

## **Final Report of the ACLP Task Force on Lessons Learned From the COVID-19 Pandemic**

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## I. Introduction

COVID-19 disease, caused by the newly emergent SARS-CoV-2 virus, emerged in China at the end of 2019, followed in early 2020 by epidemic spread in Iran, Italy, and Spain, and then in the United States and world-wide. By mid-March 2020, hospitals in New York City were overwhelmed by critically ill patients with hypoxemic respiratory failure and a variety of other syndromes, heralding the onset of the pandemic in the United States, leading to over 9.35 million cases and 232,000 deaths (as of Nov 2, 2020). Many biomedical scientists, public health professionals, physicians, and other health care workers confronted the crisis to promote scientific rigor, transparency, effective patient care, and public safety, even at the risk attendant on speaking truth to power, and the risk to their own health.

The rapid spread of disease, high level of infectiousness, risk of critical illness and death, and lack of a preventive or curative treatment made it imperative to institute patient isolation and use of personal protective equipment, and limited in-person bedside patient care. In addition, masking and social distance protocols disrupted teaching and communal activity in the hospital and almost all aspects of life outside the hospital, including social gathering, travel, employment, and economic activity. Shortly into the course of the pandemic it became evident that increased psychological stress and psychiatric illness were affecting both patients and hospital workers. Patients experienced high rates of delirium, neuropsychiatric disorders, anxiety, depression, and acute stress disorder. In affected regions, surveys indicated that 50% or more of physicians and nurses experienced clinically significant levels of anxiety, depression, and acute stress disorder. As the tide of COVID-19 disease rose and fell in individual communities, so too did pandemic fear, sadness, exhaustion, and moral injury. The situation was exacerbated by political tensions, and then further exacerbated, after the killings in short succession of Breonna Taylor, George Floyd, and Ahmaud Arberry, by heightened attention to longstanding systemic social inequality, racism, and bias, and their impact on health care delivery and outcomes. Calls arose for health care providers, institutions, and organizations to do more than simply acknowledge that systemic bias and inequality exist and instead to make meaningful changes in the way that work is conducted and care is delivered.

Consultation-liaison (CL) psychiatrists had no choice but to respond to the pandemic mental health needs of COVID-19 patients and hospital workers, and their response was remarkable. CL services rapidly developed protocols to protect their staff and enable them to continue to provide psychiatric care for hospitalized patients using both telepsychiatry and in-person care. They worked with hospital leaders and colleagues in social work, palliative care, pastoral care, and their psychiatry departments to provide psychosocial supports and psychiatric care for hospital workers, collaborated with critical care physicians to develop treatment protocols for management of sedation and delirium, and contributed clinical reports and research studies to the medical literature. Although many of these initiatives were organized locally, networking and informal exchange of information and guidance on best practices was greatly facilitated by the Academy of Consultation-Liaison Psychiatry. Its website and COVID-19 list-serv became key sources for information and for the psychosocial support of the community of CL psychiatrists.

## Report of the ACLP Task Force on Lessons Learned From the COVID-19 Pandemic

In the summer of 2020, Michael Sharpe, president of the Academy of Consultation-Liaison Psychiatry (ACLP), in recognition of the past and enduring future impact of COVID-19, and of the possibility of future pandemics, convened this Task Force to address lessons learned from the pandemic. Its charge was to summarize what the field of Consultation-Liaison Psychiatry has learned so far and to make recommendations to the ACLP to guide its organizational response going forward.

The Task Force conducted its work in August-November 2020 and focused on five domains: the development of remote work and telepsychiatry, support for the wellness of hospital staff, support for the wellness of CL psychiatrists, the psychiatry and neuropsychiatry of COVID-19, and the role of the Academy in information dissemination and advocacy. This report summarizes findings and recommendations of the Task Force.

In parallel with the work of the Task Force, an on-line anonymous survey sent to CL service directors in August 2020 asked their views on the enduring lessons for CL services to be derived from their pandemic experiences. While the responses mostly mirror the findings of the Task Force, one may serve as an epigraph for this report:

*“Despite the associated stress, the emergence of a new disease truly represents an opportunity to learn and grow—a privilege afforded physicians that should be embraced with seriousness, dedication, energy, and smarts.”*

### **II. Formation and Charge of the Task Force**

Dr. Sharpe solicited the ACLP membership for Task Force volunteers via the ACLP newsletter and email messages to the membership. Subsequently he asked Peter Shapiro to serve as the Task Force chair. Dr. Shapiro solicited the participation of some additional members.

Dr. Sharpe charged the Task Force to provide the Board of Directors with a summary of lessons learned and recommendations for future ACLP actions in five domains: remote work and telepsychiatry, support for the wellness of hospital staff, support for the wellness of CL psychiatrists, the psychiatry and neuropsychiatry of COVID-19 illness, and advocacy and dissemination of information.

### **III. Membership of the Task Force**

The members of the Task Force are:

Khyati Brahmbhatt, MD, University of California-San Francisco

Rachel Caravella, MD, New York University Langone Health

Jennifer Erickson, DO, University of Washington

George Everly, PhD, Johns Hopkins University

Karen Giles, MD, Emory University

Priya Gopalan, MD, University of Pittsburgh

## Report of the ACLP Task Force on Lessons Learned From the COVID-19 Pandemic

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R Michael Huijón, MD, University of Washington  
R. Garrett Key, MD, University of Texas-Austin  
David Kroll, MD, Harvard University  
Elizabeth Prince, DO, Johns Hopkins University  
Terry Rabinowitz, MD, University of Vermont  
Dahlia Saad-Pendergrass, MD, Hartford Hospital Center  
Daniel Shalev MD, Columbia University  
Peter Shapiro MD, Columbia University

### **IV. Work Process**

The Task Force met (remotely, by Zoom) on three occasions in August-November 2020, and conducted the remainder of its business by email and telephone and in subgroup meetings. The members formed subgroups to address each of the five domains. For each domain, Dr. Shapiro requested that the subgroup (1) generate a summary of the state of our knowledge, based on (a) review of the local experiences of the subgroup members, (b) relevant entries in the ACLP COVID-19 list-serv, and (c) the published literature, and (2) conclude with recommendations for future action by the ACLP. Subgroups prepared reports which were then shared among the entire Task Force membership for comment. Representatives of the subgroups then came together to collate the recommendations into a unified list.

Dr. Shapiro edited the subgroup reports and created draft Task Force reports which were then reviewed by the Task Force members. After receiving their comments, Dr. Shapiro prepared the final version of the Task Force report. It should be evident that credit for all the good ideas in the report belongs to the work group members, and that the responsibility for all the report's shortcomings is Dr. Shapiro's.

## **V. Executive Summary**

### **a. Introduction**

In the summer of 2020, Michael Sharpe, president of the Academy of Consultation-Liaison Psychiatry (ACLP), in recognition of the past and enduring future impact of COVID-19, and of the possibility of future pandemics, convened this Task Force to address lessons learned from the pandemic. The Task Force focused on the following domains: remote work and telepsychiatry, support for the wellness of hospital staff, support for the wellness of CL psychiatrists, the psychiatry and neuropsychiatry of COVID-19 illness, and advocacy and dissemination of information. Subgroups prepared reports for each domain.

### **b. Key findings**

#### **1. Remote Work and Telepsychiatry**

Priya Gopalan (Lead), Khyati Brahmhatt, Jennifer Erickson, and Terry Rabinowitz

Many centers developed three-level consultation models: (1) chart review, discussion with the primary team, and chart documentation, with no encounter with the patient; (2) telephone or video interview with the patient; and (3) in-room face-to face encounter. Use of telepsychiatry expanded rapidly, usually driven by the availability (or shortage) of personal protective equipment. Many centers evolved models in which some staff rotated off-site to do remote work only. In most centers, HIPAA-compliant commercial video platforms such as Zoom or Doxy.me were used, but local EMR-based platforms and FaceTime were also used. Many factors limited the use of remote telepsychiatry with patients, including availability of video equipment, patient inability or unwillingness to interact through video or telephone, availability and willingness of personnel to set up video for the patient, and hospital administration hostility to the introduction of remote work. It became evident that for many patients telepsychiatry consultation works well, but a substantial portion of CL work must be performed in the room, face-to-face, and that it is necessary to triage for appropriateness for telepsychiatry consultation.

In summary, it seems likely that some telepsychiatry in in-patient CL psychiatry is here to stay, especially when isolation and contagion are factors in patient care, but work remains to be done to facilitate its use. Studies show high patient acceptance for telepsychiatry in outpatient settings; there are no studies of efficacy and outcome for CL psychiatry work conducted by phone or video. Documentation requirements, billing routines and reimbursement for telepsychiatry have not been well-standardized.

## **2. Support for medical and hospital staff**

George Everly (Lead), R. Michael Huijón, and Dahlia Saad-Pendergrass

First responders and frontline workers in hospital and long-term care have experienced extreme stress during the pandemic, due to exceptional workloads, difficult treatment decisions, risks of becoming infected and of transmission of infection to others, and the experience of a high volume of patient deaths. Components of health care worker stress during the pandemic include Increased tension between work and home-family-selfcare obligations, moral injury and grief, uncertainty, loss of trust in systems, career disruption, and changing clinical roles.

Surveys of Wuhanese frontline workers found a high prevalence of anxiety (25%), depression, (20%), and acute stress disorder (38%). A second Chinese survey found the prevalence of elevated anxiety, depression, insomnia, and post-traumatic stress disorder (PTSD) symptoms to range from 34% for insomnia to 71% for PTSD. In New York City in April 2020, a survey of physicians, nurses, and physician assistants at one large center found 57% had acute stress, 48% depression, 33% anxiety. It is well established that severe emotional stress is associated with burnout and adverse workplace behaviors.

Resilience reduces perceived stress and burnout, and programs to improve resilience may be helpful. The Joint Commission states that it is critical that health care organizations have systems in place to support institutional and individual resilience. Psychological first aid (PFA) interventions are widely endorsed (e.g., by the American Psychiatric Association, American Psychological Association, World Health Organization, and American Red Cross). An integrated continuum of care approach has been instituted in some centers, including system-wide peer support, psychological services, wellness center with food, relaxation and meditation rooms, and biofeedback. The Johns Hopkins model includes crisis leadership consultation and training, staff peer support teams trained in PFA, employee assistance, spiritual care, wellness programs, and psychiatric services. Such coordinated programs may be cost-effective due to effects on absenteeism and turnover.

Of note, although these services have low rates of utilization (lower for MDs than nurses), informal check in with CL staff may enhance interest in service use. CL psychiatrists are uniquely situated to provide, through formal intervention or informal conversation in the course of the workday, psycho-education, support, and a normalization of the process of self-care. During the pandemic, many CL programs instituted informal check-in rounds with medical teams, check-ins with unit managers or charge nurses, multidisciplinary rounds, wellness spaces, outreach to staff sick or quarantined at home, and virtual support groups.

The ACLP can highlight research and offer training on PFA and staff support program development in its journals, meetings, webinars, and website, create a SIG and support member collaborations in research and program implementation, and liaison with AMA and American Hospital Association to advocate for structures to support hospital staff.

**3. Support for CL psychiatrists**

Rachel Caravella (Lead) and Elizabeth Prince

There is a lack of data on the prevalence of COVID-19 infection, morbidity, mortality, and mental health of CL psychiatrists during the pandemic, but many of the same concerns can be expected to apply for CL psychiatrists as for other health care workers—fear of infection, fear of transmitting illness to others, the trauma of hospital work, moral injury, and burnout. The Psychological Reactions site in the COVID-19 Resource page of the ACLP website has information on supporting other staff that could also apply to supporting CL staff themselves—and this could be publicized to benefit ACLP members. The ACLP COVID-19 list-serv was valuable as a source of peer support and emotional validation.

CL psychiatrists staffing behavioral code teams are at significant risk of infection and may have special needs for training, support, and personal protective equipment.

To honor colleagues who have died from COVID-19 and to facilitate healthy mourning by survivors, the work group recommends acknowledgement of CL staff illness and deaths and the creation of a forum for expressions of grief, using the ACLP website, newsletter, and Annual Meeting.

The work group recommends advocacy for research on CL psychiatrists' wellbeing, obtaining data on CL staff morbidity and mortality, identifying member health and wellness concerns via survey, making it possible to post anonymously to the COVID-19 list-serv, using moderated prompts to generate discussion of emotionally charged subjects, maintaining the website Resource page and list-serv, and acknowledging deaths.

**4. Psychiatry and neuropsychiatry of COVID-19**

Daniel Shalev (Lead), Karen Giles, and Heather Greenspan

Hospitalized COVID-19 patients have a high incidence of delirium and psychiatric symptoms including mood, anxiety, and psychotic symptoms; overlap with neuropsychiatric symptoms is common. Up to 85% of critically ill covid-19 patients have neuropsychiatric manifestations. Systemic inflammation, hypoxia, direct neurotropic effects of the virus, and iatrogenic effects of medications (e.g., steroids, sedatives) all contribute to development of symptoms. Many patients were intubated and sedated for weeks, and agitation during weaning from sedation became a common indication for psychiatric consultation for which evidence-based guidelines have yet to be established. Prolonged mixed or hyperactive delirium occurred commonly, often characterized by agitation that was difficult to manage, and the best treatment is still unknown. Some patients developed new onset psychosis, even seemingly after recovery from acute illness. Data on long-term effects is lacking, though recognition of “long-hauler” psychopathology is increasing. Other long-term psychiatric sequelae of acute COVID-19, and the possible long-term effects of seemingly asymptomatic infections, are unknown. More research on both acute and long-term neuropsychiatric effects of COVID-19 is needed.



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In the US, the incidence of and mortality due to COVID-19 are higher in Blacks and other minorities than in non-Hispanic whites. This disparity is partly accounted for by their disproportionately high representation among “essential workers,” including hospital workers.

Uninfected patients are also affected by the pandemic. Fear, isolation and disengagement from care worsen pre-morbid psychiatric illness, especially OCD, substance use disorders, and serious mental illness.

In some locales, problems in care for patients who required constant observation or psychiatric hospitalization were exacerbated by systems-level disruptions. Inpatient psychiatric unit bed capacity was reduced in order to isolate COVID-19 patients and mitigate exposure of uninfected patients and staff, and some units were converted into medical wards. As a result, workers in general medical-surgical settings, especially aides assigned to constant observation, had increased risk of infection.

The ACLP could play a role in encouraging needed research on pathophysiology, epidemiology, and treatment for COVID-19 patients, dissemination of guidelines, education of all physicians (not just CL psychiatrists) about COVID-19-related psychiatric illness, and in public health messaging.

### **5. Dissemination and advocacy work group**

David Kroll (Lead) and R. Garrett Key

The ACLP’s capacity for dissemination of information is considerable and varied but more can be done, and the ACLP has largely absented itself from advocacy activity so far.

The ACLP COVID-19 list-serv has provided a useful (though un-moderated) forum for postings which supported real-time discussion on urgent topics and rapid dissemination of (non-peer-reviewed) findings and information relevant to ACLP members. The ACLP website COVID-19 Resources page provides a depository for guidelines, protocols, “best-practices” advice, and training materials. It is important to keep in mind that these are not only useful to CL psychiatrists who are seeking to improve their own protocols but are also critical to CL psychiatry services that need minimum standards to point to when advocating for resources or protections in order to ensure they can conduct their work safely. Membership-wide e-mails and ACLP News are most useful for announcements and to alert members to the availability of more in-depth information found elsewhere. The journal (*Psychosomatics*, soon to be renamed JACLP) and the Annual Meeting are the major loci for presentation of new research findings and reviews. Informal interaction, networking, and discussion/question and answer periods have been largely sacrificed in the organization of this year’s virtual annual meeting, but finding structures to increase interaction within the annual meeting is a desirable goal, even if future meetings must be conducted as virtual events.

ACLP has so far not employed social media to engage the public in support of public health measures.

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ACLP's potential advocacy role depends on articulation of its values, priorities, and positions on issues related to patient care and the provision of care by CL psychiatrists. For example, ACLP could advocate for increased federal funding for research on psychosocial and neuropsychiatric aspects on COVID-19, for easing of constraints on and financial compensation for telepsychiatry, and for financial support for non-billable hours devoted to staff wellness. As part of its response to COVID-19, ACLP could also choose to advocate against systemic racism and bias and for improved health services, including CL psychiatry services, for those struggling to afford health care and for disadvantaged minority groups that have been disproportionately harmed by COVID-19. It could also work to promote diversity within its own membership and leadership. It should be born in mind that, in this time of heightened awareness about this issue, abstaining from advocating for change amounts, *de facto*, to endorsing the status quo.

Expanded or new relationships with the APA, general medical associations, and the American Hospital Association could also be vehicles for advocacy, as these organizations devote substantial resources to advocacy.

ACLP resources could be made available to assist members in dealing with individual hospitals and hospital systems.

### III. Recommendations

We recommend that the ACLP create mechanisms to invite input and cultivate discussion of advocacy issues that allows for timely expression of our values as a group and optimizes our ability to respond meaningfully to emerging issues relevant to our discipline.

We recommend that the ACLP extend its vision of excellence in clinical care to include an embrace of our role in our own wellness and that of medical care providers.

Commensurate with its vision statement, we recommend that the ACLP support the efforts of CL psychiatrists by taking an active leadership role in coordinating and directing scholarly efforts, advocacy, education, community building, and public policy in the key areas highlighted by the COVID-19 pandemic: the neuropsychiatric aspects of COVID-19, the use of telepsychiatry in CL, the role of CL psychiatrists in promoting the wellness of hospital staff, and the protection of the health and wellbeing of CL psychiatrists.

The following are specific recommendations towards these ends:

ACLP COVID-19 TASK FORCE SUMMARY RECOMMENDATIONS	
<p><b>Recommendation 1: Research</b></p> <p>Promote, lead, coordinate and direct scholarly efforts and more original research in key COVID-related topics including</p>	<p>Solicit submissions for publication in JACLP on salient topics including:</p> <ul style="list-style-type: none"> <li>• Neuropsychiatry of COVID-19</li> <li>• CL telepsychiatry</li> <li>• The wellness of CL psychiatrists including rates of infection and measures of stress</li> <li>• Medical staff support programs during the pandemic (virtual support groups, the practice of psychological first aid (PFA), stress inoculation, etc.)</li> </ul> <p>Coordinate and consider funding multi-site data sharing and gathering to promote more original and collaborative research in these key areas.</p> <p>Highlight this research, possibly through the publication of a supplement to the JACLP.</p> <p>Award the ACLP Foundation Research Professor Program to a preeminent research leader in one or more of these key areas to lecture at an upcoming annual meeting and fund the mentorship of emerging early career researchers in a relevant field by this selected professor.</p>

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<p><b>Recommendation 2: PPE and Clinician Safety</b></p>	<p>Survey current members to generate an up-to-date list of specific pandemic-related health and wellness concerns and challenges that exist.</p>
<p><b>Recommendation 3: Advocacy</b></p> <p>Educate local and national leadership organizations in the role of CL psychiatry as “front-line” and “essential.”</p> <p>Advocate for safe practice environments for CL psychiatrists.</p> <p>Promote diversity, equity, and inclusion in ACLP.</p> <p>Support equality in health care.</p>	<p>Take an immediate, public stance that research on the health and wellbeing of CL Psychiatrists is critical.</p> <p>Liaison with the American Medical Association (AMA) and the American Hospital Association to advocate for setting up structures to support hospital staff.</p> <p>Liaison with community mental health organizations to pursue ways in which local CL professionals may uniquely contribute to the well-being of the community at large.</p> <p>Advocate for the provision of appropriate PPE when in-person consultations are necessary.</p> <p>Advocate with hospitals for telepsychiatry consult services as an alternative when appropriate, especially when supplies of PPE are limited.</p> <p>Approach and lobby legislatures to formally update regulatory restrictions on telepsychiatry as well as licensing restrictions for physicians to provide telepsychiatry care across state lines.</p> <p>Advocate for use of technology for mental health commitments and digital integrated document signing for other required paperwork.</p> <p>Create open-access educational content related to health care disparities and anti-racism pertinent to CL psychiatry and especially as it relates to the COVID-19 pandemic.</p> <p>Acknowledge the lack of underrepresented minorities (URMs) in the ACLP membership and promote recruitment and retention of URMs within the organization with the ultimate goal of achieving equity in Academy initiatives and leadership.</p> <p>Take public stands against bias, racism, and inequality in health care.</p>

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<p><b>Recommendation 4: Clinical Guidance</b></p> <p>Engage the experts in the community to create clinical guidelines and best practices in the following areas, and publish and disseminate these guidelines as member resources (on the website, in print, or possibly as a supplement to the JAACL).</p>	<p>Support the development of evidence-based clinical guidelines for management of commonly occurring psychiatric complications of COVID-19 and their treatment.</p> <p>Develop CL-specific best practices and protocols regarding telehealth utilization, platforms, devices, billing, documentation of modality of care delivery, etc.</p> <p>Develop trainings on the practicalities, mechanics, and cost justifications of staff support program development (e.g. RISE program, virtual support groups, PFA training).</p>	
<p><b>Recommendation 5: Technology</b></p> <p>Optimize the use of technology tools and current platforms for the dissemination of best practices and the facilitation of advocacy work.</p>	<p><b>Email</b></p>	<p>Utilize E-mail sparingly and strategically for announcements about ACLP position statements or other important organizational news.</p>
	<p><b>Social Media</b></p>	<p>Consider utilizing the ACLP Twitter presence for public engagement on topics of significance related to our discipline and current COVID-19 developments.</p>
	<p><b>List-Serv</b></p>	<p>Maintain the unmoderated status of the COVID-19 listserv to preserve efficiency of communication and to provide a channel for open conversation among members.</p> <p>Consider methods for anonymous posting, weekly conversation starter posts, monthly topic digests, and formal listserv maintenance.</p> <p>Periodically review content to inform educational direction, advocacy efforts, and mission realignment for the ACLP. i.e. utilize it to keep a pulse on the priorities of the community.</p> <p>Encourage active members demonstrating expertise through the listserv to become more active within the ACLP at large.</p>

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	<b>Website</b>	<p>Optimize the website user experience so that the abundant published material is easily and intuitively accessible to users.</p> <p>Appoint a resource curator to maintain, update, organize, and transform the COVID-19 Resource page to a comprehensive resource site for ACLP members on the COVID-19 pandemic.</p> <p>Create a subspace within the COVID-19resources page for content on health disparities, racism, and inequality.</p> <p>Highlight research in the fields of PFA and resilience enhancement.</p> <p>Provide lectures by experts in telepsychiatry technology, neuropsychiatry, and staff/CL wellness in the monthly webinar series.</p>
<b>Recommendation 7: Education</b>	<p>Maintain a role supporting public health messaging at large.</p> <p>Partner with other subspecialty and specialty organizations to disseminate high quality information on COVID-19 and neuropsychiatry, telepsychiatry, and CL team and medical staff wellness.</p> <p>Solicit submissions for ACLP News in these key areas.</p>	
<b>Recommendation 8: Annual Meeting</b>	<p>Offer trainings/workshops at the annual meeting on staff support program development and on the practice of psychological first aid (PFA), stress inoculation, and how to train hospital staff in PFA and stress inoculation.</p> <p>Make efforts to recover the interactive and collaborative environment of the annual meeting adapted to virtual programming.</p>	

<p><b>Recommendation 9: Community Building</b></p>	<p>Recruit SIGs focused on issues germane to COVID-19 practice to participate in the tasks outlined in this report and prepare materials for the JACLP, the ACLP website, ACLP News, or annual conference presentations.</p> <p>Connect peer mentors in staff wellness programs and telepsychiatry with CL programs through the ACLP Visiting Professorship program to providing peer supervision and enhance program building and design.</p> <p>Acknowledge academy members who have died during the pandemic and provide a forum for remembrance.</p>
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## Report of the ACLP Task Force on Lessons Learned From the COVID-19 Pandemic

### List of Appendices: Subgroup Reports

- a. Remote Work and Telepsychiatry
- b. Support for Medical and Hospital Staff
- c. Support for CL Psychiatrists
- d. Psychiatry and Neuropsychiatry of COVID-19
- e. Advocacy and Dissemination of Information



## **Appendix A . Report of the Work-Group on Remote Work and Telepsychiatry**

**Priya Gopalan, Khyati Brahmhatt, Jennifer Erickson, and Terry Rabinowitz**

### **Literature Review**

Original articles on COVID-19 and telepsychiatry interventions specific to consultation-liaison (CL) psychiatry are limited in both number and scope. Prior to the COVID-19 pandemic, a large review conducted by the Agency for Healthcare Research and Quality (AHRQ) reviewed telehealth across specialties and setting, noting that most availability data were of relatively low quality with few randomized controlled trials, and that these studies showed an overall theme of equivalency of outcomes across settings including for studies investigating subspecialty consultation. This review found that telehealth in psychiatry settings may have higher treatment adherence and patient satisfaction (Totten et al). As such, most published studies on this topic focus on the topic of COVID-19 and telepsychiatry at large and need to be extrapolated to CL psychiatry.

### Review Papers

Chen et al outline important changes implemented at the federal, state, professional, and insurance levels to permit and support telepsychiatry during the pandemic. The authors provide an overview of pre-COVID telehealth noting that psychiatry as a field was an early adopter of telemedicine among medical specialties. They also note that telepsychiatry has been found to be as effective as in-person psychiatric care. Authors discuss the MGH experience and note a reduction of no-show rates by 20% when telehealth was adopted (Chen et al 2020).

Bojdani et al’s systematic review of the literature included a PubMed search of the terms “COVID-19” and “psychiatric care” and a review of 37 articles that were extracted and 13 of these reviewed. They summarized their findings to include widespread and rapidly evolving changes including regulatory and privacy rules, as well as the relaxation of telemedicine regulatory rules as being key points in the widespread implementation of these services. The review also highlighted changes in clinical workflows with outpatient, emergency departments, and other settings requiring screening for the appropriate modality (in-person, phone, or video) for COVID-19 prior to inpatient psychiatric admissions for patients who are appropriate. For CL psychiatry, the overarching theme noted by the authors included triage based on clinical need (e.g., in-person, phone. or video visits). Impact on trainees were also noted to be significant (Bodjani et al 2020).

Cabrera et al wrote a similar rapid review format using the search terms of “COVID-19,” “COVID,” “coronavirus,” “SARS-CoV-2,” “2019-nCoV,” and “psychiatry,” “psych,” “psychology,” “mental health,” “behavioral health.” The review extracted 71 articles and ultimately reviewed

12 of which 11 were thought to be of poor quality. This review concludes that studies to date have shown evidence of increasing psychiatric needs during COVID-19 both for the general population and those with COVID-19. The authors categorized studies as being in two areas: 1) the psychiatric impact during COVID-19 and 2) services changes in psychiatry during COVID-19. Of these, telepsychiatry use has been a mainstay of service changes, used both for patient care as well as consultation to primary/subspecialty teams in CL psychiatry. They describe limitations of telepsychiatry especially in areas including electroconvulsive therapy (ECT) and opioid-assisted treatments. Additional barriers include the lack of accessibility for some groups including the elderly, socioeconomic barriers, severe cognitive impairment, and very young children. As noted by other authors, Cabrera et al also note that efficacy and outcomes from telepsychiatry need to be studied.

### Case Reports and Letters to the Editors

Numerous case reports and letters to the editor have reported on COVID-19 relating to telepsychiatry interventions and/or provided position statements on the pandemic. Of these, Unützer et al provide an overview of psychiatric services across settings and suggest a need for rapid changes due to COVID-19. They note an easy conversion of CL services to telepsychiatry in contrast to inpatient psychiatric services requiring in-person evaluations with adequate PPE; overall telepsychiatry use was 90% (Unützer et al 2020).

Case reports across the world highlight how the COVID-19 lockdown has impacted the mental health of children and adolescents (Patra et al; Poon et al). These authors demonstrate how telepsychiatry can be helpful in the management of children and adolescents and argue the need for studies to show equivalency of in-person services to telepsychiatry in child and adolescent psychiatry (Patra and Patro 2020). These authors suggest that there may be a subset of populations that may be more challenging to reach via telepsychiatry (e.g., psychosis, intellectual disability, those who are at risk from a safety standpoint or due to socioeconomic constraints) (Poon et al).

Several institutions outline their own experiences with CL telepsychiatry conversion during the COVID-19 pandemic and discuss positive outcomes that have come about with the changes. Kalin et al discuss a rapid conversion of their CL service to telepsychiatry within a few days in an effort to conserve PPE and made possible by an established electronic medical record and telemedicine technology platform. The authors noted a significant benefit of converting to this modality, citing an ability to perform 96% of their consults via telehealth within a few days and allowing for continued multi-member team rounds including incorporation of trainees. They note that in-person evaluations were conducted with some failed initial video attempts due to psychosis or delirium (Kalin et al 2020).

Funk et al outline a similar experience of PPE shortages driving telepsychiatry on a CL service. They advocate for a hybrid model that allows for in-person care while still slowing for ensuring

safety of CL physicians and other providers and conservation of PPE. They also highlight the importance of inclusion of trainees in the process and suggest providing them with the task of triaging consults to phone versus video versus in-person evaluations. They also suggest that a hybrid model can also leverage the role of CL psychiatrists as leaders, informing workflows in the hospital and normalizing human reactions to current pandemic and need for caring for self and others (Funk et al 2020).

Rasimas notes that particular scenarios are especially conducive to telepsychiatry (i.e., capacity assessments, which they note to be 3%-25% of all CL consults). He found a threefold increase in their capacity consults during the pandemic, and noted that many of those were for COVID-19 patients. Potential causes for this include the lack of relatives and visitors at the bedside as a key factor as they can both help patients with their decision-making and help to buffer provider-patient communication. He suggests that CL psychiatrists use these consults to provide support and extend their liaison role in the medical community.

Some letters suggest a more measured stance on telepsychiatry for care. Goldenberg et al opine that a mental status examination may be more thoroughly conducted via telepsychiatry if a patient is not wearing a mask; however, this may be limited by video quality which would make this less effective (Goldenberg et al 2020). Montalvo et al's letter to the editor notes that while there is widespread telepsychiatry utilization, that telepsychiatry use in CL psychiatry and medical settings is not ideal and that CL psychiatrists should not relinquish their role working alongside non-psychiatric medical colleagues in inpatient hospitals and should model the importance of CL to trainees (Montalvo et al 2020).

### Position Papers

Psychiatrists across institutions advocate for systemic changes in telepsychiatry in the setting of the COVID-19 crisis. Kannarkat et al's position paper outlines the rapid evolution in regulations, administration, policies occurred in response to COVID-19 that helped deliver mental health care and notes the importance of monitoring both effectiveness and any barriers to care. Doing so, they postulate, might serve to create the basis for a significant shift in care delivery in the future (Kannarkat et al 2020).

Another detailed editorial describes a background on COVID-19 and states the main focus as outlining key roles CL psychiatrists can play in a pandemic. The authors suggest that CL services should aspire to five primary roles: patient care, advocacy, scholarship, staff support, and system support/public health. Specifically, they suggest that hybrid models can meet the high patient care needs in a timely way, that advocacy allows for humanizing patients and bringing empathy to the forefront, promoting scholarship to inform long lasting change, supporting colleagues who have symptoms of secondary trauma or burnout, and supporting the system overall (Shalev et al 2020). They also highlight challenges to providing CL services throughout the COVID-19 pandemic including infection concerns necessitating telepsychiatry, demoralization, and defining the role of CL during this global crisis (Shalev et al 2020).

Morris and Hirschtritt review factors necessitating telepsychiatry including staffing shortages, safety concerns related to COVID-19 transmission, and limiting social connection (i.e., visitor restrictions). They also note a decided lack of original research and propose a research agenda that includes investigation of patterns of use, stakeholder perspectives, and diverse models of care (i.e., community centers, rural sites, and academic centers) (Morris et al 2020).

Smith et al provide an overall reference for evidence-based guidelines for use of telepsychiatry during the pandemic, though not specific to CL psychiatry. The authors provide useful guidelines for what to do before, during, and after a telepsychiatry consultation. They describe PPE availability as an issue and even when available, the amount of PPE a provider wears may be frightening for patients with preexisting mental health conditions. They note that the CL psychiatrist may have a higher need for in-person evaluations compared to outpatient settings and urge the use of appropriate PPE. They also highlight the ethical challenges that remain (i.e., the need to balance patient needs and safety of health care workers themselves).

### **Lessons Learned (e.g., ACLP list, subgroup institutions' experience)**

The ACLP COVID-19 Task Force Telepsychiatry Subgroup have compiled lessons learned based on a review of their own institutions' experiences (University of Washington, University of Vermont Medical Center, University of California San Francisco, University of Pittsburgh Medical Center). In addition, the ACLP COVID-19 email list-serv was reviewed and the experiences of an additional 25 institutions were compiled and consolidated. The following take-away points related to telepsychiatry were extracted from these narratives:

- Many institutions **adopted video CL visits early** in the pandemic
- Most **utilized a HIPPA-compliant telehealth platform** such as Zoom to provide virtual visits
- **PPE preservation** often drove decisions to convert to telepsychiatry CL services
- **Written protocols were drafted** for many of these institutions
- **Hospital-provided tablets** were often used for patients without access to technology
- Some consult services were fully remote, but **most institutions used a hybrid model** with preservation of some in-person services
- Oftentimes, in-person evaluations were needed for **complex patients, patient consents, involuntary commitments, and other paperwork**
- Institutions tried to **limit the time of exposure if in-person evaluations** were indicated, especially in areas with limited testing access
- **Telephone consults were often used for quick recommendations** in order to limit face-to-face encounters. Direct communication with the patient might also occur, with frequency dependent upon level of complexity
- Institutions **varied widely on the management of 1:1 sitters** with many opting for tele-sitter technology when the infrastructure was available
- Some centers had no access to psychiatric hospitals that would transfer or admit COVID+ patients so **CL and psychiatric emergency room work started to include extended treatment & stabilization**

- **Several institutions had unsupportive administrators** who insisted on in-person evaluations for all
- Staffing considerations were paramount with many services re-deploying residents and/or faculty to off-site work with a **rotating staffing schedule** to limit the number of individuals rounding (i.e., exposures to patients and exposures to staff), for PPE conservation, and to avoid crowding in exam rooms/staff rooms.
- **Documentation underwent some modification** with the modality of care and the amount of contact with the patient needing to be documented at most places (i.e., in-person, video, telephone, curbside).
- **Billing/reimbursement needed to be clarified** across institutions, especially with telephonic and curbside/“e-consults”
- Some institutions used **unique tools** such as walkie-talkies and baby monitors that supported communication with COVID+ patients/units.

#### **FORMULATION OF RECOMMENDATIONS TO ACLP**

Almost all of the COVID-19 telepsychiatry studies reviewed were letters to the editor, position papers, and process papers from individual institutions’ experiences with very few original research studies. Overarching themes emerged in the literature review of telepsychiatry conversion: a) PPE shortages drove many of the telepsychiatry conversions; b) attempts to socially distance and to enhance staff preservation were important factors; c) governmental/policy changes helped to make the conversion possible.

**Recommendations on what ACLP should undertake:**

<b>Telepsychiatry, COVID-19, and CL Psychiatry</b>	
<b>Recommendation 1: Research</b>	Coordinate and possibly fund multi-site data sharing/gathering to promote more original research in this area
<b>Recommendation 2: PPE and Clinician Safety</b>	Advocate for the provision of appropriate PPE and to allow telepsychiatry consult services as an alternative if appropriate PPE is not available
<b>Recommendation 3: Advocacy</b>	Approach and lobby legislatures to formally update regulatory restrictions around telepsychiatry as well as licensing restrictions for physicians across state lines.
<b>Recommendation 4: In-Person Care</b>	Acknowledge that as CL psychiatry is often seen as “front-line” or “essential,” that some consults will require in-person care and those physicians/clinicians performing the consultations need to be supported in these efforts
<b>Recommendation 5: Technology</b>	Continue building upon the current platforms available for dissemination of best practices for telepsychiatry in CL (e.g., the listserv, the website).
<b>Recommendation 6: Documentation/Billing</b>	Documentation of modality of care delivery and billing should be formalized. Advocate for use of technology for mental health commitments and digital integrated document signing for other required paperwork.

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Appendix.

STUDY	TAKE-AWAY POINTS
<p><i>Chen, J. A., W. J. Chung, S. K. Young, M. C. Tuttle, M. B. Collins, S. L. Darghouth, R. Longley, R. Levy, M. Razafsha, J. C. Kerner, J. Wozniak, and J. C. Huffman. "Covid-19 and Telepsychiatry: Early Outpatient Experiences and Implications for the Future." Gen Hosp Psychiatry 66 (Sep - Oct 2020): 89-95.</i></p> <p><a href="http://dx.doi.org/10.1016/j.genhosppsy.2020.07.002">http://dx.doi.org/10.1016/j.genhosppsy.2020.07.002</a></p>	<ul style="list-style-type: none"> <li>• Outpatient experience</li> <li>• Reviews important changes implemented at the federal, state, professional, and insurance levels to permit and support telepsychiatry during the pandemic</li> <li>• Overview of pre-COVID telehealth: psychiatry was an early adopter; second most in the world; as effective as in-person</li> <li>• MGH experience: reduction of no-show rates by 20%</li> </ul>

*Cabrera MA, Karamsetty L, Simpson SA.  
Coronavirus and its implications for psychiatry: a  
rapid review of the early literature.  
Psychosomatics. 2020*

- Evidence of psychiatric needs increasing during COVID-19 both for general population and those with COVID-19.
- Review article with total 71 articles. Eventually reviewed 12 of which 11 were thoughts to be poor quality. 2 groups – psychiatric impact during COVID-19 and services changes in psychiatry during COVID-19
- Telepsychiatry use has been mainstay of service changes. Used both for patients care as well as consultation to primary/subspecialty teams
- Describes limitations of telepsychiatry: can't do ECT/ opioid assisted therapy. Not accessible to everyone- elderly, socioeconomic barriers, severe cognitive impairment, very young children.
- Efficacy and outcomes from telepsychiatry need to be studied

<p><i>Bojdani E, Rajagopalan A, Chen A, et al. COVID-19 Pandemic: Impact on psychiatric care in the United States. Psychiatry research. 2020;289:113069</i></p>	<ul style="list-style-type: none"> <li>• Widespread and rapidly evolving changes including regulatory and privacy rules</li> <li>• Telemedicine regulatory rules being relaxed was key</li> <li>• Outpt /ER settings use telemed, phone and screening for COVID-19 prior to inpat adm</li> <li>• Consults: triage based on clinical need if in person vs phone vs video</li> <li>• Impact on trainees is also significant</li> <li>• PPE availability an issue and even when available can be scary for pts with mental health diagnoses/symptoms.</li> <li>• CL: Higher need for in person eval in ER/Inpat compared to outpt. Needs to use PPE.</li> <li>• Ethical challenges also remain and needs to balance patient needs and safety of trainees and provider themselves.</li> </ul>
<p><i>Smith, K., E. Ostinelli, O. Macdonald, and A. Cipriani. "Covid-19 and Telepsychiatry: Development of Evidence-Based Guidance for Clinicians." JMIR Ment Health 7, no. 8 (Aug 28 2020): e21108. <a href="http://dx.doi.org/10.2196/21108">http://dx.doi.org/10.2196/21108</a>.</i></p>	<ul style="list-style-type: none"> <li>• Evidence-based guidelines for use of telepsychiatry during the pandemic</li> <li>• Several useful and clear textboxes for what to do before, during, and after a telepsychiatry consultation</li> <li>• <a href="https://mental.jmir.org/2020/8/e21108/">https://mental.jmir.org/2020/8/e21108/</a></li> </ul>
<p><b>Case Reports and Letters to the Editor</b></p>	
<p><i>Patra, S. and B. K. Patro. "Covid-19 and the Need for Child and Adolescent Telepsychiatry Services, a Case Report." Asian J Psychiatr 54 (Jul 16 2020): 102298. <a href="http://dx.doi.org/10.1016/j.ajp.2020.102298">http://dx.doi.org/10.1016/j.ajp.2020.102298</a>.</i></p>	<ul style="list-style-type: none"> <li>• Illustration of how the COVID-19-necessitated lockdown has impacted the mental health of children and adolescents</li> <li>• Telepsychiatry can help improve access</li> </ul>

*Cristina Montalvo MD, M.B.S. \*, Larkin Elderon Kao MD. A Call to Arms, Not to Disarm: The Importance of Psychiatric Care in the Acute Medical Setting During the COVID-19 Pandemic. Psychosomatics. 2020.*

- While there is widespread telepsychiatry use, authors suggest that telepsychiatry use in CL/medical settings is not ideal
- Reviews various roles CL plays and acknowledges need for social distancing and safety
- Lists roles we need to continue to play: support pts with emotional aspects of medical illness, resource management, team support and adds that patients with COVID-19 have specific needs- delirium, depression, etc. that needs support.
- Shares that increase need for support due to distress in other providers is also a role we can help with
- Encourages fellow C-L psychiatrists to stand firm in role as physicians providing critical in-person care to patients and colleagues

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<p><i>Funk MC, Beach SR, Shah SB, Boland R. Consultation-Liaison Psychiatry in the Age of COVID-19: Reaffirming Ourselves and Our Worth. Psychosomatics. 2020:S0033-3182(0020)30126-30122.</i></p>	<ul style="list-style-type: none"> <li>• Lack of adequate PPE drives increased use of telepsychiatry even as in person assessment remains the gold standard.</li> <li>• While CL roles are essential and one may insist on need for in person care- balancing various things would make a hybrid model more ideal.</li> <li>• Shift to telepsychiatry where possible can help care for patients while also conserving CL providers and PPE.</li> <li>• Triaging phone/video and in person based on clinical need and realities can also help trainees to learn these essential skills and still participate in wide range of consults</li> <li>• This model can also leverage our roles as leaders, inform workflows in the hospital and normalize human reactions to current pandemic and need for caring for self and others.</li> </ul>
<p><i>Goldenberg MN, Gerkin JS, Penaskovic KM. Being Reactive: Assessing Affect in the COVID-19 Era. Academic Psychiatry 2020.</i></p>	<ul style="list-style-type: none"> <li>• Not directly related but has a specific point about assessing Affect –MSE- in person vs telepsychiatry)</li> <li>• In person MSE assessment are hard due to need to wear masks</li> <li>• Telepsychiatry assessments are better as you can see whole face</li> <li>• However limitation so video quality may impact this in the negative direction</li> </ul>

*Kalin ML, Garlow SJ, Thertus K, Peterson MJ. Rapid Implementation of Telehealth in Hospital Psychiatry in Response to COVID-19. American Journal of Psychiatry. 2020;177(7):636-637.*

- Conversion to telepsychiatry helps conserve PPE and socially distance while maintaining trainee involvement
- They were able to convert services including CL to telepsych rapidly (few days)
- Able to do 96% of the consults via telepsychiatry
- In person done when initial video attempts fail due to delirium/psychosis
- Similar practice of specialists who provide consultation to inpatient psychiatry (neurology, internal medicine, others)
- Having a pre-established EMR and telemed technology platform was key in rapid deployment
- Pre-existing working relationships with nursing and others can help
- Nursing can bear burden of getting the visits started; efforts should be made to streamline/minimize burden
- Allows for multi-member rounds, ability to participate in team rounds, allows trainees to be part of the service.

Report of the ACLP Task Force on Lessons Learned From the COVID-19 Pandemic

<p><i>Poon NY, Pat Fong S, Chen HY. Child and adolescent psychiatry telemedicine: A singaporean experience born in Covid-19. Asian journal of psychiatry. 2020;53:102336.</i></p>	<ul style="list-style-type: none"> <li>• Child and adolescent psych (CAP) care was shifted to telepsychiatry in Singapore</li> <li>• With case example, they describe that it is possible to provide MH care through telepsychiatry even for kids</li> <li>• Evidence in CAP is increasing for the efficacy of telepsychiatry.</li> <li>• Need to make sure quality comparable to in person care</li> <li>• Maybe limited in those with psychosis, ID, safety risks, socioeconomic constraints</li> <li>• Benefit of decreased commuting and ease of scheduling.</li> <li>• Overall can improve access to care</li> </ul>
<p><i>Rasimas JJ. Capacity and the COVID-19 Surge. Psychosomatics. 2020:S0033-3182(0020)30210-30213.</i></p>	<ul style="list-style-type: none"> <li>• Capacity assessments can be 3-25 % of all CL consults</li> <li>• During COVID-19 there was a 3 fold increase in their capacity consults- many of those for COVID-19 patients</li> <li>• They suggest lack of relatives/visitors at bedside is a key factor in this as they can both help pts with their decision making but also help buffer provider-patient communication</li> <li>• Also suggest the wish to make the “right decision” and the overall challenge of that in COViD-19 patients</li> <li>• They posit a psychodynamic meaning to the team feeling an internal lack of capacity to deal with COVID-19.</li> <li>• Suggest we use these consults to provide support and extend liaison role</li> </ul>

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<p><i>Unützer J, Kimmel RJ, Snowden M. Psychiatry in the age of COVID-19. World psychiatry : official journal of the World Psychiatric Association (WPA). 2020;19(2):130-131</i></p>	<ul style="list-style-type: none"> <li>• Overview of several areas of challenges presented by COVID-19</li> <li>• Need for rapid changes to system</li> <li>• Telepsych use in outpatient allowed for 90% of all visits to be done remotely</li> <li>• Inpatient psych services with PPE were set up</li> <li>• CL services were provided by using telepsychiatry</li> </ul>
<p><b>Position Papers and Editorials</b></p>	
<p><i>Kannarkat JT, Smith NN, McLeod-Bryant SA. Mobilization of Telepsychiatry in Response to COVID-19—Moving Toward 21st Century Access to Care. Administration and Policy in Mental Health and Mental Health Services Research. 2020;47(4):489-491.</i></p>	<ul style="list-style-type: none"> <li>• Rapid evolution in regulations, administration, policies occurred in response to COVID-19 that helped deliver MH care.</li> <li>• Important to monitor effectiveness and any potential barriers</li> <li>• Might serve to create the basis for a significant shift in care delivery in the future</li> </ul>



*Shalev D, Shapiro PA. Epidemic psychiatry: The opportunities and challenges of COVID-19. General hospital psychiatry. 2020;64:68-71.*

- Describe background on COVID-19 and share main goal as outlining key roles CL psychiatrists can play in a pandemic.
- Suggest CL services ASPIRE to 5 roles: patient care, advocacy, scholarship, staff support, and system support/public health.  
Patient care: high needs during COVID-19 and our pts are usually high risk. Imp to provide timely care and also address general fear and distress about pts safety and issues that arise in those who are COVID-19 positive. Can address this with a hybrid model of in-person and telehealth consult
  - a. Advocacy: humanizing pts and bringing empathy to those who deal with both mental health and physical health issues. Social media/news outlets can be leveraged for this function
  - b. Scholarship: imp to track changes and impact of COVID-19 to inform future care
  - c. Supporting our colleagues: both prior epidemics/ current pandemic has shown high need for support of medical providers. We can play an imp role here.
  - d. Supporting the system: Given the expertise of CL psychiatrists in issues related to health anxiety and health communication, there is a clear role for involvement in public education. “CL psychiatrists should contribute to analysis of complex ethical challenges, especially as they pertain to psychiatric issues, for example quarantining unwilling patients whose judgment is impaired by mental illness”.

	<ul style="list-style-type: none"><li>• Challenges to providing CL services during COVID-19:<ul style="list-style-type: none"><li>▪ Exposure to SARS-COV2- limit exposure to pts and self. Leverage telephone/video consults. PPE when in person</li><li>▪ Morale: de- moralization, burnout, and fear associated with being at the frontlines of a dangerous epidemic. Clear and open communication and leadership focus on PPE and others ways to keep everyone safe important</li><li>▪ Value added: systems may exclude psychiatry in early changes and mandates. Imp to keep institutions aware and engaged in the role and imp of CL.</li></ul></li></ul>
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<p><i>Morris NP and Hirschtritt. Telepsychiatry, Hospitals, and the COVID-19 Pandemic. Psychiatric Services in Advance. doi: 10.1176/appi.ps.202000216)</i></p>	<ul style="list-style-type: none"><li>• Goes over areas related to staffing (tele mitigates staffing shortages), safety (related to COVID-19 transmission), social connection in the event of visitor restrictions, and could improve real-time responsiveness</li><li>• Noted lack of original research</li><li>• Proposed research agenda:</li></ul>
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## **Appendix B. Support for Medical and Hospital Staff**

**George S. Everly, Jr., PhD, FACL, Dahlia Saad-Pendergrass, MD, R.M. Huijon, MD**

**Staff Support Subgroup Report for the Academy of Consultation-Liaison Psychiatry, October, 2020**

### **Introduction**

The Vision Statement for the Academy of Consultation-Liaison Psychiatry supports the vigorous promotion of a global agenda of excellence in clinical care for patients with comorbid psychiatric and general medical conditions by actively influencing the direction and process of research and public policy and by promoting interdisciplinary education. To further that end, Paul Desan correctly points out, “Our task as consultation-liaison psychiatrists in the upcoming crisis will be to care for not only our patients but also our colleagues.” We believe that obligation applied not only to the crisis of COVID-19, but to any and all situations that threaten the well-being of our colleagues and therefore indirectly threaten the well-being of our patients. Staff support programs in healthcare facilities are not only desired, they are essential. The Academy of Consultation-Liaison Psychiatry should play an active leadership role in the establishment and maintenance of such programs, worldwide.

### **Rationale**

“Mental health has large intrinsic value as it relates to the core of what makes us human, thus anything that threatens the mental health of large numbers of people threatens the core fabric of society itself” (The United Nations, 2020, p.5). Recently, United Nations has warned of an impending mental health crisis as a result of COVID-19 (“The hidden pandemic.”). “Many people who previously coped well, are now less able to cope because of the multiple stressors generated by the pandemic. And those who previously had a mental health condition, may experience a worsening of their condition and reduced functioning” (United Nations, p. 6). “First responders and frontline workers, particularly workers in health and long-term care play a crucial role in fighting the outbreak and saving lives. However, they are under exceptional stress, being faced with extreme workloads, difficult decisions, risks of becoming infected and spreading infection to families and communities, and witnessing deaths of patients” (United Nation, 2020, p. 11).

According to the Joint Commission (June, 2020), “A health care organization’s ability to respond to the stresses and strains of providing adequate patient care during a crisis – such as the COVID-19 pandemic – is reliant upon its workers’ psychosocial well-being...To mitigate and respond to the psychological toll of crises such as the COVID-19 pandemic, it is critical that health care organizations have systems in place that support institutional and individual resilience.”

Apropos to the statement by the Joint Commission, the main theme of the World Health Organization's World Patient Safety Day (September 17, 2020) is health care worker safety. Worker safety not only pertains to physical safety, but psychosocial safety, as well.

## The Challenge

Is the prognostication from the United Nations that health care workers are experiencing "exceptional stress" coming to pass?" A review of relevant research seems to affirm the United Nations' conclusion. A cross sectional study was conducted of health care workers in Wuhan, China early in the trajectory of the pandemic. Self-administered questionnaires were distributed to 332 frontline health care professionals from January 28 to February 1, 2020. Acute stress disorder (ASD) reached a prevalence of 38.3%. Self-reported anxiety occurred in 24.7% of those sampled, and depression occurred in 20.2% of those surveyed. Structural equation modelling was used to assess the relationship between psychological symptoms and physical symptoms. ASD was significantly associated with the most common physical complaint of chest pains and the behavioral reaction of hostility in this sample which consisted of 78% females with a mean age of 32 years (Wang, Duan, Peng, et al., 2020). In a similar but more far-reaching study of 34 regionally stratified hospitals throughout Wuhan, China conducted January 29 to February 3, a total of 1257 completed a self-report survey of psychological symptoms. The surveyed found 50.4% of respondents reported symptoms of depression, 44.6% reported symptoms of anxiety, 34% reported insomnia, and 71.5% reported symptoms of posttraumatic distress (Lai, Ma, Wang, et al., 2020).

In the United States, a cross-sectional web survey of 657 physicians, advanced practice providers, residents/fellows, and nurses, conducted April 9<sup>th</sup> to April 24<sup>th</sup> 2020 (the peak of COVID-19 admissions) at a large medical center in NYC revealed 57% of those surveyed screened positive for acute stress, 48% screened positive for depression, and 33% screened positive for symptoms of anxiety. On a positive note, however, sixty-one percent of participants reported an increased sense of meaning/purpose since the COVID-19 outbreak (Shechter, Diaz, Moise, et al., 2020).

A review of these studies reveals a similar pattern of distress experienced by health care professionals. Striking similarities exist both in terms of the nature and the prevalence of distress.

Recent structured equation modelling research has shown acute stress disorder was significantly associated with the most common physical complaint of chest pains and the behavioral reaction of hostility, furthermore emotional disturbance predicated upon conflicts predicted acute stress disorder (Wang, Duan, Peng, et al., 2020). These findings are similar to ongoing research conducted by Smith and colleagues using structural equation modelling (Smith, Everly, Haight, 2012) which has consistently shown emotional distress predicated upon workplace challenges and conflicts to be associated with burnout and adverse workplace behaviors.

The use of standardized psychometrics, while useful, often yields data divorced from a sense of humanity. To compensate for this potential omission we reviewed anecdotal data

sensitive to recurring themes of concern and/or distress, and even revelation. Thematic data compiled from the University of Arizona, University of Washington, the Johns Hopkins Health Care System, Hartford Healthcare, Brigham and Women's and the ACLP listserv revealed the following recurrent themes:

- Magnification of the usual tensions between roles and work/home/self-care obligations
  - Concerns about childcare and children going back to school for in person classes
  - Fear of infecting family members
  - Burden of family worry about healthcare worker
  - Challenges in visiting elderly loved ones due to social distancing
  - Importance of the job of health care
  - Emotional exhaustion
  - Physical fatigue
  - Sleep difficulties
- Moral injury and grief
  - Grief for patients receiving palliative care without family members
  - Sense of futility
  - Frustration
  - Distress at reality of apportioning depleted resources (ventilators, PPE, etc.)
- Lack of clear path
  - Managers struggle to help team, lack guidance
  - Importance of formalized peer to peer support systems
- Wavering of trust and confidence in the systems that usually inspire faith
  - Concerns about hospital equipment, PPE at beginning of outbreak
  - Feelings of not being supported by the healthcare system
  - Feelings of isolation
  - Lack of recurring updated information
  - Information changing constantly
  - Too much information
- Career disruption
- Changing clinical roles

## **Programs to Support Staff**

In more recent research Smith (Smith, Emerson, Boster, & Everly, 2020) has shown resilience to be an exogenous variable exerting direct effects on stress and burnout and an indirect effect on intentions to quit the job. Programs to enhance resilience may reduce adverse impact of a stressful workplace.

The WHO, United Nations, American Psychiatric Association, American Psychological Association, and the American Red Cross all endorse the use of psychological first aid (PFA) interventions (see Everly, 2020; Everly & Lating, 2017). Workplace-based applications have supported the effectiveness of psychological crisis interventions (Everly, Sherman, MF, Stapleton, et al, 2006; Boscarino, J., Adams, R., & Figley, C., 2005, 2011). Furthermore, it should be noted that such help may have a lasting health promoting effect. The effects may last more

than two decades (Solomon, et al., 2005). Finally, such intervention may exert effects comparable or superior to multi-session counseling (Boscarino, J., Adams, R., & Figley, C., 2005, 2011). Rapoport (1965) insightfully noted that a little help, rationally directed and purposely focused at a strategic time, is more effective than extensive help given at a period of less emotional accessibility.

## Model Programs

As Millon, Grossman, Meagher, Millon and Everly (1999), and others urged an integrative approach to psychotherapy, Flynn (2003), Ruzek, Young, Cordova, Flynn (2004) and Everly & Langlieb (2003), urged an integrative approach to psychological crisis and disaster mental health intervention. As adapted from Millon, Grossman, Meagher, Millon and Everly (1999), “The palette of methods and techniques available to the [interventionist] must be commensurate with the idiographic heterogeneity of the [individual] for whom the methods and techniques are intended” (1999, p. 145).

Not only does the utilization of an integrated multi-faceted continuum of care conform to established best practices, there is support for the conclusion in that a multi-component continuum of psychological interventions may reduce the cost of subsequent mental healthcare by 35% (Schoenbaum, Butler, Kataoka, Norquist, Springgate, Sullivan, Duan, Kessler, & Wells, 2009). Such integrated multi-component programs can serve as potential models for supporting health care professionals (and perhaps the community at large).

Perhaps the oldest prime exemplar of such an approach to staff support is the Oasis Center serving the Hong Kong Hospital Authority’s over 43 hospitals divided into seven hospital clusters. The integrated continuum of care approach consists of a system-wide peer support team, psychological services, and a physical walk-in wellness center providing snacks, fruit, relaxation/ meditation rooms, and biofeedback access.

The Johns Hopkins Medical Institutions have instituted a collaborative continuum of care staff support model consisting of 1) consistent with Institute of Medicine recommendations, crisis leadership consultation and training (IOM, 2013; Wu, Connors, & Everly Jr.; Everly, Wu, Dang, Fowler, & Potash, 2020) 2) staff peer support team (RISE Team) trained in psychological first aid (Everly, 2020; Everly & Lating, 2017), 3) employee assistance, 4) spiritual care, 5) wellness programs, and 6) psychiatric services. According to Wu, Connors and Everly (2020), “We recommend 3 strategic principles that may be of value for other health care institutions responding to the COVID-19 pandemic: First, provide leadership focused on resilience...Second, structure crisis communications to provide information and empowerment...Third, create a continuum of staff support within the organization...They should create a peer support team to provide psychological first aid, potentially by tapping into existing employee assistance, chaplaincy, or other wellness programs, with triage when needed to higher levels of support” (p. 2). To assess the peer-support crisis intervention program called Resilience In Stressful Events (RISE), a Markov model with a 1-year time horizon was developed to compare the cost benefit with and without the RISE program from a provider (hospital) perspective. Probabilities of quitting or taking time off with or without the RISE program were estimated using survey data. Net monetary benefit (NMB) and budget impact of having the RISE

program were computed to determine cost benefit to the hospital. Results of the RISE program found a net monetary benefit savings of US \$22,576.05 per nurse who initiated a RISE call. The budget impact analysis revealed that a hospital could save US\$1.81million each year because of the RISE program (Moran, Wu, Connors, et al., 2017).

Providing training in psychological crisis intervention and health care professional peer support may not only benefit the recipients of such intervention, the providers of such care may actually find their own resilience and self-efficacy enhanced in what may be thought of as the “reciprocal empowerment effect” (Everly, McCabe, Semon, et al., 2014; McCabe, Semon, Thompson, et al., 2014; Noullet, Lating, Kirkhart, et al., 2018; Everly, & Kennedy, 2019).

### **The Program Utilization Gap**

Preliminary data from at least one unpublished study in a large health system (Hartford Healthcare), also points to high rates of depression and anxiety in employees across the board including clinical and nonclinical staff in outpatient and inpatient settings, but more concerning are the findings of low rates of utilization of employee support and wellness programs, including those which were launched during the COVID-19 pandemic. This matches anecdotal reports from multiple centers where CL psychiatrists noted both an underutilization of existing programs and a pattern of individual interest in referral to services or peer-referral for the same after informal check-ins by the CL team with clinical staff in the hospital during the workday. Stigma, depleted time and energy by work demands, a lack of familiarity and lack of education all may play a role.

### **Role of the C-L Psychiatrist**

We believe the consultation-liaison psychiatrist can play a crucial developmental and sustaining role in staff support programs for healthcare professionals. Fundamental to the work of the C-L team are long-established relationships with hospital and, increasingly, outpatient teams. As such, the C-L psychiatrist is uniquely situated to be attuned to staff distress and to provide, through formal interventions or informal conversations in the course of the workday, psycho-education, referral, support, and a normalization of the process of self-care through acknowledging and addressing emotional distress. The result can be an amelioration of the barriers above. This was, in fact, reflected in the observed responses to interventions implemented during the COVID-19 pandemic by a broad swath of C-L teams across the world. C-L colleagues reported being approached by physician and non-physician colleagues for support and advice on obtaining care for themselves or other. Many CL programs quickly instituted one or more of the following interventions in their hospitals:

1. Informal rounds to check in on nursing and other healthcare staff on a regular basis, daily or 2-3 times per week. During rounds the task was to assess morale, stress levels, provide support and identify needs to communicate back to the larger



- behavioral health systems which were often mobilizing clinical resources above and beyond the usual EAP supports. Sometimes these rounds led to referrals for individual evaluations and further care.
2. Check-ins by phone with unit manager/charge nurse/work unit head (EMT, respiratory, OT, PT, ICU, cards, ED, etc.) to be available for questions, educate on available resources and offer targeted interventions based on needs (themed groups on wellness topics e.g. Sleep hygiene, isolation from family, etc.)
  3. Multidisciplinary team rounds with palliative care and chaplain teams to work with patient families and staff.
  4. Physical spaces designated as “wellness room” – essentially a comfortable place to breathe with snacks, fresh fruit, bottled water
  5. Outreach to staff at home with illness or under quarantine to avoid feeling isolated/forgotten
  6. Virtual support groups (often via ZOOM). Variations in the format and frequency in these groups

## **The Role of ACLP in Supporting C-L Psychiatrists and Hospital Staffs in Times of Crisis and Uncertainty**

As noted, consultation-liaison psychiatrists can play a unique developmental and sustaining role in staff support programs for healthcare professionals. We must extend the ACLP vision of excellence in clinical care for patients with comorbid psychiatric and general medical conditions to include an embracing of our role in the wellness of care providers. Commensurate with its vision statement, the ACLP must then support the efforts of CL psychiatrists by taking an active leadership role in supporting the process of research, education and public policy towards excellence in staff support programs.

The ACLP can support these efforts through:

- 1) Highlighting research in the fields of PFA and resilience enhancement on its website in the CLP bibliography/annotated articles/research summaries sections on the ACLP website
- 2) Providing lectures by experts in these same fields in the monthly webinar series on the website
- 3) Creating website materials on best practices in the practicalities/mechanics of program development (e.g. RISE program, staff support virtual groups, etc.), the cost justification of such programs to serve as member resources
- 4) Highlighting/inviting for review similar research in *Psychosomatics*
- 5) Offering trainings/workshops at the annual meeting on staff support program development
- 6) Offering training/workshops at annual meeting on the practice of psychological first aid (PFA) and stress inoculation and how to train hospital staff in PFA and stress inoculation

- 7) Offering training/workshops at annual meeting on strategic planning as well as the design and implementation of integrated continua of staff support
- 8) Supporting member collaborations in research and program implementation across institutions and geographical settings through listserv groups and special interest groups (SIG's)
- 9) Connecting peer mentors with CL programs through the ACLP Visiting Professorship program- Providing peer supervision/program design
- 10) Awarding the ACLP Foundation Research Professor Program to a preeminent research leader in the fields above to lecture at an upcoming annual meeting and funding the mentorship by this selected professor of emerging early career researchers in the field (these are both a part of this ACLP program anyway).
- 11) Liaising with AMA and the American Hospital Association to advocate for setting up structures to support hospital staff.
- 12) Liaising with community mental health organizations to pursue ways in which local CL professionals may uniquely contribute to the well-being of the community at large.

## Summary

We agree with the United Nations (2020) that COVID-19 not only represents a severe psychological burden upon society, but a unique burden upon health care professionals that must be addressed. The ACLP and CL professionals represent a uniquely trained resource for health care institutions and the community at large that may be used to mitigate the psychological burden. If COVID-19 follows its predecessors, the second winter may be worse than the first in terms of physical burden. If so, this could engender an especially severe psychological reaction of fatigue, grief, depression, and even despair. ACLP should prepare for such an eventuality. We submit this report in hopes the information contained herein may be of some value in that effort.

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## **Appendix C. ACLP Task Force on COVID-19: Supporting CL Psychiatrists in their Own Wellness**

**Rachel A. Caravella, Elizabeth Prince**

### **Introduction**

Promoting the wellness of consultation-liaison psychiatrists is a critical role for our organization. Not only do our members work alongside frontline healthcare workers to care for patients with COVID-19, many of us are also tasked with spearheading staff support efforts for colleagues and hospital systems (see separate ACLP Task Force on Staff Support (Everly et al., 2020)). In addition to our usual role providing consultation to hospitalized patients and managing behavioral emergencies within the medical hospital, psychiatrists have also been redeployed to medicine services (Askalsky, 2020), providing on-site psychological first aid (Everly 2020), grappling with complex medico-legal and ethical issues (Rasimas, 2020), and creating hybrid Palliative Care - Psychiatry Consultation services (Shalev et al., 2020) all to fulfill the global mission of fighting the pandemic. However, little attention has focused on the health and wellness of our own ACLP members or CL Psychiatrists around the world. There is a dearth of literature on the prevalence of COVID-19 infections, death rate, or the mental health consequences of the pandemic on CL Psychiatrists.

### **Our Own Mental Health and Wellbeing**

While there have been a few editorials, position papers, and listserv postings discussing the value of CL Psychiatry (Funk et al., 2020) and reporting narrative experiences from the field (Huremović, 2020), there are no published reports with original data about how the pandemic has affected our own mental health and wellbeing. Numerous studies have suggested high rates of anxiety, depression and trauma-related symptoms in other frontline healthcare workers (Schechter et al., 2020) but it is unknown whether CL Psychiatrists are just as vulnerable to these symptoms. It is expected that our members are wondering how to best care for their own physical and mental health. And, just like all other healthcare workers, we anticipate that our members are just as concerned about protecting their loved ones from viral spread as well as transmission of stress and trauma from their hospital work. Finally, it is essential to acknowledge that we are all in the midst of two concurrent public health crises: COVID-19 and racism. Current research suggests striking health disparities in COVID-19 mortality rates with higher rates observed in minority populations in the US (Alcendor, 2020). Given that racial discrimination affects mental health, these data need to inform how ACLP supports all of its members. A recent article authored by two ACLP members encourages our community that, “If you believe that black lives matter, silence is not an option. (Vaughn & Amonoo, 2020)” As we come together to support each other and ACLP members through these public health crises, interventions will need to acknowledge systemic racism and foster dialogue about the intersection of racism and the pandemic.

### **COVID-19 Infections, PPE Adequacy, and Community Losses**

While there are reports on prevalence rates of healthcare workers in general (The Lancet, 2020), there are no data on the number of psychiatrists who have become sick, recovered, or

died from COVID-19. Many hospitals appear resistant to publishing statistics on the illness and death rates of their employees for reasons left to speculation. However, as clinicians who are comfortable with discussion topics typically considered taboo, we know that it is important to acknowledge the direct consequences of illness, grief and loss. From a practical perspective, this information may assist us in critically evaluating our CL services' health and safety procedures. CL Psychiatrists may have concerns about whether PPE recommendations made for general hospital staff are appropriate for CL psychiatrists and whether they provide sufficient protection for the breadth and depth of our work. For example, PPE recommendations may be quite different for CL psychiatrists staffing behavioral code teams. Other members may have concerns about provider-to-provider exposure and are looking for assistance evaluating novel CL service staffing models. Finally, explicit information about infection rates and losses to our CL community may facilitate bereavement for our colleagues lost to this disease. One prominent ACLP member posted about this topic on the ACLP COVID-19 listserv, "I hope someone out there is ahead of me planning for the horrible event of the death of a healthcare worker (Rosenthal, 2020)." Though the pandemic is not over and additional illnesses and losses are expected, any intervention to address this need will have to be dynamic and ongoing. The ACLP website, newsletter or Annual meeting might provide accessible places to acknowledge our losses and celebrate community members during this isolating time.

### **Expanding Existing ACLP Resources**

Very early in the COVID-19 pandemic, the ACLP created a dedicated COVID-19 listserv and internal resource webpage to support its members. Since its inception in March 2020, the listserv has generated hundreds of discussion threads with replies from members around the world. In addition to keeping us all informed about members' experiences and service innovations, the listserv provided an essential venue for members to find peer support, expert consultation, emotional validation, and comfort from the broader CL Psychiatry community. One member identified, "it's been great having this listserv as both an academic and emotional resource, and knowing I'm not alone in the things I see and the feelings I feel (Khandai, 2020)." This listserv along with a handful of opinion papers published from April to September 2020, represent the only sources currently available to deduce the concerns and challenges that impact the physical and emotional health of CL Psychiatrists.

The COVID-19 Member's Resource page on the ACLP Website, developed by the Education Committee and spearheaded by Dr. Paul Desan, represents another wonderful resource for ACLP members. The ACLP Website contains a page of COVID-19 resources including reports from the field, protocols, and member-submitted writing from all over the world. Currently, the COVID-19 Resource page contains a subsection on "Psychological Reactions" that includes information, papers and resource links that are meant for supporting our medical colleagues but could be applied to our own members. Specific resources that may be of use to our own members include: links to wellness apps; free Psychology happiness Course; Physician Support Line and other crisis lines; tips for good sleep and other curated resources about coping; free or reduced fee mental health care from Project Parachute; Facebook groups for peer support; and several others. With improvement in publicity, visibility and organization, the website has the

potential to serve as our comprehensive resource center and central hub for members looking to gather information.

<b>Supporting ACLP Members in their Own Wellness</b>	
Recommendation 1: Research	<b>ACLP should take an immediate, public stance that research on the health and wellbeing of CL Psychiatrists is critical. Support research and call for publications that quantify prevalence of COVID-19 infections, stress related symptoms in CL Psychiatrists.</b>
Recommendation 2: Advocacy	<b>Survey current members to generate an up-to-date list of the specific types of pandemic-related health and wellness concerns, issues and challenges that exist. Information gathered will focus and guide advocacy efforts.</b>
Recommendation 3: Support	<b>Acknowledge academy members who have died during the pandemic and provide a forum for remembrance.</b>
Recommendation 4: Technology/Listserv	<b>Maintain and improve the ACLP COVID-19 Listserv and consider methods for anonymous posting, weekly conversation starter posts, monthly topic digests, and formal listserv leadership and maintenance.</b>
Recommendation 5: Technology/Website	<b>Appoint a resource curator to maintain, update, organize and transform the COVID-19 Resource page to a comprehensive resource site for ACLP members on the COVID-19 pandemic.</b>
Recommendation 6: Technology/Website	<b>Create a subspace within the COVID-19 resources page and for content on health disparities, racism, and inequality.</b>

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## **Appendix D. Psychiatry and Neuropsychiatry of COVID-19**

**Daniel Shalev, Karen Giles, and Heather Greenspan**

### **What Consultation-Liaison Psychiatrists Experienced: An Introduction**

Given our position within general medical settings, CL psychiatrists have been at the forefront of identifying the psychiatric and neuropsychiatric aspects of COVID-19. From early in the epidemic, anecdotal reports, published case reports, and information shared on the Academy of Consultation-Liaison Psychiatry's COVID-19 list-serve reflected the recognition of the complicated psychiatric and neuropsychiatric aspects of COVID-19.

From early in the pandemic, CL psychiatrists noted a significant psychiatric symptom burden among individuals with COVID. Initial experiences of CL psychiatrists managing patients with COVID-19 (including those shared on the Academy's list-serve) included a high incidence of delirium and psychiatric symptomatology among COVID-19 patients including mood, anxiety, and psychotic symptoms. CL psychiatrists also noted the mental health impact of the epidemic on uninfected patients. Patients with serious medical problems and comorbid psychiatric disorders experienced the impacts of fear, social isolation, and disengagement from care, all of which manifested in exacerbations of underlying mental illness. CL psychiatrists bore witness to systemic social inequities which resulted in greater morbidity and mortality among people of color. Finally, many CL psychiatrists experienced disruptions in workflow and systems-of-care including difficulties admitting patients from medical services to psychiatric and challenges obtaining PPE or establishing telepsychiatry access to general medical settings for consultative psychiatric care.

### **What did we learn? Turning to the Literature**

A growing body of literature on the psychiatric manifestations of COVID-19 reinforces the early experiences of CL psychiatrists [1–6]. Data demonstrate that COVID-19 is associated with psychiatric manifestations across a range of domains, many of which may also overlap with neurologic symptoms [7]. The pathophysiology of these psychiatric manifestations is complex and multifactorial and includes stigma and stressors associated with COVID-19, iatrogenic effects of medications [8], and the neurobiological impacts of infection such as inflammation, hypoxemia, and neurotropic effects of the SARS-COV-2 virus [9]. Of note, the neurobiological impacts of infection correlate with severity of illness and up to 85% of critically ill COVID-19 patients may experience neuropsychiatric manifestations [10–12].

Among psychiatric manifestations of COVID-19, delirium may be the most significant in the acute phase of the illness and is often associated with significant agitation [13,14]. Individuals in both the acute and convalescent phases of the illness also have increased prevalence of depression and anxiety, though this seems to wane over time [15–19]. Though less frequent, COVID-19 can also precipitate psychosis in the absence of delirium [20–25]. At this time, there is not yet data on the relationship of COVID-19 to a number of other psychiatric disorders such as trauma-related disorders and neurocognitive disorders other than delirium [26]. Furthermore, there is a lack of understanding regarding the long-term effects of COVID-19 infection on the brain or the neuropsychiatric impact of seemingly asymptomatic or mild infections.

Despite greater recognition of the neuropsychiatric manifestations of COVID-19 infection, there are limited data on management of these manifestations [27–32]. General guidelines thus far have focused on avoiding iatrogenic worsening of psychiatric symptoms, awareness of medication interactions, and limiting use of QT-prolonging agents rather than evidence driving specific treatment recommendations [8,13,33–38].

In addition to the direct effects of COVID-19 infection, data suggest that multiple cohorts of the patients treated by CL psychiatrists are at high risk of psychiatric adverse effects from the pandemic. There is increasing concern about the impact of the pandemic on patients with substance use disorders, obsessive impulsive disorder, and serious mental illnesses [39–41]. In addition, individuals with serious medical conditions are at risk of new or worsened psychiatric symptoms associated with their risk profile and the stressors of the pandemic [42].

In the US, the incidence of and mortality due to COVID-19 are higher in Blacks and other minorities than in non-Hispanic whites. This disparity is partly accounted for by their disproportionately high representation among “essential workers,” including hospital workers [43-45].

Beyond individual patients, CL psychiatrists have experienced systems-level challenges in the provision of psychiatric care. Even seemingly asymptomatic patients infected with COVID-19 have proven challenging to admit psychiatrically due to the challenges of managing psychiatric inpatients with isolation needs. Furthermore, in their work at the interface of mental health and physical health, CL psychiatrists have increasingly engaged with the profound disparities in health equity that have inflected the health of all of our patients [46].

### **The Academy’s Next Steps: Leadership in Clinical Care, Scholarship, and Public Health**

Given the relative dearth of data on the psychiatry of COVID-19, the Academy should serve as a leader in coordinating and directing scholarly efforts. Key questions include:

- What are the long-term neuropsychiatric sequelae of COVID-19 infection?
- What are the neuropsychiatric impacts of seemingly asymptomatic infections and what is the public health relevance of potentially atypical presentations?
- What is the impact of the COVID-19 pandemic on the diverse patient populations receiving care from CL psychiatrists?
- What are best practices in management of COVID-19 related psychiatric complications?

In keeping with research efforts, the academy should begin creating and disseminating clinical guidelines for commonly occurring psychiatric complications of COVID-19. There are well established workforce shortages in psychiatrists and CL psychiatrists. In the exceptional circumstances of a global pandemic, access to mental health care may be even more compromised. Creating guidelines for common complications like delirium can help ensure that information is available to a range of clinicians, even where CL psychiatrists are unavailable. Furthermore, clinical guidelines for CL psychiatrists on matters like the inpatient management of psychiatric patients with COVID-19 infection can help operationalize challenges in care and give CL psychiatrists nationally a source for up-to-date information.

Beyond CL psychiatrists, the academy should take an active role in educating all clinicians about the neuropsychiatric manifestations of COVID-19. Informational resources from the academy should take an anti-stigma stance, both from mental health clinicians towards people

with COVID-19 and from non-mental health clinicians about individuals with mental health complications of COVID-19.

In keeping with the above, but perhaps more broadly, the Academy should take a role synthesizing information to ensure its members are kept abreast of evolving data on COVID-19. Over the past 9 months, there have been about 60,000 PubMed indexed articles on COVID-19. This volume of information makes it impossible for any individual to synthesize valuable knowledge in an up-to-date fashion. The Academy should leverage its resources to support members with syntheses of the most high yield information emerging about the psychiatric aspects of the COVID-19 pandemic. This is something the Academy has already modeled in its “quarterly annotation” system and that could easily be expanded to COVID-19-related content.

Finally, the Academy should also maintain a role supporting public health messaging at large and partner with other subspecialty and specialty organizations to disseminate high quality information. This is particularly urgent given the possible increases in case numbers as the weather cools and seasonal influenza spread begins. As a part of our role as public health advocates, CL psychiatrists should also serve as leaders in health equity and understand the profound negative impact of systemic racism and disparities on the physical and mental health of our patients.

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## **Appendix E. Dissemination of Information and Advocacy**

Garrett Key, David Kroll

### **I. Dissemination of Information**

Each platform used by the ACLP and its members to broadcast information relevant to COVID-19 has a specific utility related to the type of content and intended audience.

#### **1. Psychosomatics/JACLP**

The research journal of the ACLP primarily publishes clinically focused content with a limited or developing evidence base and current opinions of leaders in the field. The target audience for the JACLP is practicing C-L psychiatrists.

We suggest solicitation of submission on the following COVID-19 related topics for publication in JACLP:

Clinical guidelines for management of acute neuropsychiatric aspects of COVID-19

- a. Reports on longitudinal outcomes in patients recovered from COVID-19
- b. Reviews of existing literature on neuropsychiatric effects of COVID-19
- c. Innovative or emerging approaches to telehealth
- d. Innovative or emerging approaches to providing psychological support to hospital staff

#### **2. ACLP website**

The ACLP website, [www.clpsychiatry.org](http://www.clpsychiatry.org), provides educational and practical resources relevant to C-L psychiatrists and primarily intended to reach ACLP members and trainees. Guidelines, consensus statements, and Academy policy positions are found here.

We recommend development of resources focused on the following areas:

- a. Best practices for implementation of telehealth in C-L psychiatry
- b. Recommendations around telehealth protocols, constant observation, and direct contact in acute infection risk
- c. Best practices for documentation and billing for telehealth in the context of COVID-19

#### **3. ACLP News**

ACLP News provides clinical and practical information in smaller doses than JACLP. ACLP News focuses on a few take-home pearls and highlights small scale, innovative approaches. The target audience for the JACLP is ACLP members looking for new ideas or practical solutions to problems.

We suggest solicitation of submissions for ACLP News on the following topics:

- a. Essential practical tips related to telehealth



- b. Practical suggestions for supporting hospital staff
- c. Preliminary discussion of trending COVID-19 listserv topics
- d. Opportunities and ongoing efforts for advocacy around COVID-19

#### **4. COVID-19 listserv**

The COVID-19 listserv has provided a forum for real-time discussion between ACLP members over a wide range of urgent topics without moderation or post approval.

We make the following recommendations regarding the COVID-19 listserv:

- a. The ACLP should maintain the unmoderated status of the listserv to preserve efficiency of communication and to provide a channel for open conversation among members
- b. Listserv content should be periodically reviewed to inform educational direction, advocacy efforts, and mission realignment for ACLP
- c. ACLP members active and demonstrating expertise through the listserv should be encouraged to become more active within ACLP at large

#### **5. Email blasts**

Email blasts are used to make large announcements and to advertise important opportunities and events, such as the Annual Meeting and target all ACLP members.

We make the following recommendations regarding email blast communication:

- a. Email blasts are not useful for dissemination of clinical or scientific information
- b. Announcements about ACLP position statements or other organizational news is most appropriate for this medium
- c. Email blasts should be used sparingly

#### **6. SIGs**

The SIGs provide a venue for ACLP members to concentrate work in a particular area of interest within the realm of C-L Psychiatry. Constituents are ACLP members and these groups typically produce educational materials, literature reviews, and presentations for the Annual Meeting.

We make the following recommendations for engaging the talent and interest of the SIGs:

- a. Recruitment of SIGs focused on issues germane to COVID-19 practice to prepare materials for the JACLP, the ACLP website, or ACLP News
- b. Solicitation of SIG submissions for the Annual Meeting on topics related to COVID-19 clinical practice, systems concerns, or advocacy

## 7. Annual Meeting

The Annual Meeting provides a venue for exchange of cutting-edge research and practical information in a context where informal professional collaboration and socialization on a personal level are catalyzed. Participants include C-L psychiatrists, other psychiatrists and non-psychiatric clinicians, trainees, representatives from other industries, and members of the lay public.

We make the following recommendations regarding the Annual Meeting in 2021:

- a. Efforts to recover the interactive and collaborative environment adapted to virtual programming
  - a. Recording each session in full, with all presenters together and able to discuss with each other
  - b. Uploading the audio and visual didactic portions in advance but holding the virtual session in real time, with the presenters in attendance to discuss with each other and answer questions (this requires a moderator)
  - c. Adapting debates for a virtual platform
  
- b. If the Annual Meeting can be held in person, we recommend provision of guidance and instruction for potential presenters
  - a. Providing templates for what an effective workshop looks like
  - b. Disseminating guidelines for making a proposal more interactive on the website
  - c. Creating a more transparent process for organizing and proposing debates

## 8. Social Media

The ACLP has a presence on Twitter with the handle @CL\_Psychiatry and is used to promote the Annual Meeting and the availability of new articles or resources with tweets primarily directed to ACLP Members.

We make the following recommendation for use of the ACLP Twitter voice:

- a. ACLP should consider public engagement on topics of significance related to our discipline
  - a. Advocacy issues around mental health and stigma
  - b. Providing a source of reliable health information in the public space

## II. Advocacy Opportunities

There are many groups and organizations through which the ACLP could advocate for certain positions or resources. These will be described below, but in order for these recommendations to be useful the ACLP must also determine what kinds of issues it *should* be advocating for, what its *positions* are, and what kinds of *resources* it would be willing to commit to such advocacy. These questions might be delegated to committees and subcommittees at the discretion of the board. Areas where the ACLP *might* take a stand include:

- a. What kinds of resources and precautions are necessary for C-L psychiatrists to provide care safely and effectively in hospitals during a pandemic?
- b. What kinds of resources and precautions are necessary for other staff (e.g., constant observers) to perform their jobs safely and effectively in hospitals during a pandemic?
- c. What kinds of resources and infrastructure should be put in place to allow patients to safely and effectively access care during a pandemic?
- d. What is needed to safely and effectively for hospital systems to implement a telehealth protocol in psychiatry?
- e. What kind of support is needed from outside institutions (governments, insurance companies) in order to do all of this safely and effectively?
- f. Who are the patients most at risk of being marginalized during a pandemic, and what is the role of C-L psychiatrists and/or hospitals in addressing this problem?
- g. Can or should the ACLP ever take a stance on major social issues that are unmasked or amplified by a pandemic, such as systemic racial injustice? **(This is an area in particular where anecdotal evidence indicates that many ACLP members feel that ACLP has responded inadequately to, and this task force strongly recommends that the ACLP deeply consider this question, whether or not it chooses to publicly respond)**
- h. What kind of public health misinformation should the ACLP take responsibility for correcting during a pandemic?

We recommend that the ACLP create a mechanism for inviting input and cultivating discussion around advocacy issues that allows for timely expression of our values as a group and the ability to respond meaningfully to emerging issues relevant to our discipline.

With these considerations in mind, the following advocacy opportunities could be considered:

### 1. American Psychiatric Association

The APA already has a more robust engine for advocacy and most likely would welcome support from the ACLP. The ACLP has an opportunity to provide sub-specialty expertise in guiding the APA toward its existing advocacy efforts and should leverage its relationship with the APA to ensure that its expertise is considered.

### 2. American Medical Association/American Hospital Association/other medical organizations

General medical and other specialty organizations would benefit from the expertise of C-L psychiatrists in providing effective psychological support to staff who have been affected by the COVID-19 pandemic. The ACLP should leverage relationships with these organizations in order to promote its knowledge in this area.

### **3. Individual hospitals and hospital systems**

The ACLP should assist its members in advocating for their own resources and support needs during the pandemic by providing clear guidelines and educational materials regarding what is needed to provide safe and effective care to patients.

### **4. Local and state agencies**

The ACLP should either lobby or help its members lobby (through the use of guidelines and educational materials) for financial support of telehealth through the COVID-19 pandemic and beyond.

### **5. The public**

The ACLP should consider using its social media presence to disseminate information relevant to public health and disseminate disinformation where applicable.

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