




Rapid review and commentary on the clinical implications of the population mental health consequences of the COVID-19 pandemic in Australia

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Abstract

Objective: To provide a rapid clinical review and commentary for psychiatrists on the population mental health consequences of the COVID-19 pandemic in Australia, including evidence-based findings and interventions.

Conclusions: Whilst there was evidence of collective psychological resilience during the first 2 years of the COVID-19 pandemic, younger women, carers for those with COVID-19, and those with more household chores, childcare needs and higher economic strain, were at more risk. Interventions should therefore target people with these socio-demographic risk factors, as well as severe COVID-19 survivors, their relatives and frontline workers. However, the rapid spread of the Omicron SARS-CoV-2 variant has the potential for greater impacts on population mental health. Innovations in telehealth and online therapy should be incorporated into standard care. Ongoing research is needed to assess who remains most vulnerable to negative mental health impacts of the current pandemic, and especially the longer term outcomes of mental ill health. Further research should also investigate evidence-based approaches to resilience and well-being. Prospective risk/benefit analyses of infection control measures, economic effects and mental health consequences are needed.

Keywords: COVID-19, pandemic public health restrictions, population mental health, evidence-based, mental health interventions

Although there has been concern over the mental health consequences of the current pandemic and associated public health measures,^{1–3} there is evidence that populations in high-income countries, such as Australia, were more resilient than expected.^{4–6} However, certain groups are at more risk of negative mental health impacts and require specific targeted intervention. These at-risk groups include the following: younger females (children through to young adults and mothers), frontline workers, those with general socioeconomic disadvantage

and culturally and linguistically diverse (CALD) people.^{4,6} To inform clinical practice, we provide a rapid review of the existing research findings on population mental

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health, early information on the impact of the Omicron SARS-CoV-2 variant, and what interventions may be useful, focusing on Australia.

Research evidence

We conducted a rapid, selective review of the literature for the mental health impacts of COVID-19 in Australia. This has the limitation that we cannot provide specific systematic information across the range of COVID-19 mental health impacts that we discuss here, and as the pandemic situation evolves, further updates will be needed.

Contrary to expectations,^{1–3} mental health consequences of the pandemic in Australia were generally short term and lower than increases world-wide.⁵ There were increases in help-seeking from crisis and support organisations (Lifeline etc), and medicare-reimbursed specialist mental health services.⁵ However, increases in anxiety and depression symptomatology in Australia in the first pandemic year (10%) were less than comparable countries (25%) where the early waves were less well controlled.⁷ Furthermore, anxiety and depression symptom levels in Australia, subsequently normalised towards baseline.⁸ When depression or anxiety symptoms occurred, it was ranked as being at low levels in approximately 80% of cases.⁸

These outcomes might have arisen from preventative public health measures in Australia that minimised community transmission of COVID-19 while limiting the costs on the total economy (although there were obvious negative effects on certain exposed sectors).⁹ Strict public health measures had initial negative emotional effects in the population, but seem to have been mitigated by governmental support measures, such as JobKeeper¹⁰ and deferred mortgage or rent payments nationally via financial institutions.

The Australian experience mirrors The Lancet's COVID-19 Commission Mental Health Task Force rapid review of the evidence to April 2021 which found that while anxiety, depression and distress increased during the early months of the pandemic, most (but not all) of these impacts returned to pre-pandemic levels by mid-2020.^{5,6} Severe restrictions such as night-time curfews implemented in Victoria were associated with rates of clinically significant anxiety and depression that were over 80% higher than other Australian states with lesser or negligible restrictions.¹¹ There was longitudinal evidence of resilience in terms of life satisfaction, social connectivity, loneliness and suicide rate.⁶ Helpful self-care approaches included volunteering, exercising, time outdoors in nature and reading.⁶

Clinicians need to remain aware that some people are more vulnerable to negative mental health impacts, including younger women and those with close proximity to illness, more household chores, more childcare needs, and higher economic strain.⁶ In addition, marginalised societal groups are vulnerable to multiple impacts and will need targeted clinical care.

Longitudinal rates of suicide demonstrated little change or an initial decline during the early part of the pandemic. Comparing observed to expected rates, there was no evidence of increased suicide rates in international interrupted time-series analyses of real-time suicide data from 21 countries (including Australia) from April 1 to 30 July 2020.^{5,12} In Australia, the ABS reported that the age-standardised suicide rate was 12.1 deaths per 100,000 people in 2020, a 6.2% decrease from 2019 (12.9/100,000).¹³ Figures from New South Wales and Victoria that cover nearly 60% of the Australian population and extend to the end of 2021 show similar numbers for both males and females over the last 3 years (Figure 1).

In Australia, ambulance attendances for self-injury and suicide attempts were relatively stable between 2019 and 2020.¹⁴ Data for mental health presentations to Emergency Departments are mixed. There was a decrease in Western Australia in the first 5 months of 2020 compared to the same period in the previous year.¹⁵ In Melbourne, increases in presentations for psychosis, anxiety or substance use during the 2020 lockdown were matched by decreases in those for mood disorders or suicidal behaviour compared to control periods.^{16,17}

In terms of inpatients, a study from Melbourne's North West Area Mental Health Service found a 12% decrease in admissions to four psychiatric inpatient units following the onset of the pandemic, compared to the control period.¹⁶ Further research on the performance of the Victorian mental health system during the pandemic found that there was slight improvement in state-wide bed occupancy from 94% in 2019 to 88% in 2020, although there remained regions with occupancies above 90%.¹⁸ Rather than psychopathology, most of the transient anxiety and depressive symptoms should therefore be seen as normal human responses to abnormal, threatening circumstances, including a loss of control, and disruptions to social connectivity or normal activities.¹¹ Of course, the longer term psychological and physical effects are unknown, as are those of new strains such as Omicron SARS-CoV-2 (Omicron hereafter).

The Omicron variant arrived in Australia on approximately 28 November 2021, and at the time of writing, mid-March 2022, all Australian states and territories are in the midst of moderate outbreaks with limited public health measures being taken by Australian Governments to control community transmission compared to previous waves. As yet, there is little known of the effects of the Omicron variant outbreak on population mental health, while some of the impacts in Australia are reasonably expected to be similar to the impact of the Delta-variant in countries that experienced higher transmission rates. One potential impact of Omicron increased infection rates is that more people will be hospitalised and some will require intensive care unit (ICU) support.¹⁹ Those admitted to ICU for the previous Delta-variant demonstrated significant anxiety, depression and post-traumatic symptoms.²⁰ Another likely significant mental health impact will be for healthcare workers in terms of burnout and

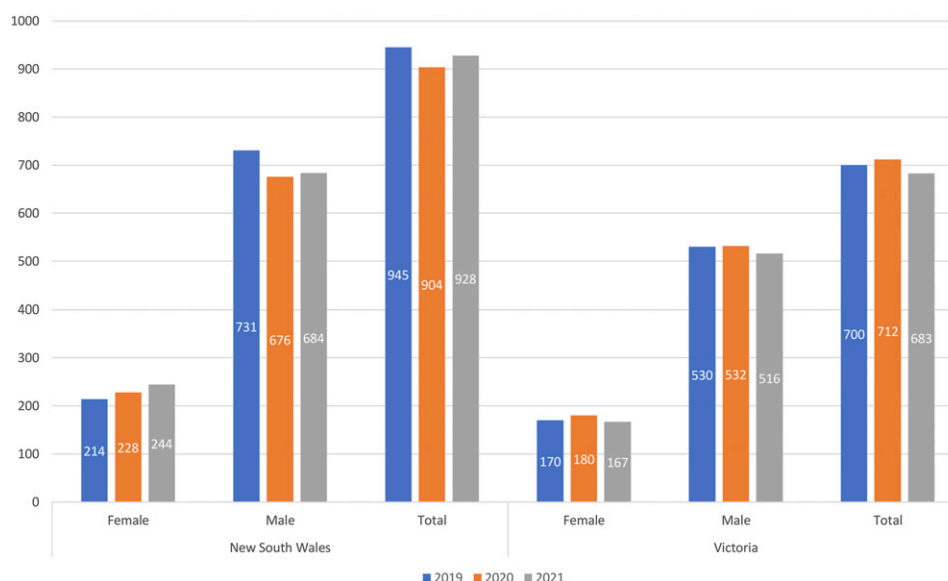


Figure 1. Numbers of suicides in New South Wales and Victoria 1 January to 31 December 2019–21. Sources: (1) <https://www.health.nsw.gov.au/mentalhealth/Pages/suicide-monitoring-system.aspx>. (2) <https://www.coronerscourt.vic.gov.au/coroners-court-monthly-suicide-report-december-2021-update>

Table 1. Clinical implications

1. Differentiate between normal and clinically significant psychological reactions.
2. Emphasise evidence-based well-being measures, for example, volunteering, exercising, time outdoors in nature and reading.
3. Consider needs for socioeconomic support.
4. Be aware of more vulnerable groups, for example, younger women, frontline workers, CALD people, people with socioeconomic disadvantage, and with the Omicron outbreak, older people, especially in residential aged care.
5. Screen for any exacerbation of existing mental illness as well as emergent illness in high-risk groups.
6. Use innovations in telehealth and online therapy to provide support during pandemic public health measures.

fatigue, especially seen in the previous Delta-variant outbreak.²¹ There might also be larger economic impacts due to effects of a poorly controlled pandemic, which might have secondary effects on mental health.

Recommendations

The evidence on trends in anxiety, depression, distress, loneliness, well-being, self-harm, suicide rates and psychiatric hospitalisations indicate that there was collective psychological resilience in the human population.^{4,5} Table 1 summarises the possible clinical implications.

However, responses to any further mental health effects of the pandemic should not be restricted to increased funding for clinical services but also include interventions at a policy and population health level. For instance, this could include further innovation and investment in evidence-based approaches to the promotion of resilience and well-being,⁶ as well as the ongoing provision of

economic and social supports that mitigate the effects of the pandemic and any public health measures, but also reduce disadvantage. Further research on the needs and interventions for improving social connectivity and meaningful activity during pandemic public health restrictions will help prepare for future events. Targeted action is required on support for marginalised, disadvantaged and at-risk groups more significantly impacted by the pandemic. Ongoing risk/benefit analyses of infection control measures, economic effects and mental health consequences are needed.

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