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expectations for service-user involvement and leadership in research proposals, and ensure that established bodies of research do not become barriers to authentic community-led innovation.^{4,9} Too often, funding processes re-inscribe existing hierarchies and established interventions by rewarding proposals that build on, and hew to, existing published work. High-risk high-reward funding streams are typically present in the basic and translational sciences or new research areas such as digital health, with such language rarely used to refer to or fund user-led innovations. To achieve deeper change, funders must be open to new ideas and new directions, guided by those on the receiving end of services.

Is the above pipeline merely a pipe dream? Our belief is that senior researchers, large research centres, and training programmes could readily take the steps described above, including substantially greater hiring, mentoring, and support of under-represented students and researchers with lived experience. Were it a priority, research funding bodies could—with relatively minor modifications to programme announcements—directly support meaningful involvement and leadership.

Failure to do the above is neither a fault of structures over which the field has no control nor stigma among some other group, but it is an individual choice on the part of those in positions of power to remain stagnant

and perpetuate processes and lines of research that marginalise the experiences and knowledge of the very populations this research aims to serve. Rather than bold language, we call for bold action.

We declare no competing interests.

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Mixed signals about the mental health of the NHS workforce

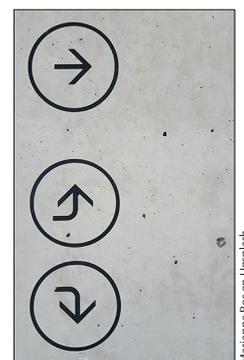


In the past few months, media headlines regarding the mental health of the UK National Health Service (NHS) workforce during the COVID-19 pandemic have reported or predicted large-scale problems ahead—eg, “Coronavirus is whipping up a mental health storm for NHS workers”, and forecasting a “tsunami” of mental health problems having “catastrophic consequences”. A 2020 systematic review of the mental health of health-care workers during previous pandemics also suggests an increase in distress and post-traumatic stress.¹

Anyone working in the health service at present has likely noticed another tsunami—a proliferation of surveys on health-care workers. If the generated evidence led to improved conditions and support for staff, multiple studies might be acceptable; however, concerns about the quality of some of these surveys mean that survey fatigue seems a more likely outcome.

Many studies lack explicit sample frames and appear to have very low response rates, making the representativeness of their results questionable—eg, a survey of health-care workers done in May, 2020, had a response rate of around 0.06% (868 responses from approximately 1.5 million NHS staff). Many surveys are cross-sectional, which, while potentially useful as snapshots, offer little to identify which factors might be predictive of mental health problems, and hence few possible foci for interventions. Also, we must remember that mental health questionnaires are not diagnostic. They overestimate rates of disorders when compared with gold standard structured psychiatric interviews, especially when completed by non-representative participants recruited through convenience sampling.

Studying health-care workers in isolation prevents us from understanding whether the effect of the pandemic



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For The Guardian article "Coronavirus is whipping up a mental health storm for NHS workers" see <https://www.theguardian.com/commentisfree/2020/may/28/coronavirus-mental-health-storm-nhs-workers>

For Royal College of Psychiatrists press release forecasting 'tsunamis' of mental illness see www.rcpsych.ac.uk <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/05/15/psychiatrists-see-alarming-rise-in-patients-needing-urgent-and-emergency-care>

For Institute for Public Policy Research newsletters 'Care fit for carers' see https://www.ippr.org/files/2020-04/1587632465_care-fit-for-carers-april20.pdf

on their mental health is different to other key workers or the general population. This understanding requires large-scale population studies containing sufficient numbers of health-care workers, and, ideally, other key workers (eg, transport and utility workers). For example, analysis of the UK population Understanding Society study (with prepandemic and postpandemic groups) found no increase in mental distress among health-care workers due to COVID-19 compared with the general population.² Similarly, an April, 2020, cohort study of wellbeing during the COVID-19 pandemic found no association between key-worker status and anxiety or depression,³ and a study using the Avon Longitudinal Study of Parents and Children database found no increased risk of anxiety or depression in key workers or health-care workers.⁴ However, another UK population study found significantly higher prevalence of depression, anxiety, and post-traumatic stress disorder in frontline workers (including health-care workers) compared with the general population.⁵

So, although substantial increases have been seen in mental health problems for the population in the UK as a whole in April, 2020, compared with 2017–19,⁶ whether this increase is a greater problem for health-care workers than for the rest of the population is uncertain. Somewhat surprisingly, some evidence exists of a significant association between being a key worker and reduced stress.³

Several possible explanations exist as to why many surveys of health-care workers alone report high rates of mental distress. First, study participation might be disproportionate among unwell staff. Second, increased distress might be temporary, especially around the height of the pandemic. Third, high symptom reporting might represent non-pathological distress, which should be normalised and supported via peer support, Schwartz rounds, and active monitoring, rather than formal psychiatric interventions, which ought to be provided if disorders are present. Fourth, survey or response bias might be present. If occupation-specific surveys (eg, teachers, police officers, health-care workers) are compared with general population studies, we consistently see increased rates of mental ill-health in the occupation-specific surveys.⁷ This finding might have a complex explanation, but we should be cautious when interpreting results from mental health surveys targeting single occupation groups. Finally, specific

increases in symptom reporting by health-care workers could also be magnified by demographic differences in the NHS workforce, such as gender and ethnicity.⁸ Given the heightened risks of both COVID-19 and mental health problems in specific demographic groups, investigation of differences and possible confounding is needed.

Additionally, aggregate surveys are likely to hide more nuanced differences. A single prevalence of mental health problems could obscure different reactions—from those with worse mental health because of the increased pressures COVID-19 has placed on the NHS, while some will have thrived due to the positive challenges, team working, and life-saving experiences.

What is needed now in research is quality, not quantity. Standardised psychiatric interviews, longitudinal designs, well defined sample frames, and assessment of response rates and bias. If we do not take these steps, we risk unnecessarily pathologising ordinary responses to extraordinary situations, and overlooking those most at risk. Rigorous research will provide evidence that can be used to improve the support offered to health-care workers. Even if some surveys did show that health-care workers have higher rates of mental health problems than before the pandemic, but no worse than confirmed increases in the general population, clear increases in the prevalence of mental health problems have been seen overall, and previous long-term research of doctors' wellbeing showed general distress rates of 30–50%.⁹ This research found that meal breaks and sleep affect mental wellbeing more than the number of hours worked.⁹ This findings was echoed in 2020, in Wuhan, China, where health-care workers reported a need for adequate rest and personal protective equipment rather than mental health interventions.¹⁰ If confronted with a second wave of the COVID-19 pandemic, we should not be surprised that health-care workers' first priorities continue to be for simple things—equipment, training, meals, and sleep—which, if compromised, can affect their mental health.

So, while the NHS is working on its mental health offer to its staff, some caution is needed. Not all surveys are created equal, and the true picture of wellbeing among health-care workers is likely to be more complex than as portrayed in the headlines.

NG reports personal fees from March on Stress outside of the submitted work. NG is the Royal College of Psychiatrists Lead for Trauma and the Military and have provided advice to the Royal College of Psychiatrists during the COVID-19

For the NHS People Plan for 2020/2021 see <https://www.england.nhs.uk/ournhspeople/>

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The missing global in global mental health



In 2020, *The Lancet Psychiatry* published a Position Paper by Moreno and colleagues¹ in which the authors claimed “an international group of clinicians, mental health experts, and users of mental health services has come together to reflect on the challenges for mental health that COVID-19 poses.” The authors recommended putting in place service provision that targets health needs and reduces disparities, both globally and within individual countries.¹ Although the authors claimed to be an international group of 24, there were no representatives from low-income and middle-income countries (LMICs) of Africa and Asia (except China), which together account for more than half of the world's population. Apart from some research and practice evidence from China, the rest of the evidence was from high-income countries (HICs) and the authors, with the exception of the author from China and one author from Colombia, were also from HICs. We believe this shows a systematic failure to ensure equity and representation at multiple levels, starting with the journal's editorial team, the peer reviewers, and the authors themselves. Beyond political correctness and token representation, global mental health should reflect equitable partnerships and incontrovertibly global collaborations that bring forth issues affecting the global community. Some of the world's densely

populated regions with complex settlement patterns are located within LMICs.² Furthermore, LMICs host 85% of the global refugee population³ and constitute some of the most socially interconnected communities. Beyond the direct health impact of the pandemic, the traditional way of life in many LMICs has been altered, and communities in these settings have been substantially affected by social disruption and isolation. For most LMICs, COVID-19 poses serious social, cultural, human rights, and mental health crises.⁴

Even in the pre-COVID-19 era, mental health services in LMICs were poorly developed and access to mental health care was substantially complicated by pervasive stigma, weak infrastructure, inadequate services, and widespread poverty. When the pandemic developed, health and social care systems were completely unprepared and inadequately equipped. The pandemic-induced disruptions in mental health services and human rights violations have worsened the vulnerability of individuals with pre-existing mental health conditions. Some countries have redirected their mental health resources to the COVID-19 response, raising issues of equitable access to mental health care.⁵ Additionally, there have been reports of increases in intimate partner violence since the outbreak of the pandemic.⁶ Distinct from HICs, there has been an