National Mental Health Commission
December 2023

Submission to the Commonwealth Government COVID-19 Response Inquiry

Australian Government
National Mental Health Commission

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About the National Mental Health Commission

The National Mental Health Commission (the Commission) provides cross-sectoral leadership on policy, programs, services, and systems (including education, housing, employment, human services, and social support), to support better mental health and social and emotional wellbeing in Australia. There are three main strands to the Commission's work: monitoring and reporting on Australia's mental health and suicide prevention system; providing expert, evidence-based policy advice to Government and the community; and engaging consumers and carers.

About the National Suicide Prevention Office

The National Suicide Prevention Office (the NSPO) was established within the Commission in 2021-22 in response to recommendations in the National Suicide Prevention Adviser Final Advice and the Productivity Commission inquiry into mental health and suicide prevention. The NSPO is a critical national driver of the work towards zero suicides by ensuring a whole-of-government approach that is informed by lived experience and creates opportunities to respond early and effectively to distress. The NSPO ensures the coordination of whole-of-government capability to deliver a national approach to reducing suicide rates in Australia. It is a significant step towards ensuring a more preventative, compassionate and person-centred mental health and suicide prevention system.

Introduction

The Commission and the NSPO welcome the opportunity to participate in the Commonwealth Government COVID-19 Response Inquiry (the Inquiry) to inform recommendations that aim to improve Australia's preparedness for future pandemics. Throughout the pandemic, the Commission provided mental health and suicide prevention related advice to the Commonwealth Government. The Commission, alongside the Commonwealth Government Department of Health and Aged Care, played a key role in providing accessible online briefings to the sector, including jurisdictions, on the impacts of the pandemic on mental health and suicidality and the Australian Government's response.

The COVID-19 pandemic posed significant health, lifestyle and economic challenges for Australians and evidence has demonstrated significant negative mental health impacts as a result. Australia's mental health sector has been agile in responding to the increasing support needs of Australians with new opportunities including the expansion of digital services and telehealth as well as innovative community-based models of care. However, there are a number of areas that require additional consideration and/or prioritisation to improve the impacts on mental health and wellbeing in the event of future pandemics, as further outlined in this submission.

The Commission's submission has been structured around responding to relevant Inquiry terms of reference as they relate to mental health and wellbeing. It draws heavily on insights from mental health research funded by the Commission throughout the pandemic period. In June 2021, the Commission funded ten organisations to each undertake Pandemic Research Projects (research projects), with the intention of better understanding the unique impact of the pandemic on key priority populations. Findings from these research projects are drawn on throughout this submission in responding to a number of the Inquiry's terms of reference.

The ten priority population groups that were the focus of these research projects were:

- People experiencing compound disaster trauma (such as those who had experienced flooding or bushfires prior to the pandemic)
- Men aged over 18 years
- Women with a disability aged over 18 years
- Children and young people aged 9-17 years

- People living in rural and remote communities
- People aged over 75 years
- People with lived experiences of sexual, domestic and family violence
- People who are LGBTQ+
- People from Italian, Turkish and Vietnamese communities
- Adult carers of those who experience mental illness, mental ill-health, and suicidality.

A summary report of the research projects is at **Attachment A**. Information regarding each research project's methodology is in **Appendix A**. The recommendations made by each of the researchers are in **Appendix B**.

The submission also draws on insights from a research project the Commission funded the University of Newcastle and University of Queensland to undertake in March 2021, using data from the Australian Longitudinal Study on Women's Health. A summary of this women's mental health in the context of COVID-19 study is in **Appendix C**.

Should you wish to discuss this submission in further detail, please contact Rachel Earl, A/g Executive Director, Rachel.earl@mentalhealthcommission.gov.au

Responding to the Inquiry terms of reference

National governance mechanisms

Development of the National Mental Health and Wellbeing Pandemic Response Plan

The National Mental Health and Wellbeing Pandemic Response Plan was developed early in 2020 in response to growing awareness of an increased need for an expanded and coordinated mental health response to address the impacts of the COVID-19 pandemic on all Australians. The Plan was developed under the co-leadership of the Commission, the Victorian Government and the New South Wales Government agencies, and was informed by all eight jurisdictions and key sector stakeholders. National Cabinet endorsed the Plan on 15 May 2020, with the Commonwealth Government committing $48.1 million to support the Plan.[1] State and territory governments also committed funding in alignment with the Plan.

The Plan recognised that some populations within the Australian community would be disproportionately affected by the impact of social and economic outcomes of the pandemic and provided a range of measures to address associated challenges. The Plan called for a whole of government approach that would build on momentum and innovation occurring at the time and address critical gaps. All jurisdictions were called on to continue their current commitments and accelerate change to include the Plan actions, tailored to meet the needs of their specific communities. Implementation of the Plan actions sat with the jurisdictions, with National Cabinet and the Mental Health Principal Committee identified as having responsibility for oversight of the Plan.

The rapid development of the Plan demonstrates that when there is an impetus, collaborative processes across the sector, jurisdictions and Commonwealth Government can be stood up. The primary success of the Plan was that it obtained 'in principle' agreement across governments that mental health and wellbeing was a key area of need. Evaluation of initial and subsequent implementation of the Plan is now warranted to make a further assessment around its effectiveness.

Key health response measures

Health communication and information provision

In the early days of the pandemic Government communications focused on encouraging widespread uptake of a range of preventative behaviours, including physical distancing and focussed on 'flattening the curve'. Recognising the possible adverse impacts of the pandemic on mental health and wellbeing, in November 2020, the Commonwealth Department of Health and Aged Care rolled out a COVID-19 mental health campaign 'How's your head today?' to urge people to prioritise their mental health, raise awareness about how to identify when something is wrong, and encourage people to seek help.

Findings from the research projects suggests that communication and information provision about the COVID-19 disease itself and the associated public health restrictions were not tailored to specific audiences leading to confusion, uncertainty, heightened distress and anxiety for certain populations. The research projects specifically demonstrated this for older Australians, culturally and linguistically diverse communities (specifically Italian, Turkish and Vietnamese communities), women with disability, and rural and remote communities. However, this does not mean that these were the only communities impacted.

For older Australians there was a clear desire for more consistent information about lockdowns, how to stay safe, and self-care during the pandemic, and for these messages to be communicated over a range of different formats (including online, television, radio and print). Older Australians expressed a distinct preference for information to be provided to them by governments, especially health departments and their medical spokespeople. Links to health department sources, local focus and trend data, and regularity of updates provided confidence in information and understanding of restrictions or other requirements. The ABC was most often mentioned as the most trusted media source of information.[2]

Some older Australians from culturally and linguistically diverse communities relied on information from their country of origin for advice, which meant they were at greater risk of being exposed to information that did not align with the situation in Australia and may have included inaccuracies about the virus and the vaccines, and this exacerbated anxiety, fear and distress. This fear was compounded by the lack of accessible information in Australia. Information was also sourced from community leaders, family members and non-government organisations that mobilised to provide information in-language.[3]

Similarly, the research into Italian, Turkish and Vietnamese communities found that few participants had been exposed to mental health communications throughout the pandemic period, although younger participants were more likely to recall having seen advertising for support services like Beyond Blue, Lifeline and others. There was also little recollection of government resources such as the Head to Health website.[4]

Research into women with disability found that this group felt abandoned by Commonwealth and state and territory governments during the COVID-19 pandemic, in terms of health messaging. Getting accurate and accessible health information was perceived to be extremely difficult, with messaging constantly changing, not being consistently accessible and not prioritising people with disability despite being at greater risk from the virus than the general population. The lack of Auslan interpreters at some major press conferences was noted, as well as the lack of understanding of the extra precautions people with disability need to take to be safe from COVID-19. However, working from home resulted in women with disability being able to start work or increase their work hours. This resulted in increased productivity, financial security, and improved emotional wellbeing.[5]

Research into people living in rural and remote communities also highlighted the need for communication to be delivered across digital and traditional media to meet the needs of different audiences. More than half of the rural and remote residents interviewed reported problems with digital connection, including problems with unreliable connections or the affordability of high-quality connection.[6]

Digital and telehealth

COVID-19 led to substantial changes in the delivery of health and mental health services, most notably an expansion and increase in use of telehealth (services via telephone or videoconferencing) and digital health services. The Commonwealth Government's announcement of new MBS telehealth items to help reduce the risk of community transmission of COVID-19, and provide protection for patients and healthcare providers, was welcomed by the mental health sector.

Findings from the research projects and additional commissioned research suggest that digital and telehealth options were largely welcomed during the pandemic and encouraged increased access to healthcare (including mental health care) through reduced cost and time associated with attending appointments.

Experiences and uptake of digital and telehealth service provisions were raised across several research projects. Key findings included:

- uptake of telehealth was particularly high in the LGBTQ+ community, with positive experiences accessing mental health care via telehealth reported during the period November 2021 to February 2022:
    - 90.9% of participants who had used mental health care services during the pandemic accessed at least some of this care via telehealth.
    - approximately three-quarters (76.6%) felt that telehealth had made mental health care appointments more accessible, more than half (58.5%) felt comfortable accessing mental health care in this way, and 31.2% felt safer accessing mental health care via telehealth.[7]
- telehealth resulted in more accessible healthcare than before the pandemic for women with disability:
    - being able to access regular General Practitioners (GPs) as well as specialist services via telehealth had seen improved health outcomes for some women with disability.
    - however, fear and anxiety of going in-person to hospitals or doctors' offices, meant that necessary in-person check-ups were missed.[8]

- in early 2022, children expressed a strong preference for in-person support if they felt they needed help (e.g. felt down, scared or worried) rather than telehealth options when it was available.[9]
- during the period May 2022 to June 2022, mental health carers reported that the people they supported, preferred to engage with services face-to-face and the move to telehealth at times led to disengagement from mental health services. There were some population groups (such as those with a psychotic disorder) for whom telehealth was not necessarily appropriate and a range of engagement options needed to be made available.[10]

In March 2021, the Commission funded the University of Newcastle and University of Queensland to undertake research using data from the Australian Longitudinal Study on Women's Health (women's mental health in the context of COVID-19 study). This research was separate to the then priority population research projects. It found that many women who had used telehealth or similar remote health services described the benefits of these services, with some reporting enhanced access to services due to the convenience of appointments via phone or online. However, some women found telehealth to be ineffective and inappropriate for their health condition. Others avoided care when there was not a face-to face option.

Indirect impacts of lockdowns and associated public health restrictions

A number of indirect impacts of lockdowns and associated public health restrictions on mental health and wellbeing were noted across the research projects. Some of these included:

- lack of social engagement and contact with extended family and friends as a key concern for children, many also struggled with remote learning.[11]
- restrictions were challenging for multicultural communities who rely strongly on their social and familial networks for support in tough times, for many lockdowns presented a dramatic change in lifestyle.[12]
- physical isolation removed opportunities for LGBTQ+ people to express and explore their identities safely, and for many, meant separation from their chosen family.[13]
- changes to typical post-disaster recovery processes including the impacts of social distancing increasing experiences of isolation from friends, family, and community, and the uncertain nature of the pandemic and the social, emotional, and economic consequences of sudden lockdowns increasing experiences of anxiety and disconnection.[14]
- domestic violence rates and rates of mental ill-health increased significantly among women with disability, with isolation caused by lockdowns being a considerable factor.[15]

The women's mental health in the context of COVID-19 study found that for a proportion of women, the pandemic created situations where they were vulnerable to abuse and violence from family, intimate partners and the general public, in places where they live, work and learn. This was particularly true for women with a history of experiencing violence, and essential workers.

Impact on deaths by suicide

Despite increased psychological distress and adverse economic outcomes, rates of death by suicide in Australia did not increase during the pandemic. National mortality data published by the Australian Bureau of Statistics (ABS) shows the rate of death by suicide in Australia was lower in 2020 (12.5 per 100,000 population) and 2021 (12.3) than in 2019 (13.3), and is in line with 2022 data (12.5).[16]

In 2020, 3.2% of these deaths had the pandemic mentioned in either a police or pathology report or a coronial finding. In 2021, the percentage of suicide deaths where the pandemic was mentioned decreased to 2.6%. The pandemic was not identified as an isolated risk factor in any suicide deaths, with an average of 6.5 risk factors and 3.5 psychosocial risk factors present for people who died by suicide where the pandemic was identified as a risk factor.[17]

While the reasons for this trend are complex, possible protective factors could include:

- a general sense of 'we are all in this together'[18]
- rises in the level of trust in others and in governments in Australia[19]

- the impact of both JobKeeper and the JobSeeker supplement, which saw housing stress and poverty decrease to lower levels than prior to the spread of COVID-19.[20] These payments also saw real incomes rise for those in the bottom decile of the income distribution from February to August 2020.[21]

It should also be noted that the impact of the pandemic was unevenly distributed across populations, as demonstrated by an increase in suicide in young men at this time.[22]

Supports for people impacted by COVID-19 and/or lockdowns

Findings across the research projects indicated that all populations studied experienced worsened mental health and wellbeing, and increased isolation and social disconnection, than prior to the pandemic. While the pandemic did not necessarily create new issues for each group, it intensified pre-existing inequities. Key issues relating to mental health and wellbeing supports during the COVID-19 pandemic are discussed below.

Mental health awareness

The Commission led the development of several mental health awareness campaigns during the pandemic, including #InThisTogether, #GettingThroughThisTogether and #ChatStarter. #InThisTogether (launched March 2020) and #GettingThroughThisTogether (launched August 2020) were developed in partnership with leading mental health organisations, experts and spokespeople to encourage a national online conversation sharing evidence-based practical tips to support the mental health and wellbeing of Australians during COVID-19. Organisations included Beyond Blue, Lifeline, Reachout, headspace, RUOK?, Orygen, the Black Dog Institute, SANE Australia, the Brain and Mind Centre, Apunipima Cape York Health Council, Smiling Mind and the Commonwealth Government Department of Health (now Department of Health and Aged Care).

These campaigns called on the community to support one another in navigating the mental health, wellbeing, and social impacts of the pandemic and promoted the equal priority that our mental health and wellbeing should be given alongside medical and physical health needs during the pandemic. These are important messages to be communicated in times of crises. It is difficult to ascertain the effectiveness of such campaigns as mental health supports, however across campaigns total exposure included almost 2,000 social media posts, almost 100 news items (online and print) and 260 broadcast items (radio and television).

In August 2021, the Commission launched the #ChatStarter campaign to support young people and parents to start conversations about mental health challenges with people they care about. #ChatStarter was developed and promoted through a partnership between the Commission and Australia's national mental health organisations who specialise in supporting children, young people and parents including batyr, Beyond Blue, Butterfly Foundation, headspace, Kids Helpline, Orygen, and ReachOut. This was in response to evidence of increasing impacts of the pandemic on the mental health of children and young people. It provided a single point of access to free, evidence-based resources already developed by the mental health sector and encouraged people to use the tips and resources freely available on the Commonwealth Department of Health and Aged Care's Head to Health website.

#ChatStarter was a collaborative approach to community mental health support, developed by the mental health sector and supported and delivered through the support of social networking platforms. It provides an example of ways to include carers, family and friends, which is a key priority for reform. The campaign also demonstrated that governments can work in partnership with business and the sector to promote Australia's mental health outcomes.

Across social media platforms #ChatStarter messaging reached an estimated audience of more than 10,868,000 people, which resulted in more than 40,000 people viewing the resources on the Head to Health #ChatStarter page. The campaign had a total of 194 individual media mentions across radio, tv, online and print.

Despite the prevalence of mental health and wellbeing related public campaigns a lack of awareness about mental health and mental health services was identified in the research projects for some groups, particularly older Australians. GPs were the preferred initial contact for many older Australians when needing care or support for their mental health.

However, most people were unaware of other mental health support services for older Australians; others found them inaccessible (due to cost and location) or too difficult to access when they moved online or that they demonstrated a limited understanding of the impacts of ageing and mental health.[23]

Children, parents/guardians and grandparents thought there should be greater awareness and understanding of mental health in the community. Some children reflecting on the pandemic said they hoped it had increased awareness of mental health, would make it easier to speak about, and seek help when needed. Around a third of children and over half of parents/guardians and grandparents also felt that schools should offer more support for children's mental health and wellbeing. Both children, and parents/guardians and grandparents asked for support for mental health and wellbeing to be built into daily activities and programs at schools rather than just having stand-alone sessions.[24]

Additional barriers to accessing services

The research projects have highlighted a number of additional barriers to accessing healthcare services experienced by priority populations, including financial and workforce barriers.

For LGBTQ+ people the most frequently identified barrier to accessing mental health care during the pandemic was the cost of services, followed by lack of availability of their preferred service, and stay-at-home orders.[25] The research on men also noted that accessing help was difficult for those who were unable to afford care through private practitioners.[26]

Difficulties accessing services and supports due to the limited availability of professional help (particularly trauma-informed services) in rural areas was highlighted for those communities experiencing compound disasters, noting however this was a pre-existing issue exacerbated by the pandemic. The high demand for mental health services was described as resulting in long waitlists and having negative knock-on effects for the service provision workforce.[27] This was also highlighted for domestic violence frontline workers.[28]

Additional difficulties included having to recount experiences many times across disconnected services, struggles to access inflexible support schemes, challenges in relation to housing shortages and COVID-related obstacles to re-building.[29]

Limited additional support for mental health carers

The research project on mental health carers found the COVID-19 pandemic increased the level and complexity of support provided by mental health family carers. The closure and restrictions on services led to family, carers and supporters needing to provide extra hours and at times constant support, including maintaining the safety of the consumer through monitoring both emotional and physical needs. It was thought that pandemic responses assumed that family members would, without financial, practical or emotional resources, fulfil the role of care provision and support to unwell and extremely distressed people with new or ongoing mental and psychological ill health.[30]

Family carers reported there were repeated if not routine breaches of family carer rights to access treatment and support for themselves and their unwell family members during the COVID-19 pandemic and access was worse than usual. Families felt invisible and broken during the COVID-19 pandemic by the deepening of existing exclusion from clinical care planning. The value of a sense of connection was highlighted and emphasised as a preferred way to be treated.[31]

Service adaptations

The research project on rural and remote communities identified a range of ways that services and organisations proactively adapted to meet needs including:

- home visits for the most severe mental health needs
- adaptation of in-patient clinics to the home setting, with hybrid telehealth support
- enhanced access to expert triage and assessment in community to avoid unnecessary hospitalisations
- mobile delivery and outreach of mental health services to remote areas
- clinicians enabled to work from home in lockdown via telehealth with secure platforms and agreed work processes
- telehealth delivery of specialist, psychological/allied health and primary care services, with MBS enabled funding

- funding for extra mental health support for health workers
- service collaboration among public and private clinics
- expanding and increasing promotion of online and e-clinic services, and/or making them free to the end user, to enable greater access.[32]

Support for industry and businesses

The Commission, in partnership with the Mentally Healthy Workplace Alliance, created a series of evidence-based, easy to use guides to support workplaces to respond to someone who may need support through the pandemic. The guides were created by experts and provided practical tips to support employers and employees to recognise the signs of mental ill-health and have safe and supported conversations about it in the workplace. The Commission recognised the different needs across workplaces and created tailored guides for:

- sole traders
- small business
- medium to large business.

In 2022, the Commission and the Mentally Healthy Workplace Alliance developed guides to complement the existing resources released in 2020. These focused on emerging issues, leaning on expert insights to provide practical actions that workplaces could take immediately. The series included:

- Helping people return to workplaces after extended periods working at home during COVID-19
- Strategies to support wellbeing of decision makers through periods of sustained pressure
- Identifying and managing fatigue and burnout during COVID-19
- The hidden impact of COVID-19 and sleep
- Creating mentally healthy hybrid teams in the recovery from COVID-19
- Responding to varied COVID-19 concerns in the workplace
- Supporting people experiencing post-COVID-19 syndrome
- Mental Health Supports

To support the engagement needs of smaller businesses and teams, a summary tailored to Small Business Owners and managers was created in collaboration with the Council of Small Business Organisations Australia.

Since they were made available on the Mentally Healthy Workplaces digital platform in January 2023, the guides have been interacted with over 1,400 times. The guidance also received endorsement from business representatives (for example, Business Council of Australia, Australian Chamber of Commerce and Industry) and the Australian Congress of Trade Unions, who all shared the guides widely with their members.

Financial support for individuals

Across the research projects those with relative financial security (amongst other factors) consistently fared better during the pandemic in terms of impacts on mental health and wellbeing. In addition to these findings, the women's mental health in the context of COVID-19 study found that relative to women who were not stressed about finances, women who reported being very or extremely stressed about money in April 2020 were more than twice (women aged 25-31) or four times (women aged 42-47) likely to report psychological distress in October 2020. Women across all age groups who reported being somewhat or moderately stressed about money in April 2020 were at significantly increased risk of psychological distress in October 2020.

Financial assistance schemes such as JobKeeper and JobSeeker were found to be valuable during this period, in particular the research project on men noted that these schemes sustained people through job losses or transitions and minimised further distress.

Community supports

Social connection and community engagement

The COVID-19 pandemic had major impacts on the nature and opportunities for social connection and community engagement. Communities typically come together in the process of moving towards recovery, and this was not initially possible during the pandemic.

The research into communities experiencing compound disasters highlighted how COVID-19 disrupted communities' capacity to draw upon resources to collaboratively address hardship and adversity and move towards recovery. Tension and division was also attributed to contrasting attitudes regarding vaccinations, difficulties re-connecting with social groups following pandemic restrictions, and a broader sense alienation from other communities that had cases of COVID-19 or were the perceived reason for pandemic restrictions (for example, when regions were placed in lockdown due to cases travelling from Metropolitan areas).[33]

Across research projects, typically people with stronger social connections and housing and financial security fared better during the pandemic.

Impacts on people experiencing family, domestic and sexual violence

Research highlighted a number of impacts on community supports specifically for people with lived experience of family, domestic and sexual violence including:

- reduced access to support services to maintain quality of life and continue therapeutic treatment
- severe isolation from friends, family and community groups, which created further barriers to obtaining support and social connection
- increased case complexity requiring multidisciplinary, integrated support across the health, social service, community, police, child safety and justice sectors
- escalating violence for victim-survivors unable to escape the perpetrator nor safely seek support at home.[34]

Future responses

Valuable insights have been gained into the experiences of a number of priority populations during the pandemic through the research projects which the Commission funded. Each research project produced a final report discussing how their cohort had been impacted by the pandemic, as well as recommendations for next steps in addressing these impacts. A list of the researchers' recommendations for future responses have been collated and included at **Appendix B**. The inquiry may wish to give consideration to whether future pandemic and crisis responses should integrate these, or similar, insights and recommendations to better meet the needs of population groups.

In addition to these recommendations, the women's mental health in the context of COVID-19 study also highlighted a number of priority action areas based on their findings that the inquiry may wish to consider to support better targeted future responses to the mental health and wellbeing needs of women. These are summarised at **Appendix C**.

Appendix A – Summary of Pandemic research projects methodology

Priority population	Research project organisation	Overview of study methodology	Participant information
People experiencing compound disaster trauma	Phoenix Australia	Literature review. Targeted interviews and focus groups across regional NSW, Victoria, SA in regions heavily impacted by recent disasters.	• 18 semi-structured interviews via telephone in April 2022. • 5 online focus groups via videoconferencing between April and May 2022 with 31 participants.
Men aged over 18 years	Australian Men's Health Forum	Online survey and interviews with men. Interviews with practitioners working with men.	• Online survey: 137 participants (136 men, 1 non-binary; 21- 88 years, mean age = 56.67 years). Majority of participants resided in NSW (41%). • Online interviews: 9 men, aged 21- 82 years (mean age = 41 years)
Women with a disability aged over 18 years	People with Disability Australia	Literature review, online survey, one-on-one interviews. Participants identified as women with a disability. All interviews online which did pose accessibility barriers.	• Online survey with 112 participants. • Thirteen one-on-one interviews were conducted either online or via phone.
Children and young people (9-17 years)	Australian Human Rights Commission	Literature review. Interviews with stakeholders with experience in child/young people's mental health. Online survey for children and caregivers. Stakeholder roundtables.	• Surveys promoted in early 2022, responses from 4,559 children; 2,796 caregivers. 884 surveys completed on behalf of child. • The majority of respondents from NSW and Victoria. Data aggregated on the basis of gender and cultural identity.
People living in rural and remote communities	Centre for Rural and Remote Mental Health	Literature review. Live data review – published records of service usage, morbidity or other trends. Interviews with residents/users, interviews with service providers and key community informants.	• 24 online resident interviews in March-April 2022, sampled from all states and NT with a spread of ages and slightly more females. • 25 key informant interviews in April-May 2022. Some in small groups. Sample from NSW, Victoria, Queensland and WA.
People aged over 75 years	Council on the Ageing Australia	Codesign through a project panel of older people. Semi-structured interviews, focus groups, online survey, telephone interviews, written submissions.	• The survey ran from Jan–Feb 2022 and received 1,119 responses, and 27 submissions. • There were 15 one-on-one interviews and five focus groups were held with a total of 32 participants.

			• Over a third of respondents were from NSW, followed by Victoria and SA.
People with lived experience of sexual, domestic and family violence	Full Stop Australia	Literature review. Analysis of internal quantitative client data. Online client survey and interviews with Full Stop Australia trauma specialist counsellors.	• 69 survey respondents, 86% identified as woman/female, 82% were aged 25-54 years, 64% identified as straight/heterosexual (64%), with 22% identifying as bisexual, gay or lesbian. • In early 2022, 13 in-depth, semi-structured interviews with Full Stop staff.
LGBTQ+ communities	LGBTIQ+ Health Australia and La Trobe University	A cross-sectional nation-wide survey of LGBTIQ+ people's experience. A qualitative study involving a series of focus group discussions with particular intersections of the LGBTIQ+ community.	• 3,135 participants completed the survey, majority from Victoria and NSW. • 23 participants in focus groups; 18 - 64 years, 11 identified as multicultural and 17 indicated they had a disability or were unsure about whether they had one.
People from Italian, Turkish and Vietnamese Communities	Mental Health Australia: Embrace Project	Community Leader consultation – interviews and an online forum Community member engagement – focus groups and in-depth interviews	• 12 Stakeholder organisation interviews, community leader's forum, 6 discussion groups (male and female groups in each language). • 12 in-depth interviews, including with those 55+ years with bilingual research assistants
Adult carers of those who experience mental illness, mental ill-health, and suicidality	Monash University and the National Mental Health Consumer & Carer Forum (NMHCCF)	Establishment of Project Steering Group to support a co-design process Literature Review, Survey, Focus Groups Data Analysis	• Seven online focus groups in April 2022 across QLD, NSW, ACT, Victoria, SA, WA and through the National forum for Embrace multicultural mental health. • 73 focus group participants, aged 21-80 years (mean age 56 years) and majority identifying as female.

Appendix B – Summary of recommendations made by the researchers that undertook the ten Pandemic research projects

Research project citation	Priority population	Recommendations
Cowlishaw S, O'Dwyer C, Bowd C, Sadler N, O'Donnell M, Forbes D, & Howard A. (Accepted, Dec 2023) Pandemic impacts and experiences after disaster in Australia: A qualitative study following the Black Summer Bushfires. BJ Psych Open [unpublished]	People experiencing compound disaster trauma	1. There is need for long-term and integrated approaches to resourcing and governing pandemic and disaster resilience and recovery processes. Mechanisms to meet this need may include: a. Establishing a collaborative National Institute with a specific focus on mental health, wellbeing, and recovery in the context of disasters and large-scale emergencies. b. Extending funding for current disaster and COVID-19 initiatives targeting mental health and wellbeing in order to address impacts of the pandemic on the duration of disaster recovery processes. 2. There is need for integrated systems for providing and accessing pandemic and disaster-related emergency and recovery support (including financial assistance) that are streamlined, trauma informed, and adopts an 'all hazards' approach. This may involve: a. Equipping all agencies and organisations involved in the large-scale emergency response and recovery to become trauma-informed at both organisational and individual levels. b. Identifying and expanding successful (local) approaches to coordinating mental health and wellbeing support for large-scale emergencies. 3. There is need for targeted initiatives to build community connection and social capital, which should be identified via regular programs of funding locally developed pilot strategies that focus on facilitating community engagement and collecting evidence that can support the potential scale up of promising practices. 4. There is a need for multi-component strategies for developing and maintaining a regional workforce that is resourced to continue providing mental health support in communities have been impacted by disasters and the pandemic. These may include: a. Enhanced support for the existing local workforce through initiatives aimed at distributing demand and reducing burnout. b. Strategic approaches to expanding the workforce available to provide mental health and wellbeing support in local communities. 5. There is a need for strategies to increase provision of mental health support in response to complex posttraumatic mental health problems, and also enhance the integration and pathways across different types of services. This may involve: a. The design and commissioning of new specialist services for posttraumatic mental health which align with initiatives that have been progressed recently in some Australian jurisdictions. b. The design and piloting of targeted programs for enhancing pathways across services which draw from lessons learned in broader health service contexts.
Hall N, Thespourinthone J, Bailey S. Men's lived experiences of mental health during COVID-19. Research Report to	Men aged over 18 years	1. Workplaces: Within workplaces there was a noticeable gap in employee support, identifying a need for all workplaces to have wellbeing programs that support the mental health of workers and equally provide strategies for self-care management and adapting to a home work environment. Employers should also establish foundations for creating a healthy workplace culture from home and consider staff morale and culture; providing opportunities for connection and a sense of shared experience, similar to that of traditional face-to-face interactions.

Australian Men's Health Forum. Western Sydney University. 2022		2. Financial support: Financial assistance schemes such as JobKeeper and JobSeeker were found to be valuable during this period, sustaining people through job losses or transitions and minimising further distress. It is recommended these support packages continue (and or) be reinstated in the event of a future crisis. 3. Connection: Keeping people connected is also an important area for future research. While those in relationships leaned heavily on those around them and some had access to immediate family and friend networks, some experienced barriers to access due to the location, time zone or government mandates. Further community outreach and support programs could be considered, as well as policy implications for those lacking in support. 4. Self-care: Self-care tools were commonly something men either had access to and used effectively or were lacking in and were seen to be replaced by less healthy coping mechanisms. Further research into beneficial self-care activities would strengthen future government initiatives, wellbeing and educational programs and support service recommendations. While a broad range of activities were engaged in (from gardening, to reading and video games), some showed more merit as grounding and supportive than others. 5. Isolation: Isolation was a continual barrier experienced by many men during the pandemic and did not discriminate across age, location or cultural background. Strategies devised to reduce isolation such as the "bubble buddy" scheme could be seen as skewed to support those who already had strong support networks. The late timing of the scheme and rule confusion created barriers for it being effectively utilised, making it a challenge for some to find or access connection. A demand for younger men's groups, such as a youth focused Men's Sheds was also noted. 6. Slowness: Slowing down was a subsequent lifestyle effect of the lockdown period and one that showed positive and negative responses. Within the older cohort, there was a strong sense of self awareness and ability to acknowledge their mental health and turn to tools for self-regulation (mindfulness, meditation, drawing, reading) and or seek support during periods of distress. The implications of this suggest, introducing mindfulness and self-regulation programs into schools could support early self-awareness and establish healthy foundations for the future of young men. 7. Help-seeking: Seeking mental health services was a consistent theme noted during this time, in some cases with men engaging with a multidisciplinary team of psychologists, counsellors, psychiatrists and psychologists. Recognising the complexity of diagnoses, there is a need for increased case management. Providing holistic case management support would relieve systems stress and ensure men were effectively supported across all facets of their mental health and wellbeing. It is also recommended there be more access to remote services, male-friendly services and services with additional capacity for longer-term support. 8. Cumulative distress: Cumulative distress was an overarching theme found to lead to significant negative health and wellbeing outcomes for men, exemplified by a compounding of all above factors. Research confirmed cumulative distress correlated strongly with the social determinants of health theory (outlined by World Health Organisation) suggesting that social variables such as employment, income, family relationships and experience of support services impacted distress levels and lead to subsequent health impacts. On this basis, it is recommended that research and actions be taken to analyse and address system distress, lack in support services, structural barriers affecting access or eligibility to payments or services, policy mandates surrounding workplace and education wellbeing programs and an increase in community support programs for men. 9. Research: With these considerations in mind, further research into post-pandemic male wellbeing outcomes is suggested. A subsequent follow-up study and/or longitudinal study examining mental wellbeing of men later down the track, would be beneficial for obtaining long term positive and negative impacts. Targeting men of greater diversity and marginalisation would also be beneficial in creating a full picture of Australian men's lived experiences of mental health and wellbeing post-pandemic

Holmes S. Pandemic Project Final Report. People with Disability Australia. 2022.	Women with a disability aged over 18 years	1. Continue bulk-billed telehealth for GP's and specialists and remove requirement for patients to have seen their doctor in-person within the last 12 months. 2. Ensure and promote data gathering and studies about women with disability. 3. Prioritise disability inclusive government responses, messaging, and information. 4. Maintain work-from-home alternative in the public service and encourage private organisations to do the same. 5. Include women with disability in the consultation and stakeholder engagement processes. 6. Increase mental health and domestic violence supports, with specialised training, understanding and accessibility requirements for women with disability.
Australian Human Rights Commission. 'Mental health shapes my life': COVID-19 & kids' wellbeing. 2022.	Children and young people (9-17 years)	Each recommendation relates to the priority areas of the Response Plan, as well as to issues raised in sections of the report. These are both indicated in brackets following each recommendation. The recommendations are: 1. Australian governments work together to fully fund and implement the National Children's Mental Health and Wellbeing Strategy (Priority Areas 1, 2, and 6 in the Response Plan) (See sections 8.3(a) and 9.3(b)) 2. The Australian Government seeks the views and experiences of children, young people and their families to inform the ongoing implementation and monitoring of the National Mental Health and Wellbeing Pandemic Response Plan, including by direct engagement through interviews, forums and surveys (Priority Area 6 in the Response Plan) (See section 9.3(d)) 3. The Australian Government regularly collects national data on the mental health and wellbeing of children and young people that can be used to inform policy and service delivery, and to monitor long-term trends in children's mental health during and beyond the COVID-19 pandemic (Priority Area 10 in the Response Plan) 4. Australian governments conduct child rights impact assessments as part of all policy and law decision-making processes that affect children's wellbeing, including in emergency responses (Priority Areas 6 and 10 in the Response Plan) (See section 9.3(d)) 5. Australian governments fund evidence based education programs in schools and community settings to improve the mental health and wellbeing literacy of children and caregivers, and increase understanding and awareness of mental health issues in the community (Priority Area 7 in the Response Plan) (See sections 4, 8.3(a) and 9.3(a)) 6. Australian governments pilot models of schooling that provide integrated and holistic mental health and wellbeing support, including by: a. co-locating health and family support services with schools where possible, or facilitating access to community-based services b. ensuring teachers receive training and support to address children's wellbeing needs and collaborate with mental health experts where necessary c. ensuring trained mental health professionals are available and accessible to all in the school community, including students and their families (Priority Areas 1, 2, 3 and 6 in the Response Plan) (See sections 7.3, 8.7 and 9.3(c)) 7. Australian governments make available free or affordable, place-based, holistic mental health services for children and their families, including in regional and remote areas (Priority Areas 1, 2, 3 and 6 in the Response Plan) (See sections 8.3(a) and 9.3(b)) 8. Mental health services for children and families offer a range of delivery options to encourage greater uptake, including face-to-face, child-friendly telehealth consultations, digital interventions, and phone helplines, where they are evaluated as providing positive outcomes (Priority Areas 1, 2, 3 and 6 in the Response Plan) (See section 8.5)

Simmons P, Dalton H, Ruming N, Powell N, Perkins D. Final report: Mental health and wellbeing impacts of the COVID-19 pandemic on rural and remote individuals and communities. Centre for Rural and Remote Mental Health, University of Newcastle, Orange NSW, Australia. 2022. [unpublished]	People living in rural and remote communities	Prioritise rural economic stability and social determinants of mental wellbeing: 1. Reduce desperation among the most vulnerable, including those without financial reserves, reliable income and quality housing. Ensure government benefits are adequate for living and provide adequate housing. 2. Invest in basic security supports for the general population. Maximise access to affordable housing and improve the stability of rural employment through de-casualisation and lengthening rural workforce contracts. In the event of future pandemics, rapidly implement income support such as JobKeeper and other protections (including PPE and vaccine distribution). Rebuild social capital in rural communities: 3. Support connectedness in rural communities. Promote and recognize volunteering, especially among the young who are perceived to be under-represented in volunteering. Encourage rural residents to participate in social and community interactions in local areas. Use short- and long term incentive and promotion strategies to support community and organisation activities (e.g., Victorian Dining and Entertainment vouchers; entertainment, sport, and cultural events of different scale). Address pre-existing vulnerabilities - rural adversity and capacity of rural mental health system: 4. Increase resources for rural mental health services to address current and projected needs. Support existing rural mental health workers with evidence-informed recruitment and retention strategies, such as the Whole-of Person Retention Improvement Framework. 5. Prioritise service access improvements, including reduced care costs for vulnerable subpopulations such as youth, older people, Aboriginal people and people those affected by multiple adversity (e.g., flood or fire). Support regional planning and place-based models of mental health care 6. Adequately resource and upskill LHNs and PHNs to plan services collaboratively at the regional level, including joint disaster preparedness planning, with consideration given to jurisdictional challenges and opportunities (e.g., state/federal boundaries). 7. Support place-based care and coordination models that are locally designed to optimise alignment of mental health needs, services and resources including peer support and use of non-hospital settings, and care delivery options including face to face, outreach, telehealth and hybrid modes. Consider holistic primary care models such as Rural Area Community Controlled Health Organisations as proposed by the National Rural Health Alliance. Invest in equitable rural access to telecommunication as a national wellbeing priority 8. Invest in equitable regional and remote digital communication connectivity: Improve reception and connection infrastructure, enhance affordability of connection and devices, and use outreach to improve skills and awareness required for uptake. (See, Regional, Rural and Remote Communications Coalition) Provide trusted communication 9. Consider a strategic communication plan to support how government information (Federal, State and local) is updated regularly, distributed and made accessible to a wide audience and tailored for groups with different needs, such as frontline employees, small business, organisations responsible for managing public contact and compliance, and people affected by state border changes

Council on the Ageing Australia. Mental health and wellbeing during the COVID-19 Pandemic: The lived experience of Australians aged 75 and over. 2023.	People aged over 75 years	1. Fund adequate and appropriate support, education and engagement for priority groups, particularly older people with pre-existing vulnerabilities to mental ill health, those in residential aged care, from CALD communities, and people with caring responsibilities, including formal and informal carers. 2. Improve messaging and communication for older Australians, including advice on how to manage mental health and wellbeing, and move beyond a focus on physical wellbeing and impacts of the Pandemic. 3. Increase accessible mental health services and preventative measures that are informed by an understanding of ageism, ageing and gerontology. Explore models that promote and normalise mental health among older Australians. Any education and promotion of mental health and wellbeing should be accompanied by adequately funded and staffed services. Digital and online services are not always accessible to older Australians. 4. Target strategies at each level of government, including local government. Develop and implement an Older Person's Mental Health Strategy that can inform the National Pandemic Response Plan. This strategy should include a social and mental health education campaign for older people and work with local government to provide a balance between local responses and national oversight. 5. Strengthen, fund and expand successful community engagement initiatives and ways of embedding community and social connections. Community-based strategies and interventions were crucial to the wellbeing and mental health of many older Australians, and successful models should be identified and funded to continue their work in diverse settings. 6. Prioritise staff training and education in mental health awareness for people providing care and services to older people. A comprehensive Pandemic Response Plan must encompass strategies to support workers and carers during times of crisis. A skilled, professional workforce that delivers appropriate care must also receive the support to recover from any vicarious trauma.
Ng F, Buckby T, Woolley J, Love E, Marwood A, Si-Lok Yu C, Mesaglio K, Frances Rellama G. Full Stop Australia Final Report: The impact of COVID -19 on the mental health and wellbeing of people with lived experiences of sexual, domestic and family violence. Sydney, Australia: Full Stop Australia. 2022.	People with lived experience of sexual, domestic and family violence	1. Recognise the Complexity of Trauma for Victim-Survivors of Sexual, Domestic and Family Violence: Full Stop Australia recommends that the NMHC engages with a violence and trauma-informed framework to shape all future policy responses to improve trauma support for victim-survivors and assist them in navigating diverse and complex service systems. 2. Prioritise Accessible, Flexible and Diverse Service Engagement and Support: Full Stop Australia recommends that the National Mental Health and Wellbeing Pandemic Response Plan, and other future policy responses, prioritise the provision of accessible, flexible and diverse support modalities for victim-survivors, such as phone, web, online, and telehealth support, alongside in person support. This support needs to be ongoing to assist clients to navigate the broader service system in an integrated way as they progress through their recovery journey from crisis through to trauma management and recovery. 3. Make Further Investment in Multidisciplinary Support: Full Stop Australia recommends sustainable investment and funding for complex, integrated care coordination and multidisciplinary support. Full Stop Australia recommends the National Mental Health and Wellbeing Pandemic Response Plan, and other future policy responses, provide for: • Sustainable, national investment and funding of crisis support for specialist trauma, sexual, domestic and family violence and child sexual abuse services to reduce unmet demand in metropolitan, rural, regional and remote locations. • Sustainable, national investment and funding of ongoing healing and recovery services for violence and trauma specialist sexual, domestic and family violence services across the continuum of care in metropolitan, rural, regional and remote locations. Including investment in supporting technology for services and victim-survivors to transition to remote service modalities as outlined in Recommendation 2. 4. Strengthen Income and Housing Supports for People Impacted by Sexual, Domestic and Family Violence: Full Stop Australia recommends the National Mental Health and Wellbeing Pandemic Response Plan, and other future policy responses, include a strengthening of income and housing support measures for people impacted by sexual, domestic and family violence. Measures should include a suite of solutions from additional social security payments and income protections to enhanced rental subsidy schemes, social housing stock development, and an expansion of safe at home programs to support people impacted by violence and abuse in appropriate cases to remain home safely whilst the abuser is removed.

		5. Invest in Support for At-Risk Groups: The many ways in which victim-survivors navigate and process their trauma differs between people. Considering the diverse needs of victim-survivors, Full Stop Australia sees community consultation as essential for future sustainable funding for violence and trauma specialist recovery services for at-risk victim-survivors disproportionately impacted by COVID-19. At-risk groups include but are not limited to Aboriginal and Torres Strait Islander people, people with a disability and chronic health conditions, culturally and linguistically diverse people, LGBTQI+ communities and young people. Full Stop Australia recommends that National Mental Health and Wellbeing Pandemic Response Plan, and other future policy responses, include supports specifically for at-risk groups and that these supports be led, co-designed and co-delivered by at-risk populations themselves within a violence and trauma specialist clinical framework. 6. Increase Community Awareness of Sexual, Domestic and Family Violence Supports and Resources, and of COVID-19 Health information: Full Stop Australia recommends that the National Mental Health and Wellbeing Pandemic Response Plan, and other future policy responses, include investment in increasing community awareness regarding accessing support and services and up to date COVID-19 health information throughout any future waves of the pandemic. For this to have a significant impact, it is critical that informative public, community health and service awareness measures are targeted to local communities with material provided in various languages, tailored to meet the accessibility needs of people with a disability, and suited to the support needs of the older persons. 7. Mitigate Crisis Impact on Staff: Full Stop Australia recommends the National Mental Health and Wellbeing Pandemic Response Plan, and other future policy responses, include investment into multimodal mental health, self-care, and wellbeing support packages for frontline workers, supported with individual and group debriefing to prevent vicarious trauma and workforce burnout in circumstances where staff are required to work from home. 8. Violence and Trauma-informed Workforce Capacity Building: Full Stop Australia recommends the National Mental Health and Wellbeing Pandemic Response Plan, and other future policy responses, include investment in trauma-and-violence-informed workforce training in all levels of healthcare, community, social service, child protection, police and justice sectors.
Amos A, Macioti PG, Hill AO, Bourne A. Pride and Pandemic: Mental health experiences and coping strategies among LGBTQ+ adults during the COVID-19 pandemic in Australia. National report. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University. 2022.	LGBTQ+ communities	1. Resourcing of LGBTIQ+ community organisations to meet extensive mental health need. Ensuring culturally safe and affirming practices in mainstream mental health services. 2. Ensuring the provision of culturally safe and affirming practices in mainstream mental health services. 3. Enhancing access to LGBTIQ+-affirming family violence services. 4. Development and promotion of family of origin violence prevention interventions. 5. Resourcing of LGBTIQ+ organisations for the provision of drug and alcohol support services. 6. Promotion of LGBTIQ+-affirming support services for drug and alcohol use. 7. Funding of LGBTIQ+-community mental health services 8. Resourcing of LGBTIQ+ organisations to facilitate accessible peer support groups 9. Continued resourcing of and access to telehealth services 10. Undertaking of focussed research on the experiences of people with an intersex variation. 11. Undertaking of research that focuses on a broader diversity of gender and sexual identities. 12. Undertaking of focussed research among First Nations LGBTIQ+ people. 13. Monitoring of LGBTIQ+ inclusion in future crisis responses.
Mental Health Australia. Mental health during the COVID-19 Pandemic in Italian, Turkish and	People from Italian, Turkish and Vietnamese communities	1. Developing a community empowerment strategy. A thorough community co-design approach involving CALD communities is essential. This includes the designing of messages and choice of communication channels in collaboration with targeted CALD communities. This is pivotal in ensuring that the right communication reaches the right people, and the messages are accepted. This also includes a focus on helping people to provide better support for loved ones, including how to open up conversations in non-stigmatising ways, how to access professional supports, and reinforcing and enhancing existing models

Vietnamese communities. 2022.		of community support that may be impacted by social distancing and isolation requirements during a pandemic. Bicultural and bilingual community health workers and community leaders and key to this process. 2. Reducing both social and self-stigma is key. Specific stigma reduction activities for CALD communities need to address culturally specific and derived stigma. Strategies need to be tailored to mitigate the impact of stigma on help seeking within CALD communities. Health literacy material that focuses on the mental health continuum should be used. 3. Strengthen and develop a multi-lingual psychologically skilled workforce. 4. Consider additional communications channels to communicate about mental health with CALD communities, including community radio, social media channels, community leaders and organisations. These need to be informed by CALD communities as preferred and trusted sources. 5. Consider a referral pathway for CALD people in Australia facing relationship tensions, as part of providing holistic mental health support for example InTouch, NIFVSP, White Ribbon, the Domestic Violence Hotline and Windermere.
Petrakis M, Walters C. Mental Health Family Carer Experiences of COVID-19 in Australia: Final report for the National Mental Health Commission from the NMHCCF as part of the Pandemic Grants for Priority Groups. Melbourne: SWITCH Research Group, Monash University. 2022.	Adult carers of those who experience mental illness, mental ill-health and suicidality	Short term 1. Australian governments to review practices in inpatient and other clinical settings to ensure family inclusion and partnership in supporting people with mental health challenges. 2. Australian governments to fund the creation of carer peer navigator roles – providing information and support – across inpatient and community services for families, carers and supporters. 3. Australian governments to prioritise the creation of carer support on-call roles, accessible via local and regional mental health triage services, to respond to crises experienced by families. 4. The Australian Government to fund available and responsive mental health carer respite to ensure carer workload does not overwhelm family members so they are able to remain in paid work. 5. In order to respond to current and future major disasters (pandemics, fires, floods, and drought), Australian governments to create local and regional mobile centres for family assistance. Long term 1. The Australian Government funds diverse modalities of consultations and therapeutic interventions to enable mental health consumer and carer choice, inclusive of but not defaulting to telehealth. 2. The Australian Government, in recognising the risk inherent in providing long-term and acute mental health care on carers, to establish domestic violence services tailored and responsive to family members experiencing acute and/or cumulative risk and violence. 3. The Australian Government, in recognising the impact of providing long-term and acute mental health care on the psychosocial wellbeing of carers, to establish suicide prevention services responsive to family members experiencing acute and/or cumulative stress and distress. 4. The Australian Government to establish funded family-carer collaborative hubs to foster, mentor and disseminate family leadership in service redesign, evaluation and research. 5. The Australian Government to provide national guidance and co-ordination for innovation across all states in administration and guardianship as it relates to mental health carers concerned about the safety of loved ones in their absence or upon their death.

Appendix C – Summary of the women's mental health in the context of COVID-19 study recommendations

- Additional and targeted supports for women who have experienced violence given a history of violence was a risk factor for psychological distress in the pandemic. Potential solutions include:
    - Development of an effective recovery strategy for women who have experienced violence.
    - Long term recovery programs included as a priority area in the next National Plan to end violence against women and children. These should be evidence based and evaluated for efficacy.
- Holistic mental health models given women are faced with a multitude of risk factors for experiencing psychological distress including poor mental health, high stress, experiences of violence, poor general health, and financial difficulty, all of which have been exacerbated during the pandemic. To be effectively addressed, these complex factors require targeted, multi-level approaches. Potential solutions include:
    - A multidisciplinary, intersectoral approach to women's mental health care that addresses histories of violence and other complex trauma, physical health issues, and financial and economic capacity.
    - Consideration of a strengths-based perspective that enables women to leverage their existing capacities.
- A focus on transitions to motherhood and perinatal mental health given women in their late twenties and early thirties were the most at risk of mental health issues during 2020. Women in this age group are likely to be starting families. Potential solutions include:
    - Promotion of help seeking behaviours to alleviate fears around disclosing mental health issues in the perinatal period.
    - Increased training and support for the perinatal health workforce to increase capacity for both identification of mental health problems and provision of mental healthcare.
    - Increased outreach support for this age group of women via the health system during pregnancy and after birth.
    - Increased access to prevention and mental health literacy programs for this age group.
- A focus on social connectedness given social support and connectedness are protective of mental health. Potential solutions include:
    - Fostering the development of social networks by access to programs similar to the Men's Shed initiative.
    - Facilitating greater access to appropriate technology to assist with human social contact during lockdowns, especially for people who live alone or have recently given birth. This includes training in the use of technology for those who need it.
- A focus on women's economic security given this is a key issue impacting on women's mental health. Potential solutions include:
    - Facilitating participation in stable, secure employment through access to flexible conditions, addressing the gender pay gap and childcare affordability, and enforcing equitable maternity and paternity leave policies.
    - Creation of accessible, flexible education pathways to paid employment.
    - Increasing social connectedness.
    - Introduction of financial support schemes for women with psychological distress.
    - Prioritisation of these initiatives for women at high risk for economic security, particularly those aged in their twenties to early thirties.
- Greater access to services given the pandemic limited women's ability to seek safety from domestic violence, and to seek healthcare more generally. Potential solutions include:
    - Increasing the availability of telehealth during lockdowns by developing workforce capacity, including high-volume crisis strategies.
    - Investigating innovative ways for support services to reach women experiencing violence while in isolation with an abusive partner.
    - Drawing on the National Mental Health and Wellbeing Pandemic Response Plan, increasing effective messaging so that those who need support and healthcare feel able to safely access services.
- Alleviating increased burdens of lockdowns and outbreaks. Women who were home schooling, undertaking paid work (or both), and those who were essential workers reported high levels of stress during lockdowns and outbreaks. Potential solutions include:

- Employers could implement strategies to assist with the burden of home schooling while undertaking paid work, for all parents (e.g. flexible work hours).
- Implementation of plans and activities in line with the National Mental Health and Wellbeing Pandemic Response Plan and the National Disasters Mental Health and Wellbeing Framework to address the increased levels of stress experienced during pandemics.

References

[1] The Hon Greg Hunt MP. Former Minister for Health and Aged Care. COVID-19: $48.1 Million for National Mental Health and Wellbeing Pandemic Response Plan. 2020. Available from: https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/covid-19-481-million-for-national-mental-health-and-wellbeing-pandemic-response-plan
[2] Council on the Ageing Australia. Mental health and wellbeing during the COVID-19 Pandemic: The lived experience of Australians aged 75 and over. 2023.
[3] Council on the Ageing Australia. Mental health and wellbeing during the COVID-19 Pandemic: The lived experience of Australians aged 75 and over. 2023.
[4] Mental Health Australia. Mental health during the COVID-19 Pandemic in Italian, Turkish and Vietnamese communities. 2022.
[5] Holmes S. Pandemic Project Final Report. People with Disability Australia. 2022.
[6] Simmons P, Dalton H, Ruming N, Powell N, Perkins D. Final report: Mental health and wellbeing impacts of the COVID-19 pandemic on rural and remote individuals and communities. Centre for Rural and Remote Mental Health, University of Newcastle, Orange NSW, Australia. 2022.
[7] Amos A, Macioti PG, Hill AO, Bourne A. Pride and Pandemic: Mental health experiences and coping strategies among LGBTQ+ adults during the COVID-19 pandemic in Australia. National report. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University. 2022.
[8] Holmes S. Pandemic Project Final Report. People with Disability Australia. 2022.
[9] Australian Human Rights Commission. 'Mental health shapes my life': COVID-19 & kids' wellbeing. 2022.
[10] Petrakis M, Walters C. Mental Health Family Carer Experiences of COVID-19 in Australia: Final report for the National Mental Health Commission from the NMHCCF as part of the Pandemic Grants for Priority Groups. Melbourne: SWITCH Research Group, Monash University. 2022.
[11] Australian Human Rights Commission. 'Mental health shapes my life': COVID-19 & kids' wellbeing. 2022.
[12] Mental Health Australia. Mental health during the COVID-19 Pandemic in Italian, Turkish and Vietnamese communities. 2022.
[13] Amos A, Macioti PG, Hill AO, Bourne A. Pride and Pandemic: Mental health experiences and coping strategies among LGBTQ+ adults during the COVID-19 pandemic in Australia. National report. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University. 2022.
[14] Cowlishaw S, O'Dwyer C, Bowd C, Forbes D, O'Donnell, Howard A. Pandemic impacts and experiences after disaster: A compound disaster perspective. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne. 2022. [unpublished]
[15] Holmes S. Pandemic Project Final Report. People with Disability Australia. 2022.
[16] Australian Bureau of Statistics, Causes of Death, 2022. September 2023. Available from Causes of Death, Australia, 2022 | Australian Bureau of Statistics (abs.gov.au)
[17] Australian Institute of Health and Welfare, Suicide and Self Harm monitoring Data, Accessed 12 December 2023, Available from https://www.aihw.gov.au/suicide-self-harm-monitoring/data/covid-19
[18] Leske S, Adam G, Catakovic A, Weir B, and Kôlves K,. Suicide in Queensland: Annual Report 2022, Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane. 2022. Available from https://www.griffith.edu.au/__data/assets/pdf_file/0033/1639473/AISRAP-Annual-Report-2022.pdf
[19] Biddle N and Gray M, Tracking outcomes during the COVID-19 pandemic (January 2021) – Cautious Optimism- external site opens in new window, COVID-19 Briefing Paper, ANU Centre for Social Research and Methods, Australian National University, Canberra. 2021. Available at: https://csrm.cass.anu.edu.au/research/publications/tracking-outcomes-during-covid-19-pandemic-january-2021-cautious-optimism
[20] Phillips B, Gray M and Biddle N, JobKeeper and JobSeeker impacts on poverty and housing stress under current and alternative economic and policy scenarios- external site opens in new window, ANU Centre for Social Research and Methods, Australian National University, Canberra. 2022. Available from https://csrm.cass.anu.edu.au/research/publications/covid-19-jobkeeper-and-jobseeker-impacts-poverty-and-housing-stress-under
[21] Biddle N, Edwards B, Gray M and Sollis K (2020d) Tracking outcomes during the COVID-19 pandemic (August 2020) – Divergence within Australia- external site opens in new window, COVID–19 Briefing Paper, ANU Centre for Social Research and Methods, Australian National University, Canberra. Available from https://csrm.cass.anu.edu.au/research/publications/tracking-outcomes-during-covid-19-pandemic-august-2020-divergence-within
[22] Clapperton, A., Spittal, M. J., Dwyer, J., Garrett, A., Kõlves, K., Leske, S., Millar, C., Edwards, B., Stojcevski, V., Crompton, D. R., & Pirkis, J. 'Patterns of suicide in the context of COVID-19: Evidence from three Australian States. Frontiers in Psychiatry, 12. 2021. Available from https://www.frontiersin.org/articles/10.3389/fpsyt.2021.797601.
[23] Council on the Ageing Australia. Mental health and wellbeing during the COVID-19 Pandemic: The lived experience of Australians aged 75 and over. 2023.
[24] Australian Human Rights Commission. 'Mental health shapes my life': COVID-19 & kids' wellbeing. 2022.
[25] Amos A, Macioti PG, Hill AO, Bourne A. Pride and Pandemic: Mental health experiences and coping strategies among LGBTQ+ adults during the COVID-19 pandemic in Australia. National report. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University. 2022.
[26] Hall N, Thespourinthone J, Bailey S. Men's lived experiences of mental health during COVID-19. Research Report to Australian Men's Health Forum. Western Sydney University. 2022.
[27] Cowlishaw S, O'Dwyer C, Bowd C, Forbes D, O'Donnell, Howard A. Pandemic impacts and experiences after disaster: A compound disaster perspective. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne. 2022. [unpublished]
[28] Ng F, Buckby T, Woolley J, Love E, Marwood A, Si-Lok Yu C, Mesaglio K, Frances Rellama G. Full Stop Australia Final Report: The impact of COVID -19 on the mental health and wellbeing of people with lived experiences of sexual, domestic and family violence. Sydney, Australia: Commonwealth National Mental Health Commission and Full Stop Australia. 2022.
[29] Cowlishaw S, O'Dwyer C, Bowd C, Forbes D, O'Donnell, Howard A. Pandemic impacts and experiences after disaster: A compound disaster perspective. Phoenix Australia – Centre for Posttraumatic

Mental Health: Melbourne. 2022. [unpublished]

[30] Petrakis M, Walters C. Mental Health Family Carer Experiences of COVID-19 in Australia: Final report for the National Mental Health Commission from the NMHCCF as part of the Pandemic Grants for Priority Groups. Melbourne: SWITCH Research Group, Monash University. 2022.

[31] Petrakis M, Walters C. Mental Health Family Carer Experiences of COVID-19 in Australia: Final report for the National Mental Health Commission from the NMHCCF as part of the Pandemic Grants for Priority Groups. Melbourne: SWITCH Research Group, Monash University. 2022.

[32] Simmons P, Dalton H, Ruming N, Powell N, Perkins D. Final report: Mental health and wellbeing impacts of the COVID-19 pandemic on rural and remote individuals and communities. Centre for Rural and Remote Mental Health, University of Newcastle, Orange NSW, Australia. 2022.

[33] Cowlishaw S, O'Dwyer C, Bowd C, Forbes D, O'Donnell, Howard A. Pandemic impacts and experiences after disaster: A compound disaster perspective. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne. 2022. [unpublished]

[34] Ng F, Buckby T, Woolley J, Love E, Marwood A, Si-Lok Yu C, Mesaglio K, Frances Rellama G. Full Stop Australia Final Report: The impact of COVID -19 on the mental health and wellbeing of people with lived experiences of sexual, domestic and family violence. Sydney, Australia: Commonwealth National Mental Health Commission and Full Stop Australia. 2022.