CRE–DH

Centre of Research Excellence in Disability and Health

SUBMISSION TO THE DISABILITY ROYAL COMMISSION

In response to the Issues Paper on the impact and responses to the Omicron wave of the COVID-19 pandemic for people with disability

in partnership with

THE UNIVERSITY OF MELBOURNE

THE UNIVERSITY OF SYDNEY

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CRE–DH
Centre of Research Excellence in Disability and Health

About this submission

This submission is made on behalf of the Centre of Research Excellence in Disability and Health (CRE-DH) funded by the National Health and Medical Research Council, 10 June 2022.

The submission is in response to the Issues Paper from the Royal Commission into Violence, Abuse, Exploitation and Neglect against People with Disability (Disability Royal Commission) - '*The impact of and responses to the Omicron wave of the COVID-19 pandemic for people with disability Issues Paper'* released on 25 March 2022.

Our response reflects on the content of the Issues Paper as well as what has happened since the publication of the paper. We organise our responses around the key issues. We start with an overarching recommendation we believe may circumvent many of the problems we have witnessed during the pandemic for people with disability.

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About the CRE-DH

The Centre of Research Excellence in Disability and Health (CRE-DH) aims to identify cost-effective policies to improve the health of people with disability in Australia. There are four interconnected research areas the CRE-DH focuses on:

- mapping the health inequities between Australians with and without disabilities,
- analysing the social, economic and environmental factors that contribute to the poorer health of people with disability,
- modelling the cost-effectiveness of health policy interventions, and
- policy analysis and reform.

The CRE-DH is an interdisciplinary research group comprised of academics from five universities, a team of international advisors and a Partner Advisory Group of stakeholders from the disability and health sectors. The CRE-DH Co-Directors are Professor Anne Kavanagh (University of Melbourne) and Professor Gwynnyth Llewellyn (University of Sydney). The CRE-DH includes Chief Investigators from the University of Melbourne, University of Sydney, Monash University, UNSW Canberra and RMIT with multidisciplinary skills in epidemiology, health economics, health and social policy, psychology, psychiatry, public administration and public health. In addition, we have Associate Investigators from a range of national and international universities and the World Health Organization. We work in collaboration with key stakeholders including DSS, ABS, AIHW and peak bodies in the disability advocacy and service sector through our Partner Advisory Group. Several members of the CRE-DH research team and the Partner Advisory Group also have lived experience of disability.

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

This submission is from the NHMRC Centre of Research Excellence in Disability and Health in response to the Issues Paper from the Royal Commission into Violence, Abuse, Exploitation and Neglect against People with Disability (Disability Royal Commission) - '*The impact of and responses to the Omicron wave of the COVID-19 pandemic for people with disability Issues Paper*' released on 25 March 2022.

Our submission is organised around the key issues raised by the Disability Royal Commission (DRC) in the Issues Paper. Our response focuses on the following key issues raised in the Issues Paper: gaps in data collection and reporting, access to vaccines and boosters, disruption to disability services, access to essential health services, infection prevention and control, and preparing for the future. We offer reflections and recommendations under these key issue areas. We make one overarching recommendation.

RECOMMENDATIONS

Overarching recommendation

1. Commonwealth decision-making bodies (Australian Technical Advisory Group on Immunisation, Therapeutics Goods Administration, Infection Control and Prevention Evidence Group, Australian Health Principal Protection Committee etc.) be required to take consideration of the specific risks to people with disability in all key decisions and document how they have considered this group and the mechanisms for implementation of decisions

Ascertainment and reporting of data on COVID-19 for people with disability and how to build the data infrastructure to support optimal responses in the future:

2. Linkage of NDIS and DSP data with COVID-19 infection, hospitalisation, ICU admission (indicating severe disease), and death data in each State and Territory. Where possible data should be reported by age group, sex/gender, ethnicity, First Nations status, type of disability, disability severity, living arrangements (e.g., group home, boarding house/supported residential service) and over time

3. Through MADIP, link NDIS, DSP, census data on disability with the Australian Immunisation Register, PBS data on COVID-19 treatments, and COVID-19 death data and report outcomes by age group, sex/gender, ethnicity, First Nations Status, type of disability, disability severity, living arrangements (e.g., group home, boarding house/supported residential service) and over time

4. Linkage of data held in MADIP with State and Territory infection and hospitalisation data to gain a picture of the entire COVID-19 pathway for people with disability. This will enable greater insight into the role of vaccines in preventing serious disease and death among people with disability and how many COVID-19 deaths could have been avoided through vaccination and antiviral treatments. This information is critical for guiding government policy with respect to access to additional vaccination and prioritising access to anti-viral treatments.

5. That the DRC recommend that the National Disability Data Asset consider scoping a project regarding the datasets, infrastructure and analytic approaches needed for governments and the community to have the information needed for prompt and tailored responses that protect people with disability in future public health emergencies thus avoiding people with disability being 'left behind', as they have in COVID-19 pandemic

Vaccination of people with disability and the disability support workforce for COVID-19 and influenza

6. Ensure that people with disability have access to COVID-19 **AND** influenza vaccination free of charge through GPs, state clinics, specialist clinics such as sensory clinics, and in-reach

7. Continue mandates for COVID-19 vaccination for disability support workers

8. Mandate influenza vaccination for disability support workers with appropriate communication strategies recognising that this workforce early in the pandemic had high levels of vaccine hesitancy

9. Ensure that people with disability who are at risk of poor outcomes from COVID-19 and influenza are prioritised in any future decision about vaccination (e.g., if new more effective vaccines become available or for boosters)

Understanding and building a sustainable disability support workforce as we 'live with COVID-19'

10. Further research to understand the extent of the disability support workforce shortages and challenges and to identify potential solutions

11. Co-design solutions to ensure that there is a sustainable workforce in the future (e.g., extending student visas)

12. Ensure that disability support workers who do not have access to paid leave are able to be compensated so they do not attend work when sick

Access to health services, specifically antiviral treatments

13. That governments develop COVID-19 test-to-treatment plans for people with disability so they have a pathway to rapidly access suitable treatments and treatment is not delayed

14. That government (TGA and Pharmaceutical Benefit Access Scheme) and independent agencies (e.g., National COVID-19 Clinical Evidence Taskforce) who make decisions and provide guidance materials about antiviral treatments are aware of the unique risks to people with disability, over and above co-existing medical problems such as diabetes, that put them at risk of serious COVID-19

15. That government communications about antiviral treatments are developed that are suitable for people with disability and services and that this information is promulgated through a range of sources (e.g., NDIS National Quality and Safeguards Commission, State and Territory governments, advocacy groups)

Infection prevention and control

16. RATs are made freely available to people with disability who require support in their homes and in the community

17. Review and update of infection control guidelines in disability settings and for worker training

18. When there are high levels of COVID-19, mandate the use of respirator masks when supporting people with disability indoors and organise appropriate fit testing

19. Develop and implement guidelines for ventilation in indoor settings where people with disability are and provide financial support to purchase additional equipment

Preparing for the future

20. The Commonwealth and State and Territory governments develop a National Disability and Health and Wellbeing Strategy with dedicated resources for implementation and monitoring of outcomes that is co-designed and co-produced by people with disability and their representative organisations. This Strategy would include preparation and response to public health emergencies such as pandemics and epidemics as well as natural disasters.

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Overarching issue and recommendation

As the DRC have noted in their Issue Paper and reports from previous hearings, there has been a delay in the responses to the issues confronting people with disability during COVID-19. We believe this is likely due to the fact that key bodies including Australian Health Protection Principal Committee (AHPPC), Australian Technical Advisory Group on Immunisation (ATAGI), Therapeutics Goods Administration (TGA), Infection Prevention and Control Expert Group (ICEG), Pharmaceutical Benefits Advisory Committee (PBAC) and other regulatory and decision-making bodies **have not had due regard to the specific risks to people with disability** related to clinical vulnerability and structural vulnerabilities related to support needs, living environments, discrimination, and other disadvantages. We therefore make an overarching recommendation that we believe will address many of the problems we have witnessed for people with disability during COVID-19.

Our overarching recommendation is:

Recommendation 1: Commonwealth decision-making bodies (Australian Technical Advisory Group on Immunisation, Therapeutics Goods Administration, Infection Control and Prevention Evidence Group, Australian Health Principal Protection Committee etc.) be required to take consideration of the specific risks to people with disability in all key decisions and document how they have considered this group and the mechanisms for implementation of decisions

Reflections and responses to the Issues Paper

We note that the Issues Paper reflects the situation in March 2022. Since then, the number of cases, hospitalisations, and death from COVID-19 in the Australian population continues to rise and new issues are emerging.

The DRC raised 13 key issues that had been identified by the disability sector in relation to the Omicron wave. Below we provide updated information on the issues where we have specific expertise and offer recommendations for the DRC to consider. Instead of responding to the questions posed by the Disability Royal Commission (DRC) we have organised our responses around the key issues identified in the Issues Paper.

Key Issue 1 – Gaps in data collection and reporting

We note there has been a substantial increase in the number of deaths from COVID-19 with updated data from the Australian Bureau of Statistics showing 5732 deaths had been registered or received by the ABS where people died with or from COVID-19 by 31 March 2022; COVID-19 was the underlying cause of death in 91% of deaths[1]. In the first two months of this year deaths were 20.5% above the historical average in Australia and in February 2022 it was the fourth most common cause of death[2]. It is also noted that nearly three quarters of people who died of COVID-19 (73.4%) had a pre-existing condition such as cardiac conditions, dementia, diabetes, and cancer[1]. It is noted that many of these conditions are associated with disability and/or are more common among people with disability.

As pointed out in the Issues Paper, the Australian Government Department of Health publishes the number of confirmed active COVID-19 cases, deaths and recovered cases for NDIS participants and workers reported to the NDIS National Quality and Safeguards Commission from registered providers of changes or events that significantly impact the delivery of services such as COVID-19 infection. Therefore, cases among NDIS participants using registered services where delivery is not significantly

affected or when NDIS participants are not using registered providers are not reported to the Commission. **We believe these figures are an undercount, potentially a substantial undercount, and therefore should not be used to assess the impact of COVID-19 among NDIS participants and workers.**

We note the DRC is interested in seeing whether it is feasible to obtain further information for First Nations Australians with disability and people with disability from culturally and linguistically diverse backgrounds (CALD).

More than two years into the COVID-19 pandemic we still do not have accurate publicly available data on the impact of COVID-19 on people with disability in Australia. Based on overseas evidence, we anticipate that people with disability will experience higher levels of morbidity and mortality. We need this information for Australia so we can learn from mistakes and plan better for COVID-19 and other infectious disease epidemics/pandemics in the future.

Information on vaccination and the impact of COVID-19 on people with disability can only be ascertained by linkage of datasets with information on disability and COVID-19 infections, hospitalisation, ICU admissions, hospitalisations, and deaths as well as data on COVID-19 vaccination. Major challenges exist because of the lack of consistent information on disability in health care data and that States and Territories and the Australian Government and Commonwealth agencies (NDIA, Australian Bureau of Statistics and Australian Institute of Health and Welfare) are custodians of different datasets (e.g., COVID hospitalisation and ICU data held by the States and Territories, Australian Immunisation Register a national register held by Services Australia, NDIS data held by NDIA). The vaccination status of NDIS participants, reported routinely by the Australian Government has been obtained by linking NDIS data with data from the Australian Immunisation Register as part of the Multi-Agency Data Integration Project (https://www.health.gov.au/initiatives-and-programs/australian-immunisation-register-linked-to-the-multi-agency-data-integration-project). In December 2021, the Commonwealth government announced $40 million to establish the National Disability Data Asset (NDDA), which will bring together Commonwealth and State and Territory datasets in an enduring data asset (www.ndda.gov.au). The NDDA offers a resource for the future in learning and responding to COVID-19 and response to other public health emergencies such as future pandemics and epidemics.

We make a series of recommendations regarding ascertainment and reporting of data on COVID-19 for people with disability and how to build the data infrastructure to support optimal responses in the future:

Recommendation 2: Linkage of NDIS and DSP data with COVID-19 infection, hospitalisation, ICU admission (indicating severe disease), and death data in each State and Territory. Where possible data should be reported by age group, sex/gender, ethnicity, First Nations status, type of disability, disability severity, living arrangements (e.g., group home, boarding house/supported residential service) and over time

Recommendation 3: Through MADIP, link NDIS, DSP, census data on disability with the Australian Immunisation Register, PBS data on COVID-19 treatments, and COVID-19 death data and report outcomes by age group, sex/gender, ethnicity, First Nations Status, type of disability, disability severity, living arrangements (e.g., group home, boarding house/supported residential service) and over time

Recommendation 4: Linkage of data held in MADIP with State and Territory infection and hospitalisation data to gain a picture of the entire COVID-19 pathway for people with disability. This will enable greater insight into the role of vaccines in preventing serious disease and death among people with disability and how many COVID-19 deaths could have been avoided through vaccination and antiviral treatments. This information is critical for guiding government policy with respect to access to additional vaccination and prioritising access to anti-viral treatments.

Recommendation 5: That the DRC recommend that the National Disability Data Asset consider scoping a project regarding the datasets, infrastructure and analytic approaches needed for governments and the community to have the information needed for prompt and tailored responses that protect people with disability in future public health emergencies thus avoiding people with disability being 'left behind', as they have in COVID-19 pandemic

Key Issue 2 – Access to vaccines and boosters

As noted by the DRC, many non-pharmaceutical interventions such as contact tracing, mask mandates, restrictions on the size of gatherings, were lifted before people with disability had the opportunity to be vaccinated and, for those that were vaccinated earlier, before third and/or booster doses had been administered. We noted that over the December/January 2021-2022 there was significant delay in in-reach vaccination into disability residential settings due to holidays and that this put some people with disability at risk.

As we approached winter there was also considerable concern that people with disability, many at significant risk, were not prioritised for the 4th dose. We note that on the 25th May 2022 ATAGI expanded the eligibility criteria for a 4th dose to include 'people with disability with significant or complex health needs or multiple comorbidities which increase risk of poor outcome from COVID-19'[3]. We note that many of the States and Territories are rolling back initiatives developed in the COVID-19 pandemic to enable people with disability to be vaccinated, such as sensory clinics and in-home vaccination. To achieve high 3rd and 4th dose vaccination coverage, these initiatives need to be maintained. We also note the success of the Victorian Department of Health Disability Liaison Officer (DLO program), which has seen many people with disability who have previously been unable to be vaccinated to receive COVID-19 vaccination.

One consideration the DRC did not raise in the Issues Paper was influenza vaccination. We know influenza cases are rising rapidly and international evidence shows that people with disability, particularly people with intellectual disability, are more likely to die of influenza[4] and to be hospitalised for vaccine-preventable conditions[5]. It also has a disproportionate impact on young people with disability where there are well known challenges to vaccination[6]. However, we understand that the same proactive approaches to enabling people with disability to be vaccinated for COVID-19 are not being offered for influenza, placing people with disability at substantial risk of both COVID-19 and influenza. Part of this has arisen because while the Australian government oversaw the COVID-19 vaccination, influenza vaccination sits in State and Territory portfolio responsibilities. Further, influenza vaccines are not usually available for free however some States and Territories have offered them for free this year. This has resulted in a situation where in-reach providers such as Aspen Medical do not offer people with disability influenza at the same time as COVID-19 vaccination unless services are proactive in seeking permission and accessing influenza vaccines through other systems.

We also note the importance of vaccinating the workforce. While the vaccine is mainly effective in preventing serious disease and death, it is likely that it does prevent some transmission from workers to people with disability. It is also likely that future COVID-19 vaccines will offer better protection against infections.

Based on our observations, we make the following recommendations with respect to vaccination of people with disability and the disability support workforce:

Recommendation 6: Ensure that people with disability have access to COVID-19 **AND** influenza vaccination free of charge through GPs, state clinics, specialist clinics such as sensory clinics, and in-reach.

Recommendation 7: Continue mandates for COVID-19 vaccination for disability support workers.

Recommendation 8: Mandate influenza vaccination for disability support workers with appropriate communication strategies recognising that this workforce early in the pandemic had high levels of vaccine hesitancy.

Recommendation 9: Ensure that that people with disability who are at risk of poor outcomes from COVID-19 and influenza are prioritised in any future decision about vaccination (e.g., if new more effective vaccines become available or for boosters)

Key Issue 3 – Disruption to disability services

We agree with the DRC that many people with disability have experienced significant disruption to services due to COVID-19 and now influenza. This has occurred on top of what has been a lack of workers in this area, further exacerbated by the pandemic and the drop in international student numbers. We do not believe this issue has been solved and is likely to be an ongoing issue into the future as we 'live with COVID-19' particularly in the context of low unemployment levels where workers may seek better paid jobs. Therefore, we think further investigation into the extent of the problem and the ways people with disability, workers and service providers have responded is needed to better understand the extent of the problem and identify solutions. We also note that many support workers are employed casually and do not have access to paid leave. They may be incentivised to attend work when unwell, as we have previously noted[7].

On the basis of this observation, we recommend that in terms of the disability support workforce:

Recommendation 10: Further research to understand the extent of the disability support workforce shortages and challenges and to identify potential solutions

Recommendation 11: Co-design solutions to ensure that there is a sustainable workforce in the future (e.g., extending student visas)

Recommendation 12: Ensure that disability support workers who do not have access to paid leave are able to be compensated so they do not attend work when sick

Key Issue 4 – Access to essential health services

We agree that access to essential health care continues to be a problem for people with disability, however, again the extent of this problem and the implications for the ongoing health and wellbeing of people with disability is unknown. We support the letter written to National Cabinet from disability advocacy groups and peak bodies.

We would particularly like to draw attention to access to anti-viral treatments and monoclonal antibody treatments. We recognise this is a rapidly evolving area and it is not possible to make definitive statements about how they should or should not be used among people with disability. Oral treatments Lagevrio (molnupiravir) and Paxlovid (nirmatrelvir + ritonavir) provide an opportunity to treat people with mild COVID-19 without requiring hospitalisation[8]. It should be noted that Paxlovid has many drug-drug interactions and will not be suitable for many people with health conditions who receive medications, however it is the preferred treatment if someone does not have contraindications. The two oral antiviral treatments can be accessed via the Pharmaceutical Benefits Scheme or other national and state and territory stockpiles providing they meet certain eligibility requirements. Oral treatments have also been distributed to Residential Aged Care Facilities and Aboriginal Community Controlled Organisations. To be effective these treatments need to be commenced within 5 days of symptom onset.

A person with a positive RAT or PCR and at least one symptom of COVID-19 is eligible for oral treatments based on other risk factors including vaccination status, age, whether they identify as Indigenous (lower age threshold >50 years), whether an individual has specific risk factors (e.g., immunocompromise, Down Syndrome, Cerebral Palsy, severe intellectual or physical disability in residential care). The National COVID-19 Clinical Evidence Taskforce has developed aids to support decisions[9]. We understand there are some variations across jurisdictions in terms of access. GPs are also notified whether someone is likely to be eligible for COVID-19 treatments when their positive test is registered with Health Direct.

It appears that knowledge about these oral treatments is limited in the community. Access can be difficult if someone does not have a regular GP or if they can't access their GP through telehealth because they have not seen their GP face-to-face in the last 12 months. We are also aware that many pharmacies do not regularly stock the medications and that people with disability and services may not be aware of their eligibility. One of the major challenges are the complicated and strict eligibility criteria for treatment. It appears that in the US, for example, that these treatments are more broadly available.

Based on our observations about oral treatments, we recommend:

Recommendation 13: That governments develop COVID-19 test-to-treatment plans for people with disability so they have a pathway to rapidly access suitable treatments and treatment is not delayed

Recommendation 14: That government (TGA and Pharmaceutical Benefit Access Scheme) and independent agencies (e.g., National COVID-19 Clinical Evidence Taskforce) who make decisions and provide guidance materials about antiviral treatments are aware of the unique risks to people with disability, over and above co-existing medical problems such as diabetes, that put them at risk of serious COVID-19

Recommendation 15: That government communications about antiviral treatments are developed that are suitable for people with disability and services and that this information is promulgated through a range of sources (e.g., NDIS National Quality and Safeguards Commission, State and Territory governments, advocacy groups)

Key Issue 5 – Effective prevention and control

We agree with the DRC that concerns remain about access and appropriate use of RATs and up-to-date infection control guidelines and training. We also add two further areas: the use of high-quality respirators (masks) (K94/P2/N95/FFP2) and safe indoor air/ventilation. We draw the DRC's attention to an article we wrote in about this in The Conversation in February 2022[10] and our most recent Statement of Concern which highlights problems in infection control and prevention and testing[11].

Testing for COVID-19

While RATs are now widely available, cost remains a significant barrier to access. NDIS participants can currently request the costs of RATs if they have core supports in their NDIS plan and SIL providers can also claim the cost of RATs. SIL providers have also received allocation of RATs to cover them until the end of June 2022. People who are recipients of the Disability Support Pension are eligible for up to 10 over 3 months. Victoria is also distributing RATs through their Disability Liaison Officer program to anyone with a disability. Other States and Territories may have similar arrangements. There is no indication how long these existing arrangements will remain in place.

Infection prevention and control

We note the most recent outbreak control guidelines for disability residential settings are from 16/3/2021[12]. We do not believe that they adequately address the risks of aerosol transmission (e.g., they recommend face masks rather than respirators). We also emphasise the importance of ongoing training of workers in infection prevention and control. Our previous research has shown that this workforce has not been adequately trained in infection prevention and control[7,13].

Use of respirators (masks)

There is now considerable evidence that respirators (K94/P2/N95/FFP2) are superior to cloth and surgical masks[14]. NDIS participants can claim for respirator masks through their core supports and there is a temporary increase in NDIS price limits (0.4.%) up until end of June

2022 to recognise the cost of PPE for workers. Each State and Territory government has their own recommendations regarding the use of masks when supporting people with disability with some recommending respirator masks in indoor settings.

Safe indoor air/ventilation

The need to ensure good ventilation inside is recognised as critical for protecting from COVID-19 transmission, however there is still little guidance and support for people with disability, their supporters, workers, and services to ensure that indoors is as well ventilated is possible. This is critical in winter where it is not possible to open windows and doors to ensure air flow. We produced a paper with recommendations for the sector, and have distributed to governments, which we attach as Appendix A. We note that investment is needed to ensure that people with disability, workers and services need to support to implement the recommendations including financial support to assess whether their cooling and heating ventilation systems are working properly and the purchase of CO_2 monitors and of HEPA air purifiers. There should be assessments of indoor settings to ensure there are a minimum number of air changes per hour. We note that the cost of this is equipment is low compared to the cost of high-level medical care.

Infection control and prevention remains central to mitigating the risks for people with disability. We recommend that:

Recommendation 16: RATs are made freely available to people with disability who require support in their homes and in the community.

Recommendation 17: Review and update of infection control guidelines in disability settings and for worker training.

Recommendation 18: When there are high levels of COVID-19, mandate the use of respirator masks when supporting people with disability indoors and organise appropriate fit testing.

Recommendation 19: Develop and implement guidelines for ventilation in indoor settings where people with disability are and provide financial support to purchase additional equipment.

Key Issue 13 – Preparing for the future

We are pleased to see that the DRC is future focussed and that the Commonwealth Department of Health is doing a review of their responses to COVID-19. The pandemic has demonstrated the many real challenges that face people with disability and the lack of coordination and integration across jurisdictions and portfolios to solve entrenched problems related to the health of people with disability. We note that the Commonwealth Department of Health has recently invested in strategies to improve the health of people with intellectual disability, however this is not sufficient to address the major issues facing all people with disability. For that reason, we encourage the DRC to consider recommending a dedicated strategy on disability and health that is a cross-jurisdictional and cross-portfolio responsibility. This is a necessary step to future-proof from ill-prepared disability and health services and public health systems. The strategy could include preparation and responses in public health emergencies such as pandemics and natural disasters.

Our recommendations is:

Recommendation 20: The Commonwealth and State and Territory governments develop a National Disability and Health and Wellbeing Strategy with dedicated resources for implementation and monitoring of outcomes that is co-designed and co-produced by people with disability and their representative organisations. This strategy would include preparation and response to public health emergencies such as pandemics and epidemics as well as natural disasters.

Other Key Issues

We note the DRC raised other key issues including fear and isolation, whether or not people with disability have been consulted, oversight mechanisms for violence and abuse (e.g., cessation of community visitor schemes), homelessness and insecure housing, violence and abuse in the home, children and young people with disability, and safety and wellbeing during floods. We agree these are critical issues to investigate, however we have restricted our recommendations to the direct public health strategies to mitigate the impacts of COVID-19. We do realise it is a careful balance to ensure that people with disability are not unduly impacted by strategies put in place to protect them from COVID-19, which may expose them to increased risks of other issues such as mental health problems, homelessness, and violence and abuse.

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APPENDIX A

IMPROVING VENTILATION TO REDUCE RISK OF COVID-19 FOR PEOPLE WITH DISABILITY

People can reduce their risks of catching COVID-19 through getting vaccinated as well as masks, N95/P2 respirators, physical distancing, and appropriate use of Rapid Antigen Tests (RATs). Another important way to reduce risk COVID-19 transmission is to improve air flow indoors. This is also called ventilation.

This fact sheet provides information on how they can improve ventilation in indoor areas and is intended for people with disability, families, services and disability support workers and others who work with people with disability.

RISK OF CATCHING COVID-19 INDOORS

Some people with disability have multiple people come into their homes to provide them with support. Some people with disability live in group homes or attend day services or employment programs with other people with disability sometimes with many people indoors. Because people with disability may come into contact with lots of people indoors, they are at risk of catching COVID-19.

The COVID-19 virus spreads between people through the air. This means that people are more likely to catch COVID-19 indoors where air is not circulating. Improving the flow of air in indoor spaces reduces the risk of infection.

Research has shown that good natural or mechanical ventilation can reduce risk of transmission risk.

HOW CAN I IMPROVE AIRFLOW INDOORS?

Open doors and windows. Make sure there is a cross-breeze by opening doors and windows at opposite ends of an indoor space. Ceiling fans and pedestal fans placed near a window can also assist in increasing airflow.

It is not always possible to open doors or windows when it is very hot or cold. People with disability and health conditions such as spinal cord injury and multiple sclerosis may have difficulty regulating their temperature and need to keep doors and windows closed so that cooling and heating systems can work properly. Spaces like toilets, bathrooms, lifts and stairwells are also hard to ventilate.

In these situations, a portable HEPA air purifier could be used.

In buildings that are mechanically ventilated it is best to consult with a mechanical engineer to see if there are ways to improve the air flow. Disability services might consider having a mechanical engineer review their ventilation system to maximise the total airflow being supplied and the air changes per hour.

HOW DO I KNOW IF AN INDOOR SPACE IS WELL VENTILATED?

People with disability and families, workers and services can check the quality of the air inside using **CO_2 monitors**. Although we cannot measure virus particles in the air, we can measure CO_2 (carbon dioxide) levels in the air. We breathe out CO_2 so if a space is not well ventilated and/or there are lots of people in a space then the CO_2 levels will be high. CO_2 monitors measure how much CO_2 is in the air. CO_2 should be measured in multiple parts of a room. If the level is less than 800 ppm then the relative risk of infection is relatively low. (The CO_2 level outside is around 400 ppm).

CO_2 monitors vary in the design (and cost) with the highest quality being non-dispersive infra-red monitors.

WHAT TO DO IF I THE CO_2 READING IS MORE THAN 800 ppm

- Where possible, open doors and windows and ensure cross-breeze
- Use portable HEPA air purifiers in poorly ventilated spaces. Air purifiers should be in areas of the room where airflow is low
- Running exhaust fans in toilets and bathrooms can increase airflow but check whether they are designed to run continuously
- Use ceiling fans and pedestal fans

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