Mental health needs of adults with severe depression, psychosis, Bipolar, and personality disorders / trauma informed, during the COVID-19 Crisis

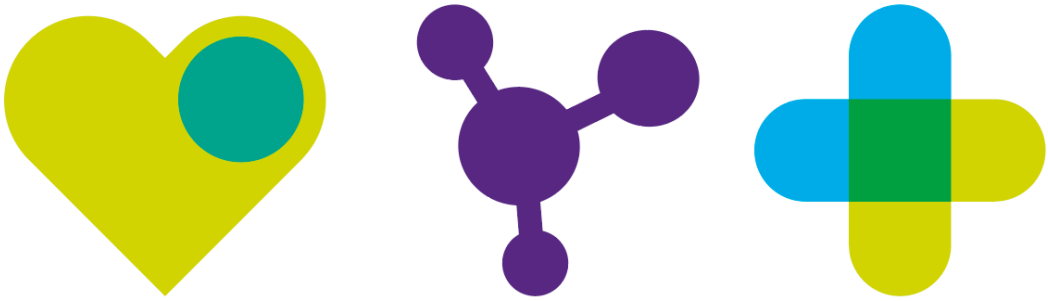
May 2020

Health Innovation Network South London

About

The Health Innovation Network is the Academic Health Science Network (AHSN) for south London, one of 15 AHSNs across England. As the only bodies that connect NHS and academic organisations, local authorities, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

This means we are uniquely placed to identify and spread health innovation at pace and scale; driving the adoption and spread of innovative ideas and technologies across large populations.



The Challenge

NHSX is keen to understand the needs of adults with severe depression, psychosis, bipolar and personality disorders / trauma developed during the COVID-19 crisis and how the changes enforced by the virus are affecting their needs

NHSX is interested in investigating the needs particularly of vulnerable groups (adults with protected characteristics such as BAME or LGBTQ, those in contact with social care and justice systems, and those who are especially vulnerable to the virus and are 'shielding'.

This report focuses on the needs that have arisen for this population cohort during COVID-19.

Responses

Six hundred and ninety organisations / clinical leads / relevant professionals were contacted directly by the Health Innovation Network throughout England during the period 11 to 21 May 2020 and asked to respond to the NHSX challenge.

The following 24 organisations/respondents replied within the time frame given for this request. Many represent large geographies and/or many organisations or departments within one organisation.

- Mental Health Foundation
- High Intensity Network
- Solent NHS Trust
- NHS England & Improvement
- East Midlands AHSN
- London Physical Health Leads Network – (9 London Mental health Trusts)
- South West London St Georges NHS Mental health Trust
- South London and Maudsley NHS Foundation Trust
- Havering Talking Therapies (IAPT) North East London NHS Foundation Trust
- Smoke Free
- Central and North West London NHS Foundation Trust
- Lewisham CCG
- Eastern AHSN
- West London NHS trust
- Pennine Care NHS Foundation Trust
- University of Nottingham
- University of Bristol
- King's College London
- Nottingham Health Care NHS Foundation Trust
- The Villa Street Medical Centre
- Big Health

- S12 Solutions
- West London NHS Trust
- Cheshire & Wirral Partnership NHS Foundation Trust.

Additionally, a representative from the Association for Clinical Psychologists responded saying the time frame was too short to feedback in time. We were also informed by another contact that the Royal College of Psychiatrists was carry out a similar needs' assessment at this time.

Themes Emerging from all Responses

COVID-19 shielding and vulnerability

- The national process for determining who are vulnerable and how to ensure they were known to the right services for support, was confusing and challenging. This led some individuals to feel really distressed especially when they felt they should be in an at-risk group but were not identified as such.
- People with serious mental health conditions were not automatically included in the vulnerable at-risk population and this has led to gaps in community support.
- NHS England directed all mental health trusts to separate their inpatient and day services into 'Green' units where all patients are known to have tested negative for COVID-19; and 'Red' units for patients who have tested positive (or who do not yet have a test result). The overall thinking is to make it safer for immune-compromised and other vulnerable people, for example those with cancer, to attend hospital for treatment more safely, while coronavirus is endemic in the community. This is now in place and is having a significant impact upon patient's pathway, transfer rates and there is a bottle neck to admission as patients wait for swab results .
- Mental Health Act Advocacy: there is a challenge to maintain and promote patient's advocacy remotely which naturally then dilutes patient rights and voices in some instances
- We have liaised with a supplier that provides clear shielding masks to support our Deaf patients and staff enabling better communication. Prior to this, the deaf population was being excluded from communications whilst staff were wearing personal protective equipment (PPE).
- Early to predict yet the true impact of COVID-19 as we have reduced our face to face contact massively due to restrictions . We anticipate a surge to mainly Primary Care in first instance with possible COVID-19 trauma related presentations. In response to this the trust has worked with IAPT over past two months to communicate to user and NHS staff groups psychological support to help manage this.

Challenges with remote contact

- People with serious mental health conditions need to be supported more, not less, during a pandemic. This remote contact support will hopefully be the safety net which keeps them out of inpatient services.
- Patients and staff are finding their home environment can feel contaminated.
- Mental Health Act Tribunals : Patients often struggle with remote/virtual contact and some

struggle to remotely maintain a sense of order, for example a manic patient on the call being invited to speak first , became entirely uninterruptable for over 30 mins , this was not in their interest clinically or legally.

- Mental Health Act Tribunals: there needs to be consideration on how to manage a patient who is COVID-19 positive and is self-isolating. Currently they are not provided with dial in codes themselves and there is an expectation a nurse will always sit with them throughout the hearing. This is not suitable as social distancing would be impossible and tribunals require considerable amounts of time.
- There are confidentiality and ethical problems as patients have other people in their home.
- On the national webinar, remote working was being talked about as being stressful for staff and much less appropriate for people with a serious mental illness. It may be a helpful addition, for example for people with agoraphobia but should not be the first or only choice for anyone with complex mental health problems.
- Disconnection from others – shared learning can be missed between colleagues, particularly when there is no opportunity for ad hoc clinical queries.
- The bipolar psychoeducation service at Nottinghamshire Healthcare NHS Foundation Trust are currently working under the assumption that they will not be able to resume any group therapeutic work delivered face to face this year. With their current waiting lists for bipolar Group Psychosocial Education (GPE) specifically this could mean patients waiting over two years before being able to access a course, which is a situation they desperately want to avoid.
- A great deal of the value that bipolar service users get from GPE is the peer to peer interactions and the connections they make with others with similar experiences. The course material itself is evidenced to improve outcomes and reduce relapse, but this evidence was produced in the context of groups being delivered face-to-face. There is some concern that these 'softer' benefits may be lost with the move to remote delivery and that it will also be more challenging to identify fewer forthcoming participants and proactively engage them in the course compared with being there in person.
- We are currently reliant on Microsoft Teams for video conferencing. Currently, the maximum number of participants on screen is nine whereas the recommended group size for GPE is 14 participants (plus up to four facilitators at different stages in the course).

Inpatient Psychiatric care

- There needs to be an inpatient psychiatric system which can safeguard people's mental health in a pandemic. This needs to be properly equipped with PPE and reserves of staff, so the system is not dependent on agency staff. In care homes, there are claims that agency staff have spread COVID-19.
- It is difficult to think of many places worse than being in a psychiatric ward at the moment. People are deeply distressed, in the midst of delusions fueled by the pandemic. People will struggle to isolate, and it will not be possible to contain everyone's distress.
- There are some records that indicate deaths in psychiatric hospitals are rising.

Crisis presentations/suicide

- We have lost two patients in the past 10 days to suicide/misadventure. Having debriefed both teams, we are fairly certain that one of the aggravating factors of both these deaths

was a deep sense of isolation caused by a lack of face to face contact with professionals due to COVID-19.

- Patients are presenting late and in crisis, with suicidal thoughts or having harmed themselves.
- There has been an increase in emergency presentations at our A&E over the past two weeks, especially cases of self-harm or suicidal ideation where COVID-19 and its repercussions play a role in patients' deterioration
- One of the High Intensity Users teams at East of England AHSN has advised that whilst they have cut down on the face to face appointments a little, they are still going ahead with face to face contact when requested. They feel that the chaotic behaviour and the regular contact/pressure these high intensity users put on other services, justifies maintaining the face to face contact. They have noted that they have not seen much change from this cohort, that many continue to meet with family and friends outside of their household, but that they are taking a pragmatic approach and weighing up whether restricting that contact would lead to an increase in inappropriate contact with emergency services.
- Other teams have advised that they have moved to virtual contact for these high intensity users and are not reporting major changes.
- Some high intensity users are showing more interest in their crisis plans, which may be because they have more time on their hands, or maybe because they are wanting to take control and get themselves prepared and discussions are around what can happen after COVID-19, with some patients thinking more positively about the future. The patients that seem to be reacting the worst are those who are being monitored and do not have the intensive support.
- COVID-19 has put increased pressure on Mental Health Act assessments, including the sourcing of Approved Mental Health Act professionals.

Additional Risk Factors

- Alcohol use.
- Online gambling.
- Domestic violence.
- Smokers: a third of all people with a mental illness and two thirds of patients in some mental health units are smokers.
- Sense of isolation / loneliness.
- Increased risk of bereavement/loss.
- There may be issues around food, particularly if combined with body image issues (which may be exacerbated by increased social media use, alongside reduced access to hair and beauty facilities).
- Reduced social contact.
- Destabilising issues of furlough/unemployment, debt, and possibly online gambling
- Increased difficulties accessing support.
- Exacerbation of conditions due to lack of social contact and ability to go out as well as losing the protective effects of routine, exercise, activities, peer support
- Carers being even more isolated and the consequences of this for themselves and the person with serious mental illness.
- There is concern for our homeless patients, who had been temporarily housed in hotels but

have now experienced a cessation of this offer.

Black, Asian, and Minority Ethnic (BAME)

- Nws reporting that Black and Asian, especially people from south Asian and Afro-Caribbean communities, are affected by this virus and are dying, is creating added anxiety
- The disproportionate impact on BAME communities and on those living in our poorest neighbourhoods needs special consideration.
- COVID-19 will create enormous fear and uncertainties adding to mental pressure on BAME alongside many other things that are happening with this virus such as strain of lockdown, financial worries, and lack of social support.
- Culturally and linguistically tailored psychological support is needed to deal with anxieties related to the virus, grief, and loss.
- Translated self-help materials are essential on mental health as well as on COVID-19 'how to keep safe' information.
- It has been noted that a high percentage of individuals accessing advice via the support and advice line are from a BAME background.

Physical health needs

- Patients in this population are at risk of missing routine physical health checks.
- Patients are at risk of delaying starting treatment, for example mood stabilisers or antipsychotics – this is because secondary care providers may not be able to provide routine or pre-treatment bloods and ECGs, either because of social distancing or reduced staffing.
- Patients may also not feel comfortable coming to clinics or engaging with staff.
- Physical health co-morbidities are a significant risk factor for coronavirus, for example one in three of those who have died in hospital from COVID-19 had diabetes. We know there is a link between severe mental illness and diabetes.
- One issue that I have encountered is district nurses being under pressure and not being able to visit more than once a day. That resulted in one patient who I had stabilised on twice daily insulin being moved to daily insulin and her diabetes becoming destabilised. I managed to stabilise her on a daily regime, however her poor diabetic control had an adverse effect on her mental health.

Requests for tech/digital interventions

- Accelerate the release of HES data to allow more linkage work to inform COVID-19 planning.
- Near patient testing that can be used in patient's homes (mobile ECG, point of care finger prick cholesterol checks and mobile scales).
- Approaches which minimise physical contact – again mobile ECG, pods that patients can check weight and BP by machine rather than in contact with a professional
- Easier access to recent blood, ECG, or other physical health check information from other sources, such as GPs including tech that enables patients to receive and pass on their results to other providers.

- Tech solutions to improve lifestyle – smoking cessation, including virtual teaching/support/resources as well as exercise, diet and opportunities for social engagement.
- There is a great need to treat smoking cessation as a priority in mental health and an urgent need to provide digital alternatives to face to face services. In addition to helping people stop smoking, such services can also provide an important lifeline for people who feel isolated.
- Tech solutions to optimise diabetes care if people cannot access GP – for example virtual clinics with the local diabetes team and web chat with specialists.
- With regard to mobile ECG – thought needs to be given to information governance issues as most of them require a monitor linked to a phone app – how to capture the reading and record in the patient's record in a quick and secure way. For example, can the reading be stored on a secure cloud which can then enable it to be downloaded and saved on the patient's record?

Digitally challenged and excluded populations:

- It needs to be noted that digital/virtual delivery works for some population groups and not others and that in the move to 'virtual by default' we must work hard to not increase inequity of access.
- Digital delivery cannot be assumed as a first line substitute for all groups – this is particularly relevant perhaps for those in prison potentially or forensic services for example, or older people shielding who may not have access to technology.
- It would be very useful if the most up to date knowledge/research could be shared about how best to implement apps for people with serious mental illness. Having apps available is one thing, although if people download and actually use them is another.
- Many patients do not have working phones, internet or video capability.
- Many patients do not like seeing themselves when talking about intimate or distressing issues.
- Many lack privacy to talk via phone/computer at home.
- Some apps can be useful, but the main issue here is enabling people to communicate effectively and have 1:1 sessions with their healthcare professional. Some of the means of communication are not intuitive. The Whereby app used through Accurx in primary care is complicated to download and not compatible with older smartphones, including older iPhones.
- Carers, some family/friends do not have access to digital devices this impacts on both carer and the person with serious mental illness.

Service responses to COVID-19:

- On our rehab wards we are creating videos to share awareness to help others with a focus on mental health awareness and wellbeing.
- Digital groups are being run on Anytime Anywhere .
- Forensic Services: Access to the internet and digital devices in general is severely limited in forensic services. During COVID- 19 SWLSTG NHS Trust have issued iPads to wards to facilitate remote psychology consultation. There is some hope that if the iPad trial goes

well, this may lessen anxieties around introducing more digital provision into the forensic setting. Cohorting has been the most challenging in this service line including challenges for those not complying. There is a published article, *Isolation of patients in psychiatric Hospitals in the context of COVID- 19* which mirrors challenges we have encountered: see **Appendix 1**

- Early in COVID- 19 lockdown, the Students' Health Service at the University of Bristol proactively contacted all patients on QOF mental health list - this includes all Bipolar / Schizophrenia / Lithium patients. All were well and did not take up the offer of additional support. We have also put in place additional support with more frequent telephone or video calls for patients who we felt were at higher risk during this time. Our social prescriber and mental health nurse have proactively contacted all our shielded patients to offer additional support.
- The bipolar psychoeducation service at Nottinghamshire Healthcare NHSFT are currently working under the assumption that they will not be able to resume any group therapeutic work delivered face to face this year. With their current waiting lists for GPE, specifically this could mean patients waiting over two years before being able to access a course, which is a situation they desperately want to avoid.
- King's College London have recently adapted the SlowMo therapy interface to provide an easy access webpage for managing COVID- 19 stress, which has been disseminated to SLaM psychosis services. SlowMo is the first digital therapeutic for paranoia and has recently completed the largest trial of a talking therapy for paranoia in psychosis. It harnesses innovative technology and inclusive, human-centred design to address barriers to therapy implementation.
- Nottinghamshire Healthcare NHS Foundation Trust is working proactively to deliver GPE remotely with a goal of starting to trial this in approximately a month, however there are some practical hurdles and concerns.
- Information governance and safety – currently Nottinghamshire Healthcare staff do not disclose their direct email addresses or contact information to service users. This is so that people in crisis go through the appropriate urgent care channels, rather than contacting therapists directly which could potentially carry a lot of risk. They have not yet been able to use Microsoft Teams in a way that prevents their email addresses being disclosed to other meeting participants.
- We created two new COVID- 19 Apps, both available on my dashboard, Impact Assessment, and Remote Working Assessment.
- All services are using where possible, digital and remotes systems, such as Attend Anywhere, Microsoft Teams Skype, Econsultation to support both patients, carers and staff.
- King's college London shared various published work on trauma informed mental health. **See Appendix 1** for links.

Staff Wellbeing

- Our CEO has a held a COVID- 19 webinar with the Staff Network Chairs (this includes our BME, LGBT, women's, Disability Mental Health , Christian and Deaf Staff Network) to discuss any concerns.

- A special COVID- 19 webinar with our CEO and Chair and BAME staff Network chairs /members was provided.
- All staff including higher risk groups due to health status were offered risk assessments and guidance to promote safe working at all times. This included BAME as part of all staff group.
- We have provided open 'Wellbeing Hubs' to provide dedicated space for breaks and wellbeing support to colleagues. These have taken the form of 'Rest and Recharge Hubs'. Five main hubs are available to staff, and each are open at least 09.00 – 17.00, with three also extending their hours to overnight. The hubs provide a dedicated physical space - away from the office or ward - for staff to rest and build principles of good stress management into their lives.

Appendix 1

Isolation of patients in psychiatric hospitals in the context of COVID- 19; An ethical legal and practical challenge. https://www.sciencedirect.com/science/article/pii/S0160252720300315

Trauma informed mental health articles:
https://www.emerald.com/insight/content/doi/10.1108/MHRJ-01-2015-0006/full/html

https://www.tandfonline.com/doi/full/10.1080/09638237.2018.1520973

https://www.cambridge.org/core/journals/bjpsych-advances/article/paradigm-shift-relationships-in-traumainformed-mental-health-services/B364B885715D321AF76C932F6B9D7BD0

https://www.centreformentalhealth.org.uk/sites/default/files/2019-04/CentreforMH_EngagingWithComplexity.pdf

https://journals.rcni.com/mental-health-practice/cpd/implementing-traumainformed-care-in-mental-health-services-mhp.2020.e1443/pdf