Mental Health Australia

Issues Paper – Mental Health Response Plan for COVID-19

Introduction

The National Mental Health Commission is developing a mental health plan responding to the COVID-19 pandemic for the Australian Government to consider with the states and territories. The plan could become a blueprint for future pandemic responses.

On 29 April 2020 Mental Health Australia facilitated an interactive webinar with National Mental Health Commission CEO Ms Christine Morgan and 30 representatives from the mental health and suicide prevention sector.

Due to tight timeframes, the Commission has requested the sector provide input into issues and challenges by Friday 1 May 2020. This document is a collation of feedback Mental Health Australia has received from the mental health sector to provide to the Commission.

In addition to Mental Health Australia's own input, the following organisations contributed verbal and written feedback to inform this document:

- Australian Association of Developmental Disability Medicine
- batyr
- Beyond Blue
- Community Mental Health Australia
- Embrace (Multicultural Mental Health project)
- Grow
- Mental Health Carers Australia
- Mental Health Coalition of South Australia
- Mental Health Community Coalition ACT
- Mental Illness Fellowship of Australia Inc.
- Neami National
- Northern Territory Mental Health Coalition
- OzHelp
- SANE Australia
- Speech Pathology Australia
- Stride (formerly Aftercare)
- Tandem Inc. Victoria
- The Royal Australian & New Zealand College of Psychiatrists
- WA Association for Mental Health.

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Overview

The current government responses to the pandemic have been generally positive and need to be reflected in any future planning framework.

The initial weakness was in not focusing more resources in a timely way on the most vulnerable, particularly people with serious and complex mental illness and the workforce that supports them. Therefore, the mental health plan should be inclusive of the full spectrum of mental health experiences, ranging from mental distress associated with the pandemic impacting the general population to the exacerbation of existing severe and complex mental illness.

The mental health plan must also acknowledge the impact on carers of changing needs for people affected by complex mental health issues, and changes to formal supports that place greater responsibility upon carers in the reduction and, in some cases, absence of face to face service provision.

The plan should acknowledge the impact a pandemic may have for people experiencing particular mental health issues such as:

Trauma: reliving previous trauma if related to illness / loss / threat to life, particularly for people recently impacted by bushfire / flood etc who may experience compounded trauma.

Obsessive compulsive behaviours: requirements for increased hygiene can trigger repetitive behaviours or distress.

Eating disorders: concern around access to food choices, stockpiling of food; disruption to routine and eating patterns.

Psychosis: the need for increased surveillance or monitoring by law enforcement or public health authorities can exacerbate paranoia and delusions.

The mental health plan needs to acknowledge the high rates of comorbidity of mental health issues and other health issues, which often reduces help-seeking behaviours.

For people who have previously experienced moderate to severe mental illness, the heightened stress related to COVID-19 will increase likelihood of a relapse or worsening of symptoms. Psychosocial supports will be particularly important in addressing and reducing this distress.

All funding bodies should be encouraged to consider flexibility regarding mode of delivery of services and KPIs for funded service providers. In particular, the rate of transition to the NDIS for people with psychosocial disability may be impacted, meaning that state funded services must continue to support clients over a longer timeframe than previously anticipated.

The mental health plan should include how each component of the mental health system (primary, sub-acute, acute, community, tertiary, carer support) will provide continuous service during each phase of a pandemic response. For example, if acute admissions are not possible, the community mental health sector will need to be expanded to provide commensurate services within the home.

We understand there will likely be four phases to the plan and the mental health system's response and capacity should be outlined across each of the proposed phases:

1. **Physical distancing**: including gathering restrictions, self-isolation and quarantine.
2. **Standing down**: easing of restrictions.
3. **Targeted action**: where monitoring allows for surges/emergence of hot spots to be managed.
4. **Long-term recovery**: sustainable responses that provide proactive addressing of risk and protective factors.

Previous mental health advocacy relating to COVID-19

Mental Health Australia has recently written directly to the Ministers for Health, Social Services, and the National Disability Insurance Scheme, to advocate for a range of strategies to address issues raised by the mental health and suicide prevention sectors during the current COVID-19 pandemic.

For a successful mental health pandemic response plan these issues must be addressed. They include:

- Increased flexibility in funding contracts to ensure service providers are able to respond innovatively to consumer need during the COVID-19 emergency period.
- Provide prioritised access to personal protective equipment (PPE) for direct service provision workforce.
- Ensure the non-government mental health workforce is financially viable through investments not debt provisions.
- Provide priority access to testing for both the mental health workforce, including disability support workers, and people with psychosocial disability who require face-to-face supports.
- Ensure that the most vulnerable people have access to assisted technology, training and data to ensure that they can access digitalised service provision when face to face service delivery is limited.
- Ensure that carers and Disability Support Pensioners have access to pandemic-related supplement and support payments.

Mental Health Australia also supports calls to improve community mental health responses as outlined in Professor Alan Rosen's recent mini Members Policy Forum presentation held 24 April 2020 and correspondence to the Australian Government (see attachment: Alan Rosen's presentation to mini-MPF 24 April 2020).

Collated responses from the mental health sector to the consultation

Phases of response

Physical distancing: including gathering restrictions, self-isolation and quarantine.

- Loneliness and isolation are more commonly experienced by people affected by complex mental illness. This is exacerbated by physical distancing and quarantine requirements.

Standing down: easing of restrictions.

- MBS telehealth items should be continued for a period of at least six months after restrictions have eased. During this time, an assessment should be undertaken about the extent to which they should be continued in light of ongoing uptake by clients and practitioners. (We note, however, that the increase in telehealth use may reflect an inability for people to access face to face services currently. Further, we note the overall number of engagements with mental health services has actually decreased, which is less than ideal and may reflect technology capability rather than lack of interest in the telehealth service.)
- As restrictions ease, people affected by complex mental illness should be able to retain the choice to source support online or via telehealth if this is their preferred method of engagement. People who wish to continue to be able to receive face to face services should be able to do so.

Targeted action: where monitoring allows for surges / emergence of hot spots to be managed.

- If there is a spike in COVID-19 cases, there is a need to support the capacity of mental health and community services to step up and support clinical teams.

Long-term recovery: sustainable responses that provide proactive addressing of risk and protective factors.

- In thinking through the medium to longer term ramifications of the pandemic, it is important to reflect on learnings from other major economic events, like the Global Financial Crisis. Evidence from Europe found that in periods of economic recession, stigma and discrimination rise and competitive job markets tend to further disadvantage people with mental health issues, particularly those which are severe and complex in nature.
- COVID-19 is likely to increase the need for support for people with moderate to severe mental illness for a considerable period following the pandemic. This includes individuals, their support networks, as well as new clients requiring support.
- Development of the Adult Mental Health Centres needs to incorporate an ability to respond to the pandemic, and future pandemics, and the fact the associated economic downturn means that support around a person's financial stressors must be picked up in a holistic model of care that is not just about treating symptoms.
- Historically, periods of economic downturn are associated with increased rates in suicide and there needs to be targeted programs in place to reduce the risk of suicide, including due to an increased individual perception of burden tied to financial hardship. This should also be addressed through the Adult Mental Health Centres.

- The mental health plan should reference other drivers of mental ill health that lie outside the health system and are further impacted by a pandemic, such as physical health, employment, housing etc. The level of intervention from these supports should be long-term to account for the prolonged mental health impact of a pandemic crisis on the whole community.
- In Australia, the provision of effective, evidence-based community support for children and families is a yawning gap in our system of mental health support services and policy. Evidence tells us three-quarters of all adult mental health conditions emerge by age 24 and half by age 14, and that 1 in 7 Australian children are already exposed to toxic levels of stress (before COVID-19). The biggest long-term mental health issue the world and Australia will face post-COVID- 19 is the lifelong mental ill health of children affected by unaddressed trauma. The greatest opportunity we have to address this trauma is effective early intervention and support for young children and families (see attachment: submission from Stride and KidsExpress).
- Continuing to increase the peer workforce as a crucial component of an effective support system will be important in supporting long-term recovery following the pandemic (see attachment: Mental Illness Fellowship Australia submission).

Engaging Lived Experience

While acknowledging the compressed timeframes, Mental Health Australia and the mental health sector urge the Commission to seek further input from consumers and carers with lived experience where possible.

Governments' responses to this pandemic are an opportunity to reaffirm the value of a lived experience workforce, and provide momentum for creating jobs for appropriately qualified peer workers. In implementing a mental health plan, all governments should draw upon the expertise and experience of existing peer-led services and models, as well as investing in the growth and sustainability of these.

To grow lived experience in service delivery will require a proactive approach by funders, such as including targets of percentage of qualified peer workers in funding agreements for broader services. Community mental health peak bodies across each jurisdiction have developed resources to assist capacity building and development of the peer workforce, and will continue to be a useful resource and leader.

There are established lived experience networks, peaks for consumers and carers in states and territories, and national representation. There are also facilitated networks, such as Beyond Blue's Blue Voices community among others, who are ready and willing to contribute to the development of mental health services, policies and programs. At a jurisdictional level, one of the most valuable COVID-19 related investments to date in South Australia has been the COVID-19 Mental Health Peer Support Line.[1]

[1] See **https://www.skylight.org.au/covid-19-support-line**

Key issues and challenges

In addition to focussing on the issues above that need to be addressed during the COVID-19 pandemic, Mental Health Australia has collated feedback from members and stakeholders for the Commission by building on where there is already consensus across the sector.

Charter 2020 has already been endorsed by over 110 mental health and suicide prevention organisations, and as such forms the basis of our response, albeit in a revised format relevant to the task at hand.

This section of the document collates issues and challenges raised by the sector to Mental Health Australia under each of the principles of *Charter 2020.*

Charter 2020 principles revised for a COVID-19 environment

- **Ensure national coordination of service provision**
  - Coordination across jurisdictions is required – this should include the Commonwealth coordinating with states and territories, and with national and/or state-wide NGOs at the jurisdictional level, and Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) coordinating with non-government organisations (NGOs) in their geographical areas.
  - Such coordination must be framed within the context of 'National leadership but regional interpretation and implementation'. This is one of the learnings to come from the ANU Global Impacts of **COVID-19 on Mental Health Webinar series**.[2]
  - There needs to be within the mental health plan a governance framework with clear agreement/ guidelines on coordination, collaboration and final responsibilities – all levels of governments, key funding bodies (NDIS, PHNs etc) and different parts of the mental health sector.
  - Direct representation of NGO community based mental health services in this coordination of service provision is critical. Perceived conflicts of interest regarding the involvement of NGOs in coordination (as they are also service providers) need to be set aside, as with LHNs and others, in order to ensure the most comprehensive service response during a crisis.
  - The public and private systems should work together flexibly to ensure they meet the needs of people affected by complex mental illness – there are examples of this already with patients in a private clinic being relocated to a public hospital.
  - Disability and health must work together; people with mental illness are covered by both these areas. It is vital government departments work together and the mental health plan integrates both these aspects of mental illness seamlessly. Note that not all people with psychosocial disability are eligible for, or covered by, the NDIS.
  - In coordinating between health systems, demand within the mental health system should be able to be met before clinicians are redeployed to the acute physical health system.
  - The next phase of the governments' approach needs to be focused on the

[2] See **https://rsph.anu.edu.au/news-events/events/global-impact-covid-19-mental-health-webinar-series-ongoing**

medium to longer term needs of local communities and therefore has to be more granular – supporting regional and local action to provide a comprehensive response to community need over time.

- We have seen in this time of physical distancing the efforts that so many people have put into building their local community – from their balconies, on the footpaths, from their driveways. As we go through the next phases of **Standing down**, **Targeted action**, and **Long-term recovery** we need those efforts ramped up at the local level, not to dissipate.

- **Build a responsive health system that is truly person led**
  - Build a response on what people with lived experience of mental illness and their carers say they need, including the structures and processes required to ensure co-design of services and responses.
  - Frame the mental health plan from the perspective of the consumer. This means focussing on services and supports needed, from early intervention and prevention through to treatment and recovery, rather than from the construct of the different parts of the sector (public, private, NGO, primary, tertiary, etc). By starting from this perspective, the mental health plan is more likely to deliver the person focussed services that are needed. It can then ensure services are provided by the appropriate part/s of the sector.
  - A particular focus is needed on the provision of services and supports for (a) people with the most complex needs; (b) the 'missing middle'; (c) people unable to use/access technology, and (d) people who have never needed support for their mental health before the pandemic.
  - Ensure people with mental health conditions (especially people with severe and complex mental illness) are classified as a vulnerable group for the purpose of accessing PPE and accessing testing. There is support for more in-home acute services such as hospital in the home however it will need attention where consumers reside with their families and the intrusion of services within the family environment particularly if the number of visitors to the home is limited.
  - Families and carers are providing additional support to their family members. The Carers Payment should be eligible for the Coronavirus Supplement that applies to people receiving other benefits.
  - Enhance telehealth capability of the mental health system (public and private). Many people are currently receiving telehealth services by phone as many public mental health services do not have the equipment or space for their health professionals to engage in video consultations. The inpatient Medicare items should be supported.
  - Access to services for people who are not accessing them, especially people with severe illnesses. There has been delayed help seeking with more deterioration once someone does present for help. Ongoing support is required for people with severe illness to avoid relapse and re-presentation to the public system.
  - There needs to be flexibility to meet the diverse needs of Australia's population. We are highly multicultural, spread across diverse landscapes, and faced with the challenges of distance. As well, there are the different needs associated with co-existing conditions, the range of socioeconomic conditions people live with

further impacted by pandemic-related unemployment, and the specific needs of particular populations groups such as our First Nations people, LGBTIQ people, CALD people, etc.

  - The mental health plan should address concerns for migrants who are in vulnerable working conditions, particularly those in face to face service provision such as in aged care, hospitality etc, who may not feel able to negotiate safe working conditions or fear job losses if they speak out. There is a need to ensure strategies address people from CALD backgrounds and consider multiple communication and outreach channels.

- **Address the social determinants of mental health issues**
  - The mental health plan should ensure strategies are in place to address stigma and discrimination and include initiatives across the social and environmental determinants of poor mental health including isolation, housing, employment, trauma, physical health, income support, and environment, etc.
  - The plan should reference other drivers of mental ill health that lie outside the health system and are further impacted by a pandemic. This includes the need to provide an integrated mental health response with access to safe and secure housing, increased welfare payments and unemployment mitigation, family violence and child abuse services, substance use and gambling help services.
  - The level of intervention from these supports should be long-term to account for the prolonged mental health impact of a pandemic crisis.
  - The mental health plan should address the need to build social cohesion by reducing social isolation. The evidence is clear this needs to go beyond telephone calls and text messages to intentional peer to peer support which makes people feel less alone, builds resilience, self-esteem and self-worth, enabling people to form relationships and build community.
  - Funding needs to be provided for specific projects and programs which can support building social cohesion and building community or social capital at the local level.
  - The mental health plan must build a caring and sharing community at the local level and maintain that community over the long term for people with mental health issues, who often feel isolated anyway, and people with emerging problems due to the pandemic. The community can be supported to build resilience and coping skills, helping people to recover, keeping people out of hospital, taking medication, reducing suicidality and helping people gain and retain education and employment.
  - The crossover of mental health issues with drug and alcohol misuse and family and domestic violence is widely reported as having intensified during the response to COVID-19. Service and professional capacity needs to be increased to meet demand during a crisis.
  - Apply targeted action to support key ‘at risk’ or ‘priority’ cohorts such as men, particularly those who become unemployed and/or isolated as a result of the pandemic. The relational nature of mental health means we need to design supports that reflect social determinants, often with social/relational interventions.
  - The mental health plan needs to acknowledge that ‘trauma load’ means some

population groups are more impacted at present such as people who have been through bushfires recently, drought etc. Need to look at these experiences through a trauma-informed lens.

- Stigma was a key barrier to help-seeking prior to COVID-19, and this will be exacerbated now and into the future. batyr has been hearing through schools and universities that racism and discrimination associated with COVID-19 are additional factors perpetuating stigma and exacerbating mental ill-health. Addressing these areas through the mental health plan will be essential so people are more likely to access the digital mental health services that are being invested in.

- **Invest in early intervention and prevention**
  - Provide programs and supports that intervene early to prevent people from becoming mentally ill and stop emerging mental illnesses from becoming more severe, including a focus on increasing mental health literacy.
  - The greatest opportunity we have to address the potential long term effects of this crisis is effective early intervention and support for young children and families. The evidence tells us early intervention can materially improve long-term outcomes for children with significant adverse childhood experiences like fear of COVID-19 and its related isolation.
  - We can initiate a generational shift in the health and wellbeing of Australians by establishing a network of community-based, integrated services dedicated to the mental health of children and their families (see attachment: submission from Stride and KidsXpress).
  - The mental health plan should find ways for services to engage proactively with people who are at increased risk. For instance, instead of relying on people who have lost their jobs to call a mental health support service, Centrelink or Jobactive providers (perhaps through a third party with the right capability set) proactively reaches out to people to support their mental health at a vulnerable time.
  - The scale of the mental health impacts of COVID-19 reveals the bottlenecks in our existing mental health system. Now is the time to implement a genuine stepped-care approach at scale, so people with high prevalence conditions with mild to moderate symptoms are not waiting to access a limited supply of high-cost clinical specialists but can be matched to effective low-intensity support that meets their needs.
  - Whilst mental health services are invested in and being delivered, prevention and community outreach will be integral to bridge the gap between people requiring support and people actually accessing support. Prevention can also contribute to better health outcomes for individuals to avoid requiring acute care, which will also help relieve pressure on mental health services experiencing higher demands through this period.

- **Fund specific Indigenous mental health, wellbeing and suicide prevention strategies according to need**
  - The mental health plan should include dedicated strategic responses that are co-designed and co-implemented with Indigenous leaders, consumers and

communities.

- *Mental Health Australia did not receive any feedback from our members who work with Indigenous Australians within the tight timeframe. Mental Health Australia recommends the Commission reaches out to organisations who are experts in Indigenous mental health to ensure their voices are heard in the pandemic mental health plan.*

- **Provide integrated, comprehensive support services and programs –**
    - The mental health plan should ensure intensive, team based and integrated care is available for people experiencing a mental health crisis. This should primarily be done through expanding community mental health service capacity.
    - The plan will be most useful if it includes all parts of the mental health system, including public, private and NGO community services. This is an opportunity to map out how to coordinate the raft of mental health services and how they interlink. Beyond the welcome telehealth measures, the plan can outline how to provide appropriate access to mental health services for people beyond the crisis.
    - Strong coordination and clear pathways to get people to the services they need is essential, given the fragmentation of the current mental health system.
    - The mental health plan should address issues faced during the pandemic across the continuum of mental health care services, this includes:
        - Ensuring advice/resources address in-patient mental health settings. Acute services are struggling in many places, with inconsistencies within and across jurisdictions. There are issues from confusing/ inconsistent messages about what work can continue during physical distancing, and what work cannot (including face to face assessments/ therapy, group work etc), difficulties accessing PPE, difficulties maintaining social distancing and patient/consumer hygiene, difficulties for vulnerable clinicians (e.g. those who are pregnant or have other health vulnerabilities) who are unable to work from home and provide telehealth because in-patient services are not allowing or supporting telehealth.
        - Supporting de-escalation of issues in congregate living. For example, for people in supported group homes and people at risk of homelessness in congregate living there have been increased tensions because of physical distancing measures and people's varying capacity to understand and follow this.

- **Expand community based mental health care**
    - The mental health plan should acknowledge community based mental health organisations are highly effective at working with people in their community, support people in their recovery journey and keep people out of hospital. Community mental health organisations have the capacity to implement services better able to respond to people under the COVID-19 environment. For example, they can provide alternatives to contact with hospitals as people need to be supported in their homes and communities. This can look like support for a range of issues, from providing perinatal mental health support through to suicide postvention support.

- It is imperative to provide integrated, comprehensive support services and programs to ensure intensive, team-based and integrated care is available for people experiencing a mental health crisis. This should be primarily done through an expanded community mental health service capacity.
- It is important to consider issues of access and equity when transitioning services to be delivered via telehealth if they cannot continue to be delivered face to face. Reliance on telephone and online support is compromised due to people's lack of access to devices, plans and data, and lack of skills in using technology. Staff skills in technology for online support is also lacking at times. Where psychosocial services have been successfully transitioned online, they have required an investment in infrastructure to support people to access these services.
- The mental health plan must include safeguards to ensure people with mental health issues and psychosocial disability, and their family or friends providing informal supports, have access to assisted technology, training and data to ensure they can access digitalised service provision when face to face service delivery is limited.
- Flexibility is needed across all jurisdictions for contracts and deliverables from Commonwealth and state/ territory government departments, the NDIA and PHNs. Realistic KPIs and milestones relevant to a pandemic environment need to be renegotiated with NGOs and other service providers.
- Though community based psychosocial support services are a crucial care component in responding to increased distress associated with a pandemic, they have been depleted through reduced funding in transition to the NDIS. This significant area of unmet need was identified in the Productivity Commission's draft report.
    - Organisational cash flow is critical to enable agility and responsiveness. Overheads such as procurement and training (PPE etc), staff development, change management etc are increasing and are critical during this time.
    - The one month 'advance' from the NDIA should be treated as a grant rather than a loan, in order to shore up cash flow for these providers and enable investment in change management, innovation and staff retention/ development/ redeployment priorities of organisations.
- There are evaluated, effective models of psychosocial support that have received Commonwealth, state or territory funding across the country, and community mental health providers who have expertise in this area could be supported to scale up these services to support people through and following this crisis.
- This is not a time to introduce new entities where existing organisations can/ are providing similar services. It is quicker and more effective to increase capacity of existing organisations which already have programs, networks, trust and local knowledge to quickly meet need.

- **Workforce support**
    - The mental health plan should provide priority access to testing for the mental health workforce, including disability support workers, and people with

psychosocial disability and family or friends providing informal support who require face-to-face supports.

- Ensure adequate supply of PPE is made available to all frontline mental health service workers to protect clients, workers and facilitate continuity of service must be supplemented with training in the correct use of PPE. There must be confidence in the health and safety of community mental health workers, for the sake of participants and workers.
- The community mental health workforce must be classified as an essential workforce and prioritised for PPE and testing. Good availability of testing for workers will go some way to encouraging participants to be confident with agreeing to face to face support.
- Flexibility with government funding and NDIS support is needed to retain the workforce throughout fluctuations in support hours delivered. This will enable organisations to re-train staff, develop more innovative models of support, and deploy staff to other areas of need.
- Community-managed, recovery-oriented psychosocial services have an existing workforce of qualified and experienced mental health support workers, including peer workers, who can quickly be deployed during a pandemic.
- Ensure the mental health workforce is supported appropriately. Create free mental health tools for essential workers, including service providers, based on international examples (see the American Red Cross' **Mental Health First Aid course for COVID**).[3]

- **Build an evidence based, accountable and responsive system for the future**
    - The pandemic has revealed a significantly increased level of engagement through digital services including peer-to-peer forums as well an increase in one-to-one services now delivered via telehealth. This represents a fundamental shift in mental health service delivery and highlights the opportunity for addressing the ongoing mental health needs through a digital lens most particularly for people affected by complex mental health issues.
    - In contrast to the comprehensive and real-time collection of public health data on COVID-19 cases, testing and recovery, there has been a lack of comparative information on mental health needs and access to services. There needs to be significant investment in the provision of data with respect to mental health conditions, including suicidality, and potentially this could be picked up in extended remit of the AIHW.
    - As far as possible, evaluation and data collection systems should be established to monitor what is working and what is not. Some of the changes that happen as a result of COVID-19 might prove very effective and should be maintained into the future if possible. Similarly, feedback mechanisms and embedding a genuine culture of continuous quality improvement and reflective practice.
    - There should be a capability mapping exercise to overlay the capacity of primary health care resources with community-based services and NGO mental health organisations able to support the overall mental health response plan. While PHNs and large mental health organisations have significant reach, this is

[3] See **https://www.redcross.org/take-a-class/classes/mental-health-first-aid-for-covid-19-online/a6R3o0000014ZIg.html**

supplemented by community-based services and NGOs that deliver in these gaps, often servicing some of the most vulnerable Australians who cannot access mainstream services.

- Service provision data during and in the aftermath of a pandemic should also include the experiences of service users (consumers and carers), in addition to provider data.

Additional issues and challenges

Rural and remote

The Northern Territory Mental Health Coalition conducted three surveys during the first half of April 2020 to provide data-driven insight to the challenges rural and remote Australians are experiencing.

The surveys sought input from NDIS providers, the mental health workforce, and NDIS participants, to understand the issues and challenges they are facing during COVID-19.

In addition to the 'Key issues and challenges' listed above, rural and remote Australians face both heightened and additional challenges. These include:

- Reduced or no support for NDIS participants.
- Increased rates of co-occurring health issues in rural and remote Australians compared to metropolitan Australians.
- Food security (including affordability, and disruption to usual delivery services).
- Overcrowded housing impacting on hygiene and physical distancing.
- Aboriginal and Torres Strait Islander clients who have "returned to country with no proper planning or supports in place, and now with no access to NDIS funded supports".
- Access to technology (including device access, phone service coverage and internet access, and low confidence in using devices).
- Isolation and loneliness.
- Access to transport.
- Funding and contract flexibility for rural and remote providers (including insufficient PPE and funding to continue face to face programs as a remote service.

Communication

There must be consistent, clear, positive messaging throughout and beyond the pandemic. This communication must be beyond about accessing available help, and include practical things people can do for their mental health and wellbeing, and how to talk to people you might be concerned about.

Details of the governments' responses to the pandemic (e.g. quarantine, physical distancing) should be available in a variety of formats to account for language ability, low literacy and diminished concentration as a result of psychotropic medications.

Changes to routine can be challenging for people with complex mental illness. Where possible, it is important to be clear how changes will impact individuals and provide information to help people anticipate further changes that may be on the horizon.

There is strong sector support for a mental health promotion campaign across a variety of different media platforms, like 'Life. Be in it' campaign.

Technology access and usability

Technology access and usability is inadequate to support video-based alternatives to face to face support for a large cohort of consumers and carers.

Issues include lack of access to the correct equipment, access to phone service coverage and data networks, and ability to use and confidence in using technology.

Carer needs

- The pressure now faced by carers is highly distressing and of great concern. Some family members with mental health issues are becoming unwell and aggressive, with elderly carers fearing for their safety and unlikely to seek support from domestic violence services. These carers are also unable to access respite services and due to physical distancing may not be leaving the home.
- Family are having accentuated issues when liaising with the NDIA due to perceived inflexibility around how to access support, and they are needing to resort to desperate measures such as visiting local MP's to attempt a resolution.
- Respite access through Carer Gateway Services is a top issue for mental health carers. Mental health carers who are struggling with their own mental health or emerging mental health carers need specific mental health carer supports that are relevant to their unique caring role. Financial pressures due to loss of work and pressure to support unwell family members is creating high levels of stress and concern of carers developing their own mental health issues.
- Carer Payment recipients should receive the coronavirus supplement. The fact that Disability Support Pension and Carer Payments are not included in the supplement is increasing stress levels for mental health carers. This would be an easy issue for the Australian Government to resolve.
- Sector members are advising there has been a significant increase of suicidal ideation among family carers across the lifespan.
- COVID-19 gives us an opportunity to communicate to the broader community why supporting people with mental health issues is different to other health needs and highlights the need for inclusion of family and carers in care.

Conclusion

Mental Health Australia will continue to support the Commission to inform its much valued work through using our extensive networks with our members and our communication platforms.

The process of government policy development is a complex one, particularly in the rapidly changing environment we are currently in. However, many of the investments being made by governments now will have long lasting impacts upon the delivery of mental health services and these should be well informed by consumers, carers, and service providers.

Mental Health Australia continues to advocate for increased investment in consumer and carer infrastructure and data collection to enable improved government engagement and decision making that could support future planning processes.

The bushfires and COVID-19 disasters have seen collaboration across all governments and across sectors that has resulted in extraordinary changes in a relatively small period of time. These efforts should be justifiably celebrated but also embedded in planning of mental health services into the future.

Appendix 1 : List of attachments

The following documents are provided to the Commission as separate attachments to this document.

1. Submission from Australian Association of Developmental Disability Medicine
2. Submission from batyr
3. Submission from Mental Health Coalition SA
4. Submission from Mental Illness Fellowship of Australia Inc.
5. Submission from Stride and KidsExpress