the purpose of this study, data of patients seen by the CLP team in the different medical-surgical wards wherein non-COVID patients were admitted during the period March 24, 2020, to October 11, 2020 (approximately 6.5 months, 201 days) were extracted from the CLP register and compared with data from the previous year in the same timeframe (ie, March 24, 2019, to October 11, 2019).

RESULTS

In 2020, a total of 562 patients were referred to CLP services. In contrast, a total of 1,005 patients were referred during the same timeframe in 2019, suggesting a 44% reduction in the number of referrals made to CLP services in 2020.

The mean number of patients seen per day declined from 5.05 to 2.82 per day. Demographic profiles revealed that patients in 2020 were younger, were more often referred from the surgical specialties, and were less often referred from neurology and neurosurgery compared to those in 2019. Further, in 2020 the number of referrals for treatment of new disorders decreased significantly, whereas referrals for abnormal behavior/uncooperativeness, self-harm attempts, and other reasons (ie, evaluation for organ transplant, sleep disturbances) increased significantly (Table 1).

In terms of clinical profiles, patients referred to CLP services during 2020 more often had metabolic/endocrine disorders, myocardial infarction, or peripheral vascular diseases and less often had chronic obstructive pulmonary disease/asthma and autoimmune disorders. Also, a significantly higher proportion of patients referred to CLP services during 2020 had involvement of the respiratory system and less often had involvement of the musculoskeletal system compared to patients in 2019 (Table 2).

When psychiatric diagnoses were compared, the results showed that a significantly higher percentage of patients in 2020 were diagnosed with delirium and depressive disorders. Further, a significantly higher proportion of diagnoses were deferred in 2020 compared with 2019. There was also a significant reduction in the number of patients considered to have no psychiatric diagnosis in 2020 (Table 2). In terms of psychiatric management in 2020, there was a significant increase in interventions in the form of use of medications only, use of medications and investigations, and use of medications and referral to a drug addiction center for further management and a significant reduction in the number of patients receiving brief counseling and other interventions (Table 2).

DISCUSSION

The results of the present study suggest that the COVID-19 pandemic and subsequent lockdown had a significant negative impact on the psychiatric referrals from non-COVID ward areas. There was approximately a 44% reduction in referral rates. No previous studies, to our knowledge, have compared referral patterns during the COVID-19 pandemic with the period prior by reviewing the exact data; hence, it is difficult to compare the findings of the present study with the existing literature. A survey of training institutes from India reported reduction in referral rates of 70%.⁴ When we compare our findings with the results of that study,⁴ the proportional reduction in referrals at our center was lower than that reported in the survey. This lower rate possibly suggests that, at our institute,

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Table 1. Demographic Profiles of Patients and Referral Patterns Seen by Consultation-Liaison Psychiatry Services in 2019 and 2020

Variable	2019 (n = 1,005)	2020 (n = 562)	T/ χ^2 (P value)
Age, mean (SD), y	44.31 (19.26)	42.28 (19.06)	2.003 (.045)*
Breakdown by age, n (%), y			
< 15	47 (4.7)	33 (5.9)	7.824 (.098)
15–30	246 (24.5)	146 (26.0)	
31–45	231 (23.0)	153 (27.2)	
46–60	250 (24.9)	118 (21.0)	
> 60	231 (23.0)	112 (19.9)	
Breakdown by age group, n (%), y			
< 60	774 (77.0)	450 (80.1)	1.969 (.16)
> 60	231 (23.0)	112 (19.9)	
Sex, n (%)			
Male	642 (63.9)	368 (65.5)	0.403 (.526)
Female	363 (36.1)	194 (34.5)	
Source of referral, n (%)			
Medical and allied branches	503 (50.0)	258 (45.9)	2.47 (.11)
Surgical and allied branches	372 (37.0)	254 (45.2)	10.05 (.001)***
Pediatrics	23 (2.3)	5 (0.9)	3.26 (.07) ^a
Neurosciences	51 (5.1)	15 (2.7)	5.17 (.02)*
Obstetrics and gynecology	50 (5.0)	24 (4.35)	0.39 (.52)
Other	6 (0.6)	6 (1.1)	1.05 (.305)
Reason for referral, n (%)			
Continuation of psychiatric treatment	105 (10.4)	44 (7.8)	2.872 (.09)
Treatment of new disorders	364 (36.2)	121 (21.5)	36.38 (< .001)***
Abnormal behavior/uncooperativeness	293 (29.2)	227 (40.4)	20.52 (< .001)***
Drug deaddiction	89 (8.9)	63 (11.2)	2.28 (.13)
Self-harm attempts	26 (2.6)	29 (5.2)	7.04 (.007)**
Clearance for surgery	97 (9.7)	46 (8.2)	0.935 (.33)
Differential diagnosis	8 (0.8)	10 (1.8)	3.06 (.07)
More than 2 reasons	5 (0.5)	2 (0.4)	0.0001(.99) ^a
Other	18 (1.8)	20 (3.6)	4.75 (.029)*

^a χ^2 test with Yate's correction.

* $P < .01$; ** $P < .05$; *** $P < .001$.

medical-surgical services were not as affected compared to others. The finding of a reduction in referral rates of 44% in our study confirms that CLP services were significantly affected by the COVID-19 pandemic.

In terms of demographic profiles, patients seen by the CLP teams during the COVID-19 pandemic were younger and more often referred from the surgical specialties. These findings are understandable considering that the elderly are more vulnerable to COVID-19 infection, which possibly led to a reduction in that population seeking medical care despite various medical-surgical illnesses. An increase in the proportion of referrals from the surgical specialties could be a reflection of a greater reduction in patients admitted in the medical specialties, whereas those requiring emergency surgical procedures continued to seek care. The present study also suggests that there was a significant reduction in the number of referrals for treatment of new disorders and a significant increase in referrals for abnormal behavior/uncooperativeness (usually for patients with delirium), self-harm attempts, and other reasons (ie, evaluation for organ transplant, sleep disturbances). This change in the number of psychiatry referrals possibly reflects the attitudes of the physicians and surgeons, who may have refrained from seeking psychiatric consultations except in those cases for which it was unavoidable.

In terms of the clinical profiles of those referred to the CLP team, a higher proportion of patients referred during the COVID era had metabolic/endocrine disorders, myocardial

infarction, or peripheral vascular diseases and less often had chronic obstructive pulmonary disease/asthma and autoimmune disorders. Also, a significantly higher proportion of patients referred during 2020 had involvement of the respiratory system and less often the musculoskeletal system compared to 2019. This profile change again reflects the urgency of care required for medical-surgical illnesses, suggesting that only patients who required urgent care were admitted to medical-surgical wards. The higher proportion of those with respiratory system involvement may be due to the initial consideration of COVID infection, but then later being found to be COVID negative.

In terms of impact of the COVID-19 pandemic on the diagnostic profile of patients seen by the CLP team, a significantly higher percentage of patients were diagnosed with delirium and depressive disorders in 2020 compared to 2019. There was also a significant increase in the “deferred” diagnosis during the COVID era. The increase in the number of patients with delirium may reflect a reduction of those with other diagnoses, rather than an increase in the prevalence of delirium in our inpatient setting. The increase in referrals for depressive disorders may reflect a general increase in low mood and anxiety due to being in the hospital setting and being vulnerable to the COVID-19 pandemic. Many studies^{4,18–21} conducted worldwide during the COVID-19 pandemic also suggest an increase in rates of common mental health problems (depression and anxiety) in the general population. Thus, this increase

Table 2. Clinical Profile of Patients Seen by Consultation-Liaison Psychiatry Services in 2019 and 2020^a

Variable	2019 (n=1,005)	2020 (n=562)	T/ χ^2 (P value)
Medical/surgical diagnosis			
Infections	119 (11.8)	62 (11.0)	0.23 (.63)
Neoplasms	140 (13.9)	83 (14.8)	0.207 (.64)
Trauma	154 (15.3)	82 (14.6)	0.151 (.69)
Poisoning	43 (4.3)	17 (3.0)	1.53 (.21)
Metabolic/endocrine disorders	92 (9.2)	92 (16.4)	18.10 (<.001)***
Epilepsy	11 (1.1)	7 (1.2)	0.07 (.78)
Other neurologic disorders	9 (0.9)	0 (0)	...
Multiple diseases (> 2)	58 (5.8)	35 (6.2)	0.13 (.71)
Chronic obstructive pulmonary disease/asthma	14 (1.4)	1 (0.2)	4.40 (.035)* ^b
Burns	18 (1.8)	14 (2.5)	0.88 (.34)
Degenerative disorder	34 (3.4)	6 (1.1)	7.76 (.005)**
Surgical postoperative cases	69 (6.9)	41 (7.3)	0.102 (.74)
Myocardial infarction/coronary artery disease	31 (3.1)	30 (5.4)	4.89 (.02)*
Peripheral vascular diseases	3 (0.3)	9 (1.6)	8.05 (.004)*
Autoimmune disorders	92 (9.2)	2 (0.4)	49.48 (<.001)***
Cerebrovascular accident	5 (0.5)	3 (0.5)	0.07 (.78) ^b
Postpartum psychosis	0 (0)	6 (1.1)	...
Other	90 (9.0)	65 (11.6)	2.75 (.09)
No diagnosis	23 (2.3)	7 (1.2)	2.08 (1.56)
System involved			
Obstetrics and gynecology	54 (5.4)	23 (4.1)	1.26 (.26)
Nervous system	125 (12.4)	65 (11.6)	0.25 (.61)
Genitourinary	56 (5.6)	27 (4.8)	0.423 (.51)
Musculoskeletal	158 (15.7)	27 (4.8)	41.25 (<.001)***
Respiratory	31 (3.1)	77 (13.7)	63.30 (<.001)***
Gastroenterology/hepatology	229 (22.8)	135 (24.0)	0.30 (.57)
Cardiovascular	75 (7.5)	54 (9.6)	2.19 (.13)
Hematology	31 (3.1)	21 (3.7)	0.47 (.48)
Endocrinology	23 (2.3)	10 (1.8)	0.45 (.50)
Dermatology	17 (1.7)	8 (1.4)	0.16 (.68)
Renal	22 (2.2)	16 (2.8)	0.65 (.41)
Eye	10 (1.0)	7 (1.2)	0.21 (.64)
Ear, nose, and throat	4 (0.4)	7 (1.2)	3.71 (.05)
Other	18 (1.8)	17 (3.0)	2.51 (.11)
Multisystem	115 (11.4)	73 (13.0)	0.81 (.36)
No system involved	37 (3.7)	8 (1.4)	6.58 (.01)*
Psychiatric diagnosis			
Delirium	337 (33.5)	219 (39.0)	4.65 (.03)*
Depressive disorder	105 (10.4)	78 (13.9)	4.11 (.04)*
Dementia	16 (1.6)	2 (0.4)	3.82 (.05) ^b
Bipolar disorder	15 (1.5)	5 (0.9)	0.68 (.40)
Anxiety disorder	19 (1.9)	8 (1.45)	0.46 (.49)
Substance withdrawal	150 (14.9)	65 (11.6)	3.43 (.63)
Adjustment disorder	78 (7.8)	55 (9.8)	1.90 (.16)
Organic psychosis	6 (0.6)	1 (0.2)	0.63 (.42) ^b
Intellectual disability	10 (1.0)	3 (0.5)	0.45 (.49) ^b
Psychotic illness	28 (2.8)	18 (3.2)	0.21 (.63)
Catatonia	9 (0.9)	2 (0.4)	0.83 (.36) ^b
Somatoform and dissociative disorders	5 (0.5)	3 (0.5)	0.07 (.78) ^b
Drug-induced side effects	5 (0.5)	3 (0.5)	0.07 (.78) ^b
Intentional self-harm	19 (1.9)	14 (2.5)	0.63 (.42)
Insomnia	3 (0.3)	3 (0.5)	0.08 (.76) ^b
Deferred	80 (8.0)	68 (12.1)	7.22 (.007)**
Other	7 (0.7)	4 (0.7)	0.07 (.77) ^b
No psychiatry diagnosis	113 (11.2)	11 (2.0)	42.65 (<.001)***
Management			
No intervention was required	52 (5.2)	23 (4.1)	0.92 (.33)
Referred to psychiatric outpatient department/telepsychiatry services	13 (1.3)	2 (0.4)	2.42 (.11) ^b
Admission to psychiatry ward	21 (2.1)
Drugs alone	29 (2.9)	48 (8.5)	24.67 (<.001)***
Brief counseling alone	148 (14.7)	51 (9.1)	10.38 (.001)***
Investigations alone	41 (4.1)	28 (5.0)	0.69 (.40)
Drugs + investigations	236 (23.5)	174 (31.0)	27.34 (<.001)***
Investigations + brief counseling	21 (2.1)	4 (0.7)	3.52 (.06)
Drugs + brief counseling	125 (12.4)	63 (11.2)	0.51 (.47)
Drugs + investigations + counseling	176 (17.5)	109 (19.4)	0.85 (.35)
Drugs and referred to drug deaddiction center	9 (0.9)	13 (2.3)	5.23 (.02)*
Clearance for surgery	80 (8.0)	34 (6.0)	1.95 (.16)
Stopped psychotropics	10 (1.0)	6 (1.1)	0.01 (.89)
Other	44 (4.4)	7 (1.2)	11.23 (<.001)***

^aData are presented as n (%). ^b χ^2 test with Yate's correction. * $P < .01$; ** $P < .05$; *** $P < .001$.

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in mental health problems in general during the COVID-19 pandemic could also have contributed to the increase in the number of referrals for depressive disorders seen in our study. The present study also suggests a nonsignificant increase in the number of referrals for self-harm attempts, which could reflect the increase in the incidence of self-harm and completed suicides across the world^{22–24}—more so in low- and middle-income countries during the COVID-19 pandemic. Another study¹² evaluating CLP services in India also reported an increase in the number of patients with self-harm referred to CLP services. This finding suggests that there is an urgent need to develop policies to curb the rates of self-harm during the ongoing pandemic. The increase in the number of cases with deferred diagnosis may be a reflection of functioning of the CLP team, ie, not evaluating patients in detail due to fear of getting infected or availability of patients for shorter duration of evaluation. Reduction in the number of cases with no psychiatric diagnosis may again reflect the reduction in the number of referrals of patients seeking routine psychiatric evaluation (ie, non-urgent cases).

In terms of psychiatric management, there was a significant reduction in the number of patients receiving brief counseling and other interventions and an increase in the number of patients receiving medications only or medication and investigations only. This change in the management pattern may reflect less time spent with the patients, possibly due to fear of infection on the part of the psychiatrist providing CLP services. These findings suggest that all the needs of patients referred to CLP services are possibly not being met during the ongoing COVID-19 pandemic.

The present study has certain limitations, which include the recording of only a few variables for analysis. Also, we cannot generalize these findings to the entire country, as the nature of CLP services provided and treatment settings vary from center to center.

The present study suggests that the COVID-19 pandemic has led to a reduction in the number of psychiatric referrals from non-COVID wards due to a reduction in the number of admissions in these areas. This finding suggests that there is a need to restructure CLP services. The reduction in referrals could be due to avoidance of contact to minimize the spread of infection. Hence, there is a need to develop new models of CLP by using technology (such as telepsychiatry and remote monitoring and surveillance systems) to provide better and more efficient patient care.

Future studies should assess the barriers to providing CLP services so that more robust strategies can be developed to overcome them. Also, training in CLP services should be given more weight in psychiatric training curriculums worldwide.

CONCLUSION

The present study suggests that compared to the pre-COVID period, during the COVID era there was a 44% reduction in the number of psychiatric referrals for CLP services, with more referrals made from surgical units and for abnormal behavior and delirium. There was a significant increase in the psychiatric referrals made for depressive disorders and self-harm attempts among the admitted patients from medical-surgical units during the COVID period. These findings suggest that there is a need to modify CLP services to address the needs of referred patients. Given that India is struggling at the time of this writing with the second wave of COVID-19 infection and that there are predictions for a third wave in the near future, medical colleges and hospitals should strengthen CLP services and train frontline health care workers to identify mental health issues in patients with or without COVID-19 infection for prompt referral and better management.

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