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Telepsychiatry in Brazil during the COVID-19 pandemic: Did we exchange a walk-on part in a war for a lead role in a cage?

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The Institute of Psychiatry of the Federal University of Rio de Janeiro is located in a small fraction of the campus where, in 1856, the National Asylum for the Alienated was established as the technological vanguard of psychiatric science and treatment in the Americas. The admixture of tradition and innovation in our institutional culture drives us to lead the National Health System (SUS) towards the best current practices while avoiding the various temporary fads that dot the evolution of technology in medicine and psychiatry. But as we stroll through the beautiful, now empty, gardens and realize the usual lively patient activities and informal meetings around the traditional cafeteria were replaced by the occasional cloth-masked patient followed by a pandemic-battlesuit-clad nurse, we cannot help but ask ourselves: How could we have been better prepared for something like that?

The simple answer is: The SUS could be ready to provide psychiatric care for a significant fraction of our patients via telemedicine. Not only would it avoid long journeys in public transportation and face to face contact with health professionals, but it would also allow psychiatrists and other mental health professionals with risk factors for severe forms of COVID-19 to contribute safely to patient care. A proactive telepsychiatry strategy could also spare precious ER capacity by identifying and addressing some of the expected increase in severe symptoms, including suicide risk, that is anticipated during the shelter at home phases of the global pandemic.

Unfortunately, attitudes toward telemedicine in Brazil are surprisingly hostile, for a country that is disproportionately technophilic for its earning levels. Brazil is known in tech circles for being an early adopter of new technologies but had no significant telemedicine activity before the COVID-19 pandemic outside some research and niche applications.[1] Virtual patient visits by video or any other means were specifically forbidden by the Federal Council of Medicine (CFM), and even limited attempts to give a legal framework to telemedicine, were met with strong resistance from physician organizations, being quickly withdrawn by the council.[2] When push came to shove, and telemedicine became not only convenient but a literal matter of life and death, the professionals, were left scrambling with a patchwork of unspecialized solutions and no know-how to implement a sophisticated program of telemedicine from scratch. In other words, we not only had to learn how to fly the plane after we took off, but we also had to build it while in freefall.

When in the middle of Rio de Janeiro's post-carnival summer, we faced the COVID-19 pandemic, a question emerged: How do we develop a protocol for the assistance of outpatients at IPUB? We knew that 67% of our patients had severe mental health disorders, and of these, most were clinically stable.[3] The same could not be said of almost 50 outpatients who awaited their follow-up consultation after the first evaluation with the screening team, who we already knew had symptoms that were severe enough to be seen in our outpatient clinic. Without a clear perspective on when social distancing will be eased and with numerous socioeconomic stressors, associated with the fear of contamination and dying, which aggravate

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psychiatric conditions, it was urgent to start a telemedicine program, even without the ideal infrastructure and despite the resistance of some mental health professionals. The absence of a perfect solution should not stop us from making incremental improvements, though. While there will always be tradeoffs in the complex interactions between infrastructure, preferences, and the capacity to emulate the more traditional, in-person consultation,[4] we were confident that we could deliver high-quality care with the creative use of available internet conferencing tools, and messaging apps.

Our working group decided to adapt an open-source alternative to popular video conferencing apps, as suggested by the IT team at UFRJ. We created virtual consultation rooms staffed by medical residents teamed with preceptors that were already working remotely due to high risk of severe COVID19 disease. Patients were called, and those who agreed to attend a video consultation received a tutorial with step-by-step instructions on how to access the platform. While our program is still in implementation and adjustments are expected to be made on the fly, patients' adherence to this new type of care has been above expectations.

Mental health professionals need to develop new skills, harness the famed adaptability of our services, and rise to the occasion. It is our duty to spearhead the push for the development of telemedicine, helping our patients and colleagues stay safe while we provide the best of our care and develop the technologies and our know-how in a sensible and responsible way. One certainty remains: the pandemic will end, but telepsychiatry is here to stay.

CONFLICTS OF INTEREST

RFG and IN are employees of the Federal University of Rio de Janeiro and report no conflicts of interest in the development of this text.

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