BRIEFING

Centre for Mental Health

Covid-19: understanding inequalities in mental health during the pandemic

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Summary

The Covid-19 crisis has had a profound effect on the nation's mental health. While most of us will emerge without lasting negative effects on our mental health, some communities and people with specific characteristics are at far greater risk of worsening mental health.

This includes people living with mental health problems, whose access to services has been interrupted; people who live with both mental health problems and long term physical conditions that put them at greater risk of the virus; older adults who are both susceptible to the virus themselves and much more likely than others to lose partners and peers; women and children exposed to trauma and violence at home during lockdown; and people from the ethnic groups where the prevalence of Covid-19 has been highest and outcomes have been the worst, notably people from Black British, Black African, Bangladeshi and Pakistani backgrounds.

For these groups, the pandemic intensifies the level of risk, the precariousness of maintaining good mental health, and difficulties accessing the right support at the right time. In testament to the pervasiveness of mental health inequalities, the people who have historically endured the biggest risks for poor mental health and the worst access to and experiences of support are among those now most exposed to the worst of the immediate shock of Covid-19. These same groups will also be the most vulnerable to mental health difficulties longer term, as the pandemic leaves behind an unequal legacy of complicated bereavement, trauma and economic repercussions which will push more people towards financial insecurity and poverty, significant risk factors for poor mental health. Unequal experiences of grief, loss, trauma, injustice and abandonment all add to the psychological damage caused by Covid-19.

In the short term, the Government should respond to increased mental distress and difficulty by maintaining a financial safety net for those who need it, offering practical help to meet the basic needs of the most isolated, and providing emergency funding for organisations which deliver targeted, culturally appropriate mental health support for as long as is necessary.

To prevent the Covid-19 crisis from exacerbating and further entrenching health inequalities, plans for recovery must be made with mental health equality in mind. Government must prioritise race equality and support trauma-informed approaches for all people whose lives have been affected by Covid-19. Plans to modernise mental health legislation and invest in community support should be resumed and renewed at the earliest opportunity. The NHS and local authorities, meanwhile, should work with third sector and community organisations to plan, develop and deliver tailored support for the most marginalised communities.

This briefing was written by Centre for Mental Health with expert input from members of a task group delegated by a group of national mental health charities that are working together to understand and respond to inequalities experienced during the pandemic.

Introduction

Several recent surveys demonstrate the burden which the outbreak and the national response is placing on mental health and wellbeing. Reports abound of worsening mental health, increased anxiety, and rising stressors. These span all ages, the general population and people living with mental health problems (Cowan, 2020; D'Arcy, 2020; YoungMinds, 2020). This is borne out by increased use of helplines, such as the service run by Anxiety UK, which reported a fourfold increase in calls during the first month of lockdown (Anxiety UK, 2020).

While we are all affected by Covid-19, directly or indirectly, the extent to which our mental health is put at risk is far from equal. As at any other time, the determinants of mental health place some groups of people at a much higher risk of mental ill health than others, and the lives of people living with mental health problems are made more difficult as a result of deeply entrenched social, economic and political inequalities.

There are several known risk-factors which make people more likely to experience mental health difficulties. These include unemployment, poverty, racism and discrimination, traumatic experiences, violence or abuse, genetics, physical illness, bereavement, chronic loneliness and a lack of access to support. Other factors and circumstances can protect our mental health. Relationships, supportive families, secure childhood experiences, good housing, economic and social opportunities, education and easy access to help can all boost our resilience in the face of stress and hardship.

The Covid-19 crisis interacts with risks and protective factors in complex ways, highlighting and aggravating mental health inequalities which are already known to exist.

This briefing outlines areas where serious concerns have emerged for individuals and communities with particular characteristics which put their mental health at risk during and after the Covid-19 pandemic.

Short term priorities

Access to services

Covid-19 has demanded incredible resource and adaptation from the NHS and local authorities. As a result, it has placed serious limitations on the ways wider services can be delivered. While mental health services have remained open, with NHS campaigns encouraging people to seek help when they need it, reports have emerged of significant challenges to accessing support and of a widespread perception that support will not be there if it's needed or that it isn't safe to seek help face-to-face.

Referrals to adult talking therapies and children and young people's mental health services have fallen sharply in some areas (Health and Social Care Select Committee, 2020), while surveys reveal that many adults living with mental health problems report their mental health has deteriorated because they are receiving less support (Rethink Mental Illness, 2020). More than a quarter of children previously receiving help have not been able to access support during lockdown (YoungMinds, 2020), and almost half of psychiatrists have seen a rise in urgent and emergency cases and a fall in the number of routine appointments (Royal College of Psychiatrists, 2020).

There are concerns that this will soon lead to a spike of demand across the system, and services are rapidly adapting with new ways of working, for example through the use of digital technologies. The short term consequences, for individuals rather than systems, are that more people who are experiencing mental health difficulties could fall through the gaps and receive no help, with some groups facing starkly different experiences.

People from a number of communities may be finding it especially difficult to get help which is appropriate for them. A survey by the LGBT Foundation (2020) suggested that while 42% of LGBT people would like to access mental health support during the pandemic, 34% had medical appointments cancelled by providers and 16% had tried and been unable to access non-Covid related health care. The form of support is also important for groups, like LGBT communities, whose needs can be poorly met by mainstream services – some 64% of survey respondents stated that they would rather be supported for their mental health by an LGBT specific organisation.

The need for culturally appropriate support is relevant for several communities which experience mental health inequalities. For example, young people, especially from Black communities, frequently report that they do not trust NHS mental health services and do not believe that they will help them or be safe to engage with. Research has shown that these young people respond better to mental health support when it is offered in a culturally appropriate format, for example, in informal settings commonly run by third sector providers or grassroots organisations (Khan *et al.*, 2017; Stubbs *et al.*, 2017). These small, holistic, community and relationship-based programmes often rely on building trust face to face. For them, and for the marginalised young people who rely on them for support, lockdown presents a significant challenge to the continuity of support.

People living with a diagnosis of mental illness

The pandemic and its consequences have had a marked impact on people living with mental health difficulties. While there is no evidence that people living with mental health problems face higher risk from the virus directly, NHS figures suggest that 6% of people who have died from Covid-19 have been treated for a mental health problem (NHS England, 2020). Figures from the Care Quality Commission show an increased death rate among people detained in hospital or subject to the Mental Health Act in the community – double in March and April 2020 compared to the previous four years (CQC, 2020a). Many of these deaths are confirmed or suspected to be Covid-19 related.

Mental health services across the UK have sought to adapt the ways they work during the crisis, and as far as possible to remain open. But there have been serious concerns including, for example, people being discharged from hospitals sooner than they might have been and with greatly reduced contact with community mental health services, families and friends.

Concerns about loss of contact with mental health services are especially serious for people who are digitally excluded, which may mean they miss assessments or other appointments.

Some of the most serious concerns for people living with mental health difficulties have been about meeting basic needs: human contact, food, money, prescriptions and physical health. Evidence from surveys and individual narratives shows that many people are struggling to get access to basic supplies, either because it is especially difficult to leave home or due to financial difficulties (or both). And while people with mental health problems are able to access help from the NHS Volunteer Responders scheme for food and medicine deliveries, communication of this was belated and for a long time unclear.

People with both mental health problems and long term physical conditions

Ensuring that the right support is provided to those with the most complex needs and comorbidities is essential in order to avoid exacerbating the already stark health inequalities for people diagnosed with severe mental illness, who on average die around 15-20 years earlier than the general population (Chang *et al.*, 2011).

People with a mental illness are more likely than the general population to suffer from multiple physical health problems including diabetes, heart and lung disorders, chronic fatigue and weight gain associated with certain medications (Wilton, 2020).

Anxiety in the general population remains higher than before the pandemic, and although this trend is levelling out for the general population, anxiety amongst people with underlying health conditions is still increasing (ONS, 2020c). Many are shielding or isolating themselves without access to the formal and informal supports that help them manage their

mental and physical health – for example, through exercise, healthy eating, support networks, home visiting, medication and regular blood testing. Concerns about physical health include the provision of routine health checks for people with a severe mental illness and regular blood tests for people taking the anti-psychotic medication Clozapine, which are necessary to monitor their white blood cell count.

The pandemic thus presents immediate risks both to the mental and physical health of this group.

Older adults

Data from the Office for National Statistics suggests that the majority of older adults are experiencing increased worry and anxiety due to Covid-19 (ONS, 2020c), and over half of older adults surveyed by Independent Age reported difficulties accessing essential supplies due to fears about their physical vulnerability to the virus (Independent Age, 2020). This is a highly understandable anxiety. Analysis by Public Health England revealed that people over the age of 80 are 70 times more likely to die from Covid-19 than adults under the age of 40 (Public Health England, 2020). Deaths from the virus are predominantly occurring in older age groups – a frightening and sad situation for many witnessing the passing of friends, family members and strangers who share their own vulnerability of age. Throughout the crisis, there has been debate about whether the deaths of older adults have been portrayed as less concerning for the population at large, manifesting through media discourse, a perceived late or insufficient focus on protecting older adults in the community and in care homes, and the initial decision to not include deaths in care homes in Covid-19 reporting. All this may nurture feelings of abandonment, helplessness and anxiety. Good communication during a crisis is a critical element of limiting psychological harm – it must be accurate and empathic, especially for those groups, like older adults, which are experiencing the worst outcomes (Bell, 2020).

Current guidance on social distancing and shielding may increase the likelihood that older adults in particular experience loneliness and negative psychological effects of social isolation. Research has associated this with higher risks for a variety of conditions, including high blood pressure, heart disease, obesity, anxiety, depression, cognitive decline and Alzheimer's disease (Shankar *et al.*, 2011; Steptoe *et al.*, 2013). While levels of loneliness across the population are thought to be generally stable, people with a diagnosed mental health condition or with a low household income are much more likely to experience increased loneliness (Fancourt *et al.*, 2020).

Before the pandemic, it was estimated that 85% of older adults living with depression received no support, as a group they were underrepresented in mental health services, and were more likely to be treated with medication, even where talking therapies are shown to be particularly effective (Burns, 2015; Frost *et al.*, 2019). Increased stressors on the daily lives of older people, especially those with vulnerabilities, may exacerbate these gaps in provision. Older adults are also a group for whom digital solutions may be less appropriate, for example where people have issues around hearing, manual dexterity or proficiency with technology.

Groups at risk of violence and abuse

Many people – mostly women and children – who live in precarious situations where they are exposed to violence and abuse, have faced being trapped in their situations with little access to refuge or support. Violence and abuse are known risk factors for serious and long-lasting mental health problems.

A weekly social study by University College London found that reports of abuse have been higher in adults under the age of 60, households with lower incomes, overcrowded homes, and among people living with children. The study highlights that this is most likely an underestimation of actual levels due to underreporting (Fancourt *et al.*, 2020).

Other sources point to a rise in experiences of abuse. Domestic abuse charity Refuge recently reported a tenfold increase in visits to its website during lockdown (BBC News, 2020a). Calls to NSPCC's Childline increased by 20% in the first four weeks of lockdown (BBC News, 2020b).

Long term considerations

Transformation of services

The health system has experienced a seismic shift in response to the pandemic. New Covid-19 hospitals have been built at scale, staff have been redeployed, and purchasing powers normally reserved for local clinical commissioning groups (CCGs) have been requisitioned by the centre (Department of Health and Social Care, 2020a).

At the same time, parts of the system not dedicated to Covid-19 have been functioning differently, whether by operating with reduced staffing (due to deployment or to staff absences) or by embracing remote working. Significant decreases in referrals to 'business as usual' services, such as children and young people's mental health services and talking therapies (IAPT) have also been reported. Mental health services are already deeply unequal on race, from access to treatment and recovery (Bignall *et al.*, 2019); even a temporary paring back to generic 'core' services will inevitably impact those whose needs were already poorly met by mainstream services. We may expect these changes to be temporary like lockdown itself, lasting only until the virus no longer has such a significant effect on our day to day lives. However, some changes brought about by the pandemic may last longer.

The use of technology, for example, has accelerated massively, advancing the digital ambitions set out in the NHS Long Term Plan. Organisations are rolling out new ways to access mental health support safely from home, and practitioners are developing and delivering support online. However, there is a danger that this service transformation could widen the digital divide and make accessing services even harder for the most disadvantaged. As a prerequisite, digital services demand that the person receiving support has the right hardware, access to the internet, and a physically and psychologically safe space in which to receive help.

Many people with mental health difficulties start from a position of exclusion by not having access to these basic things. Some may struggle with technological alternatives to the face to face support that has previously worked for them, or they may feel unable to find that safe space for confidential support without being overheard by a member of their household. This may be particularly relevant for people who have experienced trauma and abuse, or who are LGBT+ and not open with their families. Others may experience fears or beliefs around technology which make it an inappropriate medium for support.

Progress towards equality in mental health will also be deeply influenced by the future financial landscape, particularly in terms of funding for mental health services. If the current crisis is followed by austerity policies, with reductions in spending on public health, social care and mental health support in particular, we may see rising levels of mental ill health and inequality. There is longitudinal evidence that the response to a comparable, recent major economic shock – the banking crisis which began in 2008 – through austerity measures led to an increase in inequalities not limited to mental health but also to life expectancy and quality of life, especially in the poorest areas (Marmot *et al.*, 2020; Cummins, 2018).

This is not just about the NHS – it is about funding for social care, public health, social security and community support. The voluntary sector has already taken a significant financial blow, due to interrupted funding streams from cancelled fundraisers and ceased trading: a recent survey found that the majority of charities have seen reserves, cash-flow, donations and new income fall since the start of the pandemic (ACEVO, 2020). Small, grassroots voluntary organisations may be at particularly high risk. These organisations play a vital role in bridging gaps and overcoming barriers faced by marginalised communities and people with complex needs, who have historically been poorly served by mainstream services (Bell and Allwood, 2019).

Yet, as their support, though vital, is not a statutory imperative, these organisations could be vulnerable to damaging cuts in the context of a tightening public purse – as occurred post 2010 – which would leave many of those who already experience inequalities even less able to find the support they need.

Economic impact

The poorest parts of England have already endured higher rates of mortality from Covid-19 than wealthier areas (ONS, 2020b). Long term, there are significant risks that people living in deprived communities and people living in poverty will experience a disproportionate impact from rising debt, long-term unemployment, and a lack of financial security, all of which are associated with poorer mental health. New research demonstrates that those on lower incomes, especially if they are single parents, are already finding the economic impact of the pandemic more difficult than other groups (Understanding Society, 2020).

Poverty is a major risk factor for poorer mental health at any age. This is especially true for children – children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20% (Morrison Gutman et al., 2015). Employment is strongly evidenced as a determinant of mental health, with mental health problems more common amongst people who are unemployed and those in precarious work. Recent surveys exploring the experiences of people during the Covid-19 pandemic suggest that financial worries are driving a rise in anxiety across the population. They also indicate that, compared with people in employment, unemployed people are coping less well with the stress of the pandemic, are less able to find help, and much more likely to have suicidal thoughts (Mental Health Foundation, 2020).

Economic crises have been shown to have a disproportionate impact on those who already experience inequalities. Research on the 2008 economic crisis suggested that people with chronic health conditions – especially in mental health – experienced the most severe adverse effects of changes in employment. Analysis from the Institute for Fiscal Studies demonstrates that people with health conditions, young workers, and low-income families will experience the worst economic outcomes from coronavirus (Joyce and Xu, 2020). This resonates with existing evidence that those on lower incomes have a greater risk of subsequent mental health problems following disasters in their community – after major flooding, for example (Sayers et al., 2017).

Systemic racism and community betrayal

Researchers and campaigners on race and equality have long highlighted the impact of structural racism on mental health. From childhood onwards, studies have demonstrated strong and consistent relationships between exposure to racism and poorer mental health and wellbeing (Karlson and Nazroo, 2002; Williams et al., 2003; Pascoe et al., 2009; Priest et al., 2013). A significant body of research highlights the detrimental impact of environmental adversity: the prolonged 'wear and tear' of 'everyday racism' and micro-aggressions correlates with increased distress and stress over the lifetime, on the immune system, relating to a range of poorer health outcomes including mental health (Geronimus, 2006; Williams and Mohammed, 2009).

These inequalities are reflected in outcomes and prevalence of Covid-19 in BAME communities. Analysis by Public Health England found that, compared with people identified as White British, people of Bangladeshi ethnicity have twice the risk of death from the virus, and people of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity have between 10-50% higher risk of death. Men from Black ethnic groups are nearly three times more likely to be diagnosed with Covid-19 than men from White ethnic groups, and women from Black ethnic groups are more than twice as likely as women from White ethnic groups to be diagnosed (Public Health England, 2020). Most testing has been carried out in hospitals, so these figures refer to the more severe instances of Covid-19 – less serious cases are likely to go untested and unreported.

Efforts to analyse ethnic inequalities are, unfortunately, hampered by the accessibility of comprehensive data, and the lack of open debate on the causes of inequalities and the experiences of some BAME communities. We know, however, that many of the communities experiencing disproportionate numbers of Covid-19 infections and higher mortality rates are also exposed to a range of factors including higher occupational risk and pre-existing physical health inequalities, as well as higher economic vulnerability (Platt and Warwick, 2020). These determinants are themselves a consequence of marginalisation and discrimination.

We know, too, that people from some BAME backgrounds experiencing mental distress as a result of coronavirus may be doubly disadvantaged due to economic circumstances and services which frequently fail to respond to their needs in a timely and culturally informed fashion. Differences in community experiences are influenced by a range of deeply intersecting factors including geography, ethnicity and socio-economic status. People from certain ethnicities are more likely to be in lower paid work or persistent poverty, particularly Pakistani and Bangladeshi, Black African, and Black Caribbean communities. There are strong associations of poverty with mental illness and mental distress, and links between those ethnic groups which face the greatest levels of poverty and those experiencing the most restrictive forms of mental health intervention (Bhui *et al.*, 2018).

Approaches and resources aiming to improve access, experiences and outcomes are being developed and tested as part of the NHS Mental Health Implementation Plan (for example, the Patient and Carer Race Equality Framework). Initiatives focusing on broader change are also active in some local areas (Black Thrive in Lambeth, for example). In the face of stark inequalities which have been amplified by Covid-19, the ambition to improve mainstream services and systems to better meet the mental health needs of BAME communities is more important than ever.

At present, however, inequalities in mental health support persist. Many people from BAME communities who receive culturally appropriate help find it outside of the mainstream mental health offer. Sustaining this alternative offer is critically important for BAME communities. This support is often provided in informal community settings by third sector providers and local organisations with strong roots in communities. Just like many of the communities they serve, these small-scale programmes and organisations are at risk financially in terms of current cashflow and an uncertain future of public sector grants and contracts.

People who belong to marginalised or disadvantaged groups are exposed to the most severe effects of any crisis. They are less likely to have buffers, such as secure housing, stable employment and strong social support, to shield them from the full force of a traumatic event and its aftershocks. Inequality can therefore magnify – and be magnified by – trauma (Wilton, 2020). When we are at our most powerless, we often look to social institutions, such as government agencies and health care services, for support. There is evidence that, when we have faith that these institutions are acting in our best interests and doing everything they can to respond to our needs, we are at lower risk of psychological harm from a traumatic event. Conversely, when we feel that they are failing to protect us, we are at higher risk (Rhodes and Tran, 2012; Smith and Freyd, 2014). Betrayal by those who should have helped us amounts to a 'second injury' that adds to the pain of the original trauma (Symonds, 1980).

Understanding this dynamic will be important during the Covid-19 pandemic and long into the recovery period. It could help services and policymakers respond to the needs of those communities who have been and will continue to be disproportionately affected both by the virus itself and by its social and economic fallout.

People from other parts of society may feel similarly side-lined or abandoned by the national Covid-19 response. For example, those who live or work in care homes, and their families, may feel they have not been protected, putting them at increased risk of psychological harm as a result of traumatic events around them.

Trauma and vulnerability

Research emerging from areas affected by the Covid-19 pandemic and from previous epidemics has highlighted some groups with heightened chances of experiencing symptoms of post-traumatic stress disorder and other mental health problems. This includes people who have experienced intensive care (Righy *et al.*, 2019), especially those with pre-existing anxiety or depression (Nikayin *et al.*, 2016),

and healthcare workers (Douglas *et al.*, 2006; Greenberg, 2020).

Trauma in the time of Covid-19 is not, however, limited to those who have become ill or worked in hospital wards. Nor is everyone equally vulnerable to harm from the same traumatic event. One reason is that, in the absence of protective factors, the effects of trauma can be cumulative. Those of us who have already suffered distressing experiences, such as abuse, neglect, discrimination and oppression, are at higher risk of psychological harm from further adversity (Wilton 2020).

Women are ten times as likely as men to have experienced extensive physical and sexual abuse during their lives: of those who have, 36% have attempted suicide, 22% have self-harmed and 21% have been homeless (Scott and McManus, 2016). Following trauma, women are more likely to experience eating distress or disorder, self-harm, or to receive a diagnosis of 'personality disorder' which, whilst helpful for some, can lead to further trauma for others (Wilton and Williams, 2019).

All public agencies and institutions must be prepared to meet the long term needs of this group by taking trauma-informed approaches, creating more safe spaces, listening to women about their needs and responding in a holistic, tailored way now and in the future (Wilton and Williams, 2019; Bear *et al.*, 2019). The need to support women and children has been recognised by government with an emergency £76m funding stream for charities working with victims of abuse and violence. However, as the impact of trauma can manifest over long periods of time, it will be necessary to sustain this focus long after the immediate Covid-19 crisis passes.

The impact of disrupted education and social interaction on children is not yet clear. However, vast gaps are emerging. Referrals to children and young people's mental health services have dropped by an estimated 30-40% (Health and Social Care Select Committee, 2020). Available data shows that only a tiny fraction of children identified as vulnerable, for whom places had been reserved for their safety, attended school during the first weeks of lockdown (Department for Education, 2020), and there is evidence that children from more affluent families have had access to better resources and more support

with learning at home during lockdown (Andrew *et al.*, 2020). Unmet mental health needs in childhood can cast long shadows for years to come, and Covid-19 may widen inequalities for the most deprived and most vulnerable.

Grief

Tens of thousands of people may experience prolonged bereavement disorder, or complicated grief, as a result of the pandemic. Complex grieving is made more likely by the circumstances of the Covid-19 crisis. For example: sudden and unexpected loss, feelings of abandonment, and an inability to mourn in the normal religious or cultural ways. Over time, complex and prolonged grief is associated with moderate to severe depression, post-traumatic stress disorder, and suicidal ideation (Shear, 2012).

People with specific characteristics and from certain communities are likely to be at higher risk of complicated grief. Older adults, for example, are up to four times more likely to experience depression after the death of a partner (Independent Age, 2018), and the majority of deaths involving Covid-19 have been among people aged 65+ (ONS 2020a). The most deprived areas of England have recorded almost twice the mortality rate as the least deprived areas (ONS, 2020b), and there are significantly higher rates of Covid-19 and higher mortality among some minority ethnic communities, notably among Black British, Black African, Bangladeshi and Pakistani communities (Platt and Warwick, 2020; Public Health England, 2020).

The experience of loss close to home has an enormous emotional impact. This may increase both with the frequency and scale of loss – losing multiple family members, friends or neighbours – as well as the awareness that mortality is more prevalent in one's own community than elsewhere. For those communities where religious or cultural practices traditionally bring people together to mourn collectively, the inability to gather and the lack of access to religious and community spaces adds to the devastation of loss and the longevity of its impact. In this context, culturally sensitive responses to loss and distress are hugely important.

Emergency powers

If implemented, emergency changes to the Mental Health Act in the Coronavirus Act 2020 would push practice further from reform to modernise and improve legislation and practice. The Independent Review of the Mental Health Act (Wessely, 2018), for example, made specific recommendations to develop a more balanced system with more safeguards, more choice and less restriction, but no reform has yet been delivered. Emergency changes in the current extreme circumstances must not become normal practice and they must not distract from the urgent need for meaningful reform. Allowing new emergency measures to derail much needed modernisation of the Mental Health Act (which is already overdue) would be to miss an historic opportunity to change the law and the ways it is practised.

A significant proportion of mental health and related psychosocial support is commissioned or delivered by local authorities and social care, often in partnership with the NHS. The easement of local authority duties to assess, plan for, and meet individuals' care and support needs under the Care Act means the loss of vital services which help people to stay mentally healthy or live independently while recovering. Carers, especially young carers, are already at increased risk of experiencing mental health problems and many may struggle without support in difficult and stressful times.

At the time of writing, eight local authorities had implemented easements, with all but two rolling back the changes (CQC, 2020b). In these, and in any other areas where easements are sought, people who are supported with their mental health, physical and social needs (weight management, smoking cessation, social connection) could be deprioritised. Their needs are not always visible or seen as urgent, but they are vital to their mental health recovery. In light of the significant challenge to mental wellbeing posed by the pandemic, deprioritising the support of people with mental health problems could lead to an escalation of poor mental health for many and, ultimately, require more intensive interventions. The pressure on community mental health outreach teams and hospitals, which were already stretched before the pandemic, may grow as individuals are unable to keep themselves mentally healthy.

Reflections

While evidence of the mental health impacts of Covid-19 is still emerging, it is clear that people with certain characteristics and in certain circumstances have a much higher chance than others of bearing the damaging consequences of the pandemic.

This includes people who already live with mental health problems (who often also manage challenging long-term physical conditions) and people who are exposed to factors which could seriously damage their mental health, such as older adults, people who have experienced trauma and abuse, people from some minority ethnic communities, and people who live in poverty.

These are cross cutting layers of identity and inequality – one person might experience all the circumstances above. In each of these cases, inequalities in the determinants of mental health already exist (Centre for Mental Health, 2020), but the Covid-19 crisis intensifies the level of risk, the precariousness of maintaining good mental health, and the difficulties accessing the right support at the right time.

Much, of course, remains uncertain. We do not know how or when the pandemic will subside, and this will of course influence outcomes for communities. Planning to reduce mental health inequalities post-pandemic must consider the possibility and impact of both a single, deep recession this year and a series of economic shocks, each of which would create additional need for mental health support (Durcan *et al.*, 2020) and will be likely to exacerbate the inequalities we have described. In the meantime, this analysis calls for tailored support and preparation to meet the needs of those who will be worst affected.

Recommendations

To mitigate the immediate and short-term effect of Covid-19 on mental health inequalities, we recommend urgent action:

- Government should continue to provide a financial safety net for people whose livelihoods are affected by the pandemic to prevent the serious effects which financial insecurity has on people's mental health. This must recognise that not all localities and communities will experience the same economic impacts, with more help offered to those experiencing the biggest risks. This will be especially important for communities and areas of the country where levels of deprivation are already high, and where further economic instability poses a major threat to mental health.

- Emergency funding for mental health support services should be made available for as long as the pandemic continues to increase levels of need. Local government should be supported to engage a range of small, community and third sector providers to codesign and develop targeted offers for people from specific groups, such as older adults, people from BAME communities, LGBT+ people, women's groups, and support for children exposed to violence and abuse. Tailored support for people in these specific circumstances should be sustained for as long as necessary, which may be long after the immediate physical health concerns of Covid-19 have abated.

- Long Term Plan commitments to invest in community mental health capacity should be resumed as early as possible, so that people with mental health problems can access the help they need, where they live. This should be proactive and coordinated to meet the holistic care and support needs of people with mental illness, especially those who have a disability or long-term health condition, many of whom have been shielding or isolated during lockdown.

- People whose mental and physical health is stopping them from getting out to shops and pharmacies should continue to be eligible for support from the NHS Volunteer Responder scheme, and their entitlement to basic support to access essential supplies should be widely and clearly publicised.

- The NHS and other agencies must rapidly improve data collection and monitoring to fully understand inequalities. Whilst additional data collection has begun, more detailed information including ethnicity, religion, age (with more segmentation of over 65s), whether someone was receiving/known to mental healthcare services, previous experience of abuse or trauma, and socio-economic circumstances would greatly help analysis.

To protect the nation from the long-term consequences of Covid-19 on mental health inequality, and to plan for a national mental health recovery, we recommend:

- The Government should adopt a trauma-informed perspective when planning for recovery. A trauma-informed approach will seek to provide long-term, reliable support; instead of isolation and disempowerment, it will seek to bring people together, rebuilding relationships, and giving all members of the community a voice. Where there has been loss – especially where this has been disproportionate – it will recognise the impact and support people to grieve and come to terms with a changed future. As part of this, the Government and Public Health England should provide advice and support to organisations, including schools, prisons, health and care services and businesses, in trauma-informed approaches to help them create a sense of psychological safety for people who use and work in them, following the end of lockdown.

- Policies put in place as part of an exit strategy or recovery strategy should be subject to scrutiny on the impact they will have on people with mental health difficulties and on people who are at higher risk of a mental health problem as a result of their personal circumstances or background. There must be openness and transparency on all inequalities reporting.

- Tackling race inequality in the mental health system should be prioritised across government so that services properly respond to the needs of those most affected by Covid-19. This should build on existing programmes, including the NHS Patient and Carer Race Equality Framework pilots and the work of the NHS England and Improvement Advancing Mental Health Equalities Taskforce. This work should look beyond the NHS to consider public health, prevention and tackling the unequal determinants of poor mental health. It should listen to the voices of BAME service users, carers and communities, work alongside them, and respond to critical feedback to improve the quality and appropriateness of services.

- The NHS and local authorities should work with third sector and community partners to develop proactive and tailored mental health support for communities who have endured the worst health outcomes and biggest fears directly from Covid-19, as well as those most vulnerable to future economic instability. There is a significant overlap in these groups, as the most deprived communities are likely to suffer the most from an economic recession and have also been hit hardest by the virus. Support should be provided to ensure that community based organisations survive the interruption in funding and the subsequent period of economic hardship. User-led and community organisations will play a key role if mental health inequalities are to be tackled in the aftermath of Coronavirus. They provide direct help to individuals and support mainstream services by bridging cultural differences and finding better approaches for engaging marginalised communities.

- Emergency powers enabled under the Coronavirus Act 2020 should be reviewed and rolled back as soon as possible. This must pave the way for the overdue reform of the Mental Health Act in line with the recommendations of the Wessely Review and reform of adult social care funding with the needs of people of working age considered alongside those of people in later life.

- Policymakers should hold on to what has worked in supporting the social welfare of people with mental health problems during this crisis. For example, the response to homelessness in local areas, and changes to the benefits system which have made it fairer and safer for people with mental health problems – including the suspension of face to face benefits assessments, and an end to the requirement for new claimants to telephone the Department for Work and Pensions themselves to progress their claims for Universal Credit. This is a unique opportunity to identify and maintain improvements to a system which significantly disadvantages people with mental health problems.

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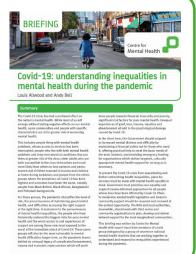
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