

Correspondence

Irish Journal of Psychological Medicine, 40 (2023).
doi:10.1017/ipm.2021.17

Social discomfort, isolation and repercussions of lockdown across psychiatric inpatient campuses

The COVID-19 global pandemic has seen governments and healthcare systems rush to contain infection rates, in order to protect healthcare services and conserve resources. Policies restricting visitors in hospital settings aim to reduce transmission and to facilitate the maximal deployment of critical resources for the safe and adequate care of patients. However, it has become clear as the pandemic has unfolded that patients and their families have also suffered as a result of such policies, now mandated in hospital and care settings across the world (Burrai *et al.* 2020).

Psychiatric facilities are somewhat unusual in healthcare settings in that egress from the facility by the patient, in the form of temporary therapeutic leave, is an important aspect of a person's recovery, providing evidence that the person is able to cope with the responsibility of managing their own safety and mental health symptomatology for a predetermined period of time (UK Department of Health, 2015). Leave is not merely a sanctioned activity, but is potentially restorative and therapeutic, a view more congruent with recovery-orientated conceptualizations of mental health service delivery (Anthony, 1993) and notions of therapeutic risk taking (Felton *et al.* 2017). Lack of access to such activity may lengthen hospital stays. Given the fact that there are already disadvantages associated with mental health inpatient status, namely separation from family and friends and decreased control over daily choices, any intervention that could decrease admission length, now necessarily withheld, should be reviewed and reinstated as soon as prevailing circumstances allow.

Health versus humanity at the bedside?

Challenges faced during complex clinical situations in the midst of the pandemic frequently have significant ethical underpinnings. Of the many moral ethical dichotomies in healthcare, the principle of utilitarianism has many vocal proponents in a time of crisis, as it essentially assists physicians in understanding priorities or exercising the principle of maximizing utility, promoting the greatest good for the greatest number of people (Mack, 2004). However, we may equally be at risk of subsuming personhood to utilitarianism, if we do not recognize that visitor restrictions can lead and have led to emotionally painful experiences since

the pandemic began. Visitors can augment patient histories and provide sources of comfort to people across a range of healthcare settings. Many inpatients are admitted for non-COVID reasons such as mental health crises and cannot see or communicate with their families in person. Yet, we remain continually cognizant of the fact that hospital visitors can potentially hamper any attempt at social distancing and unfortunately contribute to increased spread of SARS-CoV-2.

What about other risks?

Those of us working in mental health will be aware that spending time with concerned family members during a hospital stay can hasten recovery and create a healing bridge, essential to allow a person to leave acute care and feel supported in their ongoing recovery. Care partners frequently advocate for a loved one's needs and offer support in managing their physical and mental health in a variety of ways. Critically, because they know their loved ones best, they are often uniquely attuned to subtle changes in the patient's behaviour or status. This makes the presence of caregivers an important means of reducing risk of preventable harm to hospitalized and newly discharged patients (Kaselionyte *et al.* 2019). In a sense, as the pandemic took hold earlier in 2020, patients suffered a double harm – not only due to the illness for which they required inpatient care, but also due to the lack of a family presence at the bedside. The distress of cognitively impaired patients and their supporters failing to recognize the voices of loved ones during phone calls will be familiar to many of us. The mental and physical deconditioning of those with dementia who progressively lose orientation to their home surroundings, who see their care supports in the community progressively disintegrate, or who are scared to return to an isolated existence at home on their own in a so-called 'cocoon' is palpable and traumatizing.

The inability to test out progress in the real world, as one recovers from an acute episode of mental illness, could be akin to being denied physiotherapy after joint replacement and represents a double detriment, due to current restrictions, uniquely endured by psychiatric patients. A mass rise in COVID-related anxiety may also unwittingly be fuelled by restrictions on therapeutic leave, the purpose of which is, after all, to face anxiety in a controlled and supported way, once the worst of any psychiatric maelstrom has passed. We owe it to caregivers to ensure that they and their loved ones are adequately prepared for discharge back to the community, yet this stepwise approach may be all but impossible because of an absence of face-to-face contact

during an acute admission to hospital. The negative effects of restricted family presence are therefore far-reaching. Families will also have found the lack of face-to-face contact with treating clinicians deeply disconcerting. Conveying the nuance of complex treatment interventions and proposals over the phone, as well as breaking bad news has been highly unsatisfactory for many healthcare workers (Olwill *et al.* 2020). Face-to-face encounters are valuable to mental health professionals in helping to truly understand the person they are looking after and information imparted over the phone, or virtually, may be less rich and detailed and therefore less therapeutically valuable. Family members equally may hold back, not wishing to disturb frontline staff with information or questions that in fact are relevant and indeed crucial in managing risk and other complications.

Where is the balance and how can everyone be safe?

As COVID-19 cases began to decrease after the first peak, some institutions moved to ease their restricted visitation policies for non-COVID patients. It is clear from the outset that ethical tensions will persist, irrespective of any strategy that is deployed. Any move, however, to reflect and consider the consequences of continuing with emergency restrictions will be welcome, even if measures to mitigate the most onerous of the restrictions appear at first glance to offer little relief. There is little doubt that bias toward action has dominated throughout the COVID-19 crisis and greater reflection during any period of respite in infection rates could allow for the construction of a more sophisticated, as opposed to a blanket approach, to visitation and therapeutic leave. Anecdotally some healthcare settings did make exceptions to restrictive visiting policies to acknowledge individual needs of patients and families, but questions remain as to how these decisions are made and for whom.

Perhaps, there is emerging recognition that any healthcare intervention bluntly and relentlessly applied across the board can produce detrimental impact, as well as benefit for those whom it is designed to protect. Questions that could guide local ad hoc ethics committees include consideration of clinical and ethical issues that arise for patients, staff and visitors when visitation is curtailed; consideration regarding the process of weighing the benefits and risks of outside visitors in the hospital; consideration of exceptions to the policy in the light of uniformity and fairness. Perhaps the Mental Health Commission could take a more proactive position in advocating for psychiatric patients' rights in terms of visitation and provide more nuanced guidelines for our institutions to move away from

blanket restrictions. Prioritizing the organization of visitors to accommodate social distancing is also crucial, as well as adequately resourcing visits in terms of availability of personal protective equipment for all, in order to allow visits to take place safely and securely with all stakeholders' interests at the forefront of consideration. Above all, families require clear explanations about the nature of and rationale behind restrictive policies. Only by engaging with and understanding the distress care partners experience owing to lack of visits, by humanely mitigating its impact, can we reassure caregivers that they are valued partners in the recovery of their loved ones.

Conflicts of interest

None.

References

- Anthony W (1993). Recovery from mental illness. *Rehabilitation Journal* **16**, 11–23.
- Burrai J, Roma P, Barchielli B, Biondi S, Cordellieri P, Frascchetti A, Pizzimenti A, Mazza C, Ferracuti S, Giannini AM (2020). Psychological and emotional impact of patients living in psychiatric treatment communities during Covid-19 lockdown in Italy. *Journal of Clinical Medicine* **9**, 3787.
- Department of Health (2015). *Mental Health Act 1983: Code of Practice*. London, UK: Department of Health.
- Felton A, Wright N, Stacey G (2017). Therapeutic risk taking: a justifiable choice. *British Journal of Psychiatric Advances* **23**, 81–88.
- Kaselionyte J, Conneely M, Giacco D (2019). "It's a matter of building bridges . . ." – feasibility of a carer involvement intervention for inpatients with severe mental illness. *BMC Psychiatry* **19**, 268.
- Olwill C, Mc Nally D, Douglas L (2020). Psychiatrist experience of remote consultations by telephone in an outpatient psychiatric department during the COVID-19 pandemic. *Irish Journal of Psychological Medicine*, 1–8.
- Mack P (2004). Utilitarian ethics in healthcare. *International Journal of the Computer, The Internet and Management* **12**, 63–72.

A. GRIBBEN

St Patrick's Mental Health Services, James's St, Dublin 8, Ireland
(Email: andrew.gribben2@gmail.com)

C. McCARRICK

St Patrick's Mental Health Services, James's St, Dublin 8, Ireland

D. LYONS

St Patrick's Mental Health Services, James's St, Dublin 8, Ireland