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Mental health and COVID-19: are we really all in this together?

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The pandemic is a vast, expanding disaster with no end in sight, producing chronic stress, disruption, and multiple losses

The coronavirus disease 2019 (COVID-19) pandemic has been a once-in-100-years event. The scale of the disaster overshadows all others in living memory. Most disasters are focal and time-limited. This one will span a considerable period of time and the economic impact will last years. This means the mental health effects will be deeper and more sustained than in other disasters. A survey during the first month of the pandemic in Australia assessed the nation's "temperature" early, as reported in this issue of the Journal.[1] This survey and other information[2,3] confirm that the initial mental health impact has been severe, and worse may be coming. Scientific models predicted that Australia would face a second curve of mental ill health and suicide,[4,5] and this has now clearly arrived. We have been willing to turn our society and lives upside down to flatten the COVID-19 curve. The same commitment is now required to flatten the mental health curve.

After acute disasters, most people experience a transitory wave of distress that is considered normal and they do not generally require professional care. COVID-19 is fundamentally different. It is not a single shock, but a vast, expanding disaster with no end in sight, producing chronic stress, disruption, and multiple losses, and many of the usual mitigation strategies are banned or unavailable. Modelling and earlier recessions show that it is the economic consequences, especially financial stress, unemployment, and educational failure, that fuel mental ill health and suicide risk.[4,6] This impact is anything but short lived, and will produce a long, deep second wave of mental ill health and suicide.

The impact is not uniform and there are groups at especial risk: notably, the already marginalised and disadvantaged, young people, women, those living alone and those already unemployed. Young people are especially disproportionately affected, and face a generation-defining disruption that will have a multi-faceted, long term impact on their lives. Socio-economic inequality is a major risk factor for an array of negative health and social outcomes, including mental illness,[7] and the potency of this risk factor will be magnified by a pandemic followed by a recession. We may all be in this together, but some are further in than others.

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The response so far has been based upon thinking from earlier crises and disasters. The focus is on the general public and aims to stress the normative aspect, that "it is OK to not be OK", that simple coping mechanisms will get people through the crisis, and wishful thinking that professional help is available if needed. Crisis lines have been strengthened, but there has been no major effort to increase the capacity of the system, although the pivot to telehealth has sought to maintain access. These steps are welcome, but they will be inadequate on their own. The scale and sustained nature of the stress, the undermining effect of the containment measures, especially second lockdowns, and economic collapse mean that a much larger proportion of the population may need mental health care and be at risk for suicide than in more focal disasters.

The capacity of the mental health system, even before COVID-19, had been inadequate for responding to the demand.[8,9] The system is now expected to respond to the surge in need for mental health care. It has been admirable how single-mindedly governments and the health system have responded with public health measures and a boost to intensive care capacity[10] in order to flatten the infection curve and to treat infected patients. At the time of writing, 886 people have died of COVID-19 in Australia. During the same time period (February to October), more than 2000 Australians will have died from suicide,[11] let down by an inadequate health and social system response. Most suffered from clear-cut mental ill health, although only a minority had accessed mental health care.[12] It is predicted that the number of suicides will rise in parallel with the COVID-19 crisis and associated recession.[4] These lives are surely just as precious as the ones lost and threatened by COVID-19. They have not yet been lost, and many, if not all, can be saved. What can be done?

Firstly, policymakers must accept that this is not a routine disaster and that the times call for a very different approach. I believe the Prime Minister and some premiers are engaged with resolving this problem. Economic measures to soften the impact of the recession are the paramount preventive strategy, and the federal government has acted promptly with the JobKeeper and JobSeeker schemes, which have been partially extended while being reduced in stages. The global financial crisis showed how destructive austerity policies are, increasing inequality and social determinants of mental ill health, as well as weakening the social fabric and democracy itself.

Secondly, the crisis provides a unique opportunity to create the "new mental health care" by dramatically reforming and strengthening the current system. An international position paper[13] has been published, but Australia is ahead of the curve with key innovations, such as home-based care and hospital in the home, assertive outreach models, and a national youth mental health platform (headspace), supported by digital and telehealth, which not only suit the times but are evidence-based and strongly preferred by patients and families to emergency and inpatient care. Shifting the centre of gravity of mental health care to local communities via integrated care hubs linked closely with primary care is an innovation strongly supported by the federal government and Health Minister Hunt, not only through headspace, but also through the adult mental health hub model announced in 2019.[14] Integrated care hubs with deeper capacity and

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expertise in helping people (young and older) with more complex needs could easily be fast tracked in the shadow of COVID-19, initially as pop-ups boosted by digital technology and outreach. State governments should consider releasing the governance of community mental health care from large hospital-centric health networks so that it is embraced and can be accessed by local communities. And federal commissioning of community mental health care should be more coherent, guided by national evidence-based standards, with the goal of regional integration of services, reversing the fragmentation produced by the competitive tendering policies of the excessively devolved primary health network model.

The coming months will reveal whether we are really all in this together or whether the 5 million[15] Australians (and rapidly growing) who confront mental ill health each year will continue to be treated as second class citizens.

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