Australia's
Mental Health Think Tank

COVID-19 and Australia's Mental Health

An overview of academic literature, policy documents, lived experience accounts, media and community reports

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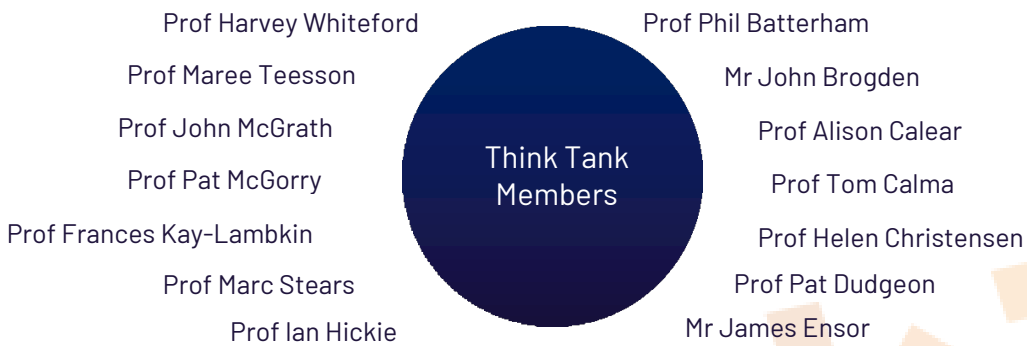
Thank you to the BHP Foundation for the bold vision and support in funding the establishment of Australia's Mental Health Think Tank.

About Australia's Mental Health Think Tank

Australia's Mental Health Think Tank was established in 2020. The Think Tank exists to forge collaborative relationships between policy makers, members of the public, researchers, industry, those with lived and living experience, carers, clinicians and politicians to enable the creation of new knowledge, policy and practice recommendations, and meaningful change that will shape an Australia where mental health is valued. The Think Tank strives to build connections from knowledge to action by stimulating bold thinking around a national response to mental health. Australia's Mental Health Think Tank's initial focus is on the ongoing mental health impacts of the COVID-19 pandemic in Australia, particularly for young people.

To address the pervasive and detrimental ongoing effects of COVID-19 on the mental health of Australians, the Think Tank envisages a 'whole system' approach whereby key stakeholders across sectors come together to learn and respond to current mental health challenges; integrating action to bring about long-term, transformational change. Importantly, the Think Tank exists to empower; to create a better mental health system; to be bold; to embrace hope and build on strengths.

At the Think Tank core is an independent group of world-leading researchers, leaders in Aboriginal and Torres Strait Islander health, health clinicians, people with lived and living experience, policy experts and human rights experts.



The Think Tank warmly welcomes contributions from the broader community. Please contact us via email at info@mentalhealththinktank.org.au or via mentalhealththinktank.org.au.

We recognise and pay respect to the Elders and communities of these lands, past, present, and emerging, who have shared and exchanged knowledge across innumerable generations, for the benefit of all. We respect and value the knowledge, cultures, and traditions of Aboriginal and Torres Strait Islander peoples. We pay our respects to those who have cared and continue to care for Country.

Executive Summary

Over the past 20 months, the COVID-19 pandemic has been a profound disruption to Australians' daily lives. Many of our daily activities and schedules have changed beyond recognition, including the way we work, go to school, see friends and family, play sport, travel, exercise and engage in hobbies. Economic insecurity and increased job loss have propelled many Australians into financial stress. With the recent Australian outbreak of the Delta Variant, there is widespread uncertainty about what the future will look like.

Compiled by Australia's Mental Health Think Tank, this is the first Australian report to tie together multiple streams of knowledge to present an overview of the mental health impacts of COVID-19 and resultant policy measures. Using the best available knowledge, it aims to understand:

What are the main ways COVID-19 has impacted on Australia's mental health?

Who has been the most impacted, and why?

What are the lessons from the COVID-19 pandemic that can inform a plan to protect Australia's future mental health?

The evidence collated in this synthesis contains important depth and insights, but it is not exhaustive. It draws on a wide-ranging knowledge base including Australian and international published literature, government plans, budgets, policy reports, inquiries, grey literature and public commentary about the mental health and wellbeing impacts of the COVID-19 pandemic, and voices from those who have generously shared their experiences around COVID-19 and mental health.

At the time of writing (August/September 2021), NSW, VIC and the ACT are amid another extended lockdown and SA, WA, the NT and QLD have been in-and-out of snap lockdowns, and with a slower than hoped vaccine rollout, there may be more lockdowns and border closures to come. Much around the pandemic, including pathways to an Australia beyond the pandemic, remain uncertain.

Unfortunately, there are gaps in the evidence and data. Much of the existing Australian published research relates to the March to May 2020 period when national lockdown and restrictions first occurred. While this provides meaningful learnings about the mental health effects of early-stage COVID-19, more research is needed to track the longer-term mental health impacts of COVID-19 in Australia.

Lessons learned

Based on the evidence presented the Think Tank identified several key insights, including:

1. **Australians are experiencing deteriorating mental health as a result of the COVID-19 pandemic**. While the pandemic experience across communities in Australia has varied, there has been a population-level deterioration in mental health which echoes experiences overseas in countries with much higher COVID-19 infection and mortality

rates. For example, there is evidence that Australians are experiencing more anxiety and depression, and are engaging with suicide prevention and other mental health support helplines, more often than prior to the pandemic.

2. **The impact of the pandemic on mental health appears to have disproportionately burdened certain members of Australian society**, including but not limited to young people; females; people living with a disability or existing mental health issue; culturally and linguistically diverse people; Aboriginal and Torres Strait Islander peoples; people on low incomes, people experiencing job loss or people living in poor-quality housing conditions.

3. **Government interventions during the pandemic have had mixed impacts on Australians' wellbeing**. Financial support and adaptations to the Medicare Benefits Scheme appear to have played an important role in protecting against the increased mental ill-health risks, including suicide risks. However, lack of systemic change to our already-stretched service system has meant that increased demand has further intensified barriers to high quality mental healthcare.

4. **The impact of social connection and disconnection on Australians' mental health is becoming increasingly clear**, as more research into the impact of the pandemic is being undertaken. The difficulties that some Australians have faced in maintaining their social connections during the pandemic appears to have led to significant mental health challenges.

Directions for reform

Over the coming weeks and months, Australia's Mental Health Think Tank will release research and recommendations for reform in response to each of the key lessons outlined above. As the Think Tank prepares those recommendations, the team warmly welcomes contributions from the broader community.

Supporting long-term community resilience and recovery has never been so important. With the full and lasting impact of this global pandemic still to be realised, we must create and invest in innovative solutions now and into the future. Pandemics and other crises can be catalyststo rebuild in new, more effective, systems but this requires vision and interconnectivity at Local and National levels.

Evidence review – what we found

Following is a summary of the key findings within the three components of this report.

Part A. Overview of Evidence: COVID-19 and Mental Health in Australia

1. Acute and long-term impacts of COVID-19 infection

Emerging global research suggests that contracting COVID-19 may be linked to acute and long-term mental health outcomes, particularly connected to 'Long-COVID'. As case numbers in Australia have been heavily geographically-focused to certain States and, within these States, to people experiencing socioeconomic disadvantage, the mental health outcomes of COVID-19 infection are likely to be disproportionately experienced by these members of Australian society.

2. Physical restriction measures such as hotel quarantine and lockdown

At a Federal / State/ Territory level, lockdowns have been instituted at different times and in different areas, significantly varying the pandemic experience for Australians. The lockdowns implemented in Australia were some of the longest in the world. There is evidence that periods of lockdown are associated with deteriorated mental health.

Undergoing hotel quarantine could have negative mental health consequences. There is limited research, but one study showed mental health was the most common presentation category amongst people referred by Sydney hotel quarantine to hospital emergency departments.

3. Economic impacts

The Australian Government's economic support package introduced in 2020 (including JobKeeper and the 'Coronavirus Supplement' to welfare benefits) buffered the negative impacts of COVID-19 on mental health to some extent. Research showed financial stress was a primary driver/risk factor for poorer mental health outcomes during the pandemic. Receiving the 'Coronavirus Supplement' income support was found to be associated with reports of improved living standards and lower anxiety. Many lost work due to lockdowns – either temporarily or for an ongoing period – and those who did experienced worse mental health outcomes. Younger people, particularly younger women, were likely disproportionately affected by the mental health impacts of employment loss.

4. General and population-level mental health impacts

There were population-level mental health impacts, with increases in psychological distress coinciding with increases in case numbers and resultant lockdowns. No significant differences were found in mental health outcomes between States and Territories, even during the 2020 elongated Victorian lockdown, suggesting that COVID-19 outbreaks and restrictions appear to have a universal effect on Australians' mental health, irrespective of location. There was also some evidence that COVID-19 lockdown and restrictions may have led to an increase in alcohol consumption and drinking behaviours, particularly amongst those who had worse mental health, had higher income, or were middle-aged. Fortunately, despite an increase in psychological distress during 2020, National and State suicide monitoring data showed no evidence of a rise in deaths by suicide in the same period.

5. Mental health impacts on specific populations

5.a Unfortunately, the pre-existing mental health inequalities between **Aboriginal and Torres Strait Islander peoples** and non-Indigenous Australians continued, with Aboriginal and Torres Strait Islander peoples experiencing higher anxiety and stress than non-Indigenous Australians during the pandemic.

A world-leading Aboriginal and Torres Strait Islander community response to COVID-19 meant there were no deaths from COVID-19 in Aboriginal or Torres Strait Islander people prior to August, 2021. However, delayed rollout of the COVID-19 vaccine has seen a disproportionate impact of the Delta variant on Aboriginal and Torres Strait Islander communities.

5.b Some evidence suggests that COVID-19 was associated with a worsening of symptoms amongst **Australians with existing mental health disorders**, including those with eating disorders, bipolar disorder, anxiety and depression. Fortunately, there was evidence that these elevated symptoms reduced over time. Very little Australian research exists exploring the impact of COVID-19 on **people with co-occurring mental health and substance use**

disorders, however international research suggests that the pandemic is likely to have a negative psychological impact on this group. Research also suggests that people with pre-existing mental health disorders may be at increased risk of contracting COVID-19.

5.c Several studies, mostly focusing on children and young people and their families, exposed the negative impact of the 2020 lockdowns and associated restrictions on the mental health of **Australians with a disability or chronic illness**, including compromised education and learning outcomes, and associated feelings of loneliness and isolation

5.d Few Australian studies specifically researched the mental health outcomes of **migrants and culturally and linguistically diverse people**, however one study found respondents born outside of Australia were more likely to report clinically significant levels of anxiety. In 2020, this group experienced unique COVID-19 related challenges, including a lack of eligibility for financial support from the Australian government, heightened racism and prejudice, and higher lockdown-related unemployment.

5.e Several Australian studies found that **Australian children, adolescents and young adults** have experienced heightened depression and anxiety during the pandemic, with research suggesting restrictions on social activities as a leading factor.

5.f There is some evidence that **older Australians** had better mental health during the pandemic than younger Australians. However, there was some indication that older Australians who were female, had lower educational attainment, received government pensions, had chronic health conditions, or were isolated had poorer mental health than those without these characteristics.

5.g Multiple Australian studies showed **Australian females** had significantly worse mental health during the April-May 2020 period of restrictions, including higher anxiety, depression, distress, self-harm and irritability, compared to males. In adolescents, identifying as non-binary or gender-diverse was associated with increased stress and anxiety relative to those identifying as male.

5.h **Parents of children under the age of 18** were found to have worse mental health during the 2020 COVID-19 restrictions compared to pre-COVID levels, particularly those supporting remote learning. However, many parents also expressed positive experiences of meaningful connection and appreciation with their families during the restrictions. Studies highlighted that parental groups who appeared to be more susceptible to poor mental health during the pandemic, included parents of children with a disability, younger parents, mothers and employed parents.

5.i Very little research has examined the mental health of **people in rural and remote communities** during COVID-19. Commentary has highlighted the cumulative effect that COVID-19 may have above the psychological stress of the recent bushfires in regional and rural communities, however one study found that people in rural or remote communities may have been less susceptible to the poor mental health risks of COVID-19 than their urban counterparts.

5.j Australian research has found a general sense of anticipatory anxiety amongst **health care workers**. Nurses and midwives had worse mental health than doctors and allied health providers. **Other non-healthcare 'frontline' workers**, including emergency services, disability workers, and those working in logistics, transport, retail, or hospitality also experienced poor mental health.

5.k One study with data collected during and after COVID-19 lockdown and restrictions found **individuals residing in unsuitable housing** (poor-quality, noisy, dark, insecure, or unaffordable) were disproportionately affected by poor mental health.

5.l Evidence shows there has been a reduction in the number of Australians who reported **gambling** behaviours, in both online and venue-based formats, since the pandemic began.

5.m One study found that higher **educational level** was associated with lower psychological distress and loneliness, and higher quality of life and psychological wellbeing, compared to those with lower levels of education.

Part B: Demands on the mental health service system

The Australian Government released several measures to support the mental health and wellbeing of Australians, including:

1. Updates to the Medicare Benefits Schedule (MBS) to support the provision of mental health care via telehealth for GPs, psychiatrists, psychologists
2. Updates to the MBS to provide access to 10 additional subsidised psychologist appointments, and
3. Funding for charities to provide extra online and call centre counselling support associated with COVID-19.

The Think Tank has identified that, despite these government measures, the pandemic put further strain on Australia's already over-burdened mental health system. Lived experience accounts from Australians surrounding their interactions with the mental health service system during the pandemic are presented in Section C.

Part C: What do Australians consider as the main issues in mental health since COVID-19?

As part of the *Alone Together Study*, 1037 adults across Australia shared their thoughts regarding the most important issues surrounding mental health between March and June 2021. We encourage you to read the rich insights provided by these Australians in the body of this report. Key themes that emerged in the analysis of their responses were:

a) the pandemic led to an increase in job insecurity, financial hardship and precarity, causing stress and anxiety about paying for housing and resources,
b) the pandemic shrunk and fragmented participants' social worlds – leading to feelings of loneliness and isolation, and
c) existing barriers to mental health treatment remained, or were exacerbated by, the pandemic, including access-related barriers (cost, waitlists, and lack of local service options), societal barriers (political and social stigma, social inequity), and holes in the mental health service system which meant people 'fell through the gaps' of available support and were not afforded the 'right' or appropriate care.

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A snapshot of COVID-19 infection in Australia

On 30th January, 2020, the World Health Organisation declared COVID-19 a global public health emergency and then on 30th March, declared a global pandemic. The first case was reported in Australia on 25th January 2020. For more than 20-months, COVID-19 has been impacting lives across the globe, frequently pushing healthcare systems beyond the limits of their capacity. By the fourth week of September 2021, more than 229 million cases had been reported worldwide, in over 190 countries, with over 4.7 million deaths.[1, 2]

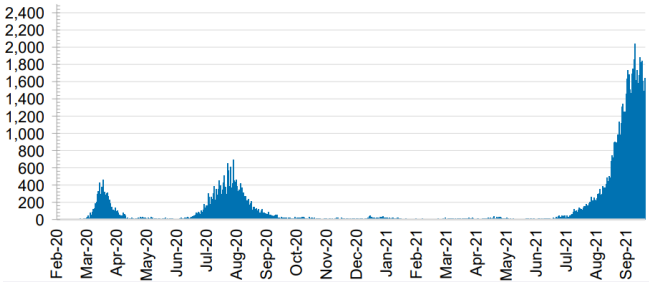


Figure 1. National daily cases. Source: Australian Government Dept. of Health. COVID-19 at a glance 21 September 2021. [3]

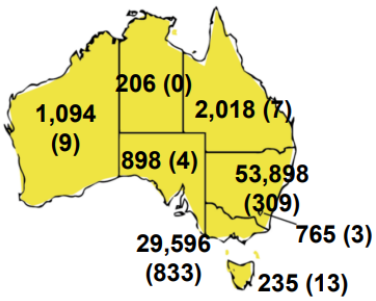


Figure 2. Cases (deaths) by State/Territory. Source: Australian Government Dept. of Health. COVID-19 at a glance – 21 September 2021. [3]

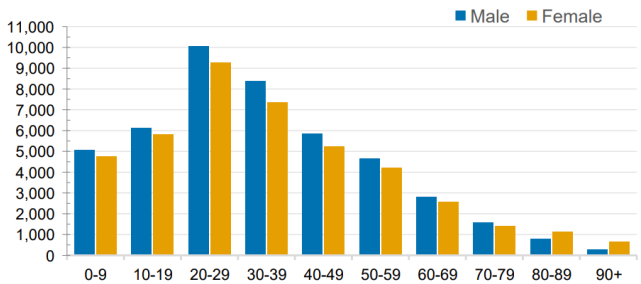


Figure 3. Cases by age group and sex. Source: Australian Government Dept. of Health. COVID-19 at a glance 21 September 2021. [3]

As of 21 September 2021, 48.50% of Australians have received both their vaccine doses, while 73.4% have received their first dose. This is far lower than the original government estimates and the rate of vaccination in Australia has remained low compared to international rates.[3, 4]

Spotlight on Aboriginal and Torres Strait Islander Communities' COVID-19 Response

While COVID-19 infection has disproportionately affected marginalised population groups around the world,[5] Australia's First Nations communities have largely avoided high rates of infection through rapid and effective health responses, including the closure of remote communities; help with protective equipment; testing and contact tracing; staff training; accommodation; vaccine drives; and ensuring culturally appropriate communications and services were implemented.[6] Up until 29 August 2021 there were no recorded deaths of an Aboriginal and/ or Torres Strait Islander person due to COVID-19.

"[This] is a story of how effective it is to empower Aboriginal and Torres Strait Islander peoples, organisations, and communities, and to trust that they have the solutions. The rapid public health control measures put in place [have been] led by Aboriginal and Torres Strait Islander health leaders and services who understood the risks and worked tirelessly with federal, State and Territory governments to deliver collective, culturally appropriate and localised solutions."- Lowitja Institute.[7]

Despite strong community-led responses, there has unfortunately been a rise in COVID-19 cases in Aboriginal communities in Western NSW - particularly in Wilcannia, Walgett and Dubbo - during the present Delta Strain outbreak. A recent Parliamentary Inquiry into the NSW Government's management of the COVID-19 pandemic heard that while there have been strong community-led responses, there has been a lack of engagement from the NSW Government. There is little data on the mental health of people in affected communities, however in the Inquiry Aunty Monica Kerwin and Mary Ronayne spoke of anger and confusion in Wilcannia and Cr Charles Lynch spoke of increasing anxiety and depression in his jurisdiction (Northern Region).

Methodology

Rapid Evidence Review

Academic and grey literature

A rapid review of peer-reviewed and pre-print literature was conducted to identify studies that included data on the impacts of COVID-19 on mental health in Australia. Studies were identified through a "snowballing" technique (iterative search, identifying sources through references and citations of other sources), beginning with a search of COVID-19 studies listed in the OpenScience Framework[8] and then conducting a search in Scopus with terms relating to COVID-19 and mental health in Australian settings. In addition, data was sourced from the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and the NSW, VIC and QLD Suicide Registries.

Policy literature

This section also provides an overview of some of the key national policy settings introduced during the COVID-19 pandemic in Australia. The policy and grey literature analysis involved a desktop review of publicly available, online resources. A sample of approximately 250 policy reports, inquiry reports, public commentary and other grey literature was reviewed, including sources which were not primarily about the mental health and wellbeing impacts of the COVID-19 pandemic, but had some key insights into wellbeing or socio-economic determinants of mental health, such as income and employment. A review of government plans, strategies and budgets implementedin response to the COVID-19 pandemic was undertaken, focused on the Australian government.

An important note: Almost without exception, the quantitative studies included within this synthesis did not include pre-COVID-19 data, although some did make comparisons to available data on similar samples prior to the pandemic. Much of the research conducted related to a veryspecific point in time – the March to May 2020 period – when national lockdown and restrictions occurred. Very little evidence exists that aims to understand how mental health outcomes may have changed in the year since and throughout multiple cycles of pandemic restrictions. Further, much of the COVID-19 research is available through pre-print servers and therefore have not yet been peer-reviewed. As such, conclusions drawn need to be interpreted with caution.

Alone Together – Lived experience qualitative responses

Qualitative data was collected between February and June 2021 and extracted from a six-month follow-up of a larger mixed-methods survey of 2056 Australian adults, which explored the impactof COVID-19 on mental health and substance use (University of Sydney HREC 2020/460). Participants included 1037 Australian adults who answered two open-ended questions Q1: What do you think are the most important issues around mental health in Australia today? Q2: "What impact has COVID-19 had on your mental health, emotions, and/or wellbeing in the past 6 months?". Data was coded and sorted into themes through a collaborative, inductive and iterative process using a thematic analysis methodology.[9] Section two of this report provides a summary of the findings of Alone Together. Shorter qualitative quotes from participants are included in relevant sections throughout the report.

Alone Together – Participant profile

- 70.8% identified as female, 28.1% as male and1.1% as non-binary.
- Participants ranged in age and their State / Territory of residence (Figures 4 & 5)
- 1% of respondents identified as Aboriginal.
- 8% reported that English was not their first language and 12% spoke a language other thanEnglish at home.
- Approximately 50% had at least one child.
- 52% had been diagnosed with a mental disorderover their lifetime.
- After paying for housing costs, 7% reported that they did not have enough money left over to pay foressential expenditure such as bills, clothing, essential transport, food and beverages.
- The median income bracket was $1075 to $1700 per week (n=198).
- 11% had experienced homelessness over theirlifetime.
- 57.19% were employed, either full-time, part-time, casual or contracted.
- 42.81% were unemployed, students, volunteers or retired.
- 53% owned the property they lived in, 38% were renters and the remaining 9% had other forms oftenure arrangements such as living in residentialcare facilities or homelessness.

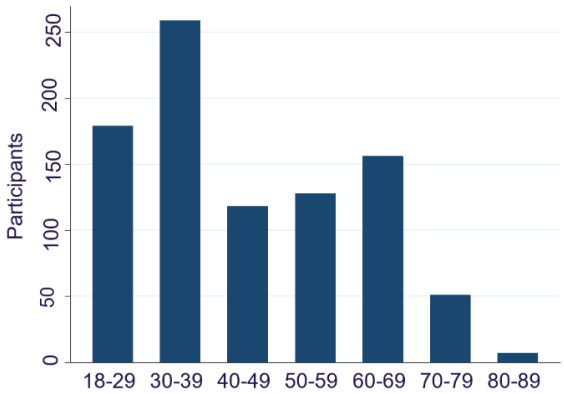


Figure 4. Alone Together participants, age distribution.

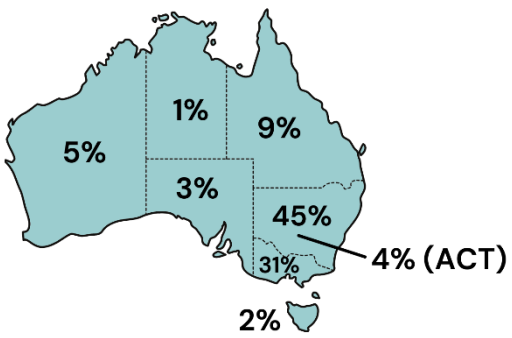


Figure 5. Alone Together participants, geographic distribution.

Part A: Evidence Review

Acute and long-term mental health effects of COVID-19 infection

COVID-19 is a complex multisystem disease which impacts not only the respiratory system but also the neurological, cardiovascular, renal, gastrointestinal, musculoskeletal and haematological systems. While case numbers in Australia to-date have been modest relative to the rest of the world (88,710 positive cases nationally as of 21 September 2021, with 9.4% of those being overseas acquired cases in hotel quarantine), emerging global evidence suggests there may besome longer-term mental health consequences of COVID-19 infection. This is an important area of concern given the age profile of cases with COVID-19 in Australia. COVID-19 positive cases have been reported across the lifespan (1-90 years), but with the highest rates of infection in young adults 20-29 years.[3] As so little research has been undertaken in Australia, we will provide a summary of international research for context, followed by a summary of the small number of Australian studies. A large US study found that compared to individuals who were hospitalised with seasonal influenza, patients who had been hospitalized for COVID-19 had a higher burden of mental health disorders (for example, a burden of 7.75 (95%CI 4.72–10.10)) for mental and substance-useconditions.[10]

There has been increasing evidence regarding the potential long-term impact of COVID-19 infection ('Long-Covid') on mental health and substance use disorders, including suicidal ideation, psychosis, anxiety, and depression.[11, 12] International evidence suggests poorer mental health including elevated anxiety and depression and post-traumatic stress disorder (PTSD) in individuals who have recovered from acute COVID-19.[13] In a recent US cohort analysis, close to one in five (18.1%) COVID-19 survivors were found to have received a psychiatric diagnosis within three months of their COVID-19 diagnosis, including 5.8% that were new-onset conditions.[13] The risk of being newly diagnosed with a psychiatric disorder was more than twice that of otherhealth events.[13]

Part of this mental health impact may be due to the massive disruption to life that 'Long-Covid' causes. More than a third of hospitalised people reported reduced quality of life, 45% required a reduced work schedule, and 22% were unable to work 6 months after infection.[14, 15] A recent UK study surveyed 1,077 patients six months post-discharge following hospitalisation for COVID-19. They identified four clusters associated with different severities of mental and physical health impairment: 1) Verysevere (17%), 2) Severe (21%), 3) Moderate with cognitive impairment (17%), 4) Mild (46%), with 3%,7%, 36% and 43% feeling fully recovered, respectively.[16]

As well as evidence that experiencing COVID-19 isassociated with increased likelihood of poor mental health outcomes, there is evidence that pre-existing mental disorders place individuals atrisk of COVID-19 infection. Taquet et al (2020) found that individuals who had been diagnosed with a psychiatric disorder within the past 12- months or past 3-years were at 65% and 80% greater risk of being diagnosed with COVID-19, respectively, compared to those without psychiatric diagnoses.[13] These findings suggest that the presence of a psychiatric disorder may increase both the proximal and more distal risk ofCOVID-19 infection.[17] It is unclear why the risk is elevated; however, socioeconomic and behavioural factors (difficulty complying with COVID-19 restrictions), physical health conditions, and smoking, have been posited.[17]

While less has been published on the mental healthoutcomes of COVID-19 survivors in Australia, a study that interviewed 11 early COVID-19 patients on their immediate experiences of infection and quarantine, found they experienced anxiety, shockand doubt upon finding out about testing positive.[18] In another Australian survey early in the April-May 2020 lockdown 15.3% of respondents had a direct experience of COVID-19, including contracting COVID-19 (n=56, 0.4%), being tested (n=539, 4.1%), living with someone who had contracted COVID-19 (n=47, 0.5%) or knowing but not living with someone who had contracted COVID-19 (n=1699,11.8%).[19]

These respondents were more likely to report clinically significant anxiety than those who had not had a direct experience of COVID-19.[19] In a longitudinal cohort of 99 Australians who tested positive for COVID-19, 32% reported persistent symptoms and 19% had 'Long-Covid (defined as fatigue or dyspnoea or chest tightness) at median 240 days after initial infection.[20] In addition, 34% of participants experienced mental health symptoms at 4-months post-diagnosis (captured with a 6-item self-report scale spanning anxiety and depression symptoms) and 24% experienced mental health symptoms at 8-months post-diagnosis.[20]

Critically, Australian data on 'Long-Covid' and information on its diagnosis, prognosis, health impact and optimal management strategies are lacking.[15, 16, 21]

As case numbers in Australia have been heavily weighted to Victoria and NSW, 'Long-Covid' will be more prevalent in these States.

There is some indication that people who experience socioeconomic disadvantage seem to be at higher risk of contracting COVID-19, meaning that the mental health effects of COVID-19 infection may be disproportionately concentrated amongst disadvantaged Australians. See Figure 6 which shows the strong overlap in COVID-19 infections in the Delta Variant outbreak as of mid-August 2021 and areas of Socioeconomic Disadvantage.

However, in Australia, the indirect mental health consequences of the COVID-19 pandemic (because of societal and economic changes) are more widespread.

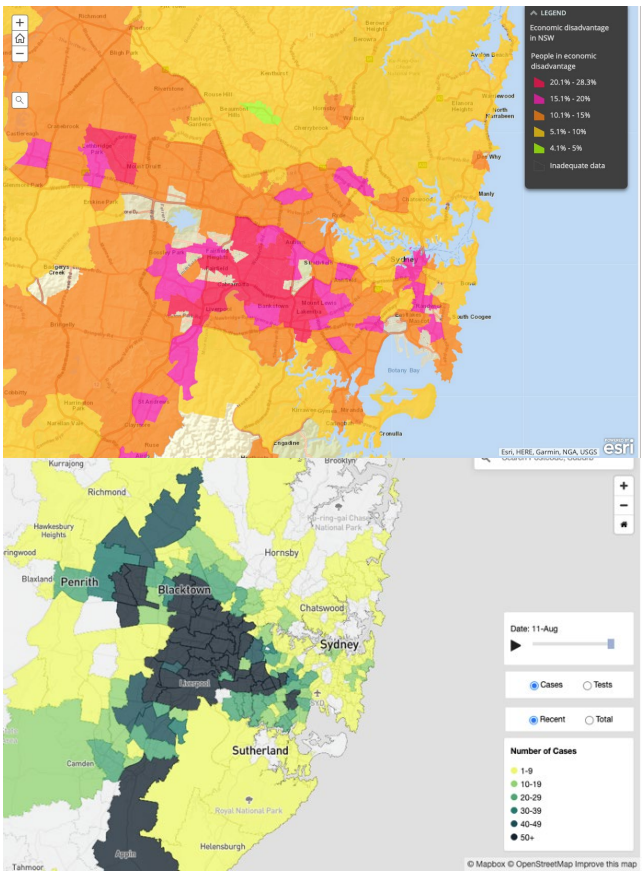


Figure 6. Two maps of greater Sydney revealing the similar geographic profile of COVID-19 infection and socioeconomic disadvantage in the Greater Sydney region. The first map, from the New South Wales Council of Social Services is a heat map of economic in disadvantage, based on the 2016 ABS Population and Housing Census and the 2015-2016 ABS Survey of Income and Housing.[22] The second map from NSW Health Data Source: Recent confirmed COVID-19 cases and number of people tested. NSW Ministry of Health, Population Data, Australian Bureau of Statistics.[23]

Physical containment/restriction measures such as hotel quarantine and lockdown

The following section relates to Australian policies and socioeconomic changes that occurred in response to the pandemic and included, but was not limited to, quarantine of people entering Australian borders from overseas and policy interventions chosen to 'flatten the curve' of COVID-19 transmission throughout Australia, including lockdown, containment and social distancing measures.[24]

"Before the Delta variant arrived, Australia reached effective local elimination of the virus in a way that very few other countries, and certainly no northern hemisphere advanced democracies did ... As a result, Australian public policy entered 2021 in a position that contained considerable strengths and weaknesses. On the strengths side, both the public health and economic consequences of the pandemic had been far less onerous in Australia than in many other similar countries. On the weakness side, there was no clear path available for Australia, or any process to consider a path agreed by different levels of government, as to how the country should re- engage with the rest of the world while the pandemic still raged. As was later seen, Australia also remained deeply vulnerable to outbreaks as its previous low levels of community transmission combined with other factors to generate a vaccination program that was far slower than in many other leading democracies."
– Prof. Marc Stears, Sydney Policy Lab

Policy Snapshot:
National measures were introduced at different times from February 2020 onwards, following the first Australian COVID-19 case on 25 January 2020, and the World Health Organisation declaration of the global outbreak as a Public Health Emergency of International Concern on 30 January 2020.[25]

The Australian Government introduced a wide range of measures, including international borderlockdowns and mandatory hotel quarantine of 14 days for those entering Australian borders.

At the State and Territory level, lockdowns were instituted at different times and in different areas, significantly varying the pandemic experience for Australians. The lockdowns implemented in Melbourne, Victoria for example, were some of thelongest in the world (including a 112-day lockdown from 7 July to 27 October 2020).

A retrospective study of emergency department (ED) presentations by people referred from Sydney-based Special Health Accommodation quarantine hotels found that mental health was the most frequently received diagnosis category (102 of 461 presentations), followed by cardiovascular conditions.[26] The most common reasons for mentalhealth presentations were anxiety, followed by suicidal ideation, and acute psychosis.[26] Mental health presentations amongst this cohort were five times higher than the proportion for all ED presentations in Australia.[26]

" I miss being able to touch or be touched. At first I thought the home carers wouldn't be able to brush my hair anymore, but they know how important it is for me so they still do it every day."
An older person sharing their experience of lockdown in Me, Us and the World: The Impact of COVID-19 on Older LGBTI Australians.[27]

Physical containment/restriction measures such as hotel quarantine and lockdown (cont.)

An Australian study examined self-perceived changes in mental and physical health during the initial COVID-19 lockdown period in April 2020 (general population, cross-sectional, n = 1559, age 18-71).[28] The authors found that over half the sample reported some deterioration of mental health, andjust under half reported deterioration of physical health.[28]

Fewer studies have reported on the mental health effects of repeated lockdowns, or the impact that length of lockdown has on mental health. In fact, there is no current research available investigating the effect of shorter, more frequent rolling lockdowns, as have been in most Australian States to quash outbreaks of the Delta Variant from late June 2021. Studies that do exist suggest that mental health outcomes were similar in Victoria's first (April 2020) and second (September 2020) lockdown. One study surveyed 1583 Victorians during the lockdown in September 2020, including 334 who had completed an earlier survey during the April 2020 lockdown and 1249 who were newly recruited, using demographic quota sampling.[29] Using cross-sectional analysis, the authors found no significant differences between the prevalence of mental health symptoms in the September 2020 lockdown compared to the April 2020 lockdown. The authors did, however, find significant differences in behaviours between the two lockdowns: compared with the April 2020 lockdown, more participants in the September 2020 lockdown reported increased screen time and choosing not to consume COVID-19 information.[29]

There is also some weak evidence, at least amongst older populations, that Australians undergoing lockdown were not significantly worse off than those not in lockdown during the COVID-19 period. One study compared older adults (55 years and older) in Victoria during the second lockdown (July – September 2020) to older adults in other States who were not in lockdown. At the time of data collection, Victorian older adults were 52 days into their second lockdown, on average. Interestingly, median quality of life scores were significantly higher in Victoria compared to the rest of Australia.[30] The authors reported that the increased government support and care to Victorians whilst in lockdown may have cushioned the impact of lockdown on older adults.

There has been some debate about whether lockdown can lead to the same or worse mental health outcomes than COVID-19 infection. Given the relatively low numbers of COVID-19 cases in Australia (when compared to global prevalence rates), some researchers argued that mental health outcomes during Australian lockdowns are a natural experiment showing the unique mental health impacts of lockdown and restrictions, rather than the combined effect of lockdown and COVID-19 infection. They concluded that the fact that Australian mental health outcomes were comparable to those of other countries with higher infection rates, hospitalisations and deaths, it means mental health impacts in Victoria may be exclusively due to indirect mental health effects of the pandemic and its mitigation.[29]

However, Meyerowitz-Katz et al made a counterargument that given there are no locations anywhere in the world where a lockdown without large numbers of COVID-19 infections was associated with large numbers of excess deaths (including suicide), shows "*quite convincingly that the interventions themselves cannot be worse than large COVID-19 outbreaks, at least in the short term.*"[31p5]

Economic impacts

Policy Snapshot:
In response to the COVID-19 pandemic in 2020, the Australian Government introduced major economic support packages for individuals, organisations and businesses. Two of the most significant were JobSeeker – for organisations and businesses – and the 'Coronavirus Supplement' – an additional payment for those receiving welfare support. The evidence indicates that these supports likely buffered the negative impacts of COVID-19 on mental health experienced in the first year of the pandemic.

The major Federal Government policy announcements in response to COVID-19 focused on 'economic stimulus', aimed at reducing unemployment and inserting additional money into the economy to prevent an economic downturn.[32] The total cost of the economic stimulus measures in the first year of the pandemic was reported by the Australian Government as totalling $189 billion. The largest of these economic measures were:

- Reserve Bank of Australia lending $90 billion to banks at low rates, on the condition that this low-income credit be passed on to small and medium-sized businesses.
- Cash flow boosts for businesses and not for profit organisations of up to $100,000, and wage subsidiesof up to $750 per week per staff member (JobKeeper), at an estimated cost of between $31.9 billion and $90 billion.
- Two lump sum payments of $750 to people receiving various government benefits, and a time-limited fortnightly 'Coronavirus Supplement' paid at a rate of $275 per week, effectively doubling the rate of income support provided to people receiving unemployment benefits through JobSeeker, AusStudy and YouthAllowance. In total these measures are estimated to cost $18 billion or more.[33] The 'Coronavirus Supplement', effectively raised the rate of JobSeeker and Youth Allowance above the poverty line.

  Note: The 'poverty line' can be calculated in two ways. In Australia, the rate of JobSeeker, AusStudy and Youth Allowance are set at a rate which is below the poverty line for either definition.

These 2020 economic supports were relatively universal. Limited accessibility requirements enabled the schemes to be implemented quickly and reach the people who needed them, including young people and families. Relaxation of eligibility requirements, like means testing, ensured individuals and families did not need to exhaust savings to be able to access support. Support was provided at a sufficient level to support cost of living, but below a level which would act as a disincentive to work where available. Young people were more likely to access both JobKeeper (through their employer) or the Coronavirus Supplement, than other age groups.[34, 35]

Most if not all COVID pandemic measures were intended to be one-off, or time limited. The AustralianGovernment extended or partially extended some key reforms beyond the original intended period as thepandemic progressed.

JobKeeper ended in March 2021. From 1 April 2021 the rate of JobKeeper returned to its previous rate witha small increase to $310 per week (or $40 to $44 a day). The rate of Youth Allowance for a person living independently returned to $206 per week (or $32 a day).[36]

Mutual obligation (i.e. requirements which include attending appointments, requirements to look for or take particular work, and restrictions on movement) forJobSeeker, which had been suspended during 2020, were reinstated in 2021. The additional Medicare supported therapy sessions and Medicare rebates for telehealth were extended until December 2021.

Mental health funding:
Mental health was identified as an ongoing priority in the 2021-22 Federal Budget, with the Australian Government announcing it was spending **$2.3 billion** including through a *National Mental Health andSuicide Prevention Plan.*[37] The plan has five key pillars:

1. Prevention and early intervention, including through digital mental health services,
2. Suicide prevention, including for Aftercare and postvention services,
3. Treatment, including expanded Headspace youth centres and expanded Head to Health adult mentalhealth services,
4. Supporting the vulnerable, with the largest investment in Aboriginal and Torres Strait Islander suicide
5. Workforce and governance, including funding to increase the size of the mental health workforce,training and support for the mental health workforce and investment in evaluation.

In 2021, when Australia began entering a further extended period of lockdowns in response to the Delta variant, additional or fast-tracked spending was announced following the latest lockdowns, including $17.7 million in August 2021 to support Head to Health clinics in Victoria and provide 'pop up' mental health support sites in areas currently facing extended COVID-19 restrictions in and around Greater Sydney.[38]

In 2021, Australia faced further lockdowns and pandemic restrictions on a scale greater than at any point in 2020. Australian Government supports for people imp acted by the 2021 pandemic lockdowns are significantly lower, more targeted and shorter term than economic supports provided in 2020. For example, a 'COVID-19 Disaster Payment' of between $200 and $750 per week was introduced for those who have lost work or income directly as a result of a COVID-19 lockdown, including some people on income support.

A short-term Pandemic Leave Disaster Payment was introduced for those directed to self-isolate or quarantine due to having COVID-19 or being a close contact of someone who does.[39] State and Territory Governments have provided some limited financial support for business and other forms of economic support.

a) Unemployment and underemployment

The pandemic had a significant impact on the Australian economy, including job losses, cuts to pay and reduction in hours for workers. During March to May 2020, which was the first peak lockdown period, the Australian unemployment rate grew from 5.2% to 7.1%.[40] The participation rate (i.e. the number of people seeking work) dropped by 3.3%.[41] Wages and hours were reduced, and underemployment hit a historic high of 13%, with youth underemployment hitting 23.6% in April 2020. That is, 1.8 million people had their working hours reduced to zero.[42] Between mid-March and late-September 2020, paid jobs decreased by 4.1% and total wages decreased by 5.2%.[43]

In early 2021, employment began to return to pre-pandemic levels, though the underemployment and unemployment picture across States and Territories has varied. In late May 2021, paid jobs were 2.6% higher than at the start of COVID-19, and total wages had increased by 3.1%.[43]

The Australian Government estimated that JobKeeper saved at least 700,000 jobs in 2020, kept 3.8 million Australians in jobs during the height of the pandemic, and assisted approximately 1 million businesses.[44]

The further lockdowns and restrictions introduced in mid-2021, as a result of the Delta Outbreak, again impacted employment, with falls in employment during lockdown periods where these extended beyond 4 weeks.[40]

At the time of writing (August/September 2021) the official unemployment rate was lower than prior to the pandemic (at 4.5%), driven in part by the large number of people dropping out of the workforce altogether; that is, more people not considered unemployed, because they are not actively looking for work during the extended lockdowns.[40] Economists remain divided as to whether Australia will experience a financial downturn or recession in the coming months and years.[45]

"My partner was forced into unemployment during the first lockdown and struggled to find work for 6 months. He was forced to live on JobSeeker and with me on JobKeeper for most of last year, financially things were hard as it has affected our future plans and savings. This has caused much anxiety and worry about our finances and future."
Alone Together participant, 29 YO F, NSW

Modelling: Impact of JobKeeper

Using systems modelling, a research report by Atkinson et al (2020) found that employment programs, like the economic incentive program JobKeeper, was predicted to be the single most effective strategy for mitigating the adverse mental health effects of COVID-19, but that ceasing these programs too early in the trajectory of mental health recovery would decrease this impact.[46]

Australian National University-led modelling suggested the introduction of COVID-19 welfare payments prevented approximately 2.2 million Australians from falling into poverty and housing stress. They predicted their removal would push an additional 740,000 people into poverty, including over 212,000 of those who were not in poverty prior to COVID-19.[47] They argue that 'with the same level of expenditure a greater reduction in poverty and housing stress could have been achieved by a better targeting with regards to poverty and housing stress, and in particular by a slightly lower JobKeeper payment and higher other payments'.[48]

Impact of underemployment and underemployment on mental health

Perhaps unsurprisingly, multiple Australian studies have found that those who lost their jobs, or had a decrease in paid hours, experienced worse mental health outcomes including psychological distress, loneliness, depression, anxiety and self-harm, than those who had steady employment.[19, 48] A nationally representative study of Australians found that COVID-19 related disruptions to work and financial distress were one of the few factors that was robustly associated with initially elevated symptoms of depression or anxiety and changes to symptoms over time.[49]

Whilst becoming unemployed or underemployed is associated with poor mental health outcomes evenoutside of a pandemic context,[50] the large scale of Australians that experienced a loss or drop in employment during 2020-2021 suggests it is a key consideration in the population-level mental healthimpacts of the pandemic. In fact, even the perceived threat of losing one's job was found to be associated with a significant increase in psychological distress, regardless of actual job loss.[51, 52] Another study found a dose-response association, in that the severity of poor mental health was linked to the amount of work loss.[48] Figure 7 shows that younger people (15-24 years) were disproportionately affected by the mental health impacts of employment loss as they are more likelyto work in industries that are hit harder by COVID-19. Figure 8 and 9 (next page) shows that women were harder hit by COVID-related unemployment relativeto young men.

There is evidence that the increase in welfarepayments was good for recipients' mental health, the loss of which likely negatively affected their mental health. In mid-2020, Australian Council of Social Services surveyed over 950 people who had been living on government benefits since before COVID-19 about the impact of the 'coronavirus supplement'. They found that anxiety and distress declined as a result of the increased payment.[53] Most of those surveyed also reported that the extra income allowed them to better afford basic necessities, including three meals a day, fresh fruit and vegetables, medicines, medical care and emergency expenses. Participants also talked about their anxiety around when the supplement would be removed.[53]

Unemployed young people are at greater risk of experiencing mental health problems than other older Australians. The Centre for Public Impact found that as youth unemployment rates rose in 2020, mental health issues (anxiety, depression, panic attacks) among young people simultaneously rose. Young people aged 15 –24, with little or no work experience, entering the job market during a crisis are especially vulnerable. In 2020, young people were more likely to lose jobs, as their jobs are more likely to be seasonal, part-time, casual, low-wage, and insecure, and concentrated in industries hardest hit by COVID-19, such as hospitality.[54, 55] In the long term, those who are moving into the labour market during a major economic downturn have a lower probability of employment, and the future earnings for this cohort are cut for a decade or more.[56-58]

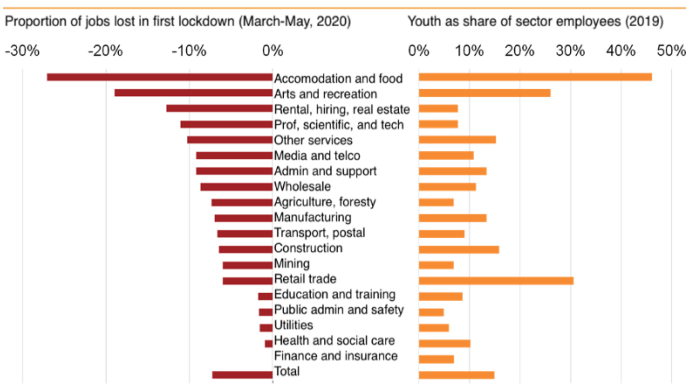


Figure 7. Youth (aged 15-24 for the purposes of this graphic) are over-represented in the industries hardest hit by COVID-19 job loss. Source: Grattan Institute - Analysis of ABS weekly payroll jobs and wages (19 May 2020 release). [59]

3. Economic impacts (cont.)

Unemployment and underemployment (cont.)

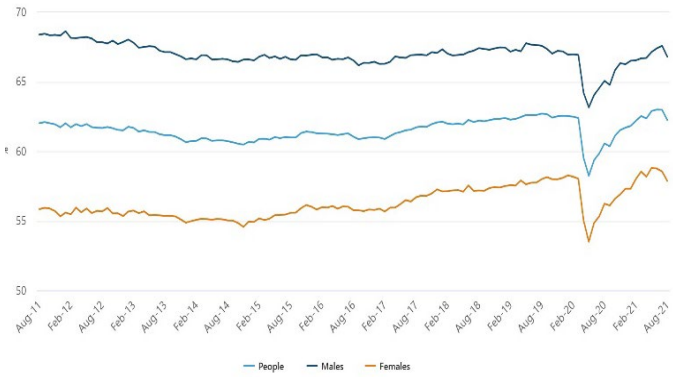


Figure 8. National employment-to-population ratio for the decade from August 2010 to August 2021 (seasonally-adjusted). Source: Australian Bureau of Statistics, Labour Force, Australia August 2021.[40]

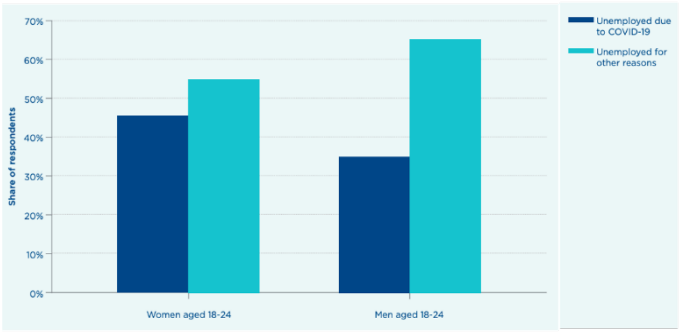


Figure 9. Causes of unemployment among young Australians, by gender (weighted to be representative of age and location) Source: The Melbourne Institute - Jobless and Distressed: The disproportionate effects of COVID-19 on young Australians.[60]

Productivity Commission

"Socioeconomic disadvantage has strong links to mental ill-health. Some population groups are at a higher risk of income poverty and deprivation than the broader population, including people experiencing financial distress, unemployed people and Aboriginal and Torres Strait Islander peoples. For example, the most disadvantaged fifth of the population are almost twice as likely to have high or very high levels of psychological distress than the least disadvantaged fifth. Financial stressors and/orcompromised financial security (such as being unemployed or having excessive debt) increase the risk of developing mental illness." [61]

Australia's Mental Health Think Tank Policy Paper

In August 2021, Australia's Mental Health Think Tank released a policy paper, drawing on the evidence of policy initiatives implemented by the Federal Government in 2020 to support Australians' mental health and wellbeing.

It highlighted that Australia's young people are experiencing a new peak in the national mental health crisis, driven by the extended COVID-19 pandemic and ongoing lockdowns. However, despite the clear indicators of the worsening mental health during the current 2021 lockdowns, economic supports remain limited and difficult to access.

As an urgent measure to support young peoples' mental health, Australia's Mental Health Think Tank strongly recommended the urgent introduction of successful initiatives from 2020, in the form of:

1. **Coronavirus 2021 Supplement** for Youth Allowance and JobSeeker, to provide sufficient financial support to people experiencing unemployment during the pandemic.

2. **JobKeeper 2.0** or equivalent national scheme for businesses, to support people to stay connected to work and provide financial security during the pandemic.

For more information visit mentalhealththinktank.org.au/policy-paper

b) Those who maintained employment: working from home

Policy Snapshot:
Workers transitioned to working from home, and most children began home schooling as schools were partly or fully closed. The Australian and State and Territory Parliaments, and Local Councils, suspended their operations (from March 2020 onwards) and, when they returned, began meeting virtually or with limited numbers, under temporary new arrangements.[62]

Ruffolo et al. 2020 found that participants who were employed and worked remotely reported significantly lower levels of psychological distress than did participants who were furloughed/laid off, fired, or continued to work in their settings with few changes.[63] On the psychosocial well-being measure, participants who worked remotely or who continued to work with little changes to their work setting appeared to experience less changes in their psychological wellbeing, compared to those who were furloughed/laid off or fired.[63]

Other Australian research has identified that a person's housing conditions may impact whether working from home will have positive or negative impacts on mental health. A qualitative analysis of an Australian general population sample found that people residing in low-quality housing at the start of the pandemic reported additional difficulties navigating the transition to working from home due to a lack of space and resources, which resulted in a lack of distinct spaces.[64] This lack of space was reported as contributing to higher levels of stress, anxiety and depression, and a sense of feeling 'trapped', along with the psychological inability to separate work from home/personal life. At the other end of the scale, participants in residences that supported spatial and psychological separation between work and home valued it immensely.[64]

"In many ways it's made things better, for example because working from home is now standard. But there is a loss of connection, and also uncertainty about what lies ahead. I also worry about those lessfortunate than us in Australia."
Alone Together participant, 44 YO M, NSW

General population-level mental health impacts

Findings from the ABS Household Impacts of COVID survey showed that Australians' mental health appeared to shift negatively in relation to changes in the COVID- 19 situation but then returned to pre-COVID-19 levels once outbreaks became contained.[65, 66] Australian research using a nationally representative dataset found similar findings showing that increased initial distress was transient for most people, and unlikely to lead to increased incidence of depression or anxiety disorders long-term.[49] ABS data suggests that poor mentalhealth indicators peaked in August 2020, November 2020 and March 2021 (see Figure 10 below). ABS data has not yet been released on the mental health impacts of the Delta Variant outbreak from July 2021. There is evidence that for some Australians the impact of COVID-19 on mental health lasted beyond lockdown. One in five Australians (22%) reported their mental health in January 2021 was 'worse' or 'much worse' than before the first wave of infections and introduction of COVID-19 restrictions in March 2020.[66] Younger adults were found to have higher prevalence of 'worse' or 'much worse' mental health relative to other age groups (29% of those aged 18-34, 21% of those aged 35 to 64 years, and 15% of those 65 years and over). Similar proportions of male (21%) and female (24%) respondents reported 'worse' or 'much worse' mental health.

During the 2020 national COVID-19 restrictions(April 2020), the ABS reported that 28% of women and 16% of men reported feeling lonely as result ofthe pandemic, and that this was the most commonpersonal stressor identified.[66] Fortunately, there is some indication this has decreased since, with areported loneliness prevalence of 19% in October 2020 and more recently, 10% in April 2021.[66]

Nationally, calls to Lifeline's helpline increased by 20% in 2020, totalling 3,000 calls a day on average.[67, 68] In August 2021, when much of Australia was put back into lockdown due to the Delta Variant, Lifeline reported the highest number of daily calls in their 58-year history. This suggested that more Australians were seeking help and support, in the face of increasing levels of distress.

Results from studies that measured the prevalence of mental disorders amongst Australian general population samples during the COVID-19 pandemic are summarised in Table 1 & 2. Unfortunately, our ability to understand the impact of COVID-19 on Australian general population mental health is hindered by the fact that none of these studies included pre-COVID-19 mental health data in their sample. However, several of them compared their findings to prevalence rates in nationally representative pre-COVID-19 surveys.

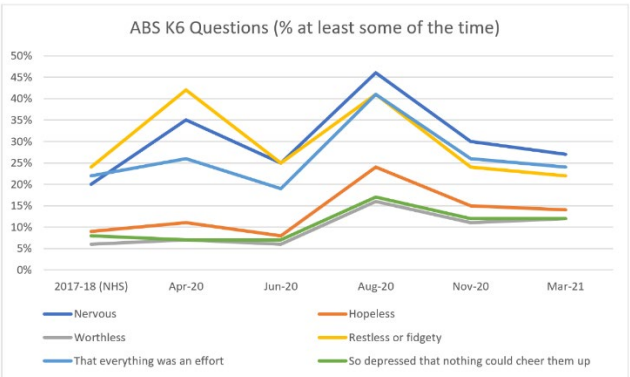


Figure 10. Psychological distress (% at least some of the time) responses to Kessler-6. Data sourced from: Australian Bureau of Statistics Household Impacts of COVID-19 survey (2020-2021)[66] and National Health Survey (2017-2018)[65]

4. General population-level mental health impacts (cont.)

Table 1. Prevalence of psychological distress in studies that included a general adult or adolescent population.

Study	N	Population	Data collection	Psychological distress prevalence
Newby, J.M., et al.[81]	5070	General **Adult** Population (not nationally representative)	March to April 2020	DASS – 21 Stress Subscale Moderate/Severe/Extremely severe: 38.7%
Rossell S, et al.[71]	5545	General **Adult** Population (weighted to be representative)	April 2020	DASS Stress Subscale Moderate/severe/Extremely severe: 21.4%
Biddle N et al.[51]	3155	General **Adult** Population (nationally representative)	April 2020	K6 – Serious mental illness (SMI) cut point: 10.6%
Griffiths D et al.[48]	2603	General **Adult** Population (not nationally representative)	March to June 2020	K6 – Serious mental illness (SMI) cut point: 17.1%
Munasinghe S, et al.[99]	582	General **Adolescent** population(not nationally representative)	April 2020	K6 – Serious mental illness (SMI) cut point: 31.54%
Li S, et al.[70]	760	General **Adolescent** population(not nationally representative)	June to August 2020	K6 – Serious mental illness (SMI) cut point: 48.3%

Table 2. Prevalence of depression and anxiety in studies that included a general adult population.

Study	N	Population	Data collection	Depression prevalence	Anxiety prevalence
Dawel A, et al.[97]	1296	General **Adult** Population (nationally representative)	March 2020	Clinically significant PHQ-9: 20.3%	Clinically significant GAD-7: 16.4%
Rossell S, et al.[71]	5545	General **Adult** Population (weighted to be representative)	April 2020	DASS Depression Subscale Moderate/severe/Extremely severe: 31.2%	DASS Anxiety Subscale Moderate/severe/Extremely severe: 24.7%

Fisher JR, et al.[19]	13289	General **Adult** Population (nationally representative)	April to May 2020	Clinically significant PHQ-9: 27.6%	Clinically significant GAD-7: 21.0%
Newby, J.M., et al.[81]	5070	General **Adult** Population (not nationally representative)	March to April 2020	DASS – 21 Depression Subscale Moderate/severe/Extremely severe: 46.0%	DASS – 21 Anxiety Subscale Moderate/severe/Extremely severe: 40.8%
Batterham, PJ et al.[49]	1296	General **Adult** Population (nationally representative)	March to June 2020	Clinically significant PHQ-9 Baseline: 20.3% Peak – 2nd wave: 23.6% Final: 18.3%	Clinically significant GAD-7: Baseline 16.4% Peak – 3rd wave – 17.2% Final – 13.5%

Differences by State and Territory

There have been substantial differences in the number of COVID-19 cases between the States and Territories of Australia, with much higher case numbers in Victoria and New South Wales than in other States.[69] Despite this, available evidence suggests all Australian Statesand Territories experienced similar mental health outcomes. In their mid-August 2020 Household Impacts of COVID-19 Survey, the Australian Bureau of Statistics reported no significant differences in mental health outcomes reported by people in Victoria when compared to the rest of Australia.[66] Similarly, a national survey of Australian adolescents (n= 760, M_{age} 14.8 [1.26]) examined mental health outcomes among young people located in Victoria after lockdown restrictions were announced on 8 July 2020, relative to respondents across the rest of Australia, or in Victoria prior to this date, and found no significant differences in mental health outcomes.[70] Another study found that living in a jurisdiction with higher case numbers was associated with *better* mental health outcomes and found that living in a State or Territory with lower COVID-19 cases was a predictor for higher negativeemotion.[70, 71]

Confirmed and suspected deaths by suicide andintentional self-harm

National and State suicide monitoring data found that there was no evidence to date that the pandemic has been associated with a rise in suspected deaths by suicide, despite an increase in the use of mental health services and an increase in psychological distress during the same period.[49, 68, 72-74] In their analysis, the Australian Institute of Health and Welfare note that an increased sense of community 'togetherness', and a reduction in financial and housing stress due to JobKeeper and JobSeeker may have helped to prevent the number of deaths by suicide.[68] During the 2019-2020 period, the suicide rates of young Aboriginal Australians aged between 0-24 and 25-44 were more than twice that of non-Indigenous young Australians (3.2 and 2.7 times as high, respectively).[68] However, the evidence was inconclusive around whether this discrepancy between Aboriginal and non-Indigenous Australians was further impacted by COVID-19.

The overall rate of hospitalised intentional self-harm for Aboriginal and Torres Strait Islander Australians increased from 203 hospitalisations to348 hospitalisations per

100,000 between 2008-09 to 2019-20, whereas the rate of hospitalisations for intentional self-harm in non-Aboriginal Australians stayed relatively stable over the same period.[68] Again, the evidence was not conclusive around whether this change was related to COVID-19.

Stronger evidence for the impact of COVID-19 on mental health came from ambulance attendance data for NSW, VIC, TAS and ACT, where there was a 17.6% increase in the crude rate of self-injury in 2020 from 2019. The increase was particularly marked in females under the age of 24. [68]

Substance Use

There is some evidence that COVID-19, particularly lockdown and restrictions, may have led to increased substance use. One Australian study occurring during Victoria's second lockdown in September 2020 found 12.3% of their 1,157 participants reported having started or increasing their substance use to cope with the pandemic.[29] Another study found increases in risky alcohol consumption amongst women in midlife (aged 45 to 64) was associated with negative emotional responses to the pandemic, including reported feelings of loneliness and depression.[75]

Results from another survey, conducted with 5,158 participants in April 2020 identified several characteristics that were associated with increased drinking .[76] They found that those who were heavier drinkers prior to the pandemic, those who were middle age, and those who were on average or higher income were more likely to report increased drinking. Certain behaviours and characteristics were also associated with increased drinking, including lost employment, eating more, stress and depression and changes in sleeping habits were all associated with increased drinking. People aged between 25-49 were also more likely to report increased drinking than those who were in the 18-24 age group.[76]

Mental health impacts on specific populations

a) Aboriginal and Torres Strait Islander peoples

Policy Snapshot:
Additional funding and flexibility in service deliveryfor Aboriginal and Torres Strait Islander communities was delivered through Aboriginal Community Controlled Health Organisations, with discrete communities establishing local border closures, before those implemented by State and Territory governments.[77] Recently, Aboriginal Health Organisations have led vaccine drives and campaigns around maintaining mental health during lockdown.

Unfortunately, the pandemic has also increasedexisting prejudices against Aboriginal and Torres Strait Islander peoples, which had increased in 2019 (from 28.6% to 52.1%) and remained at approximately the same levels (49.7%) in 2020.[78] The reason for this echoes what board member of Inclusive Australia and Yorta Yorta man Ian Hamm explained as the cause for the sustainment of racism towards Aboriginal and Torres Strait Islander communities,and that the pandemic has increased divisions, some existing prior, between communities as people were forced to isolate 'to their particular patches'.[79] Prior to COVID-19, Aboriginal and Torres Strait Islander peoples already faced health and mental health inequalities and inadequate and inequitableaccess to mental health care.[80] Cross-sectional studies in Australian samples during the height of 2020 COVID-19 restrictions found that Aboriginal and Torres Strait Islander peoples continued to experience higher anxiety and stress than non-Indigenous Australians.[81, 82]

Aboriginal and Torres Strait Islander expertise

"In considering the cultural impacts of the pandemic, we note that social isolation is contrary to Indigenous cultural practices. Enforcing travel bans, movement restrictions and quarantines disproportionately affects Indigenous populations." – Moodie, N. et al.[83]

"A strong connection to family, kinship and the community underscores the social and emotional wellbeing of Aboriginal peoples; subsequently, increased experiences of racism in addition to strict social isolation rules imposed in Australia in response to the COVID-19 pandemic inevitably cause anxiety, fear and emotional distress Together with a sense of disempowerment and lossof control, these emotional states may lead to an increase in dysfunctional coping strategies and behaviour, including alcohol and drug use. The bidirectional and interactive relationships between these risk factors may then trigger a downward spiral in social and emotional wellbeing, thereby increasing suicide risk. In the midst of, or after, the COVID-19 pandemic, re-establishing and rebuilding the connections that strengthen the social and emotional wellbeing of Aboriginal peoples have become increasingly important." – Dudgeon, P. et al [84]

"There is an increasing need for social and emotional wellbeing services in Aboriginal and Torres Strait Islander communities as a result of the events of 2020 and pre-existing effects of colonisation and inter-generational trauma. Strongcultural protective factors and resilience ensure Aboriginal and Torres Strait Islander people can withstand adverse circumstances, understanding health in a wider range of metrics than physical illness, with a focus on social, emotional, spiritual and communal wellness." Source: Lowitja Institute [7]

5. Impacts on specific populations (cont.)

b) People with pre-existing mental health and co-occurring substance use disorders

Research has explored the impact of COVID-19 on the mental health of Australians with pre-existing mental health issues. An Australian study, conducted in April 2020, found that parents with a pre-existing mental health diagnosis reported higher levels of depression, anxiety, and stress and emotion dysregulation during the pandemic, and reported higher childanxiety and depression.[82] They were also more likely to report higher parenting irritability, couple conflict, less family positive expressiveness, and more negative expressiveness.[82] Several Australian studies included in this rapidreview examined the COVID-19 experiences of those with specific mental disorders:

Eating disorders: People with a pre-existing eating disorder (n=180) showed increased restricting, binge eating, purging, and exercise behaviours during April 2020 compared to pre- pandemic.[85] They also experienced a greater increase in mental health problems compared tothe general population.

Anxiety and Depression: Staples et al. examined demand from existing mental health service users at MindSpot clinics and observed an initial rise in anxiety symptoms, which returned to baseline in the following weeks. Symptoms of psychological distress and depression measured by the K-10 and PHQ-9, and the proportion reporting suicidal thoughts and plans did not change.[86] In a sampleof adolescents, those with a history of depression or anxiety reported worse mental and physical health on all measures, including lower levels of exercise, greater use of technology, poorer sleep quality, higher levels of loneliness, uncertainty about the future, psychological distress, health anxiety and lower levels of wellbeing.[70]
There is some weak evidence that increased anxiety and depression during COVID-19 may lead to increases in substance use behaviour. One cross- sectional study of 13 829 people during COVID-19 lockdownfound that respondents with more severe anxiety and depression symptoms were more likely to drink increased levels of alcohol compared to their pre-COVID levels.[87]

Bipolar disorder: In a case control study comparing the experiences of individuals withpre-existing bipolar disorder (n= 43, M_{age}= 25.3[11.4]) with control (n= 24, M_{age}= 22.79 [12.8]) found an overall pattern of relatively mild pandemic-related negative mood symptom changes, lifestyle factors and social rhythms among those with Bipolar Disorder, which - while still higher than in control group - had decreased over time.[88]
Scarce empirical Australian research has explored the impact of COVID-19 on people with co-occurring mental health and substance use issues. Emerging international evidence indicates that risk factors associated with this vulnerable group may increase the risk of exposure to, and complications arisingfrom, the COVID-19 virus [17]. Direct COVID-19 infection, and related infection control measures and social disruptions, are associated with potential acute and long-term impactson both psychiatric and substance use disorders, contributing to the onset, recurrence and worsening of existing mental health conditions. [17]

Consumer survey
A survey of 738 consumers across seven community-managed mental health service providers around Australia found that:

- Over half of respondents reported that theirmental health had deteriorated during the COVID-19 pandemic
- Social isolation and physical distancing wereidentified as significant reasons for worsening mental health
- Over half of respondents received increasedfinancial assistance and almost all reported that the increase had positively impacted their health and wellbeing
- A third of respondents reported not being able to access a support group during the pandemic and that this had adversely impacted their mental health

Despite this, 40% of respondents reported that their previous experience of managing their mental health had assisted them in coping through the pandemic. Source: Wellways Resilience in Isolation Report.[89]

c) People with a disability

Several Australian studies have shown the negative impact of COVID-19 on the mental healthof people with a disability or chronic illness. Primarily, research in this area has focused on the COVID-19 experiences of children and young people with a disability. A survey by Children and Young People with Disability Australia with 697 respondents (4% children, the remaining family members) found that 50% reported that COVID-19had a negative impact on their child's and their own mental health.[90] Almost three quarters of families interviewed 'agreed' or 'strongly agreed' that their children and young people felt more isolated from their peers than prior to the pandemic. Using cross-sectional data, the report also found that the effect of the child's mental health during COVID-19 was the strongest predictor of education and learning outcomes during the height of lockdown restrictions.[90]

> "Restricted access to community and external outings had an impact on my son's mental health. He already struggles with issues relating to marginalisation. He struggled with the lack of freedom but I think society as a whole struggled with that. However, it needs to be recognised that children with disability often have mental health issues to begin with due to their general treatment by the mainstream world."
> Parent of child with a disability.[90]

Other studies looked at the experiences of adults andchildren with disability. Parents of Australian childrenwith an ADHD diagnosis reported their children were more likely to experience loneliness and sad or depressed mood, during the height of COVID-19 restrictions, compared to recalled levels pre-pandemic.[91] Evans et al. showed that both children and parents with existing neurodevelopmental disorders found the experience of lockdown difficult and experienced an exacerbation of existing mental health difficulties during the pandemic.[91] Another qualitative study explored the impact of COVID-19 on adults and young people with autism andtheir families. It found that the enforced social isolation during COVID-19 negatively impacted both adults and young peoples' mental health due to intense feelings of isolation and 'social loss' from missing friends and losing access to incidental forms of social connection. This lack of connection was not salved by digital forms of social interaction.[92]

5. Impacts on specific populations (cont.)

d) Migrants and people from culturally and linguistically diverse backgrounds

Few Australian studies have examined the experiences of migrants and culturally and linguistically diverse (CALD) people as a distinct subgroup, however one study did report that respondents born outside of Australia were more likely to have direct experiences of COVID-19 and were more likely to report clinically-significant symptoms of anxiety.[19]

"When I'm at the shops, people have looked at me (visibly Asian) and stepped away or moved aside"
"I can't leave Australia because if I do, I can't come back next semester. It makes me very homesick."

Young people sharing their experiences in the Hidden Cost: Young multicultural Victorians and COVID-19 report.[93]

"As a migrant to Australia, I've become a target for discrimination, especially when people are suspicious that I have contracted the virus being a foreigner or looking like one even though I am a naturalised Australian."

An older person sharing their experience of lockdown in the Me, Us and the World: The Impact of COVID-19 on Older LGBTI Australians report from the LGBTI Alliance Silver Rainbow project.[27]

The pandemic has also exacerbated existing prejudices towards CALD communities in Australia, with some reports detailing an increase in racism. An Australian National University (ANU) Centre for Social Research and Methods survey on the experience of Asian-Australians at the initial stages of the pandemic found that the proportion of Asian-Australians who were anxious and worried due to COVID-19 increased between May and August 2020. This increase was attributed to anti- Chinese racism in relation to the origin and spread of COVID-19 and other stressors such as unemployment being higher for Asian-Australians working in precarious sectors of employment in Australia.[51]

Red Cross conducted an analysis of data on people nationwide accessing emergency relief between 1st April – 31st July 2020. They found that as of 30 June 2020, there were just over 2 million people in Australia on a temporary visa and an estimated 62,000 people who did not currently hold a valid visa.[94] The vast majority of these people could not access a sustainable safety net (e.g. JobKeeper) and were unable to leave the country. Red Cross casework data indicates that between March and June 2020, unmet mental health needs at first assessment increased from 42% to 51% and the instances of clients' mental health situation posing a serious risk to their safety and wellbeing increased from 2% to 16%.[94]

e) Young people (children, adolescents and young adults under 25)

Several Australian studies examined the effect of COVID-19 on child, adolescent and young adult mental health, finding poorer mental health outcomes across all age groups. One study collected data post-initial lockdown between June and August 2020 and found that while most adolescents rated their overall health as 'good' or 'very good', most indicated that their physical and mental health had worsened as a result of the pandemic.[70] Over half of the sample reported experiencing feelings of loneliness and most felt some degree of uncertainty about the future.[70] A longitudinal study of Australian adolescents found low to moderate levels of COVID-19 related distress, a significant increase in symptoms of depression, and anxiety, and a significant decrease in life satisfaction from baseline to COVID-19.[95] Another longitudinal study following up Australian young adults during the first wave of the pandemic found increases in anxiety and depression symptoms from pre-COVID, but no commensurate increase in help-seeking.[96] Finally, there was cross-sectional evidence that young adults (i.e. those aged between 18 and 25) had poorer reported mental health across measures of

depression, anxiety and distress during the height of COVID-19 restrictions compared to older adults.[52, 81, 97]

Several characteristics were found to be associated with worse mental health amongst younger people during the COVID-19-related period. One study identified that parental pre-existing health conditions and COVID-19 psychological and environmental stressors were consistently associated with higher child anxiety and depressive symptoms, as was the child having been diagnosed with ADHD or ASD.[82] Another study found that adolescents with a history of depression or anxiety had worse mental health after the June-August 2020 lockdown than those without.[70]

The results of two studies suggested that pandemic restrictions on social activities may have contributed to poorer adolescent mental health. However, Magson et al found that adolescents who were able to maintain their social connections throughout the COVID-19 period reported significantly less depression and anxiety symptoms than those who felt disconnected.[95] Similarly, Munasinghe et al found physical distancing and social restrictions impacted on adolescents' health and well-being outcomes.[98]

Australian children and young people with a disability reported markedly poorer wellbeing outcomes during COVID-19 as can be seen above in the section on 'Australians with a disability'.

"I have had times where I've felt trapped because of COVID, not physically because my environment is safe, and I am surrounded by lots of loving people but trapped in life that hasn't moved forward because we have been living the same way over and over for a year. I feel sad that some of the things I wanted to achieve, and experience haven't happened yet, like travel and buying a property, due to COVID, and it makes me feel a bit hopeless about thinking things may never get better."

Alone Together participant, 22 YO F, VIC

f) Older people

One study found that older adults aged 45 years and over, especially those 65 years and over had much lower levels of psychological distress compared to younger populations. They also had higher levels of hope, acting as a possible protective factor against psychological distress.[52] Another study found that when measuring quality of life amongst Australians over the age of 55 in the second half of 2020 (including Victorians in their second lockdown between July – September 2020), those who were female, had lower educational attainment, received government benefit, had small social networks or chronic health conditions were significantly more likely to have a poor quality of life.[30]

There has been very little academic research exploring the impact of the pandemic on the mental health of aged care residents. In December 2020, it was reported that 74% (629 of 844) of the COVID-related deaths in Australia had occurred in aged care homes.[99] A number of COVID-19 infections in aged care facilities have led to significant deaths and likely anxiety amongst residents, staff, and their loved ones. The Royal Commission into Aged Care Quality and Safety released a COVID-19 special report, indicating that the aged care sector was 'traumatised' by the outbreaks, bereaved regarding those that died with COVID-19, and anxious around infection case numbers.[99]

Impacts on specific populations (cont.)

g) Gender

Multiple cross-sectional studies of Australian adults during April-May 2020 showed females had significantly worse mental health compared to males, including higher anxiety [19, 81, 97, 100] and depression;[19, 97, 100] distress; [100] self-harm and increased irritability[19] and negative emotion.[71] Females also appeared to be more likely to seek mental health treatment during COVID-19; a longitudinal study (n=5454, M_{age} 35.0 [13.5]), found that the proportion of females undergoing an initial MindSpot clinical assessment (for depression and anxiety) was higher during COVID-19 compared to baseline.[86] While Westrupp et al. found that women were more likely to report anxiety than men, they were less likely to smoke or consume alcohol regularly.[82] In addition, women were more likely to report their children as having higher levels of anxiety and depression, and to rate levels of family positive expressiveness higher.[82]

Similarly, amongst adolescents, gender was found to moderate score changes for depressive symptoms, with results indicating that although there were significant increases in depressive symptoms from baseline to during COVID-19 for both males and females, this effect was more pronounced in females.[95] This result was replicated for changes in anxiety. Gender significantly moderated the change in life satisfaction from baseline to during COVID-19 with females showing the greatest decrease. Females reported more symptoms of depression and anxiety at both time points.[95] Identifying as female, non-binary or gender diverse was found to be a predictor of higher stress and anxiety during COVID-19, relative to those identifying as male.[81]

h) Parents

Eight studies included within this review explored the mental health of parents in Australia and suggest that parents experienced poor mental health outcomes during this period. One study found that parents of children aged 18 years and younger had worse functioning across multiple domains compared to Australian pre-pandemic data, including increased levels of depression, anxiety and stress and increased alcohol use.[82] Olive et al found that children demonstrated more sleep problems and more weekend screen time, while more parents had poorer sleep quality despite greater weekly physical activity during the early stages of the pandemic compared to pre-pandemic nationally representative data.[101]
One qualitative study of 2,130 parents in Australia revealed the diverse experience of families during the pandemic, as many parents shared messages around loss and challenge, reporting mental health difficulties and strained family relationships.[91] In contrast, some families reported positive and meaningful experiences, including increased opportunities for strengthening relationships, finding new hobbies, and developing positive characteristics such as appreciation, gratitude, and tolerance.[91] A number of studies identified certain parent characteristics that were associated with poorer mental health during the same period:

- **Parents of children with a disability:** In qualitative analyses, parents of children with disabilities described poor mental health, including extreme distress and worry. School closures, the cancellation of National Disability Insurance Scheme (NDIS) support services and a lack of government planning for people with disabilities meant that routines were broken and parents had to juggle daily care complexities alone.[102]
- **Parents and caregivers facilitating remote learning** had significantly higher levels of psychological distress and work/social impairment than those

parents/caregivers not home-schooling or adults without children.[103]

- **Younger parents:** Younger parental age wasfound to be associated with worse psychosocial functioning and more strained family relationships.[82]
- **Mothers:** Female parents reported experiencing poorer mental health than theirmale counterparts and the disproportionate burden shouldered by female parents in households with children was often exacerbated during the pandemic period, especially with respect to childcare responsibilities.[104]
- **Employed parents:** Employed parents whose youngest child is aged five to 11 showed higherdistress than non-employed parents. Among the non-employed, fathers display the highest rates of mental distress.[105]
- **Parental relationship patterns:** Constructive communication and support between partners buffered the impacts of pandemic-related stressors on feelings of loneliness and relationship quality.[106]
- **Parent resilience:** Higher resilience levels were associated with lower levels of stress, anxiety, and depression during the time of the COVID-19 pandemic in Australian parents.[107] Higher levels of extraversion was associated with greater resilience. The relationship between resilienceand depression was influenced by the level of partner support.[107]

i) Rural and remote communities

The impact of COVID-19 on the mental health of people living in rural and remote areas appears to vary widely. An editorial by Usher et al. (2020) highlighted the increased vulnerability of rural and remote communities to long-term mental health impacts following the COVID-19 pandemic and 2019-20 bushfires. The co-occurrence of two major disasters not only halted bushfire recovery efforts but also limited community access to health services, and thus left individuals at greater risk of psychological distress.[108]

However, a national cross-sectional study (N=13,829) found that experiencing a high negative impact from COVID-19 restrictions was less likely amongst rural and remote communities than major urban centres and that rural and remote Australians were *less* likely to report clinically significant signs of depression and anxiety, thoughts of self-harm, and increased irritability than those from major cities.[19]

Another study found that exposure to bushfire smoke was associated with elevated psychological distress and decreased wellbeing. However, direct exposure to bushfire was not found to have a significant effect.[97]

The VicHealth Coronavirus Victorian Wellbeing Impact Study examined the experiences of 2,000 Victorians in February 2020 and then again during the first lockdown in March 2020. The study found that those in inner metro areas had significantly higher rates of high psychological distress (24%) compared to those in regional locations (10%). However, respondents living in areas impacted by the 2019/2020 Black Summer bushfires had the highest rate of psychologicaldistress (41%) of all sub-populations examined.In addition, Victorians living in regional areas were significantly more likely to feel disconnected from others during lockdown when compared to the Victoria-wide pooled prevalence (34% versus 24%, respectively).
This had increased substantially from February 2020, when only 10% of those in regional areas felt disconnected and the pooled prevalence forVictoria was 11% greater.[109]

Impacts on specific populations (cont.)

j) Frontline workers

Healthcare workers

Cross-sectional research in Australian healthcare settings has identified the toll COVID-19 is having on healthcare providers' mental health. A survey of healthcare workers in a large Melbourne metropolitan hospital found significant symptomsof moderate-severe levels of depression (21%), anxiety (20%) and posttraumatic stress disorder (PTSD; 29%), despite limited exposure of COVID-19 infection.[110] However, a second Melbourne-based study found that direct contact with COVID-19 patients was associated with higher anxiety scores.[111] This study also found that 29% of nurses and midwives surveyed had mild-to-severe anxiety scores which was significantly higher than doctors and other allied health care providers.[111]

A qualitative study explored the mechanisms through which COVID-19 affected hospital staff wellbeing in the first wave of COVID-19, and found that staff reported feeling confused by inconsistent messaging between government, hospital executives, managers and media.[112] All professions reported a high degree of anticipatory anxiety.[112]

Other frontline workers

Other non-healthcare 'frontline' workers, includingemergency services, logistics and transport, retailand hospitality workers, also experienced a mental health impact. One cross-sectional study found that these 'other frontline workers' appeared to have worse mental health impact than healthcare workers during the initial stages of national lockdown. This study also found that healthcare workers had significantly better health than a general population sample.[113] Disability care workers have also described worsening mental health during the pandemic. A qualitative report released through the Social Policy Research Centre described how disability workers experienced 'extreme anxiety' associated with supporting clients through the pandemic, fear of contracting the virus, and unreasonable workloads associated with the casualisation of the NDIS workforce.[114]

k) People experiencing homelessness or inadequate housing

Policy Snapshot:

There have been positive policy interventions for some housing related concerns including providing additional housing for those who are homeless. In major cities across Australia, people sleeping rough were offered accommodation in hotels during lockdown. In a report by the Centre for Social Impact, it was estimated that at least 2200 homeless people had been accommodated in this way nationally, although it was noted that the number could be closer to 10,000 people.[115] Banks provided temporary suspensions of mortgage repayments and, in some States, temporary rent suspensions and restrictions on forced evictions were introduced.[116]

A submission from Homelessness NSW to the Inquiry into Homelessness in Australia reported onthe impacts of moving homeless people into hotels. Their submission details of the negative experiences of those in temporary hotel accommodation, including being moved to hotel accommodation without food or contact, sometimes for weeks at a time.[115] Despite some mixed impacts in housing people who experience homelessness in hotels, organisations such as Sacred Heart Mission outlined the positive impact the move had on the homeless community, statingthat offering accommodation prevented an outbreak of COVID-19 in the community.[115]

One cross-sectional and mixed-methods Australian study analysed the relationship between objective and subjective housing characteristics and mental health of a non-representative Australian general population

sample (n=2,056) surveyed during June to December 2020.[64] The study found that individuals residing in poor-quality, unsuitable, insecure, or unaffordable housing were disproportionately affected by anxiety, depression and loneliness.[64] Being bothered by noise whilst at home was strongly associated with increased odds of experiencing both anxiety and depression and emerged in qualitative data as having negative impacts on work, leisure, and interactions with neighbours.[64] Participants' open-ended responses highlighted the complexity of the relationship between housing and mental health, with poor- quality housing exacerbating the negative impacts of unemployment and low income on mental health.

Interestingly, participants' sense of neighbourhood belonging had a beneficial impact on all mental health outcomes over and above theimpacts of housing.[64]

l) People who gamble

There is evidence that the lockdowns had a positive effect on gambling behaviours, as lockdowns meant the enforced closure of gambling venues and reduced public sports matches, decreasing opportunities for sports betting. Online gambling was still accessible. A study using national longitudinal data found that there was a decrease in the number of Australians who reported having gambled in the past 12 months in May 2020 (52.9%) than when asked one year earlier in April 2019 (65.9%).[117] The authors conducted population estimates which suggested this difference reflected approximately 2.6 million fewer Australians gambling in the year up to May 2020 than would have occurred without the pandemic. The authors reported that gambling rates increased by November 2020, but did not return to April 2019 levels.[117]

A cross-sectional survey of 764 Australian adults who had gambled at least once in the 12 months prior to mid-2020, also found significant median reductions in gambling frequencies in both online and venue-based formats (reported retrospectively), suggesting most people tended to moderate their access to gambling during lockdown. [118] However, the results suggested that individuals with *some* gambling problems i.e., those who were engaged in moderate-risk gambling, compared to those who were lower-risk, were likely to report gambling more often during this time. The same relationship was not found amongst high-risk gamblers. Against the authors expectations, there was no relationship between psychological distress and increased levels of gambling.

The authors thought this finding may be related to a lack of available venues open to tempt people to cope through gambling, in a way which online gambling may not invite. [118]

m) Educational Advantage

There is some evidence that people with higher levels of education experience better mental health during COVID-19 infection outbreaks. An international study including Australian participants (N= 3,809, AUS n = 273) found that higher educational level was associated with lower self-reported psychological distress, higher quality of life, improved psychosocial well-being, and lower levels of loneliness.[63] However, this study does not adjust for other variables, such as household income, nor does it contain pre-COVID-19 baseline data. Therefore, it is not possible to say whether the associations were present prior to the pandemic or whether educational advantage was somehow protective of COVID-related mental ill-health, over and above other socioeconomic factors.

Part B: Demands on the mental health service system in the pandemic

Policy Snapshot:
As a federated system of government, the Australian Government provides the funding for mental healthcare, through Medicare and PBS, and the State and Territories have primary responsibility for delivering health care services. The *National Health Reform Agreement* - which outlines how key health services, such as public hospitals will be funded - was amended in May 2020, including a funding guarantee to all States and Territories that jurisdiction would be left worse off as a result of the COVID-19 pandemic.[119]

Mental health was identified as a national priorityearly in the pandemic, including a specific package of measures designed to support the mental health and wellbeing of Australians announced in March 2020. Significant changes were implemented to the operations of health, welfare, employment, childcare, and education systems, again with variation depending on local State and Territory public health orders. Health services, public institutions, businesses and community organisations changed the way they delivered services and support, pivoting to include a stronger emphasis on outreach and the delivery of online services.

The Australian Government has summarised its overall funding for health support in response to the pandemic as delivering a **$2.4 billion** health package to protect all Australians including: "$48.1 million forthe National Mental Health and Wellbeing Pandemic Response Plan, in addition to $74 million to support the mental health and wellbeing of Australians ..." [120]

Shift to telehealth
One initiative included additions to the MedicareBenefits Schedule (MBS) to support the provision of mental health care via telehealth, to help reducethe risk of community transmission of COVID-19 and provide protection for both patients and health care providers. These new MBS items encompassed services provided by GPs, psychiatrists, psychologists and allied health workers.[121]

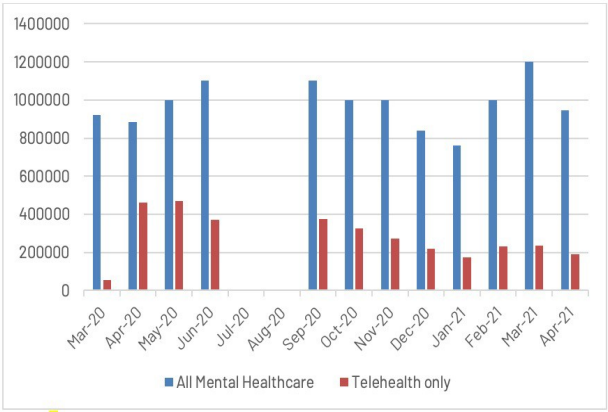


Figure 11. The total number of MBS-subsidised mental health services delivered nationally and the number of these delivered via telehealth (phone and online). Data for July and August 2020 were not available. Graph created using data sourced from: Snoswell et al, University of Queensland. Telehealth and coronavirus: Medicare Benefits Schedule (MBS) activity in Australia.[123]

Between 16 March 2020 and 24 January 2021, almost 11.5 million MBS-subsidised mental health-related services were delivered nationally ($1.3 billion paid in Medicare benefits); almost 3.7 million (32.1%) of these services were delivered via telehealth (as opposed to face to face) and $428 million was paid in benefits for telehealth services.[71]

"The capacity of the mental health system, even before COVID-19, had been inadequate for responding to the demand. The system is now expected to respond to the surge in need for mental health care." – Professor Pat McGorry, Orygen [122]

Figure 11 shows the increasing number of sessions were delivered via telehealth fromits peak in April 2020, a number that has stayed at a sizeable proportion of total mentalhealth delivery since. For example, 20% of all MBS consultations for mental health service delivery were conducted via telehealth in April2021.[123]

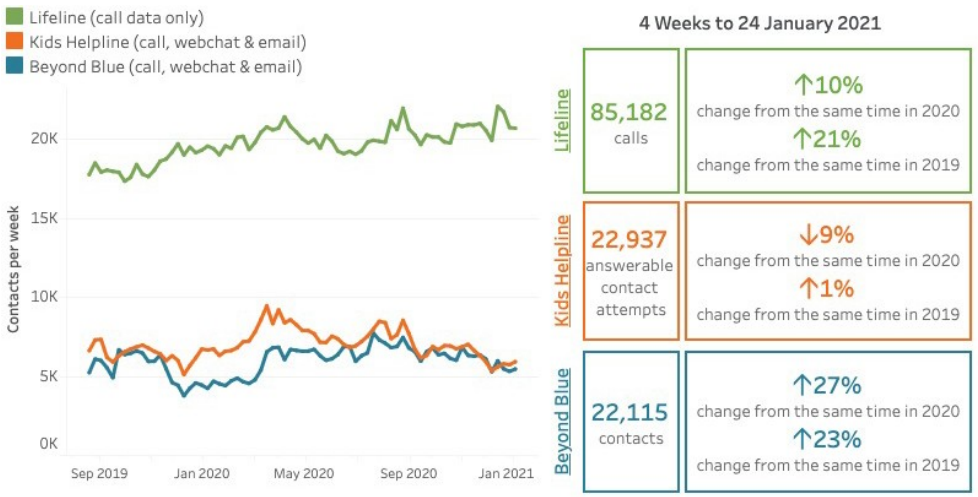
Increase in sessions for mental health services

The Australian Government also provided access to 10 additional subsidised mental health services each year. Prior to the pandemic, MBS subsidised services under the '*Better Access*' initiative were available forthose with a mental disorder to receive up to ten individual and ten group allied mental health services per calendar year. In August 2020, *Better Access* was expanded to provide10 additional MBS-subsidised individual psychological therapy sessions for patients inareas subject to lockdown restrictions due to the pandemic. In October 2020, the Australian Government expanded access to these 10 additional sessions to all Australians, as partof the 2020–21 Federal Budget.

The Australian Government funded Beyond Blue to create a dedicated Coronavirus Mental Wellbeing Support Service to provide free 24/7 mental health support, particularly for people not already connected to the mental health system. Other support organisations responded by incorporating COVID-19 support into their day-to-day services.[121]

Online and phone-based suicide prevention and mental health support services such as Lifeline, Beyond Blue and the Kids Help Line received specificboosts to allow them to respond to the increased number of people seeking mental health support. Online and call centre mental health services reported substantial increases during the pandemic, as Figure 12 demonstrates.

Gayaa Dhuwi (Proud Spirit), a newly established Indigenous mental health group, were funded to provideculturally appropriate mental health and wellbeing resources to communities, including ensuring communications resources.



Notes:
1) Direct comparisons between organisatons are not appropriate due to differences in populations being serviced, service models, funding envelopes, workforce availability and informaton systems.
2) Comparisons with previous years should be made with cauton as historical trends may be impacted by a range of events, including planned awareness raising campaigns.
Sources: Lifeline: Kids Helpline: Beyond Blue.

Figure 12. Crisis and support organisation contacts, by week of contact, September 2019 to January 2021, and the total for the 4 weeks prior to 24 January 2021. Source: Australian Institute of Health and Welfare. Mental Health Services in Australia report.[121]

Demands on the mental health system in the pandemic (cont.)

Medications

There is some evidence of increasing rates of psychiatric medication prescriptions during COVID-19. The numberof mental health-related Pharmaceutical Benefits Scheme (PBS) prescriptions dispensed peaked in March 2020 when restrictions were first introduced and declined in April. From mid-May 2020 to mid- February 2021 weekly volume of mental health prescriptions were higher than the same period one year prior across all jurisdictions.[121]

Included in the next section are the reflections of *Alone Together* participants on Australia's mentalhealth care system during COVID-19. Participantsfound that COVID-19 increased existing issues and pressures on the mental health service system. They identified several barriers to improving their mental health, each of which was exacerbated during the pandemic: the confusing, expensive and low-capacity nature of the currentmental health service system, holes in the service system and societal barriers to accessing services, including broader political and social stigma around mental health issues and social inequity.

"The mental health system was knee-deep in trouble way before COVID-19 struck. Many individuals were not getting care and a greater number were not receiving optimised care. However, COVID-19 has ramped the situation up...Call centres and web services, including those at Black Dog Institute, have seen a 40% increase inuse." Professor Helen Christensen, Black Dog Institute.[124]

Part C: What do Australians consider as the main issues in mental health since COVID-19?

Qualitative findings from the Alone Together Study

This section relays the experiences and perspectives of 1,037 Australian adults who answered two questions in the first follow-up Alone Together survey aboutwhat they thought were the current most important issues around mental health in Australia and how the pandemic had impacted their own mental health. Participant answers were collected between March and June 2021 and analysed to identify if and how the pandemic had changed Australians' understanding of what keeps them mentally healthy.

Findings Summary:
Causes of poor mental health during the pandemic
Overall, participants responses suggested that the pandemic provided two obstacles to good mental health. Firstly, the pandemic led to an increase in job insecurity, financial hardship and precarity, causing stress and anxiety about paying for housing and resources. Losing employment and receiving welfare was associated with a shame, stigma and a loss of self-respect, which further degraded participants wellbeing and mental health. Secondly, participants described how the pandemic shrunk and fragmented their social worlds – leading to feelings of loneliness and isolation. Sometimes participants described how long periods of feeling isolated left them feeling discomfort or anxiety about socialising again once restrictions had eased.

Barriers to fixing poor mental health during the pandemic
Participants identified several barriers to improving their mental health, each of which were exacerbated during COVID-19. These included the confusing, expensive and low capacity of the current mental health service system with long waitlists to access treatment and little choice in which treatment they received once they actually got support. Participants also described holes in the mental health service system which meant they 'fell through the gaps' of available support and were not afforded the 'right' or appropriate care; and societal barriers to accessing services including broader political and social stigma around mental health issues and social inequity.

Findings

Some participants described COVID-19 as creating some new and unique mental health concerns, including heightened feelings of 'uncertainty' and 'apprehension' about the future and potential further lockdowns.

"Constant worry about another lockdown and financialand social issues that would stem from that." - 29 year old female, VIC

"The feeling of remaining static, of being trapped, andof not accomplishing/doing what I needed to do. The sense of a loss of control. The worry I won't be able to connect with loved ones." - 33 year old female, WA

"I feel that my mental health has deteriorated during thepandemic as I feel I am in an almost constant state of panic. I am worried that something might happen or change at any second." - 22 year old female, VIC

However, more often participants reported that COVID-19 had 'exacerbated' and 'intensified' existing personal and systemic mental health issues amongstAustralians. Participant accounts reflected that the pandemic had impacted on their mental health through two pathways: firstly, through an increase in financial hardship and precarity and secondly, through a change in participant's social world, relationships and supports.

Alone Together findings (cont.)

While this report participant accounts of financial/income and social relationship factors separately, it is important to note that participants recognised the importance and interconnectedness of these broader social factors and their conjoint influence on mental health and wellbeing. Figure 13 shows the pathways through which participants describe the relationship between COVID-19 and mental health.

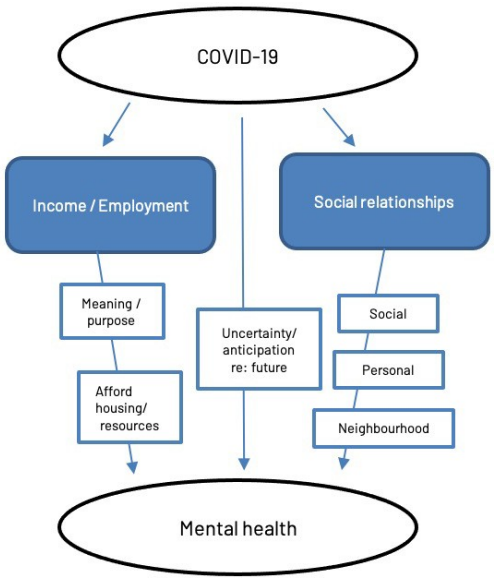


Figure 13. The mechanisms, described by Alone Together participants, through which COVID-19 impacted mental health.

1. Employment and income

Participants reported an increase in 'stress', 'anxiety' and 'hopelessness' associated with 'precarious' employment (or underemployment) or unemployment, often pre-empted by the pandemic. Specifically, 'job uncertainty', 'casualisation of the workforce' and 'loss of job security' were described as 'a big worry' and were associated with feeling 'fearful' about supporting one's family, 'paying bills' and 'keeping a roof over one'shead.' Losing one's job was also reported as losing the sense of 'meaning', 'self-respect', 'confidence' and 'source of engagement' work had provided within their lives. Becoming unemployed lead to a feeling of 'lower hope and self-esteem'. Participants were concerned about their abilityto pay for ever-increasing housing costs.

Examples of housing stress included 'unaffordable housing prices', the 'inaccessibilityof the housing market' and 'prohibitive rent'. The stigma of receiving welfare was described as 'crushing and damaging to your mental health'. The small size of welfare payments was not seen as 'sufficient income to live a 'reasonable life" especially amongst those with children. Mutual obligations requirements for Centrelink made it difficult 'living in dignity' when 'the job seeker demands are so high and the payment so small'. These mutual obligation requirements could be arduous and impact mental health issues and recovery:

"My job network providers were bloody hopeless and 3 times in a row failed to ring me for my phone appointments. Then they kept sending me the same paperwork to sign, so I'd sign it only to receive an email a couple of days later telling me to sign it again. Then the income my partner could earn changed and I kept getting no payments."
48 year old female, NSW

"Social welfare system isn't equipped to support those of us who struggle to work because of mental health issues. I cry every day at my full-time job and would like to focus on recovery, but the tiny rate of Centrelink payments means I keep struggling through."
30 year old female, VIC

The Productivity Commission Mental Health Inquiry, which was conducted pre-pandemic, had identified that mutual obligation requirements may impact participant mental health. The Productivity Commission reported that "little is known about the degree to which different intensities of [mutual obligation requirements] could precipitate clinically defined mental illness in previously well participants. ... There are good grounds to be much more cautious from a policy perspective in implementing stringent [mutual obligation requirements] for people with pre-existing mental illness, as sound reasons and plausible evidence suggest this could aggravate their illness and increase distress.[61]

Alone Together findings (cont.)

2. Social relationship and supports

Many described the lack of social and community connection as one of the major issues facing mentalhealth of Australians, including, 'loneliness', 'social fragmentation', 'societal and social exclusion'. There was a shared sentiment of 'people [were] feeling lonely and not having connections socially or with their communities' and that 'society has become very individually focused and less about support'. COVID-19 travel restrictions and isolation measures hampered participants' ability to connect with loved ones, leading to 'separation' and 'disconnection' from 'friends and family', leading to feelings of 'loneliness', 'grief' and 'loss'.

Even 12 months after the start of the pandemic, people described how the break in social contacthad a longstanding effect on their feelings about socialising, with many participants describing feelings of 'agoraphobia'.

"Just forcing a disconnect with everyone has left memore alone than I've ever been."
22 year old male, QLD

"I feel much more emotionally fragile now. I also feelmore socially anxious - being around a lot of people doesn't feel normal anymore."
32 year old male, VIC

"It's getting better than last year, more works and studies comes back to face to face. I get to interactwith more people, but at same time the idea of pandemic and the after-effect habit still stays."20 year old female, NSW

"My anxiety is severe, and most situations stress me out so badly I'm on edge and throw up. I actually haveto make the effort to communicate with my friends and family online. I had a panic attack last week and couldn't attend when I was supposed to attend my first in person class since March 2020." 23 year old Aboriginal female

Being isolated also prevented participants from supporting the mental health of their friends andfamily:

"Isolation led to losing opportunities to intervene. I felt disconnection and didn't know how to help others."
51 year old female, QLD

Not everyone felt disconnected - some enjoyed their increased 'local' nature of their world and social connections:

"One positive thing COVID did do for me is make my world more local and help me slow down. I don't want to lose this."
32 year old female, NSW

Barriers to improving mental health

Participants found that COVID-19 increased existing issues and pressures on the mental health service system. They identified several barriers to improvingtheir mental health, each which was exacerbated during COVID-19: the confusing, expensive and low- capacity nature of the current mental health service system, holes in the service system and societal barriers to accessing services, including broader political and social stigma around mental health issues and social inequity.

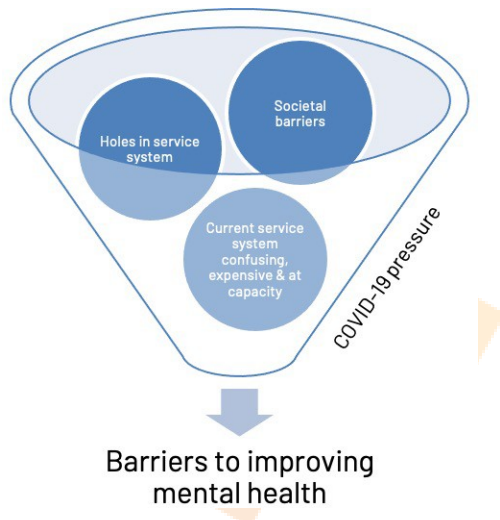


Figure 14. Alone Together participants described three barriersto improving their mental health during the pandemic. Each of these factors was exacerbated by increased service system demand during COVID-19.

Alone Together findings (cont.)

Receiving mental health care is unaffordable
Many participants described mental health treatment, services and resources as 'prohibitively expensive' and 'unaffordable...even with Medicare rebates.' The high cost of services meant some participants felt they had to make a choice between the prohibitive financial cost of treatmentand their mental health. However, the ability to access treatment was less of a 'choice' for participants who lacked the financial means to pay.

"While I acknowledge the government has increased thenumber of Medicare subsidised visits, the out-of-pocketexpense makes receiving regular, effective psychological treatment prohibitive especially as a single parent who is trying to work and support a young family."
37 year old female, NSW

"It's hard because I am already stressed about finances,but seeing a mental health professional costs money, which compounds the stress'"
25 year old female, NSW

Long waitlists to access treatment
Participants described long waitlists being a barrierto accessing needed psychology treatment:

"When people are in crisis, they need the help at that time. Not six months down the track when an opening finally becomes available at the counselling centre."
70 year old non-binary person, TAS

"There is no point making an appointment in a month ifsomeone needs help immediately."
60 year old female, NSW

Long waitlists could negatively impact continuity ofcare and therapist-patient rapport. Long wait-times meant participants had 'been unable to see the same provider more than once or twice.' Being 'seen by different [service providers] all the time', made it difficult to 'to create any trust' between clinician and client. Discussion around the lack of mental health services appeared to be particularly concentrated amongst participants in non-urban regions of Australia. One participant from 'a large town' in regional Victoria described the available care in their State: 'there is only one bulk billing psychiatrist in my area and none in the nearby two large towns.' Similarly, another participant described their experience accessing help in their regional location as 'pathetic', with 'no [mental health] services within 1100 kms' of where they lived. One participant described that even where they lived in 'Western Sydney' there was 'very limited psychiatric services... leading to very long wait lists, poor service, or no access'.

Difficulty accessing the 'right' care
Overburdened mental health services and long- waitlists meant many people described feeling theyhad little choice over which clinician would provide the 'right' fit with their care. One participant described 'the shortage of counselling and the shortduration of medical referral...exacerbated by the pandemic' as a barrier to 'obtaining help from the right person not just anyone who is available'. This was particularly the case amongst people in rural/regional areas where participants described being 'unable to find any psychologists with availability in [their] local area', particularly those that were bulk billed. There was also evidence that mental health consumers felt they were not listened to by clinician services when advocating for a change in their care.

Alone Together findings (cont.)

For example, one participant described how the low 'availability of suitable services' meant 'too many people get palmed off to services who are not equipped to helpthem and no one listens'. Another described 'people not being heard or listened to when it comes to their own care'.

Holes in the service system – the "missing middle"

The current system does not allow for prevention or early intervention. Falling within this 'gap' could have serious ramifications for a person's access to appropriate and timely treatment. For example, one participant, whose 'nine-year-old has been diagnosedwith anxiety and panic attacks' was not perceived as 'bad enough to see anyone for at least 3 months'. Her child's enforced wait in accessing treatment meant being unable to intervene or prevent worsening of his symptoms: 'Massive underfunding means people can'taccess support pre-emptively, or even in a timely fashion once things get bad.'

The lack of intensive ongoing support provided to people following crisis care for people returning to the community was described by one participant as 'almost Band-Aid treatment'. One participant describes 'If I had a physical illness, I'd be slowly dying of cancer.'

> "There is little support for people with chronic and debilitating mental health problems who aren't experiencing severe enough (i.e., outwardly noticeable) symptoms to require being held against their will." 27 year old female, NSW

Societal barriers

Public conceptualisations of what constitutes 'acceptable' mental ill-health reflected a 'complete lack of understanding of what mental health looks like'. As a result, some participant accounts reflected a sense of 'unspeakability' of mental health issues publicly, describing 'the difficulty in having the language to communicate what is happening and to be able to hear what people are saying.'

Mental health public awareness campaigns couldplace burden on individuals experiencing mental health issues to find their own solutions. Instead,the onus of supporting and facilitating access to treatment should be shared amongst a person's community:

> "Mental health messaging encourages people to reach out for help if they need it, which is great, but it often places the burden of taking action on an individual at atime when they're most vulnerable and least able to take that action."
> 40 year old female, QLD
>
> "I think it would be helpful if there was more educationfor people on offering 'mental health first aid' and especially practical support to a family or friend who discloses a mental health situation."
> 40 year old female, QLD

Many participants described the lack of recognitionand acknowledgment of mental health problems within Australian government and leadership. This 'limited' government recognition that 'mental health is critical to the health and well-being of our nation as a whole' impacted the experiences of Australians by 'making the stigma worse' around mental health.

> "People, especially politicians, underplay the seriousness of mental health." 35 year old male, TAS
>
> "There are a lot of people struggling and our leadersdon't seem to acknowledge this."
> 24 year old female, NSW

Alone Together findings (cont.)

Having a mental health issue was described as 'still very taboo' within Australian society. There was a collective sentiment amongst participants that increased awareness building about 'mild' mental health issues did not translate into social 'acceptability' of talking about experiences of mentalhealth problem.

> "It's all very well asking 'RUOK', [but] when someone says 'no' people are not really interested in your problems...: 'I am crying writing this as the loneliness isoverwhelming."
> 63 year old female, NSW

The stigma around 'getting help' and widespread conceptualisation of mental disorders as an individual responsibility were described as preventing people from seeking support and help from others. Participants described how such experiences led them to trying to cope alone 'on a daily basis' and engage in 'denial around how bad mymental health got'. Eventually 'they reach a point where they cannot go on without some help.' One participant described the help they eventually received as 'the best thing I could have done.'

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