Introduction

During the COVID-19 pandemic, many countries across the world have switched to tele mental health (TMH) systems to deliver safe and effective psychiatric care while maintaining the capacity and continuity of mental health services. A recent review of eight studies, almost all from developed countries, concluded that switching from in-person to TMH treatment during the pandemic was feasible and acceptable. However, transitioning from conventional outpatient to TMH-based services may be difficult for many low- and middle-income (LAMI) countries because they lack the necessary resources. Therefore, the feasibility and acceptability of converting to a home-based tele mental health (HB-TMH) service during the pandemic were examined in an Indian hospital. Materials and Methods: A new and expanded version of an HB-TMH service was operated for all outpatients following the onset of the pandemic. Feasibility outcomes included operational viability, service utilization, service engagement, the need for additional in-person services, and the frequency of adverse events. Patients' and clinicians' satisfaction with different aspects of the service were evaluated using Likert-style questionnaires to ascertain acceptability. The outcomes during the prepandemic and pandemic phases were also compared. Results: The switch to HB-TMH services took 6 weeks during the pandemic. Patient numbers increased greatly following this transition. Attendance improved, the requirement for in-person services was low, and no serious adverse events were reported. However, patients' satisfaction levels were relatively low during the pandemic. Clinicians were more satisfied than the patients with HB-TMH treatment during the pandemic. Differences between them were less marked but still present before the pandemic. Pre- and postpandemic comparisons revealed that both patients and clinicians were more satisfied with all aspects of HB-TMH care before the pandemic than during it. Conclusions: Though conversion to HB-TMH services was feasible during the pandemic, such services need to be improved to enhance patient acceptability.

Keywords: Acceptability, COVID-19, feasibility, home-based, tele mental health
been made to develop minimum standards of care, the evidence supporting the usefulness of such services is still insufficient.\[10\]

A major part of this initiative to enhance TMH-based services in India has been to train primary-care physicians in the use of these services to improve access to mental health care in primary care settings.\[10\]

Therefore, the current study examined the feasibility and acceptability of implementing a home-based TMH (HB-TMH) service during the pandemic in the psychiatric unit of a hospital in India. Additionally, the feasibility and acceptability of the service were compared between those who had used the service before and after the onset of the pandemic.

**Material and Methods**

The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines for reporting observational studies were followed.

The study took place in the general hospital psychiatric unit of a multi-specialty hospital in north India with a large catchment area. The adult psychiatry outpatient clinic has an annual turnover of about 15,000 new patients and 75,000 follow-up visits. The outpatient team has about 50 staff members including consultant and trainee psychiatrists, psychologists, social workers, nurses, and health assistants. The study protocol was approved by the institute ethics committee. Verbal informed consent was obtained from patients and recorded before inclusion.

The unit had been running an HB-TMH service on a smaller scale since September 2018. Following the shutdown of outpatient clinics in March 2020, a trial HB-TMH service was run for outpatients for the next 6 weeks. During this period, all aspects of the new HB-TMH service were put in place, and the entire outpatient staff was trained in its use. From May 2020, all outpatient services were switched to HB-TMH care. An expanded and hybrid version of the HB-TMH service was used during the pandemic. Differences between the HB-TMH services during the pandemic and before it are shown in [Table 1].

Feasibility outcomes included operational viability, service utilization, service engagement, the need for additional in-person services, and the frequency of adverse events. Patients’ and clinicians’ acceptability and satisfaction with different aspects of the HB-TMH service were evaluated using Likert-style questionnaires administered over the phone. Areas included aspects of video conferencing–based care such as audiovisual quality, ease of participation, acceptability, overall satisfaction, prescriptions through text messages, follow-up consultations, and the preference for future use of HB-TMH services.

The data were analyzed using the Statistical Package for the Social Sciences, version 25. Chi-square or the Students’ t-tests were used for comparisons. Association of patients’ demographic and clinical variables with their experience of the HB-TMH service was assessed by estimating Pearson’s correlation coefficients.

**Results**

**Operational viability and service utilization**

Before the pandemic, 166 patients had used the older version of the HB-TMH service over 17 months. During the 6-week trial period after the onset of the pandemic, a team of two consultants and three trainee psychiatrists provided consultations to 234 patients (90 videoconferencing and 144 phone consultations). Once the operational viability of the expanded HB-TMH service was established, the entire outpatient staff was involved in providing care. In the first 6 weeks of exclusive HB-TMH care, the patient numbers went up to 1729 (517 videoconferencing and 1212 phone consultations).

**Patient profiles**

Table 2 shows that patients seen during the pandemic were significantly more likely to be older, married, better educated, and from higher-income families located near the hospital. Psychotic disorders were significantly more common during the pandemic, whereas obsessive-compulsive spectrum (OCS) disorders and developmental disorders were more common before it.

**Satisfaction with the HB-TMH services**

Satisfaction was evaluated in patients and their clinicians who had attended at least one VC session and had completed the assessments. This included 79 of the 166 patient-clinician pairs from the pre-COVID phase and a consecutive sample of the first 157 such pairs from the 517 patients who had videoconferencing consultations during the COVID period. Ninety of these patients were new to the service, and 67 had been attending earlier.

Table 3 shows that almost all the patients (99%) and clinicians (100%) were satisfied with the different aspects of the videoconferencing-based treatment during the COVID and pre-COVID phases. However, only about 53% of the patients and 66% of the clinicians rated their overall satisfaction with videoconferencing consultations as good/very good or excellent. Similarly, good/very good or excellent acceptability of the consultations was noted in about 56% of the patients and 67% of the clinicians. The audiovisual quality of videoconferencing sessions was rated as good/very good or excellent by about 57% of the patients and 92% of the clinicians. Though about 50% of the patients rated their ease of participation in the videoconferencing sessions as easy or very easy, many reported difficulties in procuring medicines through text messages (average 54%) and with video conferencing-based follow-up (average 76%). In contrast, about 80% of the clinicians found it easy or very easy to participate in the videoconferencing sessions. Finally, about 55% of the patients and 59% of the clinicians stated that they might prefer videoconferencing-based care in the future.

Differences between the patients and clinicians: During the pandemic, satisfaction ratings were significantly higher among...
the clinicians on all aspects of video conferencing-based treatment including audiovisual quality of the sessions, ease of participation, acceptability, and overall satisfaction. However, there were no significant differences between patients and clinicians in their preference for future videoconferencing-based care. Differences between the two groups were less marked during the pre-COVID phase. There were no significant differences between them on the audiovisual quality and ease of participation in the videoconferencing sessions. The overall satisfaction levels were also not significantly different between the groups although clinicians were more likely to rate the consultations as excellent ($\chi^2 = 10.91; P < 0.01$). Significant differences were noted for the acceptability of videoconferencing consultations, but only because a higher number of clinicians rated the videoconferencing consultations as having excellent acceptability ($\chi^2 = 8.38; P < 0.01$). Lastly, clinicians were highly likely than patients to prefer future videoconferencing-based care ($\chi^2 = 9.48; P < 0.01$).

Differences between the pre-COVID versus COVID phases: Table 4 shows that patients were more likely to be satisfied with all aspects of videoconferencing-based care before the pandemic than during it. Audiovisual quality, ease of participation, acceptability, overall satisfaction, receiving prescriptions through text messages, and follow-up through video conferencing were all rated to be significantly better during the pre-COVID phase. The patients were also more likely to prefer future videoconferencing-based treatment before the pandemic than during it. Ratings of audiovisual quality among clinicians were not significantly different between the pre-COVID and the COVID phases. However, like patients, clinicians rated the ease of participation, acceptability, and overall satisfaction with video conferencing–based treatment to be significantly better before the pandemic than during it. Lastly, even clinicians were likely or highly likely to prefer future videoconferencing-based treatment during the pre-COVID compared to the COVID phase.

Service engagement, the need for additional in-person services, and adverse events

Dropout rates were low both during the pandemic (14%) and the pre-pandemic periods (11%). Only eight patients required additional in-person or emergency services during the pandemic. None of them required emergency treatment during the pre-COVID phase. No serious adverse events were reported in either phase.
Demographic and clinical correlates of patients' satisfaction

Men reported significantly greater levels of overall satisfaction ($r = 0.21; P < 0.05$), urban-based patients had less difficulty in following up through videoconferencing ($r = 0.27; P < 0.001$), and new patients without in-person contact were more likely to future prefer videoconferencing-based treatment ($r = 0.18; P < 0.05$). There were no significant associations with diagnostic groups, apart from patients with OCS disorders reporting greater ease of participation ($r = 0.21; P < 0.05$).

Discussion

Comparisons with other studies of TMH care during the pandemic

This study had a lot in common with the other reports of TMH-based care during the pandemic. The HB-TMH service used in the study met the current standards for TMH care. The feasibility outcomes included the 6-week preparatory phase before the switch, the increase in patient numbers following it, improved patient engagement, low rates of in-person service utilization, and low frequency of adverse events have also been reported earlier. The HB-TMH service used during the pandemic was based on a hybrid model of care, which employs multiple digital modes of patient-clinician communication to augment in-person care. As proposed, the increased versatility of hybrid models noted in the present study may contribute to enhanced TMH care. Like other reports of transition to TMH care, the use of phones including smartphones was preferred over traditional videoconferences in the current study. Smartphone ownership is growing in many LAMI countries including India, where access to mental health care is difficult, and communication networks are often inadequate. Smartphones may be more suited to such settings because of their mobility, low costs, options for closer monitoring, and facility for improved patient engagement. However, despite their widespread use, the

Table 2: Demographic and clinical profile of the patients

|                      | COVID (n=157) | PRE-COVID (n=79) | t-tests |
|----------------------|--------------|-----------------|---------|
| Age in years         |              |                 |         |
| Mean (SD) [Range]    | 37.72 (16.07) [5-80] | 29.53 (18.16) [3-71] | $t=3.54, P<0.001$ |
| Gender               |              |                 |         |
| Men                  | 99 (63%)     | 47 (59%)        | NS      |
| Women                | 58           | 32              |         |
| Marital status       |              |                 |         |
| Currently married    | 92 (59%)     | 34              | $\chi^2=5.11, P<0.05$ |
| Currently single     | 65           | 45 (57%)        |         |
| Years of schooling   |              |                 |         |
| Mean (SD) [Range]    | 12.82 (3.48) [0-20] | 9.37 (4.85) [0-17] | $t=6.27, P<0.0001$ |
| Occupation           |              |                 |         |
| Employed             | 64           | 19              | NS      |
| Housewives, students, retired, unemployed | 93 (59%) | 60 (76%) |         |
| Family income (rupees/month) | 65000 (83953) | 40962 (20865) | $t=2.50, P<0.05$ |
| Residence            |              |                 |         |
| Urban                | 95 (60%)     | 43 (54%)        | NS      |
| Rural                | 62           | 36              |         |
| Location             |              |                 |         |
| Local                | 20           | 1               | $\chi^2=7.12, P<0.05$ |
| Distant areas        | 137 (87%)    | 78 (99%)        |         |
| ICD-10 diagnosis     |              |                 |         |
| Depressive disorders | 38 (24%)     | 13 (16%)        | NS      |
| Psychotic disorders  | 33 (21%)     | 7 (9%)          | $\chi^2=5.52, P<0.05$ |
| Bipolar disorder     | 28 (18%)     | 9 (11%)         | NS      |
| Other neurotic and personality disorders | 26 (17%) | 6 (8%) |         |
| Obsessive compulsive spectrum disorders | 10 (6%) | 22 (28%) | $\chi^2=20.69, P<0.0001$ |
| Dementia             | 7 (4%)       | 6 (8%)          | NS      |
| Developmental disorders* | 6 (4%) | 12 (15%) | $\chi^2=9.64, P<0.01$ |
| Substance use disorders | 5 (3%) | 1 (1%) |         |
| Attention deficit hyperactivity disorder | 4 (3%) | 6 (8%) |         |

NS - not significant. *Developmental disorders included intellectual disabilities, specific learning disabilities and autism spectrum disorders
### Table 3: Perceptions of the patients versus the clinicians

| Perception Type | COVID Patients (n=157) | COVID Clinicians (n=157) | t-tests | PRE-COVID Patients (n=79) | PRE-COVID Clinicians (n=79) | Chi-square tests |
|-----------------|------------------------|--------------------------|---------|--------------------------|-----------------------------|-----------------|
| Audiovisual quality of the VC sessions | | | | | | |
| Satisfactory    | 100 (64%)              | 8 (5%)                   |         | 16 (20%)                 | 9 (11%)                     | χ²=2.76 * NS    |
| Good            | 51 (32%)               | 90 (57%)                 |         | 27 (34%)                 | 34 (43%)                    |                 |
| Very good/Excellent | 5 (3%) | 59 (38%) | χ²=134.72 * | P<0.00001 | 36 (46%) | 36 (46%) | |
| Ease of participation in the VC sessions | | | | | | |
| A little difficult (satisfactory) | 102 (65%) | 45 (29%) | χ²=46.56 * | P<0.00001 | 34 (43%) | 22 (28%) | |
| Easy (good)     | 52 (33%)               | 100 (64%)                |         | 27 (34%)                 | 38 (48%)                    |                 |
| Very easy (very good) | 1 (1%) | 12 (8%) | | | 5 (6%) | 10 (13%) | |
| Not difficult at all (excellent) | 0 | 0 | | | | |
| Acceptability of the VC consultations | | | | | | |
| Just acceptable (satisfactory acceptability) | 100 (64%) | 81 (52%) | χ²=9.982 * | P<0.0068 | 18 (23%) | 12 (15%) | χ²=11.44 * |
| Quite acceptable (good acceptability) | 54 (34%) | 64 (41%) | | | 32 (40%) | 25 (32%) | P<0.05 |
| Highly acceptable (very good acceptability) | 2 (1%) | 12 (8%) | | | 28 (35%) | 30 (38%) | |
| Excellent acceptability | 0 | 0 | | | 1 (1%) | 12 (15%) | |
| Overall satisfaction with the VC consultations | | | | | | |
| Satisfactory    | 99 (63%)               | 76 (48%)                 | χ²=6.88 * | P<0.00870 | 23 (29%) | 14 (18%) | χ²=2.86 * NS |
| Good/Very good/Excellent | 57 (36%) | 80 (51%) | 76 (48%) | χ²=6.88 * | 23 (29%) | 14 (18%) | χ²=2.86 * NS |
| Preference for VC consultations in the future | | | | | | |
| Less likely to prefer    | 90 (57%)               | 97 (62%)                 | χ²=2.0614 * | P=0.15675 | 24 (30%) | 15 (19%) | χ²=12.47 * P<0.01 |
| May prefer    | 57 (36%)               | 53 (34%)                 | | | 31 (39%) | 30 (38%) | |
| Likely to prefer    | 10 (6%)                | 5 (3%)                   | NS | | 23 (29%) | 21 (27%) | |
| Highly likely to prefer | 0 | 0 | | | 1 (1%) | 13 (16%) | |

VC - videoconferencing; NS - non-significant. *As shown above, certain categories were clubbed together while comparing the groups. The text includes comparisons of individual categories.

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Evidence for the effectiveness of smartphone-based interventions is limited, and there are concerns about the safety and security of such interventions.\cite{6,26}

Unlike other studies, a simpler model of direct TMH care was used in this study because resources for consultative or collaborative care were not available. Nevertheless, the evidence suggests that such direct-care models are effective and particularly suitable for countries where the TMH services are not properly integrated within the national health care system.\cite{16,18} Moreover, in the absence of clinic-based alternatives, home-based TMH care was the only option for treatment. HB-TMH services have been in existence for a long time but despite their proven efficacy for several psychiatric disorders, the wider implementation of HB-TMH services has not been possible to date.\cite{27,28} Nevertheless, there has been a resurgence of interest in HB-TMH care during the pandemic,\cite{6,26} and there are a few reports of HB-TMH services in this period.\cite{17,29} The feasibility and acceptability outcomes of this study were similar to these reports. Before the pandemic, TMH interventions used in LAMI countries had been predominantly clinic-based,\cite{25,28} with only occasional reports of home-based services.\cite{29} In contrast, the expanded HB-TMH service used during the pandemic in this study was wider in its scope. It catered to a large and varied group of patients, including those with serious mental illnesses and dementia who are considered to be poor candidates for HB-TMH care.\cite{7} Similarly, the range of clinicians involved and the types of patient-care services provided were more diverse than the previous reports.\cite{17,29} Patient safety has been a major concern of HB-TMH care, but it has been suggested that much of the risk can be mitigated by increased awareness, screening for potential risks, and enhanced monitoring of patients.\cite{30} These safety measures were incorporated in the HB-TMH service of this study, and the absence of any serious adverse events suggests that they were reasonably adequate.

**Perceptions of the patients and their clinicians**

The satisfaction and acceptability levels among patients of this study, particularly during the pandemic, were somewhat lower than the other satisfaction surveys carried out just before the pandemic in India\cite{31} and the US\cite{32} and during the pandemic in the US and Europe.\cite{20,21,33,34} The acceptability levels among clinicians were within the range reported by other studies conducted during the pandemic but were on the lower side of this range.\cite{20,21,34,38} A similar trend was observed for other aspects of videoconferencing treatment including satisfaction with audiovisual quality, ease of participation, e-prescriptions, and videoconferencing-based follow-up.\cite{20,32,38} The preference
Table 4: Comparisons between the COVID and pre-COVID periods

|                          | Patients | Clini ans | Chi-square tests |
|--------------------------|----------|----------|------------------|
|                          | COVID (n=157) | PRE-COVID (n=79) | t-tests | COVID (n=157) | PRE-COVID (n=79) |  |
| Audiovisual quality of the VC sessions | | | | | |
| Satisfactory             | 100 (64%) | 16 (20%) | $\chi^2=74.41^*$ | 8 (5%) | 9 (11%) |  |
| Good                     | 51 (32%) | 27 (34%) | $P<0.00001$ | 90 (57%) | 34 (43%) | $\chi^2=5.77^*$ |
| Very good/Excellent      | 5 (3%) | 36 (46%) | | 59 (38%) | 36 (46%) | NS |
|                          | [Very good-4] | [Very good-32] |  | [Very good-45] | [Very good-35] |  |
| Ease of participation in the VC sessions | | | | | |
| A little difficult (satisfactory) | 102 (65%) | 13 (16%) | $\chi^2=86.17^*$ | 45 (29%) | 9 (11%) |  |
| Easy (good)              | 52 (33%) | 34 (43%) | $P<0.00001$ | 100 (64%) | 22 (28%) | $\chi^2=78.23^*$ |
| Very easy (very good)/Not difficult at all (excellent) | 1 (1%) | 32 (40%) | | 12 (8%) | 48 (61%) | $P<0.00001$ |
|                          | [Very good-1] | [Very good-27] |  | [Very good-12] | [Very good-38] |  |
| Acceptability of the VC consultations | | | | | |
| Just acceptable (satisfactory acceptability) | 100 (64%) | 18 (23%) | $\chi^2=68.22^*$ | 81 (52%) | 12 (15%) |  |
| Highly acceptable (very good acceptability) | 54 (34%) | 32 (40%) | $P<0.00001$ | 64 (41%) | 25 (32%) |  |
|                          | [Very good-2] | [Very good-28] |  | [Very good-12] | [Very good-30] |  |
| Overall satisfaction with the VC consultations | | | | | |
| Satisfactory             | 99 (63%) | 23 (29%) | $\chi^2=24.78^*$ | 76 (48%) | 14 (18%) |  |
| Good/Very good/Excellent | 57 (36%) | 56 (71%) | $P<0.00001$ | 80 (51%) | 65 (82%) | $\chi^2=21.32^*$ |
|                          | [Good-57] | [Good-30] |  | [Good-67] | [Good-25] |  |
| Preference for VC consultations in the future | | | | | |
| Less likely to prefer    | 90 (57%) | 24 (30%) | $\chi^2=29.05^*$ | 97 (62%) | 15 (19%) | $\chi^2=71.91^*$ |
| Will not prefer/Less likely to prefer | 90 (57%) | 24 (30%) | $P<0.00001$ | 99 (63%) | 15 (19%) | $P<0.00001$ |
| May prefer               | 57 (36%) | 31 (39%) | 53 (34%) | 30 (38%) | 34 (43%) | |
| Likely/Highly likely to prefer | 10 (6%) | 24 (30%) | 5 (3%) | [Likely-10] | [Likely-13] | |
|                          | [Likely-10] | [Likely-23] |  | [Likely-10] | [Likely-13] |  |
| Prescriptions and aftercare for patients | | | | | |
| Procuring medicines by text messages (e-prescriptions) | | | | | |
| Quite difficult           | 3 (2%) | 0 | $\chi^2=15.69^*$ | 33 (21%) | 7 (9%) | $\chi^2=9.34^*$ |
| Somewhat difficult        | 104 (67%) | 32 (40%) | $P<0.00001$ | 98 (62%) | 48 (63%) | $P<0.05$ |
| Easy/Very easy            | 50 (33%) | 41 (59%) | | 26 (17%) | 24 (30%) |  |
|                          | [Easy-49 Very easy-1] | [Easy-30 Very easy-17] |  | [Easy-25 Very easy-1] | [Easy-17 Very easy-7] |  |

Very: videoconferencing; NS: non-significant. 1 As shown above, certain categories were clubbed together while comparing the groups.

for future use of HB-TMH care among patients in the COVID phase was lower than other studies during the pandemic.\[34\] Though the preference rates among clinicians were similar to some of the pandemic era studies,\[35-37\] they were substantially lower than other such studies.\[30,34,38\] Although the majority of studies from the pre-COVID era have found that patients and clinicians seldom prefer future videoconferencing-based care,\[39-41\] preference for future use of HB-TMH treatment was greater among participants of this study from the pre-COVID phase. The discrepant results of the current study concerning lower rates of satisfaction and acceptability could be due to imperfections in the HB-TMH system during its initial phase, external factors such as poor network connectivity, or methodological variables such as differences in TMH services, the number and type of patients and professionals included, and the method of conducting the satisfaction surveys.

One of the novel findings of the current study was that clinicians were significantly more satisfied than the patients during the pandemic. Differences were less marked during the pre-COVID period, but even during this phase acceptability and preference for future videoconferencing-based treatment were higher among clinicians. These results were contrary to what has been reported earlier. Prepandemic studies have usually found that satisfaction
with TMH care is greater among patients than clinicians, but this is not a consistent finding. In contrast, studies of TMH treatment during the pandemic have found equivalent rates of satisfaction among patients and clinicians. The comparisons between the pre-COVID and the COVID phases in this study indicated that lower patient acceptability during the pandemic could explain the clinician-patient discrepancy in perceptions. Dissimilarities between the demographic and clinical profiles of patients from the pre-pandemic and the pandemic phases could not fully account for the differences in acceptability between the two phases, because like other studies, these factors had a minimal influence on the satisfaction ratings. However, the pre-COVID group had fewer patients who had used the service for a longer period and had received greater individual attention from their treating clinicians. Thus, the lack of previous experience with TMH treatment, unfamiliarity with the technology, and less effective clinician-patient alliances could have contributed to the lower patient satisfaction during the pandemic. On the other hand, clinicians were more used to the technology and felt less burdened by the additional TMH consultations because their usual workload of in-person treatment had been greatly curtailed. Moreover, clinicians mostly carried out assessment and medication-management sessions, which are more likely to be associated with favorable perceptions of TMH treatment.

Methodological limitations
Although the use of Likert scales for assessing satisfaction in this study was similar to other surveys, validated scales and qualitative assessments are usually required for more in-depth investigations of patients’ and clinicians’ satisfaction. In the absence of a control group of patients who had used in-person services, it was difficult to determine whether satisfaction rates would still be the same if the patients from the COVID phase had access to conventional outpatient services. However, the relatively large number of patients from the pandemic phase and the presence of a control group from the pre-pandemic period could mitigate the lack of an in-person control group. Finally, though patient and clinician acceptability is often used to evaluate health care services, such acceptability is not a measure of their effectiveness.

Conclusions
Despite these limitations, the current study offered preliminary evidence for the feasibility and acceptance of an HB-TMH service provided by a broad group of clinicians for patients with a wide range of psychiatric disorders. It suggests that HB-TMH services based on direct-care and hybrid models may be viable options for care even in the resource-constrained settings of countries like India. However, the relatively low satisfaction rates among the patients are of some concern. Undoubtedly, much more needs to be done to improve these services to enhance this low patient acceptability. Moreover, the effectiveness of HB-TMH services will need to be established before they can be fully integrated within the wider system of mental health care in India. Nevertheless, it is hoped that the insights about the feasibility and acceptance of HB-TMH services by patients as well as clinicians will encourage further use of such services for providing mental health care. This is particularly relevant for primary-care physicians who provide the bulk of mental health care in rural and remote settings.

Key messages
Home-based tele mental health services are viable options for care even in resource-constrained Indian settings but have to be improved to enhance patient acceptability.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form, the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest
There are no conflicts of interest.

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