



## Covid-19 and the nation's mental health

### Forecasting needs and risks in the UK: May 2020

Dr Graham Durcan, Nick O'Shea and Louis Allwood

#### Summary

- The Covid-19 pandemic is likely to lead to an increase in mental ill health in the UK, as a result of both the illness itself and the measures being taken to protect people from the virus.
- If the economic impact is similar to that of the post 2008 recession, then we could expect 500,000 additional people experiencing mental health problems, with depression being the most common.
- The economic impact is likely to affect different parts of the country differently and therefore the likely increased prevalence of mental illness will be unevenly distributed.
- If the economic impact results in significant unemployment, there is a major risk of an increase in suicides unless action is taken to prevent this loss of life.
- The various 'safety net' initiatives introduced by the Government are likely to be offering some significant protection to people's wellbeing. How and when these are dismantled are also likely to be critical to the fallout in terms of mental wellbeing following this crisis.
- Some communities will be more adversely affected by the outbreak of Covid-19 and we already know that people from BAME communities are overrepresented in critical care and mortality statistics.
- We can expect that Covid-19 and the restrictions imposed by lockdown will increase the proportion of people experiencing more complicated grief reactions.
- 20% of survivors of intensive care routinely experience PTSD. The increased number of people receiving such critical care during this crisis will increase the number who are at risk of PTSD.
- Health and care workers and other frontline workers are at greater risk of developing mental health problems as a result of Covid-19.
- The mental health impact of Covid-19 will not be experienced equally: people with existing mental health difficulties and risk factors for poor mental health are likely to be affected disproportionately.
- The Government and the NHS can take steps now, to prevent mental health problems where possible and to provide access to effective support where it will be needed.

## Introduction

This briefing seeks to use evidence from existing research about the likely impact of the Covid-19 pandemic on the mental health of the UK population. It draws on published evidence to make projections about the potential impacts and which groups within the population face the highest risks to their mental health as a result of the crisis.

We should acknowledge that this crisis, the greatest social emergency since the Second World War, is unprecedented, and we cannot reliably at this point make forecasts on how the mental wellbeing of the general population will be affected. For example, the UK was not seriously impacted by the outbreak of SARS-CoV virus strain earlier in the century. The last serious pandemic was over 100 years ago (the Spanish Influenza pandemic) and there is no meaningful data on its impact on mental wellbeing, in what was a very different age and time in any case. In short, we do not know.

It is equally important to state that we will be revisiting this space several times over the next few months and there will likely be further research and further learning over time that might better inform us.

This said, there is research literature that may help us look in the right direction. Crudely this research literature divides into four groups:

- Research on the impacts of Covid-19 itself
- Research on crises such as disasters or significant events
- Research on more recent epidemics, and on SAR-CoV in particular
- Research on longer term whole population crises such as the impact of austerity policies following the 2008 banking crisis.

In this paper we have chosen to quickly scan the latter two types of research literature as these seem, combined, the most informative to the current crisis.

All research literature has limitations of course. As for the two groups of research not considered in this paper: the research on Covid-19, of which there are already in the region of 40 research reports, has all been published in this year. It reports only on the immediate psychological/mental health impacts, though in some cases has followed up a few weeks after the initial gauging of mental wellbeing has taken place. It has largely come from China, which is socially and culturally very different to the UK and the research has, through necessity, not been peer reviewed or has been more rapidly peer reviewed than would be normal. However, as some of the literature is reporting on live and ongoing studies, this is going to be very informative going forward, and particularly if we see either similarities or differences in the data on previous epidemics. The crisis/disaster research is more longitudinal and does have some useful data on prolonged effects, but it is research on particular events which were often dramatic and short lived (lasting days or weeks) and limited in the number of communities they affected.

As for the research literature we have chosen to focus on: the previous epidemic research literature reflects both the nature of those epidemics and the nature of the responses to them. Much of how a government should respond to large scale epidemic and pandemic was learnt from the 2002-2004 SARs-CoV outbreak, but nothing like the current scale of restrictions was applied at the time. This research is not informative on indirect consequences of an epidemic, such as the impact on economies. This is because, with some exceptions, the scale of the outbreaks had not been large scale. Hence we have also looked at research on longer term whole population crises and specifically on governments' responses to the banking crisis and the policies of austerity. These do inform us on the longer-term economic fallout of this crisis, especially as it is so dramatically affecting many businesses.

## Research on previous epidemics

There have been several recent epidemics and some of these have literature on their mental health impacts. These include a SARS-CoV outbreak between 2002-2004 with 8,000 reported cases across 29 countries, Ebola virus disease (EVD) in West Africa between 2014-2016 and Middle East Respiratory Syndrome (MERS) in South Korea in 2015. None of these epidemics or outbreaks has been of the scale of the Covid-19 virus, indeed the South Korean outbreak involved the confirmed infection of less than 200 people (although 6,000 people were quarantined). Equally some other epidemics have had a much higher reported death rate, the prime example being EVD which has an average fatality rate of 50% (range 25% - 90%; WHO, 2020) for those infected. Therefore, there are differences in the number of people impacted by these and the current crisis, and there may also be differences in the severity of mental health impact.

What we do know from the studies on mental health resulting from previous epidemics is that there is both an immediate impact on mental health and a longitudinal one. Typical symptoms will be those of depression, anxiety and those associated with PTSD, and sleep deprivation. West African survivors of EVD still had significant symptoms at 19 months post infection and recovery with serious depressions still being diagnosed at that point (Mory Keita *et al.*, 2017). One study found that 64% of SARS-CoV survivors (both non-health care and health care workers) still had symptoms at a clinically diagnosable level at a one-year follow-up: 36.3% with moderate to severe depression (4.4% had severe depression), 36.7% had moderate to severe anxiety (14.4% had severe anxiety) and 32% had symptoms of trauma (Lee *et al.*, 2007). Mak and colleagues' study on SARS-CoV survivors found that 58.9% had clinically diagnosable mental health problems initially and at 30 months this had reduced to 33.3%, including 25% with PTSD and 16% with depressive disorders (2009).

A study of the psychological impact on survivors of MERS indicated that those who had chronic fatigue at 12 months post discharge had a continued heightened risk of post-traumatic stress symptoms (Hee Lee *et al.*, 2019).

### Intensive care and trauma

Simply being an intensive care patient for any reason brings with it a risk of significant mental health problems. Receiving intensive care for coronavirus can be frightening for those with prior knowledge of the statistics on recovery rates for those who have required the most intensive treatment. Treatments themselves can also be physically invasive too, whether from the discomfort of intubation or the side-effects of sedation, which can include muscular dystrophy.

Rigny and colleagues (2019) conducted a systematic review and meta-analysis of published studies and established that 20% of those in critical care will suffer significant symptoms of PTSD during the 12 months after discharge and the prevalence remains high at the 12-month point. These are similar rates to survivors of civil wars (26%) and humanitarian disasters (20%). In a normal year that could result in between 50,000 to 60,000 cases of PTSD in England alone. As of 24 April 2020 there were reported to have been 6,720 patients infected by Covid-19 admitted for critical care, for whom the data on outcomes is available for 4,078. Of these, 2,067 (50.7%) have died and 2,011 (49.3%) have survived (ICNARC, 2020). If we assume (and we may be wrong to) that the survival rate is true for all 6,720 patients and that the 20% PTSD rate in survivors also applies, then as of 24 April there were at least 663 survivors likely to suffer significant PTSD over the next 12 months (ICNARC, 2020).

Pre-existing anxiety or depression are major risk factors for PTSD following any episode of intensive care (Nikayin and Rabiee, 2016).

One UK study (Hatch *et al.*, 2018) found that survivors of critical illness who report symptoms of depression have an increased risk of dying in the two years following discharge from intensive care.

Evidence emerging from China (Bo *et al.*, 2020) has also shown patterns of post-traumatic stress symptoms in Covid-19 patients who were 'clinically stable', i.e. those with coronavirus who didn't need intensive care, which suggests that psychological interventions or follow up assessments could be required for a larger population of Covid-19 patients.

Further to this, infections and admissions to critical care are not equally spread in our communities. Approximately 34% of critical care patients are from Black, Asian and minority ethnic communities (based on demographics on 6,720 patients) and they account for 31% of the deaths and 26% of the survivors (based on the 4,078 patients for whom we have outcome data) (ICNARC, 2020). This may have a variety of explanations including representation in the frontline workforce. Regardless of the reasons, it is reasonable to expect people from BAME communities will also be over-represented in the PTSD statistics resulting from this crisis.

Likewise, BAME groups' representation in the frontline workforce may mean they are disproportionately exposed to other challenges to their mental wellbeing.

## Grief, loss and bereavement

In normal circumstances, when people suffer loss and bereavement, around 7% will have a more complex reaction, with more severe and prolonged grief symptoms. The experience of grief itself does not necessitate intervention, but complex reactions can do. There are circumstances associated with this crisis which may add to the difficulty of those mourning the loss of a loved one. These include restrictions placed on visits to hospitals, care homes and even in the community and then further restrictions placed on funerals. We should therefore expect that a greater number of people will have a greater struggle over the loss of loved ones and may require some intervention. This may affect tens of thousands of people as a result of both Covid-19 and other causes of death during this time.

## Impacts on the health and care workforce

Working in health and care settings is stressful under normal circumstances, but a Canadian study comparing health care workers who worked with SARS-CoV patients to those that had not stated that the prevalence of significant distress is 50% higher in those who worked with SARS-CoV patients. Additionally, post-traumatic stress and burnout were also significantly higher for this group, and the negative effects persisted for at least 1 to 2 years after the outbreak. Health care workers who had worked with SARS-CoV infected patients had significantly decreased face to face patient contact and working hours, and they had significantly increased smoking and drinking "or other behaviours that could interfere with work or relationships" at follow-up when compared to health care workers who had not worked with these patients.

Health care workers made up 20% of SARS-CoV infections globally by 2004 (Sim & Chua, 2004) and it should therefore not be surprising that risk of infection might be a cause of significant stress and more among health care workers. Measures of the psychological impact on health staff of SARS-CoV ranged between 29% and 93.5% at the point of outbreak in different studies (see Douglas, 2009). In one Chinese study, about 10% of hospital staff reported having high levels of trauma at the time of the crisis and 40% still had significant symptoms some three years on (Wu *et al.*, 2009).

Here in the UK, the NHS is experiencing unprecedented strain, and there have been warnings about the damaging effects this has on health and care workers as well as the increasing pressure on social care and especially residential care services.

In a recent survey of its membership in which more than 6,000 doctors responded, the British Medical Association found that 44% described experiencing depression, anxiety, stress, burnout or other mental health conditions 'relating to or made worse by their work' (BMA, 2020). A survey of the broader health workforce by the Institute for Public Policy Research found that half of respondents felt their mental health had declined over eight weeks and over a fifth

were more likely to leave the sector as a result of Covid-19 (Thomas and Quilter-Pinner, 2020).

Burnout is an 'occupational phenomenon' characterised by feelings of exhaustion, feeling distanced from or negative towards one's job, and reduced professional efficacy (WHO, 2019). Before the pandemic, this was already a risk for many health care workers. Being overstretched, stressed, and experiencing burnout have been themes in NHS staff surveys in recent years; this was acknowledged less than one year ago in the Interim NHS People Plan (NHS, 2019).

It has also been noted that coronavirus puts health and care professionals at greater risk of 'moral injury' (Greenberg, 2020). A concept primarily explored in the context of military service, moral injury refers to the profound psychological distress which occurs when one's moral or ethical code is violated; this can be caused by their own actions or inactions, helplessness, or experiences of betrayal from leaders (Litz *et al.*, 2009). Moral injury can lead to shame, guilt and other negative thoughts which in turn may contribute to mental health problems such as depression, anxiety and post-traumatic stress disorder. During the Covid-19 outbreak, many health care professionals and key workers are working in a changed, challenging environment which may give rise to moral injury. They may be more exposed to decisions which they perceive to lead to patient deaths; feelings of being let down by being given insufficient resources to work safely and effectively; feelings of helplessness when self-isolating or being unable to save the lives of critically ill patients; and worries that they are putting their families or colleagues at risk (Greenberg, 2020).

Moral injury is not inevitable. Indeed, some people experience 'post-traumatic growth', where their values and self-worth are affected positively through their contributions in very challenging circumstances (Brooks *et al.*, 2020). Leaders and managers can support frontline staff to cope with these experiences by preparing them for the difficult emotions and behaviours they may experience, encouraging and providing early access to informal social support, and proactively monitoring team wellbeing.

The presence of a 'shared traumatic reality' is an additional consideration which could affect those providing mental health, social and emotional support during and after the pandemic. This occurs where therapists and other practitioners are exposed to a traumatic event, both through their clients' experience and their own direct exposure (Freedman and Mashiach, 2018). Most research in this area has drawn on experiences of war, violence, and natural disasters. In some form or other, all of our lives have been deeply changed by coronavirus, and many of those tasked with supporting others' mental health will themselves have experienced illness (or the fear of illness) first-hand, have lost loved ones or colleagues suddenly, or – longer term – been affected or know people affected by the economic impact of coronavirus.

Studies suggest that therapists who have been exposed to the same traumatic conditions as their patients can experience long term emotional distress – beyond that which they may otherwise expect to when dealing with traumatised clients. Feelings of helplessness and guilt have also been reported, and some practitioners who have provided support after major traumatic events in which they themselves were affected have described feeling less professionally confident and competent. Conversely, shared experience can also be experienced as an enabler for effective practice, as practitioners share some emotional understanding and can respond empathetically, and there is evidence that major traumatic events can provide additional motivation to provide help (Dekel and Baum, 2010).

Understanding these dynamics may be particularly important when working with those communities identified as disproportionately affected by the coronavirus outbreak and its consequences, including those from some BAME communities (Platt and Warwick, 2020). In some areas the mainstream mental health support offer has been historically poor, and so many seek and receive valuable, culturally appropriate help from community based groups and organisations. Ensuring that those providing this support are adequately prepared and supported themselves is important.

## Longer term, whole population crises

Many economies across the world were affected by banking crisis of 2008 and its aftermath. The UK Government, like many others, provided huge funds to support banks. They then sought to rectify the deficits supporting the banks had brought about through large scale cuts in public spending, implementing policies of austerity. In the UK, the most deprived areas were the hardest hit: there was a 20% cut in social security payments, with the most severely disabled bearing 15% of these costs (see Cummings, 2018).

*“...The links between financial problems and mental illness are quite well known to those working in the mental health field. Unemployment, a drop in income, unmanageable debt, housing problems and social deprivation can lead to lower well-being and resilience, more mental health needs and alcohol misuse, higher suicide rates, greater social isolation and worsened physical health. To give one example, 45% of people who are in debt have mental health problems, compared with only 14% of those who are not in debt [citing Fitch et al., 2011].” (Knapp, 2012)*

There is very clear evidence that the prevalence of mental illness rose between 2009 and 2013, both in the UK and across Europe, during a period that coincided with public spending cuts, increases in debts, and a rise in unemployment in some countries and in some regions within others (e.g. see Stuckler *et al.*, 2017). It is also important to note that whilst austerity policies impacted very widely, they did so unevenly, with some localities more affected than others (Stuckler *et al.* 2017).

Most research in this area has shown that the gaps in inequality (and consequently in mental wellbeing) between deprived areas and less deprived areas widened significantly in the period following the implementation of austerity policies (Akhter *et al.*, 2018). The importance of social security ‘safety nets’ is a theme in this research literature, and there are potential lessons to draw for our current

crisis. The ‘safety net’ is a key feature of the UK Government’s response to the current crisis, where a range of initiatives have been made available to businesses and individuals alike. Stuckler and colleagues’ (2017) review of the impact of austerity policies across Europe found that populations least affected by the crisis were those living in countries with the greater safety nets, citing Germany and Iceland as key examples (both of whose economies, and notably the latter, were significantly affected during the financial crisis). Social security payments are a key part of safety nets but so too are some employment programmes (see below).

Riumallo-Herl and colleagues (2014) reviewed the impact of unemployment on mental health in the USA and across 13 European states. They found that job loss in the 50-64 year old age group was associated with a 28% increase in depressive symptoms in the States and an 8% in Europe. Stuckler and colleagues (2018) note that similar patterns were observed in other states, including the UK. They further observe a 6.5% rise in suicide rates across Europe at this time, which remained elevated even when GDP improved. Up to 2007, suicides rates had been reducing in Europe. There is quite a strong association between suicide and unemployment (Reeves *et al.*, 2014). Equally, some policies to combat unemployment are protective and are associated with a reduction in suicide. Reeves and colleagues observed that “...Greater funding of effective labour market programmes and higher levels of social capital appear to enhance resilience among vulnerable groups, buffering the impacts of job loss and fear of job loss, and its resulting social consequences, on mental health...” (2004).

Bank and colleagues (2020) estimate that if the UK were to experience a similar economic impact after this crisis to that of the recession that followed the 2008 banking crisis, we might expect an additional 500,000 people to experience mental health conditions.

## Estimating the economic impact of Covid-19

As detailed above, the economic impacts of Covid-19 are likely to have such a significant effect on the public's mental health in the coming years. This section provides headlines about the wider economic picture and what will influence it in order to provide context for the mental health impacts of the pandemic, both in the UK and globally.

### 1. The health of the economy affects the health of the nation

The direct link between the health of the economy and the health of the nation means that recessions cause illness and deaths. The impact on mental health is well-documented (WHO, 2007). Reductions in income, employment and housing increase incidence of mental distress, whilst cash-strapped Governments with high levels of state debt cannot afford to pay for services and support (United Nations, 2019 and Cummins, 2018).

- Demand for health care goes up
- Supply of health care goes down
- Diminished mental health is observed

### 2. The UK and the world are experiencing one of the biggest economic shocks in history

In January and February, Brexit was considered to be an existential economic threat that would see increased unemployment, reduced trade and a smaller UK economy. Eight weeks later that issue has been dwarfed by what could be the single biggest economic shock in three centuries. Bigger than both World Wars and incomparable to anything since the Great Frost of 1709, unprecedented feels a flimsy description. The International Labour Organisation has forecast that half the world's labour force could lose their livelihoods as a result of the pandemic (ILO, 2020).

### 3. Early predictions of impact suggest a sudden and steep decline, followed by a recovery

HM Treasury's Forecasts for the UK Economy (Number 393) is a compilation of leading independent assessments of what is to come, while the Office for Budget Responsibility (OBR) has recently released its Covid-19 economic reference scenarios. They conclude:

- Unemployment:** During the last recession, the rate of unemployment peaked at 8.5% (Office for National Statistics, n.d). This was accompanied by rising job insecurity and poor wage growth. It took over a decade for average real wages to recover (ONS, 2020a). Average forecasts for this year predict unemployment rising from 4% to 6.4%, falling back to 5.3% in 2021/22. The key measure here will be long term unemployment. How many of those who lose their jobs, stay out of work. Mental health outcomes for this group are significantly poorer than average (OECD, 2019) and accompanied by other health risk factors including eviction and relationship breakdown.
- Public Sector Net Borrowing (PSNB)** – the difference between government income and spending in a given month – was the key driver of austerity over the last decade. Reducing borrowing meant reducing spending.

The OBR calculates that the PSNB is expected to hit £298.4bn in 2020/21 (OBR, 2020a) which is more than five times the prediction it made in March 2020. It is more in real terms than the peak in the 2008 Great Recession of £160bn (which would be £217bn today). By 2024/25, the OBR expects to have added 10% of GDP to UK net debt. Borrowing will be high.

iii. **Gross Domestic Product (GDP)** is one measure of the economy. Again, revisions have been downward. The average forecast is a fall of 4.7% (HM Treasury, 2020) this year with OBR suggesting a shock of 35% this quarter and nearly 13% this year (OBR, 2020b). If correct, that is an annual contraction not witnessed in 300 years. The US has already experienced a fall in its GDP of 4.8% for the first three months of 2020. What happens in reality depends on the continuing impact of the pandemic. Forecasts are likely to change.

To assuage some of the impact of the economic shock to the system, the UK Government has announced a series of loans, grants, furloughing and public aid schemes. The strategy is designed to create a three-month window where the economy is effectively put under general anaesthetic, underwritten by the Government. It is offering to pay 80% every salaried worker's wages, it has prohibited evictions and it has organised debt repayment holidays for all. This, coupled with small business grants of £10,000 for up to 100,000 firms, is an aggressive and comprehensive fiscal stimulus package, all of which has been invented in five weeks.

If the pandemic is a matter of riding out a three-month shut-down, then the measures above are likely to mitigate the economic impact through increased borrowing. In turn, this will mitigate the impact on mental health. But it is increasingly unlikely that this will be the case because there is no cure or vaccine for Covid-19.

#### 4. Economic recovery is entirely dependent on the severity and length of the pandemic

It is unknown how long the financial shock of the pandemic will last and therefore what shape any recovery will take. Covid-19 contagion can only be limited by testing and national/regional shut-downs. If the latter tactic is repeatedly deployed because of resurgences in the disease, the economy will endure a series of expansions and contractions. This is known as a 'W'-shaped recovery where sustained growth will be impossible. Most likely, growth will look

like a series of Ws – 'WWW' – depending on the number of waves.

There are three risk factors with a W-shaped recovery of this kind:

1. The current fiscal stimuli package is expensive and paid for by debt. Further rounds add to the debt pile and may cause the cost of borrowing to increase. This would increase both the money needed to service the debt (in taxes) and the total debt. There is also a limit to the number of fiscal packages that can be funded.
2. Shut-downs impact on hospitality, leisure, travel and tourism disproportionately. Employees in this sector are more likely to be young (ONS, 2019a), migrants (ONS, 2019b), poorly paid and in rented accommodation. There is a corresponding risk to their mental health and ability to access support services (Lankelly Chase Foundation *et al.* 2014).
3. Brexit: This is still due to take place on 31st December 2020. It is plausible that the economic shock caused by Brexit could coincide with a winter surge in Covid-19 cases and an influenza epidemic. That, hitting an economy already weakened by nine months of coronavirus restrictions, could be catastrophic and result in a Depression with a corresponding impact on mental health.

This is unprecedented territory. Despite the severity of the shock, there is a slim chance that much of the long-term impact on the economy and its impact on mental health can be avoided. However, the length and depth of the economic meltdown will depend on the ability of the world to control and eliminate this pandemic. There is currently no cure and no vaccine. It is likely that this virus will have many waves and so the damage to the economy and our health will come in several courses. The financial impact is likely to be unevenly distributed with unemployment and personal debt default high on the list of consequences. The focus on mental health should correspond to these areas, and the people who will sustain the greatest impact.



## Inequalities in mental health and coronavirus

There are several known risk-factors which make people more likely to experience mental health difficulties. These include unemployment, low income, racism and discrimination, traumatic experiences, violence or abuse. There are striking similarities between those groups who will be most affected by coronavirus and those where mental health problems are more prevalent.

### Poverty and deprivation

Figures from the Office for National Statistics demonstrate that mortality is much higher in the poorest parts of England compared with wealthiest areas (ONS, 2020b).

Poverty itself is also a major risk factor for mental illness (Commission for Equality in Mental Health, 2020). This is the case at any age but especially true for children – children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20% (Morrison Gutman *et al.*, 2015). The injustice of increased mortality from coronavirus mirrors and is caused by many pre-existing inequalities relating, but not limited to, poverty and inequality.

This will be the case as a looming economic event pushes more people into poverty. Research on the 2008 economic crisis, the UK's most recent economic shock, suggested that people with chronic health conditions – especially in mental health – experienced the most severe adverse effects of changes in employment (Janke *et al.*, 2020). There is also evidence that people who experience flooding have a greater risk of subsequent mental health difficulties if they are on lower incomes (Sayers *et al.*, 2017). Here, the indirect consequences of the coronavirus response are likely to disproportionately affect the mental health of deprived communities.

### Long term conditions

People with some long-term conditions, such as chronic obstructive pulmonary disease (COPD) and diabetes, have been identified as more clinically vulnerable to the coronavirus. These groups have been identified as being more likely to need intensive care, suffer higher mortality, and have greater cause to 'shield' themselves by staying home and avoiding contact. There is a bidirectional relationship between mental health and physical conditions – people with a mental illness are more likely than the generally population to have physical health problems and vice versa. Approximately 4.6 million people have both a long-term condition and a mental health problem – this equates to 46% of those with a mental health problem and 30% of people with long term conditions (Naylor *et al.*, 2012).

People with diabetes are two to three times more likely to experience depression than the general population. This is associated with difficulties in self-care – including poorer glycaemic control and lower medication adherence. In the context of reduced control over diet through limited choice, and a possible reduction in care and support, people with both diabetes and mental health problems may face serious challenges.

People with COPD, which affects the lungs, are three times more likely than the general population to suffer from depression and have much higher rates of anxiety (Livermore *et al.*, 2010). The presence of anxiety and/or depression in COPD patients is associated with increased mortality, exacerbation rates, length of hospital stay, and decreased quality of life and functional status (Atlantis *et al.*, 2013) – suggesting that the combined risks of mental health and coronavirus may influence significantly poorer outcomes for people with COPD and mental health problems.

People with the most serious long-term conditions and those in later life face an especial risk to their psychological as well as physical wellbeing. For example people living with kidney disease already have a heightened risk of poor mental health, and many are now being 'shielded' from the virus for at least 12 weeks – and face a protracted period of being restricted while others are able to return to a more normal life sooner – while also needing to attend regular hospital appointments, for example for dialysis.

### People who have been exposed to trauma and adversity

It has already been widely acknowledged that social distancing and lockdown measures may increase exposure to domestic violence and abuse for children and women already at risk. Emergency measures disproportionately affect women by potentially exposing them to further danger and reducing their access to external support networks and vital services which keep them safe and well. Following trauma, women

are more likely to suffer from eating disorders, self-harm, personality disorders and other mental health difficulties (Wilton and Williams, 2019). Women are ten times as likely as men to have experienced extensive physical and sexual abuse during their lives: of those who have, 36% have attempted suicide, 22% have self-harmed and 21% have been homeless (Scott and McManus, 2016).

Within the current environment, it may be difficult for services to offer choices to women and to provide access to safe physical spaces. While services can still consider how they can respond to trauma by communicating with and listening to women about their needs and responding in a holistic, tailored way, there is a greater need for trauma-informed support to be available to women and girls, both now and longer term. The importance of taking a trauma-informed approach to the recovery from Covid-19 is discussed further in a separate Centre for Mental Health briefing: [www.centreformentalhealth.org.uk/trauma-mental-health-and-coronavirus](http://www.centreformentalhealth.org.uk/trauma-mental-health-and-coronavirus).

### What we don't know

There is an awful lot we do not know at this time. We still do not know the total scale of this crisis. At the time of writing there are differences in views as to whether the infection rates, hospital admission and deaths due to the virus have peaked. Deaths in the community directly due to the virus are currently not fully reported and nor are deaths from other causes that might be indirectly caused by this crisis (e.g. due to health services not being able to detect or treat due to the focus on Covid-19).

Our communities are not being affected by the virus equally. Some communities are being more adversely affected by the virus, one example being people from BAME communities. There is considerably more to understand about this.

The evidence from the aftermath of the 2008 banking crisis taught us that the recession it caused did not hit all parts of the country equally. This is likely to be the case after

this crisis too. Some industries may take much longer to recover and may be subject to restrictions on their economic activity for longer than others. Entertainment and tourism are two possible examples. The UK recovery from the crisis will likely need to see additional efforts going into some regions, localities and communities: a major challenge for the Government's aim of 'levelling up' regional wealth (and therefore health) inequalities.

The longer-term impact of social distancing and isolation are something we know very little about, this includes the closure of schools and the ongoing impact on children and young people. There are reports of increased domestic violence during the lockdown and obvious reasons to be concerned about a potential increase in child abuse over this period. Douglas et al. (2009) noted that the stress of living through a crisis of this kind can have a heightened impact on children and young people:

*“Children face a number of challenges during a pandemic, including trauma, loss of parental support, and illness. Children’s sense of security is lost during a crisis, and parents may be unavailable due to death or isolation... Young children may have regressive behaviours, such as thumb sucking and bedwetting. Elementary children might exhibit disruptive behaviours, including aggression, nightmares, inability to pay attention, outbursts of anger, and*

*withdrawn behaviours. Stress in adolescents may be more insidious and manifest in sleep disturbances, problems with peers, isolation, and depression...”*

These difficulties may be exacerbated if parents’ own anxieties lead to ‘harsh or punitive parenting’, and further by living in quarantine conditions which reduce access to social networks as a way of coping with the additional stress.

## Conclusions

The mental health impacts of Covid-19 are likely to be significant and sustained. Projecting the extent and duration of the effects on mental health is not easy. While numerous surveys, among the public, health workers and people with mental health difficulties, all point to a sudden marked increase in psychological distress, much of this will be an immediate and natural response to the current situation.

For the majority of people in the UK, the stress, anxiety and isolation everyone is experiencing now will be short-lived. But it is also clear that for some groups of people the effects on mental health are more severe and will be longer lasting. And to a large extent, inequalities in mental health – which reflect broader economic and social inequalities – are being exacerbated in this crisis and likely to be perpetuated afterwards. For people whose livelihoods are precarious, whose physical and mental health were already poor, or whose daily lives are unsafe because of abuse and violence, the psychological impact of Covid-19 is likely to be more serious and more prolonged. We can therefore predict that the biggest mental health impacts will be felt in groups of people such as:

- People with existing mental health difficulties
- People with long-term physical health conditions

- People directly affected by Covid-19: as patients, as health and care workers and as bereaved family members, friends and colleagues
- People who experience heightened risks from being locked down at home
- People on lower incomes and with precarious livelihoods
- People from Black, Asian and minority ethnic communities.

The prevalence of mental ill health in the UK today is already high – with one in four people affected by some kind of mental health difficulty at any time. It would seem likely that Covid-19 will bring about some increase in prevalence over the coming months, and quite possibly for a number of years. While it is difficult to quantify that increase at this early stage, we can expect to see at least 500,000 more people experiencing mental ill health if the economic effects of the pandemic mirror those of the 2008 banking crisis.

Centre for Mental Health will continue to track evidence about the mental health impacts of Covid-19 and provide further forecasts over the next few weeks and months. In the meantime, there are important opportunities for government, nationally and locally, to reduce and mitigate the risks of a wave of poor mental health to come.

## Recommendations

While it is still early days in understanding and acting on the implications of Covid-19 for the mental health of the population, it is clear that the impact may be significant both immediately and for some time to come. It is therefore important to prepare for what is to come.

Where possible, it will be important to seek to prevent poor mental health resulting from the pandemic. And where necessary, it will be essential to offer timely and effective support to people who are experiencing difficulties. For many, this will mean ensuring access to existing mental health services through routine means, while for others it may require a tailored response.

At this time, we would recommend:

1. The Government should ensure that it continues to provide a financial safety net for people whose livelihoods are affected by the pandemic to prevent further financial insecurity and the serious effects this has on people's mental health. This should recognise that not all localities and communities will experience the same economic impacts, with more help offered to those experiencing the biggest risks.
2. The Government and Public Health England should provide advice and support to organisations, including schools, health and care services and businesses, in trauma-informed approaches to help them to create a sense of psychological safety for people who use and work in them following the lockdown.
3. The NHS should develop a proactive and tailored offer of mental health support to people who have received hospital treatment for Covid-19, to people who are working in health and care services with people with Covid-19, and to people who have experienced a bereavement during this time, whether from the virus or other causes.
4. The NHS should prepare for both a V-shaped and a W-shaped recession during the next five years, with resources (financial and human) to respond either to a single, deep recession this year or to a series of economic shocks each of which will create additional need for mental health support.

## References

- Akhter N, Bambrab C, Matthey K, Warren J & Kasima A (2018) Inequalities in mental health and well-being in a time of austerity: Follow-up findings from the Stockton-on-Tees cohort study. *SSM - Population Health*. 6, 75-84
- Atlantis, E. *et al.*, (2013) Bidirectional associations between clinically relevant depression or anxiety and COPD: a systematic review and meta-analysis. *Chest*. 2013 Sep;144(3):766-777. doi: 10.1378/chest.12-1911. <https://www.ncbi.nlm.nih.gov/pubmed/23429910>
- Bank J, Karjalainen H & Propper C (2020) IFS Briefing Note BN281 Recessions and health: The long-term health consequences of responses to coronavirus. London. Institute of Fiscal Studies
- Bo, H., Li, W., Yang, Y., Wang, Y., Zhang, Q., Cheung, T., Xiang, Y. (2020). Posttraumatic stress symptoms and attitude toward crisis mental health services among clinically stable patients with COVID-19 in China. *Psychological Medicine*, 1-7. doi:10.1017/S0033291720000999
- British Medical Association (2020) Stress and burnout warning over COVID-19 [Online] Available from: <https://www.bma.org.uk/news-and-opinion/stress-and-burnout-warning-over-covid-19> [Accessed 14 May 2020]
- Brooks S, Amlôt R, Rubin GJ, Greenberg N. (2020) Psychological resilience and post-traumatic growth in disaster-exposed organisations: overview of the literature. *BMJ Mil Health* 2020;166:52-6. doi:10.1136/jramc-2017-000876 pmid:29420257
- Commission for Equality in Mental Health (2020) Briefing 1: Determinants of mental health. London: Centre for Mental Health <https://www.centreformentalhealth.org.uk/commission-equality-mental-health-briefing-1> [Accessed 6 May 2020]
- Cummins, I. (2018) The impact of Austerity on mental health provision: A UK perspective. *International Journal of Environmental Research and Public Health*. 15:1145 doi:10.3390/ijerph15061145
- Dekel, R. and Baum, N. (2010) 'Intervention in a shared traumatic reality: a new challenge for social workers', *British Journal of Social Work*, 40, 1927-1944.
- Douglas P, Douglas D, Harrigan D & Douglas K (2009) Preparing for Pandemic Influenza and its Aftermath: Mental Health Issues Considered. *International Journal of Emergency Mental Health*, 11(3):137-44
- Fitch C, Hamilton S, Bassett P, et al. The relationship between personal debt and mental health: a systematic review. *Mental Health Review Journal* 2011;16:153–66
- Freedman, S.A. and Mashiach, R.T. (2018) Shared trauma reality in war: Mental health therapists' experience.' *PLoS ONE* 13(2): e0191949. <https://doi.org/10.1371/journal.pone.0191949>
- Greenberg, N. (2020) Managing mental health challenges faced by healthcare workers during covid-19 pandemic *BMJ* 2020; 368 doi: <https://doi.org/10.1136/bmj.m1211>
- Hatch, R., Young, D., Barber, V. *et al.* Anxiety, Depression and Post Traumatic Stress Disorder after critical illness: a UK-wide prospective cohort study. *Crit Care* 22, 310 (2018). <https://doi.org/10.1186/s13054-018-2223-6>
- Hee Lee S, Shin H, Park H, Kim J, Lee J, Lee H, Won S & Han W (2019) Depression as a Mediator of Chronic Fatigue and Post-Traumatic Stress Symptoms in Middle East Respiratory Syndrome Survivors. *Psychiatry Investigation* 16(1):59-64
- HM Treasury (2020) Forecasts for the UK economy [Online] Available from: <https://www.gov.uk/government/collections/data-forecasts> [Accessed 14 May 2020]
- ICNARC (2020) ICNARC report on COVID-19 in critical care 24 April 2020'. London. Intensive Care National Audit and Research Centre.
- International Labour Organisation (n.d) As job losses escalate, nearly half of global workforce at risk of losing livelihoods [Online] Available from: [https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS\\_743036/lang-en/index.htm](https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_743036/lang-en/index.htm) [Accessed 14 May 2020]

- Janke, K., Lee, K., Propper, C., Shields, K. and Shields, M. (2020), 'Macroeconomic conditions and health in Britain: aggregation, dynamics and local area heterogeneity', Centre for Economic Policy Research (CEPR), Discussion Paper DP14507.
- Keita M, Taverne B, Savané C, March L, Doukoure M, Saliou Sow M, Touré A, Etard J, Barry M, Delaporte E and the PostEboGui Study Group (2017) 8 Depressive symptoms among survivors of Ebola virus disease in Conakry (Guinea): preliminary results of the PostEboGui cohort. *BMC Psychiatry* .17:127 DOI 10.1186/s12888-017-1280-
- Knapp M (2012) Mental health in an age of Austerity. *Evidence Based Mental Health* 15:3, 54-55
- LankellyChase Foundation, Mind, The Afiya Trust and Centre for Mental Health (2014) *Ethnic Inequalities in Mental Health* [Online] Available from: <https://lankellychase.org.uk/wp-content/uploads/2015/07/Ethnic-Inequality-in-Mental-Health-Confluence-Full-Report-March2014.pdf> [Accessed 14 May 2020]
- Lee A, Wo McAlonan G, Cheung V, Cheung C, Sham P, Chu C, Wong P, Tsang K & Chua S (2007) Stress and psychological distress among SARS survivors 1 year after the outbreak. *Canadian Journal of Psychiatry*. 52(4): 233-40
- Litz, B.T., Stein, N., Delaney, E. *et al.* (2009) Moral injury and moral repair in war veterans: a preliminary model and intervention strategy. *Clin Psychol Rev* 29:695–706.
- Livermore N, Sharpe L, McKenzie D (2010). 'Panic attacks and panic disorder in chronic obstructive pulmonary disease: A cognitive behavioral perspective'. *Respiratory Medicine*, vol 104, no 9, pp 1246–53.; <https://www.nice.org.uk/guidance/cg91/documents/cg91-depression-with-a-chronic-physical-health-problem-review-proposal-consultation>.
- Mak I, Chu C, Pan P, Yiu M & Chan V (2009) Long-term psychiatric morbidities among SARS survivors. *General Hospital Psychiatry*. 31(4):318-26
- Maunder R1, Hunter J, Vincent L, Bennett J, Peladeau N, Leszcz M, Sadavoy J, Verhaeghe L, Steinberg R, & Mazzulli T (2003) The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *Canadian Medical Association Journal*. 168(10):1245-51.
- Morrison Gutman, L. *et al.* (2015) *Children of the new century*. London: Centre for Mental Health and University College London
- Naylor, C. *et al.* (2012) *Long-term conditions and mental health: the cost of co-morbidities*. The King's Fund and Centre for Mental Health
- NHS (2019) *Interim NHS People Plan* [Online] Available from: [https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan\\_June2019.pdf](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf) [Accessed 14 May 2020]
- Nikayin S, Rabiee A, Hashem MD, *et al.* Anxiety symptoms in survivors of critical illness: a systematic review and meta-analysis. *Gen Hosp Psychiatry*. 2016;43:23–9.
- OECD (2019) *Long-term unemployment rate* [Online] Available from: <https://data.oecd.org/unemp/long-term-unemployment-rate.htm> [Accessed 14 May 2020]
- Office for Budget Responsibility (2020a) *Para 6, Coronavirus analysis*. [Online] Available from: [https://cdn.obr.uk/The\\_OBRs\\_coronavirus\\_analysis.pdf](https://cdn.obr.uk/The_OBRs_coronavirus_analysis.pdf) [Accessed 14 May 2020]
- Office for Budget Responsibility (2020b) *Coronavirus Reference Scenario* [Online] Available from: <https://obr.uk/coronavirus-reference-scenario/> [Accessed 14 May 2020]
- Office for National Statistics (n.d.) *Unemployment* [Online] Available from: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/unemployment> [Accessed 14 May 2020]
- Office for National Statistics (2019a) *Occupation at UK level by sector, industry, age and ethnicity* [Online] Available from: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/adhocs/10663occupationatuklevelbysectorindustryageandethnicity> [Accessed 14 May 2020]
- Office for National Statistics (2019b) *Migrant labour force within the tourism industry* [Online] Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/datasets/>

migrantlabourforcewithinthetourismindustry  
[Accessed 14 May 2020]

Office for National Statistics (2020a) Wages and salaries (D.11) Uses: four quarter growth rate % [Online] Available from: <https://www.ons.gov.uk/economy/grossdomesticproductgdp/timeseries/cwnj/qna> [Accessed 14 May 2020]

Office for National Statistics (2020b) Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 17 April 2020 [Online] Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april> [accessed 11 May 2020].

Platt, L. and Warwick, R. (2020) Are some ethnic groups more vulnerable to COVID-19 than others? Institute of Fiscal Studies and Nuffield Foundation.

Reeves A, McKee M, Gunnell D, Chang S, Basu S, Barr B & Stuckler D (2015) Economic shocks, resilience, and male suicides in the Great Recession: cross-national analysis of 20 EU countries. *European Journal of Public Health*. 25:404–9

Rigny C, Rosa R, Amancio da Silva R, Kochhann R, Migliavaca C, Robinson C, Teche S, Teixeira C, Bozza F & Falavigna M (2019) Prevalence of post-traumatic stress disorder symptoms in adult critical care survivors: a systematic review and meta-analysis. *Critical Care*. 23:213 <https://doi.org/10.1186/s13054-019-2489-3>

Riumallo-Herl C, Basu S, Stuckler D, Courtin E & Avendano M (2014) Job loss, wealth and depression during the Great Recession in the USA and Europe. *International Journal of Epidemiology*. 43:1508–17.

Sayers PB *et al.* (2017) Present and future flood vulnerability, risk and disadvantage: a UK scale assessment. A report for the Joseph Rowntree Foundation. Watlington, UK: Sayers and partners LLP, 2017:1-98 [http://www.sayersandpartners.co.uk/uploads/6/2/0/9/6209349/sayers\\_2017\\_present\\_and\\_future\\_flood\\_vulnerability\\_](http://www.sayersandpartners.co.uk/uploads/6/2/0/9/6209349/sayers_2017_present_and_future_flood_vulnerability_)

risk\_and\_disadvantage\_-\_final\_report\_-\_uploaded\_05june2017\_printed\_-\_high\_quality.pdf

Scott S and McManus S (2016) Hidden Hurt: Violence, abuse and disadvantage in the lives of women. London: Agenda <https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf>

Sim K & Chua H (2004) The psychological impact of SARS: a matter of heart and mind. *Canadian Medical Association Journal*. 170 (5)

Stuckler D, Reeves A, Loopstra R, Karanikolos M & McKee M (2017) Austerity and health: the impact in the UK and Europe. *European Journal of Public Health*. 27(4): 18–21

Thomas, C., and Quilter-Pinner, H. (2020) Care fit for carers: ensuring the safety and welfare of NHS and social care workers during and after COVID-19. London: IPPR.

United Nations (2019) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Session 41 [https://www.un.org/en/ga/search/view\\_doc.asp?symbol=A/HRC/41/34](https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/41/34)

Wilton J and Williams A (2019) Engaging with complexity. London: Centre for Mental Health and the Mental Health Foundation [https://www.centreformentalhealth.org.uk/sites/default/files/2019-05/CentreforMH\\_EngagingWithComplexity.pdf](https://www.centreformentalhealth.org.uk/sites/default/files/2019-05/CentreforMH_EngagingWithComplexity.pdf)

World Health Organisation (2007) Impact of Economic Crises on Mental Health [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/134999/e94837.pdf](http://www.euro.who.int/__data/assets/pdf_file/0008/134999/e94837.pdf)

World Health Organisation (2019) Burn-out an "occupational phenomenon": International Classification of Diseases [Online] Available from: [https://www.who.int/mental\\_health/evidence/burn-out/en/](https://www.who.int/mental_health/evidence/burn-out/en/) [Accessed 14 May 2020]

Wu P, Fang Y, Guan Z, Fan B, King J, Yao Z, Lui X, Fuller C, Susser E, Lu J & Hoven C (2009) The Psychological Impact of the SARS Epidemic on Hospital Employees in China: Exposure, Risk Perception, and Altruistic Acceptance of Risk. *Canadian Journal of Psychiatry*. 54(5):302–311.

# Covid-19 and the nation's mental health: Forecasting needs and risks in the UK

Published May 2020

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research. Support our work here:

[www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

© Centre for Mental Health, 2020

Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.



## Covid-19 and the nation's mental health Forecasting needs and risks in the UK: May 2020

Dr Graham Durcan, Nick O'Shea and Louis Allwood

### Summary

- The Covid-19 pandemic is likely to lead to an increase in mental ill health in the UK, as a result of both the illness itself and the measures being taken to protect people from the virus
- If the economic impact is similar to that of the post 2008 recession, then we could expect 500,000 additional people experiencing mental health problems, with depression being the most common
- The economic impact is likely to affect different parts of the country differently and therefore the likely increased prevalence of mental illness will be unevenly distributed
- If the economic impact results in significant unemployment, then we should expect an increase in suicides unless action is taken to prevent this loss of life.
- The various 'safety net' initiatives introduced by the Government are likely to be offering some significant protection to people's wellbeing. How and when these are dismantled are also likely to be critical to the falloff in terms of mental wellbeing following this crisis.
- Some communities will be more adversely affected by the outbreak of Covid-19 and we already know that people from BAME communities are overrepresented in critical care and mortality statistics.
- We can expect that Covid-19 and the restrictions imposed by lockdown will increase the proportion of people experiencing more complicated grief reactions.
- 20% of survivors of intensive care routinely experience PTSD. The increased number of people receiving such critical care during this crisis will increase the number who are at risk of PTSD.
- Health and care workers and other frontline workers are at greater risk of developing mental health problems as a result of Covid-19.
- The mental health impact of Covid-19 will not be experienced equally: people with existing mental health difficulties and risk factors for poor mental health are likely to be affected disproportionately.
- The Government and the NHS can take steps now, to prevent mental health problems where possible and to provide access to effective support where it will be needed.

Centre for  
Mental Health



Centre for Mental Health

Office 2D21, South Bank Technopark,

90 London Road, London SE1 6LN

Tel 020 3927 2924

[www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

Follow us on social media: @CentreforMH

Charity registration no. 1091156. A company limited by guarantee registered in England and Wales no. 4373019.