A Framework for the Community Psychiatrist's Role in the COVID-19 Response

Jeffrey C. Fetter¹

Received: 12 August 2020 / Accepted: 30 November 2020 / Published online: 5 January 2021
© The Author(s), under exclusive licence to Springer Science+Business Media, LLC part of Springer Nature 2021

Abstract

The COVID-19 pandemic has disrupted community mental health center (CMHC) operations by limiting in-person access to patients and contributing to staff absenteeism. States adjust social distancing levels over time in response to changes in economic needs, healthcare system utilization, and COVID-19 virus transmission levels. Community mental health centers also need to balance service needs with infection risk, which requires adjusting social distancing levels in response to changes in the local conditions. This article will: (1) briefly describe epidemiological indicators most useful for judging the local infection trends, (2) describe a strategy for organizing specific agency clinical functions on a social distancing level scale, (3) propose a set of agency phases to inform administrative responses to changes in the risk to operations, and (4) discuss the role of psychiatrists as physicians in a mental health agency during a pandemic.

Keywords COVID-19 · SPMI · Community psychiatry · Social distancing · SARS-CoV-2

Introduction

The COVID-19 pandemic has disrupted Community Mental Health Center (CMHC) operations severely. Telehealth has become standard in many settings, but often our patients do not have access to smart phones or phones of any kind for that matter. Staffing levels are limited by illness, FMLA, and child care limitations, as well as by fear of coming to work during the pandemic. CMHCs need to provide enough patient outreach to serve patients while protecting staff, and safeguarding confidence in the agency's approach to COVID-19 mitigation.

Until a vaccine is available, community COVID-19 activity may continue to wax and wane across localities asynchronously (Pueyo 2020a, b). CMHCs will best serve clients and staff if they develop agility in decreasing barriers to care when local viral transmission is low, and increasing social distancing when transmission is high. Here we offer a framework for CMHC psychiatrists to manage clinical operations in the COVID-19 pandemic environment.

Situational Awareness

Interpreting local COVID-19 risk to manage CMHC clinical operations requires both understanding local COVID-19 community circulation and its impact on partner institutions.

Local COVID-19 circulation is reported by state public health departments in various forms of raw data such as the number of daily positive cases, daily deaths, or case rates per 100,000 population (NHDPH). These data do not provide enough context to interpret for CMHC operations because they do not convey speed or direction of change. Moreover, if there are not enough tests being done during an acceleration phase, test positivity will lag behind true cases in the community, leading to an underestimate of community risk (Pueyo 2020a, b). However, many departments of public health do report daily COVID-19 hospitalizations (NHDPH 2020), which leads testing data during an epidemic acceleration, giving earlier warning. It also provides an operational estimate of the status of local partner hospitals.

The second local COVID-19 measure of value is the $R(t)$ value for your state and county (Gianicolo et al. 2020). The $R(t)$ indicates the number of individuals each COVID-19 patient is infecting. Therefore an $R(t)$ above 1 means local cases are growing, below 1 means it is diminishing, and approximately 1 reflects stable spread in the community. $R(t)$ varies with the growth rate of cases in the community. Real

✉ Jeffrey C. Fetter
jfettermd@gmail.com

¹ Geisel School of Medicine at Dartmouth, New Hampshire Hospital, 36 Clinton Street, Concord, NH 03301, USA

time $R(t)$ values at the county level are available on websites such as www.covidactnow.org which uses New York Times for its raw data.

In other words, local daily new hospitalizations is an estimated the distance to the peak of the COVID-19 curve, and the $R(t)$ value is the speed with which the community is heading toward or away from the peak.

Impact on partner institutions is the second area of concern to monitor, and includes statewide intensive care unit headroom, closings of services used by CMHC clients such as substance use treatment, outbreaks at group homes, skilled nursing facilities, jails, shelters, and other congregate living settings. This information is available from local hospital associations, state departments of public health, and other local organizations.

Agency Phases

A COVID-19 Management Framework may include a set of phases that synchronize the response of the agency as a whole and orient staff to the current risk level in the community. In contrast to some Phase systems (Veteran's Administration 2020; Brian 2012), the one proposed here assumes that over the course of the COVID-19 pandemic the local conditions will warrant moving both down and up the phase levels. This means that activities traditionally described in pre-event and post-event phases will be ongoing activities. For example, making sense of the event, developing relationships with partners, and connecting people to resources span the continuum of phases in this pandemic.

Incident Command (IC) is a widely accepted organizing model for disaster management. Originally described as a standardized way to allocate resources in fire suppression operations, it has been adopted with success in hospitals (Shooshtari et al. 2017). We have adapted several key principles to CMHC pandemic management, particularly unity of

command and integrated communications. The IC meeting includes chiefs of Logistics, Operations, Planning, Public Information, and Finance branches. The rapidly changing CDC guidance in this pandemic requires close coordination between Planning Chief and the Public Information Officer who oversees staff training and messaging about Phase and Level changes. The CEO serves as Incident Commander, and a lead social worker or psychologist as Operations Chief in charge of clinical staff. The telehealth challenges in this pandemic make an information technology specialist indispensable in IC under the Operations section.

Local infection rates will drive other specific agency actions related to preserving clinical effectiveness. See Table 1 for a summary. It is critical in Phase 2, moving either up or down, that the agency review the most current CDC guidance on facility mitigation and protecting vulnerable individuals. Preparation for extensive staff absence is a key task in Phase 3, consisting of cross-training tasks as well as risk stratifying caseloads. Using the following risk stratification system across all programs of the agency permits efficient triage, and a balance of standardization and adaptation to program requirements. The goal is shifting priority patients among clinical staff during high unplanned absenteeism.

1. Red: clients who are always at high risk of hospitalization
2. Yellow: clients who should not go > 2 weeks without CMHC contact
3. Green: all other clients

Each time the agency changes Phase, Incident Command should reassess the burn rate for personal protective equipment (PPE), financial and human resource implications, and ask managers to reassess the risk-benefit balance of in-person versus remote work for all staff.

Table 1 Agency phases

Phase	COVID-19 activity	Agency response
1	Sporadic outbreaks in state	Active monitoring of local epidemiological data
2	Stable or decreasing local transmission	Review current CDC Guidance, IC convenes regularly at this level and higher. Moderate work from home
3	Widespread local transmission	Maximum work from home, staff cross training, caseload risk stratification, refresh PPE training
4	Significant staff absenteeism	Reassign high risk cases from absent to working staff, move all Levels to 4 until further instruction
5	Sudden disruptive event	All staff stand by phones, IC meets immediately

IC incident command

Social Distancing Levels

The second tool for communicating and executing COVID-19 countermeasures is a Social Distancing Level system. An agency can change different service lines' Levels independently of each other in response to clinical needs, staffing resources, facility infrastructure, telehealth resources, and the local SARS-CoV-2 indicators.

Each function may have features which require adjustments to the general scheme in Table 2. The guiding principle for any deviation from the general scheme is “crisis standard of care” (Institute of Medicine 2009). This means that in a time of scarcity and constraints, one accepts practices that deliver the best care consistent with resources and safety. For example, initial psychiatric evaluations require a higher degree of assessment than a follow up appointment with the same provider. Therefore, an agency may decide that video telehealth is required for psychiatric evaluations at Level 3, whereas a telephone encounter is acceptable for a follow up appointment at Level 3.

Examples of other functions to be assigned Social Distancing Levels include functional support services, psychotherapy, groups, child services, mobile crisis encounters, drug court urine tests, medication assisted treatment for opioid use disorders, nurse visits, and in-home family support services. Group home COVID-19 precautions also can be managed with a modified Level system; see Table 3.

Higher levels of social distancing blunt clinical staff's ability to build trust, perform detailed mental status exams, assess functioning in community situations, determine the condition of clients' homes, and generally perform the functional support that is critical to keeping SPMI patients well. For all these reasons, it is imperative to lower the

social distancing level when it is safe to do so, being ready to quickly raise social distancing during times of higher COVID-19 risk.

Psychiatrist's Role

The Incident Command model is well suited for periodic review and adjustment of agency Phase and Level status. The psychiatrist's role is best thought of as chief or member of the Planning section. The task is understanding the epidemic through a medical lens, interpreting incoming public health data for use by the IC team, forecasting impacts of local infection trends on partners and CMHC operations, and serving as a liaison to a local hospital's IC or infection control team. Being a general medical consultant is an unusual role for psychiatrists, but it is possible with the help of partners in the community, and is a necessary new function for the duration of the pandemic.

The psychiatrist can serve an important role as a liaison to emergency room and infectious disease physicians (Banerjee 2020). Attending hospital IC meetings provides the most accurate and current local situational awareness for your agency, and provides opportunities to assist with behavioral health support to evolving pandemic response efforts. Examples may include setting up telepsychiatry in temporary hospitals (Alternative Care Sites), or establishing enhanced employee assistance for emergency room and intensive care unit staff. Psychiatrists may also help plan strategies to divert behavioral health patients from emergency rooms, such as mobile crisis protocols attuned to a crisis standard of care, telehealth-based emergency services, or alternative placements like respite beds.

Table 2 Social distancing levels

1	Minimum social distancing advised by the state
2	Telehealth at staff discretion
3	In-person services only permitted with supervisor approval
4	Maximum telehealth

Table 3 Group home social distancing levels

Level	Definition	Social distancing measures
1	Minimum local circulation	Only such social distancing as recommended by state
2	Moderate/high circulation	No visits, staff in surgical masks, no staff float between homes
3	One person under investigation (PUI) in the home	Isolate/quarantine PUI, staff and patients mask
4	Two or more PUI (suggests transmission within the home)	Staff in full PPE at all times in building, patients mask

Conclusion

The COVID-19 pandemic has forced community mental health centers to provide services within the constraints of social distancing and staffing shortages. Agile adaptation to rapid changes in local resources and infection risk will permit CMHCs to offer an optimum balance of clinical services and infection control over time. Psychiatrists can play an

important role in developing and executing plans to manage this balance for the duration of the pandemic in order to provide high quality, safe mental health care to clients with severe and persistent mental illness.

Compliance with Ethical Standards

Conflict of interest I have no disclosures related to the content of this manuscript. No off-label use of medications are discussed.

References

- Banerjee, D. (2020). The COVID-19 outbreak: The crucial role psychiatrists can play. *Asian Journal of Psychiatry*. <https://doi.org/10.1016/j.ajp.2020.102014>.
- Brian, H. J. (2012). Public disaster mental/behavioral health communication: Intervention across disaster phases. *Journal of Emergency Management*, 10(4), 283–292.
- Gianicolo, E., Riccetti, N., Blettner, M., & Karch, A. (2020). Epidemiological measures in context of the COVID-19 pandemic. *Deutsches Ärzteblatt International*, 117, 336–342.
- Institute of Medicine. (2009). *Guidance for establishing crisis standards of care for use in disaster situations: A letter report*. Washington, DC: The National Academies Press.
- New Hampshire Department of Public Health (NHDPH). (2020). COVID-19 website. www.nh.gov/covid/19/. Accessed 28 July 2020.
- Pueyo, T. (2020a). Coronavirus: The hammer and the dance. The Medium. <https://www.medium.com/@tomaspueyo/coronavirus-the-hammer-and-the-dance-be9337092b56>. Accessed 28 July 2020.
- Pueyo, T. (2020b). Coronavirus: Why you must act now. The Medium. <https://www.medium.com/@tomaspueyo/coronavirus-why-you-must-act-now-or-people-will-die-f4d3d9cd99ca>. Accessed 28 July 2020.
- Shooshtari, S., Tofighi, S., & Abbasi, S. (2017). Benefits, barriers, and limitations on the use of Hospital Incident Command System. *Journal of Research in Medical Sciences*. <https://doi.org/10.4103/1735-1995.202146>.
- Veteran's Administration (2020). COVID-19 threat levels that inform administrative response. https://www.va.gov/opa/docs/VHA_COVID_19_03232020_vF_1.pdf. Accessed 28 July 2020.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.