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Earthquakes and COVID-19

We read with interest Goodwin et al's paper on 'Psychological distress after the Great East Japan Earthquake',[1] which featured in the March 2020 *BJPsych* themed issue on 'Disasters and Trauma'. This is timely given the current climate when the UK and other nations of the world are grappling with the disastrous consequences of infections with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) otherwise known as coronavirus disease 2019 (COVID-19). Although the physical impact of the global pandemic is yet to be adequately quantified, the huge psychological and social burdens on human existence are issues we need to start addressing in order to be ahead of whatever curve we may end up with globally.[2]

With time, society will be dealing with the psychiatric impact (in extreme cases) or the psychological impact (in not so extreme cases) of COVID-19. Bereavement, grief, loss, separation, anxiety, fear, paranoia, adjustment reactions and depression are foreseeable after-effects when life starts to return to what we previously considered 'normal everyday life'. Some degree of 'antisocial' behaviour will emerge with 'social distancing' becoming a norm, and physical distancing could become a weapon of subtle intimidation or bullying in the workplace or even at schools. Also, we cannot overlook supposedly minor conditions like anger or frustration fuelling the emergence or resurgence of violence against self, domestic violence and violence at the community level following such an impact on our daily lives. According to the charity Refuge, the National Domestic Abuse helpline has seen a 25% increase in calls and online requests for help since the lockdown.[3] Recently, the UK Parliament's Home Affairs Select Committee called for removal of the time limit on prosecutions to ensure perpetrators of domestic abuse during the lockdown do not get away with their crimes.[4]

Currently, there is no physical war between nations but there is a fight to contain a crowned virus – although small, pathogenic and not human, it is nonetheless powerful enough to crash the world system to a large extent. Our concern is that in addition to the above, the worsening or re-emergence of previous mental health problems in the context of a lockdown situation, as well as the new onset of mental health problems once the limitations or containment of lockdown is over could potentially overload primary and secondary mental health services.

Mental health services at all levels, including psychological services in primary care, bereavement services and secondary mental health services therefore need to start preparing for post-lockdown demand for care by making arrangements for how they will manage increased demands for services. Mental health promotion should be launched now and after the COVID-19 pandemic to prevent an overloading of the National Health Service via the mental health services' route. Proactive steps therefore need to be taken to make this overloading less likely. Will mental health services be prepared for the extra demands that will follow the aftermath of this pandemic? Only time will tell.

Declaration of interest

None.

1 Goodwin R, Sugiyama K, Sun S, Aida J, Ben-Ezra, M. Psychological distress after the Great East Japan Earthquake: two multilevel 6-year prospective analyses. *Br J Psychiatry* 2020; **216**: 144–50.

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4 Grierson J. Domestic abuse surge in coronavirus lockdown could have lasting impact, MPs say. *The Guardian* 2020; 27 April (https://www.theguardian.com/society/2020/apr/27/domestic-abuse-surge-coronavirus-lockdown-lasting-impact-mps).

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Authors' reply

We thank Drs Orlu & Olumoroti for their kind and thoughtful response to our paper on 'Psychological distress after the Great East Japan Earthquake'.[1] We agree that a focus on the psychological sequela of major societal stressors is a timely subject for study for psychiatrists, particularly given the mental health burden already evident as a consequence of coronavirus disease 2019 (COVID-19). Indeed, this novel coronavirus might be expected to place particular burdens on a wide range of the populace, worldwide. The data seems to support this. While in our study of the 2011 Japanese earthquake 10.2% of Miyagi refugees reported risk of severe mental illness (SMI) later during that year, data from COVID-19 suggests higher prevalence of SMI. Using the same measure and cut-off for psychological distress (the Kessler K6) national online surveys during March 2020 found 19.1% of Chinese at risk of SMI.[2] In April 2020 13.6% of US adults reported SMI, compared with 3.9% during 2018.[3] Using a national UK longitudinal survey and the General Health Questionnaire, the number of adults experiencing mental health problems (indicated by the 12-item General Health Questionnaire ≥ 3) rose from 23.4% (2017–2019) to 37.1% (April 2020).[4]

The main reason for this may be that COVID-19 is no 'normal' disaster. Unlike other novel zoonoses (such as the 2009 AH1N1 'swine flu') there can be a prolonged period of symptomatic or pre-symptomatic transmission, an ambiguity that can rapidly lead to the blame and stigmatisation described by Drs Orlu & Olumoroti. More than 12 months after the first case, exact transmission pathways are still unclear (viz: the current debate over aerosolisation), creating further uncertainty over effective preventive measures (for example 'safe' physical distancing, a requirement for masks with particular designs). There remains an additional risk that this coronavirus may continue to further mutate, potentially undermining vaccine efficacy. Subsequent risks cannot be readily limited to one exclusion zone (as, for example, is the case after a nuclear accident). COVID-19 infection (and subsequent mortality and morbidity) may well be seasonal and occurs in waves, with the novel challenge of national and local lockdowns that are released then re-imposed, making it difficult for both

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individuals and communities to plan their activities. Indeed, this changing landscape can seriously disrupt regular daily routines, incurring a further burden on mental health.[5]

Following major disasters only around a tenth of effected populations are chronically distressed.[6] Even for those who are initially distressed psychological health returns to pre-disaster levels within a relatively short period. Yet, unlike an earthquake or terror attack, COVID-19 threatens to pose a particularly sustained threat, with enduring health and economic consequences. During 'usual' disasters particular groups are especially vulnerable (such as women, the unemployed, those with pre-existing psychological disorders, those who have to relocate). With COVID-19 it is the young that seem particularly at risk of mental illness,[4] as well as those who have to spend time in isolation/quarantine.[2] Practitioners may need to be particularly mindful of their particular needs as the pandemic unfolds.

Declaration of interest

None.

1 Goodwin R, Sugiyama K, Sun S, Aida J, Ben-Ezra, M. Psychological distress after the Great East Japan Earthquake: two multilevel 6-year prospective analyses. *Br J Psychiatry* 2020; **216**: 144–50.

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Potential unintended consequences of removal of intellectual disability and autism from the Mental Health Act

Hollins et al argue for the removal of autism and intellectual disability from the Mental Health Act,[1] on the basis that they are not the same as the serious mental illnesses for which the Act is intended for. Although we would agree with the suggestion that both autism and intellectual disability are phenomenologically different from forms of serious mental illness such as affective and psychotic disorders, it is clear that such individuals can present with symptoms that present a substantial risk to themselves and/or others, without the need for a co-occurring mental health condition.[2]

Also of relevance is a recent article by McCarthy & Duff,[3] which details changes to mental health legislation in New Zealand, where the introduction of the Mental Health (Compulsory Assessment and Treatment) Act (MH (CAT) Act) 1992[4] intentionally excluded people with an intellectual disability and no co-occurring mental health problems. However, the unintended consequences of the legislative chasm left by this change was that it significantly limited the options for people with intellectual disability and offending behaviours, or indeed those with high-risk behaviours not qualifying as criminal offences. This led to such individuals being sent to prison, left in the community or in some individuals with very high levels of offending, being admitted to a forensic hospital. In order to correct for this issue, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 was introduced in 2004.[5] This enabled provision of compulsory care to people with an intellectual disability who had been charged or convicted of an imprisonable offence.

We would be concerned that removal of autism and intellectual disability from the Mental Health Act in the UK would have a similar impact to the introduction of the MH (CAT) Act 1992, leading to such individuals presenting with high risks to themselves and/or others potentially facing imprisonment or remaining in community placements that are unsuited for their complex needs. One suspects that this issue could be at least partially addressed by significantly increased investment in community infrastructure for individuals with intellectual disability and/or autism and particularly complex needs, but for as long as such infrastructure is lacking, many such individuals would be at risk of imprisonment or remaining in community placements that are inadequate for their needs.

Declaration of interest

Dr Tromans is the chief investigator on a National Institute of Health Research supported research study investigating adult autism prevalence within acute inpatient psychiatric settings, among both patients with and without intellectual disability. Dr Tromans is also a co-investigator on a National Health Service Small Business Research Initiative study investigating the utility of an autism tool.

1 Hollins S, Lodge KM, Lomax P. The case for removing intellectual disability and autism from the Mental Health Act. *Br J Psychiatry* 2019; **215**: 633–5.

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5 Ministry of Health. *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003*. Ministry of Health, 2003.

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