Acta Psychiatrica Scandinavica

Acta Psychiatr Scand 2020: 142: 70–71

DOI: 10.1111/acps.13176

Letter to the Editor

Letter to the editor

Optimizing psychiatric care during the COVID-19 pandemic

It is increasingly clear that there is a tension between best possible psychiatric care and efforts to reduce the spread of SARS-CoV-2. As clinicians, we now perceive several key challenges for optimal psychiatric care in the current pandemic context:

Change in routines: Daily routines are especially important for the stability and function level of many psychiatric patients across a broad range of diagnostic categories. At our clinic, several patients have decompensated from a relatively high function level to a state where hospitalization was the only viable option, primarily because of the breakdown of weekly routines resulting from the policy response to COVID-19.

Social isolation: Social isolation is part of the symptomatology of many psychiatric disorders. However, the isolation due to the COVID-19 policy response is policy-driven, rather than patient-driven. On one hand, the current policy-driven social isolation may be stress-reducing for some patients in the short term, because of less pressure to conform to social norms. On the other hand, for most of our patients, we see an exacerbation of loneliness and despair, leading to increased rumination and decompensation of otherwise stable patients.

Exposure to the 'narrative' of the pandemic: Evidence regarding the impact of disaster-induced psychological stress on patients with psychiatric illness is inconclusive, with some studies finding that psychiatric patients are more resilient to this type of stress compared with healthy controls (1,2). However, some psychotic patients may incorporate the catastrophic narrative into their delusional world (2), perhaps contributing to this patient group being less resilient than patients with affective disorders (3). Furthermore, the ongoing massive news exposure to the pandemic narrative has led to an exacerbation of anxiety in some of our patients.

Reduced in-person support: Modern psychiatric care is predominantly delivered in the out-patient setting and relies on adequate ongoing emotional as well as practical support. Despite efforts to employ telepsychiatry, the response to COVID-19 unfortunately entails a reduction in support for patients. In our clinic, many patients have expressed concern over this, possibly leading to deterioration in some. In countries which have been more impacted by the pandemic, psychiatric care has been scaled back in order to free up resources for COVID-19 patients, as well as for more liaison psychiatry to deal with emergent mental health stress among healthcare workers, patients, and families (4).

Reduced care seeking: We have seen some patients who cancel appointments at the hospital because of fear of nosocomial infection. We also have patients who have chosen to be discharged from the wards because of fear of infection or because no visits were allowed. Perhaps even more concerning is that reduced care-seeking behavior in the short term might lead to a delayed wave of serious mental illness in the long-term (4).

Mental health impact of COVID-19 exposure: Some patients with mental illness will contract COVID-19. We know from previous studies that patients with prior mental illness who directly experience a disaster have a risk of developing PTSD or depression (1). Evidence from the SARS pandemic also resulted in a substantial risk of persisting PTSD and depression among survivors after intensive care because of SARS infection (5).

Higher infection risk: Many psychiatric patients experience residential instability, homelessness, and unsafe social behavior. Furthermore, severe psychiatric illness is associated with reduced ability to self-monitor for symptoms as well as pay attention to the news. Notably, 17% of psychiatric in-patients at a center close to a SARS outbreak had not even heard about the SARS threat during the 2003 epidemic (2). Additionally, it is difficult for some psychiatric patients to understand, accept, and follow self-isolation and self-protection measures.

Higher risk of morbidity and mortality among psychiatric patients from COVID-19: Patients with mental illness often have several risk factors that can further increase morbidity and mortality of COVID-19, including a high rate of smoking, lung disease, cardiovascular disease, diabetes, and obesity. Thus, many of our patients who do contract COVID-19 are at an elevated risk of a more severe prognosis.

Risk of nosocomial COVID-19 spread in psychiatric wards: We agree with Zhu et al. (6) that the wards in psychiatric hospitals are not designed to the standards of isolation against infectious respiratory disease, that psychiatric medical staff have little experience of dealing with infectious disease, and that activities to 'stabilize' psychiatric patients may not be compatible with best practices for preventing spread of infectious disease.

At our institution, we try to avoid hospitalization and we seek to move forward discharges when possible. We are aware that these efforts may increase the risk of early psychiatric relapse (7). For new admissions, we check for symptoms of COVID-19 and screen for close contact with anyone having COVID-19 symptoms during the previous 14 days. No visitors are allowed during admission, and patients are not allowed to go outside the hospital during admission.

Risk of nosocomial spread in out-patient psychiatric clinics: In order to reduce the risk of infection, we now provide care by telephone, video, and home visits. Group activities are suspended, and we have lengthened the duration of prescriptions for stable out-patients (6). If a hospital appointment is needed, we call by phone in advance to screen for COVID-19 symptoms. We maintain appointments or home visits where there is an exacerbation of symptoms, new side-effects, lack of adherence, or a necessity to administer pharmacological therapy or legal obligations.

In Italy, where the community spread is greater than in Denmark, guidelines recommend even stricter measures (8), including that front desk and care personnel must wear personal protection equipment. In Wuhan (China), if a patient is at risk or corona-positive, the patient must be put in isolation for 14 days and must wear a surgical mask (6).

To conclude, we foresee an increasing tension between optimizing psychiatric care and minimizing the overall health impact of COVID-19. We also expect that increased psychological stress in the population and among healthcare workers shall lead to increased mental health pathology (likely depression, anxiety, PTSD, and higher suicide rates). More studies, as well as more knowledge sharing, are imperative as we continue our work in the frontline of mental health care in this new pandemic context.

Declaration of interest

None.

M. Moesmann Madsen[1,2], *D. Dines*[1], *F. Hieronymus*[3]
[1]*Department for Psychosis, Aarhus University Psychiatric Hospital, Aarhus, Denmark,* [2]*University Research Clinic for Innovative Patient Pathways, Diagnostic Center, Silkeborg Hospital, Silkeborg, Denmark and* [3]*Department of Clinical Medicine, Aarhus University, Denmark*
E-mail: michms@rm.dk

References

1. Person C, Fuller EJ. Disaster care for persons with psychiatric disabilities: Recommendations for policy change. J Disabil Policy Stud 2007;**17**:238–248.
2. Iancu I, Strous R, Poreh A, Kotler M, Chelben Y. Psychiatric inpatients' reactions to the SARS epidemic: an Israeli survey. Israel J Psychiatry Relat Sci 2005;**42**:258.
3. DeLisi LE, Cohen TH, Maurizio AM. Hospitalized psychiatric patients view the World Trade Center disaster. Psychiatry Res 2004;**129**:201–207.
4. Arango C. Lessons learned from the coronavirus health crisis in Madrid, Spain: how COVID-19 has changed our lives in the last two weeks. Biol Psychiat 2020. [Epub ahead of print] https://doi.org/10.1016/j.biopsych.2020.04.003
5. Lam MH-B, Wing Y-K, Yu MW-M et al. Mental morbidities and chronic fatigue in severe acute respiratory syndrome survivors: long-term follow-up. Arch Intern Med 2009;**169**:2142–2147.
6. Zhu Y, Chen L, Ji H, Xi M, Fang Y, Li Y. The risk and prevention of novel coronavirus pneumonia infections among inpatients in Psychiatric Hospitals. Neurosci Bulletin 2020;**36**(3):299–302.
7. Garriga M, Agasi I, Fedida E et al. The role of Mental Health Home Hospitalization Care during the COVID-19 pandemic. Acta Psychiatr Scand 2020;**141**:479-480.
8. Starace F, Ferrara M. COVID-19 disease emergency operational instructions for Mental Health Departments issued by the Italian Society of Epidemiological Psychiatry. Epidemiol Psychiatric Sci 2020;**29**:1–12.