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What does COVID mean for UK mental health care?

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The coronavirus disease (COVID) pandemic is the biggest disaster United Kingdom has seen for many decades. Not since World War II has there been such risk, displacement and change affecting the whole community. This is the first UK mass trauma in the presence of the National Health Service (NHS) in which developed mental health and social care support systems can offer help. We have no precedents on which to base our expectations of how things might 'work out' as no insult on this scale has occurred in the modern era.

There appear to be three main challenges to the mental health of the UK population and the services available to intervene.

First, a great number of already stretched frontline staff in the NHS, care sector, police forces, and elsewhere are being exposed to prolonged anxiety from several sources. Staff are already worried about their own health and that of their families. Those who cannot avoid person to person contact worry further about contracting the virus and taking it home to loved ones with some staff members even choosing to stay away from their families. Meanwhile, they are seeing members of their 'work family' become ill and in some cases die, at a higher rate than in the general population (Adams & Walls, 2020). To add to this, many frontline staff will be witnessing acute illness and death at a speed and scale not previously known except perhaps in wars and natural disasters like earthquakes and tsunamis. These factors are likely to come together to cause significantly increased rates of mental health problems such as post-traumatic stress disorder (PTSD), anxiety and depression (Benjet et al., 2016) in a system where it already takes significant time to access treatment.

Second, social distancing, though absolutely necessary, has negative consequences for the population as a whole (Brooks et al., 2020). The terminology echoes this problem as social distancing is also about keeping away socially which is the opposite of what is needed. A much better term would be personal distancing with social closeness being maintained. Despite many politicians stressing that COVID affects us all equally, it does not. Several large groups in society are suffering disproportionately. Vulnerable children are not at school when they should be and are thus missing out on education and support. Disproportionate death rates in Black, Asian and Minority Ethnic (BAME) populations among NHS staff (Cook et al., 2020) and the general population (Khunti et al., 2020) bring into stark focus issues of differential status and the social determinants of health. Such is the inequality that Public health England have already setup an inquiry. Frail elderly people are enduring a severe lockdown leading to prolonged and debilitating loneliness for many. Constant messages emerging that those above 70 years must somehow isolate for longer irrespective of their current health status reinforce negative stereotypes of older people and their contribution to society. The unfolding tragedy of large numbers of deaths in the nation's care homes will leave many angered and traumatized too. In acute settings, visiting is being restricted with loved ones unable to see sick people in hospital causing distress on both sides and (coupled with restrictions on funerals) presumably increasing the chance of abnormal grief reactions or illness. Victims of domestic violence including both adults and children are forced to spend longer in the company of their abusers and there is already good evidence of increasing rates of domestic abuse and even deaths worldwide (United Nations [UN], 2020). Children are already at significant risk of abuse, with 47% of the adult population reporting some experience of abuse during childhood; 14% report physical abuse and 6% report sexual abuse with those from deprived areas experiencing the highest rates of abuse. Not being able to access school and other sources of support as well as increased contact with potential abusers may have significantly negative effects on affected children (Bellis et al., 2014).

A survey by Rethink, a major mental health charity, has reported that 80% of people with ongoing mental health problems are reporting a worsening of their condition and many are feeling less supported because of necessary

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service changes (Rethink Mental Illness, 2020). With referrals to mental health services increasing and waiting times for assessment and treatment going up, COVID will only exacerbate these issues. We already know that people with mental health problems exhibit poorer health seeking behaviour and are more likely to experience physical illnesses and to die earlier than their peers. While (socially) distanced, people with mental health problems may be less likely to seek support if they show symptoms of COVID and decreased access to health care services for this group generally may also mean that other illnesses are not picked up as quickly, potentially leading to further mortality.

Third, the lockdown and inevitable ongoing social distancing measures are having a profound effect on our economy and, like most countries worldwide, the United Kingdom is entering recession. The prospect of mass redundancies and continuing economic hardship will lead to both an increased rate of suicide and increased demand upon services. Previous recessions, most recently those following the financial crisis of 2008, have all had these effects and increases in suicide rates were estimated at around 4%–6% internationally following 2008 (Chang et al., 2013). It is hard to imagine that we are in a better position this time around for a number of reasons: in 2008 the suicide rate was declining in the United Kingdom, we were in a period of relative prosperity, investment in health and social care (especially mental health services) had been reasonable and access to services was better than it is now after a decade of austerity. Austerity has particularly affected the vulnerable, especially those in receipt of state benefits and undergoing economic hardship already. The effect of the pandemic and consequent economic downturn are likely again to fall on this vulnerable group and place them at heightened risk once more. While protections have rightly been put in place for the employed, self-employed and the business sector, relatively little has been said about underpinning the support of this group through social security payments, local government service enhancements or health care.

Mental health services nationally have already suffered under austerity (Reeves et al., 2013), as has the wider social care safety net. In many places, care has not been what it used to be or should be for some time, with excessively long waits (especially for psychological therapy) and the regular shipping of acutely unwell patients, including children, around the country due to bed shortages (Galante et al., 2019). Given this backdrop, it is of real concern that mental health services have been partially stepped down over recent weeks, leading to growing waiting lists. As we come out of the first phase of the pandemic, services will be more needed than ever. One would hope that mental health services would be excluded from further austerity if it is required to prevent unnecessary suffering and mortality. Increased rates of mental health problems among the workforce may also that some staff do not remain in their posts or may choose to work reduced hours or fulfil a different role. Given the current staffing difficulties across the United Kingdom, any further insult to staffing levels could have serious consequences.

There are some positives among all this worry. Mental health services and primary care have shown they can be adaptive and flexible when needed, and the use of online video conferencing is now common practice after a prolonged period of uncertainty and even resistance from some clinicians. Necessity has indeed been the mother of invention. While this has been largely a positive, we must also be wary that some groups are less likely to access support virtually, particularly the older generation, patients with learning disability and those with financial constraints. In the general population, after initial panic buying and resistance to community action to reduce viral spread by some, we have seen overwhelmingly positive change. The number of people signing up overnight (literally) to the good Samaritan app was heartwarming as well as useful; and neighbours, friends and families are undoubtedly checking in on and supporting each other more both practically and psychologically. For many of us, the forced slowing of pace has allowed us time to reflect and think about our lives and where we place importance. People are reconnecting with nature and pursuits such as reading and even letter writing. There may also be a positive impact on the environment with more people able to work from home meaning less commuting. There appears to be a resetting of the value attached to roles such as caring, supermarket work and delivery work. It is to be hoped that this renewed focus on the value of hard work and helping others will lead to both improvements in conditions and salaries for such workers as well as leading us to value ‘real work’ more and the practice of making money from money less.

Mental health services have needed change for some years as it has become more and more apparent that they are unable to meet the steadily increasing demand for them in a humane and person-centred way. While there have been welcome investments in services such as Improving Access to Psychological Therapies (IAPT; Clark et al., 2018) it is acknowledged that many who need care and support cannot access it in a timely way. It may be that delivering psychological therapy by virtual means allows more timely access and becomes increasingly common with recent evidence showing that this is both acceptable to patients and comparably effective for the management of anxiety and depression (Wright & Caudill, 2020). Concerns around access would ofcourse have to be taken into account to ensure the groups mentioned previously are not disadvantaged. COVID is a demonstration of the importance of having effective, well resourced, pro-active mental health care (as well as general health care) rather than services that run at the bare minimum and then step up during times of crisis. A crisis such as COVID also shows that collaborative work from the local level all the way up to global initiatives is important to allow sharing of

evidence and experience and, in turn, work towards successful approaches to management. The changes brought by the pandemic and its effects on health workers and the community at large, especially the vulnerable groups mentioned above, will necessitate change. If as a society we do continue to volunteer in large numbers as we are now and if we value those who help others more there is a chance that we can meet the looming challenge of supporting each other through this mass trauma and its aftermath. Most will not need to see specialists but will need to feel supported and heard while also supporting and listening to others. Many will need mental health services and we will need to learn from our recent experiences to harness technology (and common sense!) to once again reach out to those who need it quickly, individually and humanely.

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