Background
COVID-19 poses unique stressors on colleagues and patients in the behavioral health setting. The milieu encourages group participation and patient behaviors can be labile at times. The shift to wearing masks by colleagues and other patients can be disconcerting to a patient who is not accustomed to interacting with others via social distancing and wearing masks. It is important to maintain a ‘person-centered’ approach to the care of the behavioral health patient. At a time when visitation is discouraged, effective communication with patients, patient representatives, and other family members about the patient’s needs becomes increasingly important to ensure that the patient feels the support of their personal team.

For inpatient behavioral health units, a key decision by the care team is to discern the most appropriate location of care for the person with symptoms consistent with COVID-19. Those with COVID-19 often require significant medical care and support that may therefore require transfer to an inpatient medical unit – or if developing severe respiratory distress, to an ICU.

Universal Source Control

- All patients should be offered a cloth mask for source control and, if tolerated, should leave the mask on when not in their rooms. Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) who are not wearing a mask enter the room. If available, organizations should consider switching patients with respiratory symptoms (e.g., cough or sneeze), including patients with confirmed COVID-19, to a medical grade facemask.

- Masks may be removed when social distancing of at least six feet is possible (e.g., after entering a private office). In order to ensure patients can take off their masks for meals and breaks, scheduling and location for meals and breaks should ensure that at least a six-foot distance can be maintained between patients so that they can remove their masks.

Testing for the Presence of SARS-CoV-2:
• Clinicians should use their judgment to determine if a patient with signs and symptoms compatible with COVID-19 should be tested based on availability of testing, community epidemiology, current CDC guidelines, and local/state health department requirements. Molecular RNA testing is becoming increasingly available and provides valuable information to help the provider manage the patient based on the presence or absence of a COVID-19 diagnosis. One negative test result may not necessarily indicate the patient is negative for the virus. The patient should also be assessed clinically for symptoms of COVID-19, although not all positive patients exhibit symptoms of COVID-19. A symptom-based strategy should be used for determining when to discontinue isolation precautions in suspect or positive patients.

**Isolation Guidelines**

**NOTE:** CMS is temporarily allowing Community Mental Health Centers to offer partial hospitalization and other mental health services to clients in the safety of their homes. Previously, clients had to travel to a clinic to obtain these intensive services. Now, Community Mental Health Centers can furnish certain therapy and counseling services (and may use the telehealth option) in a client’s home to ensure access to necessary services and maintain continuity of care. For patients who are PUI, are positive for, and/or recovered from COVID-19, this may be a preferred alternative to admission.

• **PUI but without symptoms:** Persons under investigation; (e.g. could include those with prior potential exposure to another with confirmed COVID-19) but are asymptomatic and not yet tested for SARS-CoV-2 infection, may be admitted.
  - If available, admit to a private room. Individuals who cannot comply with requests to wear a cloth mask should be at higher priority for receiving a private room.
  - This patient’s care team should assess likelihood of developing symptoms, where the patient is in the incubation period, etc. Consider consulting an infectious disease physician about testing for SARS-CoV-2. A test-based strategy to rule out asymptomatic infection involves two molecular tests spaced 24 hours apart and both are negative; or a symptom-based approach, e.g. no symptoms of acute respiratory infection for 72 hours.
  - If unlikely incubating infection – permit the patient to participate in group therapy – all in these sessions need to be wearing a mask and practice social distancing.

• **Symptomatic Patient:** If the patient presents as symptomatic, but has previously tested negative, treat as PUI until symptoms abate. Assess the appropriate location for care based on the severity of symptoms. Cohort with other PUIs based on bed availability. The patient should remain in the single room or in a designated isolation room/area if a single room is unavailable. Meals and medication should be taken in the room, and they should stay in their room to the extent it is feasible and wear a mask (if tolerated) when not able to remain in the room.

• **Known COVID-19-Positive Patients:** Patients who are positive for COVID-19 on admission should be in a private room or cohorted with other positive patients. Assess how long it has been since the date of the positive test. Refer to System IPC guideline on duration of isolation precautions and apply those criteria to determine if the patient is likely no longer able to transmit infection. If still in acute phase of illness – assess appropriateness for inpatient behavioral health. If stable and can be in this type of unit, the patient needs to wear a mask if leaving their room and should not participate in group therapy. Exposed roommates should, if possible, also have their own rooms for 14 days and if they remain symptom-free, can then share a room with others.

**Social Distancing:**
• Ministries should consider social distancing practices when determining the capacity for accepting new patients. Determine how many patients the ministry can accept if all patients and staff remain at least six feet apart at all times and that figure becomes maximum census. In the event that patient care mandates that colleagues, be closer than six feet, PPE should be worn (gown, mask, face shield, gloves) to reduce the potential for exposure.

Hand Hygiene:

• All patients and colleagues should increase the frequency of hand hygiene practices. In addition to posted handwashing protocols, there should be adequate availability of hand sanitizer throughout the unit. For inpatient behavioral health colleagues will need to oversee dispensing of alcohol-based hand rub, encourage patients to use handwashing with soap and water, or provide alcohol saturated, disposable hand wipes for hand hygiene.

Environmental Services:

• Follow routine procedures for cleaning of dishes, eating utensils and linens after use.

• When washing clothes, staff (or family care providers) should be instructed not to "hug" dirty laundry while transporting it to maintain distance from their own clothes and face. Use of a hamper is recommended. After handling linens or clothing of someone who tested positive for COVID-19, staff should wash their hands with soap and water.

• Colleagues should disinfect high-touch surfaces frequently (tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, etc.) and remove items that cannot be cleaned easily (board games, puzzles, books). Products with Environmental Protection Agency (EPA)-registration as effective against emerging viral pathogens claims are recommended for use.

Care Planning:

• It is also important that the patient remains engaged in their care plan during this time of uncertainty and stress about the virus. Colleagues should take steps to educate and empower the patient to be a part of the solution, so that they understand their role in limiting the spread of the virus through social distancing and wearing of masks (when possible).

Group Activities:

• CDC guidance currently recommends suspending all groups and activities with more than 10 people. Communal dining and all group activities with more than 10 people, such as internal and external group activities, should be canceled. Facilities should utilize non-face-to-face meeting options, such as phone, video communications, etc., to the extent possible. Patients and staff should be reminded of the importance of hand hygiene and of not touching their faces if visiting their providers is necessary.
Partial Hospital Programs- Phase 2:

Community Mental Health Centers can furnish certain therapy and counseling services (and may use the telehealth option) in a client’s home to ensure access to necessary services and maintain continuity of care. This is the preferred option for patients with known or suspected COVID-19 in lieu of attendance in-person group setting during Phase 1.

Follow your resuming operations guidance prior to beginning Phase 2 and resumption of the on-site hospital program.

All participants should be tested ONCE using a molecular test for SARS-CoV-2 prior to beginning on-site treatment. There may be a level of prevalence within the community below which the need for testing may no longer be required. Check with your Infection Control professional prior to discontinuing the testing requirement prior to treatment.

If a patient tests positive for COVID-19, the patient may not participate in on-site activities until 10 days have passed since the initial, positive test, the patient is afebrile for 72 hours without the use of fever-reducing medications, and has experienced improvement in symptoms. If the patient meets the above criteria, the patient will be considered as having recovered from COVID infection. The patient should NOT be re-tested prior to beginning on-site treatment.

All participants should be screened prior to each day they attend the program using screening questions and a temperature check as outlined in Screening at Facility Entrances guidance.

Limit therapy group size to the minimal therapeutic number of participants. The program should keep lists of all participants in each group therapy session by date of service. These lists may aid contact tracing efforts in the event of an unintentional COVID-19 exposure.

If a patient exhibits symptoms of COVID-19 disease, (fever, cough, shortness of breath/difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea) during their time at the program, the patient should immediately be isolated from the other participants and sent to a Fever and Upper Respiratory Infection (FURI) testing site to be re-tested for COVID-19. The patient should not attend any on-site activities until the results have returned. Then follow your ministry’s exposure plan for further guidance.
References:


Tracking Infections in Inpatient Psychiatric Facilities (National Healthcare Safety Network - NHSN)
https://www.cdc.gov/nhsn/ipfs/index.html

Garcia-Houchins, S. Preparing Behavioral Health Organizations for COVID-19. The Joint Commission
