Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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COVID-19 Pandemic: Impact on psychiatric care in the United States

Ermal Bojdani[a,b,c,*], Aishwarya Rajagopalan[a,b,c], Anderson Chen[a,b,c], Priya Gearin[a,b,c], William Olcott[a,b,c], Vikram Shankar[d], Alesia Cloutier[a,b,c], Haley Solomon[a,b,c], Nida Z. Naqvi[e], Nicolas Batty[f], Fe Erlita D. Festin[b,c], Dil Tahera[b,c], Grace Chang[b,c], Lynn E. DeLisi[b,g]

[a] Harvard South Shore Psychiatry Residency Training Program, Brockton, MA, United States
[b] Department of Psychiatry, Harvard Medical School, Boston, MA, United States
[c] VA Boston Healthcare System, Brockton, MA, United States
[d] Emergency Medicine Residency Program, Kern Medical, Bakersfield, CA, United States
[e] Department of Internal Medicine, University of Maryland Upper Chesapeake Medical Center, Bel Air, MD, United States
[f] Indiana University School of Business, Bloomington, IN, United States
[g] Cambridge Health Alliance, Cambridge Hospital, Cambridge, MA, United States

A B S T R A C T

The World Health Organization declared the coronavirus outbreak a pandemic on March 11, 2020. Infection by the SARS-CoV2 virus leads to the COVID-19 disease which can be fatal, especially in older patients with medical co-morbidities. The impact to the US healthcare system has been disruptive, and the way healthcare services are provided has changed drastically. Here, we present a compilation of the impact of the COVID-19 pandemic on psychiatric care in the US, in the various settings: outpatient, emergency room, inpatient units, consultation services, and the community. We further present effects seen on psychiatric physicians in the setting of new and constantly evolving protocols where adjustment and flexibility have become the norm, training of residents, leading a team of professionals with different expertise, conducting clinical research, and ethical considerations. The purpose of this paper is to provide examples of "how to" processes based on our current front-line experiences and research to practicing psychiatrists and mental health clinicians, inform practitioners about national guidelines affecting psychiatric care during the pandemic, and inform health care policy makers and health care systems about the challenges and continued needs of financial and administrative support for psychiatric physicians and mental health systems.

1. Introduction

The COVID-19 pandemic has affected the provision of psychiatric care across the world. In China, authors have depicted the challenges the disease presents to their psychiatric services (Cui et al., 2020). In Italy, the head of one of the largest psychiatric services in Lombardy has described the changes to their system (Percudani et al., 2020). In the US, we have experienced the impact on access to care, quality, and the way care itself is delivered. Even legal doctrines and privacy rules have been bypassed to provide care in a totally different environment. The provision of psychiatric care has changed depending on the setting the psychiatric physician is working. To help physicians understand the many changes in delivery of care, the American Psychiatric Association has issued national COVID-19 practice guidance, summarized in Table 1 (APA Website, 2020).

In outpatient settings, the temporary waiving of numerous regulations around telehealth by the US government on March 17, 2020, was unprecedented (Torous et al., 2020). Regulatory barriers to telemedicine were also loosened to allow for various platforms to be used across state lines (Freeman 2020). Remote consultation via telemedicine (Kavoor et al., 2020) has been reported in other countries, and the VA Healthcare System like the South Carolina and VA Boston (Myers et al., 2020) and community hospitals throughout the USA have rapidly embraced telehealth. The Italian Society of Epidemiological Psychiatry (Starace and Ferrara, 2020) has published operational instructions for mental health departments, and many of these have been implemented in the US mental health system as well, such as phone check-ins.

In the emergency department, psychiatric physicians are providing care through a variety of modalities, including using a telephone or video camera, or in person with personal protective equipment (PPE). At many hospitals, patients considered for psychiatric admission are now also undergoing rapid testing to determine COVID-19 status. COVID-19 positive and COVID-19 negative inpatient units have since been established, although split positive and negative units have been met with much controversy.

In the inpatient setting, the physical structure of psychiatric units as well as the modalities in which care is delivered pose unique challenges in terms of disease exposure to other patients, staff, and visitors. Patients share bedrooms with others and wander around the unit,

* Corresponding author at: Harvard South Shore Psychiatry Residency Training Program, Brockton, MA, United States
E-mail address: ebojdani@mclean.harvard.edu (E. Bojdani).

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Table 1
Psychiatric COVID-19 Practice Guidance, adopted from the American Psychiatric Association (APA) (APA Website, 2020)

Topic and Date	Setting affected	Guidance
Quality reporting March 22, 2020	All participating in quality reporting programs	Centers for Medicare and Medicaid Services (CMS) granting exceptions from reporting requirements and extensions
Drugs covered by Risk Evaluation and Mitigation Strategy (REMS) March 23, 2020	All, especially outpatient and community/ public psychiatry	FDA issues guidance for drugs that are part of REMS like clozapine, allowing for consideration of compelling reasons to continue prescribing without obtaining or delaying laboratory testing (ex: obtaining CBC, absolute neutrophil count)
Financial relief March 27,2020	All who received Medicare fee-for-service (FFS) reimbursements in 2019	CARES Act signed to provide relief fund payments to mitigate reduction in business earnings and continued expenses (ex: partly due to stable patients postponing care)
Telehealth March 2020	All, especially outpatient	Clarification for billing Medicare (same as in-person visit), Office of Civil Rights (OCR) waiving penalties for HIPAA violations for those serving patients in good faith through Skype of FaceTime; DEA suspension of Ryan Haight Act requiring provider conduct an initial, in-person exam of a patient before electronically prescribing a controlled substance; resources on malpractice insurance topics; SAMHSA and the Drug Enforcement Agency (DEA) providing flexibility to prescribe buprenorphine to new and existing patients with opioid use disorder via telephone
ECT March 2020	Inpatient and Outpatient	APA considers electroconvulsive therapy (ECT) an essential procedure
State specific guidance from state officials and commercial payers March 2020	All	Loosening of requirements around physicians practicing across state lines and methadone prescribing; (ex: patients with confirmed COVID-19 or symptoms can be given a 28-day take-home supply of methadone)

eating in a group cafeteria, and spending time in group therapies. No visitor policies and suspension of group activities (Starace and Ferrara, 2020) have been utilized in some, but not all inpatient units. Furthermore, similar to other countries (Xiang et al., 2020), tightening of admission criteria, especially for voluntary admissions for certain substance use disorders is taking place. Whether this may produce a setback on the fight against opioid addiction and overdose deaths is yet to be seen.

In many consultation services, a hybrid model is being implemented, utilizing available resources, triaging, and deciding whether a patient is seen in person, via telephone, or video. In many hospitals, consultations are being conducted remotely.

This pandemic has had profound effects on psychiatric physicians and trainees personally, ethically, and financially. Clinical research where patients consent to protocols has come to a halt. Like other medical specialties, major annual educational conferences have been canceled (Asmundson and Taylor, 2020). Notably, the training of residents has been drastically affected, with residents being pulled away from psychiatric rotations to in some cases work in COVID positive settings as infectious disease and medicine interns would. At many institutions, didactic education, supervision, and outpatient visits are virtual. Medical students are not coming physically to rotations that are needed for practical experience and necessary for acquiring clinical knowledge.

Across all these settings, significant concerns have arisen about availability and use of proper PPE; these concerns can evolve into fears and anxieties about becoming sick, spreading the virus to loved ones, and dying. On psychiatric units, there can be the fear that PPE "scares patients" and in addition, it is difficult to get psychotic patients to wear masks. Some psychiatric patients have a difficult time managing personal hygiene, increasing their risk of contracting the virus. In general, psychiatric staff are not trained in infectious disease protocols putting these employees at higher risk than other hospital employees.

It is uncertain what the full impact of this pandemic will mean for psychiatric care; to date, April 22, 2020, it has disrupted all stakeholders in significant ways. Through a broad lens, we hope to shed light on the impact the COVID-19 pandemic has had on psychiatric care. We present this in a framework of how the pandemic has affected the delivery of services in different settings, and how it has affected us as the physicians providing the care. The purpose of this paper is to provide examples of "how to" proceed based on our current front-line experiences and research, inform the reader about national guidelines affecting psychiatric care during the pandemic, and inform health care policy makers and health care systems about the challenges and continued needs of financial and administrative support for psychiatric physicians and mental health systems.

2. Methods

Pubmed was searched using the terms "COVID-19" AND "psychiatric care". Thirty-seven articles resulted, and all were fully reviewed for relevance. Thirteen, including several others known to the authors and based on relevance, were used. Given that data on this topic are limited to other countries, what we present here include accounts of first-hand experiences of the impact of the COVID-19 pandemic on the psychiatric care that we provide to our patients daily. Further, what we present here is also based on discussions with and interviews of other colleagues at various institutions across the country. An informal survey was sent out to colleagues across the country asking them to share fears that they experienced themselves or heard of other physicians having; these are summarized in Table 3.

3. Results

3.1. Outpatient psychiatric care

The provision of outpatient psychiatric care has evolved to include a number of virtual modalities. Healthcare systems nationwide and world-wide as well, are leveraging telehealth to provide continued access to care to patients (Myers et al., 2020). This has required adjustment in programming, such as learning how to utilize webcam-based services. For patients without smartphone or computer access, telephone-based encounters have become a standard of care. Faculty and residents alike have transitioned to completing the majority of outpatient care while working from home, and supervision of trainees has also been transitioned to virtual modalities. Such transitions have been largely welcomed but also challenging at times, especially when the required technology is slow to connect, malfunctions, there is a security breach and loss of confidentiality, or when providers are not familiar with certain technologies. There also are challenges for patients who are unable to access technology such as smartphones or do not have access to high speed internet. Furthermore, while many patients seem to have adapted to virtual visits and may even benefit from certain aspects, such as elimination of transportation barriers, some patients have communicated that they prefer in-person appointments.

Some patients are fearful of initiating medication trials without an in-person encounter with their physician, which can be a barrier to care. Further, initiation and maintenance of psychotropic medications,

including long-acting injectables, can require bloodwork. Some patients express concern about entering a medical facility to obtain laboratory tests. There are also shortages of medications. Notably, a shortage of disulfiram, which had been a problem even prior to the arrival of COVID-19, but is more pronounced in the setting of the present pandemic.

Partial hospital programs (PHPs) have also adjusted their enrollment criteria, screening patients for potential COVID-19 symptoms, and denying or delaying acceptance until the patient recovers.

Guidance around prescribing for patients with substance use disorders (SUDs) has come from national organizations and the states. These patients are particularly vulnerable to the COVID-19 pandemic for two salient reasons. First, many substances such as tobacco or marijuana create a compromised pulmonary system, increasing susceptibility to more serious consequences of coronavirus infection. Second, patients with SUDs are more likely to be in a lower socioeconomic status, leading to poor access to care. Therefore, it is paramount to consider both the guideline changes regarding SUDs as well as the actual impact patients are facing. Many associations such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) have issued guidelines, as early as March 16, 2020. Specifically, methadone clinics are loosening restrictions and allowing methadone to be prescribed in higher quantities, and Suboxone can now be prescribed via telephone without an in-person visit (APA Website, 2020). Controlled substances can also be e-prescribed directly to pharmacies. Many patients are reluctant to go into clinics to receive naltrexone injections for alcohol and/or opioid use disorder and are asking to be converted to oral naltrexone pills.

Of particular concern in the outpatient setting are older adults, who are at greater risk for both mortality following infection with SARS-CoV-2 and mood destabilization secondary to physical distancing and shelter-in-place guidelines. Many older adults are fearful of contracting the disease given the vulnerabilities unique of this demographic group. A significant portion of elderly patients are quarantined in their homes, resulting in social isolation and loneliness, which can fuel anxiety and depression. Connecting with these individuals is essential to provide treatment for acute psychiatric concerns as well as continued treatment of chronic illness. However, elderly patients may be less likely to use technology and may have greater difficulty adapting to telepsychiatry. Finding creative means to delivering care such as incorporating assistance from family members and caregivers may be especially important for this vulnerable population.

3.2. Psychiatric care in the emergency room

Emergency rooms in the community are seeing an increase in psychiatric visits, likely because it is more difficult for patients to be in contact with their therapists or psychiatrists. The care of patients seeking or referred for emergent psychiatric evaluation has also been impacted by the present pandemic. Many facilities have implemented screening protocols asking the same questions (Table 2) to triage patients for risk of exposure to the novel coronavirus and to assess level of symptoms. These protocols have evolved throughout the course of the pandemic. Initially patients deemed to be at elevated risk of exposure or demonstrating symptoms of COVID-19 were referred for supplemental medical evaluation, and in appropriate cases, testing. Now, in most healthcare systems, patients referred for inpatient psychiatric admission receive rapid COVID-19 testing prior to being evaluated by the psychiatrist and then in addition can be admitted to an appropriate unit. Some patients have expressed fear of contracting coronavirus by being in an emergency room setting, adding to their sense of suffering. To reduce risks to patients and staff alike, many consults and evaluations can be conducted using telephone visits. The physician can sit outside of the room, maintaining physical distancing, and complete an interview. They also can wait for potential cases to evaluate outside of the emergency room setting. Staff also are encouraged to physically distance from the patients. To mitigate risk of infection among staff, some hospitals are transitioning to a shift work model. Other hospitals, for a myriad of reasons, have been slow to implement such a measure.

3.3. Psychiatric care on inpatient psychiatry

Providing care for patients in the inpatient psychiatric setting has changed in part to maintain CDC-guided social distancing protocols. In a recent paper, Li describes how one could address certain challenges in inpatient psychiatric units relating to the COVID-19 pandemic (Li, 2020). Admittedly, implementing prevention measures in such units can be a challenge, especially when part of treatment traditionally includes close contact, for example frequent safety monitoring, group therapy sessions, and eating meals together. Furthermore, there are logistical factors to consider, such as shared bathrooms and sleeping rooms. Elements to contingency planning include (Li 2020): a) Disease precautions (screening, re-screening, personal protective equipment, use of designated clothing, cleaning of surfaces, and disinfection); b) restriction of visitors and minimization of non-essential contacts (e.g. medical students (Moszkowicz et al., 2020)); c) physician workforce considerations (creating back-up pools, job reassignment); d) operational adjustments (creating isolation rooms in psychiatry inpatient units, tightening criteria for psychiatric admission); and e) group therapy changes (limiting number of participants, utilizing physical distancing). As reported elsewhere and from experience, it is crucially important to have organized leadership, clear communication, and involvement of all disciplines in decision making (Li 2020).

In Massachusetts, an increased need for psychiatric beds is emerging. At various hospitals, psychiatric units have opened to provide acute inpatient care for psychiatric patients presently infected with the novel coronavirus, but not medically ill enough to be hospitalized on an infectious disease unit. Infection Control subsections have been at the forefront with respect to collaboration, design and planning for the COVID-19 units. One challenge in providing this level of care is the difficult-to-predict course of a patient's infection. While patients admitted to this unit are discussed with internal medicine colleagues and determined to be medically stable on admission, some patients develop complications and require transfer to a medical unit. This is especially important to consider in psychiatric facilities where access to emergent interventions, such as intubation, is limited and patients must be brought by ambulance to the nearest medical facility.

Another challenge is disposition planning, particularly for patients experiencing housing instability. Programs, such as the much-needed partial hospitalizations or day hospitals are largely not available. There

Table 2
Screening questions asked by mental health physicians (Note: Psychiatric patients who come to emergency rooms psychotic are not likely to answer these questions accurately.)

Topic	Example of a screening question
General ROS	Do you have fever, chills, nausea, diarrhea, myalgia, fatigue, loss of smell?
Focused Respiratory ROS	Do you have new or worsened cough, productive cough, dyspnea, painful breathing?
Travel	Have you recently traveled internationally, or to areas of increased incidence like Manhattan?
Contact	Have you had any contact with any confirmed coronavirus patient?

also may be challenges in engaging families to participate in discharge planning for patients infected with the novel coronavirus, due to fear.

The changes made above, though important for infection control purposes, have created an inpatient setting that is more isolating for both patients and clinicians. For example, a patient with a major depressive episode who experiences marked decrease in appetite and difficulty getting out of bed may benefit largely from attending group meals and socializing with others on the unit as forms of behavioral activation. The current inpatient environment in some hospitals can preclude this treatment to balance the risks of sustained transmission of SARS-CoV-2. Overall, the combination of less face to face interaction, decreased in-person programming, restricted dining to in-room meals instead of communal dining and the “no visitors policy” is likely contributing to a decrease in the effectiveness of a therapeutic milieu on the psychiatric ward. There are also concerns about a pandemic of loneliness and social disconnection following the resolution of the present pandemic. That may fuel an uptick in psychiatric hospitalizations in the coming months.

3.4. Psychiatric care on the Consultation-Liaison (CL) service

Psychiatric care on the CL service entails providing care for both patients in the emergency room and inpatient medical setting. In the emergency room, when possible, CL services are using virtual methods of care delivery even though in-person evaluation of the patient is the gold-standard (Funk et al., 2020); in some hospitals, patients in the emergency room and obstetrics floor are seen urgently and in person given the potential sensitivity and severity of the case, with appropriate PPE.

CL psychiatry continues on the inpatient wards, as well. CL psychiatrists often follow patients for prolonged periods of their hospitalization and are important in supporting patients adjusting to medical illness. This is particularly true in patients with chronic illness (Kang et al., 2020), as their risk for poor COVID-19 disease outcome, and general health care burden is high. Thus, CL services prioritize the safety of patients from risk of cross contamination or exposure to disease by staff, again emphasizing virtual evaluations where possible and indicated. Similar to the emergency room setting, members of the CL team are ready to respond face-to-face to psychiatric emergencies on medical wards when needed. More and more, hospital psychiatry programs are now experimenting with remotely handling consults to avoid unnecessary face to face contact during this pandemic. Thus, CL services provide a "hybrid model", for both trainees and their mentors, and provide a learning experience for making triage decisions (Funk et al., 2020).

3.5. Psychiatric care in the community

Patients with serious mental illness (SMI) are believed to be at increased risk of COVID-19 morbidity and mortality given their medical risk factors, lack of good hygienic habits, homelessness, and often-congregate living situation which can facilitate viral transmission (Bartels et al., 2020). Psychiatrists working with this patient population have seen the need to adjust the way they deliver care. In New York, State-supported community behavioral health organizations, and programs of assertive community treatment (PACT) have developed COVID-19 response protocols for various settings, including in shelters, mental health group home residences, clinics, and home visits, all including a component of screening questions or screening temperature, isolation pending on the response to the screen, providing the person in question with a mask or utilizing social distancing of 6-feet space, making use of help from a medical director or the state COVID hotline, and further reviewing symptoms and epidemiological risk factors to determine COVID-19 testing and disposition. For home visits, patients can be screened prior to the visit, and if symptomatic, staff can refrain from entering the home.

In a survey of 32 California non-profit behavioral health agencies, 87% lacked necessary equipment to conduct telehealth, and there was a general lack of access to PPE for staff. As decline in services and revenue occurred, some staff were furloughed or terminated (Bartels et al., 2020). In the setting of concerns for diminished workforce to care for patients and declining revenue, the State of Massachusetts has implemented policy, regulatory, and payment reforms for the provision of remote telehealth, access to residential care staff and medications, and financial support for community-based services (Bartels et al., 2020). For example, waivers were issued to allow pharmacies to prescribe a larger amount of medications and for such increased amount to be stored in group homes. Additional guidance on clozapine prescribing regarding in-person blood draws and labs was welcomed, allowing for consideration of compelling reasons to continue prescribing without obtaining (or delaying) laboratory testing (Table 1).

3.6. Effects on psychiatric physicians

Similar to other reports of healthcare workers’ responses to caring for patients with COVID-19 in China (Wu et al., 2020, Lai et al., 2020), psychiatric physicians in the US also experience stress, anxiety, and fear, based on survey results of colleagues across the country. These responses can stem from either events happening in one's own life (e.g., a family member being diagnosed with COVID-19, or fear of losing a loved one), one's work environment (new protocols to follow, ever-changing and unclear guidance on personal protective equipment), or the interplay of both (being exposed to a patient with COVID-19 at work, and then having to quarantine and isolate oneself from family for 14 days). In general, the need for psychiatric treatment by psychiatrists is increasing, and they are finding work hours becoming longer, and much needed vacation time being cancelled by their places of employment in some instances. Certain phenomena are also becoming more evident as staff compare their roles to that of others on the team or in the healthcare system. For example, some nurses or physicians whose duties require them to be physically present in the hospital engender resentment toward those who work remotely. The pandemic has also created a significant dichotomy between psychiatrists who do inpatient versus outpatient work which most do remotely, as inpatient care often necessitates face-to-face evaluation. There are also concerns about appropriate knowledge regarding COVID-19. In a study of 141 psychiatrists and 170 psychiatric nurses in two psychiatric hospitals in China, boh knowledge and attitude were assessed; 89.51% of the medical staff studied had extensive knowledge of COVID-19, and 64.63% of them had received the relevant training in hospital settings. The study suggested that increased attention should be given to the knowledge and attitudes of medical staff at psychiatric hospitals during the COVID-19 outbreak (Shi et al., 2020). In US healthcare systems, like those in other countries, knowledge about care for people positive or ill with the novel coronavirus has been variable, with guidance for best practices evolving and changing on a frequent basis. Additional personal, economic, and ethical considerations for US psychiatric physicians based on survey results are summarized in Table 3. Without consistent national guidance, it is also difficult for staff to feel secure in everchanging protocols.

4. Ethical challenges in an evolving crisis

As hospital systems adapt to meet the changing needs of patients during this crisis, psychiatrists have been faced with complex ethical challenges. It has required physicians to make clinical and administrative decisions based on sparse evidence, from studies that may not have completed peer-review (Kubota, 2020). Resource limitations magnify these challenges (including personal protective equipment, testing kits, hospital beds and staff shortages), at times making it impossible for physicians to provide the optimal standard of care.

While some ethical challenges are faced by all medical specialties,

Table 3
Concerns of psychiatric physicians across the country during the COVID-19 pandemic

Class	Example
Personal prevention	What personal protective equipment (PPE) is available for me in my work setting? How does the frequent change in guidance about PPE affect my trust in the system and guidance? How effective is a surgical mask, N95 mask, face-shield or goggle, gloves, or gown to prevent infection? Given limited supply, will I be forced to prove my worthiness as essential in order to obtain these? Am I eligible to be tested for the coronavirus? Which is the best test?
Personal treatment	If I get infected, what treatment is available? Since there is no FDA approved treatment, how effective are experimental treatments like hydroxychloroquine, azithromycin, remdesivir? Will I live or die?
Effects on others	What if I catch the disease and spread it to my children and elderly parents? What if I bring it home from work and spread it to my roommates? If I catch the disease how will I continue caring for and/or breastfeeding my infant? Will I need to delay further childbearing due to my workplace exposures?
Economic stress	How will this pandemic disrupt my income? Will my patient panel change and will I be asked to work fewer or longer hours? What if I can't adjust to providing care via telehealth and that's the only option at this moment in my setting? What if I am required to be physically present as essential, and I only feel safe working remotely? Will I lose my job? Will I quit? What if I have preexisting conditions and am at high risk to die if I catch the infection – should I quit my job altogether and risk financial stress versus work and risk exposure and death?
Ethical considerations for self	How do I balance the tenets of the Hippocratic oath while also working in systems that may not be optimized for prevention, with a risk that I may die?
Ethical considerations toward others	How do I properly provide informed consent at time of psychiatric admission around risk for COVID-19 infection while the patient is on the psychiatric unit? How can I conduct HIPPA-compliant telepsychiatry interviews from home with my family present? How do I balance providing voluntary professional services to others in need whilst I struggle to maintain afloat financially? If I am trained to be a physician, does this mean I should answer the call to front-line service and if I don't, am I guilty of not serving my profession well?
Training considerations	Will this pandemic affect my learning opportunities? Will I attain all competencies required for graduation? If I get quarantined or sick, will that affect my graduation date? How do I respond to policy that makes me feel unsafe? Is quitting even an option for trainees?

the nature of psychiatric treatment and the environment on psychiatric units create unique concerns. Unlike other specialties that treat infectious patients, psychiatric units are not set up to maintain infection control. Staff do not typically wear protective gear, patients are ambulatory and socialize in communal spaces, and some patients with severe psychiatric symptoms may find it impossible to follow even simple precautions, like hand washing or social distancing. In many ways, effective inpatient psychiatric treatment depends on interaction (i.e. group therapy), which is in direct conflict with practices that would reduce the spread of infectious disease. The increased risk of COVID-19 transmission on psychiatric units is not just theoretical; there is a growing amount of media coverage describing frequent and severe outbreaks occurring on psychiatric units, with some outbreaks leading to multiple COVID-19 related deaths (Gessen 2020, Kim 2020, Ramgopal 2020). These articles have compared the environment of inpatient psychiatric units to nursing homes, in regard to COVID-19 transmission (Kim 2020).

If the risk of contracting COVID-19 is, in fact, higher for hospitalized psychiatric patients, what would that mean? More specifically, what should psychiatry, as a profession, do with that knowledge? The American Medical Association's opinion is clear: withholding information without a patient's knowledge or consent is ethically unacceptable, except in emergency situations American Medical Association. This would include any information pertinent to a patient's medical decision-making process. If patients are, in fact, at increased risk of acquiring COVID-19 due to psychiatric hospitalization, disclosing such information would seem critical. In addition, many psychiatric patients are admitted on 72-hour emergency commitments. This takes on new ethical meaning in the midst of the pandemic. To our knowledge, there is no literature discussing how hospitals are addressing this issue. We similarly found no evidence that patients are being informed that psychiatric hospitalization may increase the risk of acquiring COVID-19, or that patients are being included in the decision to bear that risk. As more psychiatric patients contract the virus, addressing these issues may be increasingly urgent and ethically necessary. In New Jersey state psychiatric hospitals, six patients died from COVID-19 as of March 19th, 2020.

At times, this crisis has required psychiatrists to weigh the importance of various ethical principles, and effectively prioritize one in favor of another. The virtualization of patient care using video conferencing platforms is one example of this dilemma. Virtual encounters support the principle of nonmaleficence by reducing risk of viral transmission while still enabling the provision of care, and therefore beneficence. However, these principles are achieved at the expense of patient privacy, as video conferencing platforms have variably robust security that does not meet the privacy standards set by the Health Insurance Portability and Accountability Act (HIPAA). For psychiatrists, compromising patient privacy is particularly precarious given the uniquely sensitive nature of mental health information, from both a personal and legal standpoint. Fortunately, this question was addressed by Federal policy, which specifically allowed for the use of such platforms despite potential risks to patient privacy (Department of Health and Human Services, 2020). The weight of this ethical dilemma, at least, did not fall on individual providers. When policymakers cannot keep pace with the pandemic and fail to address ethical dilemmas as quickly as they are encountered, are individual physicians forced to face these challenges alone? Perhaps this is the most significant ethical burden facing physicians, and particularly psychiatrists, in the age of COVID-19: being asked to answer complex ethical questions in real-time; questions that even experienced policymakers have not yet answered.

5. Considerations around training of psychiatric residents in complex healthcare systems

During the COVID-19 pandemic Psychiatric residencies across the country are challenged to find innovative ways to support their residents as they provide care for patients infected with the novel coronavirus.

At Beth Israel Deaconess Internal Medicine, Rakowsky et al. discussed key questions that their chief residents have used to anchor themselves with as they develop new strategies to meet the challenges of training medical residents during these unprecedented times including: “What Are Our Program's Core Values and How Do We Maintain Them? How Do We Manage Communication? How Do We Maintain Community? How Do We Create a Sense of ‘Normalcy?’” (Rakowsky et al., 2020). Psychiatric residencies are faced with coming up with creative solutions to address these key components of providing a strong training foundation in the midst of constantly changing policies, residents being pulled from rotations and being redirected to meet the needs of services, social distancing requirements, and infection precautions. These are unprecedented times that have allowed us to try new strategies to engage learners including virtual meetings and self-directed learning. Residency programs must continue to be conscious of their residents’ health, physically and emotionally. This is

done by emphasizing community, even virtually, and by encouraging residents to seek appropriate care.

6. Service, leadership, and scholarship during the COVID-19 pandemic

The Accreditation Council for Graduate Medical Education (ACGME) Board of Directors in March 2020 revised their common program requirements to foster greater use of tele supervision, which has allowed residents to deliver care to patients while decreasing the potential risk and exposure to the patient, and other healthcare providers (Potts III, 2020).

Uniquely the ACGME in March 2020 announced that programs during this crisis can self-declare as in a Pandemic Emergency Status which would suspend all program requirements except those pertaining to resident/fellow work hours, supervision and safety (Potts, 2020). This allows programs to be more flexible in fulfilling their academic medical education requirements as residents and attendings actively respond on the front lines during these unprecedented times.

While the specific mission of an academic medical center may vary by setting, some goals are universal. Clinical care, research, education and teaching are the cornerstones common to all. Whereas most missions can continue uninterrupted, many will assume a different format. Changes in how clinical care has changed has been described as above. Some types of research may need to be suspended if they involve direct patient interaction but other research (such as data analysis) may continue. It is expected that the educational and teaching missions will continue uninterrupted, but perhaps in a different format with a greater emphasis on virtual techniques. The academic medical center will be a clinical, educational, and public health resource during this crisis. Indeed, the many changes precipitated by the COVID 19 pandemic represent an opportunity for evaluation and innovation that will better prepare us for the next threat to the commonweal.

7. Conclusion

COVID-19 is affecting psychiatry in ways that are profound and constantly evolving. Existing psychiatric patients and all others in the community are being faced with isolation, loneliness, sudden bereavement without being able to bury the dead, losing their livelihood, and fear of ultimately and suddenly losing their lives. All psychiatric care settings are impacted by this pandemic, and its services for people who suffer the mental consequences of having lived through this experience will be needed for years to come. While it is uncertain what this pandemic will fully mean for psychiatric care long-term going forward, we share our research and experience to facilitate dialogue, increase knowledge among psychiatric clinicians, and to inform healthcare policy makers and health care systems about the challenges and continued needs of financial and administrative support for psychiatric clinicians and mental health systems across our country.

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