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EDITORIAL

Acute mental health care during a pandemic: problems and progress

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2020 will go down in history as a year like few others. Within acute mental health care, the year started normally enough with the usual challenges and successes that punctuate mental health inpatient care. By the middle of March 2020, everything had changed.

A global pandemic, the like of which had not been seen for a century, held humanity in a firm and unforgiving grip. Around the globe, people everywhere frantically assembled defences against an invisible enemy. The characteristics of public services required near complete reinvention to try and function in circumstances not seen for generations.

I will always remember cycling to the hospital in which I work the day after the UK's lockdown. Filled with apprehension and uncertainty, thoughts of what was going to happen over the coming weeks churned within my stomach. As I pedalled through silent, empty streets, it was impossible to ignore the fact that everything had indeed changed.

Entering the unit office, I looked into the eyes of those around me for reassurance, who no doubt were looking back at me for the same reason. During the ward round that morning, I was also struck by a different relationship which was being forged with patients. Talking with our first patient, it became clear that out of this situation had emerged a co-dependence that now existed between us. It was difficult to escape the underlying feelings that as clinicans we sat in hope that our patients detained under the Mental Health Act would support us in our efforts to maintain the service which depended on the co-operation of others. It was also no doubt the case that our patient was looking back at us in the hope that we knew what we were doing and any trust they had in us was well placed that the staff could keep everyone safe.

In my editorial of 27 March (Dix 2020) I introduced the

NAPICU's guidance for COVID-19 and acute disturbance. Over the previous week, the NAPICU guidance (Dix & Tunnicliffe 2020) had been created in record speed. I was inspired by the efforts of more than 20 senior clinicians and patients from all over the country who had brought their wisdom to bear on the key issues of managing a PICU during a pandemic with breakneck speed and efficiency. We were also grateful for the publication by Zhu et al. (2020) from Wuhan, China, which provided us with the experience of mental health services first dealing with the pandemic, and allowed us to profit from their first contact with COVID-19.

What we could not know at that time, was how well we would succeed in providing services under these extraordinary conditions. Or what the consequences of the situation would turn out to be. Language rarely used in acute mental health services became the content of daily conversations. 'Personal protective equipment' (PPE) and

stranger still terms like 'donning & doffing' became familiar, and were heard everywhere in inpatient mental health hospitals.

Entire service models were redesigned also with break-neck speed. Wards that would ordinarily be assigned to localities or specific treatment needs were re-purposed to be either 'COVID positive', 'quarantine' or 'green' wards. Seemingly, mental health inpatient services become unrecognisable from what felt like just moments before. At that time, we did not and could not know how many of the staff would still be at work in the days and weeks to come. How many of us or our patients would fall ill? What was often secretly thought about, but could not be dwelled upon, was how many of us may ultimately succumb to this invisible enemy. Add to this the surreal experience of the national lockdown; incredible as the notion seemed, for the first time, patients, the staff and the wider community were truly all in it together.

In this issue of the *Journal of Psychiatric Intensive Care*, Straiton (2020) details some of the issues arising from this most unexpected and serious of circumstances. In this account, the more philosophical and human characteristics of operating mental health inpatient services within a pandemic are described. The *JPI* was also pleased to receive a fast track series of Brief Reports on managing COVID-19 in one of the hardest-hit areas of the UK: London. Clinicians at the Maudsley Hospital were able to produce and publish a series of important reports the first of which are included in this issue (Blake et al. 2020; Butler et al. 2020; Pugh et al. 2020; Skelton et al. 2020). McLean & Forrester (2020) provide us with an infection prevention and control (IPC) perspective of what may need to become the 'new normal' when considering the way in which IPC issues fit within mental health units.

During the closing months of 2020, we may now have an opportune moment to reflect on where we have been, where we are now and what is likely to face us in the New Year to come. No doubt the global mental health community has been preoccupied with the realities and challenges of daily existence and only now may we catch ourselves thinking about what we have learnt and possibly more importantly, what we will need to know to successfully navigate the road ahead.

For me, the first thought is that services have survived their greatest test in living memory. Care, compassion and determination have been evident just about everywhere one chooses to look in the mental health service and beyond. Few, if any services appear to have been defeated by the pandemic. The coalition of patients, staff and service leaders have succeeded in maintaining service integrity while at the same time maximising the safety of all of us.

It has to be acknowledged, however, that there have been casualties in the battle against COVID-19. Many of us will know patients and colleagues who have been lost to the invisible enemy. It is often pronounced that COVID-19 is an indiscriminate adversary, although more recently there is good evidence to suggest that many of us are more vulnerable than others. Like many mental health services around the world, the UK inpatient mental health service is profoundly dependent upon the skills and contribution of staff members from the BAME community. As with all societies that benefit from rich diversity, many of those requiring mental health services are also from higher risk groups, both by demographic description and as a consequence of physical health issues that often accompany mental health problems. Once again, it is difficult not to be inspired and humbled by the duty and professionalism demonstrated by colleagues from higher risk groups that have been unwavering in their efforts to support services through these most testing of times.

Possibly one thing that has been exposed during this period is the coming together of people dependent upon each other to maintain safety. We have had to collaborate on how we undertake the essential activities of living to avoid exponential spread of the disease through our inpatient services. In the coming months we will no doubt need again to rely upon this new-found dependence on each other.

Just as we could not have known back in March 2020 how things would unfold, equally in the coming months, we cannot know if a second wave of infection will come to challenge us, or if it does what the consequences may be.

We can take some reassurance, however, that we now have the benefit of battlefield experience and the confidence that this brings. Some of the knowledge still required potentially relates to mental health inpatient units' specific infection control measures that before COVID-19, there was little need to explore. While we are grateful for the knowledge and experience in managing infection from our general medical colleagues, much of this wisdom is difficult to apply by simple transportation into the mental health inpatient estate.

Most mental health inpatient facilities are designed to achieve everything other than isolation and distance from each other. Freedom of choice, of movement and positive group engagement are core themes of mental health inpatient practice. These themes must be preserved in order for the services to fulfil their core function. That said, the ways in which infection can be reduced require a specific evidence base derived from the interrogation of practice and procedure within mental health units in pursuit of better ways of reducing infection.

To this end, NAPICU has been involved with the systematic evaluation of the performance of PPE used in physical intervention. Within the PICU estate, those who are acutely unwell and are for the time being unable to regulate their behaviour or responses present particular

risks that at times require restrictive intervention. In these circumstances, close contact and opportunity for infection are unavoidable, putting staff at risk (Nguyen et al. 2020).

Using familiar methods of observing the movement of ultraviolet (UV) visible material between people to determine contact contamination has been explored in detail under controlled conditions. From these experiments we aim to improve our knowledge of PPE to protect against infection. The results of this study should be published soon and are likely to represent among the first mental health specific attempts to create an evidence base that will fit squarely into the needs of acute mental health inpatient care. This may also mark the first of many examples of a new closeness between mental health and infection control specialists.

During recent times, it has also been difficult to know how many people with mental health problems have avoided inpatient care altogether or have at least done their best to cope because of fear of accessing services. It could be that the coming months will also see a surge in acute mental health needs that had remained unengaged during the period that social distancing had been a necessity. Add to this the sheer stress and isolation that many may have experienced as a result of this pandemic, including the economic consequences, it is likely that mental health services in general and inpatient services in particular will be needed to deliver successfully in the future more than ever before.

In the years to come, it is our duty to reflect upon this standout period in history. Once again, until there has been conclusion to this first chapter, we cannot truly be clear about what we have learnt or how we may have all developed. For now, it seems that we can at least indulge in reflection that leads us to a legitimate feeling of pride that we have continued to deliver service and have possibly more than ever before realised the benefits of co-operation and empathy for delivering services. We must also experience sadness for those that have been lost within our services and beyond.

Hopefully, all of us within the mental health community will be able to look towards the coming months with much less fear and anxiety that I experienced on that cycle ride to work on the first day of lockdown. It should be of some comfort to acknowledge that all of us have experienced services in the most difficult of circumstances and have largely succeeded. Mental health care and recovery from acute mental health problems has occurred within a collective atmosphere of co-operation.

We can also be confident that as this year ends and the season turns, we will continue to learn how to improve mental health services for todays and future challenges.

The *Journal of Psychiatric Intensive Care* has been privileged to provide a platform for sharing our experiences, ideas and providing the tools for future successes. To continue this, ensure you send us your wisdom so that we can make it available to others.

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