Thrive LDN
towards happier, healthier lives

SUPPORTING PARTNERS WITH THE PUBLIC MENTAL HEALTH RESPONSE TO COVID-19:
What does the latest evidence, research and intelligence tell us?
Working paper 2

Contents

1. Context

Thrive LDN is coordinating the public mental health response to COVID-19 on behalf of Public Health England Office for London and wider partners. As part of our coordination role, we are producing regular working papers on what we do and do not know about the impact of COVID-19 on Londoners' mental health and wellbeing, implications for transition and recovery planning, and suggested actions we take, locally, sub-regionally and regionally.

It is important to note that this work is iterative and will build over time, with an aggregated working paper published every two weeks. Comments and feedback are, therefore, welcome and encouraged. We are aware that many partners are undertaking their own research and already acting on findings; please do share the evidence you have, lessons learnt and actions taken, so that we can build a more complete picture and spread best practice.

If you would like to get in touch about this work please Helen Daly (helen.daly4@nhs.net), Thrive LDN Research and Evaluation Lead, and Dan Barrett (d.barrett@nhs.net), Thrive LDN Director.

Future reports will provide more detailed insights and suggested actions around:

Week commencing	**Report**
3 August	• Bereavement • Suicide prevention • Loneliness • Anticipated demand for mental health support for children and young people • Temporal trends in potential COVID-19 stressors
17 August	• Settings (e.g. schools; workplaces) • Health behaviour • Mental health impact on people who have contracted COVID-19 • Where possible, anticipated demand for mental health support by Integrated Care System and London borough
31 August	• Mental health impact of lifting of economic and other support • Scenario planning
14 September	• Non-COVID-19 considerations

Further research areas may be added. If there is an area of research you would like to see that is covered above, please do let us know and we will do our best to schedule in a future iteration.

Scope, methodology and limitations

Scope

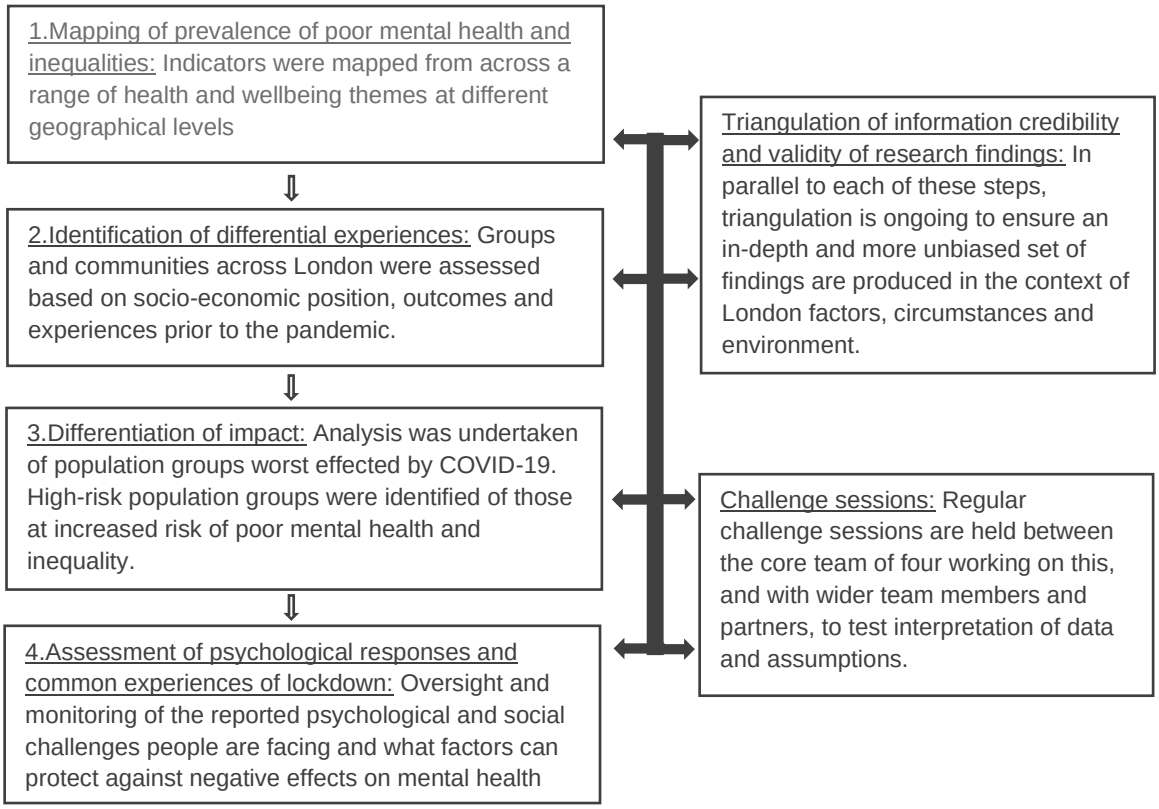
The scope of the work is common mental health problems and wider public mental health and wellbeing of Londoners. The work has a focus on advancing equality and reducing inequalities in the health and wellbeing of Londoners.

Methodology

The methodology is based on the research and triangulation of multiple sources of relevant evidence relating to the COVID-19 pandemic, population mental health data and analysis of the UK society and economy. Sources of evidence is broad, yielding findings from empirical papers, prevalence and incidence data, quantitative and qualitative research, insights from the community and voluntary sector and stories from Londoners with lived experience.

This rich and diverse range of information is methodologically varied, spanning different contexts and sample sizes, making comparisons and overall synthesis challenging. To ensure a level of rigour and reliable interpretation of the evidence the following steps are used to inform, identify and update on the impact of COVID-19 on Londoners mental health and wellbeing:

Figure 1. Research and triangulation methodology



Limitations

Fundamentally, insights are limited by the availability of data and information. There will undoubtedly be data and information sources the team are unaware of and would appreciate being made aware of. And there are also some data and information sources that we know will be available in the coming weeks. However, overall, representativeness and inclusiveness has been identified as a limitation across all sources of data and information,

with a lack of sufficient, granular intelligence available on the experiences and needs of different disadvantaged and marginalised communities in London. Thrive LDN has mobilised accompanying community participatory research and engagement projects to help address this, but wider action is needed at all levels (borough, sub-regional and regional). This is covered further in the Conclusions and Suggested actions we take sections.

2. Prevalence of poor mental health in London before COVID-19

Several indicators are measured at a national, regional and borough level, which give an indication of the prevalence of poor mental health in London. London continues to report some of the lowest life satisfaction in the UK in the year ending March 2019 (7.58 compared to the UK average of 7.71).[1] There is also significant variance across the capital, with several London boroughs (Lambeth, Hackney, Islington and Camden) persistently reporting lower average wellbeing ratings compared to the rest of the UK.[2] In 2018, 661 Londoners took their own lives; around 12 people every week.[3]

Furthermore, London is diverse and Londoners' opportunity for good mental health and wellbeing is not equal. We know from data, intelligence and research that some people are more likely to experience a better quality of life than others. The relationship between equality and mental health and wellbeing is complex. Mental health is shaped by wide-ranging characteristics,[4] which are influenced by the local, national and international distribution of power and resources.[5] Poor mental health is both a cause and consequence of inequality and prevalence is often much higher in the communities facing most inequalities, including people living in poverty or those who have experienced discrimination or adversity.

However, whilst it is important to acknowledge and address the challenges individuals and communities face, we know that London is a city rich with resources and assets which promote health, happiness and resilience, protect against negative health outcomes, and help to reduce health inequalities. By protecting and enhancing these, London will be able to maintain and sustain mental health and wellbeing and support people to build on the strength and resilience they have.

3. The known impact of COVID-19

The Mental Health Foundation's *Coronavirus: Mental Health in the Pandemic study*[6] has found that, overall, levels of distress are receding across the UK and most people are feeling able to cope. As of the third week of June, 49% of the population had felt anxious or worried in the past two weeks due to the pandemic, down from 62% in mid-March. However, the

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[1] Office for National Statistics (2019) Personal well-being in the UK: April 2018 to March 2019: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/april2018tomarch2019

[2] Ibid.

[3] Office for National Statistics (2019) Suicides in the UK: 2018 registrations: https://www.gov.uk/government/statistics/suicides-in-the-uk-2018-registrations

[4] Mental Health Foundation (2009). Mental health, resilience and inequalities: A commentary by Mental Health Foundation:

5 Public Health England (2019) Wider determinants of health: https://fingertips.phe.org.uk/profile/wider-determinants

[6] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic

study stresses that there are still millions of people across the UK who are struggling with the stress of the pandemic.

As highlighted in the previous section, many Londoners entered the pandemic from positions of disadvantage and evidence is increasing that the COVID-19 pandemic has affected the mental health of sections of the population differently, depending on their circumstances. Evidence suggests the pandemic has widened mental health inequalities; groups that had the poorest mental health pre-crisis had the largest deterioration in mental health during lockdown.[7] The economic effects are also variable. There are some signs of increasing economic inequality, with more people on lower personal incomes reporting reduced income in the household because of the coronavirus as lockdown has continued, working fewer hours, and less able to save for the future, while fewer people with higher incomes have been impacted financially.[8]

Already, estimates are that half a million people across the UK are likely to experience mental health problems as a result of the economic impact of the pandemic.[9] And even as the measures to curb the spread of COVID-19 change, differences in people's mental health will persist and likely increase.[10] This risk is amplified when individual characteristics with negative outcomes intersect with each other, for example, factors such as race, class and gender and the circumstances and conditions associated with these. Many of the factors that promote mental health or lead to poor mental health are associated with overlapping identities which inform how we live our lives and often the opportunities available to us.

However, whilst we must focus on ensuring that Londoners who need help and support receive it, we must also be careful not to over-pathologise the natural process of how people are adapting and coping with change. After the severe acute respiratory syndrome outbreak in Canada and Hong Kong in 2002–04, most adverse psychological consequences of physical distancing and quarantine resolved without the need for specialised mental health care.[11,12,13] Medicalising normal and understandable responses to the pandemic could perpetuate the stigma of mental health. A fundamental part of the public mental health response needs to be normalising feeling stresses and supporting Londoners to build on the resilience they already have.

4. Disproportionally at risk groups

There is a lack of intelligence regarding the experiences of certain marginalised or disadvantaged groups across London, despite the knowledge that these groups have been and will continue to be worst affected by the pandemic, and the groups highlighted below are

[7] Institute for Fiscal Studies (2020) The mental health effects of the first two months of lockdown and social distancing during the Covid-19 pandemic in the UK
[8] Office for National Statistics (ONS) (2020) Personal and economic well-being in Great Britain: June 2020: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personalandeconomicwellbeingintheuk/june2020
[9] Centre for Mental Health (2020) Covid-19 and the nation's mental health: May 2020. Forecasting needs and risks in the UK: https://www.centreformentalhealth.org.uk/covid-19-nations-mental-health
[10] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic
[11] Maunder RG. Was SARS a mental health catastrophe? Gen Hosp Psychiatry 2009; 31: 316–17 Mak IW, Chu CM, Pan PC, Yiu MG, Ho SC, Chan VL. Risk factors for chronic post-traumatic stress disorder (PTSD) in SARS
[12] Lee AM, Wong JG, McAlonan GM, et al. Stress and psychological distress among SARS survivors 1 year after the outbreak. Can J Psychiatry 2007; 52: 233–40.
[13] . 77 Lee AM, Wong JG, McAlonan GM, et al. Stress and psychological distress among SARS survivors 1 year after the outbreak. Can J Psychiatry 2007; 52: 233–40.

unlikely to be exhaustive. Further to this, it is not possible to easily unravel the impact and weight of intersectionality on the population's mental health. Londoners and their communities cannot be defined by a single attribute such as age group, ethnicity or location and so it is important to consider how risks and assets can be amplified when identities and characteristics do overlap across these groups.

Children and young people

A considerable body of evidence is being developed on the experiences and outcomes of children and young people in relation to COVID-19. As with other age groups, mental distress is common in children and young people who experience periods of quarantine or social isolation.[14]

The *Coronavirus: Mental Health in the Pandemic study*[15] found that young people (18-24 years old) were more likely to report stress arising from the pandemic than the population as a whole. Findings from the third week June show that 18-24 year olds were still more likely than any other age group to report hopelessness, loneliness, not coping well and suicidal thoughts/ feelings. Furthermore, the proportion of young people age 18-24 reporting suicidal thoughts or feelings, at 22%, was more than double that of the population as a whole, at 10%.

Furthermore, Young Minds survey[16] of 2,111 young people with a history of mental health needs showed concerns about losing connection with friends, non-immediate family and other trusted adults. This was especially so among those who did not feel confident or comfortable using phones or who had limited access to technology. Some young people missed physical proximity with their friends and felt that talking online was not the same.

Insights on changes to mental health needs of Black, Asian and Minority Ethnic young people using Kooth, a digital mental health support service, have shown greater increases in depression, anxiety, self-harm and suicidal thoughts than white peers during COVID-19 pandemic.[17]

> *"It's removed some of my usual coping mechanisms (e.g. socialising, spending time in nature) and therefore made my mental health a bit more wobbly. Nonetheless it's forced me to strengthen other coping mechanisms such as at-home exercises and meditation, and other self-care activities which before I'd focus on less."* [18]

Young adults have been especially badly hit during the pandemic with issues such as reduced social contact, curtailed education and diminished job prospects. There is an urgent need to put in place special measures to support the mental health and wellbeing of young

[14] Gayer-Anderson *et al* (2020) ESRC Centre for Society & Mental Health, King's College London: https://esrc.ukri.org/files/news-events-and-publications/evidence-briefings/impacts-of-social-isolation-among-disadvantaged-and-vulnerable-groups-during-public-health-crises/

[15] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic

[16] Young Minds (2020) Coronavirus: Impact on young people with mental health needs: https://youngminds.org.uk/media/3904/coronavirus-report-summer-2020-final.pdf

[17] Kooth (2020) Week 14: How Covid-19 is Affecting the Mental Health of Young People in the BAME Community: https://xenzone.com/wp-content/uploads/2020/06/BAME_infographic_June-2020_WEB-v2.pdf

[18] Partnership for Young London and Good Thinking (2020) Checking in: Voices of young people during lockdown: https://3532bf5a-d879-4481-8c8f-127da8c44deb.usrfiles.com/ugd/3532bf_7c20f5f6ef1e4c25afd7be462efa4126.pdf

people age 18-24 with a particular view to addressing uncertainty around education provision and employment opportunities.

Older people

Older people are a priority group as they bear a disproportionate impact from COVID-19. The majority of excess deaths (75%) have occurred in those aged 75 and over and the risk increases with age. Care homes have been a key feature of the pandemic accounting for 43% of all deaths from COVID-19 in England on 10 May.

Further to this older people are more likely to be clinically shielding and experience long periods of isolation, leading to widespread concern for this group as social isolation among older people is already a well-recognised and serious public health issue.[19] Little information is available on the short- and long-term health and social impacts of the pandemic and restrictions on older people as a distinct group, however information is available from studies of general population samples which disaggregate findings by age group.

For example, the *Coronavirus: Mental Health in the Pandemic study*[20] found that the resilience of people in later life has been visible in the findings, with only 6% of people age 70 and over reporting not coping well as of the third week in June. Since mid-March, people age 55 and over, and particularly people age 70 and over, have been less likely to report stress as a result of the pandemic. In addition, there were reduced levels of anxiety amongst this age group.

Furthermore, Office for National Statistics survey findings from 03 April – 10 May found that among those who were worried about the effect that the coronavirus was having on their lives, older people were more likely to have had difficulties accessing essentials, and less likely to have had their finances impacted, than younger people.[21]

Women

The *Coronavirus: Mental Health in the Pandemic study*,[22] found that across the lifetime of the survey women have been more likely than men to report being worried about their finances. In addition, as of the third week in June, more women than men reported feeling anxious, lonely, and hopeless due to the pandemic in the prior two weeks, though the percentages for both men and women overall have fallen.

It is also the case that women are much more likely to be affected by domestic violence and abuse, the risk of incidence of which have increased during lockdown. Call to the National Domestic Abuse Helpline increased by 150% during the initial stages of lockdown.[23]

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[19] Nicholson NR. A review of social isolation: an important but underassessed condition in older adults. The journal of primary prevention. 2012 Jun 1;33(2-3):137-52

[20] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic

[21] Office for National Statistics (2020) Coronavirus and the social impacts on Great Britain: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/datasets/coronavirusandthesocialimpactsongreatbritaindata

[22] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic

[23] See: https://www.refuge.org.uk/25-increase-in-calls-to-national-domestic-abuse-helpline-since-lockdown-measures-began/

Ethnic minorities

The proportion of a London borough's population that is minority ethnic varies from 13% to 69% (variation from Richmond upon Thames to Brent). The boroughs worst affected by COVID-19 are home to some of London's most diverse and vibrant communities – Newham (68%), Brent (69%) and Hackney (49%).

COVID-19 mortality data exposes the structural inequalities which exist and have led to an unfair and inequitable impact of COVID-19. It is not possible to predict the impact of disproportionate loss of life on the mental health and wellbeing for specific communities, but we can anticipate amplified experiences of grief, loss, cumulative stress and injustice. The Black Lives Matters movement has also called out institutionalised racism and a distinct power imbalance across all aspects of society.

Week 15 of the COVID-19 Social Study[24] has focused on differences in psychological and social experiences across the COVID-19 pandemic by ethnicity. Over 4,500 individuals from Black, Asian and minority ethnic backgrounds have taken part in the study to date, contributing over 20,000 surveys. Analysis has shown that people from Black, Asian and Minority Ethnic backgrounds have had higher levels of depression and anxiety across the pandemic, and lower levels of happiness and life satisfaction compared to their white counterparts. Furthermore, whilst 17% of people from white backgrounds have reported being often lonely during lockdown, this figure has been 23% amongst those from Black, Asian and minority ethnic backgrounds. Individuals from Black, Asian and minority ethnic backgrounds have also been more worried about unemployment and financial stress, although worries about catching COVID-19 and access to food have been the same as people from white ethnic groups.

It is widely accepted that the disproportionate effects of COVID-19 on the most disadvantaged, especially Black and Asian people and those from minority ethnic backgrounds, have been due to the social and economic conditions in which they live.[25] The Marmot review 10 years on[26] shows those individuals living with fewer social supports are likely to experience greater levels of mental distress. Coping with day-to-day shortages, facing inconveniences and adversity all affect physical and mental health in negative ways.[27]

Lesbian, gay, bisexual, transgender and queer (LGBTQ+)

Overall, there is very little information available about the experiences of the LGBTQ+ community. For this group we found no relevant studies on the impact of the pandemic. However, insights can be garnered from the overwhelming increase in callers to Switchboard – the LGBT+ Helpline. In May 2020, 1819 calls were logged, a 50% increase compared to May 2019. A notable number of calls from gender non-conforming and

[24] University College London (2020) Covid-19 Social Study: https://b6bdcb03-332c-4ff9-8b9d-28f9c957493a.filesusr.com/ugd/3d9db5_17cc74c304664db8ac9ea56e1dd301ae.pdf
[25] Rose N, Manning N, Bentall R et al. The social underpinnings of mental distress in the time of COVID-19 – time for urgent action [version 1; peer review: awaiting peer review] Wellcome Open Research 2020, 5:166: https://doi.org/10.12688/wellcomeopenres.16123.1
[26] Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity
[27] Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, Fair Society, Healthy Lives: The Marmot Review. London; 2010.

transgender people who have felt impacted by the news and media attention. Overall contacts are now up 35% in 2020:

- 44% more conversations around themes of 'struggling'
- 31% more conversations around the theme of being 'worried'
- 57% more conversations around the theme of 'isolation'
- 42% increase in callers whose gender identity is different than assigned at birth

People with pre-existing mental health problems

The Mental Health in the Pandemic study[28] found that people who entered the pandemic with a prior experience of mental health problems have been more likely to experience anxiety, panic, and hopelessness. Furthermore, the study shows that those with a pre-existing mental health problem have been the most likely to experience stress and inability to cope and that they have reported suicidal thoughts and feelings at a rate almost triple those in the general population.

The study noted that, during lockdown, many of the supports for people with mental health problems, such as one-to-one therapy, training courses, volunteering and supported employment opportunities, were curtailed or stopped. Particularly, peer support and community resources that relied on meeting in a physical space have had to adapt or pause their provision, resulting in the loss of or reduction in support for many people.

People with long-term, disabling physical health conditions

Some people with long-term, disabling physical health conditions have been more likely to experience poor mental health and wellbeing during the pandemic. The Office for National Statistics has found that, as of 9th-18th June, a majority (60%) of people in the official category of 'shielding' had not experienced a worsening in their mental health since being given shielding guidance, 29% said that their mental health had become slightly worse, and 7% said it had become much worse.[29]

The *Coronavirus: Mental Health in the Pandemic study*[30] supports this view and that the pandemic has hit the mental health and wellbeing of people with long-term, disabling physical health conditions particularly hard. Findings from the most recent wave of research found that a higher proportion of people with long term disabling health conditions reported having difficulty coping (26%) compared to the overall population (14%). They were also more likely to have been worried that the pandemic may make their existing mental health condition worse (46%).

[28] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic
[29] ONS Coronavirus and shielding of clinically extremely vulnerable people in England: 9 June to 18 June 2020: https://www.ons.gov.uk/releases/coronavirusandshieldingofclinicallyextremelyvulnerablepeopleinengland9juneto18june2020
[30] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic

Single parents

Gingerbread, the charity for single parent families, has seen a large spike in the number of single parents seeking support through their helpline and their online forum.[31]

The *Coronavirus: Mental Health in the Pandemic study*[32] found that a higher proportion of single parents have reported mental and emotional distress during the pandemic than the population as a whole. More than half of single parents had recently had financial concerns compared to approximately one in four adults generally. Nearly two-thirds of single parents (63%) reported having been anxious or worried in the prior two weeks compared to 49% of the overall adult population.

Income and employment

Income and employment are intricately linked to health and wellbeing. There is a strong socioeconomic gradient in mental health, with people of lower socioeconomic positions having a higher likelihood of developing and experiencing mental health problems. London's position as a global employment centre, with 6.1 million jobs being based in the capital in 2019 (equating to 20% of all the jobs in England), has a huge role to play in driving Londoners' experiences of mental health and inequality.

In an Office for National Statistics study with data collected between 20 March – 7 June, around 12.5 million people indicated that their households have been affected financially by COVID-19, a similar number to the beginning of lockdown, and the share of employees and self-employed actively working fell in the first two weeks of lockdown and remained comparable up to 7 June 2020, at 67.0% and 79.9% respectively.[33]

Furthermore, there are signs of increasing economic inequality. More people on lower personal incomes report reduced household income as lockdown continued, working fewer hours, and being less able to save, while people on higher incomes were less likely to suffer a reduced income.[34]

The Health Foundation commissioned IPSOS MORI survey[35] of 1,983 representative adults for Great Britain found that as of 10 May COVID-19 had more of a negative than positive impact on people's finances (14% positive, 41% negative), although fewer than one in five (17%) say it has had a 'significant negative impact'. However, 44% of people are yet to see an impact of the crisis on their finances. Those working full or part time were more likely to have seen a negative impact of the coronavirus outbreak on their finances.

The same survey found that the most common debt mitigation measure taken during this time was lending or giving money to a friend or family member. One in five (20%) have already done this, while a further one in three (35%) are considering it. Some of the public have needed to take financial action due to coronavirus. For example, 17% have accessed

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[31] See: https://www.gingerbread.org.uk/what-we-do/news/gingerbread-calls-on-government-and-employers-to-support-single-parents-during-covid-19-school-closures/

[32] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic

[33] Office for National Statistics (ONS) (2020) Personal and economic well-being in Great Britain: June 2020: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personalandeconomicwellbeingintheuk/june2020

[34] Ibid.

[35] The Health Foundation (2020) Public perceptions of health and social care in light of COVID-19: Results from an Ipsos MORI survey commissioned by the Health Foundation: https://www.health.org.uk/publications/reports/public-perceptions-of-health-and-social-care-in-light-of-covid-19

money from savings (with a further 16% considering this), while 15% have requested a temporary mortgage holiday (with a further 11% considering this). Fewer have taken out a loan or accessed a new credit card (both two per cent). A total of 15% have taken advantage of lenders' mortgage holidays, with one in ten (11%) planning to do so in the near future. One in ten (nine per cent) have asked for a rent deferral from a landlord, with a further 15% considering this course of action. In terms of state support, one in ten (nine per cent) have applied for statutory sick pay, universal credit or employment and support allowance.

The *Coronavirus: Mental Health in the Pandemic study*[36] found that, although the proportion of the population reporting anxiety has fallen from a high of 65% in the third week of April to 49% in June, there was less of a decline among those that are unemployed. Furthermore, those who are unemployed are reporting much higher levels of hopelessness.

5. Psychological responses and experiences of lockdown

Fear and compliance

Week 14 of the COVID-19 Social Study[37] has shown compliance with government guidelines has plateaued over the last two weeks. Levels of confidence in the central government to handle the COVID-19 epidemic remain lower in England than in other nations, but have not decreased any further in the past week. Little information is available on fear of contracting the virus and fear of going out and returning to work or school. Qualitative studies have shown that fear of transmission to family members is a prominent concern for health care workers. It is not known what the long term impact of profound fear and compliance to social distancing and lockdown restrictions will have collectively and individually on Londoners. We do know that positive social connections and relationships are fundamental for our wellbeing and the loss of these connections could have profound mental and physical effects which will need careful management if a second wave of COVID-19 infections lead to an extended lockdown period.

Depression, anxiety and stress

Concern about coronavirus and social distancing restrictions is extremely high.[38] Two-thirds (66%) of people are 'very concerned' about coronavirus, with nearly everyone (98%) in the older age groups (65+) either very or fairly concerned. A majority (77%) are also concerned about the mitigating measures of social distancing, although the concern is less acute than towards coronavirus itself. Older people (65+) are significantly more concerned (83%) about the restrictions.

The Institute of Fiscal Studies analysed the individual level effects of the pandemic on mental health using longitudinal data from the Understanding Society study and found almost a quarter of respondents reported experiencing at least one mental health problem much more than normal, up from just 10% in the most recent pre-crisis data.[39] An additional 14% of people aged 16+ report experiencing a mental health problem 'much more than

[36] Mental Health Foundation (2020) Coronavirus: Mental Health in the Pandemic: https://www.mentalhealth.org.uk/coronavirus/divergence-mental-health-experiences-during-pandemic
[37] University College London (2020) Covid-19 Social Study: https://b6bdcb03-332c-4ff9-8b9d-28f9c957493a.filesusr.com/ugd/3d9db5_17cc74c304664db8ac9ea56e1dd301ae.pdf
[38] Ibid.
[39] Institute for Fiscal Studies (2020) The mental health effects of the first two months of lockdown and social distancing during the Covid-19 pandemic in the UK

usual'. The impact of the pandemic on overall mental health scores was nearly double the deterioration seen between 2014-15 and 2017-18. The magnitude of the effect is equivalent to the difference in mental health between the richest 20% of people and the poorest 20% in the latest pre-pandemic data.

Life satisfaction and happiness

The COVID-19 Social Study[40] suggests slight improvements for life satisfaction in this period. Life satisfaction has been lower amongst people with children during lockdown, this difference has disappeared as lockdown has eased. It remains lowest in younger adults, people living alone, people with lower household income, people with diagnosed mental health conditions, and people living in urban areas.

The same study found that happiness was relatively stable across the second part of lockdown but increased slightly as lockdown restrictions began to be lifted. Happiness levels have been lowest across lockdown amongst younger adults, those living alone, those with lower household income, people with diagnosed mental health conditions, and people living in urban areas.

Thoughts of death and self-harm

The COVID-19 Social Study[41] have consistently measured thoughts of death or self-harm using a specific PHQ-9 item, with no clear change in thoughts of death since the easing of lockdown was announced. Percentages of people having thoughts of death or self-harm have been relatively stable throughout the past 13 weeks. They remain higher amongst younger people, those with a lower household income, and people with a diagnosed mental health condition. They are also higher in people living alone and those living in urban areas. PHQ-9 is a standardised clinical tool to identify increased risk for suicide attempt or death. In this context it can only be used as an indication of risk as this data is likely to be an underestimation and collected at one point in a survey response. The excess risk of suicide emerges over several days and continues to grow for several months, indicating that suicidal ideation is an enduring vulnerability rather than a short-term crisis.

Social interaction & loneliness

The social restrictions in place as part of lockdown have made communicating with friends and family for all demographics difficult but women in particular are finding it 'much harder' than men (25% of women compared to 19% of men, who are significantly more likely to find communication 'about the same').[42]

Ongoing reporting on loneliness levels continue to be stable since lockdown started, even amongst high-risk groups. Levels are higher in women, people living with children, and people living in urban areas.[43]

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[40] University College London (2020) Covid-19 Social Study: https://b6bdcb03-332c-4ff9-8b9d-28f9c957493a.filesusr.com/ugd/3d9db5_17cc74c304664db8ac9ea56e1dd301ae.pdf
[41] Ibid.
[42] The Health Foundation (2020) Public perceptions of health and social care in light of COVID-19: Results from an Ipsos MORI survey commissioned by the Health Foundation: https://www.health.org.uk/publications/reports/public-perceptions-of-health-and-social-care-in-light-of-covid-19
[43] Office for National Statistics (2020) Coronavirus and loneliness, Great Britain

Access to mental health support

Mind spoke to 8,200 people about the toll that coronavirus is taking on their mental health finding nearly a quarter of people who tried to access mental health support in the last two weeks have failed to get help.[44] The number of people calling the SANE telephone helpline rose very rapidly over the first four weeks of lockdown – with over a 200% rise in calls being made between March 25th and April 20th.[45]

6. Anticipating demand for mental health support

Careful interpretation of the information provided in this paper is required to inform the public health response. As described above, the impact of the pandemic and social restrictions imposed by government has transformed our social worlds overnight, negatively affecting the social connections and relationships with consequences including low mood, depression, stress, difficulty sleeping, irritability and anger.

However, pathologising the natural process of how people are adapting and coping with change is a risk and could perpetuate stigma of mental health. It is essential that research and engagement with Londoners on these issues is accompanied by public mental health messages that normalise feeling stressed and mitigate mental health stigma. This is not to suggest people do not need help and support, but the impact will be most felt by those lower down the social ladder and those with existing mental health problems who may face barriers such as trust, stigma, confidence or access to support.

Having said that, more Londoners will need mental health support as a consequence of the adverse economic and social circumstances created by the COVID-19 pandemic. Rapid changes in lives and livelihoods have exposed the pernicious effects of entrenched inequalities.

These recent changes have also exposed our lack of understanding of the lives of diverse peoples. Since the start of the pandemic, there has been a welcome surge in research and reports on the impact of COVID-19 on mental health and wellbeing, and though there is still so much more to understand, we need to prepare.

One area of great concern is the impact of economic downturn on mental health. Reports have indicated that people with pre-existing conditions are at highest risk, and therefore groups that are known and some unknown to services will require more support. The estimated prevalence of anxiety and depression before COVID-19 was already 12.5% in London; [46] and an estimated 1/6 working age adults meet the criteria for common mental disorders[47] which is just over a million Londoners.

An Institute for Fiscal Studies study modelled the impact of financial stress on chronic health conditions, and showed that if the economic downturn after COVID-19 is similar to the

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[44] See: https://www.mind.org.uk/news-campaigns/news/mental-health-charity-mind-finds-that-nearly-a-quarter-of-people-have-not-been-able-to-access-mental-health-services-in-the-last-two-weeks/

[45] SANE (2020) Report on SANE calls since the lockdown: http://www.sane.org.uk/uploads/SANE_Report_on_Lockdown.pdf

[46] PHE (2019) Fingertips: https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/0/gid/1938132922/pat/6/par/E12000007/ati/102/are/E09000002/cid/4/page-options/ovw-do-0

[47] NHS Digital (2014) Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

aftermath of the 2008 recession, we could expect around half a million more working age adults to suffer from poor mental health. [48] Using a simple proportionate approach, this could translate to an increase of around 80,000 working age people. This could increase prevalence of Common Mental Disorders in these adults from 16.7% to 18%.

Looking at just one area of financial hardship, a meta-analysis showed that being in debt increased risk of mental disorder by threefold.[49] The Financial Conduct Authority estimated that 17% of Londoners were already over-indebted pre-pandemic, where they were struggling to keep up with regular payments. Work commissioned by the Health Foundation[50] suggested that around 10% of people polled could rack up additional debt because of new economic problems. If we assume that an additional 10% of Londoners will become over-indebted, then the fraction of mental disorder due to debt will increase from 28% to 38% (Population attributable fraction; assuming causality). Applying this to a prevalence of 18%, then additional debt could result in 20,000 more working age adults in London suffering from poor mental health.

These numbers are relatively simple calculations based on a mixture of assumptions using the limited data we have. Nonetheless, these suggest that the increase in demand for mental health support, even only considering working age adults, would be in the region of 10's of thousands.

7. Conclusions: implications for transition and recovery planning

To support the mental health and wellbeing of Londoners, findings to date point to the need for action at all levels (borough, sub-regional and regional) and across all sectors to reduce social and economic inequalities, protect and enhance assets to support all Londoners to build on the strength and resilience they have, and take additional steps to ensure that those Londoners who need support for their mental health, which is anticipated to rise, can access it.

The overarching principle for transition and recovery planning should be based on 'proportionate universalism' – addressing whole population needs while providing bespoke support for individual, communities and groups who need it – with action informed by three levels of engagement:

- Universal: for everyone; targeting the whole population, groups or settings where there is an opportunity to improve mental health such as schools or workplaces.
- Selective: for people in groups, demographics or communities with higher prevalence of poor mental health as a result of COVID-19; targeting individuals or subgroups of the population based on vulnerability and exposure.

[48] Institute for Fiscal Studies (2020) Macroeconomic conditions and health in Britain: aggregation, dynamics and local area heterogeneity: https://www.ifs.org.uk/publications/14807

[49] Richardson et al. (2013) The relationship between personal unsecured debt and mental and physical health: A systematic review and meta-analysis: https://eprints.soton.ac.uk/359763/1/__filestore.soton.ac.uk_users_thr1g10_mydesktop_debt%2520meta.pdf

[50] The Health Foundation (2020) Public perceptions of health and social care in light of COVID-19: Results from an Ipsos MORI survey commissioned by the Health Foundation: https://www.health.org.uk/publications/reports/public-perceptions-of-health-and-social-care-in-light-of-covid-19

- Indicated: for people with pre-existing mental health support needs and those identifying with early detectable signs of mental health problems.

Furthermore, there is still much we do not know about certain groups' experiences of COVID-19, how this has impacted and may impact their mental health and wellbeing, and what support would best address their needs and build on the resilience they have. Groups include:

- Looked after children and care leavers
- Children and teenagers missing out on schooling
- Parents facing additional pressures
- Migrants, refugees and asylum seekers
- Gypsy/ Roma/ Traveller communities
- Lesbian, gay, bisexual, transgender and queer (LGBTQ+) communities
- Disabled people
- Homeless people
- Victims of domestic abuse
- People who live in areas of deprivation or in houses of multiple occupation
- People working in certain employment sectors

Thrive LDN is undertaking various targeted community participatory research and engagement projects at the moment to help improve this, but wider action is needed and at all levels, to improve the representativeness and inclusiveness of the public mental health response to COVID-19.

8. Suggested actions we take

The following suggested actions have emerged from the ongoing research and triangulation of multiple sources of insights and evidence relating to the COVID-19 pandemic, to support transition and recovery planning at a local, sub-regional and regional level. As with all the findings presented in this paper, these recommendations will be refined and will build over time with input from health and social care partners, the community and voluntary sector and Londoners with lived experience of inequality and poor mental health.

However, action is needed now. As noted at the beginning of this paper, we are aware that many partners are already taking action to support the mental health and wellbeing of Londoners, particularly at a local level, and we would welcome you sharing this with us. It would greatly assist us in building a more complete picture of what communities are experiencing with the aim of spreading and sharing best practice whilst at the same time helping to identify gaps. We are also inviting partners to consider the below suggested actions and to share any actions and activities planned over the coming months. We are also welcoming wider information and ideas about any public health interventions or community-led activities that have been successful in supporting the wellbeing and resilience of Londoners during challenging times.

Community engagement and communications

- Undertake and support community participatory research and engagement, particularly with the groups highlighted above, to understanding more about how COVID-19 has impacted the mental health and wellbeing of Londoners, how they have used their assets and systems to withstand, adapt to and recover from adversity, and what support they need going forward to strengthen their mental health, wellbeing and resilience.
- In particular, engage with and listen to communities with lived experiences of inequality, poverty and adversity, and invite them to join the conversation around decisions which affect their mental health and wellbeing.
- Engage with and learn from how community support services proactively responded to COVID-19 and identify where different approaches were used in comparison to mainstream services to ensure innovative approaches can be sustained and continued support is appropriate or sufficient for everyone.
- Communicate clear and consistent public mental health messages that: (1) amplify positive stories; (2) normalise feeling stressed and mitigate stigma; (3) acknowledge the real concerns people face; (4) Promote practical things people can do to support their own mental health and wellbeing and build resilience; (5) Encourage help-seeking behaviour and (6) Signpost people to a diverse variety of support. Thrive LDN produces regular public mental health Communications Toolkits to support partners with this.

Data, intelligence and research

- Develop better data and intelligence sources to understand how the wider determinants of mental health and wellbeing have changed as a result of COVID-19 and may change.
- Bring together findings from across academia to develop a comprehensive understanding of the research currently taking place to inform public debate and help develop appropriate responses, particularly amongst the most disadvantaged and vulnerable.
- Undertake complex system modelling to understand and intervene upon the complexities and dynamics of poor mental health in an urban environment and how they can change over time.
- Support collaborations with other urban cities to share insights and best practice.
- Consider the mental health impact of future stages of outbreak control, particularly any localised outbreak control, and ensure enhanced public mental health communications and support is proactively provided for affected communities.

Inequality

- In coproduction with target communities, develop and implement more culturally competent public mental health education and prevention campaigns, and public mental health programmes.
- Consider potential access barriers and negative consequences of digital by default for vulnerable or marginalised groups and implement mitigating measures, such as use of traditional media, simplifying referral pathways and enhanced outreach.
- Ensure that COVID-19 transition and recovery strategies promote mental health and wellbeing in all policies and actively reduce inequalities caused by the wider determinants of health to create long-term sustainable change.
- Ensure economic recovery efforts focus on creating sustainable and inclusive employment opportunities and support vulnerable people into employment.

Resilience

- Develop and implement universal and selective resilience promotion programmes, including settings-based approaches (school-based programmes; work-based programmes; care home-based programmes), parenting programmes, digital technology programmes and physical activity promotion.
- Provide free training to community leaders, faith leaders and volunteers in interventions such as mental health first aid, psychosocial guidance and psychological first aid, bereavement support, suicide prevention and trauma-informed values and principles, so that they are better equipped to support individuals who have been adversely affected by COVID-19 and look after their own mental health and wellbeing.
- Utilise neighbourhood and community assets to improve social cohesion and develop more safe places for social connection and interaction via. community and peer support.

Enhanced support

- Support education settings to improve how they approach pastoral care and supporting the wellbeing of students. Implement enhanced mental health support within education settings, such as Youth Mental Health First Aid training and trauma-informed bereavement support.
- Continued investment in apprenticeships, particularly for 18-24 year olds.
- Develop policies that improve access to affordable childcare, particularly for single parents.
- Undertake targeted outreach to people who are unemployed, struggling with debt and/ or at risk of eviction and ensure accessible mental health and psychological support is available.
- Work across sectors and with local communities to understand any localised increase in demand for mental health support and to develop and implement integrated placed-based models on a neighbourhood or Primary Care Network area.