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Recommendations for the organization of psychiatric care and psychiatric interventions during COVID-19 epidemics

According to available data in the literature, including recommendations of the Centre for Disease Control and Prevention of the National Health Commission, China, the Croatian Psychiatric Association proposes the Recommendations for the organization of psychiatric care in Croatia.

Objectives

1. To inform professionals and the public about mental health in the various epidemic groups and identify high-risk groups in a timely manner to provide adequate help and prevent extreme events
2. To provide information to the relevant authorities and contribute to shaping the overall management plan for the epidemics on the nationwide level.
3. To inform and educate on the need to deliver adequate psychological intervention in crisis situations and coordinate different services for provision of mental health
3. To train and support organizations delivering mental health services, where needed.
4. To assure the continuation of care for persons with mental disorders in the situation of epidemics.
5. To promote and organize 7x24 available and accessible psychiatric services to different populations in need, in a way compatible with the epidemiological principles. This include the introduction of different networks of communication for professionals and on-line services (telephone and telemedicine) for patients. It also includes the redistribution of the working force, according to different needs and developed services.
6. These recommendations should be implemented under the leadership mental health professionals.

Following the recommendation by the Centre for Disease Control and Prevention of the National Health Commission, China, mental health care during COVID-19 epidemics includes several levels of population affected by the epidemics:

- 1) The population of the first level: confirmed patients with pneumonia infected with the COVID-19 and medical and non-medical staff ("front line") working on suppressing the spread of infection.
- 2) Population of the second level: patients with mild forms of a respiratory infection and close contacts - patients suspected of infection isolated at home.
- 3) The population of the third level: persons associated with population of the first two levels, such as family members, co-workers, friends, staff of services who work on activities for prevention of epidemics not directly exposed, such as the commander in the field, heads of organizations and volunteers.
- 4) The population of the fourth level: the public to whom epidemic prevention and control measures apply.

	Previously healthy
First level population	Possible expected reactions: initially isolation, stiffness, denial, anger, fear, anxiety, depression, disappointment, mourning, insomnia, aggression; in later period isolation there may be loneliness or discomfort due to fear of illness, withdrawal from treatment or excessive optimism and high expectations of treatment; In patients with respiratory problems, extreme anxiety and difficulty in expression, panic, despair, fear of dying can be exacerbated.
	Interventions: 1. Understand the normal emotional response; 2. Apply psychological crisis intervention, and provide positive psychological support; 3. Apply to the concept of hope, inclusion in the therapy plan, explain that isolation is a measure of protection for loved ones and others in general 4. Inform the family, refer them to reliable and relevant sources of information 5. Assess the risks of suicide, self-harm and / or aggressive behaviour consultation psychiatrist, if necessary, through direct advisory services 6. In patients with respiratory problems, extreme anxiety and difficulties in expression, increase somatic treatment, use psychiatric treatment
	General principles of care: support and comfort. Approach patients with a dose of tolerance and understanding, understand strong emotions and strive to stabilize them, evaluate the risks of suicide, self-harm and / or aggressive behaviour; involving a psychiatrist as needed
Second level population	Possible expected reactions: panic, restlessness, loneliness, feeling of helplessness, depression, pessimism, anger, nervousness, stress due to alienation from others, sadness, shame of illness.
	Interventions : 1. Provide regular and timely information and refer to credible and reliable sources of information, scientific and medically based ones. 2. Encourage active acceptance of the measures of treatment and isolation, healthy eating, resting and exercise, more reading, listening to music, using on line methods for communication and other daily activities; 3. Accept the situation of isolation and seek positive meaning in the accident; 4. Keep social support for coping with stress: use modern communication methods to contact relatives, friends, colleagues, etc., discuss feelings, maintain communication with the community, and seek for support and encouragement; 5. Stimulate the use of telephone lines to provide psychological help or online psychological intervention.
	General principles of care: health education, encouraging cooperation. In case a person cannot cope with stress, psychiatric consultation should be included, 1) by direct contact through a counselling service, or 2) by a telephone consultation, by telephone or video link organized within or within the health system
Third level population	Possible expected reactions: anxiety, insomnia, worry, sadness, fear, and altered perception of experience, in the direction of negative anticipation. The threatening situation and contagion itself cause an acute response to stress, and requires a stress-adaptive situation, which, if it does not, can turn into post-traumatic stress disorder
	Interventions : detailed interventions explained in the Guidelines for self-help, issued by the Reference Centre of the Ministry of the health of post-traumatic stress disorder, and links at the end of the text
	General principles of care: availability of psychosocial support services by opening a psychiatric emergency telephone hotline, mobilization of different mental health professionals including psychologists, social workers, nurses, and various associations that can assist in providing psychosocial support . Some of the available resources are: 1) Croatian Red Cross https://www.hck.hr/novosti/hck-otvorio-brojeve-za-psihosocijalnu-podrsku-osobama-u-samoizolaciji/10272?fbclid=IwAR0YH1aL_scmJ8X5L2921PJStmMtNSyue274O3JSVn_SihqKBCDsR-6HQjE 2) Telephone for psychological assistance from the Mental Health Service of the Zagreb Public Health Institute Andrija Štampar, available every day from 8 am to 10 pm: 01/2991 356, 4696 376, 4696 107, 4696 297, 6468 334, 6468 335, 6468 337 and 6468 338. 3) Telephone lines of the CENTER FOR CRISIS AND SUICIDE PREVENTION 01 2376 470, 24 hours/7 4) Telephone lines open within the hospitals

Table 1. Provision of psychiatric support and care for the population with no pre-existing mental disorders before the onset of the epidemic

	Medical staff
First level population	Possible expected reactions: Excessive fatigue and tension, or even exhaustion, anxiety, insomnia, depression, sadness, grief, helplessness, depression, frustration or self-blame for the death of the patient; fear of contagion, fear of family, fear of family; over-arousal, refusal to take reasonable rest cannot ensure their health well, etc.
	Interventions: 1. Psychological crisis intervention before participating in a preparatory period, identify a stress response, and learn how to respond to stress and regulate emotions. Have preventative conversations and talk openly about feelings, support and comfort, mobilizing resources, helping patients prepare psychologically for stress. 2. Alleviate the concerns of frontline medical staff, prepare special logistic support staff, and quarantine staff should rotate as much as possible each month. 3. Plan for relaxation and rest and ensure adequate sleep and nutrition. Try to arrange for front-line staff to remain near the hospital in certain hospitals. 4. Try to maintain contact and communication with family and the outside world when possible.
	General principles of care: Rest regularly, express emotions, seek help as soon as you feel distress; organization of psychological support, psychiatrists within a health care facility, by telephone consultation / video link or direct contact if possible
Second level population	Possible expected reactions: anger, frustration, shame, self-blame, fear for family, negation, sadness
	Interventions: 1. Understand feelings; encourage active collaboration with treatment and isolation measures, promote healthy eating and resting, and perform more reading, listening to music, using modern communication methods for communication and other daily activities; 2. Accept the situation of isolation and seek positive meaning in the accident; 3. Seek social support for coping with stress: use modern methods of communication to contact relatives, friends, colleagues, etc., discuss feelings, maintain communication with the community, and receive support and encouragement; 5. Encourage the use of a hotline / video link for psychological support for healthcare professionals
	General principles of care: Rest regularly, express emotions, seek help as soon as you feel distress; organization of psychological support, psychiatrists within a health care facility, by telephone consultation or direct contact if possible
Third level population	Possible expected reactions: state of distress, negative anticipation, preparation for action, depending on the status of health care workers (first-line, etc.), variable
	Interventions: as for the general population, details are described in the separate Guidelines for self-help, issued by the Reference centre of the Ministry of Healthcare of post-traumatic stress disorder
	General principles of care: as for the general population

Table 2. Provision of psychiatric support and care for healthcare professionals

	Pre-existing psychiatric disorders
First level population	<p>Possible expected reactions: In case psychiatric medication is stopped, exacerbation of pre-existing psychiatric symptoms is possible depending on the disorder. In a very short time (the first 24-48 hours), it is reasonable to expect the development of abstinence syndrome/delirium in persons addicted to alcohol and drugs, or persons using opiates as substitution therapy. Within several days to weeks is possible to observe worsening of severe psychiatric disorders, for example bipolar disorder or psychosis, especially if full remission is not achieved in the earlier period. Elderly patients, especially in the case of dementia, may develop delirium. The development of delirium is also possible in elderly patients without pre-existing psychiatric illness.</p> <p>Interventions:</p> <ol style="list-style-type: none"> 1. Recognize the signs of the pre-existing psychiatric disorder and ensure that earlier psychoactive medications are administered in maintenance dosages (especially antipsychotics, mood stabilizers and antidepressants, and long-acting antipsychotics) where the treatment for COVID-19 infection is provided, keeping in mind possible drug interactions (see Recommendations for the pharmacological treatment during COVID-19 infection, issued by the Croatian Psychiatric Association) 2. Recognize the signs of abstinence syndrome/ delirium development in persons with pre-existing alcohol addiction, and treat the condition, in consultation with psychiatrists (see Recommendations for the pharmacological treatment during COVID-19 infection, issued by the Croatian Psychiatric Association) 3. Recognize the signs of delirium due to other causes (for example elderly population, pre-existing dementia, somatic comorbidities, pneumonia-related...), illness related or and those with illnesses and dementia, and apply appropriate therapy and treat the condition, in consultation with psychiatrists (see Recommendations for the pharmacological treatment during COVID-19 infection, issued by the Croatian Psychiatric Association) 4. Recognize signs of abstinence in persons addicted to illegal drugs, or persons using substitution therapy; treat abstinence and enable continuation of substitution therapy. Family physician or specialist for the prevention and treatment of addiction in County regions of the Institute for Public Health need to be consulted about the dosage of substitution therapy so far, and recommendations for further therapy (see Recommendations for the pharmacological treatment during COVID-19 infection, issued by the Croatian Psychiatric Association) <p>General principles of care: maintain the patients' stable mental status by ensuring the continuation of the previous pharmacotherapy, paying attention to possible interactions with antiviral drugs; pay attention to patients who may develop abstinence symptoms due to discontinuation of psychoactive agents; assess the risks of suicide, self-harm, and / or aggressive behaviour; involve psychiatric consultation as needed</p>
Second level population	<p>Possible expected reactions: In case psychiatric medications are stopped, exacerbation of pre-existing psychiatric symptoms is possible depending on the disorder. The development of abstinence syndrome/ delirium in persons with addiction, and those taking substitution therapy are possible within a very short time (first 24-48 hours). Within a few days, exacerbation of severe psychiatric disorders, such as bipolar disorder or psychosis, may occur.</p> <p>Interventions :</p> <ol style="list-style-type: none"> 1. For patients with psychiatric disorders who are undergoing long-term psychiatric treatment, it is necessary to ensure that earlier psychoactive medications are administered at a maintenance dose (especially antipsychotics, mood stabilizers and antidepressants, and long-acting antipsychotics) during self-isolation. If long-acting therapies are to be administered, it must be provided. The administration of the medication is carried out through the home visits, organized by the general practitioners, if possible, or through the person in charge of the Crisis headquarters. In the case of a pre-existing psychiatric illness and the need for measure of self-isolation, it is necessary to inform the patient to report any deterioration of his / her mental state to the family doctor or psychiatrist using the organized services (telephone, web based). 2. Patients needing long-term outpatient psychiatric treatment or substitution therapy should continue to receive psychiatric medication. It is necessary to consult the general practitioner or specialist for the prevention and treatment of addiction in County regions of the Institute for Public Health about the previous substitution therapy, as well as recommendations for further therapy. It is necessary to organize that the pharmacotherapy can be picked up at once for a period of 2 weeks by a family member

	<p>or by the staff responsible for delivering substitution therapy in isolation, defined by the Crisis Headquarter.</p> <p>3. Patients with alcohol addiction should be carefully monitored by a telephone consultation, or video consultation, or in person by a family physician or psychiatrist, to detect early signs of abstinence syndrome crisis resulting from alcohol withdrawal during self-isolation.</p>
	<p>General principles of care: maintain the patients' stable mental status by ensuring the continuation of the previous pharmacotherapy; pay attention to patients who may develop abstinence symptoms due to discontinuation of psychoactive agents in self-isolation; assess the risks of suicide, self-harm, and / or aggressive behaviour; involve psychiatric consultation as needed</p>
Third level population	<p>Possible expected reactions: exacerbation of the pre-existing psychiatric disorder, depending also on pharmacotherapy; excessive intake of alcohol and psychoactive substances as a way of coping with stress may be expected</p>
	<p>Interventions:</p> <p>1. Patients needing long-term outpatient therapy and follow-up by a psychiatrist to administer long-acting antipsychotics should continue to receive the same medication. The administration of long-acting medications is performed by a family physician or, if this is not possible due to the method of administration of the drug (for example Zypadhera) or other reasons, in psychiatric institutions. Alternatively, if this cannot be obtained, switch to oral medication should be offered. Consultations, counselling and psychosocial support are organized primarily through telephone consultations / telemedicine/ video links. In the event of a worsening condition, the patient will be referred to the emergency psychiatric service.</p> <p>2. Persons in whom the new situation causes significant psychological distress (for example occurrence of symptoms of previous psychiatric illnesses, increased use of psychoactive substances in response to a crisis) should be provided with consultations, counselling and psychosocial support primarily through telephone consultations / telemedicine/ video links, and in case of indication should be referred to the emergency psychiatric service.</p> <p>3. The principles outlined in the Self-Help Guidelines, issued by the Ministry of Health Reference centre for Post-Traumatic Stress Disorder should be applied.</p>
	<p>General principles of care: maintain the patients' stable mental status by ensuring the continuation of the previous pharmacotherapy; recognize the signs of crisis in vulnerable populations, recognize the excessive use of psychoactive substances in response to stress and to ensure the availability of psychiatric services</p>

Table 3. Provision of psychiatric support and care for the population with pre-existing mental disorders before the onset of the epidemic

ADDITIONAL NOTES

- **First-level population: for persons with (pre-existing) mental illness infected with COVID-19 who require hospital treatment**
- 1) Patients infected with COVID-19 who require urgent psychiatric treatment due to agitation/ self harm should not be considered as to have an (absolute) indication for the admission to psychiatric facilities, especially if these are not adequately prepared for the treatment of COVID-19 infection. Instead, mental health services should be widely available as consultation service, and urgent mental health care should be delivered in a separate unit of the same facilities where somatic care is provided, and only for the duration of the imminent threat.
 - 2) If a person with mental illness treated at the psychiatric ward is diagnosed with COVID-19, it should be transferred to the same facilities where persons with no mental illness are treated, following the same epidemiological and somatic triage principles. Mental health care should be continued and delivered by extensively established mental health consultation services, as population of psychiatric patients with chronic conditions present a group of persons particularly vulnerable for development of complicated COVID-19 illness, due to the presence of firmly established mortality risk factors, including smoking, comorbidities such as metabolic syndrome, hypertension, especially if they are of older age.

- 3) **NOTE:** The context of the epidemic situation is often accompanied by a restriction on basic human rights and freedoms. Nevertheless, the rights and obligations of persons with mental disabilities, especially regarding treatment decisions, remain governed primarily by the Law on the Protection of People with Mental Disorders. In this sense, for example, all procedures of forced detention and / or placement should be carried out as in peacetime conditions, but with possible adjustments (for example court hearings may be held outside the premises of the health institution itself or, exceptionally, via a video link). The same applies to all other provisions of the Law on the Protection of Persons with Mental Disabilities.
- **Second-level population: For persons with (pre-existing) mental illness infected with COVID-19 but with mild symptoms and do not require hospital treatment, or are in isolation**
- 1) Patients who have self-isolation epidemiological measures and require urgent psychiatric treatment due to agitation/ self harm should not be considered as to have an (absolute) indication for the admission to psychiatric facilities. Instead, mental health services should be widely available as consultation service, and urgent mental health care should be delivered in a separate unit of the same facilities where somatic care is provided, and only for the duration of the imminent threat. It is noting that in the case of an advanced epidemic, that is, in the case of a severe population outbreak, the risks of the patient's hospital treatment itself should always be assessed against the risks of outpatient treatment.
 - 2) If a person with mental illness treated at the psychiatric ward is suspected/diagnosed with COVID-19 in mild form or receives self-isolation epidemiological measures should can be discharged home, with continuation of psychiatric care, in available modalities.

References

- National Health Commission of China. Principles for Emergency Psychological Crisis Intervention for COVID-19 Pneumonia Epidemic (in Chinese). <http://www.nhcgovcn/jkj/s3577/202001/6adc08b966594253b2b791be5c3b9467shtml> (access February 17, 2020). 2020
- Zhou F, Ting Yu, Ronghui D, Guohui F, Ying L, Zhibo L et al. Clinical course and risk factors mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. *The Lancet* 2020; 395 (10229); 1054-1062. DOI:[https://doi.org/10.1016/S0140-6736\(20\)30566-3](https://doi.org/10.1016/S0140-6736(20)30566-3)

CPA Working Group

Associate professor Martina Rojnić Kuzman, MD., Ph.D. Department of Psychiatry, University Hospital Center Zagreb, University School of Medicine and Zagreb
Stipe Drmić, MD., Ph.D., Department of Psychiatry, Hospital Center Dubrava
Marko Ćurković, MD., Ph.D., Psychiatric hospital Vrapče
Ivan Ćelić, MD., Ph.D., Psychiatric hospital Vrapče
Associate professor Marina Letica Crepulja, MD., Ph.D., Department of Psychiatry, Clinical Hospital Center Rijeka , Faculty of Medicine, University of Rijeka
Professor Zoran Zoričić, MD., Ph.D., Department of Psychiatry, University Hospital Center Sestre Milosrdnice , School of Dental Medicine, University of Zagreb
Irena Rojnic Palavra, MD., Psychiatric hospital Sveti Ivan

Reviewed by:

Professor Alma Mihaljević Peleš, MD., Ph.D., Department of Psychiatry, University Hospital Center Zagreb, University School of Medicine and Zagreb
Aleksandar Savić, MD., Ph.D., Psychiatric hospital Vrapče