Report from King Chulalongkorn Memorial Hospital, Bangkok, Thailand

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Thailand is a developing middle-income country with a good medical system and medical personnel but limited budget and information technology. Chulalongkorn Hospital is an 800-bed general hospital with 17 inpatient psychiatric beds located in the center of the Bangkok metropolitan area. Outpatient visits per day number around 100-200. All patients receive medications from the hospital pharmacy only, as we have no local pharmacy prescription system. This hospital has one of the largest COVID-19 screening clinics and one of the largest COVID inpatient units in the country. A nearby hotel has been converted into isolation/step-down wards. So far, we have had 153 positive patients, without mortality yet. The countrywide case number has been slowly rising from under 100 a couple weeks ago to more than 2,000 with 20 deaths today. Likely, the number is under-reported due to the highly strict testing criteria and limited lab resources. Looking on the good side, the hot weather, widespread mask use due to pollution concerns, and a Facebook social distancing campaign may help. Also appreciated is the hard-work of the frontline ID, ICU, Chest, IM, and Epidemiology colleagues. Gradually, we expect a large wave of incidence in April for the whole country.

I would like to report the COVID-19 related developments in my department over the past 3 weeks in time sequence.

On March 13, 2020, I was on my first day back from paternity leave, having the “COVID-19 is far away from me” attitude. On the next day, one resident was called to see a PUI with suicidal ideation at the COVID screening clinic without much protection. We began a COVID-19 manual for psychiatric residents, a manual which included common psych presentations, caring for and protecting oneself, and practical pharmacological and non-pharmacological management for anxiety, altered mood, agitation, and delirium. The manual was shared with psychiatric residents and psychiatrists in the community. The manual was later adapted for non-psychiatric physicians and nurses as COVID-psychiatry frontline management. This guideline for medical/nursing teams, plus a psych hotline described below, may have helped lower consultation rates for our C/L team.

On March 17, one visitor to the inpatient unit was found to be COVID-positive, and another visitor proved to have been exposed. The whole unit plus its doctors were quarantined. One febrile patient passed through the screening protocol of the outpatient clinic and exposed a senior psychiatrist.

On March 19, we established a COVID-19 psych taskforce. Inpatient consults were converted to video call or telephone only. All inpatient groups were stopped. Discharge plans were advanced. Strict temperature checks, hand-washing, mask-wearing, and a symptom/exposure questionnaire for every person entering the unit were started, along with a social distancing protocol and isolation rooms for newly admitted cases. A similarly strict screening process was started for the outpatient clinic. A team of residents and nurses called stable patients in advance and refilled scripts. This lowered the actual cases per day down to 15-20% of normal numbers. The social worker started to refill and mail medication supplies for remote patients.

The Anesthesia team refused to continue ECT in April, to lower exposure and spare PPE for COVID patients, and we attempted to do more ketamine for severely depressed/suicidal patients. We

gathered all the high risk patients for a last dose of ECT in March, and will do no more ECT (except for NMS, perhaps).

There was a slight reduction in consult and ER cases. We made plans for telephone call/iPad consults in the COVID unit. Only one staff and resident with full PPE were allowed for a brief actual bedside consult if unavoidable. More personal protection was arranged for the residents seeing ER cases.

By March 23, we felt better protected in our psych facilities. Staff psychiatrists worked on writing or translating COVID-19-related articles for the psychiatric and medical communities countrywide. We covered topics such as WHO mental health recommendations, self-care during the quarantine, child/elderly psychological care, medical personnel burn-out, self-care for psychiatrically ill people during the COVID-19 crisis, personal protection protocol for psych personnel, how to establish tele-psychiatry (very new in Thailand), etc. A psychiatrist with good IT background worked on equipping the clinics with one tele-health station. We asked senior psychiatrists to stay at home while residents and juniors provided coverage. Some services started to do 2 weeks on and 2 weeks off. All classes were converted to online. All elective rotations were canceled. Stable clozapine patients could extend their CBC and refill for up to 3 months. A list of high risk patients in the community was compiled so social workers and community psychiatrists could call and monitor them regularly during the pandemic.

At this time, the incidence of COVID positive cases has been rising in community. We were contacted by the ID team as they needed mental health care, not for the very sick in ICU, but for quarantine patients in the hospital and hotel, and for patients who returned to community and were stigmatized and rejected. Mostly, they suffered from panic attacks, claustrophobia, withdrawal, depression, and suicidal urges. We started a 24/7 hotline number so that frontline physicians and nurses could contact a group of psychologists and social workers immediately. This hotline worked well for our team, as the psychologist/SW could triage cases, gather psychiatric information, do screening tools, and provide counseling via telephone. I supervised them and suggested primary care doctors prescribe psychotropics – it felt like the collaborative model. Patients who needed more care would be connected to the psych clinic and C/L team. The hotline expanded to support the medical personnel as well. ECT will be performed once every 2 weeks only for high risk cases. We arranged an acrylic box, full PPE, and N95 masks for the whole ECT team. Now surgical masks, N95 masks, and other PPEs are in short supply. The community donated DIY masks, face-shields, disposable cloth masks, and acrylic screens (for droplet protection during psych interviews). I expect to see more in-house COVID-psych consults over the next few weeks. Sadly, the media reported more completed suicides in last few days, possibly associated with the COVID societal-economic shutdown.

I hope this present account will help, especially for the areas with limited resources. What I learned is that moving fast is more important than perfection, and horizontal work is better than vertical work in this situation. Our medical system, like many, is hierarchical in normal times, but the department made a clear statement that teams should be creative and independent. Small groups communicated horizontally and and moved quickly to address the evolving situation. There were some errors and points of confusion, but horizontal collaboration often proved more effective than waiting for full instructions from above.

Guidance from the ACLP website and email list server has been valuable for me, and much appreciated. I am sending my thoughts and my heart-felt best wishes to all C/L staff in US and around the world. Take care, all.