COVID-19 Quarantine Accommodation Response: Guidance for mental health alcohol and other drugs services

[LPU to Insert Number]

1. Purpose

The COVID-19 Quarantine Accommodation Response: Guidance for mental health alcohol and other drug services, provides points of practice and links to resources for mental health alcohol and other drug (MHAOD) services and practitioners in developing and delivering specialist support to the Quarantine Accommodation Support Response across Queensland.

2. Scope

Practice points focus on in-reach services into quarantine accommodation and the role and responsibilities for MHAOD services and practitioners in this context. This Guidance does not include protocols for COVID-19 related inpatient MHAOD treatment or Personal Protective Equipment processes. Guidance is provided for the use of Hospital and Health Services (HHSs) in developing a local service response.

3. Implementation

Delivery of the HHS MHAOD Quarantine Accommodation Response requires:

- clarity about role and responsibilities of the HHSMHAOD service and of partner agencies
- promotion of this Guidance as part of a package that also includes the associated resources, and other relevant protocol and standards
- establishment of the role within HHS based clinical governance, operational management and professional support structures to enable delivery of the role in its full scope.

The roles and responsibilities of the HHS MHAOD services sit within the broader multi-agency context of the quarantine accommodation support response. HHS MHAOD service delivery should be underpinned by the Queensland Health Protocol for Quarantine Accommodation Response (Quarantine Protocol), and developed in consultation with key partner agencies, including Department of Communities (DCDSS), Australian Red Cross (ARC), HHS Public Health Unit (PHU), HHS Emergency Operations Centre (EOC), Queensland Police Service (QPS) and Hoteliers. (Link to Protocol is at Section 4)

The MHAOD service scope needs to be defined in relation to the quarantine social and emotional wellbeing package provided by ARC. This package provides a standardised, non-clinical process of engagement and support for all people in quarantine accommodation across the 14-day duration of the Public Health Order. Through the support package, people dealing with emotional distress, complex health or acute mental health concerns that are outside of the ARC role scope are referred to the appropriate partner agency for assessment, inter-agency consultation, care-coordination and support.

Key roles and responsibilities of the MHAOD services can be understood through a 3-tiered approach to service delivery and with application of the processes in documents at Section 4. HHSs may choose to deploy practitioners into the role that do not work for a MHAOD service or are not specialist MHAOD clinicians. In this situation the HHS needs to establish processes that enable facilitation of MHAOD specialist input within the service system as required.

Tier 1

- Australian Red Cross Social Emotional Wellbeing Support 14-day package
- Public Health Unit check in, support and referrals
- Community Recovery wellbeing and support (Community Recovery Hotline)
- Established primary health and mental health supports
- COVID-19 online information and programs (eg: Beyond Blue; Dear Mind; Black Dog)
- Self-managed coping, social and emotional connectedness

Tier 2

- MHAOD COVID-19 Clinical AdvisorMulti-Agency coordination-
  - consultation liaison support provided to Tier 1 wellbeing support services
  - referral and facilitation of Tier 3 HHS acute services
- Early intervention and health promotion
- Support of partner agency staff and hotel environment- coping and containment

Tier 3

- HHS MHAOD emergency, acute and inpatient services
- Comprehensive Clinical Care Approach

ARC and DCDSS Community Recovery services are largely delivered by volunteers and non-clinical staff. While these agencies specialise in delivering psychological first aid, judgement and decision making about concerns related to acuity or risk of presentations of individuals are not within scope of practice.

MHAOD service consultation liaison and support with engagement, referral and care coordination at these times is essential to operationalise the role with agencies including ARC Lifeline, QPS and primary health providers, as well as HHS PHU and acute services. The documents linked below at section 4. 'Related Documents' provide reference to stepped care options for MHAOD support and PHN guidance for scope of practice for mental health support services.

4. Related documents

- Roles and responsibilities of partner agencies
  - Queensland Health Quarantine Accommodation Response Protocol (Reviewed September, 2020)
    - (Appendix 1)
  - Mental Health Alcohol and Other Drugs Stepped Care Support Options (Revised August 2020)
    - (Appendix 2)

- Referral pathway through Quarantine Accommodation Support Response

  Example Metro North Pathway to Care (Appendix 3)
  QH Protocol- Flow chart for referrals to HHS from SHECC

- Primary Health Practitioners Mental Health Triage, Assessment and Scope of Care
  - Primary Health Network (PHN) **National Guidance Initial Referral and Assessment for Mental Healthcare**
    - https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools

5. Context

This Guidance is underpinned by the National Mental Health Pandemic Response Plan (May 2020) and recommendations of the National COVID-19 Health and Research Advisory Committee (NCHRAC, July 2020) on service responses to the mental health impacts of quarantine and self-isolation. Practice points combine the principles and recommendations contained within these documents with the Queensland Health Protocol for Quarantine Accommodation Response (Queensland Health Disaster Management Unit, April 2020) and feedback from consultation with HHS and partner agencies.

Quarantine directions came into effect under Public Health Act Legislation of 28 March 2020. The patterns of circumstance of people placed under the Order have since shifted from repatriated Australians living overseas to travelers moving across internal Australian borders. The complexity and needs of people have also shifted with quarantined people typically travelling for reasons related to urgent health needs, acute grief and loss, bereavement and complex life stressors. The challenges of coping with quarantine isolation, limited social and emotional connectedness, and an inability to access usual coping strategies, place many at increased vulnerability to significant mental health concerns that arise during or after the quarantine period.

For many people with ongoing mental health concerns or increased vulnerabilities, this combination of factors has precipitated a crisis with requirement for acute mental health assessment and support. Mandatory quarantine requirements under the Public Health Act will likely persist for the duration of the COVID-19 crisis, with daily numbers increasing significantly in Queensland since border closures have been in effect.

Recommendations of the National COVID-19 Health and Research Advisory Committee (NCHRAC, July 2020) stress that vulnerability factors which are known to contribute to acute mental distress, mental unwellness and suicidality, are also those experienced by the general population dealing with impact of COVID-19. These factors include confinement and increased economic and mental stressors, unemployment, financial distress and family breakdown or violence, increased alcohol and other drug use, pre-existing mental health concerns, grief and bereavement due to loss of autonomy and a sense of purpose, and from being socially disconnected. (Appendix 4)

6. Key principles

Comprehensive Care Approach

- The Quarantine Accommodation Response by MHAOD services is an essential element of the quarantine accommodation support multi-agency pathway. This promotes a care continuum with screening and identification of need informing the delivery of individualised and coordinated care and involving a range of primary care and specialist services.

Multi- Agency Care Coordination

- The multi-agency Quarantine Accommodation Support Response functions as an integrated system to plan and coordinate safe support and care for all quarantined individuals and response staff.
- MHAOD services provide quarantine support services through both direct specialist service to individuals with mental health and/or substance use disorders and scaffolding of the partner agencies that deliver the primary support for emotional, social and psychological coping.
- Cross-sector programs should enable assertive engagement with at risk individuals and those disengaged from treatment. Capacity to ensure timely assessment and care pathways

to effective treatment and support are essential for people with new or pre-existing mental health or substance use disorders.

Access and Equity for People with Vulnerabilities

- There are specific vulnerable and priority populations within the community who will need tailored, collaborative solutions including:
    - people with pre-existing mental health disorders and/or with a history of self-harm, suicidal behaviour or suicide attempts
    - Aboriginal and Torres Strait Islander individuals and communities
    - children and young people
    - people with complex physical, neurological and cognitive impairment
    - people with pervasive developmental conditions
    - people who are marginalised including those in homelessness, new migrants, asylum seekers.
    - health care workers and first responders
    - people who live in institutional settings (e.g. residential aged care, prisons, detention)
    - families or groups of people with complex social needs
    - people experiencing newly emerging challenges with coping and mental health
    - people dealing with family and domestic violence, discrimination or bullying while in quarantine

Prevention and early intervention approaches

- Proactive and trauma informed approaches are key to reducing mental health and substance use problems and preventing suicide.
- Support for individuals to self-manage through coping, problem-solving skills and resilience can actively enable crisis resolution and maintenance of mental wellbeing during and after quarantine.

Culturally inclusive practice and responsiveness to diversity

- Attention to cultural background, social context and diversity to better engage with families and combat stigma and discrimination.
- Appropriate and safe responses for individuals and their families require care planning with respect to cultural perspectives, understanding about mental health, wellbeing and norms for how to support others during crisis.
- Translated information about COVID-19, mental health and wellbeing should be used in the context of a person's culturally based understandings of the presenting issues.

Continual service review and adaptation

- The methods used to deliver services during a community emergency need to respond and adapt rapidly to emergent needs, and in conjunction with partner agencies. Ongoing review cycles combined with real-time data and lessons from previous events inform good practice.
- Collection and sharing of information are a joint responsibility for all service providers.

7. Key Practice Points

7.1. Apply a Comprehensive Care Approach to Quarantine Support Context

Screening and triage specific to mental health and/or indication of increased risk whilst in quarantine should be offered at points across the care pathway including:

- intake to quarantine
- as written information and education within hotel support packages
- as part of ARC and Public Health Check-ins.

Access points need to connect people to appropriate referral points.

Many people who may require mental health services due to impacts of COVID-19 have not sought help previously. It should not be assumed that people are able to understand or access the service system easily without support.

Access for people from CALD, diverse and vulnerable groups need to be tailored to their needs.

Current translated information and support options for COVID-19, mental health and wellbeing are found at www.refugeehealthnetworkqld.org.au/

Check that HHS MHAOD services can receive and support requests for assistance appropriately through 1300 MHCALL (1300 64 22 55) and ADIS 24/7 Alcohol and Drug Information Service (1800 177 833).

Role of 1300 MHCALL

- 1300 MHCALL is the recognised gateway service to HHS MHAOD services statewide and is distributed widely across partner agencies, primary health practitioners and general public in the COVID-19 response.
- The role of 1300 MHCALL is to support consultation and referral from individuals, caregivers and service agencies connected to the Quarantine Accommodation Response while meeting the needs of local HHS community and MHAOD services.

Assessment of mental health for quarantined individuals should specifically include:

- Mental state: impact of acute substance or medication withdrawal states, behavioural disturbance due to environmental, sensory needs or communication needs, acute stress response and acute trauma response

- Risk: ability to proactively self-manage dynamic stressors; medication or substance withdrawal; acute physical health needs; relationship dynamics within quarantine

Care Planning in collaboration with individual and on-site supports, including their ability to access support (consider IT/data/literacy/language) when needed and effective, available coping strategies

- **IT Access and Support options:** Discuss local options for support with Community Recovery (DCDSS) within the local quarantine multi-agency team.

Facilitate connection with established and ongoing primary and specialist mental health care providers and community supports where possible

Check transitions of care and active post-quarantine support is in place for those who need ongoing MHAOD services, in anticipation that coping and problem-solving ability may decline post-quarantine as other life stressors increase.

7.2. Active Care Collaboration with Partner Agencies

- **Establish key periods** during the 14-day quarantine cycle when distress and dynamic stressors occur within the environment and plan to enhance support at these times
- Provide **consultation and liaison services** to agency partners about presenting mental health and acute risk concerns.
- Use local **stepped care PHN process** for mental health assessment and support, and facilitate referral supports into HHS services when appropriate.
  - Refer to Appendix 1. MHAOD Stepped-Care Support Options for broad mental health support options
- **Check-in daily** with ARC, Community Recovery, Hotel staff and other involved agencies about current issues and concerns within the Quarantine facility
- **Provide timely feedback** about actions taken by mental health services and how partner agencies can support individuals and staff to resolve current issues, within bounds of confidentiality
- **Provide education and information** resources to support staff to help manage the stress of the quarantine environment

7.3. Engage Prevention and Early Intervention

- Support individuals to develop a **coping and support plan to self- manage** the quarantine environment and current stressors
- Use **environmental and sensory approaches** where possible to enable self-management of acute stress
- Provide **access to education, information and strength-based activities** across age and developmental range
- Consider **early screening and support** for individuals with **sensory impairment needs** or who are likely to have **acute trauma triggers** in quarantine environment

7.4. Collect and document information

- Document **routine information collection accurately, including the number of people in quarantine, referrals into and out of mental health services and transitional care provided,** as this may be used to inform feedback and development of the service
- Development of a National Dataset and measurement tools is underway, and this Guideline will be amended to incorporate these once available.

8. Document approval details

Endorsed 15 September, 2020
Dr John Reilly Chief Psychiatrist
Department of Health
Mental Health Alcohol and Other Drugs Branch

9. Appendix 1: Queensland Health Quarantine Accommodation Response Protocol (April, 2020)

Appendix 2: Mental Health Alcohol and Other Drugs Stepped care support Options (Revised August, 2020)
Appendix 3: MHAOD COVID-19 Clinical Advisor: Metro North Pathway to Care
Appendix 4: Recommendations of the National COVID-19 Health and Research Advisory Committee (NCHRAC, July 2020).

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National COVID-19 Health and Research Advisory Committee

Date of advice: 19 May 2020

Advice 4: Mental health impacts of quarantine and self-isolation

Recommendations:

The National COVID-19 Health and Research Advisory Committee (NCHRAC) recommends to the Chief Medical Officer and the Australian Health Protection Principal Committee (AHPPC):

1. Develop equitable and effective ways to extend and enhance high and low intensity mental health service delivery to people in quarantine and/or self-isolation via telehealth and digital services.
2. Develop an assertive and proactive service response consistent across all jurisdictions to support people subject to quarantine – screening linked to multidisciplinary care and a mental health and wellbeing service (that is beyond pointing out the availability of digital services) should be offered to everyone in quarantine from day one.
3. Ensure that screening includes a mental health assessment for people entering quarantine to identify vulnerable people. Wherever possible this assessment should take place prior to commencement of quarantine and inform decisions about the venue and facilities that should be provided.
4. Ensure that venues chosen for people in quarantine and self-isolation provide safe access to open space and green space, and safe spaces for escape from stress or abuse.
5. Collect and analyse real-time data about mental health and suicidal behaviour of people in quarantine and/or self-isolation, with rapid translation to service providers.
6. Ensure data about the number of people in quarantine are added to data dashboards for policy decision-makers at a national level, including service uptake and outcomes for this group. Consider making data about the number of people in quarantine public.
7. Develop and disseminate national guidance for the mental health workforce about the effective and consistent delivery of mental health services to people in quarantine or self-isolation, and their family and friends.
8. Engage with and support relevant groups/communities to ensure that measures to address mental health impacts of quarantine and self-isolation support self-determination and are appropriate, feasible, equitable, safe, and group specific.
9. Complement and extend the reach and impact of official advice and information using various media channels (e.g. social media), community champions and real-world coping tips in response to quarantine and self-isolation.

10. Collect information about positive experiences in quarantine and self-isolation to inform future responses and policy reform in the medium to long-term.

11. Note that experiences and impacts for people in quarantine or self-isolation are likely to be similar to those that the general population experience, although probably more severe in scale, intensity and duration.

Focus:

This advice focuses on actions to address mental health issues and/or suicide risk associated with severe restrictions on movement and social interaction imposed by quarantine and self-isolation measures. Quarantine refers to mandated isolation by authorities or on medical advice and is often carried out in hotels or other government identified living arrangements. Data are not routinely released publicly on the number of people in 'hotel' style quarantine. In the current period, there are probably around 5000 or so people in quarantine around Australia on any particular day. As jurisdictional border restrictions are eased and international travel resumes the number of people in quarantine could be expected to fluctuate.

Self-isolation can include 'staying at home' following public health order advice or medical or other authority advice. Both quarantine and self-isolation impose more severe restrictions on movement and social interaction than physical distancing and are required for people who have returned from overseas, and in some cases across jurisdictional borders, or been in contact with someone with COVID-19 disease, or have themselves got COVID-19. People at high risk due to existing health and mental health conditions may also choose to self-isolate. The general mandated period of quarantine is 14 days, although this period is extended if the person isolating develops symptoms and/or tests positive for COVID-19.

This advice is point in time and may need further review as more evidence is available.

Conclusions:

NCHRAC conclusion 1: Social isolation and quarantine have an impact on the mental health of the whole population with a disproportionate impact on some groups.

NCHRAC conclusion 2: Responses to address the mental health impacts of the pandemic should be co-designed with communities to ensure they support self-determination and are appropriate, feasible, safe and group specific.

People's experiences of self-isolation and quarantine are likely to differ depending on environmental, demographic, social, cultural and individual factors.

There are specific vulnerable and priority populations within the community who will need tailored, collaboratively built solutions, including:

- people with pre-existing mental health conditions and/or with a history of self-harm, suicidal behaviour or suicide attempts
- Aboriginal and Torres Strait Islander peoples/communities
- LGBTIQ+ people/communities
- health care workers
- people who live in institutional settings (e.g. residential aged care, prisons, detention)

- migrants and refugees
- culturally and linguistically diverse groups
- older people
- children and young people
- people with complex/chronic illness
- people who are supported in the home (e.g. older people, those with disability) who may not be able to safely achieve self-isolation
- people subject to family violence
- people with comorbid drug and/or alcohol dependency
- people in rural and remote communities.

Responses may also need to address increasing levels of stress to restrictions being eased, particularly in people with disabilities, chronic health conditions and some health workers.

NCHRAC conclusion 3: More assertive and proactive service responses, consistent across all jurisdictions, are needed to support people in quarantine as jurisdictional and national border restrictions are eased.

Support for those in quarantine should involve screening to identify vulnerable people and assertive outreach from day one, and coordination between state/territory services and national digital support services. Key measures include personal connection, regular check-ins and proactive support. Follow up after release from quarantine should be undertaken for people who have found the experience distressing.

NCHRAC conclusion 4: Environmental factors intersect with mental health and wellbeing and should be addressed for those experiencing self-isolation and quarantine.

Physical isolation and its immediate impact on individuals' mental health and wellbeing will be exacerbated where the person is in quarantine with the additional constraints and lack of individual choice such circumstances entail. Choice of venue particularly for quarantine, should take into account its physical structure, so that people have safe access to open space and green space. Being able to breathe outdoor air and having windows to be able to see outside can help reduce a feeling of being trapped in a small space. Venues should also ensure access to safe places for escape from stress or abuse when quarantine involves more than one person or a family group.

NCHRAC conclusion 5: Service delivery for mental health via effective and accessible telehealth and digital services should be extended and enhanced, with support for the mental health workforce to provide these services effectively, equitably and consistently across all jurisdictions.

NCHRAC conclusion 6: Service delivery via telehealth and digital services should be integrated with multidisciplinary care and face-to-face care into the future.

Isolation driven by the COVID-19 pandemic has shifted much service provision online. Greater investment in low and high intensity telehealth services could be a cost-effective means of expanding choice and access to health/mental health services, with particular benefits for rural and remote locations where people might otherwise be unable to access support.

The pandemic and the response to it could exacerbate existing social and economic inequities including digital inequity in terms of both access and affordability. Enhancement of telehealth and digital services must be done carefully so as not to embed and increase existing inequities. There should be support for those who cannot, or do not, access digital services.

Guidelines and resources should be developed for mental health workers to ensure that telehealth and digital mental health services are delivered effectively, equitably and consistently across all jurisdictions.

NCHRAC conclusion 7: There should be rapid investment and active support for the collection and analysis of real-time data about mental health and suicidal behaviour with rapid translation to service delivery.

Solutions include the collection and use of existing population-wide data sets in identifying needs, determining actions and evaluating outcomes of interventions. Real time data collection will dynamically inform policy responses and ensure we are well equipped for future pandemics and other disasters.

While quarantine/social isolation associated with Australia's policy responses to the pandemic are similar to other countries, international data and research may not be directly applicable to the Australian situation. Similarly, applying research based on short term disasters with rapid response and recovery (e.g. cyclones, bushfires) to this situation is not always appropriate. Local research is needed, including that which anticipates possible new outbreaks of the virus.

NCHRAC conclusion 8: Positive lessons from the recent experience should be identified and analysed to inform future policy reform in the medium to long-term.

History shows that major disruptions can cause fundamental shifts in social attitudes, beliefs and behaviours. They can also transform policy and practice. There are some indications that the physically distancing has led to increasing social solidarity which is expressed as care for neighbours and positive connection within neighbourhoods.

The community's adherence to official advice and rules will continue to be critical to future success. Behavioural science indicates people will be influenced and persuaded by a range of voices and methods. The reach and impact of official advice and information should be enhanced using community champions, real-world coping tips and various media channels.

Background

The public health response to the COVID-19 pandemic, including physical distancing and isolation to prevent the possible spread of the virus to other people, is likely to affect the mental health and wellbeing of the whole population, regardless of whether people are directly impacted by COVID-19 infection.[i] Furthermore, there is strong evidence from previous pandemics and other disasters that mental ill health and suicide increases during both the crisis and recovery phases.[ii] Almost all people affected by emergencies will experience some level of psychological distress. This will be mild and transient for most,while others will experience escalation of acuity or short term mental distress. Some may suffer a long-term decline in mental health and wellbeing.[iii]

Quarantine and self-isolation impose more severe restrictions on movement and social interaction than physical distancing and will have specific impacts for people affected. Some of the experiences and impacts for people in quarantine or self-isolation are shared with the general population, such as experiences of isolation and disruptions to usual activities, although they are likely to be more severe in scale, intensity and duration. Specific distress feelings may include feelings of loneliness, fear, sadness, grief, loss, helplessness, boredom, anger and disconnections from social networks.[iv,v,vi] The interactions between these various forms and intensity of isolation are discussed in the broader issues paper at **Attachment 1**.

Other considerations

In the course of developing this advice, NCHRAC identified the following considerations that were out of scope for this advice, but are important and related considerations:

- short, medium and long term mental health impacts of physical distancing and other public health measures on the community, which are likely to be wide spread
- the essential role of mental health and wellbeing to Australia's recovery from the pandemic
- assisting people to adjust to changing conditions as public health measures change, and
- options to address the social determinants of mental illness as part of whole of nation recovery to build resilience, mental health and wellbeing for the future.

Attachments

Attachment 1: Issues Paper: Mental health impacts of quarantine and self-isolation

Attachment 2: NCHRAC Mental Health Working Group

References

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Issues Paper: Mental Health Impacts of Quarantine and Isolation

1 Purpose

This issues paper sets out key issues relating to the topic: *mental health impacts of quarantine and isolation in the context of the COVID-19 pandemic*.

2 Background

There is strong evidence from previous pandemics/disasters and broader research that there are risks of increasing mental ill health and suicide during the crisis and recovery phase. Almost all people affected by emergencies will experience some level of psychological distress.[i] While for many this will be mild and transient, for others, this will manifest in acute short term mental distress and for others this experience may result in a long-term decline in mental health and wellbeing.

While previous epidemics have impacted greatly on the mental health and wellbeing of specific communities (e.g. HIV's impact on the LGBTI community), what makes the COVID-19 pandemic different is, not only the speed and spread of the disease, but the scale of the mental health and wellbeing impacts, potentially at the whole of population level. This means the impacts on mental health and suicidality may be deeper and long-term, both for those already living with mental health challenges and mental health issues emerging in people with no prior history.[ii]

It is also important to note that COVID-19 impacts are occurring in the context of a system where many or even most people cannot or do not access the services they need to achieve their best possible mental health. Prior to the introduction of social distancing and quarantine measures, around 10 million Australians were already experiencing poor mental health, with young people disproportionately impacted by mental health issues.

Broadly, quarantine (enforced by authorities/medical advice) and physical distancing/isolation (including by 'staying at home' and following public health order advice) can be associated with varying degrees of isolation, anger and fear[iii], and potential disenfranchisement and resentment as measures continue with little evidence of infection in the community. [iv] They are also likely to result in significant effects on time use for individuals, ranging from a decrease in productivity and the associated feelings of boredom and loneliness through to significant increases in demands and unpaid labour particularly for working parents, with the associated feelings of family stress and personal exhaustion. All of these experiences increase the risk of negative mental health outcomes in the short and long term.[v] However, there is also a need to balance the possible benefits of quarantine and social distancing, including the sense of safety and security they can provide for the community, with any call for relaxing measures.

The situation for Australia is further complicated with a drain on resilience for many in the Australian population following layers of trauma from multiple events within a relatively short period of time (3–5 years). These include a very significant and widespread drought, severe bushfires across multiple states, floods and now the global pandemic. For young people in particular, climate change in general may also be weighing on their minds. Each event in Australia has required individual responses and the integration and implementation of these different approaches within the current pandemic is complex.

The circumstances created by responses to the pandemic will be likely to significantly increase risk factors and decrease protective factors in mental ill health and suicide in both the short and long term[vi], including the realities of economic recession bringing the threat of economic insecurity, significant increases to unemployment and business stress, more social isolation, more homelessness, decreased educational engagement, poorer family relationships, decreased exercise and access to green space, increased alcohol and drug use and gambling, and experiences of trauma, loss and grief.[vii][viii][ix]

We can become myopic and insular when under threat. But crises often mark strategic inflection points and a necessary focus on the present should not crowd out considerations for the future. History shows that major disruptions can cause fundamental shifts in social attitudes and beliefs, and policy and practice transformation. One positive from this crisis is that it has forced us to find rapidly more flexible, more creative, and more effective ways of working, connecting socially, and delivering mental health services and support We may see at a population level the phenomenon of peri- and post-traumatic growth; a greater focus on social solidarity, looking after neighbours and our health and wellbeing.

Acknowledging that while some communities may emerge strongly, some others communities may need to be 're-built' as a result of the pandemic is an important first step to developing policy responses. Mental wellbeing is a foundation to rebuilding communities after the pandemic.

3 Key Issues

3.1 Immediate to short term

Physical isolation can have an immediate impact on individuals' mental health and wellbeing. This will be exacerbated where the person is in quarantine with the additional constraints and lack of individual choice such circumstances entail. The following issues identify key risks and likely experiences of the community in the short term.

3.1.1 Psychosocial

In the immediate response phase of the pandemic, there are significant risks to mental health relating to the interplay of environment and social factors and individual thoughts and behaviours. Risk factors include:

- Heightened feelings of loneliness, fear, sadness, grief, loss, boredom and disconnection from social networks.[x,xi,xii]
- Impacts of lack of physical touch on physical and mental wellbeing, which may be greater for people living alone.[xiii]
- Exhaustion and family distress in managing increased and conflicting time demands, particularly for those expected to fulfil multiple roles and undertake increased unpaid labour.
    - Some households can become a crowded space with unrealistic demands on levels of productivity – across the domains of caring for/supervising children; increased housework due to everyone being at home; and expectations that paid work can be transferred into the home and completed to the same level and intensity as before. The rapid nature of this change and increase in work adds to the stress.
    - In addition, more emotional labour is required to maintain or develop positive relationships within and outside the household (such as supporting members of extended families and supporting friends).
- Increased incidence of family violence.
- Increased child abuse and lack of opportunity for children to signal their distress to others, with many at risk children no longer 'visible' to school, day care, etc. Many have predicted an increase in reports of child abuse post pandemic as children cannot escape abusive parents and if rates of drug and alcohol use increase, this will create greater risk. For those children already in the child protection system, the isolation measures may also disrupt the contact with family or reunification.[xiv]
- For LGBTI people who already experience issues in the home, these will be exacerbated. For example, for young LGBTI people who are living in unsafe homes, school may have been the only safe place for them. Without this support there is increased risk of mental illness.[xv] With social spaces closed connection and validation may be harder to access and experience.
- Potential for triggering the re-emergence of past trauma.

- Feelings of grief and loss caused by disruption of social and religious ceremonies and rites (e.g. Easter, Ramadan, funerals and christening/naming ceremonies), as well as lack of access to social inclusion and community aid programs that usually offered by cultural and religious groups. There is cultural and personal diversity in response to grief and loss.
- Disruption to grief and loss processes, including not being able to grieve the loss of a family member 'appropriately' due to restrictions caused by health conditions, as well as restrictions on social and religious rites associated with loss (e.g. funerals).
- Anxiety regarding travel and the circumstances of family members in different communities, states or countries.
- Anxiety over privacy and data security, including in the context of working from home (sharing home spaces) and potential or risks of hacking or a misinterpretation of information due to the medium used (e.g. consumer unable to get information across effectively in a telephone conversation; communication error, including medical error).
- Concerns of returning home and transporting the virus to vulnerable communities for people from rural, regional and remote areas and Aboriginal and Torres Strait Islander peoples living away from their community.
- Specific issues associated with mandated quarantine confinement; and sense of rights being withheld, confined spaces and isolation (overseas travellers quarantined in hotels).
- People's experiences of self-isolation are likely to differ depending on cultural factors as well as individual factors such as role, role pressures, family relationships, employment status, job security and workplace expectations around productivity while working from home.
- Increased fear of experiencing racism, which may cause people already experiencing or fearing racism to isolate further than required, or be on high alert for each time they leave their home on top of virus avoidance.
- A common feeling across different situations and family / household members is 'I want to get out of here but I can't!'.
- Residents in aged care facilities are experiencing isolation where visits have been stopped or restricted and this situation creates stress for relatives especially in light of the issues being raised in the Royal Commission.
- People living with severe disability are unable to completely self-isolate because they rely on carers and are concerned about their greater likelihood of exposure.
- Health workers (including GPs, emergency workers, allied health, etc.) may experience mental distress through concerns about shortage of PPE and threats to their own and families' health.

In specific age cohorts:

- Children: May have problems with anxiety and depression during isolation and/or experience separation anxiety with difficulty returning to school later. Anxiety in children (under 12) and youth (12 and over) is quite different in presentation and treatment.[xvi, xvii.]

- Young people: As young people already experience high rates of mental ill health, it is likely they will be seriously impacted in the both short and long term. Social networks can be critical coping mechanisms for young people with mental health challenges. Prevention and early intervention is critical.
- Older people: May suffer significant anxiety and depression related to the isolation and fear of dying. As they will be far less amenable to usual counselling methods, some of the telehealth programs may not meet the need. Often in the elderly there is less psychological responsiveness and medication is often used to treat these disorders but older people may feel less capable to attend clinics due to the fear of infection or not be able to use a telehealth service without assistance. People with early dementia but still at home will be very vulnerable. Ageism is also an emerging issue, especially in the form of lack of self-determination where older people may not be consulted or involved in decision-making about their activities by well-intentioned family members or carers.

3.1.2 Economic/financial

- Significant increases in job and business insecurity, underemployment and unemployment and threat of redundancies.
- Disparities in time use whereby some workers are being expected to work longer hours (e.g. healthcare workers), some workers have significantly greater unpaid work (e.g. parents with students learning at home), and some workers have lost all or part of their paid employment.
- In the immediate response, those unemployed prior to the pandemic will have mutual obligation requirements removed from some income support payments (i.e. job seeker) and income effectively doubled through increases to income support payments with the economic stimulus packages. This however will be removed and some income support payment recipients may experience a 'cliff' effect as they return to normal conditions.
- A psychosocial/financial issue to consider is tenants having to negotiate with their landlords for rental reduction. This process is not easy for anyone but new migrants and those who are targets of racism will face additional challenges.[xviii]
- Financial stress issues may be exacerbated for older Australians planning for retirement. The immediate effect of the economic downturn has seen as much as 25% wiped from superannuation balances. This will increase anxiety for those affected, have workforce implications for older people who need to remain employed for longer than planned. This is also particularly true for mental health carers, the majority of whom are older women and who experience greater disparity in income and retirement savings.[xix]

3.1.3 Education

- Pressure within households to provide educational opportunities within the home including supervision of online schooling in a model that has not been tested before and is likely to increase educational inequities given the different capacities of families to support students with digital hardware and connectivity, physical space within households and educational support for learning tasks (different to remote learning).
- Added difficulty for people who are new to Australia, particularly parents who come from a non-English speaking background and the expectations on them to ensure their

children are receiving equal education opportunities. This puts enormous pressure on these parents and their children.

- Potential decrease in access to education supports for those children and young people with additional special needs.
- Concern for final year students in not completing their studies and sitting for final examinations as they have been preparing to do so for a number of years.
- Anxiety over whether sustained period of home schooling creates risks for all students falling behind, particularly in families and communities with the fewest resources, and among students seeking to transition from primary to secondary school.
- Experiencing a loss of 'rite of passage' for students at major transition stages (such as entering year 7 or exiting at year 12).
- Pressure on international students, such as guilt around the cost of the degree and missing contact hours and lacking emotional support while in Australia.

3.1.4 General health

- People with severe, complex and acute mental illness or chronic illness seem to be less likely to access regular or emergency health care during the pandemic, due to lack of availability, levels of anxiety around presenting to a hospital or medical 'place'. This will not only place their mental and physical health at greater risk but also increases the risk of acute episodes spiking/peaking at a later point in time.
- COVID-19 driven isolation has led to a shift of a significant amount of service provision online. There are both risks and opportunities in this shift. The risks will be greater for people in lower socio-economic groups. Consideration should be given to further assessing the risks, as well as the opportunity to maintain a more flexible, effective health system long term. Greater investment in telehealth could be a cost-effective means of expanding choice and access over the longer term, with particular benefits for rural and remote locations where people might otherwise be unable to access support.
- Remote communities face challenges to access services and the internet is patchy. Some Indigenous remote communities have expressed anxieties about being 'left to die' as they will not be prioritised for treatment due to co-morbidities, disadvantage, remoteness and racism.

3.1.5 Mental illness and suicide

- There is an increased likelihood of mental health issues emerging in those who have never had them previously (with some estimates saying there can be a 20% rise in new presentations of serious illness including PTSD within 3-6 months of the significant event). We should be anticipating these presentations from the drought and bushfires in the short to medium term during the pandemic and then later presentations as a consequences of the pandemic and the multiplier effect of the three catastrophic events converge. Levels of anxiety have already been shown to have increased (SA study).
- People find it hard to ask for help and overcome the stigma in relation to seeking help for mental health issues, noting people may be seeking help for the first time.

- There may be an exacerbation of existing mental health issues due to loss of social structures/networks and support (including lack of progress in recovery) and people's worsening economic situations.
- COVID-19 specific impact on psychosis: Some people with established psychosis may develop delusions around COVID-19 or infection and may have difficulty separating out the COVID-19 responses from illness.
- Suicide behaviour and suicide prevention will need to be addressed discretely and not just as a flow on or sub-set of mental health– especially as in a time of crisis the risk factors for suicide may be as much around circumstance and coping difficulties with distress, as the onset of mental ill health (refer: Crisis Theory). Advancing the social connection and support elements of wellbeing are highly relevant to suicide prevention – and are being critically challenged through the COVID-19 period (actions to address will need to be broader than a health response).
- Reinforce the importance of maintaining and ideally increasing existing mental health facilities and programs in hospitals, acute and sub-acute psychiatric services, community mental health services. There is a risk – as has happened in some other countries – that mental health services will be diminished to address the disease control for COVID-19.

3.2 Medium to long term

Physical isolation and distancing measures are likely to have significant mental health impacts in the medium to long term, particularly for those who were already vulnerable. It is this period that social and economic determinants of health can either support whole of population mental health or detract from it. Consequently responses to support mental health need to consider employment, education, housing, community infrastructure, and income and wealth distribution as much as the provision of services. The following issues identify key risks and likely experiences of the community in the medium to long term.

3.2.1 Psychosocial

- There are likely to be long-term impacts on family and personal relationships because of their experiences during isolation or quarantine – which can be severe for households with pre-existing or emerging issues from poor relationships to family violence.
- People with psychosocial disability may experience an increase in their presentations or exacerbation of their mental illness because of additional anxiety or periods when access to usual supports has been decreased or removed.
- There may be increased instances of racism as we come out of the quarantine/isolation stage.
- Demoralisation because of change or fear of future outbreaks is a significant danger.
- Some people may experience survivor guilt, or the guilt someone might feel if they are responsible for carrying the virus into a residential aged care home, for example.
- People who were infected with COVID-19 may experience stigma (both internalised and directed from the community).
- There may be widespread experience of burnout, particularly of healthcare workers and first responders.

3.2.2 Economic/financial

- High levels of underemployment and unemployment are likely to remain for some time during the recovery phase with associated prolonged financial distress. People may be experiencing chronic housing insecurity and risk of homelessness.[xx]
- The longer-term impact of carrying debt (possibly a generational issue) particularly for young people who are already feeling anxious about long-term global issues such as climate change.
  Increased anxiety for people who cannot meet existing debt and may lose their homes and or businesses.
- For those receiving income support, the impact of concerns about the 'return to normal' (with income reducing) as the situation eases.
- Concern in many industries about the future of the sector given the changes brought by the pandemic (including food and wine industries and universities as well as arts and cultural industries).

3.2.3 Education

- There may be an increased number of young people disengaged from education across all levels – including tertiary.
- Universities are facing multiple problems raising mental health issues for staff (especially the large number of casually employed) and students and there are significant fears for the long-term prospects of the sector.
- Child development – extended periods of isolation potentially mean less social interaction and play with others, and the laying down of the foundations for positive behaviours and resiliency that last into adulthood.

3.2.4 General health

- Reduced exercise and increase in unhealthy or reactive habits while in isolation (food intake, alcohol consumption) can result in short and long term negative mental and physical health outcomes. Increased alcohol consumption and use of other drugs, and on-line gambling can also negatively impact on levels of family violence.
- Demoralisation leads to poor physical health by all the mechanisms above.

3.2.5 Mental illness and suicide

- Mental health issues may not emerge for some time after the initial onset of the pandemic.
- There is a well document escalation of suicide risk after the initial onset of the pandemic. For example, SARS saw a 30% increased risk in people over 60 years in some countries. Following the GFC (global financial crisis), internationally, there was a 4–18% increase in suicides in middle age men who were unemployed.
- Anxiety levels may remain high due to uncertainty.

3.2.7 Birthing Practices (particularly for Aboriginal and Torres Strait Islander communities)

- Inability for women to have the usual number of support people accompanying them at birth – reduced now to only one. This has a negative impact on the woman giving birth and on those who would normally support her feeling rejected at a time of great psychological importance.
- Difficulties with bonding of parents especially mothers to new infants.
- Social isolation for new mothers at a time when they are most needing support and encouragement.
- Lack of engagement with aging mothers / aunts / grandmothers due to infection fears and inability to travel to be with family.
- Late presentations to local health services (non-maternity) to avoid hospital.
- Risk of increased rates of ante and post-natal depression.

4 Priority Populations

There are specific vulnerable and priority populations within the community who will need tailored, collaboratively built solutions. Including:

- people living in poverty, including homeless
- Aboriginal and Torres Strait Islander peoples/communities
- LGBTIQ+ people/communities
- unpaid family/friend carers
- parents
- health care workers
- school communities, teachers and families
- people with pre-existing mental health conditions
- people who have had COVID-19
- people who live in institutional settings
- migrants and refugees
- culturally and linguistically diverse groups, particularly with respect to messages and accessible communications
- older people
- young people (who often show mild or no symptoms yet can still be spreading the virus, and who are also likely to suffer from the economic impacts of the pandemic)
- people with complex/chronic illness
- people with psychosocial disability
- people with disability – both physical disability and cognitive disability (with fears of increased risk of fatality due to the virus causing anxiety and stress and a reluctance to access health services for fear of catching the virus; and a decline in service usage due to closures of various community services)
- people subject to family violence, and
- people bereaved by COVID-19 (including loved ones who have passed away both in Australia and overseas).

5 Considerations

5.1 Equity issues

- The pandemic and response to it could exacerbate existing social and economic inequities including digital inequity in terms of both access and affordability.

5.2 System deficiencies

- To address mental health issues and increased risk of suicide it will be important to consider an outreach approach but the current system is not well equipped for such an approach, particularly for those who have disengaged with treatment during the pandemic.
- In addition, parts of the mental health services system which were already stretched prior to the pandemic may experience a surge in usage as we come out of the pandemic.
- Not everything can be dealt with by a professional or health response and so social networks, volunteerism need to be strengthened.

5.3 Solutions

Any proposed actions will need to include but also move beyond a health response and consider:

- Equipping the NGO sector to scale up operations to respond to an increasing need for services in terms of services to Aboriginal and Torres Strait Islander people Aboriginal community controlled services should be preferred provider of services.
- Research to increase the body of evidence on the impact of pandemics on mental health.
- Developing more effective and accessible digital solutions to providing mental health care.
- Developing capacity in remote communities to undertake mental health work, with back up from specialist services.
- Support for parents, such as training to deal with anxiety and more knowledgeable about how to build a child's resilience would be a positive outcome.
- Strengthening long-term mental health, social welfare structures.
- Implementing mental health screening, data collection and follow up for people who have been hospitalised with COVID-19.
- Working with local government to strengthen community facilities such as neighbourhood houses and community centres to be active in community development activities.
- Co-design with community as the key stakeholder including people with lived experience; engaging with other Australians and the concept of social solidarity.
- Nation building employment; focusing employment programs on activities that rebuild and enhance society and prepare Australia for the future.
- A focus on sophisticated, clear communication that is consistent across response and recovery phases and that uses community channels and influencers in addition to traditional official channels.

- Integrated models of care across a federated system, with a focus on family and community-recovery oriented practice and a range of delivery mechanism including one-to-one consultations and therapeutic and other support groups.
- Increasing the opportunities for GPs as the first port of call, to e-learning education around mental health issues.
- Collection and use of existing population wide data sets in identifying needs, determining actions and evaluating outcomes of interventions. There is also an opportunity now to commence a highly valuable data collection exercise in real time which will inform policy responses and ensure we are well equipped for future pandemics/disasters.
- Short, medium and long term planning to identify specific actions and recommendations across each phase of the pandemic and those forecast for the future.

5.4 Cautions

- There are limitations to the transposition of international data to the Australian context; while Australia is feeling the full effects of quarantine/social isolation associated with policy responses to the pandemic, we are not (to date) experiencing the same morbidity and mortality impact of the virus as some other countries. Australia is currently doing well in the response to COVID-19 and international data and research may not be directly applicable to the Australian situation. Similarly, applying research based on short term disasters with rapid response and recovery e.g. cyclones or even bushfires to this situation is not always appropriate. Local research is needed, including that which anticipates possible second waves of the virus as is currently being seen in Japan.

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