

## **Challenges and Priorities in Responding to COVID-19 in Inpatient Psychiatry**

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**Promotional Text:**

- Describe specific challenges in responding to infectious pandemics in inpatient psychiatric settings
- Identify five contingency planning considerations for responding to COVID-19
- Suggest recommendations of organized leadership and clear communication as early priorities in responding to a pandemic in an inpatient psychiatric care setting

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None

**ABSTRACT:**

This Open Forum focuses on specific challenges, contingency planning considerations, and downstream impacts of COVID-19 on inpatient psychiatric care. COVID-19 is a novel coronavirus which has been declared a pandemic. Challenges for inpatient psychiatry include risky close contact among staff and patients, space constraints, and structural barriers in care delivery. In responding to COVID-19, nuanced considerations of five contingency planning strategies are described, including COVID-19 specific precautions, visitor restrictions, physician workforce considerations, operational adjustments, and group therapy changes. Organized leadership and clear communication are identified as early priorities in pandemic response, to minimize misinformation and address immediate challenges.

## **MAIN ARTICLE BODY:**

This Open Forum explores contingency planning for responding to COVID-19 on inpatient psychiatric facilities, with focus on clinical operations and delivery of services. COVID-19 is a novel coronavirus with symptoms of respiratory distress and fever that then can progress to death, with a mortality rate of approximately 1-2% (1, 2). COVID-19 was deemed a pandemic by the World Health Organization (3). In the United States, COVID-19 has spread to numerous states with increasing detection of cases as testing becomes more widely available. The condition is airborne and transfers through respiratory droplets. The Centers for Disease Control published recommendations for minimizing COVID-19 spread in healthcare settings, making recommendations on mitigation activities according on level of community transmission of COVID-19, such as restricting visitors, adjusting standards of care, changing elective procedures, establishing cohort units, among others (4).

Inpatient psychiatric settings present unique challenges due to open space units, patient population, close contact for treatment. In many psychiatric units, patients are free to move and interact with other patients. It can be difficult to isolate patients with behavioral dysregulation from symptoms of active mania and psychosis. In addition, staff are in close contact with patients, with regulatory requirements to visualize patients every 15 minutes and perform safety checks. Patient and clinical staff have therapeutic interactions multiple times per day for rounding and examinations. In addition, basic structural challenges also exist for infection prevention in psychiatric facilities. For example, psychiatric facilities can include shared bathrooms and non-alcohol-based hand-sanitizer due to safety precautions. Handwashing per recommendations can be a difficult task, as some psychiatric patients have poor hygiene and limited ability to comprehend directions due to psychiatric illness. Psychiatric patients are admitted to a hospital for safety concerns, and therefore cannot be discharged home to self-quarantine if symptoms develop due to COVID-19 (5).

Beyond the direct challenges in physical space and exposure risks to staff and patients, there are additional indirect challenges that can impact services delivery in inpatient psychiatric settings during a pandemic. Multiple public and clinical services are closing or may close to limit close social contact, including shelters, schools, social services, psychiatry offices, and probate court. These factors can all contribute to difficulty discharging patients, and more patients boarding in the emergency room for patients waiting for care. Several states and the federal government have declared a “state of emergency” due to COVID-19, where routine services are limited, refocused, or closed. Closure of the probate court would delay the commitment process for involuntary hospitalization, involuntary medication administration, and electroconvulsive therapy. Thus, psychiatric illness may be under-treated for a longer period of time, exacerbating the duration that some individuals remain acutely ill. Similarly, lack of social services infrastructure can be negative downstream impacts in helping patients obtain housing, follow-up visits, and next levels of care when services are shut down.

The stressor of a pandemic may cause individuals to have worsening psychiatric symptoms, such as someone with psychosomatic delusions experiencing more intense paranoia. With increasing volumes of individuals seeking care, it is important to

strategically plan and advocate for services and resources to support high quality, safe psychiatric care delivery. Otherwise, psychiatric patients will be vulnerable from not only from their mental illness but also from the repercussions of COVID-19. Contingency planning of psychiatric inpatient services requires careful decision-making and prioritization of efforts, given limitations in time and resources.

Nuanced Considerations in Contingency Planning:

1. **Managing COVID-19 Specific Precautions**—For inpatient psychiatry, an important consideration is to screen patients diligently for respiratory symptoms and fever prior to admission. Although facilities may vary in being a free-standing psychiatric facility or being an inpatient psychiatric unit attached a medical center, all facilities should consider screening for COVID-19 symptoms prior to admission, as well as rescreening for symptoms throughout the hospitalization, since asymptomatic patients may develop COVID-19 after psychiatric admission. Personal protective equipment should be used in cases where patients develop fever and respiratory symptoms, and minimized if patients do not meet both criteria, especially if personal protective equipment supplies are low. Clinical leadership should also consider having staff wear designated clothing such as scrubs during the workday, to minimize transfer of the coronavirus on various surfaces. In addition, surfaces should be cleaned often, using recommended cleaning agents such as high content ethanol-based hand sanitizer for disinfecting oneself and surfaces (6). In addition, disinfection should be performed on items and spaces of frequent use, including dining areas, doorways, common use computers, and identification cards, which contain plastic and metal and can transmit COVID-19 (7).
2. **Restricting Visitors and Minimizing Non-essential Contacts**—To minimize risk for direct contact by outsiders exposed to COVID-19, visitor restrictions for family members, non-essential employees, and students can be an important decision point, in order to protect essential staff and patients for getting exposed to additional outside individuals. However, social interactions and family meetings are important components of inpatient treatment. Thus, although decisions may be made to limit contact, doing so may impact the treatment course and affect how patients reconnect with family members and cause significant anxiety by family members who are apart from loved ones. Similarly, limiting students from observing clinical processes may affect graduation requirements for those students.
3. **Physician Workforce Considerations**—Psychiatric providers at a national shortage when there is not a pandemic (8). During the COVID-19, the provider shortage will worsen as psychiatrists are exposed and become ill. Administrators and clinical leaders will need to identify strategies to address the clinical provider shortage, including creation of back-up systems to include psychiatrists and providers who are credentialed at the facility, and becoming creative the size of staffing. Potential options for staffing include reducing team sizes and creating a back-up pool of providers who can truly practice social distancing and become available if designated frontline providers become unable to provide care. Also,

providers working in research and non-clinical administrative roles can be reassigned to clinical care as part of a back-up pool. In addition, telepsychiatry can be an important consideration for delivering inpatient services to minimize exposure of a high number of clinical providers at the same time (9). Thus, staff can still perform clinical care while minimizing hospital exposure. Staff should self-monitor for symptom development and obtain testing if symptoms such as fever or respiratory symptoms are present. In addition, those staff with higher risk, including pregnant, elderly, and immunocompromised may need to be proactively sent home to work remotely during the pandemic period.

4. **Operational Adjustments**—Limited published accounts are available on operational changes in response to COVID-19, especially in psychiatry. COVID-19 has an asymptomatic period, so some individuals may not have COVID-19 symptoms before being admitted psychiatrically (10). Designated isolation rooms may be helpful in grouping patients with COVID-19 symptoms, which may require closing one or more hospital beds if two or more patients are roomed together. After a patient develops COVID-19 symptoms, the patient should be immediately placed on precautions with a mask and gown and isolated in designated rooms for minimizing spread. If a psychiatric facility is connected to medical center, steps should be taken to facilitate transfer to inpatient medicine or inpatient pediatrics for COVID-19 testing, since many psychiatric facilities have open milieu and difficulty isolating patients without significant spread. Patients with subthreshold symptoms such as only fever or only respiratory symptoms should be monitored more closely for development of additional symptoms, such as more frequent vital signs and review of symptoms. Other medical conditions, such as viral influenza and routine causes of fever or respiratory symptoms should be explored. Additional considerations should be made around threshold for hospitalization. Psychiatric hospitalizations that are not absolutely necessary for acute safety concerns should be minimized. Patients who develop COVID-19 symptoms should be monitored closely for imminent risk of suicide, homicide, and grave disability. If considered psychiatrically stable, the patient should be discharged to outpatient care and self-quarantine.
5. **Group Therapy Changes**—Group therapy is an important component of inpatient treatment as part of the ecological milieu (11-13). Multiple individuals meet together with a trained facilitator to learn about psychological tools to address symptoms such as anxiety, depression, suicidal ideation, psychosis, and intense emotional lability, and facilitate education about psychiatric conditions, which reinforce treatment goals and positive supports. However, given that group therapy requires close contact, decisions may need to be made to facilitate changes in group treatment, including limiting the number of individuals participating in a group and social distancing that occurs among individuals. In addition, older patients with multiple medical co-morbidities with may be especially at risk in group settings with younger patients and may need to discontinue and minimize group therapy while a pandemic is occurring. However, limiting group treatment options and

reducing group size may lead to more social isolation and loneliness, which may have, in part, contributed to hospitalization.

Responding to COVID-19 requires organized leadership and clear communication. These concepts are part of a framework for High Reliability Organizations, which aims to improve clinical care through accountability and continuous learning, and can minimize uncertainty, confusion, and human error due to knowledge gaps (14). A core leadership task force group can be developed to address immediate operational concerns. The task force should include representation by clinical leaders in psychiatry, social work, and nursing, at minimum. The aim of a small core group would be to initiate and coordinate ongoing response efforts, and to minimize misinformation shared. Given the rate of new updates, the group would benefit from meeting several times a day to discuss information, implement decisions, and address clinical challenges. In addition, a strategy for communication should be developed to send out daily updates. Communicating clearly helps to address the many human resources challenges and clinical care changes in effect at the state or local level in response to COVID-19. Furthermore, additional smaller workgroups can be developed to work on staffing, COVID-19 precautions, operational, and other important contingency planning efforts.

This Open Forum article seeks to describe the nuanced considerations in responding to COVID-19 in inpatient psychiatry facilities, as well as provide conceptual and operational suggestions on early priorities to prepare for COVID-19. Clinical experts and medical leaders are closely monitoring the COVID-19 pandemic and implementing changes rapidly to respond to the crisis. Future opportunities will include learning from and reflecting about the decisions made and responses adopted, studying for efficacy and impact on patients.

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