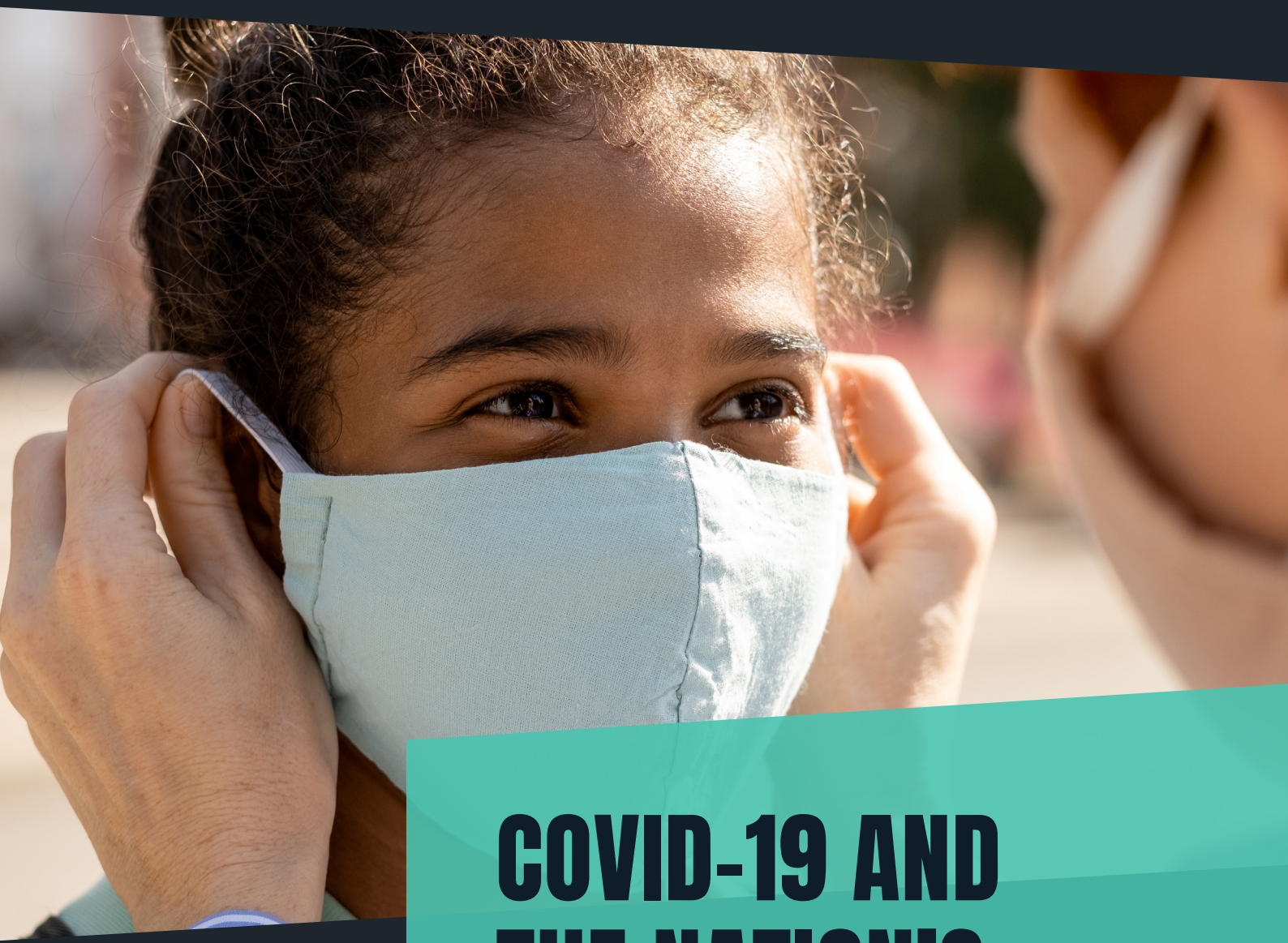
CENTRE FOR MENTAL HEALTH



COVID-19 AND THE NATION'S MENTAL HEALTH

A review of the evidence published so far

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EXECUTIVE SUMMARY

Covid-19 was a global health emergency like nothing else in living memory. While its main immediate impact was on physical health, it has had profound impacts on our mental health, too. This report explores what is known about those impacts, and how they have affected mental health services in the UK, four years on from the start of the pandemic.

The Covid-19 pandemic affected people's mental health in multiple and complex ways. Some were immediate and short-lived, as people and communities faced anxieties about the virus, and the isolation inherent in successive lockdowns. Others look set to be longer-lasting, including the traumatic impact of the pandemic on the workers, patients and families most affected by Covid-19, and the psychological legacies of disrupted education and socialisation among children and young people.

The pandemic had a profound impact on people living with a mental illness. This included a heightened risk of mortality and severe illness from the virus. Some efforts were made by government and the NHS to mitigate these risks, for example enabling speedier access to the vaccination programme.

The emotional and psychological impacts of the pandemic were not felt equally across society. As well as people with existing mental health difficulties, the effects were more pronounced among younger age groups, racialised communities, and the most deprived.

Demand for mental health services dipped sharply at the outset of the pandemic, but rose to record levels after the first wave of restrictions, and they have stayed high in the years since.

Mental health services had to adjust quickly to the pandemic, and many have retained some of those changes since restrictions ended – for example greater use of remote working and digital services.

Emergency powers to detain people under the Mental Health Act were enacted in 2020 but never used, and repealed soon after.

The UK Government lacked a coherent or proactive approach to the nation's mental health during the pandemic. There was no overarching mental health strategy, and little understanding was shown of the emotional and psychological impacts of either the virus or the restrictions deployed to contain it. Later efforts were made to mitigate those effects, with some evidence of benefit. But missed opportunities overall meant that the mental health impacts of the pandemic accumulated and remain a concern longer-term.

There are important opportunities to learn from Covid-19 and prepare for future crises of this nature to prevent or mitigate mental health harms and ensure continuity of mental health support when it is most needed.

INTRODUCTION

This report summarises the evidence available to us four years after the start of the Covid-19 pandemic about its impacts on and relationships with mental health in the UK, including on mental health services, and on the lives of people with a mental illness. It explores what we know now about the ways the pandemic affected the public's mental health and people living with a mental illness and the services that support them. And it reflects on what we have learned from that experience and how this can inform policy making both now (in dealing with the longer-term impacts from Covid-19 on people's mental health) and in the future (to prepare for future emergency responses and inform planning processes at such times).

INITIAL CONCERNS

The Covid-19 pandemic caused widespread societal disruption, morbidity and loss of life globally. This raised significant concerns at the outset of the pandemic regarding its impact on population mental health (John *et al.*, 2020). These included concerns about the direct impact of the virus on individuals infected, and whether it could lead to psychological distress (especially among those most severely affected) and long-term mental health complications (including among those with Long Covid). Additionally, frontline workers caring for Covid-19 patients have also been at risk of experiencing mental health challenges due to the demanding and stressful nature of their work.

Concerns were not, however, limited to those most immediately affected by the virus during the most acute phase of the crisis. Public health measures implemented to curb the spread of the virus, such as physical distancing and lockdowns, have also contributed to mental health concerns. These measures have resulted in social isolation, disruption of businesses, services, and education, and threats to individuals' livelihoods. The prolonged periods of physical distancing and lockdowns led to concerns about the impact on the UK economy and what that would mean for the nation's mental health (John *et al.*, 2020).

In this report, we have sought to draw on the evidence now available to identify to what extent those concerns were justified, and what we can learn from the Covid-19 pandemic to inform responses to future emergencies of this kind. The evidence base is still, of course, evolving, so this report collates what is known and understood at the time of writing, on the understanding that it may change again over time and with greater distance from the events of 2020 and 2021 in particular.

METHODOLOGY

This report is based on a review of available literature produced since the start of the pandemic. It includes reports produced by mental health organisations during the pandemic as well as academic studies that have been published since the emergency began.

In October 2023, we conducted a search for Covid using the databases Embase and Global Health, retrieving 1,283 reports. After deduplication, the researcher screened 1,023 records using the software Rayyan to expedite the process. They manually screened titles and abstracts until at least 50 reports were categorised as included or excluded. Subsequently, the researcher excluded 287 reports based on AI ratings and another 260 reports through further manual screening of titles and abstracts. An additional 226 reports were excluded using a rapid review methodology, with the aim of limiting the inclusion to 250 studies.

We also screened the websites of national organisations, from which we identified a range of documents including 15 briefings, 4 surveys, and 21 press releases in the analysis. We also searched the NHS Mental Health Services Data Set (MHSDS) web pages and included data about children and young people's mental health from the national survey for England. Additionally, a few articles were included after being found through Google searches.

FORECASTS

In the first year of the pandemic, Centre for Mental Health produced a series of four forecasting documents, using the available evidence to identify potential risks and mitigations (Durcan *et al.*, 2020; Sinclair *et al.*, 2020; O'Shea, 2020; O'Shea, 2021). They predicted that the Covid-19 pandemic would significantly impact mental health in the UK, similarly to previous epidemics, with symptoms among those affected including depression, anxiety, post-traumatic stress disorder (PTSD), and sleep deprivation (Durcan *et al.*, 2020).

These predictions were based on figures from previous coronavirus pandemics, when more than half (58.9%) of SARS-CoV survivors had clinically diagnosable mental health problems initially, which reduced to 33.3% at 30 months (Mak *et al.*, 2009).

In October 2020, the Centre developed a model to predict the need for mental health support due to the Covid-19 pandemic. The model predicted that the equivalent of 10 million people would need new or additional mental health support, with 1.5 million being children and young people under 18. About two-thirds of the people who would need support would be those with existing mental health problems, including severe mental illness (O'Shea, 2020).

In May 2021, a final forecast presented the opportunities for the UK Government, health and care providers, and integrated care systems in England to prepare for the impending impact of Covid-19 on the nation's mental health. Key groups at high risk included people who have survived severe Covid-19 illness, people working in health and care services, people economically impacted, and people who have been bereaved.

1 THE EFFECTS OF COVID-19 ON POPULATION MENTAL HEALTH

Studies of the mental health impacts of Covid-19 have looked at both the whole population and the effects experienced by specific groups. In this chapter, we summarise the available evidence so far, noting that for some of these, further evidence will come to light over time, and some longer-term impacts may be yet to manifest themselves.

WHOLE POPULATION IMPACTS

Studies of the general population suggest that public mental health and wellbeing were significantly affected by the pandemic, with the most noticeable impacts at the times of greatest crisis. This is consistent in both studies of people's overall wellbeing and those measuring symptoms of mental ill health.

A cohort of 33,703 adults in England in the University College London COVID-19 Social Study provided data from March 2020 to May 2021 (Saunders *et al.*, 2024). Of these, around two in five experienced likely symptoms of depression or anxiety at some point during that period. This study found that, for both conditions:

- 13% of people had a high likelihood of clinically significant symptoms throughout the first year of the pandemic
- 9% had early clinically significant symptoms that reduced over time
- 6% had clinically significant symptoms that emerged as the pandemic unfolded, peaking in the winter of 2020/21
- 9% had a moderate likelihood of clinically significant symptoms throughout
- 62% did not experience clinically significant symptoms at any point during that period.

A Mental Health Foundation survey found that 62% of the UK population had felt anxious or worried in mid-March, and 49% reported this in June 2020 (Mental Health Foundation, 2020a). Furthermore, one in ten people in the UK reported having suicidal thoughts or feelings (Mental Health Foundation, 2020a). This was followed by a steady but slow increase in clinical need over the summer and autumn, with another peak in November 2020 (Saunders *et al.*, 2024). This coincided with the rises in Covid-19 cases and the introduction of a month-long lockdown. The clinical need for mental health support remained high throughout the tiered restrictions introduced during winter, and peaked again in March 2021 when an extension of the regulations was announced (Saunders *et al.*, 2024).

A related study (Iob *et al.*, 2020) found that moderate or severe depression symptoms were higher than average among people with pre-existing mental or physical health problems, those with low social support or experiencing abuse, and those from more deprived groups. Greater risks were also faced by people from racialised communities and people working in essential roles in public services (including health care, childcare and education).

A longitudinal study of 46,000 adults explored the association between adversities during the Covid-19 pandemic and sleep quality (Wright *et al.*, 2021). Both the cumulative number of worries and experiences of adversity were associated with lower-quality sleep. Specific types of adversity, such as abuse, inability to pay bills, not being able to access food or medication, and catching Covid-19, showed clear associations with poorer sleep quality. Having more close friends had a moderating effect on the relationship between worries and sleep, while other social factors had limited protective effects.

From the same cohort, another study was conducted in individuals who provided data on abuse, self-harm and thoughts of suicide or self-harm on at least one occasion (Iob, Steptoe and Fancourt, 2020). 18% reported suicidal or self-harm thoughts, while 5% had self-harmed at least once. Rates of suicidal or self-harm thoughts were higher among people with a Covid-19 diagnosis compared with those without (33% and 17% respectively); likewise for suicide attempts (14% compared with 5%). People who were subject to physical or psychological abuse had very high rates of thoughts about self-harm or suicide (50%) or of having self-harmed in the week prior to being surveyed (25%). 57% of those who self-harmed and 40% who had had thoughts about it had sought some professional support (most commonly medication). Compared with previous UK survey data, however, levels of seeking help from mental health professionals (14.5% for thoughts, 4.7% for self-harm and suicidal attempts) were lower during this period (Iob, Steptoe and Fancourt, 2020).

A cross-sectional study of 691 adults in the UK examined alcohol consumption during Covid-19 lockdowns, finding that more than one in six adults increased their alcohol intake, with a higher proportion of younger adults reporting increased consumption (Jacob *et al.*, 2021). Increased alcohol consumption was associated with poorer overall mental health, increased depressive symptoms, and lower mental wellbeing.

Individuals with pre-existing mental health problems, younger adults, women, and students were at a higher risk of experiencing high levels of loneliness during the lockdown (Bu *et al.*, 2020). Protective social factors such as living with others, having close friends, and strong perceived social support were found to mitigate the risk of experiencing high levels of loneliness (ibid).

The World Health Organization (WHO) has stressed the importance of physical activity for public health and highlighted the need for activities that engage entire communities (WHO, 2018). Parkrun, a charity originating in London in 2004, organises free, weekly 5-kilometre events in public spaces worldwide. During the pandemic, a study explored the changes in health, wellbeing and physical activity levels among a sample in the UK who experienced the sudden loss of this activity (Quirk *et al.*, 2022). A sample of UK parkrun participants responded to two surveys: pre-Covid-19 in January/February 2019 and during the Covid-19 pandemic in September 2020. Physical activity fell by 6% while happiness and life satisfaction fell by 12%. People experienced the worst negative impact on their connections with others. The Covid-19 pandemic negatively impacted the wellbeing of a greater proportion of women and girls, younger adults, people who are physically inactive, people from higher deprivation areas, and people who had completed fewer parkruns. There is evidence that the wellbeing of people who were more active and people who were more involved in a community-based physical activity initiative pre-pandemic, was less negatively affected during the Covid-19 lockdown (Quirk *et al.*, 2022).

Another study investigated the association between pre-pandemic health behaviours and mental health during the Covid-19 pandemic, identifying three health behaviour clusters and showing significant increases in mental health problems between 2017/2019 and January 2021 (Jonsson *et al.*, 2022). The clusters identified were positive, moderate risk, and high risk, with varying proportions of the population falling into each cluster. There was a clear association between pre-pandemic health behaviours and mental health problems, with significant increases in mental health problems observed across the different health behaviour clusters. The largest increase in mental health problems during the pandemic was observed in individuals classified in the positive health behaviours cluster, followed by those in the moderate risk health behaviours cluster, while individuals in the high risk health behaviours cluster showed the smallest increase in mental health problems.

Taken together, these studies indicate that both wellbeing and mental health were poorer across the general population during the pandemic, especially at times of greatest stress. As the crisis eased and restrictions lessened, population wellbeing improved and symptoms of depression or anxiety became less widespread. But there are significant variations within the population, and some groups whose mental health was worse hit than others.

COPING STRATEGIES IN THE GENERAL POPULATION

A qualitative study examined the positive psychological experiences and coping behaviours perceived by both young people and older adults in the UK during the first year of the Covid-19 pandemic (Ooi *et al.*, 2023). While both age groups shared similarities in their psychological experiences and coping strategies, nuances were observed in how these were perceived and enacted. Notably, activities fostering community connectedness, stable routines, and digital engagement with hobbies emerged as common components of potential interventions to support both young people and older adults during pandemics. The heightened sense of social cohesion across age groups underscores the importance of platforms that facilitate community-building activities, which have been particularly valued amidst social distancing restrictions.

The findings from the study also highlight age-related differences in pandemic experiences and coping behaviours (Ooi *et al*., 2023). Young participants emphasised financial worries and the importance of financial support, while older adults expressed gratitude for retirement and financial security. Moreover, both age groups reported a greater appreciation for life's smaller joys and a sense of resilience amidst adversity. Digital access to arts and mental health apps was beneficial for coping, especially among older adults who may have been less inclined to engage digitally prior to the pandemic. Work-related stress played a significant role, with young people finding solace in outdoor activities as a break from remote work and learning. Additionally, volunteering behaviours differed across age groups, with in-person volunteering prominent among young participants, potentially facilitating personal growth and a sense of usefulness, while older adults found value in volunteering for research surveys, emphasising the need for accessible volunteering opportunities across age demographics (Ooi *et al*., 2023).

DIRECT IMPACTS OF COVID-19 ON MENTAL HEALTH

Intensive care patients have always faced considerable mental health risks, with 20% of those in critical care suffering significant PTSD symptoms during the 12 months after discharge, similar rates to people who have experienced civil wars and humanitarian disasters (Righy *et al*., 2019).

Pre-existing anxiety or depression are major risk factors for PTSD following any episode of intensive care (Nikayin and Rabiee, 2016), and previously during the MERS pandemic, chronic fatigue increased the risk of post-traumatic stress symptoms among intensive care patients (Hee Lee *et al*., 2019).

During previous coronavirus pandemics, more than half (58.9%) of SARS-CoV survivors had clinically diagnosable mental health problems initially, which reduced to 33.3% at 30 months (Mak *et al*., 2009). In the Covid-19 pandemic, figures for clinically significant symptoms were around half that level, with about 30% of adults scoring above established thresholds on clinical measures for mental health disorders (Pierce *et al*., 2021).

During the Covid-19 pandemic there were several factors linked to decreased chances of recovery after hospital admission with Covid-19 at six months after discharge, including being a woman, middle age, having two or more comorbidities, and more severe acute illness (Evans *et al*., 2021). The majority of survivors of a hospital admission with Covid-19 had not fully recovered at 5 months. This group of people faced a substantial and wide-ranging physical and mental health burden and negative effects on employment (Evans *et al*., 2021).

As well as the risk of hospitalisation and death from Covid-19 some people experience prolonged and debilitating illness that may continue for weeks or months (Sudre *et al*., 2021). Data from a survey of around 275,000 adults in England indicated that mental health and health-related quality of life were worse among participants with ongoing persistent symptoms of Covid compared with those who had never had Covid-19 or had recovered (Atchison *et al*., 2023). People with ongoing Covid-19 symptoms experienced loss or change of sense of smell, shortness of breath, difficulty thinking or concentrating, poor memory and chest tightness or pain. Worse mental health and health-related quality of life were reported by almost two-thirds (64%) of participants, with ongoing symptoms lasting from 12 weeks to over a year (Atchison *et al*., 2023).

Mental health and physical conditions have a bidirectional relationship, meaning people with a mental illness are more likely to have physical health problems and vice versa (Naylor *et al*., 2012). Around 4.6 million people in England have both long-term physical health conditions and mental health problems, resulting in comorbidity among 46% of people with a mental health problem and 30% of people with long-term physical conditions (ibid).

For example, people with diabetes are two to three times more likely to experience depression than the general population, which is associated with difficulties in self-care, poorer glycaemic control, and lower medication adherence (de Groot *et al*., 2012). A retrospective case analysis during the pandemic in the UK found that a considerable number of deaths occurred in individuals with diabetes, with 31.4% of all Covid deaths in the UK in people with type 2 diabetes, 1.5% in people with type 1 diabetes, and 0.3% in people with other types of diabetes (Joseph *et al*., 2021).

Contracting Covid-19 was also expected to lead to poorer mental health outcomes, given that people with chronic obstructive pulmonary disorder (COPD, a major lung condition) are at greater risk of both depression and anxiety (Rahi *et al*., 2023). Indeed, contracting Covid-19 was associated with poorer mental health outcomes up to 13 months later, with higher levels of depression, anxiety, and loneliness, and lower levels of mental wellbeing (Wang *et al*., 2022; Wilding *et al*., 2024). However, in an analysis of data from multiple longitudinal studies comprising over 50,000 participants, deterioration in mental health occurred only when participants self-reported Covid-19, regardless of whether this was confirmed by a test result (Thompson *et al*., 2022). The authors of the study suggest that the negative effects on mental health could be due to psychosocial mechanisms such as social isolation, loss of pay, worry about infecting others, and the unpredictable course of Covid-19, rather than being a direct result of SARS-CoV-2 infection.

Another cross-sectional study showed that self-isolation was linked to lower psychological wellbeing, increased loneliness, anxiety, and depression (Allen *et al*., 2022). Additionally, home-working related to a shift in sleeping and waking patterns and reduced work or income were associated with decreased psychological wellbeing and sleep quality, and increased anxiety, depression and loneliness (Allen *et al*., 2022).

A cohort study of the health care records of 12 million patients, including 226,521 patients with SARS-CoV-2 infection, showed that SARS-CoV-2 infection confirmed with a positive PCR test result was associated with increased risk of incident psychiatric morbidity, sleep problems, and fatigue in the following months (Abel *et al*., 2021). These studies point to a significant direct impact of Covid-19 on people's mental health. The mechanisms by which this happens, how long it lasts, and why it affects some people and not others, is as yet unclear.

A recent study published in *The Lancet* has found evidence of longer-term impacts on the mental health and cognitive wellbeing of people who were hospitalised for Covid-19. Three-quarters of those surveyed had at least mild depression and half had anxiety symptoms two to three years after being discharged from hospital. More than one in five had severe depression, and almost a quarter had severe fatigue and/or cognitive decline. For many, these symptoms had led them to a change of occupation (Taquet *et al*., 2024).

2 MENTAL HEALTH IMPACTS ON SPECIFIC GROUPS

The Covid-19 pandemic has been widely observed to have magnified existing inequalities in society. Its effects were felt more severely by some groups than by others. And those with the least resources, poorest living conditions and greatest precarity, have fared the worst overall. This chapter explores the impacts of the pandemic on the mental health of a number of different groups of people and communities, especially those facing the biggest risks to their mental and physical health. The impacts on people with pre-existing mental health problems are explored in Chapter 3.

OLDER PEOPLE

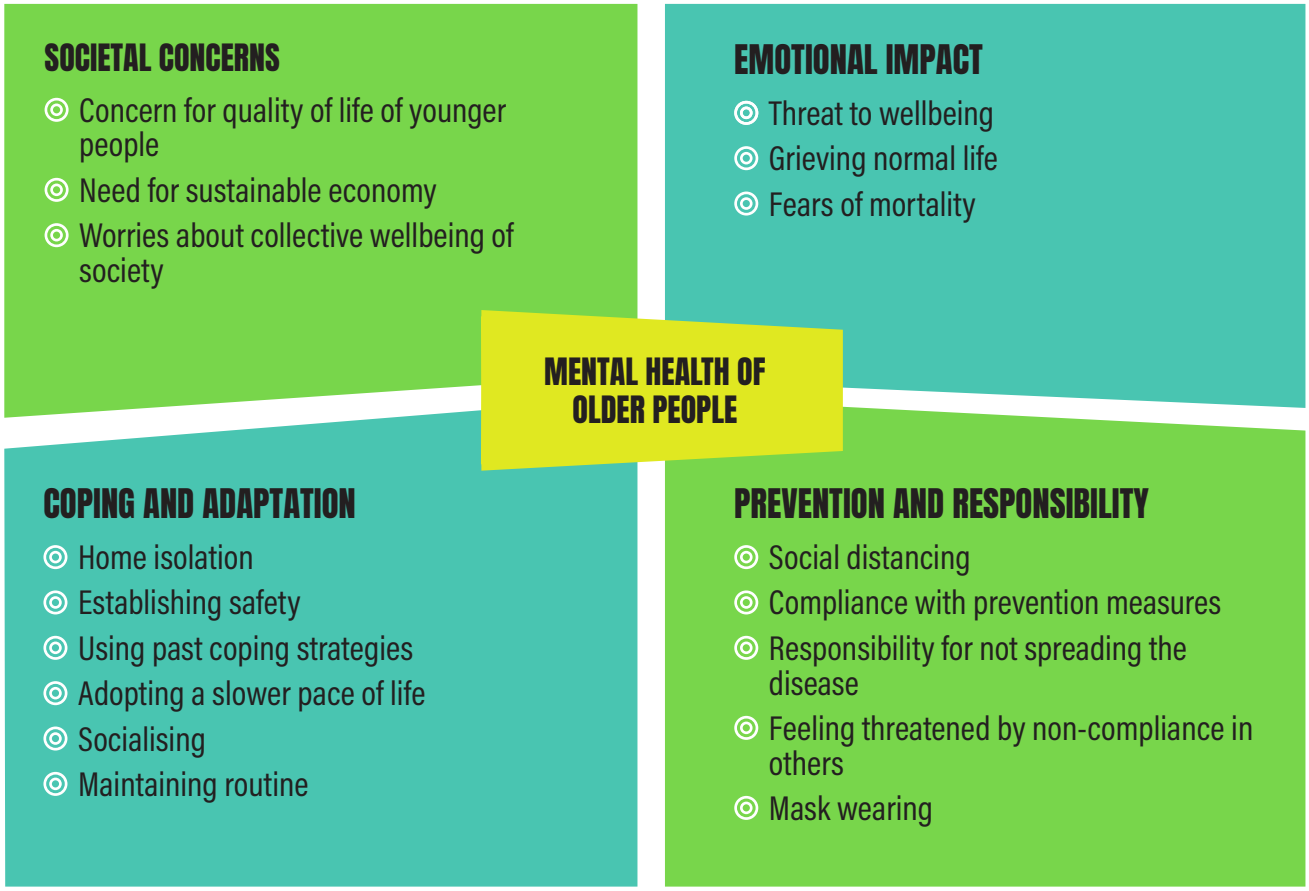
The pandemic presented an especially acute threat to the physical health and wellbeing of older people. Research has associated social isolation and loneliness with higher risks for various conditions, including high blood pressure, heart disease, obesity, anxiety, depression, cognitive decline, and Alzheimer's disease (Shankar *et al.*, 2011). These risks have been noted by medical staff from an inpatient geriatric psychiatry unit, detailing that depressive symptoms, cardiovascular morbidity, and loneliness have bidirectional relationships in older adults (Subler *et al.*, 2021). Furthermore, cognitive and motor problems resulting from Covid-19 were noted as potential fall risk factors among people being treated for depression in later life (Subler *et al.*, 2021).

In 2015 it was reported that 85% of older adults living with depression received no support and were underrepresented in mental health services (Burns, 2015). Increased stressors on the daily lives of older people, especially those with vulnerabilities, may have exacerbated these gaps in provision during the pandemic (Bell and Allwood, 2019).

Older adults struggled with multiple potential threats to their wellbeing during the pandemic including fears for mortality, grieving normal life, and concerns for the future (Mckinlay *et al.*, 2021) (Figure 1). The new health risks faced by older people during the pandemic warranted self-protective measures such as establishing safe spaces (e.g. their homes), as well as the implementation of prevention measures such as social distancing and mask-wearing (Wabnitz *et al.*, 2022).

Other challenges faced by older adults during the Covid-19 pandemic included difficulties in accessing essential services, increased feelings of loneliness and isolation, and changes in behaviours such as exercise and diet (Scott *et al.*, 2021). Coping strategies were staying busy, engaging in safe physical activities, maintaining social connections online or by phone, and adopting a positive outlook (Bloom *et al.*, 2022).

FIGURE 1: MENTAL HEALTH OF OLDER PEOPLE



CHILDREN AND YOUNG PEOPLE

During the pandemic, schools remained open, but with minimal staff and for a small fraction of school-age children for a substantial period of time (Sinclair *et al.*, 2020). Children across the UK have experienced significant disruptions, losing social interaction and stability (Sinclair *et al.*, 2020). A national survey found that primary school aged children reported significant increases in emotional, behavioural, and attention difficulties (Pearcey *et al.*, 2020). Adolescents and children with special educational needs do not appear to have been affected in the same way, with some even reporting improvements in emotional difficulties (Pearcey *et al.*, 2020).

At least 419,000 children did not attend school despite places being available for them to meet their wider needs, safeguard their wellbeing, or support their development (Sinclair *et al.*, 2020).

Levels of hyperactivity, inattention and conduct problems increased over time, while emotional symptoms remained relatively stable but declined somewhat between June and July 2020 (Raw *et al.*, 2021). The impact of the pandemic on children and adolescents' mental health varied, with some experiencing improvements and others deteriorating, emphasising the need to consider family contextual and resilience factors in understanding mental health trajectories during a pandemic (Raw *et al.*, 2021).

Data from an acute paediatric service in London shows that the number of children and young people presenting to secondary care settings due to mental health problems rose by 132% between 2019 and 2021, while admissions increased by 97%, particularly due to overdose (Medeiros *et al.*, 2022). For children and young people attending another emergency department, there was a 30% increase in young people presenting with self-harm (Reed *et al.*, 2022).

The Covid-19 pandemic has impacted children's physical activity levels, with a decrease in moderate to vigorous physical activity (MVPA) and an increase in sedentary time observed during the pandemic (Walker *et al.*, 2023). Despite some recovery in MVPA levels in 2022, sedentary time remains higher than pre-pandemic levels, indicating a continued public health concern regarding insufficient physical activity levels among children, with a likely impact on mental health.

Attendance at school has emerged as a major concern since the pandemic began. One in five children is persistently absent from school, and 150,000 missed over half their school sessions last year, with mental health difficulties one of a number of concerns contributing to this situation (Bottomley and Shafan-Azhar, 2024). While this may not wholly be a legacy of the pandemic, it remains a significant concern for children's wellbeing and attainment.

YOUNG ADULTS

One of the high-risk population groups identified early on in the pandemic was young adults, aged 18 to 24, who were more likely to report stress arising from it (Mental Health Foundation, 2020a). There are a number of reasons for this. The travel, hospitality, and leisure industries, employing predominantly young people, were some of the most severely affected by restrictions and fears of job loss. Research evidence suggests that youth unemployment has long-term "scarring" effects on mental health (Bell and Blanchflower, 2011).

Contact with services in this age group has also been disrupted, with data from the Mental Health of Children and Young People in England Survey indicating that young people aged 17 to 22 were twice as likely as their younger counterparts to seek help from mental health services, but not receive any (NHS Digital, 2020). This is likely related to the 'mental health transition gap', where young people are often discharged to their GP when they reach the upper boundary of children and young people's mental health services (Appleton *et al.*, 2022). This often leads to unmet needs among young people unable to access specialist mental health services, as well as anxieties caused by needing to switch to new health care providers (Appleton *et al.*, 2022).

SURVEY: MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE IN ENGLAND

A series of government-funded reports delves into the mental health landscape of children and young people in England, tracking changes from 2017 to 2020, 2021 and 2022. These surveys provide insight into their experiences within family dynamics, education, and services, while also looking at the impact of the Covid-19 pandemic on their worries and anxieties. The follow-ups also depict how the pandemic further influenced their familial, educational, and service experiences, drawing comparisons with previous years to track shifts over time. A detailed overview of the mental health trends is presented in Table 1, while Table 2 offers a comprehensive overview of their household circumstances and educational experiences.

Table 1 compares children and young people who have a 'probable mental disorder' with those who are unlikely to have one, in different age ranges and genders. It demonstrates that wellbeing reduced for both groups by similar amounts compared to 2017 (by 30-40%) in 2020 but those with mental health difficulties experienced far higher levels of pandemic anxiety, sleep problems and loneliness in both 2020 and 2021.

Table 2 makes similar comparisons for 1 to 16 year olds and shows that children with probable mental health difficulties had fewer resources to help them learn whilst away from school. There was no significant difference in attendance at school between the two groups in 2020, but by 2021 children with probable mental health difficulties were less likely to be in school consistently and more frequently absent.

TABLE 1: CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

		2020			2021		
		5-10	11-16	17-22	5-10	11-16	17-22
Pandemic anxiety	Unlikely disorder	N/A	10.4	12.8	N/R		
	Probable disorder		13	15.6			
			Boys	Girls		Boys	Girls
	Unlikely disorder		11	11.2		N/R	
	Probable disorder		12.5	15.8			
Wellbeing % score change from 2017		5-10	11-16	17-22	5-10	11-16	17-22
	Unlikely disorder	N/A	-38.7	N/R	N/R		
	Probable disorder		-33.4	N/R			
			Boys	Girls		Boys	Girls
	Unlikely disorder		-39.3	-38.1		N/R	
	Probable disorder		-34.4	-32.9			
Sleep problems		5-10	11-16	17-22	5-10	11-16	17-22
	Unlikely disorder	11.1	19.1	28.8	20.4	26.7	46.5
	Probable disorder	52.5	50.5	69.6	59.5	74.2	86.7
			Boys	Girls		Boys	Girls
	Unlikely disorder		16.4	21.7		21.7	24.6
	Probable disorder		53.9	63.1		66.4	66.2
Loneliness		5-10	11-16	17-22	5-10	11-16	17-22
	Unlikely disorder	N/A	2	5.1	N/A	1	4.8
	Probable disorder		21.4	35		17.1	39
			Boys	Girls		Boys	Girls
	Unlikely disorder		3.4	4		0.3	1.7
	Probable disorder		18.3	36.3		8.1	33.3

N/A = not applicable. N/R = not recorded.

Source: NHS Digital, 2020

TABLE 2: THE IMPACT OF COVID-19 ON CHILDREN WITH AND WITHOUT MENTAL HEALTH DIFFICULTIES

	2020			2021		
		Unlikely disorder	Probable disorder		Unlikely disorder	Probable disorder
MISSED SCHOOL	School attendance status	%	%	**Number of days**	%	%
	Attended throughout	1.9	3.7	0	61.8	45.8
	Returned in June / July	26.0	24.0	1-5	12.7	12.7
	School closed	57.8	56.9	6-15	19.6	29.4
	Not attended	14.3	15.5	15>	11.7	23.5
PROBLEMS OF FAMILY FUNCTIONING	Boys	13.3	39.6	**Boys**	11.3	26.0
	Girls	12.0	26.0	**Girls**	14.2	30.3
ACCESS TO RESOURCES	Quiet space	88.9	81.2	Quiet space	89.8	76.8
	Desk	80.8	70.4	Desk	-	-
	Laptop / tablet	94.2	87.8	Laptop / tablet	97.6	88.9
	Reliable internet access	92.1	84.2	Reliable internet access	90.9	81.0
	Regular support from school or college	78.0	65.7	Regular support from school or college	83.4	62.9
	Help with studies from a parent or carer	81.3	74.6	Help with studies from a parent or carer	79.8	67.7
	Learning resources	-	-	Learning resources	87.3	73.5
	Motivation to learn from home	-	-	Motivation to learn from home	74.0	41.9
	Enough time	-	-	Enough time	84.5	58.7
	None of these	0.7	4.0	None of these	0.5	3.1

Source: NHS Digital, 2020

Table 2 also shows that, in 2020, children (aged 11 to 16 years) with a probable mental health difficulty were more likely to be living in a family who reported problems with family functioning, for example with relationships, routines and cohesiveness (28%), compared to children who were unlikely to have a mental health difficulty (12%) (NHS Digital, 2020).

Children with a parent who appeared to be experiencing psychological distress were more than twice as likely to be living in families who reported problems with functioning (25%) than those whose parents showed little to no evidence of psychological distress (11%). This was observed for both boys (27% and 11% respectively) and girls (23% and 12% respectively) (NHS Digital, 2020). In particular, about one in three boys aged 11 to 16 years (36%) had a parent experiencing psychological distress who reported problems with family functioning. This was in comparison to one in five (21%) boys aged 5 to 10 years. Of girls aged 5 to 16 years, over half (54%) with a probable mental health difficulty had seen or heard an argument in the household (NHS Digital, 2020).

In 2021, rates of mental health problems increased significantly among children and young people compared with before the pandemic (NHS Digital, 2021a). Change in mental health was evident, with a substantial proportion experiencing deterioration in mental health since 2017, particularly among adolescents. Eating problems also saw a notable increase from 2017 to 2021, affecting a significant percentage of adolescents (NHS Digital, 2021a).

In 2022, there was a continued rise in the rates of mental health problems among children and young people, especially in the older age group (NHS Digital, 2022). Mental health concerns persisted, with notable proportions of young people reporting feeling unsafe at school and experiencing online bullying. Economic challenges, such as reductions in household income and food insecurity, further exacerbated mental health issues, particularly among adolescents (NHS Digital, 2022). These figures underscore the enduring impact of the pandemic on the mental wellbeing of children and young people, and its overlaps with the subsequent cost-of-living crisis.

In 2020, the survey identified that children and adolescents (5 to 16 year olds) worried most that their family and friends would catch Covid-19 (37%) and that they would miss school or work (38%) (Table 3). The 2021 survey also asked children whether life was made much worse due to the pandemic restrictions (Table 3). Data showed that young people aged 11 to 16 with a probable mental health difficulty were three times more likely to feel like their life was made worse by restrictions (27%) compared to those unlikely to have a mental health difficulty (10%). Among those aged 17 to 22, the difference was less pronounced, but those with a probable mental health difficulty were still twice as likely to feel their life had been made worse by restrictions as those unlikely to have a mental health difficulty (36% compared to 18%). However, clearly, young adults felt more impacted by restrictions compared to their younger counterparts.

TABLE 3: CHILDREN AND YOUNG PEOPLE'S FEELINGS ABOUT THE PANDEMIC

ANXIETIES CHILDREN (AGED 5-16) HAD ABOUT COVID-19 ACCORDING TO THEIR PARENTS (2020)

- Afraid to leave the house: **7.2%**
- Transmitting the infection: **16.4%**
- Catching Covid-19: **22.3%**
- Family/friends catching Covid-19: **36.7%**
- Worries about missing school/work: **37.7%**

CHILDREN AND YOUNG PEOPLE WHO SAID THEIR LIFE WAS MUCH WORSE DUE TO RESTRICTIONS (2021)

- 11-16s unlikely to have a mental health difficulty: **9.7%**
- 11-16s with a probable mental health difficulty: **26.9%**
- 17-22s unlikely to have a mental health difficulty: **18.3%**
- 17-22s with a probable mental health difficulty: **36.3%**

FAMILIES, PARENTS AND CAREGIVERS

During the lockdown, social networks and informal support have been disrupted, leading to loneliness and isolation (O'Shea, 2021). Stressful situations, control dynamics and isolation can escalate domestic abuse and violence, with the pandemic exacerbating these factors (Moreira and Pinto da Costa, 2020). Reports show an increase in intimate partner violence cases during the pandemic, but many cases likely go unreported due to increased control by perpetrators and reduced access to services (ibid).

Rethink Mental Illness (2020) has emphasised the significant burden on carers in supporting individuals severely affected by mental illness, the negative impact of reduced support on mental health, and the dramatic effects of the pandemic on carers.

Whitley and colleagues (2023) discussed the poorer mental health of home-carers compared to the general population, as well as the worsening mental health of home-carers during the Covid-19 lockdown. They found that General Health Questionnaire (GHQ-12) scores were already higher (indicating poorer health) among home-carers pre-lockdown and increased more than for non-carers during the lockdown periods. Caring for a child under 18 or someone with a learning disability was also associated with a marked increase in GHQ-12 score. Finally, home-carers with a greater care burden, and those who lost formal help during lockdown, experienced larger increases in GHQ-12 scores.

Women spending long hours on housework and childcare were more likely to report increased psychological distress; fathers and mothers adapting work patterns due to childcare had higher levels of psychological distress; and lone mothers adapting work patterns due to childcare had significantly higher GHQ-12 scores (Xue *et al.*, 2021). Other research (Wade *et al.*, 2021) highlights the critical role of caregiver mental health in children's adjustment; discusses the impact of external stressors on family dynamics; emphasises that children whose caregivers have mental health difficulties are more likely to have mental health problems; and shows differences in mental health outcomes between female and male caregivers, with a multiplying effect observed in male caregivers for substance use problems. Nonetheless, female caregivers still reported higher levels of Covid stress or disruption compared to male caregivers (Wade *et al.*, 2021).

Another study discussed the impact of the first Covid-19 lockdown on parents of school-age children (El-Osta *et al.*, 2021). A significant proportion of parents experienced loneliness and social isolation during the Covid-19 lockdown, with factors such as being a woman, parenting a child with special needs, lack of a dedicated space for distance learning, disruption of sleep patterns and low physical activity being associated with higher levels of loneliness (El-Osta *et al.*, 2021).

A study on the users of a pregnancy and parenting app discussed the impact of the Covid-19 pandemic and associated lockdowns on expectant parents and parents of young babies, highlighting increased anxiety, stress, and adverse effects on physical and mental wellbeing, as well as the reliance on web-based resources (Rhodes *et al.*, 2020).

A qualitative analysis of feelings and experiences associated with perinatal distress during the Covid-19 pandemic found that women's descriptions of distress were more aligned with anxiety and general distress rather than symptoms traditionally related to depression, despite high rates of probable depression in the sample. The thematic analysis identified five main sources of distress for perinatal women during the Covid-19 pandemic, including family wellbeing, lack of support, mothering challenges, loss of control, and work and finances (Jones *et al.*, 2022).

However, research also indicated some positive effects of the Covid-19 pandemic on the mental health of caregivers (Stallard *et al.*, 2021). In this study, "post-traumatic growth" was common among caregivers during the Covid-19 lockdown, with many reporting positive changes in behaviour or cognition.

POVERTY, DEBT AND UNEMPLOYMENT

Lack of access to decent quality employment can decrease quality of life, social status, self-esteem, and achievement of life goals (Mental Health Foundation, 2020a). In the UK, 28% of people who had identified as unemployed during the pandemic reported experiences of poor mental health, compared to 13% of people in paid employment, 20% of people in full-time education, and only 9% of people who had retired (Mental Health Foundation, 2020a).

Government measures to sustain the UK economy and replace the incomes of people who were unable to work during periods of restriction may have played a part in reducing the economic impacts on people's mental health during the pandemic itself, coupled with relaxations of some benefit rules and additional supports for homeless people. There is, however, growing evidence of the mental health impacts of the cost-of-living crisis that followed. With most of the changes to benefit and homelessness provisions quickly revoked after the lockdowns ended, these impacts have been most severe among those with the lowest incomes to start with.

WOMEN AND GIRLS

Social distancing and lockdown measures were predicted to increase exposure to domestic violence and abuse for children and women already at risk (Durcan *et al*., 2020). Emergency measures disproportionately affected women by potentially exposing them to further danger and reducing their access to external support networks and vital services (Durcan *et al*., 2020). Scott and McManus (2016) found that approximately 1 in every 20 women in England has experienced physical violence, sexual violence or abuse across their life course, compared to 1 in every 100 men. The study also indicates that experiences of violence are linked to poorer mental health, with the risk heightened by both the severity and duration of violence and abuse.

Centre for Mental Health worked with the Maternal Mental Health Alliance on a rapid review of the impacts of the pandemic on mental health during the perinatal period (Papworth *et al*., 2021). The review found that women faced extra worries during the pandemic, including fears of giving birth alone or becoming unwell with the virus during pregnancy or while looking after young babies. Some feared losing their jobs or an increased risk of domestic violence. The impacts were greater among women from racialised communities and those on the lowest incomes.

RACIALISED COMMUNITIES

Across all dimensions, racialised communities in the UK had a poorer experience of the pandemic and faced multiple intersecting inequalities and inequities throughout. This, added to existing stark inequalities, placed additional pressure on racialised communities. These effects were particularly pronounced following the murder of George Floyd in the United States in May 2020, which underlined the deeply entrenched structural discrimination faced by Black people internationally.

Health care workers from racialised communities were disproportionately affected by health inequalities during the Covid-19 pandemic, especially in frontline roles (Abdelhalim *et al*., 2021). Pre-existing co-morbidity was reported as the most prominent reason for inequalities (ibid). Social and economic factors such as poor-quality housing and living in poorer neighbourhoods may contribute significantly to the unequal impact of Covid-19 on the health workforce from racialised communities (ibid).

The UK-REACH Cohort was established to investigate disparities in Covid-19 outcomes between racially minoritised and white health care workers in the UK, aiming to examine differences in clinical outcomes, professional roles, and wellbeing, with a focus on capturing information from a diverse range of health care roles and having a significant ethnic minority representation of 26.6% (Bryant *et al*., 2022).

Black men were more than three times more likely to die from the Covid-19 virus during the pandemic than white men of equivalent age (Office for National Statistics, 2020a). The lockdown made the grieving process even more complex for families across the country and exposed the lack of culturally appropriate bereavement support (Pinto *et al*., 2023).

The Shifting the Dial programme, which worked to boost the mental health of young Black men in Birmingham, found that misinformation and social distancing significantly impacted young Black men's mental health during Covid-19, leading to fear and worry in the community (Abdinasir and Carty, 2021). A lack of targeted and accessible communication about the virus and its symptoms contributed to confusion and uncertainty. Concerns about over-policing of pandemic restrictions in Black communities and lower grades in GCSEs and A-levels, when these were moved from examinations to teacher assessments, exacerbated existing inequities and reflected ongoing forms of discrimination (Abdinasir and Carty, 2021).

The pandemic also saw higher rates of Covid-19 vaccine hesitancy among racialised communities, with vaccine hesitancy being highest among Black people at almost three-quarters (72%) (Robertson *et al*., 2021). Examples of strategies for addressing this hesitancy are inclusive communication, involving health care workers in the vaccine rollout, and promoting vaccination through trusted networks (Bryant *et al*., 2022).

The effect of the Covid-19 pandemic on racialised communities was also seen in schools. School exclusions and poor mental health are closely linked, and the risk of exclusion is far higher among some racialised groups, including Gypsy, Roma and Traveller and some Black communities (Department for Education, 2020). Fixed-term exclusions in English schools reached a record high in 2018-2019. However, according to new government statistics, the use of suspensions by schools has risen sharply again, with exclusions now also above their pre-pandemic rate (Whittaker, 2024). In the Spring Term of 2022/23, 263,904 suspensions were issued by schools in England, and there were 3,039 permanent exclusions (Department for Education, 2024). The extent to which experiences of the pandemic have contributed to the use (and disproportionate use) of exclusions from school is hard to quantify.

Young Black men's mental health needs have been overlooked and met with more coercive responses, including in schools and the justice system, than for other groups of young people (Robertson and Wainwright, 2020). Research shows that at age 11, young Black boys in the UK are not more likely than others to be identified with a diagnosable mental health problem (Khan *et al*., 2017). Yet by the time they reach adulthood, young Black men have significantly higher rates of mental ill health than their white counterparts. And responses to young Black men's mental health needs continue to be more punitive, including disproportionate use of both the Mental Health Act and higher rates of criminalisation (JCHR, 2020).

A qualitative co-produced study which assessed the impact of the Covid-19 pandemic on racialised communities in the UK, demonstrated increased health inequalities, vulnerability to Covid-19, higher mortality rates, and poorer mental health outcomes (Kaur *et al*., 2023).

LGBT+ COMMUNITIES

The Covid-19 pandemic has significantly impacted communities already facing stark mental health inequalities. A survey by the LGBT Foundation (2020) revealed that 42% of LGBT+ people would have liked to access mental health support during the pandemic (rising to more than half of trans and non-binary people, and almost two-thirds of those from a racialised community). The survey, carried out in May 2020 during the first national lockdown, found that 30% of LGBT+ people were living alone and 8% did not feel safe where they were living (rising to 17% of trans or non-binary respondents). The Foundation also revealed that the number of mental health related calls to its helpline rose by 50% in the first three weeks of lockdown compared with the three weeks prior (LGBT Foundation, 2020).

AUTISTIC PEOPLE

Autistic adults were significantly impacted by the pandemic, both directly, as indicated by higher Covid-19 infection and hospitalisation rates, and indirectly, due to severe service disruptions and social restrictions (Scheeren *et al*., 2023).

A longitudinal UK study showed that:

- Autistic young people experienced higher levels of anxiety and depression compared to those with other special educational needs and disabilities (SEND) (Asbury and Toseeb, 2022)
- Parent-reported anxiety was higher for older children and girls within the autistic group (Asbury and Toseeb, 2022)
- Household income had a significant effect on psychological distress and wellbeing in both groups, with lower-income households reporting higher distress and lower wellbeing (Asbury and Toseeb, 2022).

The study also found that caregivers of autistic pupils reported higher levels of depression and anxiety symptoms in their children than parents of children with other special educational needs and difficulties (Asbury and Toseeb, 2022).

In a qualitative study, autistic people reported a deterioration in mental health during the pandemic, with emerging or worsening symptoms of anxiety, low mood, and challenges in accessing coping mechanisms (Stewart *et al*., 2023). These changes were caused by feelings of isolation, loneliness, distress, and anxiety. However, several participants reported positive experiences of the periods of lockdown, such as reduced commuting, more control over sensory environments, and more time to pursue personal interests and self-care (ibid).

HEALTH CARE WORKERS

During the Covid-19 pandemic, various interventions were implemented around the world to support health care workers' mental health. Self-care resources, online training tools, and remote professional support were commonly used (Byrne *et al*., 2023).

Burnout had been a risk for many health care staff before the pandemic (Durcan *et al*., 2020). The health and care workforce experienced significant stress due to the Covid-19 pandemic, with high prevalence rates of anxiety (35.3%) and depression (39.1%) among health care workers surveyed during July 2020 (Chotalia *et al*., 2022).

The NHS was put under unprecedented strain, with warnings about the damaging effects on health and care staff and increasing pressure on social care and residential care services (Durcan *et al*., 2020). In a survey by the British Medical Association with more than 6,000 doctors, 44% described experiencing depression, anxiety, stress, burnout, or other mental health problems (BMA, 2020). A survey with a broader health care workforce indicated that 50% of the respondents had experienced mental health deterioration over eight weeks and over 20% reported being more likely to leave the sector because of Covid-19 (Thomas and Quilter-Pinner, 2020).

Following the initial Covid-19 pandemic peak, a significant proportion of hospital health care workers reported clinically significant symptoms of anxiety, depression, and PTSD (Wanigasooria *et al*., 2020). Being a woman, having a history of physical illness, redeployment, and working on inpatient wards, emergency departments or intensive care units were among the factors associated with higher rates of PTSD symptoms (Wanigasooria *et al*., 2020). Similarly, a survey within Northern Ireland hospitals from November 2020 to August 2021 identified a group of health service staff (13-16%) who reported persistently elevated mental health symptoms during the pandemic (Jordan *et al*., 2023). However, a multi-country analysis of the mental wellbeing of medical doctors found that the prevalence of depression and anxiety was lower in the UK compared to the rates seen in Italy and Catalonia (Quintana-Domeque *et al*., 2021).

A cross-sectional study comprising diagnostic interviews found that considerable numbers of health care workers had diagnosable mental health problems, such as depression, generalised anxiety disorder, or PTSD. In this study, about one in four health care workers experienced symptoms of PTSD (25.4%), indicating a potential need for clinical intervention (Scott *et al*., 2022). An earlier study had estimated 'probable' PTSD diagnoses in one third of UK health care staff during the first wave of Covid-19 (Lamb *et al*., 2021). Both paint a worrying picture about the wellbeing of the health care workforce, and the possibility of long-term harm and distress for those living with PTSD.

Findings from an analysis of interviews and social media data indicate that health care staff experienced significant anxiety attributed to factors such as insufficient training, inadequate risk assessments, and the challenges of adapting to new working environments while wearing PPE (San Juan *et al*., 2023). Prevalent mental health issues included trauma, PTSD, and anxiety, with the quality of pre-redeployment training significantly impacting people's mental wellbeing.

Serious worries, like the fear of transmitting the virus to their families, significantly affected the wellbeing of health care professionals (San Juan *et al*., 2023). Shortages of PPE have also been a concern.

A significant proportion of the nursing and midwifery workforce in Wales experienced probable clinical depression or possible mild depression during the Covid-19 pandemic (Gray *et al*., 2022). The highest rates of probable clinical depression were observed among individuals aged 18 to 49 years, who were twice as likely to report depressive symptoms compared to those aged 60 years and older (Gray *et al*., 2022). The findings suggest a substantial burden of poor mental wellbeing among younger members of the nursing and midwifery workforce in Wales, potentially influenced by the pandemic and with implications for long-term workforce retention (Gray *et al*., 2022).

The presence of a "shared traumatic reality" also affected those providing mental health, social, and emotional support during and after the pandemic (Wilton, 2020). Therapists and other practitioners exposed to traumatic events may experience long-term emotional distress, helplessness, and guilt, but shared experience can also enable effective practice (Freedman and Mashiach, 2018).

Bloor and colleagues provide a detailed exploration of the impact of the Covid-19 pandemic on UK GPs' wellbeing and experiences, aiming to fill an evidence gap and offering in-depth accounts of the challenges faced by GPs (Jefferson *et al.*, 2022). They highlighted the impact of the pandemic on GPs' psychological wellbeing, causes of stress and anxiety, variations in experiences among different subgroups of GPs, as well as the need for targeted support strategies.

Another study discussed interventions to enhance compassionate approaches in health care organisations, the impact of Covid-19 on health care workers' mental health, the importance of measuring the efficacy of implemented strategies, the preference for an organisational approach to rebuilding team cohesion, and the emphasis on self-care coping mechanisms during the peaks of the pandemic (Muller *et al*., 2020).

PRISONERS

Prisons in England and Wales, like other institutional settings, had to make rapid and radical changes during the pandemic to keep people safe from the virus. Swift action meant that prisons did not experience high levels of infection during the pandemic (Durcan, 2021). The price, however, was that prisoners were spending prolonged periods in extreme isolation. A review conducted during the second national lockdown found that mental health programmes in prisons often ceased at the start of the first lockdown and had not restarted at the time of the research (Durcan, 2021). A small number of prisons made use of digital technology to provide psychological support, and some found innovative ways to reach prisoners by other means.

3 HEALTH INEQUALITIES AMONG PEOPLE WITH MENTAL HEALTH PROBLEMS

The pandemic has disproportionately impacted people with pre-existing mental health problems, among other marginalised groups (Shah *et al.*, 2022) (Figure 2). In a survey of almost 3,000 people with pre-existing mental health problems, 60% of participants reported that their mental health had worsened during the pandemic (Lewis *et al.*, 2022). Younger age, difficulty accessing mental health services, low income, income affected by Covid-19, worry about Covid-19, reduced sleep and increased alcohol and drug use were associated with increased depression and anxiety symptoms and reduced wellbeing. Feeling socially supported by friends, family or services was associated with better mental health and wellbeing. Participants with a history of anxiety, depression, post-traumatic stress disorder or eating disorder were more likely to report that their mental health had worsened during the pandemic than individuals without a history of these diagnoses.

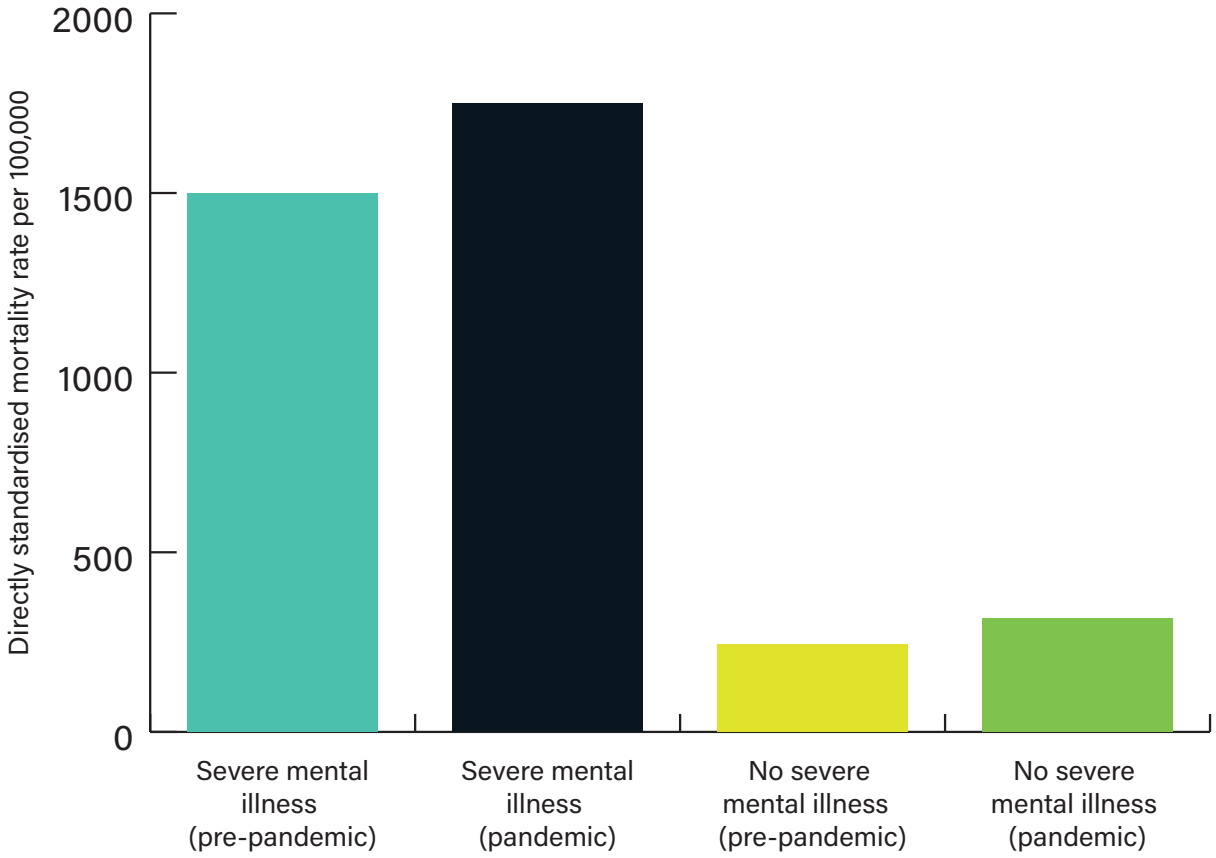
FIGURE 2: MINDMAP OF IMPACT ON PEOPLE WITH PRE-EXISTING MENTAL HEALTH PROBLEMS

PHYSICAL HEALTH, MORBIDITY AND MORTALITY

People with pre-existing mental health difficulties also had an increased risk of severe outcomes like hospitalisation and death from the Covid-19 virus (Yang *et al.*, 2020). The premature mortality rate for people with severe mental illness increased by 16% during the first year of the pandemic compared to the annual average before the pandemic (2017 to 2019) (OHID, 2023). This was similar to those without severe mental illness (15%), but the ongoing higher rate of premature mortality in people with severe mental illness meant the impact was greater (Figure 3). There were an extra 244 deaths for every 100,000 people with severe mental illness and 47 deaths for every 100,000 people without severe mental illness (OHID, 2023).

A total of 42,815 people aged 18 to 74 with severe mental illness died during the first year of the pandemic compared to an annual average of 35,025 people with severe mental illness in the three years before the pandemic (2017 to 2019). This is an extra 7,790 deaths: an increase of 22.2% (OHID, 2023).

FIGURE 3: PREMATURE MORTALITY RATES AMONG PEOPLE WITH AND WITHOUT SEVERE MENTAL ILLNESS (REPRODUCED FROM OHID, 2023)



COPING STRATEGIES AMONG PEOPLE LIVING WITH MENTAL ILLNESS

The Policy Research Unit at University College London and King's College London conducted two studies on the impact of Covid-19 on mental health services and the people they support, both internationally and in the UK (Johnson *et al.*, 2021). Key themes for people using mental health services included loneliness and isolation, lack of access to essential services and resources, family and social adversities, and strategies people with mental health problems used to cope with the pandemic. People with mental health difficulties have described coping strategies including engaging in purposeful activities, using therapeutic and self-help techniques, and using self-management tools and resources. The ways mental health services adapted and responded to Covid-19 are discussed in Chapter 4.

4 MENTAL HEALTH SERVICES DURING COVID-19

Mental health services across the UK were forced to make speedy adaptations to the onset of the pandemic. Hospitals and other face-to-face services had to adopt physical distancing measures and acquire PPE. Many community-based services shifted to working remotely, using telephone and digital communications to stay in touch with people and provide services previously delivered face-to-face. Some members of the mental health workforce moved across to providing emergency services dealing with the virus. This section explores the ways mental health services adapted to the crisis, and explores some of the legacies it has left in the system for the longer term.

REFERRALS AND DEMAND FOR MENTAL HEALTH SERVICES

At the outset of the pandemic, the volume of referrals to mental health services fell dramatically. Within a few months, however, numbers rose, and they continued rising to a higher rate than before the pandemic. In the years since, those inflated levels remained constant (Figure 4).

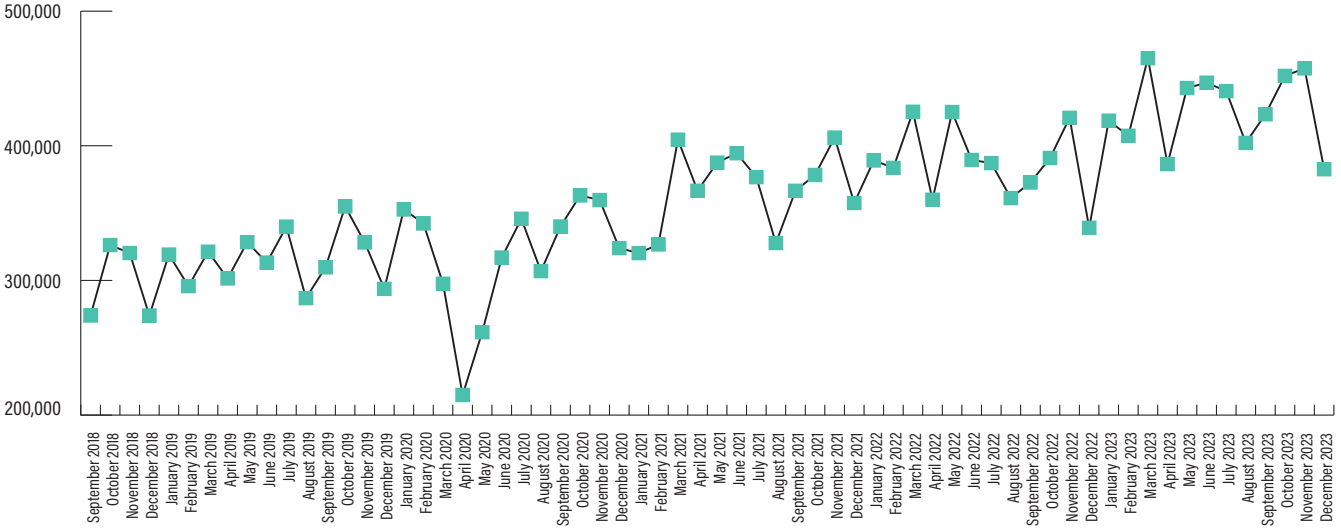
Data from NHS Digital (2021b) during the 2020-2021 reporting period indicates that:

- 2,803,244 people were known to be in contact with secondary mental health, learning disability and autism services at some point in the year. 768,083 of these were under 18 years of age
- This means that 5% of people in England were known to be in contact with secondary mental health, learning disability and autism services during this year
- 3.5% (97,103) of people known to be in contact with secondary mental health, learning disability and autism services spent time in hospital for their mental health during 2020-21. This is slightly lower than in 2019/20, when the figure was 3.6% (104,506).

New referrals have been on the rise since they dropped dramatically at the beginning of the pandemic compared to 2018-2019. The number of open referrals and people in contact with mental health services follow a similar pattern, however, more than 200,000 people who have been referred were not in contact with mental health services.

While rising referrals do indicate that the pandemic has had a lasting effect on population mental health, it is important to note that referrals had been rising in the years prior to the pandemic, and the trend since appears to be a continuation of that. The National Audit Office (2023) noted that between 2016/17 and 2021/22, referrals to NHS mental health services rose by 44%, from 4.4 million to 6.4 million. The same report noted that by June 2022, 1.2 million people were estimated to be on a waiting list for community-based mental health support, and an estimated 8 million people in England had unmet mental health needs.

FIGURE 4: NEW REFERRALS TO ADULT MENTAL HEALTH SERVICES



The metric indicates individual new referrals; however, it does not account for the possibility that the same person might have been referred to multiple services and separate referrals have been created, or that a new referral has been created for a person already in contact with services. Source: NHS Mental Health Services Dataset, NHS England, n.d

Carr *et al*. (2021) report a 30% fall in consultations for self-harm in April to June 2020 in primary care and secondary care in the UK. They highlight that the treatment gap for depression and anxiety was greater among working age adults, in deprived areas, and for self-harm. A limitation of studies based on hospital presentations is that they may not reflect community prevalence of suicidal thoughts and behaviours. This may be a particular issue if people were deterred from presenting to hospital because of fears of either over-burdening already stretched health care systems or of contracting the virus in these settings themselves. The most frequent Covid-related factors affecting whether people sought emergency help following self-harm during the first national lockdown were mental health issues, including new and worsening problems; the cessation, reduction or transformation of services (including absence of face-to-face support); isolation and loneliness; reduced contact with key individuals; disruption to normal routine; and feelings of entrapment at home during lockdowns (Hawton *et al*., 2021).

Researchers from the Edge Consortium sought to understand the spatial dynamics in mental health emergencies during the Covid-19 pandemic. A total of 32,401 clinical records of ambulance paramedics attending mental health emergencies in the East Midlands of the UK between 23 March and 31 July 2020 and the same period in 2019 were analysed and showed that people of younger age, male gender and South Asian and Black ethnicity were more likely to experience acute mental health problems during lockdown (Moore *et al*., 2021). Men were more likely than women to experience mental health emergencies attended by ambulances during the first national lockdown in the East Midlands (Moore *et al*., 2021). Furthermore, mental health emergencies among men during lockdown were more likely to involve acute anxiety and behavioural disturbance, while being less likely to involve intentional drug overdose or attempted suicide compared to the previous year (Moore *et al*., 2022).

A study from the South London and Maudsley NHS Foundation Trust analysed the impact of rapid discharge of service users detained under the Mental Health Act during the Covid-19 pandemic (Payne-Gill *et al*., 2021). They utilised a cohort study design and allocated service users to either the pre-rapid discharge, rapid discharge or post-rapid discharge group. Negative outcomes were defined as crisis service use, re-admission to a psychiatric ward, community incidents of violence or self-harm and death by suicide. Rapid discharge did not lead to poorer outcomes for service users, but there was a trend towards increased negative events in the post-rapid discharge cohort.

MENTAL HEALTH SERVICES OFFERED IN GENERAL PRACTICE AND SECONDARY CARE

In the UK, a brief survey of members of the Royal College of Psychiatrists in April 2020 predicted a 'tsunami' of demand in the coming weeks as people struggled to cope with Covid-19-associated social and economic stressors (Royal College of Psychiatrists, 2020).

The Covid-19 pandemic has underscored the importance of social support and community resilience in mitigating the psychosocial effects of the crisis. Initiatives developed during the pandemic, such as e-learning to support the psychological wellbeing of health care employees, have demonstrated the value of innovative approaches to providing support (Li *et al.*, 2021).

Appleton and colleagues (2021) discussed the success of the shift to remote consulting during the Covid-19 pandemic, indicating that while it was necessary and beneficial in certain aspects, it may not be suitable as the preferred option for all aspects of mental health support in the long term. They highlighted that remote or digital options may not work for all service users or in every situation. They also emphasised the need for further evolution and adaptation of the remote consulting model post-pandemic, considering factors such as patient safety, affordability of technology, and clinician knowledge and skill.

Remote mental health appointments were met with mixed views, with key areas for improvement such as risk management, parental burden, and engagement, and challenges related to hindering interpersonal communication and the evolving practice of remote appointments (Biddle *et al.*, 2023). Promising features of remote appointments were identified, including increased inclusivity, accessibility, and naturalistic care. The study also emphasised the evolving nature of practice towards increasing remote appointments post-pandemic. It raised concerns about remote appointments impairing the therapeutic relationship but also noted that some individuals found it easier to disclose things due to the anonymity this set-up afforded them. The impact of remote services on the scope of care provision varied among practitioners, with some seeing limitations in certain types of therapy while others found opportunities for extending services (Biddle *et al.*, 2023).

In line with aforementioned evidence, while presentations to primary care for depression and anxiety remained lower than expected, self-reported psychological distress in surveys remained higher than expected up to the end of the second wave before returning to expected levels after June 2021 (Taxiarchi *et al.*, 2023). Presentations to primary care for anxiety or depression dropped significantly during the early stages of the pandemic, particularly in the first wave, and remained lower than expected up to December 2021 (ibid). Medications prescribed for anxiety or depression were lower than expected during the first wave but returned to pre-pandemic levels during the second wave (ibid). Interpreting this finding in the light of evidence of higher levels of distress during the pandemic means understanding the complex relationship between need and demand for mental health support: levels of help-seeking do not always align with levels of need, and concerns about Covid safety and the over-burdened NHS may have deterred more people than usual. In any case, it is likely that the treatment gap during this time was especially pronounced.

Research looking at the clinical management of self-harm in UK primary care during the first wave of Covid-19 showed that the likelihood of having a GP or practice nurse consultation was similar for the pre-pandemic and Covid-19 cohorts (Steeg *et al.*, 2022). The proportion of patients referred to mental health services was lower in the Covid-19 cohort compared to the pre-pandemic cohort (Steeg *et al.*, 2022). Similar proportions of patients were prescribed psychotropic medication within three months in both the pre-pandemic and Covid-19 cohorts (Steeg *et al.*, 2022).

EATING DISORDER SERVICES

The sharpest rise in referrals to mental health services since 2020 has been seen in eating disorder services. The National Audit Office (2023) noted that NHS children and young people's mental health services in England had been making progress towards a target of 95% of referrals being seen within four weeks in the years up to 2020, but as the number of referrals rose sharply in the second half of 2020 and have remained at a high level, the numbers of people getting help quickly fell and have stayed below pre-pandemic levels ever since.

Hyam and colleagues (2022) investigated the impact of the Covid-19 pandemic on First Episode Rapid Early Intervention for Eating Disorders (FREED) services in England. There was a significant increase in referral numbers to FREED services following the first national lockdown. Presentations of anorexia nervosa diagnoses also increased during the same period. The duration of untreated eating disorders and symptom severity remained stable throughout the pandemic, suggesting that rising referrals represent an actual increase in need, not changes in help-seeking, emphasising the need for investment to match the increased referral trends.

A qualitative study among adults with eating disorders showed that the Covid-19 lockdown in the UK acted as a catalyst for exacerbating disordered eating behaviours among some people, and for promoting eating disorder recovery for others, with social and functional restrictions, as well as limitations in accessing professional support, playing crucial roles in determining mental wellbeing (Brown *et al*., 2021).

A mixed methods study identified additional themes, including disruptions to living situations, heightened social isolation, limited access to support networks, changes in physical activity levels, reduced availability of health care services, disturbances to routine and perceived control, alterations in the relationship with food, and increased exposure to triggering stimuli amidst the pandemic's challenges (Branley-Bell and Talbot, 2020). This study noted the importance of public messaging that provided safe information about food and exercise to people with eating disorders, and of digital services that are suitably adapted to their needs.

ADAPTATIONS TO MENTAL HEALTH SERVICES

A survey of UK mental health care staff investigated how mental health services adapted during the Covid-19 pandemic (Johnson *et al*., 2021). Staff were asked to rate the challenges they faced at work due to the pandemic. The biggest challenges varied depending on the setting people were working in. In hospitals and crisis houses, dealing with infections and the loss of regular activities were big challenges. Community teams faced changes in how they worked and fewer services being available. Managers and lead clinicians were more likely to report feeling stressed and having increased workloads. Many staff reported struggling to follow infection control rules, especially in hospitals and residential settings. Tensions between providing care and following safety measures were common, such as when dealing with emergencies or visiting patients at home. Staff also mentioned unclear guidance and difficulties with using protective equipment.

Acute mental health services saw a decrease in activity during the pandemic, especially in inpatient admissions and new referrals to crisis services (Johnson *et al*., 2021). Staff noted concerns about their patients, especially around loneliness and lack of support. Some reported seeing new mental health problems arising from the pandemic, like anxiety or psychosis. Staff relied on support from their employers and colleagues, along with new digital tools, to cope with the challenges. Services changed their hours and practices, with some offering more support remotely and others continuing face-to-face visits. There were concerns about certain groups being particularly affected, like those with cognitive impairments or living in unsafe environments.

They also found that many services switched to using technology for appointments and therapy, like phone calls and video chats (Johnson *et al*., 2021). Some new services were created, like crisis centres, and existing services changed to be more accessible. Staff also got more support, like quiet rooms and helplines. Overall, the pandemic made services more flexible and responsive. While many staff liked using technology for meetings and some appointments, there were concerns about using it for initial assessments and forming relationships with clients (Johnson *et al.*, 2021). Some clients found it helpful, but others struggled, especially those without access to technology or a private space. Most staff wanted to keep some changes made during the pandemic, like using technology and new service initiatives. However, they were worried about future challenges, like increased need for mental health services and ongoing inequalities (Johnson *et al*., 2021).

Another study looked at the perspectives of mental health service users and carers (Simblett *et al*., 2021) and provided a detailed account of the emotional responses of participants to the Covid-19 pandemic, including both negative emotions (fear, anger, sadness, boredom) and positive ones (happiness, relief, calm).

Social prescribing has been recognised as a valuable resource in the United Kingdom, with the potential to positively impact health and enhance individual and community wellbeing by addressing issues such as loneliness, social isolation, and vulnerabilities (Vidovic *et al*., 2021). Social prescribing programmes have been widely promoted and adopted in the NHS, indicating a growing emphasis on utilising non-medical interventions to support individuals (Wang *et al*., 2018). However, studies have shown that the uptake of non-medical prescribing, including social prescribing, in primary care has been inconsistent (Mills *et al*., 2020).

Link worker social prescribing, a widely implemented approach in the UK and elsewhere, has been recognised for its potential to provide support to vulnerable people during the pandemic. A qualitative study conducted in a deprived urban area of North East England explored how an existing social prescribing service adapted to meet clients' needs during the first wave of the pandemic, and how clients experienced these changes (Morris *et al*., 2022). The findings revealed that service providers swiftly transitioned to remote intervention delivery to continue serving existing clients and reach out to other vulnerable groups. Telephone consultations facilitated improved access to some existing clients and, in some instances, engaged individuals who had previously been disengaged from GP surgeries (ibid).

Despite the successful adaptation to remote delivery, link workers encountered difficulties in building rapport with clients, engaging them with the intervention's objectives, and providing services to digitally excluded individuals (Morris *et al.*, 2022). Limited link worker capacity resulted in variable contact with clients, with only some receiving consistent support, which was highly valued for managing their conditions and mental wellbeing. Additionally, limited access to linked services negatively impacted clients, particularly those living in less affluent circumstances or with poorer health, who experienced adverse effects on their long-term conditions (ibid).

MENTAL HEALTH ACT AMENDMENTS

The emergency Coronavirus Act 2020 in England and Wales caused concern for its potential to allow involuntary admission decisions to involve fewer health care professionals, extending time limits on detention, and facilitating treatment without consent (Allwood, 2020). These emergency amendments to the Mental Health Act were never triggered, and they were repealed within a year.

DIGITAL SERVICES

Digital and online approaches to delivering support have been proactively deployed in some peer networks to facilitate one-to-one, group, and community connections and activities (Centre for Mental Health, 2020).

One study examined the impact of the Covid-19 pandemic on service access and children and young people's experiences of presenting their concerns via a text-based online mental health service in the UK (Knipe *et al.*, 2023). The study found a sudden increase in service access at the beginning of the pandemic, followed by a reduced rate of engagement during the pandemic compared to pre-pandemic trends. Additionally, there was a significant increase in the number of children and young people accessing support from Black/African/Caribbean/Black British and white ethnic groups, as well as people from the most and least deprived areas at the start of the pandemic (Knipe *et al.*, 2023).

Another paper explored changes in user engagement patterns on the online mental health platform Kooth during the Covid-19 pandemic (Bernard *et al.*, 2022). Users during the pandemic had fewer drop-in chats with practitioners but were more engaged in journalling and commenting on existing content compared to pre-pandemic users (ibid). This suggests that there was significant unmet need brought on by a sudden shift towards digital from face-to-face mental health services during the pandemic (ibid).

NHS Confederation (2020) has looked into the challenges of transitioning mental health services to remote group sessions during the Covid-19 pandemic. It found that remote group sessions required specific training such as on patient confidentiality, as well as ongoing support for staff to deliver services effectively. As a result, the trust has been adapting electronic patient records to enhance the use of digital technology in delivering mental health services (NHS Confederation, 2020).

INPATIENT MENTAL HEALTH SERVICES

Inpatient and residential services have reported difficulties in keeping service users and staff safe from the virus, with isolation, boredom, and a lack of therapeutic activity being major challenges (Johnson *et al.*, 2021).

Inpatient and residential settings faced challenges in maintaining a therapeutic environment and preventing the spread of infection due to lack of protective equipment, distancing, and guidance. To address these issues, staff in these settings created Covid-19-specific units, quarantine, early discharge, reduced use of communal spaces, and enhanced use of technology for remote contact (Sheridan Rains *et al.*, 2021).

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES

At points during the pandemic effort, community services staff were redeployed from some children and young people's services to prioritise an urgent and timely response to the pandemic (NHS Confederation, 2022). While this may have been the right clinical prioritisation during a national crisis, its impact may be long-lasting for some children and young people. For example, service delivery and continuity of care were inevitably impacted and important work to roll out mental health support teams in schools and colleges was also disrupted (NHS Confederation, 2022). Nonetheless, workforce pressures, including shortages of staff in some key services, made it difficult for community providers to increase delivery to address backlogs of care (NHS Confederation, 2022).

VOLUNTARY AND COMMUNITY SECTOR SUPPORT

Voluntary and community sector (VCS) organisations have been providing mental health services, addressing the social determinants of mental health, and working across traditional clinical and disciplinary boundaries for many years. Many stepped into the breach rapidly when statutory services struggled to meet people's needs during the early stage of the pandemic.

The VCS has for a long time played a crucial role in advancing equality by facilitating access to support for people from disadvantaged groups who may be reluctant to access public sector services. It has been successful at building trusting relationships with service users, offering flexible services, empowering service users to take active roles within the organisation, taking a strengths-based approach, and working in ways that accommodate a person's cultural background (Bell and Allwood, 2019).

The VCS has also made a significant contribution to the diversity of the mental health system by offering a wide range of services, including nature-based therapies, different contexts for engaging with people, and different organisational structures. Coproduction resulted in services that were closely aligned with the needs of the people who will be using them, providing benefits such as improved sense of belonging, reduced stigma, reduced inequalities in care, improved access to care, increased skills and employability, reduced need for emergency health care, and improved physical and mental wellbeing. Despite this important and complementary role to that of statutory services, VCS organisations have typically struggled with inconsistent, insecure, and short-term funding from both public and charitable sector organisations (Bell and Allwood, 2019).

During the Covid-19 pandemic, there were positive developments in cross-sector relationships between mental health VCS and statutory services. The pandemic accelerated changes in both the quantity and quality of these relationships, driven by factors such as the strain on statutory services, the removal of barriers to communication and collaboration between sectors, and a virtuous circle where more statutory services worked with the VCS (Centre for Mental Health *et al.*, 2020). Almost all VCS organisations increased their involvement with the other sector during lockdown, resulting in more referrals and increased communication (Wilton and Allwood, 2021).

Greater dialogue, trust, equality, flexibility, support, less pressure, and bureaucracy were key drivers of improvement in cross-sector relationships. Changes in contracts and dynamics of relationships also contributed to these improvements. A majority of respondents to a VCS survey in Greater London reported that their organisation's funders had relaxed or changed contractual arrangements during the pandemic, with the strongest themes being less pressure and more trust (Wilton and Allwood, 2021). Organisations reported positive changes in terms of equality and collaboration, with increased opportunities for co-developing new ideas and partnership development of service models.

There is evidence, however, that innovations in commissioning and contracting during the pandemic were not sustained, with many VCS organisations reporting a return to previous practices on the part of their statutory sector partners – such as short-term contracts and competitive tendering – within just a year of the start of the pandemic (Wilton and Allwood, 2021).

CASE STUDY: MIND

Mind swiftly responded to the mental health challenges posed by the Covid-19 pandemic, offering vital support and resources to individuals across England and Wales. This case study highlights key initiatives undertaken by Mind to address these pressing needs.

Key initiatives from Mind included:

- **Coronavirus information hub:** Mind launched an information hub providing resources on mental wellbeing during the pandemic, attracting over 1.4 million views since March.
- **Support for children and young people:** Tailored resources for young audiences received over 420,000 views, addressing their unique mental health needs.
- **Infoline and legal line:** Mind's helplines saw increased activity, answering over 35,000 calls, texts, and chats throughout the pandemic.
- **Frontline collaboration:** Mind collaborated with other organisations to create Our Frontline, supporting frontline workers with mental health assistance.
- **Survey and recovery campaign:** Mind's survey findings informed a recovery campaign advocating for mental health protection, reaching decision makers and garnering grassroots support.
- **Media outreach:** Mind's initiatives received extensive media coverage, reaching over 56 million people across various platforms.
- **Active monitoring in Wales:** Mind expanded mental health support in Wales, providing free services to 3,000 individuals with mild to moderate concerns.
- **Local Mind support:** 120 local Minds adapted services online, ensuring continued accessibility for their communities.

5 SOCIETY AND MENTAL HEALTH DURING THE COVID-19 PANDEMIC

This section explores some of the wider mental health implications of the pandemic, and some learning points about the ways the threat of the virus was managed and communicated with the public.

ANXIETY AND THE PANDEMIC

The relationship between mental and physical health is complicated and characterised by many interactions and overlaps. Health anxiety is one such area that can affect people's wellbeing and outcomes very significantly. Lines *et al*. (2022) investigated the relationship between mental health and care experiences in older adults with cancer, revealing the intricate connections between self-reported mental ill health, treatment for mental health difficulties, and individuals' care experiences. This study suggests that individuals might identify mental health difficulties in themselves based on their care encounters and personal perceptions.

Feldborg *et al*. (2021) explored the correlation between anxiety and self-perception, emphasising the existing connections between mood disorders and perceptual processes. Furthermore, Reiner *et al*. (2020) discussed the link between chronic anxiousness and cardiovascular disease and mortality, underscoring the significance of self-reported symptoms in mental and physical health outcomes. Moreover, a US study examined the frequency of mental health-related hospitalisations and emergency room visits subsequent to new anxiety disorder diagnoses in children, suggesting that anxiety may trigger both healthcare-seeking behaviours and incidents of self-harm (Bushnell *et al*., 2018).

Similarly, there is a significant association between pandemic-related anxiety and self-diagnosis of mental illness, as supported by several studies. Salari *et al*. (2020) conducted a systematic review and meta-analysis, revealing a high prevalence of stress, anxiety, and depression in the general population during the Covid-19 pandemic, indicating a substantial impact on mental health. Rajkumar (2020) reviewed existing literature on Covid-19 and mental health, highlighting the global impact of the pandemic on psychological wellbeing. Asmundson *et al.* (2020) explored the differential impacts of Covid-19 stress responses on individuals with pre-existing anxiety and mood disorders, suggesting that those with pre-existing conditions may be more vulnerable to pandemic-related stress, potentially resulting in an exacerbation of mental health symptoms.

Cognitive factors (such as the ways people respond to potential risks and rewards, both immediate and delayed) have also been shown to predict both compliance levels with social distancing guidelines and mental health outcomes during the Covid-19 pandemic (Lloyd *et al.*, 2021). For example, people who tend to discount delayed rewards were less likely to observe social distancing measures, and those who are quicker to update their beliefs were less likely to violate lockdown laws. In both cases, levels of anxiety about Covid affected people's decision making, and people's mental health outcomes were affected by their beliefs and attitudes towards risks and rewards (ibid).

Another paper discussed the adverse effects of the Covid-19 pandemic on mental health, the association between cumulative worries and experiences of adversities with higher levels of anxiety and depression, and the insufficiency of measures taken during the early weeks of lockdown in the UK to reassure individuals (Wright *et al*., 2021).

THE MEDIA AND MENTAL HEALTH DURING THE PANDEMIC

Since the beginning of the Covid-19 pandemic in January 2020 the need for rapid information spread came along with various misconceptions and misinformation which consequently influenced perceptions and behaviours of the public towards the coronavirus pandemic.

A cross-national study from the UK, Norway, USA and Australia surveyed over 2,000 people on the challenges and benefits of using social media during the Covid-19 pandemic outbreak (Schoultz *et al*., 2023). This revealed both positive and negative sentiments, highlighting the need for ensuring clarity in communications about credible information sources.

Another study conducted on the quality and content of print and online UK news regarding the impact of Covid-19 on suicidality shed light on the pervasive narrative surrounding potential rises in suicide rates during the pandemic (Marzano *et al*., 2023). Despite evidence showing that suicides did not increase in the first year of the pandemic in most countries with real-time suicide data, there has been widespread concern and speculation perpetuated by sensational news coverage.

Using a bespoke database, the study analysed 372 stories about Covid-19 and suicidality in online and print news between March 2020 and May 2021 (Marzano *et al*., 2023). Alarmingly, over a third of articles and headlines claimed or predicted a rise in suicide, often attributing it to feelings of entrapment and poor mental health, especially among young people. Furthermore, a significant proportion of reports were rated as being of negative quality, lacking proper signposting to help and support. However, there were notable improvements in reporting quality over time and during phases of less stringent Covid-19 restrictions, with later articles incorporating fewer negative statements and predictions and relying more on academic evidence.

Other studies conducted in the United States have explored the potential of analysing social media posts to gain insights into the impact of the Covid-19 pandemic on suicide risk. These studies, conducted primarily among users from the United States, have shown heightened levels of suicide-related posting and discussions on suicidality (Low *et al*., 2020; Saha *et al*., 2020). However, it is crucial to recognise the limitations associated with this approach, which may complicate the interpretation of findings.

One of the key challenges lies in self-selecting biases inherent in social media platforms, where individuals choose to contribute based on personal motivations and circumstances, potentially skewing the representation of the overall population. Additionally, the unit of analysis being individual posts or tweets rather than individuals themselves introduces complexities, as multiple posts may originate from the same individual, leading to potential duplication of data. Moreover, the lack of information regarding the demographic and clinical characteristics of the individuals making these posts hinders the ability to draw accurate conclusions about the population at risk. Furthermore, the dissemination of misinformation on social media platforms exacerbates these challenges, making it difficult to discern genuine distress from more generalised concerns.

Given these limitations, it is essential to approach the interpretation of social media data with caution and to complement these insights with other sources of information. While social media analysis offers the potential for real-time assessments of changes in suicide risk, policy makers and public health authorities must consider the inherent biases and uncertainties associated with this approach. Future efforts to mitigate these limitations, such as incorporating demographic and clinical data into analyses and enhancing mechanisms for identifying and addressing misinformation, are crucial for maximising the utility of social media as a tool for understanding and addressing suicide risk during the Covid-19 pandemic in the UK.

GOVERNMENT COMMUNICATIONS AND THE PUBLIC'S MENTAL HEALTH

A focus group study conducted in March and April 2020 discussed the significant social and psychological impacts of social distancing and isolation policies on participants, including feelings of loss, ambiguity in government communication, high adherence to guidelines but observations of non-adherence, and uncertainty about the future (Williams *et al*., 2020). It also highlighted the potential waning of support for measures over time and the importance of planning for different behaviours upon relaxation of restrictions.

Wright and colleagues (2021) discussed the implementation of Covid-19 guidelines by the UK Government. The main factors facilitating compliance with Covid-19 guidelines were desires to reduce risk to oneself, family, and friends, as well as a desire to return to normality. Identified barriers to compliance included difficulties in maintaining social distancing in public, the need for support from family and friends, social isolation, mental health impacts, perceiving low risks, social pressure against compliance, and challenges in understanding and keeping abreast of changing rules (Wright *et al*., 2021). The study suggests that government communication emphasising the risks of the virus and providing clear, consistent guidance on preventive behaviours would improve compliance.

Another study from the same research group used structural topic modelling to analyse over 4,000 free-text survey responses to understand public opinion on the UK Government's response to the pandemic (Wright *et al*., 2022). They discussed the decline in confidence in central government during the Covid-19 pandemic, highlighting themes related to perceived government corruption, inconsistency in rules and messaging, lack of clear planning, and lack of openness and transparency (ibid).

UK GOVERNMENT AND DEVOLVED NATIONS' STRATEGIC RESPONSES

The UK Government published its Covid-19 mental health and wellbeing recovery action plan in March 2021 (HM Government, 2021). Prior to this, responses to the mental health impacts of the pandemic had been sporadic and reactive. Some small-scale funding had been provided, for example to enable charities to extend or adapt helplines and support services to meet rising or changing needs and to work differently. And funding for the NHS to meet rising levels of need had been provided as part of the 2020 winter planning process.

The devolved nations in the UK all took different approaches, publishing or adapting existing mental health strategies in response to the crisis.

The Scottish Government (2020) produced its mental health 'transition and recovery plan' in October 2020. The plan included a range of actions across 18 domains.

The Welsh Government (2020) adapted its existing three-year mental health strategy (for 2019-2022) to the pandemic, adding a set of actions to respond to the specific challenges that had not previously been anticipated.

In Northern Ireland, a Mental Health Action Plan was published in May 2020 that included an additional response to the crisis (Northern Ireland Government, 2020).

Among the more successful of the UK Government's responses to the crisis was the creation of the Better Mental Health Fund. The Fund provided resources for local authorities in 40 of the most deprived areas of England to invest in public mental health activity, with a focus on communities and groups experiencing the poorest mental health and biggest inequalities. An evaluation of the scheme found positive impacts from the funding, which enabled local authorities to provide additional resources to community organisations to deliver evidence-based interventions in their local and cultural context (Woodhead *et al*., 2023).

PUBLIC MENTAL HEALTH IN THE WIDER CONTEXT

The vulnerability of our mental health to the pandemic can be viewed as a sign of the importance of investing in public mental health and wellbeing and taking actions to bolster our 'resilience' in the face of emergencies.

A review of public mental health challenges in England (Ahuja *et al*., 2023) identifies nine priority areas for action, including physical health checks for people with severe mental illness, community engagement for racially minoritised groups, and improving access to psychological therapies for children and young people. They emphasise stakeholder engagement, incorporation of diverse perspectives, and ongoing evaluation to improve service delivery.

Rose-Clarke *et al*. (2020) underscore the importance of integrating mental health into global development efforts and adopting a public health approach to address social determinants. They also emphasise the need for global collaboration and activism to address mental health determinants effectively.

Campion *et al*. (2023) outline five key opportunities to improve the coverage of public mental health interventions. They advocate for settings-based approaches, integrated approaches, utilisation of digital technology, maximising existing resources, and focusing on high-return interventions. Emphasising collaboration, technological innovation, and strategic prioritisation, the report offers a comprehensive framework for enhancing public mental health intervention coverage:

- Settings-based approaches offer targeted delivery of public mental health interventions within specific environments such as health care facilities, schools, workplaces, neighbourhoods, and community centres
- Internet and phone-based interventions offer benefits such as improved access, diagnosis, treatment adherence, and stigma reduction
- Optimising resource allocation presents opportunities to enhance coverage without additional investment, for example by reallocating funds from institutional to community-based services, leveraging non-governmental organisations such as faith-based groups, and exploring complementary approaches like mindfulness and traditional healing practices
- Prioritising interventions with significant population-level impacts, especially during critical developmental stages like pregnancy and childhood, maximises coverage and long-term benefits
- Targeted actions to address social determinants and overarching factors such as socioeconomic inequalities amplify intervention effectiveness.

A public mental health approach, as advocated by Rose-Clarke *et al*. emphasises addressing the social determinants of mental health to effectively respond to future pandemics like Covid-19.

By focusing on diverse factors such as gender roles, economic policies, environmental conditions, community mobilisation, and sociocultural influences, this approach acknowledges the interconnectedness between mental health and broader societal contexts. For instance, understanding how economic insecurity and social disparities exacerbate mental health challenges during pandemics can inform policy responses aimed at mitigating these impacts. Moreover, the emphasis on collaboration and interdisciplinary approaches, as highlighted by the opportunities for collaboration, enables the mobilisation of resources and expertise across various sectors to address complex mental health needs arising from pandemics.

By adopting a public health perspective that considers the social determinants of mental health, policy makers can develop holistic strategies that promote resilience, address migration-related challenges, and tackle syndemics (in which diseases and social factors mutually reinforce one another), ultimately enhancing societal preparedness and responses to future public health crises.

Additionally, these studies underscore the importance of evidence-based interventions in addressing the mental health challenges exacerbated by pandemics. Leveraging digital technology for delivering mental health interventions and prioritising high-return interventions with significant population-level impacts offer scalable solutions for reaching diverse populations and promoting mental wellbeing during large-scale health crises. By integrating these approaches with a focus on the social determinants of mental health, policy makers can develop comprehensive strategies that address the multifaceted challenges posed by pandemics, ultimately contributing to better mental health outcomes and resilience across populations.

DISCUSSION

The Covid-19 pandemic presented huge challenges for the public's mental health across the world. Some of those challenges were short-lived, but others have left a longer legacy. Some were inevitable results of the emergency and the necessary measures to manage it; others might, with hindsight, have been managed differently to reduce the risks to people's mental health both at the time and in the longer term.

Early on in the pandemic, the Centre's forecasts presented a picture of what might happen during the crisis and in its aftermath. They drew largely from evidence collected from previous emergencies and large-scale traumatic events. Four years later, we are beginning to build a picture of what has happened – a picture that will only become truly clear over a longer timescale.

We can see that many more people have sought help for their mental health since the beginning of the pandemic. This increase in help-seeking was not short-lived; if anything, it has continued and gathered pace in the years since 2020 as referrals for mental health support have grown, especially among younger age groups. Factors other than the pandemic itself are likely to be involved in this. Referrals for mental health support were growing prior to 2020, and the cost-of-living crisis has put enormous pressure on many people's mental health in the last three years.

Data on the prevalence of mental health difficulties is harder to assess. For children and young people, surveys in England have provided a time series since 2020 that suggests very strongly that mental ill health is indeed more prevalent now than it was before the start of the pandemic. A steady rise in the decade prior to 2020 seems to have been followed by a sharp rise, and numbers have stayed high ever since. We do not have the equivalent data for adults, meaning that a clear picture has yet to emerge, but there is persuasive evidence that levels of mental ill health have been rising over the last decade, and the pandemic has contributed to many of the risk factors people face.

Responses to the mental health implications of the pandemic were varied in their speed, quality and comprehensiveness. Mental health services had to adapt quickly. In many local areas, the NHS, local councils, and the voluntary and community sector worked together at unprecedented speed to minimise gaps in care and find different ways to reach people in the midst of the crisis. This prompted innovation on a large scale, especially the adoption of digital technology and remote ways of working, many of which have been sustained since, albeit at a lower level.

The crisis created a spirit of cooperation and collaboration across sectors and organisations, working together through adversity and putting aside the barriers that have too often hampered integrated working. There is less evidence that this has been sustained since, and in many places the barriers to integration have re-emerged since the crisis subsided.

While mental health services sought to adapt to the crisis, the pandemic created enormous challenges for people living with a mental illness. In the UK, and worldwide, people living with a mental illness were more vulnerable to the virus, and mortality rates were far higher than for the general population. There is nothing inevitable about this. It is the product of inequality and inequity: that people with a mental illness are disproportionately living in poverty, with much poorer physical health, in poorer conditions than the general population. Pre-existing risks, the product of long-running and deeply rooted inequalities that cut short people's lives nationwide, made people with a mental illness more vulnerable to the virus.

To some extent this was recognised in the UK during the vaccination programme, when people with a mental illness were given priority status alongside others with long-term health conditions. The NHS in England also funded outreach programmes to ensure that people with a mental illness, especially those from more disadvantaged and marginalised groups, were aware of their right to a vaccination and supported to attend.

While mental health services adapted at speed to the crisis, there is little evidence of a strategic approach to addressing the mental health consequences of Covid-19. Decision making about the public's mental health appears to have been slow, reactive and low on the agenda. Warnings about the mental health implications of the crisis did not receive a proportionate response. Given the scale of the collective trauma that society endured, the paucity of consideration to this crucial aspect of the crisis demonstrates a clear lack of preparation or prioritisation.

On an even deeper level, the emotional, psychological and psychosocial aspects of Covid-19 provide valuable learning about how an understanding of our mental health could help to inform responses to future emergencies. Placing mental health at the heart of decision making, including at times of crisis, can help not just to improve the public's mental health, but make those decisions more robust and effective for the whole population, as well as being more equitable for those living with mental ill health (Young and Bell, 2024). It can also help to improve the communication of essential information. By understanding the nature of collective trauma, government may in future be better able to communicate information, ideas and (at times) instructions in ways that are psychologically safe and effective.

As the pandemic went on, mental health concerns did rise up the political agenda, for example as the consequences of the crisis on children's mental health began to become apparent. Some commentators drew on these concerns to criticise measures taken to protect people from the virus, such as lockdowns and school closures. These criticisms imply that our physical safety and mental health are in opposition: that keeping people safe from the virus inherently harms their mental health. Such narratives oversimplify the choices that have to be made in a crisis. They also ignore the mental health risks of not taking steps to protect the public against the virus. In our modelling of the likely mental health implications of Covid-19, it was clear that the more severe the crisis, and the longer it went on, the bigger the overall impact on the public's mental health would be.

So policy makers were, and will in future be, faced with difficult choices between courses of action all of which present challenges to the public's mental health. While the measures taken to contain the virus put people's mental health at risk, not doing so would do likewise. Decision making in this context needs therefore to minimise the risks to mental health, while mitigating those that cannot be avoided, and acting swiftly to protect people facing the biggest risks.

Such discussions underline the importance of understanding the public's mental health and having reliable means of tracking trends and changes over time. Good-quality real-time data about our mental health is essential to inform policy making across multiple domains. It enables governments, local councils, health services and others to make decisions with an understanding of their likely implications, and to adapt quickly if it becomes apparent that this is necessary.

Crucially, the pandemic exposed fault-lines in the nation's mental health, and the stark inequalities faced every day by people living with mental illness. The public's mental health was deteriorating in the years running up to the pandemic, and mental health services were struggling to deal with the consequences of many years of underfunding and austerity measures across public services. People with a mental illness were already dying 15-20 years sooner than the general population, and facing widespread hardship. The pandemic exacerbated these inequalities, creating new risks to people's mental health and reducing access to support.

We now have the opportunity to learn from this experience and build a mentally healthier future. We can act now to boost the public's mental health in the aftermath of the pandemic, protecting those who have experienced the worst effects and offering better support to groups that don't yet have access to the right support. And we can incorporate mental health into preparations for future emergencies, so that responses are psychologically informed from day one.

RECOMMENDATIONS

1. The NHS should plan ahead for future emergencies to ensure continuity of mental health services. This should include prioritising the combination of infection control and a therapeutic environment in hospitals, achieving effective and targeted digital and phone-based implementation in the community, and working with staff and service users to coproduce and prepare plans for emergency responses. Health and care services need to be aware of potential reductions in patient contact during lockdowns and of possible increases in demand for mental health care in the wake of future emergencies. Plans should include support for the family carers of people living with a mental illness, both with their own wellbeing and with enabling them to care during an emergency period. And they should include the whole population, including groups facing especial risks such as pregnant women, students, and prisoners.
2. Health and care services should provide support for their staff to address the burnout many in the workforce are experiencing now, and to prepare for this during future emergencies. This must include longer-term measures to improve working conditions, pay, and personal safety. It should include workers in all sectors and roles – including those in the voluntary and community sector.
3. The Department of Health and Social Care and NHS England must take urgent steps to improve the physical health of people living with a mental illness. This is essential both to reduce the ongoing life expectancy gap and to ensure people with a mental illness are not disproportionately vulnerable to future pandemics and epidemics.
4. The Department of Health and Social Care should establish robust surveillance systems to monitor the public's mental health, which provide routine data and that can be stepped up for enhanced intelligence-gathering during future emergencies.
5. The Government should maintain human rights protections during future emergencies: for example, it should not make changes to the Mental Health Act which reduce safeguards.
6. The Government should plan its communications during future emergencies with an understanding of the importance of mental health. Developing psychologically informed approaches to communicating with the public (for example with clear, consistent, and compassionate messaging) will help to address issues such as vaccine hesitancy and compliance with safety guidelines and regulations. This should include working with media and social media organisations to support them to promote reliable and accurate information and to counter sensationalist or inaccurate claims.
7. The Department for Education should provide tailored support for autistic young people before and during future health emergencies, managing transitions in and out of school effectively, making schools more 'autism-friendly', prioritising mental health support for those who have been unable to access it, considering a wider group for professional mental health support, involving the autistic community in future research.

8. The NHS should continue to use remote technology to deliver or support the delivery of mental health services, but not as a blanket replacement for face-to-face services. Future service delivery should offer people choices about the way they want to engage with mental health support, with adjustments to enable the safe and equitable provision of both remote and face-to-face options. This could include the development of online and remote interventions to provide mental health support to individuals during lockdowns and future pandemics.
9. The Department of Health and Social Care should continue the expansion of Mental Health Support Teams to all schools and colleges in England, and commit to implementing a 'whole school approach' to mental health. This is necessary both to address the harms to children's mental health in the wake of Covid-19 and to prepare educational establishments for future emergencies (local, national or global).
10. The Department of Health and Social Care should closely monitor referral trends and the increased demand for eating disorder services to ensure timely and well-coordinated care. Understanding the reasons for the rapid rise in eating disorder referrals following the first lockdown should be a priority for research funding in order to learn the lessons for future national emergencies.

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