Emerging Need and Early Experiences with a COVID-Specific Psychiatric Unit

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Promotional Text:

- Describe a novel approach of having a COVID+ inpatient psychiatric unit and early experiences with patients on the unit
- Identify clinical treatment information, including telehealth, medical algorithms, and transitions of care, that are important considerations for a COVID-specific inpatient psychiatric unit

- Explore challenges in clinical assessment of COVID-19 testing results and describe barriers to care as related to psychiatric hospitalization and disposition following COVID-19 positive status

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None

The COVID-19 pandemic is particularly challenging for inpatient psychiatric care, as many individuals receiving treatment are in congregate settings for meals, group therapy treatment, and social interactions as part of treatment. Infection prevention in inpatient psychiatry can be difficult, since patients who are acutely psychiatrically ill may not be able or willing to receive testing nor adhere to isolation precautions in the inpatient setting. In addition, infectious spread can be difficult to contain, and high rates of spread and mortality have been described in congregate settings.

In Yale New Haven Psychiatric Hospital, we saw an increase in the numbers of individuals suspected and tested positive for COVID-19. We decided to create a COVID-specific psychiatric unit to minimize infectious spread to non-COVID patients and reduce unnecessary use of medicine beds for those infected patients who were stable. We condensed two units (adolescent and young adult) into one unit and converted the adolescent unit into the COVID-specific psychiatric unit. A multidisciplinary leadership team worked to develop a manual to guide the admission criteria for the unit, as well as protocols for infection prevention, donning/doffing personal protective equipment (PPE), management of medical and psychiatric emergencies, on-site group therapy, in-room meals, and staff instructions. For example, patients would be admitted to the unit if considered medically stable, since the COVID-specific psychiatric unit was not physically located adjacent to a medical hospital, and medical response could be delayed.

All staff working on the COVID-specific psychiatric unit were volunteers. The nursing staff were those who previously worked on the adolescent unit and continued to serve as a team. The unit was set up to have telehealth capabilities in order to provide specialty care for patients and reduce unnecessary use of PPE. For behavioral health emergencies or an acutely agitated patient, a psychiatric provider would evaluate the patient on the unit. However, for routine visits and follow-ups, a treatment team consisting of a psychiatric attending, psychiatric APRN, and social worker would use videoconference to provide care to the COVID unit. To meet criteria for the COVID-specific psychiatric unit, the patients needed at least one COVID+ test within the last 14 days and no significant acute medical symptoms. Patients with acute medical concerns continued to be cared for on the medical unit with psychiatric consultation.

The first case was detected in Connecticut on March 8, 2020. The COVID-specific psychiatric unit was first opened on April 28, 2020. Since opening, 11 distinct individuals have been admitted to the COVID-specific psychiatric unit, at the time of writing. One patient had two admissions. Entry points to the COVID-specific psychiatric unit include patients from other parts of the state (affiliate and non-affiliate hospitals), emergency room (pre-admission COVID testing used for all patients), and medical units for patients with both psychiatric and medical need (after the medical needs are stabilized). The average age of patients admitted is 34.3, 45.5% are female (one transgender patient), and 27.3% are African Americans. No acute behavioral codes have been called, and no medical emergencies have occurred.

Emerging evidence suggests that positive testing can endure for weeks after a person is no longer infectious. Notably, our experience is that the testing course for patients has been variable. Although every patient required a COVID+ test by PCR for admission, many patients continue to remain positive or have testing courses with a negative test, positive test, and then inconclusive test, making testing results difficult to interpret. Since many group home facilities require two negative testing before allowing patients to go to congregate living settings, ongoing positive tests can present a challenge for disposition. Thus, patients who are acutely stable psychiatrically may need prolonged hospitalizations due to limited options for disposition. Community settings will need to balance the risk for COVID spread and patient autonomy and patient-centered care.

The pandemic will evolve and the need for a COVID-specific psychiatric unit may change. In our case, we found that patients with acute psychiatric need and COVID-19 positive status can be safely cared for in a COVID-specific psychiatric unit. Importantly, a COVID-specific psychiatric unit is both feasible and timely to help reduce infectious spread in inpatient psychiatric settings, and to help maintain quality of care for patients with co-occurring needs. This report helps to outline special considerations for a COVID-specific inpatient psychiatric unit, which can be useful for other behavioral health facilities preparing for infection prevention as states reopen and risk for COVID-19 spread increases. Future directions will include improving transitions of care for patients who are COVID-19 positive and need community-level care.