

The Impact of Inequality on Mental Health Outcomes During the COVID-19 Pandemic: A  
Systematic Review

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**Abstract**

Previous research on pandemics and emergencies has shown that such events often widen health inequalities in society and have a greater impact on socially disadvantaged groups. No review has so far looked at the impact of inequality factors on mental health outcomes during the novel coronavirus outbreak (COVID-19). The aim of the current review was therefore to assess the impact of inequality factors on mental health outcomes during COVID-19. After registration on PROSPERO, a systematic review was conducted for papers published up to 31 July 2020 using the databases Google Scholar, PsycINFO, PubMed (MEDLINE), and Web of Science. The following inequality factors were considered: education, income, employment, occupation, material and social deprivation, age, immigrant status, sexual orientation, functional health, cultural/racial background, sex, gender, and place of residence. Out of 1,931 references, 117 studies (300,061 participants) were included. Female sex, being of a younger age, financial insecurity, lack of access to clear messaging/information about the pandemic, proximity to large infection sites, having existing physical and/or psychological health conditions, and being subjected to abuse/stigma because of one's identity as a member of an ethnic or sexual marginalised group predicted mental health inequalities. More research is required on how inequality affects mental health in less studied vulnerable populations, such as ethnic, sexual, and gender marginalised participants, as well as how inequality factors interact to affect mental health in the long term. Recommendations for researchers, mental health practitioners, and public health authorities for mitigating adverse mental health outcomes in vulnerable populations are outlined.

*Keywords:* COVID-19; Inequality; Inequity; Mental health; Pandemic

### **Public Significance Statement**

The findings of this review suggest that several inequality factors, such as female sex, younger age, financial insecurity, having existing chronic health conditions, and being in an ethnic or sexual marginalised group predict worse mental health outcomes during the ongoing COVID-19 pandemic. There is an urgent need for mental health services to support vulnerable populations at this time, to reduce mental health inequalities and improve long-term psychological functioning.

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**Introduction**

“Social distancing is a privilege. It means you live in a house large enough to practice it. Hand washing is a privilege too. It means you have access to running water. Hand sanitisers are a privilege. It means you have money to buy them. Lockdowns are a privilege. It means you can afford to be at home. Most of the ways to ward the Corona off are accessible only to the affluent. In essence, a disease that was spread by the rich as they flew around the globe will now kill millions of the poor” (Anonymous Indian doctor, cited by Tomazin, 2020).

The novel coronavirus (COVID-19) outbreak is caused by infection with severe acute respiratory syndrome coronavirus-2 (SARs-CoV-2). It was declared by the World Health Organisation (WHO) as a Public Health Emergency of International Concern (PHEIC) on 31 January 2020 and as a pandemic on 11 March 2020. Apart from the physical health problems that are caused by the virus (e.g., respiratory symptoms, fever, cough, shortness of breath, and breathing difficulties), the recent outbreak is likely to have far-reaching mental health consequences (Marazziti et al., 2020; Rajkumar, 2020; Torales et al., 2020; Vinkers et al., 2020), particularly as the focus on COVID-19 may have diverted resources from the treatment of other pre-existing mental and physical health conditions (Mauro et al., 2020; van der Miesen et al., 2020). Additionally, COVID-19 is likely to have distinct impacts across different population groups (Kirby, 2020; Wright et al., 2020). Previous research on pandemics and emergencies (e.g., natural disasters) has shown that such events often widen health inequalities in society, and have a greater impact on socially disadvantaged groups (e.g., racialised or minoritized individuals, people with low income, migrant workers, etc.) compared to their socially advantaged counterparts (Ahmed, Ahmed, Pissarides, & Stiglitz, 2020; Purtle, 2012). Several factors of inequality have been identified by the Public Health Agency of Canada

(2018) and include a person's socioeconomic status (e.g., education, income, employment, occupation, and material and social deprivation), population group (e.g., age, immigrant status, sexual orientation, functional health, and cultural/racial background), sex and gender, and place of residence (i.e., urban versus rural). Such factors have a big impact on underlying health inequalities in society, which may be further exacerbated by the current COVID-19 outbreak (Jetten et al., 2020; van Dorn et al., 2020). In addition, these health inequalities can also manifest in greater mental health disparities between the different populations.

People are generally more likely to be healthy and less likely to have underlying health conditions if they are more affluent, White, and living in a Western country (Haslam et al., 2018; Marmot, 2015). In the context of COVID-19, those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness after contracting the virus (WHO, 2020a). As such pre-existing health conditions are more prevalent in disadvantaged groups, this puts them at higher risk of COVID-19-associated mortality (Ahmed, Ahmed, Pissarides, & Stiglitz, 2020; Johnson-Mann et al., 2020). However, less is currently known about how inequality factors affect the *psychological* health of disadvantaged populations. It is plausible that being at higher risk for COVID-19-related complications and mortality would cause individuals to be more anxious, worried, and fearful about the ongoing outbreak. Similarly, being in unstable employment, living in poorer areas, and having a lower household income, which are situations more common among marginalised populations (Bowleg, 2020), are likely to exacerbate feelings of stress, depression, and anxiety during what is already a challenging time for many (Devitt, 2020; Lund, 2020). Moreover, because the spread of COVID-19 is now known to have originated in central China (Centers for Disease Control & Prevention, 2020), several researchers have highlighted the increase in stigmatisation and prejudice towards individuals of Chinese, or, by association, wider Asian origin (Wen et al., 2020).

Something that has hitherto widely been lacking in the existing mental health literature surrounding COVID-19 and similar emergencies is the assessment of the intersectionality between inequality factors. Indeed, inequality factors often interact and thereby produce a greater impact on mental health outcomes for affected individuals than any one inequality factor alone (Gabrielli & Lund, 2020; Lapalme et al., 2019). For instance, people with mental illnesses are not only directly predisposed to poorer mental health outcomes, but often also have higher rates of chronic medical conditions and a shortened lifespan, and may struggle with poverty, housing, access to education and employment, and social connection (Kaufman et al., 2020; Yao et al., 2020). Similarly, racialised or minoritized individuals in some countries are more likely to be in unstable employment and have a lower income, which can be a further cause of stress and psychiatric morbidity (Kapilashrami & Bhui, 2020; Purtle, 2020). Moreover, when investigating sex and gender, it is important to consider how sex interferes with gender to influence vulnerability. Gender is defined as the social and cultural norms, roles, attributes, and behaviours that a society considers appropriate for men and women or boys and girls (WHO, 2020b). Current evidence suggests that the ongoing COVID-19 outbreak relates to sex and gender both directly (e.g., through differences in incidence and case fatality) and indirectly (e.g., through social and economic consequences, such as domestic violence, job insecurity, and increased workload) (Gebhard et al., 2020; Wenham et al., 2020). Consequently, a pandemic such as COVID-19 is likely to have disparate effects on the mental health of disadvantaged populations. As inequalities frequently interact and may worsen these effects, research is urgently required that considers the effects of several inequality factors on mental health outcomes during the ongoing outbreak and beyond.

Several reviews have so far been conducted to assess the effects of the ongoing COVID-19 pandemic and similar outbreaks on mental health outcomes among the general population (Kontoangelos et al., 2020; Rajkumar, 2020), healthcare workers (HCWs) (Kisely et al., 2020;

Pappa et al., 2020; Schneider et al., 2020; Spoorthy, 2020), and children and adolescents (Fegert et al., 2020). Many of these reviews are limited by small study samples (particularly for COVID-19) and primarily healthy participants from only a few affected countries. As COVID-19 is a global emergency, and has to date (as of 13 October 2020) affected 214 countries and territories, more comprehensive reviews are required that take into account different countries and their varying populations, to fully understand the mental health consequences of the virus globally and inclusively (Pierce et al., 2020). This is especially important given that vulnerable individuals are at particular risk for long-term mental health consequences as a result of the ongoing pandemic (Kelly, 2020). To our knowledge, no systematic reviews have so far been conducted to investigate the impact of the COVID-19 pandemic on the mental health of vulnerable populations and included several inequality factors to draw comparisons between findings. Therefore, the aim of the current review was to explore inequality factors that impact the mental health of various population groups during the ongoing COVID-19 outbreak, and to identify protective and risk factors that can be targeted in future interventions to reduce the impact of COVID-19 on short-term and long-term psychological well-being in vulnerable populations.

### **Methods**

This review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement (PRISMA; Moher et al., 2010) and pre-registered on PROSPERO (ref no. CRD42020200216).

### **Data Sources and Search Strategies**

A systematic search was conducted for papers published up to 31 July 2020 using the databases Google Scholar, PsycINFO, PubMed (MEDLINE), and Web of Science. Boolean combinations of the following search terms and their abbreviations were used: COVID-19; coronavirus; SARS-CoV-2; psychological; stress; distress; anxiety; depression; mental health;

psychiatric issues; dysfunction; low mood; sad; inequality; inequity; deprivation; age; gender; sex; transgender; vulnerable; disability; handicap; ethnicity; race; sexual orientation; income; unemployed; housing; education; access; rural; urban; functional health; migrant; Indigenous; First Nations; homeless; Inuit; Métis. Reference sections of included articles were scanned to identify additional studies that met inclusion criteria.

### **Inclusion and Exclusion Criteria**

Papers were included if they: (1) described the effect of the COVID-19 outbreak on any mental health outcome; (2) were written in English, French, Spanish, or Italian (as these include the official languages of Canada as well as the spoken languages of the authors); and (3) analysed differences in mental health based on any inequality factor or relationships between any inequality factor and mental health outcomes. We included the following inequality factors as outlined by the Public Health Agency of Canada (2018): socioeconomic status (e.g., education, income, employment, occupation, and material and social deprivation); population group (e.g., age, immigrant status, sexual orientation, functional health, and cultural/racial background); sex and gender; and place of residence (i.e., urban versus rural). Studies were excluded if they did not provide quantitative data related to inequality and/or mental health.

### **Data Extraction**

The first three authors independently extracted data from the identified studies. The following data were extracted: (I) author(s), (II) country, (III) sample size and participant sex (percentage female), (IV) age in years, (V) measures used, (VI) inequality factors affecting mental health outcomes, and (VII) study quality. For studies that described statistically significant outcomes, a  $p$  value  $<.05$  was considered significant.

### **Quality Assessment**

Quality was assessed using the Effective Public Health Practice Project (EPHPP) tool, which provides good interrater agreement for overall quality (Armijo-Olivo et al., 2010) across



a variety of quantitative study designs (Thomas et al., 2004). Studies were assessed on: (I) selection bias, (II) study design, (III) confounders, (IV) blinding, (V) data collection methods, and (VI) withdrawals and dropouts. Components were scored as 1 ('strong'), 2 ('moderate'), or 3 ('weak'). EPHPP guidelines were used to generate a global score as follows: no 'weak' component ratings = 'strong', one 'weak' component rating = 'moderate', and two or more 'weak' component ratings = 'weak'. The first two authors independently assessed all studies. Cohen's kappa (Cohen, 1960) was calculated to determine inter-rater reliability, showing moderate agreement (90.6%) between scores ( $\kappa=.718$ ,  $p<.001$ ). Discrepancies were due to differences in interpretation of criteria and were discussed with the third author until a 100% agreement in coding was reached.

## Results

### Paper Selection

As of 31 July 2020, the search protocol yielded 1,931 papers (see Fig. 1). After removing duplicates, 1,893 papers were reviewed based on the title. Of those, 836 abstracts were retained for review and 184 articles were reviewed based on the full text. Fifty-five articles were excluded because they were not empirical studies (i.e., they were commentaries, letters to the editor, etc. and this was unclear in the abstract) and 12 studies were excluded because they did not analyse the effect of inequality factors on mental health outcomes. All full-text articles were independently screened by the first three authors.

[Fig. 1 around here]

### Study Characteristics

A final sample of 117 studies (300,061 participants) was included in this review (see Table 1), consisting of 112 cross-sectional studies, four cohort studies, and one case-control study. The majority of the included studies were rated as 'moderate' ( $n=93$ ) or 'weak' ( $n=21$ ), and three studies were rated 'strong'. The studies were conducted in 28 different countries,

with the majority of the research being conducted in China ( $n=47$ ) or the United States ( $n=14$ ). Additionally, two studies were conducted using samples from 63 and 103 different countries. Most of the included studies ( $n=62$ ) investigated the mental health impact of COVID-19 on the general population, twenty-five investigated HCWs, ten investigated patients with COVID-19 or other health conditions, seven investigated high school or college/university students, six investigated pregnant or postpartum women, four investigated young adults, two investigated teachers or academic staff, one investigated older adults, and one investigated children and adolescents. The most commonly assessed mental health outcomes were anxiety, depression, and stress (see Fig. 2 for a summary of mental health outcomes). In terms of inequality, most studies assessed sex ( $n=97$ ), age ( $n=58$ ), chronic disease history ( $n=32$ ), or education level ( $n=28$ ), with significantly less studies comparing mental health outcomes based on place of residence ( $n=17$ ), occupation ( $n=14$ ), income ( $n=14$ ), (un)employment status ( $n=14$ ), ethnicity ( $n=10$ ), gender ( $n=2$ ), sexual orientation ( $n=2$ ), or migrant status ( $n=1$ ). The majority of studies examined more than one inequality factor.

[Table 1 around here]

[Fig. 2 around here]

## **Sex**

The majority of studies that investigated differences between sexes in relation to mental health during the COVID-19 pandemic found that women were more likely to report adverse mental health outcomes than men across all populations (e.g., Iob et al., 2020; Liu, Zhang, Wei et al., 2020; Mazza et al., 2020; Zhou et al., 2020). Seven studies also found poor mental health in pregnant women (Berthelot et al., 2020; Durankus & Aksu, 2020; Farewell et al., 2020; Liu, Chen et al., 2020; Mappa et al., 2020; Taubman–Ben-ari et al., 2020; Wu et al., 2020) and worse outcomes post-outbreak than in the pre-pandemic cohort (Berthelot et al., 2020; Wu et al., 2020). Only seven studies found worse outcomes in men (Ahmed, Ahmed, Aibao, et al.,

2020; Gao, Sun et al., 2020; Karatzias et al., 2020; Liang, Gao et al., 2020; Ozamiz-Etxebarria et al., 2020; Song et al., 2020; Verma & Mishra, 2020) and 16 studies found no differences in mental health based on sex (e.g., Cao et al., 2020; Kokou-Kpolou et al., 2020; Pedrozo-Pupo et al., 2020; Rodriguez et al., 2020).

### **Age**

In terms of age, the majority of studies found that younger age (<35 years) was associated with detrimental mental health outcomes (e.g., Badahdah et al., 2020; Berthelot et al., 2020; Kavčič et al., 2020; Maarefvand et al., 2020), with two studies showing worse outcomes in middle age (Balkhi et al., 2020; Song et al., 2020), three studies showing worse outcomes in older participants (>50 years) (Bergman et al., 2020; Cortes-Alvarez et al., 2020; Gao, Sun et al., 2020), and eight studies showing no differences in mental health based on age (e.g., Cotrin et al., 2020; Huang et al., 2020; Mappa et al., 2020; Umucu & Lee, 2020). Notably, three studies showed worse mental health outcomes in both younger and older individuals, compared to participants of middle age (Morgul et al., 2020; Qiu et al., 2020; Tian et al., 2020). Among children and adolescents, older participants reported worse mental health (Duan et al., 2020; Zhou et al., 2020).

### **Education**

Most studies found that a lower level of education predicted worse mental health across different populations (e.g., Doshi et al., 2020; El-Zoghby et al., 2020; Gao, Sun et al., 2020). However, five studies found that higher education level predicted worse outcomes (Balkhi et al., 2020; Fu et al., 2020; Mappa et al., 2020; Qiu et al., 2020; Wang, Di et al., 2020) and four studies found no differences in mental health based on education level (Liu, Yang et al., 2020; Liu, Zhang, Wei et al., 2020; Moccia et al., 2020; Pedrozo-Pupo et al., 2020). Notably, one study compared the effects of education in Jewish and Arab participants and found that higher education level positively predicted anxiety among Jewish participants, but negatively

predicted anxiety among Arab participants (an ethnically racialised and minoritized group) (Kimhi et al., 2020).

### **Income, Employment, and Occupation**

In general, more adverse mental health outcomes were reported by participants with lower average household income (e.g., Horesh et al., 2020; Lei et al., 2020; Naser et al., 2020; Ping et al., 2020), while stability of (family) income predicted better mental health (Cao et al., 2020). Contrary to expectations, however, two studies found that higher income predicted anxiety (Fu et al., 2020; Naser et al., 2020) and one study found that being in the middle-income category and having adequate living space put pregnant women at higher risk for depressive and anxiety symptoms (Wu et al., 2020). In terms of employment, participants who were unemployed (Fitzpatrick et al., 2020b; Job et al., 2020; Li & Wang, 2020; Mazza et al., 2020; Solomou & Constantinidou, 2020) or lost employment during the outbreak (Rodríguez-Rey et al., 2020b; Santos et al., 2020; Zhang, Wang, Rauch, & Wei, 2020) reported worse mental health. However, two studies also found that being employed contributed to worse mental health outcomes (Verma & Mishra, 2020) and having longer daily work hours or increased workload were risk factors for depression, PTSD, and psychological distress in HCWs (Shacham et al., 2020; Song et al., 2020; Zhu, Xu et al., 2020). As such, findings are not uniform regarding employment and may depend on individuals' life situation (e.g., changes in employment or workload as a result of the outbreak) and occupation (e.g., being a high-risk worker). For instance, Naser et al. (2020) found that being retired was negatively associated with anxiety. Additionally, Mazza et al. (2020) found that having to go out to work during the COVID-19 outbreak was associated with stress and Wu et al. (2020) found that being employed full-time put pregnant women at higher risk for depressive and anxiety symptoms. Another study found that participants on furlough reported higher distress compared to those who were unemployed and those who worked full-time (Mimoun et al., 2020). It is therefore plausible

that other associated variables, such as financial security and average household income, as well as availability of childcare and support, may be more predictive of mental health outcomes than employment status alone. Indeed, one study found that financial concern mediated the relationship between job insecurity and anxiety (Wilson et al., 2020). Additionally, two studies found that poor mental health outcomes were related to concern about profession and ability to meet living expenses (Khanna et al., 2020; Thomaier et al., 2020) and three studies found that participants with worse socioeconomic status were more likely to report adverse mental health outcomes (Iob et al., 2020; Lei et al., 2020; Park et al., 2020).

In terms of occupation, HCWs generally reported most mental health symptoms (Civantos et al., 2020; Doshi et al., 2020; Huang & Zhao, 2020; Jahrami et al., 2020; Naser et al., 2020; Seyahi et al., 2020; Zhu, Liu et al., 2020). Among HCWs, being a frontline worker (e.g., Zhang, Yang et al., 2020), working in a primary hospital or in a city or area most affected by COVID-19 (e.g., Dai et al., 2020), exposure to or contact with infected or suspected patients (e.g., Zhang, Wang et al., 2020), being a nurse (e.g., Lai et al., 2020), being female (e.g., Civantos et al. 2020), history of chronic disease (e.g., Zhu, Xu et al., 2020), younger age (e.g., Khanna et al., 2020), less experience (e.g., Arpacioğlu et al., 2020), poorer perceived support (e.g., Song et al., 2020), inadequate protective equipment/uncertainty regarding effective disease control (e.g., Zhu, Xu et al., 2020), and low job satisfaction (e.g., Wang, Guo et al., 2020) were predictive of psychological distress. However, one study reported that male HCWs reported worse mental health (Song et al., 2020) and three studies found worse mental health outcomes among participants with more work experience (Xiao et al., 2020; Zhu, Xu et al., 2020) or no differences in mental health based on work experience (Huang et al., 2020). Several studies also showed poor mental health in enterprise owners and agricultural workers (Tian et al., 2020), professional workers (Morgul et al., 2020; Wang, Di et al., 2020), and students (Naser et al., 2020; Ustun, 2020; Wang, Pan et al., 2020). Finally, five studies found no

differences in mental health based on occupation (Blbas et al., 2020; Moccia et al., 2020), employment status (Mappa et al., 2020), income (Blbas et al., 2020; Liu, Zhang, Wong et al., 2020), or overall socioeconomic status (Pedrozo-Pupo et al., 2020).

### **Place of Residence**

Several studies examined the effect of place of residence on mental health outcomes, specifically with regards to urban versus rural living or living in cities or areas/states most affected by COVID-19 (e.g., Wuhan, China). Findings were mixed regarding urban versus rural living, with some studies showing that urban living predicted more adverse outcomes (Cao et al., 2020; Duan et al., 2020; Gao, Zheng et al., 2020; Karatzias et al., 2020; Özdin & Bayrak Özdin, 2020), while others found that suburban/rural living was associated with greater psychological distress (El-Zoghby et al., 2020; Lin, Hu et al., 2020; Morgul et al. 2020; Zhang, Wang et al., 2020). Three studies found no differences in mental health based on geographical location (Liu, Yang et al., 2020; Liu, Zhu et al., 2020; Moccia et al., 2020). Individuals living or working in cities or areas most affected by COVID-19 were more likely to report worse outcomes (Dai et al., 2020; Duan et al., 2020; Lai et al., 2020; Liu, Chen et al., 2020; Song et al., 2020; Thomaier et al., 2020; Zhou et al., 2020).

### **Functional Health**

In terms of functional health, several studies explored the impact of having a chronic psychological or physical health condition on mental health outcomes during COVID-19. The majority of studies found that the history or presence of psychological (e.g., Durankus & Aksu, 2020; Özdin & Bayrak Özdin, 2020; Seyahi et al., 2020; Solomou & Constantinidou, 2020) or physical health conditions, including poorer perceived health (e.g., Gualano et al., 2020; Hao, Zhou et al., 2020; Ozamiz-Etxebarria et al., 2020; Wu et al., 2020), predicted adverse mental health outcomes, particularly in individuals who reported both psychological and physical health conditions (Alonzi et al., 2020). Five studies also investigated the effect of COVID-19

on mental health and found that physical symptoms or COVID-19 diagnosis predicted worse outcomes (Gómez-Salgado et al., 2020; Guo et al., 2020; Iob et al., 2020; Liu, Chen et al., 2020; Wang, Pan et al., 2020). Additionally, one study found that using psychotropic drugs or sleeping remedies predicted worse mental health (Costantini & Mazzotti, 2020). Contrary to our expectations, three studies found no effect of a pre-existing health condition on mental health outcomes (Moccia et al., 2020; Pedrozo-Pupo et al., 2020; Ustun, 2020) and one study found that the COVID-19 outbreak increased anxiety and depression only in participants who did not have pre-existing symptoms consistent with generalised anxiety or depression (Flentje et al., 2020).

### **Migrant Status and Ethnicity**

Ten studies investigated the effect of ethnicity and migrant status on mental health outcomes during COVID-19 and found that individuals who identified as Black, Native American, Asian, or Hispanic (Fitzpatrick et al., 2020a, 2020b, 2020c; Park et al., 2020; Taubman–Ben-ari et al., 2020), as belonging to Black, Asian, and Minority Ethnic (BAME) groups (Iob et al., 2020; Kimhi et al., 2020), or as migrant workers (Qiu et al., 2020) generally reported worse mental health than individuals who identified as White or as non-migrant workers. One study found no effect of ethnicity on mental health outcomes (Umucu & Lee, 2020) and one study found worse mental health in individuals who identified as White compared to individuals who identified as Asian or Hispanic (Liu, Zhang, Wong et al., 2020).

### **Gender Identity**

Two studies investigated the effects of gender identity on mental health outcomes during COVID-19 and found that nonbinary and transgender participants reported the highest levels of mental health symptoms (Alonzi et al., 2020; Liu, Zhang, Wong et al., 2020).

### **Sexual Orientation**

Finally, in terms of sexual orientation, two studies found worse outcomes among cisgender gay men and other men who have sex with men (Santos et al., 2020) and sexual minority participants (Park et al., 2020), particularly among individuals who lost employment due to COVID-19 (Santos et al., 2020).

### **Discussion**

The present paper represents the first review to investigate the effect of health inequality factors on mental health outcomes during the ongoing COVID-19 pandemic. The findings show that several personal and social inequality factors are likely to increase risk for adverse mental health outcomes. Specifically, female sex, being of a younger age, financial insecurity, having access to clear messaging/information about the pandemic, proximity to large infection sites, having existing physical and/or psychological health conditions, and being subjected to abuse/stigma because of one's identity as belonging to an ethnic or sexual marginalised group appear to predict mental health inequalities during the COVID-19 outbreak.

Regarding participant sex, although there were several exceptions that showed no differences between sexes or worse mental health in men, the majority of studies included in this review found that mental health outcomes during COVID-19 are worse in women. This is seemingly in contradiction to clinical research showing that while men and women have the same likelihood of contracting COVID-19, men have an increased risk of fatality (Gebhard et al., 2020; Qin et al., 2020), due to biological differences which may predispose men to a widespread COVID-19 infection and poorer prognosis (Conti & Younes, 2020; Giagulli et al., 2020; Walter & McGregor, 2020). However, despite being relatively safer from COVID-19-related complications, women consistently report higher levels of depression, anxiety, and stress, and lower levels of resilience in response to the current outbreak. This is in line with previous research that shows that women generally have a higher prevalence of PTSD (Farhood et al., 2018). There are several possible reasons for this, including women's work-life balance,



gender roles and responsibilities, domestic violence, harassment at work, and work roles (Gausman & Langer, 2020; Viveiros & Bonomi, 2020). For instance, many HCWs (e.g., nurses) are female and female HCWs are more likely to work in lower paid roles with several responsibilities (López-Atanes et al., 2020; Makino et al., 2020). Previous reviews have found that nurses are particularly prone to poor mental health outcomes during outbreaks and national emergencies (e.g., Lai et al., 2020). At the same time, due to traditional gender roles in many countries worldwide, women also hold the primary responsibility for housework and child-rearing (Kantamneni, 2020). People with responsibilities and concerns for others (e.g., carers, parents, and individuals with younger siblings) often report more adverse mental health outcomes (Fitzpatrick et al., 2020c; Jiang et al., 2020; Park et al., 2020). Especially in times of emergency, such as during the ongoing COVID-19 outbreak, female HCWs with children have to balance an increased workload at the same time as increased childcare, due to widespread school closures (Makino et al., 2020). Findings from this review further show that female sex, younger age, and less experience predict worse mental health outcomes in HCWs. However, at present, such findings are mostly correlational in nature, and future research is required to assess how sex interacts with other factors to impact mental health.

Likewise, in interpreting these results, it is important to bear in mind the prevalent stigma regarding men's mental health, which may cause men to underreport mental health issues. This is particularly true in societies where masculinity is valued in terms of 'strength' and mental illness is viewed as a 'weakness' (Wong, Ho, et al., 2016), which may lead to harmful strategies such as excess alcohol consumption (Ahmed, Ahmed, Albao et al., 2020). Indeed, there is evidence that ways of regulating emotions may contribute to men's poorer mental health outcomes in certain circumstances (Song et al., 2020). Furthermore, such societies may also expect men to be family providers, thereby disproportionately affecting men's mental health if they feel that their job or finances are at risk (Liang, Gao, et al., 2020).

These individuals may also find themselves unable to cope with increased household responsibilities as a result of lockdown measures (Verma & Mishra, 2020). Other authors have argued that their findings concerning sex differences may reflect a bias in sampling, such that the typically smaller subset of men making up the sample only agreed to take part in the study to voice their concerns about the crisis (Ozamiz-Etxebarria et al., 2020). Thus, it is worth noting that reported sex differences in mental health might actually represent *gender* differences.

In terms of age differences, a significant number of studies found that younger adults (<35 years) (as well as adolescents approaching adulthood; Duan et al., 2020, Zhou et al., 2020) reported poorer mental health outcomes compared to middle-aged and older adults, despite being statistically safer from the physical effects of the virus. In understanding this result, it is important to bear in mind that, as an age group, young adults are more likely to work jobs either deemed essential (such as service jobs), where they may be at increased risk of infection, or jobs with zero-hour contracts, leaving them financially insecure and at an increased risk of unemployment. It is also possible that this age group feels they are doing more to shoulder the burden and are ensuring that they do not become infected and pass it on to vulnerable loved ones, such as parents and grandparents (Zhu, Xu et al., 2020). As an age group, they may also be going through a number of significant life events for the first time, which are unfortunately being affected by the ongoing pandemic. Pregnant women, for example, were shown to have significantly more anxieties about their unborn children than pregnant women before COVID-19 (Berthelot et al., 2020; Wu et al., 2020) and women who were having children for the first time were especially anxious (Taubman–Ben-Ari et al., 2020). Less life experience has generally shown to impact resilience as well as mental health outcomes during previous pandemics (see Schneider et al., 2020 for a review), which may also contribute to this difference.

Counterintuitively, trying to obtain more information and oversaturating oneself with news and information from social media (which younger adults are arguably more likely to engage in) has shown to be related to worse mental health outcomes (Arpacioglu et al., 2020; Cortes-Alvarez et al., 2020; Duan et al., 2020; Gao et al., 2020; Hao, Zhou et al., 2020; Seyahi et al., 2020; Zhang, Yang et al., 2020), which some authors have used as a way of explaining differences in distress across age groups (Qui et al. 2020). In fact, time spent following news reports of the outbreak, use of social media, internet addiction, and perceived lack of helpfulness in psychological support from news/social media were associated with psychological distress across all populations (Arpacioglu et al., 2020; Cortes-Alvarez et al., 2020; Duan et al., 2020; Gao et al., 2020; Hao, Zhou et al., 2020; Seyahi et al., 2020; Zhang, Yang et al., 2020). However, this association could be bidirectional such that individuals with more underlying anxiety may spend more time following news reports of the outbreak. On the other hand, awareness and knowledge of COVID-19 and protective measures were protective of psychological distress (Huang et al., 2020; Zhou et al., 2020). This is where differences in education may come in, as those with a higher level of learning may be better able to filter obtained information more effectively. This notion is consistent with the findings of this review, where lower education level was generally associated with poorer mental health outcomes. However, a number of studies reported no differences, and five studies identified inverse effects (Balkhi et al., 2020; Fu et al., 2020; Mappa et al., 2020; Qiu et al., 2020; Wang, Di et al., 2020). In understanding this contradiction, some research has found stress to be associated with perceived inconsistency between government arrangements and scientific recommendations (Pedrozo-Pupo et al., 2020). Having a higher level of education might, therefore, allow one to identify such inconsistencies more readily. Alternatively, it might indicate that one is in a position where work is directly affected by government mismanagement (i.e., HCW, scientist, etc.). Marginalised individuals may also process

information differently if they feel they are not included in public messaging, in which case higher education may make an understanding of inequalities clearer (e.g., Kimhi et al. 2020). However, at present, such explanations are speculative, and further research is required to assess to what extent education level influences mental health outcomes in a pandemic, and to identify other variables that may explain the relationship between education level and mental health.

Alternatively, highly educated professionals have shown to struggle more with interruptions to routine activities, occupations, and work relationships (Anzai et al., 2020; Kimhi et al., 2020; Wang et al., 2020). This is supported by some of the work identified in this review, including studies which showed worse mental health in enterprise owners and agricultural workers (Tian et al., 2020), professional workers (Morgul et al., 2020; Wang, Di, et al., 2020), and students (Naser et al., 2020; Ustun, 2020; Wang, Pan et al., 2020). HCWs' mental health has also shown to be disproportionately affected by COVID-19, but this may have more to do with increased pressures at work and proximity to infected patients (Naser et al., 2020; Zhang, Yang et al., 2020; Zhang, Wang et al., 2020). Instead, enterprise owners, agricultural workers, and students may report higher levels of stress because of a sense of insecurity that COVID-19 has enforced upon their working lives. Enterprise owners may be concerned about the survival of their business and their employees' jobs, while students may be concerned about their grades and long-term prospects. Indeed, employment (and indirect or subsequent financial) insecurity were consistent predictors of distress and greater mental health symptomatology (Khanna et al., 2020; Iob et al., 2020; Lei et al., 2020; Park et al., 2020; Thomaier et al., 2020).

Another inequality factor identified in the current review was participants' place of residence. Previous research has shown that living in rural areas can negatively affect access to healthcare, such that preventable and treatable mortality rates increase as one becomes more

remote, even in countries such as Canada which have universal healthcare systems (Subedi et al., 2019). Likewise, people from rural areas are typically less likely than urban residents to seek or receive mental health services (Carpenter-Song & Snell-Rood, 2017) and are at increased risk for suicide (Monteith et al., 2020). However, our findings show that the effects of rural inequalities on mental health during COVID-19 are inconsistent, such that rural (or suburban) living predicted worse mental health outcomes in some studies (El-Zoghby et al., 2020; Lin, Hu et al., 2020; Morgul et al. 2020; Zhang, Wang et al., 2020), while urban and city living predicted worse mental health outcomes in an almost equal number of other studies (Cao et al., 2020; Duan et al., 2020; Gao, Zheng et al., 2020; Karatzias et al., 2020; Özdin & Bayrak Özdin, 2020). One possible explanation for this finding is that cities were more likely to have higher infection rates, putting people closer to the pandemic, which has shown to negatively impact mental health (Dai et al., 2020; Duan et al., 2020; Lai et al., 2020; Liu, Chen et al., 2020; Song et al., 2020; Thomaier et al., 2020; Zhou et al., 2020). If so, being more ‘remote’ might correlate with higher perceived safety and, consequently, improved mental health.

Nonetheless, being a rural resident during COVID-19 still comes with its challenges, and differences in studies may reflect subtle variations across countries and their rural areas’ access to healthcare, as well as social support, living with others, online health support availability, and availability of transport/access to hospitals (Kaufman et al., 2020, Monteith et al., 2020, Summers-Gabr, 2020). Studies included in this review often assessed place of residence as a dichotomy (i.e., urban versus rural living), thereby ignoring the nuance of remoteness. A study by Subedi et al. (2019) showed that rural Canadians’ healthcare, for example, was determined by their remoteness from everything else, such that the further away from society one was, the poorer one’s health was. People living in urban communities outside of Montreal, for example, may very well have different experiences of healthcare than residents of Canada’s Arctic Archipelago. Not only may the Montreal suburbanites have more local

hospitals/clinics, but they are also more likely to have better access to social support systems. Indeed, feeling lonely (Horesh et al., 2020), experiencing quarantine alone (Lei et al., 2020; Sun et al., 2020), not having children (Mazza et al., 2020), being single, divorced, or widowed (Cortes-Alvarez et al., 2020; Fitzpatrick et al., 2020a, 2020b; Gualano et al., 2020; Khanna et al., 2020; Liang, Ren et al., 2020; Naser et al., 2020; Peng et al., 2020; Shacham et al., 2020; Stanton et al., 2020; Tian et al., 2020; Wang, Xia et al., 2020), and living alone (Cao et al., 2020; Gualano et al., 2020; Jiang et al., 2020) have shown to predict poorer mental health outcomes as a result of a real or perceived lack of psychological and social support (Lei et al., 2020; Song et al., 2020).

Furthermore, having access to healthcare during the ongoing pandemic is particularly important if one is already living with a long-term condition. Indeed, physical long-term conditions (such as cancer, diabetes, HIV, cardiovascular disease, etc.) are associated with an increased risk for psychological distress, depression, and anxiety even under 'normal' circumstances (Sartorius, 2013). Given that hospitals and clinics are currently prioritising treatment for COVID-19 patients, there is evidence that people with chronic conditions are avoiding or are unable to access healthcare services, causing them even greater psychological harm (Mauro et al., 2020). Of the reviewed papers that examined chronic health inequalities, the majority showed that having a physical or mental health condition (or perceiving one's health as poor; Lei et al., 2020) resulted in worse mental health outcomes. Individuals who reported concurrent physical and mental health conditions reported worse mental health during COVID-19 than participants who reported either a physical or mental health condition (Alonzi et al., 2020). Additionally, physical symptoms or a diagnosis of COVID-19 were also shown to predict worse mental health, further demonstrating the psychological effects of coming into (real or perceived) contact with the virus.

The present review found a lack of evidence surrounding the effects of migrant status and ethnicity, gender identity, and sexual orientation on mental health outcomes during the COVID-19 pandemic. Only ten studies examined the impact of ethnicity and migrant status on mental health, despite clear evidence that both act as significant risk factors for poor physical and mental health outcomes (Public Health Agency of Canada, 2018). Indeed, people of colour, migrants, and Indigenous groups experience different access to healthcare than the majority of White populations in Western countries and have shown to be at higher risk for various health conditions due to a range of social factors, including stigma (Gary, 2005; Knifton et al., 2008; Williams & Mann, 2017). Furthermore, as marginalised individuals, their unique, cultural needs are often ignored or used to blame them for developing long-term conditions, which likely contributes further to distress and poor psychological well-being. For instance, Indigenous people typically see health as based on a reciprocal relationship between emotional, spiritual, physical, and mental dimensions, which is vastly different from the typical approaches of White Western healthcare systems (Reading & Greenwood, 2015), and may contribute to health inequalities. Although the articles included in this review provide some correlational evidence for differences in mental health by ethnicity and migrant status, the authors often do not attempt to discuss differences between groups or provide explanations for their findings. The apparent low focus on ethnicity with regards to the effects of the current pandemic is not unique to research, as even public health bodies have been criticised for failing to address ethnicity differences, despite evidence that COVID-19 death rates are higher in BAME participants (e.g., in the United Kingdom) (Patel et al., 2020). Furthermore, a survey reported in the British Medical Journal found that doctors from marginalised ethnic groups not only feel more pressured, but also less protected than their White colleagues, after it was discovered that 90% of doctors who have lost their lives to COVID-19 in the United Kingdom were from minoritized ethnic backgrounds (Mahase, 2020). As such, a greater focus on the

effects of ethnicity and migrant status on mental health in relation to COVID-19 is required, especially given that the risk for infection and mortality is disproportionate in marginalised individuals. Moreover, ethnicity-related differences should be taken into consideration when planning healthcare intervention strategies, that holistically integrate the most valued approaches from each culture.

Members of the LGBTQ+ community are likewise marginalised (and often ignored in wider public health messaging), and gender identity and sexual orientation have so far received little attention during the pandemic. Two studies included in this review considered the needs of people who exist outside of traditional gender norms and found that non-binary individuals had higher levels of depression and anxiety following the COVID-19 pandemic (Alonzi et al., 2020) and that people who identified as transgender were more likely to report higher levels of PTSD symptoms than cisgender individuals (Liu, Zhang, Wong et al., 2020). In terms of sexuality, cisgender gay men and other men who have sex with men reported poor mental health consequences of the COVID-19 pandemic, in part due to increased financial insecurity (as aforementioned) and interruptions to healthcare, especially around HIV prevention, testing, and treatment services (Santos et al. 2020). Similarly, sexual minority participants reported to be more stressed by rumination and co-worry with others, and to utilise more damaging coping strategies, such as substance use and behaviour disengagement (Park et al., 2020). Evidently, more research is also needed to address the specific health needs of these individuals (Salerno et al., 2020). More focused studies are essential for these populations specifically, but including gender identity and sexual orientation information as demographic questions across all studies should also be encouraged.

### **Intersectional Differences**

To fully appreciate the impact of inequality factors on psychological well-being during the COVID-19 pandemic, it is important to note that inequality factors such as those discussed



so far often interact to increase or decrease mental illness risk. In the present review, sexual orientation was shown to correlate with job security (Santos et al., 2020), while education level moderated distress differently across ethnicity groups (Kimhi et al., 2020). Other research has shown that area of residence may influence the kind of care that Indigenous Canadians receive (Subedi et al., 2019) and that long-term conditions (which lead to disability) may potentially affect job security during this time (Richmond, 2009). However, to date, few studies have considered intersectionality between inequality factors (e.g., women of colour, younger individuals with chronic conditions, unemployed LGBTQ+ participants), highlighting an urgent need for future research to fill this gap. Furthermore, few studies have so far considered mediators or moderators that might impact and explain the relationships between inequality factors and mental health outcomes. For instance, social media use, living with parents, social support, and economic stability could explain the relationship between age or education level with mental health outcomes. Similarly, being a nurse, poor work-life balance, lower income, violence at home, higher workload, and more home responsibilities may explain the relationship between sex and mental health outcomes in HCWs. Research has also suggested that distal variables, such as mistrust for government institutions, may explain mental health differences (e.g., Pedrozo-Pupo et al., 2020) and is something that should be considered by future researchers, particularly given that such variables may be influenced by minority or marginalised status.

### **Strengths, Limitations, and Future Directions**

The strengths of this review include: (1) providing a comprehensive assessment of various inequality factors influencing mental health outcomes during the ongoing COVID-19 pandemic to date; (2) including a preliminary exploration of intersectionality between inequality factors; and (3) providing recommendations for best practice based on empirical findings from a large number of studies and participant samples. Importantly, this review not

only highlights specific aspects of inequality that require attention and more research (such as ethnicity and sexual orientation), but it also identifies a lack of studies exploring intersectionality between inequality factors, which is a crucial gap. Going forward, work must continue into investigating the complexities of inequality and their effects on mental health. Despite the rigorous search criteria and study reviews conducted, this review is not without limitations. The majority of studies included in this review were cross-sectional by design and were rated as either weak or moderate in quality. There has been a distinct lack of longitudinal research, and instead most studies simply made correlational observations. Assessing differences over time, and distinguishing more clearly between different participant groups, will greatly increase the quality of future work and allow for a more robust understanding concerning mental health differences across inequality factors. Finally, there were several potentially vulnerable subgroups not included in the current review, such as individuals experiencing homelessness, and Indigenous and marginalised populations (such as Canadian Métis and Inuit Peoples). This is a significant limitation given the prominence of these populations in Canada and the differences between Indigenous and non-Indigenous people with regards to how they view health (Public Health Agency of Canada, 2018). Thus, more research should be conducted with and alongside these population groups so that their individual support and well-being needs can be identified.

Overall, the findings of this review highlight the impact of inequality factors on mental health outcomes during the ongoing COVID-19 pandemic and demonstrate an urgent need for increasing accessibility to, and provision of, mental health services, particularly for at-risk individuals and under-supplied locations. Such efforts require nationwide strategic planning and coordination, and special efforts should be undertaken to ensure a comprehensive crisis prevention and intervention system, including epidemiological monitoring, screening, referral, and targeted interventions to reduce psychological distress and prevent further mental health

problems and mental health inequalities (Qiu et al., 2020). Preventative measures such as clear messaging around the virus and ensuring support for marginalised and at-risk groups is also essential. Additionally, more research is required on how inequality affects mental health, particularly in less studied vulnerable populations (e.g., ethnic, sexual, and gender marginalised participants). Future research should necessarily explore the intersectionality between inequality factors and consider possible confounding variables that may mediate or moderate the effect of inequality on mental health outcomes. Recommendations for researchers, mental health practitioners, and public health authorities for mitigating adverse mental health outcomes in vulnerable populations are summarised in Box 1. The information provided in Box 1 can be delivered directly to employers or distributed across workplaces (e.g., hospitals and care homes), included in national campaigns around COVID-19, and referred to by those doing research related to mental health during the ongoing outbreak. A summarised version of the information provided in Box 1 (see Figure 3) can further be disseminated to the general public (e.g., through social media) to increase awareness of mental health inequalities during COVID-19.

[Box 1 around here]

[Fig. 3 around here]

## **Conclusions**

Although COVID-19 has previously been described as ‘the great equalizer’, the findings of the current review show that this is not the case when it comes to mental health outcomes. The current review found that female sex, being of a younger age, financial insecurity, having access to clear messaging/information about the pandemic, proximity to large infection sites, having existing physical and/or psychological health conditions, and being subjected to abuse/stigma because of one’s identity as belonging to an ethnic or sexual marginalised group appear to predict mental health inequalities during the COVID-19

outbreak. However, at present, little is known about how inequality factors interact to predict mental health in the short and long term. Of note, some researchers have argued that outbreaks and other emergencies may also have positive mental health outcomes on a subset of the population, at least in the long term, through improved social relationships and connections, increased feelings of belonging in the community, and reduced anxiety and depression (Mancini, 2019, 2020), although much of the evidence regarding COVID-19 specifically has so far been anecdotal. The primary aim of future research should therefore be to ensure that the mental health gap is not further widened between advantaged and disadvantaged populations in the aftermath of the current pandemic. Specifically, findings of this review highlight the inequality factors that need to be targeted as a priority to reduce the adverse psychological outcomes in vulnerable populations and increase the potential for increased psychological functioning.

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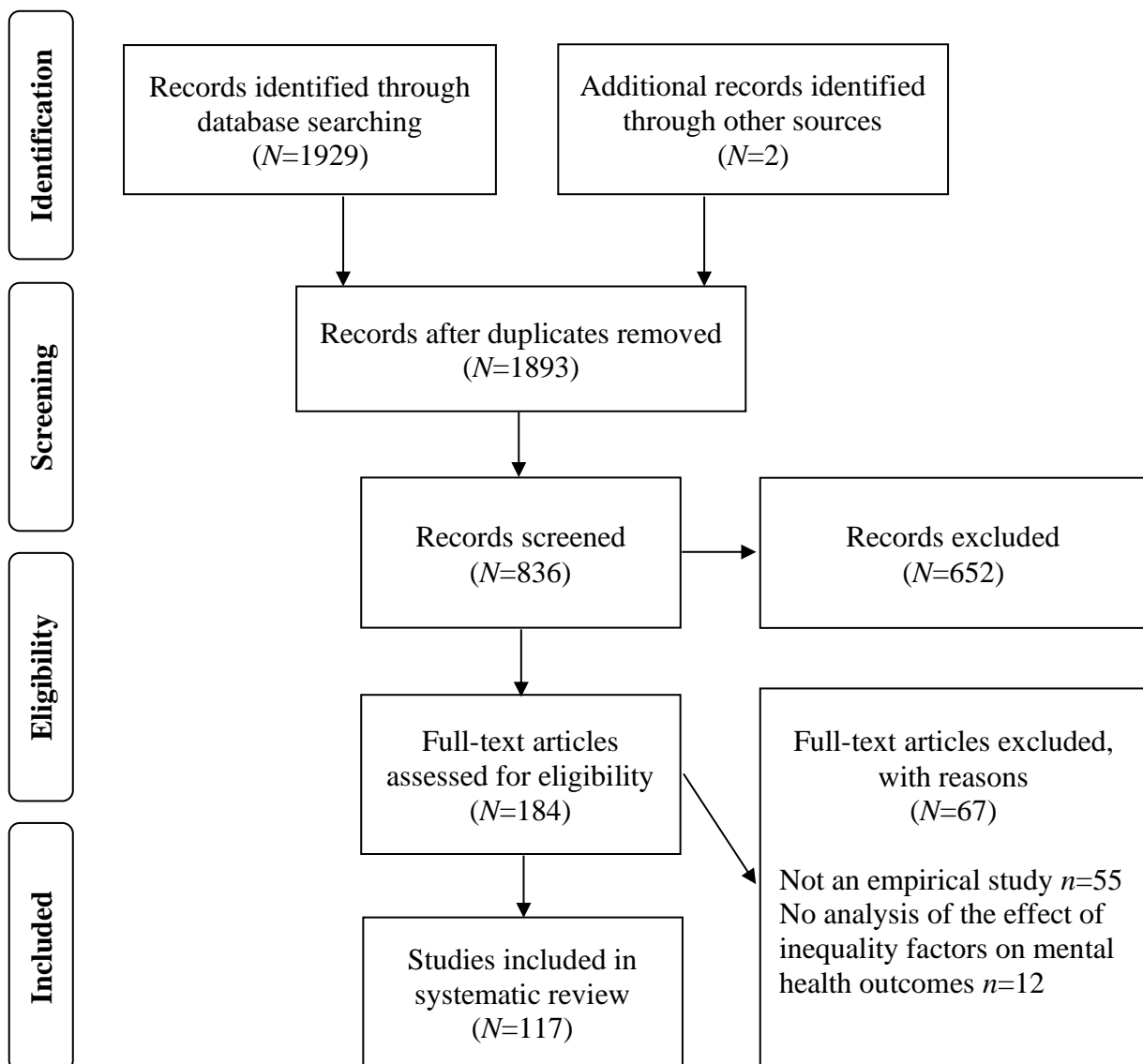
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**Figure 1**

*PRISMA Flowchart of Study Selection*

**Table 1***Characteristics of the Reviewed Studies*

Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Aafjes-van Doorn et al.	United States	Psychotherapists	339 (74%)	55.0 (16.4)	VTS	Higher trauma associated with younger age, less clinical experience, and negative online treatment experiences	3
Ahmed et al.	China	General population	1,074 (47%)	33.5 (11.1)	BAI, BDI-II, AUDIT, WEMWBS	Male sex associated with increased alcohol abuse; younger age associated with greater anxiety, depression, and lower mental well-being	3
Al Sulais et al.	Saudi Arabia	Physicians	529 (59%)	53% 30-39yrs	Understanding of quarantine rationale, quarantine behaviours, socioeconomic and psychological impact	Participants aged >60yrs experienced less isolation; women were more likely to experience fear and worry	3
Alonzi et al.	United States, Canada	Young adults	616 (48%)	26.6 (5.2)	PROMIS	Nonbinary participants reported highest depression and anxiety, followed by women and men; participants with mental and physical health conditions reported highest depression and anxiety, followed by participants with mental health conditions, physical health conditions, and no health conditions	2
Antunes et al.	Portugal	General population	1,404 (70%)	36.4 (11.7)	IPAQ, STAI, BNGS-S	Women scored higher on trait and state anxiety; adults aged 18-34yrs scored highest in trait anxiety	3
Arpacioglu et al.	Turkey	HCWs, general population	351 (62%)	32.0 (10.2)	STSS, PHQ-9	Female sex, less work experience, and history of chronic disease or trauma were related to higher stress	2
Badahdah et al.	Oman	HCWs	509 (80%)	37.7 (7.7)	GAD-7, PSS-10, WHO-5	Higher stress, anxiety, and poor psychological well-being in women and younger participants	2
Balkhi et al.	Pakistan	General population	400 (50%)	74% ≤35yrs, 26% >35yrs	Psychological impact, behavioural changes	Participants with higher education level and age >35yrs more likely to report anxiety; no effect of sex	3
Bergman et al.	Israel	Older adults	243 (69%)	69.7 (6.7)	GAD, North and Fiske's scale for ageism	Health worries and anxiety symptoms more pronounced among older adults with high ageism levels	3
Berthelot et al.	Canada	Pregnant women	Pre-pandemic 496 (100%), post-pandemic 1,258 (100%)	29.3 (4.2)	K10, PANAS, PCL-5, DES-II	History of previous psychiatric diagnosis, younger age, lower income, and lower education level associated with higher maternal psychological distress	1
Blbas et al.	Iraq	General population	894 (42%)	33.0 (10.0)	Anxiety and depression related to COVID-19	Female sex, age <30yrs, place of residence, and lower education level predicted anxiety and depression; no effect of occupation or income	2
Broche-Pérez et al.	Cuba	General population	772 (74%)	36.0 (14.6)	Fear of COVID-19	Female sex predicted middle to high levels of fear	2

Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Cao et al.	China	College students	7,143 (70%)	-	Cognitions, GAD-7, preventative behaviours, social support	Urban residency and stability of family income were protective factors against anxiety; no effect of sex	2
Civantos et al.	United States	Otolaryngologists	349 (39%)	33% 31-35yrs	Burnout, IES, GAD-7, PHQ-2	Being a resident (relative to an attending) was a risk factor for burnout; female sex was a risk factor for burnout, anxiety, and distress	2
Cortes-Alvarez et al.	Mexico	General population	1,105 (62%)	69% 18-28yrs	IES-R, DASS-21	Female sex and older age associated with psychological distress, depression, anxiety, and stress	2
Costantini & Mazzotti	Italy	General population	329 (58%)	46.5 (13.6)	CPDI, IES-R	Female sex, younger age, and use of psychotropic drugs/sleeping remedies associated with high distress	2
Cotrin et al.	Brazil	Patients in active orthodontic treatment	354 (65%)	35.5 (13.9)	Anxiety, impact of pandemic and quarantine on orthodontic treatment	Anxiety higher in women than men; no effect of age	3
Dai et al.	China	HCWs	4,357 (77%)	35.0 (8.6)	Exposure to COVID-19, risk perception, GHQ-12	Female sex, working in Wuhan, and working in primary hospitals predicted psychological distress	2
Doshi et al.	India	General population	1,499 (54%)	68% 20-40yrs	Fear of COVID-19	Female sex, lower education level, and being a HCW predicted high level of fear	2
Duan et al.	China	Children and adolescents	3,613 (50%)	10% 7-12yrs, 90% 13-18yrs	SCAS, CDI, SV-SAS, IAS, CSS	Anxiety associated with age group (higher in adolescents), female sex, and urban residency; depression associated with living in Hubei	2
Durankus & Aksu	Turkey	Pregnant women	260 (100%)	29.6 (3.8)	EPDS, BDI, BAI	COVID-19 had a greater impact on the psychology, social isolation, depression, and anxiety of women who were at greater risk of postpartum depression	2
El-Zoghby et al.	Egypt	General population	510 (66%)	46% 18-30yrs	IES-R, mental health impact, impact on social and family support	Age ≤30yrs, rural residency, female sex, university education (compared to post-graduate), and accompanying chronic disease predicted distress	3
Farewell et al.	United States	Pregnant and postpartum women	27 (100%)	56% 23-34yrs	PHQ-9, GAD-7, BRS, WEMWBS, loneliness	Pregnant and postpartum women were at greater risk of stress, depression, and anxiety related to COVID-19	3
Fitzpatrick et al. (2020a)	United States	General population	10,368 (51%)	47.4 (17.7)	SBQ-R, CES-D	Participants who were younger, Black, Native American, or Hispanic were at greater risk of suicide behaviours	2
Fitzpatrick et al. (2020b)	United States	General population	10,368 (51%)	47.4 (17.7)	CES-D, stress-related factors	Women, Hispanic participants, and participants who were not working showed elevated depression	2
Fitzpatrick et al. (2020c)	United States	General population	10,368 (51%)	47.4 (17.7)	COVID-19 fear, GAD-7, CES-D	Female sex and being Asian, Hispanic, or foreign-born were associated with fear, anxiety, and depression	2
Flentje et al.	United States	Sexual and gender minority individuals	2,288 (63%)	36.9 (14.7)	PHQ-9, GAD-7	COVID-19 increased anxiety and depression in those who did not have pre-existing symptoms consistent with generalised anxiety or depression	2
Fu et al.	China	General population	1,242 (70%)	73% ≤30, 27% >30	PHQ-9, GAD-7, AIS, SCSQ	Female sex, higher income, and higher education level predicted anxiety, depression, and sleep disorder	2

Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Gao, Sun et al.	China	Patients with emotional disorders	570 (61%)	38.6 (13.9)	COVID-19 impact and beliefs	Male sex, older age, and lower education level associated with more negative beliefs about the pandemic	2
Gao, Zheng et al.	China	General population	4,872 (68%)	32.3 (10.0)	WHO-5, GAD-7, social media exposure	Age 31-40yrs, lower education level, urban residency, and lower self-rated health were risk factors for depression; no effect of sex	2
Gómez-Salgado et al.	Spain	General population	4,180 (74%)	40.3 (13.2)	COVID-19 symptoms, GHQ-12	Female sex and number of symptoms presented predicted psychological distress	2
González-Sanguino et al.	Spain	General population	3,480 (75%)	37.9 (-)	PHQ-2, GAD-2, PCL-C-2, loneliness, belonging, discrimination, social support, spiritual well-being, self-compassion	Younger age and female sex related to poorer mental health outcomes	2
Gualano et al.	Italy	General population	1,515 (66%)	<i>Mdn</i> (IQR) 42 (23yrs)	PHQ-9, GAD-2, ISI	Female sex, accompanying chronic disease, and younger age increased likelihood of poor mental health outcomes and sleep disturbances	2
Guo et al.	China	COVID-19 patients and controls	Patients 103 (43%), controls 103 (48%)	Patients 42.5 (12.5), controls 41.4 (13.1)	PHQ-9, GAD-7, PSS-10, PCL-5	COVID-19 patients manifested higher depression, anxiety, and post-traumatic stress; women in both groups showed greater perceived helplessness	2
Hao, Tan et al.	China	Psychiatric patients	Patients 76 (37%), controls 109 (62%)	Patients 32.8 (11.8), controls 33.1 (11.2)	IES-R, DASS-21, ISI	Psychiatric patients had more health concerns, impulsivity, suicidal ideation, and reported higher anxiety, depression, stress, and insomnia	3
Hao, Zhou et al.	China	Patients with epilepsy	Patients 252 (52%), controls 252 (52%)	Patients 29.3 (11.6), controls 29.4 (11.5)	Clinical health data, K6	Patients with epilepsy reported higher psychological distress than healthy controls; diagnosis of drug-resistant epilepsy and time spent following media reports of the outbreak associated with severe psychological distress	1
Horesh et al.	Israel	General population	204 (71%)	45.9 (19.7)	PSS, BAI, WHOQOL	Female sex, younger age, lower income, and accompanying chronic disease were related to higher psychological distress and lower quality of life	2
Huang et al.	China	HCWs	587 (52%)	<i>Mdn</i> (IQR) 33 (28-43yrs)	CD-RISC, PSS	Perceived stress (inverse), female sex (inverse), knowledge of COVID-19 and protective measures, and availability of adequate PPE predicted resilience; no effect of age, education level, or work experience	2
Huang & Zhao	China	General population	7,236 (55%)	35.3 (5.6)	GAD-7, CES-D, PSQI, knowledge of outbreak	Age<35yrs predicted anxiety and depression; being a HCW predicted poor sleep quality; no effect of sex	2
Iob et al.	United Kingdom	General population	44,775 (51%)	32% >60yrs	PHQ-9	Abuse, self-harm, and thoughts of suicide/self-harm higher in women, BAME participants, and people experiencing socioeconomic disadvantage,	1

Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Jahrami et al.	Bahrain	HCWs	257 (70%)	40.2 (9.7)	PSS, PSQI	unemployment, disability, accompanying chronic disease, mental disorders, and COVID-19 diagnosis Female sex and being a physician or nurse predicted poor sleep quality and moderate to severe stress	2
Jiang et al.	China	General population	6,049 (75%)	Range 17-63yrs	PCL-5, ERQ	Lower education level, female sex, and younger age predicted moderate to severe PTSS	2
Karatzias et al.	Ireland	General population	1,041 (52%)	21% 55-64yrs	ITQ, PHQ-9, GAD-7	Younger age, male sex, urban residency, and screening positive for anxiety/depression increased PTSD	2
Kavčič et al.	Slovenia	General population	2,722 (75%)	36.4 (13.1)	CD-RISC-10, PSS, MHC-SF	Female sex, younger age, and lower education level increased odds for worse psychological functioning	2
Khanna et al.	India	Ophthalmologists	2,355 (43%)	42.5 (12.1)	Impact of COVID-19 on work and income, PHQ-9	Depression higher in younger individuals, women, those not in practice, and ophthalmologists-in-training; depression related to concern about training and profession and ability to meet living expenses	2
Kimhi et al.	Israel	General population	Jewish 605 (49%), Arab 156 (50%)	Jewish 42.4 (15.6), Arab 36.0 (13.6)	Resilience, sense of danger, feeling safe at home, BSI, well-being	Israeli Arabs reported higher distress and lower resilience and well-being; higher education level predicted anxiety among Jewish participants, but negatively predicted anxiety among Arab participants	2
Kokou-Kpolou et al.	France	General population	556 (76%)	30.1 (-)	ISI, loneliness	Lower education level, pre-existing mental health illness, and loneliness increased likelihood of being diagnosed with clinical insomnia; no effect of sex	2
Lai et al.	China	HCWs	1,257 (77%)	65% 26-40yrs	PHQ-9, GAD-7, ISI, IES-R	Nurses, women, frontline workers, and those in Wuhan reported more depression, anxiety, insomnia, and distress	2
Lei et al.	China	General population	1,593 (61%)	32.3 (9.8)	SAS, SDS	Female sex, lower average household income, lower education level, having a higher self-evaluated level of knowledge, greater economic loss, and lower self-perceived health associated with anxiety and depression	2
Li & Wang	United Kingdom	General population	15,530 (-)	-	GHQ-12, loneliness	Female sex and younger age were risk factors for psychiatric disorders and loneliness; having a job was a protective factor	2
Liang, Gao et al.	China	Young adults	570 (64%)	73% 21-30yrs	PCL-C, GHQ-12, SCSQ	Sex moderated the direct effect between psychological distress and PTSD; men experienced higher PTSD with increasing psychological distress	3
Liang, Ren et al.	China	Young adults	584 (62%)	75% 21-30yrs	GHQ-12, PCL-C, SCSQ	Lower education level predicted worse mental health and higher PTSD	2
Lin, Hu et al.	China	General population	2,446 (70%)	68% 18-24yrs	Knowledge, attitudes, impact, STAI	Younger age, female sex, suburban/rural residency, lower income, and high perceived susceptibility, severity, and impact predicted state and/or trait anxiety	2
Lin, Wang et al.	China	General population	5,461 (70%)	71% 45-60yrs	ISI, PHQ-9, GAD-7, ASDS	Female sex and younger age associated with insomnia	3

Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Liu, Chen et al.	China	Pregnant women	1,947 (100%)	89% <35yrs, 11% ≥35yrs	SAS	Living in the epidemic hardest hit area and coming from extremely high- or low-income families predicted anxiety	2
Liu, Luo et al.	China	General population	608 (59%)	53% 19-39yrs	STAI, SDS, SCL-90	Younger age predicted state anxiety, depression, and psychological abnormalities	2
Liu, Yang et al.	China	HCWs	512 (85%)	75% 18-39yrs	SAS	No effect of sex, age, education level, or geographical location on anxiety	2
Liu, Zhang, Wei et al.	China	General population	285 (54%)	48% ≤35yrs, 52% >35yrs	PCL-5, PSQI	Female sex and poor sleep quality predicted PTSS; no effect of age or education level	2
Liu, Zhang, Wong et al.	United States	Young adults	898 (81%)	24.5 (-)	CD-RISC-10, DTS, MSPSS, TWSSS, loneliness, PHQ-9, GAD-7, PCL-C	Asian American and Hispanic/Latinx participants reported less psychological distress than White participants; transgender participants more likely to report higher PTSD; no effect of age, sex, or income	2
Liu, Zhu et al.	China	Medical students	217 (59%)	21.7 (1.7)	PHQ-9, GAD-7	No effect of sex, geographical location, or grade on anxiety or depression	3
Ma, Li et al.	China	COVID-19 patients	770 (52%)	50.4 (13.1)	PHQ-9, WHOQOL_BRIEF	Male sex was a protective factor against depression	2
Ma, Zhang et al.	China	General population	728 (70%)	32.9 (10.4)	IES, Impact of COVID-19 on family and social support, MHLSS	Female sex associated with higher psychological distress; men reported increased work stress and women reported increased financial stress and stress at home	2
Maarefvand et al.	Iran	General population	3,787 (67%)	34.9 (-)	Medical history, stress, COVID-19 knowledge	Female sex, younger age, and accompanying chronic disease predicted higher stress score	2
Maguire & O'Shea	Ireland	Patients with IA	80 (38%)	50.7 (-)	PHQ-4, social interaction	Female sex associated with greater decline in general health, mood disturbance, and increased disease activity	2
Mappa et al.	Italy	Pregnant women	178 (100%)	<i>Mdn</i> (IQR) 33 (30-36yrs)	STAI, concerns about perinatal complications	Higher education level associated with state anxiety; no effect of age or employment status	3
Mazza et al.	Italy	General population	2,766 (72%)	32.9 (13.2)	DASS-21, PID-5-BF	Lower education level, female sex, unemployment, young age, having to go out to work, and a history of stressful situations/medical problems associated with depression, anxiety, and stress	2
Meo et al.	Pakistan	Medical students	530 (55%)	Women 21.2 (1.6), men 22.6 (1.6)	Psychological well-being, stress, learning behaviours	Both female and male medical students reported to be emotionally detached from their social support system, and a decrease in overall work performance	3
Mimoun et al.	Israel	General population	293 (64%)	44.6 (16.7)	BIPQ-R, DTPS, PSS	Participants on furlough reported higher distress compared to unemployed and full-time workers; among full-time workers and unemployed, older age was associated with lower stress	3
Moccia et al.	Italy	General population	500 (60%)	26% 28-37yrs	K10, affective temperament, attachment style	Male sex was a protective factor for psychological distress; no effect of education level, occupation, history of chronic disease, or geographical location	2

Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Morgul et al.	Turkey	General population	3,672 (36%)	<30 to >60yrs	COVID-19 knowledge, FAS	Age<30yrs and >50yrs, lower education level, occupation, and suburban residency predicted fatigue; no effect of sex	2
Naser et al.	Jordan	General population, university students, HCWs	4,126 (59%)	55% 18-29yrs	PHQ-9, GAD-7	HCWs: Female sex, working as a pulmonologist, being older (inverse), and higher income (inverse) predicted depression and anxiety; Students: Female sex, history of chronic disease, and higher income predicted depression and anxiety; General population: Female sex, being older (inverse), higher income (inverse), and being retired (inverse) predicted depression and anxiety	2
Nie et al.	China	COVID-19 patients	78 (55%)	58.4 (13.0)	SDS, SAS	Female sex predicted higher depression severity	2
Olmos-Gómez	Spain	University students and staff	441 (66%)	22.7 (3.7)	Sleep, emotions, physical disorders, anxiety	Female students reported more problematic psychological factors	2
Ozamiz-Etxebarria et al.	Spain	General population	1,933 (80%)	33.8 (16.7)	DASS-21	Male sex, younger age, and accompanying chronic disease associated with higher anxiety and depression	2
Özdin & Bayrak Özdin	Turkey	General population	343 (49%)	37.2 (10.3)	HADS, HAI	Urban residency, female sex, accompanying chronic disease, and previous psychiatric illness predicted depression, anxiety, and health anxiety	2
Palgi et al.	Israel	General population	1,059 (75%)	46.2 (16.5)	PHQ-9, GAD-7	Younger age and lower education level were related to more symptoms of depression; adults aged>60yrs displayed greater resilience to depression and anxiety	2
Park et al.	United States	General population	1,015 (54%)	38.9 (13.5)	Stressors, guidelines adherence, coping	Participants with fewer resources/experiencing financial strain, younger age, female sex, ethnics and sexual minority status, and caregivers reported more stressors and higher overall stress	3
Pawlak et al.	63 countries	Endoscopy trainees	770 (44%)	32.6 (-)	GAD-7	Female sex was a risk factor for anxiety	2
Pedrozo-Pupo et al.	Colombia	General population	406 (62%)	43.9 (12.4)	PSS-10 (modified for COVID-19)	No effect of sex, age, education level, socioeconomic status, or accompanying chronic disease	2
Peng et al.	China	Quarantined individuals	2,237 (40%)	Depression 35.0 (9.9), no depression 36.9 (5.1)	SDS, PSQI, IER-R, PTSS	Younger age and lower education level predicted depression; no effect of sex	2
Ping et al.	China	General population	1,139 (60%)	38.3 (12.5)	Health status, worry, HRQOL	Accompanying chronic disease and lower family income associated with anxiety and depression; no effect of sex	2
Qiu et al.	China	General population	52,730 (65%)	-	CPDI	Female sex, age 18-30yrs and >60yrs, higher education level, and being a migrant worker predicted distress	2
Rodriguez et al.	United States	General population	754 (50%)	41.7 (10.4)	PCTQ, QF	No effect of sex on link between psychological distress and drinking	2



Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Rodríguez-Rey et al. (2020a)	Spain	General population	3,055 (75%)	32.2 (13.0)	IES-R	Younger age and female sex predicted psychological distress	2
Rodríguez-Rey et al. (2020b)	Spain	General population	3,055 (75%)	32.2 (13.0)	IES-R, DASS-21	Women, younger participants, and those who lost their job during the pandemic showed strongest negative psychological symptoms	2
Santos et al.	103 countries	Cisgender gay men and other men who have sex with men	2,732 (0%)	-	Economic impact of COVID-19, HIV treatment and care impact, PHQ-4	31% reported moderate to severe psychological distress, 35% reported depression, 34% reported anxiety; individuals who lost employment more likely to report anxiety and depression	2
Savarino et al.	Italy	Patients with EGIDs	102 (37%)	35.5 (11.8)	Clinical and psychological impact of COVID-19	Female sex and lower education level associated with higher psychological perception of COVID-19	3
Seyahi et al.	Turkey	Patients with rheumatic diseases, HCWs, high-school teachers/academic staff	Patients 771 (68%), HCWs 535 (66%), teachers 917 (72%)	Patients 16-81 ( <i>Mdn</i> =42yrs), HCWs 19-58 ( <i>Mdn</i> =31yrs), teachers 21-79 ( <i>Mdn</i> =35yrs)	HADS, IES-R	Female sex, working in a hospital, lower education level, and having a comorbid disease or a psychiatric disorder were associated with psychiatric symptoms	3
Shacham et al.	Israel	Dentists and dental hygienists	338 (59%)	46.4 (11.2)	Fear of contracting COVID-19, subjective overload, GSES, K6	Background illness, subjective overload, and self-efficacy (inverse) predicted psychological distress	2
Smith et al.	United Kingdom	General population	932 (63%)	21% 25-34yrs	Health questionnaire (smoking status, alcohol use, and multi-morbidity), BAI, BDI, WEMWBS	Female sex, younger age, lower income, smoker status, and physical multimorbidity associated with poor mental health	2
Solomou & Constantinidou	Cyprus	General population	1,642 (72%)	42% 18-29yrs	Compliance with precautionary measures, quality of life, GAD-7, PHQ-9	Women, younger adults, unemployed, participants with poor psychiatric history, and those reporting greater impact on quality of life were at greater risk for increased anxiety and depression	2
Song et al.	China	HCWs	14,825 (64%)	34.0 (8.2)	PSSS, CES-D, PCL-5	Male sex, working in Hubei, middle age, less work experience, longer daily work hours, lower social support, and being a nurse were risk factors for depression and PTSD	2
Stanton et al.	Australia	General population	1,491 (67%)	50.5 (14.9)	DASS-21, physical activity, sleep, smoking behaviour, alcohol use	Female sex, lower income, age 18-45yrs, and accompanying chronic disease associated with higher psychological distress	2
Sun et al.	China	HCWs	442 (83%)	59% 26-35yrs	COVID-19 impact, IES	Female sex predicted higher arousal; being quarantined predicted higher psychological distress	2
Taubman-Ben-ari et al.	Israel	Pregnant women	336 (100%)	30.3 (5.0)	COVID-19 related anxiety, MHI-5	Arab women reported higher COVID-19 related anxiety and distress than Jewish women	3

Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Thomaier et al.	United States	Oncology providers	374 (63%)	45.7 (9.6)	PHQ-4, COVID-19 concerns, effects on decision making and practice, well-being SCL-90	Female sex, younger age, less experience, practicing in a state with more cases, inadequate PPE, and feeling that COVID-19 was interfering with job and care provision associated with anxiety and depression	2
Tian et al.	China	General population	1,060 (48%)	35.0 (12.8)	PSQ-8, coping, well-being, PHQ-4	Enterprise staff/agricultural workers, aged>50 or <18yrs, and women more likely to be in high-risk group	2
Umucu & Lee	United States	Individuals with self-reported disabilities and chronic conditions	269 (44%)	39.4 (12.2)	Personal information form, BDI	No effect of age, sex, or ethnicity	2
Ustun	Turkey	General population	1,115 (72%)	28.0 (8.8)	IES-R	Female sex, student status, age 18-29yrs, and lower income associated with higher depression; no effect of accompanying chronic disease	2
Varshney et al.	India	General population	653 (25%)	41.8 (13.6)	DASS-21, binge drinking/substance abuse	Younger age, female sex, and comorbid physical illness predicted higher psychological impact	2
Verma & Mishra	India	General population	354 (48%)	54% 18-25yrs	SAS, SDS	Employment, binge drinking, and male sex associated with depression, anxiety, and stress	2
Wang, Di et al.	China	General population	600 (56%)	34.0 (12.0)	IES-R, DASS-21	Female sex and age<41yrs were risk factors for anxiety; higher education level and working as a professional were risk factors for depression	2
Wang, Pan et al.	China	General population	1,210 (67%)	53% 21-31yrs	K6, SCSQ	Female sex, student status, physical symptoms, and poor self-rated health status were associated with greater psychological impact, stress, anxiety, and depression	2
Wang, Xia et al.	China	General population	1,599 (67%)	33.9 (12.3)	PCL-C, SCSQ	Younger age associated with higher psychological distress; no effect of sex	2
Wang, Guo et al.	China	Nurses	202 (88%)	32.0 (-)	SAS	Low job satisfaction and female sex associated with higher PTSD	2
Wang & Zhao	China	University students	3611 (59%)	-	GAD-7, PHQ-9, job insecurity, financial concern, perceived health, illness recency	Female students reported higher anxiety than male students	3
Wilson et al.	United States	General population	474 (46%)	19-85 (Mdn=40yrs)	EPDS, pregnancy-related health issues	Job insecurity directly related to greater depression and indirectly related to greater anxiety due to higher financial concern	2
Wu et al.	China	Pregnant women	Pre-pandemic 2,839 (100%), post-pandemic 1,285 (100%)	27-32 (Mdn=30yrs)	PSS-14, HADS	Pregnant women who were underweight before pregnancy, primiparous, <35yrs, employed full time, in the middle-income category, and had appropriate living space were at increased risk for anxiety and depression	2
Xiao et al.	China	HCWs	958 (67%)	-		Female sex, intermediate (compared to junior) title, deficient PPE, and contact with diagnosed patients were risk factors for anxiety and depression	2

Author(s)	Country	Participants	N (% Female)	Age in Years <sup>a</sup>	Measures	The Impact of Inequality Factors on Mental Health	Study Quality <sup>b</sup>
Yin et al.	China	HCWs	371 (62%)	35.3 (9.5)	Exposure to COVID-19 patients, PCL-5, PSQI	Female HCWs more vulnerable to PTSS than male HCWs	2
Zhang, Wang et al.	China	HCWs	2,182 (64%)	96% 18-60yrs	ISI, SCL-90-R, PHQ-2, GAD-2	Medical HCWs: Female sex, rural residency, exposure to COVID-19 patients, and organic diseases were risk factors for psychological symptoms; Non-medical HCWs: Organic diseases was a risk factor for psychological symptoms	2
Zhang, Yang et al.	China	HCWs	1,563 (83%)	32% 31-40yrs	ISI, PHQ-9, GAD-7, IES-R	Insomnia associated with female sex, lower education level, being a doctor, and working in isolation unit	2
Zhang, Wang, Rauch, & Wei	China	General population	369 (45%)	36.6 (10.5)	SF-12, K6, work status, exercise	Those who stopped working reported worse mental and physical health outcomes and greater distress; severity of distress higher in individuals with existing health issues	2
Zhou, Zhang et al.	China	High school students	8,079 (54%)	12-18 ( <i>Mdn</i> =16yrs)	PHQ-9, GAD-7	Female sex, living in Hubei, and being in the higher grade were risk factors for anxiety and depression	2
Zhu, Sun et al.	China	HCWs	165 (83%)	34.2 (8.1)	SAS, SDS, SCSQ	History of depression/anxiety was risk factor for anxiety and depression; male sex was protective for depression	2
Zhu, Xu et al.	China	HCWs	5,062 (85%)	56% 30-49yrs	COVID-19 threat perception, IES-R, PHQ-9, GAD-7	PPE (inverse), female sex, drinking history, reasonable work shifts (inverse), work experience>10yrs, exercise habit (inverse), accompanying chronic disease, and history of mental disorders predicted stress, depression, and anxiety	2
Zhu, Liu et al.	China	HCWs, general population	922 (56%)	36% 36-39yrs	SCL-90	Medical staff reported greater mental health symptoms; women had a higher risk for mental health symptoms	2

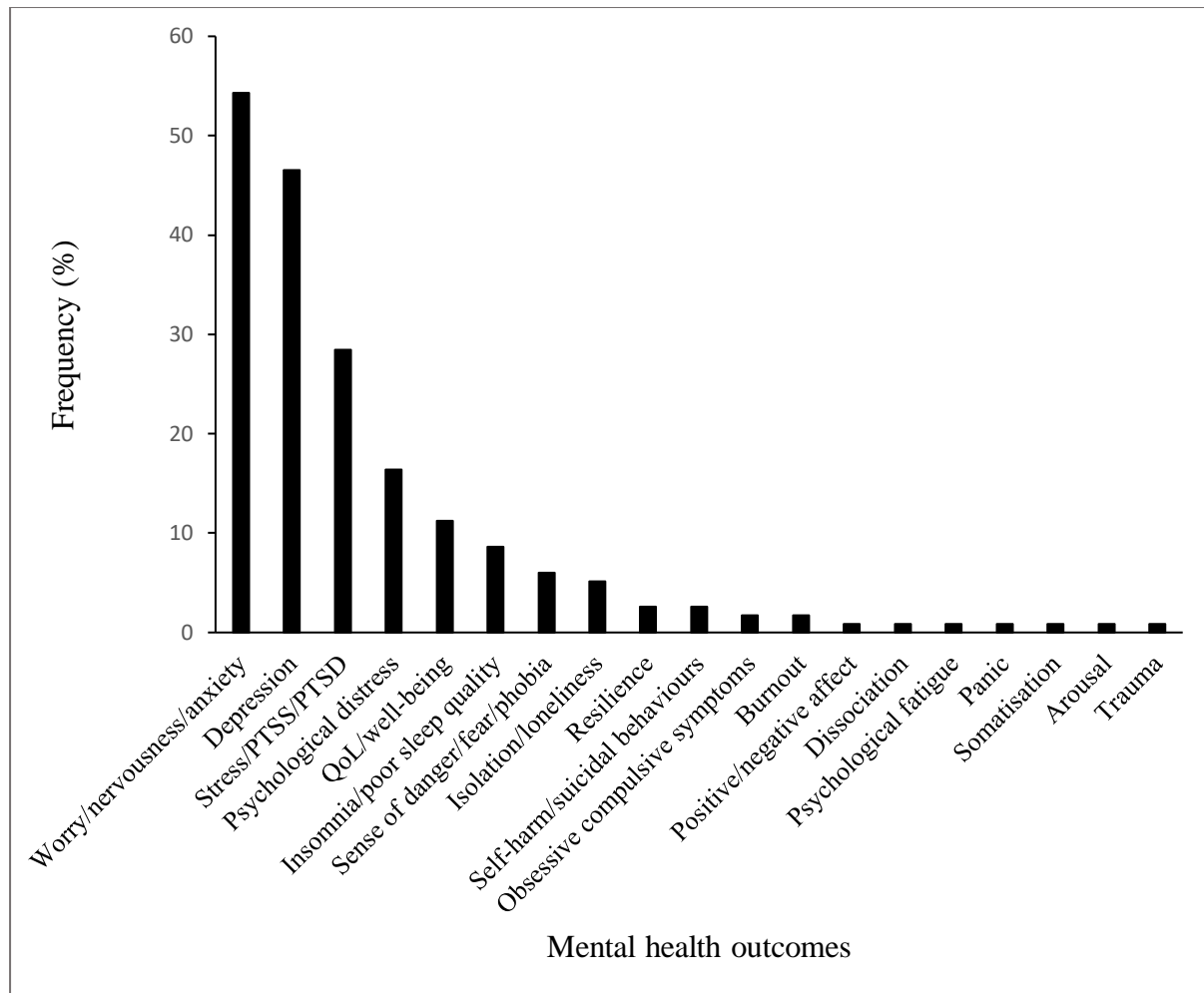
*Note.* Only outcomes directly related to inequality and mental health are presented. *Abbreviations.* *Measures:* AIS = Athens Insomnia Scale; ASDS

= Acute Stress Disorder Scale; AUDIT = Alcohol Use Disorder Identification Test; BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; BIPQ = Brief Illness Perception Questionnaire; BNGS-S = Basic Need General Satisfaction Scale; BRS = Brief Resilience Scale; BSI = Brief Symptom Inventory; CDI = Child Depression Inventory; CD-RISC = Connor-Davidson Resilience Scale; CES-D = Center for Epidemiology Scale for Depression; CPDI = COVID-19 Peritraumatic Distress Index; CSS = Coping Style Scale; DASS-21 = Depression, Anxiety, and Stress Scale; DES-II = Dissociative Experiences Scale; DTPS = Distress Thermometer and Problem List; DTS = Distress Tolerance Scale; EPDS = Edinburgh Postnatal Depression Scale; ERQ = Emotion Regulation Questionnaire; FAS = Fatigue Assessment Scale; GAD = Generalized Anxiety

Disorder Scale; GHQ = General Health Questionnaire; GSES = General Self-Efficacy Scale; HADS = Hospital Anxiety and Depression Scale; HAI = Health Anxiety Inventory; IAS = Internet Addiction Scale; IES = Impact of Events Scale; IPAQ = International Physical Activity Questionnaire; ISI = Insomnia Severity Index; ITQ = International Trauma Questionnaire; K6/10 = Kessler Psychological Distress Scale; MHC = Mental Health Continuum; MHI = Mental Health Inventory; MHLSS = Mental Health Lifestyle Scale; MSPSS = Multidimensional Scale of Perceived Social Support; PANAS = Positive And Negative Affect Schedule; PCL = PTSD Checklist; PCTQ = Perceived Coronavirus Threat Questionnaire; PHQ = Patient Health Questionnaire; PID = Personality Inventory for DSM-5; PROMIS = Patient-Reported Outcomes Information System; PSQ = Perceived Stress Questionnaire; PSQI = Pittsburgh Sleep Quality Index; PSS = Perceived Stress Scale; PSSS = Perceived Social Support Scale; QF = Quantity/Frequency/Peak Alcohol Use Index; SAS = Self-rating Anxiety Scale; SBQ = Suicide Behaviour Questionnaire; SCAS = Spence Child Anxiety Scale; SCL-90 = Symptom Checklist-90; SCSQ = Simplified Coping Style Questionnaire; SDS = Self-rating Depression Scale; SF-12 = Short Form-12; STSS = Secondary Traumatic Stress Scale; WEMWBS = Warwick-Edinburgh Mental Well-Being Scale; STAI = State-Trait Anxiety Inventory; SV-SAS = Short Version of the Smartphone Addiction Scale; TWSSS = Two-Way Social Support Scale; VTS = Vicarious Trauma Survey; WHO-5 = WHO-Five Well-Being Index; WHOQOL = WHO Quality of Life Scale. *Mental health outcomes:* HRQOL = Health-related quality of life; PTSS = Post-traumatic stress symptoms; PTSD = Post-traumatic stress disorder. *Other:* BAME = Black, Asian, and Minority Ethnic; EGID = Eosinophilic Gastrointestinal Disease; HCW = Healthcare worker; IA = Inflammatory Arthritis; PPE = Personal protective equipment.

<sup>a</sup>Age presented as mean years (standard deviation) unless otherwise specified.

<sup>b</sup>Study quality was assessed according to the EPHPP guidelines as follows: 1 = strong, 2 = moderate, 3 = weak.



**Figure 2**

*Frequency of Assessed Mental Health Factors During the COVID-19 Pandemic in the Reviewed Studies*

*Note.* PTSD = Post-traumatic stress disorder; PTSS = Post-traumatic stress symptoms; QoL = Quality of life.

**Box 1: Recommendations to Mitigate Adverse Mental Health Outcomes in Vulnerable****Populations During COVID-19 (ASSIST)**

**A – Acknowledge inequality!** This pandemic has highlighted how quickly many people become vulnerable because of existing inequalities. We must commit to ensure a fair society for all and not just during times of crisis. COVID-19 is a lesson to us all about what happens when we create an unfair society, so in the future (but starting now) we should lift up vulnerable members of society so that we really *are* all in this together. We should make sure that minoritized, racialised, and otherwise marginalised groups are listened to and included in national health campaigns while also tackling prejudices that block access to care and incite hatred and mistreatment towards them. Mental health service providers should be aware of inequality factors that may impact their clients' mental health and provide individualised treatments tailored to the client's needs. Clinicians should also check in on their clients more frequently, as the situation is still developing and may change rapidly from day to day. It is the job of policy makers and politicians, meanwhile, to make sure that funding is available for these services. Researchers should also be sensitive to risk factors when developing interventions, so that interventions can be tailored to vulnerable populations. Importantly, researchers should do more to select participant samples that are inclusive of vulnerable populations, particularly those that are at high risk of adverse mental health outcomes and less likely to take part in research, such as older participants or individuals with long-term health conditions. After all, more research is required on the mental health of marginalised and disadvantaged people during COVID-19.

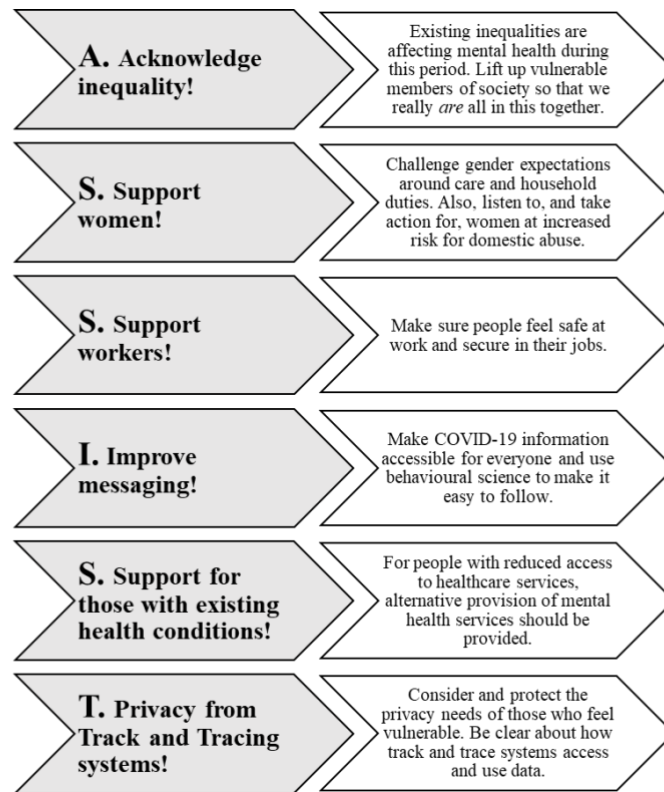
**S – Support women!** It's important that we challenge gender expectations and encourage men to take up their share of care and household duties. Take care to frame this in a way that men do not feel overburdened themselves, but so that they *want* to support the women in their lives. More efforts are required to support women at risk of domestic violence through the setting up of online services, providing safe spaces for women that take social distance and COVID-19-related health precautions into account, and creating networks for monitoring women living with partners with a history of abuse. Researchers investigating the effect of sex on mental health outcomes should consider the intersectionality (i.e., the connected nature) between sex and gender and take into account additional factors that may mediate or moderate this effect.

**S – Support workers!** Make sure people feel both safe while at work and also secure in their jobs. Support from the government is important here, and efforts to control rent and mortgage repayments might help people feel more financially secure should they be furloughed or lose their job. People working frontline or high-risk jobs (e.g., healthcare workers and essential workers) should be protected and offered sick pay and leniency with work. More research is required in non-healthcare workers as well as students who may also be at an increased risk for poor mental health outcomes during COVID-19.

**I – Improve messaging!** Make COVID-19 information accessible for everyone (e.g., not dependent on access to the internet) and easy to follow. For example, the British Psychological Society have made documents available to the public and are encouraging health communicators to utilise the COM-B model to promote behaviour change (according to the model, people must feel they have the Capability, Opportunity, and Motivation in order to make changes to their Behaviour; good messaging will encourage these three feelings). Researchers communicating findings should consider distinguishing participants based on more than one inequality factor (e.g., Black men, Black women, White men, White women) and make findings accessible online and offline to different communities. Messaging can also help vulnerable populations feel more included and empowered.

**S – Support for those with existing physical and mental health conditions!** People with existing health needs are already vulnerable but especially unlikely to be getting the support they need at this time, which may be putting them at further risk of distress. For participants with reduced access to healthcare services (e.g., due to rural residency, chronic conditions, increased risk of COVID-19-related morbidity and mortality, or lower disposable income), alternative provision of mental health services should be considered. Telehealth could be a useful strategy to make sure people can still get the mental health support they need, while staying safe during the pandemic. Increased resources are also required so that health services that treat existing conditions can continue as best as they can.

**T – Privacy from Track and Tracing systems!** Consider and protect the needs for privacy for those who feel vulnerable including migrants, people from different ethnic backgrounds, and those from the LGBTQ+ community. Transparent messaging (about how information is stored/protected/etc.) that people can trust is vital.



**Figure 3**

*The 'ASSIST' Diagram*

## Appendix A

### Box 1: Recommandations pour atténuer les effets néfastes sur la santé mentale chez les populations vulnérables pendant le COVID-19

– **Reconnaissez les inégalités!** Cette pandémie a mis en évidence la rapidité avec laquelle de nombreuses personnes deviennent vulnérables en raison des inégalités existantes. Nous devons nous engager à garantir une société juste pour tous et pas seulement en temps de crise. Le COVID-19 est une leçon pour nous tous sur ce qui se passe lorsque nous créons une société injuste, donc à l'avenir (mais à partir de maintenant) nous devrions élever les membres vulnérables de la société afin que nous soyons vraiment tous dans le même bateau. Nous devons nous assurer que les groupes minoritaires, racialisés et autrement marginalisés sont écoutés et inclus dans les campagnes nationales de santé tout en luttant contre les préjugés qui bloquent l'accès aux soins et incitent à la haine et aux mauvais traitements à leur égard. Les prestataires de services de santé mentale doivent être conscients des facteurs d'inégalité qui peuvent avoir une incidence sur la santé mentale de leurs clients et fournir des traitements personnalisés adaptés aux besoins du client. Les cliniciens devraient également vérifier leurs clients plus fréquemment, car la situation évolue encore et peut changer rapidement d'un jour à l'autre. Il appartient entre-temps aux décideurs et aux politiciens de s'assurer que des fonds sont disponibles pour ces services. Les chercheurs doivent également être sensibles aux facteurs de risque lors de l'élaboration d'interventions, afin que les interventions puissent être adaptées aux populations vulnérables. Il est important de noter que les chercheurs devraient faire plus pour sélectionner des échantillons de participants qui incluent les populations vulnérables, en particulier celles qui présentent un risque élevé de problèmes de santé mentale et qui sont moins susceptibles de participer à la recherche, comme les participants plus âgés ou les personnes souffrant de problèmes de santé à long terme. Après tout, des recherches supplémentaires sont nécessaires sur la santé mentale des personnes marginalisées et défavorisées pendant le COVID-19.

– **Soutenez les femmes!** Il est important de remettre en question les attentes sexospécifiques et d'encourager les hommes à assumer leur part des soins et des tâches ménagères. Veillez à encadrer cela de manière à ce que les hommes ne se sentent pas surchargés, mais qu'ils veuillent soutenir les femmes dans leur vie. Davantage d'efforts sont nécessaires pour soutenir les femmes à risque de violence domestique à travers la mise en place de services en ligne, en fournissant des espaces sûrs pour les femmes qui tiennent compte de la distance sociale et des précautions sanitaires liées au COVID-19, et en créant des réseaux de suivi des histoires d'abus. Les chercheurs qui étudient l'effet du sexe sur les résultats de santé mentale devraient tenir compte de l'intersectionnalité (c.-à-d., La nature connectée) entre le sexe et le genre et prendre en compte d'autres facteurs qui peuvent médier ou modérer cet effet.

– **Aidez les travailleurs!** Assurez-vous que les gens se sentent à la fois en sécurité au travail et en sécurité dans leur travail. Le soutien du gouvernement est important ici, et les efforts pour contrôler les remboursements de loyer et d'hypothèque pourraient aider les gens à se sentir plus en sécurité financière s'ils devaient être congédiés ou perdre leur emploi. Les personnes occupant des emplois de première ligne ou à haut risque (par exemple, les travailleurs de la santé et les travailleurs essentiels) devraient être protégées et bénéficier d'une indemnité de maladie et d'une clémence dans le travail. Des recherches supplémentaires sont nécessaires chez les non-professionnels de la santé ainsi que chez les étudiants qui peuvent également présenter un risque accru de problèmes de santé mentale pendant le COVID-19.

– **Améliorez la communication!** Rendre les informations sur le COVID-19 accessibles à tous (par exemple, ne dépendant pas de l'accès à Internet) et faciles à suivre. Par exemple, la British Psychological Society a mis des documents à la disposition du public et encourage les communicateurs en santé à utiliser le modèle COM-B pour promouvoir le changement de comportement (selon le modèle, les gens doivent sentir qu'ils ont la capacité, l'opportunité et la motivation pour apporter des changements à leur comportement; un bon message encouragera ces trois sentiments). Les chercheurs qui communiquent les résultats devraient envisager de distinguer les participants en fonction de plus d'un facteur d'inégalité (par exemple, les hommes noirs, les femmes noires, les hommes blancs, les femmes blanches) et rendre les résultats accessibles en ligne et hors ligne à différentes communautés. La communication peut également aider les populations vulnérables à se sentir plus incluses et plus autonomes.

– **Soutenez ceux qui ont des problèmes de santé!** Les personnes ayant des besoins de santé existants sont déjà vulnérables, mais surtout peu susceptibles d'obtenir le soutien dont elles ont besoin à ce moment, ce qui peut les exposer à un risque supplémentaire de détresse. Pour les participants ayant un accès réduit aux services de santé (par exemple, en raison de la résidence rurale, de maladies chroniques, d'un risque accru de morbidité et de mortalité liées au COVID-19 ou d'un revenu disponible plus faible), une offre alternative de services de santé mentale doit être envisagée. La télésanté pourrait être une stratégie utile pour s'assurer que



les gens peuvent toujours obtenir le soutien en santé mentale dont ils ont besoin, tout en restant en sécurité pendant la pandémie. Des ressources accrues sont également nécessaires pour que les services de santé qui traitent les maladies existantes puissent continuer du mieux qu'ils le peuvent.

– **Confidentialité des systèmes Track and Tracing!** Prendre en compte et protéger les besoins en matière de vie privée de ceux qui se sentent vulnérables, y compris les migrants, les personnes de différentes origines ethniques et ceux de la communauté LGBTQ +. Une communication transparente (sur la manière dont les informations sont stockées / protégées / etc.) en laquelle les gens peuvent avoir confiance est vitale.