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Long term societal implications of COVID-19 Mental Health

Report for British Academy, November 2020

Dörte Bemme

Charlotte Gayer-Anderson

Annie Irvine

Lucy Strang

and

Nikolas Rose

ESRC Centre for Society and Mental Health

King's College London

csmh@kcl.ac.uk

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1. Introduction

This report reviews evidence on the social inequalities in mental health and wellbeing that have been highlighted and intensified by COVID-19, assesses the likely mental health consequences of the pandemic and responses to it in the short, medium and longer term, and examines policies and practices that might mitigate these and promote resilience. We first summarise the underpinning evidence on the social determinants of mental health and on the social distribution of poor mental health prior to the pandemic. We then analyse available evidence on the effects that the pandemic and associated policies have had on the mental health of the UK population and the extent to which the mental health of particular sections of the population has been negatively impacted, with a particular focus on the impacts upon those sections of the population experiencing high levels of adversity. We focus on a number of key areas: young people and adolescents; socio-economic status and ethnicity; employment and precarity; social isolation for the over 65s, and impacts on mental health services users with severe and enduring problems of mental health. We will consider the gender variations in each of these areas, and, where appropriate, also consider the particular impact on those who are already mental health service users, where community support was already stretched to the limits pre-pandemic and has been even further restricted and disrupted by the pandemic and the lockdown. On the basis of available evidence, we consider the likely medium and long term effects of COVID-19 on mental health in each of these groups. In the final section of the report, we make some evidence based proposals on what should be done, by whom and when, to build resilience by 2030.

1.1 What is 'mental health'?

The term 'mental health' is imprecise and used in many different ways. In contemporary language, at least in the English-speaking world, sadness, anxiety, worries, sleeplessness, feelings of insecurity and many other states of feeling are now commonly referred to as 'mental health problems'. The World Health Organisation states "Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." The 2017 RCUK Report on Widening Cross-Disciplinary Research for Mental Health remarked "Definitional issues are subject to debate, are contested and need to remain contestable. Mental health and mental health problems can be both objectively and subjectively experienced and understood by a range of symptoms and experiences in various ways by different people. Mental health tends to be used as a broad term to indicate a range of concepts and understandings that include both positive states (mental health or mental wellbeing) and mental illness, but concepts of mental health and mental illness may not be mutually-exclusive."¹

The lack of clarity in the usage of terms such as 'mental health' and 'mental health problems' presents problems for evaluating claims that are made about the mental health impact of the pandemic. In this report, while we do include some evidence on severe and enduring mental health problems – 'the psychoses' – we are primarily concerned with what are

normally termed 'common mental health problems' such as depression and anxiety, along with some discussion of later consequences usually known as Post-Traumatic Stress Disorder (PTSD). Most of the evidence on the distribution of these problems comes from psychiatric epidemiology which makes use of scales such as the PHQ9 (the Patient Health Questionnaire) or the GAD (General Anxiety Disorder scale). On these scales, a sample of individuals are asked to rate themselves on a small number of items as to whether they are worrying more than usual, sleeping less than usual, feeling down, having a poor appetite and so on. A threshold is set, and a score above this is taken to indicate that an individual may have a clinically relevant problem. Changes in scores over time are reported as increases or decreases in mental health. While these scales are potentially useful as screening devices in relation to potential referral for specialist psychiatric support, taken on their own they do not easily enable one to distinguish between short term understandable and indeed 'normal' expected responses to difficult situations, such as the pandemic and lockdown, and durable changes in individual's mental states requiring specialist intervention. While we have no alternative but to draw in this evidence in what follows, the paucity of good measures of population mental health in surveys cohort studies and longitudinal research is a matter of concern and endeavours to improve such measures need to be supported and developed..

In this report we do not address the issue of long term neurological damage arising from infection with COVID 19. In the wake of the 'Spanish Flu' there was an increase in cases of encephalitis lethargica among those who had been infected leading some to examine the potential links between the two conditions (Ravenholt and Foege 1982) although the link remains speculative. However there is growing evidence that neurological damage may be present in some who have been infected with SARS-CoV-2 (Fiani, Covarrubias, et al. 2020; Wu, Xu, et al. 2020). If this proves to be the case, there is a clear need for more research on mechanisms and mitigation strategies (Mishra and Banerjea 2020) but these are beyond the scope of the current paper.

1.2. The social determinants of inequalities in mental health.

Social disadvantage shapes the extent and severity of mental distress, at individual, group, and population levels (World Health Organization 2014; Lund, Brooke-Sumner, et al. 2018). The occurrence of both common and severe mental health problems is higher, and outcomes worse, among those from low socio-economic groups, among those living in socially fragmented neighbourhoods (Adli 2011; Newbury, Arseneault, et al. 2017) and among those exposed to difficult experiences. (Arseneault, Bowes, et al. 2010; Hatch, Frissa, et al. 2011). These patterns vary by place, social group, age, and time, and by access to supportive social networks (Ehsan and De Silva 2015; Crush, Arseneault, et al. 2017). Disadvantages and exposures to adversity are often linked together in people's lives, especially in the lives of those most marginalised and disadvantaged by structural inequalities, and this increases social suffering (Kleinman, Das, et al. 1997) in those who are already marginalised and in minority ethnic groups. Financial hardship, precarious housing, insecure employment and racism can worsen mental health and poor mental health can increase each of these existing problems in a vicious cycle that entrenches both disadvantage and poor mental health. This is especially the case for children (Reiss 2013). There is also evidence that the mental

health of many of those in precarious employment, for example those who, not from their own choices, are restricted to work in temporary jobs, freelancing, zero hours contracts, and the gig economy (Harvey, Modini, et al. 2017); this is especially among young people and in areas previously dependent on traditional industries (Gross, Musgrave, et al. 2018). Poor mental health in such groups is further exacerbated by reforms of welfare regimes that focus on 'job seeking' as a condition for benefits, with particular consequences for those with disabilities and growing evidence of important impacts for mental health (Stuckler and Basu 2013; Barr, Taylor-Robinson, et al. 2015; McKee, Reeves, et al. 2017; Cummins 2018). While evidence on rates of common mental disorders among black and minority ethnic groups is poor (Weich, Nazroo, et al. 2004; Bamford, Klabbers, et al. 2020), for already-marginalised groups living with severe mental illness, notably in black and minority ethnic groups, existing disadvantages are exacerbated by stigmatising social responses and unsatisfactory responses by mental health services (Memon, Taylor, et al. 2016; Bhui, Halvorsrud, et al. 2018; Purtle 2020).

As far as mitigation of these effects is concerned, research has highlighted a range of 'buffers', from individual coping styles to strong social networks often termed 'social capital' (World Health Organization 2014; Crush, Arseneault, et al. 2017). The term 'resilience' is often used to characterise those who do well despite adversity (Werner and Smith 1982; Rutter 1985); while resilience is sometimes thought of as an individual psychological trait, research shows that it is a capacity accorded to individuals by the community networks and social milieus in which they are embedded (Drury, Cocking, et al. 2009). Evidence about the role of 'social capital' in supporting mental health is inconsistent (Ehsan and De Silva 2015; Moore and Kawachi 2017; Shiell, Hawe, et al. 2020). Nonetheless it is clear that strategies for prevention need to be rooted in an understanding of the social conditions that account for the fact that, when making their lives in conditions of adversity and precarity some people cope well and others do not.

All the factors highlighted by a large and well established body of research have been amplified by the current pandemic and its socio-economic consequences. We detail these in the following sections. The challenge, in the short, medium and long term, is to identify the social conditions, relationships, and practices that exacerbate vulnerability, and to put into place policies and practices, across all levels from national governments to local communities, ranging from environmental planning to small scale, street-level facilities, that will mitigate social, ethnic and economic inequality, insecurity and precarity. We make recommendations on these issues in each section and also draw attention to the inadequacy of the data and the need for better ways of assessing mental health consequences of social inequalities. While much remains uncertain and dependent on the course of the pandemic, the capacities of vaccines, and the local, national and international economic developments over the next decade, we with a focus on the scales and timeframes for action we summarise them at the end of this report paying attention wherever possible to the scale and timeframe of any actions that we propose.

2. Impacts on the mental health of children and young people

CONTEXT:

- Children and young people face considerable upheaval as a consequence of the COVID-19 pandemic and associated restrictions, exposing them to a variety of known psychosocial risk factors for mental health difficulties, such as:
 - several negative consequences of school closure;
 - prolonged exposure to high perceived threat of themselves and/or their families developing the infection;
 - reduced physical activity and enjoyable leisure activities which contribute to mental wellbeing;
 - increased exposure to familial stressors such as family financial difficulties, exposure to domestic violence, child abuse and/or neglect, and parental mental illness and distress.

EVIDENCE:

- Mixed evidence for the effect of the pandemic on the mental health of children and young people; some evidence of adverse effects of mental health, whilst also there is evidence that many children and young people have reported benefits for their mental health.
- More consistent evidence is being reported for the negative effects of the pandemic among children and young people with Special Educational Needs, those with existing mental health conditions, children living in low income families or areas, and children living in chaotic households.
- However, currently available research is only indicative, as most of the studies are not based on representative samples, they use heterogenous methodologies, and there is a lack of pre-pandemic data in these samples to establish whether prevalence of mental health problems has increased as a direct consequence of COVID-19.

RECOMMENDATIONS

- Whether or not the 2.3 million children in the UK living in vulnerable family backgrounds and the 4 million children living in poverty have been disproportionately affected by the pandemic, this is still an issue of grave public health concern given that these children were already less likely to seek and receive the necessary care and support even prior to the pandemic.

Distribution of poor mental health in the current situation

Whilst COVID-19 is a relatively benign illness with few physical ramifications for the majority of infected children, the pandemic and associated restrictions have subjected children and young people to a variety of known psychosocial risk factors for mental health difficulties. These include: i.) the multifaceted negative consequences of school closure (i.e. lack of routine and daily structure, disruption to educational goals and uncertainty about the future, lack of regular interaction with peers, and removal of important and protective

infrastructures external to the family network); ii.) a prolonged exposure to high perceived threat of themselves and/or their families developing the infection, and potentially for some to experience traumatic or complex bereavement; iii.) reduced physical activity and enjoyable leisure activities which contribute to mental wellbeing; and iv.) increased exposure to familial stressors such as family financial difficulties, exposure to domestic violence, child abuse and/or neglect, and parental mental illness and distress. It is therefore important to consider the evidence on the mental health needs of this group.

Prevalence of mental health difficulties, overall and by sex, age, ethnicity

Pre- and post-pandemic studies: Of the studies which collected pre-pandemic data, the Mental Health of Children and Young People in England (MHCYP) survey (NHS Digital 2020), conducted in July 2020 uses a sample of 3,570 children and young people who were previously assessed in 2017. Around 16% of young people (aged 5 to 16 years old) were identified as having a probable mental disorder (measured by the Strengths and Difficulties Questionnaire, SDQ), compared with 11% in 2017, with little overall difference in the prevalence by gender, or age group (5 to 10 years old versus 11 to 16 years old). 19% of those from white ethnic backgrounds were reported as having a probable mental health problem compared with 8% of those from black and minority ethnic backgrounds. Interestingly there appears to be variation by place; the West Midlands and East Midlands were reported as having the highest rates of probable mental health problems among children and young people in 2020 (21% and 19% respectively), compared with the lowest prevalence of 10% in London (NHS Digital 2020).

Similarly, Bignardi and colleagues (Bignardi, Dalmaijer, et al. 2020) have reported a substantial increase in depressive symptoms in a small, non-representative sample of 168 children (aged 7 to 11 years old) who were assessed during lockdown (April to June 2020), and 18 months prior to lockdown. However, no similar increases were found for symptoms of anxiety, nor in SDQ-rated emotional problems.

In contrast, in a study using data collected in October 2019 and April/May 2020 in a sample of around 750 students aged 13 to 14 years old, restricted to South West England, there was an overall *decrease* in rates of self-reported anxiety (measured using the Hospital Anxiety and Depression Scale, HADS) across the two time points (with girls falling from 54% to 45%, and boys from 26% to 18%), and fairly stable rates of depression (rates increased for girls from 31% to 34%, and boys decreased from 21% to 19%) (Widnall, Winstone, et al. 2020). Students from black and minority ethnic groups did not report poorer mental health or wellbeing at either timepoint compared to white British students (Widnall, Winstone, et al. 2020). Interestingly, findings from this study also suggested that for young people who did not feel well connected to peers and/or to their school pre-pandemic reported a greater reduction in anxiety and depression scores across the two time points, compared with those who had average or high peer and/or school connectedness prior to the pandemic.

Finally, there is evidence of an increase in children and young people seeking informal help for suicidal thoughts and self-harm; a report on users of the Kooth online platform² from July 2020 suggests that the numbers of individuals who are seeking advice for suicidal thoughts has increased by 40% compared to the same time last year, whilst there has been a 45% increase in children and young people presenting with self-harm issues (Kooth 2020).

Conversely, using NHS Digital data on the total number of A&E presentations in March and April 2020, compared with similar data in March and April 2019, Ougrin (2020) reported that hospital visits to A&E for self-harm among young people have dramatically declined (Ougrin 2020). It is not possible to determine whether this is a result of decreased rates of suicidal thoughts, or simply a reflection on the overall decline in help-seeking in primary care services for fear of infection.

Changes in symptoms during lockdown: The Co-SPACE study surveyed a sample of 2,890 parents twice between March and June 2020 about their children's mental health (using the SDQ). The sample is not representative, however, with the majority of surveyed parents being employed (73%), with an average income of >£30,000 (72.9%), and white British (93.1%). After taking into account the effects of gender, ethnicity, household income, and parental employment status, primary school children were generally more likely to be reported as having higher behavioural, and restlessness and attention, difficulties by their parents, compared to secondary school age children (Pearcey, Shum, et al. 2020b). Girls were reported as having slightly higher levels of emotional difficulties, whereas parents reported more restlessness and attention difficulties in boys (Pearcey, Shum, et al. 2020a). Across the two timepoints between March and June 2020, parents of primary school aged children reported an increase in emotional difficulties, whereas there was a decrease in emotional difficulties for secondary school children. Finally, akin to the MHCYP survey (NHS Digital 2020), the results from Co-SPACE was indicative of higher parent reported emotional difficulties among white British children compared with Black, Asian, and Minority Ethnic groups (Pearcey, Shum, et al. 2020a), but no difference between ethnic groups for restlessness and attention, or behaviour difficulties.

Cross-sectional data: One of the more robust surveys is the ImpactEd study which involves a large sample of 11,400 children aged 6 to 18. While participants are not randomly selected, the sample is relatively close to the national school population on key characteristics. ImpactEd collected data on general anxiety using the GAD-7-item scale. In July 2020, the sample of 6 to 18-year olds had low levels of anxiety (average 2.4 out of 5), with girls reporting higher levels of anxiety (score of 2.5) than boys (score of 2.1) (ImpactEd 2020). This study also found that levels of psychological wellbeing (measured with the Short Warwick-Edinburgh Mental Wellbeing Scale) remained very stable when comparing data collected May to July 2020, with comparative benchmark data from before the pandemic with slightly better psychological wellbeing in boys compared with girls (ImpactEd 2020).

This data starkly contrasts with data collected from the COVID-19 Psychological Research Consortium (C19PRC) study, which reported that 34% of their sample of 2001 13 to 18-year olds (two thirds of whom were female) scored in the elevated range for depression, and 64% of their sample of were identified as having abnormally high levels of anxiety (assessed by means of the HADS (Hospital Anxiety and Depression Scale) surveyed in April 2020) (Levita L 2020b). In this sample, 60% of boys had the highest rates of anxiety, compared with 47% of girls, whilst 53% of girls and 44% of boys showed trauma like symptoms relating to COVID-19 (Levita L 2020a).

Prevalence of mental health difficulties, in vulnerable groups

There is thus considerably disparity in the results on the impact of the pandemic on the mental health of children and young people taken as a whole.

Commentators have suggested that *children and young people living in vulnerable life situations*, e.g. those with special needs or comorbid physical and mental health conditions, those receiving statutory care, those living in low income families with low socioeconomic stability, those at risk of abuse and violence in the home, and/or those living with parents with mental illness, may have a higher risk of experiencing mental health problems (Herrenkohl, Scott, et al. 2020; Jansen, Kosola, et al. 2020). Whilst there does indeed appear to be higher prevalence rates of mental health problems among such vulnerable children compared with those unaffected, available evidence does not enable us to ascertain whether this group of children is *disproportionately* negatively impacted as a consequence of the pandemic and associated restrictions. However, this is still an issue of grave public health concern given estimates that 2.3 million children are living in vulnerable family backgrounds in the UK (Commissioner 2020), and 4 million children are living in poverty (Joseph Rowntree Foundation 2020): these children were already less likely to seek and receive the necessary care and support even prior to the pandemic (Jansen, Saxena, et al. 2017).

Individuals with comorbid physical/ mental health conditions: The Department of Education, in their survey of 1000 parents of primary school children found slightly higher levels of anxiety (parent rated, measured as levels of anxiety in the previous day on a scale of 1 to 10) among those with Special Educational Needs (SEN) (Department for Education 2020b). In addition, ImpactEd similarly found children (aged 6 to 18) with SEN and disabilities to report lower levels of psychological wellbeing compared with non-SEN children (ImpactEd 2020), as did the Co-SPACE study, in which parent reported emotion, behaviour, and restlessness/attention difficulties was higher in children and young people with SEN (Pearcey, Shum, et al. 2020a). Interestingly, in one study which included pre-pandemic data (Widnall, Winstone, et al. 2020), where there was an overall *decrease* in rates of self-reported anxiety in the whole population across the two time points (October 2019 and April/May 2020), the researchers found no change in anxiety levels for those with pre-existing health problems pre- and post-pandemic.

The Co-SPACE also found that parents of children and young people with pre-existing mental health conditions reported that their children had more difficulties with emotion, behaviour, and restlessness/attention than parents of children and young people with no pre-existing mental health conditions (Pearcey, Shum, et al. 2020a). In addition, in a recent UK survey of over 2000 young people who had been accessing mental health supports prior to the pandemic for a range of mental health conditions, around 80% (at both time points in March and June 2020) believed that the COVID-19 pandemic had worsened their pre-existing conditions (YoungMinds 2020a; YoungMinds 2020b).

Low income families: Existing social inequalities have been exacerbated as a consequence of the pandemic. Vulnerable socioeconomic groups have experienced more financial pressures, worse housing conditions, and greater health risks (Bergamini 2020). This not only affects adults exposed to these situations, but also the children (StreetGames 2020). In the MHCYP

survey (NHS Digital 2020), increased financial strain as a consequence of the pandemic was strongly associated with child mental health; children with a probable mental disorder were almost three times as likely to live in a household that had fallen behind with payments (16.3%) than children unlikely to have a mental disorder (6.4%). 6% of children with a probable mental health disorder lived in a household that experienced reduced access to medication during the pandemic, compared with 2% of those without a probable mental condition. Within the Co-SPACE sample, around two and a half times as many children living in households with a low income (below £16,000 per annum) experienced probable mental health problems compared with children of parents in higher income households (Pearcey, Shum, et al. 2020b). In addition, parents/carers of primary school aged children from single adult households generally rated their child as having more emotional difficulties than parents/carers of children from multiple adult households (Pearcey, Shum, et al. 2020b).

Similarly, children in receipt of free school meals (FSM) have been shown to have higher levels of anxiety (Department for Education 2020b) and lower levels of psychological wellbeing (ImpactEd 2020) compared with those not on FSM. Conflicting results have been found however; in the secondary school survey conducted in South West England which included pre-pandemic data (from October 2019) (Widnall, Winstone, et al. 2020), students who received FSM reported higher levels of depression pre-pandemic compared with those not in receipt of free school meals, yet comparable to those not in receipt of FSM, levels of anxiety and depression reduced, and wellbeing increased, in this group between the two timepoints.

Parental stress and mental health difficulties: Child and adolescent mental health is strongly influenced by the family system (Cobham, McDermott, et al. 2016). With prolonged home confinement during the initial lockdown (and the stressors of supervising education and activities of their children), and the ongoing demoralising economic, emotional and social pressures and losses that parents and families continue to endure (Griffith 2020), carers may have eroding capacity to fulfil their many essential roles and to buffer their children's anxieties and stresses. An established finding in the literature is that parental stress plays a vital role in child mental health via its effects on the emotional and behavioural functioning of parents (Conger, Conger, et al. 2010), and even more so during unpredictable and stressful experiences and disasters (Cobham, McDermott, et al. 2016).

Data from the MHCYP 2020 survey is indicative of such potential intergenerational effects; 30% of children whose parent showed concurrent psychological distress (according to the General Health Questionnaire, GHQ-12) were identified as having a probable mental health problem, compared with 9% of children whose parent showed no distress (although the findings do not enable us to be clear of the directionality of the effect) (NHS Digital 2020). Similarly, in a small convenience sample of 481 children from 385 families, not all in the UK, perceived COVID-19 pandemic stress in parents, parental mental health, parental hostility and lower family cohesion was associated with increases in a range of mental health problems (inattention-hyperactivity problems, emotional problems, trauma symptoms and conduct problems) in children (Whittle, Bray, et al. 2020). Some of these associations were more pronounced in single parent families, and parents with lower income relative to needs. As mental distress in parents increased most steeply during the COVID-19 pandemic (Pierce,

Hope, et al. 2020b), the intergenerational effects on the mental health of their children must be considered.

Witnessing violence & abuse in the home: The increased stress on parents and carers confer increase risk for mental health problems among children directly (as outlined above), but also indirectly via the increased exposure to domestic violence and child abuse (Rosenthal and Thompson 2020), an established contributor to mental ill health (McLaughlin, Greif Green, et al. 2012). The increased exposure to abuse and domestic violence, along with the diminished contact with systems and professionals who have regular contact with children (teachers, health professionals and social workers), heightens the risk that the early signs that call for intervention and safeguarding will be missed (Green 2020; Levine, Morton, et al. 2020; Thomas, Anurudran, et al. 2020). Indeed, during the initial lockdown, whilst calls to domestic abuse (Grierson 2020; Taub 2020) and child support helplines (Hennessy 2020) increased, calls to child protection duty teams declined, with caseloads of child protection professionals falling by 50% in some areas of the UK (Weale 2020). According to the National Youth Agency Report (published 18th August), over 1 million young people have been lost to youth services during the COVID-19 pandemic (National Youth Agency 2020). Thus while demand on services is likely to have increased, the supply of services has been further constrained as a result of the pandemic (Early Intervention Foundation 2020; Power, Hughes, et al. 2020).

Summary of the evidence

The analysis of the evidence from the initial findings from the larger and/or more methodologically robust of the ongoing studies, presented here, offers some, albeit limited, information on the mental health impacts of the pandemic in children and young people. Overall, the pattern of results is fairly mixed, with some studies suggesting heightened levels of depression and anxiety (Bignardi, Dalmaijer, et al. 2020; Kooth 2020; Levita L 2020b; NHS Digital 2020), but most studies suggesting fairly stable, or even lowered, estimates in this age group as a whole (ImpactEd 2020; Ougrin 2020; Pearcey, Shum, et al. 2020b; Pearcey, Shum, et al. 2020a; Widnall, Winstone, et al. 2020) (Rutter 2013; Danese and Smith 2020). However most of the studies available to us for this report have relied on convenience sampling of families and/or young people, with consequent problems of selection bias and unrepresentative samples. Without representation of the more disadvantaged young people, there is a risk that the findings may reflect the experiences of the 'worried well' (Danese and Smith 2020). In addition, most studies published to date are cross sectional, and do not have comparative 'benchmark' data from before the pandemic, making it difficult to draw any firm conclusions about whether the prevalence of mental health difficulties has increased specifically as a consequence of the pandemic. Finally, the heterogeneity in measures (self-report versus parent-report) used to assess mental health further limits comparability and inferences that can be made across samples. Longer-term studies will be needed to discriminate between normal, context-related emotional responses and persisting and impairing mental health difficulties; the Wellcome Trust-funded catalogue of empirical and longitudinal research COVID-Minds³ will be a helpful source of information to help to provide a dynamic evaluation of young people's mental health needs.

Longer term consequences

Children from poorer socioeconomic backgrounds are already adversely affected with respect to their future health, wellbeing, education, and social mobility. It is plausible that the developmental and mental health risks associated with the profound societal changes elicited by the pandemic are likely to be felt disproportionately by children living in poverty or families with low economic resources. The current evidence to draw from is thus far fairly scant to make any conclusive remarks, but the outlook is far from optimistic.

The MHCYP survey (NHS Digital 2020) reported that 29% of children had a parent in the household who had been furloughed or made use of the self-employed support scheme. 6% of children had parents who experience job loss, and for 28% of children, the household experienced a reduction in income during the pandemic. About 9% of children lived in a household that had fallen behind with payments during the pandemic, and 2% reported struggling to afford food or having to use foodbanks. Moreover, the Institute for Public Policy Research North (Round and Longlands 2020) report on estimates with regard to changes in rates of child poverty in the short and long term; for example, it has been posited that child poverty could rise by up to 44% during and after the pandemic in developed countries of Europe and central Asia (Fiala and Dielamonica 2020), and that within the UK, by the end of 2020, between 100,000 and 300,000 more children could be living in poverty as a consequence of the pandemic (Parkes and McNeil 2020). The groups of children believed to be most at risk to feel the full force of the economic crisis are those growing up in the most deprived parts of the UK (Longfield 2020), and those whose parents are in low income working families (around 3 million children), those whose parents are self-employed (around 2 million children), and those whose parents are newly out of work and reliant on universal credit (McNeil, Parkes, et al. 2020).

The direct and indirect consequences on mental health outcomes for children and young people living in households impacted by poverty and/or few financial resources, are severalfold. The risk for severe and chronic forms of childhood abuse and neglect (Nadan, Spilsbury, et al. 2015), and for exposure to domestic violence, is heightened, and families already experiencing substance use and mental health problems are likely to struggle given the ensuing pressures to make ends meet (Herrenkohl, Scott, et al. 2020). Educational achievement gaps leaves the poorest socioeconomic groups lagging behind their more affluent peers (Alexander, Entwisle, et al. 2007). Research has shown that all these factors are associated with later onset of mental health problems.

In addition, a particular concern exists for young people entering the labour force. If increases in unemployment and a tighter job market continue, the future outlook for adolescents now is not optimistic. For example, the Institute for Fiscal Studies (IFS) reported that young people are nearly two and a half times as likely as other employees to work in a sector which was shut down due to social distancing measures (Studies 2020). Independently, based on the UK Household Longitudinal Study, analysis by the IFS on the psychological distress measures collected prior to and during the coronavirus (COVID-19) lockdown, shows that for young adults' (aged 16 to 24), psychological wellbeing had deteriorated more than any other adult age group. The authors also reported that the

deterioration for young adults may be spread across a wider range of dimensions of psychological distress than for older adults (Banks and Xu 2020b). The mental health effects of unemployment in young people persist to midlife with those exposed to unemployment in youth having increased rates of mental health symptoms, such as anxiety, depression, and suicidal thoughts and behaviours, on long-term follow-up (Virtanen, Hammarström, et al. 2016), independent of the effects of prior mental health vulnerability (Power, Clarke, et al. 2015). We discuss this further in our section on employment.

Policy implications and mitigation strategies

In order to ensure that the collateral damage of COVID-19 is as limited, and short term, as possible, the formulation of immediate policy for the long-term support for children and young people (i.e. the future generations) should be made an urgent priority, and must not be overlooked despite the available evidence of relatively benign impact on mental health outcomes among children and young people during the initial lockdown. The COVID-19 pandemic should be a much needed catalyst to rethink the delivery of services and public health systems, and to promote more accessible, equitable and efficient measures within the public health, health services, and education sectors (Power, Hughes, et al. 2020; Tsouros 2020).

The COVID-19 pandemic is a compounding and multidimensional stressor affecting the “individual, family, educational, occupational, and medical systems, with broader implications for the macrosystem, as it exacerbates political rifts, cultural and economic disparities, and prejudicial beliefs” (Gruber, Prinstein, et al. 2020). The overwhelming consensus is that the policy implications for children and young people (and their future mental health) must be multisectoral (Herrenkohl, Scott, et al. 2020; Jansen, Kosola, et al. 2020; Tsouros 2020), and should take a preventive public health approach. This would focus on whole population strategies, using universal service delivery programs, that would “reach the widest number of families well before crises emerge and by fundamentally shifting the conditions and contexts in which they live” (Herrenkohl, Scott, et al. 2020). This might include, but not limited to: i) addressing childhood poverty and deprivation; ii) reducing inequalities in child development and learning; iii) addressing child abuse and discrimination; iv) improving health literacy for children, parents and communities, and giving children greater skills for life and coping with uncertainty; v) improving nutrition in early life and prevention of childhood and adolescent obesity; and vi) ensuring universal coverage to high quality health and welfare services (Jansen, Kosola, et al. 2020; Tsouros 2020). All of these could have lasting profound effects on the risk for anxiety, depression, and other mental health concerns two generations forward, especially given that the conditions emerging from the pandemic are exacerbating already deeply rooted inequalities within the population, and exposing the gaps and limitations in practices within child serving systems (e.g. schools, child welfare systems, healthcare settings).

Support for most disadvantaged children:

- Digital poverty and exclusion persists in the UK (Holmes and Burgess 2020) meaning that some children and young people will have felt isolated from their peers and education, and for those with limited or no technological access, it can exacerbate

social comparison and worsen their current situation (Armitage and Nellums 2020; Sinha, Bennett, et al. 2020).

- In addition, families whose incomes dropped as a result of work restrictions have struggled to feed their children (Dunn, Kenney, et al. 2020).
- There should therefore be a package of measures to support young people in disadvantaged households, including the extended provision of free school meals, breakfast clubs, free internet access, and resources for digital education.

Avoidance of future school closures, in order to not worsen achievement gaps, and maintain a 'safe space' for children who experience adversity in the home:

- Children in the UK from lower socioeconomic positions were disproportionately affected by the school closures in the first lockdown (Ziauddeen, Woods-Townsend, et al. 2020); it was reported they were less likely to have online classes from their schools, than their peers from higher socioeconomic backgrounds (32% compared with 43% for primary school children, and 40% compared with 53% for secondary school children) (Andrew, Cattan, et al. 2020). These achievement gaps may be further compounded by the fact that children's home circumstances and parents' levels of engagement vary across groups, such that families with a lack of access to computers, books, learning space, and other enrichment opportunities are required for more conducive learning but less available in households with few financial resources (Cullinane and Montacute 2020), and children of parents with lower digital literacy, or are not fluent in English, may struggle to keep up (Ziauddeen, Woods-Townsend, et al. 2020).
- Whilst progress has been made since 2011 in narrowing the attainment gap between children from lower socioeconomic backgrounds and their peers from higher socioeconomic backgrounds, it has been estimated that school closures during the pandemic could have widened this gap by 36% (Education Endowment Foundation 2020).
- In particular for children in Key Stage 2 (aged 7 to 8 years) and in Key Stage 4 (aged 15 to 16 years), school closures should be limited, as these have been identified as crucial periods to ensure that higher attaining students from lower socioeconomic backgrounds remain on the high attaining trajectory (Crawford, Macmillan, et al. 2014).
- Further, school closures can exacerbate food insecurity, particularly for children living in poverty (estimated to be 4 million, 30%) (Joseph Rowntree Foundation 2020).
- Schools in the UK have remained open for 'vulnerable' children but only 723,000 of the 2.3 million children in England with a vulnerable family background are estimated to be receiving statutory support and known to services (Commissioner 2020). The proportion of children known to be vulnerable attending school during lockdown has remained low (5% in early April to 14% in May) (Department for Education 2020a).

Improvement of child welfare systems: shifting attention from reactive models of care and risk mitigation to services that are proactive and widely available:

- Recent reviews point to crises within the child protection and family justice systems in the UK (e.g. (Family Rights Group 2018; Herrenkohl, Lonne, et al. 2019)), that have resulted in failure to protect children from harm caused by abuse and neglect(Higgins, Lonne, et al. 2019; Herrenkohl, Scott, et al. 2020). In addition, those children who could be helped by earlier and less intensive interventions are left with limited, if any, assistance, due to underfunding and authorisation to provide more broad and proactive services(Higgins, Lonne, et al. 2019). Sadly, demand for child welfare services continue to rise (Klevens and Metzler 2019), especially in the context of the pandemic(Power, Hughes, et al. 2020).
- It has been suggested by many that a public health model to improving child welfare systems is required, which would consist of inclusion of a continuum of services that combine universal (primary prevention) programs, with those that are more targeted based on population risk (i.e. blended prevention or proportionate universalism strategies)(Sanders, Higgins, et al. 2018; Higgins, Lonne, et al. 2019; Herrenkohl, Scott, et al. 2020; Thomas, Anurudran, et al. 2020).
- Such a model would not replace the need for an acute and crisis response in extreme and high-risk situations where children could be / are being harmed. But it would also include policies that ensure basic needs are being met, that families engage in the workforce, and that parents are provided with the opportunity to care for their children without compromising their long-term employment(Klevens, Barnett, et al. 2015; Herrenkohl, Scott, et al. 2020). This will help to make the acute and extreme situations less likely, and thus improve child outcomes and reduce costs to governments (Herrenkohl, Scott, et al. 2020).

Dissemination of mental health, psychoeducational and self-help resources and programs for young people, their carers, and teachers:

- In order to minimise the likelihood of substantial anxiety that can be caused by exposure to unexplained and unpredictable behaviour which is often perceived as a threat, particularly for younger children, it has been posited that at a minimum, the dissemination of psychoeducational and self-help resources for young people to promote universal advice on maintaining positive health behaviours, using age appropriate emotion focussed language, should be made available and included within coordinated statutory disaster response mechanisms (Dalton, Rapa, et al. 2020; Danese and Smith 2020; Organisation 2020). Adolescents could be involved in co-production of materials that would be targeted to them, to assist in finding effective ways to engage their interests and preferences (Danese and Smith 2020).
- Although several examples of psychoeducational materials for parents do already exist online, it is contended that not all offer practical, evidence based and accessible advice (Danese and Smith 2020). The Families Under Pressure project (<https://maudsleycharity.org/familiesunderpressure/>), offer a model of good practice.
- While during the lockdown period, services started to implement telepsychiatry appointments and therapies, which would appear to have been acceptable to some, but not all. We should establish an evidence base of acceptability and feasibility and

examine whether this 'new' way of working would reach the most disadvantaged young people who have the greatest mental health needs

- Investing in within school universal mental health / psychoeducational literacy programs are worthwhile to promote positive mental health and minimise future burden on the healthcare system (Danese and Smith 2020; Hamoda, Chiumento, et al. 2020).
- In addition, given that young people's mental health is strongly influenced by the wellbeing of their caregivers, it would be advisable to offer guidance for caregivers on the positive impact of maintaining their own well-being (Power, Hughes, et al. 2020).

3. Impacts on those from minority ethnic groups

CONTEXT

- Ethnic minorities are disproportionately affected by COVID-19. They suffer from higher rates of infection, mortality, and job losses.
- Evidence on mental health disparities for Black, Asian and minority ethnic groups under COVID is limited and biased due to the small sample size, lack of data on ethnicity, the lumping under the BAME label, the sole availability of short-term data, and a dearth of analysis on the social determinants of mental health, including racism and discrimination. Calls for better research have been made.

EVIDENCE

- Pre-pandemic inequalities in mental distress and access to care were maintained or are predicted to increase.
- Ethnicity is not an independent factor in documented increase of mental distress in the population under the first lockdown. In combination with gender important differences emerge. More recent data show comparatively higher self-reported self-harm and suicidal ideation.
- Health workers: ethnic minority health workers have higher rates of anxiety over PPE and risk of infections as well as higher rates of PTSD.
- Mental Health service users: Black, Asian and minority ethnic populations are at greater risk of infection, hospitalization and death than White British service users with a psychiatric disorder
- Black, Asian and minority ethnic populations are economically more vulnerable due to higher rates of uncertain self-employment and lesser savings.

RECOMMENDATIONS

- Race equality impact assessments for research
- See and adapt recommendations from PHE stakeholder report:
 - mandate ethnicity data collection as part of routine health systems
 - participatory research, equity audits and diverse hiring in the NHS
 - culturally competent risk assessments and prevention campaigns
 - a commitment to reducing broader inequalities in the distribution of the social determinants of mental health

Black, Asian and Minority Ethnic Groups are disproportionately affected by COVID-19

Black, Asian and minority ethnic groups are being disproportionately affected by the pandemic. Overall, despite variations amongst those of different ethnicities, those from these population groups face higher rates of infection and mortality (Kirby 2020; Stewart, Broadbent, et al. 2020; Sze, Pan, et al. 2020), and more severe economic consequences due to job losses, higher rates of uncertain self-employment, and having less savings (Platt and

Warwick 2020). In light of the stark inequality in mortality for Black Asian and minority ethnic individuals, Public Health England began publishing a now quarterly report detailing the “Disparities in the risks and outcomes of COVID-19” that includes ethnicity among other factors such as deprivation, age, sex, and comorbidities.⁴ However, the initial report has been described as a lost opportunity to recognize the underlying structural and social determinants of unequal health outcomes among Black, Asian and minority ethnic populations, including intersectional challenges, racism and discrimination (Patel, Hiam, et al. 2020). Downplaying the importance of ethnicity while presenting the newest edition of the report, government advisor Dr Raghbir Ali recently dismissed claims that structural racism is behind the disproportionately high COVID-19 mortality rates in Black, Asian, and Minority Ethnic communities. He said that: “Structural racism is not a reasonable explanation,” adding that ethnicity should not drive resource allocation but the government should focus on factors such as occupation, housing, and health problems to help more people.⁵ But while it is true that the stressors from front line and insecure occupation, precarious housing and poor health are all key factors driving increased morbidity and mortality in black and minority ethnic populations, it is precisely because of structural racism that all the factors are experienced disproportionately by these groups.

In parallel, however, a second PHE report was published entitled “Beyond the data: Understanding the impact of COVID-19 on BAME groups.”⁶ This was based on a wide stakeholder consultation, which highlighted that racism and discrimination are root causes affecting health, the risk and outcomes of COVID exposure. The group recommended 1) to mandate ethnicity data collection as part of routine health systems, 2) to support of community participatory research in which BAME stakeholders are equal partners, 3) equity audits and diverse hiring in the NHS, 4) culturally competent risk assessment tools to reduce virus exposure for key workers, 5) culturally competent prevention campaigns, and 6) the pursuit of a reduction of broader inequalities and determinants of health.

Neither of these government reports, however, paid specific attention to mental health.

How does the disproportionate burden of COVID-19 affect the mental health of Black, Asian and minority ethnic individuals in the UK?

Currently the evidence on this question is limited and unclear for a number of reasons. First, the research is based on small sample sizes and sometimes lacks key data. Existing population level and longitudinal household studies include only small samples of ethnic minority individuals. They lack the statistical power to generalize evidence (Pierce, Hope, et al. 2020b; Proto and Quintana-Domeque 2020; Smith, Gilbert, et al. 2020). For suicide, The Office for National Statistics (ONS) does not collect ethnicity or asylum status data (Cohen, Katona, et al. 2020). Second, by aggregating and labelling “BAME” into a homogeneous group the heterogeneity of experiences and health outcomes may be erased, leading to potentially harmful narratives of racialized genetic determinism (Barnett, Mackay, et al. 2019; Kapilashrami and Bhui 2020; Proto and Quintana-Domeque 2020; Smith, Gilbert, et al. 2020). Third, we only have a short term picture: current evidence covers mostly the early months of the pandemic and the first lockdown period in March and April. The mid and longer-term consequences of the pandemic on mental health may well differ significantly

due to prolonged economic and social hardship (Pierce, Hope, et al. 2020b). Finally, structural social disadvantages are not well studied. Thus, in response to the widely cited Lancet article setting the mental health and COVID research agenda (Holmes, O'Connor, et al. 2020), a number of scholars highlighted the importance of better understanding and addressing socially structured disadvantage that determines mental health outcomes (Morgan and Rose 2020), rather than individualizing mental health problems. Ethnic minorities disproportionately experience such social disadvantage, including racism and discrimination over the life course (Kapilashrami and Bhui 2020; Smith, Gilbert, et al. 2020), which should be reflected in study designs going forward.

Current evidence on pre-pandemic mental health inequalities and the consequences of the pandemic

Current evidence suggests that pre-pandemic mental health inequalities will be maintained and indeed are likely to increase. Evidence suggests that established pre-pandemic inequalities in mental distress among Black, Asian and minority ethnic populations, such as the higher prevalence of severe mental illnesses among Black, Asian and minority ethnic individuals and migrants (Bourque, van der Ven, et al. 2011), the higher rate of compulsory care (Barnett, Mackay, et al. 2019), and the underutilization of and alienation from regular mental health services (Cochrane and Sashidharan 1996; Pierce, Hope, et al. 2020b; Smith, Bhui, et al. 2020) were maintained. Some argue that the existing structural inequalities affecting Black, Asian and minority ethnic populations had already led to a “state of crisis” before the pandemic (Kapilashrami and Bhui 2020). In addition, the pandemic is predicted to increase inequalities in access to traditional and non-traditional mental health care and support services (Smith, Bhui, et al. 2020).

Research from the period of the first lockdown suggests that ethnicity is not an independent factor but is highly correlated with other inequalities that have consequences for morbidity. In longitudinal studies, self-reported mental distress has been found to be overall increased in people over 16, peaking during the first lockdown in March and April in comparison to the previous year (Banks and Xu 2020a; Daly, Sutin, et al. 2020; Pierce, Hope, et al. 2020b). Data from the UK Household Longitudinal Study (UKHLS) suggests that among adults, mental distress (measured using GHQ-12) was 8.1% higher in April 2020 than it was between 2017 and 2019 (Banks and Xu 2020a), and mental distress in April 2020 was 0.5 points higher than expected (on the GHQ-12 scale), after taking into account trends in mental distress since 2014. (Pierce, Hope, et al. 2020b). However ethnicity is not an independent factor: adjusting for age, sex, marital status, education, income and vulnerability to the health effects of COVID-19, these studies did not find a difference in the deterioration of mental health problems between White and non-White individuals in the UK population (Ash Routen, Willis, et al. 2020).

However, while ethnicity did not emerge as an independent factor, when Black, Asian and minority ethnic status was combined with gender it showed that Black, Asian and minority ethnic individuals and British White women experienced similar rates of deterioration of their mental health; White British men experienced less distress (Proto and Quintana-Domeque 2020). Reviewing these studies, the Public Health England mental health

surveillance report concludes: “It is unlikely that ethnicity in itself is the cause of differences in the mental health and wellbeing impact of the pandemic. Instead, ethnicity may be correlated with other factors that may cause a difference.”⁷ This, of course, is precisely what is meant by demonstrating that Black, Asian and minority ethnic groups experience ‘structural disadvantage.

More recent data reaching until mid-September from the UCL COVID-19 Social Study, likewise found “no evidence that increases or decreases in levels of depression during the pandemic were associated with ethnicity”, but at the same time reported that “the self-reported frequencies of abuse, self-harm and thoughts of suicide/self-harm were higher among Black, Asian and minority ethnicity respondents (when grouped together)”⁸ (Frank, Iob, et al. 2020; Iob, Steptoe, et al. 2020).

Many ethnic minorities are also more economically vulnerable to the current crisis than are white ethnic groups. Men from minority groups are more likely to be affected by the lockdown because self-employment – which has become increasingly precarious in the current situation – is “especially prevalent amongst Pakistanis and Bangladeshis. Pakistani men are over 70% more likely to be self-employed than the white British majority” (Platt and Warwick 2020). The authors continue: “While in the population as a whole women are more likely to work in shut-down sectors, this is only the case for the white ethnic groups. Bangladeshi men are four times as likely as white British men to have jobs in shut-down industries, due in large part to their concentration in the restaurant sector, and Pakistani men are nearly three times as likely, partly due to their concentration in taxi driving. Black African and black Caribbean men are both 50% more likely than white British men to be in shut-down sectors.” (Platt and Warwick 2020) “Bangladeshis, black Caribbean and black Africans also have the most limited savings to provide a financial buffer if laid off. Only around 30% live in household with enough to cover one month of income. In contrast, nearly 60% of the rest of the population have enough savings to cover one month’s income.” (Platt and Warwick 2020)

It is important to note that mental health service users from ethnic minorities are at even greater risk of infection and death. The likelihood of adults with psychiatric disorders to become infected, hospitalized and die with COVID-19 is higher than among those without a psychiatric disorder (Yang, Chen, et al. 2020). In addition, a study from South London found those service users from ethnic minority backgrounds are more likely to get infected and die than service users from White British backgrounds (Stewart, Broadbent, et al. 2020).

Health workers: higher levels of anxiety and PTSD

Due to the higher risk of infection and mortality for Black, Asian and minority ethnic populations, health workers from ethnic minorities were found to be at high risk of PTSD and had higher anxiety levels about COVID and PPE than colleagues not from Black, Asian and minority ethnic groups (Gilleen, Santaolalla, et al. 2020; Moorthy and Sankar 2020). As individuals from black and minority ethnic populations are overrepresented among front line health workers, they are disproportionately at risk, and thus, the Royal College of Psychiatry and the NHS have issued guidelines to mitigate the mental health impacts on

Black, Asian and minority ethnic health workers.⁹ We address this overlap of ethnicity and occupation in the section of this report on employment and mental health.

Policy recommendations and mitigation strategies

Race equality impact assessments

- To make research more relevant to ethnic minorities, Smith et al call for a “race equality impact assessment” to be applied to the research questions and methodology. “When reporting findings, authors should be expected to state how they think their research might affect those from ethnic minority groups. Funding bodies and journal editors should expect to see this race equality impact assessment, just as they now increasingly expect to see a Patient and Public Involvement statement and assessment.” (Smith, Gilbert, et al. 2020)

Adapt recommendations of PHE Stakeholder report to mental health

- Mandate ethnicity data collection as part of routine health systems
- Support community participatory research with BAME stakeholders as equal partners
- Ensure equity audits and diverse hiring in the NHS
- Develop a culturally competent risk assessment tool for key workers
- Undertake culturally competent prevention campaigns
- Take action to reduce broader inequalities in the distribution of the social determinants of poor mental health.

4. Impacts in relation to socio-economic status

CONTEXT

As analysed by the *PHE report on the Disparities in the Risks and Outcomes of COVID-19*:

- People in deprived areas are more likely to be diagnosed and to have poor outcomes following diagnosis than those in less deprived areas.
- High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed.
- Poor outcomes remain after adjusting for ethnicity, but the role of underlying health conditions requires further investigation

EVIDENCE

- There is much evidence that experience of social stressors arising from structural disadvantages experienced disproportionality by those of lower SES increases levels of self reported anxiety and depression
- Specific stressors negatively impacting reported mental health include financial insecurity, job insecurity and food insecurity

RECOMMENDATIONS

- Given the clustering of vulnerabilities within specific types of households, policy measures to mitigate exacerbation of socio-economic inequalities caused by the pandemic need to go beyond a focus on individual stressors to address the co-occurrence of these factors of insecurity and precarity in the most disadvantaged households.

The clearest account of the current evidence on the socio-economic inequalities in the impact of COVID-19 is given in the *PHE report on the Disparities in the Risks and Outcomes of COVID-19*, and we can do no better than to quote from it at length:¹⁰

The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females. This is greater than the ratio for all cause mortality between 2014 to 2018 indicating greater inequality in death rates from COVID-19 than all causes. Survival among confirmed cases, after adjusting for sex, age group, ethnicity and region was lower in the most deprived areas, particularly among those of working age where the risk of death was almost double the least deprived areas... In summary, people in deprived areas are more likely to be diagnosed and to have poor outcomes following diagnosis than those in less deprived areas. High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes remain after adjusting for ethnicity, but the role of underlying health conditions requires further investigation.

Given that these areas of deprivation have a high concentration of people of lower socio-economic status, what do we know of the mental health consequences?

The evidence suggests that a greater number of people with low household income or relative socioeconomic position reported symptoms of anxiety and depression than those with higher income or position (Frank, Iob, et al. 2020; Shevlin, McBride, et al. 2020). Shevlin et al's survey of a representative UK sample found: "Higher levels of anxiety, depression and trauma symptoms were reported compared to previous population studies, but not dramatically so. Meeting the criteria for either anxiety or depression, and trauma symptoms was predicted by young age, presence of children in the home, and high estimates of personal risk. Anxiety and depression symptoms were also predicted by low income, loss of income, and pre-existing health conditions in self and other.

Further impacts on mental health are related to specific stressors. In one study, having contracted COVID-19, experiencing financial difficulty, or having difficulty in accessing food or medicine were given as reasons for why the mental health of individuals from lower SES position was negatively affected (Wright, Steptoe, et al. 2020). Employment – or rather the lack of it or the fear of loss of it – was also a key stressor. Adults who experienced loss of income early in the lockdown reported higher levels of anxiety (Shevlin, McBride, et al. 2020) and mental distress (Chandola, Kumari, et al. 2020). Having some paid work or continued connection to a job during the pandemic is associated with better mental health than not having any work (Burchell, Wang, et al. 2020b). However, employed and higher qualified adults also experienced increased mental distress (as did the population as a whole) (Niedzwiedz, Green, et al. 2020; Pierce, Hope, et al. 2020b). As is self-evident, financial insecurity, linked to precariousness of employment, exacerbates stress and this is likely to have a direct effect on mental health via the impact of stress on the immune system. "Heightened stress is known to weaken the immune system, increasing susceptibility to a range of diseases and the likelihood of health risk behaviours. Therefore, poverty may not only increase one's exposure to the virus, but also reduce the immune system's ability to combat it." (Patel, Nielsen, et al. 2020)

There are also age related effects. For school age children from deprived families in food poverty, one key factor is food insecurity which is exacerbated by school closures during lockdown and which has mental health consequences. Thus, as Van Lancker and Parolin argue, "Research shows that school lunch is associated with improvements in academic performance, whereas food insecurity (including irregular or unhealthy diets) is associated with low educational attainment and substantial risks to the physical health and mental wellbeing of children." (Van Lancker and Parolin 2020). Poor diet and food insecurity are linked to lower life-expectancy, weakened immunity, and poorer mental health and wellbeing (Tarasuk, McIntyre, et al. 2007; Power, Doherty, et al. 2020). For older people, specific anxiety about COVID-19 was elevated, no doubt linked to the frequent discussions in the media about the severe effects of the virus on those aged 65 and over (Shevlin, McBride, et al. 2020). In addition, two studies found that having a low income was associated with loneliness and increasing levels of loneliness during the lockdown. (Bu, Steptoe, et al. 2020a; Bu, Steptoe, et al. 2020c). We return to this in the later section of this report on the impact of the pandemic on the mental health of older people.

Policy recommendations and mitigation measures

- The stressors that contribute to poor physical and mental health tend to cluster together and amplify one another.
- Thus “Policy measures that aim to mitigate the health and socio-economic consequences of the COVID-19 pandemic should consider how vulnerabilities cluster and interact with one another both within individuals and different household types, and how these may exacerbate already existing inequalities” (Mikolai, Keenan, et al. 2020).
- A public health approach to tackling these inequalities is therefore most appropriate (Rose, Manning, et al. 2020).
- This might include :
 - investment in local community facilities and services - local authority
'community and voluntary sector organizations - across a range of health and social sectors.
 - the rebuilding of public mental health infrastructure and community mental health services
 - Provision of resources to support service user and survivor, carer, mutual aid and self-help groups

5. Impacts on adults in or seeking paid employment.

Likely changes in the labour market and world of work, resulting from COVID-19:

- An **increase in unemployment** and a **tighter jobs market**, which will particularly affect young people (younger workers, school leavers, graduates), women, migrant and minority ethnic groups, given their overrepresentation in more insecure forms of work. With more competition for jobs, existing challenges may be exacerbated for those who were already unemployed and seeking work pre-pandemic, particularly people with long-term health conditions and disabilities.
- A shift to **more home-based working** and increased use of **online/distance technology** for those whose roles are compatible with remote working. Some roles (e.g. teaching) may involve a **hybrid approach** combining face-to-face and remote working.
- Pending completion of a nationwide vaccination programme and demonstrated effectiveness of vaccines against likely viral mutations, greater **risk of workplace exposure** to the virus for people working in certain sectors (including healthcare workers, educators, other essential services, public transport and public facing roles in retail, hospitality and leisure).

Related potential mental health effects:

- Job insecurity, job loss, unemployment and associated financial hardship are all associated with poorer mental health (stress, depression, anxiety, elevated risk of suicide).
- Home-based remote working may have mental health benefits (work-life balance, time gained by lack of commute, scheduling flexibility), but also mental health challenges (isolation, loss of social benefits of work, reduced physical activity, technology fatigue)
- Should schools and childcare settings close again, the juggling of multiple responsibilities of work, childcare and education, may lead to stress and anxiety for working families. Evidence indicates that women bear the greater risk in this respect, given their typically larger role in domestic and family labour.
- People directly exposed to the virus and its impacts in the course of their work may experience stress, anxiety, depression and symptoms of PTSD or vicarious trauma. Women and ethnic minorities may be at greater risk in this respect, given their overrepresentation among frontline health and care workers.
- There may be a risk of burnout for frontline healthcare workers and others whose workload has increased as a result of adaptations to new ways of working (e.g. educators delivering hybrid provision)

Measures put in place to reduce the spread of Covid-19 among populations, have led to significant changes in the labour market and in the way people carry out their work. Significant reductions in the **availability of work** and changes to the **organisation of work**

have potential for adverse mental health effects. We focus primarily on these two factors in the discussion below, first outlining the most salient changes that can have mental health impacts and then turning to evidence on those impacts themselves.

Additionally, there is a group of essential workers who have had greater **exposure to the virus** (risk of infection and witness to its effects) and thus may experience mental distress caused more directly by this exposure. Lastly, reductions in availability of work and greater competition for vacancies mean that the situation for people who were already **unemployed** and subject to conditional welfare benefits prior to the pandemic will undoubtedly have become more challenging, particularly for those with long-term health conditions. The potential mental health effects on this group are briefly noted.

COVID-19 measures have reduced the availability of work

The COVID-19 pandemic has led to a fall in the employment rate, with corresponding increases in redundancies, unemployment rate and benefit claimant count.^{11,12} The Coronavirus Job Retention Scheme (CJRS)¹³, commonly known as ‘furlough’, has partially protected income for some people. However, earnings for those in insecure forms of work (zero-hours contracts and agency work) have been less well protected by furlough. Recent qualitative research shows that while this is recognised as an unrepresented and generous intervention, there has been variable benefit to individuals due to the scheme’s linkage to previous earnings, meaning less generous support for people in insecure forms of work.^{14,15} A House of Lords inquiry into the effectiveness of government financial support for employment during the pandemic is currently under way,¹⁶ and a report assessing the management of the schemes was published in October 2020 by the National Audit Office.¹⁷

The impact on employment has not been evenly distributed. The largest job losses are expected in retail, hospitality and leisure, sectors already characterised by more insecure employment forms.^{18,19,20} Workers in these sectors, among whom women, young people and minority ethnic groups are overrepresented (Adams and Prassl 2015; Schneider and Harknett 2019; Farina, Green, et al. 2020; Office for National Statistics 2020), find themselves at enhanced risk of job insecurity, reduced income and consequent negative mental health impacts (Adams-Prassl, Boneva, et al. 2020b; Adams-Prassl, Boneva, et al. 2020a; Florisson, Gable, et al. 2020).^{21,22} The impact on the cultural and creative arts sectors is also expected to result in many venue closures and associated redundancies.^{23,24}

As noted by Benzeval et al. “the largest economic shocks have fallen on those least able to mitigate.²⁵ Those most affected are BAME individuals, single parents and those in the lowest quintile of long-run income” (p.18). Furthermore, there is evidence that new benefits claimants in the wake of the pandemic reflect a different demographic distribution from the ‘traditional’ claimant population, namely somewhat larger proportions of younger people, men, minority ethnic groups and people *without* health conditions or disabilities.²⁶

Younger workers, school leavers and graduates

Young people, including younger workers, school leavers and graduates, are being particularly affected. Pre-pandemic, younger people²⁷ were already more likely to be in insecure and low-paying forms of work (Gardiner, Gustafsson, et al. 2020), and concentrated in retail, hospitality and leisure sectors whose operations have been restricted by COVID-19

mitigation measures (Brewer, Cominetti, et al. 2020). Because of its effects on these sectors, the pandemic has resulted in younger people being particularly likely to become unemployed or experience a drop in earnings (Brewer, Cominetti, et al. 2020; Gardiner, Gustafsson, et al. 2020)^{15, 28}.

Periods of unemployment have a 'scarring' effect: future earnings and employment prospects are negatively impacted. Long-term scarring has been found to particularly affect those experiencing unemployment in their youth (Gregg and Tominey 2004; Bell and Blanchflower 2011; McQuaid, Raeside, et al. 2014). During a recession, young people are particularly affected by unemployment and its scarring effects (Bell and Blanchflower 2011; Tumino 2015)^{29,30}. Scarring effects may be worse for young males with lower educational qualifications (Arulampalam, Gregg, et al. 2001).³¹ Analysis by the Resolution Foundation suggests that graduates may be earning 13% less than they would have done in the absence of the pandemic, whilst lower-qualified school leavers may face unemployment rates 27-37% lower (Gardiner, Gustafsson, et al. 2020).

Self-employment

The self-employed have been affected in heterogeneous ways by the pandemic. Whilst some have ceased trading, others have continued with minimal impact and others still have made significant modifications to their ways of operating in order to sustain their business. Nonetheless, research by Blundell suggests that the self-employed have been 'particularly hard hit'.³² While government support to the self-employed has been in some ways more generous than for employees, it has been poorly targeted; 1/6 of those receiving the Self-Employment Income Support Scheme (SEISS) have experienced no loss in earnings, whilst 2/3 who did not claim SEISS have experienced loss of income during the pandemic (Brewer, Cominetti, et al. 2020). Over half of self-employed people are reporting lower earnings, and one in six formerly self-employed were not working at all in September 2020. People who had only been self-employed for as short time were not eligible for the self-employment support schemes. Analysis of Labour Force Survey data by the Institute of Employment Studies shows that the largest decline in employment has been for men in self-employment, but nonetheless "many of those in more precarious self-employment have sought out, and found, employee work during the crisis in order to mitigate the impacts on their business - while others may have held off on setting up a business or going freelance because of the crisis".³³

Many people working freelance in the cultural and creative arts were unable to benefit from self-employment support, because their employment structures (e.g. also holding an employee contract as an income supplement) rendered them ineligible^{34,35}.

Mental health risks related to availability of work

Job insecurity, job loss and unemployment (and the wider context of a recession) are associated with adverse mental health impacts, including heightened risk of depression, anxiety and suicide, particularly among men (Montgomery, Cook, et al. 1999; Blakely, Collings, et al. 2003; Paul and Moser 2009; Stuckler, Basu, et al. 2009; Nordt, Warnke, et al. 2015; Frasilho, Matos, et al. 2016; Kim and von dem Knesebeck 2016; Llosa-Fernández, Menéndez-Espina, et al. 2018; Bartelink, Zay Ya, et al. 2020; Deady, Tan, et al. 2020; Kawohl and Nordt 2020).³⁶ These effects may be stronger where people experience unemployment in

their youth (Daly and Delaney 2013; Strandh, Winefield, et al. 2014). Adverse mental health effects come about through **financial hardship** and through the **psychological impacts** of loss of valued social roles, identities, routines and support networks (Ezzy 1993; IWH 2009). These factors make up one of the key pathways through which COVID-19 may affect the mental health of working aged people (Haw, Hawton, et al. 2015).

There is extensive evidence of an association between financial hardship, poverty, debt and poor mental health (Fell and Hewstone 2015; Elliott 2016) and recent UK austerity measures are clearly associated with declines in mental health (Barr, Kinderman, et al. 2015; Lowe and DeVerteuil 2020)³⁷. Financial difficulties may lead to food insecurity and housing insecurity, which are themselves associated with poor mental health (Pevalin 2009; Brown, Benzeval, et al. 2012; Pourmotabbed, Moradi, et al. 2020)^{38,39} as well as risks to physical health. Ongoing qualitative research is highlighting the mental health effects of financial hardship for low income families, that has been exacerbated by COVID-19 mitigation measures (including school closures over spring/summer 2020).⁴⁰

At a broader societal level, it has been noted that the contraction of the cultural and creative arts sectors carries long term public mental health implications, given the important social and therapeutic role of the arts in wellbeing, diversity and inclusion,^{41,42}

Impact on mental health: what is known and what can be projected at this point?

Recent survey research indicates that people who have lost their employment in the wake of the pandemic are reporting worse mental health than those who have continued in part-time work or have been furloughed; workers who reduced their hours or were furloughed in fact did not report a deterioration in mental health (Burchell, Wang, et al. 2020a). However, former Expert Advisor on Health and Work Professor Dame Carol Black has drawn attention to the potential negative mental health effects of long-term furlough.⁴³ As noted by Thompson (2020) "For many employees with caring responsibilities the prospect of being furloughed on 80% pay may have been a welcome outcome in the short-term. But for many others, being furloughed can bring a loss of meaningful activity, self-identity, social interaction, and also raise concerns about job and financial security".⁴⁴

UK survey data indicates a notable increase in mental distress for those in employment prior to the pandemic, which may be linked to actual or anticipated job loss (Pierce, Hope, et al. 2020c). An Australian survey found that it was financial distress, rather than job loss *per se*, which had a more negative impact on mental health, thus concluding that "minimizing social and financial disruption during the COVID-19 pandemic should be a central goal of public health policy" (Dawel, Shou, et al. 2020). Evidence brought together by Public Health England indicates that people who experienced financial loss during the early stages of lockdown reported higher levels of anxiety and mental distress.⁴⁵

While recent surveys suggest that levels of self-reported mental distress at the beginning of the lockdown are beginning to return to pre-pandemic levels, survey results from August 2020 find that, "depression and anxiety are still highest in young adults, people living alone, people with lower household income, people living with children, and people living in urban areas".⁴⁶ Thus there is an apparent persistence of mental distress among groups who have been most significantly affected by economic shocks (as well as social isolation and role conflict).

Survey data from late September 2020 shows that over a quarter of workers fear redundancy, rising to 40 percent in the sectors hardest hit by social distancing measures (Brewer, Cominetti, et al. 2020).

UK data from the period immediately before and during the first national lockdown suggests that there has been no rise in suicide rates in the short term.⁴⁷ However, risk of suicide increases as duration of unemployment grows (Milner, Page, et al. 2013; Milner, Page, et al. 2014), suggesting that if the labour market does not recover quickly, a rise in unemployment-related suicide may be seen over the coming years. That said, the experience of unemployment due to a pandemic may have different psychological effects than in other contexts, with the shared experience bringing a sense of social solidarity that potentially has a mitigating effect (Deady, Tan, et al. 2020). As noted by Deady et al. “although the links between economic recessions and suicide are well documented, what is less clear is how the relationship plays out in the context of larger sociocultural and health events such as COVID-19” (Deady, Tan, et al. 2020).

Overall, it must be noted that the long-term effects of COVID-19 on employment rates cannot be accurately predicted (a) whilst the furlough scheme remains in place, supporting job retention (and deferring possible redundancies) in the short term; and (b) until there has been full implementation of effective vaccination (at which point we might assume that social distancing measures can be substantially relaxed, enabling affected sectors to resume normal operation). We note an ongoing parliamentary inquiry into the impact of COVID-19 on employment,⁴⁸ the findings of which will be of interest to the present exercise. The [Institute for Employment Studies](#) is producing regular analyses of labour market data, and continues to convey some optimism regarding labour market recovery in the relatively short to medium term, though the likelihood of enduring impact on younger people’s employment is acknowledged.¹⁵

Despite an overall correlation between unemployment and poor mental health, the picture is complex at subgroup level. Individual and contextual factors, including financial and social buffers, gender, age, education, health, personality traits and coping strategies shape the lived experience of unemployment for different people, as will duration of unemployment (Ezzy 1993; IWH 2009; Norström, Virtanen, et al. 2014; Menéndez-Espina, Llosa, et al. 2019; Bartelink, Zay Ya, et al. 2020). These factors should be borne in mind when making predictions about mental health impacts and designing policy responses. However, as noted by Burchell et al. there are “great individual differences between those who thrive without paid work, and those who suffer extreme psychological hardship, but when dealing with averages, the findings tend to be very predictable” (Burchell, Wang, et al. 2020a).

In summary, current labour market predictions would suggest a likely increase in mental health problems relating to job insecurity and unemployment, and this should be prepared for. However, there will be disparity in impacts on different subpopulations and heterogeneity in individual experiences. Individuals’ perceptions of job insecurity and levels of optimism about future re-employment will inevitably vary as the situation continues to unfold. The mental health impacts of unemployment vary according to subjective, contextual and temporal factors, and it is thus very difficult to make specific predictions.

Policy recommendations and mitigation measures related to changing availability of work

Mitigation measures against the potential mental health impacts of job insecurity and unemployment centre around strategies to maximise **job retention**, to enhance **financial security** for those who have lost (or had to reduce) their work, and to improve prospects for **re-employment** (through job creation and skills enhancement). Whilst acknowledging that the quality of work has an influence on how beneficial it is to wellbeing, evidence supports the positive effect, overall, of employment on mental health (van der Noordt, Ijzelenberg, et al. 2014). There is also some evidence to suggest that a relatively small number of working hours per week could produce important gains in wellbeing (Kamerāde, Wang, et al. 2019), pointing to the potential effectiveness (for mental wellbeing) of job creation via **short-time working policies**, as advocated by Burchell et al (Burchell, Wang, et al. 2020a).

Evidence suggests that the furlough scheme has been protective of mental health (in comparison to the alternative of job loss) (Burchell, Wang, et al. 2020a). It is acknowledged that the unprecedented generosity of the scheme is not financially sustainable in the long term, but some have proposed a **targeted furlough scheme** aimed at providing financial stability to those in sectors most affected by social distancing regulation (see, for example, Burchell et al (Burchell, Wang, et al. 2020a); The Joseph Rowntree Foundation⁴⁹). Whilst the initial furlough scheme is generous, it has operated at employers' discretion and this is perceived to have led to inequitable application.⁵⁰ Those from black and minority ethnic groups were less likely to be furloughed and more likely to become unemployed.⁵¹ Continuation of the scheme should address apparent disparities, including attention to transparency and fairness/equity of application within and across organisations.

The OECD has made a series of recommendations on how to support recovery in the cultural and creative arts (CCS) sectors, including ensuring that "public support for COVID-19 relief does not exclude CCS firms and workers due to their non-traditional business models and employment contracts".⁵² Fujita et al. present a case for **prioritising job retention** wherever possible – finding policies that enable the 'riding out' of the pandemic in sectors/businesses that are likely to bounce back – given the evidence that retaining attachment to an employer preserves skills, human capital and earnings in the longer term.

⁵³

In the wake of the pandemic, there has been a sharp rise in applications for Universal Credit, a benefit which spans unemployment and employment. Problems of Universal Credit's design and administration have been much discussed,⁵⁴ including its detrimental impact on claimant mental health (Cheetham, Moffatt, et al. 2019; Wickham, Bentley, et al. 2020). At a broad level, the potential distress of people who are economically affected by COVID-19 could be ameliorated by more general **improvements to design, administration and generosity of the welfare system**, the problems of which pre-date the pandemic. The OECD notes that, "a number of workers do not meet the criteria to receive adequate support [from unemployment benefits]. Even if entitlement rules are usually the same for all dependent employees, conditions on minimum employment duration or earnings before the unemployment spell are often harder to meet for those who lose a part-time job or have employment trajectories involving frequent transitions between employment and unemployment. Consequently, the risk of falling into poverty is often greater for non-

standard employees “⁵⁵ Despite the complexity they suggest that there are available policy instruments to strike the right balance between work incentives and income security for such employees.

Sustained welfare spending and more generous unemployment protection during recession are associated with smaller increases in suicide rates (Haw, Hawton, et al. 2015; Norström and Grönqvist 2015). The £20 per week uplift to Universal Credit and Working Tax Credit that was quickly implemented in response to the national lockdown has been described as a ‘lifeline’ and a large group of welfare charities have signed a joint open letter urging Government to make this increase permanent. ⁵⁶ Likewise, Brewer et al. (Brewer, Cominetti, et al. 2020: 14) caution that “it is very unwise that current Government policy is still to reverse the £1,000 a year boost to Universal Credit and Working Tax Credits in April 2021 ... Cutting this support is a bad idea, both for the health of our economy and the living standards of over 6 million families” (p.20). ⁵⁷ Citizen’s Advice has advocated both for maintenance of the Universal Credit uplift, as well as **debt relief** and additional support for rent arrears and to meet essential bills.⁵⁸ In short, **adequate welfare spending** will be crucial to mitigating the mental health effects on those who have suffered economic shocks as a result of the pandemic.

Universal Basic Income (UBI) is a policy response that generates controversy and presents much complexity, but has been suggested by some as a timely response to the pandemic’s economic impact.⁵⁹ Ståhl and MacEachen (2020: outline the case for UBI as a policy response to COVID-19 and Canada is re-considering the introduction of UBI, following an earlier pilot⁶⁰. There is little available evidence of UBI interventions, as they have rarely been implemented in full, nor evaluated, but a recent scoping review of interventions ‘similar to basic income’ noted evidence of positive impact on mental health (Gibson, Hearty, et al. 2020).

Finally, investment in **job creation schemes, Active Labour Market Policies (ALMPs) and skills training** to support re-employment are likely to form part of an effective response (Wilson, Cockett, et al. 2020). ^{61,62,63,64,65} Increased spending on Active Labour Market Programmes (ALMPs) is associated with smaller increases in suicide rates following recession (Stuckler, Basu, et al. 2009). A 2017 systematic review of interventions to reduce the impact of unemployment and financial hardship on mental health (Moore, Kapur, et al. 2017) concluded that, although there are many problems with the evidence, there are reasonably consistent findings that brief ‘job club’ interventions can be effective for unemployed people at high risk of depression. They also pointed to the importance of reduction in financial strain, for example through help with debt management, alongside re-employment support. A particular focus on support for younger jobseekers seems warranted, as does specialist support for women/mothers⁶⁶.

COVID-19 measures have changed the organisation of work

Many people whose work can be carried out from their home have moved to remote working during periods of lockdown and ongoing social distancing measures. For many, this constituted a significant shift in the organisation of their work, requiring adjustments to their physical and social working environment and modes of communication. There is

speculation that remote working will become a more commonplace mode of operating in the longer term, regardless of any Government-enforced restrictions⁶⁷. The House of Lords COVID-19 Committee consultation on *Life Beyond COVID* revealed a strong public view that “the world of work will change forever”,⁶⁸ with one expected change being a sustained shift to remote working, for many people whose work was previously office-based. The committee’s inquiry into the long-term wellbeing impacts of living life online has a key focus on the world of work.⁶⁹ The findings of the ongoing inquiry will thus be of interest to the present exercise.

Mental health risks of remote working

There are trade-offs in these new arrangements, with homeworking (in some cases) allowing greater scheduling flexibility, thus facilitating better work-life balance; but also a potential loss of social interaction⁷⁰ and reduction in physical activity which make important contributions to mental wellbeing.^{71,72,73} The blurring of home/work boundaries may also lead to difficulties in maintaining balance, and a sense of ‘disorientation’ in one’s environment. Lack of a suitable workspace or appropriate equipment may also be a physical and mental stressor. Recent qualitative research from the UK suggests that employees working from home may find it more difficult to raise mental health concerns with their employer, due to both the reduction in contacts (meaning managers and co-workers are also less able to notice indicators of emergent mental health problems in others) and concerns around job insecurity⁷⁴. Survey evidence suggests young people may find long-term working from home more challenging to their mental health than older workers⁷⁵. Converting previously face-to-face delivery of services (e.g. healthcare, teaching) to an online/distance format may bring additional workload and stress (see further below).

The ability to move to homeworking is not evenly distributed among roles, sectors and income groups; jobs that have converted relatively easily to remote working correlate to higher paid professional roles.^{76,77,78,79} While the *economic* impact is thus unlikely to be such a significant risk to mental health for this group of workers, it is important to consider ways of mitigating other risks, including ways to maintain social connection, achieve effective balance and boundaries around work, and maintain physical activity and exposure to the outdoors.

Mental health risks of school and childcare closures

During the closures of school and childcare settings, there were additional demands placed on working parents⁸⁰ in balancing responsibilities of paid work, childcare and home education.⁸¹ There is evidence to indicate that this juggling of roles increased stress and anxiety for working parents, and that mothers took on the majority of this task (Walsh, Purdy, et al. 2020),^{82,83,84,85,86,87} experiencing greater stress and adverse mental health effects as a result (Pierce, Hope, et al. 2020c; Walsh, Purdy, et al. 2020; Zamarro and Prados 2020)^{88,89,90,91}. Labour Force Survey data indicates that self-reported symptoms of depression increased almost fourfold among parents of children under age 16 during the first months of the pandemic.⁹² Subsequent periods of school closures are likely to heighten the practical and emotional strain on families (again particularly mothers), exacerbated by the more stringent expectations placed on the delivery of school-facilitated home learning this time around. While there is much speculation about medium and long-term consequences for

children's mental health, it is, of course, too early to make evidence based assessments of such durable negative impacts.

Mental health risks of returning to the workplace

There is emerging evidence (at this stage primarily qualitative and anecdotal) that COVID-19 is producing new sources of work-related stress (and associated mental health problems) for workers who have remained in or returned to their workplaces. Those who have returned may face continued uncertainty about long-term job security. They are also more exposed to risk of contracting COVID-19, as they travel to and from work. A recent report identifies the phenomenon of 'furlough envy' and that differential treatment was damaging to workplace relationships and team spirit.⁹³

There are special stresses on school, FE and HE staff who are delivering in place, with new challenges of social distancing, PPE, increased workloads, combining in-person and remote teaching, and adapting resources. A recent survey by the National Association of Headteachers pointed to stress, exhaustion and high levels of intention to leave the profession.⁹⁴ Work-life conflict, unmanageable job demand, perceived effort-reward imbalance and lack of fairness or 'organisational justice' in the workplace are all correlated with poorer mental health. More broadly, the ongoing uncertainty, unpredictability and 'pivoting' that are being asked of workers in general may, in the long term, be a risk factor for chronic stress and anxiety.⁹⁵

As with job insecurity and unemployment, it is important to note that different people will respond to changes in their altered work situation in different ways. Personality traits, character strengths (Martínez-Martí, Theirs, et al. 2020), social supports and the quality of employer actions and responses may mitigate the mental health risks of long-term home working or adjusting to new working styles.

Policy recommendations and mitigation measures related to changing organization of work

- For most people, the worries and stresses of dealing with adjustment to new and/or challenging work circumstances represent expected responses requiring predominately social/practical interventions (including a key role for employers). In most cases, the most appropriate response is not psychological treatment, but the amelioration of the stressful situations occasioning the mental distress and encouragement of wellbeing behaviours that can mitigate the potential negative effects of changes in the social and physical working context.
- Promotion of 'healthy homeworking' may be a useful approach, emphasising such things as physical activity, time outdoors in green/blue space, social connection and boundary setting. Such guidance has already been produced by mental health organisations⁹⁶ and in the mainstream media⁹⁷. A government led campaign, providing simple, consistent and evidence-based messages, may have value. There are also implications for employers in supporting and monitoring the mental wellbeing of staff working remotely on a long-term basis.

- Policy attention should be given to emerging evidence on the inequitable use of furlough, the psychological effects of furlough and conversely of *not* being selected for furlough. Employers should provide transparency about who is or is not being asked to return to the workplace, and the underpinning rationale. Employer recognition of the additional workload that may arise for people delivering hybrid provision/services (e.g. educators, possibly primary care?) may help to mitigate work-related stress and burnout.
- For those returning to work, provision of adequate PPE and early implementation of workplace protocols to prevent transmission is crucial to mitigate workers' distress (Giorgi, Lecca, et al. 2020).⁹⁸
- Given that stress and anxiety related to combining work and childcare/home education seems to have ameliorated with the reopening of schools,⁹⁹ this supports the governmental commitment to keeping schools and childcare settings open and enacting further closures only as a last resort. From an equality perspective, the evidence that mothers typically carry the greater risk in this respect, should be borne in mind.

Some workers have been more exposed to the virus

A subset of the working age population has been more directly exposed to COVID-19 in terms of risk of infection in the course of carrying out their work, and through direct and prolonged involvement with others who have become ill with the virus. Primarily, and most significantly, this includes health and social care professionals,¹⁰⁰ who have worked throughout the pandemic, experienced higher rates of infection (Nguyen, Drew, et al. 2020; Shah, Wood, et al. 2020) and may suffer stress, anxiety, depression or vicarious trauma through their role in supporting high volumes of seriously ill and dying patients (Carmassi, Foghi, et al. 2020; Pearson 2020; Vigo, Patten, et al. 2020). Early evidence, largely from China and Singapore, indicates high rates of post-traumatic stress among healthcare workers (Benfante, Di Tella, et al. 2020), and a narrative review by Giorgi et al (Giorgi, Lecca, et al. 2020) also highlights the particular mental health risks to healthcare workers, although UK evidence brought together by Public Health England presents a more varied picture (some studies finding worse mental health among key workers, other finding opposite or no effects).¹⁰¹ While there has been ongoing recognition and appreciation of NHS workers and other social care and essential workers, with the weekly 'clap for carers', there is also need for more concrete governmental support,¹⁰². There is a growing risk of stress and burnout for frontline healthcare staff as the situation prolongs.

Policy recommendations and mitigation measures for key workers

- The evidence is not consistently pointing to negative mental health impacts among key workers. Nonetheless it is prudent to anticipate a heightened need for psychological support among this group (Vigo, Patten, et al. 2020).
- At a preventive level (as already noted), provision of adequate PPE and early implementation of effective workplace protocols to prevent transmission can mitigate workers' distress (Giorgi, Lecca, et al. 2020)¹⁰³.

Those already unemployed will now face greater obstacles

The disadvantaged situation of long-term unemployed people, including those with mental and physical health problems in receipt of conditional welfare benefits, has not been caused by COVID-19 but will be exacerbated as the labour market tightens. Analysis by the Institute of Employment Studies reveals that “progress in narrowing the (very wide) employment gap for disabled people has stalled during this crisis and may be at risk of going into reverse. Disabled people are now more than two and-a-half times more likely to be out of work than their non-disabled peers”¹⁰⁴. Evidence brought together by Public Health England¹⁰⁵ indicates that adults outside of employment experienced greater loneliness during the lockdown than those in work.

Policy recommendations and mitigation measures for those unemployed

Consideration should be given to the way conditionality is managed for this group of claimants over the longer-term period of recession and economic recovery.

- The UK’s assessment- and conditionality-based welfare system, and associated sanctions regime, causes mental distress to people both with and without pre-existing mental health conditions (Williams 2019; Dwyer, Scullion, et al. 2020; Lowe and DeVerteuil 2020; Wickham, Bentley, et al. 2020; Williams 2020; Wright 2020). This will only be exacerbated if people remain subject to the same demands under an increasingly challenging labour market landscape. Removing conditionality may improve mental health of claimants with long-term conditions, or at least not exacerbate mental distress.

6. Impacts for adults over 65 with a focus on social isolation

- Emerging evidence suggests that older people are at a significantly lower risk of experiencing social isolation, loneliness, and poorer mental health outcomes during the pandemic compared to other age groups.
- Furthermore, risk factors for loneliness are near identical before and during the pandemic.
- Policy changes that could address existing issues and gaps in mental health support amongst older adults include improving access to and literacy with online technologies and resources; developing methods to identify loneliness and isolation among their patients and appropriate clinical and public health actions to support them; and consideration of the needs and capabilities of older people in rolling out telephone and virtual medical consultations and treatment and other innovations.

Social Isolation and Loneliness as Public Health Concerns

Social isolation has been defined as ‘the objective state of having few social relationships or infrequent social contact with others,’ while loneliness ‘is a subjective feeling of being isolated’ Wu (2020: p.28. Social isolation and loneliness are distinct but inter-related concepts, with isolation often being a risk factor for loneliness, and have both been increasingly identified as serious risks to public health. There is a growing body of evidence that illustrates the harmful effect of social isolation on mental and physical health: it has been established as a major risk factor for anxiety, depression, increased blood pressure, poor cognitive functioning and increased risk of heart disease. (DiNapoli, Wu, et al. 2014) (Nicholson 2012) (Sun, Norman, et al. 2013). Furthermore, social isolation has been associated with an almost 50% increased risk of developing dementia. (National Academies of Sciences 2020). Similarly, a number of studies have explored the effects of loneliness and have established associations with poor mental and physical health (Beutel, Klein, et al. 2017); (Cacioppo, Hawkley, et al. 2010); (Mullen, Tong, et al. 2019); (Theeke 2010) and increased mortality risk (Holt-Lunstad, Smith, et al. 2015), particularly amongst those suffering chronic loneliness (Shiovitz-Ezra and Ayalon 2010).

Social isolation and loneliness among the older population is a particular public health concern in many countries, including the United Kingdom. Prior to the pandemic, loneliness had already been identified by the UK government ‘one of the greatest public health challenges of our time,’ particularly amongst older adults, and a cross-Government strategy was launched to tackle the issue.106

COVID-19 Lockdown

In March 2020, as part of the UK government’s efforts to control the spread of COVID-19, those aged over the age of 70 or suffering a serious underlying medical condition such as heart disease were advised to follow social distancing measures especially stringently. Those

with certain high-risk conditions were advised to 'shield' by staying at home entirely, except for specific purposes.¹⁰⁷ In total, more than 2.2 million people were advised to shield.¹⁰⁸ Government guidance on shielding and social isolation in general changed several times over the course of the pandemic, although extremely clinically vulnerable people were continued to be advised to stay at home as much as possible.¹⁰⁹

Given concerns around isolation and loneliness, and the particular burden of lockdown restrictions on the clinically vulnerable, concerns were expressed from the early days of the pandemic about the mental health of older people. In their March 2020 guidance on COVID-19, Public Health England highlighted concerns around the risk of self-isolation, particularly in relation to experiences of loneliness and its potential effect on mental health.¹¹⁰ In June 2020, WHO highlighted their concerns about the wellbeing of older adults, making particular reference to self-isolating for those suffering cognitive decline and syndromes such as dementia, who could become more anxious, stressed, withdrawn or agitated. (World Health Organisation 2020).

However, it is important to note that pre-pandemic literature on associations between older age and loneliness have overall been mixed, suggesting that some of these concerns might be misplaced. (Victor & Yang, 2011; Cohen-Mansfield et al., 2016; Losada-Baltar et al., 2020)

Evidence on effects of social isolation and loneliness among older adults during the pandemic

A small number of studies investigating the effects of social isolation and loneliness among older adults during the pandemic were identified in this review, almost all of which were surveys using general population samples and disaggregated findings by age group. The surveys used a variety of measures to assess loneliness and impacts on mental health. While several of these studies will continue to produce results, currently published results focus on the first months of the UK lockdown. Results from these studies were largely consistent, with older adults generally experiencing less loneliness and poor mental health.

The COVID-19 Psychological Wellbeing study (Groarke, Berry, et al. 2020) sought to understand the prevalence and predictors of loneliness during the pandemic. It used a cross-sectional online survey design of 1964 adults between the ages of 18-87, which ran from 23 March to 24 April, 2020. Loneliness was measured using the Three-Item Loneliness Scale, which scores social connectedness, relational connectedness and self-perceived connectedness. Data was disaggregated by age category, with 96.7% of those aged 65 and older found to be experiencing low or no loneliness, the lowest prevalence of any age group by a significant margin. By contrast, only 59% of those aged between 18-24 experienced low or no loneliness during this period. The study found no association between loneliness and gender overall. The study also found that risk factors for loneliness during the pandemic were similar to those prior to it, and the authors recommended that mental health interventions during the pandemic be targeted at the most at-risk groups: the young, unemployed, those with low income or education, and people with existing mental health conditions. However, an important limitation of this study is the small sample size of participants aged 65 and over (around 3% of the total sample) and the study authors

acknowledge that as a result, no definitive conclusions as to age differences and loneliness can be reached.

A number of studies used data from the UK Household Longitudinal (UKHLS) panel, a national, longitudinal cohort study of household members aged 17 or over. In a study by Pierce, Hope, et al. (2020a: 17,452 participants from Waves 8 or 9 of the panel completed an online survey in April 2020. Mental health in this study was assessed using the General Health Questionnaire (GHQ-12), a measure of non-specific mental distress experienced in the past two weeks. The study found an overall increase in mental distress in people aged 16 or older in the UK compared with the previous year. However, this increase was not equally distributed across all population groups, with younger people amongst those for whom mental distress increased under the conditions of the pandemic. Of those participants over the age of 70, just under 18% were experiencing a significant level of mental distress; the highest proportion was found in the 16 to 24 age category (36.7%). The study authors noted a number of limitations to the study. The GHQ-12 is a screening tool rather than a clinical assessment and is known to underestimate socioeconomic and ethnic disparities. They also acknowledged that as the survey took place around one month after the beginning of lockdown, the results might represent a short-term spike in emotional response, that might stabilise or change as the lockdown progressed.

Li and Wang (2020: also used UKHLS panel data, this time from the first wave of Understanding Society COVID-19 Study, to assess the prevalence and predictors of general psychiatric disorders and loneliness in the UK. 15,530 respondents completed an online or telephone surveys from 24-30 April. This study also employed the GHQ-12 to measure general psychiatric disorders, and measured loneliness by a question adapted from English Longitudinal Study on Ageing (ELSA): "In the last 4 weeks, how often did you feel lonely?" Respondents could respond with one of three options: "hardly ever or never," "some of the time," and "often". The study found that older people had significantly lower GHQ-12 psychiatric disorder scores and a lower caseness ratio than those in younger age categories. Respondents in the 65 and older category were found to have a GHQ-12 caseness ratio of around 19%, by far the lowest result; the ratio across all age groups was 29.2%. Older people also had the lowest prevalence of loneliness: just under 27% of respondents reported sometimes or often feeling lonely, compared to 36% across all groups. The study also identified employment and living with a partner as key social determinants of general psychiatric disorders and loneliness during the pandemic.

A third study (Bu, Steptoe, et al. 2020d) used the UKHLS panel data as a baseline source to compare socio-demographic predictors of loneliness before and during the pandemic, comparing it with data gathered from the UCL COVID-19 Social Study (findings from this study have also been published separately by Bu, Steptoe, et al. (2020b:). The analysis used UKHLS data collected between January 2017 and June 2019 from 31,064 participants aged 18 and older, and UCL Study data from 67,142 participants aged 18 and older in the UK, collected from 23 March and 10 May 2020. For both datasets, the three-item UCLA loneliness scale (UCLA-3) was used to measure loneliness. Participants were asked how often they felt that they lack companionship; how often they felt isolated from others; and how often they feel left out, with responses ranging from hardly ever/never, some of the time, or often. Additionally, participants were also asked how often they felt lonely, with responses coded

on the same scale as the UCLA-3 items. Overall, levels of loneliness were higher in the UCL Study dataset, with 50.8% of respondents feeling lonely some or all of the time, compared to 46.9% in UKHLS. In both datasets, people aged 60+ were less likely to be lonely compared to those aged between 18-30, and groups who were already at risk for loneliness, such as young people and those living alone, experienced an increased risk during the pandemic. The study authors therefore recommended that interventions aimed at reducing or preventing loneliness as a result of the pandemic be targeted at those groups previously identified as at high risk.

Initial results from the *COVID-19 Survey in Five National Longitudinal Studies* (Henderson, Fitzsimons, et al. 2020) present pronounced generational differences in mental health during the pandemic. The study uses data from a web survey collected between 2 to 31 May from over 18,000 participants of four nationally representative cohort studies of four generations of people, the oldest of whom were born in 1958 (age 62). Mental health was assessed using a number of measures, including the UCLA Loneliness 3-item scale for loneliness, PHQ-2 for depressive symptoms and GAD-2 for anxiety symptoms. The data was disaggregated by age and gender. In the 62-year-old group, approximately 17% of males and 26% of females reported high loneliness, the lowest levels of any age group; by contrast, 42% of male and 45% 19-year olds experienced high loneliness during this period. Similarly, in the 62-year-old group, 7% of males and 10% of females had high levels of depressive symptoms, and 6% of males and 14% of females had high anxiety symptoms. Both of these results were the lowest levels of any age group by a considerable margin. A further analysis of a subsample aged 62 compared symptoms of psychological distress from an assessment in January-March to another assessment in May, fewer participants reported symptoms of psychological distress at the latter date. Further research was recommended to explore these unexpected results.

Finally, researchers from the University of Stirling have released preliminary findings from a survey of 1429 people in Scotland, of whom 84% were aged 60 or older (Whittaker 2020). This study has produced different results from the other identified studies on the mental health impacts of social isolation. 56% reported that social distancing made them experience more loneliness. Greater loneliness was reportedly associated with worsening mental and physical health. The study also reported that protective factors against loneliness and poorer mental health included better perceived social support and a larger social network. However, full results from this study have not yet been released, and information on participant recruitment, scales used to measure loneliness and poor mental health, and baseline data are not yet publicly available.

Non-COVID-19 Quarantine and Mental Health Research

A recently published rapid review of 24 studies published in *The Lancet* explored the impact of quarantine on mental health (Taylor, Agho, et al. 2008). The review included two studies that assessed the prevalence of distress during quarantine across different age categories. An Australian study of 2760 horse owners quarantined because of equine influenza used an online survey to identify the characteristics associated with psychological distress, as determined by the Kessler 10 Psychological Distress Scale. 80% of those aged

between 65-74 and 100% those aged 75+ were found to be experiencing low to moderate level psychological distress; by contrast, 57.1% of those aged 16-24 were found to have experienced these levels of distress. Another study, which used an online survey of 129 quarantined persons to explore the psychological effects of quarantine during a SARS outbreak in Toronto, Canada, found that respondents exhibited a high prevalence of psychological distress. However, age, among other demographic factors such as marital status and education, was not associated with psychological outcomes (Hawryluck, Gold, et al. 2004).

Fancourt, Steptoe, et al. (2020): consider possible explanations for why mental health has not seemed to worsen during this pandemic, compared to previous quarantines. They suggest that as most people in the UK were permitted some trips outside of their home; the advance warning from experiences in other countries that a lockdown was imminent; and the increasing availability of virtual communications and other online activities may all have mitigated the psychological experience.

Policy Recommendations and Mitigation Strategies

Despite the concerns expressed towards the start of lockdown, emerging evidence suggested that older people are at lower risk of experiencing social isolation, loneliness, and poorer mental health outcomes compared to other age groups. Furthermore, evidence suggests that risk factors for loneliness were near identical before and during the pandemic. However only a small body of research on this topic has yet been published, and in-depth analysis of protective factors that are contributing to the resilience of older people is currently lacking. Study authors and commentators have proposed that mental health-related interventions during and after the pandemic target other groups that are at higher risk. However, some policy recommendations for older adults may be drawn out from the research.

- Given the evidence on the resilience of older adults during the pandemic, the path to improving mental health outcomes for older people is likely to come more from public health messaging than from large-scale policy changes.
- Physical exercise, volunteering and maintaining personal relationships during and beyond the pandemic should be emphasised as these have proved beneficial for mental health and wellbeing (Diamond and Willan 2020).
- Policy should address gaps in mental health support amongst older adults, such as access to the online technologies and resources that have proliferated during the pandemic. Disparities in access to and literacy with these kinds of technology among the older population is a significant issue to be addressed; in 2019, the Office for National Statistics found that 29% of people aged 65 and over have never used the internet (Statistics 2019). I
- In relation to health care, telephone and virtual consultations and treatment may be unsuitable for some older people. Their needs and capabilities should be considered when rolling out such changes to health care in the long-term (British Psychological Society 2020) and clinicians and health workers should develop methods to identify isolation and loneliness among their patients and develop appropriate clinical and public health actions to support them (Wu 2020).

- Health workers and carers supporting older people could also incorporate mental health and physical activity checks as part of their assessment (Beaney, Salman, et al. 2020). Similarly, training programmes for health care workers should encompass guidance and education on social isolation and loneliness (National Academies of Sciences 2020).

6. Policy recommendations and mitigation strategies

For children and young people:

The broad and overwhelming consensus is then that the policy implications that should be considered for the benefit of the mental health of children and young people are multisectoral and should take the form of a public health prevention approach. This might include:

- *Package of measures to support young people in disadvantaged households*, including the extended provision of free school meals, breakfast clubs, free internet access, and resources for digital education.
- *Avoidance of future school closures*, in order to 1) not worsen achievement gaps between children from lower socioeconomic backgrounds, and 2) to maintain a 'safe space' for children who experience adversity in the home.
- *Improvement of child welfare systems*, shifting attention from reactive models of care and risk mitigation to services that are proactive and widely available. E.g. inclusion of policies that ensure basic needs are being met, that families engage in the workforce, and that parents are provided with the opportunity to care for their children without compromising their long-term employment.
- *Dissemination of evidence-based (and co-produced with young people), mental health, psychoeducational, and self-help resources and programs for young people, their carers, and teachers*, in order to promote universal advice on maintaining positive health behaviours.
- *Increased funding towards CAMHS services* to enable services to cope with potential in rising demand, and to establish feasibility and acceptability of telepsychiatry appointments and therapies, in particular for the most disadvantaged young people.

For those from minority ethnic groups

- Race equality impact assessments for research
- Adapt recommendations from PHE stakeholder report:
 - mandate ethnicity data collection as part of routine health systems
 - participatory research, equity audits and diverse hiring in the NHS
 - culturally competent risk assessments and prevention campaigns
 - a commitment to reducing broader inequalities in the distribution of the social determinants of mental health

Protect the mental health of Black, Asian and minority ethnic group health in line with the recommendations by the Royal Society of Psychiatry and the NIMH. Both are calling for a COVID-19 Risk Assessment Framework that takes their circumstances into account.

For those who are disadvantaged in low SES

- Policy measures to mitigate exacerbation of socio-economic inequalities caused by the pandemic need to go beyond a focus on individual stressors to address the co-

occurrence of these factors of insecurity and precarity in the most disadvantaged households.

For adults in or seeking paid employment.

- Strategies to address financial insecurity and potential stressors of new/adapted ways of working are the priority response to mitigate the emergence of mental health problems among people in or seeking employment. *Give priority to policies that address financial insecurity* protecting incomes and providing income replacement at levels that sustain a decent living standard. These include:
 - Policies focused on maximising job retention where possible, e.g. short-time working policies to maximise the number of individuals who are able to remain attached to their employer, whilst the economic downturn is ‘ridden out’; targeted furlough schemes for those businesses/sectors whose operation continues to be particularly affected by social distancing measures
 - Improvements to the design, administration, and generosity of welfare benefits, responding to known flaws and problems that pre-date the Covid-19 pandemic. This includes retention of the £20 uplift to Universal Credit and Working Tax Credit that has been seen as a ‘lifeline’ for families during the pandemic
 - Interventions to improve re-employment prospects for people who have become unemployed, e.g. Active Labour Market Programmes (ALMPs), adult skills training, job creation (Young people should be a particular focus for these policies)
 - *Removal of welfare benefit conditionality and sanctions for unemployed people with long-term health conditions and disabilities*
- *Attention to healthy working environments*, proactive wellbeing behaviours and stress reduction for people who have adapted to new ways of working during the pandemic:
 - Keeping schools and childcare settings open to the greatest extent possible; closures only as a last resort
 - A government-led ‘healthy homeworking’ public messaging campaign, emphasising the benefits of breaks, physical activity, time in green/blue space, social connection and boundary setting
 - Emphasising the role of employers in providing appropriate equipment for physically safe homeworking and monitoring and supporting the mental wellbeing of staff working remotely in the longer term
 - Transparency in decision-making on selection for furlough, short-time working, or return to the workplace, providing the rationale and ensuring fair and equitable application of policies. Individual risk factors should be considered, relating to both physical and social wellbeing.
 - Employers should monitor the workload implications for staff who are being asked to work in ‘hybrid’ ways, or whose workload has otherwise increased as a result of adaptation to new ways of working. Existing best practice evidence on stress-management intervention should be followed.

- Provision of adequate PPE and implementation of safe working protocols to reduce risk of virus transmission for employees who are required to return to the workplace
- Anticipation of some increase in need for psychotherapeutic support for keyworkers in health, social care or other frontline roles, who have had more prolonged and direct exposure to the virus and its effects

For adults over 65:

- *Public health messaging about managing mental health:* Highlight the importance of physical exercise, volunteering and maintaining personal relationships during and beyond the pandemic for mental health and wellbeing
- *Digital access and literacy:* Address disparities in access to and literacy with online technologies and resources especially among those over 65 as the use of these tools proliferates
- *Consider the needs and capabilities of older people* when extending the use of telephone and virtual consultations and treatment in health care
- *Address isolation and loneliness* by developing methods for health and social care workers to identify these conditions among their patients and the appropriate clinical and public health actions to support them
- *Incorporate mental health and physical activity checks* as part of assessment and training programmes for health care workers and carers supporting older people; these should encompass guidance and education on social isolation and loneliness.

FOOTNOTES

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