COVID-19

COVID-19's effects on emergency psychiatry

The pandemic's impact on both ED patients and clinicians has been surprising and complex

LIGHTSPRING/SHUTTERSTOCK

Victoria Brooks, MD
Assistant Clinical Professor
Department of Psychiatry
University at Buffalo Jacobs School of Medicine
Medical Director
Comprehensive Psychiatric Emergency Program
Erie County Medical Center
Buffalo, New York

Coronavirus disease 2019 (COVID-19) is affecting every aspect of medical care. Much has been written about overwhelmed hospital settings, the financial devastation to outpatient treatment centers, and an impending pandemic of mental illness that the existing underfunded and fragmented mental health system would not be prepared to weather. Although COVID-19 has undeniably affected the practice of emergency psychiatry, its impact has been surprising and complex. In this article, I describe the effects COVID-19 has had on our psychiatric emergency service, and how the pandemic has affected me personally.

How the pandemic affected our psychiatric ED

The Comprehensive Psychiatric Emergency Program (CPEP) in Buffalo, New York, is part of the emergency department (ED) in the local county hospital and is staffed by faculty from the Department of Psychiatry at the University at Buffalo. It was developed to provide evaluations of acutely psychiatrically ill individuals, to determine their treatment needs and facilitate access to the appropriate level of care.

Before COVID-19, as the only fully staffed psychiatric emergency service in the region, CPEP would routinely be called upon to serve many functions for which it was not designed. For example, people who had difficulty accessing psychiatric care in the community might come to CPEP expecting treatment for chronic conditions. Additionally, due to systemic deficiencies and limited resources, police and other community agencies

Disclosure
The author reports no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.

COVID-19 and emergency psychiatry

Clinical Point

Visits to our psychiatric service by children/adolescents initially decreased after schools closed

Discuss this article at www.facebook.com/MDedgePsychiatry

refer individuals to CPEP who either have illnesses unrelated to current circumstances or who are not psychiatrically ill but unmanageable because of aggression or otherwise unresolvable social challenges such as homelessness, criminal behavior, poor parenting and other family strains, or general dissatisfaction with life. Parents unable to set limits with bored or defiant children might leave them in CPEP, hoping to transfer the parenting role, just as law enforcement officers who feel impotent to apply meaningful sanctions to non-felonious offenders might bring them to CPEP seeking containment. Labeling these problems as psychiatric emergencies has made it more palatable to leave these individuals in our care. These types of visits have contributed to the substantial growth of CPEP in recent years, in terms of annual patient visits, number of children abandoned and their lengths of stay in the CPEP, among other metrics.

The impact of the COVID-19 pandemic on an emergency psychiatry service that is expected to be all things to all people has been interesting. For the first few weeks of the societal shutdown, the patient flow was unchanged. However, during this time, the usual overcrowding created a feeling of vulnerability to contagion that sparked an urgency to minimize the census. Superhuman efforts were fueled by an unspoken sense of impending doom, and wait times dropped from approximately 17 hours to 3 or 4 hours. This state of hypervigilance was impossible to sustain indefinitely, and inevitably those efforts were exhausted. As adrenaline waned, the focus turned toward family and self-preservation. Nursing and social work staff began cancelling shifts, as did part-time physicians who contracted services with our department. Others, however, were drawn to join the front-line fight.

Trends in psychiatric ED usage during the pandemic

As COVID-19 spread, local media reported the paucity of personal protective equipment (PPE) and created the sense that no one would receive hospital treatment unless they were on the brink of death. Consequently, total visits to the ED began to slow. During April, CPEP saw 25% fewer visits than average. This reduction was partly attributable to cohorting patients with any suspicion of infection in a designated area within the medical ED, with access to remote evaluation by CPEP psychiatrists via telemedicine. In addition, the characteristics and circumstances of patients presenting to CPEP began to change (***Table, page 35***).

Children/adolescents. In the months before COVID-19's spread to the United States, there had been an exponential surge in child visits to CPEP, with >200 such visits in January 2020. When schools closed on March 13, school-related stress abruptly abated, and during April, child visits dropped to 89. This reduction might have been due in part to increased access to outpatient treatment via telemedicine or telephone appointments. In our affiliated clinics, both new patient visits and remote attendance to appointments by established patients increased substantially, likely contributing to a decreased reliance on the CPEP for treatment. Limited Family Court operations, though, left already-frustrated police without much recourse when called to intervene with adolescent offenders. CPEP once again served an untraditional role, facilitating the removal of these disruptive individuals from potentially dangerous circumstances, under the guise of behavioral emergencies.

Suicidality. While nonemergent visits declined, presentations related to suicidality persisted. In the United States, suicide rates have increased annually for decades. This trend has also been observed locally, with early evidence suggesting that the changes inflicted by COVID-19 perpetuated the surge in suicidal thinking and behavior, but with a change in character. Some of this is likely related to financial stress and social disruption, though job loss seems more likely to result in increased substance use than suicidality. Even more distressing to those coming to CPEP was anxiety about the illness itself, social isolation, and loss. The death of a loved one is painful enough,

Table

How COVID-19 affected usage of our psychiatric emergency service

Patient population/ condition	Effects
Children/ adolescents	Visits by children/adolescents initially decreased as school-related stress abated, then gradually began to increase, perhaps in response to home stressors
Suicidality	Changes inflicted by COVID-19 perpetuated the existing surge in suicidal thinking and behavior, but with distinctive changes to patient characteristics. Social distancing disrupted sources of social support and isolated some individuals, potentially increasing suicidality
Substance use disorders	Requests for detoxification became less frequent because people who were not in severe distress avoided the hospital. However, alcohol-dependent individuals who might typically avoid clinical attention were requiring emergent medical attention for delirium. Overdoses (primarily opioids) increased
Chronic mental illness	Some patients with chronic mental illness decompensated due to reduced access to community treatment resources. To combat this, mental health clinics recruited mobile teams or developed carefully scheduled, nursing-run "shot clinics" to ensure that patients who require long-acting injectable medications or medication-assisted treatment for SUDs continued to receive treatment
New-onset psychosis	Previously high-functioning individuals in their 30s, 40s, and 50s without a history of mental illness began to present with new-onset psychotic symptoms
Homelessness	Limitations on occupancy reduced the availability of beds in shelters and residences, resulting in increased homelessness
Home stressors	Domestic violence involving children and adults increased, possibly due in part to forced proximity

COVID-19: coronavirus disease 2019; SUDs: substance use disorders

Clinical Point

Presentations to the ED by patients with substance use disorders surged, but the patient profile changed

but disrupting the grief process by preventing people from visiting family members dying in hospitals or gathering for funerals has been devastating. Reports of increased gun sales undoubtedly associated with fears of social decay caused by the pandemic are concerning with regard to patients with suicidality, because shooting has emerged as the means most likely to result in completed suicide.[1] The imposition of social distancing directly isolated some individuals, increasing suicidality. Limitations on gathering in groups disrupted other sources of social support as well, such as religious services, clubhouses, and meetings of 12-step programs such as Alcoholics Anonymous. This could increase suicidality, either directly for more vulnerable patients or indirectly by compromising sobriety and thereby adding to the risk for suicide.

Substance use disorders (SUDs). Presentations to CPEP by patients with SUDs surged, but the patient profile changed, undoubtedly influenced by the pandemic. Requests for detoxification became less frequent because people who were not in severe distress avoided the hospital. At the same time, alcohol-dependent individuals who might typically avoid clinical attention were requiring emergent medical attention for delirium. This is attributable to a combination of factors, including nutritional depletion, and a lack of access to alcohol leading to abrupt withdrawal or consumption of unconventional sources of alcohol, such as hand sanitizer, or hard liquor (over beer). Amphetamine use appears to have increased, although the observed surge may simply be related to the conspicuousness of stimulant intoxication for someone who is sheltering in place. There was a noticeable uptick in overdoses (primarily with opioids) requiring CPEP evaluation, which was possibly related to a reduction of available beds in inpatient rehabilitation facilities as a result of social distancing rules.

Patients with chronic mental illness. Many experts anticipated an increase in hospital visits by individuals with chronic mental illness expected to decompensate as a result

COVID-19 and emergency psychiatry

Clinical Point

A population of patients with new-onset psychotic symptoms has surfaced during this pandemic

of reduced access to community treatment resources.[2] Closing courts did not prevent remote sessions for inpatient retention and treatment over objection, but did result in the expiration of many Assisted Outpatient Treatment orders by restricting renewal hearings, which is circuitously beginning to fulfill this prediction. On the other hand, an impressive community response has managed to continue meeting the needs of most of these patients. Dedicated mental health clinics have recruited mobile teams or developed carefully scheduled, nursing-run "shot clinics" to ensure that patients who require long-acting injectable medications or medication-assisted treatment for SUDs continue to receive treatment.

New-onset psychosis. A new population of patients with acute mania and psychosis also seems to have surfaced during this pandemic. Previously high-functioning individuals in their 30s, 40s, and 50s without a history of mental illness were presenting with new-onset psychotic symptoms. These are individuals who may have been characteristically anxious, or had a "Type A personality," but were social and employed. The cause is unclear, but given the extreme uncertainty and the political climate COVID-19 brings, it is possible that the pandemic may have triggered these episodes. These individuals and their families now have the stress of learning to navigate the mental health system added to the anxiety COVID-19 brings to most households.

Homelessness. Limitations on occupancy have reduced the availability of beds in shelters and residences, resulting in increased homelessness. Locally, authorities estimated that the homeless population has grown nearly threefold as a result of bussing in from neighboring counties with fewer resources, flight from New York City, and the urgent release from jail of nonviolent offenders, many of whom had no place to go for shelter. New emergency shelter beds have not fully compensated for the relative shortage, leading individuals who had been avoiding the hospital due to fear of infection to CPEP looking for a place to stay.

Home stressors. Whereas CPEP visits by children initially decreased, after 6 weeks, the relief from school pressures appears to have been replaced by weariness from stresses at home, and the number of children presenting with depression, SUDs, and behavioral disruptions has increased. Domestic violence involving children and adults increased. Factors that might be contributing to this include the forced proximity of family members who would typically need intermittent interpersonal distance, and an obligation to care for children who would normally be in school or for disabled loved ones now unable to attend day programs or respite services. After months of enduring the pressure of these conflicts and the resulting emotional strain, patient volumes in CPEP have begun slowly returning toward the expected average, particularly since the perceived threat of coming to the hospital has attenuated.

Personal challenges

For me, COVID-19 has brought the chance to grow and learn, fumbling at times to provide the best care when crisis abounds and when not much can be said to ease the appropriate emotional distress our patients experience. The lines between what is pathological anxiety, what level of anxiety causes functional impairment, and what can realistically be expected to respond to psychiatric treatment have become blurred. At the same time, I have come across some of the sickest patients I have ever encountered.

In some ways, my passion for psychiatry has been rekindled by COVID-19, sparking an enthusiasm to teach and inspire students to pursue careers in this wonderful field of medicine. Helping to care for patients in the absence of a cure can necessitate the application of creativity and thoughtfulness to relieve suffering, thereby teaching the art of healing above offering treatment alone. Unfortunately, replacing actual patient contact with remote learning deprives students of this unique educational opportunity. Residents who attempt to continue training while limiting exposure to patients may mitigate their own risk but could also be missing an opportunity to learn how

continued on page 38

continued from page 36

COVID-19 and emergency psychiatry

Clinical Point

In some ways, my passion for psychiatry has been rekindled by COVID-19, sparking an enthusiasm to teach and inspire students

to balance their needs with making their patients' well-being a priority. This raises the question of how the next generation of medical students and residents will learn to navigate future crises. Gruesome media depictions of haunting experiences witnessed by medical professionals exposed to an enormity of loss and death, magnified by the suicide deaths of 2 front-line workers in New York City, undoubtedly contribute to the instinct driving the protection of students and residents in this way.

The gratitude the public expresses toward me for simply continuing to do my job brings an expectation of heroism I did not seek, and with which I am uncomfortable. For me, exceptionally poised to analyze and over-analyze myriad aspects of an internal conflict that is exhausting to balance, it all generates frustration and guilt more than anything.

I am theoretically at lower risk than intubating anesthesiologists, emergency medicine physicians, and emergency medical technicians who face patients with active COVID-19. Nevertheless, daily proximity to so many patients naturally generates fear. I convince myself that performing video consultations to the medical ED is an adaptation necessary to preserve PPE, to keep me healthy through reduced exposure, to be available to patients longer, and to support the emotional health of the medical staff who are handing over that headset to patients "under investigation." At the same time, I am secretly relieved to avoid entering those rooms and taunting death, or even worse, risking exposing my family to the virus. The threat of COVID-19 can be so consuming that it becomes easy to forget that most individuals infected are asymptomatic and therefore difficult to quickly identify.

So I continue to sit with patients face-to-face all day. Many of them are not capable of following masking and distancing recommendations, and are more prone to spitting and biting than their counterparts in the medical ED. I must ignore this threat and convince myself I am safe to be able to place my responsibility to patient care above my own needs and do my job.

Most of my colleagues exhibit an effortless bravery, even if we all naturally waver briefly at times. I am proud to stand shoulder-to-shoulder every day with these clinicians, and other staff, from police to custodians, as we continue to care for the people of this community. Despite the lower clinical burden, each day we expend significant emotional energy struggling with unexpected and unique challenges, including the burden of facing the unknown. Everyone is under stress right now. For most, the effects will be transient. For some, the damage might be permanent. For others, this stress has brought out the best in us. But knowing that physicians are particularly prone to burnout, how long can the current state of hypervigilance be maintained?

What will the future hold?

The COVID-19 era has brought fewer patients through the door of my psychiatric ED; however, just like everywhere else in the world, everything has changed. The only thing that is certain is that further change is inevitable, and we must adapt to the challenge and learn from it. As unsettling as disruptions to the status quo can be, human behavior dictates that we have the option to seize opportunities created by instability to produce superior outcomes, which can be accomplished only by looking at things anew. The question is whether we will revert to the pre-COVID-19 dysfunctional use of psychiatric emergency services, or can we use what we have learned—particularly about the value of telepsychiatry—to pursue a more effective system based on an improved understanding of the mental health treatment needs of our community. While technology is proving that social distancing requires only space between people, and not necessarily social separation, there is a risk that excessive use of remote treatment could compromise the therapeutic relationship with our patients. Despite emerging opportunities, it is difficult to direct change in a productive way when the future is uncertain.

The continuous outpouring of respect for clinicians is morale-boosting. Behind closed doors, however, news that this county hospital failed to qualify for any of the second

round of federal support funding because the management of COVID-19 patients has been too effective brought a new layer of unanticipated stress. This is the only hospital in 7 counties operating a psychiatric emergency service. The mandatory, "voluntary" furloughs expected of nursing and social work staff are only now being scheduled to occur over the next couple of months. And just in time for patient volumes to return to normal. How can we continue to provide quality care, let alone build changes into practice, with reduced nursing and support staff?

It is promising, however, that in the midst of social distancing, the shared experience of endeavoring to overcome COVID-19 has promoted a connectedness among individuals who might otherwise never cross paths. This observation has bolstered my confidence in the capacity for resilience of the mental health system and the individuals within it. The reality is that we are all in this together. Differences should matter less in the face of altered perceptions of mortality. Despite the stress, suicide becomes a less reasonable choice when the value of life is magnified by pandemic circumstances. Maybe there will be even less of a need for psychiatric emergency services in the wake of COVID-19, rather than the anticipated wave of mental health crises. Until we know for sure, it is only through fellowship and continued dedication to healing that the ED experience will continue to be a positive one.

Related Resource

- American Association for Emergency Psychiatry, American College of Emergency Physicians, American Psychiatric Association, Coalition on Psychiatric Emergencies, Crisis Residential Association, and the Emergency Nurses Association. Joint statement for care of patients with behavioral health emergencies and suspected or confirmed COVID-19. https://aaep.memberclicks.net/assets/joint-statement-covid-behavioral-health.pdf.

References

1. Wang J, Sumner SA, Simon TR, et al. Trends in the incidence and lethality of suicidal acts in the United States, 2006-2015 [published online April 22, 2020]. JAMA Psychiatry. doi: 10.1001/jamapsychiatry.2020.0596.
2. Reger MA, Stanley IH, Joiner TE. Suicide mortality and coronavirus disease 2019--a perfect storm? [published online April 10, 2020]. JAMA Psychiatry. doi: 10.1001/jamapsychiatry.2020.1060.

Clinical Point

It is only through fellowship and continued dedication to healing that the ED experience will continue to be a positive one

Bottom Line

Coronavirus disease 2019 (COVID-19) led to changes in the characteristics and circumstances of patients presenting to our psychiatric emergency service. Despite a lower clinical burden, each day we expended significant emotional energy struggling with unexpected and unique challenges. We can use what we have learned from COVID-19 to pursue a more effective system based on an improved understanding of the mental health treatment needs of our community.