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Therapeutic alliance, social inclusion and infection control – towards pandemic-adapted mental healthcare services in Switzerland

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Summary

The COVID-19 pandemic has challenged the Swiss mental healthcare system. Many services were downsized or closed, and admission to treatment and care institutions was restricted during lockdown. These measures were necessary according to the general containment and mitigation strategies of federal and cantonal authorities, but this situation has had negative consequences for care and treatment of service users. This paper asks for a rethink of key aspects of the Swiss mental healthcare system that have been demonstrated not to be adaptable to the pandemic. In particular, the paper suggests diversifying care and treatment settings, and strengthening outpatient and outreach services. Finally, some proposals to foster social inclusion during and after the pandemic are outlined.

Keywords: *COVID-19, pandemic, mental health services*

Introduction

The COVID-19-pandemic heavily impacted the Swiss healthcare system in spring 2020, with the peak of cases and deaths occurring in early April 2020 [1]. In general, the country's healthcare system – although caught by surprise – has coped well with the sharp increase of infections. Apart from some local shortages of beds, staff and equipment, unmanageable situations were rare.

The Swiss mental healthcare system was likewise taken by surprise and challenged by the immediate need to cope with infections while trying to maintain treatment and care for people with mental illness. Hence, the mental healthcare system was initially not prepared for the impact of the pandemic and alterations regarding service provision were handled very differently across regions. In some catchment areas, mental healthcare delivery was maintained with a complete range of services and a few adjustments due to hygienic and physical distancing measures. Other regions were affected dramatically as the systems changed as a result of shutdowns of services and closures of institutions and facilities (e.g., day hospitals, day centres, sheltered occupational rehabilitation programs, ambulatory clinics, outreach services).

At the same time, many hospitals have changed their admission policies and have assigned wards to treat patients in quarantine or isolation with staff using appropriate personal protection equipment (e.g., masks, gowns, gloves). Telemedicine communication via smartphone, video conferencing or landline have been established in many outpatient and outreach services to compensate for apparent shortcomings. Psychiatric care home residents were often not allowed to leave the premises, as it was assumed by public health authorities that physical distance and hygienic measures could not be upheld outside the care home. However, most decisions for keeping services open or closed were not based on scientific advice but rather on administrative regulations.

Altogether, due to the shutdown of services and the massive restrictions in institutional settings, it was in many cases impossible to maintain the therapeutic alliance, clearly one of critical success factors in psychiatric treatment [2]. Additionally, the already high degree of social exclusion for people with mental illness in Switzerland [3] became more evident as authorities cancelled social events and face-to-face contacts in social networks were drastically reduced. At the same time, home visits by outreach

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professionals were cut in many (though not all) regions, although they are the only personal contact for many service users [4]. The shutdown also hampered professional contacts with family members and other carers, which may have induced feelings of neglect by mental health services.

After experiencing the initial peak of infections in spring 2020, the country is now (October 2020) again confronted with a rising rate of infections. For society in general, and for the healthcare system in particular, the entire "post-peak" period will become a huge challenge. Whereas the period up to the peak of the pandemic aimed at containing and mitigating the spread of the virus, the post-peak phase is characterised by fewer restrictions, increasing social interactions and the risk of rising infections [5]. The main societal, political and public health challenge is to keep the effective virus reproduction number below 1 in order to avoid the healthcare system becoming overwhelmed and at the same time being able to re-introduce certain liberties that will help to re-boost the economy.

Given the non-availability of an effective treatment or a vaccine for the general population and the uncertainty about the length of immunity, this post-peak phase might last for several months, if not years, as only physical restrictions are able to mitigate the virus spread under such circumstances [6]. As the results of early simulation research have shown, such restrictions were supposed to be necessary for the upcoming two to four years [7]. Leading Swiss epidemiologists now expect the pandemic to last at least until the end of 2021 [8]. To further aggravate the situation, the demand for psychiatric and psychological treatment is expected to grow as a result of its socioeconomic repercussions, as evidenced by earlier epidemics, pandemics and other shock events [9, 10]. Clinicians and scientists expect long-term consequences for people who suffer from social isolation, financial hardship and possible unemployment, leading to an increase in demand for treatment of survivors, grieving family members, healthcare workers and the general population in the event of further increasing infection rates and related COVID-19 illness spikes. The increase in unemployment alone is likely to lead to several thousand additional suicides globally, according to recent estimates based on scenarios published by the United Nations' International Labour Organization in March 2020 [11]. Now, the total number of job losses worldwide has been shown to be much larger than in the predicted underlying worst-case scenario. This may also account for the number of expected suicides. However, the further development depends on both infection rates and the welfare state response. Until autumn 2020, the economic fallout of the pandemic has mainly been absorbed by measures such as the furlough scheme. Therefore, the welfare state response is increasingly seen as the second line of pandemic response that has public health consequences, too [12].

What are foreseeable consequences for Swiss mental health services? And – more importantly – how should the country's mental health services be adjusted in order to be prepared for the long-term post-peak phase of the pandemic, with a need to keep up infection control while avoiding the loss of therapeutic alliance and fostering social inclusion of service users?

Consequences for Swiss mental healthcare services

Mental healthcare services will remain part of the general public health response to the pandemic in their respective catchment areas. This means, in particular, ensuring ongoing psychiatric treatment and care while avoiding service closures during possible future lockdowns. Thus, all services in mental healthcare, as well as in social care, for people with mental disorders are required to develop and implement procedures that allow the provision of person-centred care that may be adapted to the circumstances, such as by utilising telemedicine applications (see below). All providers of mental health care, particularly large institutions, should consider how to reorganise their structures in order to be prepared to maintain general psychiatric services without substantial reduction of their capacities. A further challenge is to provide treatment and care to those patients who avoid institutional settings, as happened in many countries during the peak phase [13].

Future peaks of the pandemic are to be expected and a – not unlikely – rise of the reproduction number to 1.5 will likely bring the Swiss healthcare system to the brink of collapse if it is related to a surge in COVID-19 illness [14]. Therefore, all services should consider developing and implementing contingency plans that cover situations such as large-scale infection rates both in service users and in staff. Providers ideally will prepare operating procedures that ensure that service users and staff will be tested, quarantined or isolated according to the national and cantonal standards. Furthermore, regional treatment mandates can make it necessary to assign specific areas in inpatient settings in order to provide the infrastructure needed, such as small wards for infection control and psychiatric treatment of infected individuals. Moreover, inpatient as well as day care and outpatient settings should be able to provide treatment and care while complying with hygienic measures and physical distancing.

The demand for mental health care in recent years was rising, particularly in outpatient services [15], and it is to be expected – as mentioned – that this trend will continue in the post-peak phase. Consequently, services will probably need to scale up their capacities and offer flexible treatment services. It has to be anticipated that the increasing demand cannot entirely be met by current capacities. This is especially true for outpatient and outreach services, as they will be the backbone of future mental health services. It is also questionable whether the expansion of services can be achieved with the currently available staff. It is very likely that mental healthcare facilities will need to recruit and train new staff to serve the changing needs. This will also entail a chance to develop new professional roles, such as Advanced Nurse Practitioners [16] in outpatient mental health care (mental health nurses with a Master's degree), who may serve as first responders and gatekeepers in order to refer service users to the appropriate treatment.

General outline of pandemic-adapted mental health services in Switzerland

Although mental health care services try to deliver person-centred care, this needs to be adapted during a pandemic. Italian experience from the current pandemic suggests that

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a community-centred orientation is needed in the entire healthcare system [17]. Acute care hospitals and mental hospitals run a high risk of becoming infection clusters [18, 19], as became apparent during the current crisis in nursing homes. Therefore, treatment and care settings should to be much more diversified than before the pandemic.

Inpatient treatment and residential care should be used much less during an epidemic and must be adequately organised to minimise the risk of transmission of infections. According to the Italian Society for Psychiatric Epidemiology, which published guidance on this matter during the pandemic peak phase, entrance to inpatient care should be restricted to emergency admissions only [20]. This is certainly to be recommended during a pandemic peak phase, and we also recommend reducing inpatient admissions in general. The primary target group of inpatient treatment should be patients with any kind of urgent or emergency case, be they voluntary or compulsory. This may also include patients who are unable to adhere to public health restrictions owing to an acute exacerbation of their mental disorder. Furthermore, inpatient treatment should also be available to voluntary patients who need a safe environment because of the current social circumstances and to patients who need special treatment settings such as inpatient psychotherapy.

However, inpatient psychiatric settings must be available for individuals with acute and severe mental health problems and crises of any kind, and must not be used for any purposes related to prevention of infections that are not related to mental health. We have experienced that the Swiss law on children and adult protection, as well as the law on epidemics, are not always utilised according to their purposes. The recent extraordinary public health situation brought the risk of using psychiatry as a mere institution to provide restrictive settings to control nonadherent behaviour, even if it was not directly derived from mental disorders. This impulse should be resisted by all healthcare providers in order not to increase stigma on psychiatry and psychiatric patients or to fall back to allocating psychiatry the role of mere behaviour control.

Likewise, care home admissions should only be utilised in cases that seem absolutely necessary. As already mentioned, during the peak phase residents were commonly not allowed to leave the premises. As new spikes and lockdown measures are possible, this situation is unsustainable for longer periods of time. This adds to the risk of creating infection clusters and, therefore, care home utilisation should be minimised as far as possible and be replaced by outreach services.

Shifting to outreach services during the post-peak phase may be the key measure to re-establishing person-centred care and therapeutic alliance, which are difficult to maintain under the rule of infection control in inpatient settings. Furthermore, outreach services may foster infection-related trust in mental health services as many service users have avoided coming into institutional care. Home treatment has been established and evaluated in several places across the country prior to the pandemic [21, 22]. Studies have shown that many patients who are commonly treated in inpatient settings are able to be cared for at home. Additionally, a subgroup of service users prefer not to be treated in inpatient settings, but rather at their own place [23]. Therefore, we recommend expanding outreach treatment services to all cantons and catchment areas. We are aware that this is not in line with recommendations from other professional organisations (e.g., German Psychiatric Association DGPPN [24]) that stress the risk of spreading the infection through home visits during the pandemic. However, in our view, these risks are much lower than in institutions, when safety procedures are followed [20]. The expansion of home treatment / outreach services may also serve as an advancement of mental health provision in general.

Following the same rationale, we also recommend expanding to all cantons supported housing services similar to those that have been already established in Zurich [25] and Bern [26]. Care home settings are not better than outreach services in providing long-term care for people with mental illness [27]. In addition, as for treatment settings, service users show a strong preference to be cared for at home [28]. The pandemic should be a strong impetus to reduce the comparatively high number of care home places in Switzerland. Shifting to outreach care will imply that infection control measures such as distance keeping, face masks and regular physical health checks must be upheld.

The shift to outreach care should be supported by an increasing use of telemedicine applications [29]. During the pandemic peak phase, many services have switched from face-to-face contacts to virtual contacts. Although many professionals have been sceptical about whether this could work, it turned out to be possible, was accepted by many service users and helped to minimise the infection risk. Provided that service users who want to have virtual contact have access to the right equipment, are able to handle the devices and can afford the acquisition, this step could save travel time in many cases and could serve to increase caseloads of outreach staff. Telemedicine is, however, not always appropriate for mental healthcare services as the therapeutic alliance may be negatively affected or the situation at service users' home does not allow therapeutic contact because of listeners or other interferences. Additionally, it became evident during the pandemic that many staff needed technical and social guidance for working over the Internet by using conference applications. Finally, data protection regulation must be applied to maintain privacy and confidentiality.

The recent pandemic has also underscored and accentuated the problems of the Swiss reimbursement scheme for mental illness. As inpatient treatment admissions were decreasing owing to administrative restrictions and avoidance by patients, outpatient and outreach services were insufficiently reimbursed and were not able to compensate for the loss of treatment. It has, thus, become clear that a pandemic-adapted mental healthcare system needs a strong outpatient part, as has been demonstrated in many regions in recent weeks. Therefore, the current disincentives to outpatient and outreach settings should be overcome.

Fostering social inclusion during and after the pandemic: micro-communities and supported employment

People with mental illness have – on average – smaller social networks than the general population, which is a clear disadvantage in terms of social support and social inclu-

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sion. Community mental health services should aim at supporting service users to enlarge and maintain their social networks. However, research has failed to establish evidence for such interventions [30, 31]. This is very unfortunate in times where there is a need to have sufficient social support, but to limit the size of the network in order to serve infection control.

New sociological research during the current pandemic has suggested that micro-communities could be part of the non-pharmacological mitigation strategy for responding to the virus after the peak phase [32]. A micro-community is established by voluntary social contacts with a strictly limited number of people where community members do not change. Although there is no evidence yet that this will work for people supported by community mental health services, we recommend an intervention based on peer support and already existing friendships and acquaintanceships that tries to combine social support and epidemic mitigation – this may also be helpful in non-pandemic times.

Another social inclusion concern is the future of Supported Employment programmes during and after the pandemic. Supported Employment programmes have been established across Switzerland and have been evaluated very positively [33, 34]. Today, even developed countries will probably have to cope with a massive rise of unemployment in the coming months and years. Initial hopes for a short-term recession where the economy was supposed to bounce back after a deep fall have apparently faded. Most likely we will see a recession that will last at least several months [35, 36], before getting back to economic recovery. The experience from the 2007/2008 recession has shown that people with mental illness have a high risk of being dismissed from their jobs and that Supported Employment programmes have suffered tremendously from the economic downturn [37]. As the current economic outlook for Switzerland is even bleaker than at that time and will remain so according to the latest economic outlook from August 2020 [38], we expect severe problems when trying to get people with mental illness back into the general labour market.

To mitigate the effect of the economic downturn on the occupation opportunities of people with mental illness, we propose three measures. Firstly, furloughed employees (Kurzarbeitende, personnes avec une réduction de l'horaire de travail) who suffer from mental illness should be eligible to be admitted to Supported Employment programmes that aim at job retention. Secondly, to compensate for the structural disadvantage that people with mental illness have in the future labour market, hiring credits and wage subsidies should be considered as incentives for employers [39]. Thirdly, as the future labour market will undoubtedly be much more digitalised than before, specific digital and social skills training should be offered in Supported Employment programmes [40].

Conclusion

The COVID-19-pandemic changed the Swiss mental healthcare services immediately and will presumably continue to do so in the upcoming months. In cases of probable upcoming lockdowns, we see a considerable risk of losing touch with service users who have a high need for care and treatment as a result of the recent public health restrictions. To avoid loss of contacts, further deterioration of therapeutic alliance and increasing social exclusion, we propose a rethink of key aspects of the current mental healthcare system. By having a more diverse spectrum of care and treatment services with an emphasis on outpatient and outreach services, we are convinced that the entire mental healthcare system will be better prepared, more resilient and more person-centred should the pandemic last for a longer time or should there be future peaks and lockdowns. Finally, we wish to stress that the contemporary situation and the required changes will certainly need a high degree of input of the experiences and knowledge of service users. This situation may also be an opportunity to include service user expertise in policy and research. The unprecedented changes that the entire country and its healthcare system has experienced in recent months and will likely see in the future cannot be managed only by professional judgement.

Disclosure statement

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