

Coronavirus on the Inpatient Unit: A New Challenge for Psychiatry

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March 16, 2020

For weeks now, the coronavirus epidemic has monopolized the media. As cases of COVID-19 have crossed borders and then oceans, the pandemic has caused fear and anxiety as Americans struggle with the uncertain nature of this highly contagious disease. Those exposed may be infectious before they are symptomatic, and the expression of the virus varies greatly: Some people have a mild illness and others quickly progress to severe pulmonary disease with a bilateral interstitial pneumonia that requires intubation and respiratory support. So far, the number of people infected and the absolute mortality is a fraction of what we have seen with this year's [seasonal flu](#), but in countries where the virus has spread quickly, medical systems have not been able to keep up with demand for high-intensity care and mortality rates have been many times higher than that of the [flu](#). Italy, in particular, has not been able to halt the spread, even with the entire country on lockdown, and the medical system has been overwhelmed, resulting in rationing of care and many deaths.

In the last week, the pandemic has resulted in a tremendous disruption to American life as people who fear they may have been exposed self-quarantine, and everything from Disneyland to the National Basketball Association has shut down. Universities are sending students home, medical conferences and religious services are being canceled. Hospitals are preparing for a surge of admissions, and we worry that the need for intensive care will overwhelm our system. Our lack of ability to test for the virus has left us particularly vulnerable. Morbidity and mortality rates have been particularly high in the elderly and those with underlying medical conditions.

COVID-19 represents a new challenge for the inpatient psychiatry unit. Some patients on an acute psychiatric unit may be agitated, uncooperative, or even violent, and it's not hard to imagine the distress of anyone who has a patient spit on them as we're all trying to remember not to shake hands. Inevitably, there will be patients who present for psychiatric admission with no respiratory symptoms, who are admitted and then become ill and are diagnosed with COVID-19. In the meantime, the potential is there for contagion to other patients on the unit, the hospital staff, and visitors to the unit.

While many hospital units treat infectious patients, the issues with psychiatry are different; psychiatry units are not set up to have aggressive infection control, staff and patients don't typically wear protective gear, and people with psychiatric illnesses are ambulatory and interactive. The treatment of psychiatric illnesses involves more – not less – social interaction and patients attend groups and occupational therapy sessions; they dine in communal areas and watch television together in day rooms. Cell phones are typically not permitted for issues of privacy, and patients may use communal telephones. Patients who are very ill with psychiatric disorders may resist hygiene measures, and they may intrude on the personal space of others.

Patients with known COVID-19 can be isolated or transferred to another unit if more intensive medical care is necessary, but by that time, others have been exposed and potentially infected. How to contain this potential risk has been a topic of concern for psychiatric units everywhere. Following a potential or confirmed exposure, it's not completely clear who should be sent home for self-

quarantine: Do the staff who have had contact with the patient leave for 2 weeks, and if so, is there enough staff to replace them? Do they continue to work with protective equipment and leave only if they become symptomatic and test positive? Do staff remain at the hospital, or do they go home at night, potentially infecting those on public transportation and their family members? Presumably new patients would not be admitted to the unit, but our psychiatric system is taxed already with a lack of available beds.

In South Korea, patients and staff at the Daenam hospital [reportedly](#) faced this exact scenario. The hospital was locked down and 101 patients in the psychiatric facility developed COVID-19; 7 of those patients died, an outcome we hope to never see again. As of this writing, there are two patients on a [22-bed geropsychiatric unit at the UW Medical Center – Northwest](#) in Seattle who developed COVID-19 after they were admitted to the unit. They have been isolated, and the rest of the patients on the unit have been quarantined. The staff are now wearing masks, gowns, and gloves.

"We started precautions for all 22 patients.... We instituted our protocols for every room around, donning and doffing personal protective equipment (PPE). We had conversations with their family members," said [Santiago Neme, MD, MPH](#), an infectious disease physician at UW Medical Center – Northwest, in a [press conference](#) released by the university. "The patients were transferred and both remain stable. All patients on the unit were tested even though there were no concerning symptoms."

These measures are necessary for infection control, but they are not helpful for the treatment of psychiatric disorders. Treatment consists, in part, of getting patients out of their rooms and involved in therapeutic activities in a milieu that removes them from the usual stresses of their daily lives. Isolation and fear of contracting a life-threatening illness is unlikely to shorten lengths of stay or promote psychiatric healing. How insurance companies will respond to any need for extra days is one more concern to throw into the mix.

[Paul Summergrad, MD](#), chairman of psychiatry at Tufts University in Boston, has been very interested in what facilities around the world have been doing. "In Washington state, after the nursing home infections, they sent home over a hundred staff members who had been exposed. In Hong Kong, the psychiatric hospitals have limited how patients circulate on the units even if no one is infected; this is not something that would go over well in the U.S.," he said in an interview. Dr. Summergrad believes that higher death rates are seen in countries with higher smoking rates, and patients with psychiatric disorders are more likely to smoke than the general public, possibly placing them at higher risk for more severe morbidity and mortality.

[Patrick Triplett, MD](#), clinical director of the department of psychiatry at Johns Hopkins University in Baltimore, communicated with me about their plans to manage a scenario in which a patient becomes ill on a psychiatry unit.

"If we think a patient might be infected, we will isolate them in a room with a closed door (We would need to account for their psychiatric needs as well during this period, say constant observation, for example.) and call the centralized command center, where the Hospital Epidemiology and Infection Control (HEIC) team gets involved. They will determine if the patient should be tested for COVID-19. If it's determined that the patient is infected, they will likely be transferred to a floor with negative pressure rooms. We would coordinate psychiatric nursing needs with the receiving unit, based on the patient's clinical needs."

Dr. Triplett elaborated on the exposure of staff and visitors. "We take our lead on postexposure management from [HEIC] and Occupational Health. There are procedures in place for environmental cleaning, waste, linens, etc. The [Centers for Disease Control and Prevention] has [guidelines](#) on work restrictions for staff who have cared for patients with confirmed COVID-19, and HEIC helps determine

the provider's risk category. We would also involve them in determining risk levels and management for other patients on the floor and visitors. But prior to any known exposure, we are already limiting visitors for patients per the governor's mandate of only one adult visitor per patient."

The next couple of weeks will be telling, and as we readjust to a life of social distancing, it is certain to be a challenge to keep ourselves and our patients safe, healthy, and emotionally strong.

*Dr. Miller is coauthor with Annette Hanson, MD, of *Committed: The Battle Over Involuntary Psychiatric Care* (Baltimore: Johns Hopkins University, 2016). She has a private practice and is assistant professor of psychiatry and behavioral sciences at Johns Hopkins, both in Baltimore.*