National Mental Health Commission

The COVID-19 pandemic through the experiential lens of priority populations

Summary Report of Pandemic Research Projects

December 2023

Australian Government
National Mental Health Commission

Acknowledgements

This report draws on research conducted between June 2021 and October 2022 funded by National Mental Health Commission (the Commission) grants. The Commission would like to acknowledge and thank the research participants who shared their personal experiences of the pandemic and its impact on their mental health and wellbeing, as summarised in this report. We would also like to thank the organisations who conducted the research for their contributions to this report, and for facilitating the sharing of a number of priority populations' experiences of the pandemic in Australia to better our understanding of the mental health and wellbeing needs of Australians, and of the system required to meet these needs, particularly in times of crisis.

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands throughout Australia. We pay our respects to their clans, and to the elders, past present and emerging, and acknowledge their continuing connection to land, sea and community.

Acknowledgement of Lived Experience

We acknowledge the individual and collective expertise of those with a living or lived experience of mental ill-health and suicide, as well as the lived experience of their families, carers, and kin. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

A note about language

The Commission acknowledges that language surrounding mental health and suicide can be powerful, emotive and at times contested. People make sense of their experiences in different ways, and there is no consensus on preferred terminology.

The Commission has been conscious to use terminology throughout this report that is respectful of those whose experiences we are describing and is well understood by the audience reading this report.

This report covers a broad range of topics in relation to mental health and suicide prevention. The language used to discuss these topics adheres to the language conventions outlined in the Life in Mind National Communications Charter, where applicable. The National Communications Charter represents a unified approach and promotes a common language in referring to issues around mental health, mental ill-health and suicide, with the intention of reducing stigma and promoting help-seeking behaviours. For this reason, and within the context of this report, the Commission aligns its terminology with the conventions in the Charter.

For instances where using certain terminology may misrepresent the source being cited, the terminology used by the source has been used.

The Commission endorses the Mindframe Guidelines on Media Reporting of Severe Mental Illness in the Context of Violence and Crime and requests that media using this report do so in accordance with the Guidelines.

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Executive Summary

While the COVID-19 pandemic (the pandemic) has impacted the mental health and wellbeing of all Australians, it has not impacted all people and communities equally.

> *"I need to be able to have visits from my family and friends… I feel that while protecting me from COVID, they have taken everything I live for away."*
> Research participant living in Residential Aged Care (COTA, 2022)

In the months leading up to May 2020, the Commission worked with key stakeholders to lead the development of the National Mental Health and Wellbeing Pandemic Response Plan. The Plan recognised that some populations within the Australian community would be disproportionately affected by the impact of social and economic outcomes of the pandemic and provided a range of measures to address associated challenges.

In June 2021, the Commission funded 10 organisations to undertake separate Pandemic Plan Priority Populations Research Projects (see Table 1) in order to better understand the unique impact of the pandemic on key priority populations. Each project produced a final research report discussing how their cohort had been impacted by the pandemic, as well as recommendations for next steps in addressing these impacts.

The 10 groups explored through these projects were:

- People experiencing compound disaster trauma (such as those who had experienced flooding or bushfires prior to the pandemic)
- Men aged over 18 years
- Women with a disability aged over 18 years
- Children and young people aged 9-17 years
- People living in rural and remote communities
- People aged over 75 years
- People with lived experiences of sexual, domestic and family violence
- People who are LGBTQ+[a]
- People from Italian, Turkish and Vietnamese communities
- Adult carers of those who experience mental illness, mental ill-health, and suicidality.

Four key **themes** were identified as consistent across the projects, and these are summarised in Table 1.

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[a] The acronym 'LGBTQ+' is used in the research project, Pride and Pandemic, to refer to people who identify as lesbian, gay, bisexual, trans or queer. The '+' reflects engagement with additional identities, as there are a wide range of different identity terms, not otherwise identified by the acronym, used by people who identify as same-gender or multi-gender attracted or gender diverse. The researchers were not able to recruit a sufficient number of people with an intersex variation to enable analysis and disaggregation of the data to reflect their experiences. As such, and so as not to misrepresent the experiences of people with an intersex variation, Pride and Pandemic is referred to as a study of LGBTQ+ communities.

Table 1 - Summary of themes across the projects

THEME 1: Mental health and disaster recovery in the context of the pandemic

- Research findings demonstrate that all populations involved in the research experienced worsened mental health and wellbeing, and increased disconnection, when compared to how they were feeling before the pandemic.
- Ordinarily through disaster recovery, communities tend to draw upon resources and collaboratively address hardship and adversity. This has not been possible due to restrictions on movements and gathering. This has been exacerbated by contrasting attitudes to public health measures increasing pressure on community unity.

THEME 2: Existing inequalities have been exacerbated by the pandemic

- The pandemic had significant impacts on the social determinants of health for Australian communities and changes in these factors can be seen as contributing to increases in psychological distress.
- The inequalities associated with social determinants have been felt disproportionately across the community. The experiences of priority populations are discussed in this report across: (1) economic stability; (2) education access and quality, (3) healthcare access and quality; (4) social and community context and safety; and (5) neighbourhood and built environment.

THEME 3: Experiences of loneliness and social isolation

- Social connection is considered protective for mental health and wellbeing.
- All priority populations experienced increased loneliness and isolation, often at rates far higher than the general population.
- For many communities, sadness and loneliness was particularly felt when their ability to share life milestones was restricted. Some groups experienced loss of identity and connection to culture. Isolation also led to a loss of social and communication skills, with these skills continuing to be impacted even when restrictions were lifted.
- Public debate and messaging at times heightened tension in the community and further contributed to a sense of isolation.

THEME 4: Challenged access to support services

- Each community identified barriers to accessing mental health supports and services, including a lack of services, as well as sudden loss or absence of appropriate and accessible services that were present before the pandemic.
- Broadly, barriers to accessing support were systemic and cultural:
  1. Systemic barriers, including those based on social issues (e.g. cost, ability to physically engage, wait times, and availability).
  2. Cultural barriers and stigma, including not having access to culturally safe care; need for mental health education for consumers and for allied health professionals.
- While not always the case, for many priority populations, telehealth was seen as having greatly improved accessibility to healthcare beyond the benefit of reduced risk of COVID-19 transmission, through reduced cost and time associated with attending appointments (especially for those living away from Metropolitan Centres).

Introduction

The National Mental Health and Wellbeing Pandemic Response Plan

In the months leading up to May 2020, the Commission published the National Mental Health and Wellbeing Pandemic Response Plan. The Plan identified specific challenges to mental health and wellbeing associated with the pandemic and outlined a range of measures to address these and future challenges.

The Plan recognised that there were groups within the Australian community who would experience the negative social and economic impacts of the pandemic more than others. The Commission refers to these groups as priority populations. On 30 June 2021, the Commission funded 10 organisations to undertake **Pandemic Plan Priority Populations Research Projects**[b] to help us build a better understanding of the impacts of the pandemic on some of the priority populations and their communities.[c]

The 10 groups these projects focused on were:

- People experiencing compound disaster trauma (e.g., people who have faced multiple disasters such as those who had experienced flooding or bushfires prior to the pandemic)
- Men aged over 18 years
- Women with a disability aged over 18 years
- Children and young people aged 9-17 years
- People living in rural and remote communities
- People aged over 75 years
- People with lived experiences of sexual, domestic and family violence
- People who are LGBTQ+[d]
- People from Italian, Turkish and Vietnamese communities
- Adult carers of those who experience mental illness, mental ill-health, and suicidality.

To analyse the impacts on these priority populations and their experiences of the pandemic, each research group used its own unique methodology and analysis.[e] While this makes it challenging to compare experiences of different groups, we are able to gain an understanding of how each group was coping before the pandemic, and how they were feeling in the second half of 2022. Each research group produced a final research project report discussing how priority populations had been impacted by the pandemic, as well as recommendations for next steps to address these impacts. An overview of the research approaches and methodologies of the 10 research projects is summarised in Table 2.

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[b] The Commission notes that although the Plan identified Aboriginal and Torres Strait Islander people and their communities being at high-risk of mental ill-health during and after the pandemic, it was not possible to establish a research project in the timeframe allocated. An overview of findings relating specifically to Aboriginal and Torres Strait Islander people can be found on page 12.

[c] The Commission views community as a broad term which could include the place a person lives or works, where they interact with others (e.g. their school or sporting club), or the group of people with which a person shares common culture, identity, values, beliefs, behaviours or experiences.

[d] The acronym 'LGBTQ+' is used in the research project, Pride and Pandemic, to refer to people who identify as lesbian, gay, bisexual, trans or queer. The '+' reflects engagement with additional identities, as there are a wide range of different identity terms, not otherwise identified by the acronym, used by people who identify as same-gender or multi-gender attracted or gender diverse. The researchers were not able to recruit a sufficient number of people with an intersex variation to enable analysis and disaggregation of the data to reflect their experiences. As such, and so as not to misrepresent the experiences of people with an intersex variation, Pride and Pandemic is referred to as a study of LGBTQ+ communities.

[e] All research projects collected data nationally, with the exception of the Phoenix Australia research on people experiencing compound disaster trauma which focused on the experiences of people living in regional NSW, Victoria, SA in communities heavily impacted by recent disasters.

Table 2: Summary of Priority Population Research Projects

Priority Population	Research Grant Recipient	Rationale for research	Overview of study methodology	Participant information	In-text abbrev.
People experiencing compound disaster trauma	Phoenix Australia	Disproportionate prevalence (or risk of) mental ill-health, mental illness, and/or suicide prior to the pandemic	Literature review. Targeted interviews and focus groups across regional NSW, Victoria, SA in regions heavily impacted by recent disasters.	• 18 semi-structured interviews via telephone in April 2022. • 5 online focus groups via videoconferencing between April and May 2022 with 31 participants.	Phoenix, 2022
Men aged over 18 years	Australian Men's Health Forum		Online survey and interviews with men. Interviews with practitioners working with men.	• Online survey: 137 participants (136 men, 1 non-binary; 21- 88 years, mean age = 56.67 years). Majority of participants resided in NSW (41%). • Online interviews: 9 men, aged 21- 82 years (mean age = 41 years)	UNSW, 2022
Women with a disability aged over 18 years	People with Disability Australia		Literature review, online survey, one-on-one interviews. Participants identified as women with a disability. All interviews online which did pose accessibility barriers.	• Online survey with 112 participants. • Thirteen one-on-one interviews were conducted either online or via phone.	PWDA, 2022
Children and young people (9-17 years)	Australian Human Rights Commission	Highlighted by Government as a key area of interest prior to the pandemic	Literature review. Interviews with stakeholders with experience in child/young people's mental health. Online survey for children and caregivers. Stakeholder roundtables.	• Surveys promoted in early 2022, responses from 4,559 children; 2,796 caregivers. 884 surveys completed on behalf of child. • The majority of respondents from NSW and Victoria. Data aggregated on the basis of gender and cultural identity.	AHRC, 2022
People living in rural and remote communities	Centre for Rural and Remote Mental Health		Literature review. Live data review – published records of service usage, morbidity or other trends. Interviews with residents/users, interviews with service providers and key community informants.	• 24 online resident interviews in March-April 2022, sampled from all states and NT with a spread of ages and slightly more females. • 25 key informant interviews in April-May 2022. Some in small groups. Sample from NSW, Victoria, Queensland and WA.	UoN, 2022
People aged over 75 years	Council on the Ageing Australia		Codesign through a project panel of older people. Semi-structured interviews, focus groups, online survey, telephone interviews, written submissions.	• The survey ran from Jan–Feb 2022 and received 1,119 responses, and 27 submissions. • There were 15 one-on-one interviews and five focus groups were held with a total of 32 participants. • Over a third of respondents were from NSW, followed by Victoria and SA.	COTA, 2022
People with lived experience of sexual, domestic and family violence	Full Stop Australia		Literature review. Analysis of internal quantitative client data. Online client survey and interviews with Full Stop Australia trauma specialist counsellors.	• 69 survey respondents, 86% identified as woman/female, 82% were aged 25-54 years, 64% identified as straight/heterosexual (64%), with 22% identifying as bisexual, gay or lesbian. • In early 2022, 13 in-depth, semi-structured interviews with Full Stop staff.	Full Stop Australia, 2022
LGBTQ+ communities	LGBTIQ+ Health Australia and La Trobe University	Limited research into mental health and wellbeing for this community prior to the pandemic	A cross-sectional nation-wide survey of LGBTIQ+ people's experience. A qualitative study involving a series of focus group discussions with particular intersections of the LGBTIQ+ community.	• 3,135 participants completed the survey, majority from Victoria and NSW. • 23 participants in focus groups; 18 - 64 years, 11 identified as multicultural and 17 indicated they had a disability or were unsure about whether they had one.	Pride and Pandemic, 2022
People from Italian, Turkish and Vietnamese Communities	Mental Health Australia: Embrace Project		Community Leader consultation – interviews and an online forum Community member engagement – focus groups and in-depth interviews	• 12 Stakeholder organisation interviews, community leader's forum, 6 discussion groups (male and female groups in each language). • 12 in-depth interviews, including with those 55+ years with bilingual research assistants	MHA, 2022
Adult carers of those who experience mental illness, mental ill-health, and suicidality	Monash University and the National Mental Health Consumer & Carer Forum (NMHCCF)		Establishment of Project Steering Group to support a co-design process Literature Review, Survey, Focus Groups Data Analysis	• Seven online focus groups in April 2022 across QLD, NSW, ACT, Victoria, SA, WA and through the National forum for Embrace multicultural mental health. • 73 focus group participants, aged 21-80 years (mean age 56 years) and majority identifying as female.	Monash-NMHCCF, 2022

This report summarises the findings of the 10 research projects and identifies four key **themes** that were consistent across the research:

- Theme 1: Mental health and disaster recovery in the context of the pandemic
- Theme 2: Existing inequalities have been exacerbated by the pandemic
- Theme 3: Experiences of loneliness and social isolation
- Theme 4: Challenged access to support services

Throughout this summary report, it is important to consider the role of **intersectionality** for priority populations. Intersectionality is a term that describes how a person can belong to, or identify with, multiple groups, and the way in which this might further impact their experience in the world. When an individual is part of multiple priority populations, they can be exposed to overlapping forms of stigma, discrimination, and compounding disadvantage. These intersecting experiences can amplify the harmful impacts on a person's wellbeing.

Background

To minimise the spread of COVID-19, public health orders were implemented across Australia from March 2020, and continued in some jurisdictions into 2022. While the implementation and management of public health orders varied across each state and territory,[1] the most common restrictions included:

- Stay at home orders (known as lockdowns[f]) with restrictions on movement for significant proportions of the population
- Movement to online delivery of public services, including healthcare and education
- National and international border closures
- Other health measures such as social distancing, density limits and mask mandates.

Despite efforts to gradually 'return to normal' throughout 2022, for many Australians the mental health impacts of the pandemic were still being felt. Rates of psychological distress[g] have fluctuated across the duration of the pandemic but continue to be higher than pre-pandemic levels.[2]

While the pandemic has impacted the mental health and wellbeing of all Australians, it has not impacted all communities equally. Before the pandemic, some communities were identified as already having higher rates of mental ill-health and psychological distress, thereby making them priority populations.[3,4] It is important to understand how the pandemic is impacting the mental health of these priority populations in order to design supports to address wellbeing gaps and ensure improvements in mental health over time.

A note on Aboriginal and Torres Strait Islander Communities

The National Mental Health and Wellbeing Pandemic Response Plan recognised Aboriginal and Torres Strait Islander people as likely to be at high-risk for both physical and psychological impacts of the pandemic. The Commission worked with national organisations to establish a project to capture the pandemic experiences of Aboriginal and Torres Strait Islander communities, however it was not possible to establish a project in the time frame required.

Although no project specifically addressed the experiences of Aboriginal and Torres Strait Islander people, projects on children and young people (AHRC, 2022) and rural and remote

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[f] Lockdowns were most extensive in VIC, and to a lesser extent in NSW; all parts of the country experienced some lockdowns.

[g] Psychological distress reflects non-specific psychological symptoms of stress, anxiety and depression. There is a strong correlation between high levels of psychological distress and mental ill-health.

communities (UoN, 2022) provided some findings regarding Aboriginal and Torres Strait Islander people within their sampled priority populations:

- AHRC (2022) reported that of those surveyed, 4% of children (n=199) and 4% of parents/guardians and grandparents (n=99) identified as Aboriginal and/or Torres Strait Islander.
    - Children identifying as Aboriginal and/or Torres Strait Islander were more likely than non-Indigenous participants to report that they needed 'extra help' (such as through schooling) but felt they were unable to receive this support (22% compared to 16% in the general sample).
    - Caregivers identifying as Aboriginal and/or Torres Strait Islander were more likely than non-Indigenous participants to report financial challenges to meet the basic needs of their families (26% compared to 13% in the general sample).

- In UoN's research five health key informants reported on the impacts of the pandemic and public health risk mitigation measures on communities with high proportions of Aboriginal and/or Torres Strait Islander people.
    - Their research highlighted that communities with high proportions of Aboriginal and Torres Strait Islander people placed a lot of importance on relationship building and community engagement.
    - Their research highlighted the importance of recognising that each geographical region has different needs, perspectives, and cultural nuance.
    - Their research also noted that while public health measures like lockdown and border closures reduced the likelihood of infection, these measures placed pressure on Aboriginal and Torres Strait Islander people and their social and emotional wellbeing due to isolation from families. In particular, the disruption to Aboriginal and Torres Strait Islander people's cultural practices of grieving by not coming together to mourn was described as "very detrimental to their whole way of being" (UoN, 2022; health worker from NSW).

> *"In terms of supporting Indigenous community, it [border restrictions] potentially protected them because it meant that we were able to get the vaccination rates up and all the rest of it…but it also failed to consider the impacts on families who are separated and families who live interstate from each other, and families who are struggling as a consequence of not being able to be together through one of the most difficult things that people will have lived through in their lifetime..."*
>
> Healthcare worker interviewee from Queensland commenting on the impact of border restrictions on Aboriginal and Torres Strait Islander families, rural and remote experiences (UoN, 2022)

Theme 1: Mental health and disaster recovery in the context of the pandemic

1.1 Poorer mental health and wellbeing for priority populations

The pandemic intensified pre-existing inequities that priority populations were facing, leading to increased feelings of mental ill-health, isolation, loneliness, anxiety and distress being reflected across all of the research reports. Several communities had particularly high rates of mental ill-health as well as suicidal thoughts and behaviours:

- Monash-NMHCC (2022) found that nearly a third (26.7%) of family carer respondents had thoughts of suicide during the pandemic compared to data from AIHW which indicated that in 2020-21, 16.7% of Australians (aged 16-85 years) had serious thoughts about taking their own life at some point in their lives[5].
- LGBTQ+ people reported the highest rates of distress of any priority population, with 63.8% of participants self-reporting that their mental wellbeing had worsened since the beginning of the pandemic (Pride and Pandemic, 2022). More than one-quarter (26.0%) of LGBTQ+ participants reported having ever attempted suicide in their lifetime, and 6.6% reported attempting suicide during the pandemic.
- Over the pandemic, the number of victim-survivors of sexual, domestic and family violence (SDFV) seeking support increased, with more complex client presentations including severe anxiety and distress. Exacerbated trauma impacts, caring duties, and increased life stressors contributed to increased suicide attempts, suicide ideation, depression and other mental health illnesses (Full Stop Australia, 2022).

Spotlight finding: Experiences of LGBTQ+ Australians pre-Pandemic (2019) and through the Pandemic (2020 to 2022)

- The Pride and the Pandemic report highlighted that the impact of the pandemic on mental health and wellbeing was particularly severe for LGBTQ+ Communities. In the LGBTQ+ community sample, 62.7% reported high or very high levels of psychological distress. This is a markedly higher rate than the 12.5% reporting the same in the general population. It is also an increase to rates reported in the 2019 *Private Lives 3* national Australian survey of LGBTQ+ Adults, which found 57.2% of people surveyed reported high or very high levels of psychological distress.
- Many respondents highlighted their sense of isolation due to reduced face-to-face interaction and support from friends and family. This distress was also apparent in rates of diagnosed mental illness: 57.6% of participants had received a mental health diagnosis prior to the Pandemic, and of these, 71.0% felt that their condition had gotten worse because of the Pandemic.
- Despite feelings of disconnection and increased mental ill-health, respondents emphasised that they still felt support from the LGBTQ+ community through increased engagement with online groups. A number of LGBTQ+ friendly digital forums and online spaces were used by some respondents as a successful 'buffer' to feelings of isolation. However, these online forums did not fully provide the support of face-to-face interactions.

> *"… I'm used to speaking to my friends online. And I think that's fairly common for LGBT young people. But a lot of liberating experiences and a sense of freedom and a sense of comfort [...] only really comes from being in [physical] shared spaces that are, you know, LGBT-friendly, where everyone is."*
> Pride and Pandemic (2022) research participant

For some population groups, reports of distress may have been impacted by pre-existing notions of mental health and wellbeing and their mental health literacy. For example, gender-based norms around vulnerability may impact men's self-assessment of their own levels of distress. Data from the UNSW (2022) research with men suggested that over the course of the pandemic the majority of men sampled experienced distress levels that were similar to pre-pandemic levels, but nervousness and restlessness were relatively more common experiences. Similarly, COTA (2022) found that while many Older Australians were impacted by loneliness and isolation in the pandemic, 64.3% of respondents self-reported their mental health had stayed the same throughout the pandemic.

> *"You need to make people aware, that stress, especially for us older people, is a mental health problem – they just don't understand that. What we need to do is provide ways for older people to recognise impact of stress on their mental health."*
> Research participant aged over 75 years (COTA, 2022)

Through the research projects, it was evident that the pandemic gave rise to significant worry about the present and the future as well as feelings of unease and fear. First-person accounts describe living through the pandemic as a “nightmare”, the “apocalypse”, experiencing a “new reality” and “living in a movie” (UoN, 2022).

The concepts of cumulative stress and distress are referenced in several projects as part of the explanation for depleted mental health and wellbeing. Cumulative stress occurs when there is no opportunity for rest between demands.[6] This was particularly evident for carers who became the sole supporters of people with mental health challenges during the pandemic, with many reporting feelings of disconnection and isolation from family, friends, services, and supports (Monash-NMHCCF, 2022). UNSW (2022) also noted that in men’s experiences of the pandemic there was a cumulative effect of distress across multiple situations and spheres of life. This aligns with the situational approach to mental health literacy and suicide prevention.[7,8]

> *“There must be understanding that responses are not pathological, isolation and loneliness are normal feelings and reactions to lockdowns, with a focus instead on what can be done to support people during lockdowns.”*
> Research participant aged over 75 years (COTA, 2022)

1.2 The process of recovery through and from the pandemic

In Australia, when we think of disasters we have tended to focus on the frequency and severity of extreme weather events. The pandemic also meets the requirements to be classified as a disaster, with the Australian Disaster Resilience Agency defining a disaster as “a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts.”[9]

The Australian Red Cross has developed several recovery-focussed materials outlining the typical process of recovery during and after disasters.[8] After a ‘honeymoon’ period where communities are galvanised through a shared sense of coming together to survive, communities then experience disconnection and feelings of frustration, anger and grief. Over time, communities come together again and begin to gradually climb towards reconstruction.

Phoenix (2022) found that for disaster-impacted communities in Victoria, New South Wales and South Australia, the pandemic disrupted typical post-disaster recovery processes. Compared to other disasters that may have been experienced in recent memory in Australia, the pandemic:

- forced people apart and kept them separated
- was a protracted disaster – there was not as clear an end point as typically associated with natural disasters.

Phoenix (2022) note that most people who experience cumulative disasters will recover over time, though the recovery process may be lengthier and more complex depending on the nature of the disaster and the health and wellbeing supports available. However in the pandemic social distancing increased experiences of isolation from friends, family, and community. Similarly, the uncertain nature of the pandemic and the social, emotional, and economic consequences of sudden lockdowns increased experiences of anxiety and disconnection.

Community unity and rebuilding which is critical to recovery from a disaster like the pandemic, was also tested by contrasting attitudes to COVID-19 vaccinations, difficulties re-connecting with social groups following pandemic restrictions (for example, people who experience social anxiety and distress within their mental health challenges), and a broader sense of division and alienation from other communities that had COVID-19 cases or were the perceived reason for pandemic restrictions (for example, when regions were placed in lockdown due to cases travelling from Metropolitan areas). In the UoN (2022) research, an interviewee linked hostilities to feelings of insecurity and desperation among people who were uncertain about the pandemic and its spread, and whose lives and incomes had been seriously disrupted.

Theme 2: Existing inequalities have been exacerbated by the pandemic

2.1 Overview of social determinants in Australia and the ways they have been impacted by the pandemic

The Department of Health and Aged Care has grouped the social determinants[h] of health into five major domains,[10] all of which have been impacted by the pandemic:

- **Economic stability:** such as employment and income. Government support programs such as JobKeeper and JobSeeker sought to provide an economic safety net during the pandemic,[11] though it should be noted that these supports were only available for those who met eligibility criteria.
- **Education Access and Quality:** including how movement towards online learning in primary, secondary and tertiary schooling has impacted attendance.[12]
- **Healthcare Access[i] and Quality:** including the use of alternative mental health and wellbeing supports such as crisis-help services[5] and access to telehealth for a wide range of health and mental health services.
- **Social and Community Context**: such as feelings of connection, life satisfaction and overall wellbeing.[13]
- **Neighbourhood and Built Environment:** including access to safe, secure and affordable housing.[13]

> *"If someone's ability to access their basic needs, such as housing, food, education, technology and support services, had been impacted due to the pandemic, they had significantly reduced outcomes than those that did not."*
> PWDA (2022)

> *"The COVID-19 pandemic has exacerbated pre-existing inequalities, created new ones, and heightened the impact of …. Assumptions and discrimination for those with Lived experience."*
> COTA (2022)

2.2 Variation within and between the experiences of priority populations during the pandemic

The impacts associated with these social determinants have been felt disproportionately across the community,[14] with challenges amplifying poor outcomes for some groups.

Economic stability

Income and employment was a key concern for priority populations. Every group was impacted

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[h] The World Health Organisation (WHO) has identified social determinants of health as key factors influencing health equality, and some of the most important factors for health outcomes

[i] Access/accessibility in health and mental health means that everyone can obtain the right care for them, at the right place and right time, irrespective of income, geography, and cultural background. As highlighted in Vision 2030, many things need to be considered for mental health to be truly accessible.

by financial insecurity and job loss, with some groups impacted through flow on effects (e.g., children were impacted via the financial impacts on their caregivers).

Though each community expressed distress, the anxiety around the loss of income was felt particularly strongly in the Culturally and Linguistically Diverse (CALD) communities studied, who ranked financial distress and job loss as key factors adversely impacting their mental health (MHA, 2022).

Adult family carers (the majority of whom are women) reported a significant increase in the number of hours they had to provide care during the pandemic. This was due to services being withdrawn or found to be no longer suitable for the person with mental illness, and carers experienced a loss of economic stability as they gave up employment to meet the additional support needs of their family member (Monash-NMHCCF, 2022).

UNSW (2022) reported that men felt stress and anxiety over the actual or perceived risk of losing their job and this impacted their sense of financial security. For men who continued to work through the pandemic there was a significant increase in psychological distress (UNSW, 2022). This was attributed to working from home and often cramming more into their day and working longer hours (UNSW, 2022).

> *"[When they're not working]…they're missing the contact. That's driving them nuts...plus not having a purpose you know. When they're not working, they don't have a purpose. But they've still got their children and their families to look after and stuff like that. They're finding it hard to do. A lot of people's pride had been torn down."*
> Male research participant (UNSW, 2022)

Not every experience was entirely negative though. For women with disability, the move to online work, study and experiences meant that access to previously restricted services and communities was broadening, and increased their employability (PWDA, 2022).

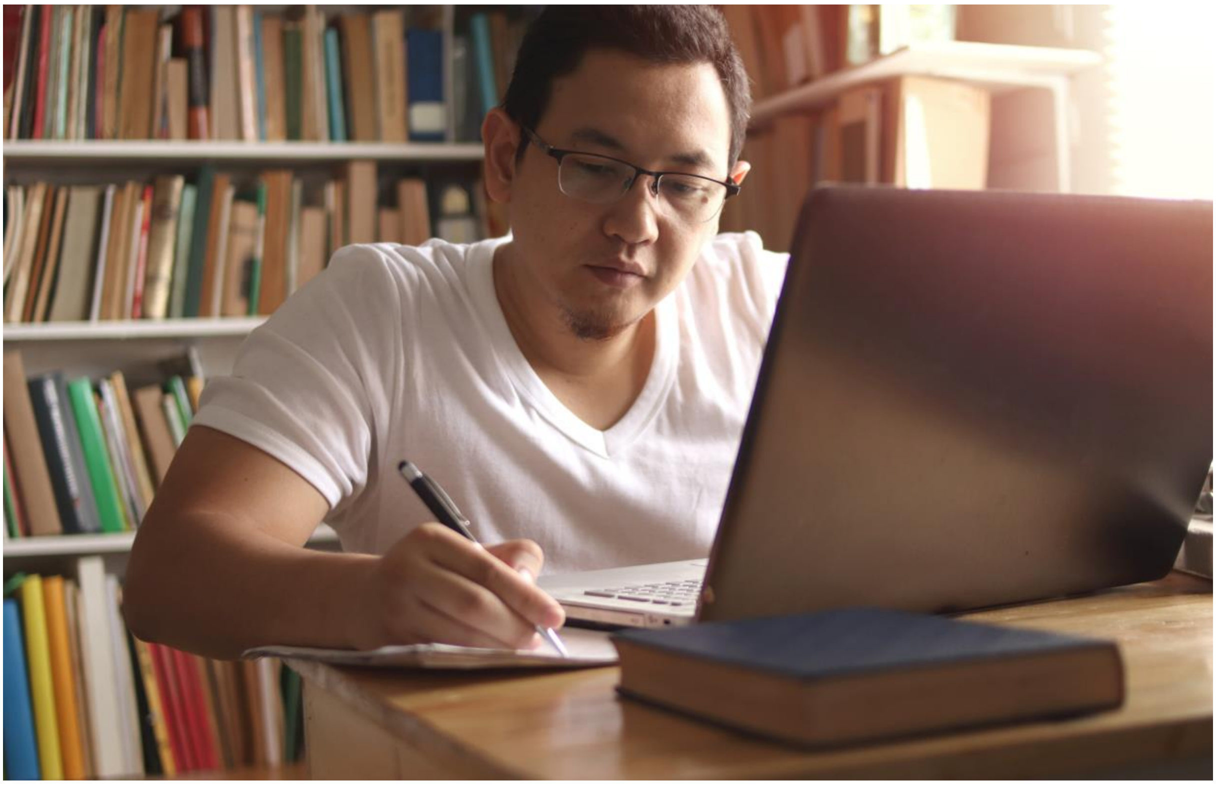
Spotlight finding: The Digital Divide

The research identified a clear divide between outcomes for those who had the access and skills to engage with digital technologies and those who did not. The digital divide impacts all generations and disproportionately affects:

- People from CALD communities
- Aboriginal and Torres Strait Islander communities
- Households with low incomes
- People with disabilities
- Rural and regional communities
- Older adults.

Fast and reliable internet was a particular concern throughout the pandemic, and poor and inconsistent internet access was a source of significant frustration (AHRC, 2022; UoN, 2022; Phoenix, 2022). Access to education was dependent on technology, and digital literacy was another key component that impacted mental health outcomes.

While it is important to recognise that digital access provided a profound benefit for many, the research shows that equal access to mental health and wellbeing services can be supported through digital equity. Digital equity promotes civic and cultural participation, employment, lifelong learning, and access to essential services.



Education Access and Quality
Most primary, secondary, and tertiary education moved online early in the pandemic with this movement causing disruption across the sector.[15] Digital equity is now playing a key factor in the accessibility of education. Many children and young people expressed anxiety about the quality of their education, with young people nearing the end of secondary school particularly worried about the potential impact of this on their current and future job prospects (AHRC, 2022).

Spotlight Finding: Digital Technology: the experiences of children and young people

Children's increased use of technology during the pandemic was seen to have both positive and negative influences on their mental health (AHRC, 2022). From the perspective of children and their parents, carers and grandparents, use of technology for games and social media was one of the top three things that helped children stay happy and hopeful during the pandemic. Technology was used to connect with family and friends, for entertainment, and for remote learning.

> *"I'm glad that we have cool technologies that we can use to communicate easier with family members from far away!"*
> Research participant aged 12-13 years (AHRC, 2022)

When asked whether children had experienced problems or negative experiences with digital technology or social media in the last two years, the top three selected problems or negative experiences were:

1. Using social media or technology for gaming or things like YouTube a lot more than usual
2. Tiredness from extra time on screen
3. Being distracted by social media or technology a lot more than usual

> *"I didn't like learning at home because I had to do all the work in front of a screen for more than school hours… my eyes were hurt from looking at the screen."*
> Research participant aged 9 – 11 years (AHRC, 2022)

The long-term effects on children of additional reliance on technology during the pandemic remains to be seen, but AHRC note the ongoing challenge will be to balance the benefits and risks of use. Digital technologies were critical for remaining connected and continuing learning, but for some they contributed to increased distraction, fatigue or distress.

Healthcare Access and Quality
Access to digital technologies again played a key role in accessibility of healthcare. Both PWDA (2022) and Pride and Pandemic (2022) highlighted that for many people with a disability, telehealth was widely accessible and convenient, and in some cases may have improved overall health outcomes (PWDA, 2022). However, the move to digital health and telehealth was not suitable for everyone, with some communities disengaging or losing access to services they were using prior to the pandemic (Monash-NMHCCF, 2022). Across rural Australia, one of the largest struggles identified was inadequate access to mental wellbeing supports, including those delivered through telehealth and digital health solutions (UoN, 2022). This is further outlined in Theme 4.

There were also significant barriers to accessing important public health information for some groups, which reduced awareness of available supports. Both MHA (2022) and COTA (2022) noted that access to information was a challenge for multicultural community members due to language barriers. MHA (2022) found that mainstream messaging about how to get support was not effective for multicultural communities, with few across their sample recalling any communications about mental health support services. COTA (2022) reported that for older people from multicultural communities there was limited engagement with official information sources about the pandemic, lockdown measures and how to look after their health, as well as reliance on families to translate and explain this information. This resulted in a lack of information, and ongoing fear and confusion.

People with disabilities were also less likely to be able to access public health information. Getting accurate information was difficult due to messaging constantly changing, not being consistently accessible and not prioritising people with disability. One interview participant explained they felt like the "hidden minority" (PWDA, 2022). In its Statement of Concern on the pandemic (2020), the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability identified serious concerns regarding access to information for disabled people and called on all governments to ensure information was available in a variety of formats[16]. Notwithstanding this, PWDA (2022) noted the inconsistent use of Auslan interpreters at major press conferences, particularly for federal announcements.

Social and Community Context

A sense of increasing pressure on family or household relationships was a theme in the research. Some Australians experienced family and relationship breakdown due to being required to spend more time together.

Balancing home and work responsibilities was very challenging for many households and some parents struggled with combining work and home schooling. With support structures (people to share responsibilities) and children who were engaged in their learning, home schooling and work could occur harmoniously under one roof. However, stress in the home was found to increase in response to a variety of factors including, parents being single or isolated, or children not focusing on their studies. Difficulty and stress in navigating the balance between work and family responsibilities was found to be especially prevalent within the CALD communities surveyed (MHA, 2022).

The UNSW (2022) research on the experiences of men highlighted that lockdowns increased household tension, particularly when people were not used to being in each other's presence for the extended lengths of time. Similarly, MHA (2022) reported that some CALD families studied experienced breakdown under the stress. COTA (2022) respondents spoke of the 'tension and stress and fighting between couples' during lockdowns, and increased anger experienced towards them from their adult children.

Pride and Pandemic (2022) highlighted the importance of 'chosen family', differentiated from family of origin, with some LGBTQ+ people experiencing distress around having to return to live with their family of origin during the pandemic. In many instances this meant having to move to an environment in which they felt unsafe and unsupported. Even though many had digital access to friends and their chosen family during this time, they still experienced increased feelings of isolation. While many were grateful to still be able to engage and connect with community, they also communicated that virtual meeting technology was not a true substitute for the real thing.

Neighbourhood and Built Environment

Access to housing was one of the most consistent concerns identified across the research projects, with some populations particularly vulnerable to housing insecurity. The issues of increasing property prices, inaccessible housing[j] and a lack of available housing were found to cause significant harm to the mental health of women with disability. More than half of respondents reported that housing stress and insecurity had increased due to the pandemic (PWDA, 2022). Aboriginal and Torres Strait Islander women with a disability identified that overcrowding was an additional and significant factor contributing to housing stress (PWDA, 2022).

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[j] Inaccessible housing is a broad term used here to describe housing that is not physically accessible, such as for older people or people with disability; and not affordable to live in for many people due to cost of living and rent.

Spotlight finding: Challenges of accessing safe and secure housing for victim-survivors of sexual, domestic and family violence (SDFV)

Public health measures that restricted movement, combined with increased household tension and stress, were key factors in increased rates of SDFV during the pandemic.

Full Stop Australia service providers reported increased case complexity for victim-survivor's seeking safety and support from SDFV. Family carers supporting people with mental health challenges (the majority of whom were women) reported increased experiences of domestic violence from both the person they supported (22.8%) and from other members of their household (19.8%) (Monash-NMHCCF, 2022).

> *"On several occasions I felt unsafe, in the sense that I could not contain his slide into PTSD and acting out his distress."*
> Research participant (Monash-NMHCCF 2022)

PWDA (2022) also found increased rates of SDFV experienced by women with disability, including for women who had no previous experience of SDFV. In instances where these women were able to report their abuse to disability support services, several of the respondents reported that these organisations were not responsive to SDFV-related behaviour. Organisations were either pretending it was not happening, or at times siding with perpetrators when conflict arose. In many cases, organisations were unable to provide support around SDFV, with the PWDA acknowledging many organisations were at capacity. A quarter of Full Stop Australia's victim-survivor survey respondents indicated experiences of violence during the pandemic impacted their mental health by causing very high levels of distress. However, distress from SDFV directly was not the only factor impacting victim-survivor's mental health during the pandemic.

Homelessness and/or risk of homelessness was one of the contributing factors to victim-survivor poor mental health during the pandemic (67%; Full Stop Australia, 2022). Crucially, 60% of surveyed victim-survivors attribute their homelessness to escaping SDFV. While experiencing homelessness, victim-survivors sought out a range of housing options, including crisis accommodation, motels or hotels, short stays with family or friends, or refuges, while others slept rough on the streets.

Interviews with counsellors revealed that there was an overwhelming lack of appropriate and accessible housing and accommodation for people experiencing SDFV during the pandemic. Another major factor that increased the risk of homelessness or directly contributed to it was housing affordability. Many victim-survivors could not afford to pay rent or make mortgage payments, while Centrelink, welfare and emergency payments were not enough to survive on (Full Stop Australia, 2022).

> *"Whilst violence and abuse increased, services reached capacity and were unable to meet demands for their services, from counselling to crisis accommodation. There was nowhere for women to go."*
> Research participant (PWDA 2022)

Theme 3: Experiences of loneliness and social isolation

3.1. The pandemic has influenced experiences of loneliness and social isolation in Australia

Social isolation and loneliness[k] are associated with poor health outcomes,[17,18] including increased risk of mental health conditions.[19] It is not just *being* socially isolated, but *feeling* socially isolated, commonly referred to as loneliness, that has detrimental health impacts. People can be socially isolated but not feel lonely, and vice versa.

Isolation experienced during the pandemic has had repercussions on the mental health and wellbeing of Australians. Throughout the course of the pandemic, Australians experienced higher rates of loneliness, sadness, boredom, and isolation,[20] and many found their personal relationships were impacted by increased stress and anxiety.[24] States that experienced prolonged lockdown restrictions had populations with higher rates of loneliness than other parts of Australia.[13]

All priority populations experienced increased loneliness and isolation, often at rates far higher than the general population. In particular, mental health family carers reported that their experiences of loneliness and isolation were already extremely high before the pandemic and reported feeling 'invisible' in discussions of the impact of the pandemic where this lived experience was not acknowledged (Monash-NMHCCF, 2022). LGBTQ+ communities and young people noted the distress of physical separation from their support networks (Pride and Pandemic, 2022; AHRC, 2022). For people aged 75 years and over, the distress caused by isolation and separation from family and friends was described as "brutal" and linked to increased loneliness, isolation, anxiety, and living with fear (COTA, 2022). These feelings also extended past family and friends to encompass the loss of more casual interactions, such as through work or community events (UNSW, 2022). The lack of face-to-face or human experiences, such as physical touch and inability to see expressions due to use of masks, also added to distress.[24]

> *"The whole mask thing. I really don't know what the right approach to the pandemic is or was but not seeing peoples' face fully definitely I think impacts us as humans. I'm the sort of guy that would talk to somebody over apples at the supermarket or something. Without getting those cues of being able to see somebody's mouth or smile you just become less likely to do that and so then you just further retreat inside yourself."*
>
> Research participant living in a community impacted by multiple disasters (Phoenix, 2022)

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[k] Social isolation is the state of having minimal contact with others, whether that be few social relationships, social roles, group memberships, and infrequent social interaction. Social isolation differs from loneliness, which is a subjective unpleasant or distressed feeling about having a less social contact than desired. Some definitions include loneliness as a form of social isolation while others state that loneliness is an emotional reaction to social isolation. Social isolation and loneliness are not necessarily both experienced — it is possible to be socially isolated but not lonely, and to be socially connected but to feel lonely. See: AIHW (2021) "Social Isolation and loneliness" https://www.aihw.gov.au/reports/australias-welfare/social-isolation-and-loneliness-covid-pandemic.

For many communities, sadness and loneliness were particularly felt when their ability to share life milestones with family, friends and loved ones was restricted. Members of the CALD communities expressed the challenge of being “cut off from the normal joys” of life like preparing for the birth of babies (MHA, 2022). These sentiments were also echoed by older adults and rural and remote communities who felt that one of the worst impacts of the pandemic was the inability to mark important life events such as family celebrations, deaths and funerals (COTA, 2022; UoN, 2022).

> *“[the pandemic] changed the way I interact with other people, I find it very difficult to get to know people, make friends, hard to go to events to meet new people, because everyone is so used to being at home, spending more time with family. Feels like everywhere you go, have shields up –very strange.”*
> Vietnamese research participant (MHA, 2022)

Experiences of isolation also extended into some groups experiencing loss of identity and connection to culture. For multicultural communities, restrictions were challenging as many cultures rely strongly on their social networks for support in tough times (MHA, 2022). The pandemic also impacted people’s abilities to worship together and engage their faith-based social support networks. In the MHA (2022) research, this was described as a challenge for members of the Turkish Muslim community, the Italian Catholic community and Christian and Buddhist communities among the Vietnamese speakers.

Isolation also led to a loss of skills. Services supporting women with a disability noticed a loss in social skills over the course of the pandemic due to support groups, schools and other activities in the community being postponed or suspended (PWDA, 2022). A deterioration in functioning was also noted in older adults, with some older people even losing their ability to speak or clearly communicate (COTA, 2022).

Spotlight finding: Experiences of older adults in residential aged care

Clear drivers of distress were uncovered for older adults living in residential aged care (RAC) over the pandemic (COTA, 2022). 41% of residents experienced a decline in their mental health during the pandemic, with 11% of respondents experiencing mental ill-health for the first time.

Lockdown and locked-in: Lockdown often meant being locked in a bedroom. 44% of residents strongly linked their mental health decline to lockdowns, with the sense that these experiences would continue to impact their mental health.

> *“It was terrible, terrible. So lonely. Alone all day in my room.”*
> Research participant living in Residential Aged Care (COTA, 2022)

Separation from loved ones: Enforced separation from family had harmful impacts on the mental health of many people living in RAC, as well as their loved ones. Telephone and video calls were a key form of connection, but not all RAC rooms have a landline, and this can be an additional cost.

> *“I need to be able to have visits from my family and friends… I feel that while protecting me from COVID, they have taken everything I live for away.”*
> Research participant living in Residential Aged Care (COTA, 2022)

Access to mental health support: Despite distress, only two research participants accessed mental health support. Barriers ranged from services being too expensive or unavailable in RAC to a sense that the needs of older adults would not be understood. Some believed that additional support was not needed or that General Practitioner (GP) support was sufficient.

> *“The aged care centre will do nothing for me unless my family call by phone or email and make a huge fuss. How would I access mental health support when I cannot even get help to go to the toilet?”*
> Research participant living in Residential Aged Care (COTA, 2022)

3.3. Public debate and health messaging contributed to feelings of isolation and distress

Public debate and messaging at times heightened tension in the community and contributed to feelings of isolation and distress. Contrasting values and perspectives on public health orders and vaccinations created divisions that impacted community cohesion and disrupted recovery.

Many older Australians suggested that communication about the pandemic and lockdowns pitted generations against each other. COTA (2022) suggest that this perception was due to both official messaging and cultural discussion, where phrases such as “boomer remover” became popularised. Participants highlighted the distressing perception that “older or vulnerable people are just death statistics and it's okay to die so that young people can have freedom” (COTA, 2022).

> *"Adequate help and consideration for the most vulnerable in our community...those living with disability, Indigenous Australians, the homeless, the disadvantaged and the aged, so that they do not become dispensable statistics and their needs are taken into account before they are pushed aside to become the collateral damage in favour of the economy...Life is precious to all and should not be undervalued."*
> Research participant aged over 75 years (COTA, 2022)

For people with disability, public health measures ending caused immense confusion and concern as many continued to be at high risk of morbidity or severe illness. This emphasis on 'moving forward' left many feeling deprioritised, anxious, and as though their health and lives are not valued (PWDA, 2022).

Children and parents commented that news and information about the pandemic also had a negative impact on children's mental health and wellbeing. AHRC (2022) noted that children's uptake of information can be adversely impacted when available information is intended for adult audiences and when there is inaccuracy and misinformation in their primary sources. In narratives collected from parents, it was found that the "barrage of fear" across the news was distressing for their children. Other views were that communications needed to focus more on what "we could do to positively affect our state of being" (AHRC, 2022).

3.4 Responses to the pandemic have also improved relationships

Online and phone communication was viewed as essential, having allowed increased access and frequency of social interactions across all project reports. This was particularly utilised by LGBTQ+ people and CALD people with family and friends overseas (Pride and Pandemic, 2022; MHA, 2022). The development of 'friend bubbles' by some state and territory governments was deeply valued by men as well as young people and children (UNSW, 2022; AHRC, 2022).

Due to the move to online socialising for the wider community, PWDA (2022) found that women with disability had more accessible social lives. For men surveyed, 43% of those that had children reported an improvement in their relationship with their children as a result of the pandemic (UNSW, 2022).

Theme 4: Challenges accessing support services

4.1 How the pandemic affected access to services, systems and supports

During the pandemic, a range of government and health sector initiatives were established to address pandemic-related mental health challenges:[21]

- The increase in telehealth (services via telephone or videoconferencing) was a significant change to service access and delivery for mental health services.
- Crisis lines expanded their services and moved towards 24-hour access.[22]
- The Better Access Initiative was expanded so that people experiencing severe or enduring mental health impacts from COVID-19 and associated restrictions, could access up to 10 extra Medicare subsidised psychological therapy sessions each calendar year (up to 20 sessions in total) until 31 December 2022.
- Head-to-Health Pop Up clinics were established to provide additional support to people of all ages living in New South Wales and Victoria who were experiencing mental health issues because of the pandemic. All clinics offered free telehealth or COVID-safe face-to-face appointments. A GP referral or mental health treatment plan was not required. These Pop-Up clinics have been transitioning over time to permanent services currently being established by the Commonwealth and state and territory governments.

Uptake of telehealth and digital services

The pandemic and subsequent movement to online and telehealth mental health support has changed the way Australians seek out and engage with mental health systems and services. Telehealth services have become major modes of accessing mental health support, even as public health measures previously limiting face-to-face delivery have relaxed. Between 16 March 2020 and 9 January 2022, almost 25 million MBS-subsidised mental health-related services were processed[23]:

- MBS-subsidised mental health services delivered via telehealth peaked during April 2020. At this time about half of MBS mental health services were delivered via telehealth.
- In the four weeks to 9 January 2022, 30.2% of MBS mental health services were delivered via telehealth, despite in-person delivery being available to some people at this time.

For many priority populations, telehealth was seen as having greatly improved accessibility to healthcare beyond the benefit of reduced risk of COVID-19 transmission, through reduced cost and time associated with attending appointments (especially for those living away from Metropolitan Centres) (Monash-NMHCCF, 2022; UoN, 2022; Pride and Pandemic, 2022).

Uptake of telehealth was particularly high in the LGBTQ+ community, with 90.9% of participants who had used mental health care services during the pandemic accessing at least some of this care via telehealth. While there was a preference for in-person psychological support for LGBTQ+ people, especially to build rapport with a therapist, there was appreciation that telehealth enabled the opportunity to keep being supported by professionals remotely. Approximately three-quarters of participants (76.6%) felt that telehealth had made mental health care appointments more accessible, more than half (58.5%) felt comfortable accessing mental health care in this way, and 31.2% felt safer accessing mental health care via telehealth (Pride and Pandemic, 2022).

Accessing traditional services

Access to services was disrupted during the pandemic, particularly for communities previously impacted by disasters and those in rural and remote locations. In both instances, access to in-person services was made almost impossible during the pandemic due to public health orders restricting movement. This caused considerable stress for those who did not have fast and readily available internet or phone connection (UoN, 2022; Phoenix, 2022).

Similar findings occurred with mental health family carers, who reported that the move to telehealth caused disruption for people who were accessing services prior to the pandemic. While telehealth was found to be generally beneficial if the first appointment was face to face, there were also reports of disengagement and non-attendance of sessions held by telehealth, which in-turn caused increased stress and burden on carers (Monash-NMHCCF, 2022).

Although some priority populations found telehealth and digital health services to be hugely beneficial, this was not the experience of all priority populations. Several priority populations highlighted the need for a range of engagement options, and in many instances, there was a preference to seek support through a trusted professional service or GP (UoN, 2022; COTA, 2022; UNSW, 2022; Monash-NMHCCF, 2022). Children and young people also preferred to access services face-to-face (AHRC, 2022) and parents reported that their young people refused to engage with telehealth, and this was a cause of much distress especially when they had been on a waitlist for access (UoN, 2022; Monash-NMHCCF, 2022). Similarly, carers reported that the people they supported preferred to engage with services face-to-face (Monash-NMHCCF, 2022). There were some population groups (such as those with a psychotic disorder) for whom telehealth was not necessarily appropriate, and these people struggled to get access to appropriate and safe services throughout the pandemic.

> *“She’s a 16-year-old child who has mental health issues … she flatly refused to do the telehealth and wouldn’t do it so that’s pretty much through all COVID she went without any psychology appointment ... And then like I said, for them to take her out of the service because she wasn’t attending, that’s another blow because you’ve waited so long to get into these services.”*
> Participant living in a Rural and Remote region (UoN, 2022)

Spotlight finding: the value of safe and accessible General Practitioner support

For older people, members of the LGBTQ+ and CALD communities, GPs were identified as trusted service providers throughout the pandemic.

For older people, primary care was the service level most people engaged with during the pandemic, and these services were instrumental in supporting people to remain well. COTA (2022) reported GPs were the first choice of older Australians for advice on physical and mental health.

> *"I am amongst the lucky ones who seem to have coped and survived well. The importance of knowing I still could have telehealth connections to my GP whenever required was important to me."*
> Research participant aged over 75 years (COTA, 2022)

For LGBTQ+ people, 72.2% reported having a regular GP, and 60.5% reported that their GP or health clinic knew about their sexual orientation or gender identity. Through the pandemic, relatively high engagement (face-to-face/telehealth) with GPs was maintained with 35.6% of respondents having a GP consultation two-to-three times per year and 36.9% four-to-11 times per year during the pandemic.

The MHA (2022) research reinforced that GPs are held in esteem across the CALD communities surveyed, but with a caveat that “extreme stigma” around mental health support was a barrier. Because GPs are trusted providers and are primarily seen as addressing physical health needs, they were at times able to provide mental health support to CALD communities despite some community members holding stigmatising views on mental ill-health. It was noted that while people were not always willing to talk about mental health with their own GPs, for fear that their family would be judged poorly, parents were open to their adult children visiting a GP several suburbs away to avoid the risk of their family ‘losing face’.

Spotlight finding: Experiences of Mental Health Carers

There are more than 240,000 people in Australia who are informal/unpaid Mental Health Carers for people in their lives.[i] For the research participants (n=101) engaged by Monash-NMHCCF (2022), time spent on caring and support responsibilities **almost doubled** during the pandemic, with average hours per week increasing from 26.30 hours per week to 40.35 hours per week (Monash-NMHCCF, 2022).

The pandemic presented a time of heightened stress and distress for Mental Health Carers because the services and supports that were ordinarily available to their loved ones decreased due to demand, workforce availability and COVID-19 safety concerns. This meant that Mental Health Carers found themselves being drawn upon with increasing levels and complexity of support and care for their loved ones, especially as the health and wellbeing of those needing care deteriorated.

> *"I have missed a lot of work and don't have much sick leave or long-service leave left. I need to care for her on my own without other support and this full-time responsibility is challenging, I feel so alone in this."*
> Research participant (Monash-NMHCCF, 2022)

As well as an increase in absolute hours of support provided, there were changes to the ways this support was provided. 73.3% of Carers provided support in the family home, 47.5% provided support in person outside the family home, 29.7% provided support online and 58.4% provided support via the telephone. Some Mental Health Carers identified that providing support by telephone is more tiring than face-to-face. Increased support provision meant increased demands on time, emotions, and finances.

For carers, the most stressful periods of the pandemic were:

(1) The beginning of the pandemic: Uncertainty and changing rules led to stress about how to provide support to people outside of the home while balancing restrictions. Many carers noted that those they support experienced an increase in symptoms at the beginning of the pandemic, including suicidal behaviours. It was challenging to support first episodes of psychological distress during this period and a lack of respite was available for carers providing support in their own home.

(2) Protracted restrictions and lack of service access: As restrictions extended, the people that carers support, especially young people, were unable to access services. Research participants reported that people they cared for were placed on long waiting lists, including when people were suicidal. Exhaustion rose as carers missed sleep to be with their loved ones or to check on them.

(3) End of social protections and reduction in restrictions: When social protections (such as JobKeeper) ended, uncertainty increased for carers and those they support. This included experiences of rental eviction and loss of income. This was coupled with a reduction in health protection mandates, which meant that cases of COVID-19 increased in families and further impacted mental health challenges.

[i] Diminic S, Hielscher E, Lee YY, Harris M, Schess J, Kealton J & Whiteford H. The economic value of informal mental health caring in Australia: summary report. Brisbane: The University of Queensland; 2016.

4.2 Barriers to accessing support: systemic and cultural barriers

A barrier, for the purposes of this report, is an obstacle or an obstruction that impedes the process of receiving support and can limit or prevent people from achieving equality.[24] For priority populations, access to support services was made more difficult due to both systemic and cultural barriers.

Systemic barriers are policies, practices or procedures that result in some people receiving unequal access or being excluded.[25] This can include services not being accessible to people (such as having no wheelchair access, or caps on how many people can be present in a health setting which prevented carers, translators, families and kin from attending appointments or being able to act as supports following hospital admittance), as well as not considering the needs of a community when changing a policy, so they are not able to engage with the service in the same way.

- Gridlock was experienced across the mental health service system as more people sought support through the pandemic. For communities impacted by disasters (Phoenix, 2022) and in rural/remote locations (UoN, 2022), the question was asked: 'Where does the help come from when we can't do it?' Participants, both community members and providers, reflected on the general scarcity of professional support services in rural and regional communities. These pre-existing challenges in accessing services were initially compounded by disasters, which led to an expressed need for increased mental and physical health care, and access to helping professionals who were disaster and trauma-informed.

> *"And for some [specialist] clinics the wait for psychological therapy is a year, well, that's literally pointless, it's not a wait at all, it's a failure dressed up as a queue."*
> Participant living in a Rural and Remote region (UoN, 2022)

- Access to disability support can be critical to meeting fundamental needs such as essential health-related services and social connection. People with disability experienced changes in both NDIS and non-NDIS support that was available throughout the pandemic (PWDA, 2022). Many women with disability cut back or went without services during lockdowns. Similarly, Pride and Pandemic (2022) observed that 45% of the survey respondents who accessed the NDIS reported that that they received less support during the pandemic.
- Financial stress was one of the most frequently cited barriers to accessing mental health support across the projects, with this being the most common barrier to accessing healthcare for members of the LGBTQ+ community (Pride and Pandemic, 2022). Similarly, family carers reported having lost employment, or being unable to access carer support payments, which meant they were unable to pay for gap fees of a mental health provider and that providers who bulk-billed had lists longer than six months (Monash-NMHCCF, 2022). Rules and requirements around financial assistance programs such as JobKeeper and JobSeeker made the programs difficult to access for some communities, such as CALD communities, and without this financial support, many were not able to engage with mental health services (MHA, 2022).
- As previously highlighted in this report, access to digital technologies was a key systemic barrier.

> *“Accessing help during this period was difficult for some, unless they were in a sufficient financial position to pay privately.”*
> Research on the experiences of men, UNSW (2022)

Cultural barriers are issues arising from a misunderstanding of meaning, caused by cultural differences. These barriers can cause outright conflict as well as distress, anxiety, and frustration.[26]

- Language continues to be a barrier for many communities, including issues with translation as well as how language is used to identify and communicate across generations. For CALD and older adult populations, it was noted that the language employed by mental health services may not resonate, and for some there may not be a cultural or language equivalent for a concept in their language. Different ways of communicating the symptoms of mental ill-health and distress may be required (MHA, 2022; COTA, 2022).
- LGBTQ+ participants identified a strong preference to access services seen as safe and accessible, and in some instances specifically catered to the needs of their community. They identified the most persistent barriers to accessing support as discrimination and a lack of providers who are inclusive, affirming, and knowledgeable of LGBTQ+ needs (Pride and Pandemic, 2022). Similar sentiments were expressed by the older adults who stated that even if services were available, needs would not be met because there was a lack of appropriate mental health services for older Australians (COTA, 2022).

Spotlight finding: Experiences of Frontline Workers

Research highlighted the toll that providing formal and informal support to others had on frontline workers through the pandemic. UoN (2022) conceptualised frontline workers broadly as including those engaging with others as customers, clients, students, clients, patients and inmates.

For those working in these support roles, which at times continued to be face-to-face, there were fears about COVID-19 virus exposure and passing the virus onto family (UoN, 2022; Full Stop Australia, 2022). These fears and stressors were further intensified as many also managed increased caring duties with home-schooling children and caring for other family members.

New protocols and procedures introduced to prevent the spread of the disease, did provide some assurance but were also complex and onerous for frontline workers to follow (UoN, 2022).

Full Stop Australia (2022) highlighted that for those that were delivering supports via telehealth, separation between home and work life was difficult. Work from home circumstances brought trauma-based work into worker's homes and reduced the immediacy of debriefing with colleagues at the offices. Counsellors who had supported victim-survivors of SDFV in-person indicated the difficulties of providing therapeutic trauma support remotely, and retaining the engagement of their long-term clients while managing the surge in call demand throughout the pandemic.

From a surge perspective, health services (including mental health services) had expanded waitlists, and this negatively impacted the ability of the workforce to deliver responsive support. In particular, Phoenix (2022) found that in interviews, providers universally described the emotional exhaustion and burnout they experienced as a result of continued work within disaster and COVID-19-impacted communities. The continuous nature and high level of workload was described as significantly affecting the mental health of these help providers, and this was recognised in both interviews and focus groups.

> *"Feelings of hopelessness and helplessness as well, [a colleague] was feeling a lot of guilt, blaming himself for not helping the community enough or letting the community down in his role."*
> Phoenix (2022)

In summary

The pandemic has significantly impacted the mental health and wellbeing of Australians. People's experiences of public health orders and restrictions contributing to increased feelings of loneliness, anxiety and distress, with a sense of disconnection and isolation from community being a key theme in the research. People's economic stability was also affected with every group studied experiencing financial insecurity and job loss. Access to education, housing and healthcare were key concerns raised, also contributing to increases in psychological distress. While these impacts were felt by all Australians, the experiences shared through these research projects indicate that priority populations have been disproportionately impacted, exacerbating existing inequalities associated with the social determinants of health.

Recognising the risk that pandemics and disasters will likely occur more frequently, it is important that we learn from this experience and ensure responses are guided by the voice of lived experience. It is critical that we learn from people's experiences in times when the system is tested so we can build systems that are fit for purpose and services that are better prepared to meet the needs of people at all times.

References

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[1] Parliament of Australia. COVID-19: a chronology of state and territory government announcements (up until 30 June 2020) [Internet]. AIHW; 2020 [cited 2023 11 October]. Available from: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp2021/Chronologies/COVID-19StateTerritoryGovernmentAnnouncements.

[2] Data available through a collaboration between the AIHW and the Centre for Social Research and Methods at the Australian National University.

[3] Australian Institute of Health and Welfare. Prevalence and impact of mental illness [Internet]. AIHW; 2023 [cited 2023 23 October]. Available from: https://www.aihw.gov.au/mental-health/topic-areas/mental-illness.

[4] Australian Institute of Health and Welfare. Mental health services [Internet]. AIHW; 2023 [cited 2023 23 October]. Available from: https://www.aihw.gov.au/mental-health/overview/mental-health-services.

[5] Australian Institute of Health and Welfare. Australian prevalence estimates of suicidal behaviours [Internet]. AIHW; 2023 [cited 2023 11 December]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/prevalence-estimates-of-suicidal-behaviours?fbclid=IwAR0vHoFE8-cL3T8rC6sUCvlyHs4hL1xEQv17UA1tbWnyjtmuwiVnAR-zrW8

[6] O'Hara D, Edmeades K, Whitton S. Recovery basics: working in recovery. Australian Red Cross. 2022 [Available from: https://www.redcross.org.au/globalassets/cms/emergency-services/recovery-basics/recovery-basics---working-in-recovery-a5-d5-web-f.pdf.

[7] Ashfield J, Macdonald J, Smith A. A 'Situational Approach' to Suicide Prevention. Why we need a paradigm shift for effective suicide prevention. 2017.

[8] Ashfield J, Macdonald J, Francis A, Smith A. A 'Situational Approach' to Mental Health Literacy in Australia. Redefining mental health literacy to empower communities for preventative mental health. 2017.

[9] National Emergency Management Agency. 'Disaster' [Internet]. NEMA; 2023 [cited 2023 11 December]. Available from: https://knowledge.aidr.org.au/glossary/?wordOfTheDayId=&keywords=&alpha=D&page=2&results=50&order=AZ

[10] US Department of Health and Human Services. Social determinants of health [Internet]. 2020 [cited 2023 23 October]. Available from: https://health.gov/healthypeople/priority-areas/social-determinants-health.

[11] Australian Institute of Health and Welfare. Changes in the health of Australians during the COVID-19 period 2022 [Available from: https://www.aihw.gov.au/getmedia/cb5f5bbb-df0b-4a1c-9796-25ea2e94e447/aihw-aus-240_chapter_2.pdf.aspx.

[12] Sacks D, Bayles K, Taggart A, Noble S. COVID-19 and education: how Australian schools are responding and what happens next [Internet]. PwC; 2020 [cited 2023 23 October 2023]. Available from: https://www.pwc.com.au/government/government-matters/covid-19-education-how-australian-schools-are-responding.html.

[13] Pawson H. COVID-19 effects on housing and homelessness: the story to mid-2021. 2021.

[14] Australian Institute of Health and Welfare. Social determinants of health [Internet]. AIHW; 2022 [cited 2023 23 October]. Available from: https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health.

[15] Australian Institute of Health and Welfare. Primary and secondary schooling [Internet]. AIHW; 2023 [cited 2023 23 October]. Available from: https://www.aihw.gov.au/reports/australias-welfare/primary-and-secondary-schooling#impact.

[16] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. Statement of concern - The response to the COVID-19 pandemic for people with disability [Internet]. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability; 2020 [cited 2023 11 December]. Available from https://disability.royalcommission.gov.au/publications/statement-concern-response-covid-19-pandemic-people-disability.

[17] Friedler B, Crapser J, McCullough L. One is the deadliest number: the detrimental effects of social isolation on cerebrovascular diseases and cognition. Acta Neuropathol. 2015;129(4):493-509.

[18] Laugesen K, Baggesen LM, Schmidt SAJ, Glymour MM, Lasgaard M, Milstein A, et al. Social isolation and all-cause mortality: a population-based cohort study in Denmark. Sci Rep. 2018;8(1):4731.

[19] Pai N, Vella SL. The physical and mental health consequences of social isolation and loneliness in the context of COVID-19. Curr Opin Psychiatry. 2022;35(5):305-10.

[20] National Health and Medical Research Council. Mental health impacts of quarantine and self-isolation 2020 [Available from: https://www.nhmrc.gov.au/sites/default/files/documents/reports/Committee%20reports/nchrac-report-Mental-health-impacts-of-quarantine-and-self-isolation0620.pdf

[21] Australian Government Department of Health. Supporting the mental health of Australians through the Coronavirus pandemic [Internet]. DoH; 2020 [cited 2023 23 October]. Available from:

---

https://www.health.gov.au/sites/default/files/documents/2020/03/covid-19-national-health-plan-supporting-the-mental-health-of-australians-through-the-coronavirus-pandemic.pdf.

[22] Greg Hunt MP Former Minister for Health and Aged Care. Media Release: Lifeline’s crisis text service goes 24/7 to help more Australians [Media Release]. 2022 [updated 7 February 2022. Available from: https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/lifelines-crisis-text-service-goes-247-to-help-more-australians.

[23] Australian Institute of Health and Welfare. Mental Health Impact of COVID-19 [Internet]. AIHW; 2022 [cited 2023 11 December]. Available from https://www.aihw.gov.au/getmedia/620b8637-5043-4c3c-b309-02d6161e2be9/mental-health-impact-of-covid-19.pdf.aspx.

[24] Diversity for Social Impact. Breaking barriers: types and their definitions 2021. Available from: https://diversity.social/breaking-barriers/.

[25] Government of Manitoba. The Accessibility for Manitobans Act 2022 [Available from: https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=a1.7.

[26] HARAPPA. Cultural barriers to communication: meaning, examples and how to overcome cultural barrier 2021 [Available from: https://harappa.education/harappa-diaries/cultural-barriers-to-communication/#:~:text=A%20cultural%20barrier%20is%20an,creates%20stress%20in%20the%20workplace.