

Effect of the COVID-19 Pandemic on Psychiatric Service Use Among Psychiatric Outpatients



Cengiz KILIÇ¹, Özge TÜRKOĞLU², Kezban Burcu AVANOĞLU³,
PSYDEMIC Study Group⁴, Elif ANIL YAĞCIOĞLU⁵, Berna Diclenur ULUĞ⁶

ABSTRACT

Objective: Both general medical and mental health services were disrupted during the pandemic. It is unclear how these disruptions played out for people with various mental health diagnoses. We compared change in mental health status and use of mental health services between four psychiatric groups: schizophrenia spectrum disorders, bipolar disorder, unipolar depression, and anxiety/obsessive-compulsive disorder (OCD).

Method: Using a semi-structured interview, 492 outpatients with psychiatric disorders who had used psychiatric services at a university hospital before the pandemic were assessed on the phone during the pandemic.

Results: About half of the sample reported a need for contact with mental health services during the pandemic, half of whom actually used services. Need for contact was much lower in the schizophrenia group than other diagnostic groups, whereas actual use of services was lower in the unipolar depression and anxiety/OCD groups.

Conclusions: Patients with severe mental disorders, such as schizophrenia or bipolar disorders, may not be in a more disadvantageous position in terms of psychiatric service use during the pandemic. The pandemic response structure of mental health services should be modified to fit the needs of anxiety/depression spectrum patients.

Keywords: COVID-19, Mental Health, Pandemic, Outpatient, Services Use

INTRODUCTION

COVID-19 and Mental Health

The COVID-19 pandemic has led to the death of more than 6 million people worldwide (WHO, 2019). There has been a psychological toll as well, with a global increase in the prevalence of mental health problems in the general population (Georgieva et al. 2021, Mortier et al. 2021, Zhang et al. 2022). Although some studies found no effect of the pandemic on psychotic symptom levels (Pinkham et al. 2020, Özçelik Eroğlu et al. 2022), distress (Grossman-Giron et al. 2022), or OCD symptoms (Moreira-de-Oliveira et al. 2022), most have shown a general worsening in anxiety and depression levels (Gobbi et al. 2020, Lewis et al. 2022, Quittkat et al. 2020); distress (Van

Rheenen et al. 2020); obsessive-compulsive disorder (OCD) symptoms (Benatti et al. 2020, Tükel et al. 2022); psychotic symptoms and suicidal ideation (Muruganandam et al. 2020, Szmulewicz et al. 2021, Strauss et al. 2022, Bassiony et al. 2023) in people with pre-existing mental disorders. This may be due to direct effects of the pandemic including increased risk of acquiring COVID-19 or having a worse prognosis once infected (De Hert et al. 2022), which can be attributed to reduced risk-awareness and non-compliance with preventive measures (Chevance et al. 2020, Wang et al. 2021), or to having additional medical comorbidities known to be associated with worse prognosis (Wang et al. 2021, Tzur Bitan et al. 2021). Reduced access to services due to lockdowns also likely caused symptom worsening; moreover, indirect effects of the

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^{1,5,6}Prof., ^{2,3}Psychiatrist, Hacettepe University, Department of Psychiatry, Ankara; ⁴PSYDEMIC Study Group: Özlem Şeyda Uluğ¹, Istanbul Arel University, Department of Psychology, İstanbul; Prof., Kathy Magruder², Medical University of South Carolina, ABD; Psychiatrist, Melike Karaçam Doğan³, Psychiatrist, Hayri Can Özden⁴, Psychiatrist, İ. Mert Erdoğan⁵, Psychiatrist, Esen Ağaoglu⁶, Psychiatrist, Nilgün Oktar Erdoğan⁷, Psychiatrist, H. Ertuğ Baki⁸, Psychiatrist, Oğuz Kaan Yalçinkaya⁹, Psychiatrist, Cengiz Arca¹⁰, Psychiatrist, İbrahim Aylak¹¹, Tuğba Taşdemir¹², Talat Demirsöz¹³, Nurhayat Eni¹⁴, Hacettepe University, Department of Psychiatry, Ankara; Psychiatrist, E. Selin Aliyev¹⁵, Hacettepe University, Department of Child and Adolescent Psychiatry, Ankara, Turkey.

e-mail: cengizk@hacettepe.edu.tr

pandemic (lockdowns and other mandates, high uncertainty, etc.) on patients with psychiatric disorder may have been more severe compared to the general population (Solé et al. 2021).

Use of Mental Health Services During the Pandemic

Mental health services are globally less developed compared to general medical services and have additional access barriers (Thornicroft and Tansella, 2013). These include stigma related to having a mental health condition and associated utilization of mental health services, as well as unavailability of or low priority given to such services (Öngür et al. 2020). Emerging evidence indicates that acute COVID-19-related medical concerns and lockdown measures led to delays in patients' psychiatric care seeking, as has been reported for patients with other problems, such as cardiac and neurologic conditions (Öngür et al. 2020). Studies showed decreased rates of admissions/hospitalizations and emergency room (ER) visits (Rømer et al. 2021, Szmulewicz et al. 2021, Busch et al. 2022), significant rates of missed appointments (Muruganandam et al. 2020, Seo et al. 2021, Kertzscher et al. 2022) and discontinuation of medications (Muruganandam et al. 2020, Gupta et al. 2022) for psychiatric patients. Several studies have examined if use of mental health services differ in relation to specific groups of mental disorders. Some found increased rates of services use for patients with psychosis (Deren et al. 2023) and eating disorder (Akgül et al. 2023) or general mental health outpatient visits (Yang et al. 2020). In a retrospective chart review of psychiatric outpatients, there was a decrease in use of mental health services for patients with schizophrenia, depression, and anxiety disorders during a three-month period within the pandemic, with the greatest reduction in those with anxiety disorders (Seo et al. 2021). Mental health-related hospitalizations and emergency department visits declined immediately after the onset of the pandemic, again with the largest decline in hospitalization in those with anxiety disorders (Saunders et al. 2021). In two other retrospective studies, psychiatric emergency department visits were reduced for most psychiatric diagnosis subgroups except for patients with schizophrenia (Hamlin et al. 2022, Muştucu et al. 2023). Conflicting results could be due to different samples or to differential availability of telemedicine.

Aims of the Current Study

Our primary aim was to understand factors related to use (or under use) of mental health services during the pandemic, with a focus on the effects of worsening of mental symptoms, and to compare different diagnostic groups in terms of services use. We hypothesized that there would be a general decrease in the use of mental health services for all diagnostic groups during the pandemic; and that patients with severe mental disorders (typically considered to be conditions such as

schizophrenia or bipolar disorder) would be more negatively affected than others (i.e., they would report higher rates of "worsening of symptoms" and would rate their current mental health as worse than others). Finally, we hypothesized that patients with severe mental disorders would report higher need for and lower use of mental health services during the pandemic compared to other patients.

METHOD

The Setting

Our outpatient clinic is located at the city center and receives around 80-100 outpatient visits a day. Most of these patients are seen at the general psychiatry outpatient clinic by 7 or 8 third and fourth-year psychiatry residents, with oversight by the faculty consultants in charge. Reasons for use of outpatient services are multiple. In addition to new admissions and follow-up visits, there are those sent from courts or from prisons to be assessed for a forensic report, those who come for a medication refill only, and those who come for testing, including blood tests, projective and neurocognitive tests. There are also several specialty outpatient services, such as geriatric psychiatry, gender dysphoria clinic, drug dependence clinic, and forensic psychiatry admissions, all of which operate on certain days of the week.

The Sample

The appointments at our psychiatry outpatient clinic were reduced when COVID-19 measures were implemented and most patients who called the clinic were advised not to come unless there was an urgent problem. The number of all monthly contacts (private appointments, blood tests, NPT and other psychological assessments, forensic cases, etc.), which had been relatively stable over time (1700-1800 before the pandemic), dropped abruptly to 1200 in March and to 320 in April 2020 (Figure 1). The drop in patient volume was similar across the four major diagnostic groups (telemedicine contacts were not assessed).

Our target population was all general psychiatry outpatients between 18-65 years old (N=943) who were seen by psychiatry residents of Hacettepe University Psychiatry outpatient department within the month of December 2019. Out of the eligible 943 patients included, 361 could not be reached despite three attempts, and 90 refused. We ended up with 492 completed interviews. A further 68 people were excluded (see below) because they did not belong to any of the four major diagnostic groups that we wanted to study. The analyses therefore were based on 424 patients. All patients that were included had International Classification of Diseases 10th Revision (ICD-10) diagnoses given by an experienced (3rd and 4th year psychiatry resident) clinician. The ICD-10 diagnostic groups variable (primary diagnosis

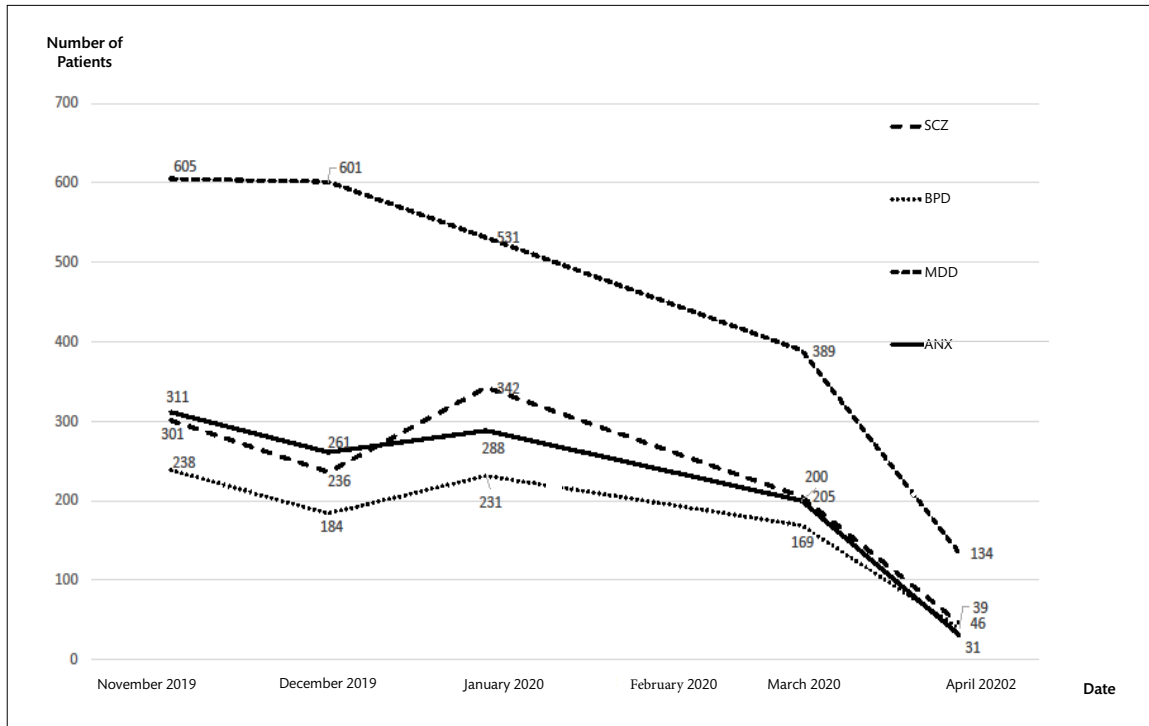


Figure 1. Volume of all psychiatry outpatient visits (N=1786) by diagnosis before and during the pandemic. SCZ: Schizophrenia, BPD: Bipolar affective disorder, MDD: Major Depressive Disorder, ANX: Anxiety disorders

derived from the official patient records) was grouped into four broad categories: 1. bipolar disorder, 2. major depressive disorder (unipolar depression), 3. anxiety disorder (including obsessive compulsive disorder), 4. schizophrenia (including other psychotic disorders). A hierarchy of severity was applied for grouping comorbid conditions (i.e., ‘schizophrenia and depression’ was grouped under schizophrenia, ‘bipolar and OCD’ was grouped under bipolar, and ‘major depression and generalized anxiety disorder’ was grouped under major depression). Sixty-eight people, with primary diagnoses of alcohol-drug related disorders, somatization, attention deficit hyperactivity disorder, autism spectrum disorder, eating disorders, and sexual dysfunction were not included in the analyses, since these groups were very heterogeneous, with few people in each group. The female/male ratio was higher among patients who participated in the study compared to those who did not; there was no significant difference between the two groups in terms of age.

Measures

Our main instrument was a semi-structured interview, which included items on demographics, use of general and mental health services, COVID-19 experience, worsening of symptoms, emergence of new symptoms, and severity of illness (Patient’s Global Impression, PGI and Clinical Global Impression, CGI) (Guy, 1976). Clinical data from the patient records (primary and secondary ICD-10 diagnoses, clinic visit data, illness duration) were also extracted. At the time of

data collection, there were no established measures in Turkish to assess COVID-19 related anxiety; therefore, we developed an 8-item scale with 4-choice Likert response set to assess that. A general question “How much anxiety/distress did the following cause during the pandemic?” was followed by eight specific questions, such as: “acquiring the virus”, “passing it on to my close ones”, etc. coded as “none, a little, moderately, very much”. The internal consistency (alpha) of the 8 items was 0.83.

Procedure

Twelve 3rd and 4th-year psychiatry residents, trained as interviewers and data abstracters, contacted all eligible patients and coded the responses on the online questionnaire. As was required by the ethics board, the interviewer recorded the respondent’s verbal consent; written consents were taken from 15 patients who did not want to give recorded consent. Up to three calls at different times were required before classifying them as “non-contact”. For those who answered the phone, the interviewer described the study using a standard text and invited the respondent to participate in the study. Information on time of calls, and result of calls were recorded on an online Excel sheet. During the six months of data collection (October 2020-March 2021), 492 interviews were completed. The study PI held regular Zoom meetings with the interviewers to give feedback and provide supervision on any problems that occurred. The study was approved by the

Non-Interventional Clinical Ethics Committee of Hacettepe University (2021-04-04).

Variable Selection/Transformations

The two main outcome variables were: perceived need for contacting mental health services (“*did you feel the need to contact mental health services during the pandemic?*”) and actual use of (any) mental health services (“*did you use any mental health services during the pandemic?*”). Several independent variables were chosen as predictors of use and need for contacting services. Respondents were asked to rate symptom severity during the pandemic as “no change, got better, got worse, fluctuating”; this variable was recoded as 1=got worse, 0=all others (“worsening of symptoms” variable). A seven-point assessment of PGI was asked of the respondent (1=no symptoms of illness, 7=worst days of my illness) and the response was coded; the CGI was coded by the interviewer (psychiatry resident) based on their impression during the interview (1= no illness, 7= most severe illness).

Statistical Analyses

The four diagnostic groups were compared in terms of our selected predictor and outcome variables (worsening of clinical symptoms, emergence of additional symptoms during the pandemic, subjective need for contacting mental health services, actual use of services) using Chi-square or ANOVA. Independent predictors of need for contact with mental health services and of actual use were investigated using logistic regression analyses. Variables found to be significant in univariate analyses, basic demographic variables, and variables related to our hypotheses were included in the regression analysis.

RESULTS

Comparison of the Diagnostic Groups

Tables 1a and 1b compare the diagnostic groups in terms of research variables. Categorical variables were compared using chi-square (Table 1a), and continuous variables were compared using one-way ANOVA (Table 1b). Tables show that there were significant differences between Schizophrenia group and the other groups on several measures: the Schizophrenia group diverged from others in terms of male-female ratio being close to unity, and lower percentage of married cases. The Schizophrenia group reported much lower need for psychiatric services than other groups. Among those who reported a need, however, actual use of services was highest among Schizophrenia patients, followed by Bipolar Disorder, and least for Anxiety Disorder and Major Depressive Disorder. The reasons put forward for the need for contact, as well as the reasons for non-contact, did not differ between diagnostic groups (data not reported). Although

the Schizophrenia group had much longer duration of illness than other diagnostic groups, their scores on the PGI (self-assessment of illness severity) as well as their COVID-19-related anxiety were significantly lower than those in the other groups. Most of the patients (N=65, 73%) in the Schizophrenia group had been hospitalized before, compared to only 6.5% (N=6) in Anxiety Disorder, 12.1% (N=21) in Major Depressive Disorder and 42.6% (N=29) in Bipolar Disorder groups, $p=0.000$. Diagnostic groups also differed in terms of a positive COVID-19 test: Bipolar Disorder group had the lowest (only 1 patient out of 68), and Major Depressive Disorder group had the highest rate (14.9%) of a positive COVID-19 test.

The percentage reporting worsening of symptoms and emergence of new symptoms did not differ between the four diagnostic groups. Among those who reported emergence of new symptoms, type of new symptoms (sleep problems, OCD symptoms, etc.) did not relate to diagnostic group. Percentage of patients with an accessible doctor/psychologist was similar between diagnostic groups.

Predictors of Need and Use of Services

Independent predictors of need for contact with mental health services and actual use were examined using binary logistic regression. Fourteen independent variables were entered into the equation: sex (male=1, female=2), age (18-65), education (1=primary school, 4=university), employment (0=not employed or working from home, 1=employed and goes to work), marital status (0=not married, 1=married), location (0=from Ankara, 1=from outside Ankara), past hospitalization (0=no, 1=yes), accessible doctor/psychologist (0=no, 1=yes), worsening of symptoms (0=no, 1=yes), additional symptoms (0=no, 1=yes), had been PCR positive (0=no, 1=yes), PGI (1-7), COVID-19 Anxiety Score (0-24), and diagnostic group (0=Schizophrenia, 1=Bipolar Disorder, 2=Major Depressive Disorder, 3=Anxiety Disorder); the Schizophrenia group was chosen as the reference group. Table 2 shows the predictors of need for mental health services (Column 1), and actual use of services (Column 2). The predictors of the need for contact with mental health services were PGI score (self-reported severity of own symptoms), accessibility of a doctor/psychologist, and belonging to Bipolar Disorder, Major Depressive Disorder, or Anxiety Disorders groups (higher need compared to the Schizophrenia group). None of the demographic variables or COVID-19-related variables were predictive of the need for contact.

The same set of predictor variables were regressed onto actual use of mental health services. The predictors of actual use (Column 2) were: accessibility of a doctor/psychologist and belonging to Major Depressive Disorder or Anxiety Disorder groups (lower services use compared to the Schizophrenia group).

Table 1a. Categorical Sociodemographic Variables of the Sample By Diagnostic Group

		Bipolar Disorder N (%)	Major Depressive Disorder N (%)	Anxiety Disorder N (%)	Schizophrenia N (%)	Total N (%)	Chi sq, p
Sex	Female	49 (72.1)	136 (78.2)	65 (69.1)	46 (51.7)	296(69.6)	19.75, 0.001
	Male	19 (27.9)	38 (21.8)	29 (30.9)	43 (48.3)	129 (30.4)	
Marital status	Married	34 (50.0)	97 (55.7)	51 (54.3)	24 (27.0)	206 (48.5)	21.49, 0.001
	Not married	34 (50.0)	77 (44.3)	43 (45.7)	65 (73.0)	219 (51.5)	
Employment	Employed	19 (27.9)	54 (31.2)	24 (25.8)	22 (24.7)	119 (28.1)	1.642, 0.65
	Not employed	49 (72.1)	119 (68.8)	70 (74.2)	67 (75.3)	305 (71.9)	
Education	University	34 (50.0)	60 (34.5)	31 (33.3)	29 (32.6)	154 (36.2)	14.97, 0.09
	High School	17 (25.0)	54 (31.0)	38 (40.4)	34 (38.2)	143 (33.6)	
	Middle School	3 (4.4)	13 (7.5)	8 (8.5)	11 (12.4)	35 (8.2)	
	Elementary School	14 (20.6)	47 (27.0)	17 (18.1)	15 (16.9)	93 (21.9)	
Worsening of symptoms	Present	12 (17.9)	36 (20.8)	12 (13.2)	8 (9.0)	68 (16.2)	6.87, 0.076
	Absent	55 (82.1)	137 (79.2)	79 (86.8)	81 (91.0)	352 (83.8)	
Additional symptoms	Present	14 (20.9)	26 (15.0)	12 (13.2)	7 (7.9)	59 (14.0)	5.61, 0.13
	Absent	53 (79.1)	147 (85.0)	79 (86.8)	82 (92.1)	361 (86.0)	
Subjective need	Present	36 (52.9)	89 (51.1)	58 (62.4)	18 (20.2)	201 (47.4)	36.534, 0.001
	Absent	32 (47.1)	85 (48.9)	35 (37.6)	71 (79.8)	223 (52.6)	
Contact with services	Present	22 (61.1)	32 (36.0)	23 (39.7)	15 (83.3)	92 (45.8)	17.974, 0.001
	Absent	14 (38.9)	57 (64.0)	35 (60.3)	3 (16.7)	109 (54.2)	
PCR positivity	Present	1 (1.5)	26 (14.9)	6 (6.4)	8 (9.0)	41 (9.6)	12.0, 0.0007
	Absent	67 (98.5)	148 (85.1)	88 (93.6)	81 (91.0)	384	

Table 1b. Continuous Sociodemographic Variables of the Sample By Diagnostic Group

	Bipolar Disorder N (%)	Major Depressive Disorder N (%)	Anxiety Disorder N (%)	Schizophrenia N (%)	Total N (%)	F, p	Levene test, p
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)		
Age	44.69 (11.7)	44.53 (13.2)	40.70 (13.6)	45.97 (11.0)	44.02 (12.71)	2.74, 0.043	3.99, 0.008
Duration of illness (years)	13.34 (7.7)	8.69 (8.7)	9.93 (7.7)	18.44 (10.1)	11.76 (9.43)	26.85, 0.001	3.46, 0.016
CGI	3.12 (1.4)	3.17 (1.4)	3.33 (1.4)	3.13 (1.3)	3.19 (1.38)	0.42, 0.74	1.08, 0.359
PGI	3.18 (1.6)	3.51 (1.6)	3.84 (1.6)	2.75 (1.6)	3.37 (1.64)	7.74, 0.001	0.20, 0.895
Covid Anxiety Scale	10.84 (6.1)	12.55 (5.4)	11.82 (5.4)	7.48 (5.6)	11.05 (5.89)	17.01, 0.001	1.19, 0.312
Total N (%)	68 (13.8)	174 (35.4)	93 (18.9)	89 (18.1)	424		

CGI: Clinician's Global Impression; PGI: Patient's Global Impression

Table 2. Predictors of Subjective Need for and Use of Mental Health Services

	Need for Contact		Actual Contact	
	Exp (B)	CI (lower-upper)	Exp (B)	CI (lower-upper)
Gender (female)	0.659	0.37-1.18	0.681	0.30-1.53
Age	1.010	0.99-1.04	0.997	0.96-1.03
Education	1.064	0.83-1.37	0.976	0.69-1.39
Employed/goes to work	0.775	0.43-1.40	0.785	0.35-1.78
Married	0.879	0.49-1.58	1.060	0.46-2.42
Location	0.775	0.34-1.79	2.667	0.79-9.01
Hospitalization	1.524	0.75-3.12	1.837	0.70-4.84
Illness duration (years)	0.999	0.97-1.03	1.033	0.99-1.08
Available therapist/doctor	1.934	0.97-3.86	7.546	3.08-18.50
Worsened during pandemic	1.568	0.75-3.29	0.605	0.26-1.41
Additional symptoms	1.935	0.90-4.16	1.647	0.69-3.95
PCR positive	0.886	0.38-2.07	0.369	0.09-1.58
Patient's Global Impression (PGI)	2.037**	1.69-2.46	1.024	0.80-1.32
Covid Anxiety Scale	1.009	0.97-1.06	0.991	0.93-1.06
Diagnostic groups (ref: Schizophrenia)				
Bipolar Disorder	5.197**	2.06-13.1	0.308	0.06-1.57
Major Depressive Disorder	4.805**	1.91-12.08	0.184	0.04-0.88
Anxiety Disorder	6.854**	2.55-18.40	0.166	0.03-0.83
Model Summary	Chi sq: 155.94, p<0.001		Chi sq: 58.81, p<0.001	
Hosmer-Lemeshow test	Chi sq: 4.85, df:8, p=0.774		Chi sq: 5.46, df: 8, p=0.708	

CI: Confidence interval

DISCUSSION

Our results are in line with previous chart-reviews showing a general decrease in use of mental health services during the pandemic (Yalçın et al. 2021, Kalanj et al. 2023). Our study was not limited to chart review, however, and to the best of our knowledge, it is the first to assess mental health services use of psychiatric outpatients during the pandemic, using a clinician-administered interview. Contrary to our expectations, we found that the Schizophrenia group reported the lowest need for help during the pandemic. Interestingly, though Anxiety Disorder and Major Depressive Disorder patients reported a higher need for help compared to the Schizophrenia group, fewer of them used services. The need for contact in the Bipolar Disorder group was also higher than that in the Schizophrenia group, but the Bipolar Disorder group did not differ from the Schizophrenia group in terms of actual use of services. Taken together, these findings suggest that patients with a severe mental disorder, such as schizophrenia or bipolar disorder, seem not to be at a disadvantage in

terms of worsening of symptoms, getting appointments or contacting the clinic during the pandemic. In contrast to studies reporting increased recurrence of illness (Bassiony et al. 2023, Nooraen et al. 2023), worsening of symptoms (Nooraen et al. 2023, Dindar et al. 2024), and increased ER visits (Goldschmidt et al. 2023) during the pandemic, it is interesting that our patients with severe mental disorders report lower disruption during the pandemic, a finding also reported by other studies (Gupta et al. 2022, Pinkham et al. 2020, Özçelik Eroğlu et al. 2022). The Schizophrenia group in particular reported much lower need for contact and lower PGI scores, suggesting less worsening of clinical status.

Why is everything so favorable for the Schizophrenia group? Is it because they have low insight and cannot judge their status in a realistic way? Or do we have a biased sample? Or did they not need so much help after all? Our design cannot answer these questions, though it is possible that our mental health care system is more suited to the needs of Schizophrenia or Bipolar Disorder patients and not to those

of the Major Depressive Disorder and the Anxiety Disorder patients. Schizophrenia and Bipolar Disorder patients had much longer duration of illness than the others, so they were likely more stable in their medications and symptoms. It is also possible that patients with severe mental disorders may be more resilient to some effects (i.e., isolation) of the pandemic (Pinkham et al. 2020, Özçelik Eroğlu et al. 2022).

Though the sample size was small to conduct multivariate analyses within each diagnostic group, preliminary analyses suggest that living outside of Ankara and having been previously hospitalized are important predictors of use of services in the Major Depressive Disorder group, whereas having an accessible psychiatrist/psychologist is the sole predictor of use of services among the Anxiety Disorders group only (analyses not reported). Our findings, if consolidated by future research, may help us reshape our services to better fit the needs of all types of diagnostic groups during pandemics. The current structure of our service provision may be sufficient to serve people with severe mental disorders, but we may be neglecting the large group of anxiety/depression spectrum patients. Combined with the fact that the Anxiety Disorder and the Major Depressive Disorder groups had higher scores on COVID-19 anxiety, a finding also reported by Seo et al. (2021), managing COVID-19-related fears among these groups may be the first step to improve help-seeking during the pandemic.

Strengths and Limitations

Most of the existing studies that compare services use across diagnostic groups rely on chart reviews, which cannot show contacts with multiple health services. Studies of patients who had appointments during the pandemic are limited, since they exclude those who avoid hospitals out of fear of COVID-19. To avoid those limitations, we selected a sample who contacted our clinic before the pandemic (when no pandemic awareness existed) and assessed them about one year later. We used official ICD-10 diagnoses of the patients enrolled in the study, which are more reliable than self-reports of patients on their diagnoses.

Collecting self-report data using online questionnaires is valuable when the sample is the general population. When the target is mental health patients, however, interviews have clear advantages over self-reported data. Some patients may not give reliable information because of their psychopathology (fears, lack of trust, delusions, etc.); clinician's judgment may be superior to self-reported data in such cases. On the other hand, interviews are time-consuming and costly, since they require specialist/clinician time. Our advantage was that we were able to recruit most of our experienced residents as interviewers. Nevertheless, having 12 interviewers would necessarily increase inter-rater variability, the effect of which we did not analyze. Our sample, on the other hand, was large enough to conduct essential statistical analyses.

Although we used the official ICD-10 codes in the patient charts, we were not able to include all psychiatric diagnoses; and we needed to regroup diagnoses for ease of analysis. We also had to use judgement (a hierarchy) in grouping comorbid cases, which may have resulted in bias (probably a type II bias). The differences observed between the four diagnostic groups would probably be more pronounced, had we compared non-comorbid (i.e., pure) diagnostic groups. We had to drop 68 patients that belonged to the "other diagnosis" category, since this group included 26 drug dependence cases, and several other diagnoses, which were too small to be meaningfully analyzed. Our assessments of psychiatric symptom worsening, COVID-19 related anxiety, PGI or CGI did not specify exact time periods; rather our questions were worded as "during the pandemic...", which referred to the past 10-12 months.

CONCLUSION

This study showed that the pandemic may have a differential effect on different diagnostic groups of psychiatric patients. What we found, in essence, was that patients in the anxiety/depression spectrum are having more trouble accessing a doctor/psychologist when they need one. Further, needs of different types of patients are different as well. The organization of mental health services during the pandemic, at least in our clinic, is probably sufficient for those with severe mental disorders, but may be lacking in serving less severe patient groups. Future studies should ideally include an assessment of patients' personal preferences on this topic. It may not be possible or feasible to provide an accessible doctor for every patient; but apparently that may be the key to success, at least for anxiety/depression/OCD spectrum patients who constitute the majority of all mental patients.

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