Evidence to Health Committee
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This Evidence Briefing considers key research studies and briefing papers outlining the impact of the pandemic on the mental health of the population in Northern Ireland (NI) and provides recommendations for a Trauma-Informed Recovery Plan, which would consider the need to address the impact of the pandemic in relation to key at risk groups, children and young people, suicide prevention and mental health inequalities.

A Trauma-Informed Mental Health Recovery Plan

Trauma is an experience or event that causes distress because it threatens life or personal integrity, overwhelms our ability to cope, and causes feelings of helplessness. Trauma creates biological dysregulation (the fight, flight or freeze response). The goal of trauma-informed approaches, services and interventions is to promote emotional regulation. Emotional regulation occurs in a context of **physical and psychological safety**. Trauma-informed practice therefore prioritises physical and psychological safety across all levels of communities and organisations. This approach also recognises that humans have evolved to live in social groups, in **families and communities**, and it is through **relationships** that psychological safety is established and healing is promoted.

This approach recognises that our mental health can be impacted by our normal emotional responses to the events of the last year. Aspects of the pandemic have been universal experiences; however several population groups have been disproportionately affected by trauma, and these groups should be targeted for preventative interventions and treatments if necessary. Trauma informed values and principles should serve as a framework for policy, practice and service delivery. The most widely used definition of trauma-informed approaches is provided by the US Substance Abuse and Mental Health Services Administration (SAMHSA), who define "trauma-informed" as: A program, organisation, or system that:

> *"Realizes the widespread impact of trauma and understands potential paths for recovery. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system. Responds by fully integrating knowledge about trauma into policies, procedures, and practices. Seeks to actively resist re-traumatization."* (SAMHA, 2018)

This approach prioritises the wellbeing and psychological safety of staff who are providing services, who need to be well-regulated themselves in order to support the physiological co-regulation of others. The illness and death resulting from COVID-19 remains a threat and restricting the spread of the virus is an important goal. The provision of COVID-safe environments and the continued efficient rollout of the vaccination programme are necessary contexts for the delivery of mental health services, preventative interventions and a return to education.

The principles of trauma-informed approaches, which we should remain mindful of as we emerge from the pandemic, are: trustworthiness and transparency; collaboration and mutuality (authentic partnerships with service users) and equality, empowerment and respect. Trauma informed practice recognises the traumatic impact of inequality and discrimination and is cognisant of cultural, historical and gender-related trauma (CDC, 2021). In NI this points to the ongoing need to discuss and address issues associated with the conflict, in a trauma-sensitive manner, and recognise the continuing fear and sense of threat that affects many individuals and communities.

Key at Risk Groups

The pandemic, and the latest lockdown have taken its toll on the population's wellbeing with the ONS reporting that **life satisfaction, happiness and feeling that things are worthwhile** dropping, and

declining optimism about when life will return to normal (ONS, 2021). Nonetheless, it is anticipated that most people will not develop mental illness as a result of the pandemic. One research programme examined sub populations with different trajectories through the pandemic. **The majority were "resilient"** (56.6% not at risk of depression; 68.3% not at risk of COVID related PTSD). This reflects the fact that most people do not develop mental illness following distressing events. Most people experienced elevated anxiety at the start of the pandemic, however there were groups whose mental health improved, as they adapted to the demands of the restrictions. However some experienced a deterioration in mental health as the chronic stress of the pandemic mounted, or due to worries about the long-term economic consequences (Shevlin et al., 2021).

Studies show that particular population groups are at higher risk of having adverse mental health impacts. These are **young people, women, people with children at home, people with pre-existing mental or physical illness, people with low incomes and those with low levels of educational attainment** (Pierce et al., 2020; Solomu and Constantinidou 2020). **Carers, again in particular female carers also reported high rates of trauma and stress** (Wade et al., 2021) People with a lower income were also less likely to report an improvement in symptoms, probably as a result of this being a chronic stressor (Fancourt et al, 2020). In August 2020 the NHS Confederation reported that providers were anticipating a **20% increase** in the demand for mental health services as a result of the pandemic. **Loneliness** (Groarke et al., 2021) and living alone (Fancourt et al., 2020) were associated with poorer mental wellbeing and the risk of depression.

People with certain psychological characteristics were also more likely to experience adverse mental health effects; these were death anxiety, intolerance of uncertainty, external locus of control (believing that factors outside of their control are responsible for what happens to them) and lower levels of resilience (their perception of how easily they bounce back after hardship). A study of the impact of the pandemic in the Spanish population highlighted the potential for post-traumatic growth, with people reporting how the pandemic had led to positive outcomes (Vazquez et al., 2021).

There are several studies from the UK and Ireland charting the mental health impact of the pandemic. The data from the start of the pandemic in March 2020 demonstrates an increase in the proportion of the population with symptoms of anxiety (around one in 5) and depression (around one in 4) (Hyland et al., 2020; O'Connor et al., 2020). Two studies showed that depression levels stayed relatively stable (Hyland et al., 2020; O'Connor et al., 2020) and one found that depression also declined (Fancourt et al., 2020). Several studies show that **infection with COVID** is associated with a higher risk of neurological and psychiatric illnesses, particularly among those with more severe infection and people who were hospitalised (Taquet et al., 2021).

A local study revealed **higher rates of distress and PTSD in health and social care workers** in NI (depression 30%; anxiety 26%; PTSD 30%; insomnia 27%) again, **women** had a higher risk than men (Shannon et al., 2020). Data from the current wave of this study suggests that health care workers who have been affected by COVID may be at particular risk of prolonged physical and mental illness (Shannon, personal communication).

One in 10 new mothers suffer **post-natal depression**, which if untreated, can also have a detrimental impact on their child. The Maternal Mental Health Alliance (2021) are concerned that the stress of the pandemic and the restrictions on hospital visits have resulted in many more women being at risk of this illness. Furthermore, the reductions in face-to-face post-natal appointments may have led to an increase in hidden unmet need.

One study shows that **NI has high rates of vaccine hesitancy (32.6%) and resistance (16.3%)** compared with the UK generally (24.8% & 6.1%). This was associated with being female and younger, mistrust of experts, paranoia, neuroticism, religiosity, internal locus of control, and low altruism, low

agreeableness, low conscientiousness, low cognitive reflection, and more negative attitudes towards migrants (Murphy et al., 2021).

Recommendations

1. Funding should be available to increase the capacity of mental health services to provide evidence-based treatments (particularly for depression and anxiety). Support should also be provided for staff in mental health services.
2. Support and services should be for informal/ unpaid carers.
3. Support and trauma-focused treatments should be available for those sub populations that have experienced higher levels of trauma and loss, including health and social care workers, and those working in funeral services and care homes.
4. Mental health support should be targeted towards those who have been hospitalised in ICU due to COVID 19 and their families, and to people with symptoms of "long COVID".
5. Social and mental health support should also be offered to people who have been pregnant or given birth during the pandemic.
6. We must continue to promote the importance of self-care, using the evidence based "Take 5 Steps" and the support available locally (e.g. through media campaigns).
7. In keeping with a trauma-informed approach, a cross-departmental approach to mental health recovery is required as the determinants of mental health; housing, employment, debt and social relationships, are outside of the remit of the Department of Health.

Children and Young People

The group who have been most severely impacted by the restrictions associated with the pandemic are children and young people. Separation from friends is incredibly stressful for children and prolonged stress or adversity in childhood is associated with mental illness in later life (e.g. McLafferty et al., 2015; DeVenter et al., 2013) and also increases the likelihood of behavioural, attentional and emotional problems (Hill, 2019). School closure not only causes the stress of separation and uncertainty, it also removes opportunities for surveillance of children who may be at risk, and children are denied opportunities to participate in activities which regulate the stress response (art, music, drama, dance, and sport).

The most recent report from the Co-Space study (Feb 2021) provides evidence regarding the effect of the third wave of the pandemic where the schools were closed for an extended period of time. Behavioural, emotional, and restless/attentional difficulties have increased again, particularly in primary school aged children. A third of primary school aged boys (33%) and 23.1% of primary school age girls had problems with hyperactivity or inattention. **In January 30.8% of secondary school-aged girls reported emotional problems** (compared to 15.6% of boys) and these were at the highest levels since March 2020 (Skripkauskaite et al., 2021). A recent review of 27 studies concluded that **school closures are associated with *"considerable harms"* to health and wellbeing.** The studies found a decrease in emergency department (ED) presentations and hospital admissions, and delayed presentations (Viner et al., 2021). The findings also found an increase in screen time and social media use, and reductions in physical activity. Whilst there are concerns about the impact on sleep and diet, the findings were inconclusive. Both the Co-space study and the review found strong evidence that young people in **deprived areas**, and children with **Special Educational Needs** were at even greater risk (Skripkauskaite et al., 2021; Viner et al., 2021). In NI the recent prevalence study, prior to the pandemic, found that **children here have higher levels of mental illness than other parts of the UK and Ireland** (Bunting et al., 2020). It is therefore particularly important that in this region we protect our children and young people from any possible further harm.

Recommendations

8. The full return of all children and young people to school should be the top priority of the Executive as we emerge from lockdown. However, the risk of transmission of COVID remains a concern and mitigations need to be in place so that reopening is safe (e.g. Gurdasani et al., 2021). Upon return, pupil and teacher wellbeing must be safeguarded, and the workloads of both groups minimised, to support a strong emphasis on reconnecting children with teachers and peers and emotionally regulating activities such as play, art, music, sport and dance.
9. The social and extra-curricular clubs and classes that promote wellbeing and emotional regulation in children and young people must also be given priority as we emerge from lockdown, with activities preferred by girls and boys available.
10. All children should have access to a good quality summer wellbeing programme delivered at community level. In keeping with a trauma-informed relational approach, the programme could be centred around existing community provision but incorporate physical activity, dance or sport; healthy food; creative projects, including options for music, drama and art/ crafts; and should align with community celebrations which involve parents and others within the community, to promote self-esteem and hope.

Suicide Prevention

The link between suicidal thoughts and mental illness is well recognised; however, suicidal thoughts and behaviours are also associated with crisis; and even in the absence of mental illness, people can engage in suicidal behaviour when faced with situations where the distress is overwhelming, particularly if they have a sense of defeat and entrapment. The research shows that there is generally no evidence of an increase in suicide rates (John et al., 2020). Surveillance of probable suicides indicates that there has been no rise in England (Appleby et al., 2020) and NI (PHA personal communication). In Japan there was a 20% decrease in suicides at the start of the pandemic, and then a 7.7% rise (John et al., 2020). A UK wide study found an increase in rates of suicidal thoughts as the pandemic progressed; and suicidal thoughts were highest in the 18-29 age group (12.5%) (8.4% in those aged 30–59 years and 1.9% in those aged over 60 years). In keeping with the patterns from the other studies of mental health, people in lower Socio Economic Groups and people with pre-existing mental illness were more likely to experience suicidal thoughts (O'Connor et al., 2020). The rates of suicidal thoughts increased as the pandemic progressed, and the latest data from late October/ November shows evidence of defeat and entrapment starting to increase again, particularly in young people, people in lower SES, women and those with pre-existing mental illness (O'Connor, personal communication).

Recommendations

An increase in suicides is not an inevitable outcome of the pandemic. Suicide rates are influenced by several factors, including the proportions with untreated mental illness and adverse life events. There are therefore many interventions that the Executive could put in place to minimise the likelihood of an increase in suicide rates. The recommendations below are based on Gunnell et al. (2020):

11. Training for health and social care staff in suicide awareness as per the Protect Life 2 Strategy and the Towards Zero Suicide Programme.
12. Crisis intervention services are currently under review. Following the completion of the review we need to ensure that there are clear assessment and care pathways for people who are in suicidal crisis; and adequately resourced follow-up services, including digital/ online interventions (and incorporating existing crisis helplines).
13. Universal interventions which will have an impact on suicide rates (and also the mental health impact of the pandemic more generally) include financial safety nets and support for people who have lost income and employment; public health responses that tackle domestic violence and safe consumption of alcohol; and support for people facing isolation, entrapment, loneliness and bereavement.

14. We must remain vigilant in relation to access to methods of suicide, and promote the responsible media reporting of suicide (and the risk of suicide in the pandemic) in accordance with Samaritans media guidelines (Samaritans, 2020).

Mental health inequalities

NI has higher rates of mental illness when compared with the other UK regions and this is also the case for children and young people (Bunting et al., 2013; Bunting et al., 2020). We also have high levels of trauma related mental illness, childhood adversities and deprivation (Ferry et al., 2014; McLafferty et al., 2015). Deprivation and inequality were the biggest predictors of area level mental illness and suicide prior to the pandemic, and the pandemic will have resulted in a widening of mental health inequalities. It is essential that these are addressed in our strategy to rebuild. The Centre for Mental Health have set out recommendations to address the mental health inequalities resulting from the pandemic. In their briefing on mental health inequalities (Allwood and Bell, 2020) highlighted the marginalised groups (in recommendation 14) who had difficulties accessing mental health services who should be targeted in a mental health recovery plan.

Recommendations

15. The Mental Health Strategy represents a plan to developing excellent mental health services based on a trauma-informed, recovery model. The strategy and the development of services, particularly in relation to crisis intervention, dual diagnosis and eating disorders, should continue to be prioritised. There needs to be an increase in the budget for mental health services commensurate with the increased rates of pre-pandemic mental illness in NI, and the evidence of more severe and chronic mental illness as well as the increase resulting from the pandemic.
16. The expansion of post pandemic mental health services should address inequalities in provision and ways of improving access to services for LGBT people, people from BAME groups, older people and people at risk of abuse and violence.
17. The financial “safety net” for people whose livelihoods are affected as a result of the pandemic should be extended, and there should be a cross-Departmental focus on reducing inequalities, and supporting people into employment (especially young people).
18. It is important that the communities and areas with pre-existing high levels of deprivation are prioritised for regeneration.
19. There should be a programme of events and actions to memorialise and remember those we have lost to COVID, particularly where the loss has been disproportionate, such as in care homes.
20. Support should be provided to organisations such as schools and health and care services and businesses, to adopt trauma-informed approaches to help engender a sense of psychological safety as we approach the end of lockdown.

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