COVID-19 GUIDANCE FOR INPATIENT PSYCHIATRIC FACILITIES

23 APRIL 2020
These materials were prepared as part of the Rapid Response Network, a joint initiative between the California Mental Health Services Oversight and Accountability Commission (MHSOAC) and Social Finance, Inc. to support jurisdictions in fast-paced research and decision making driven by COVID-19.

The network aims to facilitate connections among jurisdictions facing similar challenges, and to supplement that shared experience with support from external experts—in order to deliver fast, customized, digestible research and analysis that strengthens local capacity.

We recognize that the pace of these responses means that they are likely to be both incomplete and imperfect. If you have suggestions for improvement or questions about these materials, we would love to hear from you. Please email Jake Segal (jsegal@socialfinance.org) or Sean Burpoe (sburpoe@socialfinance.org).

With gratitude for the support of the Robert Wood Johnson Foundation and invaluable in-kind support from GLG, which supports the RRN through access to their expert network.
The most complete resource issuing guidance specifically for inpatient psychiatric facilities we found was developed by New York State’s Office of Mental Health. Among other items, OMH advised:

- Maintaining hospital-wide standards related to COVID-19
- Discontinuing group therapy
- Lessening documentation requirements
- Upon discharge, foregoing outpatient appointment requirements if they are unavailable within 7 days

Where it exists, other state-level guidance – including from California, Colorado, and North Carolina – is limited and primarily related to discharge, telehealth waivers, and billing.

As of April 20, federal guidance for inpatient psychiatric care specifically is limited to a two-page set of interim considerations from SAMHSA, and some, including leaders from the American Psychiatric Association, have called for more extensive guidance.

Most other guidance, including for engaging with non-directable clients, is generic and/or extrapolated from that for residential treatment facilities, homeless service providers, and detention centers.

2. See slide 6 of this resource for more information on state-level responses.
Those with mental health disorders are at higher risk for COVID-19 for several reasons, including:

- Difficulty to ensure personal protection due to environment or awareness of risk
- Confined psychiatric facilities
- Barriers to accessing timely health services (including mental health-related discrimination)
- Mental health disorder comorbidities, including high susceptibility to stress
- Regular interaction with outpatient clinics, which are largely closed

COVID-19 guidance for inpatient psychiatric care facilities has been less prominent than that for long-term care facilities, hospitals, and in jails and prisons.

Inpatient psychiatric care facilities face unique challenges in the face of COVID-19, such as determining who to admit and what is a genuine emergency as well as in practicing social distancing among inpatients in an environment in which treatment can include group activities.

Quarantine, isolation, and concern, all factors in the response to COVID-19, can lead to and/or exacerbate serious mental illness.

# FEDERAL GUIDANCE FOR INPATIENT PSYCHIATRIC CARE

While more limited than for long-term care facilities, for example, some guidance has been issued from federal entities for inpatient psychiatric care.

| **SAMHSA** | • The Substance Abuse and Mental Health Services Administration issued limited “initial considerations,” cited by CMS and others, alongside brief considerations for mental health care.\(^1\)\(^2\) This guidance primarily mirrors that for all healthcare facilities.  
• Considerations include maintaining awareness of psychosocial group treatment, partnering with paraprofessional staff to meet staff ratios, and increasing cleaning. |
| **CMS** | • The Centers for Medicare & Medicaid Services extended some hospital guidance to psychiatric hospitals, including enabling inpatients to be relocated to expand bed capacity.\(^3\)  
• The guidance advised special consideration before those with psychiatric or cognitive disabilities are discharged to home if they have mild COVID-19 symptoms. |
| **Joint Commission** | • A webinar for behavioral health organizations offers methods for minimizing exposure in community settings with overnight stays, including providing clear signage, increasing cleaning, avoiding crowded food distribution, relying on telehealth if possible, and following CDC guidance for institutions of higher education.\(^4\)  
• Separate guidance issued for COVID-19 patients at risk of suicide advises that 1:1 observation be conducted while maintaining view of the patient in a closed room.\(^5\) |

\(^{5}\) “Monitoring High Risk Patients with Known or Suspected COVID-19,” The Joint Commission, 9 April 2020.
Leaders from the APA offered insights on how providers assisting those with serious mental illness (SMI) might operate in the face of COVID-19.

- **COVID-19’s existence** can lead to increased paranoia, delusions, hallucinations, cognitive deficits, disorganization, and anxiety among those with SMI.
- **Symptoms will likely not abate** if those with SMI have COVID-19.
- **Crowding, lack of movement and disrupted patterns** can lead to increased outbursts and, accordingly, increased staff exposure.
- **Steps taken by inpatient hospitals:**
  - Restricting visitors
  - Limiting the movement of patients and/or restrict patients to their own unit
  - Moving off-unit activities onto the unit
  - Having adequate PPE on hand
  - Consolidating coronavirus-positive patients
- **By the authors’ assessment,** additional guidance for inpatient facilities is necessary.

### STATE-LEVEL GUIDANCE

With some exceptions (including NYS), state-level guidance is limited and primarily related to discharge, telehealth waivers, and billing.

<table>
<thead>
<tr>
<th>New York State Office of Mental Health</th>
<th>California Department of Health Care Services</th>
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<tbody>
<tr>
<td>• Maintain hospital-wide standards related to COVID-19.</td>
<td>• If a patient exhibits symptoms, contact the local public health department and isolate the patient in a room.</td>
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<tr>
<td>• Discontinue group therapy.</td>
<td>• Patients with COVID-19 may be admitted in the absence of severe symptoms.</td>
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<tr>
<td>• Lessen documentation requirements.</td>
<td>• Report staff diagnoses or investigations to DHCS.</td>
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<tr>
<td>• Upon discharge, forego outpatient appointment requirements if they are unavailable within 7 days.</td>
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<tr>
<th>Colorado Office of Behavioral Health</th>
<th>North Carolina Dept. of Health and Human Services</th>
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<tr>
<td>• Enable verbal consent to treatment.</td>
<td>• As relevant, encourage ambulances to redirect patients without COVID-19 symptoms and with behavioral health systems from an emergency department to alternative sites of care.</td>
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<td>• Expand telemedicine, including to those isolated in their rooms.</td>
<td>• Consider converting local behavioral health facilities into crisis and assessment centers.</td>
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<td>• Modify emergency licenses to enable behavioral health service provision in a statewide emergency.</td>
<td>• Consider adopting policies for emergency forced medication.</td>
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<tr>
<td>• <em>OBH advises consulting a guide developed by Signal Behavioral Health.</em></td>
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• Many states have issued guidance contextualizing telehealth and in-state licensure waivers,¹ ² as well as detailing billing instructions for telehealth.³

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1. “States Modifying In-State Licensure Requirements for Telehealth in Response to COVID-19,” Federation of State Medical Boards, 15 April 2020.
GUIDANCE ON ENGAGING WITH NON-DIRECTABLE PATIENTS

Resources for residential treatment facilities, homeless service providers, and detention centers offered guidance that may be applicable

• Writing for intermediate care and residential treatment facilities, CMS advised having clients in their room with the door closed, and if that is not possible, having clients wear masks and maintain six-foot social distancing. CMS also advised helping clients by adhering to CDC infection prevention and control practices and maintaining some daily routines to the extent possible.¹

• Several resources, for example one for homeless service providers,² identify mental health as a factor in leading an individual to have opposition to quarantine, pointing readers to generic guidance from the CDC about mental health and coping.³ In guidance for professionals interacting with individuals experiencing unsheltered homelessness, the CDC advised contacting local health authorities if individuals do not comply with facility isolation requirements.⁴

• Acknowledging that psychiatric facilities are not jails and prisons, APA president-elect Jeffrey Geller and Margarita Abi Zeid Daou point to CDC guidance for correctional facilities as applicable to inpatient psychiatric hospitals.⁵ Among other elements, the extensive CDC guidance advises regular verbal screening and temperature checks for incarcerated/detained persons to counteract potential hesitance to report symptoms.⁶

USEFUL RESOURCES

If you only have a few minutes or are looking for something specific


• **Considerations for healthcare professionals providing care to those with serious mental illness, including inpatient facilities.** Jeffrey L. Geller and Margarita Abi Zeid Daou, “Patients With SMI in the Age of COVID-19: What Psychiatrists Need to Know,” American Psychiatric Association, 7 April 2020.

• **Thorough guidance for residential facilities, including for handling clients with symptoms and for facility staff who are sick and/or facing staffing shortages.** National Council for Behavioral Health, “COVID-19 Guidance for Behavioral Health Residential Facilities,” 25 March 2020.