



OPEN LETTER

The social underpinnings of mental distress in the time of COVID-19 – time for urgent action [version 1; peer review: 4 approved]

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Abstract

We argue that predictions of a 'tsunami' of mental health problems as a consequence of the pandemic of coronavirus disease 2019 (COVID-19) and the lockdown are overstated; feelings of anxiety and sadness are entirely normal reactions to difficult circumstances, not symptoms of poor mental health. Some people will need specialised mental health support, especially those already leading tough lives; we need immediate reversal of years of underfunding of community mental

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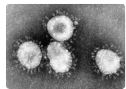
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health services. However, the disproportionate effects of COVID-19 on the most disadvantaged, especially BAME people placed at risk by their social and economic conditions, were entirely predictable. Mental health is best ensured by urgently rebuilding the social and economic supports stripped away over the last decade. Governments must pump funds into local authorities to rebuild community services, peer support, mutual aid and local community and voluntary sector organisations. Health care organisations must tackle racism and discrimination to ensure genuine equal access to universal health care. Government must replace highly conditional benefit systems by something like a universal basic income. All economic and social policies must be subjected to a legally binding mental health audit. This may sound unfeasibly expensive, but the social and economic costs, not to mention the costs in personal and community suffering, though often invisible, are far greater.

Keywords

Mental distress, social disadvantage, BAME, universal basic income, benefit system reform



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Introduction

There has been much discussion about the mental health implications of coronavirus disease 2019 (COVID-19) - both of the pandemic itself and of the 'lockdown'. Many have predicted short, medium, and long-term mental health problems. There is some belated recognition of the crucial role of social inequality, and the disproportionate toll born by the most disadvantaged groups in society. However, the main emphasis has been on expanding access to specialist mental health services to cope with an anticipated surge in mental health problems. As members of the Society and Mental Health COVID-19 Expert Group, hosted by the [Centre for Society and Mental Health](#) at King's College London, we argue that there is an urgent need for an alternative approach.

Some surveys have reported increased levels of anxiety and sadness and attributed those to the pandemic^{1,2}. These are normal and understandable responses to situations involving threats and disruptions to habitual forms of life; the curtailing of social contacts and increased social isolation; and encounters - both actual and virtual - with sickness and death. Though undoubtedly distressing, for most people these are not symptoms of mental disorder and will not lead to enduring mental health problems requiring specialist therapeutic intervention. As successful public health interventions during previous crises have shown, the most effective support for those who experience such distress is practical. This includes information to support immediate problem-solving, assistance with everyday tasks, ensuring financial and housing security, maintaining trust by openness and honesty, and, crucially, the (re)building of community infrastructures and informal social support networks³.

But when it comes to mental health, as with so many other dimensions of COVID-19, we are not 'all in it together'. As so clearly shown by a whole body of evidence on the social determinants of mental health, the greatest risk of developing serious and enduring mental distress will fall upon those already impacted by social inequality, and this will be exacerbated by the current crisis and its aftermath⁴. Elevated risks of poor psychological wellbeing for the already vulnerable are linked to isolation, economic stress, stigma, racism and social exclusion⁵ which will be exacerbated as resources are further diverted by COVID-19 responses. Further, we know that physical and mental health are interdependent and entwined, and thus mental health will be affected by the experience of COVID-19⁶. There are clear gender implications of COVID-19, and while reports have largely focused on the increased mortality among men, there has been almost no attention to the double burden that the lockdown has imposed on the mental health of women from the most disadvantaged communities many of whom have increased domestic responsibilities while at the same time being obliged to continue paid employment often in front-line jobs. Those experiencing the greatest social disadvantage are thus most likely to suffer the worst mental health impacts, and those with pre-existing mental health conditions may experience a deterioration in their mental health exacerbated by a further reduction in levels of social support available to them.

In our view, such evidence from the social sciences, which is born out by the knowledge of those with lived experience of mental ill health, should have been central to pandemic preparedness planning. We believe that it must now urgently be deployed to identify the places and communities that need most support. Resources must be rapidly, preemptively and unconditionally directed to address immediate material requirements, and strengthen both informal and formal support networks. Interventions such as those proposed by Holmes *et al.*^{7,8} based in psychology, psychiatry, pharmacology, genetics, molecular biology, neurology, neuroscience, cognitive sciences, computer science, and mathematics will be ineffective if they do not address the underlying social causes of mental ill health.

Immediate action should be taken to tackle the conditions that impact directly on the most socially excluded, especially Black, Asian, and minority ethnic (BAME) communities. These include poor and overcrowded housing conditions; the experience of racism, xenophobia and violence; obesogenic, degraded and polluted environments; financial insecurity, callous conditional welfare benefits; precarious work, exposed conditions for front line workers in care homes, transport workers, delivery drivers, warehouse packers and taxi drivers; children's education damaged by schools impoverished by a decade of financial restrictions and lack of access to the resources for digital education, and community facilities hollowed out by a decade of austerity. Hasty policies, such as the curtailing of the rights of mental health patients to proper assessments before involuntary detention as included in the Coronavirus Act 2020, should rapidly be reversed. The social realities impacting mental health will not disappear when lockdown eases. They will only be intensified as the economic consequences of the pandemic play out.

We welcome the publication of the Public Health England review of *Disparities in the Risk and Outcomes of COVID-19*, which shows very clearly the impact of COVID-19 on those most socially disadvantaged⁹, and note that our argument is supported by the belated publication of the literature reviews and especially the stakeholder input¹⁰. The epidemiological evidence confirms that excess burden of COVID-19 born by those from Black and minority ethnic backgrounds is largely accounted for by the dimensions of social disadvantage that we have noted, and this is powerfully reinforced by the contributions of community organizations and mental health service users. If we are to implement policies which bring about progressive and transformative improvements in the mental wellbeing of our most disadvantaged communities as we enter the next phase of recovery from the pandemic, it is critical that the expertise of social scientists, and of those with lived experience of mental ill health, play a key role in policy development and implementation.

This evidence on the social substrates of poor mental health has important lessons for the short, medium, and long-term policies needed to mitigate the transition of understandable distress to significant and enduring mental health problems. Mental health and well-being is enhanced by elevated social solidarity, informal social support, mutual aid and mutual innovation in relation to crisis conditions¹¹, by measures to increase equality¹², and by providing the resources necessary for the realization of capabilities^{13,14}. As we set out in [Table 1](#), to create "the optimum structure for mentally healthy life"⁷ we must harness

Table 1. Mental health for all - building back better, building back fairer.

Promoting mental health	Addressing mental illness
Introduce mental health audits and inequality impact assessments of pandemic and post-pandemic policies across all sectors.	Rapid investment in local community facilities and services - local authority 'community and voluntary sector organizations - across a range of health and social sectors.
Replace conditional welfare support with unconditional measures that promote capabilities for the most disadvantaged, such as free, accessible public transport.	Reverse the rolling back of service users' rights to health and social care services that occurred in pandemic legislation.
Ensure sustained adequate support for children from disadvantaged families being 'home schooled' including access to meals, breakfast clubs, facilities for internet access and resources for digital education.	Re-Invest in community mental health teams, rebuild public mental health infrastructure and community mental health services.
Design economic policies to maintain a strong safety net of income security, particularly within the most traditionally vulnerable groups, including a - recovery-basic income package which will support all, including the most financially disadvantaged.	Provide resources to support service user and survivor, carer, mutual aid and self-help groups.
Ensure equality in access to health services by taking immediate and effective action to tackle institutional racism and to promote anti-racist and inclusive decision-making and practice.	
Address gender-based discrimination and promoting equal access for lesbian, gay, bisexual and transgender people and people with disabilities.	
Rapid investment to support mutual aid, community groups and voluntary sector organizations decimated by a decade of austerity, with an emphasis on; women's refuges, homeless charities, community-based support by and for black and minority ethnic people.	

resources from sociology, anthropology, geography, politics, and economics to inform rapid policy innovation, alongside legal changes, which will, on the one hand, address the fundamental social causes of mental ill health, and, on the other, create the social conditions that maximize human well-being.

The fault-lines in British society have been starkly disclosed by the pandemic. To 'build back better' in the long aftermath of

COVID-19, we need to create the social and material environments that not only address the causes of mental ill health but also enhance the capabilities of all citizens to create lives of meaning and purpose for themselves.

Data availability

Underlying data

No data is associated with this article.

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This is a timely and important letter. One of the most important and central features of this letter is the authors insistence on the normality of increased levels of anxiety and sadness and their refusal to regard this as reflective of an underlying 'tsunami' of mental health problems. This is entirely correct and this message needs to be applauded and amplified across the range of public health and health policy settings. Similarly I agree entirely with the authors insistence on the important of the impact, overlap and interplay (the intersection) of enduring inequalities and disadvantages in relation to ongoing levels of mental health within the population at large. Furthermore their insistence that these issues must be addressed in terms of questions of ethnicity, gender and labour market participation are also accurate and apposite. However, I think the most important point that they make, and it is one that is frequently overlooked, is the impact that the pandemic conditions will have on people who are already impacted by social inequality. The conditions and consequences of lockdown have clearly exacerbated already existing inequalities, and it is in these instances that, it seems to me, there is the strongest potential for an elevated risk of poor psychological wellbeing.

The authors are correct to identify the need for a range of initiatives that enable these marginalised people to improve their situations with a view to the realization of respective capabilities. In this sense, I regard this letter as a very useful and timely provocation, but I feel there is a need to think about what to do next, on foot of this provocation. There is a need to develop ways of thinking about how societies might move towards the realization of respective capabilities post-lockdown. Central to this is the need to find ways to involve these respective groups in developing their own responses to these enduring inequalities and disadvantages (in a spirit of democratic participation and involvement). These responses must be responses that challenge those inequalities and disadvantages at all levels, across everyday experience, across policy and practice, and in terms of ideological critique and more besides.

Involvement of those people most directly affected by these inequalities is crucial in beginning to move to address these inequalities, but these inequalities are not in and of themselves new. For example, the inability of precariously employed people to take time off due to sickness is not a

new development of the COVID-19 pandemic. However, the public health implications of this situation, in the context of a global infectious disease pandemic are, and this novelty offers an opportunity for progressive change – if not for the protection of individual workers (contemporary capitalism appears, to date, immune to this critique), then for the protection of society as a whole. These are the types of arguments it becomes possible to make, and these are types of arguments that need to be developed. This letter and the thinking that underpins it can play a crucial role in provoking the development of such arguments.

Is the rationale for the Open Letter provided in sufficient detail?

Yes

Does the article adequately reference differing views and opinions?

Yes

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Yes

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Medical sociology, health policy, participation and involvement.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

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Rose and colleagues are prominent scholars who have brought insights from across the social and health sciences to promote a compelling case for significant action to address inequalities in both physical and mental health. Below, we offer further points of support, critique and clarification in the spirit of co-operation, which appears to be central to the agenda of Rose and colleagues.

The open letter is particularly useful in drawing renewed attention to how necessary it is to remind decision-makers of the need for structural changes to ensure equity in health for all. Many of the key arguments posed in the letter have also been evident in emergency management and community psychology literatures for some time. These literatures document how adverse socio-economic conditions often worsen outcomes from natural and person-centered disasters, particularly for people who already endure vulnerabilities (Luna, 2009; Tierney, 2019; Wisner et al., 2004; Blake et al., 2017)¹⁻⁴. As is the case with other disasters, socio-political situatedness in terms of poverty, insecure work, discrimination and marginalization, and poor housing are influencing peoples' psychological, physical, cultural and spiritual reactions to COVID-19. Therefore, it is vital to contest the unjust, social structures that perpetuate and exaggerate such adverse conditions, and champion for fairer and just solutions. We can do so by drawing on existing resources, such as the Sendai framework that offer responses to inequalities in outcomes following disasters. Such frameworks offer pathways of action to address urgent and critical responses to protect livelihoods, health and ecosystems for everyone (United Nations, 2015)⁵.

We agree that many of the well-publicized predictions of a 'tsunami' of mental health concerns stemming from the present pandemic may well be overstated. Rose and colleagues rightfully assert that, regardless, it is important to address issues around resourcing and community development, and to stretch our collective efforts towards socio-economic transformations. It is also necessary to note that, due to ongoing inequities and a lack of adequate response to the consequences of everyday injustices (poverty and discrimination), mental illness is already endemic in many countries. Systems of response also need to be re-designed to address the inverse care law (Hart, 1971)⁶ whereby people who need care the least consume the most. Conversely, people who need care the most, access the least.

Increases in service access proposed by Rose and colleagues are urgent. It is important to put initiatives in place to help people in distress to cope by enhancing early intervention and peer-support systems. Training more mental health professionals to meet the existing complex needs of diverse communities is crucially important. Our concern with an emphasis on therapeutic training and interventions that predominantly target individuals in distress is not to question its effectiveness in addressing certain difficulties such as trauma, anxiety and low mood. Nor is the

only challenge the limited reach (i.e., the number of people that can be assisted) of this strategy and issues of scalability. Our concern relates to how such responses are predominately ameliorative, rather than preventative in orientation. Responses to wide-scale human suffering that *only* focus on therapeutic interventions should be treated with suspicion as often conservative, bureaucratic, and as a failure of political imagination. The fixation on therapeutic responses can act as an 'action distraction', which contributes to a fixation on responses to reduce suffering within individuals. This can result in the pacification and obscuring of calls for wider reaching efforts to promote community level wellness, and to prevent mental ill-health through preventive macro structural changes. To address health inequities and differentials across persons and population groups, we must also address the structural inequities that drive ill-health. We need to look further 'upstream' and prevent people from becoming ill (Hodgetts & Stolte, 2017)⁷. Increased access to therapeutic interventions needs to be positioned overtly as part of larger strategies towards systemic change. We applaud Rose and colleagues for also raising the need for a broader change agenda.

As Rose and colleagues also propose, redistributive policies and practices are important in addressing issues of inequity and health inequalities. In doing so, these authors adopt a well-worn population health position that is enshrined in many nation states within graduated taxation and cash transfer systems. We would add that, the levels of inequity that many communities now face, despite the existence of such redistributive initiatives, suggests the need to consider other more radical strategies for change. After all, it is in historical moments like the present that it becomes more possible to seize the initiative and to consider rebooting the whole socio-economic system (neoliberalism), which is driving inequities in life chances and health. In this context, increases in redistributive policies can be re-imagined as 'stopgap measures' that are useful whilst we formulate more sustainable and transformative systems for ensuring equity, social justice and health for all. This requires us to ask if, for example, now is the time for jubilee? Is now the time to introduce policies such as universal basic incomes, maximum wage settings, and resource co-ownership models? Should the ancient concept of the commons (shared resources that are available to humanity) be embraced as a central principle for a more just economic system (Standing, 2019)⁸? What we are signaling here is the need to be even bolder and to broaden the conversation regarding how to relieve people from debt servitude and ensure nobody has to subject themselves to often abusive and dehumanizing penal welfare and social service systems (Hodgetts & Stolte, 2017)⁷. Such structural transformations may actually reduce the need for therapists and such expensive service systems. We should be asking more questions to which we do not have perfect answers.

One avenue for addressing discrimination in the health, penal welfare and social services nexus in many nation states is to disassemble these systems and to provide the resources they consume directly to people in need. If people are resourced to govern their own affairs collectively, the chances of their flourishing alongside others are increased. This line of reasoning speaks to issues of self-determination and is a feature of calls from indigenous groups, in particular, to (re)gain guardianship over the resources that have been taken from them. Additionally, in addressing issues of inequality and discrimination in present systems, it is important to not limit our historical gaze. For example, Rose and colleagues assert that economic supports have been stripped away over the last decade. We agree, and would also foreground the impacts of longer time scales of dispossession and inequality that have set the stage for injustices in many nation states today. The present crises in many countries have been shaped by Neoliberalism over the past 40 years. These crises are also the products of historical processes of colonization/imperialism that continue to

negatively impact minoritized communities.

Relatedly, responses called for by Rose and colleagues will need to be reformulated in context specific ways. What is appropriate for the United Kingdom in addressing issues of diversity may not necessarily be appropriate in contexts such as Aotearoa New Zealand. In our context, the English version of the Treaty of Waitangi [1] (signed in 1840 by the British Crown and Māori leaders) set the stage for the dispossession of land, resources, power and cultural practices from Māori. Subsequent exploitation by the Crown has resulted in ongoing structural inequities. As such, systemic changes will need to include the enactment of genuine Treaty of Waitangi principles that are not exploitative and extractive. This could mean that, for example, iwi (tribes) exercise guardianship over the provision of health, social and education services for their members, and for other people residing within their tribal boundaries. This would likely result in a refocusing of initiatives away from short-term economic returns and towards a longer-term, inclusive and equitable strategic focus. For instance, Māori often operate from the position of intergenerational planning, capacities and relationships whereby certain decision-making roles are assigned to kaumatua (elders) as wisdom holders, alongside often middle aged "executive leaders" (enactors) who are supported by rangatahi (youth), and inspired by pēpi (infants). More broadly, such transformations are about honouring localised treaties and embracing indigenous rights and knowledges through enactments of generational change strategies designed to achieve healthy futures for all.

We are surprised that the open letter appears to take on a somewhat executive tone and does not feature the language of collaboration as much as we feel is warranted. From our perspective, achieving effective change requires us to look out beyond our own expertise, models and journals. Recognising the socio-political situatedness of people's lives and who gets to have a voice in decision-making processes is particularly crucial during and after disasters. Rasche (2018)⁹ reminds us that the social location and expertise of speakers often brings about possibilities to become an authority on other peoples' situations. It is important that we engage directly with people who are adversely affected by the structures and issues to which we are trying to find effect responses. Policies and systems that are co-designed with the people being targeted tend to be more effective. To work effectively with others, it is also important we decentre our own 'expert' voices in order to hear the voices of others who have gained phronetic wisdom from having to carry the weight of adversity. Part of our shared change agenda must be to address inequities regarding who gets to be central to conversations and initiatives for change, and whose knowledge is valued and heard in these processes. We cannot leave the formulation and implementation of change strategies to the usual suspects.

We are sure Rose and colleagues would agree that there are considerable sensitivities in considering efforts to work in partnership across dominant and marginalized communities. In the process, it is important to avoid falling into the trap of using labels that collapse diverse communities together as the 'others' (Fakim & Macaulay, 2020)¹⁰. For example, the BAME acronym used by Rose and colleagues is considered highly problematic by many members of the diverse groups that are supposedly 'encapsulated' in this term. For many, BAME is a distancing, cold and administrative 'white term'. It homogenises and simplifies the heterogeneity of the intertwined histories of adversity that are experienced in varying ways by diverse groups of people. Such terms also act as apolitical euphemisms for historically politicised and reclaimed notions, such as Black, queer and indigenous.

A key message in our response is that what we need to advocate collectively is not only more equitable access to mental health and community services, but also access to justice, sustainable incomes, adequate housing, good food, and supportive and violence-free relationships. As Rose and colleagues note, we need to 'build back better'. This requires us to unpack whose notion of 'better' is being advocated. Who gets to decide what we mean by the creation of societies that are more equitable and offer fairer access to resources, so as those necessary to promote and sustain human flourishing. We were surprised that in asserting the need to build back better, Rose and colleagues did not refer to existing global structures that offer avenues for negotiating and enacting shared visions for humanity and wellness.

There is an opportunity to link our efforts in with the 17 interwoven United Nations Sustainable Development Goals (SDGs). Widely consulted and signed-up to by stakeholder groups from almost 200 United Nations, the SDGs have been in effect since 2016 and will run till 2030. Directly relevant to our present dialogue, psychologists specifically fought to have mental health included in this global development agenda, under [SDG-3](#). Of the remaining 16 SDGs, particularly important are SDG-17 (Partnerships for development whereby those targeted are positioned centrally in the formulation, design and implementation of change processes) and SDG-8 (Decent Work for all, which includes access to Sustainable Livelihoods and Wellbeing at Work). In advocating for change it is important to avoid re-inventing the wheel. As imperfect as they are, the 17 SDGs offer a platform for change on a global scale and in ways that preserve our geographical specificities. The wider point of these goals, and other structures like the Global Compact and the Sendai Framework, is that they offer accountability structures that can help determine the distribution of resources and opportunities for action within and across nation states. These initiatives can be harnessed to help us redress structural inequities, injustices, exclusions and violations of Human Rights.

We would like to thank Wellcome Open Research for providing this opportunity to respond to the seminal open letter by Rose and colleagues.

[1] There are English and Māori or Te Reo versions of the treaty and complexities around translation.

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Is the rationale for the Open Letter provided in sufficient detail?

Yes

Does the article adequately reference differing views and opinions?

Yes

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Yes

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Yes

Competing Interests: No competing interests were disclosed.

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Reviewer Report 06 August 2020

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Kim Hopper

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This is a fiercely argued brief for structurally informed corrective action during the pandemic, issued by an impressive group of petitioners. In eight evidence-sourced paragraphs, it manages to deliver both an indictment – the predictably unequal impact of COVID-19 on already disadvantaged groups – and an urgent call to civic arms – directed by a hybrid of technical expertise (from social and clinical sciences) and vernacular knowledge. It returns concerns about mental health effects to more general considerations of everyday securities and de-stigmatizes the relief and prevention efforts called for. In sum and substance, it converts an analysis of epidemiological contours into the warrant for social reform such an analysis has (at least since the time of Virchow) regularly invited but rarely entrained. The “rebuilding” agenda itemized here has

an urgency and scope that are radical and entirely reasonable; it owns, not refuses, the subtext that haunts the daily bills of mortality.

Is the rationale for the Open Letter provided in sufficient detail?

Yes

Does the article adequately reference differing views and opinions?

Yes

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Yes

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Public and cross-cultural mental health; social determinants of population health.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Reviewer Report 15 July 2020

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This is a well written and presented opinion piece from a large group of multidisciplinary experts. The authors argue for the need to focus on refunding and resupporting social and mental health systems which have been defunded in recent years, as a more appropriate response to the mental health needs identified by the current pandemic, rather than focusing primarily on providing increased acute services. They make the important point that the pandemic will most severely affect those who are already most socially excluded, namely the Black, Asian and minority ethnic communities, and describe a series of useful "building blocks" for building mental health back

better and fairer in the post pandemic world.

Is the rationale for the Open Letter provided in sufficient detail?

Yes

Does the article adequately reference differing views and opinions?

Yes

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Yes

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Mental health services research.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.
