Covid APPG briefing notes 160920 by Professor Sir Graham Thornicroft

1.   Briefly, what are your **key concerns** regarding mental health and the covid-19 pandemic?

- **Mental health is the 'hidden Covid crisis**[1]
- **And colleagues in China have called mental health a 'parallel epidemic'**
- Yao H, Chen JH, Xu YF. Patients with mental health disorders in the COVID-19 epidemic. Lancet Psychiatry. 2020;7(4):9.

- **Basline - before covid** - ¼ pop has mhp and of these ¼ gets help[2] called the **'treatment gap'**
- And a deteriorating trend of increases number of cases
- **Recent worrying trends**: Slee et al 2020 shows **increase in anxiety and dep of about a 1/3 over** last 5 years in young people
- **Since Covid:** Jia et al BMJ Open show that **dep and anxiety and stress worse** during lockdown especially for **younger, female and at risk groups eg the lonely (Daisy Fancourt)**

- **Immediate effects**
- **Alcohol and cannabis** use has increased (Global Drug Survey, Winstock et al)
- Cannabis use increased 44% among users during Covid
- 48% of British drinkers have increased their consumption
- 30% of drinkers said increased alcohol consumption had worsened their mental health and 47% disclosed that their physical health had deteriorated.

- **Longer term consequences of economic recession**
- A recent model showed that **job losses due to COVID-19** will result in up to **9,570 additional suicides per year worldwide.** Kawohl W, Nordt C. COVID-19, unemployment, and suicide. The Lancet Psychiatry. 2020;7(5):389-90.
- Also expect risk of post recession for suicide. (Hawton BMJ 2013) especially for **men and young people (from last recession)**– therefore support furlough, flexible working
- The pandemic is laying the foundations for a worldwide suicide increase as a result of **increased exposure to known risk factors,** such as economic stress, social isolation, decreased access to community support, barriers to mental health treatment, and exacerbated physical health problems, especially among older adults
- Reger MA, Stanley IH, Joiner TE. Suicide mortality and coronavirus disease 2019—a perfect storm? JAMA psychiatry. 2020
- Stuckler and Basu used the striking summary **"recessions can hurt, but austerity kills"**

2.   For those suffering from a **pre-existing disorder** or condition, what impact has Covid-19 had on their condition?

- Virtual consultations- more difficult to make in person **initial assessments and urgent home visits**
- Transition period organisational changes e.g. changes to prescriptions
- **Repurposing** of psychiatric to medical/covid wards
- **Redeployment** of staff reduces continuity of care
- Lack of **vocational support and day care** during lockdown and social distancing
- Fewer/different self help groups and **digital divide**
- Have more **pre-existing physical disorders and so more vulnerable to severe covid**

- More likely to smoke and to be immunocompromised
- And more likely to be **homeless** or in insecure accommodation
- For other infectious diseases, people with SMD are likely to be at increased risk of: (i) exposure to the disease; (ii) accessing less effective healthcare; and (iii) increased vulnerability for significant morbidity and mortality (1).

3. Have those suffering from pre-existing mental health conditions had **adequate support** and access to services?

- **Partial** – clinical services in some areas diluted or suspended eg IAPT
- **Discontinuity** of care where care co-ordinators are redeployed
- Greater demands for **psychological support**
- **diversion of resources** from mental health settings
- **Greater levels of anxiety /depression** with low social support or domestic conflict

4. Has there been an **increased demand** for mental health services, and to what has an increase been driven by those seeking help for the first time?

- **for men** (higher suicide risk) online and on call supports eg Royal Foundation initiatives and MIND and Samaritans- clear general and targeted messaging about how to access help- NB **end of furlough**
- Need for hotlines and Royal Foundation/Heads Together initiatives
- eg **homeless being discharged from hotels** to be roofless again
- elderly shielded and living alone - **loneliness**
- **Excessive shielding eg OCD** or those not help seeking – so more information about options for elective remote consulting to the general public and remote IAPT
- More help seeking - effect of **reducing stigma** in terms of increased help seeking
- But also **reluctance to go** to a health centre or clinic except in a crisis to avoid infection

5. What impact does having coronavirus and/or a **close family member** having the virus have on individuals' mental health?

- Contributions to **layer upon layer of stress** ie unemployment or work insecurity, domestic conflict, child care, lack of access to open air/recreation, no day care, no respite, students and school children at home, less personal space
- Variable **medication supply** and liaison with pharmacies and fit notes
- Lack/less **respite care** options
- Family and caring responsibilities – **less able to work** or go out from home
- Carers themselves have greater levels of anxiety and depression

6. What impact has the pandemic had on the **ability of service providers** to provide care?

- Early in covid about a **third of infections** among health care workers
- High pressure **demands on staff,** some off work unwell, or shielding, or in social isolation or in quarantine and guilt
- Anxiety depression and ptsd among staff
- Uncertainty over **PPE**
- Variable availability for covid **testing**
- Staff redeployed to **unfamiliar roles** eg psychologists to care coordinator roles
- **Vulnerable staff members eg BAME,** pre existing conditions, age, gender
- Train contact tracers to assess mental health dimension of those affected and referrals
- NB also stigma against staff working with Covid positive patients

7. Is the efficacy of mental health services reduced with a move towards **digital services?** In light of this, do those in need of help have equal access to services?

    - Also **mixed picture,** lack travel time and cost, flexible remote consulting, ability to bring in family members,
    - **Digital divide** / access to computers, tablets smartphones
    - So we need to know - **in what circumstances** is remote acceptable or preferably
    - For which groups, and with what levels of choice
    - **And to understand views of patients and views of staff**
    - Improve stability and predictability of platforms
    - **Blended** contact eg one staff member at clinic or home visit and one remotely consulting
    - **Paranoid patients** may be unwilling to have remote consultations

8. What **Government support** has been made available to those in need of help during the first lockdown, and in your opinion, to what extent was this support effective?

    - **Mixed picture** – some very **positive developments eg homeless people to hotels** and decent accommodation
    - **Furlough has been very helpful** to date, but future prospects now unsure
    - Views on **clarity and consistency of public messaging** re health anxiety for trust
    - **Do not reduce provision of mental health care – rather increase increase it**

9. Is the increase in the prevalence of mental health problems **felt equally across society?** If not, do those who experience this to a greater degree have **adequate access** to help?

    - Affects those already vulnerable and is an amplifier or **magnifying glass for pre-existing disparities,** lower income and more personal/care contact and more overcrowded accommodation or usually homelessness and gig economy
    - **Major risk factors** for mortality from COVID-19, such as diabetes and hypertension , are increasingly common in LMICs, especially among those with lower education levels
    - indices of economic and social disadvantage, such as **poor housing and homelessness, unemployment, social isolation and loneliness,** are important risk factors for contracting the virus and factor **interact**
    - **Building back better** was a concept introduced by the United Nations Secretary-General's Special Envoy for Tsunami Recovery, former US President William Clinton (117). Since then, it has become the approach for nearly all post-disaster reconstruction programs, including upending previously unchallenged and inadequate policies and practices.
    - In 2013, the same principles of building back better were used by the WHO to provide a framework to support the development of sustainable, post-disaster mental health systems, globally (118).

Key resource: 2020 WHO Policy Brief: COVID-19 and the Need for Action on Mental Health UN/WHO

Recommended actions:

1. **APPLY A WHOLE-OF-SOCIETY APPROACH TO PROMOTE, PROTECT AND CARE FOR MENTAL HEALTH**

- Mental health actions need to be considered essential components of the national response to COVID-19. A whole-of-society approach for mental health in COVID-19 means: • including mental health and psychosocial considerations **in national response plans** across relevant sectors, for example

supporting learning and nurturing environments for children and young people who are confined at home;

- responding proactively to reducing pandemic-related adversities that are known to harm mental health, for example **domestic violence and acute impoverishment;** and • crafting all communications to be sensitive of their potential impact on people's mental health, for example by communicating empathy for people's distress and including advice for their emotional well-being.

2. ENSURE WIDESPREAD AVAILABILITY OF EMERGENCY MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

- Mental health and psychosocial support must be available in any emergency. Achieving this objective during the COVID-19 pandemic means: supporting community actions that **strengthen social cohesion and reduce loneliness**, for example supporting activities that help isolated older adults stay connected;
- **investing in mental health interventions that can be delivered remotely**, for example quality-assured tele-counselling for frontline health-care workers and people at home with depression and anxiety;
- ensuring **uninterrupted in-person care** for severe mental health conditions by formally defining such care as essential services to be continued throughout the pandemic; and • protecting and promoting the human rights of people with severe mental health conditions and psychosocial disabilities, for example, by monitoring whether they have equal access to care for COVID-19.

3. SUPPORT RECOVERY FROM COVID-19 BY BUILDING MENTAL HEALTH SERVICES FOR THE FUTURE

- All affected communities will need quality mental health services to support society's recovery from COVID-19, and this requires investment in the following:
- using the current momentum of interest in mental health to catalyze mental health reforms, for example by developing and funding the implementation of national services re-organization strategies that shift care away from institutions to community services;
- making sure that mental health is part of universal health coverage, for example by including care for mental, neurological and substance use disorders in health care benefit packages and insurance schemes;
- **building human resource capacity to deliver mental health and social care**, for example among community workers so that they can provide support; and
- organizing community-based services that protect and promote people's human rights, for example by involving people with lived experience in the design, implementation and monitoring of services. Rapid implementation of these recommended actions will be essential to ensure people and societies are better protected from the mental health impact of COVID-19.
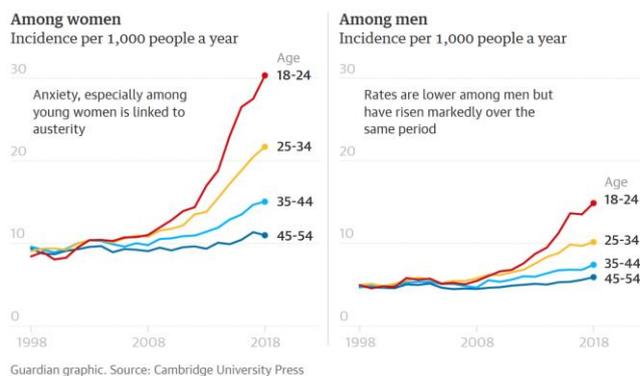
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Key sources

Freemantle et al 2020 British Trends in generalised anxiety disorders and symptoms in primary care: UK population-based cohort study The British Journal of Psychiatry (2020) Page 1 of 7. doi: 10.1192/bjp.2020.159
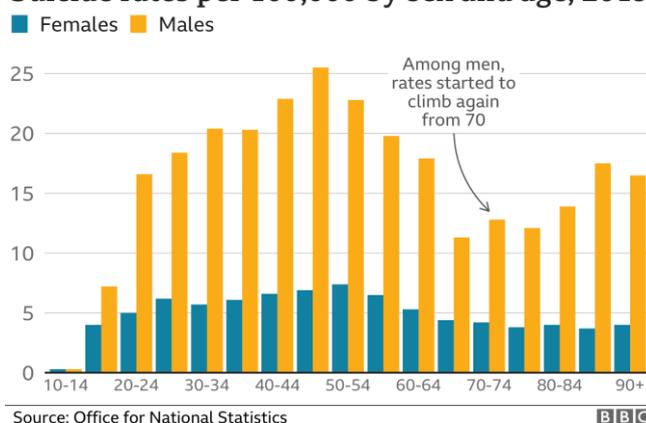
Results Generalised anxiety recording rates increased in both genders aged 18–24 between 2014 and 2018. For women, the increase was from 17.06 to 23.33/1000 person years at risk (PYAR); for men, 8.59 to 11.65/1000 PYAR. Increases persisted for a composite of anxiety and depression (49.74 to 57.81/1000 PYAR for women; 25.41 to 31.45/1000 PYAR for men). Smaller increases in anxiety were seen in both genders age 25–34 and 35–44. Anxiety rates among older patients remained stable, although a composite of anxiety and depression decreased for older women. About half of drug-naïve patients were prescribed anxiety drugs within 1 year following diagnosis. The most common choice was a selective serotonin reuptake inhibitor. Benzodiazepine prescription rate has fallen steadily. Conclusions We observed a substantial increase in general practitioner consulting for generalised anxiety and depression recently, concentrated within younger people and in particular women

Anxiety among young people has trebled over the past 20 years

Among women
Incidence per 1,000 people a year

Anxiety, especially among young women is linked to austerity

Age
18-24
25-34
35-44
45-54

1998   2008   2018

Among men
Incidence per 1,000 people a year

Rates are lower among men but have risen markedly over the same period

Age
18-24
25-34
35-44
45-54

1998   2008   2018

Guardian graphic. Source: Cambridge University Press

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Suicide rates per 100,000 by sex and age, 2019
■ Females ■ Males

Among men, rates started to climb again from 70

10-14 20-24 30-34 40-44 50-54 60-64 70-74 80-84 90+

Source: Office for National Statistics   BBC

Jia R, Ayling K, Chalder T, *et al*. **Mental health in the UK during the COVID-19 pandemic:** cross-sectional analyses from a community cohort study. *BMJ Open* 2020;10:e040620. doi:10.1136/ bmjopen-2020-040620

Results: Mean scores for depression ($-x =7.69$, SD=6.0), stress ($-x =6.48$, SD=3.3) and anxiety ($-x = 6.48$, SD=3.3) significantly exceeded population norms (all p<0.0001). Analysis of non-modifiable factors hypothesised to be associated with mental health outcomes indicated that being younger, female and in a recognised COVID-19 risk group were associated with increased stress, anxiety and depression, with the final multivariable models accounting for 7%–14% of variance. When adding modifiable factors, significant independent effects emerged for positive mood, perceived loneliness and worry about getting COVID-19 for all outcomes, with the final multivariable models accounting for 54%–57% of total variance.

Conclusions: Increased psychological morbidity was evident in this UK sample and found to be more common in younger people, women and in individuals who identified as being in recognised COVID-19 risk groups. Public health and mental health interventions able to ameliorate perceptions of risk of COVID-19, worry about COVID-19 loneliness and and boost positive mood may be effective.

References

1.   Vigo D, Patten S, Pajer K, et al. Mental Health of Communities during the COVID-19 Pandemic. *Can J Psychiatry* 2020: 706743720926676.
2.   Thornicroft G. Most people with mental illness are not treated. *Lancet* 2007; **370**(9590): 807-8.