Public Mental Health and the Ethics of COVID-19 Lockdowns

Michael Wee

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About the Author

Michael Wee is the Education and Research Officer at the Anscombe Bioethics Centre, and a member of the Pontifical Academy for Life. He is also Associate Lecturer in bioethics at St Mary's seminary in Birmingham and has written for The Catholic Herald and Church Life Journal.

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Introduction

Since the advent of the ongoing coronavirus crisis, mental health has emerged as a major talking point in the media. Pandemics are a time of heightened anxiety for the population at large, **[1]** and this anxiety is also fuelled partly by the relentlessness of media cycles, and exacerbated by the rapid spread of false, often alarming information on social media. It is no surprise that there has been an increased interest in mental health self-help advice during this time, with many websites and organisations offering simple tips such as getting enough sleep, exercising and staying connected with others. **[2]** Tackling the specific problems associated with media consumption has also emerged as a common theme in some of these resources, which advise checking only reputable sources and limiting the time spent on watching or reading the news.

As good as all that advice may be, it should also serve as a salutary reminder that mental health care cannot be left primarily to self-help efforts and individual troubleshooting while containing and eradicating the spread of coronavirus take priority. Sometimes, that may be too little, too late. To use media consumption as a case in point, it is well known that in many jurisdictions there are guidelines related to reporting suicides, in view of the evidence that certain media portrayals of suicide can increase suicide rates in the community. **[3]** In such circumstances mental health concerns need to, and indeed do, proactively shape public policy. Prevention in this case is far better than reacting to problems only as they arise.

The Need for a Public Mental Health Perspective

Suicide, however, is far from the only mental health concern that ought to be brought to bear on policymaking. Yet there are obvious challenges afoot. Just to name three: 1) Mental health is not always treated as an immediate or high priority; 2) Mental health problems are often mistaken for character defects like laziness; 3) It can be difficult to pinpoint mental health concerns clearly and explicitly because ‘mental health’ **[4]** is such a broad term.

But let us take an analogy with physical health. Governments are known to impose, for public health reasons, strict rules on pollution, sugar-levels in canned drinks, and smoking, among other things. Additionally, authorities undertake positive promotion of public health through immunisation programmes and healthy lifestyle campaigns. No one expects society and the choices it makes available to be completely risk-free, but some degree of risk management is certainly appropriate. How might we think about public mental health with a similar attitude? If, for example, anxiety levels in the population were an explicit concern that shaped reporting guidelines on COVID-19, how different might news coverage around the world have looked, compared with what many of us have seen in the past six months? Adopting an attitude of shared responsibility for mental health, how might we seek to promote resilience in the population during a pandemic?

These questions are not entirely novel, **[5]** but they have become all the more urgent in relation to one significant feature of this pandemic – the imposing and easing of lockdowns in many cities and countries. Lockdowns, even when morally justified, raise many ethical issues, some of which have become clearer with the benefit of hindsight. The purpose of this briefing paper is therefore twofold: Firstly, to explore the key ethical issues relating to lockdowns, and secondly, to focus on mental health as a particular case study for how these principles might be applied to structure decision-making about lockdowns and other drastic public health measures.

I will begin by discussing the ethical considerations involved in imposing lockdowns. Authorities, as I shall argue, need to weigh up not just concerns about the loss of life (though such concerns are the primary motivating factor in this scenario) but also the impact of the lockdown on other aspects of the common good of society. I will then home in on the psychological impact of lockdowns, presenting some key aspects of mental health that should be weighed up in ethical decision-making, in the hope that such a process of ethical reasoning can help guide future policymaking in relation to pandemic lockdowns. I will conclude by posing seven questions which I believe are necessary to making public mental health a priority in governmental responses to pandemics and other health emergencies.

Lockdowns and Ethical Decision-Making

Numerous countries have imposed lockdowns, of varying degrees of severity, in their efforts to mitigate community transmission of SARS-CoV-2, the coronavirus responsible for the respiratory disorder COVID-19. Although these lockdowns may have helped slow down the spread of the virus, it is unclear what role mental health concerns have played in the decision-making processes of state authorities. Have such concerns been given due consideration before the imposition of restrictions generally unknown to peacetime, or have they been more of an afterthought? Many now fear the mental health impact of social distancing rules and lockdowns will be profound, the full extent of which we have yet to grasp. **[6]** Some groups that have been seen as particularly vulnerable to the effects of lockdown are children, those with existing mental health conditions, and those belonging to marginalised and vulnerable groups – refugees, the homeless, and those living with domestic violence, just to name a few.

At the time of writing, many countries have emerged from their respective lockdowns; shops and restaurants are open, and over the summer months in the Northern Hemisphere people were flocking to beaches, parks and beauty spots. At the same time, state authorities remain vigilant over signs of a 'second wave' of coronavirus – indeed, either lockdowns or tightened social distancing rules have been re-imposed in various places such as South Korea, Leicester and Melbourne. The question of whether lockdowns should ever be used again, even if they were justified the first time round, weighs heavily on many minds. Some have argued that whatever the future re-emergence of the virus may be like, lockdowns should never be imposed again on account of their overall damage to society and individual lives. It is worth reflecting on the ethics of lockdown, before discussing the mental health impact of lockdown as it relates to the ethical issues or questions identified.

The Ethics of Lockdown

It is perhaps a matter of broad agreement, among people of varying ethical and religious persuasions, that saving lives is one of the most important considerations – but at the same time, that it is not the only goal where individuals and where public policy are concerned, and that it does not necessarily override all other considerations. Certainly in relation to lockdown, many who argue about its merits at least do so with implicit acceptance of this ethical perspective. This is suggested by the fact that those who disagree with lockdown often do so either by disputing the actual epidemiological effectiveness of lockdown, **[7]** or else by arguing that other considerations – such as the lost potential of herd immunity, or the economic costs of lockdown, or else the loss of civil liberties – outweigh the case for imposing one. **[8]**

On an individual level and especially in relation to end-of-life decision-making, this ethical perspective is well-established, and is sometimes referred to as the ordinary and extraordinary means distinction in the medical ethics literature. **[9]** Ordinary means are those medical interventions – surgery or medication, for example – that, despite their risks, are proportionate to the benefits they promise. But there are instances where one may choose to forego even life-saving treatment because its negative side-effects are too burdensome in relation to the relatively limited benefits it may bring. Such treatment would be considered 'extraordinary means' and not morally obligatory.

This is not necessarily out of any disrespect for the value of life, or out of a desire to intentionally end one's life. It is simply that the costs – understood broadly – of the proposed treatment, such as any accompanying physical or mental suffering, are too great to bear. One thinks of a patient refusing chemotherapy or heart surgery when they are already old and frail – these interventions might extend life for a short while, but present many burdens or complications. In such situations few would suggest that life must be extended no matter the consequences. **[10]** But judgements about withdrawing or refusing treatment, no doubt, are also intensely personal and vary from person to person: whether they are right or wrong is a matter of what the individual can be reasonably expected to shoulder.

Where public health is concerned, a similar logic may be said to apply. The outbreak of a lethal and infectious disease requires containment measures for the sake of the common good. Just as we might accept risky surgery for the sake of better health where it is proportionate to the goal and the problem at hand, communities will sometimes have to put up with public health measures in order to combat an epidemic. The more infectious and lethal the disease, the more stringent the measures needed. Lockdowns are rarely used by governments, though their effectiveness in mitigating outbreaks has received some support in the literature by now, **[11]** even if this is not universally agreed upon. **[12]** They are, as one bioethicist argues, the 'nuclear option' – lockdowns are the most potent public health weapon we have for limiting a 'viral wildfire', though they should be avoided where possible. **[13]**

Yet mitigating disease is not, nor can it be, the sole concern of government. There may be situations where the costs – once again broadly conceived, and not just economic – of certain measures, including lockdowns, are simply too great for the community to bear. In such a case, a decision by the authorities not to impose lockdown would be akin to a patient

refusing extraordinary means that would have preserved their life. It may not be out of neglect of the value of the lives of those most at risk from the disease, and the foreseeable deaths need not be intended by those making such a decision.

Nonetheless, the sensitivities of such a scenario are self-evident. Authorities should make clear the rationale for their decision – whichever way it goes – so as to maintain public trust, as well as follow general principles of transparency and accountability.

Problems of Practical Reasoning

On this point, one may question what range of factors the legitimate authorities must take into account in such decision-making processes. This is a complex task and practical reasoning surely cannot require one to think of every possible or conceivable consequence – the more remote the effect, the less relevant, all other things being equal. That is why having a clear, coherent picture of different considerations to be weighed up is essential for informed decision-making on such a level. To that end, having a common language through established measures (e.g. of economic or social costs) is essential – with the caveat that one should guard against the risk of oversimplification or over-reliance on quantitative measures.

A related question concerns how much evidence might be reasonably required for any particular factors to play a critical role in decision-making. In situations of emergency, it would be impractical to wait for a full evidence base, and a certain degree of guesswork is expected and not unjustifiable. The first round of lockdowns around the world was imposed, it must be said, on the basis of hypothetical modelling or predictions at a time where comparatively little was known about SARS-CoV-2. Nonetheless, as new evidence comes to light, decisions can and should be continually reviewed.

It is outside the scope of this paper to evaluate whether the various lockdowns imposed in the first half of 2020 were justified on the basis of the principles just outlined. Local factors will often be decisive – for instance, population density may be a predictor of how quickly a virus is likely to spread, and furthermore critical care capacity is different in each country, and that is certainly a major consideration in determining whether or when to impose a lockdown. But what I wish to do in the next section is to try and illustrate, in more practical terms, the difficulties involved in weighing up factors when deciding whether a lockdown is proportionate or not where mental health is concerned, which is one significant consideration where costs need to be taken into account. This, it is hoped, will shed further light on the process of ethical reasoning necessary for such a decision.

Weighing Up the Psychological Impact of Lockdown

What might the psychological impact of lockdown be? Without undertaking proper data collection and regression analysis, it is hard to say with any degree of scientific accuracy. Nonetheless, it is possible at least to put together a broad snapshot. Beginning with overall demand for mental health services as an indicator, the UK's Royal College of Psychiatrists reported in May 2020 that '43% of psychiatrists have seen an increase in their

urgent and emergency caseload while 45% have seen a reduction in their most routine appointments'. **[14]** Neither statistic is particularly encouraging – the former may reflect the stresses of the pandemic, including of lockdown, while the latter may be a sign of 'pent up demand', with regular patients not accessing mental health services until it is too late, **[15]** possibly due to a fear of infection.

More generally in the UK population, the Office for National Statistics (ONS) revealed that at the beginning of lockdown 49.6% of people reported high anxiety, and in particular 39% of those married or in a civil partnership reported high levels of anxiety, compared with 19% in the last quarter before the pandemic. **[16]** No doubt, increased time spent at home, the loss of social contact and of usual coping strategies – which for many might be embedded in the workplace and local communities such as churches and sports groups – will have contributed to these statistics.

This finding from the ONS is consistent with previous studies of epidemic-related isolation, with those who have a history of psychiatric illness being particularly vulnerable to increased anxiety due to isolation. **[17]** Indeed, those with pre-existing mental health problems have often been singled out as an at-risk group during this pandemic for worsening mental health, **[18]** alongside other vulnerable groups such as young adults, those who are older and isolated and those with long-term, disabling physical health conditions, just to name a few. **[19]** Children are also potentially at risk, particularly those for whom school has been a 'de facto mental health system'. **[20]** For many students around the world schools closures may have led to increased mental health problems. **[21]**

In the long-term, the psychological impact of lockdown has to be considered in relation to its economic impact, given that poverty is 'a major risk factor for poorer mental health at any age' and employment 'is strongly evidenced as a determinant of mental health, with mental health problems more common amongst people who are unemployed and those in precarious work'. **[22]**

Practical Issues in Decision-Making

No doubt, one can imagine the difficulty in weighing up mental health-related variables – which may appear ill-defined – against the threat of a new, lethal virus, which presents a far more tangible consideration, in order to make an informed ethical decision about lockdown. Nonetheless, as even the broad snapshot outlined above should suggest, it is clear that simply staying at home to curb viral transmission is by no means a 'neutral' option that might save lives with just minimal impact on the population.

At the same time, an inescapable question for any decision-maker is: How many of these mental health effects would have been felt even without a lockdown, and with pandemic related infections and deaths rising? Even without a full lockdown in those countries that pursued such a strategy, many firms would have asked employees to work from home; people might be more cautious about going outside; shops and restaurants may have had reduced opening hours, or even closed temporarily due to sharply decreased demand. In a global crisis of this kind, not having a lockdown is no guarantee to preventing economic disruption – in the second quarter of 2020, Sweden saw its economy shrink by 8.6%, its largest ever quarterly fall in Gross

Domestic Product in decades (although other European countries which undertook lockdowns have fared worse, by the same measure). **[23]**

Nor should the onset of mental illness be seen as inevitable if appropriate protective measures are taken **[24]** and early mental health care responses provided to those who do develop symptoms of anxiety and anger. **[25]** One notable strategy in this pandemic has been the increase in telemedicine, with psychiatry being no exception, and temporary funding during a pandemic lockdown for telepsychiatry services can be used to 'target vulnerable patient populations to mitigate high-risk, high-demand situations'. **[26]**

Going beyond more clinical and therapeutic approaches, it is also useful to point out that even as economic disruptions may lead to an increased risk of mental health problems, properly calibrated responses that address the social and material welfare of those at risk can also help to mitigate the psychological impact of public health measures, and may even serve to target more underlying, systemic issues that cause vulnerability in certain populations in the first place. As one author puts it, how much use is a meditation app for a woman who has lost her job and cannot feed her family? **[27]** By contrast if an economic disruption is dealt with swiftly and according to principles of justice and equity, then so can mental health issues arising from poverty be tackled.

One may also be surprised to find positive mental health effects arising from pandemics and even lockdowns. While children and adolescents are often seen as an age group of particular concern, given that about half of mental health problems begin by age 14, **[28]** one study found that school closures actually led to a drop in anxiety levels among teenagers. **[29]** While there were many predictions of suicide rates increasing following lockdown, this has not always been borne out by the evidence. Just to take one example, Japan – which is known for its high suicide rate – saw a 20% reduction in its suicide rate in April, with speculation that this may have been due to the 'daily stresses of work and school' being reduced by lockdown. **[30]** In New Zealand, the Chief Coroner actively refuted rumours that the suicide rate increased during lockdown, and it was also reported that 'calls for service to police in relation to mental health and self-harm related matters remain steady, with no significant spike or decline'. **[31]**

Another perspective that ought not to be neglected is the potential for developing resilience in a pandemic, by tapping on 'altruism, empathy, trust and amity':

> *Different communities and cultures have different inherent characteristics and mechanisms which determine how well they can resist the negative effects [of the COVID-19 pandemic]. Resilient societies, like resilient families, depend on their members' ability to create and maintain good relationships based on human dignity, respect, cooperation, compassion and empathy. Moral psychology shows that empathy acts as social glue, increases cohesiveness and cooperation between individuals as well as between communities and societies*. **[32]**

Indeed, the whole idea of post-traumatic growth, which provides a useful counterpoint to post-traumatic stress, is a major theme in the field of positive psychology, **[33]** and serves as a timely reminder that the narrative of mental health that we can weave from a context of

crisis is not necessarily negative. In fact, it is incumbent on us to find sources of resilience and post-traumatic growth to combat the negative psychological effects of public health measures. Returning to a theme from early on in this paper, part of this responsibility no doubt falls to the media, who play an important role in shaping narratives around a pandemic. While drawing attention to the potential negative psychological impact of a pandemic or of public health measures is right and proper, an over-emphasis on the negative – at the expense of promoting solidarity and common meaning – may itself lead to fatalism about mental health in a pandemic.

Key Takeaways for Ethical Analysis

This discussion, it is hoped, shows that mental health alone is already a complex area where the trade-offs in relation to a policy of lockdown are concerned. A government may quite reasonably conclude that too lengthy a lockdown may simply be too calamitous for a country, in both economic and psychological terms, despite some lives being saved. On the other hand, a government may also decide that a lockdown of specified length is justifiable for the sake of the public health benefits of viral transmission being curbed, but provided that targeted measures are put in place to also mitigate or prevent a concurrent epidemic of mental health issues, many of which might occur even without a lockdown.

But more importantly than specific decisions that might be taken is, for the purposes of this paper, the process of ethical reasoning behind them. Some key takeaways that, in my view, can help inform future thinking about mental health and lockdowns are:

- It is not a given that lockdowns are always justified as a response to an infectious disease, just because they may save lives. Lockdowns may be judged too costly – with cost broadly construed – to be ethically justified, but this does not necessarily amount to intending the deaths of those who might be saved with a lockdown.
- Nonetheless, governments must be clear about the trade-offs involved in pursuing a lockdown or in not pursuing one, and communicate their reasoning process clearly to their citizens. The psychological harms and benefits of lockdown must be given due consideration, as well as the ability to target potential negative effects – keeping in mind that negative effects are not always inevitable.
- The variety of mental health consequences from lockdowns suggests that different groups in the population are at different levels of risk and will be affected differently. More work must be done to find out the precise nature of different at-risk groups. Such work will likely point towards pre-existing structural inequalities that epidemics, and particularly lockdowns, will expose even further, through the uneven mental health effects of public health measures. These structural problems may make certain mental health effects more difficult to target in the midst of an ongoing epidemic.
- Even the decision not to impose a lockdown does not free governments from concerns about mental health problems, which are likely to pose an additional challenge during any epidemic.
- Furthermore, the fact that in some circumstances there may be psychological benefits to be gained from lockdown, or at least a reduction of regular stressful social activities, points to everyday problems that we do not notice or acknowledge, let alone

think to support. A return to the hurly burly does not mean a return en masse to a healthy psychological state, but may for some be a return to the usual range of stressors, for which they will need additional support.

Conclusion: Making Public Mental Health a Priority in Pandemics

As mentioned, it was not the intention of this paper to argue for one conclusion or another in relation to whether lockdowns imposed in 2020 have indeed been justified from an ethical point-of-view. Instead the point has been to elaborate on the practical reasoning processes that are necessary for such decisions to be made well, and to shed light on the complexity of such policymaking in a pandemic, with specific reference to the case of mental health.

In one sense, none of this ought to be terribly surprising. There are always trade-offs in acting one way or another, particularly in a rapidly evolving crisis. Not to act in a particular way is not necessarily to be free of responsibility for consequences. A similar logic to what has been applied to mental health will surely be of use for considering, for example, economic consequences in deciding whether or not to impose a lockdown. Yet it is also the case that mental health is not often thought about explicitly, or accorded due weight, in public policy decisions that may have to be taken quickly. Hence it is hoped that this briefing paper makes some contribution to redressing this situation, by outlining key points for consideration in thinking about mental health factors in a decision regarding lockdown. The notion that mental illness is not inevitable is not an excuse to disregard mental health, but an invitation to think more proactively about public mental health as a necessary component of any comprehensive response to a health emergency such as an epidemic that may require onerous public health measures.

At the outset of this paper, I suggested that one barrier to public mental health becoming a more potent driving force in public policy is the difficulty of pinpointing mental health concerns clearly, leading to mental health being overlooked because the concept is too broad or too general. Tomlinson and Lund note that mental health is still not an established global priority in part because 'it has been difficult to develop a common construct that can be promoted'; mental health, they contend, needs to speak 'in the language of national and international policy makers' in order to gain greater prominence. **[34]**

The work needed to develop such a common language is likely to be a long-term endeavour. But at present, a clear sense of the ethical questions that must be addressed is indispensable. Alongside the process of ethical reasoning that is needed, of which the last section provides a summary, the following practical questions should be kept in mind in order for mental health to be accorded due importance in the decision-making process:

1. Which groups in society might be particularly vulnerable mental health-wise as a result of the proposed public health measures?
2. 2. What is the wider impact of such public health measures on general mental health, especially in relation to increase in risk factors (e.g. isolation) and the loss of protective factors (e.g. access to religious/ community support)?

3. What might the overall impact on suicide rates and demand on mental health services be?
4. Is this significantly worse than the mental health situation that would be brought about in the health emergency without such public health measures being undertaken?
5. What steps can be taken to mitigate mental health issues arising from the crisis as a whole, and in particular, public health measures?
6. What structural causes of mental health issues need to be targeted and addressed as part of the response to health, economic and social impacts of the crisis?
7. How can resilience and psychological growth be encouraged and promoted as a narrative in the crisis?

Endnotes

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[9] See, for instance, 'Editorial: Ordinary and extraordinary means', *Journal of Medical Ethics* 1981;7:55–56, doi: https://doi.org/10.1136/jme.7.2.55 The term 'ordinary and extraordinary means' has historically been

associated with Catholic thought in medical ethics, though as this editorial points out, it has come to be used by non-Catholic thinkers as well. Nonetheless, it is worth noting that different scholars use the terms with different nuances or criteria in mind. For a Catholic perspective on the historical development of the term and conceptual interpretation of it, see P. Taboada, 'Ordinary and Extraordinary Means of the Preservation of Life: The Teaching of Moral Tradition', presented at the 14th General Assembly of the Pontifical Academy for Life, Vatican City, Feb 2008, and reproduced in *Catholic Culture*: https://www.catholicculture.org/culture/library/view.cfm?recnum=8772

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[20] E. Golberstein *et al.*, 'Coronavirus Disease 2019 (COVID-19) and Mental Health for Children and Adolescents', JAMA Pediatrics 2020;174(9):819–820 at 819, doi: https://doi.org/10.1001/jamapediatrics.2020.1456. Data from 2012- 2015 suggests that in the US, of adolescents who used mental health services, 57% accessed school-based mental health services, and 35% used these school-based services exclusively.

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The Anscombe Bioethics Centre
82-83 St Aldate's, Oxford, OX1 1RA, United Kingdom
Tel: 07734 964 620
Email: admin@bioethics.org.uk
Reg. Charity No. 274327