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Case Report

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Managing COVID + ve patients on inpatient adolescent psychiatry unit- A unique challenge

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Introduction

The Corona virus disease 2019 (COVID-19) has had a profound impact on the physical as well as mental well-being of people around the globe. The response to and resulting consequences of the COVID-19 pandemic poses significant challenges for patients suffering from mental health disorders as demonstrated by a recent study by Xie et al. examining adult COVID-19 patients admitted for inpatient psychiatric treatment for first-episode mental health issues [1]. Children, too, have the potential to experience adverse mental

health outcomes due to distress resulting from the pandemic: a study by Jolly et al. examined recently surfacing reports on varied presentations of pediatric patients undergoing hospitalization in psychiatry hospitals in context of COVID-19. One major source of stress is the institution of widespread social distancing practices as schools have transitioned to partial or full-time virtual learning [2]. In addition, extracurricular activities have undergone restrictions or been canceled entirely and in-person contact with peers and other important social supports has been limited. These changes place strain on children which can lead to distress and worsening mental health outcomes [2]. The



pandemic has also caused significant economic stress for many families. Increased unemployment, forced changes in interpersonal interactions, the wide-ranging effects caused by the safety measures being taken in response to COVID-19, and even concern over COVID-19-related illness or death itself may directly impact the mental health of children as well as indirectly impacting their mental health due to increased stress experienced by parents and the family as a whole [2]. Moreover, children who become COVID-positive and are subject to specific safety protocols in their care are under additional pressure that can further exacerbate mental health problems related and unrelated to the COVID-19 pandemic. There have been limited studies evaluating the treatment of COVID-19 pediatric patients admitted for the treatment of mental health disorders [3,4]. Here we present two cases of COVID-positive pediatric patients in an inpatient psychiatric facility and how the milieu was changed around them.

Cases

Our first patient is an 18-year-old Caucasian female, whom we will refer to as Patient X. with a history of post-traumatic stress disorder, reactive attachment disorder, bipolar disorder type 1, and unspecified intellectual disability. She was admitted to the inpatient unit at PPI with concerns related to expressing homicidal ideations toward her parents. During the course of her inpatient stay, she screened positive for COVID-19 during routine screening of all patients on the adolescent service in the context of a suspected exposure on the unit.

At the time of patient's diagnosis, she was found to be asymptomatic. The patient reported having mild symptoms, such as stuffy nose and intermittent headaches, as well as loss of taste sensation, while on the unit. Since the patient was found to be mildly symptomatic and was still in need of acute psychiatric hospitalization due to ongoing psychiatric concerns and placement issues, Patient X remained on the

inpatient psychiatry unit. Various modifications were made to the patient's room accommodation, as well as arrangements for individual and group therapy attendance. During the initial portion of quarantine, Patient X was kept in isolation in her room with a one-to-one sitter waiting outside the patient's room to help with her behavioral needs. The patient, while predominantly compliant with staff directions, experienced worsening of her anxiety and mood liability due to isolation and the resulting inability to see or interact with other patients on the milieu. Patient X scratched and kicked holes into the walls of her room and required repeated redirections during the period of isolation. Initially, arrangements were made for the attending physician and staff to see the patient while outfitted with an N95 mask, face shield, and proper personal protective equipment. Later on, tele psychiatry interviews were conducted via tablet in lieu of in-person interactions and examinations to avoid potential exposure for the physician during the patient's COVID-positive period. Patient X also attended individual and group therapy sessions via tele psychiatry services. One of the persistent concerns that the patient had was the lack of in-person interaction: she reported ongoing frustration with this aspect of her isolation. After 10 days of isolation, based on infectious diseases protocol from our health system, it was decided that the patient could return to the milieu. This decision was made in the context of recommendations by the COVID-19 Task Force, as the patient was asymptomatic, and therefore was deemed to have a very low risk of being infectious at the time. Patient X reported complete resolution of all her symptoms, including her previously reported symptoms of stuffy nose, headache, and loss of taste sensation. Another patient on the unit, whom we will refer to as Patient Y, was a 15 years old Hispanic-American female with history of disruptive mood dysregulation disorder and autism spectrum disorder who was admitted to the inpatient unit in the context of having arguments and displaying aggressive behaviors towards her family. The patient had been previously diagnosed with major



depressive disorder recurrent severe, ADHD, generalized anxiety disorder, and autism spectrum disorder. Patient Y was also found to be COVID-positive during routine testing of all inpatients in the context of a suspected exposure related to one staff member on the unit. The patient remained asymptomatic during the entire period of her isolation. The patient was maintained in similar precautions as Patient X. Patient Y had more behavioral concerns during her isolation, and her contact precautions and isolation were more challenging to manage. The patient was intermittently aggressive, engaging in self-harm behaviors such as scratching herself or banging her head into a wall, and attempting to spit at staff members when approached. Patient Y demonstrated a significant lack of understanding as to the overarching context and underlying motivations of her behaviors and actions. The patient also showed poor participation in tele psychiatry therapy sessions. Patient Y continued to take her medications as prescribed during the course of isolation. The patient was tested again on day 10 and tested negative. Patient Y was eventually discharged for long-term residential care, as was part of her initial treatment plan. The rest of the patients on the unit were tested periodically as per hospital protocol, and all tested negative.

Discussion

Prior to the two COVID-positive patients described in this work, our hospital had not had any COVID-positive cases on the inpatient unit. These cases, therefore, required the implementation of creative solutions, new policies, and compassionate considerations to care for these COVID-positive patients and minimize the potential for transmission of COVID-19 to future patients. In the follow-up period of positive screening, there were various discussions held by the COVID-19 Task Force to determine the guidelines that should be instituted to better prepare the unit and staff for potential COVID-19 exposures in future. One of the most significant concerns was the

inability to identify the potential source of exposure via contact tracing. Given the widespread nature of COVID-19 in the community, it was very difficult to pinpoint and contact-trace the source of infection for the COVID-positive patients. Apart from strengthening the screening protocol for staff members, students, and other trainees, it was decided that all incoming admissions would be tested for COVID-19, as many patients can be asymptomatic, thus leading to the potential exposure of other patients and staff members. Additionally, the discourse focused on increasing usage of tele psychiatry in situations where there are COVID-positive patients on the unit to minimize exposure to physicians, therapist, and other staff members. Mask fit testing for members of treatment teams was implemented. More signs and posters related to proper hand washing techniques and mask wearing were displayed at multiple places on the milieu. Both patients and staff were reminded of proper mask wearing and hand hygiene practices multiple times by members of the treatment team and the COVID-19 Task Force. Positive and negative reinforcement techniques were formulated by the COVID-19 Task Force for better implementation of social distancing protocols and proper mask wearing techniques. Positive enforcements included recognition of particular units across the hospital with the highest adherence to hand hygiene and social distancing practices. For staff members with unsatisfactory adherence to safety protocols despite repeated reminders, a three-warning protocol was established, followed by implementation of corrective action in cases of habitual non-adherence. Caring for COVID-positive patients, especially those with extensive and complicated psychiatric histories and social issues, on the inpatient unit presents a unique set of challenges for both the treating facility and the patients. Patients were removed from the milieu and isolated in their rooms, a procedure that increased stress experienced by patients as it both changed their environment and altered social interactions with peers and staff. Additionally, the COVID-positive patients

experienced behavioral challenges including aggression toward staff and self-injurious behaviors. COVID-19 is spread rapidly among patients via respiratory droplets [5]. Psychiatric care, which, by nature, requires close contact [6] in the form of social interactions on the unit, safety checks, group and individual therapy, and shared materials and facilities [6], face certain obstacles in COVID case management. The nature of the psychiatric unit may prevent adequate social distancing [7]. Similar scenarios at other institutions, including those in the Bronx [8], have presented solutions including assuming that all shared spaces are contaminated, keeping one available unit specifically for persons under investigation for COVID, and capping the unit at a lower-than-usual census. Although our institution has not yet established a specific unit for persons under investigation for COVID, such a measure may be implemented should there be continued concern for COVID outbreaks on the unit. Furthermore, COVID precautions on the inpatient unit may exacerbate patient stress and anxiety. Recently, family visitation has been widely limited on our unit and others [9]. This, in conjunction with decreased social interaction on the milieu, may cause heightened distress and feelings of loneliness. Our hospital had previously suspended visitation at the beginning of the pandemic and began to instead provide the use of video-conferencing for patients to meet with their family members. In light of recent COVID cases, such considerations may be reinstated and expanded upon. As the COVID-19 pandemic continues, it has presented new challenges to the medical system [10] and psychiatric care [4]. Inpatient psychiatry, in particular, must contend with particular difficulties in terms of patient care and management of isolated COVID-19 outbreaks. Overall, this experience, while challenging, resulting in increased preparedness of staff and physicians in the hospital, not only in terms of preparation for and response to instances of potential exposure, but also in the continuation of providing adequate psychiatric services to patients in the

event of another COVID-positive patient on the unit.

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