Establishing cultural differences dealing with lockdown and the impact of COVID-19 on mental health services, UK

being a Thesis submitted in partial fulfilment
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by

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Overview

This thesis portfolio comprises three parts:

Part One: Systematic Literature Review

The systematic literature review looked at the impact of COVID-19 on mental health services. A literature search using five databases found fifteen papers that met the inclusion criteria. The Mixed Methods Appraisal Tool (MMAT; Hong, 2018) was used to assess the quality of the papers and were analysed using Narrative synthesis. Three main themes were identified: service activity, impact on staff, and impact on clients. The findings revealed that COVID-19 has had both negative and positive impacts on mental health services and likely these are likely to be noticed for years to come.

Part Two: Empirical Paper

The empirical paper investigated if there was a difference in how Collectivist and Individualistic cultures dealt with lockdown in relation to post-traumatic growth, adjustment, and psychological impact. Participants completed an online questionnaire which measured post-traumatic growth, adjustment, and psychological impact. The findings between the two groups were compared using a T-test to establish any significant cultural differences. A multiple regression was conducted if a significant difference was found to establish whether this was due to culture or other factors. The findings suggest that both cultural groups found lockdown equally difficult to adjust to and experienced the same psychological impact. However, those from a Collectivist background experienced more post-traumatic growth in response to lockdown. Clinical implications and future research are discussed.

Part Three: Appendices

Part three consists of the appendices of both the systematic literature review and empirical paper. Epistemological and reflective statement are also included.

Total word count (excluding appendices): 20,080.

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Part One – Systematic Literature Review

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Part One – Title of Systematic Literature Review

The impact of COVID-19 on mental health services in the UK. A systematic review

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Please see Appendix C for the Guideline for Authors".

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Abstract

Background: In response to COVID-19, the UK Government implemented three national lockdowns. Research has established that COVID-19 and its restrictions impacted the mental health of people in the UK, which is likely to have had a knock-on effect on its mental health services.

Aim: The review aims to establish the impact of COVID-19 on mental health services in the UK.

Method: A literature search was conducted in November 2022 using the following databases: Academic Search Premier, CINAHL, MEDLINE, APA Psyc ARTICLES and APA PsycINFO. 15 articles were selected for the review and analysed using Narrative Synthesis.

Results: Three themes arose from the findings: impact on service activity, impact on staff and impact on clients. The review found that COVID-19 had a major impact on service delivery, changing the way work is conducted with services becoming more efficient and flexible. However, COVID-19 had a negative impact on NHS staff.

Conclusion: Overall the review establishes that UK NHS services were considerably impacted by COVID-19, with staff being particularly hit. However, in response to these difficulties, services made provision to support staff, continued to seek efficiencies and to work more closely with other agencies. Nonetheless it is clear that the UK NHS will feel the effects of COVID-19 for many years to come.

Introduction

In March 2020 the World Health Organisation declared COVID-19 a pandemic.(1) The UK Government implemented three national lockdowns in response: the first on the 23rd of March 2020; the second on 4th of November 2020 and the third on the 5th of January 2021.(2) The lockdowns imposed restrictions on people's ability to socialise, access facilities and work.

COVID-19 has impacted the mental health of people in the UK; this has been demonstrated by the rates of mental distress increasing from a national mean of 19% in 2019 to 27% in April 2020, with increased rates of anxiety and insomnia (3-5).

This increase of mental health difficulties is likely to have impacted mental health services, beyond the adjustments made to reduce infection transmission by wearing personal protective equipment (PPE), testing, working remotely and segregating clients in inpatient setting (6,7).

The UK has a unique health care system, the National Health Service (NHS); a publicly funded system which is free at the point of access. It is designed to prevent, diagnose, and treat physical and mental health issues.(8) The NHS has been under attack for several years, with services described being at "breaking point" from long waiting lists, underfunding and staffing.(9) Although this review does not aim to address NHS services solely, it is important to recognise its prominence in the UK. Of the 901 services the Care Quality Commission (CQC) inspected in England 575 were NHS led (63%).(10) NHS services are provided to a larger population compared to non-NHS services. For example, the mental health charity Mind proposed to offer 350,000 people access to mental health support in England and Wales(11) compared to the 1.24 million accessing primary NHS mental health care through Improving Access to Psychological Therapies (IAPT) and 3.25 million using secondary mental health support from the NHS in 2021/22 in England.(12) Therefore, the NHS context is important as COVID-19 is likely to have impacted an already fragile system and impacted the staff it depends on. The review aims to look at the impact COVID-19 has had on mental health service delivery, referrals, presentations, staff, and client's access.

Although COVID-19 had a global impact on mental health services and a previous literature review has investigated this (13), the review focused on services preparedness, reorganisation of acute settings and infection control, arguably focusing less in-depth on clinician and client impact. This review aims to establish the impact of COVID-19 on mental health services (services) in the UK, given the UK's unique service configurations and economic/political context as this may differ to the global impact.

Method

Data sources and search strategy

A systemic literature search was conducted in November 2022. With the research supervisor and university library advisor's involvement the search strategy was determined. Five electronic databases (Academic Search Premier, CINAHL Complete, MEDLINE, APA PsycArticles and APA PsycInfo) were searched for English-language peer-reviewed academic journals to establish the impact of COVID-19 on mental health services in the UK. Searches were conducted using the following search terms (* indicated truncation):

("covid-19" or "covid 19" or coronavirus* or pandemic* or lockdown* or quarantine*)

AND

((psycho* or psychiatric or "mental health" or psychotherap* or tele* or neuropsych* or inpatient) (service* or therap* or intervention* or program* or train* or supervision* or treatment))

AND

(adapt* or chang* or amend* or adjust* or modif* or alter*) AND (uk or united kingdom or Britain or england or wales or scotland or northern ireland)

Selection strategy (Inclusion and Exclusion Criteria)

The tables below outline the rationale of the inclusion (Table 1) and exclusion (Table 2) criteria for the selection of journals.

Table 1. Inclusion criteria and Rationale

Inclusion Criteria	Rationale
Population: Mental health services in the UK including specialist services e.g., Child and Adolescent Mental Health Services (CAMHS), Community Mental Health Team (CMHT), psychiatric hospital, perinatal mental health.	The review aimed to investigate the impact of COVID-19 pandemic on mental health services in the UK including specialist mental health services with psychological support (e.g., Learning disabilities and neuropsychology settings). Research where mental health service themes were reported (e.g., Mental health trusts) were included.

Context: Impact on the service due to COVID-19 e.g., delivery, referrals etc.	The review aimed to investigate the impact of COVID-19 pandemic on mental health services in UK. Research examining other factors such as staff wellbeing were included if those also had relevance for or mentioned service changes.
Language: English	English is the only language the researcher can read and understand fluently. Also, the review focused on impact in UK.
Study Design: Qualitative, Quantitative and Mixed-Methodology	Qualitative, Quantitative and Mixed-Methodology papers were included due to the variation of the research methodology evident in the search. Qualitative data provided rich data and highlighted themes; quantitative data provided robust, generalisable findings of the impact of COVID-19 on mental health services in the UK.
Study Type: full text, primary research articles, published in an academic peer-reviewed journal.	The review aimed to explore empirical research which included research questions, collected data on the impact of mental health services in the UK, and reported the findings.

Table 2. Exclusion criteria and Rationale

Exclusion Criteria	Rationale
Population: Services that were not specific to mental health or specialist psychological support e.g., general hospital, GP surgeries, etc.	The review aimed to investigate the impact of COVID-19 pandemic on mental health services in the UK. Therefore, other health services that were not specific to mental health or specialist psychological support were excluded.
Context: Any study that did not look at the impact on mental health services in the UK.	The review aimed to investigate the impact of COVID-19 pandemic on mental health services in the UK. Therefore, studies conducted in any country other than the UK or examining global impact of COVID-19 on mental health services were excluded. Studies addressing the impact of pandemic on staff or clients were also excluded if impact of mental health service was not investigated.
Language: Any non-English Language	Translating papers was not possible. Also, the papers written in a different language were unlikely to be conducted in the UK.

Study Type: Secondary research articles, studies not published in peer-reviewed journals. Papers that are abstracts, literature reviews, meta-analyses, commentaries, letters, editorials, reports, conferences, grey literature, case reports, opinion articles and book chapters.	The review aimed to explore original and primary research to provide robust conclusions.

The 3,886 papers identified in the search were screened to ensure they met these criteria. Initially duplicates were removed, leaving 2,930 papers. Titles and abstracts were screened leaving 33 papers to be assessed for eligibility using the inclusion/exclusion criteria and MMAT. Once the final 14 papers were selected, a hand-search of their reference lists was completed to identify any other relevant papers missed in the initial search. The same criteria were applied to any papers identified. An additional paper was included from this, leaving 15 papers in total for the systematic review. Figure 1 summarises the process.

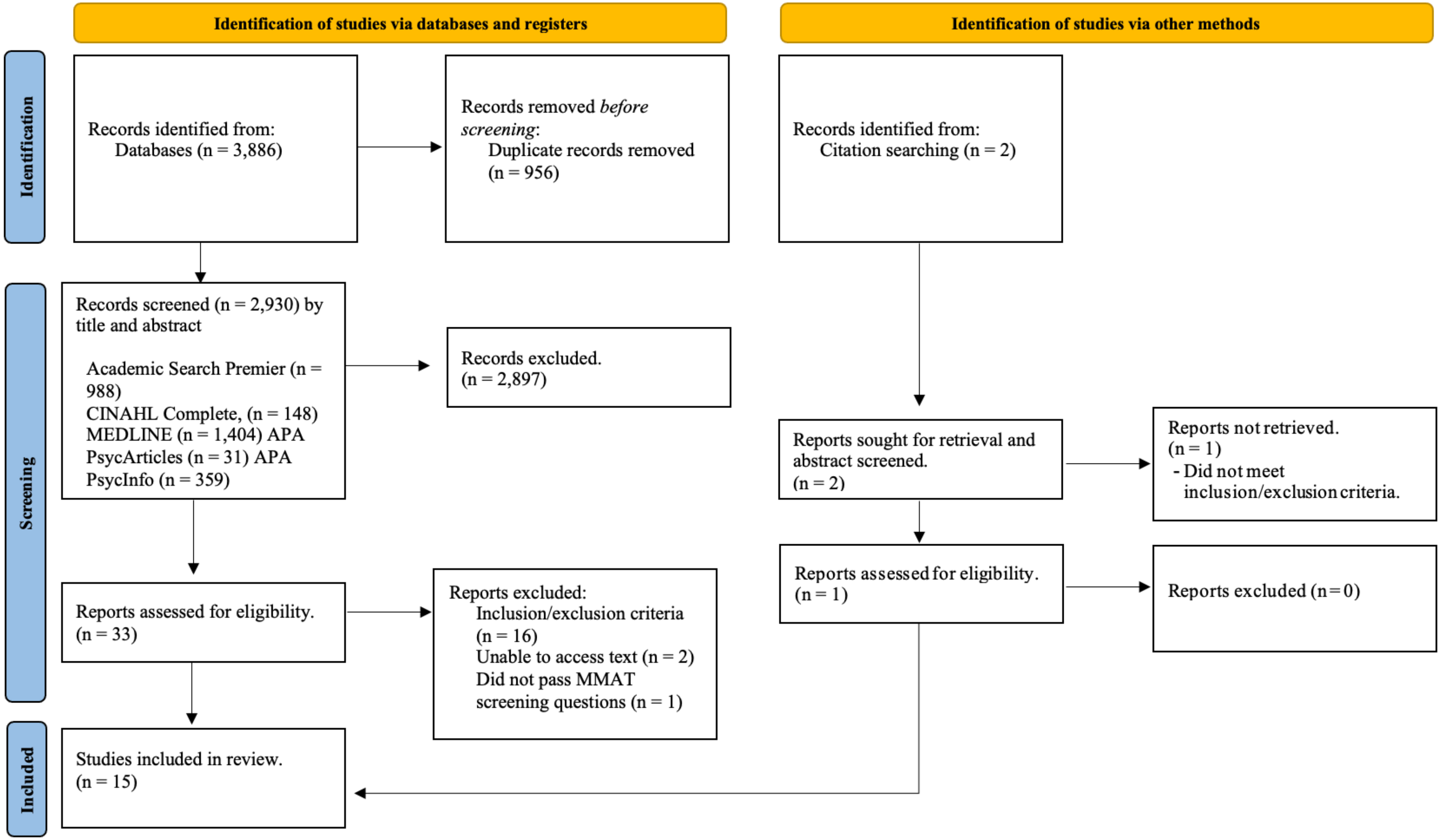

Figure 1. PRISMA flow diagram of article selection process.(14)

Data extraction and Quality assessment

Key data were extracted from the studies included in the review such as the research aims, sample, design, and key findings; this information was inserted into Table 2. Then a quality checklist was completed for all papers. The Mixed Methods Appraisal Tool (MMAT) ((15) was used to critically assess the articles due to their methodological heterogeneity. Two screening questions in the MMAT assess if a study is suitable for analysis; *S1. Are there clear research questions? S2. Do the collected data allow to address the research questions?* One paper did not meet the criteria of the screening questions and was therefore excluded (see Figure 1). Quality scores were completed to contextualise findings clearly, making them more accessible and the quality easy to indicate. ((16) A percentage was calculated for each study using the MMAT scores by obtaining the average satisfied quality (Appendix D & E) which is the process recommended by the MMAT author .(16)

An independent researcher also reviewed a blind sample of five papers, to increase reliability of the quality assessments. Few discrepancies in scoring were found with 80% agreement. Discrepancies were discussed and resolved collaboratively.

Data analysis

Due to the methodological heterogeneity of the studies, a meta-analysis was not appropriate, so a narrative synthesis was conducted to combine findings to reach conclusions with a view to informing clinical practice.(17) Guidance from Popay was used to increase transparency and inform data analysis.(18) This method allowed creation of meaning and establishing similarities across services to establish the impact COVID-19 had on mental health services in the UK.

Key findings were extracted (Table 3). Characteristics of impact were summarised into categories e.g., service delivery, clients and staff, enabling identification of themes, comparison, and critique to inform conclusions and clinical implications.

Results

In total, 15 studies were included in the review. Although the studies used varied methodologies, the principal focus on the impact of COVID-19 on mental health services in the UK was evident in all studies. Table 3 shows the data extracted from each study included in the review.

Quality assessment

A percentage was calculated for each study using the MMAT scores (Appendix D & E) using the process recommended by the MMAT author.(16) Papers scored between 40 – 100%; the five mixed method studies scored mainly 80% (n=4 80%; 5 n=1 100%); all three qualitative studies score 100% (n=3 100%) and the quantitative studies had the most variety from 40-100% but majority scored 100% (n=1 40%; n=2 80%; n=4 100%).

The main problematic area for mixed methods studies (19-22) were the lack of rationale for using the methodology, and for quantitative studies(23,24) the lack of clarity as to whether the outcome data were complete. Several papers had limitations due to their lack of generalisability either because of the number or type of participants, number of services or time of data collection during lockdown.

Table 3. A descriptive overview of included studies

Author(s), Date, Country	**Research Aim(s)**	**Sample**	**Design**	**Main Findings**	**Limitations (Quality Score)**
Wilson, Dalton-Locke, Johnson, Simpson, Oram & Howard (2021). (21)	- Explore staff perceptions of impact of COVID-19 pandemic on service delivery and outcomes for women in the perinatal period in the UK.	N =363 staff working with women in perinatal period. (236 were female, 91.2% worked in the NHS and 84% in England)	Mixed - Online self-report questionnaire with both structured and open-ended questions by staff that worked with women in the perinatal period. - Descriptive statistics - Inductive semantic thematic analysis - Data collected from 22nd April – 12th May 2020.	- Reduced face to face contact with women in the community, making it more difficult to assess risk/safeguarding and parent-infant bond. - Referral and admission rates decreased by more than 10%. - Increase of anxiety, depression, and substance abuse. - Infection control in inpatient setting found concerns of nurses wearing masks so babies had limited interaction with facial feature, also mothers and babies separated when COVID-19 suspected. - Virtual appointments allowed flexibility.	- Staff across several different mental health services surveyed, did not contact perinatal networks to target perinatal specific groups, only those with perinatal experience kept but sampling could have been improved. - Although the quantitative measure was appropriate a non-standardised measure used. - Participants only had to answer one question in each section, leading to limited data. - Self-selecting recruitment therefore there may have been some bias in the participants that chose to participate. (80%)

Bakolis, Stewart, Baldwin, Beenstock, Bibby, Broadbent, Cardinal, Chen, Chinnasamy, Cipriani, Douglas, Horner, Jackson, John, Joyce, Lee, Lewis, McIntosh, Nixon & Landau (2021). (23)	- To investigate changes in daily mental health service use and mortality in response to the introduction and the lifting of the COVID-19 ‘lockdown’ policy in Spring 2020.	N = 10 UK NHS mental health providers.	Quantitative - A regression discontinuity in time (RDiT) analysis of daily service-level activity between 1st January 2019 – 31st May 2020. - 4 out of 10 sites provided data for extension of 31st July 2020.	- Reduction in referrals (IRR 0.62, 95% CI 0.55 to 0.70), inpatient admissions (IRR 0.75, 95% CI 0.67 to 0.83) and caseloads (IRR 0.85, 95% CI 0.79 to 0.91) compared with the pre lockdown period. - All community services saw a shift from face-to-face to non-face-to-face contacts which remained post lockdown. - Total contacts reduced for liaison and home treatment teams but increased for adult mental health, child/adolescent mental health services, early intervention psychosis and older adult services. - No significant difference in non-attendance or cancelled appointments.	- 9 out of the 10 sites extracted daily activity data (90%) and 4/10 were able to provide subsequent data for the extension (40%). - Specific services within the sites were looked at which is unlikely to reflect the full activity of each site. - Contacts were collected from electronic health records and may reflect logging habits rather than service activity e.g. multiple contacts may have been recorded in one entry. (80%)
Gregson, Randle-Phillips, & Delaney (2022) (25)	- Investigate the experiences of psychologists delivering psychological services in UK to people with learning disabilities during COVID-19 pandemic. - Staff’s perception of impact of COVID-19 on people with learning disabilities.	N=12 psychologists (11 females, 1 male; 11 clinical psychologists, 1 counselling psychologist)	Qualitative - Semi-structured interviews conducted via Microsoft Teams - Thematic analysis used.	- Changes in service delivery with all non-crisis work being conducted online, paused, or cancelled. - Difficulties with technology, either not having experience or access or technological issues. - Inability to use therapeutic tools effectively for example picture cards, non-verbal communication or a screen being too small.	- Self-selecting recruitment via social media therefore those who had a particular interest were more likely to participate and those who did not have access were unable to. - Due to the lack of diversity of the sample the results are difficult to generalise. - Staff’s perception therefore findings of service user experience

	- Explore how these experiences may impact future practice.		- Data collected January – February 2021.	- Loss of engagement or motivation working virtually both from clients and staff sessions/meetings. - Difficulty building therapeutic alliance virtually. - Staff unable to offer a “good enough service” and focusing more on risk management. Feeling burnt out and drained. - Staff working from home and rotas for office, online meetings more efficient and increasing frequency of meetings e.g. formulation discussions working well. - Wellbeing interventions for staff introduced e.g. drop-in sessions and peer support.	or impact are unlikely to be accurate as it was not their lived experience. (100%)
Bennett, Gosling, Harter, & Watson (2021). (26)	- Establish changes in the delivery of paediatric neuropsychological rehabilitation during and after the first national lockdown. - Explore what could be learned from experiences from shared clinical practice.	N = 36 members of the Paediatric Neuropsychological Rehabilitation Specialist Interest Group (PNRSIG). (86% clinical psychologists, 2 Northern Ireland and the remaining from England, both	Quantitative - 15-question online questionnaire on survey monkey. - Descriptive statistics (assumed not explicit)	- Shift from face-to-face appointments to remote working. - 53% offered assessments remotely. - Previous interventions e.g. psychoeducation, cognitive rehab still offered remotely. - Work with school decreased. - Up to 82% hospital multi-disciplinary teams moved to remote working. - Post-lockdown face-to-face assessments almost reverted to pre-covid levels to clear the backlog, most other work continued online. - Hybrid or blended working	- Not clear what participants were directly asked and whether they answered according to pre-determined answers or not. Therefore there is a chance of researcher bias if staff did not have opportunity to share their own ideas in the survey. - No mention of what statistical analysis was used but assumed it to be descriptive statistics.

		NHS and independent)	- 14th October – 30th November 2020.	- 80% felt confident delivering interventions and rehabilitation remotely and clients had responded well. - Reduced travel, geographical reach, and liaison with other services/agencies. - 89% of staff had access to necessary technology however only 17% of families were perceived to “definitely” have access.	- 36/116 responded therefore the sample size is extremely low and the results can’t be generalised, also those who responded may have a particular interest or strong beliefs about the topic. (40%)
Chen, Jones, Underwood, Moore, Bullmore, Banerjee, Osimo, Deakin, Hatfield, Thompson, Artingstall, Slann, Lewis, & Cardinal, (2020). (27)	- Measure changes in mental health and community physical health service activity and mortality associated with the pandemic and lockdown.	N = 1 NHS mental health trust.	Quantitative - Service data extracted from four clinical record systems. - Interrupted time series analysis with respect to the time of UK “lockdown”. Two clinical records until May 2020 and the remaining two until August 2020.	- Sharp reduction at lockdown in referrals to primary care mental health (MH) services, psychological therapy, and all secondary care MH teams apart from Early Intervention Psychosis services (no significant change). Reverted for secondary care services subsequently. - Gradual decrease in telephone calls to the NHS 111 MH crisis service and a small immediate drop in triage assessments by that service - The changes in referrals to secondary care were proportionally less for patients with serious mental illness (SMI); for example, referrals to crisis teams did not change for those with SMI, and referrals to Community MH Team’s reduced less. - Services accepted less referrals.	- Activity measured by clinical documentation reduced, however this could reflect documenting behaviour rather than service activity e.g. if multiple contacts are recorded as one. - Trust area had ‘low middle`’ COVID-19 infection rates therefore the results may not be generalisable to areas where the infection rate differed. (100%)

				- Fewer detained and voluntary inpatient admissions, however readmissions did not change. - Activity dropped and shifted to telephone consultation.	
Bauer-Staeb, Davis, Smith, Wilsher, Betts, Eldridge, Griffith, Faraway, & Button (2021). (28)	- Examine changes in access to mental health services and service delivery during early stages of the COVID-19 pandemic.	N = 5 NHS trusts	Quantitative - A descriptive time series examining patterns in referrals to services (1st January 2019 to 24th May 2020) and appointments (1st January 2020 to 24th May 2020) taking place.	- The number of referrals dropped by an average of 55% in the early weeks after the March 2020 lockdown was announced, reaching a maximum reduction of 74% in the initial 3 weeks after lockdown in the UK, which gradually recovered to a 28% reduction by May. - 75% of scheduled appointments attended and 59% took place remotely. - Self-referrals from minoritised groups increased towards the end of May 2020, surpassing the entire timespan. - Slight Patient Health Questionnaire-9 and Generalised Anxiety Disorder Assessment-7 average increase post-lockdown. - Post lockdown 89.2% of appointments took place remotely.	- Measurement reliant on documentation behaviour, e.g. some appointments may have been recorded as face-to-face when this wasn't the case due to habit or lack of system update. (100%)
Abbas, Kronenberg, McBride, Chari, Alam, Mukaetova-Ladinska,	- Explore the effects of COVID-19 on acute adult mental services during 4-	N = 1 NHS trust (Leicester Partnership Trust).	Quantitative - Retrospective analysis	- CRHT referrals and inpatient admissions were both lower during the COVID-19 period than during the control periods by approximately 12% and 20%, respectively.	- Only looks at 1 NHS trust in England which was an area described as an COVID-19 "hot spot", these results may not be

Al-Uzri, & Brugha (2021). (29)	week period of lockdown measures.		- Number of crisis resolution and intensive home treatment service (CRHT) referrals and inpatient admissions during a 4-week period starting March 16, 2020 (COVID period) and compared with the same period in 2018 and 2019 (control period).	- No significant difference between the two groups demographics such as ethnicity. - Statistically significant differences between the two groups, diagnoses on admission ($\chi2=20.8$, $p=0.01$); more patients admitted during the COVID-19 period received a diagnosis of schizophrenia, schizotypal, delusional, or other nonaffective psychotic disorder. Most admissions were compulsory, and the percentage of patients who were considered to pose a risk of aggression was higher. - 1/3 admitted showed psychotic symptoms related to COVID-19.	generalisable to other areas with different infection rates or other parts of UK e.g. Northern Ireland. (100%)
Sheehan, Dalton-Locke, Ali, Vera San Juan, Totsika, & Hassiotis (2022). (19)	- Experiences of staff working with people with learning disabilities and/or autism within a variety of mental health services during the first wave of the pandemic.	N = 648 staff working with learning disabilities and/or autism. (401 females, 78.9%, 421 white ethnicity 82.2%), working in mental	Mixed UK-wide online survey comprising of three main sections: (a) work challenges; (b) staff perspectives of patients and family	- NHS staff more concerned about being infected with COVID (84.8%, 70.4%, P <0.001), lack of personal protective equipment (65.7%, 52.9%, P = 0.009) and putting infection control into place (73.2%, 56%, P <0.001). This was also the same for using new training without adequate training (84.5%, 66.1%, P <0.001) and not having tools or equipment for remote working (79%, 56.5%, P <0.001).	- Majority of staff worked in the NHS; therefore these results may not be generalisable to non-NHS mental health settings. - Majority of staff worked in the England so the results also may not be generalisable to other parts of the UK e.g. Scotland.

		health services for a mean of 14.5 years, 81.3% based in England, 57.6% worked in the community and 83.1% in the NHS)	carers' difficulties and (c) sources of help at work in managing the effects of the pandemic. - Both quantitative Likert scale questions and open-ended qualitative questions. - Descriptive statistics - Content analysis - 22nd April – 12th May 2020.	- Remote working improved work-life balance and reduced waiting times and non-attendance for those in need. Staff were also more productive due to the flexibility. - More time spent in supervision and improved communication between professionals – more efficient. - Changes in ways of working such as less reliance on in-patient admissions, willingness to discharge use of compassion focused therapy and staff-wellbeing. - In-patient staff more concerned about infection and lack of personal protective equipment compared to community. - Community staff were more likely to express concern about the practicalities of a rapid shift to remote working, engaging patients remotely and difficulty managing work-life balance.	(80%)
Newbronner, Spanakis, Wadman, Crosland, Heron, Johnston, Walker, Gilbody, & Peckham (2022). (20)	- Establish how satisfied people with severe mental illness are with the support received during the pandemic. - Understand any difficulties encountered when accessing	N = 367 participants with severe mental illness. (51% male, 47.4% female, 1.6%	Mixed Survey - Descriptive statistics - Thematic analysis.	- 14.5% of those who's mental health had deteriorated had either not got the support they wanted or not sought help. - 43.1% of participants were not confident they would receive the support they needed. - Shift from face-to-face to online and phone consultation.	- Depth of data not particularly rich as it was optional for participants to provide a response in the free text sections of the survey, only 40% of participants chose to do so. (80%)

	both mental health and primary care services. - Consider ways to mitigate these difficulties and assess the perceived need for future support from mental health services.	transgender, 77% White British 77.4%, 51%)	- Data collected between July and December 2020.	- NHS Community Mental Health Team 52.7% had received support in person and 65% completely satisfied, support in person rated higher. - 13.4% did not have access to digital devices and the free text showed that many that did may not have had exclusive access or limited internet. Also concerns about privacy of online appointments e.g. trying to find a private place at work.	
Mannion, Konteh, & Jacobs (2022). (30)	- To explore how NHS mental health trusts in England adapted and responded to the challenges posed by the COVID-19 pandemic. - identifying lessons that can be learned during and beyond the pandemic.	N = 52 participants (4 Chief executives, 16 clinical directors, 4 patient representatives)	Qualitative 52 semi-structured interviews across four case study sites. - Framework method - March – April 2021	- Significant drop in demand of services. Believed to be due to clients avoiding access e.g. not wanting to put burden on healthcare or thought it was “not open for business”. - Surge in referrals after lockdown e.g. child/adolescent mental health service referrals often from schools when schools reopened referrals increased. - Presentations more serve and increase in self-referrals and crisis including those with no MH history. - Increasing discharge of medically fit clients to make room for COVID-19 clients.	- Only looked at four trusts therefore the results may not be generalisable across all UK trusts. - Only interviewed four patients therefore these results may also not be generalisable. (100%)

				- Infection control: keeping infected clients separate and lack of personal protective equipment. - Move to remote working increased efficiency e.g. less travel and reducing carbon footprint. However, some trusts struggled as were technologically behind - Online appointments not appropriate for those needing a safe space. - Negative impact on Staff e.g. feeling burnt out, worried about infection. - Collaboration: accelerated progress of integrated care systems and working together. Less bureaucracy	
Puzzo, Aldridge-Waddon, Stokes, Rainbird, & Kumari (2022). (31)	- Provide an analysis of the impact of COVID-19 related restrictions on routine outcomes within a large forensic mental health service in London, UK.	N = 1 NHS forensic mental health service.	Quantitative - Time series analysis. - Data extracted April 2018–March 2020 and then March 2020–March 2021.	- There was an overall increase in long-term segregation hours during the pandemic; 140%, (95% Cl 107, 171%) during Lockdown 1 to 90% (95% Cl 63, 113%) during Lockdown 3. - The most negative outcomes were evident during Lockdown 3. Incidents of violence were significantly more frequent during including physical assaults to service users (206%, 95% CI 57%, 346%), non-physical assaults to service users (206%, 95% CI 53%, 339%), and self-harm (71%, 95% CI 0.4%, 135%). Use of enforced	- Only looks at one forensic mental health service so the results are unlikely to be generalisable to other mental health settings. - Issue with causality, outcomes not necessarily due to restrictions. (100%)

				medication also increased during Lockdown 3 (317%, 95% CI 175%, 456%). - Social visits, leave and group therapeutic intervention all reduced or stopped. - Significant decrease in the number of admissions (66%).	
Burton, Wall, & Perkins (2022). (32)	- Understand community-based frontline staffs experiences of leadership during the pandemic and the impact of leadership on their ability to work to deliver a community care service in a crisis.	N = 21 Participants who worked within an NHS Community Mental Health Team at a trust in North-West of England, UK. (12 females, 9 males; 13 community mental health nurses)	Qualitative 21 Semi-structured interviews three months after the first wave of the pandemic. - Thematic analysis - 5th June – 29th July 2020.	- Perception of senior managers: authoritarian model of decision-making was used to make care in the community happen, with little flexibility and autonomy; inconsistent information and guidance; concerns around staffing levels and issues with information flow. - Staff: wanting to see people face to face, changes in roles e.g. collecting medication not interacting one-to-one with clients; having to manage complex risk in the community, reluctance to discharge, not taking leave. - Team: support through regular supervision, good communication and peer support. - Home working: staff mentioned feeling “isolated and forgotten about”; presence of children and technology issues made working from home stressful; not as vocal in meetings.	- Study did not include several community professionals including psychiatrists, GPs, and occupational therapists so the results may not be representative of all those providing community mental health services. - The study was only conducted in one community mental health team in the North-West so the results may not be generalisable to the rest of the UK. - Study only looks at the first wave of the pandemic therefore the impact of the whole COVID-19 period is not measured. (100%)

Bentham, Driver, & Stark (2021). (22)	- Aimed to assess the wellbeing of health professionals and quantify the adaptations to working practices in a Child/Adolescent Mental Health Service (CAMHS) during the pandemic.	N = 51 clinicians working in NHS child/adolescent mental health service (37 female; 24 therapists, 16 nursing staff)	Mixed Online questionnaire with both open-ended qualitative reflection questions and wellbeing scale, multiple-choice or Likert scale questions. - Descriptive statistics - Thematic analysis - Data collected between 4th – 12th May 2020.	- Wellbeing for child/adolescent mental health service clinicians significantly lower than general population (46.5 vs 53). 17% of clinicians reached the cut off indicating an increased risk of depression and psychological distress. - 70% clinicians worked from home, those who worked from home 100% of the time had significantly higher levels of COVID-19 worry. - Increase telephone and video platform appointments. - Clinicians rated their ability to build a rapport, conduct an assessment, assess risk, and provide interventions lower compared pre-pandemic but this had no significant impact on wellbeing. - Clinicians reported a lack of adequate personal protective equipment, but this had no impact on wellbeing. - Daily meetings and supervision were perceived to be more important during the pandemic. - A significant association was observed between clinicians' worry about pandemic and perceived importance of reflective space or psychological support.	- Only 6 weeks into pandemic so may not be representative of the full impact of COVID-19 on child/adolescent mental health service. - Small sample size of child/adolescent mental health service clinicians; therefore the results may not be generalisable to other mental health setting or all child/adolescent services. (80%)

Johnson, Dalton-Locke, Vera San Juan, Foye, Oram, Papamichail, & Simpson (2021). (33)	The COVID-19 pandemic has potential to disrupt and burden the mental health care system, and to magnify inequalities experienced by mental health service users.	N = 2,180 participants working in face-to-face mental health care in the UK (88.9% worked for NHS; 30.6% nurses, 16% psychologists; 83.4% worked in England; 80% female, 87% White ethnic background). .	Mixed Online questionnaire (data collected between 22 April 2020 to 12 May 2020) - Descriptive statistics - Content analysis	- Community staff stated changes in ways of working and adoption of remote working as the biggest challenge. - Mangers stated that the biggest challenge was providing support for staff and increased workload. - Inpatient staff shared they could not consistently follow rules set by infection control (50.5%) and 35.2% said the same in the community. - Reduced activity in relation to inpatient admissions and new referrals for crisis and community setting, however the responses varied. - Staff described seeing presentations directly related to COVID-19 such as delusional beliefs regarding COVID-19 infection or quarantine. First presentations of mental health problems such as psychosis were reported amongst health care workers. - Services increased their hours e.g., working weekends. Home visits only, when necessary, but others stopped. - Staff reported changes in the support they offered e.g., offering food deliveries.	- Due to the novelty of COVID-19 a validated tool in the questionnaire was not used. - Data was only collected until May 2020; therefore, it is not clear if the results are representative of the rest of the lockdowns that occurred. (100%)

				- Reduced bureaucracy and removing barriers to change. Increased support for staff and working more efficiently.	
Tromans, Chester, Harrison, Pankhania, Booth, Chakraborty (2020). (24)	- Establish patterns of mental health referrals and admission at Leicester Partnership Trust in two 8-week periods (prior and commencement of lockdown).	N = 1 NHS Mental health trust.	Quantitative Data extracted retrospectively from electronic records from 27th January – 17th May 2020. - Descriptive statistics	- Admissions reduced during lockdown in all services (adult and older adult mental health) bar child/adolescent mental health service, psychiatric Intensive Care and learning disabilities. - Referrals to all services reduced except forensic services which saw a slight increase (pre=51, lockdown= 64) - There was no significant difference between the number of serious incidents pre-lockdown (n = 23) and during lockdown (n = 20).	- The data was only obtained from one region so the results may not be generalisable to other regions. (80%)

Characteristics of included studies

All studies investigated the impact of COVID-19 on services in the UK specifically examining service activity including referrals, presentation, and delivery. Three papers also investigated the impact of COVID-19 on staff working in services;(22,30,32) two the impact of COVID-19 on clients (20,31) and three the impact of COVID-19 on staff and clients.(21,25,26)

Five studies used mixed methods design,(19-22,33) seven were quantitative (23,24,26-29,31) and three qualitative.(25,30,32) Some studies focused on the impact in specific services, such as one perinatal service,(21) two learning disabilities (LD) services,(19,25) one paediatric neuropsychology service,(26) one forensic service(31) and one community service.(32)

All studies were conducted in the UK, 9 studies had sample sizes ranging from 12 - 2,180 participants (mean of 378 participants) the 8 of which were staff and 1 included service users;(19-22,25,26,30,32,33) the remaining 6 extracted data from 1 – 10 NHS services/trusts.(23,24,27-29,31) Collectively the studies covered the period between March 2020 and April 2021.(29,30)

Narrative synthesis of findings

Key findings were extracted from the 15 studies within this review, which generated three themes: Service activity, Impact on Staff, and Impact on Clients. These themes were then divided into subthemes, as seen in Table 3:

Table 4. Key themes from included studies.

Main Theme	Subthemes
Service activity	- Referrals and admissions - Presentations - Service delivery
Impact on Staff	- Work - Wellbeing
Impact on Clients	- Access to services

Service activity

All 15 studies examined the impact of service activity on services; this included the impact COVID-19 had on the number of referrals and admissions, changes in presentations observed, and how support was provided.

Referrals and admissions

Nine papers established a reduction in referral rates and inpatient admissions during lockdown.(20,21,23,24,27-30,33) The extent varied, one high quality (80%) paper reported a reduction of 10%.(21) However, another high-quality paper(28) established that initially referrals dropped by an average of 55% in the early weeks of lockdown but gradually recovered to 28% by May 2020. Puzzo and colleagues found a significant decrease in the number of admissions (66%)(31) whereas Abbas and colleagues reported that crisis resolution and intensive home treatment service (CRHT) referrals during lockdown reduced by 12% and inpatient admission reduced by 20%.(29) Furthermore, Tromans and colleagues saw reduced referrals to all services except forensic services which had a slight increase (pre=51, lockdown= 64), and found reduced admissions during lockdown in all services except child/adolescent mental health service (CAMHS), psychiatric intensive care unit (PICU), and LD.(24)

Interestingly Bauer-Staeb and colleagues noticed an increase in self-referrals from people from ethnic minorities, especially black clients quicker than white clients in May 2020; this surpassed previous referral rates from this group.(28) Mannion found a referral spike after lockdown especially in CAMHS referrals and believed this to be due to schools reopening as referrals fluctuated in line with schools opening.(30) They also reported an increase in crisis and self-referrals, including from people with no mental health history. Chen and colleagues claimed that changes in referral rates to secondary care were proportionally less for patients with serious mental health difficulties (SMI).(27) Referrals to crisis teams remained unchanged for those with SMI, and referrals to community mental health team's (CMHT) reduced less. However, services accepted fewer referrals during lockdown which may explain in part or exclusively the reduction in referrals.(23) Conversely, Mannion and colleagues noticed a significant drop in service demand but believed this to be due to clients avoiding access e.g. not wanting to burden healthcare services or thinking they were “not open for business” pg.3.(30)

Despite reduced referrals and admissions, one paper commented that the biggest challenges for managers were to support staff with increased workload, leading services to increase their hours and opening on weekends to manage the demand of clinical need.(33)

Presentations

Two high quality (100%) papers commented on the increase of presentation severity.(28,30) Bauer-Staeb and colleagues established a slight increase in PHQ-9 and GAD-7 score averages during lockdown compared to pre-lockdown. (28)

Another three high quality papers (80 - 100%) observed differences in the presentations and an increase in COVID-19 related psychiatric symptoms.(21,29,33) For example, staff saw people presenting with COVID-19 related delusional beliefs regarding COVID-19 infection or quarantine. First time presentations of mental health problems such as psychosis were also noticed amongst healthcare workers. Abbas and colleagues similarly found that one third of those admitted had psychiatric symptoms related to COVID-19, such as beliefs that staff were ‘poisoning’ people with COVID-19, “COVID-19 was planned, and they can put the world under lockdown so can sort out things” pg.245.(29) More patients admitted during the COVID-19 period received a diagnosis of schizophrenia, schizotypal, delusional, or other nonaffective psychotic disorder.(29) Most admissions were compulsory, and a higher percentage of patients were considered to pose a risk of aggression.(29) Wilson and colleagues supports the two high quality papers in the difference in presentation, however not in severity or COVID-19 related symptoms; they reported instead higher anxiety, depression, and substance abuse in perinatal women during lockdown.(21)

Service delivery

Twelve papers commented on the adjustment from moving to remote working from face-to-face contact. (19-23,25-28,30,32,33)

Wilson and colleagues reported that reduced face to face contact with women in the community made assessing risk/safeguarding and parent-infant bonds more difficult.(21) This was supported by Burton and colleagues who found that staff were having to manage complex risk in the community, despite this being inappropriate for clients.(32)

Most staff (70%) worked from home (22) or had a hybrid approach with staff working from home (WFH) sometimes, and rotas for office working.(25,26) Online meetings were seen as more efficient, and meetings were held more often, e.g. formulation discussions worked well during lockdown.(25) A low-quality paper (40%) by Bennett and colleagues found that previously used interventions e.g. psychoeducation, cognitive rehabilitation, were still offered remotely and up to 82% hospital multidisciplinary teams moved to remote working.(26) Moving to remote working reduced travel, increased geographical reach, improved liaison with other services/agencies and was more efficient.(19,25,26,30,33) However, Bakolis and colleagues' paper found that the move to remote contacts did not make a significant difference to non-attendance or cancelled appointments (23) although Sheehan and colleagues reported reduced non-attendance.(19)

Several papers found other changes in the ways services functioned.(19,30) Sheehan and colleagues reported less reliance on in-patient admissions, more willingness to discharge and use compassionate approaches such as Compassion Focused Therapy, and emphasis on staff-wellbeing.(19) Mannion and colleagues also indicated increased discharge of medically fit clients, to make room for COVID-19 patients.(30) Gregson and colleagues also saw an increase in wellbeing interventions for staff such as drop-in sessions.(25)
Some staff acknowledged a change in their role such as offering food deliveries and fetching resources rather than one-to-one support.(32,33)

Two papers acknowledged reduction in bureaucracy during COVID-19; establishing increased collaboration which accelerated progress of integrated care systems (ICS) and working together; staff felt this removed barriers to change and led to more flexibility.(30,33) However, Burton and colleagues established that staff perception of senior managers differed, claiming that the authoritarian model of decision-making was still used to offer care in the community during lockdown, with little flexibility and autonomy.(32)

Service delivery differed in inpatient settings. There was a greater emphasis on infection control and restrictions, for example mothers and babies were separated when COVID-19 was suspected in mother and baby units (MBU).(21) Puzzo and colleagues also noted that there was an overall increase in long-term segregation hours during the pandemic;(31) 140% during Lockdown 1 to 90% during Lockdown 3. Incidents of violence were significantly more frequent during Lockdown 3, including physical assaults to service users (206% to 346%), non-physical assaults to service users (206% to 339%), and self-harm (71% to 135%). Use of enforced medication also increased during Lockdown 3 (317% to 456%). Furthermore, social visits, leave and group therapeutic intervention all reduced or stopped during lockdown.(31)

Impact on staff

Papers which commented on COVID-19's impact on staff identified how ways of working changed such as working from home, changes in roles and manging staffing levels. The papers also recognised the impact on wellbeing and how this was mitigated.

Work

Johnson and colleagues found that inpatient staff could not consistently follow rules set by infection control (50.5%) and 35.2% said the same in the community.(33) Lack of PPE was mentioned in several papers. (19,22,30) However, Bentham and colleagues' paper reported that this concern had no impact on staff wellbeing.(22)

Sheehan and colleagues established that remote working improved work-life balance and increased staff productivity due to the flexibility.(19) However, when comparing inpatient to community staff, community staff were more likely to express concern about the practicalities of a rapid shift to remote working, engaging patients remotely and managing work-life balance.

The papers outlined differing results on staff experiences working with clients online. Bennett and colleagues, a low-quality paper (40%), found that 80% of staff felt confident delivering interventions and rehabilitation remotely and that clients responded well.(26) However, a high-quality paper (100%) by Gregson and colleagues reported that staff working with people with LD were unable to use therapeutic tools effectively, picture cards, non-verbal communication, and small screens impaired communication. Staff also experienced a loss of engagement or motivation both from clients and staff. Staff had difficulty building therapeutic alliances virtually and felt unable to provide a “good enough service”, focusing more on risk management than intervention.(25) Bentham and colleagues similarly found that CAMHS staff rated their ability to build rapport, conduct assessments, assess risk, and provide interventions lower compared to pre-pandemic, however, this had no significant impact on staff wellbeing.(22)

Burton and colleagues found that senior management struggled with staffing levels in acute inpatient wards due to staff self-isolating, shielding, and general staff illness; therefore CMHT team leaders were asked to redeploy community staff to inpatient wards.(32) In the interviews staff expressed anxiety around pressure to volunteer or concern about being redeployed if they were perceived to lack cooperation or raise too many questions. Staff in the CMHT shared that redeployment created gaps in the teams working in the community.(32)

Wellbeing

Two high quality papers found that the COVID-19 period had a negative impact with staff feeling “burnt out” and “drained”.(25,30) Staff WFH felt “isolated” and “forgotten about; the presence of children and technology issues made WFH stressful, many staff also did not take their leave.(32) People WFH 100% of the time had significantly higher levels of COVID-19 worry than those who WFH part of the time.(22) They also found that CAMHS clinicians' wellbeing was significantly lower than in the general population (46.5 vs 53) and 17% of clinicians showed an increased risk of depression and psychological distress. This supports Johnson and colleagues' findings that first presentations of mental health problems such as psychosis were reported amongst health care workers.(33)

A number of wellbeing interventions for staff were introduced such as drop-in sessions, wobble rooms, reflective spaces and peer support.(19,22,25) Bentham and colleagues established a significant positive association between clinicians' worry about the pandemic and perceived importance of reflective space or psychological support.(22)

Impact on clients

Papers looking at the impact of COVID-19 on clients identified barriers to accessing the service and the experience of changes in service delivery.

Access to service

Newbronner and colleagues established that 13.4% had no access to digital devices and many used shared devices or had limited internet access.(20) Bennet and colleagues found that only 17% of families definitely had access to remote devices.(26)

Clients expressed concern about privacy of online appointments, for example, trying to find a private place at work to have the appointment where they would not be overheard.(20) Of those whose mental health had deteriorated, 14.5% had either not received the support they wanted or had not sought help; this was believed to be due to the fact 43.1% of SMI participants were not confident they would receive the support they needed.(20)

Some service-users, particularly those with autism or those who were more independent, favoured virtual appointments. Staff attributed this to service-users feeling more comfortable at home, or less stressed in the online interaction.(19,25)

Discussion

The review aimed to investigate the impact of COVID-19 on mental health services in the UK. Three themes arose: service activity, impact on staff and impact on clients.

Overall, COVID-19 reduced the number of admissions and referrals to services, however some services such as forensic, CAMHS, PICU and LD did not experience the same reduction in admissions.(21,23,24,27-31,33) This may have been due to an increase in pressure to keep clients in the community. Burton and colleagues found that although they had fewer clients, those being cared for at home had greater, more complex, needs which resulted in staff maintaining risky clients in the community although it was recognised that this was not the right location for their care.(32) If staff felt this pressure to maintain complex, risky clients in the community then this may explain reduced reliance on in-patient admissions during the pandemic.(19) Furthermore, Chen and colleagues found that services accepted fewer referrals during lockdown which could explain referral reduction and highlights perceived pressure to keep people in the community.(27) Some 14.5% of clients did not access services for support when they deteriorated, assuming services were closed or they would not receive the support they needed.(20,30) All these factors together may explain why there was a reduction in referrals and admissions in lockdown. In CAMHS there was a sharp increase post-lockdown as schools reopened and could make referrals.(28,30)

Bauer-Staeb and colleagues noticed an increase in self-referrals from ethnic minorities, especially from black clients which surpassed previous referral rates from this group.(28) This may imply that ethnic minority communities' need for psychological therapy increased due to the impact of COVID-19, however, it is not clear whether there was a difference in COVID-19 impact between people from ethnic minority backgrounds and White people in the UK. Furthermore, there was no demographic difference in clients admitted or referred during lockdown (29) so there is no evidence of differences in ethnicities or genders involvement in services due to COVID-19. Nonetheless, COVID-19 is likely to increase already existing health inequalities. Services providing less flexible care and using non-traditional alternatives is likely to exacerbate difficulties engaging certain groups with services such as ethnic minorities.(34) Only one paper mentioned referrals and admissions surpassing pre-lockdown levels; this questions previous findings that mental health difficulties increased from COVID-19 (3-5). However, it could be argued as levels of psychological distress increased in the UK, services may have increased the threshold to accept into services. For example, up to 60% of children do not have access to CAMHS as these services reject presentations that do not reach their high criteria;(35) it is not unfeasible that COVID-19 has exacerbated the threshold and services are now experiencing similar circumstances which may suggest why research has established that mental health difficulties have increased but referral rates have not, meaning many do not believe or are being told their difficulties are not “bad enough”.

Much clinical time was spent assessing and managing risk/safeguarding through remote means, which staff found difficult.(21,22,25,31,32) If risk/safeguarding issues were more difficult to assess, perhaps the number of serious incidents (SI) in services increased, however little change was observed in the numbers of SI’s during this time (pre-lockdown n = 23; lockdown n = 20).(24) Change in practice, may suggest managing risk virtually felt riskier for clinicians, but the same skills were required and utilised, however there is not yet research to support this. The ability to manage risk despite the difficultly with remote working may have been due to better collaboration with other services and professionals.(19,26,30) COVID-19’s push for working collaboratively with other professionals and agencies helped accelerate the implementation of ICS;(30) coinciding with the NHS long term plan (LTP) which proposed “integrated care systems everywhere” to bring together local organisations, integrate primary care, services, and social care pg.29.(36) It is likely that better information sharing, and integrated services have helped safeguard clients effectively using remote means.

During COVID-19 people accessed services with different presentations.(21,29,33) Acute services saw an increase of people with psychosis, with one third experiencing psychological symptoms related specifically to COVID-19.(29,33) Staff working in services also reported first presentations of mental health problems such as psychosis in healthcare workers.(33) Research has established a clear link between stress, and trauma with mental health difficulties;(37,38) suggesting that increased stress levels in the pandemic led to first presentations of severe mental illness. Bentham's paper found that clinician wellbeing was significantly lower than the general population; 17% of clinicians reached the cut off for increased risk of depression and psychological distress;(22) this supports research that found that many healthcare workers reached the threshold of burnout (67%), anxiety (20%) and depression (11%).(39) Clinician stress was therefore likely a build-up of: fear of contracting COVID-19, increased client complexity, working remotely without adequate training, lack of PPE and feeling unable to offer a "good enough service"; all potentially leading to first time mental health presentations in staff.(19,22,25,27,29,30,32,33)

Interestingly, psychological therapy pre-covid (face to face) was compared to during covid (remote therapy) finding no significant difference in outcome, which suggests that clinicians were still able to utilise their skills and provide a service clients required despite feeling it was not satisfactory.(40)

The clear negative impact of COVID-19 on services' staff wellbeing indicates that services rightly implemented support such as drop-in sessions, wobble rooms and increased frequency of meetings. (19,22,25) Preliminary findings established benefits of psychological interventions for NHS staff from increased functioning and wellbeing scores.(41,42) However, more research needs to be conducted in this area to establish what interventions are most beneficial. The implementation of staff wellbeing provisions also indicates that COVID-19 accelerated the NHS LTP's focus on staff wellbeing to reduce sickness and retaining the workforce.(36) However, government funding for NHS staff wellbeing hubs in England ended in March 2023 threatening closure of a much-needed resource and a contradiction of the LTP.(43) Therefore, it is imperative that clinical psychologists continue focusing of the wellbeing of staff they work with to ensure that team's morale is upheld to help buffer potential negative impacts of these services ceasing. If staff wellbeing is not supported this is likely to have a huge impact on the workforce and the quality-of-care clients receive.

The review found that staff struggled to use therapeutic tools effectively, experienced a loss of engagement or motivation and had difficulty building a therapeutic alliance virtually, leading them to feel the service provided was unsatisfactory.(22,25) However, one paper found that 80% of staff felt confident delivering interventions and rehabilitation remotely and that clients had responded well.(26) There is probably a difference in settings underlying this paradox as both LD and CAMHS clinicians struggled (22,25) whereas Paediatric Neuropsychological Rehabilitation clinicians did not.(26) However, the quality scores of papers reveal that Bennett and colleagues achieved 40% (26) and the other two between 80-100%,(22,25) therefore studies with higher ratings are more likely to have valid and reliable results, especially when all three services offered similar mental health support such as individual therapy, parent and family work and psychoeducation. It is probable that majority of staff had difficulty delivering therapy as the studies high in quality results are more likely to be reliable and findings repeatable as Bennet and colleagues' study would be difficult to replicate.(26)

The main impact of COVID-19 on services' clients was the increase in restrictive measures such as the prevention and/or reduction of leave for clients in inpatient settings, increase in long-term segregation hours during the pandemic and increase in enforced medication.(31) These practices were used to manage risk, however they also appeared to lead to an increase in aggression and self-harm (31) demonstrating that they were counterproductive.

The studies concluded that COVID-19 had a lasting effect on the delivery of services, as many staff still work (partly) remotely, there is better collaboration, and an increased focus on staff wellbeing; factors which align with the NHS LTP.(36) Although there have been positive changes, many wellbeing hubs are at threat of funding cuts despite increased demand which is likely to have an impact on staff retention.(43)

Quality of review and future research

The studies included in the review varied in methodology, however similarities between the aims, samples and findings could be themed and compared. Overall, the articles in this review provide important insight into the impact of COVID-19 on mental health services. Almost all studies in this review contained a high-quality rating, with 14 studies receiving a score of 80% -100% on the MMAT quality rating scale, demonstrating good quality in approach, data analysis and interpretation. The remaining study scored 40% mainly due to lack of clarity in relation to non-response bias, the use of inappropriate measures, and unclear statistical analysis.

The findings reflect practices in different services such as LD, paediatric neuropsychological rehabilitation, acute services and so findings may be context dependent. However, the overarching themes were present in all papers and indicate general concerns across settings. Furthermore, many papers reported similar findings suggesting that most services experienced similar difficulties and changes despite differences in the clients they serve.

Most studies covered the COVID-19 period until May 2020, the first two months of the pandemic; therefore this is unlikely to be representative of the whole COVID-19 period in all UK areas. Only one paper covered pre-COVID lockdown to March 2021 and reported differences between the impact of each lockdown, with the third being most impactful; therefore future studies should provide specific dates of the COVID-19 period to establish if certain time periods were more difficult than others.

All authors commented on their lack of generalisability due to numerous reasons including sample size, location of study (for example focusing on one trust) and the period of COVID-19 covered.(19-33) However, due to COVID-19's novel nature the research currently available is broad and therefore lack of opportunity to be strict about the parameters of the research included. Furthermore, the papers were naturalistic studies observing the impact COVID-19 had on services as it was impossible to have randomised controlled trials due to COVID-19's effect on all aspects of life and services. Nonetheless the studies have allowed us to learn how services can adapt to difficult situations and can hopefully encourage change in the future of sometimes stagnate service models and deliveries.

Although this review did not aim to specifically establish the impact COVID-19 had on NHS services, many of the papers did focus on the NHS therefore these findings may not generalise to non-NHS settings. It may be beneficial to conduct further research on non-NHS services to ascertain if the impact differed.

Conclusion

Overall, the review established that COVID-19 had a major impact on service delivery in changing the way meetings and client work was conducted, such as using remote methods. This has allowed services to become more efficient and flexible. The flexibility has allowed the progression of ICS formation (part of the NHS LTP) as COVID-19 meant working more closely with other agencies to manage complex cases and assess risk. Furthermore, COVID-19 highlighted the impact of stress and lack of support on staff and culminated in the development of staff wellbeing interventions which are also a key feature of the NHS LTP. Although the pandemic has taken a toll on services and their staff, this review highlighted some positive changes for clients and staff. Although the review emphasises UK services' robustness in the face of adversity, it also demonstrated that the already fragile system experienced further destabilisation in staff impact, with 17% reaching the threshold of mental health difficulties and some experiencing first presentations of psychosis, potentially due to less structure and guidance on how to manage the unprecedented situation and risk of redeployment. The lack of bureaucracy regarded as positive by staff, also meant complex clients were in the community without sufficient support, placing increased pressure on staff to keep them safe. This review has demonstrated that although UK services have managed, it is likely that the impact of COVID-19 on services will be felt for years to come, especially with the risk of staff wellbeing hubs closing and potentially leading to even lower retention rates. Therefore, it is vital that clinical psychologists working within services focus on their team's wellbeing to uphold morale due the impact low staff wellbeing can have on clients, and to avert retention difficulties.

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Part Two -Empirical paper

Establishing cultural differences dealing with lockdown in relation to post-traumatic growth, adjustment, and psychological distress.

By Harleen Sidhu and Dr Annette Schlösser

This paper is written in the format ready for submission to the Journal of Cross-Cultural Psychology.

Please see Appendix F for the Guideline for Authors".

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Abstract

Background: Loneliness affects a large percentage of the population (Pyle & Evans, 2018) and can lead to various mental health difficulties including anxiety and depression (Richardson, Elliott, & Roberts, 2017). Therefore, many found the national COVID-19 lockdowns distressing (Pierce et al., 2020) due to restrictions on freedom and increased social isolation. Both Individualistic and Collectivist cultures in England experienced social isolation at the same time. Collectivist cultures adopt a group mindset, placing group needs above their own (Hui & Triandis, 1986) and Individualistic cultures an individual mindset, where personal needs have greater emphasis (Markus & Kitayama, 1994). Therefore cultural groups may experience different levels of post-traumatic growth (positive change after a stressful event), adjustment and psychological distress in response to lockdown. This research aims to ascertain whether certain cultural groups are more vulnerable in response to social isolation and help reduce negative consequences of events such as lockdown in the future (Madhav, Oppenheim, Gallivan, Mulembakani, Rubin, & Wolfe, 2017).

Methods: A between-groups design was used to investigate the difference between Collectivist and Individualistic cultures levels of post-traumatic growth (PTG), adjustment and psychological distress in relation to lockdown. A total of 174 participants completed an online survey.

Results: No difference was established between levels of psychological distress or adjustment due to lockdown between the cultural groups. However, those from a Collectivist culture experienced higher levels of PTG in response to lockdown; gender, age and previous mental health involvement did not influence this difference.

Implications and future research are discussed.

Introduction

COVID-19 and loneliness

On 11th March 2020 the World Health Organisation (WHO, 2020) declared COVID-19 (a novel virus causing repository symptoms particularly characterised by a high temperature, a new, continuous cough and a loss or change to sense of smell or taste) as a pandemic. The English Government implemented a national lockdown on March 23, 2020, November 4, 2020, and January 5, 2021, in response to this. These lockdowns imposed strict restrictions on socialisation and ability to work, and significantly reduced access to services, enforcing social isolation nationally.

Pre-pandemic research established that loneliness affects 46% of the UK population, with 5% stating that they always feel lonely (Pyle & Evans, 2018). Loneliness correlates with a greater likelihood of mental health problems such as anxiety, stress, and depression (Richardson, Elliott, & Roberts, 2017). Children who experience social isolation are more likely to face mental health difficulties, further indicating that loneliness can have a negative impact on psychological wellbeing (Matthews et al., 2015). Loneliness reduces the immune system's response, making those experiencing social isolation more susceptible to illnesses (Cohen, Doyle, Skoner, Rabin, & Gwaltney, 1997). However, loneliness has been found to differ culturally; members of Collectivist cultures experience higher levels of loneliness compared to those from an Individualistic culture (Lykes, & Kemmelmeier, 2014). Loneliness occurred more in Collectivist cultures in response to lack of contact with family whereas lack of interactions with friends was a predictor for Individualistic cultures (Lykes, & Kemmelmeier, 2014).

Preliminary research in response to the initial national lockdown in March 2020 indicates that rates of psychological distress in those aged 16 and above increased from a national mean of 19% in 2019 to 27% in April 2020 (Pierce et al. 2020). However, characteristics such as being an ethnic minority, living without a partner, being a keyworker and being at greater risk from COVID-19 infection did not affect an individual's change in mental distress (Pierce et al., 2020). Furthermore, the most often reported effects of social isolation due to COVID-19 have been low mood and irritability (Gualano, Lo Moro, Voglino, Bert, & Siliquini, 2020).

Differences between collectivism and individualism

The UK is a multicultural society where ethnic minorities make up 21.3% of the population nationally (Sharfman, 2019) and up to 46% in major cities such as London (Office for National Statistics; ONS, 2022).

There are various ways of distinguishing between cultures, but commonly 'Collectivism' and 'Individualism' is used (Hofstede, 2001). Collectivism is a cultural construct associated with economically developing Eastern countries such as India and China, where there is a 'we' mindset, concern about how decisions affect others (Hui & Triandis, 1986) and emphasis on social harmony (Leong, Tseng, & Wu, 1985). Those from Collectivist cultures are more likely to describe themselves in relation to a collective self, in relation to their relationships for example "My sister thinks I'm kind" (Triandis, 2001). Individualism is evident in well-developed Western countries such as the UK and USA where an 'I' mindset is fostered; individual's own needs and desires outweigh the groups and behaviours are based on personal attitude rather than in-group norms (Markus & Kitayama, 1994; Triandis, 2001). In this culture individuals are more likely to describe themselves in relation to a personal self, focusing on individual character traits for example "I am funny" (Triandis, 2001). Hofstede

(2001) created an index score and ranks of Individualism/Collectivism in order to ascertain levels of Individualism and Collectivism for 76 countries.
In England and Wales 9.3% and 4% of the population are of an Asian and Afro-Caribbean heritage respectively (ONS, 2023), therefore using Hofstede's Index Scores as a guide, these ethnicities would be defined as Collectivist as the countries of origin are rated lower in terms of Individualism; for example, India is rated 48 and Jamaica 39 (Hofstede, 2001). Conversely, 81.7% of England and Wales' population are ethnically White (ONS, 2023) therefore Individualistic using Hofstede's index, as Great Britain is rated 89 and Poland (the most common non-British, White background in England; Stickney, 2021) rated 60 (Hofstede, 2001). This model is not without critic, for example low face validity and internal reliability has been argued; however it is commonly used in literature and is currently the best we have with newer studies replicating Hofstede's findings (Gaines et al., 1997; Herbert et al 2018; Jiang, Wei, & Zhang, 2022).

Depression arises from different sources according to one's cultural group: those from Collectivist cultures are more likely to experience depression in response to interpersonal issues whereas those from an Individualistic culture tend to experience depression due to difficulties related to lack of success (Tafarodi & Smith, 2001; Heppner et al., 2006). Psychological resilience, adapting well to stressful and traumatic events, is a buffer against mental health issues (MacLeod, Musich, Hawkins, Alsgaard, & Wicker, 2016), which also varies between the two cultural constructs. Asian American (Collectivist) veterans are suggested to be less resilient compared to their White (individualist) counterparts, experiencing higher levels of PTSD (Herbert et al 2018). In addition, social support correlates with resilience for White Americans but not Asian Americans, which could be explained by people from Collectivist cultures possibly not wanting to place pressure on relationships and maintaining social harmony (Herbert et al 2018).

Despite members of Collectivist cultures reporting more social support than those from Individualistic cultures (Herbert et al 2018) it is likely that there is a difference in quality of social support between the groups (Herbert et al 2018). In Collectivist cultures people believe they should provide social support rather than receive it (Taylor et al., 2007) and uptake of mental health services is lower (Tiwari, & Wang, 2008).

Day to day experiences differ according to culture. People from Individualistic and Collectivist cultures differ in their ideology and living arrangements. For example, individuals from Collectivist cultures are more likely to live together with their extended family (Vandello, & Cohen, 1999), and so there may be differences in how these cultures have dealt with the effects of a lockdown. Collectivism may also be a protective factor against psychological maladjustment to the COVID-19 pandemic, despite research showing that people expressed higher concern for their relatives than themselves (Germani, Buratta, Delvecchio, & Mazzeschi, 2020). Those from a Collectivist culture make up 25% of the NHS workforce and more than 42% of doctors and dentists (NHS Digital, 2023). As these key worker roles are akin to helping the community and face to face, this too is likely to have had an impact on Collectivist cultures during lockdown and furthered health inequalities leading to more deaths (Williams, David, Babalola, & Maguire, 2022).

Furthermore, transmission of COVID-19 is significantly higher in Individualistic cultures (Jiang, Wei, & Zhang, 2022). This could be due to people not abiding by restrictions as personal autonomy is favoured over the collective goal of reducing COVID-19 (Jiang, Wei,

& Zhang, 2022). Collectivist countries such as Japan, Hong Kong and Taiwan managed the spread of COVID-19 much more effectively than European countries and the USA (Liu, 2021) potentially due to placing higher emphasis on safety of others rather than inconvenience to self (Cheng et al., 2020). However, not all Collectivist cultures responded well to the COVID-19 pandemic, such as India, demonstrating that there is variation within Collectivist cultures (Liu, 2021). Furthermore, New Zealand, an Individualistic culture, dealt with the pandemic considerably better than all other Individualistic cultures, with the lowest mortality rate and Ardern, New Zealand's prime minter, creating a sense of community in the country (Baker, Wilson, & Anglemyer, 2020) further suggesting this area should be explored.

Gaps in the literature

As discussed, loneliness, including lockdown, can influence mental health outcomes (Richardson et al., 2017; Pierce et al., 2020) and it is likely that the effect differs culturally with different predictors for mental health difficulties and loneliness (Tafarodi & Smith, 2001; Heppner et al., 2006; Lykes, & Kemmelmeier, 2014). Although research has looked at the effects of England's COVID-19 lockdown on mental health, this study aims to build on the existing literature and there are still a number of gaps including how people adjusted to lockdown, any positive aspects of it and whether this differed culturally.

Research has established that lockdown was a difficult time for many people (Pierce et al, 2020), potentially traumatising at times with fears of becoming unwell and changes to all aspects of life. However not a lot of research has been done establishing any positive impacts of lockdown. Research has established that some people experience positive changes after a stressful event which is known as post-traumatic growth (PTG) (Tedeschi & Calhoun, 2004).

PTG may arise in various ways such as changes in priorities, strengthened relationships and appreciation of life.

Schaefer and Moos' model of life crisis (1992) explains how external and personal factors can lead to positive responses to stress, such as PTG. This theory highlights the uncertainty of life and how many factors are uncontrollable. However, it also recognizes that individuals have the autonomy to respond to circumstances within their control. Personal factors which may contribute to PTG include self-efficacy, emotional regulation, confidence, and health (Schaefer & Moos, 1992). Environmental factors promoting PTG are family, personal relationships, friends, and community (Vloet, Vloet, Bürger, & Romanos, 2017; Schaefer, & Moos, 1998). People who experience higher levels of PTG experience fewer symptoms of PTSD (Kleim, & Ehlers, 2009).

Although some research has begun to examine the effects of PTG related to COVID-19 on NHS staff (Chen et al., 2021), very little research has considered cultural differences in PTG. Kleim, & Ehlers (2009) reported that non-White ethnicity and religiousness were predictors of PTG. Furthermore, in Islam, Buddhism, Hinduism, and Christianity suffering is seen as a part of life and can have a positive influence (Tedeschi & Calhoun, 1995). Differences in coping strategies have been identified culturally; within Collectivist cultures five coping styles are prominent: acceptance, reframing and striving; family support; religion; avoidance and detachment; and private emotional outlet (Heppner et al., 2006). People in Individualistic cultures on the other hand tend to adopt active coping and planning (Cross, 1995; Bailey & Dua, 1999; Heppner, 2008). This implies that people in Collectivist cultures adopt emotion-focused coping styles and people in Individualistic cultures tend to adopt problem-focused strategies (Bailey & Dua, 1999), therefore if cultures differ in how they coped with lockdown, then they may also differ in levels of post-traumatic growth. Gender differences exist in PTG, as women experience higher levels of PTG compared to men, moderated by age with older women demonstrating higher levels of PTG compared to younger women (Vishnevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010). Cultural differences are yet unknown, so this research aims to identify whether cultural differences too can be identified in PTG following lockdown.

Lockdown was an unprecedented situation where everyone in England had to adjust to conditions they had not experienced before. Research has established that difficulty adjusting can lead to mental health difficulties (Sinha, 2010). The transition model (Hopson & Adams, 1976) explains the process of adjustment for an individual. First immobilisation occurs when an individual feels overwhelmed by their situation. Then, in minimisation, an individual avoids or denies the situation, often followed by depression when this strategy can no longer be implemented. After the depression stage, individuals move onto accepting the reality of the situation which leads them to test out new behaviours to deal with this. In the last two stages, seeking meaning and internalisation, the individual can reflect on the situation and process and uses this understanding to internalise the new situation. Research has established that women tend adapt better than men (Haslberger, 2010), however it is not yet clear how people adjusted to lockdown and if this differed culturally.

Rationale for the proposed study

As the national lockdowns were a shared, potentially traumatic, event affecting individuals on a global level, preventing people from socialising, advised to stay at home and unable to work as usual, it is likely to have impacted both collectivist and individualistic culture's mental health, adjustment, and outlook on life and it is important to investigate this further.

Over recent years there has been a large increase in multi-culturalism as different cultures are learning to live together. For example, in 1991, ethnic minorities made up 5.9% of the UK population (White, 2012) whereas now it is estimated they make up 21.3% nationally (Sharfman, 2019) and up to 46% in major cities such as London (ONS, 2022). This increase of a secular multicultural society where members of both Collectivist and Individualistic cultures live together and learn from each other's traditions, requires further exploration of the effects of culture on mental health. Expanding our knowledge in this area can help guide clinical practice and increase the appropriateness and effectiveness of interventions for the different populations the NHS serves.

Pandemics are likely to reoccur in the future (Madhav, Oppenheim, Gallivan, Mulembakani, Rubin, & Wolfe, 2017). Twenty-four novel coronaviruses have been identified, four of which are closely related to the current COVID-19, suggesting that future pandemics are very likely (Doucleff et al., 2021). More global travel, urbanisation, climate change and contact with animals increases the risk of novel illnesses evolving (Keesing et al., 2010; Madhav, Oppenheim, Gallivan, Mulembakani, Rubin, & Wolfe, 2017). It is therefore imperative to learn from the COVID-19 pandemic to reduce future mental health impact. Establishing cultural differences in relation to lockdown will help identify which cultures could benefit from which intervention, to mitigate negative impacts of future pandemics.

Additionally, there is a gap in the literature regarding cultural differences on the impact of lockdown. As PTG can have a positive impact on mental wellbeing, identifying cultural differences may be beneficial in clinical practice and aid future research.

It is expected there will be a difference between Collectivist and Individualistic cultures levels of PTG, adjustment, and psychological distress in relation to lockdown. This research could ascertain whether certain cultural groups are more vulnerable to mental health difficulties in response to social isolation; intervention for these groups may be provided earlier to help reduce the chances of negative consequences of events such as lockdown in the future. Furthermore, patient centred care is a core value of both the NHS and clinical psychology (NHS, 2019; Rogers, 1979), therefore ensuring that clients' cultural backgrounds are considered when providing care is essential in fulfilling this value.

Research question

- Is there a difference in how members of Collectivist and Individualistic cultures dealt with lockdown in relation to PTG, adjustment, and psychological distress?

Hypothesis

There will be a significant difference between people from Collectivist and Individualistic cultures in scores of PTG (using PTGI; Tedeschi and Calhoun, 1996), adjustment (using WSAS; Mundt, Marks, Shear, & Greist, 2002) and psychological distress (using GHQ-12; Goldberg, & Williams, 1988) in relation to lockdown.

As members of Collectivist cultures are likely to have more social support (Herbert et al., 2018), live with extended family (Vandello, & Cohen, 1999) and are more likely to be of non-White ethnicity (Hui & Triandis, 1986) compared to people from Individualistic cultures, these personal and environmental factors are likely to lead to differing levels of PTG and adjustment. Furthermore, as PTG and adjustment is associated with better psychological outcomes (Kleim, & Ehlers, 2009; Sinha, 2010), it is therefore likely that people from both cultures experienced varying levels of mental health difficulties in relation to lockdown. However, variables such as age, gender and involvement with mental health services may affect this relationship.

Method

Design

A between-groups design was used to investigate the difference across the two cultural groups and their levels of post-traumatic growth (PTG), adjustment and psychological distress. The independent variable was culture: Individualistic or Collectivist. This was assigned by ethnicity based on Hofstede's (2001) index scores and ranks of Individualism/Collectivism of countries, with Asian and African backgrounds identified as Collectivist and White and European backgrounds as Individualistic. Culture was assigned using ethnicity because scales measuring Collectivism and Individualism were long and low in reliability, for example the Self-Construal Scale by Singelis (1994) consisted of 24 questions and the shorter version had only been validated in Italian; therefore using these scales would have increased the length of the study, amplifying attrition which would have impacted the power, reliability and validity of the study of the study (D'amico, & Scrima, 2016). Data on age, gender, and previous involvement in mental health services were also collected to ensure any differences found were due to culture and not these other factors. There were three dependent variables: levels of PTG, adjustment and psychological impact.

Inclusion criteria

Participants: English resident during a lockdown, over the age of 18, and not from a dual-heritage background (due to difficulty assigning a cultural group).

Participants

In total 174 participants aged between 18-97 (mean age = 37; SD = 15.83) were recruited through volunteer sampling in England. Other demographic information was collected, such as gender (53 male, 119 female and 2 non-binary), ethnicity (see table 1), previous mental health involvement (131 No, 43 yes) and whether they resided in England during lockdown (6 no, 168 yes).

Table 1. Summary of participants' ethnicity.

Ethnicity	Frequency	Percentage
Asian or Asian British - Bangladeshi	5	2.9
Asian or Asian British - Chinese	2	1.1
Asian or Asian British - Indian	58	33.3
Asian or Asian British - Other	5	2.9
Asian or Asian British - Pakistani	9	5.2
Black or Black British - African	4	2.3
Black or Black British - Caribbean	2	1.1
Mixed - White and Asian	1	0.6
Mixed - White and Black Caribbean	1	0.6
Other	6	3.4
White - English / Scottish / Welsh / Northern Irish / British	73	42
White - European	6	3.4
White - Other	2	1.1
Total	174	100

Procedure

Ethical approval for the study was granted from the University of Hull Research Ethics Committee (REF:FHS444; See appendix G for approval letter). The information sheet (appendix H), consent form (appendix I), debrief form (appendix J), and poster (appendix K) were all approved within this process.

An online questionnaire and poster were distributed via social media asking people to take part in the study. Specific social media groups and threads were used to advertise the study to try and obtain diverse population range such as "Indians in the UK" and "BAMEvoices". The first page displayed the information sheet where informed consent was obtained. Demographic information: (English residency during a national lockdown; age; gender; ethnicity; lockdown work arrangements; previous involvement in mental health services) was collected from all participants. Gender and previous involvement in mental health services was coded so could be easily analysed.

Measures

All participants completed the following measures:

- *Work and Social Adjustment Scale (WSAS) - (Mundt, Marks, Shear, & Greist, 2002).* The WSAS consists of 5 items assessing the impact a certain problem has on home management, social activities, private activities, close relationships, and ability to work. The scale achieved 0.70 to 0.94 for internal consistency and good reliability (Mundt et al., 2002). This was used to establish how well each culture adjusted to lockdown as the scale allowed flexibly around the area of interest e.g. Because of

[Lockdown], my ability to work was impaired. 0 means not at all impaired and 8 means very severely impaired. Difficulty to adjust can have an impact on an individual's day to day functioning which the WSAS assesses: scores: 0-9 = Low impairment, 10-19: Moderate impairment, and 20-40 = Severe impairment.

- *Short General Health Questionnaire (GHQ-12) - (Goldberg, & Williams, 1988)*

  The GHQ-12 is a 12-item scale used as a screening tool for mental health difficulties. Each item is rated on a Likert scale from 0 "better than usual" to 3 "much less than usual". Scores above 15 indicate distress and scores above 20 indicate severe levels of distress. The GHQ-12 achieved 79% sensitivity and 77% specificity (Goldberg et al., 1997) and Cronbach's Alpha α=.90 for the Likert method of scoring (Hankins, 2008). The GHQ-12 was used to determine the overall psychological impact of lockdown on each cultural group.

- *Post-Traumatic Growth Inventory (PTGI) – (Tedeschi and Calhoun, 1996)*

  The PTGI is a 21-item scale and measures five different aspects of PTG: relating to others, new possibilities, personal strength, spiritual enhancement, and appreciation. Each item is rated on a Likert scale from 0 "I did not experience this change in response to [Lockdown]" to 5 "I experienced this change a great deal in response to [Lockdown]"; higher scores indicate higher levels of PTG. The alpha reliability for these items is α=.90 (Tedeschi & Calhoun, 1996). This measure was chosen as it was the most reliable and most used measure of PTG as research has established behavioural changes coincide with questions the PTGI asks, therefore indicating validity (Shakespeare-Finch, & Barrington, 2012).

All participants had the right to withdraw from the study until they submitted their response. Participants were provided with an email address to contact the researcher if required. The debrief was in writing at the end of the questionnaire, with information on support services (See Appendix J).

Researcher Stance

The researcher conducting the study is a British Asian woman; raised by a first-generation immigrant father and a second-generation immigrant mother of Indian descent and Sikh religious identity. Due to this, the researcher had prior knowledge of feelings of religious discrimination against Sikh's within the community. For example, following their marriage in India the researcher's parents were issued a Hindu marriage certificate therefore not acknowledged as Sikh. As a result Sikh organisations and temples encouraged Sikhs to identify ethnically as "Punjabi" or "Sikh". The researcher was also aware of other political divisions and cultural backgrounds for example Kurdistan, an autonomous region bordering Iraq, Iran, Syria and Turkey although autonomous since 1992, had only been acknowledged by the Iraqi government since 2005. Therefore all of this was considered whilst assigning culture as the researcher did not wish to marginalise these groups further.

Data analysis

The data were inspected and cleaned - those not meeting the inclusion criteria were removed and a pairwise deletion was conducted on participants with missing data for any of the three scales (WSAS, GHQ-12 and/or PTGI). This removed 25 participants' data as 6 did not reside in England during a lockdown, 2 were dual heritage and 17 had incomplete data. The incomplete data was removed due to uncertainty of its validity, as a number of answers had been missed or had little variation. Finally the remaining 149 participants were coded to a cultural group of either 1=Collectivist or 2=Individualistic. Those from an Asian or Black ethnicity were assigned as Collectivist and those from a White ethnicity were assigned Individualistic (Hofstede, 2001). The three participants that selected “other” stated they were “Sikh” or “Kurdish”; therefore these participants were assigned as Collectivist as the researcher was aware of political divisions in India where many Sikhs do not wish to identify as Indian and Kurdistan’s Collectivist culture (as mentioned above in the researcher stance) and its close proximity to Iran and Turkey, scores of 41 and 37 respectively (Hofstede, 2001).

Sample size calculation

A sample size calculation was performed in relation to the research question: Is there a difference in how members of Collectivist and Individualistic cultures dealt with lockdown in relation to post-traumatic growth, adjustment and psychological distress? This was based on testing the difference between Culture Type using a T-test. Age, Gender, and Involvement with Mental Health Services were added to an additional multiple regression to determine if these variables predict any differences observed. In the absence of any indication from relevant research literature, a generic moderate effect size of 0.50 was assumed (Serdar, Cihan, Yücel, & Serdar, 2021).

According to Cohen (1992), to detect an effect size of 0.5 for the research question: *Is there a difference in how members of Collectivist and Individualistic cultures dealt with lockdown in relation to post-traumatic growth, adjustment and psychological distress?* a t-test with 80% power and using a 5% significance level would require 64 participants for each group. This means 64 participants from a Collectivistic culture, and 64 from an Individualistic cultural background were required.

Results

For each participant, WSAS, GHQ-12 and PTGI scores were calculated and used to ascertain an average score for both cultural groups (Table 2). A Kolmogorov–Smirnov test of normality was conducted for each scale all of which were non-significant (p>.005) and therefore normally distributed and met the assumptions of the tests conducted. These averages were entered into three t-tests for each dependent variable. A Levene's test was conducted to establish whether equal variance could be assumed (Gastwirth, Gel, & Miao, 2009). As the test for WSAS, GHQ-12 and PTGI were non-significant (p>.005), equal variance was assumed for all t-test outputs.

Table 2. Summary of mean cultural group scores for WSAS, GHQ-12 & PTGI in relation to lockdown.

	Cultural group	Mean score	SD
WSAS	Collectivist	16.44	8.18
	Individualistic	15.92	8.82
GHQ-12	Collectivist	16.67	7.82
	Individualistic	16.70	8.16
PTGI	Collectivist	51.08	24.91
	Individualistic	32.24	22.73

WSAS

The analysis revealed there was no significant difference in WSAS scores between Individualistic (mean = 15.92; SD = 8.82) and Collectivist (mean = 16.44; SD = 8.18) individuals [t (147) = 0.37, p=.711. See Figure 1

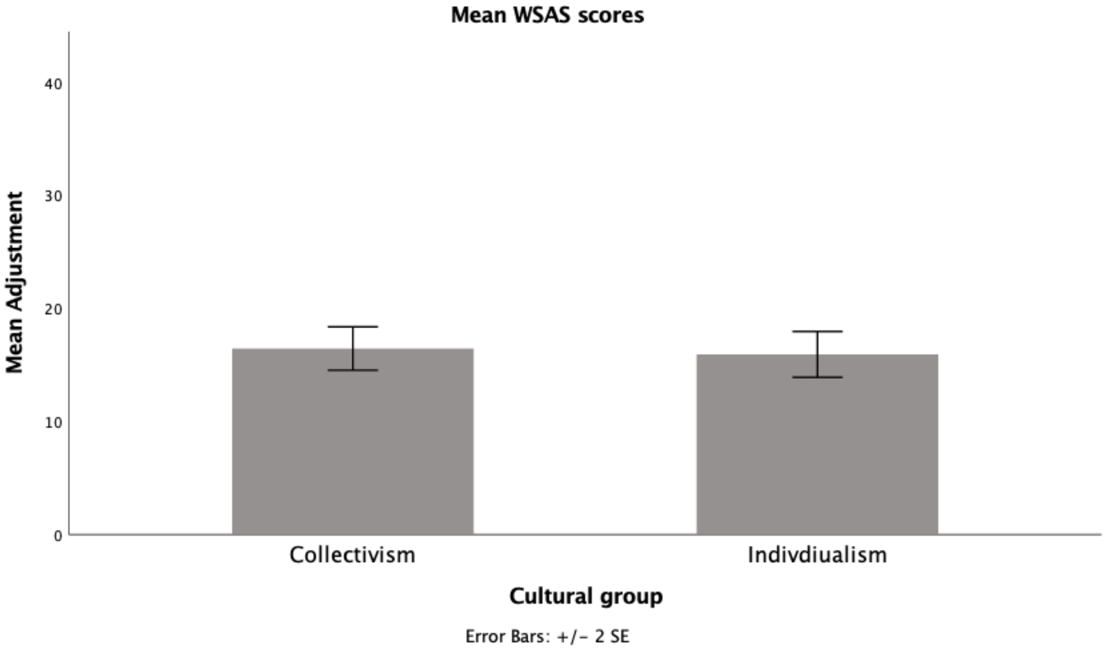

Figure 1. Shows a graph of mean WSAS scores for each cultural group measuring adjustment.

GHQ-12

The second t-test revealed there was no significant difference in GHQ-12 scores between Individualistic (mean = 16.70; SD = 8.15) and Collectivist (mean = 16.67; SD = 7.82) individuals [t (147) = -0.20, p=.984. See Figure 2

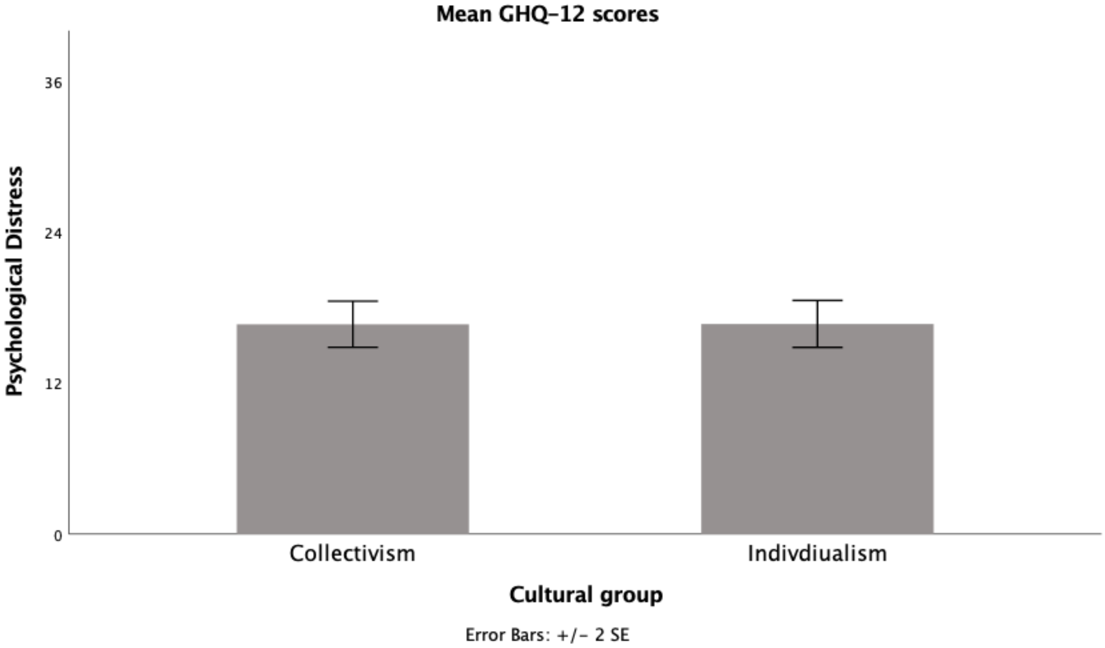

Figure 2. Shows a graph of mean GHQ-12 scores for each cultural group measuring psychological distress.

PTGI

The final t-test revealed there was a significant difference in PTGI scores between Individualistic (mean = 32.24; SD = 22.74 and Collectivist (mean = 51.08; SD = 24.74) individuals [t (147) = 4.83, p=<0.001. See Figure 3.

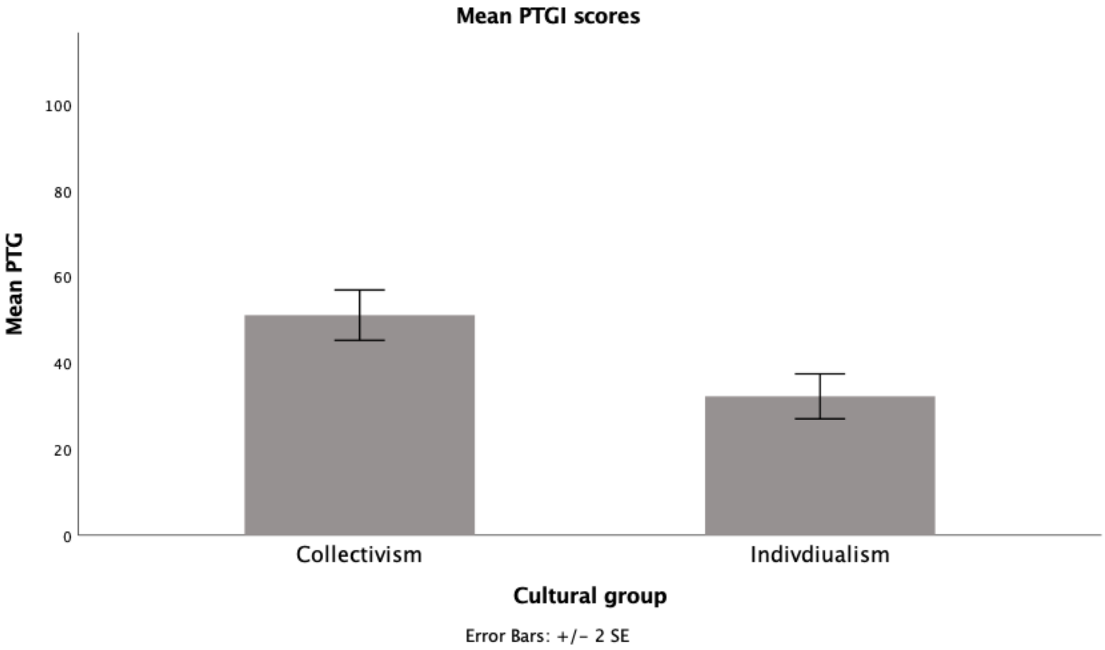

Figure 3. Shows a graph of mean PTGI scores for each cultural group measuring PTG.

Due to the significant result a multiple regression was conducted to ascertain which variables were influencing this difference. Cultural group was added to model 1 which accounted for 13.7% of the variance in PTG, whereas model 2 introduced the factors: age, gender, and MH involvement which explained 15.7% of the variance in PTG. The change in R^2, an increase of 2%, was not significant, *F*(3,144) = 1.17, p = .324.

From the ANOVA both models were significant; model 1 F(1,147)=23.30, p <.001, model 2 *F*(4,144)=6.72, p = .324. Model 2 was the best fitting model for predicting PTG by accounting for more variance. Cultural group (B = -18.36, p <.001) contributed significantly to the model 2, whereas the other predictors: age, previous mental health involvement and gender did not (see Table 3).

Table 3 . Summary of multiple regression for variables predicting PTG following lockdown.

Model		B	SE	b	t	P value
1	Constant	69.93	6.21		11.26	<.001
	Cultural group	-18.85	3.90	-.37	-4.83	<.001
2	Constant	74.28	11.02		6.74	<.001
	Cultural group	-18.36	4.17	-.36	-4.41	<.001
	Age	-0.21	0.13	-.12	-1.58	.117
	Gender	2.58	4.26	.05	0.61	.546
	Previous MH involvement	-1.55	4.56	-.03	-0.34	.734

Discussion

The study aimed to establish differences in how members of Collectivist and Individualistic cultures in England dealt with lockdown in relation to PTG, adjustment, and psychological distress. It was expected that PTGI, WSAS and GHQ-12 scores in relation to lockdown would differ between the cultural groups. Three t-tests were conducted. No differences were found between WSAS and GHQ-12 scores for the cultural groups; suggesting that both Collectivist and Individualistic groups found lockdown equally difficult psychologically and to adjust to. The WSAS scores for both cultural groups were 16 which meets the moderate impairment threshold and the GHQ-12 scores, rounded up, were 17 which suggested evidence of psychological distress. However, there was a significant difference between PTGI scores between the cultural groups. The Collectivist group scored 51 whereas the Individualistic group scored 32, on average; this suggests that those from a Collectivist culture experienced higher levels of PTG in response to lockdown. The follow up regression for PTG found that cultural group was a significant predictor of PTG whereas age, previous involvement in MH services and gender were not.

The fact that both cultures found lockdown equally difficult to adjust to and distressing, refutes the hypothesis that there will be a significant difference between Collectivist and Individualistic cultures levels of adjustment, and psychological distress in relation to lockdown. However, the difference in PTGI scores between the cultural groups supports the hypothesis: there will be a significant difference between Collectivist and Individualistic cultures levels of PTG.

Although both cultural groups found lockdown equally distressing, there could still be different sources triggering distress. As previous research has ascertained, people in Collectivist cultures experience depression in response to interpersonal issues and Individualistic cultures due to lack of success (Tafarodi & Smith, 2001; Heppner et al., 2006). Perhaps people in Collectivist cultures found lack of interpersonal interaction distressing whereas Individualistic members experienced the lack of progression such as the increase in redundancies and unemployment in lockdown as upsetting (Francis-Devine, Powell, & Clark, 2022), given that work is closely linked to success (Davidsson, 2012). These findings also support that psychological distress increased in lockdown, but characteristics such as being an ethnic minority did not affect an individual’s change in psychological distress (Pierce et al., 2020). Furthermore, there are known cultural differences in coping strategies: within Collectivist cultures five coping styles have been identified: acceptance, reframing and striving, family support, religion, avoidance and detachment, and private emotional outlet (Heppner et al., 2006), whereas Individualistic cultures adopt active coping and planning (Cross, 1995; Bailey & Dua, 1999; Heppner, 2008). This may suggest that for both cultural groups strategies they had relied on previously may not have been viable during lockdown and its unpredictability such as utilising family support and planning, which may explain why both groups found lockdown equally difficult. Future research may wish to investigate whether the source of distress differed culturally and whether this linked to difficulties utilising coping strategies.

The fact that those from a Collectivist culture experienced more PTG in response to lockdown supports previous findings that environmental factors such as family, personal relationships, friends, and community contribute to PTG (Vloet, Vloet, Bürger, & Romanos, 2017; Schaefer, & Moos, 1998). Collectivist cultures usually have a greater sense of community and importance is placed on relationships, so this may explain the cultural difference, especially during a time people had to come together to support one another. Furthermore, previous research found those Collectivist cultures believe they should provide social support rather than receive it (Taylor et al., 2007) which may explain why those from a Collectivist culture experienced a more positive response to lockdown.
As those from “Asian or Asian British” and “Black or Black British” ethnicities were defined as Collectivist, using Hofstede’s index, this supports previous findings that non-White ethnicity was predictive of PTG (Kleim, & Ehlers, 2009). Research has found gratitude and social support predicted PTG in Chinese earthquake survivors (Zhou, & Wu, 2016), which may also pose a possible explanation why those from a collectivist culture experienced more PTG.

As previously discussed, 25% of the NHS is made up of members of Collectivist culture (NHS Digital, 2023), these individuals are more likely to experience discrimination and harassment compared to their Individualistic counterparts (WRES, 2023). It could be argued that surviving difficulties such as these has made those from a Collectivist culture better equipped to deal with lockdown and experience more PTG than those from an Individualistic culture as may not experience as many difficulties in day-to-day life, due to white privilege (Leonardo, 2004).

Higher levels of PTG are associated with fewer PTSD symptoms (Kleim, & Ehlers, 2009); the fact that those from Collectivist cultures had higher levels of PTG could suggest that members of this culture are less likely to develop trauma symptoms in response to social isolation. Perhaps those from an Individualistic culture are more likely to develop trauma symptoms due to lockdown and may need more psychological support compared to Collectivist cultures in response to social isolation or future lockdowns as pandemics are likely to reoccur (Madhav et al., 2017). Members from Individualistic cultures may also be more prone to the damaging effects of stress due to their relative lack of social support as social support has been found to be a buffer to mental health difficulties. This should be kept in mind during clinical work. Future research could investigate whether there are cultural differences in trauma and other psychological states in response to social isolation, including lockdown.

Despite the statistical significance of the t-test and regression, only a small amount of variance was explained (15.7%) therefore other factors not included in the study might explain more of the variance in PTG. For example, research has indicated that religiousness, extraversion, openness to experience and agreeableness predicted PTG (Kleim, & Ehlers, 2009; Wilson & Boden, 2008) but these factors were not measured in the study. Future research could be conducted to establish if religiousness, extraversion, openness to experience correlates with culture and if they explain greater variance in PTG.

A limitation of the study is that Collectivism and Individualism was defined using Hofstede's index as a guide (Hofstede, 2001), assigning non-White ethnicity (Asian or Asian British, Black or Black British) as Collectivist and White ethnicity as individualist. This was done because scales measuring Collectivism and Individualism were long and low in reliability, for example the Self-Construal Scale by Singelis (1994) consisted of 24 questions and therefore would have increased rates of attrition by increasing the length of the study, increased the chances of missing data, leading to more participant data being removed and providing unreliable results and a study with low power (D'amico, & Scrima, 2016).

Hofstede's index has been argued to have low face validity and internal reliability (Minkov et al., 2017). However a more recent study measuring Collectivism and Individualism found similar findings to Hofstede, with Asian and African countries rated high for Collectivism and European countries rated high for Individualism (Minkov et al., 2017).

Furthermore, the fact that Collectivism and Individualism was compared in relation to White ethnicity compared to non-White ethnicity could be argued to be reductionist, as it is not clear whether specific ethnicities varied in their response to lockdown and those from a dual-heritage background could not take part using this definition. Nonetheless, all Collectivist participants, except 6, were from an Asian or Asian British background suggesting that these results can be generalised to this group but may not be generalisable to those form a Black background as they were less represented. The paucity of research within this area and cultural differences identified in this study, support that more research is needed and further validation of the cultural constructs. It would be beneficial to investigate specific differences across ethnicities to ensure that clients receive person-centred care within clinical practice (NHS, 2019; Rogers, 1979).

The study was retrospective, asking participants to look back at their experiences of lockdown. However lockdown was an unparalleled experience, and the scores reflected this difficulty; suggesting that the results were meaningful.

Although the WSAS (Munt et al., 2022) and PTGI (Tedeschi & Calhoun, 1996) were chosen due to their high reliability, the studies which demonstrated this were older. Many newer studies used populations or context that did not relate to the population in this study, for example WSAS and young people (Jassi et al., 2020) and PGTI reliability and validity in French (Cadell, Suarez, & Hemsworth, 2015). Therefore the papers used were believed to be the most appropriate.

Conclusion

Overall, the study identified that both cultural groups found lockdown equally impactful and a difficult adjustment, suggesting no cultural difference in how lockdown was experienced. However, those from a Collectivist background experienced more PTG in response to lockdown perhaps due to a greater sense of community and mutual support during this period. Furthermore, difficult experiences in Collectivist day to day life such as discrimination and harassment may suggest that this group was better prepared to deal with lockdown and the positive impact of it. As those from an Individualistic culture experienced less PTG in response to lockdown they may experience more trauma symptoms in response to social isolation, and future lockdowns if another pandemic were to occur. Future research may wish to investigate this further, as it is important to keep cultural differences in mind during clinical work to ensure patient-centred care. This study suggests that although there are some cultural differences as to how both cultural groups have dealt with lockdown which may be explained by differences in relation to community and experience, there are still similarities between the two groups.

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Part Three – Appendices

Appendix A: Reflective statement

Empirical Paper

Choosing a topic

Although it has been three years since I was preparing for the Clinical Psychology Doctorate interview some days it feels like one, and others a lifetime ago. I recall frantically trying to think about the questions I might be asked, panicked I'd be asked potential thesis ideas. I remember thinking, "I haven't left the house in 4 months, I have nothing original in my brain!". Once I calmed down and was able to mentalise again, I reflected on the thought I had had. Realising that yes, I had in fact spent 4 months in the house and although it had been difficult, there were many parts I had enjoyed and, I felt, the time had flown by, as had my immediate family and friends from similar backgrounds to me. However, many of my friends from White backgrounds seemed to have a different experience to me and did not seem as hopeful for the future. Although I found this interesting it was an incredibly fleeting thought, and I didn't think too much about it.

In the time between handing in my undergraduate thesis and gaining a position on the doctorate, I began working as a peer support worker. In this role I worked in an incredibly diverse area where all members of staff were from a minority background, despite being from an Asian background myself I had never experienced being a majority other than in my own home or at the temple. It was in this role I noticed the cultural difference again, at work very little was mentioned about lockdown, if it was staff acknowledged it was difficult but were appreciative of rule relaxations and what we were now able to do, however when I would go home and listen to a podcast by comedians Chris and Rosie Ramsey I would notice their different perspective and the frustration of things not being back to normal.

In September 2020 I set off to Hull, a place I had never stepped foot in and was excited for a new chapter in my life. Here I noticed a similar pattern, housemates from a similar background to me acknowledged that we had had a difficulty lockdown and there was a high chance we would experience another but seemed accepting of this and were happy to sacrifice once again for others, however housemates from a White background shared that they were struggling and did not see any hope of this ending, appearing flat and deflated, frustrated that something they felt didn't impact them was effecting them. As I had now noticed this distinction several times, in different settings, I began to think it was important to focus my research on this cultural difference as I was interested to see if the pattern, I had observed was generalisable, or just down to chance.

Designing research

As I was intrigued to establish if there was in fact a cultural difference in how people dealt with lockdown and if the pattern observed was generalisable, I was drawn to a quantitative design. I also had previous experience with quantitative research so was familiar with the process and this added security to what I had mentally prepared to be a difficult three years. I acknowledged that the data would not be as rich compared to conducting a qualitative study but when searching through the literature, the limited research on cultural differences highlighted the need to establish a significant difference in culture which could then allow further research in the future.

As I had wanted to establish cultural differences, I did not want to exclude certain ethnic backgrounds as I wanted this to be a broad project which allowed for further, more specific research in the future. Therefore assigning Collectivist and Individualistic as the independent variable felt appropriate and broader.

I had initially decided I would use a questionnaire to assign the culture of Collectivist or Individualistic as this would be a uniform and valid way to determine the independent variable, however looking at the questionnaires they did not seem suitable. Many measured variables in addition to culture, some had varying degrees of Individualism and therefore would have caused difficulty assigning to the cultural group, and many were long which would have contributed to further attrition (Triandis & Gelfland, 1998; Clark et al., 1987). I had looked at the social contractual scale (SCS) (Singelis, 1994) as a potential contender, however when I explored it, it was very difficult to establish its validity, papers referred to its low validity, but this also included different version and different languages (D'amico, & Scrima, 2016.) All this and its length meant that it did not feel worthwhile asking participants to spend their time completing a scale which would have the same issues as not completing one at all. Therefore, it was decided that Hofstede's index (Hofstede, 2001) would be used to assign cultural group. This was because it was a quick process, did not impact participation and the same validity as using a scale. Previous research had established that non-White ethnicity was associated with Collectivism and Hofstede's index also aligned with this (Gaines et al., 1997 Hofstede, 2001) however, this meant that dual-heritage participants could not take part using this way to assign cultural group.

It did not seem appropriate for participants to assign their own cultural group, as Collectivism and Individualism is not commonly used in everyday language and wanting a broad sample from different cultures may had made this a difficult question to answer, increasing potential attrition and invalid responses. For example, I am aware that both my parents would have found that question difficult to answer despite one being British born and the other Indian.

It was decided that it would be interesting to learn more about the differences in how the cultures adjusted to lockdown, using the Work and Social Adjustment Scale (Mundt, Marks, Shear, & Greist, 2002), and the psychological impact using the GHQ-12 (Goldberg & Williams, 1997). However, as I had also observed positive responses to lockdown, I also wanted to investigate this, therefore it was decided that cultural differences in post-traumatic growth (PTG), a positive response to a stressful experience, would be established using the post-traumatic growth inventory (Tedeschi, & Calhoun, 1996).

Recruitment and data collection

This was the most exciting time in the process of my thesis. It felt like all the reading and writing was now coming alive. Distributing the questionnaire online over various sites and groups and trying to ensure to obtain broad but equal number of Collectivist and individualist cultures felt daunting and I was concerned there would be significantly more Individualistic compared to Collectivist participants. Throughout data collection I kept an eye on any major tipping towards one culture or another, luckily it was even throughout, and people seemed willing to take part.

Data Analysis

Once I had my data, I was able to clearly establish how broadly I had been able to cast my net. Looking at my raw data I was disappointed to see that only 6 of my 174 participants were of “Black or Black British” ethnicity. However as 79 were of “Asian or Asian British” ethnicity, I hoped that it could be argued that although the results may not generalise to Black or Black British ethnicity they may to Asian or Asian British ethnicity.

Using Hofstede’s index and research that correlated Collectivism and non-White ethnicity (Gaines et al., 1997 Hofstede, 2001) each participant that met the inclusion criteria and did not have missing data was assigned either Collectivist or Individualistic. I enjoyed sorting through all the data, and this really helped me to engross myself in it.

Three t-tests were conducted to compare the two groups, one for adjustment in lockdown, one for psychological distress and the final for post-traumatic growth. As there was no significant difference between adjustment or psychological distress between the cultural groups, no further analysis seemed necessary, and it felt appropriate to conclude that both groups found lockdown equally as difficult. As a significant difference was established between the two cultural groups and PTG, a multiple regression was conducted. The multiple regression was chosen to establish whether it was in fact culture predicting this difference or whether other variables such as age, gender and previous involvement with mental health services was influencing this. When the regression established that yes it was in fact culture predicting this difference I was thrilled as it proved that the difference, I had seen was not due to chance and was in fact a cultural difference.

Writing up

I had mixed feelings about writing up my empirical paper. I was excited that something that had pondered finally had an answer, I was able to spend time writing about something I was interested in. However, I also knew that this meant that I was coming towards the end of my training, and I was in fact writing a thesis and a lot was riding on this. To manage, I was able to break the process down and focused on each section at a time. This allowed me to feel I was making progress, ticking small tasks off but also distanced the fear that came with the idea of having to write up a full empirical paper.

Systematic literature review (SLR)

The SLR has been the most difficult and unenjoyable aspect of this process. As I had chosen a topic on cultural differences and lockdown/COVID-19 for my empirical I was narrowed down to these for my SLR. I had tried to think of SLR topics for cultural differences but due to the limited research available this was not feasible. Due to lockdown/COVID-19 endless amount of research it was difficult to find a gap of where a literature review hadn't been done. As I needed the SLR to be clinically linked I decided I would look at the impact of COVID-19 on mental health services. I felt this was something I knew impacted me directly with my role as a clinical psychologist and thought it was important to establish. I was happy with my decision; however I then came across a review that looked at the global impact of COVID-19 on mental health services (Duden, Gersdorf, & Stengler, 2022). When I saw this, I felt deflated and was back at square one. However, I had time to think and when looking at their paper they had included 29 papers and only those up to 2021. Therefore, I acknowledged that conducting an SLR generally on the impact on mental health services would have been too broad and not as clinically relevant. I decided to focus on the impact on mental health services in the UK with specific focus on the impact on service activity, staff and clients; all things that have a direct impact on clinical psychologists. Other papers found in grey literature have looked at the impact on mental health services in relation to structure (Aslam, 2021) which also had limited clinical relevance for a clinical psychologist.

As COVID-19 appeared to be an incredibly researched area the literature search obtained a large volume of papers. However, the majority were not relevant. Screening all the papers took a great deal of time and was frustrating at times. Nonetheless once this was completed it felt like I was finally able to get moving with the process and felt more enthusiastic about it. I was able to spend time in my room with highlighters and printed out papers looking for themes and links. This allowed me to really understand the papers and begin writing. Writing up the SLR was not as laborious as I had expected, shockingly at times I enjoyed it. However, I can't say that I am in a rush to do one again soon despite acknowledging its strengths as if I had read a single paper in my SLR rather than looking at their quality and comparing them to others, I would have had a different conclusion as to what impact COVID-19 had on mental health services in the UK.

Final thoughts

Overall the process of writing my thesis has been a long one. I have learnt much about myself and research in this time. I know this journey will be imperative in my clinical practice, ensuring that I am up to date with theory to aid my work (and the quality of the paper is taken into consideration) and furthering future research to ensure that all cultures are considered to ensure person centred practice.

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Appendix B: Epistemological statement

The way we view the world can impact the ways in which we do and interpret things, therefore before undertaking a research project it is important to establish one's ontological and epistemological position, due to likely influence on research procedure, data analysis and interpretation. This statement aims to outline the different ontological and epistemological positions, and which influenced this piece of work.

Ontology relates to assumptions about reality (Guarino, Oberle, & Staab, 2009). Realists believe that reality can be observed and measured with a single truth, whereas relativists (those on the opposite end of the continuum) believe that reality is subjective and can be interpreted in multiple ways (Fletcher, 1996).

Epistemology is concerned with knowledge; how we acquire and justify what we believe (Audi, 1998). On one end of the spectrum there is positivism, where reality can be objectively observed without bias (Fletcher, 1996; Alharahsheh, & Pius, 2020). On the other, there is interpretivism, which coincides with subjective sense making by acquiring an in-depth view of the world (Alharahsheh, & Pius, 2020). An individual's epistemological position is likely to determine the methodology of their research. As positivists align with quantitative methodology due to observable generalisabilities, whereas interpretivists affiliate with qualitative practice due to the rich data and opportunity to interpret findings through their own lens (Michell, 1997).

The research aims have been influenced by the researcher's epistemological and ontological stance.

Conducting research comparing groups lends itself to a positive-realist stance due to the assumption that reality can be observed and measured, and this knowledge can be generalised.

Although this is the case, the limits to these understandings should be acknowledged. Quantitative research allows uniform measurement of all participants and their responses. However, as the data was interpreted by a researcher with their own lens as a British Asian female with their own experience of both cultural groups in and out the context of lockdown this is likely to have some impact on how objectively the data was understood which aligns more with a Postpositivist lens (Reed, 2010).

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Appendix C: Submission guidelines for The Journal of Health Services Research & Policy

Manuscript Submission Guidelines: *Journal of Health Services Research & Policy (JHSRP)*

This Journal is a member of the Committee on Publication Ethics

Please read the guidelines below then visit the Journal's submission site http://mc.manuscriptcentral.com/jhsrp **to upload your manuscript. Please note that manuscripts not conforming to these guidelines may be returned.**

The editorial office does not provide individual advice or feedback on draft papers or abstracts before submission.

Only manuscripts of sufficient quality that meet the aims and scope of *Journal of Health Services Research & Policy* will be reviewed.

There are no fees payable to submit or publish in this journal.

As part of the submission process you will be required to warrant that you are submitting your original work, that you have the rights in the work, and that you have obtained and can supply all necessary permissions for the reproduction of any copyright works not owned by you, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere. Please see our guidelines on prior publication and note that *Journal of Health Services Research and Policy* does not accept submissions of papers that have been posted on pre-print servers.

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1. What do we publish?

1.1 Aims & Scope

The Journal of Health Services Research & Policy publishes scientific research on health services, health systems and health care from a wide range of disciplines. The Journal also engages in, and responds to, current scientific, methodological and policy debates in health care that are relevant to many health systems. The Journal aims both to reflect current concerns and to contribute to setting health services, health systems and health care policy agendas internationally.

We welcome submissions reporting on research and/or policy analyses concerning low-, middle and high-income countries. In all cases, the international relevance of the submitted work should be clearly drawn out.

As we are a multidisciplinary journal with an international readership we specifically consider a number of criteria in deciding on publication:

- the importance and originality of the research/policy question;
- the appropriateness of the methods used and how well the research has been carried out;
- the strengths and weaknesses of work presented in the article, including the level of critical engagement with the existing evidence base and critical reflection on the findings and implications of the work;
- the extent to which the implications of the findings for policy or practice have been drawn

out and have been justified;

- the writing, organisation and presentation of the work reported in the paper;
- the degree to which the paper would be understood by an international audience, which is not necessarily familiar with the health system in question.

1.2 Article Types

We consider the following types of submissions:

- **Original research**

Original research papers report on original primary research that uses quantitative and/or qualitative methods to examine a health care or health policy research question or issue and their implications on health services, health systems or health care policies.

Papers reporting quantitative work should be up to 3500 words with up to 30 references, plus up to five figures, and/or tables and boxes.

Papers reporting qualitative or mixed methods work should be up to 6000 words with up to 30 references, plus up to two figures, and/or tables and boxes.

- **Reviews**

We consider systematic reviews of published research, which may include rapid evidence syntheses, scoping reviews, meta-ethnography, meta-narrative reviews and realist reviews.

Reviews can be up to 6000 words with up to 50 references, up to five figures and/or tables and boxes, plus one online supplement only.

Where review work exceeds the maximum number of 50 references, authors are encouraged to present additional material in an online supplement.

- **Conceptual/methodological articles**

We welcome submissions that discuss theoretical, conceptual or methodological issues in the context of health services and systems research and health care policy. This may include papers that develop novel frameworks or concepts that help advance the analysis of (perennial) health services and systems research questions and health care policy issues, or that propose and/or test innovative methodological approaches to examine research and/or policy questions that are of concern in the fields of health services and systems or health care policy research.

Conceptual or methodological articles can be up to 4000 words with up to 30 references, plus up to two figures, tables or boxes.

- **Essays**

Essays include commentaries or theoretical pieces that discuss a particular health services or systems research, or health care policy issue that is (or should be) of concern across a wide range of countries and health systems. We welcome Essays that compare and contrast a given research or policy question or issue, trace their historical origins and development, and/or reflect on the wider application and use (or misuse) of a given issue or concept. Essays should always discuss implications for policy along with presenting evidence of policy impact to support the argument.

Essays can be up to 3000 words with up to 20 references, plus up to two figures, tables or boxes.

Abstracts:

Original research and Review articles should include a structured abstract (objectives, methods, results, conclusions). Conceptual/methodological papers and Essays should include an unstructured abstract.

Word count:

Word counts exclude text in the abstract, references, tables and figures. Please do not exceed the word limit.

Editorials: Please note that we do not consider unsolicited editorials.

Protocols: Please note that the Journal does not accept Protocols.

1.2.1 Virtual collection: Environmental sustainability and the health care system

The Journal of Health Services Research & Policy features a virtual collection of articles that explore issues around environmental sustainability, including the impacts of climate change, and the health care system. We welcome contributions (original research, reviews, conceptual or methodological articles, essays) that offer original insights, critical perspectives or present new research and thinking addressing such themes as:

- What changes can be implemented to achieve a ‘greener’ health system?
- How can we reduce the environmental impact of health services?
- What are the social and economic impacts of climate change on health systems and service delivery?
- What policies can we design to reduce the health inequalities brought about by climate change in settings that are already overstretched?
- What are the key changes in service delivery that are necessary to ensure health care will be sustainable when faced with extreme weather and changes in disease incidence resulting from climate change?

1.3 Writing your paper

The SAGE Author Gateway has some general advice and on how to get published, plus links to further resources. SAGE Author Services also offers authors a variety of ways to improve and enhance their article including English language editing, plagiarism detection, and video abstract and infographic preparation.

When devising the paper please be aware that the text must be written in a way that cannot be construed as legally objectionable, infringing copyright, defamatory, obscene or likely to be actionable by law.

Original research: quantitative work

Observational studies (cohort, case-control, or cross-sectional designs) should be reported according to the STROBE statement. For reporting statistical methods and results we encourage authors to review the SMAPL guidelines when preparing the manuscript.

Original research: qualitative work

Qualitative and/or mixed methods studies should be reported according to SRQR guidance, COREQ criteria, or other relevant guidance as appropriate.

Reviews

Systematic reviews should be reported according to PRISMA guidelines or respective extension for scoping reviews. For realist reviews please follow the RAMESES publication standards. For reporting meta-ethnography please consider the eMERGe Reporting Guidance. General guidance on how to get published is available from the SAGE Author Gateway, plus links to further resources.

1.3.1 Make your article discoverable

When writing up your paper, think about how you can make it discoverable. The title, keywords and abstract are key to ensuring readers find your article through search engines such as Google. For information and guidance on how best to title your article, write your abstract and select your keywords, have a look at this page on the Gateway: How to Help Readers Find Your Article Online

2. Editorial policies

2.1 Peer review policy

All papers submitted for publication are considered for peer review. The Editors decide within 4-6 weeks whether the paper should be sent out for peer review, or rejected at the first stage. Papers may be rejected without peer review it the paper is of poor quality, outside the scope of the Journal, or not considered sufficiently original or topical given the space constraints of a quarterly journal.

Papers selected for peer review will be sent out to two reviewers. Usually we choose one reviewer who can comment primarily on the methodological aspects of the paper, and one who can primarily assess its policy relevance and implications.

Authors are invited to suggest two or three potential reviewers, one of whom may be used. We usually invite reviewers who have published peer-reviewed work in a relevant field as identified from bibliographic databases; reviewers will typically not be based at the same institution as the submitting author.

For ethical reasons, attempts are made to mask reviewers to the identity of the authors by excluding the names and affiliations of authors and acknowledgements from the manuscript. Peer reviewers are required to treat the contents of the manuscript as confidential, and this should not be discussed with anyone else without prior permission from the editors.

Reviewers are asked to comment on the following issues in their reports:

1. Importance of the research/policy question
2. Originality of the research/policy question
3. Strengths and weaknesses either of the study design, data collection and data analysis (for research papers) or the policy analysis/commentary (for policy papers)
4. The writing, organisation and presentation of the data in the paper
5. The extent to which the implications of the findings have been drawn out and have been justified
6. The degree to which the paper would be understood by an international audience which is not necessarily familiar with the health system in question (not applicable for systematic reviews)

There is no ‘scoring’ system, and reviewers are not asked explicitly to give their opinion as to whether or not the paper should be published.

The Editors aim to reach a decision on each peer reviewed paper within 4-6 weeks of receipt of the reviews. Three decisions are possible: accept; resubmit; and reject. Authors are sent the editorial decision together with copies of the peer reviewers' comments (anonymised). The Editors usually send individualised feedback letters to authors, if the authors are being invited to resubmit the paper. Reviewers will receive a copy of the other reviewer's anonymised comments for information.

Covering letter

The covering letter is important. To help the Editors in their preliminary evaluation, please indicate why you think the paper suitable for publication.

2.2 Authorship

Papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.

The list of authors should include all those who can legitimately claim authorship. This is all those who:

1.
    1. Made a substantial contribution to the concept or design of the work; or acquisition, analysis or interpretation of data,
    2. Drafted the article or revised it critically for important intellectual content,
    3. Approved the version to be published,
    4. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship should be listed in the Acknowledgments section. Please refer to the International

Committee of Medical Journal Editors (ICMJE) authorship guidelines for more information on authorship.

Authors should meet the conditions of all of the points above. When a large, multicentre group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship.

2.3 Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

Please supply any personal acknowledgements separately to the main text to facilitate anonymous peer review.

2.3.1 Third party submissions

Where an individual who is not listed as an author submits a manuscript on behalf of the author(s), a statement must be included in the Acknowledgements section of the manuscript and in the accompanying cover letter. The statements must:

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Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki

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For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative. Please do not submit the patient's actual written informed consent with your article, as this in itself breaches the patient's confidentiality. The Journal requests that you confirm to us, in writing, that you have obtained written informed consent but the written consent itself should be held by the authors/investigators themselves, for example in a patient's hospital record. The confirmatory letter may be uploaded with your submission as a separate file.

Please also refer to the ICMJE Recommendations for the Protection of Research Participants

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This journal is able to host additional materials online (such as those required for reporting of systematic reviews; or datasets and images etc) alongside the full-text of the article. Supplemental material files may be subjected to peer-review alongside the article, if directly relevant to the conclusion. It is the responsibility of the authors to ensure that the material is relevant, clearly labelled as ‘Supplement X_online_supp’, and correctly referenced in the main body of the article.

Supplemental material files must be able to ‘stand alone’, as they will be uploaded online as supplied. They will not be checked for accuracy, copyedited, typeset or proofread. The responsibility for scientific accuracy and file functionality remains with the authors.

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When submitting a manuscript, the title page, main text, tables or boxes, figures and acknowledgements must be saved and uploaded as separate files:

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- Main text file – Manuscript title, Abstract, Main Text and References (minus author details, acknowledgements and any running heads of author names, to allow anonymized review)
- Keywords (3 keywords)
- Tables [or Boxes] – separate file(s)
- Figures – separate file(s)
- Appendix – separate file(s)
- Acknowledgements – separate file
- Supplementary file – supplementary material can be added. Online-only material should be clearly marked.

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If you do not already have an ORCID iD please follow this link to create one or visit our ORCID homepage to learn more.

5.2 Information required for completing your submission

You will be asked to provide contact details and academic affiliations for all co-authors via the submission system and identify who is to be the corresponding author. These details must match what appears on your manuscript. The affiliation listed in the manuscript should be the institution where the research was conducted. If an author has moved to a new institution since completing the research, the new affiliation can be included in a manuscript note at the end of the paper. At this stage please ensure you have included all the required statements and declarations and uploaded any additional supplementary files (including reporting guidelines where relevant).

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As an example of how to supply this information please use the example below:

Joe Bloggs, Department of Research, University, Town, ZipCode, USA
Email: JoeBloggs@email.com
Twitter: @drjoebloggs

6. On acceptance and publication

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7. Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the *Journal of Health Services Research & Policy* editorial office:

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Manager, Editorial Office
Journal of Health Services Research & Policy Editorial Office
Department of Health Services Research & Policy
London School Hygiene & Tropical Medicine,
15-17 Tavistock Place, London WC1H 9SH, UK

Tel: +44 (0)20 7927 2107 ;
Email: Christine.Rivett-Carnac@lshtm.ac.uk

The editorial office does not provide individual advice or feedback on draft papers or abstracts before submission.

Appendix D: MMAT Data Quality Assessment checklist

Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Appendix E: Quality assessment scores

Category of study designs	Methodological quality criteria	Wilson, Dalton-Locke, Johnson, Simpson, Oram, & Howard (2021).	Bakolis et al (2021)	Gregson, Randle-Phillips, & Delaney, (2022).	Bennett, Gosling, Harter, & Watson, (2021).	Chen et al (2020)	Bauer-Staeb et al (2021)	Abbas et al (2012)	Sheehan, Dalton-Locke, Ali, Vera San Juan, Totsika, & Hassiotis (2022).	Newbronner et al (2022)	Mannion, Konteh, & Jacobs (2022).	Puzzo, Aldridge-Waddon, Stokes, Rainbird, & Kumari (2022).	Burton, Wall, & Perkins, (2022).	Bentham, Driver, & Stark (2021).	Johnson, Dalton-Locke, Vera San Juan, Foye, Oram, Papamichail, & Simpson (2021).	Tromans, Chester, Harrison, Pankhania, Booth, Chakraborty (2020).
SCREENING QUESTIONS	S1. Are there clear research questions?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	S2. Do the collected data allow to address the research questions?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	Y		Y					Y	Y	Y		Y	Y	Y	

	1.2. Are the qualitative data collection methods adequate to address the research question?	Y		Y					Y	Y	Y		Y	Y	Y	
	1.3. Are the findings adequately derived from the data?	Y		Y					Y	C/Y	Y		Y	Y	Y	
	1.4. Is the interpretation of results sufficiently substantiated by data?	Y		Y					Y	Y	Y		Y	Y	Y	
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Y		Y					Y	Y	Y		Y	Y	Y	
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?															
	2.2. Are the groups comparable at baseline?															
	2.3. Are there complete outcome data?															
	2.4. Are outcome assessors blinded to the intervention provided?															
	2.5 Did the participants adhere to the assigned intervention?															

3. Quantitative non-randomized	3.1. Are the participants representative of the target population?		Y					Y	Y	Y		Y				Y
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?		Y					Y	Y	Y		Y				Y
	3.3. Are there complete outcome data?		N					Y	C	C		Y				C
	3.4. Are the confounders accounted for in the design and analysis?		Y					Y	Y	Y		Y				Y
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?		Y					Y	Y	Y		Y				Y
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	Y			Y	Y	Y							Y	Y	
	4.2. Is the sample representative of the target population?	N			Y	Y	Y							Y	Y	
	4.3. Are the measurements appropriate?	Y			N	Y	Y							Y	Y	
	4.4. Is the risk of nonresponse bias low?	Y			C	Y	Y							Y	Y	
	4.5. Is the statistical analysis appropriate to answer the research question?	Y			C	Y	Y							Y	Y	
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed	N							N	N/Y				N	Y	

	methods design to address the research question?															
	5.2. Are the different components of the study effectively integrated to answer the research question?	Y							Y	Y				Y	Y	
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Y							Y	Y				Y	Y	
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Y							Y	Y				Y	Y	
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Y							Y	Y				Y	Y	
Total number of Y		4/5	4/5	5/5	2/5	5/5	5/5	5/5	4/5	4/5	5/5	5/5	5/5	4/5	5/5	4/5
Percentage (%)		80	80	100	40	100	100	100	80	80	100	100	100	80	100	80

Appendix F: Submission guidelines for the Journal of Cross-Cultural Psychology.

Submit paper

Journal of Cross-Cultural Psychology (*JCCP*) publishes material in three categories: (1) regular, unsolicited manuscripts, (2) brief reports, and (3) special issues. We do not publish book reviews. Summary details of each category are as follows:

1.Regular, Unsolicited Manuscripts. This is *JCCP*'s main emphasis. See Aims and Scope for a detailed description of appropriate manuscripts.

Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/jccp. Authors will be required to set up an online account on the SageTrack system powered by ScholarOne. Manuscripts will be sent out anonymously for editorial evaluation. Obtaining permission for any quoted or reprinted material that requires permission is the responsibility of the author. Submission of a manuscript implies commitment to publish in the journal. Authors submitting manuscripts to the journal should not simultaneously submit them to another journal, nor should manuscripts have been published elsewhere in substantially similar form or with substantially similar content. Authors in doubt about what constitutes prior publication should consult the Editor.

Manuscript length should normally be 15 to 35 double-spaced, typewritten pages. Longer papers will be considered and published if they meet the above criteria. Manuscripts should be prepared according to the most recent edition of the American Psychological Association Publication Manual. Manuscripts are reviewed by the Editorial Advisory Board. Allow up to 3 months for a publication decision and up to 1 year for publication.

2. Brief Reports. Accepted Brief Reports should be no more than 10 double-spaced manuscript pages long, including title page, references and any tables.

3. Special Issues. An important part of *JCCP*'s publication policy is the periodic publication of special issues or special sections of regular issues. Current needs, emerging trends, and readership interest guide the publication of material in this category. Ideas or suggestions for special issues or special sections should be discussed with Walter J. Lonner (Walter.Lonner@wwu.edu), Founding and Special Issues Editor, or other members of the Editorial Advisory Board, especially current Editor, Deborah L. Best (best@wfu.edu).

Orcid

As part of our commitment to ensuring an ethical, transparent and fair peer review process SAGE is a supporting member of ORCID, the Open Researcher and Contributor ID. ORCID provides a unique and persistent digital identifier that distinguishes researchers from every other researcher, even those who share the same name, and, through integration in key research workflows such as manuscript and grant submission, supports automated linkages between researchers and their professional activities, ensuring that their work is recognized. The collection of ORCID iDs from corresponding authors is now part of the submission process of this journal. If you already have an ORCID iD you will be asked to associate that to your submission during the online submission process. We also strongly encourage all co-authors to link their ORCID ID to their accounts in our online peer review platforms. It takes seconds to do: click the link when prompted, sign into your ORCID account and our systems are automatically updated. Your ORCID iD will become part of your accepted publication's metadata, making your work attributable to you and only you. Your ORCID iD is published with your article so that fellow researchers reading your work can link to your ORCID profile and from there link to your other publications.

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Appendix G: Research Ethics Committee approval letter

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University of Hull
Hull, HU6 7RX
United Kingdom
T: +44 (0)1482 463336 | **E:** e.walker@hull.ac.uk
w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Harleen Sidhu
Faculty of Health Sciences
University of Hull
Via email

12th July 2022

Dear Harleen

REF FHS444 - Is there a difference in how members of collectivist and individualistic cultures have dealt with lockdown?

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

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OF HULL

Liz Walker | Professor of Health and Social Work Research |
Faculty of Health Sciences
University of Hull
Hull, HU6 7RX, UK
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@UniOfHull /UniversityOfHull universityofhull

Appendix H: Research Information Sheet.
Version number: 1
Date: 03/04/2022

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YOU ARE WELCOME TO MAKE A COPY OF THIS INFORMATION

How have you dealt with lockdown?

I would like to invite you to participate in a research project which forms part of my doctorate research. Before you decide whether you want to take part, it is important for you to understand why this research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

We know very little about how we have responded to lockdown. This study is looking to understand more about how people coped with lockdown and what influence this has had in terms of adjustment, welfare, and impact. We hope that this study will help us understand more about this area, which may hopefully help to influence psychological practice in the future.

Why have I been invited to take part?

You are being invited to participate in this study because you resided in England in one of the national lockdowns between 2020 and 2021.

What will happen if I take part?

If you agree to take part, please tick the consent box below to begin the online questionnaire. The questionnaire will take approximately 20-30 minutes, please complete it in a quiet room, free of distractions. You will first be asked some short questions about you (e.g., your age, your gender, ethnicity). Then you will be asked to fill out three questionnaires which measure adjustment, post-traumatic growth, and welfare.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read this information page, please contact me if you have any questions that will help you decide about taking part. If you decide to take part, please tick the consent box below and feel free to make a copy of this information (e.g., take a photo or print) for your own records (optional).

What are the possible risks of taking part?

Participating in the study will require 20-30 minutes of your time and this may be inconvenient for you. Some people may experience emotional distress when they think about lockdown because it might bring up difficult memories. If this happens, please feel free to take a break from the questionnaire. At the end of the questionnaire there will be various sources of support that might be helpful to contact should you feel you need this (e.g., your GP, mental health charities, and family and friends).

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, it is hoped that the information you give us will help us to understand more about how people have coped with lockdown. It may also help to inform current practices in therapy settings.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2018 (GDPR).

All the personal information that you provide will be kept strictly confidential. Data you provide in the questionnaire may be used in research publications and presentations, but you will not be identified in these. To protect your anonymity, you will be assigned a code, to ensure it will not be possible to identify you from the information you provide. To protect the security of your answers, they will be stored on an encrypted NHS laptop. After the research is completed, all of responses will be deleted from the encrypted NHS laptop. These will be stored securely in an online storage repository at the University of Hull for ten years.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a ‘task in the public interest’ You can provide your consent for the use of your personal data in this study by clicking the box below. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Information Compliance Manager (dataprotection@hull.ac.uk). If you wish to lodge a complaint with the Information Commissioner’s Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free to withdraw from the study at any point during completion of the questionnaire by exiting the screen. Withdrawing from the study will not affect you in any way. However, after you submit your responses/ complete the questionnaire, withdrawal of your data will no longer be possible, as the data is anonymised. If you choose to withdraw from the study before this point the data collected will be deleted.

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's online repository https://hydra.hull.ac.uk. The findings may also be published in academic journals or presented at conferences. At the end of the questionnaire there will be an exit screen with the link to a blog, where you can access the results when the research is written up if you wish to do so.

Who can I contact if I need to talk to someone?

We hope that people will enjoy completing the questionnaire and reflecting on lockdown. However, if you feel upset and would like to talk to someone, the following options might be worth exploring:

- Family and friends
- Your GP
- Samaritans. To talk about anything that is upsetting you, you can contact Samaritans 24 hours a day, 365 days a year. You can call 116 123 (free from any phone), email jo@samaritans.org or visit some branches in person.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Harleen Sidhu

Clinical Psychology Aire Building
The University of Hull Cottingham Road Hull

HU6 7RX
E-mail: h.sidhu-2020@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for further advice and information:

Dr Annette Schlösser

Clinical Psychology,

Aire Building
The University of Hull

Cottingham Road
Hull HU6 7RX

Email address: a.schlosser@hull.ac.uk

Thank you for reading this information and for considering taking part in this research. By continuing with the questionnaire, you confirm that you understand the information provided, the terms of participating and give your consent to your data being used in this research.

Appendix I: Participant Consent Form

Version number: 1

Date: 19/01/2022

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Consent Form

Title of Study: How have you dealt with lockdown?

Name of Researcher: **Harleen Sidhu**

1. I confirm that I am over 18 years of age and resided in England in at least one of the national lockdowns (**March 23, 2020; November 4, 2020, and/or January 5, 2021)**

2. I confirm that I have read the information sheet dated………… (Version……..) for the above study. I have had the opportunity to consider the information, **ask questions and have had these answered satisfactorily.**

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. I understand that once I have completed the questionnaire, I cannot withdraw my anonymised data. I understand that the data I have provided up to the point of withdrawal nay be retained or excluded from data analysis and this will be decided by the researcher.

4. I understand that all information I provide will be treated as confidential and used for research purposes only.

5. I am aware that the results of the study will be written up for a doctoral thesis and submission to a professional journal.

6. I agree to take part in the above study.

Appendix J: Debrief Sheet

Version Number: 1

Date: 21/04/2022

Thank you for taking the time to take part in the study!

Purpose of the study?

We know very little about how we have responded to lockdown. This study is looking to understand whether there are cultural differences in how people have coped with lockdown and whether culture has influenced adjustment, welfare, and impact. We hope that this study will help us understand more about this area, to influence psychological practice in the future.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2018 (GDPR).

All the personal information that you provide will be kept strictly confidential. Data you provide in the questionnaire may be used in research publications and presentations, but you will not be identified in these. To protect your anonymity, you will be assigned a code, to ensure it will not be possible to identify you from the information you provide. To protect the security of your answers, they will be stored on an encrypted NHS laptop. After the research is completed, all of responses will be deleted from the encrypted NHS laptop. These will be stored securely in an online storage repository at the University of Hull for ten years.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by clicking the box below. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Information Compliance Manager (dataprotection@hull.ac.uk). If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's online repository https://hydra.hull.ac.uk. The findings may also be published in academic journals or presented at conferences. At the end of the questionnaire there will be an exit screen with the link to a blog, where you can access the results when the research is written up if you wish to do so.

Who can I contact if I need to talk to someone?

We hope that people will enjoy completing the questionnaire and reflecting on lockdown. However, if you feel upset and would like to talk to someone, the following options might be worth exploring:

- Family and friends
- Your GP
- Samaritans. To talk about anything that is upsetting you, you can contact Samaritans 24 hours a day, 365 days a year. You can call 116 123 (free from any phone), email jo@samaritans.org or visit some branches in person.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Harleen Sidhu

Clinical Psychology Aire Building
The University of Hull Cottingham Road Hull

HU6 7RX
E-mail: h.sidhu-2020@hull.ac.uk

What if I have further questions, or if something has gone wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for further advice and information:

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Appendix K: Recruitment Social Media Post
Version Number: 1

Date: 21/04/2022

Hello! Were you living in England during one of the Covid 19 lockdowns? We know very little about people's responses to lockdown. This study is looking to understand how people coped with lockdown and what influence this had on adjustment, welfare, and impact. We hope that this study will help us understand more about this area, to influence psychological practice in the future.

If you are interested in taking part, please click the questionnaire link (Website link).

Appendix L: Work and Social Adjustment Scale

Work and Social Adjustment Scale (WSAS)

Mental health can affect one's ability to do certain day-to-day tasks in their lives. Please read each item below and respond based on how much your mental health impairs your ability to carry out the activity.

		Not at All		Slightly		Definitely		Markedly		Very Severely
1.	Because of my mental health my **ability to work** is impaired. '0' means 'not at all impaired' and '8' means very severely impaired to the point I can't work.	0	1	2	3	4	5	6	7	8
2.	Because of my mental health my **home management** (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired.	0	1	2	3	4	5	6	7	8
3.	Because of my mental health my **social leisure activities** (with other people e.g. parties, bars, clubs, outings, visits, dating, home entertaining) are impaired.	0	1	2	3	4	5	6	7	8
4.	Because of my mental health, my **private leisure activities** (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired.	0	1	2	3	4	5	6	7	8
5.	Because of my mental health, my ability to form and maintain **close relationships** with others, including those I live with, is impaired.	0	1	2	3	4	5	6	7	8

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Appendix M: Post Traumatic Growth Inventory

Post Traumatic Growth Inventory

Client Name:________________________________ Today's Date:_______________

Indicate for each of the statements below the degree to which this change occurred in your life as a result of the crisis/disaster, using the following scale.

0 = I did not experience this change as a result of my crisis.
1 = I experienced this change to a very small degree as a result of my crisis.
2 = I experienced this change to a small degree as a result of my crisis.
3 = I experienced this change to a moderate degree as a result of my crisis.
4 = I experienced this change to a great degree as a result of my crisis.
5 = I experienced this change to a very great degree as a result of my crisis.

Possible Areas of Growth and Change	0	1	2	3	4	5
1. I changed my priorities about what is important in life.						
2. I have a greater appreciation for the value of my own life.						
3. I developed new interests.						
4. I have a greater feeling of self-reliance.						
5. I have a better understanding of spiritual matters.						
6. I more clearly see that I can count on people in times of trouble. Text						
7. I established a new path for my life.						
8. I have a greater sense of closeness with others.						
9. I am more willing to express my emotions.						
10. I know better that I can handle difficulties.						
11. I am able to do better things with my life.						
12. I am better able to accept the way things work out.						
13. I can better appreciate each day.						
14. New opportunities are available which wouldn't have been otherwise.						
15. I have more compassion for others.						
16. I put more effort into my relationships.						
17. I am more likely to try to change things which need changing.						
18. I have a stronger religious faith.						
19. I discovered that I'm stronger than I thought I was.						
20. I learned a great deal about how wonderful people are.						
21. I better accept needing others.						

Appendix N: Short General Health Questionnaire

Short General Health Questionnaire (GHQ 12)

Have you recently?

1. Been able to concentrate on what you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2. Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. Felt you were playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4. Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5. Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6. Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7. Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8. Been able to face up to your problems?	More so than usual	Same as usual	Less so than usual	Much less able
9. Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11. Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. Been feeling reasonably happy, all things considered	More so than usual	About same as usual	Less so than usual	Much less than usual;