



# Living with COVID-19: What Do Psychiatric Hospitals Need to Consider in the Coming Months?

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## 1. Context

As a contagious disease, COVID-19 was first identified in December 2019 in Wuhan, China (1). The first confirmed death from the disease in Iran was reported in 19th February in Qom, and the country's healthcare system was suddenly in crisis. Psychiatric hospitals, also faced a crisis. As the weeks go by, it is becoming increasingly clear that psychiatric hospitals must live with COVID-19 for weeks or months, while also providing their inpatient and outpatient services. It will be a big challenge to strike a balance between beneficence and non-maleficence to psychiatric patients. The following is taken from the expert opinion and experience, as well as a review of the experiences of other countries, in three parts: (1) special challenges of psychiatric hospitals, (2) recommendation for inpatient services, and (3) recommendation for outpatient services.

## 2. Special Challenges of Psychiatric Hospitals

(1) Many admitted patients, due to their psychiatric and cognitive symptoms, do not follow health issues, especially physical distancing and hand washing. Training, educating, and any other intervention are usually ineffective until the improvement of psychiatric or cognitive conditions, which will take at least a few days.

(2) Many psychiatric patients are at a higher risk of severe illnesses associated with COVID-19. Diabetes, cardiovascular diseases, heavy tobacco use, pulmonary disease, and overweight are very common in chronic psychiatric patients. This makes it much more critical to care for such patients in a closed environment for several days (2, 3).

(3) Many psychiatrists, nurses, and staff working in psychiatric hospitals have gradually moved away from general medicine after years of working in the field and may

act unskilled in cases where patients have medical problems. It is difficult to change such a situation, especially in times of crisis.

(4) Many patients that are referred to psychiatric emergency rooms are aggressive and agitated. Applying physical restraint in such cases is often inevitable. During the COVID-19 pandemic, the process of applying physical restraint may expose staff to aerosols from early-stage patients and disease carriers who are asymptomatic. According to current protocols, when staff is exposed to suspected aerosols, they should use face shields, N95 masks, and special clothing. This procedure is difficult to perform in psychiatric triage because, first, on the one hand, there is often not enough time to use this equipment, and on the other hand, it is not usually acceptable by staff to permanently use this Personal Protective Equipment (PPE). Second, the patient's physical restraint by staff wearing such PPE may increase the patient's fear and agitation. As a result, more aggression may occur, possibly leading to breaking the face shield and destroying the mask during physical restraint (4).

## 3. Recommendation for Inpatient Services

(1) Reduce bed Occupancy Rate (OR) by stopping elective admissions. The less crowded the rooms are, the less likely it is for patients and staff to get infected, and the more likely it is for them to keep physical distancing and hygienic practice.

(2) Only should critically ill patients be hospitalized. Try to provide more outpatient and remote services (5).

(3) Establish remote services to manage and follow emergency patients with COVID-19. Try not to hospitalize

them as much as possible, although it is sometimes inevitable (6).

(4) Set aside a separate ward in the hospital for patients suspected to COVID-19. Specifying an isolated room in any ward is not the right strategy, as it increases the chance of infecting others due to common facilities in psychiatric hospitals and the difficulty of controlling patients' behavior (6).

(5) If a patient is suspected to COVID-19 after admission, he should be transferred to an isolated ward, and his personal belongings, room, and toilet should be disinfected.

(6) Identify at-risk patients in the triage based on the Centers for Disease Control and Prevention (CDC) guidelines (7). Try to give appropriate care to these patients using remote services. If hospitalization is inevitable, it is necessary to follow them carefully and discharge them as soon as possible.

(7) Postpone appointments to keep away patients' relatives from contact with patients and psychiatric residents and ask them to use telecommunication instead (5).

(8) Do not allow food and stuff to enter the hospital by families or plan to carefully disinfect them (8).

(9) Do your best to reduce the Length of Stay (LOS). This may include more intensive treatment, more after-discharge treatment, and more serious follow-ups by social workers for patients referred by judicial bodies or are homeless (5).

(10) Do not forget the golden key: Education! The first is staff education, as they have often been away from the general practice of medicine and need to remind health tips. The second is patients' education, which should be done repeatedly in the person-to-person form adjusted to psychiatric and cognitive symptoms. Hand washing, physical distancing, and non-touching of the face and eyes are the most important tips. The third is family education to accept that this time is a special one and how they should care differently for patients and keep them healthy in this situation (1).

(11) Patients' body temperature should be carefully checked three times a day. The body temperature of all people entering the hospital should be checked, including staff (6, 8).

(12) Cancel out-of-hospital counseling as much as possible. Referring a patient to other hospitals, especially centers for COVID-19, may put the patient at risk of infection.

(13) Use N95 masks for infected or suspected cases in ECT room as a logical and conservative approach because the process is often accompanied by cough and the possibility of producing aerosols (9).

#### 4. Recommendation for Outpatient Services

(1) Plan fewer patients' appointments to reduce congestion in the waiting room (5, 6).

(2) If it is possible to postpone a patient's visit, it should be considered (10).

(3) If the infrastructure for telecommunication exists, develop it, and if it is not, create it quickly (1).

(4) Many psychiatric patients with severe mental illnesses cannot use the Internet appropriately due to their socioeconomic status and psychiatric/cognitive symptoms. Using the phone in such a situation is a faster and perhaps more effective solution.

(5) When planning appointments with patients, give them an option for using telecommunication.

(6) When planning an appointment, each patient should be reminded to bring only one with him/her, to have a Mask, and to come exactly on time.

(7) Make modifications in the patient's waiting room to keep up with physical distancing.

(8) Medications should be prescribed for a longer period to reduce referrals to the clinic (10).

Finally, I would like to point out that in Iran, during the last two years, following the political and economic crises, the country's hospitals, including psychiatric hospitals, have not been in a good economic condition. The COVID-19 crisis will make the situation even worse. Many patients will not be able to pay for out-of-pocket fees, there is no hope for the insurance system as payments are often reduced and delayed, and the government is involved in reduced revenues and financial pressures. Unfortunately, it is possible that in economic crises, mentally ill people will not be a priority for governments. The extensive use of charitable support is a way to escape this situation.

#### Footnotes

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