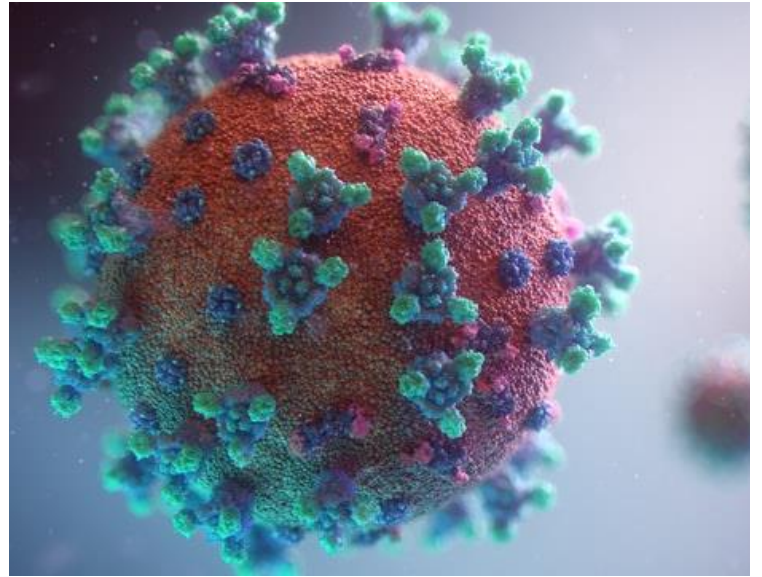


PSYCHOLOGICAL DISTRESS AND COVID-19



A Review of the Literature and Suggestions for Clinical and Forensic Practice

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16th April 2020



Government
of South Australia

SA Health

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INTRODUCTION

In late 2019, an outbreak of novel coronavirus (COVID-19) was discovered in Wuhan, China, which has now spread globally to 113 countries. To date, there are over 2 million confirmed cases and almost 130,000 deaths from COVID-19 worldwide. These numbers are likely to increase significantly as the spread continues on all continents. The World Health Organisation declared COVID-19 to be a pandemic on March 12th, 2020, which denotes a global outbreak of the disease (WHO, 2020b).

Pandemics are characterised by a sense of urgency and are frequently marked by confusion and uncertainty. In the early stages of a pandemic, there is often limited information and ample uncertainty about the severity of the disease and the odds of infection, as well as possible misinformation about the best methods of prevention and management (Kanadiya & Sallar, 2011). Uncertainty can persist even into the latter stages of the pandemic, when there are questions as to whether the pandemic is over. While initially high levels of anxiety will subside for most over time as the virus is contained, for health care workers, those quarantined, and individuals with life-threatening cases of COVID-19 there are likely to be increased risks of long-lasting mental health problems (Black Dog Institute, 2020). The indeterminate nature of the COVID-19 pandemic, in terms of outcomes and length of impact, is also likely to contribute to poor psychological wellbeing in all.

The impact of the COVID-19 pandemic on communities worldwide has been far-reaching, with safety measures having been implemented by governments worldwide, involving social distancing and self-isolation, mandated isolation and quarantine, and the restriction of public activities and services. These measures have resulted in mass unemployment, shortages of basic food and other supplies, social isolation, and downturns in the world's stock markets. In addition, there has been increased pressure placed on essential services (i.e. healthcare, supermarkets, social security systems) as they struggle to cope with the sudden increased demand on their services.

As the pandemic continues, people may be called upon to care for sick family members and friends and be exposed to the death of loved ones including children either in person or through the media, which can be especially traumatizing. Traditions around death, dying and grief may not be able to be observed, due to social distancing and other safety measures, which may be experienced as traumatic and dehumanizing (Schoch-Spana, 2004). The psychological impact of mass deaths on the general public also needs to be considered, as this is likely to leave people susceptible to adverse psychological symptoms (Ursano & McCarroll, 1990).

Therefore, a pandemic such as COVID-19 has the potential to significantly affect the psychological wellbeing of many people worldwide in both the short- and long-term and in many differing ways, similarly to what has been observed in past pandemics. As a psychologist working in the current climate of COVID-19, it is important to consider both the impact of COVID-19 on psychological wellbeing and the psychology behind how people cope with the threat of pandemic infection and potential loss of life. In doing this, it is imperative to draw on the learnings from past pandemics and the psychological responses to them.

The purpose of this document is to provide a review of the literature on psychological distress arising from virus outbreaks, and to offer some practical strategies around providing psychological services during this time.

Elevated psychological distress in the early stages of the COVID-19 pandemic in China has been documented (Wang et al., 2020; Javardi et al., 2020), with more than half of the Chinese respondents in the study by Wang and colleagues having rated the psychological impact as moderate-to-severe, and about one-third reported moderate-to-severe anxiety. Similar results were reported in the early stages of the SARS pandemic of 2003, where several psychiatric comorbidities such as depression, panic, anxiety, psychomotor excitement, suicidality, delirium, and psychotic symptoms were reported (Xiang et al., 2020). In the H1N1 (Swine Flu) pandemic in 2009, there was evidence of significant anxiety in response to the outbreak (Rubin et al., 2009) and widespread avoidance behaviours and negative psychological responses, which were more prevalent in females, older people, and those who were not employed full-time (Lau et al., 2010). Similarly, a study exploring people's emotional and behavioural responses to the Avian Flu outbreak found that females and older people were more likely to express negative emotional responses and exhibit avoidance behaviours in response (e.g., avoiding leaving their residence, avoiding crowds and avoiding visiting hospitals; Smith et al., 2009).

Other psychological consequences have been extensively documented in both the current COVID-19 pandemic and in previous pandemics, epidemics and viral outbreaks. The literature suggests possible negative psychological outcomes both during and after the health crisis including:

- Elevated stress levels and worrying levels of psychological distress (Lee et al., 2007);
- Elevated symptoms of depression (Qiu et al., 2020; Mak et al., 2009; Lee et al., 2007);
- Anxiety (Qiu et al., 2020; Lee et al., 2007);
- Worries about loved ones getting ill, worry about possible symptoms being present, and the absence of a definitive treatment for COVID-19 (Maoukaddam and Shah, 2020);
- Posttraumatic stress (Lee et al., 2007; Mak et al., 2009);
- Panic disorder (Qiu et al., 2020);
- Exacerbation of obsessive-compulsive symptoms, specifically contamination obsessions and cleaning and washing compulsions (Maoukaddam and Shah, 2020; Wheaton et al., 2012). It was predicted that the success of cognitive-behavioural therapy techniques for excessive health anxiety (e.g. psychoeducation, cognitive restructuring, exposure therapy) may be undermined by frequent media reports documenting the spread of the disease (leading to over-inflated estimates of likelihood) and the need to employ stringent precautionary measures (leading to excessive estimates of severity) (Wheaton et al., 2012);
- Adopting a more pessimistic outlook on life (Peng et al., 2010);
- Increases in suicide deaths (Cheung, Chau and Yip, 2008; Mak et al., 2009);
- Poorer objective and perceived quality of life after 12-24 months follow-up, in those who survive infection (survivors of MERS - Batawi et al., 2019, SARS - Ngai et al., 2010, swine Flu/H1N1 - Luyt et al., 2012, and Avian Influenza - Chen et al., 2017);
- Elevated fear and safety behaviours being correlated with general distress, contamination cognitions, disgust sensitivity, body vigilance, and anxiety sensitivity related to physical concerns (Ebola virus – Blakey et al., 2015); and
- Increased psychiatric morbidity in general (Peng et al., 2010).

In a review of the literature on employees in disaster-exposed organisations (Brooks et al., 2020), it was postulated that some people who have to contend with significant challenges - moral or traumatic - experience a degree of post-traumatic growth (a bolstering of psychological resilience, esteem, outlook, and values) after exposure to highly challenging situations. This may also be the case in the COVID-19 pandemic.

There have also been a number of positive health related impacts associated with epidemic/pandemic documented, including reports of individuals caring more about the feelings of family members, perceiving more support from family/friends, sharing feelings more with others when unhappy, paying more attention to mental health concerns, and taking more time to engage in rest, relaxation and exercise as a result of having been through a pandemic (Lau et al, 2006).

There may also be benefits of a degree of anxiety in a pandemic/epidemic, as increased anxiety has been positively associated with the likelihood of engaging in behavioural changes recommended to prevent the spread of infection (e.g. H₁N₁ – Rubin et al., 2009). This speaks to the potential benefits of functional anxiety to focus attention and motivate appropriate, proactive behaviour. However, for those with pre-existing anxiety and anxious thinking styles, worries about contracting COVID-19 could potentially become excessive and lead to severe levels of distress and associated maladaptive coping mechanisms (i.e. avoidance).

Key points:

- The impact of pandemics on psychological wellbeing is extensive, ranging from increased fear to increased incidence of death by suicide. They are also enduring.
- Most commonly reported is an increase in anxiety during and after pandemics. This may, however, encourage behavioural change to reduce the impact of a pandemic.
- The indeterminate nature of the COVID-19 pandemic, in terms of outcomes and length of impact, is also likely to contribute to poor psychological wellbeing in all.
- Females and older adults may be more likely to experience greater psychological distress in response to a pandemic.
- Positive effects of a pandemic may also include increased connection with others, addressing of mental health concerns, and increased self-care.

MECHANISMS THAT CAUSE PSYCHOLOGICAL DISTRESS

In a pandemic, it is vital to be able to predict the cohorts of people who are more likely to experience adverse psychological outcomes, so that measures can be put in place to triage those who are more at risk. In a review by Perrin and colleagues (2009), a number of determinants of adverse psychological outcomes in an influenza pandemic were identified, which included high perceived life threat, low social and emotional support, residing in a high-prevalence region, ambiguity and uncertainty surrounding the given disease, isolation and quarantine, being in the same home or health facility as sufferers of the given disease, low individual education level, female gender, being elderly, personally knowing someone affected by the disease, frequent modification of infection control procedures and public health recommendations, being deprived of family visits (Perrin, McCabe, Everly & Links, 2009).

The myriad of psychosocial issues caused by a pandemic also need to be considered, as they will have a significant impact on the type and severity of psychological distress experienced by affected individuals. In the Iranian COVID-19 outbreak, an array of psychosocial issues, were outlined in a study by Javadi and colleagues (2020), including:

- (1) Abnormal mourning for the death of loved ones;
- (2) Home quarantine and disruption of daily living;
- (3) Increased sensitivity and obsession about cleaning, and washing, as well as having anxiety, worries, and psychological distresses;
- (4) Closure of schools, universities, and offices in some areas, as well as social-educational-recreational and even home-related effects of disrupting these routines;
- (5) Increased sensitivity and overwhelming condition in certain careers due to controlling and curing the disease, and;
- (6) General psychosocial distress in society as well as problems caused by rumours and debilitation of social capital.

The mass closures of businesses, industries, and services in society in a pandemic can lead to widespread unemployment and significant financial stress. In one study, income reduction was found to be the strongest predictor of the development of a psychological disorder in cohort of 300 workers in Beijing, China, where mass isolation was enforced following the 2003 SARS outbreak (Mihashi et al., 2009).

Resiliency and psychological health in a crisis have also been linked with personality factors, such as self-efficacy, tolerance of uncertainty, and locus of control. Self-efficacy plays a key role in stress reactions and quality of coping in threatening situations (Bandura, 1997), as it operates as a cognitive regulator of stress and anxiety arousal. In studies where perceived control is varied experimentally, it has been demonstrated that when people perceive they can exercise some control over aversive events, they display lower physiological arousal and fewer impairments to performance than do those with a perceived lack of personal control, even when subjected equally to the aversive events (Geer, Davison, & Gatchel, 1970; Glass, Singer, Leonard, Krantz, & Cummings, 1973).

An individual's ability to tolerate uncertainty can also influence their ability to cope in a pandemic. For example, in a study of individuals during the Swine Flu/H1N1 pandemic (Taha et al., 2014), it was found that a greater intolerance of uncertainty was related to lower appraisals of self- and other control, which predicted low levels of problem-focused coping and greater reports of H1N1-related anxiety. Additionally,

individuals with a high intolerance of uncertainty were more likely to experience elevated levels of anxiety, were more likely to perceive the pandemic as threatening and also were more likely to use emotion-focused (e.g. emotional expression, emotional avoidance) coping strategies rather than problem-focused coping strategies (e.g. problem solving, cognitive restructuring).

People assessed to have an internal locus of control cope better because they view themselves as being in command of their lives and destinies, whereas those with an external locus of control view themselves as victims of fate with little perceived self-efficacy in being able to influence many life events and outcomes (Perrin et al., 2009).

Exposure to media coverage has also been found to increase psychological distress in the midst of an epidemic or pandemic, even among individuals at low risk for contracting the disease (e.g. Ebola virus – Thompson et al., 2017).

Key points:

- There are various individual and global risk and protective factors associated with psychological response to a pandemic.
- Risk factors for adverse psychological outcomes may include, but are not limited to, disruptions to daily living and occupation, income disruption, increased proximity to others with the disease, low emotional and social support/ connection, increased worry within oneself and society, and media exposure.
- Individuals who perceive greater control over their lives appear to cope better with adversity than individuals with poorer self-efficacy and greater intolerance of uncertainty.

BEHAVIOURAL IMPACTS OF COVID-19

Psychological factors are key in gaining an understanding of the potentially maladaptive and antisocial reactions that can occur in a pandemic, such as stigmatization, aggression, racism, and hoarding behaviours (Taylor, 2019). These behaviours are often driven by fear in the face of a novel threat and associated uncertainty, and meet psychological needs for control, autonomy and power. These behaviours may also include actions that threaten the lives of others or self, through flouting prescribed safety measures put in place to curb the transmission of the disease.

Some recent examples of maladaptive and antisocial behavioural reactions to COVID-19 in Australia include:

- Panic buying (e.g. toilet paper, frozen foods);
- Failure to adhere to social distancing guidelines, continuing to gather in crowds;
- Anger and frustration at staff in essential services (i.e. verbally and physically abusing health staff, supermarkets, police, government workers);
- Refusal to self-isolate when instructed to;
- Behaviours intended to deliberately infect others (eg. deliberately coughing/spitting on people/objects – see Farrell & Tilley, 2020);
- Stigmatizing individuals of Chinese descent, and;
- Increase in incidents of domestic violence (Ollie, 2020)

Stigmatization is unfortunately not uncommon in pandemics, and can be driven by misinformation, fear messaging, and inadequate leadership (Morganstein et al., 2010). There have been examples of shunning, social isolation and stigmatisation from past outbreaks, such as bereaved families and victims of MERS being shunned and socially isolated from the general public even after being treated and declared free of the disease (Shah et al, 2020). In the COVID-19 pandemic, there have already been examples of stigmatisation towards people of Chinese descent (Fang, Renaldi & Yang, 2020), linked to the origination of the virus in Wuhan Province, China.

There have also been reports of increased intimate partner violence (IPV) and violence against children in the early stage of the COVID-19 pandemic (Wanqing, 2020), and we are now seeing this trend in Australia as well, with a recent 75% increase in Australians seeking online help resources for domestic violence (Ollie, 2020). In China's Jianli County, for example, the local police station reported receiving 162 reports of Intimate Partner Violence in February 2020, which is three times the amount reported 12 months prior (O'Donnell, Peterman & Potts, 2020). A similar trend has also been found in the UK (Parveen & Grierson, 2020), and in other crises - reports on previous Australian bushfire crises have indicated increased rates of domestic violence as a direct result of the crisis (Parkinson and Zara, 2013).

All of these maladaptive behaviours have the potential to increase psychological distress in three ways – by harming those directly affected by them, by causing distress to the wider public exposed to them, and by attracting punishments to those engaging in them.

Key points:

- Maladaptive behavioural responses increase during a pandemic due to perceived novel threat and greater uncertainty (i.e. increased psychological distress).
- Stigmatisation and racism directed towards those of Chinese descent, aggressive behaviours, and hoarding are among the most common anti-social reactions to COVID-19. Domestic violence is expected to increase in Australia during COVID-19, and has increased in countries with earlier outbreaks.
- These behaviours, in turn, are expected to exacerbate psychological distress on an individual and societal level.

VULNERABLE POPULATIONS

As in any crisis situation, there are some cohorts of society who are more vulnerable than others due to pre-existing factors.

In the case of COVID-19, predisposing vulnerability factors have been suggested for both frontline health workers and the general public, such as childhood trauma (Lee et al., 2018;), trauma in general (Sutker et al., 2002; Hamner, 1994), pre-existing mental health conditions (Yao, Chen & Xu, 2020), personality disorder traits (Lee et al, 2018), an inadequate support system, excessive alcohol intake (Lee et al, 2018), and comorbid psychiatric illness (Lee et al., 2018; Peng et al., 2010)

There is also physical vulnerability for COVID-19 to consider, with groups in society such as the immunocompromised (ASCI, 2020), the elderly, the young, women, and migrant workers denoted as particularly vulnerable and more susceptible to psychological distress (Qiu et al., 2020).

MENTAL HEALTH DISORDERS

The potential impact of COVID-19 on individuals with pre-existing mental health disorders is multifaceted – individuals with mental health diagnoses are at greater risk of increased psychological distress and exacerbation of their mental illness (Yao et al, 2020), have underlying vulnerabilities to physical illness, and are traditionally more likely to experience unique barriers to accessing healthcare and mental health services than the general public. In addition, the effects of mental illness on cognitive function and healthcare behaviours may make treatment of COVID-19 more challenging and potentially less effective. Differing mental health disorders will pose particular challenges during this pandemic. These issues will be discussed in turn.

PHYSICAL VULNERABILITY OF INDIVIDUALS WITH MENTAL HEALTH DISORDERS

For some who are infected with COVID-19, there are serious health complications including the development of pneumonia (Department of Health, Australian Government, 2020). The risk of developing pneumonia has been found to be significantly higher in psychiatric patients with diagnoses of schizophrenia, bipolar disorder, depression, and anxiety (Li et al., 2018; Seminog & Goldacre, 2013), and has been indicated as a major cause of death in patients with schizophrenia (Haga et al., 2018).

This elevated risk in mental health populations may be due to a number of factors, including: the use of atypical antipsychotics/large doses of antipsychotics and their effect on physical health (i.e. Holt, 2019; Correll et al., 2015); compromised immunity associated with mental health diagnoses (i.e. Jones and Thomsen, 2012); increased risk for pneumonia by smoking (Almirall et al., 2008; Baik et al., 2000; Nuorti et al., 2000) and elevated levels of smoking in mental health populations (Quint and Brown, 2013), increased risk of diabetes mellitus in mental health populations (Robinson, Luthra and Vallis, 2013), increased risk of cardiovascular disease in mental health populations (i.e. De Hert, Detraux & Vancampfort, 2018), and the relationship between these factors and the risk of more serious outcomes in the event of COVID-19 infection (Guo et al., 2020; Guan et al., 2020; Liu et al., 2020).

ACCESS TO SERVICES

Many people with mental health disorders attend regular outpatient visits for assessment, therapy, and prescriptions. However, recent nationwide regulations on travel, social-distancing and enforced quarantine have resulted in the reduction of face-to-face consultations with all community practitioners and the rise of telehealth and video consultations. While there is a lot of supporting evidence for the efficacy of telehealth and video consultations (e.g. Langerizadeh, Tabatabaei, Tavakol et al., 2017; Bashshur, Shannon, Bashshur & Yellowlees, 2016), some individuals may have difficulties engaging with therapy through this platform due to the nature of their illness (e.g. paranoia/delusions about technology in psychotic illness).

EFFECT OF MENTAL ILLNESS ON HEALTHCARE BEHAVIOURS AND COVID-19 DIAGNOSIS AND TREATMENT

Cognitive difficulties that can occur in mental illness, such as difficulties with memory and executive functioning, may result in the neglect of health care behaviours, such as neglecting minor infections that then become more serious (Quint & Brown, 2013). Similarly, it is possible that common symptoms of mental health disorders such as depression (i.e. fatigue, lack of motivation, feelings of helplessness), anxiety (i.e. avoidance, social anxiety), and obsessive-compulsive disorder (i.e. fear of contamination), may present barriers to help-seeking if an individual develops symptoms of COVID-19.

Severe symptoms of mental illness, such as severe paranoia and psychotic delusions about health care/authority/parasitosis, increase the risk of clinical decompensation (Moukaddam and Shah, 2020), and are also likely to reduce the willingness of individuals to submit to COVID-19 testing and treatment.

If an individual with a mental health disorder is suspected of having COVID-19, it will be imperative to assess and manage the possible implications of their mental health diagnosis on testing, engagement with treatment, adherence to treatment, and potential response to quarantine and isolation. This will need to be done on a case-by-case basis, given the number of considerations that will need to be taken into account.

SPECIFIC MENTAL HEALTH DISORDERS

POSTTRAUMATIC STRESS/PTSD

Individuals who have previously been diagnosed with PTSD are most likely to develop psychopathology following subsequent exposures to traumatic events (Breslau et al., 2008; Breslau et al, 1999). Exposure to more than one traumatic event can be conceptualized as a dose–response model, resulting in a hypothesized increased vulnerability to psychological consequences; hence as individuals are exposed to more traumatic events they have a greater likelihood of stress/PTSD related symptoms (Sutker et al., 2002). Individuals with pre-existing PTSD may also be prone to experience exacerbations of PTSD symptoms following the onset of medical illness (Hamner, 1994).

Previous research has demonstrated that PTSD is associated with poor self-reported physical health as well as high rates of physical health comorbidities (O'Donovan et al., 2015; Boscarino, 2004; Kubzansky & Koenen, 2009; Cavalcanti-Ribiero et al., 2012). People living with PTSD commonly manifest dysregulations in the systems that regulate the stress response, which may unmask a predisposition to, or

accelerate the progression of, autoimmune (AI)/inflammatory diseases and compound the disease burden in these patients. (Neigh & Ali, 2016). A large retrospective cohort study of 666,269 Iraq war veterans showed that individuals with PTSD had a two-fold increase in the risk of autoimmune diseases, compared to those without any psychiatric illness, and a 51% increased risk when compared to individuals with other psychiatric illnesses (O'Donovan et al, 2015). These findings are likely to have ramifications for people with PTSD in the COVID-19 pandemic, as they join other immunocompromised cohorts in being more susceptible to COVID-19 and poorer outcomes.

ANXIETY AND OBSESSIVE-COMPULSIVE DISORDER (OCD)

The very nature dictates that fear and anxiety are present in the wider community from the early stages of a pandemic. For someone with existing anxiety, this can exacerbate existing anxiety symptoms and prolong recovery. The absence of a COVID-19 vaccine as yet also exacerbates the public's anxiety. The trajectory and end result of this pandemic are somewhat unknown, which is likely to be particularly damaging for those who struggle with uncertainty or who are already engaged in habitual catastrophic thinking.

For individual's with pre-existing OCD or conditions involving cleanliness, neatness, germ-phobia, tidiness or some obsessive behaviours, the outbreak of COVID-19 may actually reinforce that their problem-behaviours were actually what kept them safe (Moukaddam and Shah, 2020). This could lead to longer term treatment-resistance and difficulty managing obsessive-compulsive symptoms.

SUICIDAL IDEATION/DEPRESSION

The data on past outbreaks and suicide is conflicting, but it is reasonable to expect the current COVID-19 pandemic will lead to increased suicide risk for certain populations - likely due to the havoc, loneliness and financial insecurity caused by the pandemic. Unemployment, social isolation, lack of social support, relationship problems, inability to grieve the death of a family member/close friend, and misuse of alcohol/drugs are all also risk factors for suicide (Beyond Blue, 2020), and are likely to increase with pandemic isolation and lockdowns.

Social distancing and quarantines may trigger those currently dealing with suicidal thoughts, and make these people less visible to others, taking away an avenue that would normally lead to an external help/support response. Research shows the social and economic fallout from the pandemic may amplify the risk for some people well after the outbreak has ended (i.e. long-term financial hardship, unemployment) due to the effects of compounding stress and hopelessness. Additionally, safety measures to slow the transmission of COVID-19 have disrupted the way therapeutic interventions are normally offered in the community. Although research has shown that the quality of the therapeutic alliance using telehealth is comparable to face-to-face (Langarizadeh et al., 2017; Bashshur et al., 2016), there may be drawbacks to the collection of non-verbal information that may indicate changes in behaviour, mental state, and ultimately, suicide risk.

Social isolation measures are likely to lead to a lack of access to protective factors (i.e. time spent with social supports, structured daily activities, meaningful employment/training) although the use of social media and phone/video technology could help with providing a second-best alternative.

PSYCHOSIS (MAINLY PARANOID OR INFECTION-RELATED TYPE)

Typically, repeated media exposure to an alarming fact (in this case, spread of COVID-19), coupled with a distrust of organizations and government as well as misattribution of physical symptoms, can result in delusions and thus clinical decompensation (Moukaddam and Shah, 2020). Fears and increases in stress can also rapidly lead to clinical decompensation and must be carefully monitored. Increased discussions in the mainstream and social media about conspiracy theories related to infectious outbreaks are also likely to have a negative effect on symptoms of paranoid or infection-related psychosis and reinforce beliefs the individual may already have about healthcare professionals, the government, and dangers associated with COVID-19 assessment and treatment. A lack of trust in healthcare authorities is also likely to lead to less compliance with critical safety recommendations aimed at curbing the spread of COVID-19.

In his doctoral dissertation, Maguire (2014) investigated risk perception and protective behaviours within a cohort of outpatients with schizophrenia. A number of vulnerability factors for people with schizophrenia in pandemic influenza were identified, including problematic lifestyle factors (e.g. smoking, alcohol abuse, illicit substance use, increased rates of obesity), comorbid medical disorders (e.g. COPD, ischaemic heart disease, Type II Diabetes), mental illness factors (e.g. negative and positive symptoms of schizophrenia), cognitive impairment (i.e. memory, organization), and reduced pain perception. In COVID-19, these factors place affected individuals at much higher risk of infection and poorer outcomes.

BORDERLINE PERSONALITY DISORDER (BPD)

The havoc caused by societal changes to curb the transmission of COVID-19 are distressing for most, but likely to cause particular anguish for individuals with borderline personality disorder. Threats to stability are likely to cause heightened stress in individuals with BPD, and social isolation and distancing from loved ones may trigger feelings of abandonment and unworthiness. Likely adjustments to the delivery of mental health services and availability of mental health staff will bring changes to the usual routine for individuals with BPD, which will threaten their sense of stability. Paranoid thoughts may also increase with ongoing seclusion.

ADDICTIVE DISORDERS (SUBSTANCE ABUSE, INTERNET GAMING, GAMBLING)

Addiction thrives in isolation, as it is easier to justify engaging in an addictive behaviour in an environment without fear of judgement or social consequence. A key component of addiction recovery is staying connected to other people, however this is likely to be compromised in pandemics by government-led guidelines to self-isolate. Hence, individuals with a pre-existing addictive disorder are likely to find isolation difficult during a pandemic, and this is likely to be exacerbated by the increased stress, boredom, and disruption to usual routines that comes from a sudden pandemic. In addition, addiction support groups and individual therapists are likely to cease or commence online due to social-distancing, and inpatient substance abuse clinics are likely to restrict visitors, resulting in a reduction in crucial support to maintain addiction recovery.

INDIVIDUALS IN MANDATORY QUARANTINE

Isolated and/or quarantined individuals may experience a range of psychological responses such as depression, acute stress disorder, PTSD, sleep disturbances, and anxiety symptoms. (Morganstein et al.,

2010). Longer durations of mandatory quarantine have been associated with poorer mental health, specifically, posttraumatic stress symptoms (Hawryluck et al., 2004), avoidance behaviours (Reynolds et al., 2008), and anger (Marjanovic, Greenglass & Coffey, 2007). Isolation during a time of crisis can also lead to significantly elevated levels of depression in certain cohorts (Liu et al., 2012). In a Canadian study of people quarantined in the SARS pandemic (Hawryluck et al., 2004), it was found that those quarantined for more than 10 days showed significantly higher post-traumatic stress symptoms than those quarantined for less than 10 days.

The symptoms of the viral infection may also cause worsening cognitive distress and anxiety among the general public due to the fear of contracting the illness (Xiang et al., 2020). Financial stress due to widespread temporary and permanent closures of business and industry is also likely to cause significant psychological distress. In the Equine Influenza outbreak in Australia in 2007, no humans were infected but still had to be quarantined and restricted in movements to prevent the spread to horses. In a study by Taylor and colleagues (2008), findings indicated that this affected population had highly elevated levels of psychological distress and that, although prevalence of high psychological distress was greater in infected control zones and States, elevated levels of psychological distress were experienced in horse-owners nationally, and not just in areas where equine influenza was present.

Research in past pandemics has also demonstrated that being quarantined was significantly and positively associated with avoidance behaviours post-quarantine, such as minimising direct contact with patients and not reporting to work (Marjanovic, Greenglass and Coffey, 2007), and continuation of vigilant handwashing and avoidance of crowds (Cava et al, 2005) - for some, the return to normality was delayed by many months.

INDIVIDUALS ON THE FRONT LINE (HEALTHCARE WORKERS)

Frontline workers in a pandemic/epidemic have been shown to be more at risk of developing mental health conditions over time (Lee et al., 2007), especially for posttraumatic stress (Greenberg et al., 2020; Mak et al., 2009; Lee et al, 2007; Lee et al., 2018). For example, medical staff who performed MERS-related tasks during the MERS outbreak in 2015 showed the highest risk for post-traumatic stress disorder symptoms even after time had elapsed (Lee et al, 2018).

Importance of mental health care for medical/frontline workers – Chen et al, 2020; but in the past has been under-utilised for reasons including getting infected was not an immediate worry for staff, and they did not want their families to worry, and they were more worried about shortages of protective equipment. Some had feelings of incapability when faced with critically ill patients, and desired training on psychological skills to deal with patient distress over their own psychological interventions (Chen et al, 2020).

Many staff mentioned that they did not need a psychologist, but needed more rest without interruption, enough protective supplies, and training in psychological skills to deal with patients' anxiety, panic, and other emotional problems.

Key points:

- Individuals with pre-existing mental health disorders are more susceptible to adverse physical and psychological outcomes during and after a pandemic.
- Individuals with PTSD are both more likely to experience exacerbation of current illness, given the traumatic nature of a pandemic, and development of additional psychopathology.
- Social isolation measures are likely to lead to a lack of access to protective factors (i.e. time spent with social supports, structured daily activities, meaningful employment/training) although the use of social media and phone/video technology could help with providing a second-best alternative.
- Telehealth services may not be able to adequately assess nuances of risk in those with psychotic, depressive and other mental health conditions.
- Those in mandatory quarantine may experience increased symptoms associated with PTSD, anxiety, and depression. These symptoms may impact upon return to work and psychological wellbeing for months after COVID-19.
- Front-line healthcare workers are exposed to some of the most traumatic effects of pandemics, and despite the adverse psychological impact this typically has on them, wish to increase their ability to assist others with patients' psychological distress.

Virus outbreaks in forensic settings have the potential to overwhelm healthcare services, place additional demands on specialist facilities in the community, and contribute to community transmission that will disproportionately impact already marginalised communities (Kinner et al., 2020). Past influenza outbreaks in Australian prisons have already shown the potential for rapid spread of influenza among prison inmates (Awofeso et al., 2001).

In this COVID-19 pandemic, it is imperative to consider the cohorts of people detained in forensic sectors and develop appropriate and ethical management strategies to mitigate the physical and psychological risks of harm from COVID-19 in these settings. For those who are detained, detention in itself contributes to a loss of sense of self as a competent, autonomous adult (Fiske, 2016), and in times of crisis, personal autonomy, a sense of control and a sense of self-agency are crucial in mitigating the effects of trauma (Benight & Bandura, 2004). According to Bandura (1997, 2001), “among the mechanisms of human agency, none is more central or pervasive than people’s beliefs in their efficacy to manage their own functioning and to exercise control over events that affect their lives”. This highlights the importance in the current pandemic to address institutional barriers to autonomy and self-agency and try to develop compensatory strategies to enhance an individual’s perceived self-efficacy and agency.

Fears, worries, and uncertainty about the transmission of COVID-19, especially for isolated or quarantined individuals, has the potential to cause both an increase in stress-related illnesses and the exacerbation of pre-existing mental disorders (Duan & Zhu, 2020). Facility lockdowns and the restriction of protective activities such as exercise and family visits, also have the potential to negatively affect the psychological wellbeing of detained individuals. In a study of the relationship between the levels of self-reported physical exercise and mental well-being in a cohort of 914 prisoners within New South Wales, a significant inverse relationship between self-reported exercise in minutes per week and hopelessness was identified (Cashin, Potter & Butler, 2009). The impact of segregation in the event of COVID-19 infection also has the potential to increase negative psychological outcomes amongst those detained, with previous studies demonstrating the psychological consequences of segregation and solitary confinement (O’Keefe et al., 2013; Way et al., 2007; Anderson et al., 2003; Sestoft et al., 1998).

FORENSIC MENTAL HEALTH

Patients in forensic psychiatric settings are a particularly vulnerable cohort, due to contending with a severe mental illness, having committed a crime and being cared for against their will in an institutional environment with a high level of security (Hörberg, Sjögren, & Dahlberg, 2012). Forensic psychiatric consumers are constrained and controlled by the legislation in their jurisdiction and hospital routines, which they need to be for reasons of security (Gordon & Lindqvist, 2007). Forensic mental health consumers are also more likely to have a history of trauma and other co-morbid mental health conditions (Palijan et al., 2010), which increases their susceptibility to negative psychological outcomes from COVID-19 (Lee et al., 2018; Peng et al., 2010; Breslau et al., 2008).

In the context of the COVID-19 pandemic, forensic mental health consumers need to be afforded the same considerations as outlined for all mental health consumers and staff outlined earlier in this document, but there are additional issues that also need to be considered in this cohort, as outlined below.

FOR FORENSIC MENTAL HEALTH CONSUMERS IN AN INPATIENT FACILITY

- **EFFECTS OF BEING DETAINED** - Forensic Mental Health consumers are detained against their will, and this has an impact on levels of psychological distress. Compared with voluntary admissions, involuntary admissions have been associated with longer stays in hospital, higher readmission rates, higher risk of being involuntarily readmitted and a greater likelihood of dying by suicide (Kallert, Glockner & Schutzwahl, 2008). This is likely to be further exacerbated in the context of COVID-19, given findings emerging from the literature for the general public (e.g. Lee et al., 2018; Peng et al., 2010), a lack of control and self-agency felt by forensic mental health consumers, and their reliance on their facility to protect their safety and the safety of other consumers and staff during a pandemic. This might be particularly confronting and challenging for those who have a distrust of authority as a feature of their illness. Forensic Mental Health Consumers under facility lockdown may experience additional barriers to self-care, such as a lack of autonomy to make changes to their routine, engage in exercise, and start new healthy habits/interests. There are also likely to be increased levels of anxiety and worry about the transmission of COVID-19 within facility walls during the COVID-19 pandemic, and considerations need to be given to how a consumer's sense of autonomy, competence, and relatedness/belonging can be enhanced in this context.
- **THE FORENSIC MENTAL HEALTH EXPERIENCE** - The experiences of consumers in a forensic mental health setting have the potential to enhance or be detrimental to their overall psychological wellbeing. Experiences such as not receiving sufficient information, not being involved in treatment decisions, perceiving professionals as having power over consumers, and experiencing coercive measures have been found to contribute to consumers feeling out of control during their hospitalisation. (Munk-Jørgensen, Mortensen & Machón, 1991). Boredom in the ward environment has also been found to influence experiences of detention for patients in several studies, highlighting the need for recreational, educational or occupational activities (Akther, Molyneux, Stuart et al., 2019). COVID-19 safety measures have the potential to decrease recreational, educational or occupational activities, and also decrease an individual's sense of control in their own life. Measures to counteract this will be beneficial in forensic mental health settings. A few studies have suggested that patients' empowerment and confidence can be increased when they receive appropriate individualised information, which is repeatedly delivered and provided in accessible language, and when they are given some responsibility for their care (Akther et al., 2019; Kallert et al., 2005).
- **DISRUPTIONS TO STAFFING AND THERAPEUTIC INTERVENTIONS** - The provision of consistent psychological treatment in forensic mental health settings may be impacted by COVID-19, with staff moving towards working offsite and providing interventions via online video sessions. Video consultations have the potential to deprive psychologists of contextual and subtle information about a consumer's presentation, and therefore may be less adequate in giving psychologists the ability to identify early warning signs of deterioration in mental state. Video sessions may also be contraindicated for consumers with paranoid symptoms and/or delusions about technology, as this would exacerbate their symptoms and damage the therapeutic relationship.
- **INCREASED STRESS** – The increase in stress for individuals during pandemics is well documented. The role of stress in the exacerbation of severe mental illness (i.e. psychotic disorders, bipolar

disorders) is also well documented. For example, the neural diathesis–stress model of schizophrenia proposes that stress, through its effects on cortisol production, acts upon a pre-existing vulnerability to trigger and/or worsen the symptoms of schizophrenia (Walker, 1997). Thus, helping consumers to manage stress more effectively and reducing stressors in their environment will be an important measure to implement for illness and risk management in forensic mental health settings during COVID-19.

- **NEED FOR STABLE PROVISION OF NECESSARY MEDICATIONS** - Most forensic mental health consumers are reliant on psychotropic medications to maintain stability in their mental state, as well as medications for physical health issues, and may hold fears and uncertainty about the ongoing provision of their medications in the context of medication shortages in other contexts. Any disruption to medication regimes in forensic mental health will likely result in significant destabilisation and may have resulting impacts on the consumer's risk to self, risk to staff, and risk to other consumers. Where possible, putting measures in place to safeguard the supply of necessary medications will help consumers to feel more at ease.
- **ACCESS TO SAFETY MEASURES TO PREVENT TRANSMISSION OF COVID-19** - Depending on the facility in which they are detained, forensic mental health consumers may be unable to enact all of the safety and wellbeing measures recommended by government authorities (i.e. hand sanitisation, social distancing, access to exercise, access to in-person or video/phone contact with loved ones) due to facility space, layout, and isolation facilities, and the potential ban of alcohol-based hand sanitiser in bedrooms/units due to its alcohol content. IN addition, facilities no tin lockdown will have staff coming and going on a daily basis, which increases the risk of community-facility transmission of COVID-19.
- **POTENTIAL EXPOSURE TO TRAUMATIC EXPERIENCES** – If a facility experiences an outbreak of COVID-19, it is possible that forensic mental health consumers will be exposed to an increased number of “Code Blue” (medical emergency) and “Code Black” alerts (threatened safety of staff or patients), as well as the heightened risk of infection and possible resulting death to themselves, their fellow consumers, and staff. The consumers may also hear of a loved one who has been infected or even passed away, without having the capacity to visit or contact them. These factors would cause increases in traumatic stress and potentially exacerbate existing traumatic stress.
- **GRIEF AND LOSS** – If a consumer is advised of a loved one who has been infected or even passed away, they will face obstacles to go through the normal process of grieving, as they may be restricted from attending funerals of family and friends, and will not be able to spend time other members of family or friends for support (unless facilitated by technology). This could increase the likelihood of developing complicated grief reactions over time.
- **STIGMATISATION** – Forensic Mental Health consumers already face significant stigmatisation and isolation in the wider community, and if they test positive for COVID-19 this stigmatisation would be compounded, and potentially isolate them from other consumers and staff within their own facility as well. This would have negative implications for their overall psychological well-being.

- **LACK OF ACCESS TO PUBLIC HEALTH EDUCATION CAMPAIGNS** - Maguire (2014) recommends many public health modifications in the event of a pandemic, for example increased posters at GP offices and public wash spaces. Many forensic mental health consumers will be restricted in accessing the community and thus will be restricted to information provided in wards/units and in the media (TV/radio). Research has also demonstrated that people with a diagnosis of schizophrenia are more likely to trust internet sources or family and friend for health information than information from their GP (Maguire, 2014), but have limited or no access to the internet or loved ones in a pandemic. This may impact their access of trusted health information about COVID-19 in the current pandemic.

FOR FORENSIC MENTAL HEALTH CONSUMERS BEING DISCHARGED TO THE COMMUNITY

- **NEED FOR STABLE PROVISION OF NECESSARY MEDICATIONS** - As forensic mental health consumers are discharged into the community, it is imperative to have a well-rehearsed mode of medication provision in place, to ensure ongoing medication access and compliance. If supply shortages of psychotropic medication occur, it will likely jeopardise a successful community transition, as well as cause the consumer a considerable amount of stress. Where possible, putting measures in place to safeguard the supply of necessary medications will help consumers to feel more at ease and manage their risk of relapse in the community.
- **IMPACTS ON TRANSITION TO THE COMMUNITY** - For those who are being discharged to the community from an inpatient setting during COVID-19, there are likely to be fears about provision of services in the community to ensure smooth transition to community living and monitoring of risk. These consumers are also likely to be discharged to their own accommodation, where they may be alone and forced to self-isolate in the time of COVID-19 safety recommendations, which exposes them to some of the possible negative consequences of isolation/quarantine outlined for all individuals (i.e. symptoms of depression, acute stress disorder, PTSD, sleep disturbances, and anxiety - Morganstein et al., 2010; avoidance behaviours - Reynolds et al., 2008; anger - Marjanovic, Greenglass & Coffey, 2007). If avoidance symptoms persist, discharged consumers may have difficulty adjusting to their new life in the community, which may jeopardise their discharge and engagement with essential service and meaningful occupational pursuits.
- **IMPACT ON RISK MANAGEMENT** - The safety measures implemented to stem the spread of COVID-19 pandemic, such as social distancing, affects the availability of ongoing face-to-face psychiatric/psychological care in the community, which is an important part of assessing the risk of both relapse of illness and violence. Video consultations, whilst useful and clinically effective on the whole (e.g. Varker et al., 2019), they also have the potential to deprive community-based clinicians of contextual and subtle information about a consumer's presentation that might indicate changes in risk (i.e. whether the consumer is malodorous/engaging in regular self-care, non-verbal indicators of anxiety/stress/depression that may be out of screen in a video consultation). Where possible and practical, face-to-face sessions may be better for monitoring ongoing risk. If this is not possible, it will be necessary to gather other forms of information from collateral sources (i.e. nursing/other staff, loved ones) who may be in face-to-face contact with the person and who might be able to give you more detailed information about the person's presentation and behaviour.
- **IMPACT ON COMMUNITY CORRECTIONS** - Community Correctional services are also likely to be affected by the COVID-19 pandemic and may be compelled to discontinue face-to-face consultations

and provisions of urine drug screening due to COVID-19 transmission risk. This may increase the risk of drug and alcohol use amongst forensic mental health consumers in the community, especially in the period following discharge from an inpatient service, which will increase the likelihood of deteriorations in mental state (both from the drug use itself, and from secondary factors such as lack of sleep, misadventure, trauma).

Key points:

- Being detained is synonymous with reduced autonomy, and in a Forensic Mental Health setting, it can contribute to increased distrust of professionals, reduced self-efficacy and boredom, and may increase psychological distress. Provision of individualised information and increased consumer voice in care options may mitigate these effects.
- It is likely consumers will experience increased stress, which is well known to trigger or exacerbate symptoms of schizophrenia and other mental health disorders. Reducing stressors in a consumer's environment where possible, as well as assisting consumers to manage internal markers of stress effectively, may mitigate this risk.
- In the current pandemic, it will be important to address institutional barriers to autonomy and self-agency and try to develop compensatory strategies to enhance an individual's perceived self-efficacy and agency.
- Disruption to staffing, medication access, and therapeutic interventions threatens continuity of care and increases risk of destabilisation for consumers.
- Forensic Mental Health consumers being discharged into the community face unique challenges in the COVID-19 pandemic. Safeguarding consistent supply of medication and basic needs is paramount, as it monitoring consumers discharged to their own properties, who then have to self-isolate in this pandemic and face the effects of isolation. Finding ways to monitor mental state and risk effectively will be necessary in the COVID-19 climate.
- Whilst video consultations are useful for enabling continuity of care, important non-verbal aspects of mental state to assess for risk are not obtainable. It may be necessary to access this information via those who have had face-to-face contact with the consumer.
- Reduced drug and alcohol screening due to Community Corrections COVID19 restrictions has the potential to result in increased consumption of these substances in this group, which could result in deterioration of mental state.

PRISONS, YOUTH DETENTION CENTRES, AND ONSHORE AUSTRALIAN IMMIGRATION DETENTION FACILITIES

The prison, youth justice and immigration detention contexts share many similar potential considerations with forensic mental health, detailed above. These include the effects of being detained against one's will, disruptions to staffing and therapeutic interventions, increased stress, a need for the stable provision of necessary medications and healthcare, access to COVID-19 related safety measures, potential exposure to traumatic stressors, grief and loss issues, and stigmatisation issues.

Like forensic mental health consumers, prisoners, detained youth, and detainees in immigration detention are more likely to have a history of trauma and other co-morbid mental health conditions (Baranyi et al., 2018; Fazel et al., 2016; Fazel, Wheeler & Danesh, 2005; Priebe, Giacco & El-Nagib, 2016), which increases their susceptibility to negative psychological outcomes from COVID-19 (Lee et al., 2018; Peng et al., 2010; Breslau et al., 2008). They also face the effects of overcrowding, where they are vulnerable to COVID-19 and its inevitable spread throughout these facilities.

In addition to psychological vulnerabilities, there are a number of groups within correctional populations who are more physiologically vulnerable to COVID-19 than the general population, including Aboriginal and Torres Strait Islander peoples 50 years and older with one or more chronic medical conditions, people 65 years and older with chronic medical conditions, people 70 years and older, and people with compromised immune systems (CDNA, 2020).

CORRECTIONAL PRISONERS/DETAINEES

Aboriginal and Torres Strait Islander peoples are over-represented in both prisons and youth detention (Walker & McDonald, 2020), where there are also overrepresentations of vulnerable individuals with learning disabilities and mental health difficulties (O'Hara, 2010). Given these challenges, there are implications for risk in these environments where changes to staffing to rising levels of COVID-19 infection could result in adult prisoners and child detainees spending extended periods of time isolated in their cells. Many educational programs and family visits are also likely to be suspended to comply with COVID-19 social-distancing measures, and likely to leave children in detention feeling further isolated and vulnerable. When combined with the growing stress and anxiety stemming from the pandemic itself, extended periods of isolation are likely to have dire consequences for mental health and increase the risk of self-harm and violence in these populations (Bulman, 2020).

DETAINEES IN IMMIGRATION DETENTION

The detention of asylum seekers in facilities such as immigration detention centres has been a highly contentious issue in Australia and throughout the world (Essex, 2019), with growing evidence that the detention of asylum seekers exacerbates psychological symptoms (e.g. Keller, Rosenfeld, Tring-Shevrin et al., 2003; Schauer, Neuner, Karunakara et al., 2003). Populations in immigration detention have typically been exposed to high levels of pre-migration trauma, including war, violence, torture, discrimination, persecution and stigmatisation (Priebe, Giacco & El-Nagib, 2016; Song, Kaplan, Tol, Subica, & Jong, 2014; Kirmayer et al., 2011; Schubert & Punamäki, 2011), and have elevated levels of diagnosable psychiatric disorders (Robjant, Hassan & Katona, 2009; Keller, Rosenfeld, Tring-Shevrin et al., 2003; Steel et al.,

2004). Those with pre-existing mental health difficulties may be less effective at self-advocating in a legal context and may be more likely to be detained at the outset (Robjant, Robbins & Senior, 2009).

The physical health of these detainees is often compromised and generally poorer than that of the general population (Fazel, Wheeler, & Danesh, 2005; Johnston, Smith, & Roydhouse, 2012; Keyes, 2000; Reed et al., 2012), and they often have limited health system literacy and difficulties related to language and culture (Cheng, Drillich & Schattner, 2015). Being placed in immigration detention has been flagged as significant stressor in its own right (Fazel et al., 2012; Fazel et al., 2005), with effects found to compound with increasing length of time in detention (Green & Eagar, 2010; Robjant, Hassan & Katona, 2009; Robjant, Robbins & Senior, 2009; Sultan & O'Sullivan, 2001), although even brief periods of detention have been found to have negative mental health consequences (Cleveland & Rousseau, 2013).

The indeterminate nature of some detention orders has also been linked to negative psychological health outcomes, with some qualitative studies finding that detainees' loss of agency and feelings of uncertainty, hopelessness and powerlessness were linked to an exacerbation of psychiatric symptoms (Cleveland et al., 2018; Physicians for Human Rights, 2003). This may be compounded by the COVID-19 pandemic, which in its nature, has an indeterminate outcome and length of impact.

On the whole, individuals in immigration detention are likely to be at significantly greater risk of adverse physical and psychological health outcomes in the COVID-19 pandemic and possess the characteristics to be regarded as an especially vulnerable population (The Lancet, 2020). As with other populations discussed, the most physiologically vulnerable within this population are the elderly, young children, the immunocompromised, and those with psychiatric comorbidities. The safety of individuals in immigration detention in the COVID-19 pandemic may also be at risk due to potential language and cultural barriers to implementing COVID-19 safety measures.

Key points:

- Both psychological (e.g. mental health conditions, history of trauma) and demographic factors (e.g. overrepresentation of Aboriginal and Torres Strait Islanders, vulnerability of the elderly and immunocompromised) increase the likelihood of adverse medical and psychological outcomes in the event of an COVID-19 outbreak for already marginalised and vulnerable prisoners, detained youth, and detainees in immigration detention.
- Being placed in immigration detention has been flagged as significant stressor in its own right, with effects found to compound with increasing length of time in detention. The most physiologically vulnerable within this population during the COVID-19 pandemic are the elderly, young children, the immunocompromised, and those with psychiatric comorbidities.
- The safety procedures put in place in forensic facilities during a viral outbreak are likely to increase isolation and have adverse consequences for psychological wellbeing.
- Forensic facilities face ongoing issues with overcrowding, which restricts the effectiveness of any COVID-19 safety precautions and makes them difficult to implement. This will likely lead to the inevitable spread of COVID-19 throughout these facilities.
- Those with intellectual disabilities and poorer language abilities may experience difficulties accessing information and engaging in safety precautions for COVID-19.

RECENT ADVOCACY

An open letter signed by over 370 professionals and academics working in the criminal justice sector throughout Australia was recently sent to Australian governments, detailing the impact of COVID-19 in the forensic sector and proposed measures to reduce the risk of transmission of COVID-19 in facilities such as prisons and youth detention centres (ABC News, 2020). Discussion points and recommendations in the letter covered:

- The elevated risk of COVID-19 transmission in overcrowded prisons, with shared facilities, poor air circulation, and limited access to handwashing and sanitising facilities in many correctional facilities.
- Outbreaks of COVID-19 in prisons and detention centres will have a substantial flow-on effect to the community as both staff and prisoners are continually coming in and out of prisons
- The disproportionate effect on vulnerable populations over-represented in prisons (e.g. Aboriginal and Torres Strait Islander peoples, people from low socio-economic backgrounds, people experiencing homelessness, people with disabilities). Many people who are incarcerated also have chronic conditions which makes them vulnerable to more severe forms of COVID-19
- Prison healthcare is already stretched and would likely result in under monitoring of COVID-19 symptoms, and would result in difficulties isolating positive COVID-19 cases
- The option of decarceration as a measure to prevent prisons becoming COVID-19 hotspots (as has been implemented in Iran and currently proposed in Ireland, United States and the United Kingdom), with prioritisation for release given to those with vulnerabilities, those with the least serious offences, those with an impending release date.
- That prisoners are informed on the status of COVID-19 and their rights
- Ensuring prison compliance with international laws and the standards for health treatment of prisoners, including the UN Standard Minimum Rules for the Treatment of Prisoners (Rule 24) and the Basic Principles for the Treatment of Prisoners (Rule 9)
- To ensure best-practice sanitation (including alcohol-based sanitisers if necessary) and social distancing techniques to promote prisoner and staff safety
- To support not-for-profit and government agencies to work with prisoners and their families to find them safe accommodation when they are released; and
- To minimise the psychological impact of restrictions on prisoners (e.g., frequent opportunities to communicate with family online, in the absence of face-to-face visits; increased access to and availability of phones; judicious approach to the use of solitary confinement)

The letter attracted significant media attention, and since that time, there have been a number of responses to this campaign, including the drafting of a second letter to be sent to Australian governments soon. Most significantly, the NSW Government introduced a Bill on Tuesday this week to release some prisoners on conditional release on parole (see attached). There have also been two Supreme Court cases where bail applications on the basis of COVID-19 considerations have already been successful (Broes [2020] VSC 128 (19 March 2020) - Supreme Court of Victoria; R v Stott (No 2) - Supreme Court of ACT).

Additionally, the National peak body for Aboriginal and Torres Strait Islander Legal Services (NATSILS) recently made a statement calling on the Prime Minister, Attorney General and all levels of State and Territory Government to take immediate action to protect Aboriginal and Torres Strait Islander people in prison, including considering early release (NATSILS, 2020). They posited that Aboriginal and Torres Strait Islander people are over-represented in prison, have chronic health issues, and are living with disability, which places them most at risk to COVID-19. They requested immediate early release, particularly people who are on remand, women who are victims of family violence and sentenced for lesser offences like fines and public order offences, young people and those most at risk of transmitting COVID-19, like elderly and people with health conditions. The need to prevent any Aboriginal deaths in custody from COVID-19 was highlighted, as was the need for transparency and avoidance of blanket lockdowns or solitary confinement, especially for young people. The need for prisoners to have safe access to their family and visitors, adequate medical care, COVID-19 testing and legal support was stressed, including access to video facilities. Concerns about the impact of policing, the closure and delay of courts, and civil law impacts during the COVID-19 pandemic were raised, and the need for consideration of alternatives to imprisonment, diversion, and on providing increased support to remote communities. The ceasing of bush and circuit court was raised, including the impact on legal services when court resumes and the urgent need for additional resources to adequately respond to this pandemic.

"This pandemic will have a huge impact on our communities, our lives, and our services for many months to come. It is vital that the Prime Minister and all levels of Government act now to show leadership for First Nations people." (NATSILS, 2020)

On 31st March 2020, the Communicable Diseases Network Australia (CDNA), in conjunction with the Australian Health Protection Principal Committee (AHPPC) released comprehensive guidelines for outbreaks of COVID-19 in correctional and detention facilities (CDNA, 2020). These guidelines apply to all detention and correctional facilities in Australia, including prisons, juvenile detention centres and youth justice centres, community correctional centres and onshore Australian immigration detention facilities. These guidelines include infection control measures to prevent the exposure to and transmission of COVID-19 in these populations, as "avoidance of exposure is the single most important measure for preventing COVID-19 in correctional and detention facilities". They also highlight populations at greatest risk for severe illness from COVID-19, including Aboriginal and Torres Strait Islander peoples 50 years and older with one or more chronic medical conditions, people 65 years and older with chronic medical conditions, people 70 years and older, and people with compromised immune systems. The onus is now on these facilities to take adequate precautions to protect these vulnerable populations.

These are significant achievements in the advocacy of prisoners and detainees, who are amongst the most vulnerable members of our society in the COVID-19 pandemic. Similar systemic reforms have also been suggested on overseas jurisdictions to reduce both the number of prisoners burdening the prisons systems and the criminal justice system. (e.g. USA - Crook, 2020).

Key points:

- Various professionals and sectors of the criminal justice system have recently advocated for special considerations for forensic populations in the time of the COVID-19 pandemic.
- Recently, an open letter addressed to the Australian and State Governments signed by numerous professionals and statements from relevant peak bodies have attracted mass media attention. The impact of such work has likely contributed to the early release on parole for some prisoners in NSW.
- Comprehensive guidelines for correctional and detention facilities in Australia have been released, and thus these facilities now have the responsibility to implement these measures.

SUMMARY AND RECOMMENDATIONS FOR PRACTICE

In summary, past pandemics, epidemics and virus outbreaks have demonstrated similar effects on psychological wellbeing – although many people cope well under threat, there appears to be a trend of increased psychological distress commencing in the early stages of a pandemic and having long-lasting and mostly negative impacts on psychological wellbeing over the longer term. Frontline health workers to the crisis have unique psychological vulnerabilities, as do those with past traumatic experiences, those with pre-existing mental health issues, and those who are detained and at the mercy of their institution.

RECOMMENDATIONS FOR PRACTICE

Based on the information gathered above, it is necessary to develop a coordinated and timely approach to psychological interventions for COVID-19-related psychological distress. Whilst it is imperative to develop assessment, treatment and management plans on a case-by-case basis, the literature has provided some broader considerations and interventions that might be useful in responding to psychological distress in the current crisis.

Using the structure proposed by Morganstein and colleagues (2017), the management of behavioural health aspects of a pandemic can be divided into three phases:

1. Preparedness
2. Early outbreak response
3. Later response and recovery

PHASE 1: PREPAREDNESS

An effective public health program of risk assessment and communication, public health prevention measures, and consequence management is crucial in and enhancing psychological, emotional, and behavioural responses (Morganstein et al., 2017). This should be put into place before the onset of a pandemic where possible and be accessible to communities at risk and practiced by all. To achieve this, effective political and community leadership, appropriate pre-event organization, and staffing and funding are required.

According to the Pan American Health Organisation (PAHO/WHO, n.d.) individuals are likely to present with a number of feelings, symptoms and expectations in the period after being advised of a coming pandemic and the time it arrives. These can include over- or under-estimation (denial) of the coming pandemic, exaggeration of pre-existing personality traits (positive and negative), and anticipation of the disease leading to feelings of anxiety, stress, insecurity and hypervigilance. Psychologist can play a role in alleviating some of this early anxiety, giving accurate information, and helping individuals to develop effective coping strategies for the coming pandemic.

PHASE 2: EARLY OUTBREAK RESPONSE

"Monitoring and managing psychological distress in the early stages of a pandemic appear to be key in mitigating some of the negative psychological outcomes associated with pandemics, and especially in preventing longer-term exacerbations of psychological distress and clinical diagnoses. If psychological interventions are delayed in crisis, there are likely to be significant ramifications in the longer-term." (Wang et al, 2020)

Using the existing literature of previous pandemics and contagious outbreaks, the following suggestions have been compiled as a guide for interventions in the earlier stages of a pandemic.

INTERVENTION/ CONSIDERATION	POSSIBLE ACTIONS
INITIAL TRIAGE	<p>Triage cases based on past determinants of adverse psychological outcomes (Perrin, McCabe, Everly & Links, 2009), namely those who:</p> <ul style="list-style-type: none"> ▪ Have a high perceived threat to their life ▪ Have low social and emotional support ▪ Are residing in a high-prevalence region ▪ Have ambiguity and uncertainty surrounding the given disease ▪ Are in isolation and quarantine, ▪ Are in the same home or health facility as sufferers of the given disease ▪ Have a low individual education level ▪ Are of female gender ▪ Are elderly ▪ Personally know someone affected by the disease ▪ Are affected by frequent modification of infection control procedures and public health recommendations, ▪ Are being deprived of family visits <p>Those with a high perceived threat to their lives may have this perception because of underlying trauma (past and current), which has been demonstrated to make someone more vulnerable to distress.</p> <p>Assess for past trauma or current traumatic stressors (i.e. domestic violence), so that more vulnerable individuals are prioritised for care. Utilise measures such as the Impact of Events Scale (IES) or other measures of posttraumatic stress to provide a baseline measure for distress, and re-administer and monitor this over time.</p> <p>Consider other factors such as whether someone has been affected by any other recent major environmental stressors – i.e. Australian bushfires. Consider the effect of compounding stress after even non-direct contact with the recent summer bushfires.</p>
ASSESSMENT	<p>Collect baseline measures to establish a baseline of psychological distress, psychological needs, and coping styles, that can be monitored over time.</p>

	<p>Some measures that could be useful:</p> <ul style="list-style-type: none"> - Brief measure of anxiety, stress and depression – Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995), or Kessler Psychological Distress Scale - K10 (Kessler et al, 2002) – <i>To assess weekly</i> - Perceived Stress Scale (PSS – Cohen, Karmarck & Mermelstein, 1983), to measure the extent of stress perceived by the person – <i>To assess monthly</i> - <i>Brief Measure of coping styles, to assess currently methods of coping being utilised – i.e. Brief-COPE (Carver, 1997) – assess in early response period and then after pandemic is over</i> - <i>Measure of impact of events – Impact of Events Scale (IES-R – Weiss and Marmar, 1996) - assess individuals for COVID-19 related posttraumatic stress symptoms</i> - <i>Basic Psychological Needs Satisfaction Scale (BPNSS; Den & Ryan, 2000; Gagné, 2003). Use to assess perceived satisfaction with relatedness, autonomy and competency - assess monthly. Consider how satisfied the person is with their level of relatedness to others, autonomy in their life, and sense of competence in the things they do.</i>
<p>PROVIDING PSYCHOLOGICAL FIRST AID</p>	<p>Psychological First Aid is an essential tool for clinicians and the survivors in addressing stress-related reactions after traumatic events like the COVID-19 pandemic (Birkhead and Vermeulen, 2018).</p> <p>Key principles of Psychological First Aid:</p> <ul style="list-style-type: none"> • Establish safety; identify safe areas & behaviours • Maximize individuals' ability to care for self & family & provide measures that allow individuals & families to be successful in their efforts • Teach calming skills & maintenance of natural body rhythms (e.g., nutrition, sleep, rest, exercise) <ul style="list-style-type: none"> • Schedule regular exercise time outside, sleep routine • Could have social distancing lunches outside at the same time each day (set up facilities for this – chairs, places to sit) • Affect regulation strategies • Mindfulness and other strategies to maintain focus on the present moment • Maximize & facilitate connectedness to family & other social supports to the extent possible (this may require electronic rather than physical presence) <ul style="list-style-type: none"> • Also can provide ongoing support to family and friends of the person

	<p>and encourage them to make frequent contact</p> <ul style="list-style-type: none"> • Foster hope & optimism while not denying risk <p><i>For a more comprehensive guide, see:</i></p> <p>Psychological First Aid Guide – Red Cross:</p> <p>https://www.redcross.org.au/getmedia/23276bd8-a627-48fe-87c2-5bc6b6b61eec/Psychological-First-Aid-An-Australian-Guide.pdf.aspx</p>
<p>GIVING ADEQUATE AND ACCURATE INFORMATION</p>	<p>Provide clear information about COVID-19 – how it spreads, safety precautions to take, what to do to seek help. Make sure that the information given to individual is appropriate to age, education, and literacy level.</p> <p>Check in with the individual over time to assess retention of information and re-educate if necessary.</p> <p>Use prompting strategies for those with impaired memory functioning and/or intellectual disability, such as putting up signs with visual information, putting hand sanitizers and colourful signage in central locations such as beyond doors, canteen entrances, the middle of entrance halls and lift lobbies raises its use to a considerable extent (Lunn et al., 2020).</p> <p>Providing precise and clear information regarding measures that can enhance perceived control over threat, might be appropriate for eliciting coping methods that limit anxiety.</p> <p>Recommendations from study by Maguire (2014):</p> <ul style="list-style-type: none"> • Psychiatrists and mental health nurses may need to take a more active role in providing important physical health information re a pandemic as they have the most contact with the patient • Regardless of which health professional is involved, it seems important that an assertive approach is adopted. An active enquiry about health issues generally is likely to be the most effective approach, as well as the provision of information on potential health threats, such as an emerging pandemic influenza. It may be disadvantageous to patients with schizophrenia for clinicians to have an expectation that physical symptoms or concerns will be disclosed spontaneously. • Health information about preventative measures, not only against influenza but also against medical disorders people with schizophrenia are prone to, such as ischaemic heart disease, chronic obstructive pulmonary disease and diabetes mellitus, is important. • As family and friends ranked both the second most trusted and second most used source for people with schizophrenia to gain health information (and the second most trusted and third most used in the GP group), clinicians might consider encouraging and supporting them as contributors to the provision of health information, as is the case in many chronic neurodegenerative diseases. This might include provision

	<p>of information sheets and pamphlets that they could share with the patient at a later time.</p> <ul style="list-style-type: none"> • As this study suggests there are poor levels of factual knowledge about influenza in terms of symptoms that characterize it, and its duration. Therefore, it is likely to be important during the early phases of an influenza outbreak for health authorities to specifically target and assist this population with educational processes, especially with regard to what symptoms to be vigilant for and where to go and what to do if these symptoms occur • Need to receive accurate information on (1) vulnerability factors which can increase the seriousness of contracting influenza e.g. existing heart or lung disease, diabetes mellitus, pregnancy, and factors which increase the likelihood of contracting it (such as smoking), (2) ways in which the influenza is spread from person to person, and effective protective measures to minimize one's risk of contracting influenza, and (3) potential complications of influenza, which have a bearing on potential seriousness for a person who has contracted it
LIMITING MEDIA EXPOSURE	<p>Limit unhelpful levels of and types of media exposure</p> <p>Encourage accurate information sources and replacement of strategies for excessive media reading/seeking.</p> <p>For at risk individuals, work with them to implement strategies to limit media exposure through technology and newspaper. Previous research has shown that repeated exposure to media coverage of a traumatic event may prolong acute stress experiences and exacerbate stress (Holman, Garfin & Silver, 2014).</p>
MAKING REFERRALS IF REQUIRED	<p>It may be necessary to refer an individual to another service for further help/intervention, for example</p> <ul style="list-style-type: none"> • Psychiatry referral (medication prescription, psychiatry sessions) • Specialist services – crisis helplines, Domestic Violence resources/help/shelter, support for homelessness, financial support, education <p>Domestically violent situations will be particularly problematic in the event of mandatory lockdowns, as it increases the likelihood of victims being abused without the ability to temporarily escape their environment. Tension in relationships is also more likely to increase with enforced lockdowns, as everyone is likely to experience the effects of social isolation and anxiety about access to essential services.</p> <p>Approach these situations guided by a trauma-informed approach which acknowledges the presence of possible trauma in the individuals past and current realities, and respond with this in mind.</p>

<p>CONSIDERING POSSIBLE NEGATIVE EFFECTS OF SAFETY MEASURES</p>	<p><i>Impact of closures:</i></p> <p>It is important to consider the potential impact of forced closures of business and industries on the person – this could be financial stress someone is experiencing either directly or indirectly if a member of their household/family has experienced sudden unemployment or reduction in income.</p> <p>It is also important to consider the effect of school closures and resulting pressures from parents who need to home-school their children as well as continue to juggle other responsibilities.</p> <p>Consider reduced access to basic supplies (food, medicine, clothing) and consider how this could be managed so that people have everything they require for at least their basic needs. It may be necessary to reassure and educate the person on how these supplies will be maintained, particularly in the case of psychotropic medications.</p> <p><i>Impact of hygiene measures:</i></p> <p>Safety measures such as hand washing and sanitising, education about the spread of the virus may lead to increased anxiety about cleanliness and sanitisation.</p> <p>For those who experience symptoms of OCD and who hand-wash excessively to alleviate anxiety about contamination, this may be particularly problematic</p> <p><i>Impact of use of personal protective equipment:</i></p> <p>For frontline health workers, it is important to consider the effect of constant use of Personal Protective Equipment (PPE) and hand sanitisation measures, and impact of this on the staff/patient relationship</p> <p><i>Potential disruption to usual therapeutic measures (e.g. psychology/psychiatric sessions, medication, group programs):</i></p> <p>Preserving continuity in provision of psychiatric and psychological care to individuals in detention is imperative and should remain so during the Covid-19 outbreak. (Liebrenz, Bhugra, Buadze & Schleifer, 2020).</p> <p><u>If face-to-face sessions continue:</u></p> <ul style="list-style-type: none"> - Utilise and provide PPE masks, disinfectants and protective measures if continuing to provide face-to face sessions <p><u>If the continuation of face-to-face sessions is not an option:</u></p> <p>The following is a summary of suggestions from the APS guide “APS - Telehealth measure to improve access to psychological services for rural and remote patients under the Better Access initiative: Consideration for providers.” (Australian Psychological Society Limited, 2020). For a complete version of the</p>
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APS recommendations, please access:

<https://www.psychology.org.au/getmedia/4dd9dd91-1617-421b-928c-531d019f05c2/17APS-Telehealth-Web.pdf>

- Set up alternative modalities for therapy to replace face-to-face sessions (when necessary)
- Seek advice on secure video sharing platforms so as to maintain client confidentiality if using telehealth options
- Assess suitability of clients for telehealth delivery – consider their access to technology, cost of access, any barriers to access (i.e. lack of privacy, visual/hearing/language impairments), their presenting symptoms and symptom severity, extent of presenting crisis, quality of their social support network currently, suicide/self-harm history and current risk of harm to self and/or others. If not suitable for telehealth, compile a detailed referral plan to a service that can provide this option.
- Consider limitations of telehealth delivery – due to the limited view on screen in videoconference sessions, the clinician’s ability to undertake a comprehensive mental state examination may be limited. For example, subtle non-verbal cues may not be obvious if providers do not have a full image (entire body) of the client in view or where the visual and/or sound quality are poor (time lags and video-audio misalignment).
- Establish a risk contingency plan upon intake - consider establishing a contingency plan for managing any risk-related situations that may arise during the course of treatment.
- Consider how you will terminate a telehealth service
- Review the efficacy of telehealth sessions regularly with the client - If the client’s presentation changes or their circumstances change, they may no longer be a suitable candidate for telehealth
- Help individuals consider the things they need to do to maintain their own confidentiality during a video session
- Put security measures in place to keep electronic client information secure (i.e. update virus software, back up information regularly, avoid using public-domain free wifi networks, use separate business and personal devices), encrypt person data and use an encrypted email service
- Seek regular supervision to discuss any issues with providing sessions, any clinical issues arising from your practice using telehealth (as well as usual supervision topics).

<p>CONSIDERING POSSIBLE NEGATIVE EFFECTS OF ISOLATION/QUARANTINE</p>	<p>Consider whether there is anything that you can do to alleviate some of the negative effects of isolation and quarantine, such as:</p> <ul style="list-style-type: none"> • Help to facilitate contact between the person and their loved ones • Help facilitate the setting up of technology to keep in touch with loved ones • Help manage boredom • Help them to keep a structured routine, or develop a new one • Think creatively to help the person have options for activity despite isolation • Encourage helpful coping strategies to deal with unpleasant emotions • Consider someone's perception of their power/control, relatedness to others, and competence, and try to implement strategies to improve all of these to enhance psychological well-being
<p>CONSIDERING THE IMPACT OF POTENTIAL EXPOSURE TO DEATH AND DYING</p>	<p>The event of the death of loved ones is likely to cause significant psychological distress in any context. In the context of COVID-19, people are likely to experience higher than usual levels of distress in these situations given that they may be prevented from seeing a loved one when ill/dying or prevented from engaging in usual grieving practices (i.e. attending a funeral), due to both current government policies and social distancing recommendations.</p> <p>Consider cultural and religious practices and belief around death and dying, and how the person can observe these as much as possible within restrictions.</p> <p><i>Frontline health workers:</i></p> <p>It is imperative to consider the role of frontline workers and their potential exposure to mass fatalities and management of bodies, which can increase their risk of developing posttraumatic stress.</p>
<p>ADDRESSING ANY EXTERNAL OR INSTITUTIONAL BARRIERS</p>	<p>For those residing in care (i.e. nursing homes, inpatient facilities, Correctional facilities), it is important to address any institutional barriers that might prevent a person from utilising helpful coping strategies.</p> <p>Strategies to overcome institutional barriers could include:</p> <ul style="list-style-type: none"> - measures to reduce feelings of isolation, such as enhanced visiting hours or creative IT solutions that allow patients to connect virtually with family and friends when direct contact is not possible - consider the impact of staff wearing protective equipment when interacting with consumers and manage this accordingly - it may be quite confronting and depersonalising for the person to see staff in PPE, and may cause additional stress. If unavoidable, talk to the consumer about how they feel and help them to develop coping strategies for this. <p>Assist people to seek resources for financial help if they need it, to alleviate</p>

	<p>financial stressors</p> <p>Facilitate choice and personal control where possible and appropriate within restricted environments, to enhance the person's sense of agency. Continue to monitor the consumer's satisfaction with psychological needs of agency, competence, and relatedness.</p>
<p>CONSIDERING NEGATIVE IMPACT OF INADEQUATE SUPPLIES</p>	<p>Having inadequate basic supplies (i.e. food, water, clothes, accommodation) was found to be a source of frustration and was associated with anxiety and anger at 4-6 month follow up after a period of quarantine (Brooks et al., 2020).</p> <p>Being unable to get regular medical care and prescriptions may also cause distress.</p> <p>Consider effect of safety measures - i.e. if there is a shortage of PPE, masks, etc, a person who has tested positive for COVID-19 might experience distress about potentially infecting staff (Morganstein et al., 2010)</p> <p>Consider the effect of a shortage in safety measures - i.e. if there is a shortage of PPE, masks, etc, a front-line health worker might experience significant distress about potentially being infected. This might increase the likelihood of the development of posttraumatic symptoms with repeated exposures over time.</p>
<p>STIGMATISATION</p>	<p>Consideration will need to be given to the psychological distress caused by stigmatisation in inpatient, correctional and community settings - this may be experienced by those infected with COVID-19, those living with a confirmed case, those of Chinese descent (due to potential xenophobia), and those working with confirmed cases (i.e. healthcare workers).</p> <p>Recommendations from the WHO (2020a):</p> <p><i>Do not refer to people with the disease as "COVID-19 cases", "victims" "COVID-19 families" or "the diseased". They are "people who have COVID-19", "people who are being treated for COVID-19", or "people who are recovering from COVID-19", and after recovering from COVID-19 their life will go on with their jobs, families and loved ones.</i></p>
<p>CONSIDERING EFFECT OF "TIPPING POINTS"</p>	<p>Consider that there may be certain event that occur in the COVID-19 pandemic that act as "tipping points", or events that dramatically increase or decrease fear and helpful or health risk behaviours (Morganstein et al., 2010). Examples of this could be:</p> <ul style="list-style-type: none"> - Forced quarantine - Lock down of a facility - Forced and extended isolation from loved ones - Sudden escalation of positive COVID-19 cases in the community - The first positive COVID-19 case within a facility where the person resides/works - Witnessing or hearing of the deaths of particularly vulnerable individuals (i.e. children)

	<ul style="list-style-type: none"> - Shortages of medication, treatment interventions, staff, personal protective equipment (PPE) <p>Devise a plan for the likely scenarios that could occur in your workplace and area of practice, including providing psychological first aid, providing continuity of care, and managing risk issues.</p>
ADDRESSING MALADAPTIVE COPING	<p>Consider maladaptive behaviours that may be related to COVID_19 psychological distress, such as</p> <ul style="list-style-type: none"> • panic buying, spending excessive amounts of money • ignoring safety guidelines • anger and frustration at staff in essential services • refusal to self-isolate when instructed to • behaviours that put others at risk (eg. deliberately coughing/spitting on people/objects) <p>Remember that maladaptive coping behaviours are often driven by fear in the face of a novel threat and associated uncertainty, and strive to meet psychological needs for control, autonomy and power.</p> <p><i>Consider Transference and Countertransference</i> - These behaviours may cause transference and countertransference reactions in inpatient settings in particular, where a person's sense of control, autonomy and power is diminished, and where their behaviour might be seen as an attempt to manipulate, cause trouble, and deliberately threaten staff. Use self-reflection to assess any impact of transference/countertransference on yourself and provide consultation to other staff on strategies to do the same.</p> <p><i>Consider interventions for maladaptive coping</i> - Consider early interventions for maladaptive coping behaviours and transference issues, to prevent longer-term consequences, manage risk, and prevent the development of unhelpful coping repertoires.</p> <p>Explore the function of the behaviour/s and work with the individual to develop other ways to meet the psychological need expressed.</p> <p>Encourage the individual to move towards approach-coping strategies and away from avoidance-coping strategies</p>

SPECIFIC RECOMMENDATIONS FOR FORENSIC CONTEXTS

Liebranz and colleagues offer some general recommendations for detained individuals suffering with mental illness during the Covid-19 outbreak (Liebrenz, Bhugra, Buadze & Schleifer, 2020):

- *Preserving continuity in provision of psychiatric and psychological care to individuals in detention is imperative and should remain so during the Covid-19 outbreak.*
- *Early coordination between regional prison authorities, prison psychiatry, and general medical and general psychiatric care providers (e.g. in cases of referrals). This must also include close liaison with court diversion schemes, probation officers and others. Some clear guidance needs to be developed urgently regarding visitors to prisons and jails.*
- *Given the potential shortage of time and human resources, the more severe psychiatric and psychological cases must be carefully triaged. Here, factors such as pre-existing mental illness, self and extraneous endangerment, violence and aggressive behaviour, refusal to eat, and also assessments and recommendations of experienced security staff should be taken into account.*
- *Given the flood of perceivable unsettling information on Covid-19, staff providing psychological or psychiatric treatment should be informed regularly and urgently about symptomatology and presentation and on the realistic clinical course, also in comparison to other infectious diseases or in comparison to other daily risks. Sharing of accurate information without bias and panic is critical.*
- *Ensuring the provision of masks, disinfectants and protective measures in sufficient quantity for psychological and psychiatric staff visiting individuals in detention.*
- *Particular attention should also be paid to certify that staff deployed to provide psychological/psychiatric care in institutions are informed and/or sensitized of known potential risk factors for a more severe course of a Covid-19 infection of their own (advanced age, somatic comorbidities, chronic respiratory diseases, hypertension, cancer, known immune deficiencies etc.). Due to the currently limited understanding of Covid-19, it may be advisable to prohibit employees with such conditions from providing psychological or psychiatric care to individuals in detention and prisons.*
- *If there is a sudden shortage of staff providing psychological and psychiatric care to detained individuals with a mental illness, staff from general psychiatry may have to fill consequential gaps. This needs careful planning on an urgent basis so that the potential of extremely long working hours of medical staff during the current outbreak can be managed successfully.*
- *It should not be forgotten that psychiatric and psychological care must not just be provided to affected individuals among the general population, but also to vulnerable groups such as people in detention, homes, and asylum centres. Those who survive the infection may experience survivor guilt and those who experience loss of loved ones may experience grief; all the above alongside those who are quarantined will require substantial support.*

The recommended safety measures implemented by the Australian Federal and State Governments in the wake of COVID-19 have necessitated change to the way that psychologists in both community and forensic settings conduct their core business. Face-to-face assessments and therapy are no longer practical, and psychologists have sought alternative ways to maintain therapeutic consistency in their practice, such as through the use of video sessions.

Recent recommendations have been made by The APS College of Forensic Psychologists (APS College of Forensic Psychologists, 2020), for adapting to the current difficulties with assessing and treating individuals in the forensic sector. These have included a summary of concerns voiced by APS Forensic College members in the early stages of the COVID-19 outbreak in Australia, which can be seen below:

- *A decrease in forensic referrals from some sources and increased difficulty accessing required audio-visual equipment.*
- *Difficulty accessing some prisons, other prisons permit online access.*
- *Difficulties with quality of telephone lines into prisons.*
- *Limits to what we can do in the forensic arena regarding assessment, treatment and ensuring meeting standards of our profession as well as telehealth guidelines.*
- *Booked teleconferences with prisons have been cancelled with statement of booking error. Prisons seem to be having difficulty keeping up with the demand for remote professional visits.*

Some preliminary recommendations were made to guide efforts to use online methods for forensic psychology assessments and interventions, which included:

- *The courts have permitted forensic evaluations where assessments have been completed remotely.*
- *Advise all parties beforehand assessments or interventions that will be completed remotely.*
- *Important to note to referrer and document in the report that the use of telephone or online assessment as a limitation for forensic psychology reports and not necessarily best practice standards.*
- *If completing face to face assessment or interventions, ensure you abide by all health requirements.*
- *When completing remote assessments or interventions with clients, need to ensure that they are safe to talk and that they do not have concerns regarding spyware (e.g., in family law due to stalking) and not in breach of bail conditions for example*
- *As with the provision of face to face services, what may be suitable for other areas of psychology such as clinical assessment and treatment work may not be suitable in the forensic sphere and as forensic psychologists we need to cohesively and collectively reflect to our stakeholders including the courts, lawyers and professional bodies as well as other psychologists the practice standards we have for forensic work in the telehealth space.*
- *Ensure that any remote assessments or interventions with clients comply with ethical and legal requirements including Privacy Act, Informed Consent, Confidentiality, managing risk of harm to self and others.*
- *There are a number of psychological assessments that are available for Remote On-Screen Administration, however, we are not aware of any psychological test publishers that have a mechanism to guarantee that the intended examinee is, in fact, the individual that completes the assessment when Remote On-Screen Administration is the chosen administration method. This is a significant concern for forensic evaluations. All Remote On-Screen Administration need to abide by the APS ethical guidelines, Online psychological testing guide, and the APS Ethical guidelines for the use of psychological assessment tests.*

The APS College of Clinical Neuropsychologists have also recently compiled recommendations for adapting assessments to COVID-19 conditions for clients who may not have access to telehealth (Scholes, Stargatt, Dodds et al., 2020), which may be particularly pertinent for psychologist working in forensic settings during the COVID-19 pandemic. Key points are outlined below:

1. Delaying the assessment: where possible an assessment should be delayed until a full, standardised face to face assessment can occur. However, this delay can be managed with a stepwise model that continues to provide support for your client.
 - a) Email clients a form/set of questions for gaining background/history details in written form
 - b) Carry out a video call to obtain further background details and to gain rapport.
 - c) Email or send via online platforms questionnaires that can be carried out remotely.
 - d) Provide interim strategies based on their need and the questionnaire data – as required
 - e) Provide the full assessment when face to face assessment is again possible.

However, if the referral is deemed urgent and the risk of not carrying out the assessment outweighs the limitations and possible risks to the integrity of results when providing testing under COVID 19 restrictions- the following can be considered:

2. Face to face with infection control in place
 - a) Communicate to client prior to the assessment the processes which will take place and gain their written consent to engage in the face to face assessment
 - b) Carry out the history interview via videoconference or phone call
 - c) When client arrives for the face to face assessment, they wait in their car until they are called to come into the clinic.
 - d) Set up assessment table (or two separate tables) so that you are 1.5 m or more apart
 - e) Have a cleaned iPad, blocks, test forms, pen and stylus ready at client end of table prior to the client's arrival
 - f) A stylus for responding on the iPad may be better than allowing client to touch the screen
 - g) Provide verbal instructions for all tasks, or demonstrate with a second set of stimuli if available
 - h) A clear screen can also be set up on the desk to reduce droplet particles going between assessor and client (these can be purchased online and are called 'sneeze guards')
 - i) Masks and gloves can be used by clinician and client if possible
 - j) Manage Social Distancing in waiting rooms and corridors
 - k) Ask client to wash their hands before entering the room
 - l) Have hand steriliser and cleaning products at hand
 - m) Ensure there is air flow in the room
 - n) Limit the time in the room to 1 hour blocks – either have a break on the same day or have the client return across days
 - o) Cover hands before handling and cleaning client's objects after they have left.
 - p) Forms can be photographed and shredded, sprayed with Glen 20 ® or similar; or put in a folder whilst wearing gloves and left for 24 hours.
 - q) Wash hands
 - r) you may prefer to provide feedback via videoconference or via social distancing in the clinic using the above infection control techniques.

3. A mixed approach: face to face + telehealth
 - a) Gain a history via written documents and a video conference or phone call
 - b) Send online questionnaires and/or emailed questionnaires
 - c) Conduct verbal tests via telehealth
 - d) Provide infection managed face to face assessment for the measures that require tools and forms.
 - e) Provide feedback via videoconference or phone call

(continued over page)

4. Within clinic telehealth

- a) Where your client doesn't have the capability or they don't have access to manage technology remotely, or where you are concerned about other risks and assessment integrity (e.g. gaining robust scores such as index measures), within clinic telehealth can help.
- b) You will need access to two treatment rooms, two laptops with a telehealth platform, document camera to transmit visual stimuli and iPad assessment tools.
- c) Inform your client and referrer beforehand and discuss the limitations of this format.
- d) Obtain signed consent
- e) It may be helpful to provide the client with a checklist regarding what to expect
- f) Set up a client room and a clinician room – using the above infection control measures
- g) You need to be sure that your client is not impulsive or distractible if you are leaving them alone as they may push buttons or open forms ahead of time.
- h) Having a trusted family member in the room with them with instructions to monitor those issues may help (who you can see on screen to ensure they are sitting quietly). Keep in mind that having a third party present can increase the client's anxiety or impact rapport or attention. This will need to be documented as a caveat in the report.
- i) Client and family member will need to sign documents confirming that they will adhere to the test rules and requirements.

Reports:

As per the APA telehealth guidelines, reports need to be transparent.

- a) It should detail exactly how the assessment was adapted under COVID19 conditions.
- b) It should detail the limitations of the assessment process used (statistical, methodological, engagement with client, and absence of information that could be obtained)
- c) It should detail the increased margin for error/wider confidence intervals in coming to an opinion
- d) It should detail the risks (e.g. environmental control variables, interference to assessment, recording etc) and what attempts were made to manage them, as well as how successful those attempts were likely to have been.
- e) Include a statement about how confident you are that the referral questions have been answered
- f) Conclusions should be made with caveats such as to review under normal standardised conditions

RESPONSE

After the initial stages of an outbreak have ended, there is likely to be some decline in feelings of uncertainty and anxiety/fear due to increased levels of information, as has been the case in previous pandemics (e.g. H1N1 pandemic – Cowling et al., 2010). However, there will be those individuals whose symptoms persist, and who will require psychological interventions beyond psychological first aid.

Psychological interventions after initial Psychological First Aid could include:

- Cognitive therapy to challenge cognitive bias when consumer overestimate the risk of contracting and dying from COVID-19; and work on catastrophising cognitions more broadly
- Cognitive Behavioural Therapy (CBT) to manage any anger, frustration, generalised anxiety, unhelpful coping habits
- Acceptance and Commitment Therapy (ACT) to work on acceptance of the unknown and strategies to move forward
- Behavioural therapy could focus on relaxation exercises to counteract anxiety and activity scheduling (e.g., home-based exercise and entertainment) to counteract depression in the home environment; behavioural therapy could also be utilised to counteract avoidance behaviours that may have developed during the crisis. It has been documented in previous pandemics and outbreaks that many people did not automatically recommence their previous routines, daily activities, and social contact after isolation had passed – this is likely to be worse the longer isolation occurs for.
- Trauma-focussed therapy to address traumatic aspects of exposure – Eye Movement Desensitisation and Reprocessing (EMDR); Trauma-focussed CBT
- Dialectical Behavioural therapy (DBT) to increase distress tolerance skills
- Continue to assess levels of psychological distress (stress, anxiety, depression, trauma) and continue to triage cases based on psychological need
- Work on coping skills – enhance approach coping strategies and minimise avoidant coping strategies
- Assess feelings around stigma (for those who have had the virus) and have discussions about strategies for self-disclosure about having had the virus.
- Continue to assess basic psychological needs of relatedness, competence and autonomy, and address any needs that aren't being met adequately (Deci & Ryan, 1985)
- Encourage individuals to resume group programs as indicated

MEASURES THAT COULD BE IMPLEMENTED FOR CONSUMERS WHO ARE DETAINED

As psychologists we are not able to shield our patients/consumers from all the negative impacts of a pandemic, but we can make every effort to minimise institutional barriers to coping. The Royal College of Psychiatrists (2020) has recommended the following:

Plan	<ul style="list-style-type: none"> - Plan interventions on an individual basis, case by case - Each individual should have a minimum of a weekly MDT review, and a daily review of their care if they display COVID-19 symptoms. - Every secure hospital setting should have a simple social distancing policy in place which is compliant with public health guidance and preferably drafted with the knowledge and acceptance of the patients and preferably co-produced. - In secure forensic hospital settings, the responsible clinician (or deputy) should ensure that there is a review of each patient's pre-existing physical health vulnerability and consider any particular vulnerabilities for the circumstances as a result of their mental disorder. This will help to make patient level decisions when required. - If the patient's discharge is pending, consider whether it still safe to send them home, taking account of the risks of COVID-19 being in the secure hospital setting and risks of transmitting this at home/next placement and the potential risks of the next placement to the patient. If there is to be any deferral of discharge, this will have to be discussed sensitively with the patient and their family or significant others. If a patient's discharge were not pending, is there any case for bringing this forward? This is unlikely, but should be formally considered in the interests of everyone's physical health safety - Consider the individuals who are prescribed clozapine, and the logistics around continuing regular blood tests
Include	<ul style="list-style-type: none"> - Include individuals and their family members in planning and management of their situation whenever possible
Educate	<ul style="list-style-type: none"> - Provide appropriate education on COVID-19 and transmission risks, hygiene precautions etc. – consider education level, level of cognition, learning needs - Smoking habits and rules will need to be discussed with individuals. Staff may no longer be able to escort patients for smoking or "fresh air breaks", and individuals with access to unaccompanied leave may not be able to access this with increased restrictions on movements in and out of the facility. This will need sensitive communication to patients and should be backed up with written information or posters. As COVID-19 can impact lung function, patients who smoke should be encouraged to give up smoking as a matter of priority for their health.
Provide	<ul style="list-style-type: none"> - Provide every individual with basic measures to engage in hand hygiene and other COVID-19 safety measures. This will mean being given the same information as the

	<p>general public being assisted in following the advice given.</p> <ul style="list-style-type: none"> - Staff must ensure that patients and their families have as much accurate, accessible information as possible about COVID-19 and are engaged as much as they can be with staff in providing the safest possible services. - Consider whether the individual can have visits with family by Skype or by other interactive media. Where such communication possibilities do not exist, units must prioritise setting up facilities for such communication as soon as basic safety precautions have been implemented. - Ward/units should try and maintain some group activities with adjustments to maintain morale, communication and provide reassurance to individuals.
Treat	<ul style="list-style-type: none"> - Provide at least minimum care to each individual according to their needs - In the event of an individual displaying COVID-19 symptoms, their physical healthcare will have to take priority. This may require a pause of therapies, and psychiatric assessment to reevaluate medications. Therapy should be continued via phone or video when patients are in isolation. - Individuals who test positive should be isolated. As far as possible this should be with the patient's agreement and cooperation. If an individual lacks the capacity to understand the need for isolation, or declines to comply, then isolation may need to be enforced in the broader best interests of the patient as well as others. This is likely to be under the Common Law doctrine of necessity. The individual will require regular medical reviews whilst in isolation, and considerations will need to be given to what extent s/he is able to cooperate voluntarily, and what measures are in place to ensure cooperation for the few cases where there are difficulties.
Manage	<ul style="list-style-type: none"> - Managing behavioural crises - the nature of the secure hospital unit population is that, from time to time, a particularly distressed patient may threaten or enact violence towards themselves or others and staff must intervene. New protocols must be drawn up in each hospital/ward/unit for the possibility that patients who are infected with COVID-19 who may require physical restraint. <p style="text-align: right;"><i>(Royal College of Psychiatrists, 2020)</i></p>

Additionally, In the current pandemic, it will be important to address any institutional barriers to autonomy and self-agency inherent in forensic contexts, and help detained individuals to try to develop compensatory strategies to enhance their perceived self-efficacy.

Thoits (2016) summarises transformatory and compensatory coping strategies that can help in response to unavoidable and unsolvable stress (see Table 1, below), and these have been paired with our suggestions for implementation in forensic contexts.

Table 1:

Suggestions for transformatory and compensatory coping in response to constraints (Thoits, 2016)

<i>Suggestions for transformatory and compensatory coping</i>		<i>Possible forensic implementation</i>
Transformatory coping strategies (constructing new meaning from a traumatic event)	<p>Using one's own experiences as a basis for helping others or effecting positive change in the lives of others</p> <p>Banding together with other individuals in the same context, and seeking change</p>	<p>Detained individuals could talk to each other in the same context and use their own experiences to help each other (could be done formally or informally). They could also discuss possible changes to the environment to improve psychological outcomes and seek changes to be made where appropriate and practicable.</p> <p>Unfortunately, social distancing measures in a pandemic might prevent this from being feasible in a group setting, but there may be ways around this, such as sending around surveys etc.</p>
Compensatory coping strategies (using alternative sources of gratification to cope with unavoidable and unsolvable stress)	<p>Acquiring new roles or activities in which to invest oneself (i.e. sign up for volunteer work, enrol in a class, take up sports or fitness activities)</p> <p>Redistributing investments of time/energy/commitment to current role involvements by withdrawing as much as possible from stressful/problematic domains</p>	<p>Detained individuals could volunteer for meaningful roles within their unit/wards/divisions, could start a new physical health and/or fitness regime, could engage in new learning activities such as an online course (where possible) or a new hobby (i.e. learning an instrument, craft, drawing/painting). Unfortunately, group activities and classes would be prevented by social distancing measures in a pandemic.</p> <p>They could also reduce unhelpful activities such as spending a lot of time talking about/reading/watching pandemic-related information or withdrawing from any existing roles/activities that they find stressful.</p>

RECOVERY

As previous outcome studies have demonstrated, there is a significant proportion of people who struggle to re-engage with their normal lives after a pandemic and can continue to self-isolate and engage in safety behaviours, which can exacerbate existing psychological distress over the longer term (Marjanovic, Greenglass and Coffey, 2007; Cava et al., 2005). As much as reasonable, instilling a sense of normalcy and helping to re-establish routines can be effective in fostering resiliency. This may include:

- Planning for return to work/study/training
- Observing rituals, returning to regular routines/, and engaging in regular activities
- Helping people re-engage with organised social groups such as churches, social activities, sporting groups
- Keeping families and members of a community together (especially in any required relocations)
- Ongoing psychological therapy for individuals who remain distressed and who are vulnerable to ongoing psychological distress in the longer-term

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APPENDIX

APPENDIX 1: REFERENCES

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Workshops and Professional Development

- Online workshop: Bessel van der Kolk, MD, On the Global Coronavirus Crisis: Steering Ourselves and Our Clients Through New & Developing Traumas
 - <https://catalog.pesi.com/Item/bessel-van-der-kolk-md-global-coronavirus-crisis-steering-clients-developing-traumas-credit--57744>
- APS Online Event: Integrating Digital Technologies into your Therapeutic Practice – Wed 22nd April. 6:30pm:
 - <https://www.psychology.org.au/Event/21295?view=true>
- APS Online Event: Medico Legal Issues and Psychology: Legal Issues for Telehealth Psychology Services – Wed 22nd April. 7:00pm:
 - <https://www.psychology.org.au/Event/21474?view=true>
- APS Online Event: Loneliness and Social Isolation in the Time of COVID-19 – Thurs 23rd April 8pm AEST:
 - <https://psychology.org.au/Loneliness-socialisolation-event>

Psychological First Aid

Psychological First Aid Guide – Red Cross:

<https://www.redcross.org.au/getmedia/23276bd8-a627-48fe-87c2-5bc6b6b61eec/Psychological-First-Aid-An-Australian-Guide.pdf.aspx>

COVID-19 specific resources

AHPRA – News and COVID-19 updates: <https://www.ahpra.gov.au/News/COVID-19.aspx>

Mental Health and Psychosocial Considerations During COVID-19 Outbreak | World Health Organization - Information handout: <https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf>

Coronavirus (COVID-19) information and resources for psychologists (APS members only): <https://www.psychology.org.au/for-members/resource-finder/resources/Info-sheets/COVID-19-Info-Sheet>

Psychology Tools website – Psychology resources for COVID-19: <https://www.psychologytools.com/psychological-resources-for-coronavirus-covid-19/>

FACE COVID | Russ Harris - Practical steps for responding effectively to the Corona crisis, using the principles of acceptance and commitment therapy (ACT):

https://drive.google.com/file/d/1_O8grFdwMDuGVIE_RvdRfhHhf6xf3tY8/view?fbclid=IwAR2bqlQ8WWPzmemAf7ExBlSL3grQmR10HBs9u_uTa3DxXPDDh3wiPi1cjxQ

Tip Sheet - Coronavirus (COVID-19): managing stress and anxiety:

<https://services.unimelb.edu.au/counsel/resources/wellbeing/coronavirus-covid-19-managing-stress-and-anxiety>

Beyond Blue - Top tips for looking after your mental health while self-isolating:

<https://coronavirus.beyondblue.org.au/managing-my-daily-life/coping-with-isolation-and-being-at-home/managing-your-mental-health-while-in-self-isolation-or-quarantine.html>

Psychosocial responses to COVID-19 - NHS Education for Scotland: Helpful considerations for coordinating a response to COVID-19 in professional environments:

<https://learn.nes.nhs.scot/28063/coronavirus-covid-19/psychosocial-support-and-wellbeing>

American Psychological Association – Pandemics -

<https://www.apa.org/practice/programs/dmhi/research-information/pandemics>

American Academy of Clinical Neuropsychology - COVID-19 Links and Resources -

<https://theaacn.org/covid-19-links-and-resources/>

COVID Trauma Response Working Group | UCL / NHS - <https://www.traumagroup.org/>

- A group of psychological trauma specialists in the UK have formed a working group to help coordinate trauma-informed responses to the COVID outbreak. Policy documents include:
 - [Advice for hospital staff during the COVID pandemic](#)
 - [Guidance for planners of the psychological response to stress experienced by hospital staff associated with COVID: early interventions](#)

Psychological Assessment and Telehealth Resources

Guidance on psychological tele-assessment during the COVID-19 Crisis -Wright, Mihura & McCord (2020); American Psychological Association (APA):

<https://www.apaservices.org/practice/reimbursement/health-codes/testing/tele-assessment-covid-19>

MHS Digital Resource Toolkit - MHS Public Safety have put together an online tool kit of resources including **Guidelines for Prisons, Correction and Detention Facilities, Strategies for Law Enforcement Agencies, and Guidelines for Treatment Providers in the United States.** http://info.mhs.com/ps-digital-resource-toolkit?utm_campaign=PS%20-%20Covid%20update&utm_source=hs_email&utm_medium=email&utm_content=86090432&hsenc=p2ANqtz--mB9kD5bhPonJnmOPmw7GgDiiVpeatkObjtVB3-Wd05KOvLvUmePvcT4woR_Sh8-NLYhnzYAlw3q6rKt-_5STlyA2vFw&hsmi=86090432

Resources for essential workers

APA - Ethical guidance for the COVID-19 era:

<https://www.apa.org/ethics/covid-19-guidance>

Beyond Blue - Protecting your mental health and wellbeing as a healthcare worker:

<https://coronavirus.beyondblue.org.au/impacts-on-my-work/essential-services/protecting-your-mental-health-and-wellbeing-healthcare-worker.html>

Advice for Sustaining Staff Wellbeing in Critical Care During and Beyond Covid-19 - Intensive Care Society - "It is okay not to be okay". A fantastic resource for those who will be working to support front-line healthcare staff: <https://www.ics.ac.uk/ICS/Education/Wellbeing/ICS/Wellbeing.aspx?hkey=92348f51-a875-4d87-8ae4-245707878a5c>

Sustaining The Well-Being Of Healthcare Personnel During Coronavirus And Other Infectious Disease Outbreaks - Center For The Study Of Traumatic Stress:

https://www.cstsonline.org/assets/media/documents/CSTS_FS_Sustaining_Well_Being_Healthcare_Personnel_during.pdf.pdf

Managing Healthcare Workers' Stress Associated with the COVID-19 Virus Outbreak | National Center For PTSD - Details institutional support and self-care strategies:

<https://www.ptsd.va.gov/covid/COVID19ManagingStressHCW032020.pdf>

Cognitive Therapy for PTSD (CT-PTSD): Guidance for Conducting Memory Work Remotely (Oxford Center For Anxiety Disorders And Trauma) - Excellent practical advice for conducting memory work in PTSS such as 'reliving'

<https://www.dropbox.com/s/abgwokufnod67hv/Guidance%20for%20PTSD%20Remote%20Working%2018MAR%20FINAL.pdf>

Self-care resources

APA – Self-care for psychologists during the COVID-19 outbreak:

<https://www.apa.org/news/apa/2020/03/psychologists-self-care>

Looking after your mental health during the coronavirus outbreak <https://www.beyondblue.org.au/the-facts/looking-after-your-mental-health-during-the-coronavirus-outbreak>

Black Dog Institute – Importance of self-care planning: COVID-19 mental health and wellbeing resources

https://www.blackdoginstitute.org.au/docs/default-source/default-document-library/covid-19_self-care-planning_black-dog-institute.pdf?sfvrsn=4

Lifeline – Mental health and wellbeing during the Coronavirus COVID-19 outbreak:

<https://www.lifeline.org.au/get-help/topics/mental-health-and-wellbeing-during-the-coronavirus-covid-19-outbreak>

Tip Sheet: Talking with Children about COVID-19

<https://humanpsychology.com.au/wp-content/uploads/2020/03/Tip-Sheet-Talking-with-Children-about-COVID-19.pdf>

Domestic Violence resources

Domestic Violence Resource Centre Victoria: COVID-19 and Family Violence Resource page -

<https://www.dvrcv.org.au/help-advice/coronavirus-covid-19-and-family-violence>

Relationships Australia – Family Violence Resources (Links and resources to help those affected by family violence):

<https://www.relationshipsvictoria.com.au/services/familyviolence/resources/>

COVID-19: online safety help for domestic and family violence workers:

<https://www.esafety.gov.au/about-us/blog/covid-19-online-safety-help-domestic-and-family-violence-workers>

APPENDIX 3: LIST OF PSYCHOLOGICAL ASSESSMENTS AVAILABLE FOR REMOTE ON-SCREEN ADMINISTRATION

Expressive Vocabulary Test Second Edition
Expressive Vocabulary Test Third Edition
Peabody Picture Vocabulary Test Fourth Edition
Peabody Picture Vocabulary Test Fifth Edition

MEMORY

Multidimensional Everyday Memory Ratings for Youth™ (MEMRY™)

PERSONALITY

NEO™ Personality Inventory-3 (NEO™-PI-3)
NEO™ Five Factor Inventory-3 (NEO™-FFI-3)
Sixteen Personality Factor Questionnaire Fifth Edition
Millon Adolescent Personality Inventory
Millon Pre-Adolescent Clinical Inventory
Millon Clinical Multiaxial Inventory-IV
Millon Index of Personality Styles Revised
Minnesota Multiphasic Personality Inventory-2
Minnesota Multiphasic Personality Inventory-2-Restructured Form
Minnesota Multiphasic Personality Inventory-Adolescent
Minnesota Multiphasic Personality Inventory-Adolescent-Restructured Form

PSYCHOPATHOLOGY

Adolescent Psychopathology Scale™ (APS™)
Adolescent Psychopathology Scale–Short Form™ (APS-SF™)
Personality Assessment Inventory™ (PAI®)
Personality Assessment Inventory™–Adolescent (PAI®-A)
Personality Assessment Screener® (PAS®)
SPECTRA™: Indices of Psychopathology

SUICIDE

Suicidal Ideation Questionnaire (SIQ)
Suicidal Ideation Questionnaire Junior (SIQ-JR)

TRAUMA

Child Abuse Potential Inventory (CAPI)
Child Sexual Behavior Inventory (CSBI™)
Detailed Assessment of Posttraumatic Stress™ (DAPS™)
PTSD and Suicide Screener™ (PSS™)
Trauma Symptom Checklist for Children™ (TSCC™)
Trauma Symptom Checklist for Young Children™ (TSCYC™)
Trauma Symptom Inventory™-2 (TSI™-2)

DEVELOPMENT

(DP™-3) Developmental Profile 3

ADAPTIVE FUNCTIONING

(SCQ) Social Communication Questionnaire

(SRS™-2) Social Responsiveness Scale, Second Edition

(Piers-Harris™ 3) Piers-Harris Self-Concept Scale, Third Edition

Sensory Profile 2

ADI-R

Vineland Adaptive Behavior Scales Third Edition

PDDST-II (The Pervasive Development Disorders Screening Test-II)

*****Note from APS College of Forensic Psychologist (National Committee):***

This is a list of tests that are available for Remote On-Screen Administration. Please note, however, we are not aware of any psychological test publishers that have a mechanism to guarantee that the intended examinee is, in fact, the individual that completes the assessment when Remote On-Screen Administration is the chosen administration method. This is a significant concern for forensic evaluations. All Remote On-Screen Administration need to abide by APS ethical guideline Online psychological testing guide and APS Ethical guidelines psychological assessment tests.

LINKS:

APS ethical guideline - Online psychological testing guide: <https://www.psychology.org.au/for-members/resource-finder/resources/Principles-of-testing/online-psychological-testing>

APS Ethical guidelines psychological assessment tests - <https://www.psychology.org.au/for-members/resource-finder/resources/ethics/Ethical-guidelines-psychological-assessment-tests>