

Barriers and Facilitators to Infection Prevention and Control in Behavioral Health
Settings: A Survey of Infection Prevention Professionals in North America

By

Isabelle Boullier

B.S., University of Rhode Island, 2024

Thesis

Submitted in partial fulfillment of the requirements for the Degree of Masters of Public
Health at Brown University School of Public Health

PROVIDENCE, RHODE ISLAND

MAY 2026

This thesis by Isabelle Boullier is accepted in its present form
by the Brown School of Public Health as satisfying the thesis requirements
for the degree of Masters of Public Health

Date _____

Kevin Gibas, MD, MPH, Advisor

Date _____

Shilo McBurney, PhD, Reader

Date _____

Karen Andes, PhD
Director, Master of Public Health Program

Approved by the Graduate Council

Date _____

David P. Lindstrom
Dean of the Graduate School

Preface and Acknowledgements

I would like to sincerely thank my advisors and mentors Dr. Shilo McBurney, of Brown University's School of Public Health Department of Epidemiology, and Dr. Kevin Gibas, of the Department of Epidemiology and Infection Prevention at Rhode Island Hospital, for their extensive mentorship and advising of this research.

Financial support. *None reported*

Potential conflicts of interest. *All authors report no conflicts of interest relevant to this article.*

TABLE OF CONTENTS

INTRODUCTION.....	1
METHODS.....	2
RESULTS.....	6
DISCUSSION.....	12

LIST OF TABLES & FIGURES

Table 1, APIC and SHEA Survey Respondent Characteristics and Demographics.....	7
Figure 1, Frequency of Pathogens Causing Outbreaks in Behavioral Health Settings.....	8
Table 2, Perspectives on Infection Prevention & Control (IPC) in Behavioral Health Settings.....	9
Figure 2, Perspectives on Challenges to Infection Prevention & Control Practices in Behavioral Health Settings	11
Figure 3, Perspectives on Facilitators to Infection Prevention & Control Practices in Behavioral Health Settings	12

INTRODUCTION

Infection prevention and control (IPC) is a cornerstone of patient safety across all healthcare settings and is essential for preventing transmission of healthcare-associated infections (HAIs). HAIs are associated with substantial morbidity, prolonged hospitalizations, and increased mortality risk.¹ Effective IPC practices, including consistent hand hygiene, appropriate use of personal protective equipment (PPE), and environmental cleaning, are critical to preventing infectious outbreaks and mitigating strain on healthcare systems.² Despite this, implementation and adherence to IPC practices remain highly variable across care settings and patient populations, reflecting differences in clinical workflows, physical environments, staff training, and resource availability.³

Behavioral health settings have increasingly been recognized as priority settings for the development of tailored IPC strategies and programs.⁴ These settings present distinct operational and clinical challenges arising from the intersection of congregate care environments and specialized therapeutic and clinical needs.^{5,6} Despite these unique challenges, IPC in behavioral health settings has historically received less attention than in acute-care settings, contributing to important gaps in evidence-based guidance on IPC best practices.

The COVID-19 pandemic further highlighted longstanding structural and operational barriers to the implementation and adherence to IPC best practices across healthcare settings, including resource limitations, constrained diagnostic testing capacity, physical environment and infrastructure challenges, lack of standardized IPC guidelines, and limited access to dedicated IPC personnel.⁷ These challenges were often found to be

magnified in behavioral health settings, where communal care delivery and shared spaces are integral to psychiatric therapeutic care goals.⁷ Group therapy, shared dining, and common recreational areas are foundational to promoting social connection, peer support, and structured routines, yet these same features complicate standard IPC measures such as isolation, cohorting, and physical distancing during outbreaks.^{8,9} As a result, behavioral health facilities must frequently navigate competing priorities between maintaining therapeutic engagement and implementing effective IPC measures, particularly during outbreaks and periods of heightened transmission risk.^{3,7} Collectively, these challenges underscore the need for IPC strategies that are both contextually appropriate and aligned with the therapeutic goals of behavioral health care.

While IPC practices have been extensively studied in acute-care settings, data to inform sustainable, patient-centered IPC implementation in behavioral health settings remain limited. A better understanding of setting-specific barriers and facilitators is critical to developing practical and effective IPC approaches for these under-studied healthcare settings. To address these gaps, we conducted a cross-sectional survey of IPC professionals in the United States and Canada in 2025-2026 to characterize barriers, facilitators, and key themes influencing IPC implementation and adherence in behavioral health settings.

METHODS

Ethical Considerations

The study protocol was reviewed and approved by the Brown University Health Institutional Review Board. Prior to participation, respondents were provided with a

description of the survey, its intended use, and notification that participation was voluntary and anonymous. Informed consent was implied through survey submission.

Members of the SRN who participated in the study were automatically assigned a numeric or alphabetic identifier, which served as the sole unique identifier and was used to maintain respondent anonymity. No such identifier was assigned to ARN members, making their responses completely anonymous. The survey did not collect any personally identifiable information. Participation consisted of a one-time, cross-sectional assessment with no longitudinal follow-up. Survey items were designed to be non-intrusive and non-leading, thereby minimizing potential risk to participants.

Study Design

Data on operational and epidemiologic factors influencing IPC practices in behavioral health settings were collected using two independently administered but identical cross-sectional survey instruments distributed through the Association for Professionals in Infection Control and Epidemiology (APIC) and the Society for Healthcare Epidemiology of America (SHEA) Research Networks (ARN/SRN). Although the study primarily targeted institutions within the United States, participation also included respondents from Canada.

Eligibility Criteria

Eligible participants included members of APIC and/or SHEA with responsibility for IPC programs and/or institutional policy development, including hospital epidemiologists, infection preventionists, and healthcare administrators. Eligible SRN participants were SHEA members who had opted in to receive SRN-sponsored surveys. Participants

eligible from the ARN were members who had designated their practice setting as behavioral health, as well as individuals who received the survey from APIC's Behavioral Health-specific community forum.

For SRN respondents, a unique alphanumeric identifier was collected. This identifier is routinely assigned to SRN participants by SHEA and is used to respond to SRN-sponsored projects while enabling response tracking and de-duplication without compromising anonymity, with only one response permitted per institution. Unique identifiers were not collected for APIC respondents, as surveys distributed through APIC were administered at the individual membership level rather than the institutional level.

Participating individuals represented a diverse array of institutions which included a wide range of behavioral health care environments, including inpatient psychiatric units, residential treatment facilities and group homes, partial hospitalization programs, intensive outpatient programs, and dedicated psychiatric or behavioral health emergency services.

Survey Instrument

Survey items were informed by a scoping review of the literature to identify commonly reported barriers and facilitators to IPC implementation in behavioral health settings. The final survey consisted of 13 questions, including multiple-choice, Likert-scale, and open-ended items. Participants were queried regarding perceived barriers and facilitators to IPC adherence, professional role, institutional characteristics, and relevant operational factors.

The survey was administered using REDCap (Research Electronic Data Capture), a secure, web-based data collection platform. Survey responses were anonymous at the time of completion. Completion of individual survey items was not mandatory; questions with missing data were excluded from analysis and are identified accordingly in the results. Missing responses per question are reported in descriptive tables. The number of missing responses per question were all 4% or less.

Recruitment and Data Collection

Survey recruitment was facilitated through targeted email outreach coordinated by the ARN/SRN. Invitation emails included a brief study description, secure electronic survey link/QR code, and an estimated completion time. All outreach included a formal statement emphasizing that participation was voluntary. For each survey, data was collected over the course of six weeks (SRN survey: November 26, 2025 - January 7, 2026; ARN survey: December 10, 2025 - January 21, 2026).

Statistical Analysis

Survey responses were summarized using descriptive statistics). For single-choice and Likert-scale items, response frequencies were calculated as percentages of the total number of respondents (n=189). For multi-response (“select all that apply”) questions, percentages were calculated similarly by dividing the number of responses by the total number of participants (n=189), meaning for these questions percentages can sum to greater than 100%. All analyses were completed using RStudio (R version 4.5.2) (R Foundation for Statistical Computing, Vienna, Austria).

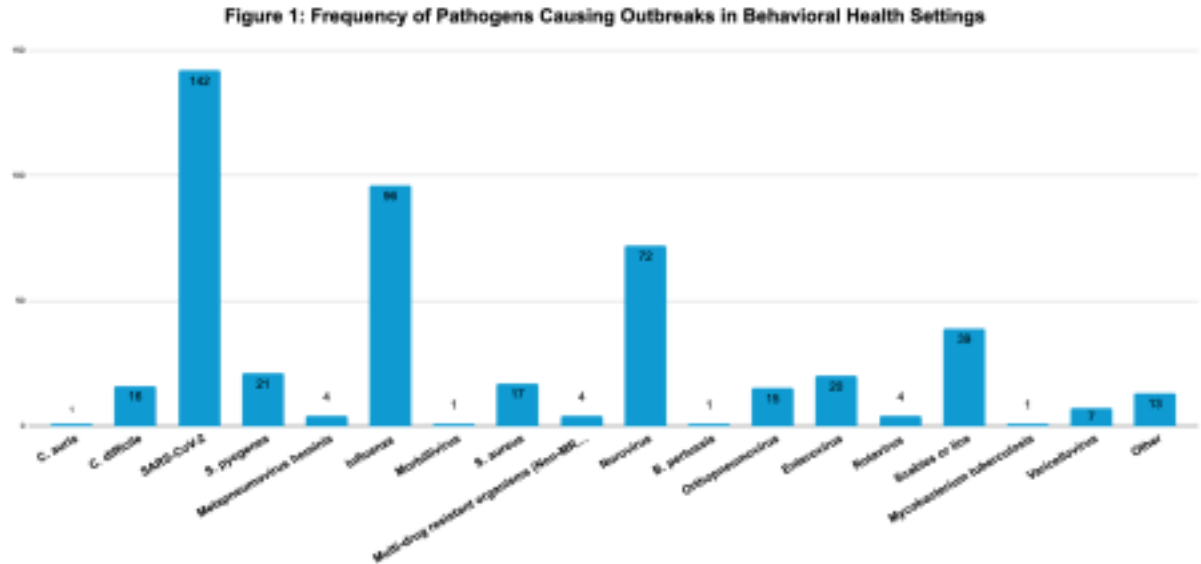
RESULTS

A total of 189 respondents completed the survey (17% response rate, n=189/1095), representing a 31% response rate from the SRN (n=30/95) and a 16% response rate from the ARN (n=159/1,000). As seen in Table 1, respondents were predominantly infection preventionists (76%, n=144) and hospital epidemiologists (13%, n=25), representing public (31%, n=58), academic and teaching (32%, n=60), nonprofit (25%, n=48), and for-profit (10%, n=19) healthcare systems/organizations.

Over three quarters (76%) of respondents reported implementing a IPC mitigation plan for hospital acquired infections or outbreaks in prior twelve months, with SARS-CoV-2 (75%, n=142), influenza virus (51%, n=96), and norovirus (38%, n=72) being the most cited pathogens (Table 2, Figure 1). Other commonly cited pathogens causing outbreaks in behavioral health settings included scabies or lice (21%, n=39), rhino/enteroviruses (10%, n=20), methicillin-resistant *Staphylococcus aureus* (MRSA) (9%, n=17), and respiratory syncytial virus (RSV) (8%, n=15).

Table 1. APIC and SHEA Survey Respondent Characteristics and Demographics (n=189)

Survey Question	% (n)
Respondent's Organization Membership	
SHEA	16% (30)
APIC	84% (159)
Respondent Job Role	
Hospital Epidemiologist	13% (25)
Infection Preventionist	76% (144)
Hospital Administrator/Executive	3% (5)
Other	7% (14)
Not Reported	1% (1)
Type of Healthcare System	
Public Hospital/Healthcare System	31% (58)
Non-Profit Private Hospital/Healthcare System (Non-Academic)	25% (48)
For-Profit Private Hospital/Healthcare System (Non-Academic)	10% (19)
Academic/Teaching Hospital/Healthcare System	32% (60)
Not Reported	2% (4)
Type of Behavioral Healthcare Setting at Healthcare Organization <i>Select all that apply</i>	
Inpatient behavioral health units	93% (175)
Group homes/residential treatment facilities	29% (54)
Partial hospitalization programs	22% (42)
Intensive outpatient programs	37% (69)
Dedicated behavioral health/psychiatric emergency services	38% (72)
Other	20% (37)
Behavioral Health Patient Population Served at Healthcare Organization <i>Select all that apply</i>	
Pediatric Patients (< 12 years old)	45% (85)
Adolescent patients (12-17 years old)	54% (102)
Adult patients (18-64 years old)	89% (169)
Geriatric patients (>= 65 years old)	75% (143)
Geographic Location of Healthcare Organization <i>Select all that apply</i>	
Northeast (CT, ME, MA, NH, NJ, NY, PA, RI, VT)	25% (48)
Mid-Atlantic (DE, DC, MD, VA, WV)	9% (17)
Southeast (AL, FL, GA, KY, MS, NC, SC, TN)	12% (24)
South Central (AR, LA, OK, TX)	8% (16)
Midwest (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI)	28% (54)
Southwest (AZ, NM)	3% (6)
Mountain West (CO, ID, MT, NV, UT, WY)	5% (9)
Pacific (AK, CA, HI, OR, WA)	10% (20)
Canada	2% (4)



Among respondents whose organizations encompassed multiple types of behavioral health settings (n=123), half identified inpatient adult psychiatric units as the most challenging for consistent implementation or adherence to IPC measures (50%, n=61), followed by inpatient adolescent or pediatric psychiatric units (24%, n=30) (Table 2). Overall, patient-related factors were the most frequently reported barrier to IPC implementation or adherence (87%, n=164), including behaviors associated with psychiatric illness or cognitive impairment that may limit compliance. Environmental and physical space constraints were also commonly cited (77%, n=145), underscoring challenges related to unit design, infrastructure, and limited isolation capacity. Staff resistance or reluctance to adhere to IPC protocols was reported by 38% of respondents (n=71). In contrast, fewer than 15% identified traditional resource limitations, such as insufficient supplies, staffing, training, or leadership support, as primary barriers.

Table 2. Perspectives on Infection Prevention & Control (IPC) in Behavioral Health Settings

In the past 12 months, approximately how many times has your team implemented an IPC* mitigation plan for a confirmed or suspected healthcare/facility-acquired infection in a behavioral health setting?	
0	20% (38)
1 - 5	61% (115)
5 - 10	6% (11)
10 - 15	5% (9)
15 - 20	3% (5)
>20	1% (3)
Unsure/Not Reported	4% (8)
What IPC resources does your organization currently have for behavioral health settings? <i>Select all that apply</i>	
Dedicated infection preventionist(s) assigned to behavioral health settings	62% (117)
Access to real-time IPC consultation or support for behavioral health units	58% (110)
Behavioral Health-specific IPC protocols or guidelines	62% (118)
For-Profit Private Hospital/Healthcare System (Non-Academic)	68% (128)
Outbreak response or mitigation plans that include behavioral health settings	61% (116)
Routine IPC training provided to behavioral health staff	63% (119)
Leadership engagement or support for IPC efforts in behavioral health	65% (123)
Environmental cleaning protocols adapted to behavioral health environments	35% (67)
Designated spaces for isolation or quarantine within behavioral health settings	0.1% (2)
What are the biggest barriers to implementing IPC protocols in behavioral health settings? <i>Select up to three</i>	
Patient factors	87% (164)
Environmental constraints specific to behavioral health treatment settings	77% (145)
Lack of IPC staff assigned to behavioral health units	11% (20)
IPC staff not adequately trained in behavioral health-specific challenges	10% (19)
Limited leadership support or prioritization of IPC in behavioral health	14% (26)
Inadequate availability of supplies	12% (22)
Inconsistent or insufficient staff training on IPC protocols	14% (27)
Staff resistance or reluctance to follow IPC protocols	38% (71)
Other	4% (8)
Agree/Disagree: <i>"Infection prevention is appropriately prioritized in behavioral health settings at my organization."</i> (n=189)	
Strongly agree	16% (31)
Agree	30% (57)
Neutral	29% (54)
Disagree	19% (35)
Strongly disagree	5% (10)
Not Reported	1% (2)

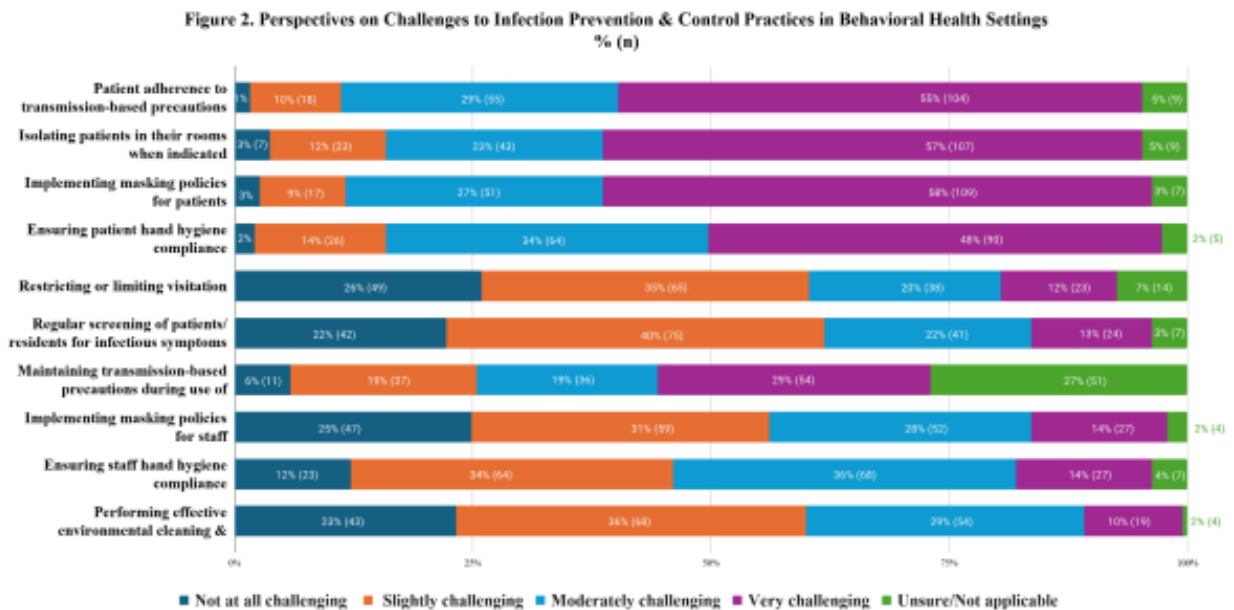
Which behavioral health setting presents the most difficult for consistent implementation of/adherence to IPC practices (n=123)¹	
Inpatient general adult psychiatric units	50% (61)
Inpatient geriatric psychiatric units	11% (13)
Inpatient adolescent or pediatric psychiatry units	24% (30)
Group homes/residential care	11% (13)
Partial hospitalization programs	2% (3)
Other	2% (3)

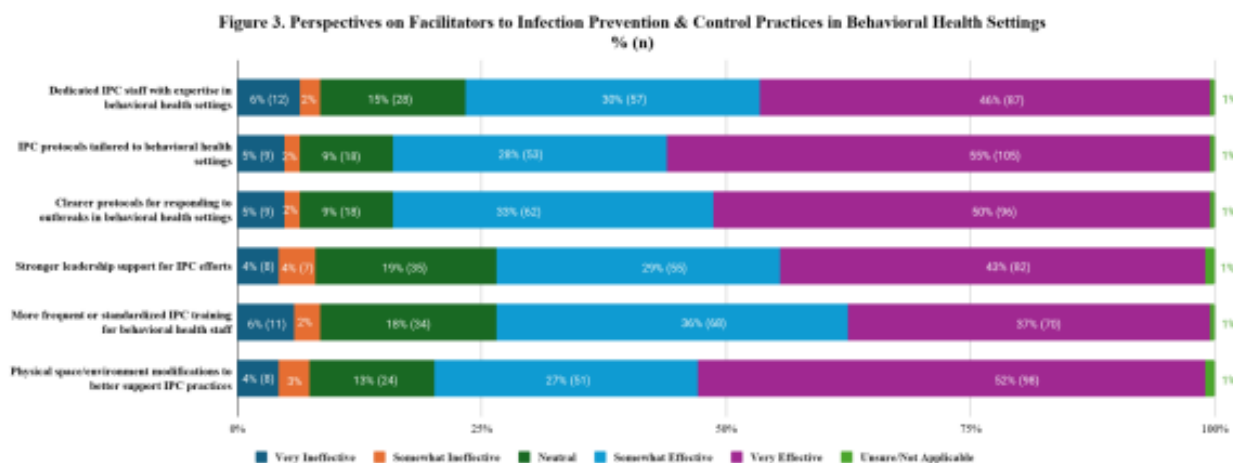
¹= *The number of responses for this question is only 123 due to the branching logic which only allowed participants having more than one type of behavioral health setting at their organization to complete this question.*

**IPC, infection prevention and control*

Respondents generally perceived that patient adherence to IPC practices in behavioral settings was a major barrier to consistent IPC, with 84% (n=159) of respondents finding patient adherence to transmission-based precautions “moderately” or “very” challenging (Figure 2). In terms of specific precautions, a significant majority of participants found that ensuring patient adherence to isolation (79%, n=150), masking (85%, n=160), and hand hygiene (81%, n=154) was “moderately” or “very” challenging (Figure 2). In contrast, regular screening of patients for symptoms (62%, n=117) was only perceived as “not at all” and “slightly challenging,” and less than half (47%, n=90) of respondents found adherence to transmission-based precautions during the use of restraints as “moderately” or “very” challenging. There was less consensus on staff compliance, with respondents nearly evenly divided on the perceived challenge of ensuring staff adhered to core IPC protocols such as masking and hand hygiene (Figure 2). In terms of other factors, respondents generally found restricting or limiting visitation (60%, n=114) and performing effective environmental cleaning (59%, n=111) to be “not at all” or “slightly challenging.”

When asked if IPC was appropriately prioritized in behavioral health settings, respondents were split evenly; half of respondents agreed to some extent, while the other half were ambivalent or disagreed (Table 2). Respondents generally expressed high levels of confidence in the effectiveness (“somewhat” or “very” effective) of all of the surveyed IPC interventions. As displayed in Figure 3, tailored IPC protocols (84%, n=158) and having clearer protocols for responding to outbreaks (84%, n=158). Respondents also perceived that making physical space or environmental modifications to better support IPC practices (79%, n=148) and having dedicated IPC staff with expertise in behavioral health settings (75%, n=144) as highly valued interventions. Strong leadership support (72%, n=137) and frequent or standardized IPC training (73%, n=138) represented the lower end of perceived effectiveness of the surveyed strategies.





DISCUSSION

This cross-sectional survey of IPC professionals identifies persistent, setting-specific challenges to IPC implementation and adherence in behavioral health settings. Our findings highlight a fundamental misalignment between IPC practices developed for acute-care environments and the structural, operational, and clinical realities of behavioral health care, which limits both feasibility and sustainability of standard approaches. Importantly, the challenges identified reflect not a lack of awareness or commitment to IPC principles, but rather a persistent implementation gap driven by contextual barriers that constrain translation of existing IPC standards into routine practice. Together, these findings underscore the need for setting-specific research to inform adaptation of IPC standards for behavioral health care and support a shift toward context-appropriate, tailored approaches that better meet the needs of both patients and care teams in these unique environments.

In our survey, patient-related factors emerged as the most frequently cited barriers to IPC implementation and adherence, particularly for core measures such as patient masking, hand hygiene, isolation, and compliance with transmission-based precautions. Underlying

cognitive impairment, acute psychiatric symptoms, and behavioral dysregulation may limit patients' capacity for consistent adherence to IPC practices and diminish the effectiveness of standard interventions.³ These findings are consistent with prior literature characterizing populations cared for in behavioral health settings as at increased risk during infectious disease outbreaks due to the combined effects of clinical vulnerability and exposure within communal care environments.^{7,11} Importantly, efforts to enforce IPC practices such as isolation or masking in these settings may raise ethical and safety considerations, including risks of patient distress, escalation, or use of restraints, underscoring the need for IPC approaches that are trauma-informed, therapeutically aligned, and tailored to the behavioral health context.⁷ These findings highlight the limitations of applying acute-care IPC standards without modification and reinforce the need for setting-specific guidance that accounts for the unique clinical and ethical considerations inherent to behavioral healthcare.

The second most frequently identified challenges to consistent adherence and implementation of IPC measures in behavioral health settings were physical and environmental constraints inherent to the care environment, reflecting the structural realities of behavioral healthcare delivery. Communal living spaces, shared rooms, and reliance on therapeutic group activities are foundational to behavioral health treatment models but can complicate standard IPC measures such as isolation, cohorting, and physical distancing. Consistent with prior literature, individuals working in IPC have frequently cited these structural and operational features as barriers to IPC adherence and outbreak mitigation.¹⁰ Notably, only 35% of respondents reported access to dedicated isolation or quarantine spaces, representing a critical limitation during outbreaks

requiring rapid containment. At the same time, respondents emphasized that physical space and environmental modifications were among the most effective facilitators of IPC adherence in these settings. Together, these findings suggest that while environmental adaptations are necessary, they are insufficient in isolation; sustainable IPC implementation in behavioral health settings also requires dedicated expertise and operational frameworks capable of translating IPC guidance into feasible, context-appropriate practice rather than direct adoption of acute-care standards.

Beyond modifications to the physical environment, respondents emphasized several organizational and programmatic facilitators as critical to improving IPC implementation, adherence, and outbreak response in behavioral health settings, including access to dedicated IPC personnel with behavioral health expertise, availability of clear and actionable outbreak-response protocols that account for the nuances of behavioral health care delivery, and IPC guidance explicitly tailored to these settings. These results suggest that effective IPC in behavioral health settings depends not only on physical adaptations, but also on specialized expertise and context-specific operational frameworks capable of translating IPC standards into feasible practice. These findings align with prior qualitative work by Houben and colleagues, which identified that although there may be limited prioritization of IPC within psychiatric institutions, the presence of a dedicated IPC expert who is able to contextualize guidance, educate frontline staff, and elevate IPC as a shared clinical responsibility can be a critical facilitator of implementation and adherence to IPC measures.³

Taken together, these findings highlight the need for deliberate development of behavioral health-specific IPC guidance that moves beyond direct modification of

acute-care standards toward flexible, adaptive frameworks designed for the realities of behavioral health care delivery. In practice, this could include IPC protocols that incorporate tiered, patient-centered frameworks, wherein a core set of standard precautions is consistently maintained, while more restrictive measures — such as masking requirements, isolation, or limitations on communal activities - are flexibly escalated or de-escalated according to individual patient risk, symptom burden, behavioral stability, and therapeutic objectives. Flexible outbreak-response algorithms that account for shared therapeutic activities, congregate living environments, and staffing constraints, along with guidance that explicitly incorporates trauma-informed principles to minimize patient distress, escalation, or unsafe use of restraints, may offer greater feasibility than rigid, one-size-fits-all standards. Similarly, adaptable recommendations for environmental design, cohorting strategies, staff training, and IPC staffing models could provide practical direction where existing guidance is absent, impractical, or poorly aligned with behavioral health workflows. At a minimum, behavioral health units should have access to dedicated isolation spaces to permit isolation of patients in a single room or cohort during an outbreak to stop the chain of transmission. Rather than relying on ad hoc, facility-level adaptations, these findings suggest a need for coordinated guideline development that emphasizes adaptability, clinical judgment, and ethical considerations, informed by empirical data and frontline experience. Such guidance could support more consistent, feasible, and therapeutically aligned IPC implementation, strengthening outbreak preparedness while preserving the core treatment environments essential to behavioral healthcare.

This study has several potential limitations. Participation was voluntary and limited to members of the SRN or ARN, which may overrepresent institutions with greater IPC resources, expertise, and engagement. Consequently, the perspectives captured may not fully reflect the experiences of behavioral health settings with more limited IPC infrastructure, potentially limiting the generalizability and transportability of these findings. Although respondents represented a range of behavioral healthcare environments, barriers identified in this survey may underestimate challenges faced in settings not well represented within these professional networks. In addition, the overall response rate was relatively low (17%), which raises the possibility of nonresponse bias, as individuals or institutions with a stronger interest in IPC or greater experience managing IPC challenges may have been more likely to participate. Further, while the survey was administered anonymously, unique institutional identifiers were collected only for SRN respondents and not for ARN participants (as they were not available from the ARN), precluding formal verification of duplicate responses among ARN submissions. However, given the targeted distribution strategy and professional membership requirements, the likelihood of duplicated responses is low. Despite these limitations, the survey yields important insight into IPC challenges unique to behavioral health care environments and identifies actionable strategies to support improved IPC adherence and implementation going forward.

The results of this survey contribute important evidence to a limited body of literature by elucidating setting-specific barriers and facilitators to IPC implementation and adherence across behavioral health care environments. Our findings highlight the need for behavioral health-specific guidance that accounts for the unique therapeutic models,

environmental constraints, and patient populations inherent to these settings. By identifying modifiable structural, environmental, policy, programmatic, and workforce-level facilitators, this work provides a foundation to inform targeted quality improvement initiatives and supports the development of tailored IPC policies, guidelines, and implementation frameworks for behavioral healthcare. These findings may inform efforts by professional societies, healthcare systems, and policymakers to advance IPC guidance that is evidence-based, operationally feasible, and aligned with therapeutic care delivery. Collectively, this work underscores the importance of developing context-appropriate IPC standards to enhance patient safety and outbreak preparedness across the spectrum of behavioral health settings.

REFERENCES

1. Patient Safety Network. (2024, June 15). Healthcare-associated infections. Healthcare - Associated Infections.

<https://psnet.ahrq.gov/primer/health-care-associated-infections#:~:text=According%20to%20a%20study%20by,one%20of%20these%20infections%20annually>

2. Kubde, D., Badge, A. K., Ugemuge, S., & Shahu, S. (2023). Importance of Hospital Infection Control. *Cureus*, 15(12), e50931. <https://doi.org/10.7759/cureus.50931>

3. Houben, F., van Hensbergen, M., den Heijer, C. D. J., Dukers-Muijers, N. H. T. M., & Hoebe, C. J. P. A. (2022). Barriers and facilitators to infection prevention and control in Dutch psychiatric institutions: a theory-informed qualitative study. *BMC infectious diseases*, 22(1), 243. <https://doi.org/10.1186/s12879-022-07236-2>

4. North Texas Help. (n.d.). Types of mental health treatment settings and levels of care. Types of Mental Health Treatment Settings and Levels of Care | North Texas Help. <https://www.northtexashelp.com/mental-health-treatment-settings.html>

5. Rovers JJE, van de Linde LS, Kenters N, et al. Why psychiatry is different - challenges and difficulties in managing a nosocomial outbreak of coronavirus disease (COVID-19) in hospital care. *Antimicrob Resist Infect Control*. 2020;9(1):190.

doi:10.1186/s13756-020-00853-z

6. Fukuta Y, Muder RR. Infections in psychiatric facilities, with an emphasis on outbreaks. *Infect Control Hosp Epidemiol*. 2013;34(1):80-88. doi:10.1086/668774

7. Barnett B, Esper F, Foster CB. Keeping the wolf at bay: Infection prevention and control measures for inpatient psychiatric facilities in the time of COVID-19. *Gen Hosp Psychiatry*. 2020 Sep-Oct;66:51-53. doi: 10.1016/j.genhosppsych.2020.07.004. Epub 2020 Jul 12. PMID: 32682153; PMCID: PMC7354767

27

8. Association for Professionals in Infection Control and Epidemiology. (n.d.). APIC Infection Prevention & You. Behavioral health.

<https://infectionpreventionandyou.org/settings-of-care/behavioral-health/>

9. Syed, S. (2024, March 27). Understanding the influence of space on participation within mental health care and the surrounding community. *Inquiry Journal*.

<https://www.unh.edu/inquiryjournal/blog/2024/03/understanding-influence-space-participation-within-mental-health-care-surrounding-community#:~:text=The%20work%2Dmediated%20interactions%20allow,a%20significant%20barrier%20to%20participation>

10. Boullier IV, Gibas KM. Enhancing infection prevention and control in behavioral health settings: barriers, facilitators, and tailored strategies. *Antimicrob Steward Healthc Epidemiol.* 2026;6(1):e36. Published 2026 Jan 29. doi:10.1017/ash.2025.10290

11. Rovers JJE, van de Linde LS, Kenters N, et al. Why psychiatry is different - challenges and difficulties in managing a nosocomial outbreak of coronavirus disease (COVID-19) in hospital care. *Antimicrob Resist Infect Control.* 2020;9(1):190. Published 2020 Dec 1. doi:10.1186/s13756-020-00853-z