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Editorial

Psychological Impacts of Coronavirus Outbreak on Western Australia without Prolonged or Stringent Lockdown

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Choi applied the mentalizing model to describe the psychological impacts of coronavirus outbreak on a patient with borderline personality disorder (BPD); and considered how the lockdown effects and COVID-19 pandemic stressors combined to increase the expression of psychopathology [1].

The Coronavirus infection (COVID-19) has caused a global pandemic and public health emergency [2]; and restrictive and prolonged lockdowns have been implemented in many parts of the world. Many people found their lives changed by the restrictive measures when confined at home for a prolonged period of time, unable to go to work, school or attend social gatherings. Understandably, the confinement was particularly distressing for those with psychological vulnerability or pre-existing psychiatric disorders [3]. In most parts of the world, the effects of lockdowns are conflated with that of COVID19 pandemic as these two events co-occurred within a narrow timeframe. Here, we describe our experience in a youth and adult mental health service based in the South Metropolitan area of Perth, Western Australia (WA), where no prolonged formal lockdown occurred - though short period closure of restaurants, bars, cafes, gyms, schools, recreational classes and facilities as well as restriction on social gatherings did occur; and hard border closure insulating WA has been imposed from 15th March 2020 with partial relaxation for inter-state travelling on 15th November [4]. Yet, our service has experienced increases in acute and subacute presentations of mental health deteriorations in both new and existing clients. As such, we postulate that the COVID19 pandemic may contribute to psychological distress, independent of factors related to the confinement specific to government-imposed lockdowns.

Based on qualitative experience and accounts by clinicians in our group, we have identified six key themes in the increase of service demand.

The first group is clients with borderline personality disorder, with underlying hyper-sensitivity to stress [3]. During the pandemic many individuals with borderline personality disorder presented to the Emergency Department (ED) were distressed and emotionally dysregulated with intensified feelings of emptiness and abandonment by friends and family, similar to the patterns described by Choi.

Related to this group are clients with existing post-traumatic stress disorder who required more support, while expressing increased ideations of deliberate self-harm or self-cutting and seeking mental health treatment through ED.

The third group is clients with anxiety disorders (pre-existing or subthreshold). Media coverage of COVID19 (on mortality, panic buying, closure of non-essential business, contagion and fear of severe illnesses) all appeared to heighten anxiety, in line with previous reports of public health emergencies causing psychological effects on fear and worry [5], especially in the absence of interpersonal communication [6]. Disease outbreaks increase panic,

depression, anger and uncertainty; and financial stress can cause 25% to 33% increase in anxiety during pandemics [7]. In our qualitative experience, such effects appear to be translated to increased ED presentations.

The fourth group is individuals who misuse alcohol and other psychoactive substances, with an increase in drug induced psychosis presented to the ED. Psychoactive substance, methamphetamine and alcohol were used by some to counter stress and aversive boredom related to the pandemic, in line with stress as a well-known risk factor for addiction and addiction relapse vulnerability [8].

The fifth group is clients with eating disorders, with some experiencing marked deterioration in eating and weight loss during COVID19. Some reported an increase in rumination and obsessive thinking (likely caused by more unstructured time at home, due to closure of schools, recreational classes and facilities): that is, reduced structured recreational and social time decreases time spent on externally orientated activities, and by default increases time available for rumination.

The final group consists of children, adolescents and youths presenting with DSH and suicidal ideations *de novo* without direct referencing COVID19 or related stressors. We postulate that this group appears expressing DSH symptoms due to increased general distress - which permeate their families, significant adults (with increase in unemployment, financial stress, adult mental health problems and parental conflicts) and stressors at school.

During the pandemic, many psychiatrists, GPs and other health professionals have switched to telehealth for the first time, while some outpatient consultations were rescheduled due to clients' fear of contagion in visiting hospitals or clinics. For patients with eating disorder, we found that telehealth has not been useful, failing to detect changes in weight and physical observations such as blood pressure and heart rate. And some clients deliberately wore baggy clothes to disguise their weight loss online. We experienced an increase in patients with eating disorders admitted in poorer physical states.

In conclusion, we seek to highlight a range of acute and subacute psychiatric presentations to our regional and state-wide mental health service - related to the COVID19 pandemic. In Australia, a 15% surge in patients seeking psychological support since the start of pandemic has been reported [9]. Here, we highlight that certain psychological impacts of COVID19 can occur, independent of the lockdown effects as we have not experienced a formal and prolonged government-imposed lockdown.

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