

RCPsych in NI. Psychiatry of Old Age briefing on COVID for meeting at Department of Health.

Faculty was asked to provide briefing based on two questions:

1. Will there be an increase in the incidence of new presentations of mental illness because of (a) the virus itself, (b) the consequences of the lockdown and other containment measures - or (c) the economic problems caused by the pandemic?

2. We have all had to downturn some services for our current population attending our teams - limiting access, providing phone follow up only etc:
 - Will this have an impact on their treatment and progress which we will have to try to account for when/if things get back to normal? Has the pandemic had a different effect on the population already diagnosed with mental illness as compared to the rest of the population?

Opinion has been sought from the entire faculty through the NI college emailing list. A separate paper has been prepared for Dr Mulholland by POA academic trainees. For simplicity the answers have been divided into (i) issues specific to Psychiatry of Old Age and (ii) issues also relevant to other psychiatric specialties.

Issues identified Specific to Psychiatry of Old Age

- Several reports of decreased referrals for dementia and functional illness from primary care. Possibly fewer people presenting to GP, possibly fewer GPs wanting to burden services, possibly with less social care provision and lockdown people in difficulty aren't being noticed. **At present assessments by video/ phone are taking longer than anticipated as the admin load is higher. Home visits in PPE are prohibitively long (where PPE is available).**
All teams are anticipating a sharp rise in referrals and all feel they will not hit department KPIs/ waiting times when this happens. All fear there will be pressure to maintain targets and this will have a negative effect on ability to use clinical judgement to mitigate risk. **A wide scale relaxation of targets for a period of adjustment would probably be welcome across the health service and could have public support.**

- Suspension or reduction of options that might reduce likelihood of admission such as Home Treatment/ Day centres/ respite/ addictions/ psychological work etc have contributed to acute admissions at the same time that discharge is becoming harder

for the same reason. The acute bed system is stretched in several trusts. Prioritising these to re-open/ go back to seeing patients at home when safe to do so would help. Strategically it should be discussed that most trusts have reduced bed numbers and increased home treatment and other options. If these are unavailable suddenly, as happened in COVID, the acute bed system becomes very stretched. Trusts might develop a surge plan to deal with a sudden increased need for psychiatric admissions in the future where other treatment options have stopped.

- Among the older population reports are made of increased anxiety/ depression/ Obsessive compulsive disorder, mania, psychosis and drug and alcohol use. A proportion of these seem directly to COVID (eg a delusional belief that the person has caused the outbreak) and others to the effects of isolation and normal supports and routines being stopped. Again prioritising the re-opening of support services , day centres etc would be helpful.
- Post COVID we expect to find a spike in inappropriate placements made by health and social services as patients were discharged quickly as part of the surge. This often presents as problematic behaviour and depression.
- Suspension of ECT during the outbreak in some trusts during the outbreak. How to obtain emergency ECT is reported as unclear by some teams.
- Part IV doctors and doctors performing capacity assessments were concerned about the potential risk of spreading COVID between sites (hospital, placements, homes). They would have welcomed early guidance on the use of video technology o perform assessments.
- A doctor has identified a rise in demand for medicolegal capacity assessments as a surge of older people prepared wills and financial arrangements. Solicitors are reporting there was not enough capacity to meet the demand.
- Sensory impairment as a barrier to understanding COVID information and as a barrier to phone/ video reviews.
- Delirium has been noted in COVID cases presenting to liaison. Unclear if this is a feature specifically of COVID and this requires research. The restricted community options for management (eg stepdown) make management difficult.
- Patients with mild cognitive impairment need reviewed to track progression and start early treatment if they convert to Alzheimer's disease. Monitoring has been disrupted by COVID and they need prioritised for review (not dealt with as if they were "well").

- Patients with cognitive impairment (dementia) unable to follow advice re safety and shielding. Leading to infection risk to them and potential spread to others. Clear advice on legalities of management would be appreciated. DOLS does not seem to adequately fit here as the POSH criteria seem inappropriate (ie you do not know infection status or risk- we were being briefed that POSH needed to be quite specific and higher level of suspicion and risk ie death).
- Several reports of an increase in urgent placement requests as families find they are unable to manage- solution might be to surge beds in care home providers/ step down and increase or at least maintain SW provision in this area rather than redeployment.
- Early lack of clarity over the availability and criteria for COVID testing meant that hospitals and nursing/ care homes had different standards for discharge- some would require a negative test to allow transfer and the risk of patients who had recovered clinically from COVID but tested positive were initially not well understood. POA staff may be facing strained relationships with colleagues in the care home sector as a result of this confusion.
- Several reports of care packages being withdrawn (by non-trust providers) if there was a family member in the house to provide any care. This appears to have been a blanket decision rather than case-by case.
- All are noting increased pharmacological management of behavioural problems in dementia due to COVID. This presents stroke and falls risks that cannot be monitored well as visits are reduced. A solution would be that homes have a better baseline ability at behavioural management- perhaps training in CLEAR or similar should be mandatory in care homes and this could be regulated by RQIA as part of certification.
- All note increased stress and anxiety in the nursing home/ care home sector and are concerned for the effects on staff and residents. A possible effect on referral to adult services/ occupational health is anticipated. Similarly we expect a rise in numbers of fellow residents who have developed psychiatric problems.
- **Communication is repeatedly highlighted as a problem. In the early stages there was insufficient equipment and IT resource to quickly move to phone/ video review. The hub/spoke system was particularly vulnerable to communication breakdowns. Rapid re-organisation was difficult for switchboards. A better communication plan would be useful.**
- Information was not readily available to allow a switch to phone/ video review. Several reports of people having no phone details/ only available via next of kin/

unable to answer due to cognitive or sensory problems and also instances of carers having removed landlines (presumably having had repeated calls from unwell patients). Strategy for updating and maintaining records would be useful.

- Similarly reports of patients moving in with family for isolation- very good in that it probably reduced health service/ social care burden but caused difficulties in temporary registrations/ working across boundaries. The current advice from department would handle all of this under the discretion in an emergency category but this doesn't really help much given the numbers involved.
- With the general drop in Home Treatment and Community team availability all reported more functional admissions and all note that they seem to generally be more unwell. The Outbreak seems to have increased severity of illness through stress/ withdrawal of support/ isolation. Research recommended.
- All teams are reporting disruption of scans and other investigations that will likely delay diagnosis in some cases of dementia unless an effort is made to "catch-up" but it is a hard to see how this can be done inside existing job plans.
- Post the initial outbreak all teams are expecting increases in functional presentations (depression, anxiety, PTSD etc) among survivors, people stressed during lockdown and also carers.
- As per the attached technical analysis the possible neuropsychiatric effects of COVID are still unknown (there is a precedent in the encephalitis lethargica outbreak post Spanish Influenza). Research/ monitoring is recommended.
- **Economically speaking all respondents are concerned that trusts will have to make savings following the COVID spend. Previous experience in several trusts is that Social care budgets (placements and care packages) may have reduced funding. Previous experience is also that some psychiatric services sitting under several service groups may have funding diverted (this was a previous experience with RAID services).**
- **Economically, the need to catch up on clinical work disrupted by COVID is also a concern. Additional clinics may need resourced. Staffing is always problematic due to different pay rates for part-time and full time staff making extra clinics unattractive.**

Issues also relevant to all specialties

A primary problem is identified with communication across all trusts and not specific to psychiatry. Information was initially sparse and often had to be obtained from non-trust and non HSC sources. The results were often contradictory and added to complexity and anxiety. Local resources arrived and were often re-written quickly. The effect was of doctors losing clinical time to keep up with rapidly changing advice. Several teams noted that decision making was often dependent on higher levels of management outside psychiatry and the decision cycle was slow.

Consideration could be given to a communication/ information dissemination/ information review role inside each trust and devolving decision making more in the event of a crisis.

The decreased ability to perform physical healthcare on psychiatric wards has been highlighted. Some teams were being asked to prepare for a much higher level of physical healthcare on their wards to compensate for an inability to transfer to transfer physically unwell patients to general hospital. The staff numbers, skill sets and equipment would have made this very unsatisfactory and probably resulted in risk to safety and exposure to litigation.

Some newer wards have been designed with a patient-centric ethos that decreased their physical suitability during the COVID outbreak eg the use of non-easily disinfected furnishings leading to room closures. As noted regarding physical healthcare the status of psychiatric units as hospitals in the same sense as general hospitals can be unclear.

Lack of testing for admissions or the ability to isolate until tested increased risks of undiagnosed COVID patients spreading the virus on the wards. The Mental Health Order would permit someone to come in with little pre-screening. Gatekeeping of admissions by psychiatric nurses and AHPs would be less likely to prevent entry of COVID or physically unwell/ vulnerable patients than gatekeeping by doctors.

Procurement of personal protection equipment (PPE) was also raised. What little there was was focused on inpatient services and even these were sometimes taken to stock other areas. Fit testing was slow in several trusts and not yet complete- a particular concern where psychiatric hospital staff were dealing with spitting/ agitated patients and where CPR may have to be started.

Several teams identified confusion around occupational health guidance in the initial period as to which staff should self-isolate. Increased levels of anxiety and effects on staffing noted.

Reports of some difficulty obtaining medications due to supply chain issues. Problems with making sure patients had adequate supplies of medication on discharge and were properly prepared for arranging and picking up medications from pharmacies during lockdown.

Suspension of services such as OT and Physiotherapy in lockdown is reported in some trusts. This has had a negative effect on recovery for patients and may contribute to incomplete care plans on discharge.

Cases reported of patients on depot medications declining to let staff enter home to give medication due to perceived COVID risk. Similar reports of patients declining lithium/clozapine clinics for fear of infection.

Trusts unable to provide video link/ webcams/ governance of same to clinicians quickly. Department advice on allowing expedient use of existing tablets/ phones etc would be useful.

Contact with GPs is reported to be slow as they are very busy and communications have in some places shifted to post rather than email/ fax. A communication strategy for hospitals to GPs in crisis would help.

The hospital lockdown with limits on passes and visitors have been problematic. There has been difficulty in staffing to allow passes for exercise with complaints deterioration noted from patients and families. Interestingly the unavailability of passes and restrictions on visitors seems linked to a decrease in incidents in acute wards. May be linked to tighter control of contraband- this could be investigated.

The general opinion is that our colleagues in medicine and surgery have not been using DOLS much more during the COVID outbreak due to time/ organisational constraints. The suitability of DOLS around the COVID patients needing to be isolated/ shielded is confusing when applied in medical and psychiatric wards, to placements and people staying at home who are potentially under a new DOLS. The 12 month introduction period which was to give time to generate data and allow trusts to develop systems seems to have been disrupted. At the least an extension of the 12 month introduction period seems warranted. Many feel it was unfit for purpose and COVID has highlighted this and are asking for a complete review.

The status of regional bedflow was unclear for the first weeks before being suspended. It is unclear when or how it is being reviewed. A daily/ weekly review would seem best if there is a spike in admissions.

One POA team reports being made into a specialist COVID ward and discharging/transferring patients to allow this. With the suspension of regional bedflow it filled with acute admissions again and there have been no COVID positive admissions yet and no isolated ward to put them in now. A dedicated COVID ward would require keeping up to 7 beds unoccupied and the acute bed shortage won't permit this. The ward's status as a COVID ward is now unclear.

