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Contents

Mental health services in the wake of COVID-19 and opportunities for change

Professor Kelly carries out a detailed analysis of the likely mental health needs in the context of coronavirus infectious disease 2019 (COVID-19).[1] The pandemic has indeed evoked a strong response in support of mental health provision worldwide in view of the realisation of both its direct and indirect effects on psychological function. In the UK, COVID-19 offers an opportunity to revisit the current state of mental health services and develop ways to maximise healthcare delivery.

Pre-existing declining performance indicators, serious shortage of skilled workforce and the increase in demand have taken a toll on mental health services in recent years.[2] This is the backdrop of the 2019 new funding bill in the UK, the 'long term strategy for the NHS in England', which might not be as generous as initially believed.[3] Awareness of the repercussion of COVID-19 on mental health is increasing as data becomes available. The unpreparedness towards the pandemic, the necessity to shift resources towards COVID-19, and recent data suggesting collateral casualties in those patients with cancer and other conditions (whose priorities have become secondary to the pandemic),[4] alarmingly suggest that shortcomings in mental health service provision may lie ahead.

Based on the documented psychosocial consequences of the severe acute respiratory syndrome (SARS) persisting beyond the duration of the infection,[5] a surge in COVID-19-related mental health problems is likely. The global scale of the magnitude of COVID-19 compared with SARS is much higher, 4,528:1 (and increasing) according to John Hopkins University (on 14/10/2020, 38,204,270 vs. 8,437 established cases).[6] These alarming figures, suggest that there is an urgent need for service planning to ensure that resources are proportional to the level of demand and sufficient to address inclusively all the individuals at risk (patients, those with pre-existing physical and mental health conditions, the general population and healthcare workers).[7] While championing for the extra resources, similarly to China,[8] community mental health teams would need to shift to online consultations for the foreseeable near future. This approach would greatly facilitate the assessment of individuals in quarantine or isolation, whereas online self-assessment tools could improve efficiency by screening participants in need of secondary-care mental health services. Patients with COVID-19 and individuals with pre-existing physical and mental health conditions could be routinely screened for common mental health symptoms as part of discharge planning and hospital-based liaison teams could be involved with overt or high-risk cases.[8]

In view of the work pressure affecting health workers, it would seem advisable to create a confidential mental health support online service to specifically provide information and address their psychological needs. Computer-based apps could deliver brief interventions to enhance mental health resilience while providing *ad hoc* practical information.[8,9] Aside the immediate changes to address mental health needs, COVID-19 will most likely define a new way of working in mental health for generations to come.

Declaration of interest

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1 Kelly BD. Coronavirus disease: challenges for psychiatry. *Br J Psychiatry* 2020; **217**: 352–3.

2 Iacobucci Gareth. Mental health services: CQC warns of "perfect storm" *BMJ* 2019; **367**:l6032.

3 https://www.independent.co.uk/news/health/nhs-funding-health-foundation-government-bill-a9318966.html

4 Lai AG, Pasea L, Banerjee A, et al. Estimating excess mortality in people with cancer and multimorbidity in the COVID-19 emergency. *medRxiv*; 2020. doi:10.1101/2020.05.27.20083287.

5 Tsang HW, Scudds RJ, Chan EY. Psychosocial impact of SARS. *Emerg Infect Dis*. 2004;**10**(7):1326–1327. doi:10.3201/eid1007.040090.

6 John Hopkins University. COVID Dashboard. John Hopkins University, 2020. Available from: https://coronavirus.jhu.edu/map.html

7 Arora T, Grey I, Östlundh L, Lam KH, OO, Arnone D. The prevalence of psychological consequences of COVID-19 amongst healthcare workers, the general population and COVID-affected patients: a systematic review and meta-analysis. *J Health Psychol*, in press.

8 https://blogs.bmj.com/bmj/2020/04/28/mental-health-support-in-wuhan-in-response-to-covid-19-pandemic/

9 Marshall JM, Dunsan DA, Bartik W. The digital psychiatris: in search of evidence-based apps for anxiety and depression. *Front Psychiatry* 2019;**10**: 831. doi:10.3389/fpsyt.2019.00831

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Author's reply

I am very grateful to Professor Arnone for his response to my editorial.[1] I agree that 'COVID-19 offers an opportunity to revisit the current state of mental health services and develop ways to maximise healthcare delivery'. There are many lessons to learn, not least of which is the need for community mental health teams 'to shift to online consultations for the foreseeable near future', as Professor Arnone points out.

Although I agree that we need to upskill in the area of online work and to increase access to technology, the pandemic has also highlighted the limitations of online working and consultations conducted while wearing face coverings. If these are the only methods available for assessing patients, they will suffice, but much is lost: certain aspects of facial expression, nuances of conversation and significant dimensions of rapport. We need to work on other aspects of these interactions to make up for these deficits.

Professor Arnone's point about funding is also very well made. Mental health services will play a key role in managing our responses to future resurgences of COVID-19 as well as the long-term consequences of the virus.

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Much of the distress linked with COVID-19 will be clearly associated with psychosocial problems (isolation, unemployment, bereavement), but some will be firmly biological, following from COVID-19 infection itself. Managing these kinds of complex, biopsychosocial problems is precisely what psychiatry has done for decades. Psychiatry has never been as purely biological as the biologists would like, or as purely psychosocial as others would wish. It is a unique mix, and COVID-19 is our greatest challenge yet.

Declaration of interest

none declared.

1 Kelly BD. Coronavirus disease: challenges for psychiatry. *Br J Psychiatry* 2020; **217**: 352–3.

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Response to the article 'The role of prenatal stress as a pathway to personality disorder: longitudinal birth cohort study'

We have discussed the paper by Brannigan et al[1] at our journal club, and we wish to raise some of the points that arose from a critical appraisal of this paper, and the panel discussion that ensued.

First, the figures presented in the abstract appear to be inaccurate. The figure 3.28 (odds ratio for any stress exposure) has been taken from the fully adjusted results; the figure 3.13 (odds ratio for exposure to moderate stress) has been taken from the unadjusted results, and the figure 7.02 (odds ratio for those exposed to severe stress) does not appear at all in the results. There appears to be an error in Table 1 – under the heading 'maternal psychopathology' the figures 3402 (93.8%) and 224 (6.2%) should be the other way around.

However, the main concerns raised were around the statistical methods used. 'There was some variability in the number of prenatal questionnaires returned. Therefore, we adjusted for the numbers of questionnaires returned to account for this.' This provides no information on how many questionnaires were returned by each participant and how this was adjusted for. Does this not mean that, for some participants, 'prenatal stress' could actually refer to 'self-reported stress during a single month of pregnancy'?

'A modal measure of stress was used as it best represented the individual scores when compared with the mean, which was less accurate due to variability in the number of returned prenatal questionnaires.' From this we were struggling to understand the reasoning behind use of the mode; we felt it possible that single highly stressful events would not have been captured in the final data.

By using diagnosis of personality disorder on a hospital discharge register as the primary outcome of interest, there were only 40 positive cases, and only 9 with no comorbid psychiatric diagnosis. This is a very small sample to compare with the 3586 without a diagnosis. Moreover, some of the covariates that the authors controlled for had groups of participants as small as one individual, which made the overall results too unstable to interpret.

Various psychosocial mechanisms were suggested, including 'early life separation from parents, childhood trauma and parenting styles', however, there was no suggestion that these variables were related directly to levels of prenatal stress.

Mental health support in the perinatal period is clearly of huge importance for the well-being of mother, baby and the wider family, and research into this area is needed. However, there is a responsibility to ensure that the statistics are robust, and conclusions justified, particularly in view of the extensive media coverage generated by this paper.

Declaration of interest

None declared.

1 Brannigan R, Tanskanen A, Huttunen MO, Cannon M, Leacy FP, Clarke MC. The role of prenatal stress as a pathway to personality disorder: longitudinal birth cohort study. *Br J Psychiatry* 2020; **216**: 85–9.

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Re: 'The role of prenatal stress as a pathway to personality disorder'

In their recent paper, Brannigan et al (2020) describe their examination of the relationship between self-reported maternal stress during pregnancy, and the subsequent development of personality disorder in the offspring. We would like to raise several points about the study and the conclusions drawn by the authors.

The study is based on the results of a subjective, single-item, three-point Likert scale completed at unspecified point(s) during pregnancy. Women were asked whether they had experienced 'no stress', 'some stress', or 'notable stress' since their last antenatal appointment. Of the entire cohort of 6468 women, 3626 completed the Likert scale questionnaire at least once during their pregnancy; these women were included in the analysis. A further 2842 women were not included in the analysis, presumably because they did not complete the questionnaire. We question whether this is a valid or meaningful measure of stress during the antenatal period.

A wide range of biological, psychological and social stressors may contribute to subjective feelings of stress. Perhaps it is the ongoing impact of these stressors, rather than prenatal maternal stress *per se*, that lead to the increased odds of a subsequent diagnosis of personality disorder. Furthermore, in many cases stress does not resolve immediately after giving birth: is it possible that ongoing maternal stress in the postnatal period (and beyond) might have a more significant impact on parenting practices, and thus on a child's development?

Maternal well-being and mental health is an important area of study, and the authors rightly note that there is a strong evidence base to support the use of interventions to reduce maternal stress. However, this paper implies a causal link between antenatal maternal stress and subsequent diagnosis of personality disorder that is not evidenced by the method and results presented here. We feel that research in this area should be reported carefully, to avoid contributing to a potentially harmful culture of mother-blaming.

Declaration of interest

none declared.

1 Brannigan R, Tanskanen A, Huttunen MO, Cannon M, Leacy FP, Clarke MC. The role of prenatal stress as a pathway to personality disorder: longitudinal birth cohort study. *Br J Psychiatry* 2020; **216**: 85–9.

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