



Public Health
England

Protecting and improving the nation's health

Protecting the mental health of vulnerable people living in institutions following infectious disease outbreaks

A rapid review

Contents

| | |
|--|----|
| Review question | 3 |
| Main messages | 3 |
| Background | 4 |
| Objective | 4 |
| Methodology | 4 |
| Evidence | 5 |
| Supplementary evidence | 6 |
| Limitations | 7 |
| Conclusions | 8 |
| Disclaimer | 9 |
| References | 10 |
| Annexe A: Methods | 11 |
| Literature search | 11 |
| Protocol | 11 |
| Sources searched | 11 |
| Search strategy | 11 |
| Screening | 15 |
| Data extraction and quality assessment | 15 |
| Annexe B: Data extraction | 18 |
| About Public Health England | 21 |

Review question

What interventions are effective in supporting mental health of vulnerable people living in institutions (care homes, refuges, and prisons) following infectious disease outbreaks?

Main messages

1. Two studies were identified across peer reviewed and non-peer reviewed literature sources: one qualitative study and one mixed methods cross-sectional study. Both were conducted within nursing homes during the coronavirus (COVID-19) outbreak and outside of the UK. No studies were identified from other residential settings.
2. Interventions examined the re-introduction of visiting following lockdown and the use of student volunteers for telephone contact with residents.
3. Both studies found mental health and wellbeing benefits from social contact or connectedness for people living in institutions, but both had significant limitations and/or weaknesses. One identified adverse intervention outcomes of anxiety regarding infection risk.
4. Supplementary evidence described interventions for wellbeing including digital support for connection, enhancing opportunities for socially distanced activities, and innovative ways to maintain creative and fun pastimes, or to maintain routines, but their effectiveness was not evaluated.

Background

There is potential for infectious disease outbreaks to occur in institutions where vulnerable people live within a closed setting, such as care homes, homeless hostels and prisons. Residents are at increased risk of infection and experiencing more severe disease compared to boarding schools or other institutions with younger and healthier populations. Public Health England reported 6,811 suspected COVID-19 outbreaks across 15,476 care homes in England between 9 March and 19 July 2020. (1) COVID-19 outbreaks have been associated with worsening mental health, either directly through experiencing infection or through fear and anxiety for the disease. Infection prevention control measures adopted during outbreaks, particularly quarantine and isolation measures, have also been associated with deterioration in mental health. (2 to 4)

A rapid review on interventions to support mental health of vulnerable people in residential institutions was commissioned by the Department of Health and Social care in July 2020, to inform the mental health and psychosocial support response to the pandemic.

For the purpose of this rapid review, mental health is defined as a state of wellbeing, in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. (5) Mental disorders represent disturbances to a person's mental health that are often characterised by some combination of troubled thoughts, emotions, behaviour and relationships with others. (5) Both promotion of mental health and wellbeing and prevention of mental disorders were in scope for this review.

Objective

The objective of this rapid review was to identify and assess the evidence on interventions to protect and support the mental health of vulnerable people living in institutions during the COVID-19 lockdown, and their effectiveness.

Methodology

A literature search was undertaken to look for primary evidence related to COVID-19, Severe Acute Respiratory Syndrome (SARS) or Middle Eastern Respiratory Syndrome (MERS) outbreaks published (or available as preprint) between 1 January 2000 and 6 August 2020. See [Annexe A](#) for details of the methodology. A protocol was developed a priori.

The research question looked at adults aged 18 years or older living (like sleeping) in an institution. This included residential institutional settings where vulnerable people resided, for example, prisons, residential care homes, refuges/hostels, supported living, detention centres but not boarding schools or university halls of residence. This review did not specify a focus on people with dementia or learning disabilities, although these groups were likely to be

represented within the institutions searched. This review was also interested in outbreak situations where lockdown or quarantine measures had been put in place for longer than one week at scale such as SARS, MERS and COVID-19. This review included any interventions that had outcome measures for mental wellbeing or mental ill health. Quantitative and qualitative studies were included. Papers written in languages other than English, and conference abstracts were excluded.

Data extraction was carried out using a standardised template. The Mixed Methods Appraisal Tool 2018 (6) was used to assess quality of evidence. Overall quality scores were not given in line with recommendations for use of the tool: main strengths and weaknesses were identified in the narrative summary.

Evidence

There were 633 unique records initially identified from PsychInfo, Embase, Medline, PsyArXiv, WHO and grey literature sources. After title and abstract screening, 28 full-text articles were reviewed and 2 were included in this review. A PRISMA diagram is provided in [Annexe A](#).

Both included papers were cross-sectional (one mixed-methods, one qualitative) and conducted in nursing homes during the COVID-19 pandemic. One study was conducted in the USA, one in the Netherlands.

Verbeek and others (7) carried out a mixed methods cross sectional study reporting on the initial results of implementing new national guidelines for allowing visitors back into nursing homes across the Netherlands; after initial guidance to prevent COVID-19 spread advised against all but most necessary visits. The study focussed not only on wellbeing outcomes but on outcomes related to infection risk. Twenty-six nursing homes with residents with significant physical and mental health needs including dementia were included in the study representing each local authority. Data were collected from staff at participating homes who were nominated to represent the programme via a mix of questionnaires, telephone interviews, WhatsApp group conversation and analysis of institutional documents.

All respondents reported that staff were feeling positive about the possibility of allowing visitors back. Staff reported that residents and family felt 'joy' and positive emotional benefits of reconnecting: they regarded the visits as a huge added value above other creative solutions such as window visiting and video conferencing. In general, both the residents and their family members were emotional when seeing each other after such a long time. It was reported that, in some cases, residents did not recognise their family due to the long period of visitation restrictions. There were also negative impacts, for example staff reported that putting the protocol into practice locally was stressful, both staff and visitors were worried about the risk of infection, and a minority of families were reported to be too afraid to visit. With regards to trade-off with physical health, it was noted that there were no COVID-19 infections within 3 weeks of visitors returning despite evidence of community circulation. There was variable compliance with infection prevention and control guidance, with the majority of care homes requiring visitor number restrictions, screening and hand sanitisation but fewer requiring PPE or supervision .

The majority of participating homes allowed visitors for all residents in principle; but only 6 out of 26 allowed visits for over 80% of residents; due to logistical difficulties, local prioritisation of need or presence of COVID-19 infection.

There were potential limitations in this study. The only participants in the study were members of staff at the nursing homes (with only one nominated member per home participating in telephone interviews and not all represented in the WhatsApp); who reported indirectly on benefits to residents and families. No data was directly collected from residents or their families and no comparators were used, for example, before and after visitation or comparison to another institutional setting. Staff outcomes were measured using unvalidated tool. There were also no specific quantitative mental health outcome measurements, only qualitative data collected on wellbeing outcomes, and limited integration of wellbeing and other quantitative findings.

Van Dyck and others (8) carried out a qualitative survey looking at the wellbeing impacts on residents and volunteers of a weekly befriending call intervention where student volunteers call nursing home residents. The intervention took place in 3 participating nursing homes in New Haven, USA. The 30 students who took part in the programme and the recreation directors at the nursing homes were surveyed. Feedback about the programme was generally positive. Recreation directors reported that residents appreciated the programme and benefited from it. Volunteers reported personal benefits as well such as giving them a purpose, and a feeling of improved wellbeing and social connectedness. Phone calls were generally interactive and several volunteers identified unique and actionable needs for the residents they were talking to. Volunteers recognised that residents experienced social isolation, restlessness and anxiety: many experienced social isolation before the pandemic. Lack of technology and visual and hearing impairment posed challenges to implementation, recreational directors often needed to help practically resolve these to achieve effective connection.

There were several limitations to this study. The main ones being the small sample size of 30 and that survey, sampling and analysis methods were not reported, meaning it is difficult to assess whether conclusions are adequately supported by the data. No residents were surveyed directly and there were no specific quantitative mental health outcome measurements, only qualitative data collected on mental wellbeing outcomes.

Supplementary evidence

Evidence was identified during screening that did not meet inclusion criteria but was relevant to the research question. Given the lack of available evidence, a summary of this literature is provided for additional insight into possible interventions to improve mental health in institutions following an infectious disease outbreak (although it is noted that effectiveness has not been measured or reported). These activities include digital support for connection, enhancing opportunities for socially distanced activities, and innovative ways to maintain creative and fun pastimes, or to maintain routines.

Anecdotal evidence highlighted different forms of technology that can be used to alleviate social isolation in the elderly during lockdown, for example free communication platforms, companion robots and video games. The 'digital divide' that exists between older people and technology was also raised, particularly for those with low education and income. (9) In one example an elderly Alzheimer's care home resident who started showing signs of anxiety, confusion, poor appetite and agitation following lockdown improved after regular FaceTime sessions were set up between the daughter and her father. (10) Dudley council purchased tablets for their nursing and care home providers along with technical support to set them up, provide training and technical support. This allowed residents to connect with family, friends and faith groups. In a report by the Social Care Institute for Excellence on actions of care homes and supported living facilities, multiple care homes talked about the importance of video calling and both staff and residents expressed an interest in continuing them after lockdown. (11)

A commentary described the importance of balancing infection management and person centred care to maintain mental health in the residents; (12) highlighting the importance of increasing the frequency of social activities, and maintaining group social activities (following social distancing guidelines), and continued opportunities for residents to go outside (for walking or otherwise), to see family and interact with other residents in a safe way. Data gathered by the Social Care Institute for Excellence also highlighted the importance of making meals and food special; and that recreating shops and cafes was perceived to be particularly helpful for those with autism and/or learning difficulties as it helped provide a 'new normal' for those who struggle with a change in routine and also helped support skill development. (11) The report also included examples of socially distanced activities that have been carried out: movie and popcorn nights, afternoon tea and barbeques, and even an outdoor cinema which one care home opened to the local community. Some care homes provided arts and crafts and games which included zoom/socially distanced bingo, making planters out of old tyres, hunt the teddy, making fat balls for birds and making and sending cards to families. Another craft example featured a charity that teaches prisoners needlework with set patterns which are then sold, giving prisoners a sense of income as well as aiming to improve discipline, hope and self-esteem. (13) As the charity was no longer able to go into prisons they created extra kits to be distributed to the prisoners so that this creative task and income source could continue during lockdown.

Limitations

This review only identified 2 English language studies that fit the inclusion criteria. The restriction of the review to English language studies only will have missed relevant literature from other settings including the Middle East and Asia where initial SARS Co-V and MERS outbreaks were situated. Neither of the included studies were experimental, and both were appraised to have risk of bias which reduces confidence in findings. The majority of the excluded studies were descriptions of approaches but without evaluation of applied interventions with outcome measurement. Further reading of the grey literature highlighted

some case studies of actions that had taken place in the community but of which no formal study with outcomes had taken place.

Conclusions

The 2 studies included in this review identified positive wellbeing outcomes associated with social contact, although neither explicitly measured mental health outcomes using validated measures. The first identifies complexities associated with contact between family and residents and improved reported benefits of in-person over video and window social visits. The second identifies bi-directional benefits of connectedness between volunteers and residents with befriending calls.

It is difficult to draw conclusions on how to effectively support mental health in institutions following outbreaks given the lack of available evidence. No papers were found relating to prisons or other residential homes indicating a gap in the literature. The new context of the pandemic in Western countries may mean that relevant studies were missed through limiting the search to English language and those which have been published. However, there is a need for robust studies looking at specific interventions to address challenges posed in institutions. An important limitation of these studies was the lack of reported mental health or wellbeing outcomes from residents themselves.

Nonetheless, the interventions:

- highlight the importance of maintaining social contact to enhance mental wellbeing of residents, using creative and digital approaches where necessary
- highlight bidirectional benefits for volunteers, staff and family members but that these visits can also be stressful and impacted by anxieties about infection prevention and control
- give greater insight into the strength, benefits and implementation challenges of a broad range of innovations associated with social contact through various means with care home residents

This review found additional approaches utilised by institutions to enhance mental health and wellbeing, but with no outcome measures. There is a clear research gap for such approaches that would benefit from being evaluated. Given the lack of direct evidence, it is important to consider the application of the wider evidence base around mental health promotion and preventing mental ill health that may be applied to these settings. Further research should also consider the interplay between the cognitive ability of residents to understand any pandemic situation and control measures in place and their wellbeing.

Disclaimer

PHE's rapid reviews aim to provide the best available evidence to decision makers in a timely and accessible way, based on published peer-reviewed scientific papers, unpublished reports and papers on preprint servers. Please note that the reviews: i) use accelerated methods and may not be representative of the whole body of evidence publicly available; ii) have undergone an internal, but not independent, peer review; and iii) are only valid as of the date stated on the review.

In the event that this review is shared externally, please note additionally, to the greatest extent possible under any applicable law, that PHE accepts no liability for any claim, loss or damage arising out of, or connected with the use of, this review by the recipient and/or any third party including that arising or resulting from any reliance placed on, or any conclusions drawn from, the review.

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Annexe A: Methods

Literature search

This report employed a rapid review approach to address the review question: What interventions are effective in supporting mental health in residential institutions (care homes, refuges and prisons) following infectious disease outbreaks?

Protocol

A protocol was produced by the project team before the literature search began, specifying the research question and the inclusion and exclusion criteria.

Sources searched

Embase, Medline, Psych Info, PsyArXiv preprints, WHO COVID-19 Research Database, grey literature (8 separate sources with COVID-19 specific content where available: Counselling in Prisons Network; Prison and Offender Research in Social Care and Health Network; Offender Health Research Network; Prison Officers Association; University of British Columbia Collaborating Centre for Prison Health and Education; Clinks; Google (10 pages); Social Care Institute for Excellence)

Search strategy

Searches were conducted for papers published between 1 January 2000 and 6 August 2020.

Search terms covered key aspects of the research question, including terms related to the intervention. The search strategy for Ovid Medline is presented in **Box 1**.

Box 1. Search strategy Ovid Medline

| | |
|---------------|---|
| Mental health | <ol style="list-style-type: none"> 1 exp mental health/ (158032) 2 exp mental stress/ (82056) 3 exp psychological well-being/ (18655) 4 exp psychological resilience/ (3637) 5 ((mental or psychological or psychiatric or psychosocial or emotional) adj (health or illness or disorder* or stress or disease* or problem or fatigue or distress or wellbeing or "well being" or resilience or adaptation)).ti,ab,kw. (410420) 6 "mentally ill".ti,ab,kw. (9407) 7 psychosocial*.ti,ab,kw. (133480) 8 psychiatr*.ti,ab,kw. (335886) 9 "mental health problem*".ti,ab,kw. (16296) 10 exp dysthymia/ (8358) 11 exp anxiety/ (209802) 12 exp wellbeing/ (83899) |
|---------------|---|

| | |
|------------------------------------|--|
| | <p>13 exp psychological well-being/ (18655) 14 wellbeing.ti,ab,kw. (25837) 15 "well-being".ti,ab,kw. (97032) 16 wellness.ti,ab,kw. (14269) 17 exp happiness/ (9305) 18 happiness.ti,ab,kw. (8394) 19 "personal satisfaction".ti,ab,kw. (923) 20 exp social isolation/ (22985) 21 "social isolation".ti,ab,kw. (10024)</p> |
| <p>Setting</p> | <p>"non healthcare setting".ti,ab,kw. (44) 24 "non health setting".ti,ab,kw. (6) 25 institution*.ti,ab,kw. (468762) 26 ((religious or educational or academic or professional or correctional or "higher education") adj (institution* or institute or organi?ation* or facilit*)).ti,ab,kw. (21883) 27 exp residential home/ (7080) 28 exp residential care/ (11989) 29 (residential adj (care or home*)).ti,ab,kw. (5487) 30 nursing home/ (51914) 31 nursing home*.ti,ab,kw. (39287) 32 exp home for the aged/ (10882) 33 exp prison/ (15222) 34 prison*.ti,ab,kw. (19195) 35 detention.ti,ab,kw. (4291) 36 detaine*.ti,ab,kw. (2868) 37 exp halfway house/ (996) 38 refuge*.ti,ab,kw. (15415) 39 hostel*.ti,ab,kw. (1122) 40 "homeless shelter".ti,ab,kw. (651) 41 exp university/ (111828) 42 exp college/ (110747) 43 universit*.ti. (65643) 44 college*.ti. (36705) 45 "halls of residence".ti,ab,kw. (36) 46 "supported hous*".ti,ab,kw. (402) 47 commune*.ti,ab,kw. (2926) 48 "communal living".ti,ab,kw. (87)</p> |
| <p>Infectious disease outbreak</p> | <p>exp coronaviridae/ (18109) 51 exp Coronaviridae infection/ (17901) 52 ((corona* or corono*) adj1 (virus* or viral* or virinae*)).ti. (304) 53 (coronavirus* or coronavirus* or coronavirinae* or CoV or HCoV*).ti,ab,kw. (35386) 54 (2019-nCoV or 2019nCoV or nCoV2019 or nCoV-2019 or COVID-19 or COVID19 or CORVID-19 or CORVID19 or WN-CoV or WNCov or HCoV-19 or HCoV19 or 2019 novel* or Ncov or n-cov or SARS-CoV-2 or SARSCoV-2 or SARSCoV2 or SARS-CoV2 or SARSCov19 or SARS-Cov19 or SARSCov-19 or SARS-Cov-19 or Ncover or Ncorona* or Ncorono* or NcovWuhan* or NcovHubei* or NcovChina* or NcovChinese* or</p> |

| | |
|------------|---|
| | <p>SARS2 or SARS-2 or SARS coronavirus2 or SARS-coronavirus-2 or SARS coronavirus 2 or SARS coronavirus2 or SARS coronavirus2 or SARS coronavirus2 or SARS coronavirus-2 or SARS coronavirus2 or SARS coronavirus-2 or SARS coronavirus2 or SARS coronavirus2).ti,ab,kw. (38048)</p> <p>55 (respiratory* adj2 (symptom* or disease* or illness* or condition*) adj10 (Wuhan* or Hubei* or China* or Chinese* or Huanan*)).ti,ab,kw. (612)</p> <p>56 ((seafood market* or food market* or pneumonia*) adj10 (Wuhan* or Hubei* or China* or Chinese* or Huanan*)).ti,ab,kw. (1651)</p> <p>57 ((outbreak* or wildlife* or pandemic* or epidemic*) adj1 (Wuhan* or Hubei or China* or Chinese* or Huanan*)).ti,ab,kw. (132)</p> <p>58 ((infection or disease) adj outbreak*).ti. (1465)</p> <p>59 exp pandemic/ (27736)</p> <p>60 pandemic.ti. (18491)</p> <p>61 exp epidemic/ (106616)</p> <p>62 epidemic*.ti. (28117)</p> <p>63 contagion.ti,ab,kw. (2826)</p> <p>64 exp severe acute respiratory syndrome/ (9078)</p> <p>65 SARS.ti,ab,kw. (22074)</p> <p>66 exp Middle East respiratory syndrome coronavirus/ (2445)</p> <p>67 MERS.ti,ab,kw. (5414)</p> <p>68 exp quarantine/ (2504)</p> <p>69 quarantine.ti. (863)</p> <p>70 "self isolation".ti. (18)</p> <p>71 lockdown.ti. (506)</p> <p>72 "lock down".ti. (7)</p> <p>73 "forced isolation".ti. (0)</p> <p>74 "physical distancing".ti. (40)</p> <p>75 "social distancing".ti. (231)</p> <p>76 confinement.ti. (2729)</p> <p>77 confined.ti. (5331)</p> <p>78 "institutional outbreak*".ti. (38)</p> |
| Population | <p>80 exp student/ (255161)</p> <p>81 student*.ti,ab,kw. (366220)</p> <p>82 exp aged/ (2995354)</p> <p>83 elder*.ti,ab,kw. (374977)</p> <p>84 exp prisoner/ (16608)</p> <p>85 prisoner*.ti,ab,kw. (9435)</p> <p>86 inmate*.ti,ab,kw. (6024)</p> <p>87 ((imprisoned or detained) adj (person* or people)).ti,ab,kw. (74)</p> <p>88 exp refugee/ (13149)</p> <p>89 refugee*.ti,ab,kw. (11910)</p> <p>90 exp agricultural worker/ (19297)</p> <p>91 exp migrant worker/ (1653)</p> <p>92 "migrant* worker".ti,ab,kw. (1571)</p> <p>93 "migrant farm worker".ti,ab,kw. (155)</p> <p>94 exp resident/ (45041)</p> |

| | |
|--|---------------------------------|
| | 95 resident*.ti,ab,kw. (241403) |
| | 96 exp homeless person/ (2078) |
| | 97 homeless*.ti,ab,kw. (13083) |
| | 98 "institutional risk factor |

Table 1. Inclusion and exclusion criteria

Eligibility criteria:

| | Included | Excluded |
|---------------------|--|--|
| Population | Human. Adults 18 years older living (i.e. sleeping) in an institution as their main place of residency and do not have an alternative place to live | Non-human studies, Children less than 18 years. |
| Settings | Prisons, residential care homes, refuges/hostels, supported living | Boarding schools, hospitals |
| Context | COVID-19, SARS, MERS and any other infectious disease where lockdown or quarantine has been put in place | Other infectious diseases which do not require quarantine. |
| Intervention | Any intervention that is designed to improve mental wellbeing or reduce or prevent common mental health disorders including anxiety, depression, Obsessive Compulsive Disorder or Post Traumatic Stress Disorder Including clinical treatment Can include whole institution (ie staff and resident intervention) | Any intervention which does not have an explicit aim of improving mental wellbeing or mental disorder Any intervention targeted at staff only |
| Comparator | Comparator not required. | |
| Outcomes | For mental wellbeing use of a validated tool such as the Warwick-Edinburgh Mental Well-being Scale. Use of validated scores for anxiety and depression or PTSD Presence of clinical diagnosis. Qualitative: change in mental health or wellbeing as focus | |
| Language | English | |
| Date of publication | Since 2000 | |
| Study design | <ul style="list-style-type: none"> • experimental or observational studies • systematic reviews | <ul style="list-style-type: none"> • Guidelines • Opinion pieces |

| | Included | Excluded |
|------------------|---|-----------------|
| | <ul style="list-style-type: none">• qualitative studies• mixed methods studies• surveys | |
| Publication type | Published and pre-print Grey literature | |

Screening

Title screening was done by one reviewer and abstract screening was done by 2 reviewers for all records (disagreements were resolved by discussion).

Full text screening was done by one reviewer and checked by a second.

Figure 1 illustrates this process.

Data extraction and quality assessment

Data extraction was done by one reviewer and checked by a second.

The Mixed Methods Appraisal Tool 2018 was used to critically appraise both studies and key sources of bias were identified in the narrative summary.

Variations across populations and subgroups, for example cultural variations or differences between ethnic, social or vulnerable groups will be considered, where evidence is available.

Figure 1: PRISMA Flow diagram

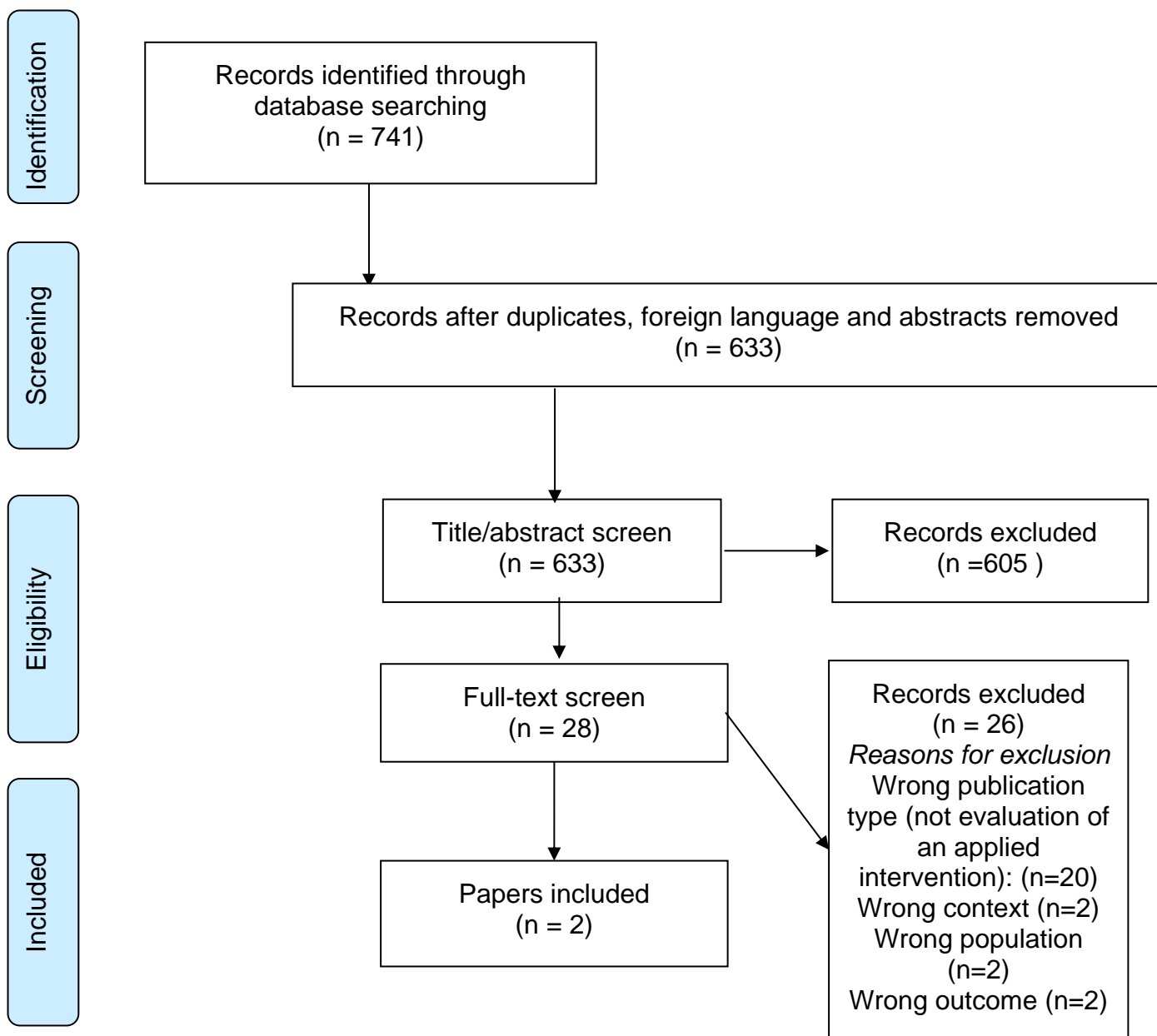


Figure 1: PRISMA Flow diagram

Accessible text version of figure 1

A PRISMA diagram showing the flow of studies through this review, including 741 studies identified from database searches in a search covering the period 1st January 2000 and 6th August 2020.

From these records removed before screening:

- Duplicate records removed (n=108)

N=633 records screened, of which n=605 were excluded, leaving n=28 papers sought for retrieval. All identified reports were retrieved. Of these n=26 were excluded:

- Wrong publication type n=20
- 1. Wrong context n=2
- 2. Wrong population n=2
- 3. Wrong outcome n=2

N=2 papers were included in this review.

Annexe B: Data extraction

Table 1: Data extraction

| References | Study Design | Intervention | Methods | Key findings | Risk of bias (informed by MMAT 2019) |
|---|---|---|--|--|--|
| <p>Van Dyck, L and others</p> <p>Combating Heightened Social Isolation of Nursing Home Elders: The Telephone Outreach in the COVID-19 Outbreak Program</p> | <p>Study type: qualitative study.</p> <p>Objective: To implement and report on a student befriending programme to alleviate social isolation experienced by nursing home residents during the COVID-19 pandemic.</p> <p>Setting: 3 nursing homes in New Haven, USA.</p> <p>Population: 30 elderly residents from the 3 nursing homes in total. No data on ethnicity or sex of participants.</p> | <p>Student volunteers were assigned to a resident for weekly befriending 30 minute phone calls.</p> | <p>Nursing homes were contacted and interested elderly residents were recruited. Students and recreation directors gave feedback after the intervention – sampling and design of data collection is unclear.</p> | <p>Authors concluded that the programme was successful in promoting the social wellbeing of the elderly residents through reducing isolation.</p> <p>Implementation: Front-line healthcare works did not have the capacity to identify appropriate residents for the programme, but this was overcome through use of recreation administrators.</p> <p>Challenges of restlessness, anxiety and isolation were exacerbated by lack of technology, visual and hearing impairments. These factors, when present, needed to be overcome by staff</p> | <p>Small study sample and unclear data collection, sampling and analysis methods. Therefore it is difficult to assess if conclusions made were adequately supported by the data.</p> <p>No feedback collected directly from residents.</p> <p>Qualitative approach appropriate but would have been strengthened by a structured approach and use of complementary quantitative measures.</p> <p>Intervention duration unclear.</p> |

| | | | | | |
|--|--|--|--|---|--|
| | <p>Volunteer students from Yale and recreation directors at the three nursing homes.</p> <p>Funding source: not specified.</p> | | | <p>assistance for effective connection to take place.</p> <p>Outcomes: Recreational directors reported residents participating 'deeply appreciated' the programme and benefited from the calls. Volunteers reported positive effects on their own wellbeing.</p> <p>Other: Feelings of isolation preceded the outbreak for many residents</p> | |
| <p>Verbeek, H and others 2020</p> <p>Allowing Visitors Back in the Nursing Home During the COVID-19 Crisis: A Dutch National Study Into First Experiences</p> | <p>Study type: mixed methods cross-sectional.</p> <p>Objective: Report findings on how guidelines for opening nursing homes for visitors were applied locally and report on the impact on wellbeing for residents, families and staff.</p> | <p>The implementation of new national guidelines for allowing visitors back into nursing homes across the Netherlands; after initial guidance to prevent COVID-19 transmission has advised against all but necessary visits.</p> | <p>Data collected from nursing home staff using various methods:</p> <p>Telephone interviews with contact persons of 26 nursing homes (100%), 24 electronic questionnaires were returned (92%), and for 23 nursing homes</p> | <p>Authors concluded that there was value and a positive impact in allowing families to visit again.</p> <p>Implementation: Visits were stressful to organise and increased workload for staff.</p> <p>Outcomes: Staff reported that staff, residents and families experienced</p> | <p>Only staff were included in the sample, no residents, or family of residents, of the nursing homes were included meaning results may have been biased towards staff opinion.</p> <p>Mental health and wellbeing outcomes were qualitative only.</p> |

| | | | | | |
|---|--|--|--|---|--|
| <p>and Impact on Well-Being.</p> | <p>Setting: 26 nursing homes across The Netherlands, representing all health authority areas.</p> <p>Population: Residents, families of residents and staff of the nursing homes.</p> <p>Funding source: Dutch Ministry of Health, Welfare and Sports, Radboud University Medical Centre, and Maastricht University.</p> | | <p>(88%) documentation, including local protocols, was received. In total, 30 persons participated in the WhatsApp group, representing 20 nursing homes (77%), of which 4 nursing homes were represented by 2 persons and 3 nursing homes were represented by 3 persons.</p> | <p>joy and positive emotional benefit from seeing each other; but also experienced anxiety related to risk of infection.</p> <p>Other: Variable implementation of infection control measures as per government guidance within timescale given. However, no homes participating reported infection in the three weeks following implementation of visiting.</p> | |
|---|--|--|--|---|--|

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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