# Public mental health and the COVID-19 pandemic

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COVID-19 has presented society with a public health threat greater than any in living memory, leaving us to question almost every aspect of our society. An ever increasing concern is how we protect the global population from mental illness and whether public mental health policies can achieve this. In this article I reflect on the history of mental health service development, and furthermore on how COVID-19 might impact on the delivery of public mental health strategies into the future.

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## Introduction

The pandemic of COVID-19 is the biggest public health threat for 100 years (Ashton, 2020a). Over 1 year on from the first cases in Wuhan, China, and with over two million deaths worldwide, the resurgence of the virus and its impact on national economies and societies will lead to a fundamental reappraisal of the way we live and our relationship with the natural and built environment. The political ramifications of the pandemic are yet to be felt but if previous experience is anything to go by they will wide-ranging (Ashton, 2020b). The Coronavirus, one of the most humble forms of life, has ruthlessly interrogated every aspect of the way we organise ourselves and in this our approach to mental health and mental health services is not exempt (Ashton, 2020c). To understand where the future of mental health lies in the aftermath of COVID, we must first revisit its past (Ashton, 2019). It is to be hoped that one outcome of the pandemic will be a future in which much more attention will be paid to public mental health.

## The roots of public mental health

As with public health in general four phases can be identified in the evolution of approaches to mental health beginning with the Elizabethan Poor Laws in Britain and its colonies (Ashton, 2019). Those laws were administered by parish overseers through the provision of workhouses for the able-bodied poor and working with a combination of parishes to provide care for the sick and poor. The 'Workhouse Test' was applied whereby it was a condition for receiving relief from the parish to enter a workhouse, having surrendered all your assets, and to carry out set work in return. The application of the principle of 'lesser eligibility' meant that the treatment should not be superior to that of the lowest social class.

When it came to those who we would now describe as suffering from severe and enduring mental illness but who were for many years labelled as 'lunatics', there were a number of potential destinations ranging from the poorhouse for 'pauper lunatics' to the local bridewell or house of correction for vagrants, and prisons where it was common for mentally ill people to be incarcerated together with mentally sane prisoners. Frequently the parishes would contract out the care of the insane to private madhouses run by proprietors who may not be medically qualified and where abuse was common. Perhaps the most famous madhouse was the Bethlehem Hospital in London where the public could pay to view the inmates as a form of popular entertainment.

In the second phase, following changes in agriculture associated with the Enclosure Acts of the 18th and 19th centuries, and the displacement of peasants from rural areas, the rapid urbanisation that was characteristic of the industrial revolution led to a crisis in the care of the insane. Scandals in private madhouses where patients could be found in rags and in chains, fed on gruel, led to demands for reform fuelled by public sympathy for King George III, whose mental illness was a symptom of his Porphyria together with the sentiments of 'Liberty, Equality and Fraternity' emanating

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from the French Revolution. The resulting County Asylum Act of 1808 led, over time, to the construction of a network of asylums that were usually self-contained communities, complete with farms, workshops and gymnasia. They soon filled up with thousands of patients who had been kept hidden at home by families dreading the fate of loved ones in the private madhouses.

Over the next century these institutions, which had been borne of an enlightened impulse, influenced by mainstream public health considerations of environmental and hygienic measures, became ever less therapeutic and more custodial bringing their own scandals.

In parallel with the decline in public health itself, with the erosion of local public health departments in town halls the asylum system was eclipsed by the rise in therapeutics following the Second World War and the belief that the future would be one of targeted pharmacological interventions (Ashton & Seymour, 1989).The therapeutic optimism that followed the discovery of anti-depressants and major tranquillisers may have revolutionised the treatment of the major psychoses but the closure of the asylums was not accompanied by compensating investment in community mental health services and in retrospect it can be seen that the therapeutic optimism was oversold.

As with the physical aspects of public health, the 1970's and 80's brought a dawning realisation that a holistic approach to mental health would require a framework that integrated knowledge from the social, behavioural and environmental sciences as well as the bio-medical. It became apparent that institutionally based specialist services could never meet demand, and that full public engagement in the co-production of health together with whole hearted partnership working was essential. In the aftermath of the anti-psychiatrists of the 1960's and 70's the hegemony of medicine in psychiatry, as in the broader field of public health, seemed misplaced (Szasz, 1972).The future is now multi- and inter-disciplinary based on team working and partnerships not least with the public, its associations and institutions.

Straws in the wind of a new approach were to be found in the work of Gerald Caplan of Manchester Medical School, the Tavistock Institute in London, the Hadassah Centre in Jerusalem and later the United States. Caplan's book ' An approach to Community Mental Health', published in 1961, described a comprehensive approach to mental health which drew on the public health approach to tuberculosis control with its multifactorial focus, building on and mobilising community assets for mental health and optimising the use of specialist skills in supporting a movement for mental health. Caplan's work was highly influential with President Kennedy and his programme of community mental health centres but with Kennedy's assassination in 1963 the movement lost momentum and never crossed the Atlantic in any meaningful way (Caplan, 1961). In the succeeding years there has been a growing literature on protective factors such as locus of control, self-esteem, and sense of coherence that might provide the golden threads of mental resilience (Ashton, 2019).

More recently there has been a growing pressure to develop whole population approaches to mental health at the same time as the campaign to achieve parity between physical and mental health has gathered momentum. As in the New Public Health where the use of multiple whole system interventions, focussing upstream on the determinants of health, is now mainstream, there is an opportunity to embrace this approach for mental health through the newfound enthusiasm for 'Public Mental Health' (Mental Health Foundation, 2016).

We can frame our response to the ongoing epidemic of dementia in an ageing society as akin to that our predecessors in public health took with cholera and tuberculosis. We can also begin to see that as with the prevention and management of chronic brain disease and mental health difficulties, the integration of the biological, the social, psychological and environmental at a population level, and with an upstream focus is likely to bear the most fruit. In COVID-19 we have a new disease which is set to test our imaginations, our ability to adapt, to be bold and to act without the baggage of preconceived ideas.

## COVID-19 and mental health

Since the new Corona virus made its appearance at the end of 2019 the main preoccupation of national governments and health ministries has been with efforts to control its spread and minimise the associated mortality rates. As the pandemic has evolved concern has grown about the occurrence of associated long term morbidity, so-called 'Long Covid' (Ashton, 2020d). From the outset there have also been worries about the impact on the mental health of sufferers, their carers and those affected by the wider social and economic impacts of the crisis (Ashton, 2021a).

In the early days of the pandemic the main focus of concern was on the prospects of an increase in the suicide rate, something that Louis Appleby, the joint chair of the National Suicide Prevention Group for England was initially at pains to play down, perhaps in part because of his longstanding interest in preventing sensational publicity from fanning the flames of suicide contagion (Ashton & Donnan, 1981). Appleby and his colleagues have been tracking the evidence linking suicide to the COVID pandemic and have raised a number of caveats to drawing

early conclusions, suggesting that changes in the risk of suicide may be dynamic (Pirkis *et al.* 2020; Ashton, 2021a).

In recent years Durkheim's hypothesis has been questioned by Tomlinson by reference to the Northern Ireland experience during the 'Troubles', where claims of reduced suicide rates during the period of political violence and widespread murder do not appear to be a consistent finding (Tomlinson, 2012).Certainly it would seem that the social solidarity, that was such a feature of the first COVID lockdown in England, and that would have led to predictions of it providing a protective effect according to Emile Durkheim's classic work on the subject, does not appear to have been sustained in the more recent lockdowns (Lukes, 1975). It remains to be seen how this plays out.

## Towards a framework for public mental health in response to the COVID pandemic

Notwithstanding the special case of suicide and self harm, as one aspect of the pandemic, a public health perspective must cast the net wide if we are to fully comprehend its manifestations and the implications for a coherent response. To date the narrow focus on virology and specialist medical interventions concerning the acute illness have distracted attention from the collateral damage other than the potential for ' Long Covid'. As the tsunami of death recedes it behoves us to address the long term burden of sequelae not least with respect to population mental health. I propose the following five major themes of concern:

1. The direct impact of the virus as a result of the serious physical manifestations of infection, including organic and functional brain injury whether in the medium or longer term.
2. The wider impact of the virus on the physical and mental health and wellbeing of the general population
3. The mental health impact on specific groups of the population who are especially at risk
4. Collateral damage through the impact on health and social services, including that to the wellbeing of staff and on the longer term resilience and viability of services.
5. The wider and longer term impact of the pandemic on social and political stability, on social institutions and on the conduct of everyday life.

One aspect that has come to the fore during the pandemic has been the phenomenon of the small but highly vocal and organised groups, that are now to be found internationally, who militantly oppose science in general and vaccination in particular and who may yet undermine our efforts to control the Coronavirus.

Such groups have a long history of opposition to public health interventions dating back to the Anti-Vaccination League in Britain in 1866 (Ashton, 2021b). The main arguments deployed by them against vaccines range from the understandable fear of needles to arguments about personal freedom, religious objections and general suspicion of science.

The College of Psychiatrists of Ireland has drawn attention to the potential impact of the COVID-19 pandemic on mental health services in the Republic of Ireland and the extent of these impacts should not be underestimated in our current state of knowledge, not least because it seems that as many as 10% of those affected by the virus may be experiencing long-term effects (Minihan *et al.* 2020). As we learn more about nature's latest challenge to our hubristic custodianship of Planet Earth we must use the crisis as an opportunity to rethink our approach to mental health and mental health services as well as the way we co-exist in our human habitat.

In its ruthless interrogation of our way of life the humble Corona virus has surely demonstrated that the status quo is not an option ; rather that we must now make that bold step to rethink our modus operandi together with our organised efforts at protecting mental health along public health lines.

## Conflicts of interest

JA has no conflicts of interest to disclose.

## Ethical standards

The author asserts that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval was not required for publication of this manuscript.

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