

ACLP WEB FORUM: CONSULTATION-LIAISON PSYCHIATRY IN THE ERA OF THE COVID PANDEMIC - May 30, 2020

Questions & Answers

Did you notice any difference of presentation in terms of severity of delirium in black and ethnic minority patients?

A great question, but not one that is possible to answer at this time. If you allow for speculation - the detection and treatment of delirium is overall limited, and it seems certainly plausible that disparities exist - in detection and diagnosis and treatment. As an incredibly complex biologic phenomenon, I suspect it would be extremely difficult to wade through those potential disparities (could the rater be biased in their interpretation of "agitation" for example) and determine whether delirium severity is different in specific populations. Of note, in our own hospital they investigated racial disparities in mortality from Covid-19, and fortunately have not found a difference in survival based on race or ethnicity. Of course, that is within the greater context of minority communities having much higher rates of active Covid-19 overall. A great study suggestion! Lisa Rosenthal

How did you engage with departments/services typically outside of liaison relationship (eg, respiratory therapy, physical/occupational therapy, etc)?

The Liaison relationship can be broad depending on the institution and pre-existing relationships and we encourage maintaining a broad partnership with SLP, PT, OT, Nutrition, RT, ECMO specialists, techs, etc,... as their roles can be influential in the care of all patients. This engagement can happen simply by introducing oneself and discussing relevant aspects of care but can be nurtured through shared educational opportunities, case conferences, and taking the opportunity to proactively reach out to these disciplines to engage them when feasible. It enriches the consultation experience and improves patient care. Nasuh Malas

How were residents and fellows involved in coverage?

Residents and fellows should be involved in the coverage process. It is important to be proactive and transparent with the residents, even including them in some departmental town halls, emails, and discussions in changes to workflow, care, scheduling. This should be done in concert with close involvement and conversation with the residency and fellowship directors. Residents and fellows maintained regular clinical obligations, so long as they were able to and were not particularly vulnerable to exposure, and did so while maintaining social distancing, rotating residents to ensure limited spread risk and to minimize burnout, and leveraging technology when possible. This was flexed up or down based on patient volumes and infection risk and in accordance with how the department and the health system adjusted practice. Nasuh Malas

Any role for SSRIs after delirium clears for residual anxiety?

Another great study suggestion. I did a brief PubMed search for SSRIs and delirium and post-ICU syndrome and found nothing. That said, we know there is a high prevalence of PTSD after critical illness, and early use of SSRIs can be quite helpful. Overall, depending on organ dysfunction, SSRIs seem a fairly low risk intervention. Beta blockers may also be helpful after trauma, so speculatively there may be a role here too, depending on cardiovascular and other risks. Lisa Rosenthal

Who brings the computer/tablet into the patient's room?

This varies by location. At our institution, we attempt to use native devices when feasible. Carts with tablets are also used, or laptops. These are brought into the room by nursing, techs, other volunteer staff, or physician members of the care team depending on the nature of the care and what is needed from the use of a tablet or computer. Nasuh Malas

Can one of you comment on the concern about suicide in front line health care workers like Dr. Breen in NY?

It is a tragic reminder of how impossibly demanding our job can be, at the crux of trauma, exhaustion, helplessness, and moral injury. Dr. Breen's premature death helped shed light on some of these challenges and mobilized most healthcare systems across the country to build programs to facilitate resilience and well-being for their staff.

Disaster psychiatry principles suggest "making meaning" as part of resilience – are there any clinical examples?

Yearning for meaning in an otherwise random and senseless disaster is a central tenet of trauma work. Clinically, it can be as simple as, "you have the disease, but now you will have the immunity and will be able to live without anxiety the others have to endure and to know that you will likely not pass it onto your loved ones." Or putting things into historical context, "this is something that has happened to your grandparents and every generation before them; the human race is built to endure such events and to thrive afterwards." Damir Huremović

To what extent are the supports being discussed for staff the purview of CL Psychiatry rather than Psychiatry more broadly or other parts of the hospital structure?

CL Psychiatry often will take an active role in informing other areas of hospital psychiatry or the larger department, both given the interactions with these services as well as the unique position of being at the interface of medicine and psychiatry. With that said, this should be done collaboratively and is ultimately the purview of the service line and departmental leadership but certainly informed by experiences and interactions with CL Psychiatry. Nasuh Malas

What is code lavender?

Code lavender is an interdisciplinary mental health "rapid response", where a team (chaplaincy, social work, nursing, leadership, behavioral health (CL), child life, etc) specifically trained to participate in these "codes" can be deployed in real time to a unit or clinical situation to help support clinical teams in real time during distressing moments. It existed before COVID. Vera Feuer

Have you incorporated the concept of "moral injury" into the psychological framework of disaster?

Moral injury in this outbreak is a considerable source of frustration and disillusionment among healthcare personnel, possibly with more significant fallout than from the other aspects trauma (at least, among health workers). Medical professionals tend to not process demoralization and anger very well; I fear those will be turned inwards and processed as such, leading to a considerable uptick in

substance use, reckless behavior, and, likely, suicidality in the longer run (not during the acute phase).
Damir Huremovic

Could you comment more on equity, specifically where it relates to the CL staff schedule?

Some of our staff are older or with health conditions that put them at higher risk. Others live with people who are high-risk and fear taking hospital germs home to them. Still others have a lot of child care needs and find it difficult to come in while schools and camps are closed. For all of these situations, taking a shift on-site in the hospital just present more challenges than folks without those issues.

Do you take that into account when designing the rotation schedule? If you take those personal situations into account, do you have any way to respond to other CL staff who may feel that they are being asked to bear more of the burden of coming into the hospital and getting exposed?

We had a rotation system that specifically ensured equity: we equally brought in nurses, residents and fellows, and attendings in some combination. If anyone needed a medical exemption, UPMC has a system to request this, but only one person was granted this "officially." We found that many more than we would have anticipated had some reason to be consider "high risk" such as family members with asthma, etc, so we considered everyone to be high risk and so used the rotation system as the means to mitigate as opposed to pulling people off altogether. That said, UPMC did have a system in place for free hotels if someone was concerned about putting family members at list. Priya Gopalan

Could you explain a bit more about psychological first aid and the stage at which it is most effective? Where is the evidence that PFA works? Does the scientific literature on psychological first aid available to date provide any evidence about the effectiveness of PFA interventions (eg, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4264843/> OR <https://pubmed.ncbi.nlm.nih.gov/23077267/>)?

Sufficient evidence for psychological first aid is widely supported by available objective observations and expert opinion and best fits the category of "evidence-informed" but without proof of effectiveness. Please see the more detailed summary just posted under

We talk a lot about the downsides to telehealth compared to in person. Beyond convenience, are there any advantages to telehealth compared to in person?

Yes, absolutely. For patients with social anxiety/trauma, telemedicine has some real benefits. Telehealth has allowed for flexibility in staffing across multiple hospitals without having to physically send a doctor from one facility to another. I'm exploring it long-term for evening home call residents to prevent them from coming in. Additionally, for our 3 hospitals that are rural, having our ambulatory services be telehealth has allowed for referrals to our evidence-based clinics to patients who live very remotely.
Priya Gopalan

Is anyone doing EEGs on COVID patients?

EEG tends to largely present with diffuse background slowing (e.g. 'garden variety' delirium, no EEG 'signature', even in a patient with suspected SARS-CoV-2 encephalitis). Damir Huremović

How much risk of sequelae do you think has to do with patients not having family support in the hospital (no visitor policies)?

It certainly adds an additional layer of stress/trauma to patients as well as providers. In some of our support groups one theme was discussing how difficult managing isolated patients and the lack of family support was for frontline providers. Vera Feuer

Has anyone seen use of antibody testing for patients testing negative for acute COVID, but unexplained delirium with negative work-up otherwise?

Yes, we will often test patients 2-3 times if we have a high suspicion of COVID due to the potential for a false negative test, particularly in high risk populations or populations that exhibit symptoms that are consistent with COVID or COVID-related sequelae (such as Pediatric Multisystem Inflammatory Syndrome). This should be guided by clinical judgment and close monitoring of the evolution of symptoms, while maintaining a broad differential. Nasuh Malas

I am surprised that mentally ill patients with medical comorbidities on long term antipsychotics, who are becoming COVID-19 positive and delirious and slowly recovering. Any thoughts about neuroprotection effect of antipsychotics?

There has been a great deal of speculation about many medications that might have antiviral effects, including haloperidol, VPA, and others. There is a post on the website about this. However, Standardized Mortality Ratios in patients with severe mental illness are quite high for most diseases compared with controls, and are HIGHEST for pulmonary processes, including 7 times higher SMR in pulmonary disease overall, and 9 times for influenza. Taking any antipsychotic is predictive of mortality overall, though it is difficult to determine the exact impact for every disease. I personally doubt antipsychotics are particularly antiviral. Lisa Rosenthal

Thanks to all the speakers! I know the World of Warcraft Corrupted Blood event served as a model for epidemics and its data was adapted by the CDC and WHO specifically because it had "bad actors". Was there anything in terms of psychology, behavior, and mental health we learned from it?

Exercises and experiences through simulations such as WoW Corrupted Blood, Dark Winter Exercise, or CDC Zombie Apocalypse Preparedness initiative have taught us that behavior of individuals and groups in affected societies is highly unpredictable and impossible to model. Apart from that, we learned nothing, because we continue to fail to include behavioral scientists, psychiatrists, or psychologists in projects that anticipate and plan for such disasters. Damir Huremović

What is the "trauma" causing PTSD in individuals in quarantine?

The trauma can come from many sources. Job loss, financial impact, illness, death, isolation, domestic violence, child abuse, racism, health disparities, educational impact - the list is long. Also, we are seeing a lot more acute stress and anxiety, but some individuals will exhibit PTSD. Since we are still in the midst of these acute stressors, the impact is not yet fully known. Vera Feuer

Humans need community to survive. Forced isolation can be perceived as life threatening on an emotional level. Yes. Another one on the list of various potential traumas.

Do you think our diagnostic thresholds should change since practically the whole patient population has had their daily lives disrupted?

I, personally, do not think so. We should, however, be open to revising criteria should legitimate evidence arise and suggest so. Damir Huremović

Thank you for that wonderful presentation Dr. Huremovic! There was an interesting article in the Las Vegas Review Journal that looked at data from the coroner's office which showed completed suicides had decreased during the COVID pandemic. How can this be best explained based on our current models of pandemic psychiatry?

Madianos and Evi (2012) concluded that, at least in the short term, there is often a drop in suicide rates in the immediate aftermath of a disaster. They attribute this to “the honeymoon” period, or what Gordon (2011) calls the “pulling together” phenomenon. If the immediate impact of a disaster does not overwhelm the coping capacity of individuals, it will likely mobilize resilience DURING the event. Not sure similar observation can be made for prolonged periods AFTER the disaster. Damir Huremović

Have you seen any differences in responses to COVID-19 in persons co-infected with HIV and COVID-19?

Very limited experience so far. I heard from two colleagues that their HIV patients who contracted COVID-19 had relatively mild cases, despite compromised immunity. It may make sense if we consider the 'cytokine storm' to be the central pathophysiological cascade in most critical COVID-19 cases.

Damir Huremović

Dr. Rosenthal, any increase in clotting with VPA?

No personal experience - we should ask Dr Rasmus and Sher about theirs. I am aware of thrombocytopenia, and you could speculate that risks in covid clotting might actually benefit from VPA. It looks to me like the evidence is mixed whether risk of stroke is higher (hemorrhage) or lower (anti-clotting). I don't see great data about it. Lisa Rosenthal

Has anyone noticed pts coming in with mild or asymptomatic Covid-19 infection and psychotic symptoms?

Yes. No confirmed causation. Damir Huremović

What have been the best strategies in managing the mental health of health personnel - greetings from Monterey, Mexico?

Multiple ways to connect with various levels of care from prevention, early identification and treatment. Utilizing liaison teams for enhancing resilience and checking in with teams, who can serve as contacts to larger mental health support structures within the health system. Vera Feuer

I have had 2 patients with non-severe Covid-19 Disease, and both became so overwhelmed with panic secondary to the diagnosis itself they became suicidal! Any experience with this?

We have seen some of this in pediatrics-also kids with just fear of diagnosis becoming panicked or suicidal. Vera Feuer

I've had patients in NYC who have lost 8 relatives over a span of 1.5 weeks. Every time they heard a siren, every time there was a knock on their door, their hypervigilance kicked right in, and they immediately assumed another relative had died. Trauma is not just personal, but vicarious as well.

YES!!!! Same for us providers- we are becoming vicariously traumatized by helping our patients and our health care providers. Vera Feuer

How have you navigated monitoring of suicidal hospitalized Covid-19 infected patients? Frequently patients are put on a 1:1, but that is at some risk for the monitor. What strategies have you found to be effective?

We have used telehealth with 1:1 sitters, too. With some risk stratification, we have expanded our telesitter program, which pre-existed Covid successfully. Higher risk patients would require a person in the room, but the telesitter equipment has served well for those who are not imminently lethal and/or impulsive. Priya Gopalan