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Special Article

Report of the Academy of Consultation-Liaison Psychiatry Task Force on Lessons Learned From the COVID-19 Pandemic: Executive Summary



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Background: The COVID-19 pandemic forced consultation-liaison psychiatrists to adapt to unprecedented circumstances. The Academy of Consultation-Liaison Psychiatry (ACLP) recognized the need and opportunity to assess its response and convened a task force in mid-2020 to review the lessons learned from the initial experience of the COVID-19 pandemic. **Objective:** The aim of the study was to summarize experience and make recommendations to the ACLP Board of Directors about potential ACLP directions related to current and future pandemic response. **Methods:** In August–November 2020, the task force reviewed local experiences, ACLP list-serv contributions, and the published literature and generated recommendations for ACLP actions. **Results:**

Recommendations addressed telepsychiatry, hospital staff wellness, support for consultation-liaison psychiatrists, the need for additional research on psychiatric and neuropsychiatric aspects of COVID-19, and the ACLP's role in advocacy and dissemination of information. The task force report was submitted to the ACLP Board of Directors in November 2020. **Conclusions:** As the preeminent organization of consultation-liaison psychiatrists, the ACLP can implement actions related to pandemic awareness and preparedness for the benefit of consultation-liaison psychiatrists, other health care workers, patients, and the general population.

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Key words: COVID-19, telepsychiatry, advocacy, wellness, ACLP.

INTRODUCTION

This is a summary of the report of a “Task Force on Lessons Learned by CL Psychiatrists from the COVID-19 Pandemic” commissioned by the Board of Directors of the Academy of Consultation-Liaison Psychiatry (ACLP) in the summer of 2020 and submitted in November 2020. The task force focused on 5 domains—remote work and telepsychiatry, the wellness of hospital and medical staff, the wellness of consultation-liaison (CL) psychiatrists, the psychiatry and neuropsychiatry of COVID-19, and the ACLP's role in advocacy and dissemination of information—and provided a number of recommendations for actions to be

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undertaken by ACLP as an organization. The summary provides background, key findings in each domain, and recommendations. The full text of the Task Force Report is included in the [Appendix](#), and is also available on the ACLP website (clpsychiatry.org).

BACKGROUND

COVID-19, 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 worldwide. 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 November 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 of 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 personal protective equipment (PPE) 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 of Breonna Taylor, George Floyd, and Ahmaud Arbery in short succession, 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.

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.¹⁻⁴ 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 support 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 ACLP. Its website and COVID-19 list-serv became key sources for information and for the psychosocial support of the community of CL psychiatrists.

Formation and Charge of the Task Force

In the summer of 2020, Michael Sharpe, president of the ACLP, in recognition of the past and enduring future impact of COVID-19, and of the possibility of future pandemics, convened the task force to address lessons learned from the pandemic. 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.

At Dr. Sharpe's request, the task force took as its charge to summarize what the field of CL 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 5 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, as of November 19, 2020.

In parallel with the work of the task force, an online 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. (Survey results were presented by Dr. Shapiro in “Emotional Responses of CL Service Chiefs to the COVID-19 Pandemic,” in a panel presentation entitled “Leadership in Crisis: Lessons Learned from the COVID-19 Pandemic,” ACLP Annual Meeting, November 12, 2020.) 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.”

Membership of the Task Force

The following list shows the members of the task force:
Khyati Brahmhatt, MD, University of California-San Francisco.

Rachel Caravella, MD, New York University Langone Health.

Jennifer Erickson, DO, University of Washington.

George Everly, Jr., PhD, Johns Hopkins University.

Karen Giles, MD, Emory University.

Priya Gopalan, MD, University of Pittsburgh.

Heather Greenspan, MD, Emory University.

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 A. Shapiro MD, Columbia University.

Work Process

The task force conducted its business by email, telephone, and videoconference in August-November 2020. The members formed subgroups to address each of the 5 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.

KEY FINDINGS

Remote Work and Telepsychiatry

Priya Gopalan (Group 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. The use of telepsychiatry expanded rapidly, usually driven by the availability (or shortage) of PPE.⁵⁻⁷ Many centers evolved models in which some staff rotated off-site to do remote work only. In most centers, Health Insurance Portability and Accountability Act-compliant commercial video platforms such as Zoom or Doxy.me were used, but local electronic medical record-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.^{2,3,8-11}

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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 carried out 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.¹² Documentation requirements, billing routines, and reimbursement for telepsychiatry have not been well-standardized.^{13–16}

Support for Medical and Hospital Staff

George Everly Jr. (Group 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 because of 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.¹⁷ Components of health care worker stress during the pandemic include increased tension between work and home-family-self-care obligations, moral injury and grief, uncertainty, loss of trust in systems, career disruption, and changing clinical roles.¹⁸

A survey of Wuhanese frontline workers found a high prevalence of anxiety (25%), depression, (20%), and acute stress disorder (38%).¹⁹ A second Chinese survey found the prevalence of elevated anxiety, depression, insomnia, and posttraumatic stress disorder symptoms to range from 34% for insomnia to 71% for posttraumatic stress disorder.²⁰ 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, and 33% anxiety.¹⁸ It is well established that severe emotional stress is associated with burnout and adverse workplace behaviors.²¹

Resilience reduces perceived stress and burnout, and programs to improve resilience may be helpful.²² 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).^{23–27} 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 because of effects on absenteeism and turnover.^{23,24,28–31}

Of note, although these services have low rates of utilization (lower for MDs than nurses) (Shechter et al.¹⁸ and Nash SS et al., personal communication), 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 help for 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 Special Interest Group, and support member collaborations in research and program implementation, and liaison with the American Medical Association and the American Hospital Association to advocate for structures to support hospital staff.

Support for CL Psychiatrists

Rachel Caravella (Group 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.^{2,12,18,31,32} Recognition of systemic racial bias and disparities in health care during the pandemic may exacerbate distress for health care workers including CL psychiatrists who may struggle to understand how best to address these problems in the course of their daily work.^{33–35} 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.³⁶

CL psychiatrists redeployed to medical services and those staffing behavioral code teams are at especially significant risk of infection and may have special needs for training, support, and PPE.³¹

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.

Psychiatry and Neuropsychiatry of COVID-19

Daniel Shalev (Group 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.^{37–50} 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.^{51,52} Prolonged mixed or hyperactive delirium occurred commonly, often characterized by agitation that was difficult to manage, and the best treatment is still unknown.^{53–62} Some patients developed new-onset psychosis, even seemingly after recovery from acute illness.^{63–68} Data on long-term effects are lacking, although recognition of “long-hauler” psychopathology is increasing.^{69–73} Other long-term psychiatric sequelae of acute COVID-19, and the possible long-term effects of seemingly asymptomatic infections, are unknown.⁷⁴ More

research on both acute and long-term neuropsychiatric effects of COVID-19 is needed.

In the United States, 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.^{75–77}

Uninfected patients are also affected by the pandemic. Fear, isolation, and disengagement from care worsen premonitory psychiatric illness, especially obsessive-compulsive disorder, substance use disorders, and serious mental illness.^{78–81}

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, 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.³⁵

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.

Dissemination and Advocacy Work Group

David Kroll (Group 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 abstained from advocacy activity so far.

The ACLP COVID-19 list-serv has provided a useful (although unmoderated) 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 to ensure they can conduct their

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work safely. Membership-wide emails and ACLP News are most useful for announcements and to alert members about 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 used social media to engage the public in support of public health measures.

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.^{34,82–85} 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 nonbillable hours devoted to staff wellness. As part of its response to COVID-19, ACLP could also choose to advocate more vigorously 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.^{34,84} 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 American Psychiatric Association, 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.

RECOMMENDATIONS FOR ACTION BY THE ACLP

The task force makes the following recommendations for action by the ACLP. In some cases, they can be

enacted by the Board of Directors and ACLP management. Many will require the active involvement of Special Interest Groups, other committees and work groups (including some yet to be convened), and individual ACLP members.

Promote Research and Scholarship on Topics Related to the Pandemic

- Encourage, solicit, and coordinate scholarly efforts, including multisite studies, on neuropsychiatry, CL staff wellbeing, programs to support hospital staff, and implementation of telepsychiatry.
- Advocate with agencies such as the National Institutes of Health for research funding for CL psychiatry-related aspects of the pandemic.
- Use the journal and the annual meeting to highlight this research.
- Use the ACLP Foundation Research Professorship and early career mentorship programs to support scholarship on pandemic response.

Develop and Disseminate Clinical Guidance and Best Practices

- Engage experts in the CL and medical communities to develop clinical guidelines and best practices guidelines for management of commonly occurring psychiatric complications of COVID-19, management of behavioral emergencies involving infectious patients, CL-specific protocols for telehealth utilization, billing and documentation, and staff support programs, such as PFA.
- Offer trainings on providing PFA, teaching stress management and promotion of resilience, and other models of support for hospital staff.
- Use the annual meeting, email, website, and journal and periodic webinars to publicize and disseminate them.

Understand and Advocate for the Safety of CL Psychiatrists

- Survey ACLP members to identify specific pandemic-related health and wellness concerns.
- Advocate for recognition that CL psychiatrists are “frontline” and “essential” health care providers.
- Advocate for the provision of safe practice environments and the adequate provision of PPE to CL psychiatrists.

- Support the use of telepsychiatry as an alternative to face-to-face consultation when appropriate, especially when supplies of PPE are limited.
- Approach and lobby legislatures to formally update regulatory restrictions on telepsychiatry and to ease licensing restrictions for physicians to provide telepsychiatry care across state lines.
- Advocate for the use of technology for mental health commitments and digital integrated document signing for other required paperwork.
- Aid and advocate for individual members, when necessary, in support of safe working conditions.

Make a Commitment to Equity and Against Systemic Bias and Racism

- Publicly affirm ACLP's resolution in support of equity and inclusion and against systemic bias and racism in health care.
- Expand ACLP efforts to improve diversity, equity, and inclusion in both membership and leadership of ACLP itself. Acknowledge the relative lack of underrepresented minorities in the ACLP membership and promote recruitment and retention of underrepresented minorities within the organization with the ultimate goal of achieving equity in academy initiatives and leadership.
- Create open-access educational content related to health care disparities and antiracism pertinent to CL psychiatry and especially as it relates to the COVID-19 pandemic.
- Create a subspace within the COVID resources page for content on health disparities, racism, and inequality.

Use ACLP Resources to Communicate, Inform, Support, and Advocate

- Partner with other subspecialty and specialty organizations to disseminate high-quality information to psychiatrists, other medical professionals, government, and the general public and to support and advocate for resources for care of our patients, hospital staff, and ourselves.
- Use the ACLP presence on social media such as Twitter and Facebook for public engagement on topics of significance for CL psychiatry and current pandemic developments.

- Use email to alert the membership about new position articles and guidelines posted on the ACLP website.
- Maintain the ACLP COVID-19 list-serv as a forum for open, rapid, and unmoderated conversation among members. Consider methods for anonymous posting, weekly conversation starter posts, monthly topic digests, and formal listserv maintenance. Periodically review content of the list-serv to identify educational and advocacy needs and priorities and to identify active members demonstrating special expertise.
- 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.

ACLP Community Building

- Acknowledge and honor CL psychiatrists who have become ill or died as a consequence of the pandemic and provide a forum for remembrance.
- Make efforts to recover the interactive and collaborative environment of the annual meeting adapted to virtual programming
- Recruit Special Interest Groups focused on issues germane to COVID-19 practice to participate in the tasks outlined in this report and prepare materials for the JAACL, the ACLP website, ACLP News, or annual conference presentations.
- Encourage all ACLP members to collaborate and participate in these efforts.

SUPPLEMENTARY DATA

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.jaclp.2021.05.001>.

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