The impact of COVID-19 on Londoners' mental health and wellbeing:

Direct Impacts of COVID-19

ThriveLDN
towards happier, healthier lives

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Direct impacts of COVID-19

Introduction & context

Current evidence suggests there is a direct mental health impact of COVID-19. Various forecasting models indicates that the prevalence of poor mental health is expected to increase and that this could impact on demand for mental health services over the next three years. Research from the King's Fund[1] suggests that up to 75% of the population will experience normal distress that should resolve with the right support but could escalate if left unaddressed. The research goes on to suggest that 15-20% of the population will experience mild to moderate disorder and 3-4% severe disorder. Furthermore, research from the Strategy Unit[2] suggests there will be around a 33% increase in demand for mental health services over the next three years across the UK, which equates to an extra £1 billion a year or around 8% of annual NHS expenditure on mental health services.

This briefing examines the direct mental health impact of COVID-19 for; survivors of the virus and the bereaved, along with collective trauma associated with the pandemic, the ongoing vaccination programme and the exacerbated issue of digital exclusion. Whilst it is necessary to consider these factors independently as part of the response to the pandemic, it is vital to put prevention of poor mental health at the centre of recovery and ensure that Londoners who need help and support receive it.

Recovery from the virus

The health and wellbeing trajectory for those recovering from COVID-19 is not uniform and can have serious implications for both physical and mental health on a longer-term basis. "Long COVID" has been defined as not recovering for several weeks or months following the start of symptoms that were suggestive of COVID-19, whether you were tested or not. Long-term complaints of people recovering from acute COVID-19 include extreme fatigue, muscle weakness, low grade fever, inability to concentrate, memory lapses, changes in mood and sleep difficulties.

The latest evidence from the ONS places prevalence of long COVID at between 3% and 12% of those who have been infected, or between 7% and 18% when considering only people who were symptomatic at the acute stage of infection[3]. The

[1] The King's Fund (2021) Covid-19 recovery and resilience: what can health and care learn from other disasters? https://features.kingsfund.org.uk/2021/02/covid-19-recovery-resilience-health-care/
[2] The Strategy Unit (2021) Estimating the impacts of COVID-19 on mental health services in England https://www.strategyunitwm.nhs.uk/sites/default/files/2020-11/Modelling%20covid-19%20%20MH%20services%20in%20England_20201109_v2.pdf
[3] The Office for National Statistics (2021) How common is long COVID? That depends on how you measure it: https://blog.ons.gov.uk/2021/09/16/how-common-is-long-covid-that-depends-on-how-you-measure-it/

adverse effects of medium to long term health conditions on mental health is generally well understood, with individuals with poor health over a longer period of time suffering from significantly lower life satisfaction and higher rates of mental health problems such as depression and anxiety.[4]

The increasing case rates across England and the emergence of a new, more transmissible variant poses a risk for the prevalence of Long COVID. In the week ending 31 October 2021, ONS estimated 1.9% of the total UK population (1.2 million people) were suffering from long COVID, similar to the rates seen a month earlier[5]. However broader research studies have suggested the true number may be over 2 million people and on the rise.[6] Using a simple proportionate approach, this could translate to hundreds of thousands of Londoners experiencing uncertainty about their recovery from COVID-19, debilitating physical and mental health issues and reduced opportunity to return to normal activities such as work, socialising or exercise. This is likely to translate to hundreds of thousands of Londoners experiencing uncertainty about their recovery from COVID-19, associated physical and mental health issues and reduced opportunity to return to normal activities such as work, socialising or exercise.

Learnings from previous infectious disease epidemics have shown that exposure can have direct links to psychological distress and trauma, for those who experience and suffer from symptoms and traumatic treatment (for example, intubation and the use of ventilators), those who witness patients who suffer from, struggle against and die of the infectious disease, and those who experience the realistic or unrealistic fear of infection, social isolation, exclusion, and stigmatisation.

Further to this, US analysis has found that COVID-19 survivors have significantly higher rates of psychiatric diagnoses, with 18% developing a mental health issue within 3 months of a COVID-19 diagnosis. Those who contracted COVID-19 were twice as likely as the general population to develop a mood or anxiety disorder for the first time, and older adults with COVID-19 were found to have a 2 to 3 times greater risk of developing dementia. It is worth noting that psychiatric history is a

[4] The King's Fund (2012) Long term conditions and mental health – the cost of co-morbidities: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

[5] The Office for National Statistics: Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 2 December 2021: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/2december2021

[6] Whitaker, M., Elliott, J., Chadeau-Hyam, M., Riley, S., Darzi, A., Cooke, G., Ward, H., Elliott, P.(2021) : Persistent symptoms following SARS-CoV-2 infection in a random community sample of 508,707 people: https://spiral.imperial.ac.uk/bitstream/10044/1/89844/9/REACT_long_covid_paper_final.pdf

potential risk factor for being diagnosed with COVID-19, independent of known physical risk factors.[7]

Vaccination

Due to the unprecedented scale and speed of the roll out of the COVID-19 vaccination programme, with around 89% of people in the U.K aged 12 and over having received at least one dose of the vaccine[8], the impact on population mental health and wellbeing, such as health anxiety or stress is not surprising.

The ramp-up of the vital COVID-19 vaccine programme will see the NHS deliver more vaccines over the coming weeks than ever before. Even with the additional protection that vaccine boosters will give, the threat from Omicron remains serious. The UK chief medical officers on 12 December increased their assessment of the COVID-19 threat level to 4, and advice from SAGE is that the number of people requiring specialist hospital and community care could be significant over the coming period.

The declaration of a Level 4 National Incident, in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in COVID-19 cases is likely to be a source of stress and anxiety for many Londoners. that this pressure to be vaccinated in such a short period of time could once again make people feel anxious or apprehensive about their own health and that of loved ones.

Whilst it is necessary to address these issues which may present as a barrier to vaccine uptake, it is important not to medicalise human behaviours and Londoners' responses and comprehension of complex advice and information whilst dealing to the ongoing impact of COVID-19 and restrictions as part of our daily lives.

The evidence base and insights available on perception of and hesitancy around vaccination is rapidly expanding. ONS findings have shown overall intention to be vaccinated has been steadily increasing as the U.K. rollout of the vaccine has continued at pace, (96% likely/very likely as opposed to just 78% in December 2020). Vaccine hesitancy remains highest in young people, Black or Black British people and those living in the most deprived areas[9]. Within previous national vaccination programmes in the UK, reported vaccine uptake has been lower in areas with a higher proportion of minority ethnic group populations, though significant

[7] The Lancet (2020) Bidirectional associations between COVID-19 and psychiatric disorder: retrospective cohort studies of 62354 COVID-19 cases in the USA: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30462-4/fulltext

[8] BBC News (2021) Covid vaccine: How many people in the UK have been vaccinated so far?: https://www.bbc.co.uk/news/health-55274833

[9] ONS (2021) Coronavirus and vaccine hesitancy, Great Britain: 9 August 2021: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandvaccinehesitancygreatbritain/9august2021

progress has now been made to build positive narratives around vaccinations within these communities in the context of COVID-19. Although experiencing a significant fall in vaccine hesitancy, the London region still had the second highest hesitancy rate in the U.K and as of the end of June 2021, 1 in every 9 adults aged 50 and over in Greater London had not yet received a single dose of the vaccine, a rate twice as high as any other English region.[10]

Insights gathered from community research activities with Toynbee Hall[11] have identified how experiences of structural racism and inequality have compounded mistrust, suspicion, and fear within marginalised communities, which may lead to confusion, misinformation, and reduced uptake of the vaccine by ethnic minority groups as a consequence.

Given the clear disparities which exist for Black, Asian and minority ethnic groups, which have thus far experienced higher rates of infection, serious disease, morbidity and mortality, it is clear that culturally competent and tailored communications are required as part of the rollout of the COVID-19 vaccination, with flexible models of delivery to ensure that everything possible is done to promote high uptake in BAME groups and in groups who may experience inequalities in access to, or engagement with, healthcare services. In particularly, it is important to address the issue of trust for Black communities in London, who may have low trust in healthcare organisations and research findings due to historical issues of unethical healthcare research.

Bereavement

A bereavement from COVID-19 is likely to be a very sudden and challenging kind of bereavement for most people. Provisional data from the ONS shows there have been 20,515 deaths occurring in London between 6 March 2020 and 15 October 2021 that involved COVID-19; this represents over 21% of all deaths occurring over this period (96,182 deaths).[12] COVID-19 has and will continue to have a major impact on the individual and societal experience of death, dying, and bereavement. Social isolating measures, the lack of usual support structures and the changes implemented to services including end of life and palliative care has also influenced experiences of grief and mourning for death of all causes during this period.

[10] ONS (2021) Coronavirus vaccine hesitancy falling across the regions and countries of Great Britain: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/coronavirusvaccinehesitancyfallingacrosstheregionsandcountriesofgreatbritain/2021-08-09

[11] Thrive LDN (2020) Thrive Together: A summary of recent experiences and ideas to support the wellbeing and resilience of all Londoners: https://thriveldn.co.uk/wp-content/uploads/2020/11/Thrive-Together-report.pdf

[12] ONS (2021) Deaths registered weekly in England and Wales, provisional: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/latest

In the period of March 2020 to March 2021, London recorded 17,441 COVID-19 related deaths, the second highest amount of any region in England and Wales and had the highest mortality rate in the U.K at 264.8 per every 100,000 people. Mortality rates from the virus were higher than England's average rate of 193.9 in every 100,000 people in all but 7 of London's 32 boroughs and were amongst the highest in London's most deprived boroughs, such as Newham (430.1), Barking and Dagenham (418.2), Tower Hamlets (384.7), Redbridge (343.1) and Hackney (342.8).[13] Research[14] has shown that per COVID-19 death up to 5 people will be bereaved (or feel the close impact of loss) and will potentially require access to bereavement services.

A review of complicated grief confirms the pandemic has increased the prevalence of risk factors associated with complicated grief, for example, sudden or unexpected death and low levels of appropriate social support.[15] Previous pandemics appear to cause multiple losses both directly related to death itself and also in terms of disruption to social norms, rituals, and mourning practices. This affects the ability for an individual to connect with the deceased both before and after their death, potentially increasing the risk of complicated grief. It is well documented that Black, Asian, and racially minoritised communities have been significantly and negatively impacted by COVID-19, resulting in disproportionate amounts of grief and loss across many cultural and geographic communities.

Loss of life by COVID-19 is a challenging kind of bereavement, with family, friends and communities requiring care and support, especially in the first days and weeks following their bereavement.[16]

Collective trauma

In the short to medium term, it is likely that communities will experience collective psychological reactions as a result of negative outcomes from the pandemic and the impact it has had upon their lives. As response to and recovery from the pandemic progresses, the unfair outcomes experienced by certain groups disproportionately

[13] ONS (2021) Deaths due to COVID-19 by local area and deprivation: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsduetocovid19bylocalareaanddeprivation

[14] New Study highlights 'exceptional challenges' of bereavement during COVID-19 Pandemic https://www.cardiff.ac.uk/news/view/2480146-new-study-highlights-exceptional-challenges-of-bereavement-during-covid-19-pandemic

[15] Burke L.A., Neimeyer R.A. Prospective risk factors for complicated grief: a review of the empirical literature. In: Stroebe M., Schut H.,van den Bout J., editors. Complicated grief: Scientific foundations for health care professionals. Routledge/Taylor & Francis Group; 2013. pp. 145–161

[16] Burke L.A., Neimeyer R.A. Prospective risk factors for complicated grief: a review of the empirical literature. In: Stroebe M., Schut H., van den Bout J., editors. Complicated grief: Scientific foundations for health care professionals. Routledge/Taylor & Francis Group; 2013. pp. 145–161

affected by COVID-19, such as care home residents, disabled people, and racialised and minoritised groups will be felt and these communities will feel the collective memory of trauma. Collective memory can persist beyond the lives of the direct survivors of the events, and is remembered by group members[17], compromising future generations' opportunities for good mental health and wellbeing. Although trauma is a highly individual, personalised experience, manifestations of collective trauma are the same and are already being seen, for example in increased rates of depression and anxiety in the general population[18], increased incidences of eating disorders[19] and self-harm, and the highest number of alcohol related deaths in 20 years[20], to name but a few of the social consequences that have become more prevalent since the onset of the pandemic.

The psychological toll of COVID-19 is already apparent in the general population; however specific groups have been experiencing more critical mental health concerns, with the effects more likely to persist. Londoners with pre-existing mental health conditions, front-line workers and young people have reported increased symptoms of depression, anxiety, and stress related to COVID-19, as a result of psychosocial stressors such as isolation, life disruption, stress, or fear of negative economic effects.

Concerns in terms of stress and burnout, depression, anxiety, and even post-traumatic stress disorder (PTSD) for frontline workers and the public sector workforce[21] are now being realised against a backdrop of pre-existing problems, such as chronic underfunding, workforce issues and system fragmentation. In particular, the extent of distress and concern about shortages of personal protective equipment (PPE) and levels of protection in clinical settings was greater for black and minority ethnic backgrounds compared to white counterparts[22].

[17] Hirschberger G. Collective Trauma and the Social Construction of Meaning. Front Psychol. 2018;9:1441. Published 2018 Aug 10. doi:10.3389/fpsyg.2018.01441

[18] Office for National Statistics (2021) Coronavirus and depression in adults, Great Britain: July to August 2021: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/julytoaugust2021

[19] The Lancet (2021) COVID-19 and eating disorders in young people: https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(21)00094-8/fulltext

[20] Office for National Statistics (2021) Quarterly alcohol-specific deaths in England and Wales: 2001 to 2019 registrations and Quarter 1 (Jan to Mar) to Quarter 4 (Oct to Dec) 2020 provisional registrations: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/quarterlyalcoholspecificdeathsinenglandandwales/2001to2019registrationsandquarter1jantomartoquarter4octtodec2020provisionalregistrations

[21] Bermingham, R. (2020), 'Health and social care system and COVID-19: What are experts concerned about?', POST Horizon Scanning, published 14 May 2020.

[22] Gilleen, J., Santaolalla, A., Valdearenas, L. and Fusté, M. (2020), 'The Impact of the COVID-19 Pandemic on the Mental Health and Wellbeing of UK Healthcare Workers', The Lancet preprint, available at SSRN; Moorthy, A., and Sankar, T.K. (2020), 'Emerging public health challenge in the UK: perception and belief on increased COVID19 death among BAME healthcare workers', Journal of Public Health, 42(3), pp. 486-492.

Digital Exclusion

The COVID-19 pandemic has continued to place a greater importance on digital connections due to the rapid transition to online services. However, connecting and accessing services online is not an option for all Londoners. Digital exclusion can have many causes including an absence of devices, connectivity limitations and inability to afford data, a lack of digital skills and confidence and a lack of close at hand support.

A 2020 Office of National Statistics study showed that 93% of adults in Great Britain used the internet at least weekly, with 89% of adults using the internet daily or almost daily.[23] However, in the same study, 9% of respondents stated they had not accessed the internet in the past month and in a separate study, 16% of respondents said they were unable to use the internet without assistance[24].

Londoners who are more likely to be digital excluded include older Londoners, asylum seekers, disabled people, low-income young Londoners and low-income families. The public health crisis and rapid digital transformation risks exacerbating existing healthcare inequalities further, as those who lack the skills, means or confidence to use digital services are more likely to become digitally isolated. This gives rise to inequalities in access to opportunities, services, knowledge and goods which can have a detrimental impact on mental health.

A report on digital exclusion published by Christians Against Poverty in December 2021 outlines that those who do not use the internet missed out on; higher earnings, improved chances of finding work, retail savings, more frequent connection with family and friends, and time saved when accessing services25. These advantages are also key contributors to financial wellbeing, and digital inclusion allows access to tools and resources to manage a person's wider wellbeing.
This is emphasised by the ONS t, who state that digital exclusion means that people are missing out on a wide range of advantages. Services are often ‘digital by default’ and much interaction with public bodies and banks is now online – even more so with the coronavirus restrictions. Regardless of age, disabled people make up a large proportion of internet non-users - 56% in 2018, much higher than the 22% estimated disabled people in the population.

[23] Office of National Statistics (2020) Home Internet and Social Media Usage: https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2020
[24] Lloyd’s Bank (2020) UK Consumer Digital Index 2020: https://www.lloydsbank.com/banking-with-us/whats-happening/consumer-digital-index/key-findings.html
25 Christians Against Poverty (2021) The Digital Divide: Digital_divide_briefing.pdf (capuk.org)

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