



COVID-19 in Western Australia

Bulletin 2: The impact on mental health



Contents

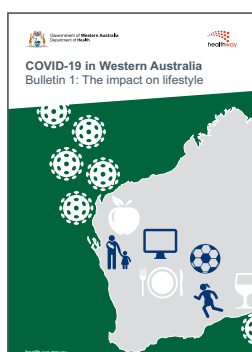
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Introduction

COVID-19 has resulted in unprecedented changes to the daily lives of Western Australians.

This bulletin is the second in a series of bulletins produced by the Epidemiology Branch of the Department of Health investigating the impact of COVID-19 on various aspects of the lives of Western Australians. This bulletin investigates the impact of the COVID-19 pandemic on the mental health of the Western Australian population. Bulletin 1 presents an introduction to the project and an overview of the COVID-19 control measures in Western Australia, as well as lifestyle impacts of the COVID-19 control measures.

Please find Bulletin 1 here:



<https://ww2.health.wa.gov.au/Reports-and-publications/COVID19-in-WA-bulletins>

Despite the current success in controlling COVID-19 in WA, concerns remain about what impact the pandemic may have had on mental health. This bulletin reports on data from three different sources to describe changes in mental health that occurred during the first period of COVID-19 restrictions in WA. The identification of any impacts on mental health is vital to understanding, and responding promptly, to issues that could arise if restrictions are required to be reintroduced in the future.

Mental Health

Mental health refers to the capacity to interact with people and the environment, and the ability to negotiate the social interactions and challenges of life without experiencing undue emotional or behavioural incapacity (1).

Mental health problems encompass a wide range of conditions that vary in severity and duration (2).

COVID-19 control measures

For WA, the major impacts of the COVID-19 control measures, so far, have been felt during March, April and May 2020. For a timeline of COVID-19 interventions and case counts for WA during this period, please see Bulletin 1.

Responses to COVID-19 during this time included stay-at-home orders, physical distancing recommendations, the closure of recreation facilities and non-essential businesses, limits on the sale of medicines, recommendations for home-schooling and purchase limits on staple food items and takeaway alcohol.

Methods

To better understand the impact of the COVID-19 pandemic on the mental health of the WA population, the WA Department of Health used data collected from three different sources, reflecting different aspects of mental health.

1. The **WA Health and Wellbeing Surveillance System (HWSS)** collects information on the mental health and wellbeing of WA residents via a population-based survey. This survey provides information on population level mental health, including aspects of social and psychological behaviour, that are not collected by other data sources.
2. The **Mental Health Information Data Collection (MIND)** collects information on the use of public, community-based mental health services. Occasions of community mental health service use are a key indicator of the demand and provision of services for less severe mental health issues.
3. The **Emergency Department Data Collection (EDDC)** collects information on all presentations to Emergency Departments (EDs) at public hospitals in WA. Presentations can be classified as to whether they are related to mental health or alcohol and other drug (AOD) consumption (these categories are not mutually exclusive, for example ED presentations for conditions such as delirium associated with alcohol withdrawal would be included in both categories). Presentations at EDs reflect acute health care need and the more severe end of the mental health spectrum. Alcohol and other drug (AOD) related presentations at EDs reflect behaviours that may indicate underlying mental health problems.

Introduction to the HWSS



The HWSS is a continuous data collection initiated in 2002 to monitor the health status of the population of WA. A random sample of approximately 550 Western Australians is interviewed each month via computer-assisted telephone interviews. The sample is weighted to reflect the Western Australian adult population.

In addition to the standard information collected by the HWSS, a number of COVID-19 specific questions were included in the HWSS from 1 May 2020.

Key indicators of population level mental health from the HWSS include: the proportion of people experiencing high or very high levels of psychological distress as measured by the Kessler Psychological Distress Scale (K10); the proportion of people often or always feeling a lack of control over life in general, over personal life, and over health; and diagnosis of a mental health condition, or use of a mental health service, in the last 12 months.

The Kessler Psychological Distress Scale (K10) is a standardised instrument consisting of 10 questions that measure psychological distress by asking about levels of anxiety and depressive symptoms experienced in the past four weeks. Each item on the K10 scale is scored from one 'none of the time' to five 'all of the time'. Scores of the 10 items are then summed, resulting in a range of possible scores from 10 to 50. These scores are categorised into low, moderate, high and very high levels of psychological distress (3,4). Low psychological distress is regarded as not requiring any intervention, while moderate and high levels require self-help and very high levels require professional help (4).

Feelings of control relate to an individual's belief as to whether outcomes are determined by external events outside their control or by their own actions (5). Feelings of a lack of control have been found to have an adverse effect on health and to increase the risk of mortality (6). Higher self-control is also related to better self-reported general health, higher emotional wellbeing, higher fruit and vegetable intake, lower consumption of alcohol and cigarettes, as well as a lower BMI (7).

For more information on the HWSS, including the questionnaire used, see: <https://ww2.health.wa.gov.au/Reports-and-publications/Population-surveys>

Introduction to the MIND



MIND was established in 2018 to replace the Mental Health Information System. Data are sourced from administrative and clinical management systems. The collection records information about public community-based mental health occasions of service to support planning and monitoring of mental health services in WA. This data source does not collect information from private service providers.

For more information on MIND see: <https://www.datalinkage-wa.org.au/data/available-datasets>

Introduction to the EDDC



The EDDC is a comprehensive data set of all presentations to EDs at public hospitals and major contracted health entities Joondalup Health Campus, Peel Health Campus and St John of God Midland in WA. In addition to data specifically related to episodes of care within ED, the collection also includes demographic data.

For more information on EDDC see: <https://www.datalinkage-wa.org.au/data/available-datasets>

Population mental health

Analysis and interpretation of the HWSS

For the standard HWSS questions, this bulletin compares responses from March-April-May 2020 ('COVID-19 period') to an average of responses for the same three-month period over the previous five years (2015-2019). These long-term averages serve as a 'baseline period' so comparisons can provide an indication of the impact of COVID-19 restrictions on the mental health and wellbeing of the WA population.



COVID-19 period	Baseline period
March-April-May 2020	Average of March-April-May 2015-2019

Results are based on responses from 1,803 adults within the State for the COVID-19 period, and 8,946 adults for the baseline period. Results are for adults from 16 years unless otherwise specified.

The COVID-19 specific questions are available for 635 adults for May 2020 only.

For important additional information on the analysis and interpretation of the HWSS, including information on the demographic characteristics of the sample, please refer to Bulletin 1.

Results

There were only minor changes in key indicators of mental health collected in the HWSS during the COVID-19 period compared with the baseline period. There was a slight increase in the proportion of the population experiencing high or very high levels of psychological distress. In addition, the proportion of the population reporting that in the last four weeks they often or always felt a lack of control over their lives, over their personal lives and/or over their health, slightly increased. None of these differences were statistically significant.

Key indicator	COVID-19 period	Baseline period
Prevalence of high or very high psychological distress	10%	8%
Males	10%*	8%
Females	10%*	9%
16-64 years	11%	9%
65+ years	3%	4%

Key indicator	COVID-19 period	Baseline period
Often or always feeling a lack of control over life in general	7%*	5%
Males	9%*	4%
Females	5%*	6%
16-64 years	8%*	5%
65+ years	3%	3%
Often or always feeling a lack of control over personal life	6%*	4%
Males	7%*	3%
Females	5%*	4%
16-64 years	7%*	4%
65+ years	2%*	2%
Often or always feeling a lack of control over health	7%	5%
Males	7%*	4%
Females	6%*	6%
16-64 years	7%*	6%
65+ years	4%	5%

*Survey estimate has a Relative Standard Error of between 25% and 50%, meaning there is a higher chance that the survey estimate is different from the population results and should be used with caution.

There were increases in the proportion of the population reporting a current mental health condition (diagnosed by a doctor in the last 12 months), including a statistically significant increase amongst men. The proportion who had used a mental health service (for example a psychiatrist, psychologist or counsellor) in the last 12 months (recent use) also showed an increase across males and females, as well as younger and older age groups. However, none of these differences were statistically significant. As both current mental health condition and recent mental health service use relate to the past 12 months we cannot be certain any changes were specifically due to COVID-19.

Key indicator	COVID-19 period	Baseline period
Current mental health condition	21%	14%
Male	23% [#]	9%
Female	19%	19%
16-64 years	24%	15%
65+ years	7%	10%
Recent mental health service use	15%	8%
Male	16% [*]	8%
Female	14%	9%
16-64 years	17%	10%
65+ years	3%	2%

*Survey estimate has a Relative Standard Error of between 25% and 50% and should be used with caution.

Statistically significantly different.

Respondents in May were also asked what impacts the COVID-19 emergency had on their daily lives.



22%* were unable to work in their existing employment

35% experienced a loss of income

44% were very or fairly worried about the outbreak

44% felt isolated from family and friends



*Survey estimate has a Relative Standard Error of between 25% and 50% and should be used with caution.

Who was impacted?

Men



11%*
unable to work
in existing job

23%*
experienced a
loss of income

Women



32%*
unable to work
in existing job

45%
experienced a
loss of income

People aged 16-64 years



26%*
unable to work
in existing job

40%
experienced a
loss of income

People aged 65+ years



8%
unable to work
in existing job

14%
experienced a
loss of income

*Survey estimate has a Relative Standard Error of between 25% and 50% and should be used with caution.

Who was worried?

Men



46%
worried about
the outbreak

39%
felt isolated from
family and friends

Women



43%
worried about
the outbreak

49%
felt isolated from
family and friends

People aged 16-64 years



42%
worried about
the outbreak

45%
felt isolated from
family and friends

People aged 65+ years



54%
worried about
the outbreak

41%
felt isolated from
family and friends

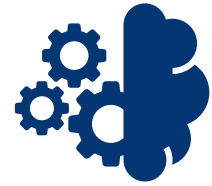
Summary



There are indications that some people were experiencing aspects of poorer mental health during the COVID period compared with the baseline period across a range of measures. People were not only concerned about the disease, they were also experiencing stressful life events such as job and income losses and isolation from family and friends. The measurement of overall population-level mental health will continue to be monitored, to determine whether the increases in psychological distress and lack of control have persisted beyond the initial period of restrictions. While the successful control of community spread and the subsequent easing of restrictions in WA may have eased some of the triggers for poorer mental health in this State, job and income losses and the persistence of COVID-19 globally may still be having detrimental impacts on population-level mental health.

Community mental health service use

Analysis and interpretation of the MIND



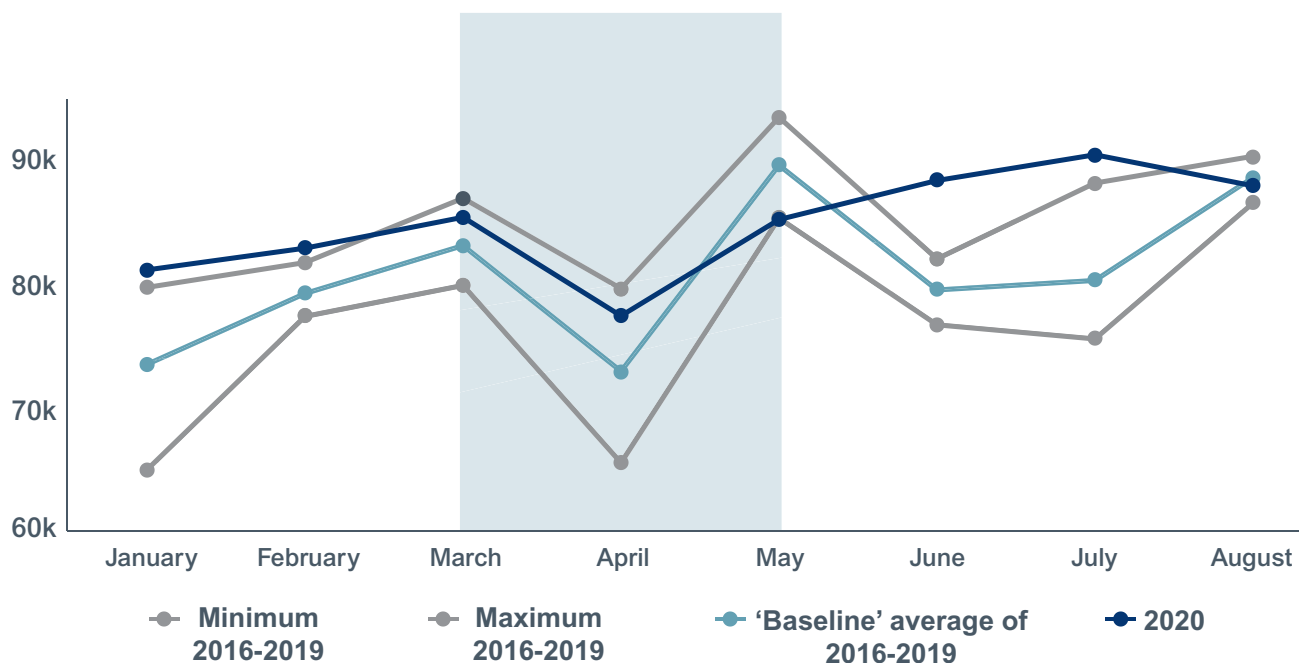
Mental health occasions of service (service use) represent the number of 'treatment episodes' rather than the number of people. One person may have several occasions of service over time for ongoing health treatment or during periods of illness.

Trends in service use are presented for 2020 compared with an average over the previous four years (2016-2019). These long-term averages serve as a 'baseline' so comparisons can provide an indication of the impact of COVID-19 restrictions on the use of community mental health services.

Results

Overall the trend in the use of community-based mental health services was elevated but consistent with the baseline trend for the first half of 2020. However, June and July showed a deviation from the baseline trend, with substantial increases in the use of services. These increases in service use in June and July exceeded the maximum number of occasions of service recorded for those same months across any of the previous four years. Results for August suggests the trend may be returning to baseline.

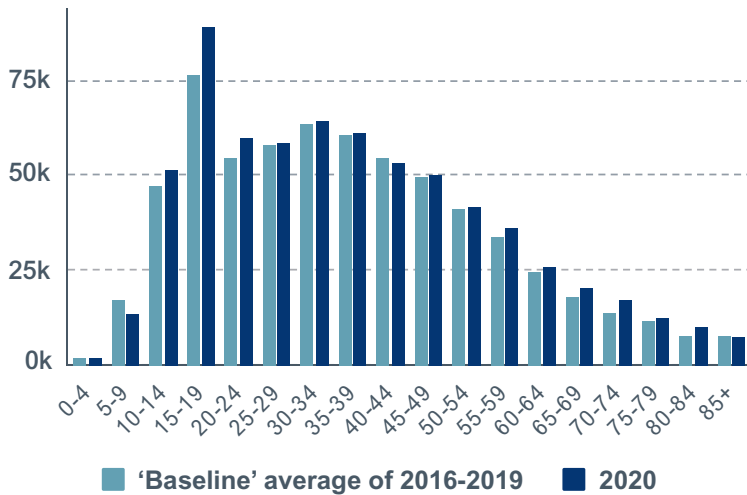
Community mental health service use



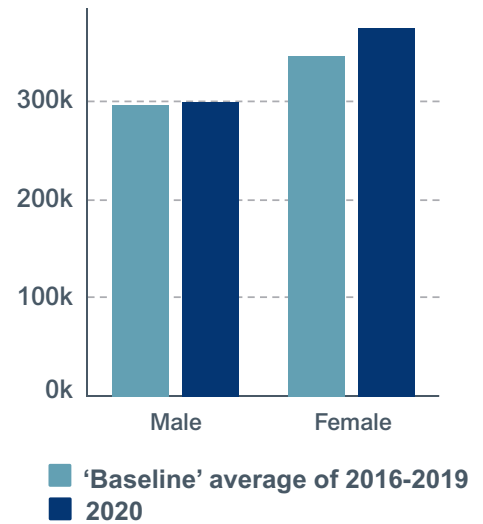
Who was using community mental health services?

Increases in service use in 2020 appear to be driven by younger people (those aged 10-24) and women.

Community mental health service use by age, January-August combined



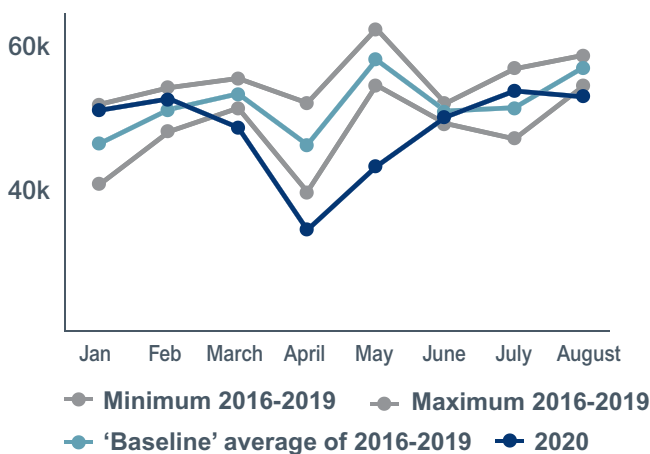
Community mental health service use by sex, January-August combined



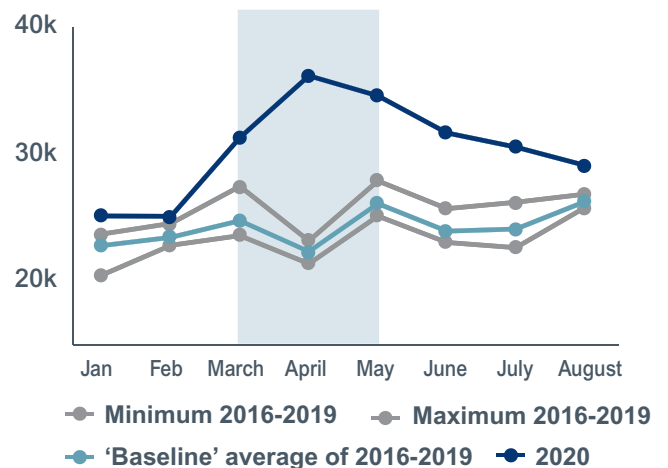
How were people accessing services?

Consistent with recommendations for physical distancing, the mode of service delivery for community-based mental health services changed substantially from March 2020 compared with the baseline. There was a marked decrease in face-to-face consultations, to levels lower than those reported during the past four years, and a corresponding increase in consultations occurring by phone. This change was sustained over several months, but the most recent data from August suggests the mode of service delivery is trending back towards baseline levels.

Face-to-face consultations by month



Phone consultations by month



Summary



The COVID-19 pandemic appears to have impacted on community mental health service use in two ways. First, for those people who were already accessing care when the COVID-19 control measures were introduced, a substantial proportion saw their mode of service change from face-to-face meetings to telephone consultations.

Second, there seems to have been a subsequent increase in service use in the months following the COVID-19 period. This is consistent with data from the HWSS that provided evidence to suggest some people were experiencing poorer mental health.

Emergency mental health service use

Analysis and interpretation of the EDDC

Prior to September 2017, information on the presenting diagnosis or symptoms was not captured consistently across all rural emergency department sites. As such, data for 2019 only is used as the baseline comparison period.



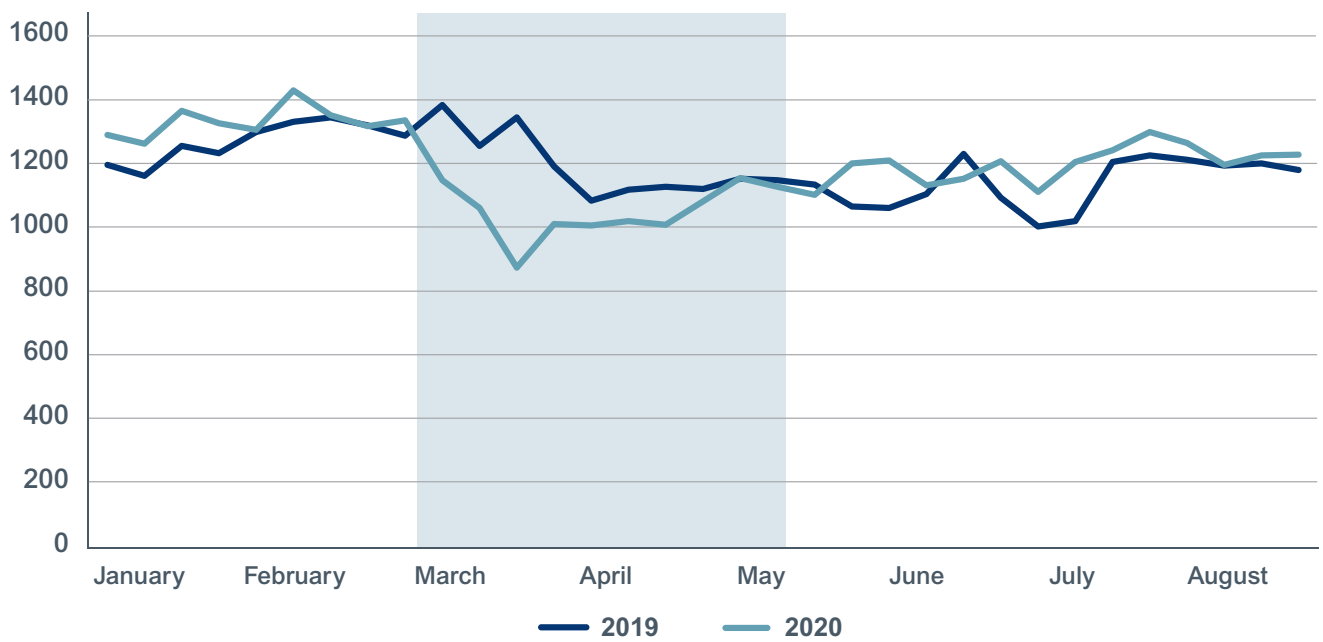
Results

ED presentations overall have been consistent with, or slightly higher than the same time point in the previous year (data not shown). However, from March 2020 ED presentations decreased sharply and stayed well-below the 2019 level until June. The trend from June 2020 to the most recent data available in August shows presentations have returned to 2019 (pre-COVID-19) levels.

Mental health and AOD presentations to ED during 2020 have shown similar patterns to ED presentations overall.

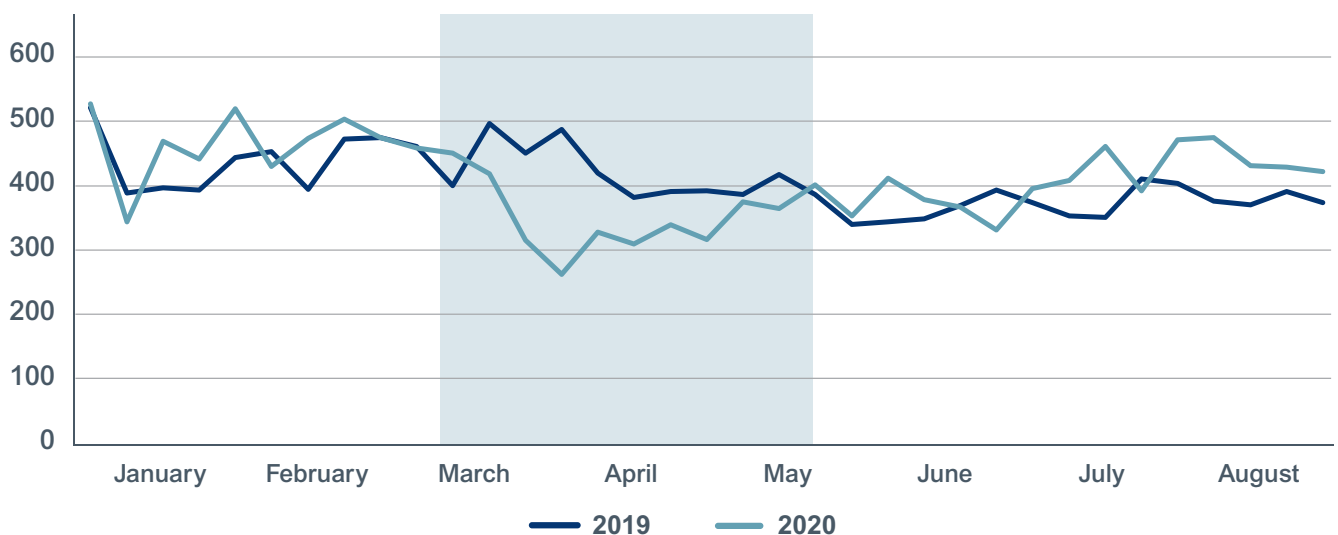
The number of mental health ED presentations in 2020 has been consistent with, or higher than the same time point in 2019, following a broad seasonal trend. However, from March 2020 mental health ED presentations decreased sharply and stayed well-below the 2019 level until mid-May. The trend from June 2020 to the most recent data available in August suggests presentations may be returning to 2019 (pre-COVID-19) levels.

ED presentations for mental health related conditions by month



AOD ED presentations in 2020 have been consistent with or higher than 2019, following a broad seasonal trend. However, from March 2020 AOD presentations decreased sharply, and stayed well-below the 2019 level until late-May. The trend from June 2020 to the most recent data available in August suggests AOD ED presentations may be returning to 2019 (pre-COVID-19) levels.

ED presentations for alcohol and other drug related conditions by month



Summary



The COVID-19 period saw a sharp decrease in ED presentations overall and specifically for mental health and AOD related conditions. Anecdotal evidence suggests fear of catching COVID-19 at a health service provider site played a role in the downturn, although the closure of licensed venues including pubs and clubs may also have contributed to the decrease in AOD presentations. Concerns over a rebound effect in which presentations increase sharply to compensate for the previous decrease do not seem to have been realised and presentations appear to be returning to approximately baseline levels.

Acknowledgements

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