Australian Government
National Mental Health Commission

RESEARCH BRIEF
#MakingTime national summer communications 2020-2021

2020 has been a challenging year in many respects for Australians. The experiences of bushfires, natural disasters and the global coronavirus pandemic have had unique and pervasive impacts for all Australians and their communities, not least in relation to mental health and wellbeing. The evidence is clear that these experiences can increase the level of mental illness and/or distress in the community overall[1], and also exacerbate the severity of symptoms for people with lived and living experience of mental illness.[2,3]

This paper presents key findings from a select review of research literature around the mental health impacts of the events of 2020.

Through extensive consultation with people with a lived experience of mental health (carers and consumers) and people who are impacted by last summer's bushfires and natural disasters, together with advice sought from mental health clinicians and treatment experts about how people can take care of themselves and loved ones during this extraordinary summer and festive season is predominantly to **make time** to care for your mental health and wellbeing. For each person's this will be different and require individual approaches that work best for each person.

Mental health in the community

Pre-2020 levels of mental illness in the community were estimated at one in five Australians will experience a mental health condition in any 12 months, with nearly one in two experiencing a mental health difficulty over their lifetime.[4] Other data indicates in 2017-18 around one in eight (13%) Australians aged 18 years and over experienced high or very high levels of psychological distress, and three in five adults experienced a low level of psychological distress.[5]

In 2020, however, the community prevalence of mental illness and psychological distress is likely to be significantly higher. This is suggested by the increased rates uptake of mental health services, as well as various surveys conducted throughout the pandemic. Of note, the evidence is showing higher levels of mental distress for people living in Victoria[6], as a likely result of the tighter and longer duration of lockdown restrictions in that state.

- In the four weeks to 6 December 2020, compared to the same time in 2019
  - the average number of users of the Head to Health website was 374% higher - 4,377 average users per day, and the average number of users of the Reachout website 8,905 average users per day, a 12% increase from the same 4 weeks in 2019
  - the number of MBS-subsidised mental health services was 16% higher - 1,164,28 services delivered in the past 4 weeks (9,969,021 services delivered from 16 march to 6 December 2021)
  - the number of contacts with helplines (Lifeline, Kids Helpline and Beyond Blue) together has increased by 25% on the same time last year – that is 114,336 answered contacts in the last 4 weeks
- Following a spike in March 2020, mental-health related scripts dispensed are 7% higher than the same time in 2019[7]

- Occasions of service through headspace services per week were unchanged – and expecting to see a seasonal drop in December (this may be due to capacity issues, rather than a lack of need, with service capacity increasing via online and outreach services)
- A study by the Black Dog Institute into acute mental health responses at the beginning of the pandemic (27 March to 7 April 2020) found 78% of respondent's mental health had worsened since the COVID-19 outbreak.[8]
- Research by the ANU showed the proportion of the Australian population experiencing psychological distress levels consistent with having 'probable serious mental illness' increased from 8.4% in February 2017 to 10.6% in April 2020;[9] in May, 47% of respondents thought their stress had worsened, 40% felt their outlook for the future had worsened and 40% thought the amount of time they feel lonely and isolated had increased; [10] and in October, anxiety and worry due to COVID-19 was found to have continued to increase, particularly for women and young people. [11]
- Melbourne University's *Taking the Pulse of the Nation* survey found that on average, about one in five Australians have experienced anxiety and felt depressed most of the time during the seven months to October 2020.[12]

The Commission has also heard many people are experiencing levels of fatigue, potentially as a response to sustained exposure to COVID-related stressors.[13]

Vulnerable groups

The experience of the pandemic and other events of 2020 have not be borne equally across the Australian population.

Of key concern, **people affected by the 2019-20 bushfires and other natural disasters** have faced repeated layers of trauma and stressors that place them at particular vulnerability. The recently released report of the Royal Commission into National Natural Disaster Arrangements found "compelling evidence" of the impacts of natural disasters on mental health, including increased rates of stress, depression, anxiety, post-traumatic stress disorder, as well as suicide, substance abuse, aggression and violence, and poor sleep.[14]

As well as triggering higher rates of psychological distress, bushfires and other natural disasters can impact upon people's ability to recover and rebuild, posing additional risks of poor mental health. Disasters can limit or remove access to mental health services and supports (e.g. due to damage to roads, poor internet access, and service closures), and can have negative impacts on other factors that are ordinarily protective of good mental health (particularly housing and financial resources).

The COVID-19 pandemic presented additional challenges for people in disaster-affected communities. The physical distancing associated with the public health response to the pandemic created a challenge in accessing components of care that are well established as effective in supporting recovery after a disaster. For instance, recovery practice has shown that low-key, informal outreach (such as 'cuppa and a chat' or 'backyard BBQ' events) works well in traumatised communities. However, sustaining or reimagining how to offer these events virtually was difficult during the pandemic. Closure of state borders have also severely affected people in fire regions who could no longer reach family, friends and health services.

As a consequence, it has been harder to identify and help people struggling with the recovery process. Further, many in disaster-affected communities have been left feeling overlooked and forgotten as the national focus has shifted to responding to the pandemic

Across the Australian population more broadly, negative psychological outcomes of the pandemic are associated with a number of other social, economic and demographic factors, including lower levels of education, low income and financial loss, and lack of social networks, as well as history of mental illnesses or previous traumas. [15] Research also indicates heighted levels of psychological distress as a result of the pandemic amongst students, parents, carers and retirees, people who identify as non-binary or a different gender, and Aboriginal or Torres Strait Islander people.[16, 17, 18] The social and economic impacts of the pandemic will also have had a disproportionate and possibly exacerbating effect on groups already experiencing vulnerabilities – such as domestic violence, gambling, alcohol and other drug addictions, housing insecurity, and disability – with consequent negative impacts on mental wellbeing.

The negative impacts for **young people** have been particularly pronounced:

- For 0-17 year olds in NSW and Victoria, there have been higher levels of emergency department presentations for both mental health-related reasons (up 27% in NSW and 25% in Victoria) and for intentional self-harm and suicidal ideation (up 31% in NSW and 35% in Victoria)[1] [19]
- Calls to Kids Helpline are up 47% in Victoria (in the 4 weeks to 1 November 2020, compared to the same time in 2019)
- The April 2020 ANUPoll results indicate the proportion of 18 to 24-year olds experiencing severe psychological distress increased from 14% in 2017 to 22.3% in April 2020.[20]
- 23% of Australians aged 18-24 reported high levels of mental distress over the six months to September, more than twice the rate recorded before the pandemic.[21]

The research has also noted the vulnerability of young Australians to changes in the labour market due to the pandemic, with a higher proportion of young adults working in industries most affected by the pandemic such as hospitality, and on casual contracts. This combination of financial stress and insecurity and the existing higher rates of mental illness amongst younger people presents significant risk for ongoing mental distress amongst this group.

Research indicates there may be marked and longer term impacts of mental health and wellbeing of **people who went into 'hard lockdown' or quarantine**. The evidence suggests there are significant and lasting psychological impacts of quarantine and isolation[22], including depression, anxiety, stress-related disorders and anger,[23] and negative impacts on resilience after periods as short as two weeks.[24] These findings are of particular importance for people living in Victoria, people diagnosed with COVID-19 (who also face an increased likelihood of being diagnosed with a psychiatric disorder[2526]), and for returning travellers, who are more likely to have experienced single person isolation.

For people with lived and living experience of mental illness, adapting and responding to the events of 2020 pose particular challenges, and heightened risk for psychological distress. [27, 28] Public

[1] NSW data refers to 16 September to 27 October 2020, compared to same period 2019. Victoria data refers to 21 September to 1 November 2020, compared to same period in 2019.

health measures such as mask-wearing and physical distancing may inadvertently appear threatening to people with severe mental illnesses such as psychosis, or hamper the development of therapeutic relationships necessary for effective treatment.[29] For many, face-to-face services have been delivered instead via telehealth, which now comprises approximately one third of MBS-subsidised mental health services.[30] The ability to access factors protective to good mental health, such as physical exercise and social connection through workplaces, family and friends, among other routines and coping strategies, may have been curtailed by physical restrictions.

Looking forward: easing of restrictions and looming financial hardship

As we approach the end of the 2020 calendar year, the experience and impact of COVID-19 is shifting. The number of new and locally acquired cases has remained low and on a downward trend over the past month[31], restrictions are gradually being lifted over the month of November, and borders opening across Australia. Survey data from the ABS shows that, as restrictions are eased, fewer Australians reported feeling personal stress (24% in June, compared to 43% in April) and loneliness (9% in June compared to 22% in April), with feelings of hopelessness and restlessness reducing to rates comparable to those reported in 2017-18.[32]

Although there are many social, physical and economic benefits of restrictions easing, some may feel a **sense of unease or anxiety about emerging from lockdown**. For example, of respondents to a Relationships Australia in survey in May-June 2020, around 60% reported feeling more scared or anxious about visiting crowded places now than in the past, and feeling annoyed when seeing other gathering in big groups. Results of this survey also indicated variation in the timeframes people expected to be feeling comfortable with doing everything they did pre-COVID, from 1 year (45%), 6-12 months (34%) and 1-2 months (19%).[33]

Furthermore, **Australia's economic context** poses important challenges in the short, medium and longer term that may increase exposure to risk factors for poor mental health and suicidality. In September 2020 an economic recession was officially announced after the ABS reported a 7% fall in gross domestic product (GDP) during the June 2020 quarter. This represented the biggest drop in GDP ever recorded in Australia.[34] Research has found economic recessions (and associated unemployment, reduced income and financial stress) are associated with suicidal behaviours, substance-related disorders and poor mental health outcomes.[35, 36]

To date, the AIHW Suicide and Self Harm Monitoring website reports no significant increase in suicide deaths in 2020 in comparison to previous years in the jurisdictions who have capability of reporting via Suicide Registers[2]. There is a concern about increased levels of self-harm, especially noted amongst women.

In Australia in 2020, changes to income support arrangements (i.e. JobSeeker, JobKeeper, Coronavirus Supplement) and other financial relief (e.g. mortgage holidays provided by banks) may have had a 'buffering' effect, with no evidence of increased rates of suicide over the period of the pandemic. However, as the longer-term economic, social and psychological impacts of the pandemic start to unfold, some experts are warning of a **'second wave'** of COVID-related mental health effects.[37], [38] As these supports phase out from late 2020 through to early 2021, it will be important to track any further impacts for mental health and wellbeing.

[2] https://www.aihw.gov.au/suicide-self-harm-monitoring/data/covid-19

Australian Government
National Mental Health Commission

Summer 2020-2021: a focus on resilience and coping

While the easing of restrictions is being welcomed by many,[39] it is important to note that this is a move not 'back to normal' but rather progressing to 'COVID-normal', with Australians still encouraged to practice social distancing, mask wearing and good hand hygiene. **This sets the scene for a very different holiday period over 2020 and into 2021.**

While there are a number of **potential protective factors** associated with the holiday period, ongoing public health advice around COVID-safe practices will necessitate different approaches to social and family gatherings, travel, and other activities that characterise the usual Australian summer.

While the 'Christmas Effect' – that is, increased presentation of mental health issues over the holiday period – is largely the stuff of urban myth,[40] the holiday period may present additional stressors for vulnerable groups, particularly where there may be financial stress or strained relationships.

The end of 2020 will be seen for many as a significant milestone. There is now an opportunity to promote positive, strengths based approaches that encourage people to make the most of the summer period: to 'boost their stores', bolster the factors that can protect their mental health and wellbeing and help them 'bounce back' if/when things go wrong. In short, to showcase people's resilience and how we have and will continue to 'get through this together'.

Resilience has been highlighted in recent research around COVID-19 and other disaster responses as an effective strategy to cope with the mental health challenges of COVID-19.[41] Definitions of resilience commonly focus on the ability to overcome the adverse effects of stressful situations and positively respond and adapt to the new post-event context.[42,43] The research base in this area is broad and diverse, presenting resilience variously as a personality trait, a process or an outcome[44], an individual characteristic as well as a quality seen at a community level. [45]

Factors associated with resilience at an individual level include social support (including from friends, family and in the workplace), proactive behaviours such as goal setting and turning obstacles into positive experiences, and coping styles that encompass acceptance and 'hardiness' (a sense of meaning and purpose, belief in being able to control one's destiny and a belief that change is a normal part of life).[46] Other strategies to strengthen individual resilience include mindfulness/paying attention to the present moment, exercise, better sleep and spiritual health.[47]

At a community level and specifically in terms of disaster responses, building resilience can be enhanced by addressing social inequities and vulnerabilities, improved service capacity, establishing buffers for social supports, and – importantly – encouraging community participation in identifying problems and generating solutions, as well as establishing trust and flexible communications networks.[48] These latter points are also supported by research indicating the importance of working with vulnerable communities through partnership with community leaders and organisations specific to those groups.[49]

Australian Government
National Mental Health Commission

References

[1] Vindegaard N, and Benros ME. (2020). COVID-19 pandemic and mental health consequences: Systematic review of the current evidence. *Brain, Behavior, and Immunity*, 89, 531-542. https://doi.org/10.1016/j.bbi.2020.05.048

[2] Cullen, W., Gulati, G., & Kelly, B. D. (2020) Mental health in the COVID-19 pandemic. *QJM Monthly Journal of the Association of Physicians, 1135(5)*, 311-312. cited in Paredes, M., Apaolaza, V., Fernandez-Robin, C., and Hartmann, P. (2021) The impact of the COVID-19 Pandemic on subjective mental well-being: The interplay of perceived threat, future anxiety and resilience. *Personality and Individual Differences, 170*. https://doi.org/10.1016/j.paid.2020.110455

[3] Ismael F, Bizario JCS, Battagin T, Zaramella B, Leal FE, Torales J, et al. (2020). Post-infection depressive, anxiety and post-traumatic stress symptoms: a retrospective cohort study with mild COVID-19 patients. medRxiv, 2020.2008.2025.20182113. doi:10.1101/2020.08.25.20182113

[4] Australian Bureau of Statistics. (2009). National Survey of Mental Health and Wellbeing: Summary of Results, 4326.0, 2007. ABS: Canberra.

[5] Australian Bureau of Statistics. National Health Survey: First results, 2017-18. Cat. No. 4364.0.55.001. Canberra: ABS; 2018. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Psychological%20distress~20.

[6] Biddle N and Gray M. Tracking wellbeing outcomes during the COVID-19 pandemic (October 2020) – Reconvergence. Australian National University; 2020. https://csrm.cass.anu.edu.au/sites/default/files/docs/2020/11/Tracking_wellbeing_outcomes_during_the_COVID-19_pandemic_October_2020_PDF.pdf

[7] Dashboard issued 19 August 2020

[8] Newby J, O'Moore K, Tang S, Christensen H, & Faasse K. Acute mental health responses during the COVID-19 pandemic in Australia. medRxiv. 2020.

[9] Biddle N, Edwards B, Gray M, & Sollis K. Initial impacts of COVID-19 on mental health in Australia. Australian National University; 2020.

[10] Biddle N, Edwards B, Gray M, & Sollis K. Mental health and relationships during the COVID-19 pandemic. Australian National University; 2020.

[11] Biddle N, Edwards B, Gray M, & Sollis K. Tracking wellbeing outcomes during the COVID-19 pandemic (October 2020) – Reconvergence. Australian National University; 2020.

[12] Melbourne Institute: Applied Economic and Social Research. (2020) *Taking the Pulse of the Nation. Research Insights 19-23 October 2020.* Melbourne University. Available from: https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0009/3529485/Taking-the-Pulse-of-the-Nation-19-23-October.pdf

[13] Forensicare. Managing crisis fatigue: expert mental health advice during COVID-19, 16 September 2020. https://www.forensicare.vic.gov.au/managing-crisis-fatigue-expert-mental-health-advice-during-covid-19/

[14] Commonwealth of Australia, Royal Commission into National Natural Disaster Arrangements, *Final Report* (2020). Available from: https://naturaldisaster.royalcommission.gov.au/system/files/2020-11/Royal%20Commission%20into%20National%20Natural%20Disaster%20Arrangements%20-%20Report%20%20%5Baccessible%5D.pdf

[15] Henssler, J., Stock, F., van Bohemen, J., Walter, H., Heinz, A., & Bradt, L. (2020) Mental health effects of infection containment strategies: quarantine and isolation – a systemic review and meta-analysis. *European Archives of Psychiatry and Clinical Neuroscience.* https ://doi.org/10.1007/s0040 6-020-01196 -x

[16] Newby J, O'Moore K, Tang S, Christensen H, Faasse K. Acute mental health responses during the COVID-19 pandemic in Australia. medRxiv. 2020.

[17] Rhodes A. COVID-19 Pandemic: Effects on Australian children and families. 18. Melbourne Vic: RCH National Child Health Poll. Victoria. The Royal Children's Hospital; 2020. Available from: https://www.rchpoll.org.au/wp-content/uploads/2020/07/nchp-poll18-report-covid.pdf.)

[18] Broadway, B., Mendez, S., and Moschion, J. (2020) Behind closed doors: the surge in mental distress of parents. Melbourne Institute Research Insights: Melbourne University 21/20. https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0011/3456866/ri2020n21.pdf
[19] Department of Health. (2020) Vic and NSW mental health services dashboard issued 5 November 2020 (unpublished)

[20] Biddle N, Edwards B, Gray M, & Sollis K. Hardship, distress, and resilience: The initial impacts of COVID-19 in Australia. Australian National University; 2020.
[21] Kabatek, J. (2020). *Jobless and distressed: the disproportionate effects of COVID-19 on young Australians.* Melbourne Institute Research Insight 26/20. Available from: https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0004/3504613/ri2020n26.pdf.
[22] Brooks, S., Webster, R., Smith, L., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. (2020) The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet*, 395: 912-20. https://doi.org/10.1016/S0140-6736(20)30460-8
[23] Henssler, J., Stock, F., van Bohemen, J., Walter, H., Heinz, A., & Bradt, L. (2020) Mental health effects of infection containment strategies: quarantine and isolation – a systemic review and meta-analysis. *European Archives of Psychiatry and Clinical Neuroscience.* https ://doi.org/10.1007/s0040 6-020-01196 -x
[24] Van Hoof, E. Lockdown is the world's biggest psychological experiment - and we will pay the price. Brussels: We Forum; 2020 Apr 20. Available from https://www.weforum.org/agenda/2020/04/this-is-the-psychological-side-of-the-covid-19-pandemic-that-were-ignoring/
[25] Ismael F, Bizario JCS, Battagin T, Zaramella B, Leal FE, Torales J, et al. (2020). Post-infection depressive, anxiety and post-traumatic stress symptoms: a retrospective cohort study with mild COVID-19 patients. medRxiv, 2020.2008.2025.20182113. doi:10.1101/2020.08.25.20182113
[26] Taquet M, Luciano S, Geddes JR, & Harrison P J. (2020). Bidirectional associations between COVID-19 and psychiatric disorder: a study of 62,354 COVID-19 cases. medRxiv, 2020.2008.2014.20175190. doi:10.1101/2020.08.14.20175190
[27] Barber, S., Reed, L., Syam, N., & Jones, N. (2020) *Severe mental illness and risks from COVID-19*. Centre for Evidence-Based Medicine. University of Oxford, 5 August 2020. Available from: https://www.cebm.net/covid-19/severe-mental-illness-and-risks-from-covid-19/
[28] Newby J, O'Moore K, Tang S, Christensen H, & Faasse K. Acute mental health responses during the COVID-19 pandemic in Australia. medRxiv. 2020.
[29] Mental health and CODI-19: change the conversation, *The Lancet Psychiatry*, 7(6). Published online 4 May 2020. https://doi.org/10.1016/S2215-0366(20)30194-2
[30] Department of Health. (2020) Vic and NSW mental health services dashboard issued 5 November 2020 (unpublished)
[31] Australian Government, Department of Health, Coronavirus (COVID-19) at a glance – 9 November 2020. https://www.health.gov.au/sites/default/files/documents/2020/11/coronavirus-covid-19-at-a-glance-9-november-2020_0.pdf
[32] Australian Bureau of Statistics. Household Impacts of COVID-19 survey. ABS. Cat. No. 4940.0 24-29 June 2020. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/detailed-release-june-2020
[33] Relationships Australia (2020) COVID-19 and its Effects on Relationships. May/June 2020 Survey: What effects will the easing of COVID-19 restrictions have on people's relationships and mental health? Available at https://www.relationships.org.au/what-we-do/research/online-survey/COVID19-and-its-Effects-on-Relationships/mayjune2020-survey-write-up
[34] The Hon Josh Frydenberg MP Treasurer of the Commonwealth of Australia. National Accounts June Quarter Statement [press release]. 2 September 2020.
[35] Frasquilho D, Matos MG, Salonna F, Guerreiro D, Storti CC, Gaspar T, et al. (2015) Mental health outcomes in times of economic recession: a systematic literature review. *BMC public health*. *16(1)*, 1-40.

[36] Milner A, Morrell S, LaMontagne AD. Economically inactive, unemployed and employed suicides in Australia by age and sex over a 10-year period: What was the impact of the 2007 economic recession? International journal of epidemiology. 2014;43(5):1500-7. Cited in Kaleveld, I., Bock, C., and Maycock-Sayce, R. (2020) *COVID-19 and Mental health: CSI Response.* Centre for Social Impact, October 2020. Available at https://www.csi.edu.au/media/uploads/csi_fact_sheet_covid_and_mental_health.pdf

[37] McGorry, P. (2020) Mental health and COVID-19: are we really all in this together? *Medical Journal of Australia.* https://doi.org/10.5694/mja2.50834

[38] Brain and Mind Centre (2020). *Road to Recovery: Restoring Australia's Mental Wealth, Uncovering the road to recovery of our mental health and wellbeing using systems modelling and simulation.* University of Sydney. https://www.sydney.edu.au/content/dam/corporate/documents/brain-and-mind-centre/road-to-recovery_brain-and-mind-centre.pdf

[39] Loxton D, Forder P, Townsend N, Barnes I, Byrnes E, Barnes I, Mishra G, Tooth L, & Byles J. (2020) ALSWH COVID-19 Survey, Report 5: Survey 5, 24 June 2020. Available at: https://alswh.org.au/wp-content/uploads/2020/09/ALSWH-COVID-19-Survey-5-Report-Final.pdf

[40] Sansone, R and Sanson, L. (2011) The Christmas Effect on Psychopathology. 8(12), *Innovations in Clinical Neuroscience*, 10-13.

[41] Paredes, M., Apaolaza, V., Fernandez-Robin, C., & Hartmann, P. (2021) The impact of the COVID-19 Pandemic on subjective mental well-being: The interplay of perceived threat, future anxiety and resilience. *Personality and Individual Differences, 170*.

[42] Gibbs, L., Harms, L., Howell-Meurs, S., Block, K., Lusher, D., & Richardson, J. (2015). Community well-being: Applications for a disaster context. Australian Journal of Emergency Management, 30(3), 20–24.

[43] Brooks, S., Amlot, R., Rubin, G., & Greenberg, N. (2018) Psychological resilience and post-traumatic growth in disaster-exposed organisations: overview of the literature. *BMJ Mil Health, 166(1)*, 52-56. doi: 10.1136/jramc-2017-000876.

[44] As outlined in Paredes et al (2021).

[45] Gibbs, L., Harms, L., Howell-Meurs, S., Block, K., Lusher, D., & Richardson, J. (2015). Community well-being: Applications for a disaster context. Australian Journal of Emergency Management, 30(3), 20–24.

[46] Brooks, S., Amlot, R., Rubin, G., & Greenberg, N. (2018) Psychological resilience and post-traumatic growth in disaster-exposed organisations: overview of the literature. *BMJ Mil Health, 166(1)*, 52-56. doi: 10.1136/jramc-2017-000876.

[47] As outlined in Paredes et al (2021).

[48] Gibbs, L., Harms, L., Howell-Meurs, S., Block, K., Lusher, D., & Richardson, J. (2015). Community well-being: Applications for a disaster context. Australian Journal of Emergency Management, 30(3), 20–24.

[49] Lin, L, Savoia, E., Agboola, F., and Viswanath, K. (2014) What have we learned about communication inequalities during the H1N1 pandemic: a systematic review of the literature. 14, *BMC Public Health.*

The impact of financial distress on mental health during COVID-19

Briefing note

28 August 2020

Summary

COVID-19 is not the only health risk we face in 2020. High unemployment, inadequate incomes and social isolation together have a toxic effect on mental health, as the Federal Government's Mental Health and Wellbeing Pandemic Response Plan acknowledges:

''Unemployment, income decline, and unmanageable debts are significantly associated with poor mental wellbeing, increased rates of common mental disorders, substance-related disorders and suicidal behaviours. In Australia, suicides amongst unemployed working age men increased at a higher rate than for other groups in the period including the Global Financial Crisis of 2007-09.
For people suffering financial stress as a result of the pandemic, it will be essential to provide basic financial security while reducing administrative complexity and providing targeted support when transitioning to the recovery phase."[i]

This ACOSS briefing summarises research on the relationship between financial distress, unemployment, and poor mental health [ii] - especially psychological distress, depression and anxiety, which if severe or prolonged can give rise to suicide.[iii] We then examine the impact of COVID19 and high unemployment on mental health.

Key findings

- Inadequate incomes, unemployment, loss of a sense of personal control and social support each risk corroding mental health and increase the risk of suicide.

- People who were unemployed or on Newstart/Youth Allowance were at least three times more likely to experience psychological distress, anxiety and depression than those in paid work. This difference is attributable to a combination of unemployment and inadequate income, and (closely related to these two factors) a lack of social support and a sense of personal control.

- People on low incomes are likely to have a far greater risk of high psychological distress. In 2011, more than one in four people in the lowest

Ph (02) 9310 6200 E: info@acoss.org.au
www.acoss.org.au
ISSN: 1326 7124

20% of households by income had current psychological distress at a high or very high level, compared to one in 20 of those in the highest 20%.

- The onset of COVID-19 and related loss of jobs and incomes from February to April 2020 has increased psychological distress as well as the incidence of persistent depression or anxiety (which rose from 10% in 2017 to 19% overall in April 2020, to 29% among people who lost their jobs, and to 41% among those experiencing financial hardship). Among those who lost their jobs, 11% reported suicidal ideation.

- Subsequently, after the Coronavirus Supplement and JobKeeper Payment were introduced and lockdowns were eased, financial hardship among the lowest 10% by income fell from 60% to 46% and the proportion of people experiencing personal stress due to COVID-19 fell sharply from 43% to 24%.

1. Inadequate incomes, unemployment, loss of a sense of personal control and social support each risk corroding mental health and increase the risk of suicide

(1) Inadequate income is a major contributor to poor mental health among people who are unemployed, and those with low incomes generally

Financial hardship is a key mediating factor between unemployment and poor mental health. Research conducted from 2003 to 2007 among young adults found that people experiencing financial hardship were almost twice as likely (1.9 times) to experience depression (controlling for a range of other factors):
One fifth (22%) of the increased risk of depression for people who were unemployed could be *solely* attributed to financial hardship.
This is in addition to its indirect impacts, for example on social isolation (discussed below). [iv]

Independently of employment status, poverty and inadequate income substantially increase the risk of depres**sion and psychological distress.** In 2011, more than one in four people in the lowest 20% of households by income had current psychological distress at a high or very high level, compared to one in 20 of those in the highest 20%.[v]

Housing unaffordability is a key mediating factor between unemployment or insecure employment and mental ill health. Research in 2016 found that unaffordable housing was responsible for 20% of the negative effect of unemployment and insecure employment on mental health. If the main income-earners in people's households become insecurely employed, the odds of them also experiencing housing affordability stress were five times greater. People especially vulnerable to 'double precarity' (employment and housing) include single parents, people who live alone, and people recently separated or divorced. [vi]

''I have severe depression and anxiety, compounded by being on Newstart. I have to see a psychologist once a month but can only afford to do so on a mental health plan, which only covers 10 sessions a year, and even then I am out of pocket.''

"For first 6 months I didn't turn lights on at night, and kept bumping into furniture & walls or falling in the dark. I once went 3 days without food and fainted, crashing into edge of table & the floor, woke up covered in bruises. I waited as long as possible before refilling prescriptions. This meant my mental illnesses got much worse & I ended up in a psych unit... I had debt collectors hassling me about bills I couldn't afford. I rarely went outside. I cried all the time. I thought constantly about suicide. I am now more than $8,000 in debt." [vii]

''The loans added to HECS to help pay for text books are often spent on paying bills I've been putting off or paying back debts just to be able to stop drowning in financial worry….The concerns for my financial well-being make it even harder to get my life in order as the anxiety fuels my other mental health issues."

"I have never experienced such mental anguish and despair as I have when I was on Newstart. I was suicidal and my mental health declined, I couldn't sleep because of the financial problems.''

"I am only alive due to the kindness of a friend. I lost my home last year and was going to commit suicide. He has given me a place to live. I would like to be able to rent a place and the proper amount of JobSeeker would allow that." [viii]

(2) Unemployment substantially increases the risk of psychological distress, anxiety and depression

Research conducted from 2003 to 2007 among young adults found that people who were unemployed were 2.4 times more likely to suffer from depression or anxiety than people in paid employment (21% compared to 9%). [ix]

In 2014, people receiving Newstart Allowance (now JobSeeker Payment) were found to be more than three times likely than employed people to experience depression, panic disorders and anxiety disorders. [x] Another study using a 2007 survey found that mental health deteriorated with longer durations of unemployment.[xi]

The risk of death by suicide is far greater for people who are unemployed than among those in paid employment**.** In 2013, a meta-analysis of international

research on the link between unemployment and suicide estimated that the risk of suicide among people who were unemployed was on average 1.7 times that of people still employed. In Australia from 2001-2010 there were 6,900 suicides among people not in paid employment, comprising 0.06% of males and 0.02% of females who were not employed

The risk of suicide is exacerbated by *long-term* unemployment.[xii] For every 1% increase in unemployment, a 0.79% increase in suicide rates under 65 years has been estimated.[xiii]

When unemployment rose from 4% to 6% after the Global Financial Crisis (2007-2009), suicide among people out of paid work rose by 22% among men and 12% among women.[xiv]

"Sometimes it has made me feel suicidal. I feel depersonalised, and a failure in general. That I don't have the same rights as an employed person."
Female, 50 and over, single with no children, South Australia [xv]

"Self-esteem [is] a big issue, especially when you go for interviews. Yeah, you don't feel that fantastic, at all … See where anyone who's been unemployed … See the longer you remain on it the harder it is to do an interview; to pull off an interview confidently. You really got to psyche yourself up." Male, unemployed long-term [xvi]

(3) Lack of control (mastery) and social support are also key mediating factors between unemployment and declining mental health

Limited social support is both a consequence of inadequate income and an aggravating factor for poor **mental health.** Research conducted from 2003 to 2007 among young adults found that people with low levels of social support from friends were 1.3 times as likely to experience depression (controlling for a range of other factors). Low social support *solely* accounted for 19% of the difference in the incidence of depression and anxiety between unemployed and employed people.[xvii]

Respondents to a survey of people on Newstart Allowance in 2012 reported that living on a very low income restricted their social connections and support. [xviii]

Loss of a sense of control (mastery) is another consequence of both unemployment and inadequate income, and it also increases the risk of anxiety and depression. Research conducted from 2003 to 2007 among young adults found that people with low levels of mastery were four times (4.1) as likely to experience depression (controlling for a range of other factors):
Low level of mastery solely accounted for 29% of the difference in the incidence of depression between unemployed and employed people. [xix]

"*When you have nothing, having a person constantly threaten to take the last little thing you have away from you is hell. I have come close to killing myself on several occasions when I have had payments stopped." Male, 25-49, single with no children, SA*

"I never know whether I am ok or whether I might be cut off payments. Desperate to maintain person to person contact just in case I get things wrong." Female, 50+, single with no children, VIC [xx]

"[I] do not do any of the following:- Go out for entertainment, socialising. Do courses, join activity groups that cost. Walk if my shoes need repair. Access regular mental health care." [xxi]

You … can't really do anything that much because you can't go out … For example … friends and family … [I] get to see them once a month just because you don't have the financial resources. [xxii]

2. The onset of COVID19 and related job and income losses has increased psychological distress and damaged mental health

By April 2020, when the lockdowns were at their peak and the government's income support response was not yet in place, levels of depression and anxiety in the community had risen markedly.

In April 2020, 19% of all adults reported persistent feelings of depression or anxiety, compared with 10% of all adults in 2017. This was especially so for people who were unemployed (29%), those in financial hardship (41%), and younger people (25% of people under 40 years old).[xxiii] In another survey conducted at this time, 9% of all respondents expressed thoughts of self-harm or being 'better off dead'.[xxiv]

People who lost their jobs or paid working hours experienced especially elevated levels of psychological distress, depression, and suicidal thoughts. In one survey in April 2020, 35% of those who lost their jobs at this time exhibited severe psychological distress, compared with 28% of those still employed. [xxv]

Another survey in that month found that those who lost their jobs were 1.5 times more likely to exhibit clinically significant symptoms of depression than those whose jobs were unaffected, and were 1.3 times as likely (11% in all) to have thoughts of self-harm or being 'better off dead.' [xxvi]

3. Subsequently, a stronger income support safety net and lifting of lockdowns were associated with reduced hardship and psychological distress

By May 2020, people on the lowest incomes were much less likely to report financial stress than at the onset of COVID19 in February**.** The proportion of people in the lowest 10% of household incomes (most of whom rely on social security

payments) finding it 'difficult or very difficult' on their present income declined from 60% in February 2020 to 46% per cent in April. The introduction of the Coronavirus Supplement in that month (which mainly goes to those on the lowest incomes) contributed to this outcome. [xxvii]

The overall population was somewhat less likely to report financial stress**.** The proportion of people saying that they were finding it 'difficult or very difficult' on their present income fell from 27% in February 2020 to 21% in May. The introduction of both the JobKeeper Payment and Coronavirus Supplement in that month contributed to this outcome. [xxviii]

People were less likely to report feeling lonely**.** In May 2020, 36% of people felt lonely at least some of the time, compared with 46% in April at the height of the lockdowns. Loneliness remained high among younger people (59% for those aged 18-24 and 49% for those aged 25-34).[xxix]
Both the easing of lockdowns and improved income support likely contributed to this outcome.

People were less likely to report personal stress**.** The number of people experiencing one or more sources of personal stress due to COVID-19 declined by nearly half from April (43%) to June (24%).[xxx]

'The positive impact of the financial assistance provided to [Aboriginal and Torres Strait Islander people] by government through the pandemic, which has brought many people above the poverty line, is acknowledged. Still, social disparity will exacerbate health disparity making culturally safe solutions imperative.' [xxxi]

'The income support packages implemented to address economic upheaval caused by COVID-19 by multiple levels of government appear to have significantly reduced financial stress for those at the bottom of the distribution.'[xxxii]

"Since getting the extra $550 has help me in a lot of ways. Not worrying about when I'm going to eat the next time or falling behind bills and getting kicked out as after being homeless for over 10 years and getting my own flat I never want to go back there as my depression and anxiety ain't good and my mental health was real bad where I just wanted to end my life."

"I have lost sleep, my mental health has deteriorated dramatically, and I have considered suicide. I don't know if I will be able to survive the lowered rate of Jobseeker. I have been trying to find someone to adopt my cat so that she can be taken care of should I completely lose hope and end my life."

"I'm worried about not being able to afford my medication again. I will miss fresh food, and I am not looking forward to being in debt again. I am not looking forward to being suicidal again."

"SAFE, we are safe. We are safe now. Enough money to live. Please don't ever force us back to Newstart. We won't survive.[xxxiii]

Acknowledgements

This ACOSS Briefing Paper was drafted by Dr. Peter Davidson from www.needtoknowconsulting.org with research support by Penny Dorsch, editing by Jacqueline Phillips and Dr. Cassandra Goldie. ACOSS thanks key ACOSS Members who provided advice.

Sources

Recent Australian surveys

ACOSS (2020), Coronavirus supplement survey, May 2020.
ACOSS (2019), Getting by on income support, November 2019.
ACOSS (2018), Voices of Unemployment, results of an ACOSS survey of jobactive service users.
Anglicare Australia (2020), Rental affordability snapshot.
https://www.anglicare.asn.au/docs/default-source/default-document-library/rental-affordability-snapshot-2020.pdf?sfvrsn=4
Australian Bureau of Statistics (2019), National Health Survey: First Results, 2017-18. Canberra, Australia.
https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.001?2017-18?OpenDocument
ABS RAPID survey (June 2020).
Australian Institute of Health and Welfare (2015), How are people with mental illness faring? Australia's Welfare 2015. Australian Government, Canberra.
https://www.aihw.gov.au/getmedia/466fe218-f07e-43ee-89af-75297c3818e7/AW15-7-2-How-are-people-with-mental-illness-faring.pdf.aspx
Atkinson J et al (2020), Road to recovery – restoring Australia's mental wealth. Brain and Mind Centre, University of Sydney.
https://www.sydney.edu.au/content/dam/corporate/documents/brain-and-mind-centre/road-to-recovery_brain-and-mind-centre.pdf
Butterworth P (2020), How to protect mental health through the COVID-19 crisis. Melbourne Institute Research Insights 6/20.
https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0004/3369973/ri2020n06.pdf
Broadway B et al (2020), Behind closed doors: the surge in mental distress in parents. Melbourne Institute (2020) Research insights 21/20.
https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0004/3369973/ri2020n06.pdf
Biddle N, et al (2020), Tracking outcomes during the COVID-19 pandemic (May 2020) – Job and income losses halted and confidence rising. ANU Centre for Social Research and Methods.
Biddle N et al (2020), Hardship, distress, and resilience: The initial impacts of COVID-19 in Australia, ANU Centre for Social Research and Methods.
Collie A et al (2020), COVID-19 Work and Health Study: A study looking at the health and work of Australians who have lost work during the COVID-19 pandemic. School of Public Health and Preventive Medicine, Monash University. Update 3 August 2020.

https://bdfcdd70-42a4-4a07-9f87-70dde2632e4a.filesusr.com/ugd/144449_9a96b389f3e04989bf483e8bdcccdb2b.pdf
Collie A et al (2019), Reporting on the 2014 NHS The Health of Disability Support Pension and Newstart Allowance Recipients, Analysis of National Health Survey data. School of Public Health and Preventive Medicine, Monash University.
Dudgeon, P et al (2020), A National COVID-19 Pandemic Issues Paper on Mental Health and Wellbeing for Aboriginal and Torres Strait Islander Peoples. University of Western Australia Poche Centre for Indigenous Health.
Fisher L (2020), Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey. The Medical Journal of Australia – Pre-print – 10 June 2020 https://www.mja.com.au/system/files/2020-06/Fisher%20mja20.00841%20-%2010%20June%202020.pdf
550 Reasons to Smile - https://www.550reasonstosmile.com/

Academic articles

Barnes M (2017), Seeking help in times of economic hardship: access, experiences of services and unmet need. BMC Psychiatry Vol 17 No 84.
Bentley R et al (2019), The 'double precarity' of employment insecurity and unaffordable housing and its impact on mental health. Social Science & Medicine Vol 225 pp9-16.
Butterworth P, Olesen SC and Leach LS (2012) The role of hardship in the association between socio-economic position and depression. Australian and New Zealand Journal of Psychiatry Vol 46 pp364–373.
Butterworth P et al (2006), Hopelessness, demoralization and suicidal behaviour: the backdrop to welfare reform in Australia. Australian and New Zealand Journal of Psychiatry 2006 Vol 40 pp 648–656.
Crowe L & Butterworth P (2016), The role of financial hardship, mastery and social support in the association between employment status and depression: results from an Australian longitudinal cohort study. BMJ Open 2016;6:e009834.
Crowe L, Butterworth P, Leach L (2015), Financial hardship, mastery and social support: Explaining poor mental health amongst the inadequately employed using data from the HILDA survey Laura, SSM -Population Health Vol 2, December 2016, p407. https://www.sciencedirect.com/science/article/pii/S2352827316300210
Deady, M et al (2020), Unemployment, suicide and COVID-19: using the evidence to plan for prevention. Medical Journal of Australia, 3 August 2020. https://www.mja.com.au/journal/2020/213/4/unemployment-suicide-and-covid-19-using-evidence-plan-prevention
Flatau, P.,Galea,J.,& Petridis,R.(2000).Mental health and wellbeing and un-employment. Australian Economic Review, Vol 33 pp 161–181.
Haw C et al (2015), Economic recession and suicidal behaviour: Possible mechanisms and ameliorating factors. International Journal of Social Psychiatry 2015 Feb Vol 61 No 1 pp 73-81. https://pubmed.ncbi.nlm.nih.gov/24903684/
Isaacs A (2018), Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and other policy areas, Frontiers in Psychiatry Vol 9 p536.
Kiely, K & Butterworth, P (2013), Social disadvantage and individual vulnerability: A longitudinal investigation of welfare receipt and mental health in Australia. Australian and New Zealand Journal of Psychiatry, Vol 47 No 7 pp 654–666.
Milner A, et al (2013), Long-term unemployment and suicide: a systematic review and meta-analysis. New Zealand Journal of Psychiatry, April 10, 2013. https://journals.sagepub.com/doi/abs/10.1177/0004867413484094

Milner A, et al (2014), Economically inactive, unemployed and employed suicides in Australia by age and sex over a 10 year period: what was the impact of the 2007 economic recession? International Journal Epidemiology, 2014, pp 1-8.
Morris A & Wilson S (2014), Struggling on the Newstart unemployment benefit in Australia. The Economic and Labour Relations Review 2014 25: 202 https://bit.ly/2CR3J0p
Too L et al (2019), The association between mental disorders and suicide: A systematic review and meta-analysis of record linkage studies, Journal of Affective Disorders 259 (2019) 302–313. https://linkinghub.elsevier.com/retrieve/pii/S0165032719306202

Government reports

Australian Government (2020), National Mental Health and Wellbeing Pandemic Response Plan, May 2020.
National Skills Commission (2020), A snapshot in time – the Australian labour market and COVID19.
Productivity Commission (2019), Draft report into mental health. Australian Government, Canberra. https://www.pc.gov.au/inquiries/completed/mental-health/draft
RBA (2020), Statement on Monetary Policy, August 2020.

NGO reports and submissions

ACOSS (2020), Recovering employment.
ACOSS (2020), Information on accessing income support payments. https://www.acoss.org.au/information-on-accessing-income-support-centrelink-payments/
Mental Health Australia (2019), Submission to Senate Inquiry into the Adequacy of Newstart and related payments.
Orygen Centre of Excellence in Youth Mental Health (2019), Submission to Senate Inquiry into the Adequacy of Newstart and related payments.
Royal Australian & New Zealand College of Psychiatrists (2019), Submission to Senate Inquiry into the Adequacy of Newstart and related payments.
Suicide Prevention Australia & Wesley Mission (2020), Reducing distress in the community following the COVID-19 pandemic June 2020 https://www.suicidepreventionaust.org/wp-content/uploads/2020/07/White-Paper_Reducing-distress-following-the-COVID-19-pandemic.pdf

[i] Australian Government (2020), National mental health and wellbeing pandemic response plan.
[ii] This report was drafted by Dr Peter Davidson from www.needtoknowconsulting.org and benefited from input from ACOSS member organisations, staff, and other policy experts.
[iii] Suicidal ideation is not a mental illness but mental health disorders such as depression and anxiety can be precursors to suicide, along with the experience of prolonged psychological stress. Too L et al (2019), The association between mental disorders and suicide: A systematic review and meta-analysis of record linkage studies, Journal of Affective Disorders 259 (2019) 302–313
[iv] Crowe L & Butterworth P (2016), op cit.
[v] Isaacs A (2018), Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and other policy areas, Frontiers in Psychiatry Vol 9 p536.
[vi] Bentley R et al (2019), The 'double precarity' of employment insecurity and unaffordable housing and its impact on mental health. Social Science & Medicine Vol 225 pp9-16.
[vii] ACOSS (2019), Getting by on income support, November 2019.
[viii] ACOSS (2020), Coronavirus supplement survey, May 2020.

[ix] Crowe L & Butterworth P (2016), The role of financial hardship, mastery and social support in the association between employment status and depression: results from an Australian longitudinal cohort study. BMJ Open 2016;6:e009834

[x] Collie A et al (2019), Reporting on the 2014 NHS The Health of Disability Support Pension and Newstart Allowance Recipients, Analysis of National Health Survey data. School of Public Health and Preventive Medicine, Monash University.

[xi] Butterworth P, Olesen SC and Leach LS (2012), The role of hardship in the association between socio-economic position and depression. Australian and New Zealand Journal of Psychiatry 46: 364–373. https://onlinelibrary-wiley-com.wwwproxy1.library.unsw.edu.au/doi/epdf/10.1111/1753-6405.12121

[xii] Milner A, Page A, LaMontagne AD (2013), Long-term unemployment and suicide: a systematic review and meta-analysis. PLoS One 2013; 8.e51333. In one study, the risk of suicide rose by 73% by the time people were unemployed for 5 years.

[xiii] Suicide Prevention Australia & Wesley Mission (2020), Reducing distress in the community following the COVID-19 pandemic June 2020 https://www.suicidepreventionaust.org/wp-content/uploads/2020/07/White-Paper_Reducing-distress-following-the-COVID-19-pandemic.pdf

[xiv] Milner A, Morrell S, LaMontagne A (2014), Economically inactive, unemployed and employed suicides in Australia by age and sex over a 10 year period: what was the impact of the 2007 economic recession? International Journal of Epidemiology, 2014, pp1-8. [Over the period from 2001-2010 there were 6,900 suicides in all among people not in paid employment, comprising 0.06% of males and 0.02% of females who were not employed]

[xv] ACOSS (2018), Voices of Unemployment, results of an ACOSS survey of jobactive service users.

[xvi] Morris A & Wilson S (2014), Struggling on the Newstart unemployment benefit in Australia. The Economic and Labour Relations Review 2014 25: 202.

[xvii] Crowe L, et al (2015), op cit.

[xviii] Morris A & Wilson S (2014), Struggling on the Newstart unemployment benefit in Australia. The Economic and Labour Relations Review 2014 25: 202.

[xix] Crowe L & Butterworth P (2016), op cit.

[xx] ACOSS (2018), Voices of Unemployment, results of an ACOSS survey of jobactive service users.

[xxi] Getting by on income support, November 2019, ACOSS

[xxii] Morris A & Wilson S (2014), op cit.

[xxiii] Butterworth P (2020), op cit.

[xxiv] Fisher J et al (2020), Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey. The Medical Journal of Australia Pre-print 10 June 2020. [While surveys show increases in known risk factors, fortunately as of July 2020 suicide deaths have not increased compared with comparable time periods]

[xxv] Collie A et al (2020), COVID-19 Work and Health Study: A study looking at the health and work of Australians who have lost work during the COVID-19 pandemic. School of Public Health and Preventive Medicine, Monash University.

[xxvi] Fisher J et al (2020), op cit.

[xxvii] Biddle N, et al (2020), Tracking outcomes during the COVID-19 pandemic (May 2020) – Job and income losses halted and confidence rising. ANU Centre for Social Research and Methods.

[xxviii] Biddle N, et al (2020), ibid.

[xxix] Biddle N, et al (2020), Tracking outcomes during the COVID-19 pandemic (May 2020) – Job and income losses halted and confidence rising. ANU Centre for Social Research and Methods.

[xxx] ABS RAPID survey (June 2020).

[xxxi] Dudgeon, P. et al (2020), op cit.

[xxxii] Biddle N, et al (2020), op cit, p7.

[xxxiii] 550 Reasons to Smile - https://www.550reasonstosmile.com/

MEDIA MESSAGES for use in responding to Brain and Mind Institute – Road to Recovery: Restoring Australia's Mental Wealth

TOP LEVEL MESSAGES

- We [Commission] welcome the Brain and Mind Institute modelling of the social and economic realities of the pandemic. It is always helpful to have these reference points to affirm the response to the mental health impacts the government has delivered to date, and to be able to consider what may need to be done into the future.
- Modelling has been a vital part of National Cabinet's decision making and the Government's response to the COVID-19 pandemic, and is central to the National Mental Health and Wellbeing Pandemic Plan agreed to by National Cabinet.
- The numbers that the Brain and Mind Institute model provides today are not a forgone conclusion, our responses to date, and into the future can significantly impact and intervene to ensure that our mental health and wellbeing is supported and appropriate treatment and care is available.
- We agree with the model's recognition that key policies around employment, education, housing and other ~~stressors~~ social programs are central to our mental health and wellbeing. We are pleased that the government recognises the significance of these and has responded over the past five months in such a comprehensive way to support the mental health and wellbeing needs of all Australians by putting in place a range of social protection measures like job keeper and the coronavirus supplement to income support, as well as the direct and comprehensive mental health investments.
- Comprehensive weekly monitoring and fast turnaround research of how Australians have been impacted by the pandemic has underpinned the decision making on where and how to respond to the mental health and wellbeing need of Australians since early March. We recognise that this kind of information needs ~~further~~ continuing investment as it is critical to decision making.
- The Brain and Mind Institute's new modelling is a timely summary of the factors that effect the mental health and wellbeing of Australians and provides us with another perspective to consider as we continue to monitor and respond to Australia's mental health and wellbeing requirements during the pandemic.
- Given that we are undertaking a period of unprecedented reform in mental health, suicide prevention and wellbeing across government and across our health and wellbeing systems, we continue to look to our experts to inform this work.
- ~~If you accept that this model reflects the current scenario for Australia's mental health, suicide prevention and wellbeing, the~~ The billions of dollars the government has spent on economic measures ~~that have been put in~~ during this pandemic have helped to keep~~place~~ people in jobs and to keep businesses going. In addition the coronavirus supplement for people on jobseeker and other payments has financially assisted those who have lost jobs during the pandemic. These ~~have~~supports have wide ranging social protection benefits that underpin our mental health and wellbeing.
- We know that poverty can impact negatively on mental health and wellbeing and we know that having a job not only increases your income, it increases your social connections and networks - workplaces can be places of community support. Likewise, post secondary education is important - not only because it increases your chances in the labour market, but because it keeps you socially connected and can give you networks and a community.

Formatted: Font: (Default) +Headings (Calibri Light)
Formatted: Indent: Left: 0.63 cm, Hanging: 0.63 cm
Formatted: Font: (Default) +Headings (Calibri Light)

- ~~We are very conscious of the significance of unemployment and reduced access to education has on a person and a whole of community's mental health and wellbeing.~~ Preventing a society wide shock by addressing sudden rises in unemployment is a protective factor to our overall wellbeing. We do acknowledge that there are some vulnerable groups in some industries and that ~~for~~ far too many young people and women in our community ~~that~~ have been~~were~~ directly impacted by ~~sudden unemployment~~sudden job loss ~~and we have~~. We have tried to respond quickly to their mental health and wellbeing needs.

- As we expected, there is an increase in the number of the Australian population experiencing psychological distress and mental health symptoms during the pandemic, and there has been an increase in calls to crisis and support lines during the pandemic. However, there is no current evidence suggesting there has been an increase in the national prevalence of clinically diagnosable mental illness, or suicide deaths.

USE TOP LINE MESSAGEs ABOVE AND ADD, IF NEEDED, FROM THE DETAIL MESSAGES BELOW.

Modelling

- Modelling provides valuable insights into how the pandemic may affect outcomes for the population in different scenarios. It also allows us to test different policy options for mitigating the impacts of COVID-19. ~~Models need to be continually~~One of the advantage of this sort of modelling is that it can be updated with new and up to date data to take account of emerging trends and outcomes.
- The Government provided $2.6 million in its $48.1 million mental health package (announced on 15 May 2020) to improve data collection about mental health service use, and will fund an organisation to undertake modelling of the mental health and suicide risks during the pandemic.
- This initiative will ~~build on~~sit alongside the Government's ~~the~~ $15 million investment for the Australian Institute of Health and Welfare (AIHW) to establish a National Suicide and Self-Harm Monitoring Project. The AIHW is working with states and territories to provide information as up to date as possible about mental health and suicide risk.
- To date, available evidence internationally has not indicated any increase in suicide rates associated with COVID-19 or the measures taken to reduce its spread.
    - Given the status of the research evidence, and the current situation facing Australians, it is problematic and unhelpful to talk publicly about an 'expected rise' or an 'inevitable rise' in suicides or speculate based on unconfirmed cases or modelling given that this may increase community fears generally and place those vulnerable to suicide at greater risk.

Economic and social determinants on mental health

- On 21 July 2020, the Prime Minister, Treasurer and Minister for Families and Social Services announced:
    - The JobKeeper Payment will be extended by six months to 28 March 2021 to support job retention, maintaining employment links and business cash flow, as well as providing income support to eligible employees. (JobKeeper is $1,500 per fortnight until end of September, then for full time workers it is $1,200 until the end of the year, then $1,000 until the end of March 2021. The amounts from end of September are lower for part time workers. Total cost: $86 billion)
    - The temporary Coronavirus Supplement for those on JobSeeker and some other income support payments will be extended until 31 December 2020. This will support many Australians ~~who have lost jobs during the pandemic and gives extra income to those who were already on income support prior to the pandemic and are still on income support. who may have found themselves out of work, through no fault of their own~~. (JobSeeker supplement is $550 per fortnight until end of September, then drops to $250 per fortnight with the amount you are allowed to earn before your income support is reduced rising to $300 per fortnight. At the moment, this is the situation up until end of this year, when it will be reviewed).

Government's record investment in mental health.

- The Australian Government has made mental health and suicide prevention a national priority, with record investments in mental health, boosted with additional measures to respond to COVID-19 and natural disasters, with expenditure for mental health services estimated to be in excess of $5.2 billion in 2019-20 alone. (States and territories spend about another $5 billion in total on mental health, so a total of around $10 billion per year is spent by all governments on mental health services).
- The Government is working towards zero suicides and appointed Ms Christine Morgan as the first National Suicide Prevention Adviser reporting directly to the Prime Minister. Towards zero means the Government has a total commitment to respecting the life of every Australian. For that reason, the Adviser is working with relevant Ministers to drive a whole-of-government approach to suicide prevention activities.

Formatted: Font: (Default) +Headings (Calibri Light)

Formatted: Normal, Indent: Left: 0 cm

Government mental health investment in response to the pandemic

- We do not accept that Australia has taken a wait and see approach to recognising and responding to the mental health and wellbeing needs of Australians during the pandemic. In fact, Australia was the first country to take a proactive and significant response to the mental health and wellbeing impacts of COVID19, and was one of the first to develop and implement a National Mental Health and Wellbeing Pandemic Plan.
- Since March 2020, the Government has announced a number of emergency response measures to boost the mental health supports available to Australians during the unprecedented COVID-19 pandemic. This includes:
  - $74 million to support the mental health and wellbeing of all Australians during the COVID-19 pandemic. This package provides targeted and practical measures to support mental health and wellbeing for Australians during this crisis, giving people direct access to online support and counselling services when and where they need it most; and
  - an additional $48.1 million investment to support the three immediate priorities in the National Mental Health and Wellbeing Pandemic Response Plan; Data and Modelling, Outreach and Connectivity.
  - In addition, telehealth was expanded so that mental health services could be provided over the phone and by video conference.
- The Government is working with providers funded through these packages to monitor service usage closely. While services continue to experience strong demand, thanks to this Government investment, services are able to meet the surge in demand for their services.
- The investments in response to the COVID-19 pandemic are in addition to existing funding of other initiatives to provide more permanent mechanisms to deliver the right services, at the right time to those Australians in most need, such as:
  - $64 million investment in mental health and suicide prevention activities, in response to initial advice from the National Suicide Prevention Adviser. The funding supports services that are working to build resilience in youth; ensure that crisis line services are available for those in need; expand the reach of

aftercare services; and ensure that supports are available for those who may have lost someone to suicide; and

- expansion of the Beyond Blue Way Back Support Service which provides non-clinical, assertive outreach, follow up care and practical support to individuals after a suicide attempt or suicidal crisis. The Brain and Mind Centre report notes the importance of attempted suicide aftercare. The Government has reached agreement with the majority of jurisdictions to provide this vital service in partnership with states and territories.

Young Australians

- It has been a tough time for young Australians as they have faced the challenges of learning from home, social isolation and worry about the impacts of COVID-19 on their future. In a normal scenario growing up and dealing with life's challenges is hard enough and their mental health and wellbeing is vulnerable. We are very focussed on ensuring that a range of support and mental health treatments are available in community, via phone and online, via their GP of if they needed urgent and significant levels of care, hospital.

  Government announcements

  - $24.7 million to reduce wait times for young people aged 12 to 25 years and make capital improvements at selected headspace services to ensure young Australians can get information, advice, understanding, counselling and treatment, when and where they need it.
    - This is part of an investment of $152 million over seven years to reduce waiting times and improve the quality of services at existing headspace services;
  - $6.8 million to boost headspace's digital work and study service to provide a comprehensive digital support service for young Australians during and following the COVID-19 pandemic; and
  - $0.6 million committed to Emerging Minds, in partnership with the Satellite Foundation to support children and young people who have a parent or guardian with a mental illness who may have faced greater caring responsibilities and fewer opportunities to maintain their own mental health and wellbeing during the COVID-19 pandemic.

Mental health system reform

- In October 2018, the Government announced a Productivity Commission inquiry into the role of mental health in supporting economic participation and enhancing the nation's productivity. The inquiry considered how mental illness can affect all aspects of a person's quality of life including physical health, social participation, education, employment and financial status.
- The Productivity Commission's final report into mental health was provided to the Treasurer at the end of June 2020. It will inform a new blueprint for a mentally healthier Australia. This is more important than ever given the recent challenges to the mental health and wellbeing of Australians. The report will be tabled in Parliament in the coming months.
- The work of the Productivity Commission is an important component of the Government's work to build a stronger mental health system, along with the National Mental Health Commission's development of Vision 2030 for Mental Health, the recommendations of the Prime Minister's Suicide Prevention Adviser and the report of the MBS review.

Awareness Raising

- The Brain and Mind Institute concluded, based on their modelling, that awareness raising initiatives have a detrimental impact on mental health outcomes in the population. They concluded this because awareness

raising initiatives can be successful in encouraging people to seek help and the Brain and Mind Institute thought that the right help might not be forthcoming for people so perhaps we shouldn't encourage people to seek help.

- Awareness raising initiatives play an important role in influencing social attitudes, and promoting the importance of self-care, and community connectedness through a sense of belonging and social connectedness.
- The national mental health communications campaign aims to provide Australians with the confidence to reach out for help and information they need to better support their mental health.
- The Government acknowledges the tension between a need to get the balance right in allocating resources to upstream population health approaches like awareness raising and more targeted efforts to provide services and support to individuals most at risk, which is why it is critical that the awareness raising projects form part of, but not the entirety of much larger mental health support packages.

Women's Mental Health Alliance

Impacts of COVID 19 on women's mental health and recommendations for action - UPDATE October 2020

Executive summary

This report from the Women's Mental Health Alliance provides an update on the impacts of COVID-19 on women's mental health, incorporating data gathered since the publication of our first policy brief in June 2020.

There is now substantial data to show that the first and second waves of COVID-19 restrictions have had significant impacts on women's mental health. Population survey data shows women are significantly more likely than men to have experienced negative mental health impacts, leading to a substantial increase in demand for mental health support among women in the general community. Mental health services in Victoria have reported a significant increase in women presenting with serious mental health issues during COVID-19, including severe anxiety and depression.

The escalation in mental health issues among women is due, at least in part, to intensification of pre-existing gendered social and economic inequalities including the overrepresentation of women in insecure work and unequal responsibility for unpaid care. The frequency and severity of intimate partner violence has also increased during the pandemic with confinement to the home creating additional risks. Other forms of inequality and discrimination – in particular, racism, ageism and economic inequality – are compounding mental health impacts for women.

COVID-19 has impacted the mental health and wellbeing of Victorian and Australian women and girls in different ways, depending on their social, economic and cultural locations:

- Significant numbers of **women without a pre-existing mental health condition** are presenting to mental health services with heightened anxiety, new depression and new Obsessive-Compulsive Disorder
- Victorian **women with existing mental health conditions** have reported more severe psychological symptoms than men, including suicidal thoughts, suicide attempts or self-harm
- One in ten women in a relationship report experiencing **intimate partner violence** during the pandemic, with half reporting an increase in severity
- Women have been disproportionately on the **COVID frontline**, exposing them to the dual stressors of high-pressure work environments and potential infection
- **Young women** have reported higher levels of mental distress than young men, and are more likely to report strained relationships at home
- COVID-19 has created an additional mental health burden for **pregnant women and new mothers**, with services noting heightened anxiety, depression and OCD presentations in pregnant women

- On top of fear and anxiety about contracting the virus, **older women** are more likely than older men to be isolated due to social distancing measures, and more likely to feel depressed or anxious
- **Migrant women and refugee women** face an increased risk of COVID-19 transmission, job loss and major financial stress, social isolation, exposure to racist abuse and discrimination, and increased risk of family violence
- Isolation has been amplified for **women with disabilities** who may have lost critical disability supports for daily living, formal peer support groups or informal supports, as well as potentially facing additional barriers to accessing health information and facilities
- **Aboriginal and Torres Strait Islander people** report high levels of psychological distress, and there has been an increase in suicides in the Aboriginal and Torres Strait Islander community
- By disrupting vital connections to community and peer support, COVID-19 restrictions are likely to reinforce existing mental health inequalities for **LGBTIQ Victorians** who generally experience substantially higher levels of psychological distress, depression or anxiety
- **Mental health carers** (who are predominantly women) report financial, emotional and relational challenges arising from the withdrawal of many in-person supports and prolonged confinement to the home
- The Coronavirus JobSeeker supplement has made a tangible difference for **single mothers**, who face high rates of financial hardship, but compliance obligations and the prospect of returning to the low rate is creating undue stress.

It is evident that COVID-19 has amplified the structural inequalities that drive poor mental health outcomes for women, underlining the importance of using gender impact analysis to inform policy-making and budgeting as we emerge from the pandemic.

At the same time, the pandemic has highlighted and intensified existing inequalities and gaps in Australia's social support and mental health systems. It has drawn attention to the need for fundamental reform of these systems to ensure they effectively meet the needs of women and girls, and are resilient to respond to future emergencies, which – like COVID-19 – are likely to disproportionately impact women's mental health.

Immediate action is needed to prepare for and respond to the anticipated further increase in demand for mental health and family violence support services as we emerge from the pandemic.

Governments must also seize the opportunity presented by the COVID-19 recovery, together with the Productivity Commission Inquiry into Mental Health and the Royal Commission into Victoria's Mental Health System, to address systemic inequalities that detrimentally impact women's mental health.

This report makes a series of recommendations for a gender transformative recovery to support women's mental health across four themes:

1. Creating the infrastructure needed to support planning and decision-making for a gender equal recovery
2. Applying an intersectional gender lens to policy-making and budgeting to address the underlying gendered social and economic inequalities that drive poor mental health outcomes for women and girls
3. Ensuring equitable access to appropriate mental health support for all women and girls
4. Providing other needed supports for women's mental health and safety

1. The gendered impacts of the pandemic on mental health

There is now substantial data to show that that COVID-19 is having significant impacts on women's mental health, and that this is compounding existing mental health inequalities between women and men. This is because mental health and wellbeing are shaped by the social, economic and physical environments in which women live and work. As these environments vary among different groups of women, so too do the mental health impacts of the pandemic.

Women are more likely to have experienced negative mental health impacts

The ABS Household Impacts of COVID-19 Survey indicates that women are significantly more likely than men to have experienced negative mental health impacts.[1] Australian women were more likely than men to feel: restless or fidgety (44% of women compared with 38% of men); nervous (50% compared with 41%); that everything was an effort (45% compared with 36%). From May to August, the increase in women feeling so depressed that nothing could cheer them up increased from 10% to 16%.[2] 28% of women have experienced loneliness, compared with 16% of men.[3]

This has led to a significant increase in demand for mental health support among women without a pre-existing mental health condition. For example, Australia's only dual specialist clinic in women's mental health at the Alfred Hospital has reported a major spike in demand. The service recorded 110 new referrals in one week in late July 2020, compared with an average of 4-5 new referrals per week in 2019, representing a 2100% increase in demand. Clinic Director, Prof Jayashri Kulkarni, reported that these referrals are of women from the general community (rather than women with pre-existing mental health conditions) who are presenting with heightened anxiety, new depression and new Obsessive-Compulsive Disorder.[4]

The escalation in mental health issues among women is due, at least in part,[5] to intensification of pre-existing gendered social and economic inequalities.

Women are overrepresented in insecure work and job loss

For the first time in Australia, women have suffered greater loss of work than men during a recession, with the top three industries to lose jobs being large employers of women (namely, accommodation and food services, retail, and arts and recreation).[6]

Overall, women accounted for 61% of job losses in Victoria between February and July this year.[7] It has been reported that, in July, the rate of female job loss was almost five times the rate for men in Victoria. The Stage 4 lockdown may also have accelerated this trend.[8]

Job losses have been particularly pronounced for young women; 26% of women aged 18-24 in Victoria reported losing their job compared to 11% of young men.[9] Migrant and refugee women and Aboriginal and Torres Strait Islander women are also over-represented in the industries most affected by COVID-19.[10]

Women perform a disproportionate share of unpaid care and household labour

Women already make up the majority of unpaid carers, and have taken on a greater share of additional care responsibilities for children, other family members and at-risk community members during self-isolation.[11]

The ABS Household Impacts of COVID-19 July survey shows that women were twice as likely as men to report performing most of the unpaid domestic work (80% compared to 39%) and more than three times as likely to report performing most of the unpaid caring responsibilities (38% compared to 11%)

in their household.[12] Data from Victoria presents an even starker picture: 76% of Victorian mothers surveyed by VicHealth were primarily responsible for looking after their pre-school aged kids, compared with only 8% of fathers, while 3 in 4 (72%) Victorian mothers spent the most time helping their kids with remote learning, compared with just 1 in 4 fathers (26%).[13]

In a survey of 1500 Victorians conducted on behalf of the Victorian Equal Opportunity and Human Rights Commission (VEOHRC), female participants with caring responsibilities were more likely than male participants to report experiencing stress (52% to 40%), feeling overwhelmed (51% compared to 25%) and exhausted (47% to 26%) as a result of balancing these competing demands.[14] 29% of participants in the VEOHRC survey had felt disadvantaged, treated unfairly or discriminated against due to their parenting or caring responsibilities during COVID-19.[15]

ABS data shows men have also taken on more caring responsibilities during COVID-19: The average amount of unpaid work in May-June 2020 increased by over 3.5 hours each day for women and by over 2.5 hours each day for men. Since men spent less time on caring responsibilities before lockdown, the relative increase in care work was greater for men. This reduced the gender gap in childcare, but the gender gap in responsibility for housework generally stayed the same.[16]

Women are on the frontline

Women have also been disproportionately on the COVID frontline: the majority of health and aged care workers, social assistance workers, teachers and retail workers are women – exposing them to the dual stressors of high-pressure work environments and potential infection. In the second wave, we have seen high numbers of infections among health workers. It is difficult to obtain sex-disaggregated data on infection rates among Australian health workers, but international data suggests that women account for 70% of infections among healthcare workers.[17] Given women make up 75% of all health professionals and 88% of nurses and midwives in Australia,[18] and that Personal Protective Equipment is reported to be ill-fitting for women,[19] we can surmise that they are also disproportionately represented in the infections data. The Women's Mental Health Clinic at the Alfred reports that it is seeing more nurses with anxiety than ever before.[20]

As Professor Lyn Craig observes,

> 'it is striking how many of the jobs that are now seen as essential involve care, and how many of them are female-dominated. Not coincidentally, they also pay well below the level the skills and qualifications would require if they were predominantly done by men.'[21]

Other forms of inequality compound mental health impacts for women

Data from a national survey of nearly 14,000 Australians during the first month of COVID-19 restrictions showed that those most likely to have experienced poor mental health outcomes are those who have lost jobs, lived alone or in poorly-resourced areas, were providing care to dependent family members, were members of marginalised minorities, women or young.[22] This is consistent with data from the UK, which suggests that being young, a woman and living with children, particularly preschool age children, has had a particularly strong influence on the extent to which mental distress has increased under the conditions of the pandemic.[23]

Other forms of inequality and discrimination – in particular, racism, ageism and economic inequality – are compounding these mental health impacts for women. The frequency and severity of intimate partner violence also increases during and after emergencies,[24] with confinement to the home creating additional risks. Recent research undertaken by the Australian Institute of Criminology has

found that the pandemic has coincided with the onset or escalation of violence and abuse and that many women are experiencing multiple and complex forms of family violence.[25] The risk factors compounding poor mental health outcomes for women are explored in more detail below.

Women bear a triple load with inadequate support

It has been observed that women are carrying a 'triple load' during the crisis, which includes paid work, care work, and the mental labour of worrying.[26] All these factors lead to emotional, social and financial stress and anxiety, and can exacerbate existing mental health conditions, trigger new or recurring conditions, and impede recovery.

At the same time, limited availability of gender-specific or gender-responsive services means women may not be able to access the support they need.

2. Mental health impacts vary among women

Women with existing mental health conditions

Those with current mental health concerns are especially at risk during emergencies and can experience barriers to accessing the appropriate medical and mental health care they need during the pandemic,[27] resulting in decline, relapse or other adverse mental health outcomes.

Data from a survey conducted by Monash Alfred Psychiatry research centre during the first lockdown indicated that women in Australia were reporting more severe psychological symptoms than males:[28]

- 35% of females have moderate to severe levels of depression, compared to 19% of males
- 27% of females have moderate to severe levels of stress, compared to 10% of males
- 21% of females have moderate to severe levels of anxiety, compared to 9% of males
- 17% of females reported suicidal thoughts, compared to 14% of males. The highest rates of suicidal thoughts were among young women aged 18-24, with 37% of women in this age group reporting suicidal thoughts, compared to 17% of men.

In a survey of mental health consumers run by the Victorian Mental Illness Awareness Council (VMIAC) during the second lockdown in August 2020 (following a previous survey in April 2020), 73% of female respondents reported that their mental health was worse during the second wave.[29] Though this was lower than the percentage of male respondents who identified that their mental health was worse during the second wave, VMIAC points out this does not necessarily mean men's mental health was worse than women's during the second wave, because women experienced greater deterioration in their mental health during the first wave, when 79% of female respondents reported that their mental health was worse than before COVID-19, compared to 52% of male respondents.[30] Women also reported higher levels of depression and hopelessness during the second wave than men, and the survey found very concerning rates of suicidal ideation during the second wave, with 42% of women respondents and 75% of transgender, gender diverse and non-binary respondents reporting suicidal ideation, compared to 31% of male respondents.

These serious mental health impacts have been reflected in presentations to mental health services and emergency departments, with services in Victoria reporting a significant increase in women presenting with serious mental health issues throughout COVID-19, including severe anxiety, depression and – increasingly – self-harm. [31]

Support and advocacy services are reporting that women who had previously been able to manage their mental health issues with medication and psychiatric support are no longer coping. For example, with the second round of stage 3/4 restrictions, the Women's Mental Health Clinic at the Alfred, the Royal Women's Hospital and VMIAC have all reported an increase in anger, compared with the first round of Stage 3 restrictions.[32] Anger expressed as self-harm is a common presentation among Victorian women.[33]

While additional funding has been provided to frontline information services, such as Beyond Blue and Lifeline, a major service gap remains for those with pre-existing mental health conditions.

Women experiencing family and sexual violence

Recent national research by the Australian Institute of Criminology (AIC) found one in ten women in a relationship said they had experienced intimate partner violence during the pandemic. Half of those women said the abuse had increased in severity since the outbreak of the pandemic in Australia. Of those women experiencing physical or sexual violence, two-thirds reported experiencing violence for the first time or an escalation in violence. Of those women experiencing coercive control, over half reported that the behaviours started or escalated during the pandemic.[34]

The AIC findings are reflected in views of specialist family violence practitioners who have reported that the 'pandemic has led to an increase in the frequency and severity of violence against women alongside an increase in the complexity of women's needs'.[35] This is consistent with existing evidence that suggests that the frequency and severity of family violence – including sexual violence – increases during emergencies.[36] It is also now being reflected in crime statistics: the latest crime data shows there were significantly higher than expected volumes of family violence incidents recorded by Victoria Police in May and June 2020.[37]

Family violence appears to have increased particularly in places with stricter lockdowns; strict lockdowns both place women at greater risk of violence and make it more difficult to access support services.[38] COVID-19 stay-at-home restrictions can also mean that LGBTIQ people may be forced to choose between hiding their identity or risk rejection and abuse from families.

Family and sexual violence can have significant negative impacts on women's mental health, including anxiety and depression, panic attacks, fears and phobias, and hyper vigilance.[39] It has been suggested that one reason for the increased volume of calls to support services late at night is because callers are 'seeking help to deal with trauma, including nightmares, flashbacks and/or sleep disturbances. It is believed the COVID-19 restrictions are exacerbating experiences of trauma as being confined to their homes triggers victim/survivors' memories of being or feeling trapped.'[40]

During COVID-19, the Women's Mental Health Clinic at the Alfred has reported an increase in women presenting to mental health services who are at risk of or experiencing family violence, including a notable increase in women experiencing more extreme forms of violence and abuse.[41] There have also been reports in the community of women facing increased pressure regarding dowry payments which may put them at risk of violence.[42]

Despite welcome funding injections for family violence response services, there is still a lack of affordable, long-term affordable housing options available for victim-survivors. Government support for women and children leaving a perpetrator is also limited to a one-off crisis payment, which can only be accessed within a limited time frame. While the Coronavirus supplement has made a huge

difference to women's safety at this time, there are concerns that, as it is rolled back, many women will be placed at greater risk.[43]

Young women

Survey data shows young women are reporting higher levels of mental distress than young men (24% compared to 21%).[44] Concerningly, there was a 33% increase in presentations at hospital for self-harm among children and young people in Victoria in the six weeks to August, compared to the previous year.[45] Though sex-disaggregated data is not publicly available, we know that women are over-represented in hospital presentations for self-harm overall.[46]

Young women were also more likely than young men to report that relationships were strained at home (30% compared to 19%) and were significantly more likely to report difficulties staying in contact with friends and family during the first lockdown (41% compared to a state average of 30%).[47]

In Victoria, a survey of 2000 people found women aged 18-24 were 2.5 times more likely to have lost their job during the first lockdown, compared to their male counterparts (26% compared to 11%).[48] A national survey showed that the employment rate of young women had dropped 7% below that of young men and had not caught up by September.[49] These larger effects are attributed to young women's greater representation in the industries directly affected by COVID-19, and increased caring responsibilities during the pandemic.[50]

Pregnant women and new mothers

It is becoming evident that COVID-19 has created an additional mental health burden for pregnant women and new mothers. The perinatal period is a time when social support and connectedness is pivotal for maternal and infant emotional wellbeing. Yet the very means of managing COVID-19 in the community (i.e. with social isolation and physical distancing) is disrupting the normal maternal experience. If unaddressed, this could have longer term psychosocial repercussions for the woman, her children and family.

The Royal Women's Hospital's (the Women's) perinatal outpatient clinics have seen pregnant women with noticeably heightened anxiety and depression. The distress experienced by pregnant women during the first lockdown is now becoming more chronic, manifesting as anger, grief and heightened uncertainty, leading to exhaustion, helplessness and despair as the rates of COVID-19 infections and mortality climbed during the second lockdown. There has also been a worsening in pre-existing OCD, or new-onset OCD, in pregnant women.

Reasons for increased stress in pregnant women and new mothers include: less contact with their extended family and friends; fear they or their partner will lose their job and what this could mean for them financially with a new baby; not having assistance with childcare; repeatedly seeing worrying information on the news and in social media; concern that they or their children could become unwell, or even die; and having to spend more time with a partner who may be abusive.

Many pregnant women and new mothers are isolated and lack support, both at home and in hospital, due to social distancing measures. Mothers whose babies are born either prematurely or are sick and require care in hospital are finding this experience even more isolating because of restrictions on visitors. The inability to draw on both formal supports (e.g. maternal and child health services) and informal support (e.g. mothers' groups and family and friends) is leading to an increase in stress and anxiety, which may have profound short- and long-term mental health implications for women.[51] Migrant women and those whose families live overseas have experienced a considerable increase in

anxiety because the support they would normally receive from relatives visiting from overseas in the postnatal period is not currently possible.

Older women

On top of fear and anxiety about contracting the virus, older women are more likely than older men to live alone or in residential care[52] meaning they are more likely to be isolated due to social distancing measures. Some family violence response services have reported an increase in calls from older people experiencing violence, including from adult children who have returned to their parents' home due to job loss. A national survey found that older women were more likely than older men to reported feeling depressed or anxious at least some of the time (26% compared to 19%).[53]

At the same time, we have seen a resurgence of deep-seated ageist attitudes.[54] In July, the World Health Organisation highlighted that government responses to COVID-19 must respect the 'rights and the dignity of older people' and that older people are not expendable.[55] The intersection of ageism and gender inequality is likely to put older women at increased risk of negative mental health outcomes during COVID-19.

International students and migrant and refugee women

Migrant and refugee women,[56] including international students, who are often already disadvantaged, are among those most severely impacted by the COVID-19 crisis. In addition to having an increased risk of COVID-19 transmission, many of these women are facing job loss and major financial stress, social isolation, and increased risk of family violence. They also have a lower likelihood of being digitally connected due to the 'digital divide' and may not have access to timely and accurate multilingual information about COVID-19. All these factors increase the likelihood of poor mental health among migrant and refugee women.

Migrant communities have been disproportionately impacted by COVID-19 due to their concentration in low paid, insecure but essential jobs such as food manufacturing, food service and cleaning, as well as on the front lines of the pandemic (e.g. in aged care). They also often have limited capacity to practise social distancing due to high density housing, inability to work from home and avoid public transport, limited autonomy at work and lack of access to sick leave. Migrant women in particular bear the caring and mental health burden in their communities.

COVID-19 has exacerbated pre-existing mental health inequalities for international students,[57] who are among some of the hardest hit by the COVID-19 crisis in Australia. Many international students who were employed in the retail and hospitality sector have been unemployed since the beginning of the pandemic and are unable to return home. While some international students may have been eligible to access the one-off payment announced by the Victorian Government, they are not entitled to federal government COVID-19 income support payments and are not eligible for Medicare. Migrant and refugee women also have limited access to healthcare and income support.

A recent study found that 85% of young people from multicultural backgrounds in Victoria had directly experienced racism during the COVID-19 pandemic.[58] Research suggests Asian women in Australia are bearing the brunt of heightened racial abuse during COVID-19 pandemic, having experienced an increase in racial slurs, name calling and physical intimidation. People who frequently experience racism are almost five times more likely than those who do not experience racism to have poorer mental health.[59] As frontline workers, particularly in health and retail, migrant and refugee women are particularly exposed to racist abuse and discrimination.

Women with disabilities

During the first few months of the pandemic, women with disabilities reported stress in accessing food, Personal Protective Equipment (PPE) and supports for essential daily living. While barriers to these essentials are improving, the increased isolation of Victorians during COVID-19 has been amplified for women with disabilities who may have lost critical disability supports for daily living, formal peer support groups or informal supports. They may also face additional barriers to accessing health information and facilities.

Not all women have safe access to the internet; for example, some women with disabilities may have never been taught how to use technology or may not be able to use it independently. Women with disabilities may also experience additional types of trauma, including those arising from additional forms of violence and family violence. These compounding issues have a significant impact on housing and other referral options.

Within residential disability services, as within Mental Health inpatient services, COVID-19 outbreaks have been reported. The stress of managing the pandemic within high density institutions was the focus of a week of hearings at the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disabilities in August 2020.

Further, women with psychosocial disabilities who are in contact with VMIAC have disclosed increased harassment and bullying from the National Disability Insurance Agency (NDIA) as they seek assistance with their plans.

Aboriginal and Torres Strait Islander women

There is limited data on the mental health and wellbeing of Aboriginal women in Victoria during COVID-19. However, VACCHO reports that their member organisations have responded to a disproportionately high number of Aboriginal suicides in Victoria, as well as family violence issues.[60]. 30% of suicides in Aboriginal communities involved women and they were more likely to occur in regional areas.

A VicHealth survey found that 28% of Aboriginal and Torres Strait Islander people reported high levels of psychological distress during the first lockdown, compared to 16% of the general population, while 70% of Aboriginal and Torres Strait Islander people in Victoria reported low levels of life satisfaction (increased from 47% during February 2020).[61]

LGBTIQ+ people

COVID has the potential to reinforce existing mental health inequalities for LGBTIQ Victorians. Recently released findings from the Victorian Population Health Survey on the health and wellbeing of LGBTIQ Victorians showed substantially higher levels of psychological distress and diagnosis with depression or anxiety in comparison with the general population. LGBTIQ Victorians were also significantly more likely to be diagnosed with two or more chronic diseases, to experience unemployment, housing and economic instability, and to be isolated from family, friends and community.[62]

Connection to community and peer-support have a protective effect on the mental health of LGBTIQ people, who experience higher rates of anxiety and depression than their heterosexual and cis-gender peers.[63] However, with COVID-19 restrictions, these connections have been disrupted with the closure of community venues and limited face-to-face interaction.

Experiences of rejection are linked to significant negative mental health impacts for LGBTIQ people, while family acceptance has a positive impact of health and wellbeing. During COVID-19 restrictions in Victoria, LGBTIQ people may be separated from friends and 'families of choice', which can negatively impact mental health and wellbeing.

Mental health carers

Mental health carers, two thirds of whom are women,[64] continue to be under enormous pressure during the 'second wave' of the COVID pandemic. Many consumer supports continue to be provided over the phone or online, in place of in-person supports, which is having ongoing financial, emotional and relational impacts on families and carers.

From August to mid-September, 92% of total calls to the Tandem carer support line were from women, with 55% of calls coming from first time callers reaching out for support. Issues that continue to be reported include: challenges with consumer distress in the context of increased isolation and mental ill-health; lack of hospital beds leading to consumer hospital discharge in spite of significant self-harm and suicide risk, without adequate communication and safety planning with carers and families; challenges accessing essential mental health treatment when the person they support is fearful of doing so; and ageing carers under increased strain and risk, due to personal safety and health concerns. Understanding the rapidly changing restrictions is also causing confusion and anxiety for carers, as well as creating compliance challenges for the people they care for.

Increased and prolonged confinement to the home has impacted carers' mental health and wellbeing, and there has been an increase in carers reporting family and relationship conflict and instances of violence, where the person is becoming increasingly unwell. Carers fear the potential consequences of police involvement for the person they are caring for.

The financial impact on mental health carers remains significant. They remain ineligible for any Federal Government COVID-related income support supplements. While the Victorian Government has provided a supplement to the Mental Health Carer Support Fund, this has been modest and only available to those carers of people connected to an Area Mental Health Service.

Women facing other social and economic challenges

COVID-19 has had a disproportionate impact on single mothers, who make up around 80% of single parent households. Employment of single mothers with dependent children is down 8% (compared with 5% for single fathers).[65] As of August 2020, 15% of women reported receiving the Coronavirus Supplement, compared to 11% of men.[66] Single mothers already face high rates of poverty, and financial hardship is a determinant of mental ill-health.

The temporary Coronavirus Supplement has provided tangible improvements in health and wellbeing for single mothers and their children.[67] However, the plans to reduce it are creating undue stress for single mother households.[68]

Further distress is often caused by the eligibility requirements and compliance obligations for income support, such as mutual obligations.[69] For example, the Parents Next program primarily targets Indigenous and single mothers with pre-school aged children. Despite the pandemic, there has been a 'gradual increase' in mutual obligation requirements since early June. These obligations are seldom able to be met without extensive social interaction, contrary to current medical advice.[70]

COVID-19 has increased social isolation for women experiencing homelessness and placed additional pressure on women who were already struggling to support themselves and their children. Some of

these women reported during the first lockdown that, although they were aware they could send their children to school if they needed to, they were reluctant to do so as they didn't want to flag to child protection and other government services that they were 'not coping'.

We are also seeing the impacts of cumulative trauma. Respondents living in areas impacted by the 2019-2020 Victorian bushfires have the highest rate of psychological distress (41%) of all sub-populations examined in the VicHealth COVID-19 survey.[71]

3. Recommendations for a gender transformative recovery to support women's mental health

The need for a gender lens on policy making and budgeting

COVID-19 has amplified the structural inequalities that drive poor mental health outcomes for women, including the overrepresentation of women in insecure work and unpaid care. It has also highlighted and intensified existing inequalities and gaps in Australia's social support and mental health systems. It has drawn attention to the need for fundamental reform of these systems to ensure they effectively meet the needs of women and girls, and are resilient to respond to future emergencies, which – like COVID-19 – are likely to disproportionately impact women's mental health.

COVID-19 has underlined the importance of using gender impact analysis to inform policy-making and budgeting. While the gendered impacts of the pandemic have sometimes been acknowledged, policy and budget decisions do not appear to have been informed by this analysis. Measures that addressed the gender unequal impacts of the pandemic – like access to free childcare and the COVID-19 JobSeeker supplement – were the first to be rolled back, while other economic recovery measures – such as additional infrastructure spending – disproportionately benefit men.

As the UN Working Group on Discrimination Against Women and Girls has said:

> *The [COVID-19] crisis is an opportunity to address structural inequalities and deficits that have consistently held women back, and to re-imagine and transform systems and societies. In order to fully comprehend the gendered impacts of the crisis, it is crucial to understand the structural discrimination underlying the emergency which is not only causing but exacerbating serious violations of women and girls' human rights.*[72]

Governments must seize the opportunity presented by the COVID-19 recovery, together with the Productivity Commission Inquiry into Mental Health and the Royal Commission into Victoria's Mental Health System, to address systemic inequalities that detrimentally impact women's mental health.

At the same time, action is needed to prepare for and respond to the anticipated further increase in demand for mental health and family violence support services as we emerge from the pandemic.

Government responses to the mental health impacts of COVID-19

The Alliance welcomes the additional mental health funding provided by the federal and Victorian governments, as well as the release of the National Mental Health and Wellbeing Pandemic Response Plan (Pandemic Response Plan) and the appointment of Australia's first Deputy Chief Medical Officer for Mental Health. Some positive measures have been introduced to respond to the mental health impacts of the pandemic – such as the expansion of telehealth, increased funding for phone and information services (including for perinatal mental health and eating disorders), and the increase in

the number of sessions available on a Mental Health Treatment Plan – that should be retained and built on as we move into the recovery phase and beyond.

Unfortunately, the Pandemic Response Plan does not recognise the particular impacts of COVID-19 on women, other than in relation to gendered violence. The Plan does not recognise that the gendered social and economic inequalities that drive violence against women also directly drive poor mental health outcomes among women and girls, as illustrated in this paper. For example, while the Pandemic Response Plan alludes to the role of the social security system in supporting mental health and wellbeing, it is silent on the need for ongoing access to adequate income support after the cessation of short-term measures, such as the higher rate JobSeeker payment. Nor does the Plan address the needs of mental health carers, other than in relation to bereavement support for suicide.

We welcome the focus in the Pandemic Response Plan on improving data and research, with more immediate monitoring and modelling of mental health impacts to facilitate timely and targeted responses across the spectrum of mental ill-health. The gendered inequalities outlined in this paper highlight the importance of ensuring that all data collected is gender-disaggregated.[73]

The recent 2020-21 Federal Budget was a missed opportunity to redress the unequal impacts of the pandemic. In addition to poor targeting of stimulus spending, focused on male-dominated sectors, there was little to no investment in social services, such as income support, childcare and social housing, to support those most impacted by the pandemic.

Recommendations from the Women's Mental Health Alliance

To better support women's mental health during the COVID-19 response and recovery, the Alliance recommends that governments:[74]

1. **Create the infrastructure needed to support planning and decision-making for a gender equal recovery**
    a. Collect gender-disaggregated data to inform policy-making and budgeting and to monitor gender equality outcomes during the pandemic and in the recovery period
    b. Ensure women's equal representation in all COVID-19 response planning and decision making, including investing in specialist women's organisations like the Women's Mental Health Alliance and organisations working with women affected by multiple forms of discrimination and disadvantage, to support gender analysis of crisis response and recovery planning
2. **Apply an intersectional gender lens to policy-making and budgeting to address the underlying gendered social and economic inequalities that drive poor mental health outcomes for women and girls**
    a. Ensure the design of economic stimulus packages and social assistance programs is informed by an intersectional gender analysis, to ensure the benefits of these measures are fairly distributed, address inequalities and enable women to pursue economic opportunities
    b. Apply an intersectional gender lens to social security and other areas of policy to ensure that new measures introduced in response to the crisis are effective in helping to reduce the numbers of women living in poverty and supporting financial security and independence for women throughout their life course, including:
        i Reintroducing free universal childcare

ii Retaining the JobSeeker supplement and expanding the rate increase to other payment types including the Carer Payment

c. Address the unequal division of unpaid care work and household labour including by:

iii Accounting for unpaid domestic and caring work in national accounts alongside GSP and other measures of formal economic activity

iv Assessing the impact of public policy and spending measures on women's unpaid work

v Identifying and implementing measures to reduce the economic burden on women engaged in unpaid work, such as relief for utility bills

vi Reviewing access for all workers to paid leave (including paid parental leave) for family and community caring responsibilities, drawing on international models to inform enhancements to the Australian system

vii Promoting flexible work and family-friendly policies in the workplace, including initiatives to increase uptake by men

viii Addressing gender norms that underpin the division of household labour and the undervaluing of unpaid care work

d. Develop strategies to value and fairly remunerate those working in the feminised health, social assistance and education sectors

e. Provide financial support to international students and other women on temporary visas who are unable to access income support and/or Medicare

3. Ensure equitable access to appropriate mental health support for all women and girls

a. Apply an intersectional gender lens to the implementation and monitoring of the Pandemic Response Plan, including consideration of the specific social support and mental health needs of women and girls

b. Ensure the universal public health approach is gender- and culturally responsive, enabling women to access mental health information, online resources, helplines and support that best meet their needs, when and where they need it, including by resourcing both generalist mental health helplines and specialist agencies such as PANDA

c. Ensure there is enough capacity within the mental health system to manage the anticipated surge in demand for mental health support among women and girls as restrictions ease

d. Retain extension of the Medicare Benefits Schedule (MBS) to cover telehealth consultations for mental health and increase access and affordability by increasing the Medicare rebate, as well as providing a diversity of support options for those unable to use telehealth

e. Retain the additional sessions available through Medicare Mental Health Treatment Plans to address the increase in people needing support for mild to moderate mental health issues

f. Support perinatal mental health by expanding access to appropriate, affordable support services for women during pregnancy and after a baby's birth

g. Invest in coordinated care for people with pre-existing mental health conditions who are not able to self-manage during the COVID-19 response and recovery, strengthening and making

use of the full suite of outreach, community-based and home-based health and support options to prevent entry to acute care

h. Invest in workforce development to ensure the mental health workforce is equipped to support women who have experienced gendered violence

i. Address systemic barriers to equal access to mental health and other social services and supports for Aboriginal and Torres Strait Islander women, migrant and refugee women (including women on temporary visas), and women with disabilities, including by challenging racism and ableism and embedding cultural safety in service delivery

j. Resource organisations working with women affected by multiple forms of discrimination and disadvantage, including the Aboriginal community-controlled sector, to lead COVID-19 response and recovery support and planning for their communities

k. Provide specialised and targeted mental health support for those experiencing compound trauma from multiple emergencies/disasters, such as bushfire and drought

l. Provide additional financial, practical and mental health support for carers

4. Provide other needed supports for women's mental health and safety

a. Provide additional resources to keep women and children safe during public health restrictions and minimise the potential for escalating violence, including increasing investment in safe accommodation, specialist family violence services and legal services, to respond to increased demand and allow for innovations in remote service delivery

b. Improve the NDIA's understanding of – and capacity to respond to – the needs of women with psychosocial disabilities.

About the Women's Mental Health Alliance

The Women's Mental Health Alliance was established in 2019 in the context of the Royal Commission into Victoria's Mental Health System.

There is international consensus that a gender-sensitive approach to mental health reform is necessary. However, there is a lack of awareness about the prevalence, risk factors and experience of poor mental health among women and girls, and limited evidence about how best to prevent and respond to mental ill health among women and girls and promote their mental wellbeing.

The Alliance undertakes collective advocacy to ensure the mental health of women and girls is prioritised in the recommendations of the Royal Commission and in current and future mental health reforms.

---

[1] Each ABS data update measures different COVID-19 impacts so it is difficult to compare trends over time. This section highlights key gendered mental health and wellbeing impacts measured by the ABS since April 2020.

[2] Australian Bureau of Statistics, 4940.0 – Household Impacts of COVID-19 Survey, **7 – 17 August 2020,** Australian Bureau of Statistics, Canberra.

[3] Australian Bureau of Statistics, 4940.0 – Household Impacts of COVID-19 Survey, **7 – 17 August 2020,** Australian Bureau of Statistics, Canberra.

[4] Information provided by Prof Jayashri Kulkarni, Director of Monash Alfred Psychiatry Research Centre (MAPrc), August 2020

[5] Adams-Prassl, A., Boneva, T., Golin, M. and Rauh, C (2020). The Impact of the Coronavirus Lockdown on Mental Health: Evidence from the US. Cambridge Institute for New Economic Thinking (Cambridge-INET) Working Paper Series No: 2020/21; Cambridge Working Papers in Economics: 2037. This US study found that, while losing one's job or having extra responsibilities did correlate with a decrease in mental health, this did not explain the negative effect on women's mental health.

[6] Richardson, D & Denniss, R (2020), Gender experiences during the COVID-19 lockdown: Women lose from COVID-19, men to gain from stimulus, The Australia Institute, viewed 29 July 2020, and Past recessions have mostly smashed male-dominated industries. But not this time The Guardian 18/08/20;
[7] Equity Economics (2020) Gender-based impacts of COVID-19: Analysis shows that Victoria's opening up favours male over female jobs, Equity Economics, Australia, September 2020. Between March and 25 July 2020, 7.1% of Victorian women lost their job compared to 6.2% of men: Batchelor, R (2020) COVID-19: Women and work in Victoria McKell Institute Victoria, Melbourne.
[8] Batchelor, R (2020) COVID-19: Women and work in Victoria McKell Institute Victoria, Melbourne, August 2020.
[9] VicHealth (2020), Coronavirus Victorian Wellbeing Impact Study: Report for survey 1, Victorian Health Promotion Foundation, Melbourne.
[10] Dinku Y, Hunter B, Markham F (2020), How might COVID-19 affect the Indigenous labour market? Australian Journal of Labour Economics, 23:2, p 200.
[11] Workplace Gender Equality Agency (2020). Gendered impact of COVID-19, Sydney, 2020
[12] Australian Bureau of Statistics, 4940.0 – Household Impacts of COVID-19 Survey, 06-10 July 2020, Australian Bureau of Statistics, Canberra.
[13] VicHealth (2020), Coronavirus Victorian Wellbeing Impact Study: Report for survey 1, Victorian Health Promotion Foundation, Melbourne.
[14] Victorian Equal Opportunity and Human Rights Commission, *Workplace gender equality and COVID-19* (2020 - forthcoming) www.humanrights.vic.gov.au.
[15] Victorian Equal Opportunity and Human Rights Commission, *Workplace gender equality and COVID-19* (2020 - forthcoming) www.humanrights.vic.gov.au.
[16] Workplace Gender Equality Agency (2020). Gendered impact of COVID-19, Sydney, 2020.
[17] Noe L and Swanson E (2020) Tracking Gender Data on COVID-19 – Part 4: The availability of sex-disaggregated information on healthcare worker cases and deaths Data2x 27 August 2020.
[18] In Australia, 75.4% of health professionals, which includes pharmacists, medical practitioners, midwives, nurses, social and welfare professionals, and medical laboratory scientists, are women. Women are also 88.4% of midwifery and nursing professionals in Australia: Workplace Gender Equality Agency (2020). Gendered impact of COVID-19, Sydney, 2020.
[19] Dennis A (2020) Here's the proof we need. Many more health workers than we ever thought are catching COVID-19 on the job The Conversation 26 August 2020.
[20] Information provided by Prof Jayashri Kulkarni, Director of Monash Alfred Psychiatry Research Centre (MAPrc), August 2020.
[21] Craig L (2020). COVID-19 has laid bare how much we value women's work, and how little we pay for it. The Conversation.
[22] Fisher JRW, Tran TD, Hammarberg K, Sastry J, Nguyen H, Rowe H, Popplestone S, Stocker R, Stubber C, Kirkman M. Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey. Medical Journal Australia 2020, preprint 10 June.
[23] Pierce M, Hope H, Ford P et al (2020) Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population The Lancet Psychiatry, 21 July 2020.
[24]Parkinson, Debra Frances (2017): Women's experience of violence in the aftermath of the Black Saturday bushfires. Monash University. Thesis.
[25] Boxall H, Morgan A & Brown R (2020) The prevalence of domestic violence among women during the COVID-19 pandemic. Statistical Bulletin no. 28, Australian Institute of Criminology, Canberra.
[26] Chung H (2020). Return of the 1950s housewife? How to stop coronavirus lockdown reinforcing sexist gender roles. The Conversation.
[27] World Health Organisation (2019). Mental health in emergencies factsheet World Health Organisation, Geneva.
[28] COVID-19 and mental health: findings from the MAPrc survey. The MAPrc online survey was open to the general public aged 18+ years; 29% of males and 39% of females identified that they have a current diagnosis of a mental illness. The analysis uses data collected between 3 April and 3 May 2020 and includes 1495 adults (81.6% were female). The over-representation of women in survey responses may itself be an expression of the anxiety and other negative mental ill health impacts experienced by women.
[29] VMIAC (2020) Mental Health and COVID-19 Findings Survey #2v Victorian Mental Illness Awareness Council, Melbourne, September 2020.
[30] VMIAC (2020) Mental Health and COVID-19 Survey Findings, Victorian Mental Illness Awareness Council, Melbourne May 2020. VMIAC launched a second survey in August to understand how the second wave has affected consumers..
[31] Information provided by Prof Jayashri Kulkarni, Director of Monash Alfred Psychiatry Research Centre (MAPrc), August 2020
[32] Information provided by Dr Tricia Szirom, CEO of Victorian Mental Illness Awareness Council; Prof Jayashri Kulkarni, Director of Monash Alfred Psychiatry Research Centre (MAPrc); Dr Lia Laios, Consultant Psychiatrist at the Royal Women's Hospital (August 2020).
[33] Information provided by Prof Jayashri Kulkarni, Director of Monash Alfred Psychiatry Research Centre (MAPrc), August 2020.

[34] Boxall H, Morgan A & Brown R (2020) The prevalence of domestic violence among women during the COVID-19 pandemic. Statistical Bulletin no. 28, Australian Institute of Criminology, Canberra.
[35] Naomi Pfitzner, Kate Fitz-Gibbon, Jacqui True (2020), Responding to the 'shadow pandemic': practitioner views on the nature of and responses to violence against women in Victoria, Australia during the COVID-19 restrictions. Monash University. Melbourne.
[36] Parkinson, Debra Frances (2017): Women's experience of violence in the aftermath of the Black Saturday bushfires. Monash University. Thesis
[37] Rmandic S, Walker S, Bright S and Millsteed M (2020), Police-recorded crime trends in Victoria during the COVID-19 pandemic. *In Brief* Number 10, September 2020. Crime Statistics Agency, Melbourne.
[38] Fitz-Gibbon K et al (2020) More help required: the crisis in family violence during the coronavirus pandemic The Conversation, 18 August 2020.
[39] VicHealth (2017). Violence against women in Australia: research summary. Victorian Health Promotion Foundation. Melbourne. An Australian study found that approximately 77% of women who have experienced three or four types of gender-based violence had anxiety disorders, 56% had Post-Traumatic Stress Disorder and 35% had made suicide attempts: Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, Teesson M, Bryant R, McFarlane AC, Mills KL, Slade T (2011), 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', JAMA, vol. 306, no. 5, pp. 513–521.
[40] Fitz-Gibbon K et al (2020) More help required: the crisis in family violence during the coronavirus pandemic The Conversation, 18 August 2020.
[41] Information provided by Prof Jayashri Kulkarni, Director of Monash Alfred Psychiatry Research Centre (MAPrc), May 2020.
[42] Information provided by Women's Health in the North, May 2020.
[43] Edwards T and Goldie C (2020) Dear Senators: For many of us the pandemic is a blessing, Power to Persuade: Women's Policy Action Tank, Melbourne, September 2020.
[44]Kabatek J (2020) Jobless and distressed: the disproportionate effects of COVID-19 on young Australians, October 2020.
[45] Clayton R (2020) Statistics show increase in children presenting to hospitals after self-harming ABC Online, 8 August 2020.
[46] Women's Health Victoria (2020) Mental health: Self-harm: Rate (per 1,000), 2017. In: Victorian Women's Health Atlas [Website] Women's Health Victoria, Melbourne.
[47] VicHealth (2020), Coronavirus Victorian Wellbeing Impact Study: Report for survey 1, Victorian Health Promotion Foundation, Melbourne.
[48] VicHealth (2020), Coronavirus Victorian Wellbeing Impact Study: Report for survey 1, Victorian Health Promotion Foundation, Melbourne.
[49] Kabatek J (2020) Jobless and distressed: the disproportionate effects of COVID-19 on young Australians, October 2020.
[50] Kabatek J (2020) 5 charts on how COVID-19 is hitting Australia's young adults hard, The Conversation 2 October 2020.
[51] Gausman J and Langer A (2020). Sex and Gender Disparities in the COVID-19 Pandemic. Journal of Women's Health. 465-466.
[52] Women's Health Victoria (2017) Spotlight on older women's health and wellbeing. Women's Health Victoria. Melbourne.
[53] Melbourne Institute: Applied Economic & Social Research (2020), Taking the Pulse of the Nation Tracker, The University of Melbourne.
[54] Brooke J and Jackson D (2020). Older people and COVID-19: Isolation, risk and ageism. Journal of Clinical Nursing.
[55] Leaders speak out about their concerns regarding older people in the context of COVID-19, WHO 16 July 2020
[56] In this report, migrant and refugee women refer to women who are from a refugee or migrant background. This includes women living in Australia temporarily or permanently, across diverse visa categories and conditions, as well as first and second generation citizens.
[57] Orygen (2017), The National Centre of Excellence in Youth Mental Health. Under the radar. The mental health of Australian university students. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2017
[58] CMY and ANU (2020) Hidden Cost: Young multicultural Victorians and COVID-19 Summary Report [September], Centre for Multicultural Youth and Australian National University, Melbourne.
[59] Department of Health and Human Services. (2017) Racism in Victoria and what it means for the health of Victorians, State Government of Victoria, Melbourne.
[60] VACCHO (2020) More should be done to ensure Aboriginal Communities are well placed to emerge from the COVID-19 pandemic [Media Release] Victorian Aboriginal Community Controlled Health Organisation, Collingwood, 27 August 2020.
[61] VicHealth (2020), Coronavirus Victorian Wellbeing Impact Study: Report for survey 1, Victorian Health Promotion Foundation, Melbourne.
[62] Victorian Agency for Health Information 2020, The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria: Findings from the Victorian Population Health Survey 2017, State of Victoria, Melbourne.
[63] Carman M, Bourne A and Fairchild J (2020) COVID-19: impacts of LGBTIQ communities and implications for services – A research briefing paper by Rainbow Health Victoria, Rainbow Health Victoria, Melbourne.
[64] Data provided by Tandem Inc.

[65] Anti-Poverty Week (2020) Briefing on Poverty, Unemployment & Covid-19 3 July 2020
[66] Australian Bureau of Statistics, 4940.0 – Household Impacts of COVID-19 Survey, **7 – 17 August 2020,** Australian Bureau of Statistics, Canberra.- Household financial stress and stimulus payments
[67] Edwards T (2020) 550 Reasons to Smile: Why single mothers are so happy these days Power to Persuade: Women's Policy Action Tank, Melbourne, July 2020.
[68] Edwards T and Goldie C (2020) Dear Senators: For many of us the pandemic is a blessing, Power to Persuade: Women's Policy Action Tank, Melbourne, September 2020.
[69] Senate Education and Employment References Committee (2019), Jobactive: failing those it is intended to serve, Chapter 8: Targeted Compliance Framework, Commonwealth of Australia, Canberra.
[70] Klein E, Vincent E (2020) After Robodebt, it's time to address ParentsNext The Conversation, 5 June 2020.
[71] VicHealth (2020), Coronavirus Victorian Wellbeing Impact Study: Report for survey 1, Victorian Health Promotion Foundation, Melbourne.
[72] UN Working Group discrimination against women and girls. (20 April 2020). Responses to the COVID-19 pandemic must not discount women and girls. United National Human Rights Office of the High Commissioner, Switzerland.
[73] In Victoria, it is encouraging to see that the interim report of the Public Accounts & Estimates Committee on the Victorian Government's response to COVID-19 has recognised the disproportionate impact of the pandemic on women and recommended that *'the Victorian Government consider collecting gender disaggregated data during the pandemic that can inform decision making and investment to reduce the gender impact of the crisis'* (recommendation 8).
[74] Some of these recommendations are drawn or adapted from recommendations put forward by Our Watch: Our Watch (2020), *COVID-19 and primary prevention of violence against women – Position Paper*, Our Watch, Melbourne.

Wesley mission

Suicide Prevention Australia

UNDER EMBARGO

Joint white paper:

Reducing distress in the community following the COVID-19 pandemic

June 2020

Contents

Wesley Mission

Implementing effective solutions to protect Australian lives requires a whole of government and whole of community approach. Australia's response to the COVID-19 pandemic has practically demonstrated the success that a joined-up approach can have.

A popular analogy describing the impact of the COVID-19 crisis is, 'we're all in the same storm, but not in the same boat'. This bears out in our experience at Wesley Mission, with some people reaching a point of crisis within days and many others who, after months of increased isolation or having depleted their available resources, will find themselves in crisis even after the significant threat of the virus has passed. Understanding the social and economic factors that underlie distress and increase people's vulnerability to suicidality is critical if we are to address the important secondary impacts of this pandemic.

Suicide prevention has been essential to the work of Wesley Mission since the then Superintendent, Rev Sir Alan Walker, began Lifeline in 1963. Responding to the growing number of suicide deaths in Australia, Wesley LifeForce was established in 1995 and is a national program providing suicide prevention services that educate and empower local communities, supporting people most at risk. More than 40,000 people have been trained through the program to intervene to prevent suicide.

In this paper you will hear reflected the voices of people from some of the more than 100 community-led networks who have reported on the impact that the COVID-19 pandemic has had in their local community. With a presence in every state and experience in areas where the problem of suicide hits the hardest Wesley LifeForce Networks are uniquely able to engage Australia's diverse communities at a grassroots level.

Also included are perspectives from frontline Wesley Mission teams in the areas of homelessness, early intervention work with children and their families, financial and gambling counselling, mental health support for older people along with emergency relief services. The recommendations provided in this paper are proposed to alleviate the distress experienced by the vulnerable people that Wesley Mission's services connect with every day.

We are proud to be a member organisation of Suicide Prevention Australia and to partner with a national peak body that powerfully advocates for this most vital issue. Together, we invite you to consider how we can all contribute and advocate for solutions to support a resilient Australia.

Rev Keith V Garner AM
CEO/Superintendent

Suicide Prevention Australia

The COVID-19 pandemic has proven to be a unique crisis: one which has resulted in more than 400,000 lives lost around the globe at the time of writing this paper. Lives that we must remember.

We also recognise the impact of COVID-19 extends to millions of others, many of whom have lost their jobs, been separated from their loved ones, and – perhaps for the first time – are struggling with their mental health and wellbeing.

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We count among our members the largest and many of the smallest suicide prevention and mental health not-for-profits, practitioners, researchers and leaders. We are proud to publish this paper in partnership with Wesley Mission, which brings more than a century of expertise in compassionate care for many of the most vulnerable in our community.

We have focused on the broader social and economic factors that we know link with distress. This is an important departure from a mental health specific approach, which fails to consider the many Australians in distress who do not experience mental illness but are in crisis because of their life circumstances. People who are out of work, who are experiencing violence at home, who are homeless or who have a drug or alcohol addiction and are vulnerable to distress and suicidality.

We have provided a positive roadmap of proposals to address the needs of these groups in Australia's recovery from the COVID-19 pandemic. Importantly, we have focused on protective factors – solutions that if taken up, will do much to ensure the mental health and wellbeing impacts of the COVID-19 response are minimised.

We are pleased to see the Australian Government proactively consider the mental health and wellbeing of Australians in its National Mental Health Pandemic Response Plan. Drawing from recent evidence and on the ground practice, this paper is designed to provide government with a series of considerations to inform the rollout of the plan. We hope these considerations prove to be useful in designing a considered approach to our recovery effort; one that considers the opportunity that we are presented with to transform our economy and society for the better.

Nieves Murray
Chief Executive Officer

Executive summary

The COVID-19 pandemic is a watershed event in the history of Australia and the world: challenging our public health systems and experts, and bringing unprecedented shifts in our global economy, society and how we live as families and individuals.

Australia has, however, emerged from the pandemic much stronger than most. We are uniquely placed to rebuild our economy and society more rapidly than many other countries around the world. The Australian Government, in partnership with private and not-for-profit sectors, can now proactively set in place the foundations necessary for a healthy and flourishing Australian society. The National Mental Health and Pandemic Response Plan has sent a strong signal that the Australian Government intends to embark on this effort. However, we are signalling policymakers to consider the underlying factors that bring distress in our community.

This paper will highlight some of the risk factors that are now emerging. In doing so, we do not intend to raise concern in the broader community, but rather draw from evidence and Wesley Mission's frontline experience to shine a light on areas the government might consider as it plans and mobilises Australia's recovery effort in the medium term.

The first section summarises **themes emerging from the evidence**. This summary provides an overview of some of the latest literature on COVID-19 and previous pandemics; and the link between major events such as COVID-19 and suicidality. This evidence is sobering, however there are early findings in the literature that point to the capacity of well-targeted mental health interventions to minimise risk. Most of these interventions have already been taken up in the National Mental Health and Pandemic Response Plan. For example, the significant expansion and promotion of alternative modes of mental health service delivery.

We have then provided **a brief overview of the relationship between emerging changes in our economy and how these could increase the risk factors for suicide**. We have not attempted to predict what an increase, if any, would equate to, but rather to signal the relationship between economic recession, unemployment and financial distress. We are urging the government to carefully consider the future of protective measures such as JobKeeper and JobSeeker in its plans for economic recovery.

Wesley Mission, through interviews with its specialist homelessness service, has identified that **changes to the safe housing arrangements for people experiencing homelessness are likely to impact their wellbeing**. The shift to hotel-style accommodation and back to former hostel arrangements will disrupt the lives of an already vulnerable population; in addition to those Australians who may become homeless if the economic downturn continues in the medium term. We ask the government to take up the recommendation of the recent Draft Report of the Productivity Commission Inquiry into the Mental Health Commission and consider investment in long-term, safe, affordable housing so that Australians who lack the security of a place to call home have options available to them.

The Australian Government has already shown significant leadership in upscaling support for victims of domestic violence. There are reports from leading domestic and family violence organisations, including Wesley Mission's operations on the ground, that **social distancing measures have exacerbated the conditions that increase risk for victims of domestic and family violence**, and the Australian Government's investment is a step in the right direction. More needs to be done however, to support workers in this challenging field to recognise the signs where families may be at risk of suicidal behaviours. We call on the Australian Government to consider an investment in targeted suicide prevention training for these frontline personnel, in addition to other key touchpoints for vulnerable members of the community.

Finally, the **media plays a significant role in informing the community about the developing COVID-19 situation**. There is a strong public interest in transparent, factual information concerning COVID-19. However, our independently commissioned analysis of media sentiment has found coverage, particularly concerning the relationship between the pandemic response and suicidality, has at times been alarmist. We encourage the Australian Government to continue widely promoting its fact-based sources of information on COVID-19, while informing the media of its role in safe reporting and language use concerning suicide.

We welcome the proactive response taken by governments across Australia to COVID-19: an unprecedented disruption in our economy, society and way of life. We hope that this report provides a useful snapshot of some of the considerations that will prove to be important as governments consider the mental health and suicide prevention aspects of their recovery effort.

Together, we can achieve a world without suicide.

Summary of recommendations

	Recommendations
Economic overview	The Australian Government consider: 1. Increasing the base rate of JobSeeker after the coronavirus supplement expires. 2. Extending JobKeeper beyond September 2020 to target employers in industries that continue to see the most significant impact.
Domestic violence	Governments to consider: 3. Funding the adaption of existing suicide prevention and mental health training programs to build Domestic and Family Violence (DFV) workforce capacity to screen for mental health issues, suicide risk and practice suicide interventions with at-risk groups.
Social isolation	The Australian Government to consider: 4. Government to fund the development and delivery of mental health and wellbeing screeners in retirement villages. 5. Government to invest in a model of care for retirement villages, which addresses and responds to older Australians mental health and wellbeing. 6. Government to deliver a national survey into the impacts of COVID-19 on the mental health and suicidality of all Australians.
Substance abuse and alcohol consumption	Governments to consider: 7. Funding for tailored (preferably pre-service) suicide prevention training and education for frontline hospital staff. 8. Include addressing suicide risk within future national, state and territory drug and alcohol strategies. 9. Funding packages to support screening by alcohol and substance service providers for mental health issues and suicidal ideation in at-risk clients and consumers.
Homelessness	Governments to consider: 10. Extending moratoriums on evictions to support people who will experience prolonged financial distress. 11. Addressing long-term housing and strategies, including the Housing First approach, in the recovery phase of COVID-19.
The role of media	The Australian Government should continue to: 12. Widely promote fact-based sources of information on COVID-19.

What the evidence says

The current COVID-19 pandemic was first confirmed in Australia in late January 2020 and has seen a total of 7285 cases and 102 deaths[1]. Australian Government response measures have included social distancing, closure of many businesses and services, boosting the capacity of health systems and economy through the provision of support packages, isolation of people who contract the virus and contact tracing the people they encounter, travel restrictions and fines for people caught breaking social distancing measures in some states and territories[1].

Australia is already beginning to see the impact response measures are having on the lives of Australians. The Australian Bureau of Statistics (ABS) report 45 per cent of Australians aged 18 years and over have been financially impacted by COVID-19 over the period mid-March to mid-April 2020, and 31 per cent of household finances have worsened[2]. The ABS further identified changes in mental health and wellbeing throughout COVID-19, in comparison to data from 2017-2018 National Health Survey, reporting almost twice as many Australians are experiencing anxiety during social distancing[2].

We have undertaken a review of recent literature on COVID-19 and other pandemics to identify the public mental health and suicide impact.

Five key themes have emerged from our evidence review:

- the relationship between pandemic response measures and mental health
- links exist between increased suicide rates, attempts and behaviours during pandemics
- risk factors for suicide during pandemics
- mental health for frontline workers during pandemics
- methods for addressing the public health impact.

The relationship between pandemic response measures and mental health

Pandemic response measures such as physical distancing, quarantine, travel restrictions and criminalisation for people who don't comply with such orders can amplify social isolation, anxiety, stigma, discrimination and feelings of uncertainty within the broader community. This can lead to poor mental health or the exacerbation of existing mental health problems[3,4].

Response measures compromise access to common protective factors for suicide such as social support and connection, employment, planning for the future and access to mental health care[5]. COVID-19 and past global pandemics report psychological impacts such as loneliness, helplessness, fear and anger because of quarantine or social distancing[9,4,6,7,8]. In a rapid review of the psychological impact of quarantine, it was reported that such impacts are experienced due to "confinement, loss of usual routine, and reduced social and physical contact with others[9]".

Increases in anxiety levels during COVID-19 have been reported globally. A web-based cross-sectional survey in China (n=603) to assess population mental health burden during COVID-19 identified one in three participants demonstrated anxiety disorders yielding similar results to the psychological impact caused by SARS[10,11]. The study further reported higher rates of depressive symptoms among young people than older people, and high rates of poor sleep quality among healthcare workers[10]. A cross-sectional survey in Hong Kong on the psychological impact during COVID-19 (n=1715) reported risk perception towards COVID-19 in the community was high, with 97 per cent of respondents reporting they were worried about COVID-19 and an increase in general anxiety levels identified[12].

Suicidality during pandemics

While evidence concerning the impact of COVID-19 on the community is still emerging, past pandemics such as SARS[15] and The Great Influenza[13] have been linked to increased levels of distress. During the SARS epidemic in 2003, the suicide rate in Hong Kong reached an

unprecedented high (18.6 per 100,000 people), from previous years (16.5 per 100,000 people in 2002 and 15.3 per 100,000 people in 2001)[14,15].

A study into the impact of suicide rates during the SARS epidemic found a significant increase among older people aged 65 and above over the month of April 2003 in comparison to previous years[14]. The significant increase in suicide rates among older people was attributed to loneliness and disconnectedness[14]. It was further determined through examination of cases notes from Coroner Court's death records that the SARS epidemic appeared to trigger suicidal thoughts among older people[14].

In March 2020, a man from Bangladesh died by suicide due to stigma and discrimination from people within his community who suspected he had COVID-19, and in February 2020 a man in India died by suicide to prevent transmission to other people within his community[16]. Stigma and discrimination are perpetuated by fear and misinformation during pandemics and can prevent people from engaging in help-seeking behaviours and accessing support services[6].

Risk factors for suicide during pandemics

While evidence concerning the impact of COVID-19 on the community is still emerging, past pandemic response measures can amplify risk factors for suicide such as unemployment, financial stress, social isolation, mental illness (e.g. depression, post-traumatic stress disorder (PTSD) symptoms), homelessness, domestic violence and drug and alcohol misuse[5,9].

Evidence indicates that COVID-19 will have significant social, economic and financial impacts on individuals, communities and broader economies[4]. This impact is already being felt in Australia, with one in 13 Australians (7.5 per cent) reporting "their household lacked the money to pay one or more bills on time, and one in 10 (10 per cent) had to draw on accumulated savings to support basic living expenses[2]". Grattan Institute estimates that between 1.9-3.4 million Australians will be unemployed due to physical distancing, and while the JobKeeper wage subsidy will provide support for many, the unemployment rate is estimated to rise between 10 and 15 per cent[17].

During COVID-19, several countries (China, France, Brazil, Italy and the United States) have reported increases in domestic violence[28]. Pandemic response measures pose significant safety concerns for people who may be in isolation with their abuser, who are unable to seek help due to the forced closure of shelters and support services[28]. These concerns will be further compounded by limited financial income and unemployment because of COVID-19[28].

Stress is a key risk factor for alcohol misuse[18]. A study of hospital employees (n=549) exposed to SARS to examine alcohol abuse/dependence symptoms in Beijing, identified that three years post outbreak, current alcohol/dependence symptoms were associated with being quarantined or working in 'high risk' units[19].

The mental health of frontline workers

Frontline workers are increasingly at risk of developing poor mental health during pandemics due to potential exposure to the virus, potential to transmit the virus to their loved ones, moral injury (e.g. 'not doing enough' narratives), having to work in environments where necessary equipment (whether medical or preventative e.g. masks) are under resourced or being assigned to work in 'high risk' units[20,21,22].

A strong evidence base exists on the increase of emotional distress among healthcare workers during and post pandemic outbreaks[6,7].

A study surveyed the psychological impact of SARS exposure on hospital workers in Beijing (n=549) and found 10 per cent experienced high levels of PTSD symptoms following the epidemic[23,6]. Employees who quarantined, worked in high-risk units (e.g. SARS units) or had loved ones who were infected, were "two to three times more likely to have high PTSD symptom levels, than those without these exposures[21,6]". These results are consistent with a survey of healthcare workers at three Toronto hospitals (n=1557), in which higher psychological stress

scores were reported among nurses and healthcare workers who provided care to SARS patients[24].

Similar results are found in a study of hospital practitioners (n=359) involved in responding to the MERS outbreak in Korea in 2015, where those directly involved in MERS-related care provision demonstrated the highest risk for PTSD symptoms[25].

Aligning the Australian Government's pandemic response with the evidence

Overall, the Australian Government's pandemic response aligns with existing evidence. Actions the government have taken, which align with recommendations from the evidence review include:

- establishing a COVID-19 support line and additional funding to expand existing support services
- expanding Medicare-subsidised telehealth services for all Australians, with extra incentives to General Practitioners (GPs) and other health practitioners also delivered
- funding accurate timely data and modelling of the mental health impacts of COVID-19
- investment into suicide prevention research and service improvement to enhance evidence-based support
- dedicated mental health support for frontline health workers through digital platforms developed to provide advice, social support, assistance in managing stress and anxiety, and more in-depth treatment without having to attend in-person sessions
- strengthening mental health services to reach vulnerable groups such as older Australians, culturally and linguistically diverse communities, carers of people who live with a mental illness and Aboriginal and Torres Strait Islander peoples
- initiatives and schemes to support Australians experiencing financial hardship and unemployment
- providing information and guidance on maintaining good mental health during the pandemic and how to access further mental health services and care through existing digital mental health portal, Head to Health.

Economic overview

This summary publicly reports the economic shifts that have been seen following the COVID-19 response. It outlines the evidence concerning the association between economic downturn and suicidality, and potential mitigating factors; and some early recommendations for Australian Governments to consider.

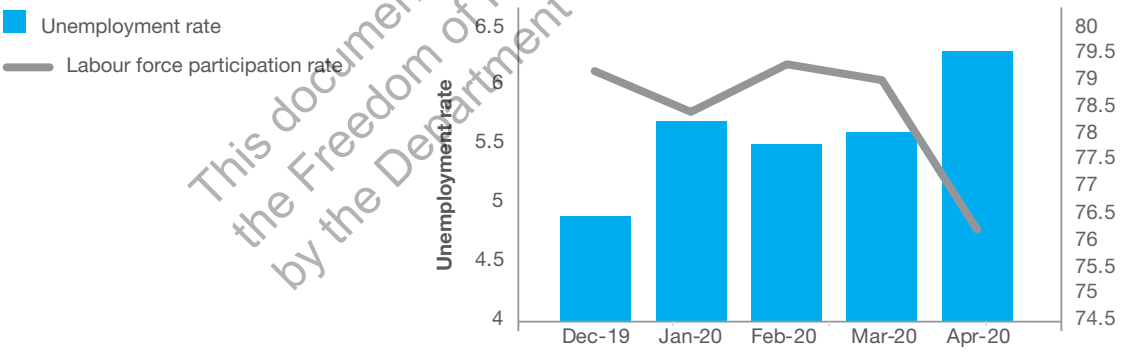
Our concern in this paper is not to conduct an in-depth analysis of the economic impacts, but to discuss the relationship between those impacts and a potential increase in suicidality or the suicide rate; and interventions that might ameliorate this impact.

The current situation

Australia is uniquely placed among the countries affected by the COVID-19 pandemic. A strong public health response combining a comprehensive testing regime, rapidly imposed border restrictions, progressive 'lockdown' measures and physical distancing resulted in a small caseload in comparison with our population[26]. At the time of writing this paper, physical distancing measures were being gradually loosened, with sectors in the economy that had largely lain dormant for two months (such as the food and accommodation sectors) beginning to open for business.

The COVID-19 response has significantly impacted the Australian economy. The introduction of these changes has seen significant shifts in Australia's labour market, with total employment falling by almost 600,000. Figure 1.0 below plots the downward shift in the labour force participation rate from December 2020 to April 2020; a decrease of nearly 3.5 per cent; together with the increase in unemployment during the same period[27].

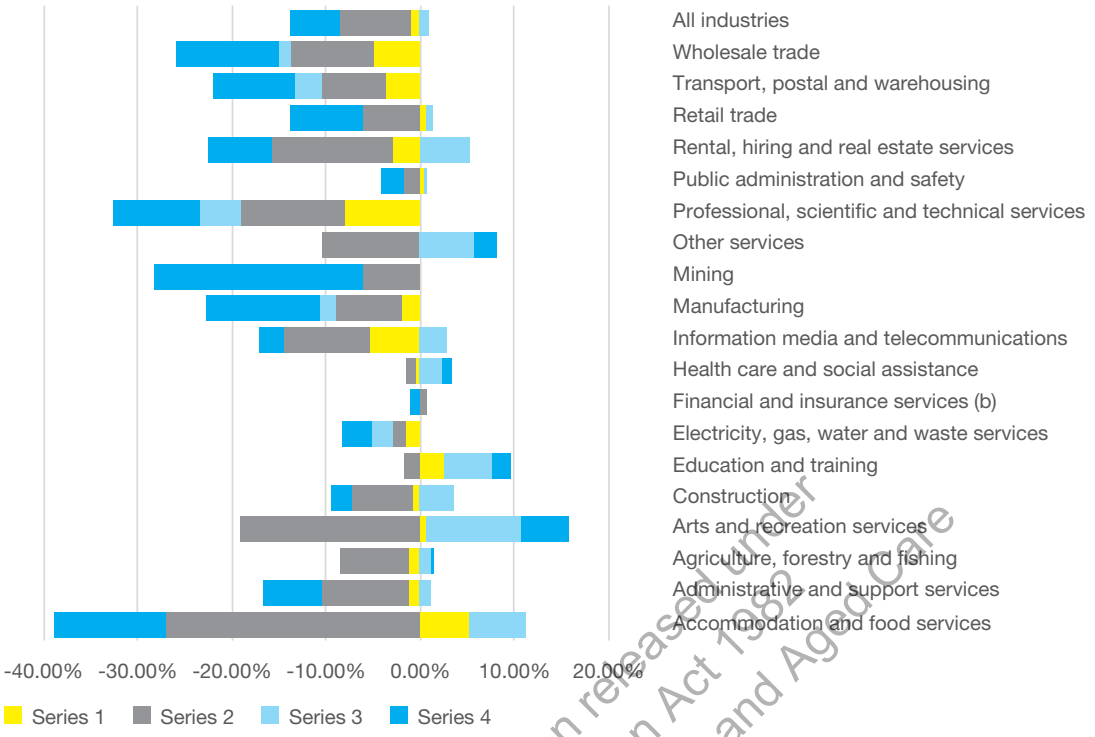
Figure 1.0 Changes in the unemployment rate and labour force participation rate



Source: Australian Bureau of Statistics

The industries most affected by the shutdown have seen the greatest proportion of job losses (Figure. 2.0). These include the accommodation and food services industry, which has seen nearly a third of all jobs lost since the introduction of shutdown measures in March, and the arts and recreation industry, which has seen nearly 19 per cent of jobs lost since lockdown measures were imposed[28].

Figure 2.0 Changes in jobs by industry: 14 March – 2 May 2020



Source: Australia Bureau of Statistics

The impact of the COVID-19 response on Australia's economy has however, been moderated by the Australian Government's significant investment in measures designed to stem the impact on employment and business; and provide the newly unemployed with a safety net.
The government's 'JobKeeper' payment is a job retention measure enabling businesses affected by COVID-19 to claim a $1,500 fortnightly contribution toward the wages of each employee[29].
The treasury's revised estimates show the JobKeeper payment is subsidising the wages of 3.5 million people, costing an estimated $70 billion over six months[30].

The second significant change was an adjustment to the JobSeeker payment available to the unemployed. In April 2020, the Australian Government added a $500 fortnightly Coronavirus Supplement to the JobSeeker payment for unemployed people, while relaxing mutual obligation requirements[31]. Both JobSeeker and JobKeeper were announced as temporary measures and are due to expire in September 2020.

Economic impact and suicide/suicidality

While it can be challenging to demonstrate causality between suicide and any single factor, there is an association between economic recession and increasing suicide rates, particularly in high-income nations. A systematic review found 31 of 38 previous studies had established a positive association between economic recession and suicide. The same study also establishing that the global recession following the 2008 financial crisis, had also been associated with an increase in suicide rates in Europe and North America[32]. Analysis of suicide rates in Australia found the impact on suicide rates following the 2008 crisis was less significant, reflecting the greater resilience of the Australian economy. Although some sectors, particularly construction, had seen a marked increase in suicide rates that correlated with a significant downturn in the industry[33].

The downstream impacts of economic downturn are also linked with increasing suicide rates. **Unemployment** is a well-established risk factor for suicide; particularly in high-income countries

such as Australia. An analysis of time series data across 30 countries from 1960-2012 found that the effect of unemployment was particularly significant on male suicide in all welfare state regimes; with a heavier impact seen in those states where unemployment protections were less generous[34].

Financial distress, another common outcome of economic downturn, also links with suicidality. A systematic review of the health impacts of indebtedness found people who could not service their debts experienced suicidal ideation and depression more often than the general population[35]. While a separate study found levels of personal debt are also associated with suicidal ideation, suicidal attempts and suicide even after adjusting for socioeconomic factors, lifestyle behaviours and other risk factors[36].

There is also evidence however, that access to social safety nets and unemployment support measures ameliorate the impact of economic recession on suicide risk. A 2014 review of literature associated with risk factors and preventative strategies, tentatively found that nations that maintained social welfare spending during recessions (rather than embarking on an austerity regime), invested in targeted unemployment interventions and fostered responsible media reporting, saw less significant increases in their suicide rates during economic recessions. Similarly, an analysis of time series data across 30 countries from 1960-2012, found that the effect of unemployment was particularly significant on male suicide in all welfare state regimes; with a greater impact seen in those states where unemployment protections were less widely available or supported[37].

The outlook for Australia

While Australia has better weathered the COVID-19 pandemic in comparison with many other countries, the continuing economic impacts is expected to be longer lasting. The most recent forecasts from the treasury show Australia is in recession and will see a decline in Gross Domestic Product (GDP) of more than 10 per cent in the June quarter; the largest fall in Australia's history and representing a loss of $50 billion to the economy[38]. Treasury has also estimated a continued increase in the unemployment rate, which is predicted to increase to 10 per cent by the end of June[39].

The Reserve Bank of Australia's most recent outlook has forecast a faster recovery for Australia; predicting that while a further 7 per cent of Australians will become unemployed by the end of the June quarter, the gradual easing of lockdown measures will see the economy begin to recover by December 2020; with full recovery perhaps possible by December 2021[40]. Even if this somewhat conservative outlook comes to fruition, approximately 900,000 more Australians will be out of work by September; at the time when the JobKeeper and JobSeeker payments are due to expire.

Proposals for consideration

As outlined above, the availability of social supports is an important mitigating factor for the impact of unemployment on distress. The JobKeeper and JobSeeker payments have been a welcome source of relief for businesses seeking to retain their staff and the newly jobless. The availability of these measures are perhaps an important factor in the less than predicted suicide rates indicated by the National Suicide Prevention Adviser in May[41]. The Australian Government has however, clearly stated that JobKeeper and the Coronavirus Supplement to JobSeeker are intended as temporary measures only, and that continuing them in the longer term would not be fiscally sustainable.

Given the important protective role social safety nets play in reducing distress and suicide risk, we ask the Australian Government to consider an approach that maintains fiscal responsibility, while ensuring that the many Australians who are seeking work will have adequate basic support. Taking the Coronavirus Supplement out of the equation, the base rate of JobSeeker (formerly Newstart) has not increased in real terms since 1994, despite the increasing cost of the necessities of life such as housing, groceries and utilities[42]. An increase to the base rate has

however, attracted broad support from business as well as the not-for-profit sector: with the Business Council of Australia and the National Council of Social Services joining the call[43].

We agree that the base rate of JobSeeker needs to increase following the gradual phasing out of JobSeeker and JobKeeper provisions, so that people experiencing the challenges of employment insecurity can meet their basic needs and have the support necessary to find meaningful work when it becomes available.

We also suggest that the Australian Government consider extending JobKeeper, in adjusted form, beyond September 2020. The extension would target the subsidy to employers in industries that continue to see the most significant impacts, such as the food and accommodation services as well as the arts and recreation industries. This extension would moderate the fiscal impact of JobKeeper, while ensuring businesses in industries most vulnerable to job loss are supported to retain their employees until a broader economic recovery is apparent.

Recommendations

The Australian Government to consider:

- increasing the base rate of JobSeeker after the coronavirus supplement expires
- extending JobKeeper beyond September 2020 to target employers in industries that continue to see the most significant impact.

Emerging areas of suicide risk following the COVID-19 pandemic

Domestic violence

What does the evidence say about domestic violence?

Domestic and family violence (DFV) involves a variety of abusive and controlling behaviours that can be physical or non-physical. Evidence shows that women who experience intimate partner violence (IPV) are at higher risk for suicidal ideation and attempts, with research linking the severity of IPV with suicidality[44].

Government-mandated social distancing, travel restrictions and closures of schools are vital public health responses to supressing disease transmission. The impact of response measures can have significant wellbeing and safety concerns for individuals trapped in their homes with a violent perpetrator. Perpetrators commonly monitor and control their partner's actions and isolate victims from friends and family[45]. There are emerging reports from DFV agencies that perpetrators are using tactics such as 'self-imposed restrictions' to increase fear and control[46].

An interview with senior management for Wesley Mission's Community Service Centres reported that although domestic violence is an embedded component of their work, preparation is underway for an expected increase in domestic violence cases.

DFV agencies have stated that individuals experiencing hardship are misinformed about general levels of restriction by their perpetrators[47]. The Women's Safety NSW survey on the impacts of COVID-19, report more than 40 per cent of survey respondents have witnessed an increase in the number of people requesting support, and 44.9 per cent identified 'escalating and worsening violence' as being a major issue impacting those in need[48].

Wesley Mission reported that although domestic violence is an embedded component of their work, preparation is underway for an expected increase in domestic violence cases[49].

Problem gambling, substance abuse, alcohol consumption and financial hardship are key indicators for the prevalence of domestic violence. These indicators increase the likelihood, frequency and severity of domestic violence cases.

Similarly, when asked about evidence of trends of domestic violence amongst people in need, a general decline in the number of people seeking and accessing face-to-face support services was reported. This could be due to physical isolation measures, fearing disease transmission if outdoors or being unaware that services are still operating. This could also be due to increased monitoring by perpetrators, which reduces the visibility of DFV occurring within communities[50].

Evidence from the interview showed that emergency relief support services have observed an increased number of callers presenting with problem gambling and financial hardship. The next wave of people needing support, are expected to present with an increase in domestic violence cases.

Problem gambling, substance abuse, alcohol consumption and financial hardship are key indicators for the prevalence of domestic violence. These indicators increase the likelihood, frequency and severity of domestic violence cases[51]. The Women's Safety NSW survey showed that 36.2 per cent of respondents stated that violence and abuse stemmed from financial pressures and stresses, due to the pandemic. Compounding risk factors such as financial distress and lack of social support leads to an increased risk of DFV[52].

Domestic violence in relation to suicide prevention and mental health

The Australian Federal Government declared COVID-19 a disaster in May 2020[53]. Analysis of previous disasters and catastrophic events has shown an increase in domestic violence cases for many months after their conclusion. Examples include:

- an increased chance of IPV one to two years following the 2010 earthquake in Haiti
- close to 50 per cent increase in reports of domestic violence in Othello, Washington post-eruption of Mount St. Helens
- partner physical abuse nearly doubling in some counties in Mississippi post-Hurricane Katrina[54].

Wesley LifeForce Network members reported that, drawing from their experience of the 2009 Black Saturday fires, it was important to include considerations of domestic and family violence impacts in disaster management planning. Staff also require targeted training to equip them to identify post traumatic stress (PTS) in domestic and family violence victims.

In an Australian case study investigating domestic violence following the 2009 Black Saturday Bushfire catastrophe, more than half of female participants directly related their experience of domestic violence as being new or increased[55]. A later study found domestic and family violence survivors had reported increased incidence of mental illness (for example, post-traumatic stress disorder and depression) because of the disaster. It is important to address the domestic violence impacts on mental health and suicide outcomes that are likely to occur due to the COVID-19 pandemic.

Wesley Lifeforce surveyed 30 of its community Suicide Prevention Network members across 23 of its networks. Networks represented three major cities, 13 regional, four remote and three very

More than a third (37%) of our survey respondents said the pandemic has increased domestic violence in their communities.

remote areas in Australia on the impact of COVID-19 on domestic violence in communities. More than half of respondents reported the pandemic has negatively impacted domestic violence in their communities. Network members identified comprehensive disaster planning, specialist training in early identification of PTSD as key mechanisms for building resilience and equipping frontline workers to assist in a disaster response[56].

Network members noted that DFV anger management classes via phone have not been as effective as face-to-face and increases in alcohol and drug use in communities has led to an increase in domestic violence cases[57].

Mental illness, unemployment and financial distress are key risk factors for suicide[58]. The risk of suicide increases when a combination of risk factors occurs[59]. Evidence demonstrates that the severity of IPV is strongly associated with an elevated risk of suicide and poor mental health (e.g. PTSD, depression and anxiety). By addressing the mental health needs of victims, the risk of suicide can be reduced[60].

On 9 August 2019, the Federal Government released the Fourth Action Plan of the *National Plan to Reduce Violence against Women and their Children 2010-2022*[61]. The framework has been developed to reduce violence against women and children. Although it has been drafted from evidence-based research and consultations with community and experts, the plan does not address suicide prevention among victims.

Recommendation

We recommend government:

- fund the adaption of existing suicide prevention and mental health training programs to build DFV workforce capacity to screen for mental health issues, suicide risk and practice suicide interventions with at-risk groups.

Substance abuse and alcohol consumption

What does the evidence say about substance abuse and alcohol consumption?

Recent literature has explored the impact of the COVID-19 response on addiction or substance abuse disorders. Overall, findings show the impact of COVID-19 on people with alcohol and other drug problems has been largely indirect as they evolve from risk factors such as social isolation, housing, incarceration, employment and reduced access to recovery or health services[62]. The increased use of substances in combination with the above risk factors is linked to suicide, which is why the research recommends a multidisciplinary approach to substance abuse[63,64]. Such an approach provides flexible access to services and reduces risk of relapse and suicide.

Those who suffer from underlying health conditions such as diabetes, cancer, heart and respiratory diseases, related to the prolonged use of substances such as alcohol, cigarettes and other illicit substances, are severely at-risk for COVID-19. This is primarily due to the immunocompromised state of persons who suffer from the former, as well as damage to lung tissue inhibiting their ability to respond to infection[65]. Literature suggests that opioid use, which has already increased in recent times would be compounded by the outbreak of COVID-19[66]. Often those with opioid use disorder, experience co-morbidities that make them more susceptible to other health issues. Stimulant use is linked to inflammation and damage to lung tissue, which also increases susceptibility[67].

Social distancing measures and restrictions may hinder the ability of persons with substance abuse disorders to access recovery services or attend syringe service programs such as methadone clinics[68]. This may lead to reduced supervision or assistance to administer

We interviewed Wesley Mission's emergency relief management, who informed us that a lack of physical support for people struggling with substance abuse may increase their rates of use. This is especially the case where the client is also experiencing social isolation.

medications and increases risk of opioid overdoses or fatalities. There is also the risk of individuals relapsing on opioids if support services are limited or not easily accessible. Divulging in substance use to alleviate exceptional fears, stresses and grief associated with being isolated and living through a pandemic is known to occur[69]. The disruption of community access to illicit substances may cause a surge in treatment seekers. This has consequences for potential overdose risk, as well as the extremely high pressure and demand for community, rehabilitation and health services.

The societal stigma that exists around people with substance abuse issues may also be worsened by hospital resources being at capacity and prioritising allocation of resources towards COVID-19[70]. People with substance abuse disorders may not be prioritised if they present with COVID-19 symptoms, due to existing stigmas. Such stigmas include the flawed perception that 'weak character and poor choices' are causes of addiction[71].

Substance abuse and alcohol consumption in relation to suicide prevention and mental health

Social isolation is highlighted as one of the key risk factors for both substance abuse and suicidality[72]. An interview with senior management from Wesley Mission providing support in emergency relief, suggests that a lack of physical support for persons struggling with substance abuse may increase levels of use, particularly when social isolation is also a factor involved[73]. The significant stresses on both mental health and general wellbeing caused by COVID-19,

means that risk factors for both substance use and suicide are impacted. Research also suggests that underemployment, poverty and marked increases in opioid abuse are factors contributing to increased suicide rates in the United States[74].

Evidence shows that lengthy or repeated exposure to a stressful and traumatic event increases the risk of alcohol abuse or dependence. Results from a survey assessing the psychological impact of the 2003 SARS outbreak of 549 randomly selected hospital employees in Beijing,

An assessment of the psychological impact of the 2003 SARS outbreak of 549 randomly selected hospital employees in Beijing, revealed symptoms of alcohol abuse and dependence in individuals that were quarantined or worked in high-risk areas.

China, revealed symptoms of alcohol abuse and dependence three years post outbreak in individuals that were quarantined or worked in high-risk areas. The study also found a significant association between PTSD symptoms and alcohol abuse/dependence. The findings suggest that the associated mental health consequences of experiencing the SARS epidemic can result in long-term alcohol abuse and dependence[75].

Wesley Mission's Specialist Homelessness Services highlighted that being confined to a small space and unable to indulge in harmful drug and alcohol behaviours, may perpetuate detoxification and withdrawal symptoms. Such symptoms can be life-threatening and involve

29.63% of Wesley LifeForce Suicide Prevention Networks' survey respondents identified that the pandemic has negatively impacted alcohol and drug abuse in their communities.

considerable fear for risk of suicide[76]. This is supported by research indicating that risk of suicidal ideation is increased in persons experiencing emotional distress from opioid withdrawal[77].

Referencing Wesley LifeForce Suicide Prevention Networks' survey[78], findings on the impact of COVID-19 on alcohol and drug abuse in communities indicate that a majority, 29.63 per cent, believe this issue has negatively impacted their communities. An already existing problem in many communities, some network members have noticed an increase in substance use and alcohol consumption due to COVID-19.

Recommendations

The provision of timely and community-based support has been commonly raised as a recommendation for suicide prevention throughout literature[79]. Through multidisciplinary approaches, it has provided people greater flexibility as they tackle not just substance use problems, but other life problems[80]. The outbreak of COVID-19 has resulted in the emergence of a variety of services such as counselling being held remotely via telehealth, or the use of technology for many organisations to work from home[81]. This has implications on service delivery as the move to online delivery expands the reach of and individual accessibility to many services.

Telehealth is an example where government funding allows vulnerable persons to access vital consultations and services remotely to maintain social, physical and mental health[82]. Similar programs in the United States have also been raised in the literature to assert that the combination of government funding with widely reaching services, is a strong approach to reducing the health inequities that are exacerbated by the current circumstances[83]. We suggest for the government to continue to fund telehealth and other flexible service provisions for individuals who experience substance use problems. As an upstream prevention measure, government funding of community awareness campaigns to support early detection and prevention of substance use problems, may also lessen the impact on frontline acute service in meeting increased demand because of COVID-19.

We ask government to consider:

- funding tailored (preferably pre-service) suicide prevention training and education for frontline hospital staff
- include addressing suicide risk within future national, state and territory drug and alcohol strategies
- funding packages to support screening by alcohol and substance service providers for mental health issues and suicidal ideation in at-risk clients and consumers.

Social isolation

What does the evidence say about social isolation?

Social distancing includes self-isolating at home, curbing travel modes and opportunities, closure of non-essential business and schools and restrictions on social gatherings, such as funerals and weddings, to limit spreading the disease[84].

Specific groups such as older people, young people, women, people living with a mental illness, people with substance use issues, people experiencing homelessness, migrant workers, and people from culturally and linguistically diverse communities, can be disproportionately impacted by social distancing measures[85].

Operators from Wesley Mission's Mental Health and Resilience program informed us during interviews that loneliness and isolation among older people is being exacerbated by the COVID-19 response. As older people are less likely to have access to social media or possess digital literacy, their access to social connection can be severely limited.

Links exist between social isolation and the experience of psychological harm[86]. For example, post-traumatic stress symptoms are heightened by extended periods of isolation, financial distress, and worry of contracting infection[87]. Heightened anxieties due to pandemic fears can intensify existing mental health problems[88].

44.44% of our survey respondents felt mental health and wellbeing in their community has been negatively impacted, while one-third believed there has been a strong negative impact. Respondents stated that this is a difficult time for individuals with existing mental health illness, and mental health issues such anxiety and depression can stem from social isolation.

Recent research into the psychological impacts of COVID-19 highlight the damaging impacts of social isolation and loneliness on mental health and wellbeing[89]. The authors stated, "a major adverse consequence of the COVID-19 pandemic is likely to be increased social isolation and loneliness, which are strongly associated with anxiety, depression, self-harm and suicide attempts across the lifespan[90]."

A little less than one-third of Wesley LifeForce Suicide Prevention Networks' survey respondents (29.63%) believed that suicide has been negatively impacted in their communities, while one-fourth (25.93%) believed it has been strongly negatively impacted.

44.44 per cent of respondents in Wesley LifeForce's Suicide Prevention Networks survey[91] felt mental health and wellbeing in their community has been negatively impacted. Respondents stated that this is a difficult time for individuals with existing mental health concerns and anxiety and depression can stem from social isolation. Respondents shared concerns that suicide has also been negatively impacted in their communities, reporting suicides among young people

have occurred during the pandemic. Fears were also shared about the impact increased social stressors and social isolation will have on community wellbeing during COVID-19 and potential adverse outcomes.

Social isolation and older Australians

Maintaining bonds and social interactions for older people can be a challenge due to COVID-19 social distancing and social isolation measures.

Older Australians are more vulnerable to COVID-19, and as a result, are likely to be isolated and segregated for longer periods of time. Wesley Mission's Mental Health and Resilience Program for Older Australians have reported increased rates of loneliness and isolation among their clients, particularly those who are more anxious about their vulnerability to COVID-19. Older people are less likely to have access to social media and technology which limits their access to social connection during COVID-19[92].

Evidence demonstrates links between increased suicide rates and epidemics. One study in Hong Kong following the SARS outbreak reported significant increases in suicide rates among adults aged 65 and over[93]. Suicide rates during this period reached a historical high at 18.6 per 100,000 people. The study identified that loneliness and disconnectedness experienced by older people as likely to be associated with increased suicide rates[94].

Wesley LifeForce, in partnership with Western Sydney University, initiated and conducted quantitative research to represent the population needs of older people living independently in Wesley Mission's retirement villages. The Wesley Village Residents Wellbeing Prospective Research conducted prior to COVID-19, focused on residents mental health, wellbeing and suicidality[95]. The research involved older people living independently and examined the impact of social engagement, environmental and socio-cultural factors on loneliness, anxiety, depression and suicidal ideation. Key results from the research indicated:

- a large proportion of women living alone[96] are at risk of loneliness and as a result at higher risk of poor mental health and suicide which may be heightened during social distancing
- older men who did not express social engagement with Wesley Mission activities were more likely to experience depression and anxiety
- links between poor mental health and suicidality were associated with residents' apartment size i.e. people living in larger units had less reports of loneliness[97].

These results can more broadly indicate the potential impact of social distancing and social isolating as experienced in older Australians during COVID-19.

Recommendations for older Australians

- Government to fund the development and delivery of mental health and wellbeing screeners in retirement villages.
- Government to invest in a model of care for retirement villages which addresses and responds to older Australian's mental health and wellbeing.

Recommendations for social isolation

Government to deliver a national survey into the impacts of COVID-19 on the mental health and suicidality of all Australians[98].

Homelessness

What does the evidence say about homelessness?

There are more than 100,000 people who are homeless across Australia. Census data from 2016 reports the majority of Australians experiencing homelessness are male (58 per cent) and more than 20 per cent were between 25-34 years old[99]. Aboriginal and Torres Strait Islander peoples make up one quarter of all Australians experiencing homelessness[100].

Individuals who are homeless or at-risk of homelessness are at higher risk of exposure to COVID-19. Lacking access to basic hygiene and sanitation facilities, living in congregate spaces such as shelters or encampments, and being more transient and mobile, prevents effective monitoring, quarantining and opportunities for disease treatment[101].

Research reports that those experiencing homelessness have an increased prevalence of chronic disease, comorbidities and a lower life expectancy in comparison to people living in homes[102]. Other factors that increase the impact of COVID-19 among people experiencing homelessness include existing mental health problems, substance abuse, compromised immune systems and limited access to support services[103].

Homelessness in relation to suicide prevention and mental health

In April 2020 the NSW Government announced an interim stop on evictions of residential tenants by landlords for 60 days to assist in increasing support for people experiencing financial distress during COVID-19[104]. Banks have also declared a maximum six-month deferment on mortgage payments[105]. While these measures are welcome, they are temporary and provide only short-term relief.

37.04% respondents believed that homelessness has been negatively impacted in their community. Furthermore, respondents noted that although many people experiencing homelessness have been accommodated in hotels, the concern is around overcrowding in homes in remote areas and the strategy to maintain accommodation post-COVID-19.

As explored earlier in this report, financial distress and insecurity are key risk factors for mental health issues[106]. The unemployment impact of the pandemic will have a long-term effect on the financial distress and debt experienced and may place people at risk of homelessness once government supports are withdrawn.

Wesley Mission's Specialist Homelessness Services[107] provide prevention and early intervention, crisis intervention, transitional housing for up to two years, rough sleeper engagement, and post-crisis support to vulnerable populations. They shared how their work practices have changed to comply with social isolation and distancing measures. Individuals who had formerly been housed temporarily in hostels and shelters including those that were rough sleeping, are now accommodated in hotels[108].

Wesley LifeForce Suicide Prevention Networks survey[109] reported 37.04 per cent respondents believed homelessness had been negatively impacted in their community. Respondents further noted that although many people experiencing homelessness have been accommodated in hotels, there are concerns for overcrowding in homes in remote areas and the strategy to maintain accommodation post-COVID-19.

Studies have shown that inadequate housing or homelessness is linked to poor mental health impacts[110]. Pollution, poor lighting, noise and less access to green spaces prominent in slum settings can intensify mental health problems and experiences of violence[111].

Wesley Mission's Homes for Heroes program[112] is a transitional accommodation facility providing outreach and case management support and referrals for veterans who are at risk of homelessness. In an interview with program management, general heightened anxiety in relation to social isolation measures was reported among at-risk veterans. A decrease in social connection due to physical distancing has led to a relapse in substance abuse and an increase in alcohol consumption. This is concerning for vulnerable veterans at risk of homelessness as evidence demonstrates a link between substance abuse and alcohol consumption to increased suicide rates[113].

Secure, long term housing provides stability and safety which enables people to access mental health and substance use supports. The Housing First model is an evidence-based approach to ending homelessness by quickly transitioning people into affordable housing, while providing ongoing support to maintain housing security. The Housing First model has been implemented in the US, UK, Europe, Canada and New Zealand[114,115].

Research into the efficacy of the Housing First model demonstrates reductions in homelessness, substance abuse and use of crisis services, increases in people accessing mental health services, and improvements in health and wellbeing[116,117,118,115,119].

Recommendations

- Governments to extend the moratorium on evictions to support people who will experience prolonged financial distress during the recovery phase of COVID-19.
- Governments to address long-term housing and accommodation strategies, including the Housing First approach, in the recovery phase of COVID-19.

The role of the media

The unfolding COVID-19 pandemic is changing the way Australians work and live, and the media is assisting to inform the public about COVID-19, the government's response and the actions expected of all Australians to help contain the virus.

The media has an essential place in civil society - informing the community about matters of public interest, and, often, holding decision-makers to account. During a crisis this informational role is particularly important, as accurate, timely updates allay public concern and influence responsible health behaviours; while ambiguity or the lack of accurate information can exacerbate distress levels [120].

Research following the H1N1 virus, for example, found that the invisible threat of the virus, combined with predictions by virologists of worst case scenarios, heightened anxiety in Canada [121]. A separate analysis of media coverage of the H1N1 virus in the Netherlands found the type and sentiment of media coverage linked with the type of information provided by media sources [122]. The Dutch Centre for Infectious Disease Control shared alarming information and predictions, leading to media coverage that was alarmist and created unnecessary levels of anxiety in the community about the threat the virus presented [123].

As with previous pandemics, the COVID-19 virus has presented a new and invisible threat to public health, albeit a threat that has proven to be much greater in light of the faster spread and higher mortality rate of the virus. The evidence shows that the media requires access to neutral, fact-based information from reliable sources to convey coverage that informs, rather than raises distress in the community.

Official sources of information

The Australian Government regularly shares reliable, accurate and timely information about COVID-19 via several platforms:

- the Department of Health website (health.gov.au) provides comprehensive daily updates on key facts and figures, public health advice and information about support services
- the Coronavirus Australia app is available on both android and Apple devices. The app provides users with up-to-date, factual information and health advice, the latest caseload data, key contacts, a symptom checker and 'push' notifies users of urgent information.

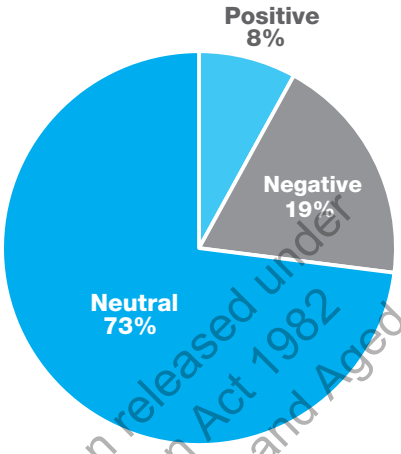
The information shared via these platforms is neutral and fact-based. The media, as with the rest of the Australian public, has access to these channels.

Coverage of COVID-19

We commissioned an independent sentiment analysis to ascertain whether the media's availability of fact-based, reliable government information had positively influenced the nature of Australian coverage about COVID-19.

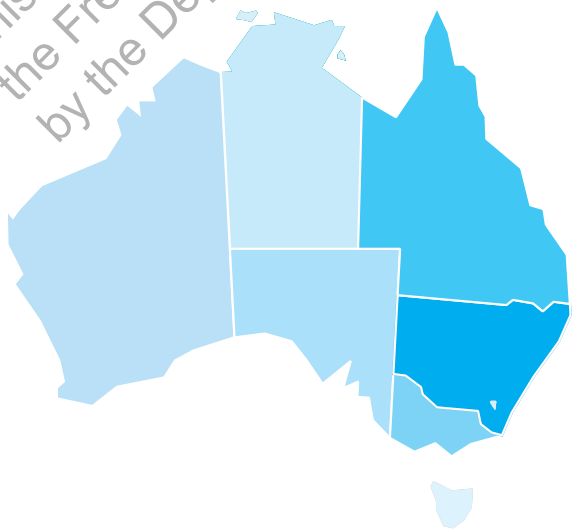
The analysis in Figure 4.0 shows nearly three quarters of all content taking a neutral stance. The availability of accurate, reliable and neutral information from reliable government sources may be influencing the style of coverage. Our analysis commissioned from Meltwater shows key words used in COVID-19 related content are not emotive, and include neutral terms such as 'covid', 'cases, 'home', 'virus' and, perhaps reflecting the localised nature of coverage, 'Australia'.

Figure 4.0 Sentiment Analysis Jan-May 2020



Source: Meltwater analysis commissioned by Suicide Prevention Australia

The analysis also shows coverage was more extensive in jurisdictions with higher COVID-19 caseloads. As depicted in Figure 5.0, New South Wales, Queensland and Victoria have seen greater coverage of the COVID-19 crisis through their media channels. This points to a greater demand for information about COVID-19 in states where consumers were more likely to be affected.



Source: Meltwater analysis commissioned by Suicide Prevention Australia

The total volume of negative coverage (19 per cent), however, was more than double than that of positive coverage (eight per cent) about the pandemic. As Australian Governments progressively ease lockdown restrictions, we are hopeful that media reportage concerning these changes will begin to address the balance between positive and negative coverage concerning COVID-19. We encourage the Australian Government to continue widely promoting its fact-based sources of information on COVID-19 and promote stories of hope.

A note on safe language

Suicide Prevention Australia and Wesley Mission are signatories of Everymind's National Communications Charter. While both organisations strongly believe the media should shine a light on suicide as a preventable problem, we believe this should be in a way that reduces stigma around mental health and suicide and encourages people to seek help[124].

Recommendation

The Australian Government should continue to:

- widely promote fact-based sources of information on COVID-19.

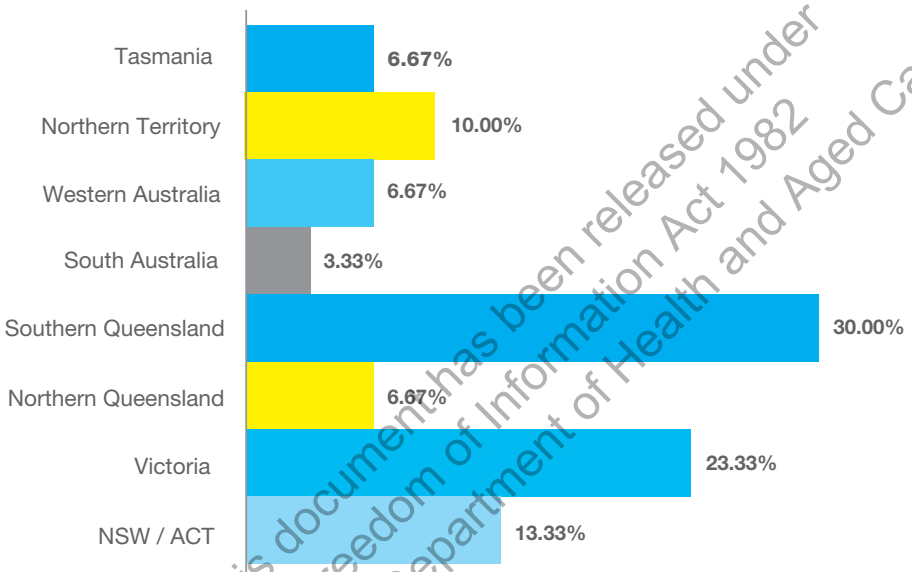
Appendix
Impacts of COVID-19 Wesley LifeForce Suicide Prevention Networks Survey

Survey results from Wesley LifeForce Suicide Prevention Network members.

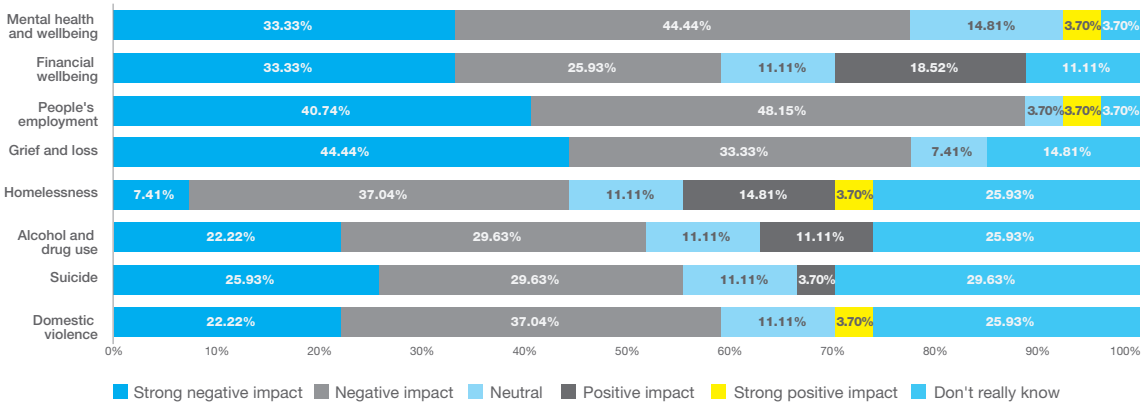
Demography

The following data was collected from 6 May to 12 May 2020. The survey contained 21 questions and elicited a maximum of 30 responses via a survey and an online webinar poll from across 23 Wesley LifeForce Suicide Prevention Networks. Sites surveyed included three major cities, 13 regional, four remote and three very remote areas across Australia.

a. The distribution of survey participants as per their regional cluster is shown in the graph below.



b. Respondents were asked to rate the impact on the following issues in their community as a result of COVID-19 (n=30).

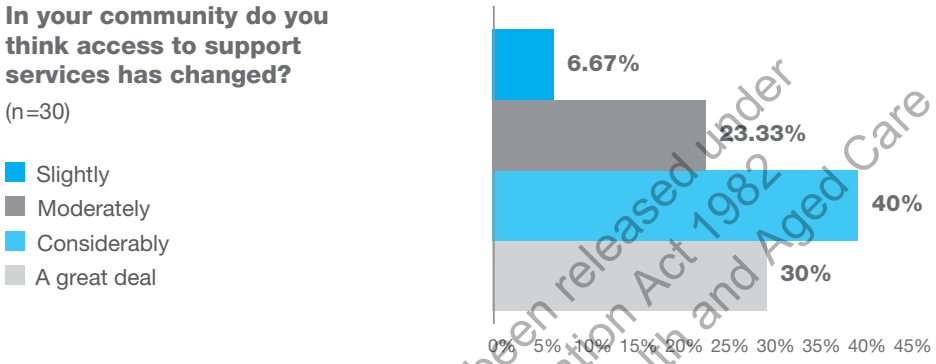


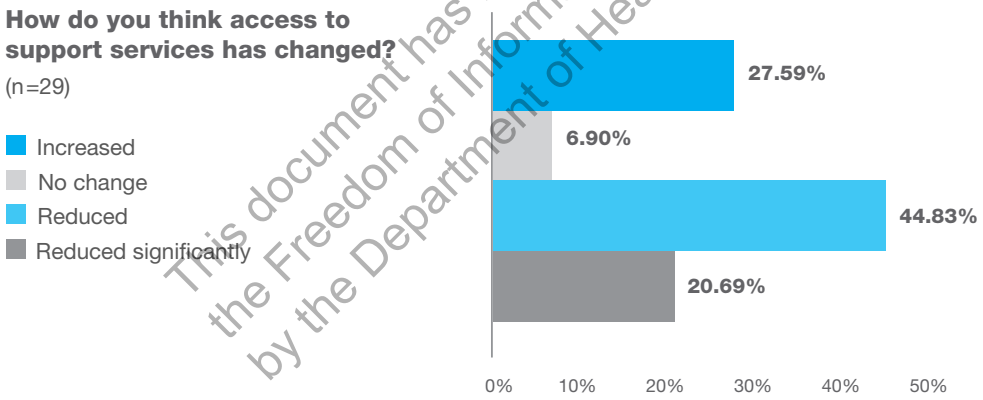
These results indicate that for each of the key issues, the majority of the respondents felt there has been either a negative or strongly negative impact, indicating the need to explore the intersection of these issues with increasing risk for worsening mental-health health outcomes and suicidality.

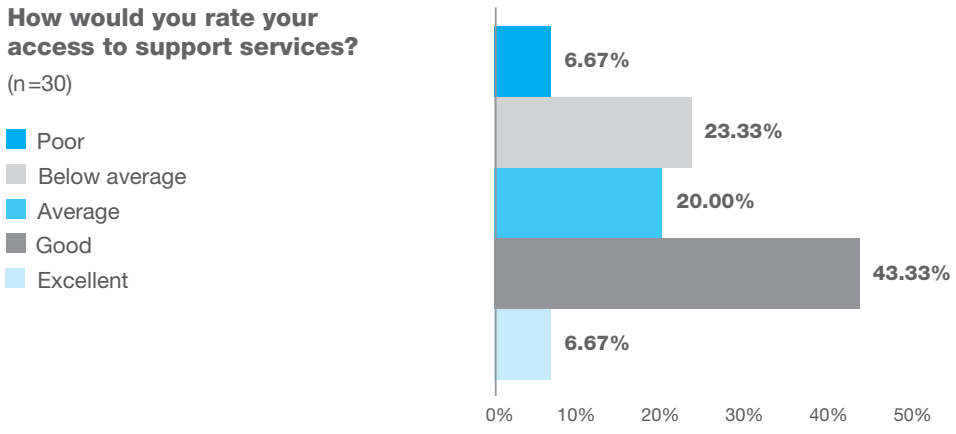
Close to 50 per cent of the respondents reported a negative impact on people's employment in their community, and the majority (33.33 per cent) reported a strong negative impact on financial wellbeing. As per some Suicide Prevention Network members, in regional and remote rural areas individuals working in non-essential industries have lost employment. As a result of these issues, Network members have expressed concern for coping strategies such as an increase in gambling, and the long-term impacts of such behaviours.

A significant amount (44.44 per cent) also believed COVID-19 has had a negative impact on grief and loss in their communities. This is especially true in communities where kinship ties are strong, and a feeling of guilt remains from being unable to formally bid farewell to loved ones who have died by suicide or any other cause.

c. For this question, support services refer to services offered for domestic violence, suicide prevention, mental health and wellbeing, drug and alcohol use, homelessness, grief and loss programs, employment and financial wellbeing.





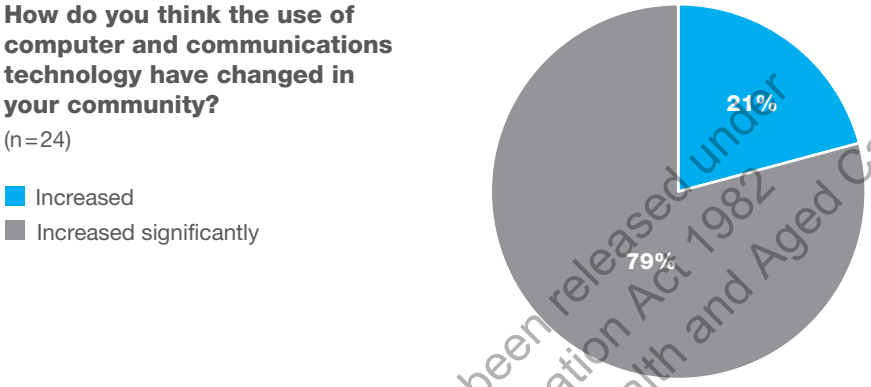


As demonstrated in the graphs above, 40% per cent of the respondents reported that access to support services have considerably changed, with 44.83 per cent believing that access has

reduced. Even so, 43.33 per cent of the respondents still believe that they would rate their access to support services as being 'good', with only 6.67 per cent rating their access as being 'excellent'. Reflections from Network members suggest that a demonstrated drop in access to services may be due to individuals feeling safer by staying indoors. While some believe that services are offering more support and flexible options, other respondents also believe that in-person consultations are more effective than telehealth operations, the demand for services has increased or individuals lack resources to avail alternative opportunities for support. More targeted support services are requested for young people, as being considered a vulnerable and at-risk population, in the communities.

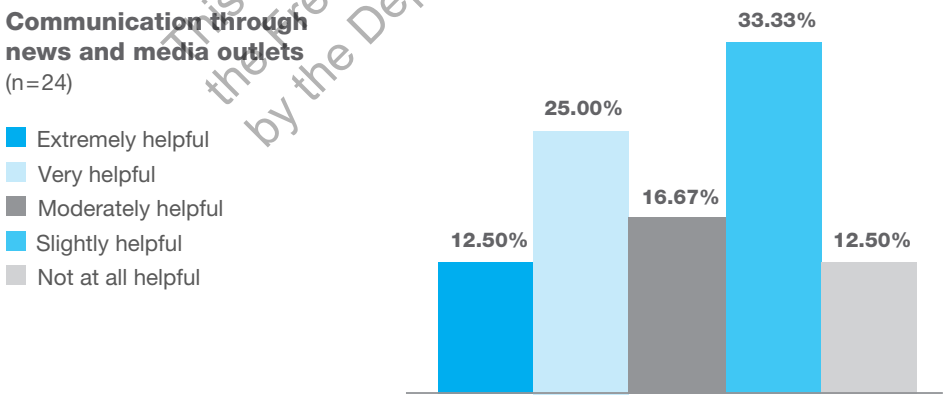
Regarding support services, it was also noted that travel restrictions and lack of public transport in regional and remote areas has prevented access to support services. As such, the services are not transitioning across towns, and with a shortage of collective group of services, some network sites are facing fragmented service delivery.

d. **How do you think the use of computer and communications technology have changed in your community?**
(n=24)



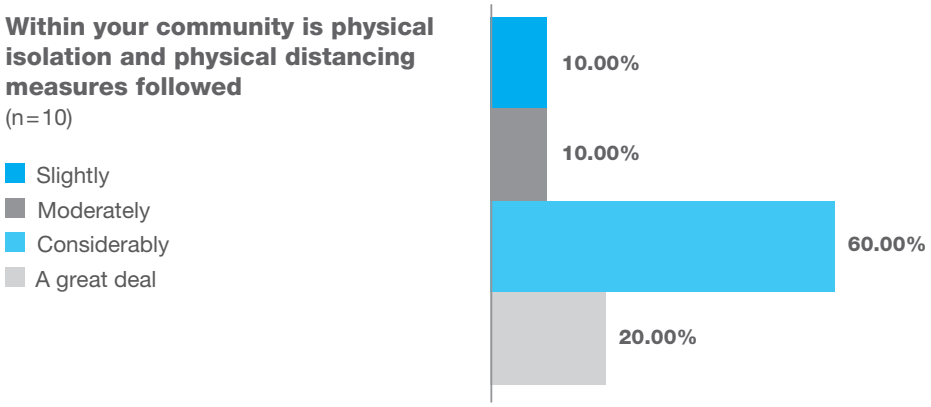
A noteworthy majority of 79 per cent of respondents answered the question above believing that there has been a significant increase in the use of computer and communications technology in their community. However, some respondents still felt that this mode of communication can be complex and disadvantageous for the older population or remote communities that lack access, understanding of and financial means to the internet, mobile phones or computers.

e. **Communication through news and media outlets**
(n=24)

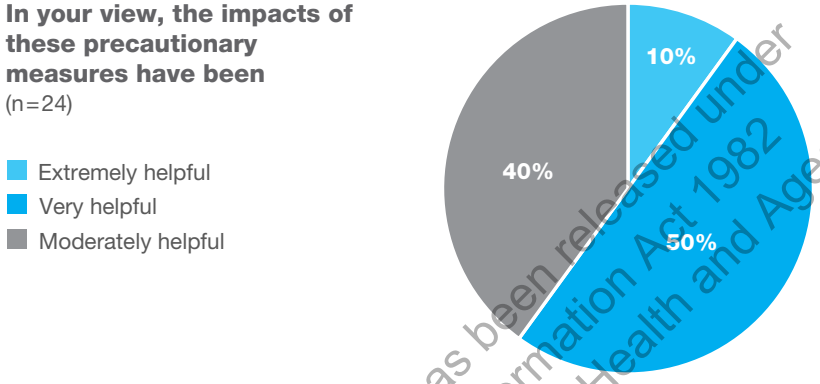


When asked about communication through news and media outlets, we received a varied response, with the majority (33.33 per cent) believing that the communication has been slightly helpful. Network members reported that although they would like to remain informed and updated, there has been an overwhelming amount of information, often portrayed negativity which has contributed to panic, fear and confusion. Streamlining information, accompanied by messages of hope, are recommended to ensue less anxiety in communities.

Within your community is physical isolation and physical distancing measures followed
(n=10)

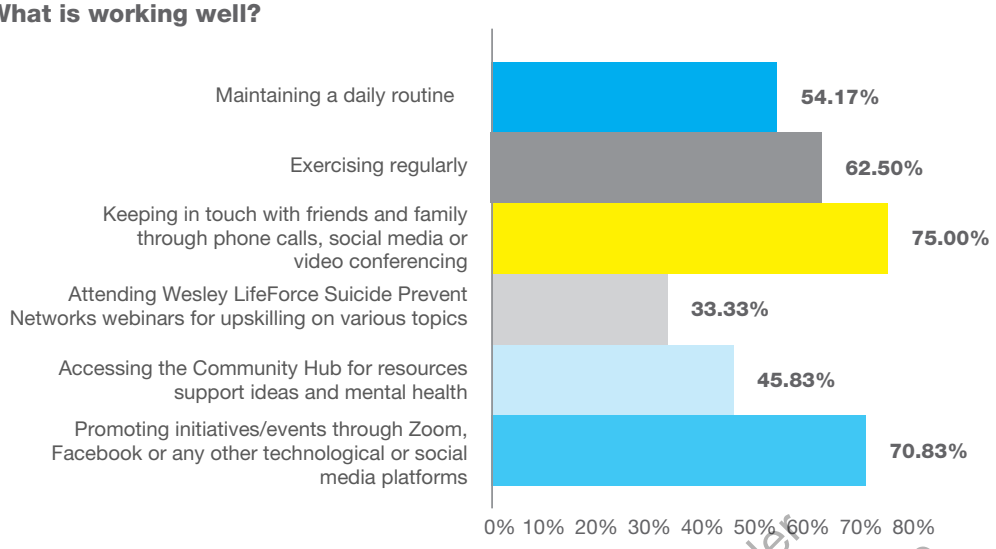


In your view, the impacts of these precautionary measures have been
(n=24)



Although the sample size is small, six out of the 10 respondents for this question believed that (a) physical isolation and physical distancing measures have been considerably adhered to, with 50 per cent reporting that the impacts of these precautionary measures have been very helpful. In addition to adhering to precautionary measures to help reduce disease transmission, some Network members stated that working from home and home schooling is a challenge in the current climate. Additionally, there is the likelihood of increased disconnectedness amongst individuals that do not have access to or knowledge of technology and online platforms. While some respondents believe that such measures have resulted in increased appreciation for friends and family, others worry that the emotional and mental health cost of social isolation is yet to be recognised.

Suicide Prevention and COVID-19: What is working well?



In regard to suicide prevention and the COVID-19 pandemic, 75 per cent of respondents believed that keeping in touch with friends and family through phone calls, social media or video conferencing is working well for them. This feeds into the idea that computer and communications technology are playing key roles in helping individuals remain socially connected.

Of all respondents, 45.45 per cent believe that support from government and service providers has been average. When asked how support from government and service providers can be improved, network members provided multiple and varied responses. Some members believed that ongoing and increased funding for telehealth appointments for mental health counselling is important for communities that have experienced compounding impacts of disaster trauma. This also includes greater coordination from government in preventive and educational services to address adverse psychosocial outcomes. There is also a recommendation to continue funding cycles on a long-term basis, with attention given to financial counselling and technological services for ease of access to online support.

Additionally, it was recommended that mental health resources should be streamlined and targeted toward vulnerable groups including but not limited to, young people, older people, Aboriginal and Torres Strait Islander communities, and the unemployed. This also includes frontline, essential workers that have faced stress and anxiety during COVID-19 response efforts.

Communities also believe that there is a lack of pathways to care for community members and are calling for more guidelines on the services available and how to connect with services during this time. This is especially true for remote and rural areas where a shortage of local health personnel and resources, long distances and current limitations on public transport have hindered access to support services. Furthermore, it was suggested that in addition to employing more social workers for counselling and support, in order to maintain efficacy, some essential services should continue offering face-to-face support for individuals who require that connection.

References

1. Australian Department of Health. (2020). Coronavirus (COVID-19) current situation and case numbers, Australian Government, available online at <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers>.
2. Australian Bureau of Statistics. (2020). 4940.0 – Household impacts of COVID-19 Survey, 14-17 Apr 2020, Australian Bureau of Statistics, Canberra.
3. Mamun, M.A. & Griffiths, M.D. (2020). First COVID-19 suicide case in Bangladesh due to fear of COVID-19 and xenophobia: Possible suicide prevention strategies, Asian Journal of Psychiatry, 51.
4. Courtet, P., Olie, E., Debien, C. & Vaiva, G. (2020). Keep socially (but not physically) connected and carry on: preventing suicide in the age of COVID-19, Journal of Clinical Psychiatry, 81(3).
5. Life in Mind. (2020). Risk and protective factors for suicide, Life in Mind, available online at < https://lifeinmindaustralia.com.au/about-suicide/suicide-across-the-lifespan/risk-and-protective-factors>.
6. Xiang, Y., Yang, Y., Li, W., Zhang, L., Zhang, Q. & Cheung, T. (2020). Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed, The Lancet Psychiatry, 7(3).
7. Shah, K., Kamrai, D., Mekala, H., Mann, B., Desai, K. & Patel, R.S. (2020). Focus on mental health during the Coronavirus (COVID-19) pandemic: applying learnings from the past outbreaks, Cureus 12(3).
8. Pfefferbaum, B. & North, C.S. (2020). Mental health and the COVID-19 pandemic, The New Englang Journal of Medicine.
9. Brooks, S.K., Webster, R.K., Smith, L.E., Woodland, L., Wessely, S., Greenberg, N. & Rubin, G.J. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence, Lancet, 395.
10. Huang, Y. & Zhao, N. (2020). Generalized anxiety disorder, depressive symptoms and sleep quality during COVID-19 epidemic in China: a web-based cross-sectional survey, Journal of Psychiatry Research.
11. Su, T.P., Lien, T.C., Yang, C.Y., Su, Y.L., Wang, J.H., Tsai, S.L. & Yin, J.C. (2007). Prevalence of psychiatric morbidity and psychological adaptation of the nurses in a structured SARS caring unit during outbreak: a prospective and periodic assessment study in Taiwan, Journal of Psychiatry Research, 41(1-2).
12. Kwok, K.O., I, K.K., Chan, H.H., Yi, Y.Y., Tang, A., Wei, W.I. & Wong, Y.S. (2020). Community responses during the early phase of the COVID-19 epidemic in Hong Kong: risk perception, information exposure and preventive measures, mdRxiv.
13. Wasserman, I.M. (1992). The impact of epidemic, war, prohibition and media on suicide: United States, 1910-1920, Suicide and Life-Threatening Behaviour, 22(2).
14. Cheung, Y.T., Chau, P.H. & Yip, P.S.F. (2008). A revisit on older adults suicides and Severe Acute Respiratory Syndrome (SARS) epidemic in Hong Kong, International Journal of Geriatric Psychiatry, 23.
15. Centre for Suicide Research and Prevention. (2017). Number of suicides and suicide rates in Hong Kong, 1997-2016, available online at < https://csrp.hku.hk/wp-content/uploads/2017/09/2017WSPD_slide.pdf.pdf>.
16. Mamun, M.A. & Griffiths, M.D. (2020). First COVID-19 suicide case in Bangladesh due to fear of COVID-19 and xenophobia: Possible suicide prevention strategies, Asian Journal of Psychiatry, 51.
17. Coates, B., Cowgill, M., Chen, T & Mackey, W. (2020). Shutdown: estimating the COVID-19 employment shock, Grattan Institute.
18. Clay, J.M. & Parker, M.O. (2020). Alcohol use and misuse during the COVID-19 pandemic: a potential public health crisis?, The Lancet, 5.
19. Wu, P., Liu, X., Fang, Y., Fan, B., Fuller, C.J., Guan, Z., Yao, Z., Kong, J., Lu, J. & itvak, I.J. (2008). Alcohol abuse/dependence symptoms among hospital employees exposed to a SARS outbreak, Oxford Journals Alcohol and Alcoholism, 43(6).
20. Pfefferbaum, B. & North, C.S. (2020). Mental health and the COVID-19 pandemic, The New England Journal of Medicine.
21. Greenberg, N., Docherty, M., Gnanapragasam, S. & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid-19 pandemic, BMJ, 368.
22. Nobles, J., Martin, F., Dawson, S., Moran, P. & Savovic, J. (2020). The potential impact of COVID-19 on mental health outcomes and the implications for service solutions, National Institute for Health Research, University of Bristol.
23. Wu, P., Fang, Y., Guan, Z., Fan, B., Kong, J., Yao, Z., Liu, X., Fuller, C.J., Susser, E., Lu, J.& Hoven, C.W. (2009). The psychological impact of the SARS epidemic on hospital employees in China: Exposure, risk perception, and altruistic acceptance of risk, Canadian Journal of Psychiatry, 54(5).
24. Maunder, R.G., Lancee, W.J., Rouke, S., Hunter, J.J., Goldbloom, D., Balderson, K., Petryshen, P., Steinberg, R., Wasylenki, D., Koh, D. & Fones, C.S.L. (2004). Factors associated with the psychological impact of Severe Acute Respiratory Syndrome on nurses and other hospital workers in Toronto, Psychosomatic Medicine, 66(6).
25. Lee, S.M., Kang, W.S., Cho, A-H.,Kim, T. & Park, J.K. (2018). Psychological impact of the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients, Comprehensive Psychiatry,87.
26. Australian Bureau of Statistics. (2020), Labour force, Australia, Detailed, cat. no. 6291.0.55.001, viewed 20th May 2020 at <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6291.0.55.001Apr%20 2020?OpenDocument>.
27. Australian Bureau of Statistics. (2020), Labour force, Australia, Table 01. Labour force status by Age, Social marital status, and sex, time series spreadsheet, cat. no. 6291.0.55.001, viewed 20th May 2020 at <https://www.abs.gov.au/ausstats/abs@archive.nsf/log?openagent&6291001.xls&6291.0.55.001&Time%20Series%20Spreadsheet&12E2D05BDA7BC69FCA25856E0023B677&0&Apr%202020&21.05.2020&Latest>.

28. Australian Bureau of Statistics. (2020). Weekly Payroll Jobs and Wages in Australia, Australia, Table 01. Labour force status by Age, Social marital status, and sex, time series spreadsheet, cat. no. 6160.0.55.001, Week ending 2 May 2020, viewed 25th May 2020 at <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/6160.0.55.001Main%20Features5Week%20ending%202%20May%202020?opendocument&tabname=Summary&prodno=6160.0.55.001&issue=Week%20ending%202%20May%202020&num=&view=>.
29. Australian Taxation Office. (2020). JobKeeper Payment, online article, accessed 21st May 2020 at <https://www.ato.gov.au/general/jobkeeper-payment/>.
30. Department of Treasury and Australian Taxation Office. Joint Treasury and ATO statement - JobKeeper update, accessed 21st May 2020 at <https://www.ato.gov.au/Media-centre/Media-releases/Joint-Treasury-and-ATO-statement---JobKeeper-update/>.
31. Australian Government. (2020). 'Income support for individuals', Fact sheet: economic support for the coronavirus, accessed 21st May 2020 at <https://treasury.gov.au/sites/default/files/2020-04/Fact_sheet-Income_Support_for_Individuals.pdf>.
32. Oyesanya M, Lopez-Morinigo J, Dutta R. Systematic review of suicide in economic recession. World Journal of Psychiatry. 2015 Jun;5(2):243-254. DOI: 10.5498/wjp.v5.i2.243.
33. Jiang, Heng; Jin, Xiao-Hua and Liu, Chunlu. The effects of the late 2000s global financial crisis on Australia's construction demand [online]. Australasian Journal of Construction Economics and Building, The, Vol. 13, No. 3, 2013: pp.65-79.
34. Norström T, Grönqvist H. 'The Great Recession, unemployment and suicide', Journal of Epidemiological Community Health 2015; 69:1 pp.10-116.
35. Turunen, E. Hiilamo, H. (2014). 'Health effects of indebtedness: a systematic review', BMC Public Health. May 22, vol. 14, 489.
36. Meltzer H, Bebbington P, Brugha T, Jenkins R, McManus S, Dennis MS. (2010). 'Personal debt and suicidal ideation', Psychological Medicine, published online 16 June 2010. doi: 10.1017/S0033291710001261, 2010
37. Norström T, Grönqvist H. 'The Great Recession, unemployment and suicide', Journal of Epidemiological Community Health 2015; 69:1 pp.10-116.
38. Frydenberg, J The Hon. (2020). 'The economic impact of the crisis', Ministerial Statement on the Economy, Parliament House, Canberra
39. Ibid.
40. Reserve Bank of Australia. (2020). Statement on Monetary Policy, May, accessed online at <https://www.rba.gov.au/publications/smp/2020/may/pdf/statement-on-monetary-policy-2020-05.pdf>.
41. These figures were referred to by the National Suicide Prevention Adviser during her press conference with the Prime Minister announcing the National Mental Health Pandemic Response Plan. The data referred to has not yet been published.
42. Community Affairs References Committee. (2020). Adequacy of Newstart and related payments and alternative mechanisms to determine the level of income support payments in Australia, Senate, Senate Printing Unit, Parliament House, Canberra.
43. Business Council of Australia. (2019). A plan for a stronger Australia, Melbourne, accessed at <https://d3n8a8pro7vhmx.cloudfront.net/bca/pages/4678/attachments/original/1554878192/A_plan_for_a_stronger_Australia_-_vol1_-_noembargo.pdf?1554878192>.
Australian Council of Social Services. (2020). Surviving, not living: the (in)adequacy of Newstart and related payments, Submission to Senate Community Affairs References Committee, accessed at <https://www.acoss.org.au/wp-content/uploads/2019/11/SurvivingNotLiving.pdf>.
44. Cavanaugh, C. E., Messing, J. T., Del-Colle, M., O'Sullivan, C., & Campbell, J. C. (2011). Prevalence and correlates of suicidal behaviour among adult female victims of intimate partner violence. Suicide & life-threatening behaviour, 41(4), 372–383. https://doi.org/10.1111/j.1943-278X.2011.00035.x
45. Campbell A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. Forensic Science International: Reports, 2, 100089. https://doi.org/10.1016/j.fsir.2020.100089
46. Taylor, R (2020). The Impact of COVID-19 on Individuals Experiencing Domestic and Family Violence. Counselling, Consultancy and Training Services.
47. Taylor, R (2020). The Impact of COVID-19 on Individuals Experiencing Domestic and Family Violence. Counselling, Consultancy and Training Services.
48. Foster, H. and Fletcher, A. (2020). Impact of COVID-19 on Women and Children Experiencing Domestic and Family Violence and Frontline Domestic and Family Violence Services. Women's Safety NSW. Date Accessed: 1 May 2020. https://www.womenssafetynsw.org.au/wp-content/uploads/2020/03/COVID-19-DV-Responses_WSNSW-Survey.pdf
49. Wesley LifeForce conducted phone interviews with senior management Wesley Mission service providers from multiple areas within the organisation regarding the impacts of COVID-19 on clients and their mental health and wellbeing. Included are anecdotes from the discussions.
50. Taylor, R (2020). The Impact of COVID-19 on Individuals Experiencing Domestic and Family Violence. Counselling, Consultancy and Training Services.
51. Campbell A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. Forensic Science International: Reports, 2, 100089. https://doi.org/10.1016/j.fsir.2020.100089

52. Campbell A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. Forensic Science International: Reports, 2, 100089. https://doi.org/10.1016/j.fsir.2020.100089
53. COVID-19 Declared a disaster. Australian Government, Australian Taxation Office. 7 May 2020. https://www.ato.gov.au/Non-profit/Newsroom/General/COVID-19-declared-a-disaster/
54. Campbell A. M. (2020). An increasing risk of family violence during the Covid-19 pandemic: Strengthening community collaborations to save lives. Forensic Science International: Reports, 2, 100089. https://doi.org/10.1016/j.fsir.2020.100089
55. Parkinson, D. (2017). Investigating the Increase in Domestic Violence Post Disaster: An Australian Case Study. SAGE Journals: Journal of Interpersonal Violence. Vol 34, Issue 11, pages: 2333-2362. https://doi.org/10.1177/0886260517696876
56. The following data was collected from 6 May to 12 May 2020. The survey contained twenty-one (21) questions and elicited a maximum of thirty (30) responses via a survey and an online webinar poll from across twenty-three (23) Wesley LifeForce Suicide Prevention Networks. Sites surveyed included 3 major cities, 13 regional, 4 remote and 3 very remote areas across Australia.
57. The following data was collected from 6 May to 12 May 2020. The survey contained twenty-one (21) questions and elicited a maximum of thirty (30) responses via a survey and an online webinar poll from across twenty-three (23) Wesley LifeForce Suicide Prevention Networks. Sites surveyed included 3 major cities, 13 regional, 4 remote and 3 very remote areas across Australia.
58. MacIsaac, M.B., Bugeja, L.C. and Jelinek, G.A. (2017), The association between exposure to interpersonal violence and suicide among women: a systematic review. Australian and New Zealand Journal of Public Health, 41: 61-69. doi:10.1111/1753-6405.12594
59. MacIsaac, M.B., Bugeja, L.C. and Jelinek, G.A. (2017), The association between exposure to interpersonal violence and suicide among women: a systematic review. Australian and New Zealand Journal of Public Health, 41: 61-69. doi:10.1111/1753-6405.12594
60. Cavanaugh, C. E., Messing, J. T., Del-Colle, M., O'Sullivan, C., & Campbell, J. C. (2011). Prevalence and correlates of suicidal behaviour among adult female victims of intimate partner violence. Suicide & life-threatening behaviour, 41(4), 372–383. https://doi.org/10.1111/j.1943-278X.2011.00035.x
61. National Plan to Reduce Violence against Women and their Children 2010-2022. Australian Government, Department of Social Services. 9 August 2019. https://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022
62. Volkow, Nora D. "Collision of the COVID-19 and addiction epidemics." Annals of Internal Medicine, 2 April 2020, doi: https://doi.org/10.7326/M20-1212
63. Marsden, John, et al. "Mitigating and learning from the impact of COVID 19 infection on addictive disorders." Addiction, 06 April 2020, doi: https://doi.org/10.1111/add.15080
64. Baldessarini RJ (2020). Epidemiology of suicide: recent developments. Epidemiology and Psychiatric Sciences 29, e71, 1–3. https://doi.org/10.1017/ S2045796019000672
65. Volkow, Nora D. "Collision of the COVID-19 and addiction epidemics." Annals of Internal Medicine, 2 April 2020, doi: https://doi.org/10.7326/M20-1212
66. Marsden, John, et al. "Mitigating and learning from the impact of COVID 19 infection on addictive disorders." Addiction, 06 April 2020, doi: https://doi.org/10.1111/add.15080
67. Volkow, Nora D. "Collision of the COVID-19 and addiction epidemics." Annals of Internal Medicine, 2 April 2020, doi: https://doi.org/10.7326/M20-1212
68. Kar, Sujita Kumar, et al. "COVID-19 Pandemic and addiction: Current problems and future concerns." Asian Journal of Psychiatry, vol. 51, article 102064, 10 April 2020, doi: https://doi.org/10.1016/j.ajp.2020.102064
69. Volkow, Nora D. "Collision of the COVID-19 and addiction epidemics." Annals of Internal Medicine, 2 April 2020, doi: https://doi.org/10.7326/M20-1212
70. Volkow, Nora D. "Collision of the COVID-19 and addiction epidemics." Annals of Internal Medicine, 2 April 2020, doi: https://doi.org/10.7326/M20-1212
71. Kar et al., (2020) & Volkow et al., (2020)
72. Colledge, Samantha, et al. "Depression, post-traumatic stress disorder, suicidality and self-harm among people who inject drugs: a systematic review and meta-analysis." Drug and alcohol dependence, vol. 207, article 107793, 1 February 2020, doi: https://doi.org/10.1016/j.drugalcdep.2019.107793
73. Wesley LifeForce conducted phone interviews with senior management Wesley Mission service providers from multiple areas within the organisation regarding the impacts of COVID-19 on clients and their mental health and wellbeing. Included are anecdotes from the discussions.
74. Baldessarini RJ (2020). Epidemiology of suicide: recent developments. Epidemiology and Psychiatric Sciences 29, e71, 1–3. https://doi.org/10.1017/ S2045796019000672
75. Ping Wu, Xinhua Liu, Yunyun Fang, Bin Fan, Cordelia J. Fuller, Zhiqiang Guan, Zhongling Yao, Junhui Kong, Jin Lu, Iva J. Litvak, Alcohol Abuse/Dependence Symptoms Among Hospital Employees Exposed to a SARS Outbreak, Alcohol and Alcoholism, Volume 43, Issue 6, November-December 2008, Pages 706–712, https://doi.org/10.1093/alcalc/agn073
76. Kar, S. K., Arafat, S., Sharma, P., Dixit, A., Marthoenis, M., & Kabir, R. (2020). COVID-19 pandemic and addiction: Current problems and future concerns. Asian journal of psychiatry, 51, 102064. Advance online publication. https://doi.org/10.1016/j.ajp.2020.102064

77. Farhoudian, A., Baldacchino, A., Clark, N., Gerra, G., Ekhtiari, H., Dom, G., Mokri, A., Sadeghi, M., Nematollahi, P., Demasi, M., Schütz, C., Hashemian, S. M., Tabarsi, P., Galea-Singer, S., Carrà, G., Clausen, T., Kouimtsidis, C., Tolomeo, S., Radfar, S. R., & Razaghi, E. M. (2020). COVID-19 and Substance Use Disorders: Recommendations to a Comprehensive Healthcare Response. An International Society of Addiction Medicine (ISAM) Practice and Policy Interest Group Position Paper. Autonomic Neuroscience: Basic & Clinical, 11(2), 129-146. https://doi.org/10.32598/bcn.11.covid19.1
78. The following data was collected from 6 May to 12 May 2020. The survey contained twenty-one (21) questions and elicited a maximum of thirty (30) responses via a survey and an online webinar poll from across twenty-three (23) Wesley LifeForce Suicide Prevention Networks. Sites surveyed included 3 major cities, 13 regional, 4 remote and 3 very remote areas across Australia.
79. Alexander et al., (2020); Marsden et al., (2020) & Volkow et al., (2020)
80. Alexander et al., (2020); Marsden et al., (2020) & Volkow et al., (2020)
81. Marsden, John, et al. “Mitigating and learning from the impact of COVID 19 infection on addictive disorders.” Addiction, 06 April 2020, doi: https://doi.org/10.1111/add.15080
82. Marsden, John, et al. “Mitigating and learning from the impact of COVID 19 infection on addictive disorders.” Addiction, 06 April 2020, doi: https://doi.org/10.1111/add.15080
83. Alexander et al., (2020) & Kõlves, Kairi, Yu Wen Koo, and Diego De Leo. “A drink before suicide: analysis of the Queensland Suicide Register in Australia.” Epidemiology and psychiatric sciences, vol. 29, e94, 24 January 2020, doi: https://doi.org/10.1017/S2045796020000062
84. Douglas Margaret, Katikireddi Srinivasa Vittal, Taulbut Martin, McKee Martin, McCartney Gerry. Mitigating the wider health effects of covid-19 pandemic response BMJ 2020; 369 :m1557
85. Douglas Margaret, Katikireddi Srinivasa Vittal, Taulbut Martin, McKee Martin, McCartney Gerry. Mitigating the wider health effects of covid-19 pandemic response BMJ 2020; 369 :m1557
86. Douglas Margaret, Katikireddi Srinivasa Vittal, Taulbut Martin, McKee Martin, McCartney Gerry. Mitigating the wider health effects of covid-19 pandemic response BMJ 2020; 369 :m1557
87. Douglas Margaret, Katikireddi Srinivasa Vittal, Taulbut Martin, McKee Martin, McCartney Gerry. Mitigating the wider health effects of covid-19 pandemic response BMJ 2020; 369 :m1557
88. Druss BG. Addressing the COVID-19 Pandemic in Populations With Serious Mental Illness. JAMA Psychiatry. Published online April 03, 2020. doi:10.1001/jamapsychiatry.2020.0894
89. Holmes, Emily & O’Connor, Rory & Perry, V & Tracey, Irene & Wessely, Simon & Arseneault, Louise & Ballard, Clive & Christensen, Helen & Silver, Roxane & Everall, Ian & Ford, Tamsin & John, Ann & Kabir, Thomas & King, Kate & Madan, Ira & Michie, Susan & Przybylski, Andrew & Shafran, Roz & Sweeney, Angela & Bullmore, Ed. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. The Lancet Psychiatry. 10.1016/S2215-0366(20)30168-1.
90. Holmes, Emily & O’Connor, Rory & Perry, V & Tracey, Irene & Wessely, Simon & Arseneault, Louise & Ballard, Clive & Christensen, Helen & Silver, Roxane & Everall, Ian & Ford, Tamsin & John, Ann & Kabir, Thomas & King, Kate & Madan, Ira & Michie, Susan & Przybylski, Andrew & Shafran, Roz & Sweeney, Angela & Bullmore, Ed. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. The Lancet Psychiatry. 10.1016/S2215-0366(20)30168-1.
91. The following data was collected from 6 May to 12 May 2020. The survey contained twenty-one (21) questions and elicited a maximum of thirty (30) responses via a survey and an online webinar poll from across twenty-three (23) Wesley LifeForce Suicide Prevention Networks. Sites surveyed included 3 major cities, 13 regional, 4 remote and 3 very remote areas across Australia.
92. Wesley LifeForce conducted phone interviews with senior management Wesley Mission service providers from multiple areas within the organisation regarding the impacts of COVID-19 on clients and their mental health and wellbeing. Included are anecdotes from the discussions.
93. Cheung YT, Chau PH, Yip PS. Dec 2008 A revisit on older adults suicides and Severe Acute Respiratory Syndrome (SARS) epidemic in Hong Kong. Int J Geriatr Psychiatry. 2008 Dec;23(12):1231-8. doi: 10.1002/gps.2056.
94. Cheung YT, Chau PH, Yip PS. Dec 2008 A revisit on older adults suicides and Severe Acute Respiratory Syndrome (SARS) epidemic in Hong Kong. Int J Geriatr Psychiatry. 2008 Dec;23(12):1231-8. doi: 10.1002/gps.2056.
95. The Wesley Village Residents Wellbeing Prospective Research, was conducted with extensive effort devoted to research fieldwork from social work and research students from Western Sydney University. This has provided a very strong and representative data set, which will be a valuable resource for ongoing analyses, and which will provide opportunities for the direction of future research and future policy implications for older people’s wellbeing.
96. About 80% of women in the sample.
97. Wesley Mission op cit.
98. Holmes, Emily & O’Connor, Rory & Perry, V & Tracey, Irene & Wessely, Simon & Arseneault, Louise & Ballard, Clive & Christensen, Helen & Silver, Roxane & Everall, Ian & Ford, Tamsin & John, Ann & Kabir, Thomas & King, Kate & Madan, Ira & Michie, Susan & Przybylski, Andrew & Shafran, Roz & Sweeney, Angela & Bullmore, Ed. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. The Lancet Psychiatry. 10.1016/S2215-0366(20)30168-1.
99. Homelessness and homelessness services (2019). Australian Institute of Health and Welfare. Australian Government. https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services

100. Mission Australia. (2020). What is homelessness. Mission Australia. https://www.missionaustralia.com.au/what-we-do/homelessness-social-housing/what-is-homelessness.
101. Tsai, J. and Wilson, M. (2020). COVID-19: a potential public health problem for homeless populations. The Lancet Public Health. Vol.5, Issue 4, E186-E187. https://doi.org/10.1016/S2468-2667(20)30053-0
102. Wood, L., Davies, A., Khan, Z. (2020). COVID-19 Precautions: Easier said than done when patients are homeless. Med J Aust 2020; 212 (8): 384-384.e1. doi: 10.5694/mja2.50571. https://www.mja.com.au/journal/2020/212/8/covid-19-precautions-easier-said-done-when-patients-are-homeless-0
103. Lima NNR, de Souza RI, Feitosa PWG, Moreira JLS, da Silva CGL, Neto MLR. People experiencing homelessness: Their potential exposure to COVID-19. Psychiatry Res. 2020;288:112945. doi:10.1016/j.psychres.2020.112945
104. Funding boost and new emergency measures to protect tenancies (2020). NSW Government. https://www.nsw.gov.au/nsw-government/ministers/minister-for-better-regulation-and-innovation/media-releases/funding-boost
105. Sakzewski, E. (2020). Are banks freezing mortgages? Here are the banks putting payments on hold amid coronavirus. ABC News. https://www.abc.net.au/news/2020-03-26/are-banks-freezing-mortgages-banks-putting-payments-on-hold/12090642
106. Holmes, Emily & O'Connor, Rory & Perry, V & Tracey, Irene & Wessely, Simon & Arseneault, Louise & Ballard, Clive & Christensen, Helen & Silver, Roxane & Everall, Ian & Ford, Tamsin & John, Ann & Kabir, Thomas & King, Kate & Madan, Ira & Michie, Susan & Przybylski, Andrew & Shafran, Roz & Sweeney, Angela & Bullmore, Ed. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. The Lancet Psychiatry. 10.1016/S2215-0366(20)30168-1.
107. Wesley LifeForce conducted phone interviews with senior management Wesley Mission service providers from multiple areas within the organisation regarding the impacts of COVID-19 on clients and their mental health and wellbeing. Included are anecdotes from the discussions.
108. Wesley LifeForce conducted phone interviews with senior management Wesley Mission service providers from multiple areas within the organisation regarding the impacts of COVID-19 on clients and their mental health and wellbeing. Included are anecdotes from the discussions.
109. The following data was collected from 6 May to 12 May 2020. The survey contained twenty-one (21) questions and elicited a maximum of thirty (30) responses via a survey and an online webinar poll from across twenty-three (23) Wesley LifeForce Suicide Prevention Networks. Sites surveyed included 3 major cities, 13 regional, 4 remote and 3 very remote areas across Australia.
110. Lima NNR, de Souza RI, Feitosa PWG, Moreira JLS, da Silva CGL, Neto MLR. People experiencing homelessness: Their potential exposure to COVID-19. Psychiatry Res. 2020;288:112945. doi:10.1016/j.psychres.2020.112945
111. Lima NNR, de Souza RI, Feitosa PWG, Moreira JLS, da Silva CGL, Neto MLR. People experiencing homelessness: Their potential exposure to COVID-19. Psychiatry Res. 2020;288:112945. doi:10.1016/j.psychres.2020.112945
112. Wesley LifeForce conducted phone interviews with senior management Wesley Mission service providers from multiple areas within the organisation regarding the impacts of COVID-19 on clients and their mental health and wellbeing. Included are anecdotes from the discussions.
113. Baldessarini RJ (2020). Epidemiology of suicide: recent developments. Epidemiology and Psychiatric Sciences 29, e71, 1–3. https://doi.org/10.1017/ S2045796019000672
114. AHURI. (2018). What is the Housing First model and how does it help those experiencing homelessness?, The Australian Housing and Urban Research Institute (AHURI), available online at <https://www.ahuri.edu.au/about-us/who-we-are-and-what-we-do>.
115. NSW Government. (2018). NSW Homelessness Strategy 2018-2023, NSW Government.
116. Fitzpatrick-Lewis, D., Ganann, R., Krishnaratne, S., Ciliska, D., Kouyoumdjian, F. & Hwang, S.W. (2011). Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review, BMC Public Health, 11(638).
117. Gulur, L., Stefancic, A., Tsemberis, S. & Fischer, SN. (2003). Housing, hospitalisation, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes, Journal of Community & Applied Social Psychology, 13(2).
118. Padgett, DK., Gulcur, L. & Tsemberis, S. (2006). Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse, Research on Social Work Practice.
119. Gaetz, S., Scott, F., and Gulliver, T., (2013) Housing First in Canada: Supporting Communities to End Homelessness, Canadian Homelessness Research Network Press, Toronto.
120. Vasterman, P. L., & Ruigrok, N. (2013). 'Pandemic alarm in the Dutch media: Media coverage of the 2009 influenza A (H1N1) pandemic and the role of the expert sources'. European Journal of Communication, vol. 28, no. 4, pp.436–453. <https://doi.org/10.1177/0267323113486235>.
121. Taha SA, Matheson K, Anisman H. H1N1 was not all that scary: uncertainty and stressor appraisals predict anxiety related to a coming viral threat. Stress Health. 2014;30(2):149 157. doi:10.1002/smi.2505
122. Vasterman, P. L., & Ruigrok, N. (2013). Pandemic alarm in the Dutch media: Media coverage of the 2009 influenza A (H1N1) pandemic and the role of the expert sources. European Journal of Communication, 28(4), 436–453. https://doi.org/10.1177/0267323113486235
123. Ibid.
124. Life in Mind. (2020). The Charter, online article, Everymind, accessed 2 June 2020 at <https://lifeinmindaustralia.com.au/the-charter>.

Wesley Mission

220 Pitt Street Sydney NSW 2000
PO Box A5555 Sydney South NSW 1235
(02) 9263 5555
communications@wesleymission.org.au

wesleymission.org.au

ABN 42 164 655 145

Suicide Prevention Australia

GPO Box 219 Sydney NSW 2001
(02) 9262 1130
policy@suicidepreventionaust.org

suicidepreventionaust.org

STATE OF THE NATION
IN SUICIDE PREVENTION

A survey of the suicide prevention sector

September 2020

Suicide Prevention Australia

Suicide Prevention Australia

Highlights

Our respondents

42% organisations

31% individuals

27% unspecified

An emerging, collaborative sector serving communities across Australia

69% collaborate with Government and/or other organisations

1 in 5 suicide prevention organisations started up within the past 5 years

Increasing demand for suicide prevention support

78% report an increase in demand

65% need more funding and support to cope

67% agree more funding needed to support priority populations

Key risks to suicide rates*

82% Employment

81% Social isolation

77% Relationship breakdown

Ways to address risk

- Lift the base rate of JobSeeker
  Fund clear vocational pathways to work
- Enhance digital and face to face peer-to-peer support
- Broaden Better Access Scheme to cover relationship counselling

Sector and community back a whole of government approach to suicide

95%
State of the Nation participants support a whole of government approach

70%
of Australians support a Suicide Prevention Act

Access to better data on suicide prevention

75% of suicide prevention organisations need access to better data on suicide

83% of all participants agree there are gaps in data collections systems

Suicide prevention workforce has critical gaps in skills and training

Integrating lived experience

Minimum standard suicide intervention training for frontline workers

Understanding the needs of priority groups (e.g. LGBTQI+)

*Participants could select more than one response.

Executive Summary

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We number among our membership many of the largest and smallest suicide prevention organisations, as well as individuals with lived experience of suicide, research and subject matter expertise.

About the survey

We designed the State of the Nation in Suicide Prevention Survey to gather in-depth intelligence from our membership and the broader suicide prevention sector. The survey, and this report, are structured around four key themes: the current operating environment; risks and protective factors; our National Policy Platform priorities of whole of government reform, accurate, reliable data and workforce strategy; and the funding environment. The information we have gathered on this area will inform our policy and advocacy work in 2020/21.

Suicide Prevention Australia aims to conduct the State of the Nation survey annually, with the results to be released every World Suicide Prevention Day. In this baseline iteration we have combined quantitative questions to provide the basis for mapping trends with open-ended, qualitative questions. These have enabled us to gather insights that will shape future iterations of the survey.

A collaborative, resilient sector

The COVID-19 pandemic is proving to be a 'black swan' event, with economic and social ramifications extending far beyond the public health crisis caused by the virus. Australia has been doubly affected, having experienced a severe bushfire season only months before the COVID-19 pandemic reached our shores. The compounding impact of these crises means many in our communities are vulnerable to distress.

The suicide prevention sector is rising to the challenge. While more than three quarters of our participants reported a significant increase in demand for their services, suicide prevention organisations and experts are highly collaborative. More than two thirds work with Government agencies, other not for profit and community-based organisations, with only one in twenty delivering their services and programs in isolation.

Many participants reported transitioning in person and face-to-face services to online modes of service delivery in response to COVID-19 physical distancing measures. Participants noted the benefits of being able to provide their services more broadly and increase their reach by providing services via online platforms.

Most organisations need more support

While the suicide prevention sector has proven to be resilient, most need more support. One in three suicide prevention organisations have informed us they require additional funding and support to cope with continued increases in demand. This support should be an urgent priority for Government in the 2020-21 Federal Budget, particularly at a time when thousands of Australians are newly vulnerable to distress and impacts on their wellbeing.

Suicide Prevention Australia is proud to represent a sector that supports the most vulnerable Australians. Most suicide prevention organisations support groups that experience greater rates of suicide, with many working with young people, Aboriginal and Torres Strait Islander communities, with LGBTQI+ Australians, Culturally and Linguistically Diverse (CALD) communities, the homeless and the unemployed. A majority of participants, however, have advised that greater investment in programs and services targeting priority groups is required.

The suicide prevention sector shares community perceptions about emerging areas of suicide risk

Participants in this survey ranked social isolation and loneliness, unemployment and job security, and family and relationship breakdown as the most significant emerging risks to suicide. The high level of concern about these emerging areas of risk were shared by respondents to Suicide Prevention Australia's recent YouGov poll of the broader Australian population, which also ranked social isolation and unemployment as two of the leading risks to suicide rates.

The sector, however, has provided constructive advice on the policy interventions that would mitigate emerging risk factors for suicide. Examples of our participants' ideas include increasing social supports such as JobKeeper and JobSeeker; tailored methods for peer to peer and community connection including face to face and digital options; and broadening the Better Access initiative to cover relationship counselling. These proposals are in line with Suicide Prevention Australia's recent advocacy work.[1]

Strong support for our National Policy Platform priorities

We surveyed the sector to gauge continued support for our National Policy Platform and to gather ideas to progress adoption of our three pillars. The National Policy Platform, published in April 2019, outlines three priorities or 'pillars' for systemic suicide prevention reform: a whole of government approach; accurate, reliable data on suicide and suicidal behaviour; and workforce strategy.

There was strong support for the sector for these priorities. An overwhelming majority of participants support a whole of government approach to suicide prevention. Our survey participants also described a whole of government model in line with our National Policy Platform: including a permanent suicide prevention function at the national level; assigning responsibility for suicide prevention to first ministers; and using Commonwealth funding to drive a nationally consistent approach to suicide prevention policy and accountability.

A majority of participants expressed an urgent need for accurate, reliable data on suicide prevention. This data goes beyond data on suicide deaths: the sector needs reliable, rapid information on self-harm and suicidal behaviours, as well as information on social determinants. This is particularly pressing given the significant structural changes to industries, communities and the Australian economy currently underway due to the COVID-19 pandemic.[2]

The sector requires data to determine how these shifts are impacting the mental health and wellbeing of Australians; many of whom are now struggling to maintain or find employment, service their debts, access affordable housing, or other social supports.

Our survey respondents also advised that the skills and training needs of the suicide prevention workforce need better planning and investment. Continuing our call for a standalone national suicide prevention workforce strategy will be a focus for Suicide Prevention Australia in the lead-up to the National Suicide Prevention Adviser's final report, due in late 2020.

The sector wants to see funding for suicide prevention drive accountability and change

Finally, funding for suicide prevention should be used as a mechanism for driving accountability and change. Many of our participants expressed a clear view that public funding should be allocated to programs and services with proven outcomes, or with clear evidence of quality, safety and efficacy.

For more information

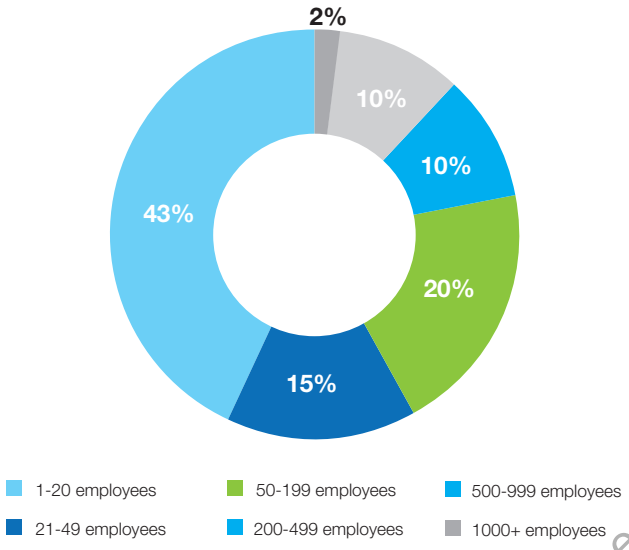
If you would like more information on the State of the Nation Survey and its results, please contact **policy@suicidepreventionaust.org**

The suicide prevention sector

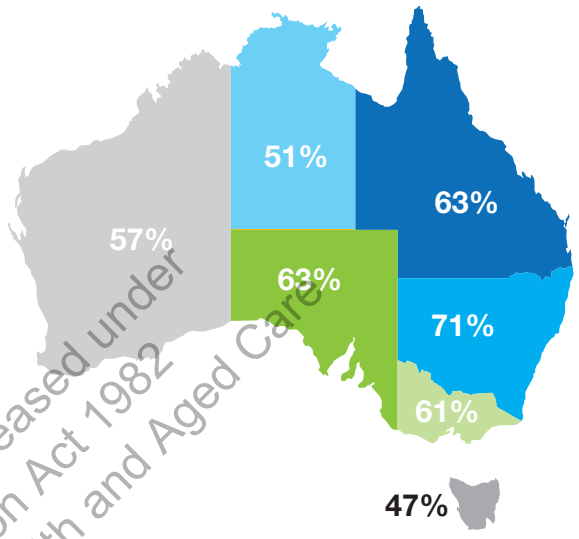
Suicide Prevention Australia

A diverse sector, serving communities across Australia with a range of needs.

Organisation size



Geographic spread – where organisations provide services

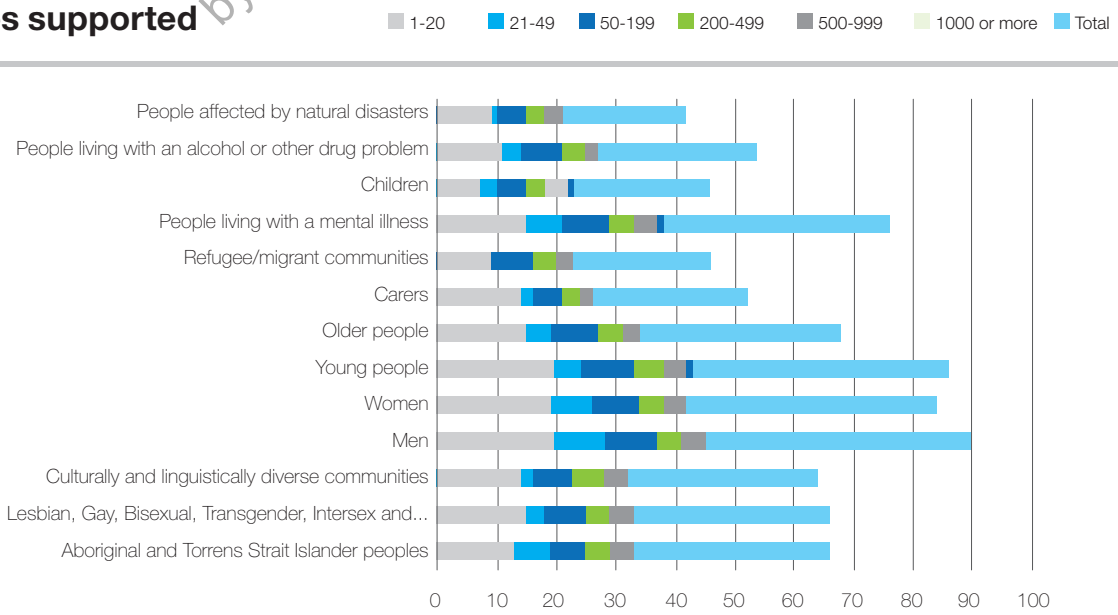


The sector is emerging and highly collaborative

- One in five (20%) organisations were established within the last 5 years, with the remainder (80%) established more than 6 years ago.
- More than two thirds (69%) of respondents said they work with Government agencies, other not for profit organisations and community based organisations, with only 4.7% reporting no collaboration with other organisations

The sector supports vulnerable populations and communities

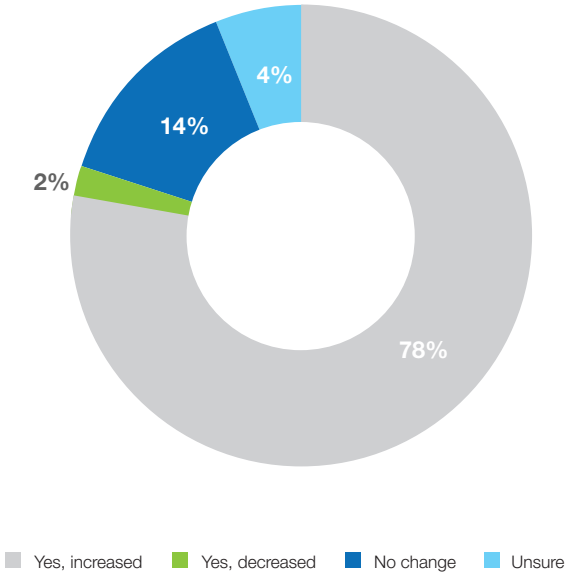
Communities supported



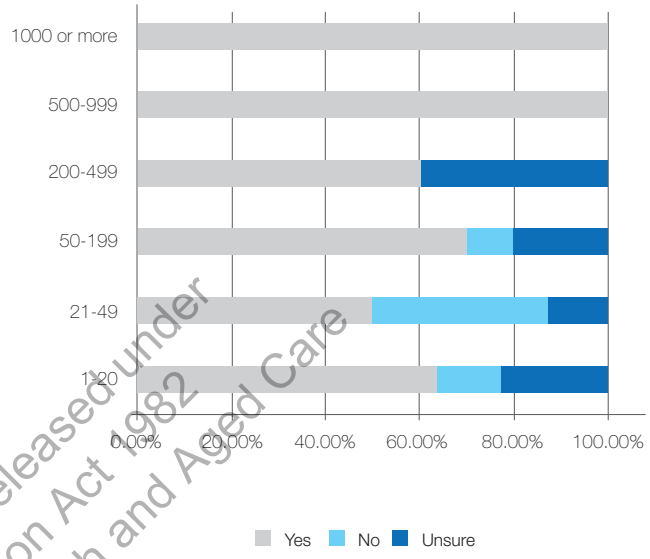
Demand for suicide prevention services is increasing and organisations need additional support

Suicide Prevention Australia

Has demand for your services changed over the last 12 months?



Does your organisation need additional funding and support to cope with demand?



COVID-19 has influenced a shift online

We asked participants who had reported changes in their service delivery patterns to provide open text feedback on the factors influencing this shift.

Many participants reported transitioning in person and face-to-face services to online modes of service delivery in response to COVID-19 physical distancing measures. Participants noted the benefits of being able to provide their services more broadly and increase their reach by providing services via online platforms.

Some respondents reported challenges in transitioning to online services. For example, one participant reported young people have experienced difficultly maintaining engagement in virtual meetings, and others reported discontinuing workshops and gatekeeper training programs due to distancing measures.

Push to respond to increases in service demands

Participants reported increases in service demands within the last 12 months across differing support services (e.g. helpline services, online forums, training, and workshops). One participant identified difficulty responding to the increase in service demand with limited funding.

Suicide Prevention Australia

Risk and protective factors

A challenging year for our communities

We asked our survey respondents to provide their view on risks and protective factors for suicide and distress.

Respondents to our survey shared broader community perceptions about emerging areas of suicide risk.

State of the Nation respondents ranked social isolation and unemployment as two areas posing the highest risk to suicide rates over the next year.

This response mirrored Suicide Prevention Australia's recent YouGov poll of 1,000 Australians, which also ranked social isolation and unemployment within the top four risks to suicide rates.[3]

Predicted risks to suicide rates*

*Respondents were able to select more than one option

	Top rated risk	Second rated risk	Third rated risk	Fourth rated risk
State of the Nation (n=140 sector participants)	82% Social isolation and loneliness	81% Unemployment and job security	77% Family and relationship breakdown	59% Cost of living and personal debt
YouGov poll (n=1,000 Australians)	67% Drugs and alcohol	66% Social isolation and loneliness	63% Cost of living and personal debt	56% Unemployment and job security

In context: What are risks and protective factors?

Suicide is a complex, multi-factorial human behaviour and is usually a response to many contributing factors, or 'risk factors' rather than a single cause.

Most people who have one or more risk factors for suicide will not engage in suicidal behaviour; for example, many people with an experience of mental ill health do not experience suicidality.[4] At the same time, there is evidence that a wide range of factors can contribute to a person's vulnerability to distress and suicide.

Examples of risk factors include, but are not limited to:

- Mental ill health
- Unemployment and financial distress
- Access to means of suicide
- Unsafe reporting of suicide in the media
- Relationship and family breakdown
- Social isolation and disconnection from social supports.[5]

Protective factors, on the other hand, 'protect' people from suicidal behaviours. Examples of protective factors include:

- Physical health and wellbeing
- Connection with family and friends
- Coping strategies or life skills
- Employment
- Access to clinical and non-clinical support options.[6]

Young people with a lived experience of mental ill health or suicide are already experiencing high levels of isolation. Investing in building peer to peer communities, both face to face and digitally, is important in creating connection, support networks & safety nets.

Survey respondent

Interventions needed to tackle emerging suicide risks*

Top rated risk	Second rated risk	Third rated risk
Social isolation and loneliness	Unemployment and job security	Family and relationship breakdown
-Enhance digital opportunities for peer to peer support -Fund targeted digital and face to face supports for high risk groups (rural and remote, older Australians LGBTQI+, Aboriginal and Torres Strait Islander) -Support local government initiatives that drive community connection	- Continue JobKeeper in the medium term -Raise the base rate of JobSeeker -Clear education and training pathways to work for young people	- Evidence-based interventions to support fathers and mothers from pregnancy onward - Subsidise relationship counselling via the Better Access Initiative - Enhance funding for early intervention parenting programs

*Extrapolated from key words and themes derived from participants' open text responses (n=130).

Suicide Prevention Australia

Suicide Prevention Australia's National Policy Platform Priorities

Suicide Prevention Australia published our National Policy Platform in 2019. The Platform sets out three 'pillars' for systems level suicide prevention reform, which were identified in consultation with our members:

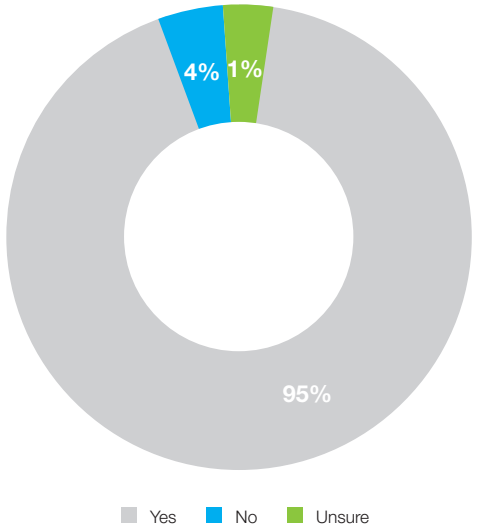
- Whole of government reform
- Accurate, reliable data on suicide prevention
- Workforce strategy.

We surveyed the sector to gauge current attitudes toward our National Policy Platform pillars. We also asked participants for their ideas on how we might progress adoption of our Platform by Government.

Pillar One:
A whole of government approach to suicide prevention

There is overwhelming support for a whole of government approach to suicide prevention and the right system to support it

Do you believe a whole of government approach to suicide prevention is required?



In context: What is a whole of government approach to suicide prevention?

Suicide is a multi-factorial human behaviour and is more than an expression of mental ill health: which is why Suicide Prevention Australia advocates for a whole of government, whole of community approach to suicide prevention. The Fifth National Mental Health and Suicide Prevention Plan reinforces this position, outlining that suicide protective and risk factors are more wide ranging than mental health and clinical treatment options.

A whole of government, whole of community approach means every level of Government, every agency within Government, the not for profit and private sectors are actively involved in preventing suicide in Australia. The "'whole of government' approach" also involves better cross-portfolio coordination to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention.

Suicide Prevention Australia, in consultation with our members, has offered to Government a model for a whole of government approach to suicide prevention in Australia:

- Passing a Suicide Prevention Act to provide a legislative framework for a three-yearly National Suicide Prevention Plan, integrating actions with a responsible agency, committed funding, measurable performance indicators and a suicide reduction target.
- Setting up a National Suicide Prevention Office, preferably housed within the Department of Prime Minister and Cabinet, to manage information sharing, performance, evaluation and funding for suicide prevention.
- Using intergovernmental agreements and contracts to negotiate nationally consistent approaches to suicide prevention funding and policy with the States and Territories. This would influence system change, avoid duplication, and provide a more seamless service to consumers.
- Including social benefit via mental health and suicide prevention as a compulsory outcome of Government procurement initiatives, and building this into tendering and contract evaluation processes.

Participants in our survey offered proposals for a whole of government approach strongly aligned to the model outlined in our Platform (see table below).

Suicide prevention needs a whole of system, not just whole of government approach. An accountability framework needs to be enforced so that approaches that are promised and not delivered can be highlighted.

Survey respondent

Sector ideas for a whole of government approach to suicide prevention*

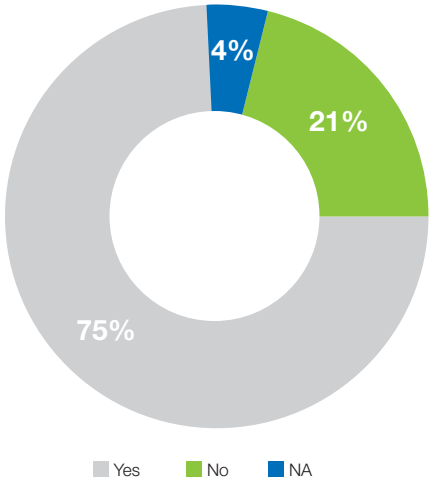
Roles and Responsibilities			
National Cabinet	**Commonwealth Government**	**State and Territory Governments**	**Local Government**
Develop new intergovernmental agreement on suicide prevention Pool funding and develop nationally consistent policy framework Drive information sharing, including real time data on the social determinants of suicide	Permanent Suicide Prevention Adviser role within a central agency Cabinet proposals assess suicide prevention and mental health impacts Organise funding based on proven or likely outcomes of the program or service, not through brand recognition	First Ministers responsible for suicide prevention Suicide prevention housed within a central agency Cabinet proposals assess suicide prevention and mental health impacts	Strong role in place-based strategies Whole of government collaboration with State and Territory Governments at the community level

*Table developed using key words and themes derived from participants' open text responses (n=75).

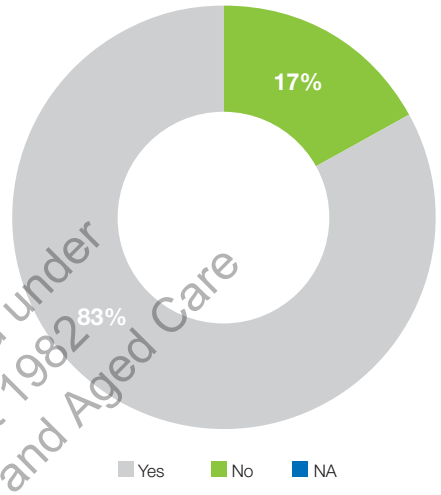
Pillar Two:
Accurate, reliable data

The suicide prevention sector needs access to data on suicide and there are gaps in current data collection systems

Does your organisation need access to reliable, accurate suicide prevention data?



Are there gaps in data collection systems for suicide prevention?



In context: Why we need accurate, reliable data on suicide and suicidality

The Australian Institute of Health and Welfare reports 3,046 deaths by suicide were registered in Australia in 2018, equating to approximately 8 deaths per day.[7] Among Australians aged 15-44, suicide was the leading cause of death in 2016-2018.

Accurate, reliable and timely data is critical to enabling evidence-based policy, planning, service delivery and informed research. The World Health Organisation has stated that "improved surveillance and monitoring of suicide and suicide attempts is required for effective suicide prevention strategies".[8]

Key data sources for suicide deaths in Australia include the Australian Bureau of Statistics (ABS) which annually releases Causes of Death data, and the National Coronial Information System (NCIS) in which coroners across all jurisdiction contribute data on suicide deaths.

A number of factors impact the accuracy of reporting on deaths by suicide. For example, there is a lack of guidance for coroners in their practice and making a determination of suicide is typically at the coroner's discretion. Increases in the number of cases left open that may be suicides can mean suicide deaths are being underreported, and Suicide Death Registers currently only exist in Queensland, Victoria and Tasmania.

Delays in coronial processes and inconsistencies in practice determining cause of death can significantly impact the quality of ABS mortality data.

Without a clear picture of suicide in Australia, it is challenging to implement effective strategies and interventions to reduce the rate of suicide and save lives. That is why our National Policy Platform calls for the establishment of a national authority to lead the coordination and integration of state-based data and distribution of suicide data to assist service delivery and research. This body should work in partnership with State Suicide Death Registers (which should be established in every jurisdiction) and relevant organisations to achieve these improvements in data collection, including liaising with the ABS, AIHW and the NCIS.

The agreed risk factors for suicidality extend beyond mental ill health and encompass social determinants: factors such as unemployment, financial distress, relationship breakdown, and housing insecurity.[9] Respondents to our survey agree that the linkage and availability of data on social determinants is critical if we are to reduce the rate of suicide.

The proposals offered by participants in this survey to improve the accuracy, quality and reporting of suicide data were broadly in line with the above observations.

States and territories don't provide timely data on suicide and as such bodies rely on annual ABS data. Long delays in accessing accurate data means it isn't possible to identify clusters of suicides and intervene in a timely manner.

Survey respondent

Sector ideas for improving the accuracy, quality and reporting of suicide data*

Enhance cross-jurisdictional collaboration & information sharing	Establish Suicide Death Registers in every jurisdiction	Appoint data collection workers across jurisdictions	Establish data hub for trends and latest confirmed data
Develop national reporting framework & code	Ensure data is accessible by the sector and in line with safe reporting guidelines	Standardise suicide and self-harm classification	Create a real-time database on emergency department presentations and ambulance call outs

*Table developed using key words and themes derived from participants' open text responses (n=75).

Suicide Prevention Australia

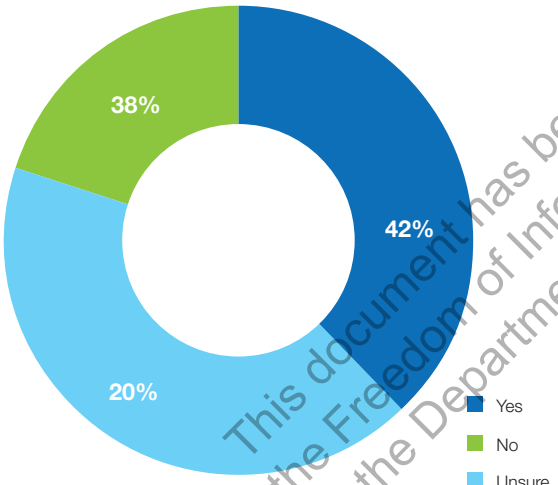
Pillar Three: Workforce

Our National Policy Platform emphasises the need to build workforce capacity in suicide prevention, beyond the bounds of the mental health sector and acute care system.[10] A key aspect of building this capacity should be a standalone suicide prevention workforce strategy and implementation plan; a complement to, rather than as a stream within the National Mental Health Workforce Strategy currently in development.

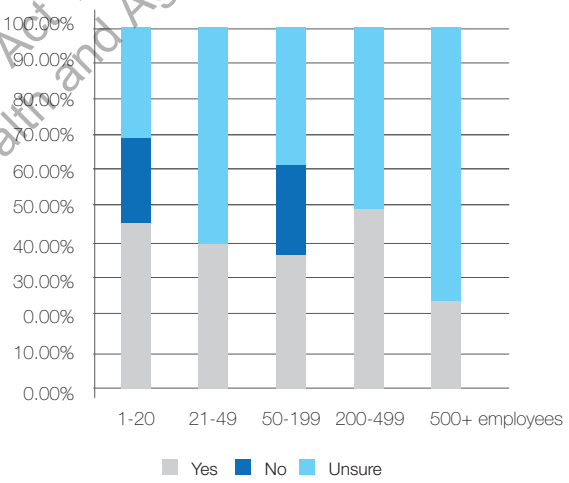
We asked participants in our survey to describe the challenges, skills and training needs of their organisation as well as the broader suicide prevention sector. Suicide Prevention Australia will use this intelligence to inform the next phase of our advocacy work on the scope and content of a national suicide prevention workforce strategy.

Many organisations expect to hire new staff in 2020-21, although many are also unsure about their requirements

Intention to hire new staff in 2020-21



Intention to hire new staff in 2020-21: by organisation size



In context: Defining the suicide prevention workforce

Suicide Prevention Australia takes the view that the suicide prevention workforce should be defined as broadly as possible. A broad view of the scope of the suicide prevention workforce reflects a whole of community approach to suicide prevention: and includes everyone who is likely to interact with or make decisions that affect someone who might be vulnerable to suicide.

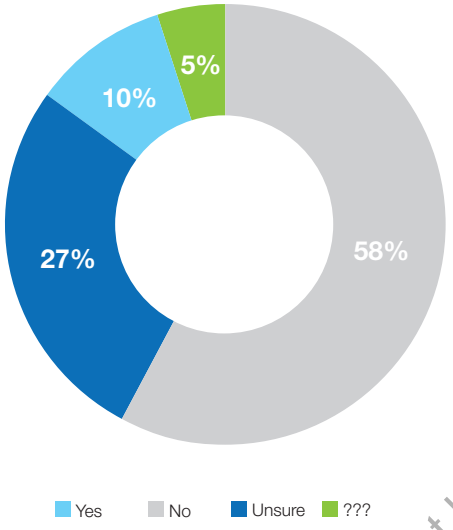
As outlined in our previous representations to Government, Suicide Prevention Australia defines the suicide prevention workforce across three broad groups:

- The clinical workforce, encompassing doctors, nurses, and allied health professionals who interface with individuals at risk of suicide and in suicidal crisis.
- The formal suicide prevention and mental health workforce, encompassing those working in a suicide prevention, response, crisis support or postvention setting: for example, emergency first responders, the lived experience workforce, postvention workforce, personnel involved in the delivery of digital health services, counsellors, social workers, and other mental health workers. In most cases, this segment of the workforce should co-exist and be complementary to the mental health workforce, leveraging and sharing infrastructure where appropriate.
- The informal suicide prevention workforce, which includes (but is not limited to) personnel from across Government Departments, social services, employer groups, miscellaneous service providers, community based organisations and other settings where individuals vulnerable to suicide or suicidality are likely to present.

Suicide Prevention Australia

Most respondents said there are critical gaps in the skills, training and qualifications of the suicide prevention workforce

Does the suicide prevention workforce have the right training and skills?



Key gaps in skills and training*

Learning from lived experience

Stigma reduction

Understanding the needs of priority groups (e.g. LGBTQI+)

Minimum standard suicide intervention training for clinicians

A suicide prevention workforce strategy is required to address training gaps to build and maintain a competent and compassionate workforce. The strategy would need to develop a specific postvention plan for an inclusive workforce - clinical, non-clinical, lived experience, peer supporters, gatekeepers, tertiary institutions, workplaces and government officials (health, justice, education, housing).

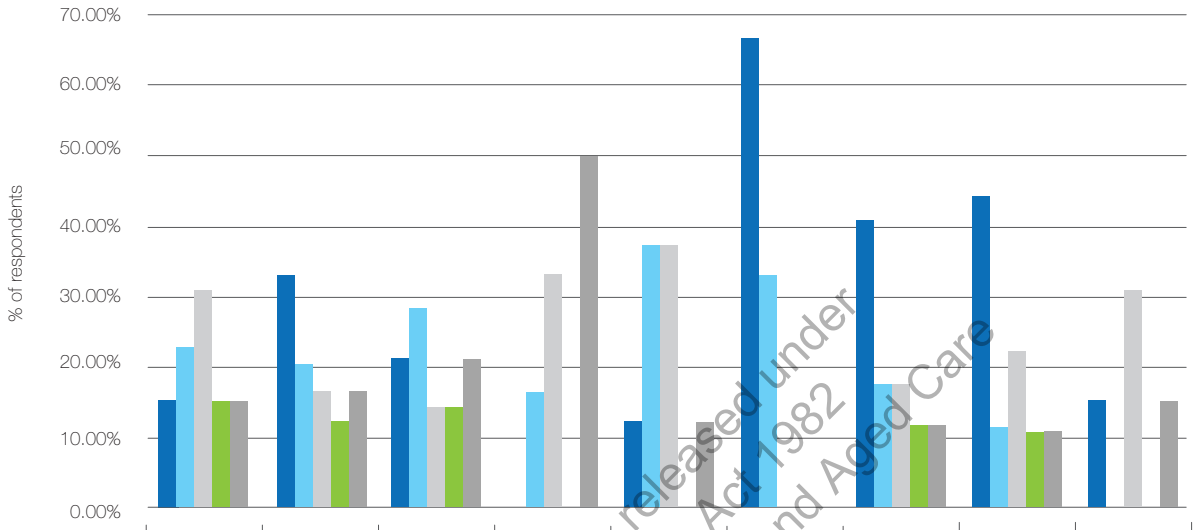
Survey respondent

Suicide Prevention Australia

Funding

Funding certainty is linked to organisation size

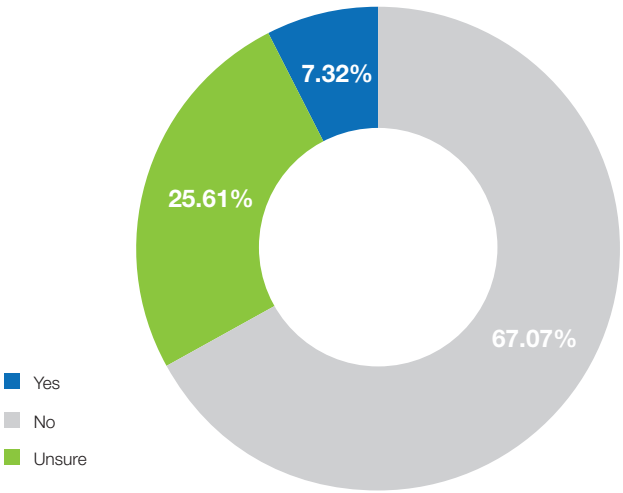
Funding sources



employees	Common wealth Government	State/ Territory Government	Philan thropic foundations	Local funding agencies	Private sector agencies	Membership	Private donations	Sales of goods and services	Other
1-20	15.38%	33.33%	21.43%	0.00%	12.50%	66.67%	41.18%	44.44%	40.00%
21-49	23.08%	20.83%	28.57%	16.67%	37.50%	33.33%	17.65%	11.11%	0.00%
50-199	30.77%	16.67%	14.29%	33.33%	37.50%	0.00%	17.65%	22.22%	40.00%
200-499	15.38%	12.50%	14.29%	0.00%	0.00%	0.00%	11.76%	11.11%	0.00%
500-999	15.38%	16.67%	21.43%	50.00%	12.50%	0.00%	11.76%	11.11%	20.00%

The sector wants to see investment in interventions for priority populations

Are programs and services targeted to priority populations appropriately funded and resourced?



In context: How is the suicide prevention sector funded?

Suicide prevention in Australia is supported through a complex series of funding arrangements between Government and service providers; between the Commonwealth, State and Territory Governments; philanthropic sources and donations; and through providers selling services and products supporting suicide prevention. The Australian Institute of Health and Wellbeing's 2018 Australia's Health Report has summarised these arrangements, highlighting the lack of clarity and consistency of funding for suicide prevention.[11]

This is an outline of how funding for suicide prevention in Australia is organised now:

Commonwealth funding: The Commonwealth Government is a significant source of direct funding for suicide prevention. There is, however, a lack of reporting clarity for the quantum of Commonwealth expenditure. Suicide prevention funding is often grouped with mental health services funding: for example, the $461 million investment in youth mental health and suicide prevention in the 2019/2020 Budget. In January 2020 the Commonwealth Government announced a dedicated $64m in funding for suicide prevention, following the initial report of the National Suicide Prevention Adviser.[12] Even so, the announcement combined single year investments with 2-3 year investments, making it unclear how the funding will be allocated over the forward estimates.

Commonwealth support for the States and Territories: The Commonwealth is a significant source of funding to the jurisdictions. These arrangements are organised through a range of high level agreements: for example, the Hospitals Agreements and the National Agreements on Psychosocial Support Measures. The high level agreements are further supplemented by contracts between Governments for individual programs and services.

State and Territory funding: The jurisdictions support the Commonwealth Government's suicide prevention activities with their own locally delivered plans and programs. Investment in these plans and programs is not, however, reported on by any jurisdiction: and funding for suicide prevention services are generally grouped together with mental health services funding in State and Territory Budget papers. The NSW Government announced $87 million, however, to implement its Toward Zero Suicide initiatives in the 2019-2020 Budget.

Primary Health Networks (PHNs): The Australian Government provides significant allocations to PHNs to fund health activities, including suicide prevention, according to local need. The PHNs are also leading delivery of the national suicide prevention trials to improve strategy at the local level for at-risk population groups. Data concerning the trials has not yet become available, although the evaluation phase is currently underway.

Philanthropic sources: Many not for profit organisations operating in the suicide prevention sector receive funding from philanthropic sources. This includes private donations from individuals, as well as donations from organisations exercising corporate social responsibility.

Participants reported gaps and issues in the way funding is organised now

Short contracts and grant funding cycles

Lack of measured outcomes and accountability

Significant demands on Government to fund COVID-19 public health response

Increased economic pressures driving down philanthropic funding sources

References

1- Suicide Prevention Australia & Wesley Mission. (2020). Reducing distress in the community following the COVID-19 pandemic, online report available at https://www.suicidepreventionaust.org/wp-content/uploads/2020/07/White-Paper_Reducing-distress-following-the-COVID-19-pandemic.pdf

2- Australian Bureau of Statistics. (2020). Coronavirus (COVID-19) personal levels of concern in the community, actions taken as a result of COVID-19, and use of stimulus payments. 4940.0 - Household Impacts of COVID-19 Survey, Detailed Release, June 2020, accessed 23 August 2020 at <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4940.0>.

3- Suicide Prevention Australia. (2020). World Suicide Prevention Day Poll, YouGov, summary results available on request.

4- World Health Organisation. (2014). Preventing suicide: a global imperative, online report, accessed 23 August 2020 at <https://www.who.int/mental_health/suicide-prevention/exe_summary_english.pdf?ua=1>.

5- Ibid.

6- McLean, J. Maxwell, M. Platt, S. Harris, F. Jepson, R. (2008). Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review, Scottish Government Social Research, accessed 23 August 2020 at <https://dspace.stir.ac.uk/bitstream/1893/2206/1/Suicide%20review%5b1%5d.pdf>.

7- Australian Institute of Health and Welfare. (2020). Suicide and intentional self-harm, AIHW, available online at <https://www.aihw.gov.au/reports/australias-health/suicide-and-intentional-self-harm>.

8- World Health Organisation. (2019). Suicide. Accessed 22 August 2020, available at <https://www.who.int/news-room/fact-sheets/detail/suicide>.

9- World Health Organisation. (2014). Preventing suicide: a global imperative, online report, accessed 23 August 2020 at <https://www.who.int/mental_health/suicide-prevention/exe_summary_english.pdf?ua=1>.

10- Suicide Prevention Australia. (2019). National Policy Platform. Sydney, available online at <https://www.suicidepreventionaust.org/wp-content/uploads/bsk-pdf-manager/2019/05/Suicide-Prevention-Australia-National-Policy-Platform-April-2019-high-res.pdf>.

11- Australian Institute of Health and Welfare. (2018). Australia's Health 2018, Australia's health series no. 16. AUS 221. Canberra: AIHW.

12- Hunt, The Hon. Greg MP. (2020). 'Suicide prevention and mental health package signals once in a generation reforms', media release, accessed 23 August 2020 at <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/suicide-prevention-and-mental-health-package-signals-once-in-a-generation-reforms>.

Suicide Prevention Australia

For more information about this report:
Rebecca Burdick Davies
Director, Policy & Government Relations
policy@suicidepreventionaust.org
www.suicidepreventionaust.org

Brief for National Suicide Prevention Adviser: SPA and Wesley Joint White Paper

This is Version 1.0 – dated 02/07/20 for initial high level briefing

About the report:

- The document is written as a White Paper and co-authored by SPA and Wesley.
- It is due for public release on Monday 6 July.
- The paper draws on a scan of evidence, a selection of surveys published during COVID (e.g. ABS snapshots) and a survey completed by Wesley services and the suicide prevention networks supported by Wesley.
- It outlines some of the issues that could increase distress for the community, potential association with suicide (without any estimation of risk) and makes some recommendations for government (summarised below).
- It suggests the recommendations are to assist with the implementation of the pandemic mental health response plan and Australia's economic and social recovery from COVID.
- The report suggests that overall the government's pandemic response is in line with evidence to date, but some additional recommendations are made.

Report recommendations:

A summary of recommendations within the report are provided below with some notes and context for consideration.

Recommendations	Notes
Economic overview	• Economic recessions have been associated with increases in suicide (mainly for men) – but there is significant variability, with increases in suicide linked to austerity measures. • The report notes that Australia did not see a rise in suicide rates during the GFC. • Their call to increase Job seeker is in line with their previous position papers which have called for an increase in Newstart.
The Australian Government consider: 1. Increasing the base rate of JobSeeker after the coronavirus supplement expires. 2. Extending JobKeeper beyond September 2020 to target employers in industries that continue to see the most significant impact.	
Domestic violence	• The report does not reference the fact that Domestic and Family Violence was integrated as a key consideration in the Pandemic Response Plan. • Also does not reference the Commonwealth package for Family Violence announced early in the pandemic. • Initial advice in November was supportive of building capacity of our frontline workers across a range of services to respond to distress and suicidality – and the pandemic
Governments to consider: 1. Funding the adaption of existing suicide prevention and mental health training programs to build Domestic and Family Violence (DFV) workforce capacity to screen for mental health issues, suicide risk and practice suicide interventions with at-risk groups.	

	response plan highlights need to connectivity between different services.
Social isolation The Australian Government to consider: 1. Government to fund the development and delivery of mental health and wellbeing screeners in retirement villages. 2. Government to invest in a model of care for retirement villages, which addresses and responds to older Australians mental health and wellbeing. 3. Government to deliver a national survey into the impacts of COVID-19 on the mental health and suicidality of all Australians.	• A series of announcements sought to address social isolation , with a specific focus on older people – e.g. early funds to support expansion of official visitors. • There are a range of national surveys already in play re COVID, with the next national survey of mental health and wellbeing due to be done this year (but may have been moved – can have checked). • Some broader context about existing programs in aged care may be required from Department of Health.
Substance abuse and alcohol consumption Governments to consider: 1. Funding for tailored (preferably pre-service) suicide prevention training and education for frontline hospital staff. 2. Include addressing suicide risk within future national, state and territory drug and alcohol strategies. 3. Funding packages to support screening by alcohol and substance service providers for mental health issues and suicidal ideation in at-risk clients and consumers.	• The report does not appear acknowledge that the Government made a commitment to increase funding for AOD services delivered online (e.g. Hello Sunday Morning and Counselling Online) and also provided additional support for information for schools and communities. • I suspect that by pre-service that SPA doesn't mean university training if the need is immediate – but November advice supported a greater focus on a range of workforces, including the AOD workforce. • Suggest it is also broadly aligned with advice to suggest greater alignment between our AOD strategy and our suicide prevention strategy – as outlined again in Initial advice. • July advice will have a focus on AOD and evidence review commissioned. • The Taskforce and EAG did an early paper on AOD, suicide risk and COVID in March if it is needed.
Homelessness Governments to consider: 1. Extending moratoriums on evictions to support people who will experience prolonged financial distress. 2. Addressing long-term housing and strategies, including the Housing First	• July advice likely to include information on housing stress and homelessness – based on commissioned evidence review. • Social determinants (including housing) references in the pandemic response plan.

approach, in the recovery phase of COVID-19.	• No specific response to their recommendations.
The role of media The Australian Government should continue to: 1. Widely promote fact-based sources of information on COVID-19.	• Report doesn't really mentioned the campaigns led by the Commission. • Report doesn't really specifically reference the work of *Mindframe*, only the Communications charter. • Opportunity to reinforce the call from our lived experience members of the EAG to ensure public discussion is hopeful and is considerate of those who are in distress.

Risk:

On page 13 the report cites the Press Conference where the National Suicide Prevention Adviser and the Minister for Health discussed suicide data broadly:

> The JobKeeper and JobSeeker payments have been a welcome source of relief for businesses seeking to retain their staff and the newly jobless. The availability of these measures are perhaps an important factor in the less than predicted suicide rates indicated by the **National Suicide Prevention Adviser in May** (41).

Mental Health Impacts of Poverty, Employment and Social Security

1 Key summary/ speaking points

- Globally, both poverty and inequality are recognised as having a harmful impact on human health and wellbeing, as well as to sustainable development and economic growth.[1]
- Australia does not have an official national poverty line and internationally there is no single definition of poverty and there are differing views as to how best to measure it.
- Available evidence suggests that the direction of causation between mental ill-health and poverty is cyclical, such that, poverty increases the risk of mental disorders and mental disorders increase the likelihood that an individual will descend into poverty.[2,3]
- In Australia, 37.6% of people with severe mental ill health live in income poverty (defined as 60% of median income) compared to 15% of those with moderate mental ill health and of those with no mental ill health 12.6%.[4]
- Recent research suggests that the Coronavirus Supplement and Jobkeeper have significantly reduced poverty in Australia compared to pre-pandemic estimates but that these effects will be reversed with the planned phasing out of these measures.

Note on statistics: caution should be used when interpreting and comparing statistics contained in the following brief due to inconsistent definitions and thresholds for poverty between research studies/surveys.

2 Poverty and mental health

2.1 Defining poverty

There is no single definition of poverty and there are differing views as to how best to measure it. Income is often used to identify people living poverty given it is a major resource people rely on to meet their basic needs and living costs.

Australia does not have an official national poverty line. The World Bank uses the International Poverty Line of US$1.90 a day. In 2017, the World Bank introduced two complementary global poverty lines, which can be used as a benchmark for countries across the world whose level of development makes the International Poverty Line of little use. The US$3.20 and US$5.50 per person, per day poverty lines complement, not replace, the International Poverty Line.

Many international poverty studies however, identify people as living in poverty when household income is below either 50% or 60% of the median income for all households.[5] This is referred to as the Poverty Line.

In Australia, the ABS Survey of Income and Housing and the ABS Household Expenditure Survey use the 60% measure to identify 'low income households.'[6] A 2020 report by the Australian

Council of Social Services (ACOSS) and the University of NSW (UNSW) on poverty uses the 50% measure. This is the same benchmark used by the OECD.

Looking more broadly at inequality in Australia, the Productivity Commission (PC) has cautioned the use of measuring income alone. The PC suggests measuring how evenly consumption is distributed is more useful, as consumption contributes most directly to wellbeing. Additionally, income patterns alone do not capture the importance of in-kind transfers from government, such as health, education, childcare subsidies and government housing.[7]

2.2 Mental health and wellbeing

Globally, both poverty and inequality are recognised as having a harmful impact on human health and wellbeing, as well as to sustainable development and economic growth.[8] Disadvantage (including poverty) directly impacts on wellbeing by limiting people's ability to achieve the life outcomes they value.[9]

Additionally, the concept of inequality affects people's wellbeing through their values and preferences in relation to the societal distribution of resources as well as their expectations about acceptable living standards.[10] Inequality is also correlated with poor health and has been linked to obesity, violence, mental illness and suicide.[11]

Available evidence suggests that the direction of causation between mental ill-health and poverty is cyclical, such that, poverty increases the risk of mental disorders and mental disorders increase the likelihood that an individual will descend into poverty.[12,13] Research assessing the effectiveness of interventions to break this cycle suggest that mental health interventions are consistently associated with improved economic outcomes whilst evidence for poverty alleviation interventions is in its infancy, currently inconclusive and likely to be dependent upon the exact details of the intervention implemented (e.g. loan, conditional or unconditional cash transfer, etc).[14]

In Australia, there are substantial mental health inequalities between the richest fifth and the poorest fifth of the income distribution irrespective of geographic distribution.[15] Lower socioeconomic status is associated with elevated psychological distress (as assessed by the K10), such that more than one quarter of people in the poorest one-fifth of Australians are experiencing high to very high levels of psychological distress at any one time compared to about 1-in-20 in the richest one-fifth of Australians.[16]

It has been speculated that the association between poverty and psychological distress may be one of the driving factors behind evidence that increasing expenditure on mental health services alone in Australia has not translated to overall improvements in population mental health.[17] However, this is an area that needs further research before definitive conclusions can be made.

2.3 Australia's poverty statistics (pre pandemic)

- Poverty in Australia is above the OECD average level.[18]
- Persistent and recurrent poverty affects a small, but significant proportion of the population.[19]

    - Approximately three per cent of Australians (roughly 700,000 people) have been in income poverty continuously for at least the period 2014-2018.[20]
- In 2017-18, the average equivalised[21] disposable household income was $1,062 per week.[22]
- Close to three in four (73%) households were in debt. Of these households, 28% had a debt that was three or more times their annualised disposable income.[23]
- Households are likely to remain in the same income group from one year to the next. Whilst this reflects positively in some respects, with household incomes not appearing to decrease, those in the lowest income groups are more likely to be in this group persistently and require assistance to break their cycle of disadvantage.[24]
- Pre-COVID poverty rates were dominated by single parents. Around 20.2 per cent of such households were in poverty, much higher than all other family types.[25]
- In 2017-18, 17.7% of children under 15 were living in poverty and in Australia child poverty is consistently higher than overall poverty.[26]
- People living in rural and remote Australia experience higher rates of poverty than those who live in metropolitan areas.[27]
    - In 2017-18, the equivalised disposable household income outside Australia's capital cities was, on average 18.76% less ($918 versus $1,130 in capital cities per week).[28]
    - Mean net household worth was, on average 30% lower ($799,600 versus $1,144,200).[29]
    - People living outside capital cities were more likely than those in capital cities to be in the lowest household income quintile (23.3% percent versus 20.6%).[30]
- 37.6% of people with severe mental ill health live in income poverty (defined as 60% of median income) compared to 15% of those with moderate mental ill health and of those with no mental ill health 12.6%.[31]

2.3.1 The impact of COVID-19 on poverty in Australia

- Whilst Australian GDP and employment have recorded very large declines since March 2020, as at 1 September, household income had actually risen. This has been a result of the temporary changes to income support from the Government through Jobkeeper, Jobseeker and the Coronavirus Supplement.[32] However, household income is likely to decline in the December quarter as the unemployment rate rises and cuts to Jobkeeper and the Coronavirus supplement take effect.[33]
- Research from the ANU and the Australia institute suggests that the Coronavirus supplement and and Jobkeeper have significantly reduced poverty in Australia compared to pre-pandemic estimates (in some estimates by up to 1/3).[1,34] Prior to the September changes to the Coronavirus Supplement and in the midst of a recession, there were fewer people living in poverty in Australia than there were in the period leading up to it. Without these income support changes the current recession would have increased the number of people in poverty in June 2020 from 3.0 million to almost

[1] The ANU modelling discussed uses the 50% of median income measure for poverty.

5.8 million. However, with their introduction the number of people in poverty in June 2020 was actually reduced by 13% to 2.6 million.[35]

- Changes to the additional subsidies that came into effect in September 2020 are likely to have changed this result by now. The ANU modelling suggested (in July) that these changes would increase the number of persons living in poverty by 740,000.[36]

2.4 Food insecurity and COVID-19

- A commonly used tool for identifying food insecurity used in a number of studies including the National Health Survey is the occurrence of a person or household who ran out of food and did not have enough money to purchase more at any time in the last 12 months.
- Prior to the COVID-19 pandemic, the main groups of people accessing food relief were families living on low income, the unemployed, single-parent families, the homeless and people with a mental illness.[37] Note, this is reported by a not-for-profit food relief organisation and it is unclear as to what has been defined as mental illness.
- In 2020, people have been experiencing food insecurity for the first time. A survey of 1,001 Australians conducted between 25 June – 15 July identified that over a quarter (28%) of people experiencing food insecurity this year reported having never experienced it before COVID-19.[38]
- Just over half of food secure Australians (53%) surveyed reported a decline in their mental health since COVID-19 was declared a pandemic.[39]
    - The most common emotions experienced as a result of not having enough food include stress (49%), depression (46%), anxiety (41%) and sadness (39%).[40]

3 Employment

3.1 Employment and poverty

- Among the various forces acting on inequality and poverty, the one constant that matters is having a job.[41] In Australia it is the biggest risk factor for living in poverty.[42]
- In theory Australia's social security system provides a safety net for those who find themselves unemployed however, from the early 1990s to the end of 2019 (pre temporary coronavirus changes to social security payments) the adequacy of unemployment payments verses the poverty line had steadily decreased.[43] For example, social security payments for single people without children are generally below the poverty line.[44]
- For more information on the impact of changes to social security payments on poverty in Australia see section 2.3.1 above.

3.2 The impact of COVID-19 on employment

- Australia's economy is currently experiencing it's biggest contraction since the 1930s with recovery likely to be 'uneven and bumpy.'[45] Between March and July, the number of employed people decreased by 556,8000 and the unemployment rate increased from 5.2% to 7.5%.[46] Furthermore, the unemployment rate is currently unlikely to represent the full scope of unemployment in Australia as many individuals whose employment (or

employment search) has been impacted by the pandemic are likely not to be not actively seeking employment and therefore not represented in official statistics.

- Overall, the Reserve Bank of Australia anticipates that the unemployment rate will rise to 10% later in 2020 and then decline gradually to a rate of around 7% in 2022.[47]
- In addition to unemployment, underemployment also remains high.[48]
- Some industries that have been hit hardest by COVID-19, such as retail and accommodation, account for a large proportion of casual workers across Australia.[49]
- Job losses have been largest for young people (under 35) and those in the occupations which are lowest paid on the basis of hourly earnings, whilst employment has actually increased for occupations with the highest hourly earnings.[50]
- Charities have reported an increase in the number of newly unemployed people seeking food relief as a result of COVID-19.[51]

4 Centrelink's Income Compliance Program ("Robodebt")

4.1 Background

- In 2015 a new Income Compliance Program was implemented. It built upon established social security compliance activities and was designed to identify social security overpayments through discrepancies between the annual income reported by an individual to Centrelink and income assessed by the ATO for the same period.
- The program has been characterized by three key changes to pre-2015 compliance procedures:
    - Moving to an online platform which limits interaction with Services Australia staff. This online platform is now in its third iteration.
    - Significant increase in the volume of compliance interventions initiated by the Department of Human Services (now Services Australia).
    - Perceived reversal of the onus of proof (such that individuals are required to prove that they do not owe a debt rather than Services Australia prove that a debt is owed). The ICP introduced greater obligations for individuals to confirm or disprove discrepancies in the first instance rather than the pre-2015 procedures whereby Services Australia undertook the checking process or used its powers to find the information before a debt was raised.[52] However, Services Australia maintains that the ICP does not reverse the onus of proof, insisting that this has always been the responsibility of the customer. This continues to be an area of dispute.[53]
- The ICP has been the subject of two senate inquiries (one of which is ongoing), has been reviewed by the Office of the Commonwealth Ombudsman twice and is currently the subject of a class action lawsuit in addition to increasing calls for it to be the subject of a Royal Commission. Furthermore, the Senate Community Affairs Reference Committee's is currently recommending that Services Australia immediately terminate the Income Compliance Program.[54]

- In May 2020 the Commonwealth Government announced that around 470,000 debts issued under the ICP were 'insufficient under law' and would be repaid to individuals.[2] This was followed by an apology from the Prime Minister in June 2020 for "any hurt, harm or hardship which people had experience due to the government's actions under the income compliance program."[55]
- Concerns persist about the overall policy, operation and administration of the program and the impact on individuals who have been subjected to it.
- No new initiation letters have been sent out under the program since mid November 2019, as part of standard practice ahead of the Christmas period.[56] Services Australia has indicated that compliance activities will recommence after the pandemic, but has not confirmed that these activities will include the ICP.[57]

4.2 Mental health impacts of the Income Compliance Program

- During the first Senate Committee inquiry, the Committee found that the Income Compliance Program was "incredibly disempowering to those people who had been affected, causing significant emotional trauma, stress and shame."[58]
- Many of these impacts have been raised in regards to the experiences of receiving initial discrepancy letters or engaging with the review/appeals process. Dissenting senators imply that such evidence should be disallowed because neither the practice of raising claims or the process of review/appeal are new to the Income Compliance Program as initiated in 2015.[59] However, if such processes have not altered, then the exponential changes to the scale of their implementation indicate that further consideration is warranted. [Note that prior to 2015, only the highest risk discrepancies were investigated at a rate of around 20,000 per year, whereas, after the ICP changes 216,000 interventions were initiated between September to December 2016 alone].[60]
- According to the second Senate Inquiry's majority second interim report, despite changes to the program in the intervening years, "there has been no reduction in the overall negative impacts on individuals who receive initiation letters and debt notices through the program."[61] ***Findings of this report should be interpreted with caution, recognising that dissenting senators assert that the Committee has in some cases, adopted positions based on evidence provided by groups and individuals without examining or testing these claims directly*.[62] Nevertheless, the report suggests the following:
    - That themes of disempowerment, overwhelming stress and emotional upheaval continue to be common in accounts and submissions from individuals, the community organisations which assist them, and other key stakeholders.[63]
    - That some individuals in certain segments of the population, e.g. those who were already experiencing financial difficulty and long term poverty, the sudden

[2] 34

and unexpected allegations of debt have had 'ruinous' impact their mental health[64] including, breakdown, anxiety and depression requiring medication, sleeplessness, stress causing physical illness, and fear[65]

- Despite the vulnerability flags used by Services Australia (e.g. 'psychiatric problems or mental illness'), vulnerable people continue to be contacted and subjected to the program without the supports they require.[66]

- The Committee also confirms that it has received evidence suggesting at least two suicides connected to the Income Compliance Program and it is not clear how many more may also be linked to the program.[67]

Appendix: Background on Centrelink's Income Compliance Program (ICP)

Table 1: Timeline of the Income Compliance Program, investigations and reviews

Date	Type	Description
2015	Program change	• New income compliance program established and piloted through the *Better Management of the Social Welfare System* measure announced in the 2015-16 Budget.[68]
July 2016	Program change	• Introduction of the Online Compliance Intervention (OCI) system
Feb 2017	Senate inquiries	• Senate referred the first inquiry into the compliance program to the Community Affairs References Committee (SCARC). • Employment Income Confirmation (EIC) system replaces OCI.[69]
Early 2017	Commonwealth Ombudsman reviews	• The Office of the Commonwealth Ombudsman reviewed the income compliance system with a focus on accuracy and usability of the program.[70] Eight recommendations were made and accepted by the Department of Social Services with implementation anticipated to be completed by August 2017.[71]
21 Jul 2017	Senate inquiries	• SCARC's first inquiry into Centrelink's compliance program final report tabled (*Design, scope, cost-benefit analysis, contracts awarded and implementation associated with Better Management of the Social Welfare System initiative*).[72] 19 recommendations were made although they were not supported by the Commonwealth Government's response.[73]
April 2019	Commonwealth Ombudsman reviews	• The Office of the Commonwealth Ombudsman issued an implementation report which considered how their 2017 recommendations had been implemented finding that all recommendations were complete or in progress and issuing a further four recommendations.[74]
Mid-2019	Program change	• Check and Update Past Income (CUPI) system to replace EIC commences rollout.[75]
31 July 2019	Senate inquiries	• Senate referred the second inquiry into the compliance program to the (SCARC).

Nov 2019	Legal cases	• Federal Court finds that income compliance debts raised based on average income were 'not validly made' and in response, Services Australia ceases the use of this practice.[76]
11 Feb 2020	Senate inquiries	• SCARC second inquiry into Centrelink's compliance program tabled their first interim report.[77]
May 2020	Government response	• Commonwealth Government announces that around 470,000 debts issued under the ICP were 'insufficient under law' and will be repaid to individuals.[78]
11 Jun 2020	Government response	• Prime Minister apologized for any hurt, harm or hardship which people had experience due to the government's actions under the income compliance program.[79] This apology was echoed by the government agencies responsible for the program.[80]
Sep 2020	Senate inquiries	• SCARC second inquiry into Centrelink's compliance program into Centrelink's compliance program tabled their second interim report.[81]

Table 2: Iterations of the online Income Compliance Program system	
System	**Information and criticism**
Online Compliance Intervention (OCI), rolled out in July 2016[82]	• Processes and operation of the system and steps taken to advise individuals of the assessment and requirements to verify or update income. [83] E.g. in many instances individuals did not receive the letters and first heard of their debts via phone calls from debt collectors.[84] • OCI system challenging to navigate and Centrelink support limited.[85] • Concerns around the accuracy of debts raised.[86]
Employment Income Confirmation (EIC), rolled out in February 2017[87]	• Integrated feedback from the OCI system to ensure that letters were delivered and received, improved explanation of how a debt is calculated and improved online system functionality.[88]
Check and Update Past Income (CUPI),	• Integrated additional feedback from the EIC system including Services Australia completing assessments likely to result in zero

rolled out from mid-2018 to mid-2019[89]	or low debt outcomes without the individuals involvement and improved explanations of review and debt processes.[90]

5 REFERENCES

[1] National Rural Health Alliance, Poverty in Rural and Remote Australia Fact Sheet, November 2017. Available: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf

[2] World Health Organization. "Breaking the vicious cycle between mental ill-health and poverty." *Geneva: Mental health core to development information sheet* (2007). Accessed: https://www.who.int/mental_health/policy/development/1_Breakingviciouscycle_Infosheet.pdf

[3] Lund, Crick, Mary De Silva, Sophie Plagerson, Sara Cooper, Dan Chisholm, Jishnu Das, Martin Knapp, and Vikram Patel. "Poverty and mental disorders: breaking the cycle in low-income and middle-income countries." *The lancet* 378, no. 9801 (2011): 1502-1514.

[4] Australian National Health Survey 2007/08 in OECD (2012), *Sick on the Job?: Myths and Realities about Mental Health and Work*, Mental Health and Work, OECD Publishing, Paris, https://doi.org/10.1787/9789264124523-en.

[5] Australian Bureau of Statistics. Household Income and Wealth, Australia, 2013-14, September 2015. Cat No. 6523.0 Canberra. ABS. Available: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/6523.0main+features12013-14

[6] Australian Bureau of Statistics. Household Income and Wealth, Australia, 2013-14, September 2015. Cat No. 6523.0 Canberra. ABS. Available: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/6523.0main+features12013-14

[7] Productivity Commission, Rising inequality? A stocktake of the evidence, Commission Research Paper, 2018 Canberra. Available: https://www.pc.gov.au/research/completed/rising-inequality

[8] National Rural Health Alliance, Poverty in Rural and Remote Australia Fact Sheet, November 2017. Available: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf

[9] Productivity Commission, Rising inequality? A stocktake of the evidence, Commission Research Paper, 2018 Canberra. Available: https://www.pc.gov.au/research/completed/rising-inequality

[10] Productivity Commission, Rising inequality? A stocktake of the evidence, Commission Research Paper, 2018 Canberra. Available: https://www.pc.gov.au/research/completed/rising-inequality

[11] National Rural Health Alliance, Poverty in Rural and Remote Australia Fact Sheet, November 2017. Available: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf

[12] World Health Organization. "Breaking the vicious cycle between mental ill-health and poverty." *Geneva: Mental health core to development information sheet* (2007). Accessed: https://www.who.int/mental_health/policy/development/1_Breakingviciouscycle_Infosheet.pdf

[13] Lund, Crick, Mary De Silva, Sophie Plagerson, Sara Cooper, Dan Chisholm, Jishnu Das, Martin Knapp, and Vikram Patel. "Poverty and mental disorders: breaking the cycle in low-income and middle-income countries." *The lancet* 378, no. 9801 (2011): 1502-1514.

[14] Lund, Crick, Mary De Silva, Sophie Plagerson, Sara Cooper, Dan Chisholm, Jishnu Das, Martin Knapp, and Vikram Patel. "Poverty and mental disorders: breaking the cycle in low-income and middle-income countries." *The lancet* 378, no. 9801 (2011): 1502-1514.

[15] Isaacs, A.N., Enticott, J., Meadows, G. and Inder, B., 2018. Lower income levels in Australia are strongly associated with elevated psychological distress: Implications for healthcare and other policy areas. *Frontiers in Psychiatry*, *9*, p.536.

[16] Isaacs, A.N., Enticott, J., Meadows, G. and Inder, B., 2018. Lower income levels in Australia are strongly associated with elevated psychological distress: Implications for healthcare and other policy areas. *Frontiers in Psychiatry*, *9*, p.536.

[17] Isaacs, A.N., Enticott, J., Meadows, G. and Inder, B., 2018. Lower income levels in Australia are strongly associated with elevated psychological distress: Implications for healthcare and other policy areas. *Frontiers in Psychiatry*, *9*, p.536.

[18] Davidson, P., Saunders, P., Bradbury, B. and Wong, M. (2020), Poverty in Australia 2020: Part 1, Overview. ACOSS/UNSW Poverty and Inequality Partnership Report No. 3, Sydney: ACOSS.

[19] Productivity Commission, Rising inequality? A stocktake of the evidence, Commission Research Paper, 2018 Canberra. Available: https://www.pc.gov.au/research/completed/rising-inequality

[20] Productivity Commission, Rising inequality? A stocktake of the evidence, Commission Research Paper, 2018 Canberra. Available: https://www.pc.gov.au/research/completed/rising-inequality

[21] As defined by the Australian Bureau of Statistics. Household Income and Wealth, Australia, 2017-18, July 2019. An equivalence scale is used to adjust household incomes to take account of the economies that flow from sharing resources and enable more meaningful comparisons between different types of households. Equivalising factors are calculated based on the size and composition of the household, recognising that children typically have fewer needs than adults.

[22] Australian Bureau of Statistics. Household Income and Wealth, Australia, 2017-18, July 2019. Canberra. ABS. Available: https://www.abs.gov.au/statistics/economy/finance/household-income-and-wealth-australia/latest-release

[23] Australian Bureau of Statistics. Household Income and Wealth, Australia, 2017-18, July 2019. Canberra. ABS. Available: https://www.abs.gov.au/statistics/economy/finance/household-income-and-wealth-australia/latest-release

[24] University of Melbourne, Living in Australia: a snapshot of Australian society and how it is changing over time, 2019. Available: https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0005/3126038/LivingInAus-2019.pdf

[25] Phillips, Gray & Biddle, ANU Centre for Social Research and Methods (2020), 'COVID-19 JobKeeper and JobSeeker impacts on poverty and housing stress under current and alternative economic and policy scenarios' (https://csrm.cass.anu.edu.au/sites/default/files/docs/2020/8/Impact_of_Covid19_JobKeeper_and_Jobeeker_measures_on_Poverty_and_Financial_Stress_FINAL.pdf)

[26] Davidson, P., Saunders, P., Bradbury, B. and Wong, M. (2020), Poverty in Australia 2020: Part 1, Overview. ACOSS/UNSW Poverty and Inequality Partnership Report No. 3, Sydney: ACOSS.

[27] National Rural Health Alliance, Poverty in Rural and Remote Australia Fact Sheet, November 2017. Available: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf

[28] Australian Bureau of Statistics. Household Income and Wealth, Australia, 2017-18, July 2019. Canberra. ABS. Available: https://www.abs.gov.au/statistics/economy/finance/household-income-and-wealth-australia/latest-release

[29] Australian Bureau of Statistics. Household Income and Wealth, Australia, 2017-18, July 2019. Canberra. ABS. Available: https://www.abs.gov.au/statistics/economy/finance/household-income-and-wealth-australia/latest-release

[30] Australian Bureau of Statistics. Household Income and Wealth, Australia, 2017-18, July 2019. Canberra. ABS. Available: https://www.abs.gov.au/statistics/economy/finance/household-income-and-wealth-australia/latest-release

[31] Australian National Health Survey 2007/08 in OECD (2012), *Sick on the Job?: Myths and Realities about Mental Health and Work*, Mental Health and Work, OECD Publishing, Paris, https://doi.org/10.1787/9789264124523-en.

[32] RBA media release 1/09/2020 "Statement by Phillip Lowe, Govenor: Monetary Policy Decision." Accessed: https://www.rba.gov.au/media-releases/2020/mr-20-20.html

[33] RBA (2020) Speech by Phillip Lowe (Govenor) to Citi's 12th Annual Australia nad New Zealand Investment Conference 15/10/2020. "Recovery from a Very Uneven Recession" Accessed: https://www.rba.gov.au/speeches/2020/sp-gov-2020-10-15.html

[34] Grundolf, Matt (2020) Poverty in the age of Coronavirus: the impact of the JobSeeker coronavirus supplement on poverty, Canberra: The Australia Institute, accessed: https://www.tai.org.au/sites/default/files/P949%20Poverty%20in%20the%20age%20of%20coronavirus%20%5BWEB%5D.pdf

[35] Phillips, Gray & Biddle, ANU Centre for Social Research and Methods (2020), 'COVID-19 JobKeeper and JobSeeker impacts on poverty and housing stress under current and alternative economic and policy scenarios' (https://csrm.cass.anu.edu.au/sites/default/files/docs/2020/8/Impact_of_Covid19_JobKeeper_and_Jobeeker_measures_on_Poverty_and_Financial_Stress_FINAL.pdf)

[36] Phillips, Gray & Biddle, ANU Centre for Social Research and Methods (2020), 'COVID-19 JobKeeper and JobSeeker impacts on poverty and housing stress under current and alternative economic and policy scenarios'

(https://csrm.cass.anu.edu.au/sites/default/files/docs/2020/8/Impact_of_Covid19_JobKeeper_and_Jobeeker_measures_on_Poverty_and_Financial_Stress_FINAL.pdf)

[37] Foodbank, Hunger Report 2020, October 2020. Available: https://www.foodbank.org.au/wp-content/uploads/2020/10/FB-HR20.pdf

[38] Foodbank, Hunger Report 2020, October 2020. Available: https://www.foodbank.org.au/wp-content/uploads/2020/10/FB-HR20.pdf

[39] Foodbank, Hunger Report 2020, October 2020. Available: https://www.foodbank.org.au/wp-content/uploads/2020/10/FB-HR20.pdf

[40] Foodbank, Hunger Report 2020, October 2020. Available: https://www.foodbank.org.au/wp-content/uploads/2020/10/FB-HR20.pdf

[41] Productivity Commission, Rising inequality? A stocktake of the evidence, Commission Research Paper, 2018 Canberra. Available: https://www.pc.gov.au/research/completed/rising-inequality

[42] Davidson, P., Bradbury, B., and Wong, M. (2020), Poverty in Australia 2020: Part 2, Who is affected? ACOSS/UNSW Poverty and Inequality Partnership Report No. 4, Sydney: ACOSS.

[43] Australia Institute 2020 https://govteams.sharepoint.com/sites/nmhcvision2030team/Shared%20Documents/All%20the%20little%20extra%20bits/Poverty%20brief%20incl.%20employment%20and%20robodebt/Poverty%20research/Research%20to%20look%20at/The%20impact%20of%20the%20job%20seeker%20supplement%20on%20poverty.pdf

[44] Davidson, P., Saunders, P., Bradbury, B. and Wong, M. (2020), Poverty in Australia 2020: Part 1, Overview. ACOSS/UNSW Poverty and Inequality Partnership Report No. 3, Sydney: ACOSS.

[45] RBA media release 1/09/2020 "Statement by Phillip Lowe, Govenor: Monetary Policy Decision." Accessed: https://www.rba.gov.au/media-releases/2020/mr-20-20.html

[46] ABS Labour Force, Australia

[47] RBA media release 1/09/2020 "Statement by Phillip Lowe, Govenor: Monetary Policy Decision." Accessed: https://www.rba.gov.au/media-releases/2020/mr-20-20.html

[48] RBA media release 1/09/2020 "Statement by Phillip Lowe, Govenor: Monetary Policy Decision." Accessed: https://www.rba.gov.au/media-releases/2020/mr-20-20.html

[49] Parliament of Australia, COVID-19: Impacts on casual workers in Australia, May 2020

[50] RBA (2020) Speech by Phillip Lowe (Govenor) to Citi's 12th Annual Australia nad New Zealand Investment Conference 15/10/2020. "Recovery from a Very Uneven Recession" Accessed: https://www.rba.gov.au/speeches/2020/sp-gov-2020-10-15.html

[51] Foodbank, Hunger Report 2020, October 2020. Available: https://www.foodbank.org.au/wp-content/uploads/2020/10/FB-HR20.pdf

[52] Commonwealth Ombudsman, *Centrelink's automated debt raising and recovery system* (2017) report no. 02|2017 accessed: https://www.ombudsman.gov.au/__data/assets/pdf_file/0022/43528/Report-Centrelinks-automated-debt-raising-and-recovery-system-April-2017.pdf

[53] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[54] Dr Darren O'Donovan, 'The "problem" is not "fixed". Why we need a royal commission into Robodebt', The Conversation, 23 June 2020; Peter Whiteford, Andrew Podger and David Stanton, 'Robodebt needs a royal commission', The Canberra Times, 4 August 2020.

[55] The Hon Scott Morrison MP, Prime Minister, House of Representatives Hansard, 11 June 2020, p. 3930.

[56] Mr Craig Storen, General Manager, Customer Compliance Division, Services Australia, Committee Hansard, 16 December 2020, p. 15.

[57] Ms Musolino, Services Australia, Proof Committee Hansard, 31 July 2020, pp. 7, 21.

[58] Journals of the Senate, No. 18, 18 September 2019, p. 535.

[59] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), pp51 accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancepr ogram.pdf;fileType=application%2Fpdf

[60] The Hon Alan Tudge MP, Minister for Human Services, 'New technology helps raise $4.5 million in welfare debts a day', Media release, 5 December 2016; Committee Report 2017, p. 18; Services Australia, Submission 20, p. 17.

[61] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), pp15 accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[62] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), pp51 accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[63] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), pp15 accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[64] See, for example, Ms Taryn Harvey, Chief Executive Officer, Western Australian Association for Mental Health, Committee Hansard, 4 October 2019, p. 33; Mr David Taylor, Policy Analyst and Media Liaison, Jobs Australia, Committee Hansard, 9 October 2019, p. 63; Newcastle University Legal Centre, Submission 14, p. 1; Name withheld, Submission 50, [p. 1]; Name withheld, Submission 59, [p. 2].

[65] ACOSS, Submission 7, p. 4. In Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[66] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), pp 27. accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancepr ogram.pdf;fileType=application%2Fpdf

[67] Ms Craik, AASW, Committee Hansard, 9 October 2019, p. 33.

[68] Commonwealth of Australia, Budget Measures: Budget Paper No. 2 2015–16, p. 116; Liberal Party of Australia and The Nationals, The Coalition's policy for better management of the social welfare system, June 2016.

[69] Services Australia, Submission 20, p. 12; Commonwealth Ombudsman, Centrelink's Automated Debt Raising and Recovery System: Implementation Report, April 2019, (Ombudsman Report 2019), p. 14.

[70] Senate Community Affairs Reference Committee, Parliament of Australia, *Design, scope, cost-benefit analysis, contracts awarded and implementation associated with the Better Management of the Social Welfare System initiative* (2017), Committee Report 2017.

[71] Department of Human Services, Submission 66.1, Senate Community Affairs References Committee inquiry into Design, scope, cost-benefit analysis, contracts awarded and implementation associated with the Better Management of the Social Welfare System initiative, p. 1.

[72] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), accessed:

https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[73] Australian Government, Australian Government response to the Community Affairs References Committee Report: Design, scope, cost-benefit analysis, contracts awarded and implementation associated with the Better Management of the Social Welfare System initiative, 28 September 2017.

[74] Commonwealth Ombudsman, *Centrelink's automated debt raising and recovery system* (2017) report no. 02|2017, pp 27-29 accessed: https://www.ombudsman.gov.au/__data/assets/pdf_file/0022/43528/Report-Centrelinks-automated-debt-raising-and-recovery-system-April-2017.pdf

[75] Services Australia, Submission 20, p. 12; Commonwealth Ombudsman, Centrelink's Automated Debt Raising and Recovery System: Implementation Report, April 2019, (Ombudsman Report 2019), p. 14.

[76] Ms Campbell, Department of Social Services, Proof Committee Hansard, 31 July 2020, pp. 19, 23; Ms Musolino, Services Australia, Proof Committee Hansard, 31 July 2020, p. 23; Order of Justice Davies in Amato v The Commonwealth of Australia (Federal Court of Australia, VID611/2019, 27 November 2019); Victoria Legal Aid, An in-depth look at our robo-debt test case, 14 April 2020, www.legalaid.vic.gov.au/about-us/news/in-depth-look-our-robo-debt-test-case (accessed 18 May 2020)

[77] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[78] The Hon Stuart Robert MP, Minister for National Disability Insurance Scheme and Minister for Government Services, 'Changes to the Income Compliance Program', Media Release, 29 May 2020.

[79] The Hon Scott Morrison MP, Prime Minister, House of Representatives Hansard, 11 June 2020, p. 3930.

[80] Ms Kathryn Campbell AO CSC, Secretary, Department of Social Services, Proof Committee Hansard, 31 July 2020, pp. 1–2.

[81] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[82] Services Australia, Submission 20, p. 12; Commonwealth Ombudsman, Centrelink's Automated Debt Raising and Recovery System: Implementation Report, April 2019, (Ombudsman Report 2019), p. 14.

[83] Senate Community Affairs Reference Committee, Parliament of Australia, *Design, scope, cost-benefit analysis, contracts awarded and implementation associated with the Better Management of the Social Welfare System initiative* (2017), Committee Report 2017, pp 3.

[84] Senate Community Affairs Reference Committee, Parliament of Australia, *Design, scope, cost-benefit analysis, contracts awarded and implementation associated with the Better Management of the Social Welfare System initiative* (2017), Committee Report 2017, pp 45.

[85] Senate Community Affairs Reference Committee, Parliament of Australia, *Design, scope, cost-benefit analysis, contracts awarded and implementation associated with the Better Management of the Social Welfare System initiative* (2017), Committee Report 2017, pp. 41–43, 59–69.

[86] Senate Community Affairs Reference Committee, Parliament of Australia, *Centrelink's compliance program : second interim* report (2020), pp. 10. accessed: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024338/toc_pdf/Centrelink'scompliancep rogram.pdf;fileType=application%2Fpdf

[87] Ms Campbell, Department of Social Services, Proof Committee Hansard, 31 July 2020, p. 2; Ms Michelle Lees, Deputy Chief Executive Officer, Customer Service Delivery, Services Australia, Proof Committee Hansard, 31 July 2020, pp. 2, 3, and 17 August 2017, p. 5.

[88] Services Australia, Submission 20, p. 12

[89] Ms Campbell, Department of Social Services, Proof Committee Hansard, 31 July 2020, p. 2; Ms Michelle Lees, Deputy Chief Executive Officer, Customer Service Delivery, Services Australia, Proof Committee Hansard, 31 July 2020, pp. 2, 3, and 17 August 2017, p. 5.

[90] Services Australia, Submission 20, p. 12; Ombudsman Report 2019, p. 11–12.

We should have a brief for senate estimates about 'what mental health services are available/used by jobseekers'.

In line with the estimates work we discussed at team meeting yesterday, see below request from [redacted] I'm wondering if you could make a start on this work by pulling together everything we already have on this topic; content from Pandemic Plan, any content from [redacted] data updates [redacted] should have these from the senate briefing materials), publically available information from Dept Health on supports available, funding announcements, etc...

"The government recognises this continues to be a challenging time for those looking for work and encourages job seekers to access the full range of assistance available to them – including access to skills training, assistance for other work preparation activities and referral to relevant support services – including mental health services, if required."

Content from Pandemic plan

- Isolation measures are likely to result in significant effects on time use for individuals, ranging from a decrease in productivity or unemployment, and the associated feelings of stress, boredom and loneliness [6]
- Meeting immediate mental health and wellbeing needs,
    - recovery phase considerations, Consider mechanisms to improve access to services available to support those in distress due to the pandemic and its impacts.
    - A strategy will be developed for identifying and prioritising new service models, prevention and early intervention focus includes Addressing physical and mental health, personal safety, income, employment, and housing.

- Focusing on mental health and suicide risk factors in their social context.
  It is well established that adversity is a risk factor for mental health problems, and the hardship experienced as a result of COVID-19 will have mental health impacts in the long term. Feelings of fear and helplessness may subside for some, but for others, the pandemic will bring about new experiences of mental ill-health and exacerbate pre-existing mental health conditions. Key to a longterm recovery strategy for mental health will be both individual and community responses that encourage resilience building.
  Social and economic impacts are some of the most significant risk factors for the development of mental health issues as a result of the pandemic. Responses that minimise risk factors and promote protective factors constitute a significant component of a successful mental health response plan. Every element of the pandemic response should include mental health and human impact assessment.
- Financial strain and unemployment
    - The financial impact of COVID-19 is going to see considerable long-term effects on individuals, families and society, and it will be necessary to ensure that long-term mental health supports are supplementary to social supports. While unemployment increases the risks to mental health and suicide, poor mental health is also a significant barrier to gaining and maintaining stable employment.
    - It is not just the already-unemployed who suffer in economic downturns – although their chances of gaining employment diminish as people more readily employable than them lose their jobs and also become job seekers. For people who have planned and committed to their financial futures a sudden downturn in the economy where they lose their small business or job can be a highly stressful event that changes how they live their lives and can create

serious dilemmas in dealing with debts that they took on when they thought they were in a position to pay them off. Unemployment, income decline, and unmanageable debts are significantly associated with poor mental wellbeing increased rates of common mental disorders, substance-related disorders and suicidal behaviours25. In Australia, suicides amongst unemployed working age men increased at a higher rate than for other groups in the period including the Global Financial Crisis of 2007-09 and men and women of working age in paid work had lower incidence of suicides26 .

- Financial counsellors have a prominent role in supporting individuals and families suffering financial loss or struggling with debts as professionals who work with those in financial difficulty. The people who use these services post-COVID-19 are likely to be in a heightened state of anxiety and presenting more complex social and emotional problems. Financial counsellors should be upskilled through the provision of mental health training such as psychological or mental health first aid for financial counsellors.
- Many people have lost their employment or are working reduced hours during the COVID-19 crisis period. In addition, people who experienced financial difficulty during the crisis period are likely to be in rental or mortgage arrears. In the long-term, we can expect that it will take time for people to be back in their pre-COVID-19 employment position. As a result, people who become unemployed or who remain unemployed are at higher risk of mental health problems. It is vital that programs are available to ensure people can engage in meaningful activity that is vocationally oriented.
- For people suffering financial stress as a result of the pandemic, it will be essential to provide basic financial security while reducing administrative complexity and providing targeted support when transitioning to the recovery phase, particularly for those operating small businesses that have collapsed due to the pandemic.

- Evidence suggests that while there is no way to predict suicide risk accurately, based on current modelling it appears likely that suicide attempts and suicide deaths will increase as a result of the current pandemic and early reports indicate potential increases in contact with suicide prevention services associated with COVID-1941 . Suicide risk may be heightened by:
  - The combination of home confinement and increased economic and mental stressors42 .
  - Disruption to the ability to earn and work will could lead to a loss in the sense of purpose and identity for many43 .
  - Associated economic and social impacts including unemployment, financial distress and family breakdown or violence

Content from NMHC COVID-19 data projects

- If there is time to investigate requesting custom data analyses, I'd recommend starting with the ABS who have collected some information about mental health, health service use and stimulus payments in the Household Impacts of COVID-19 Survey. The Melbourne Institute may also have some useful data from their Taking the Pulse survey. One of their reports from June said that at that time, there wasn't enough data to comment on the mental health of people receiving Jobseeker. But as the survey is weekly, they may have sufficient data now.

- The ANU had this to say about life satisfaction and Jobkeeper: Those who were not in the labour force had lower levels of life satisfaction than those who were employed 30 or more hours. The lowest level of life satisfaction based on the employment variables, however, was for those who were unemployed, with a life satisfaction measure about 0.46 points lower than those employed 30 hours or more per week, and significantly lower than those who were employed but were not working any hours at the time of the survey. The JobKeeper payments appear to have had benefits in terms of life satisfaction, which could be due to perceived job security, income security, having a continued employment link, or lack of stigma associated with being unemployed.

- Main sources for COVID briefing docs
  https://govteams.sharepoint.com/:x:/s/nmhcmhrprojectteam/ESKp057uMYNCjso4eCCce64BcfNdHNqK6TH2gdGxAP7cWw?e=akKbXS

Publicly available information from DoH on MH supports available to jobseekers

Mental Health	• Better Access
	• Beyond blue
	  ○ Helpline
	  ○ Unemployment booklet 'Taking care of yourself after losing your job'
	  ○ Corona Virus Mental Wellbeing Support Service
	• Headspace digital work and study service
	• Head to Health (website)
	• Head to Help (Victoria only)
	• Lifeline
	• MensLine Australia
	• MindSpot
	• Open Arms (Veterans and families)
	• SANE Australia
	• Suicide Callback service
	• Relationships Australia
	• Q-Life
	• Virtual psychologist (free in rural and remote areas)

Employment and financial assistance*
 	
* All activities and services which provide employment support and financial assistance are consistent with promotion of population mental health and prevention of mental ill health.
	• Services Australia
	  ○ income support
	  ○ social workers counselling (132 850)
	  ○ Financial information service officers (1800 805 260)
	• Jobactive
	• JobAccess (disability)
	• National Debt Helpline
	• MoneySmart website
	• Retrenchment rapid response framework
	• What's Next?

Other supports available (govt and non-govt)

- Bank mortgage repayment pauses – at discretion of banks?
- Rental assistance schemes (varies by state and territory)

Funding announcements (Federal govt)

- First Economic stimulus package (12 March)
- Second economic stimulus package (22 March)
- a safety net package of $1.1 billion to expand mental health and tele-health services, increase domestic violence services and provide more emergency food relief (29 March)
- a JobKeeper payment passed in legislation on 15 April, to keep more Australians in jobs and support businesses affected by the COVID-19 restrictions
- Pandemic plan, $48.1M total (15 May) – specifically actions relating to enable targeted support for groups in the community that have been particularly vulnerable during the pandemic
- further economic stimulus packages announced, including HomeBuilder (4 June) and JobMaker (24 June)
- Additional 10 Medicare subsidised psychology sessions for people impacted by further restrictions due to the Pandemic (2 August)
- Support mental health services in Victoria (6 August) – total $12M + additional $13.4M investment in PHNs (supplementing existing supports available)
    - $5M headspace (outreach services)
    - $2.5M Beyond Blue expand capacity, extend counsellor webchat hours to operate 24/7, and boost the ability to refer people with severe and complex needs for five additional sessions
    - $2.5M – Lifeline (Victorian calls specifically)
- $31.9 million of additional funding for Victoria (17 August)
    - 15 new Adult mental health centres for 12 months ($26.9 million)
        - Greater Melbourne: Berwick, Frankston, Officer, Hawthorn, Yarra Junction, West Heidelberg, Broadmeadows, Wyndham Vale, Brunswick East.
        - Regional Victoria: Warragul, Sale, Bendigo, Wodonga, Sebastopol and Norlane.
    - targeted digital and online assistance for high risk populations ($5 million)
        - butterfly foundation
        - EDFA
        - National LGBTI Health Alliance (Q-Life service)
        - PANDA
        - Victorian Aboriginal Health Service (Yarning SafeNStrong helpline)

Commented [CH1]: Taken from MRP document https://govteams.sharepoint.com/:w:/s/nmhcmhrprojectteam/ETeVidW2nkhLpfvrEfJ8hbUBlpvSG8ng0_Xfhh17ThyMMw?e=Ngexlu and https://govteams.sharepoint.com/:w:/s/nmhcmhrprojectteam/EXp024a8vGVJqzBJ30DgGKcBCBkQusH60LRopgjyYQYMLQ?e=zM1boE

Tracking outcomes during the COVID-19 pandemic (August 2020) – Divergence within Australia

ANU Centre for Social Research and Methods

Professor Nicholas Biddle;[1] Associate Professor Ben Edwards;[1] Professor Matthew Gray[1] and Kate Sollis[1]

1 ANU Centre for Social Research and Methods

Australian National University

September 3rd, 2020

DOI:

Abstract

In order to monitor the impacts of COVID-19, the ANU Centre for Social Research and Methods has established a COVID-19 impact monitoring survey program. The first wave of data collection occurred in April 2020, during the peak of the first wave of infections in Australia. This was followed by a survey in May 2020 as restrictions began to be eased across Australia, and infection rates were declining in most States and Territories. The third wave of data collection occurred in August 2020, a time during which infection rates in Victoria (and Melbourne in particular) were at their highest yet observed, Sydney continued to have a small number of new infections each day, and the rest of the country was for the most part experiencing zero confirmed cases. If the first two waves of data collection were at a time of 'we are all in this together', our third wave of data collection occurred when jurisdictions were experiencing significant divergence in terms of severity of lockdown, other policy interventions, and infection/mortality rates. The aim of this paper is to update the national-level trends in wellbeing outcomes using the most recently available data, as well as provide an initial analysis of divergence of outcomes within Australia.

Data collected using Life in Australia™ is still the only longitudinal survey of a large, representative sample of Australians with information from the same individuals prior to and during the Coronavirus pandemic. We show that anxiety and worry due to COVID-19 have increased since their low in May 2020, whereas measures of subjective wellbeing and psychological distress have also worsened. Hours worked have increased across Australia since May 2020, but people who are employed are more worried about losing their job than they were in May 2020. We find a relative worsening in outcomes for Victoria compared to the rest of Australia between May 2020 and August for six key outcomes in particular: psychological distress; loneliness; life satisfaction; satisfaction with direction of country; expected likelihood of being infected by COVID-19; and hours worked.

Acknowledgements

The May ANUpoll was partially funded by the Australian Institute of Health and Welfare (AIHW) as was the analysis of August ANUpoll data presented in this paper. The authors would like to thank Matthew James and Cathy Claydon for the considerable input into the design of the May survey, as well as comments on an earlier draft of this paper. The authors would also like to thank a number of people who were involved in the development of the April, May and August 2020 ANUpoll questionnaires, including Diane Herz, Dr Benjamin Phillips, Dr Paul Myers, Diana Nguyen, Matilda Page, and Charles Dove from the Social Research Centre, as well as Professor Ian McAllister and Lawrence Rogers from the ANU.

Executive Summary

This paper provides estimates of how outcomes of the Australian population are tracking as the COVID-19 pandemic continues to impact in Australia. It uses data collected as part of the ANU Centre for Social Research and Methods COVID-19 impact monitoring program. Surveys have been conducted with the same group of respondents in January and February just before the COVID-19 pandemic started in Australia as well as in April, May and August after the pandemic started to impact in Australia in major way.

In August 2020 about one-in-five Australian adults reported having been tested for COVID-19, up from about one-in-twenty in May and about one-in-fifty in April 2020.

Australians have reported high rates of anxiety and worry due to COVID-19 over the period April to August 2020; the rate was highest in April (66.7 per cent), fell quite substantially in May (57.3 per cent) and increased again between May and August (62.6 per cent). There has been a greater increase in anxiety and worry due to COVID-19 in Victoria compared to other areas of Australia, and a greater increase between April and May 2020 for females compared to males.

There has been a substantial decline in the per cent of people who are following the physical distancing requirements from earlier in the year, such as keeping 1.5 meters away from others, and avoiding crowded or public places. Declines were greatest outside of Victoria, but even in that State there have been fewer people following the requirements since April.

Following massive job losses between February and April 2020 the employment rate has increased slightly between April and May and again between May and August 2020. The average number of hours worked (including those who worked zero hours) fell from 21.9 hours per week in February to 18.5 hours per week in May, but has then increased to be 19.7 hours in August. The largest falls in hours worked have been for women and those aged 65 to 74 years of age, although men and other age groups have all experienced a reduction in the number of hours worked. In Victoria there was virtually no recovery in hours worked between May and August 2020, unlike in the rest of Australia where there was some recovery.

Despite the increase in average hours worked since May 2020, perceived job security has worsened significantly. The largest increase in perceived job insecurity has been amongst those who have completed Year 12 but do not have a degree.

COVID-19 had a big negative impact on household incomes. Income fell quickly and substantially between February and April and since April 2020 has not recovered. While average income has fallen, the JobKeeper and COVID-19 Supplementary social security payments have limited the size of the average income loss and have seen incomes increase at the bottom end of the income distribution. The largest drops in income (in dollar terms) have been for younger Australians and older Australians (relative to those aged 35 to 44 years), those born overseas in non-English speaking countries and those who have completed Year 12 but do not have a university degree.

In April 2020 45.8 per cent of the adult Australian population said they felt lonely at least some of the time. With the easing of social restrictions by May this had fallen to 35.7 per cent but by August it had increased to 40.5 per cent. Loneliness worsened in Victoria relative to other areas of Australia between May and August 2020.

Overall psychological distress increase between February 2017 and April 2020, followed by a significant reduction, although still higher than the pre COVID-19 levels, between April and

May. Psychological distress has worsened slightly between May and August. The worsening between May and August has been driven by declines in the mental health of women and people living in Victoria.

Life satisfaction declined substantially during the first wave of the pandemic in Australia and following some improvement between April and May, has fallen between May and August 2020. It has fallen more in Victoria between May and August 2020 than it has in other areas of Australia that have not experienced the second wave of COVID-19 and the reimposition of strict lockdown conditions.

As measured by life satisfaction there is a strong negative association between loneliness, low income, and housing stress on subjective wellbeing. Furthermore, those working short part-time hours have experienced a greater fall in life satisfaction. An important finding is that those who have remained employed but are working zero hours per week at the time of the survey have a higher level of life satisfaction than do the unemployed.

1 Introduction and overview

In order to monitor the impacts of COVID-19, the ANU Centre for Social Research and Methods has established a COVID-19 impact monitoring longitudinal survey program. It builds upon data collected in January and February 2020 prior to COVID-19 restrictions being implemented and significant numbers of cases in Australia, and is therefore following the same group of individuals prior to and through the COVID-19 pandemic period. This program provides population level estimates of the impact of COVID-19 and allows measurement of the variation in and the determinants of the change in outcomes for Australians.

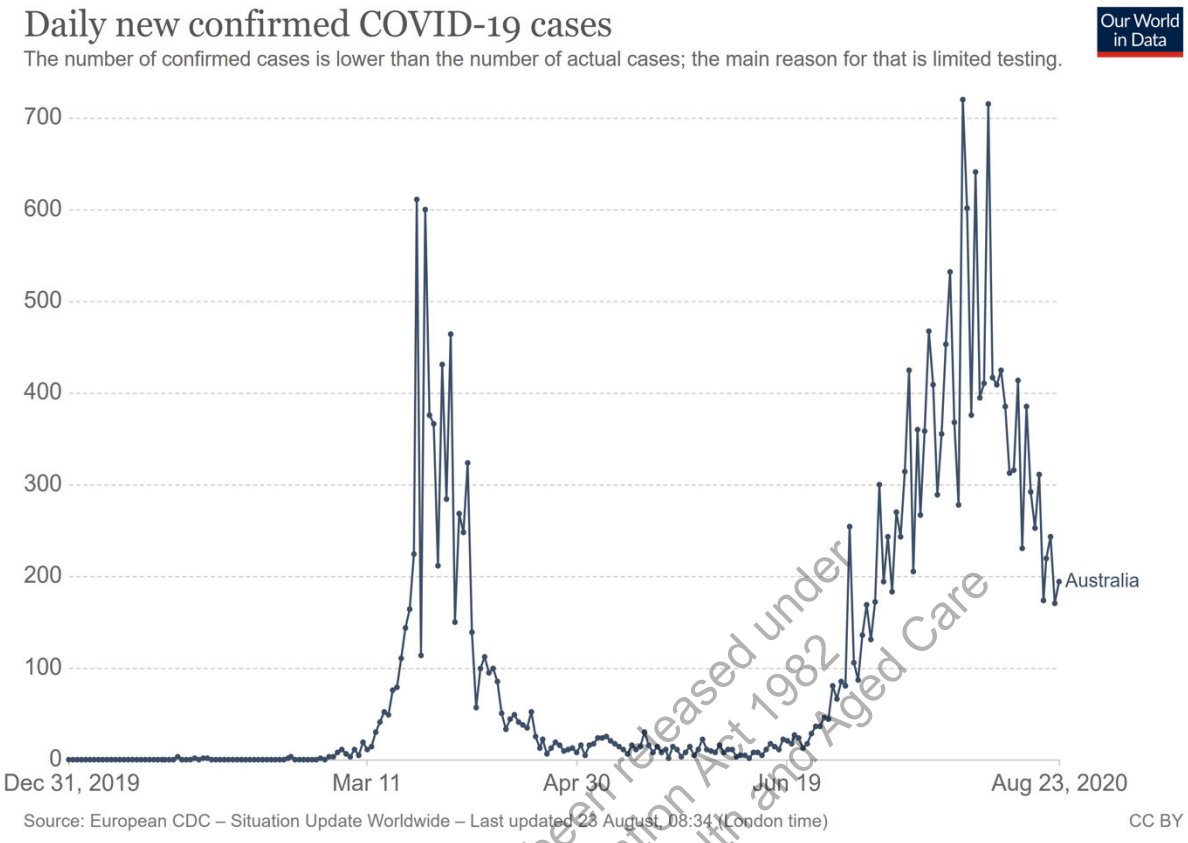
The surveys include a core set of questions on attitudes to COVID-19, labour market outcomes, household income, financial hardship, life satisfaction and mental health. In addition, each survey contains some specific questions of policy interest at the particular point in time in which the data was collected. The first wave of the COVID-19 monitoring surveys was conducted in April and this was followed by a second wave of data collection in May 2020. The data presented in this paper was collected in mid-August 2020 and additional waves of data will be collected in late 2020 and 2021, with data from these surveys made available from the Australian Data Archive as soon as possible after the data collection has finished.

1.1 COVID-19 infections, deaths, and restrictions in Australia

When the first paper summarising the May 2020 ANUpoll was finalised (May 25th) there were 7,109 confirmed infections in Australia, with 102 confirmed deaths.[1] By the time of finalising this paper (August 28th), however, there were 25,448 confirmed cases in Australia, and 584 confirmed deaths. Figure 1 shows, however, that cases have not occurred consistently across the period. The first wave of infections peaked at a little over 600 confirmed cases in late March, with very few cases occurring from mid-April through to mid-June. Cases increased again from late-June through to mid-August, peaking at a little over 700 cases per day.

While infection rates have fluctuated across the period spanned by our data surveys (with two clear peaks) mortality rates have stayed quite low by international standards (in *per capita* terms). As shown in Figure 2, Australia has lower *per capita* mortality rates than the UK, the US, Italy, Sweden, Brazil, and even Norway. With a mortality rate of 10.9 per million persons, Australia has a higher mortality rate than Taiwan (0.294), New Zealand (4.562), Singapore (4.615), South Korea (5.949), Japan (8.223), but a lower mortality rate than all other developed countries with robust data collection systems.

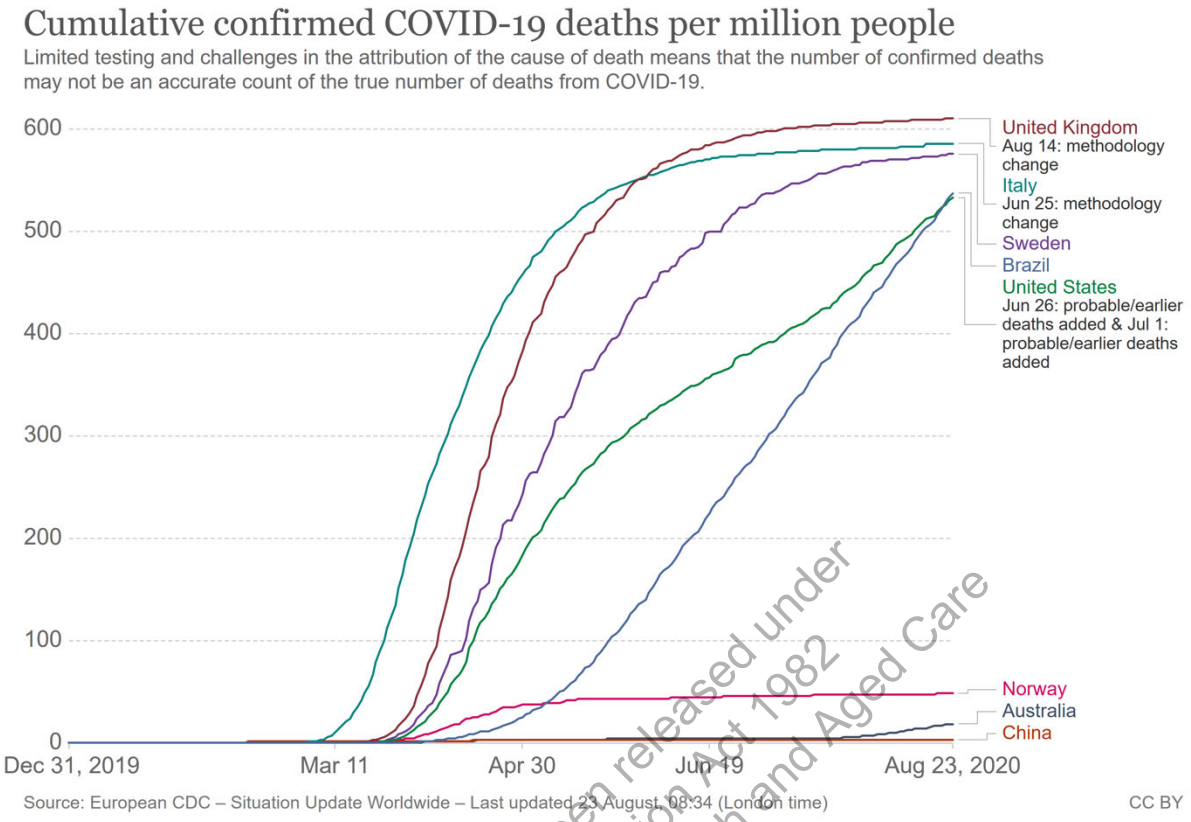
Figure 1 Confirmed COVID-19 cases by day, Australia



Note:

Source: Data and chart from Our World in Data, University of Oxford, Oxford Martin Programme on Global Development and Global Change Data Lab (https://ourworldindata.org/).

Figure 2 Deaths per one million population, Australia and selected other countries

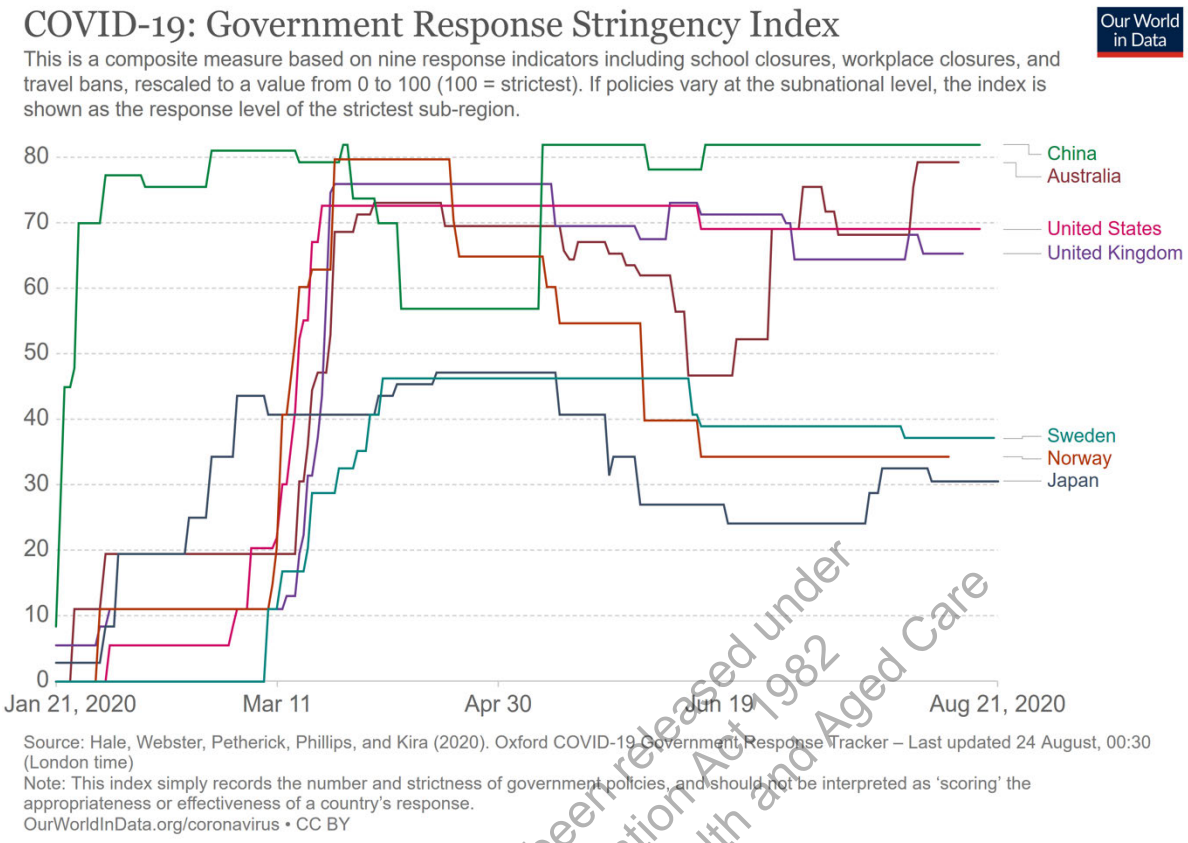


Source: Data and chart from Our World in Data, University of Oxford, Oxford Martin Programme on Global Development and Global Change Data Lab (https://ourworldindata.org/).

While Australia has moderate infection rates and low mortality rates relative to other comparable countries, Australia has one of the most restrictive policy frameworks in terms of local and international travel, with borders between Australia and the rest of the world effectively closed, and travel restricted between most Australian States and Territories. There also continues to be significant restrictions on gathering size, opening hours for many businesses, public transport, and many education restrictions.

The severity of the restrictions in Australia can be demonstrated by the Oxford Stringency Index (Hale et al. 2020). This index, a composite measure across the maximum value within a country for nine types of policy responses to COVID-19 had a value of 79.17 for Australia at the time of writing, with the next highest values amongst developed, democratic countries being 68.98 in the US, 68.06 in the UK, and 67.13 in Canada. All three of these countries, however, had vastly higher mortality and infection rates than Australia.

Figure 3 Oxford Stringency Index for Australia and other countries



Source: Data and chart from Our World in Data, University of Oxford, Oxford Martin Programme on Global Development and Global Change Data Lab (https://ourworldindata.org/).

The restrictions on travel and the physical distancing and isolation measures that are captured by Figure 3 are having and have been having major negative effects on the Australian economy. The Australian Bureau of Statistics (ABS 2020a) estimates from the Labour Force Survey (LFS) suggest that seasonally adjusted employment fell by a little over 600,000 people between March and April 2020 (from around 12,989,000 individuals in March to 12,382,000 individuals in April) with a further, albeit smaller, decline between April and May 2020 (to 12,118,000 individuals). There have been some improvements between May and July (the most recent data available) though the 12,461,000 individuals employed in July 2020 was still well below the peak experienced prior to the spread of COVID-19.

Although Labour Force Survey data is not available for August at the time of writing, weekly payroll data suggests that employment has again declined from July into August (ABS 2020b). Nationally, the change in the index was -0.8 per cent between the 25th of July and the 8th of August, with total wages declining by -0.6 per cent over the same period.

The most recent decline in jobs, however, has not been evenly spread across States and Territories. Tasmania and the Northern Territory experienced a small increase in payroll jobs between July and August, with New South Wales, South Australia and Western Australia experiencing small declines. Queensland (-0.9%) and the Australian Capital Territory (ACT, -1.5%) experienced larger declines, but it is Victoria (-1.6%) that has been impacted the most during the second wave of infections described in Figure 1.

Victoria has also been most impacted from a health perspective. The vast majority of infections in Australia have occurred in Victoria, particularly during the second wave. Of the 25,448 confirmed cases in Australia, 18,822 or almost three-quarters (74.0 per cent) have occurred in Victoria. Of the 584 confirmed deaths, an even greater share (496 or 84.9 per cent) have occurred in Victoria. Indeed, because the Oxford Stringency Index is based on the most restrictive set of regulations within a country, it is in fact Victoria that is driving Australia's relatively high ranking on the index (Stage 3 restrictions in Melbourne from July 9 and Stage 4 restrictions in Melbourne from 2 August).

Since early August, people living in metropolitan Melbourne have been subject to what are known as Stage 4 restrictions. These restrictions include a curfew from 8pm to 5am with the only allowable reasons for leaving home during the curfew being work, medical care and caregiving. At other times people are only allowed to leave home: to purchase necessary goods and services within 5km of home (unless essential goods and services are further away); to exercise (once per day for no longer than one hour and within 5km of home); to provide care or access health care; and work for permitted workers. When leaving home the wearing of a mask is mandatory unless an exemption applies.

In most areas of Victoria outside of metropolitan Melbourne what are known as Stage 3 restrictions apply. These are not as strict as the Stage 4 restrictions but are still highly restrictive with only four reasons allowed for leaving home: to shop for necessary goods and services; provide care, for compassionate reasons or to seek medical treatment; to exercise or for outdoor recreation; and for work or education, if it can't be done at home. The wearing of a facemask when leaving home is mandatory. The borders between Victorian and other states and territories of Australia are closed with few exceptions and for people who do leave Victoria for other areas of Australia they are required to go into quarantine for a period.

1.2 Data collection and remainder of paper

Not long after the Stage 4 (Melbourne) and Stage 3 (rest of Victoria) restrictions were imposed, (10th August) respondents on Life in Australia™ were invited to participate in the August 2020 ANUpoll (the 41st wave of data collection from the panel). Life in Australia™ is Australia's only probability-based online panel, managed by the Social Research Centre with adult panel members from across Australia, representing all income levels, education categories, adult age cohorts, and major industries and occupations.

This paper provides a summary of data from this survey, collected between the 10th and 24th of August 2020. It adds another month's data to the first and only longitudinal survey data on the impact of COVID-19 with respondents interviewed in April (Biddle et al. 2020a) and May (Biddle et al. 2020b) as well as in January and February prior to the spread of COVID-19.

The August 2020 ANUpoll collected data from 3,061 respondents aged 18 years and over across all eight States/Territories in Australia, and is weighted to have a similar distribution to the Australian population across key demographic and geographic variables. Data for the vast majority of respondents was collected online (94.1 per cent), with a small proportion of respondents enumerated over the phone. A limited number of telephone respondents (17 individuals) completed the survey on the first day of data collection, with a little under half of respondents (1,222) completing the survey on the 11th or 12th of August.

The data presented in this survey has both cross-sectional and longitudinal relevance, with very high rates of linkage through time. Of those who completed the August 2020 wave of data collection, 2,916 individuals (95.3 per cent) also completed the May 2020 ANUpoll, 2,833

individuals (92.6 per cent) also completed the April 2020 ANUpoll, 2,828 individuals (92.4 per cent) also completed the February 2020 Life in Australia™ survey[2], and finally, 2,790 individuals (91.1 per cent) also completed the January 2020 ANUpoll (during the height of the Black Summer Bushfire crisis).

In total, we have data on almost two-and-a-half thousand Australians (2,492 total respondents) for all five waves of data collection in 2020. However, unless otherwise stated, when data for a given month is presented, it is based on the cross-sectional sample for that particular month.

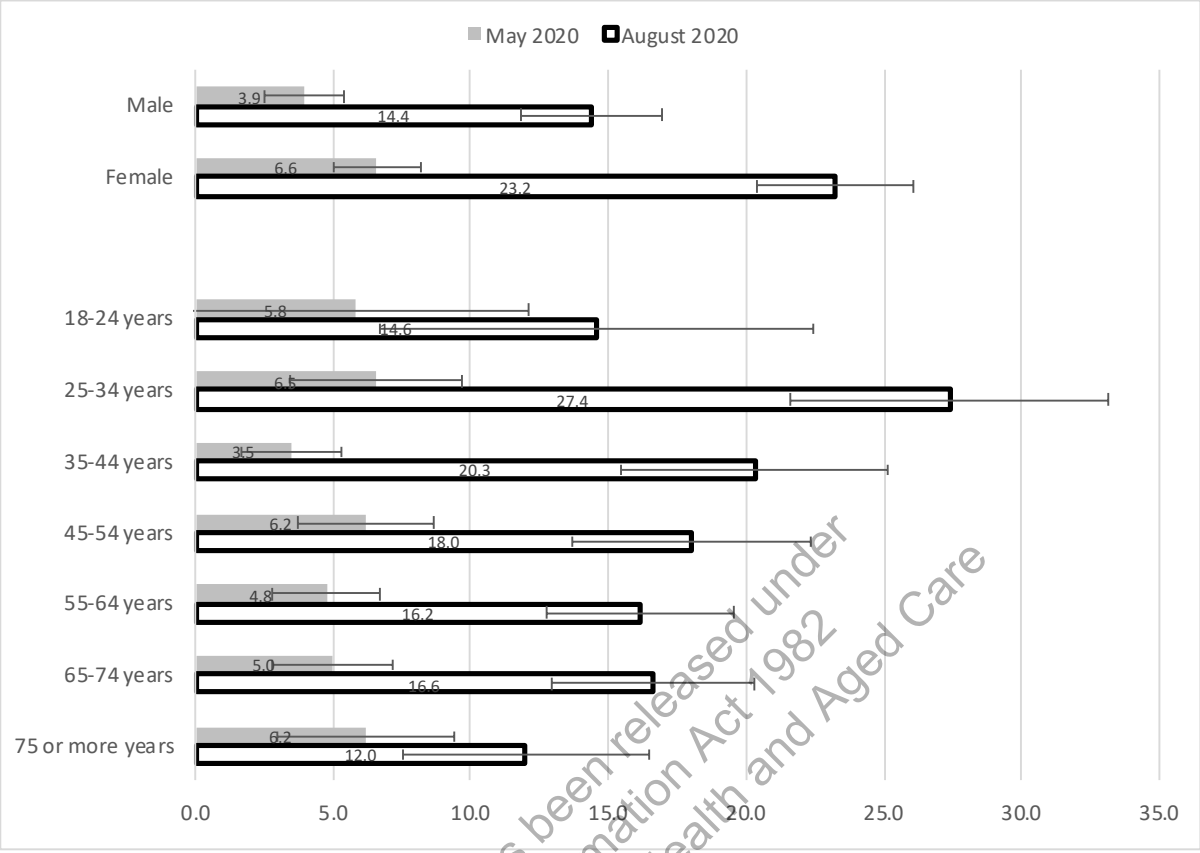
This paper provides a summary of outcomes for Australians during the peak of the second wave of COVID-19 infections (August 2020), as well as how selective outcomes have changed since before the spread of COVID-19 (January or February 2020, depending on the measure used) or since the initial wave of infections (April or May 2020). We begin our analysis at the national level focusing on views and attitudes directly related to COVID-19 (Section 2); followed by adherence to physical distancing recommendations (Section 3). This is followed by changes in economic circumstances (Section 4); and changes in mental health and wellbeing (Section 5). We then provide a detailed analysis of how outcomes in Victoria have diverged from the rest of Australia (Section 5), holding constant other individual level characteristics. The final section of the paper concludes.

2 Views on and exposure to COVID-19

One of the ways in which countries and jurisdictions can understand and respond to outbreaks of COVID-19 is through high quality and rapid testing and tracing of cases. According to West et al. (2020) of the Mayo Clinic in the US 'expanded testing for COVID-19 is a necessary immediate step toward understanding and resolving this crisis.' Australia has had a high number of tests relative to the size of the population (6,052,236 at the time of writing), but many people are likely to have been tested more than once – for example health workers, those with particular health conditions, or those who travel frequently. The proportion of the population who have been tested is therefore likely to be much smaller than the number of tests as a proportion of the population. As far as we are aware, data from ANUpoll is the only large, probability-based sample which gives the rate of testing for individuals.

In August 2020, 19.3 per cent of Australian adults were estimated to have been tested for COVID-19. This is a very large increase from May 2020 when only 5.2 per cent of adults were estimated to have been tested, and even more so from April 2020 when only 2.1 per cent had. Testing is not evenly distributed across the adult population, nor is change through time. As shown in Figure 4 (which is based on the May and August cross-sectional samples), females were far more likely to have been tested than males, with those of prime working age (aged 25 to 34 years in particular, but also aged 35 to 44 years) the most likely to have been tested.

Figure 4 Per cent of Australian adults who have been tested for COVID-19 by age and sex, May and August 2020



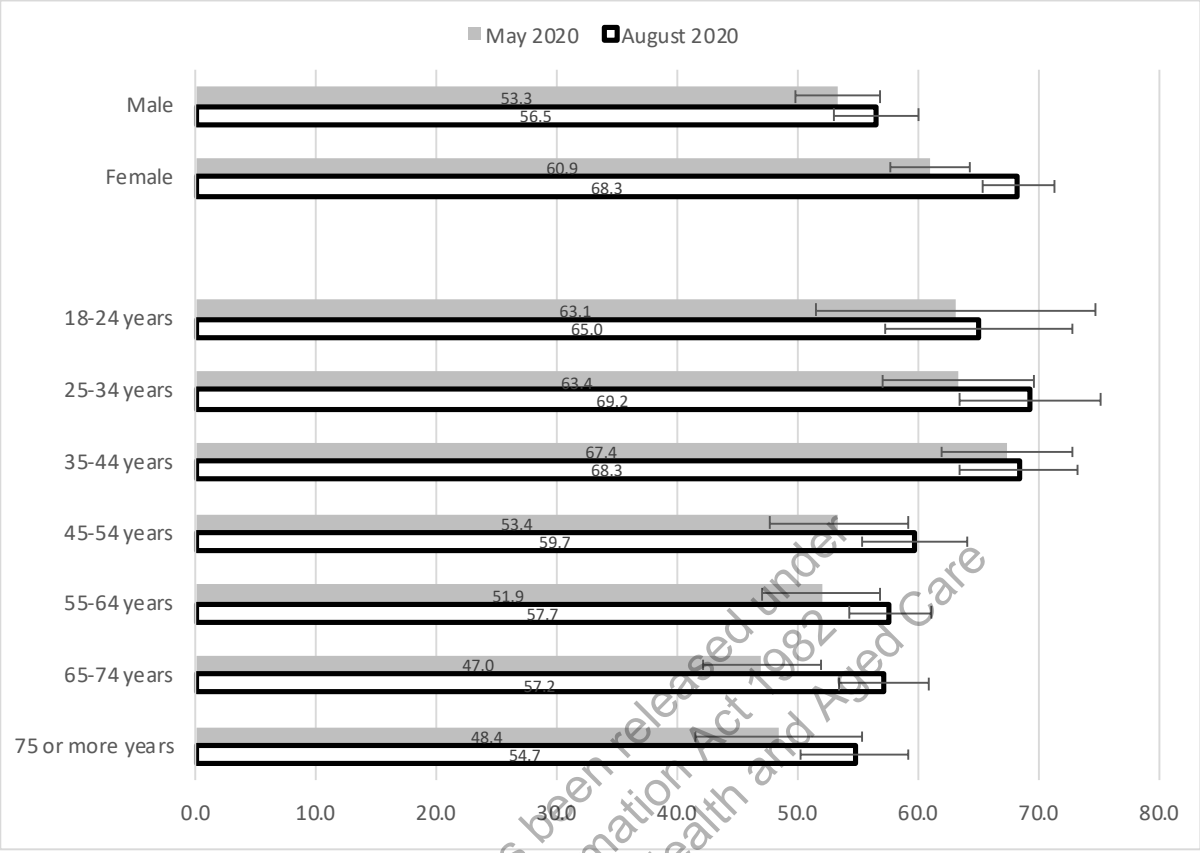
Notes: The "whiskers" on the bars indicate the 95 per cent confidence intervals for the estimate.

Source: ANUpoll, May and August 2020.

Australia continues to experience high rates of anxiety and worry due to COVID-19, with fluctuations through time that reflect the trends in infection rates during the COVID-19 pandemic. More than three-in-five Australians (62.6 per cent) in the August ANUpoll reported that they were anxious and worried, an increase from May 2020 (57.3 per cent), but still a slight decline from the April 2020 peak (66.7 per cent).

Between May and August, the biggest increases in anxiety and worry occurred for females, increasing from 60.9 per cent in May to 68.3 per cent in August (Figure 5). Females had higher rates of anxiety and worry than males before the second wave of infections, and this gap has increased over the period. There has, however, been some convergence by age, with the largest increase in anxiety and worry experienced by those aged 65 to 74 years – from 47.0 per cent to 57.2 per cent. Young Australians, and particularly those aged 25 to 34 years, continue to have the highest rates of anxiety and worry though.

Figure 5 Per cent of Australians who reported anxiety and worry due to COVID-19 by age and sex, May and August 2020



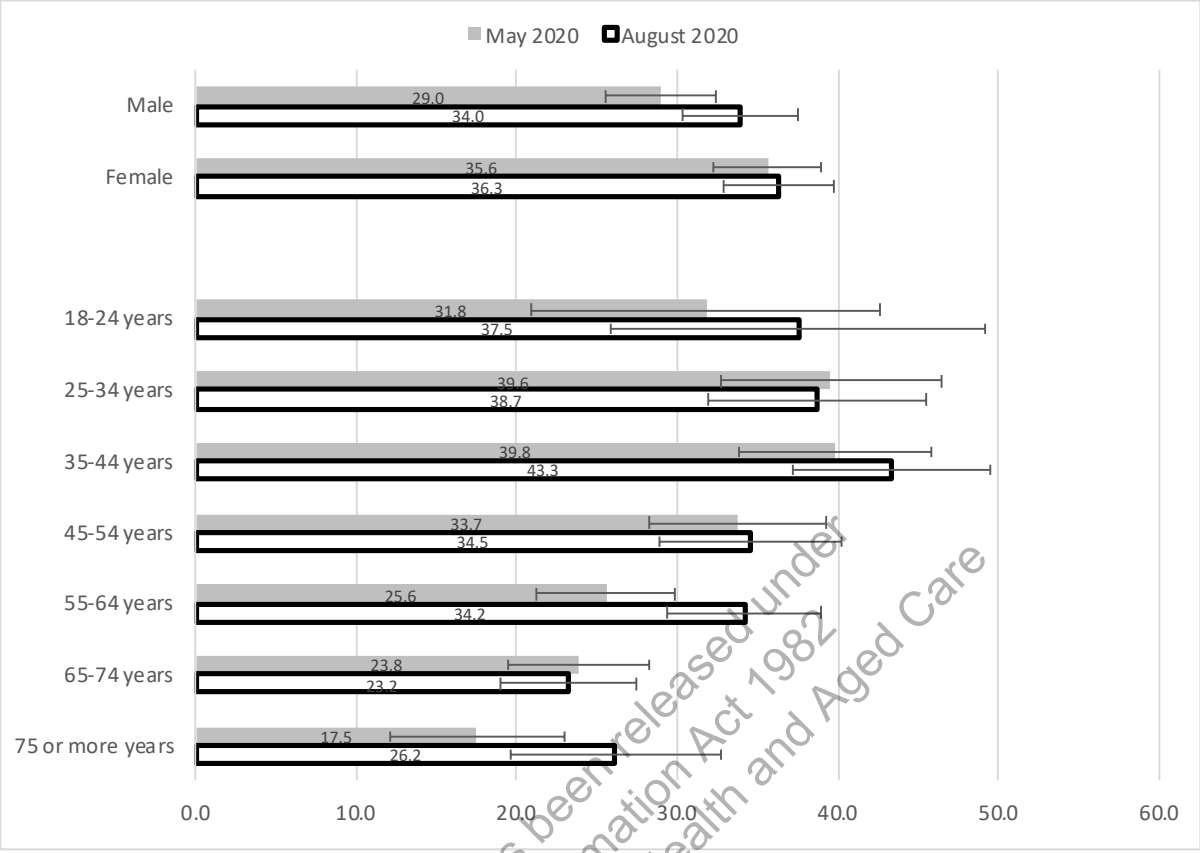
Notes: The "whiskers" on the bars indicate the 95 per cent confidence intervals for the estimate.

Source: ANUpoll, May and August 2020.

In April, May and August 2020 respondents were asked about how likely they thought it would be that they would become infected by COVID-19 over the next six-months. There was an initial fall in the percentage of Australians who thought that it was likely or very likely that they would be infected by COVID-19 from 39.5 per cent in April to 31.5 per cent in May 2020. The expected likelihood rose again though between May and August, to 34.1 per cent of the population. Given the total number of COVID-19 cases in Australia was only 988 per one million persons (less than one-tenth of one per cent of the population), this represents an extremely high over-estimate of likely infections, unless something changes dramatically in Australia over the next six months.

The fall in the percentage of Australians thinking that it is likely or very likely that they will be infected by COVID-19 over the next six-months between April and May 2020 was greater for males than females (Biddle et al. 2020b). This was reversed between May and August 2020 though (Figure 6) with males now roughly as likely to think that they will be infected (34.0 per cent) as females (36.3 per cent).

Figure 6 Per cent of Australians who think it likely or very likely that they will be infected by COVID-19 in next 6 months by age and sex, May and August 2020



Notes: The "whiskers" on the bars indicate the 95 per cent confidence intervals for the estimate.

Source: ANUpoll, May and August 2020.

3 Physical distancing behaviours

In the absence of a vaccine or effective anti-viral treatment for COVID-19, the main public health responses continue to be physical/social distancing; reductions in travel and population movement; contact tracing; and isolation/quarantining for those who have a heightened probability of having COVID-19.

There has been a significant decline in the per cent of people who are following the physical distancing requirements from earlier in the year, such as keeping 1.5 meters away from others, and avoiding crowded places. In total, 72.2 per cent of Australians reported that in the 7 days preceding the survey they always or mostly avoided crowded places in August 2020, compared to 94.3 per cent in April 2020. A smaller percentage said they always or mostly avoided public places (55.8 per cent), a substantial decline from April (86.5 per cent). There was a smaller decline in the per cent of people who said they always or mostly kept 1.5 metres from others from 96.0 per cent in April to 86.9 per cent in August.

These three variables are highly correlated with each other. They were combined using an additive index with a value of 3 for those who never did any of the three physical distancing behaviours, and a value of 15 for those who always did all three. The index fell from an average of 13.2 in April to 11.4 in August. Even more interestingly though, the change was not consistent across the population, as shown through a linear regression model with the additive

index value in August as the dependent variable, and the value in April as a control variable. The largest relative declines were for those aged 25 to 64 years; those born overseas in an English speaking country; and those who lived outside a capital city. There were smaller declines for those aged 65 years and over, and for those with a postgraduate degree.

Table 1 Factors associated with physical distancing behaviour, August 2020

	Coeff.	Signif.
Physical distancing index in April 2020	0.598	***
Female	0.109	
Aged 18 to 24 years	0.524	
Aged 25 to 34 years	-0.192	
Aged 45 to 54 years	0.077	
Aged 55 to 64 years	0.134	
Aged 65 to 74 years	0.661	***
Aged 75 years plus	0.774	***
Indigenous	0.502	
Born overseas in a main English speaking country	-0.591	***
Born overseas in a non-English speaking country	0.003	
Speaks a language other than English at home	0.273	
Has not completed Year 12 or post-school qualification	0.252	
Has a post graduate degree	0.617	**
Has an undergraduate degree	0.250	
Has a Certificate III/IV, Diploma or Associate Degree	0.296	
Lives in the most disadvantaged areas (1st quintile)	0.111	
Lives in next most disadvantaged areas (2nd quintile)	0.211	
Lives in next most advantaged areas (4th quintile)	0.218	
Lives in the most advantaged areas (5th quintile)	0.187	
Lives in a non-capital city	-0.403	**
Constant	2.942	
Sample size	2,688	

Source: ANUpoll, May and August 2020.

Notes: OLS Regression Model. The base case individual is female; aged 35 to 44; non-Indigenous; born in Australia; does not speak a language other than English at home; has completed Year 12 but does not have a post-graduate degree; lives in neither an advantaged or disadvantaged suburb (third quintile); and lives in a capital city

Coefficients that are statistically significant at the 1 per cent level of significance are labelled ***; those significant at the 5 per cent level of significance are labelled **, and those significant at the 10 per cent level of significance are labelled *.

Given the imposition of Stage 4 lockdown restrictions in Melbourne and Stage 3 restrictions in the rest of Victoria alongside a more general relaxation in other parts of the country (apart from State/Territory borders), it is not surprising that there has been a divergence in behaviour between Victoria and the rest of the country. Based on the additive index, there was a significant decline in the rest of Australia from 13.1 in April 2020 to 10.8 in August 2020. For Victoria, on the other hand, the index value stayed reasonably steady between the Wave 1 and Wave 2 infections, 13.4 in April 2020 and 13.0 in August 2020. It should be noted though that this difference is still statistically significant, showing that even in Victoria there has been a small decline in adherence to physical distancing recommendations.

When we last asked about physical distancing behaviour (in April), masks were not recommended to be worn, apart from health workers or those who otherwise had significant exposure to people who were likely to be infected. By August, however, masks were not only more likely to be worn, but were required in a number of circumstances and we therefore

asked two new physical distancing questions – whether a person wore masks indoors when in a public place, or outdoors when in a public place. In the August survey, 39.3 per cent of respondents said they mostly or always wore masks indoors, and 37.3 per cent said they mostly or always wore masks outdoors.

Combining the two (that is, whether or not someone always or mostly wore masks **both** indoors and outdoors), the most frequent mask wearers as identified through a regression analysis were young Australians (aged 18 to 24 years) and older Australians (75 years and over); those who spoke a language other than English at home; those with an undergraduate or postgraduate degree; and those who lived in a capital city. It is noteworthy that despite the discussion in the media and by politicians that young people are not observing distancing rules, data from the August ANUpoll suggests that rates of mask wearing by those aged 18 to 24 years are similar to rates amongst those aged 75 years or older. Both these groups are significantly more likely to wear masks than other age groups.

Table 2 Factors associated with mask wearing behaviour, August 2020

	Marginal Effect	Significance
Female	0.031	
Aged 18 to 24 years	0.142	**
Aged 25 to 34 years	-0.073	*
Aged 45 to 54 years	-0.022	
Aged 55 to 64 years	-0.042	
Aged 65 to 74 years	0.034	
Aged 75 years plus	0.138	***
Indigenous	-0.018	
Born overseas in a main English speaking country	-0.053	
Born overseas in a non-English speaking country	0.029	
Speaks a language other than English at home	0.078	*
Has not completed Year 12 or post-school qualification	0.047	
Has a post graduate degree	0.148	***
Has an undergraduate degree	0.098	**
Has a Certificate III/IV, Diploma or Associate Degree	0.049	
Lives in the most disadvantaged areas (1st quintile)	0.044	
Lives in next most disadvantaged areas (2nd quintile)	0.081	**
Lives in next most advantaged areas (4th quintile)	0.046	
Lives in the most advantaged areas (5th quintile)	0.066	*
Lives in a non-capital city	-0.130	***
Probability of base case	0.534	
Sample size	2,901	

Source: ANUpoll, May and August 2020.

Notes: Probit regression, with results presented as marginal effects. The base case individual is female; aged 35 to 44; non-Indigenous; born in Australia; does not speak a language other than English at home; has completed Year 12 but does not have a post-graduate degree; lives in neither an advantaged or disadvantaged suburb (third quintile); and lives in a capital city.

Coefficients that are statistically significant at the 1 per cent level of significance are labelled ***; those significant at the 5 per cent level of significance are labelled **, and those significant at the 10 per cent level of significance are labelled *.

4 Economic circumstances

Australia's economic circumstances have been impacted substantially by the COVID-19 pandemic. International comparisons and cross-jurisdictional analysis in large countries like the US have shown that the negative economic effects of COVID-19 have come from a combination of individual decision making (people deciding not to consume goods or services); the flow-on economic effects of other countries and jurisdictions (reduced trade), and the economic costs of physical distancing restrictions and other isolation measures (Aum et al. 2020).

4.1 Employment and hours worked

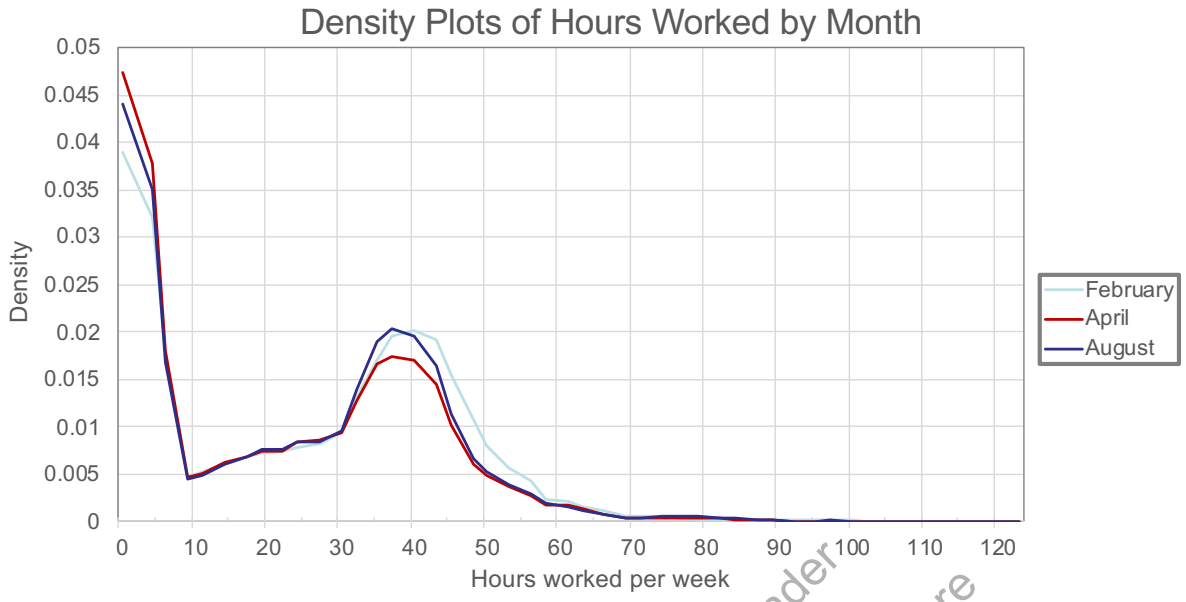
Using data from Life in Australia™, there were massive job losses between February and April 2020 with the proportion of the adult population employed falling from 62.0 to 58.9 per cent. There was further, but smaller, falls in the employment rate to 57.1 per cent in May. With some of the physical distancing restrictions being eased (with the exception of Victoria), between May and August the employment rate increased to 59.1 per cent. While this is higher than the low point observed in our data, it remains well below the pre-COVID-19 level.

Hours worked has followed a similar path. Average hours worked (setting the hours of those who were not employed to zero) for Australian adults declined from 21.9 hours per week in February 2020, to 18.7 hours per week in April, with little further change between April and May (18.5 hours per week). We observed an increase between May and August 2020, up to an average of 19.7 hours per week.

Much of this decline between February and April 2020, and then increase between April/May and August was driven by a reduction in the proportion of people who did not work any hours in the reference week (Figure 7).

Not all of the increase in the proportion of the population who worked zero hours is due to job loss, with a significant increase in the proportion of the employed who reported that they were working zero hours. Prior to COVID-19 (February 2020), only 0.8 per cent of employed adults were working zero hours. This increased more than fivefold between February and April (to 4.4 per cent), and then declined between April and May (to 3.2 per cent) and then again between May and August (to 2.4 per cent).

Figure 7 Distribution of hours worked, February, April and August 2020



Source: ANUpoll, April and August 2020 and Life in Australia Wave 35, February 2020.

As outlined in the introduction, using the longitudinal nature of the Life in Australia surveys we are able to track changes in employment outcomes at the individual level. Using the linked February-August sample and setting those who were not employed to zero hours, 32.6 per cent of the population worked fewer hours in August than in February 2020, 46.9 per cent worked the same number of hours and 20.5 per cent worked more hours. While overall hours worked have declined, for about one-in-five Australians the COVID-19 period has been associated with an increase in the number of hours worked.

Using a regression analysis and focusing to start with on those who were employed in both periods (the first column of results in Table 3), it is estimated that women's working hours fell by 2.2 hours per week more than the fall for men over the February to August 2020 period. The largest fall in hours was for those aged 65 to 74 years who experienced a 5.6 hour per week greater fall in hours worked than those aged 35 to 44 years.[3] Those who were born overseas also worked fewer hours in August than those born in Australia, controlling for hours worked prior to the spread of COVID-19 (about a 1.7 hour per week greater fall than those born in Australia).

One of the more interesting findings from our comparison between hours worked in August and April at the individual level is that the first six months of the COVID-recession appears to have impacted on the middle part of the education distribution the most. Compared to those who have completed Year 12 but do not have a university qualification, those who have a post-graduate degree were working 4.1 more hours in August, whereas those with an undergraduate degree were working 2.9 hours more per week. This is not surprising, as recessions tend to impact less on the relatively high skilled (Borland, 2020). What is surprising though is that those who have not completed Year 12 were also working 2.9 hours more per week than those who had completed Year 12, controlling for age and hours worked in February.

Looking at the total linked sample in the second column of results (that is setting those who were not employed to zero hours and allowing for movement into and out of employment),

the direction of the associations are quite similar, but the statistical significance isn't always the same.

Table 3 Factors associated with hours worked, August 2020

	Employed in both waves		Total linked sample	
	Coeff.	Signif.		
Hours worked in February 2020	0.581	***	0.653	***
Female	-2.231	***	-1.188	
Aged 18 to 24 years	-1.449		-2.059	
Aged 25 to 34 years	0.313		0.292	
Aged 45 to 54 years	0.458		0.308	
Aged 55 to 64 years	-0.297		-2.537	**
Aged 65 to 74 years	-5.640	***	-7.657	***
Indigenous	-0.656		-5.001	*
Born overseas in a main English speaking country	-1.641	*	0.045	
Born overseas in a non-English speaking country	-1.683		-2.088	
Speaks a language other than English at home	0.009		-0.289	
Has not completed Year 12 or post-school qualification	2.854	*	1.248	
Has a post graduate degree	4.089	***	3.808	**
Has an undergraduate degree	2.889	**	2.073	
Has a Certificate III/IV, Diploma or Associate Degree	1.786		0.166	
Lives in the most disadvantaged areas (1st quintile)	0.280		-0.968	
Lives in next most disadvantaged areas (2nd quintile)	-1.429		-2.960	***
Lives in next most advantaged areas (4th quintile)	0.300		-1.156	
Lives in the most advantaged areas (5th quintile)	-0.814		-1.079	
Lives in a non-capital city	-0.218		0.382	
Constant	12.792		9.174	
Sample size	1,450		2,400	

Source: ANUpoll, August 2020 and Life in Australia Wave 35, February 2020

Notes: OLS Regression Model. The base case individual is female; aged 35 to 44; non-Indigenous; born in Australia; does not speak a language other than English at home; has completed Year 12 but does not have a post-graduate degree; lives in neither an advantaged or disadvantaged suburb (third quintile); and lives in a capital city

Coefficients that are statistically significant at the 1 per cent level of significance are labelled ***; those significant at the 5 per cent level of significance are labelled **, and those significant at the 10 per cent level of significance are labelled *.

4.2 Labour market security

While hours worked have increased since the May 2020 tracking survey, the perceived job security of those who are employed has worsened significantly. In all three of our post-COVID-19 tracking surveys, respondents who were currently employed were asked what they thought the chances were of them losing their job at some stage over the next 12-months. In April 2020, the average perceived probability was 24.6 per cent, far higher than ever recorded using a similar question on the Household, Income, and Labour Dynamics in Australia (HILDA) survey (Foster and Guttman 2018). Job insecurity declined to 22.0 per cent in May, but has increased again in our most recent data to an average expected likelihood of 25.0 per cent, significantly higher than the May average, but not significantly different from the previous April 2020 peak.

Most of the growth in job insecurity between May and August 2020 has been driven by the middle part of the education distribution.[4] For those who have completed Year 12 but do not have a degree, there was an increase in the average expected probability of losing one's job by 4.6. For those who had not completed Year 12, the increase was only 1.6, whereas for those

who have a university degree there was a further decline between May and august 2020 (by -0.1 for those with an undergraduate degree and -1.3 for those with a postgraduate degree). Particularly in the last few months, the economic effects of COVID-19 have manifested themselves as a middle-education recession.

4.3 Income and financial stress

At the time of writing, Australian National Accounts data for the July quarter were not available, with the latest available data being for very early part of the COVID-19 pandemic, with the Australian economy contracted by 0.3% in the March quarter 2020 (ABS 2020c).[5] However, using weekly payroll data, the ABS (2020b) has found that between the week ending 14th March 2020 and the week ending 8th August 2020 (just prior to the data collection for this paper), total wages decreased by 6.2 per cent.

Offsetting some of the decrease in wages over the period, social security and other payments by government have increased substantially. These include the Economic Support payment of $750 for existing social security payment recipients and the provision of a $550 per fortnight Coronavirus Supplement to new and existing eligible income support recipients (including those receiving student support payments, Jobseeker Payment (unemployment benefit or Parenting Payment). In addition to the above payments made mostly to those who were not employed, the JobKeeper payment of $1,500 per fortnight for each eligible employee to employers to enable them to continue to pay their employees was paid to businesses from the first week of May. Many employees will have continued to receive their wages from employers prior to then (including in the April ANUpoll), in anticipation of the payment.

In separate research using the ANU Centre for Social Research and Methods' PolicyMod microsimulation model and preliminary August 2020 ANUpoll data Phillips et al. (2020) showed that in aggregate terms the introduction of these payments 'have reduced measures of poverty and housing stress, with both now below what they were prior to COVID-19.' However, the research also found that 'the protective impact has been reduced somewhat by the July policy announcement to make these supplementary payments less generous.' (p ii).

Using data from the February and April 2020 surveys it estimated that average household after-tax income fell by 9.1 per and per person household after-tax income fell by 10.4 per cent (Biddle et al. 2020a).[6] Data from the April, May and August 2020 ANUpolls shows no further change in per person household income since April (it is estimated to be $663 per week in April, $665 per week in May, and $669 per week in August). Despite significant increases in hours worked since April 2020, there have been no improvements in income for Australian households. A potential explanation for this is that those whose hours worked had increased since April were those in receipt of JobKeeper payment.

Looking over the period February to August 2020 and controlling for income in February 2020, there was a larger drop in per person household income for young Australians (by an extra $95 per week than those aged 35 to 44 years) and older Australians (by an extra $87 and $62 per week for those aged 65 to 74 years and 75 years and older respectively). There was also a larger decline in income for those born overseas in a non-English speaking country (an extra $93 per week decline than those born in Australia). Those with relatively high levels of education had a smaller decline than those who had completed Year 12 but did not have a university degree, with income in August higher by $75 per week for those with a postgraduate degree and $80 per week for those with an undergraduate degree, conditional on income in February.

Table 4 Factors associated with per person household income, August 2020

	Coeff.	Signif.
Income in February 2020	0.643	***
Female	-30.840	
Aged 18 to 24 years	-95.292	*
Aged 25 to 34 years	11.876	
Aged 45 to 54 years	1.062	
Aged 55 to 64 years	-1.754	
Aged 65 to 74 years	-87.878	***
Aged 75 years plus	-61.564	**
Indigenous	-82.904	
Born overseas in a main English speaking country	18.277	
Born overseas in a non-English speaking country	-92.752	***
Speaks a language other than English at home	24.916	
Has not completed Year 12 or post-school qualification	-5.053	
Has a post graduate degree	75.409	
Has an undergraduate degree	80.384	**
Has a Certificate III/IV, Diploma or Associate Degree	-10.170	
Lives in the most disadvantaged areas (1st quintile)	-28.516	
Lives in next most disadvantaged areas (2nd quintile)	6.234	
Lives in next most advantaged areas (4th quintile)	25.913	
Lives in the most advantaged areas (5th quintile)	41.601	
Lives in a non-capital city	25.935	
Constant	213.334	
Sample size	2,412	

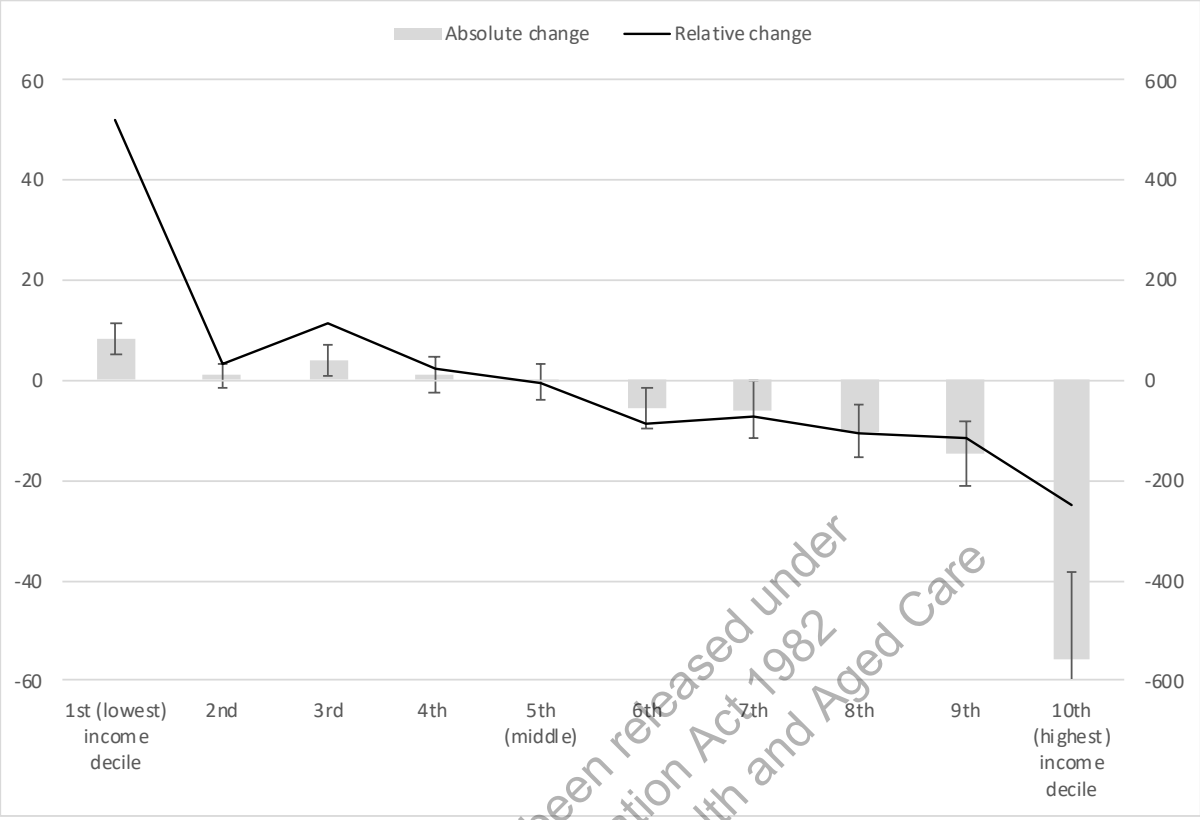
Source: ANUpoll, August 2020, and Life in Australia™, February 2020.

Notes: OLS Regression Model. The base case individual is female; aged 35 to 44; non-Indigenous; born in Australia; does not speak a language other than English at home; has completed Year 12 but does not have a post-graduate degree; lives in neither an advantaged or disadvantaged suburb (third quintile); and lives in a capital city

Coefficients that are statistically significant at the 1 per cent level of significance are labelled ***; those significant at the 5 per cent level of significance are labelled **, and those significant at the 10 per cent level of significance are labelled *.

Change in income between February and August 2020 is negatively correlated with income in February 2020 (correlation coefficient = -0.4804), as reflected by the poverty calculations in Phillips et al. (2020). This is further demonstrated in Figure 8, which gives the average change in income (for those in both samples) by the decile of income in February 2020 in both absolute and relative (to February 2020 income) terms.

Figure 8 Change in per person household after-tax income between February and August 2020, by income decile in February



Notes: The "whiskers" on the bars indicate the 95 per cent confidence intervals for the estimate. Restricted to those who completed both the February and August 2020 surveys.

Source: ANUpoll, August 2020 and Life in Australia Wave 35, February 2020

We have also seen a continuous decline in the per cent of Australians who think it is difficult or very difficult to live on their current income. In February 2020, 26.7 per cent said they were finding it difficult or very difficult, decreasing to 22.8 per cent in April, 21.7 per cent in May and 18.7 per cent in August. This decline is likely due to those at the bottom part of the income distribution experiencing an increase or only a small decline in income, as well as less opportunities for expenditure during the COVID-19 period.

5 Mental health and wellbeing

The COVID-19 pandemic is having a negative impact on mental health and subjective well being across the world, and Australia is no exception (Biddle et al. 2020c). The decline in hours worked are likely to impact on people's subjective wellbeing, with long-run, cross-country evidence (Schröder, 2020: p. 1) suggesting that 'life satisfaction of men and especially fathers … increases steeply with paid working hours. In contrast, the life satisfaction of childless women is less related to long working hours, while the life satisfaction of mothers hardly depends on working hours at all.' Employment and loss of income have also been shown to have a strong association with mental health outcomes, although the causal direction of this association is difficult to establish (Murphy and Athanasou. 1999).

The social isolation created by lockdowns are also likely to have a negative impact on mental health and wellbeing (Hamermesh 2020). For example, Gerino et al. (2017) has shown that

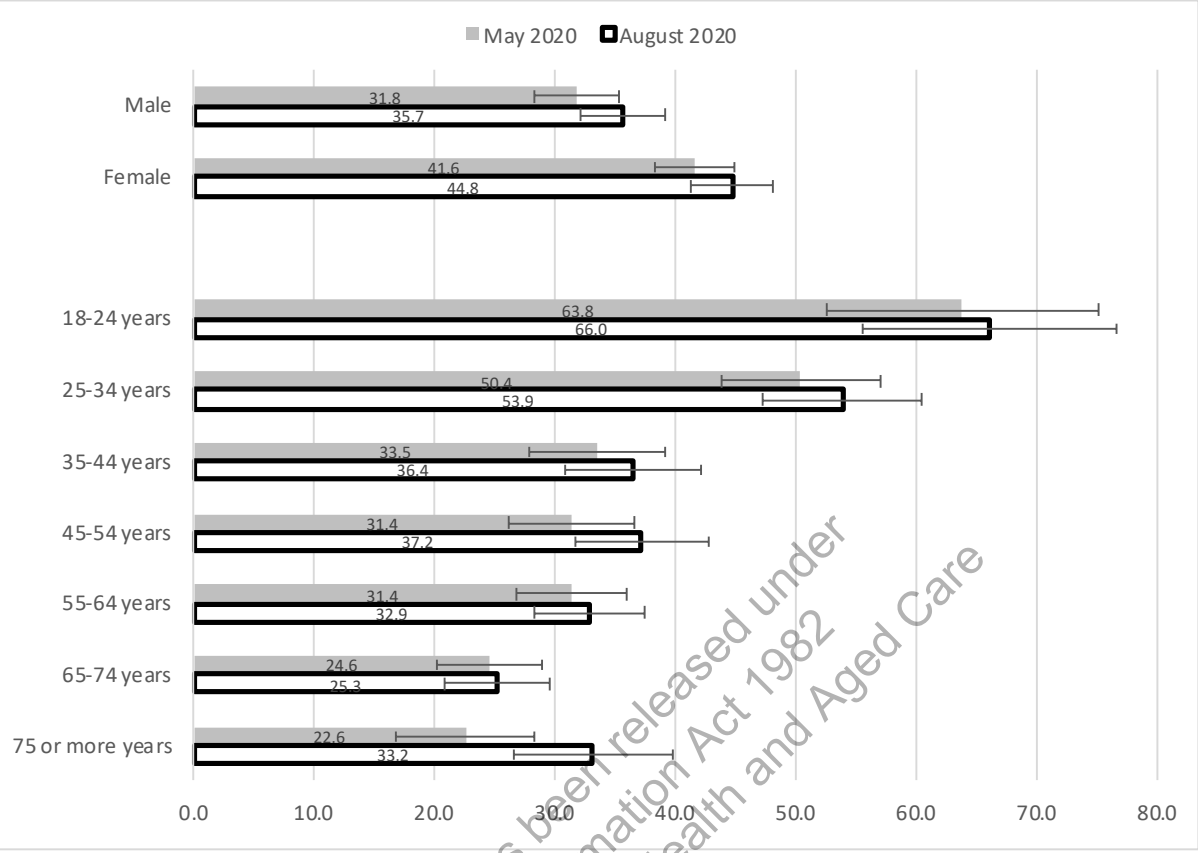
loneliness influences mental (as well as physical) health amongst older populations, whereas Richardson et al. (2017) showed that 'after controlling for demographics and baseline mental health, greater loneliness predicted greater anxiety, stress, depression and general mental health over time' for a sample of UK university students.' These negative effects of loneliness may be counterbalanced by reduced stress due to fewer pressures on time and finances. Another counterbalancing effect of the COVID-19 crisis is likely to be comparisons that people have made or are making with regards to how bad things could have been in Australia, with the current infection and mortality rates compared across jurisdictions, countries, demographic groups, or early-pandemic projections.

5.1 Loneliness

Since the start of the COVID-19 period, we have asked individuals how often in the last week they have felt lonely. When we first asked in April 2020, 45.8 per cent of respondents said they had felt lonely at least some of the time (that is, one or more days per week). This declined to 36.1 per cent in May 2020 when most restrictions had begun to be lifted across Australia, but increased again to 40.5 per cent in August during the second wave of infections and the return to lockdown conditions in some parts of the country.

Females continue to experience higher rates of loneliness than males (44.8 per cent in August for females, compared to 35.7 per cent for males), as do those aged 18 to 24 years (Figure 9). Between May and August 2020, however, the largest increase in loneliness was amongst those aged 75 years and over, with a more than 10 percentage point increase from 22.6 per cent in May to 33.2 per cent in August.

Figure 9 Per cent of Australians who experienced loneliness in previous week, by age and sex, May and August 2020



Notes: The "whiskers" on the bars indicate the 95 per cent confidence intervals for the estimate.
Source: ANUpoll, May and August 2020.

5.2 Mental health outcomes

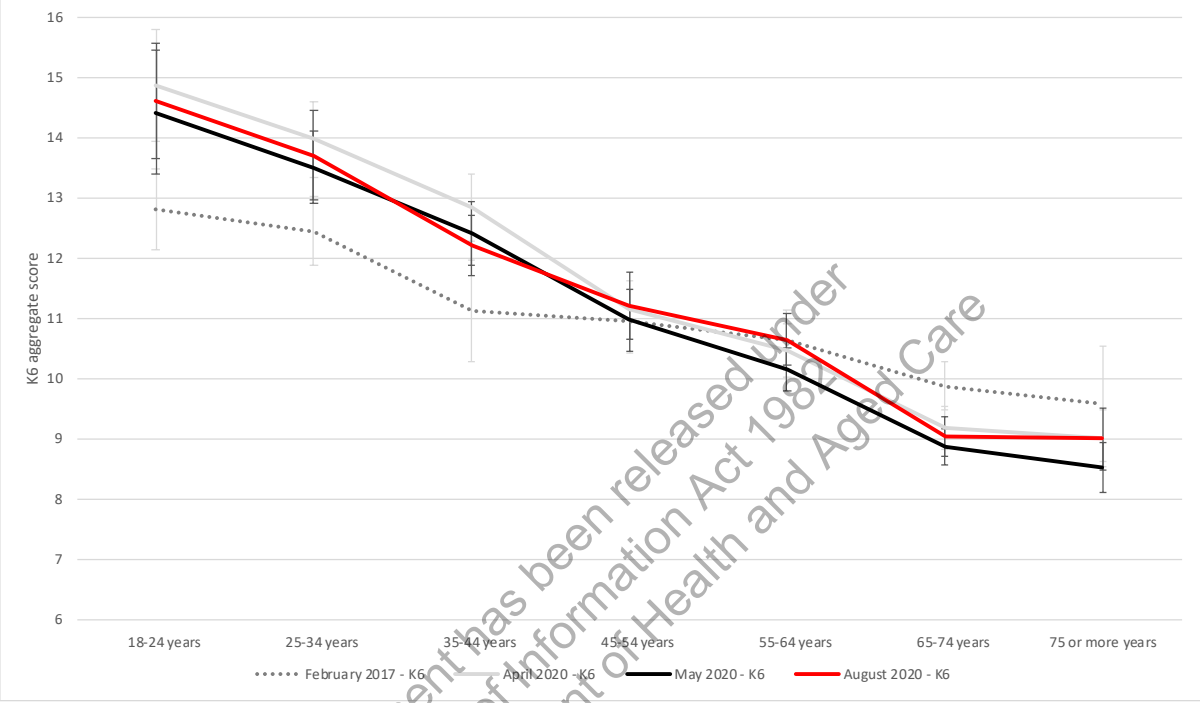
We have been tracking mental health outcomes in our COVID-19 monitoring surveys using the Kessler 6 (K6) scale which is a measure of psychological distress.[7] Respondents who score highly on this measure are considered to be at risk of a serious mental illness (other than a substance use disorder). These questions were previously asked in February 2017 and therefore allow us to measure long-term change through time in outcomes.

The K6 measure of psychological distress used in this paper has been constructed to have a minimum value of 6 and a maximum value of 30. In February 2017 when the question was last asked on Life in Australia™, the average value was 11.2. By April 2020, the score had increased to have a mean of 11.9. Between April and May 2020 there was a significant reduction in psychological distress, although the K6 measure was still above the pre-COVID-19 values (mean = 11.5 in May 2020). Mental health worsened again though between May 2020 and August 2020, with an average in our most recent data collection of 11.7.

There was a divergence in psychological distress over the most recent period between males and females, with the latter having higher levels of psychological distress to start with. Specifically, males maintained the same level of psychological distress between May and August 2020 (11.2 on the K-6 scale). Females, on the other hand, worsened from 11.7 to 12.0 amongst the linked sample, with the difference of 0.3 being statistically significant.

Much of the worsening in mental health in the early stages of the COVID-19 pandemic occurred amongst the young population (Figure 10), and particular those aged 18 to 24 years. For this group, psychological distress stayed reasonably stable over the most recent period. For older Australians, there was a reduction in psychological distress in the early stages of the pandemic. However, while psychological distress is still lower for those aged 65 years and over, the only age group that worsened substantially between May and August 2020 were those aged 75 years and over.

Figure 10 Psychological distress by age, February 2017 and April, May and August 2020



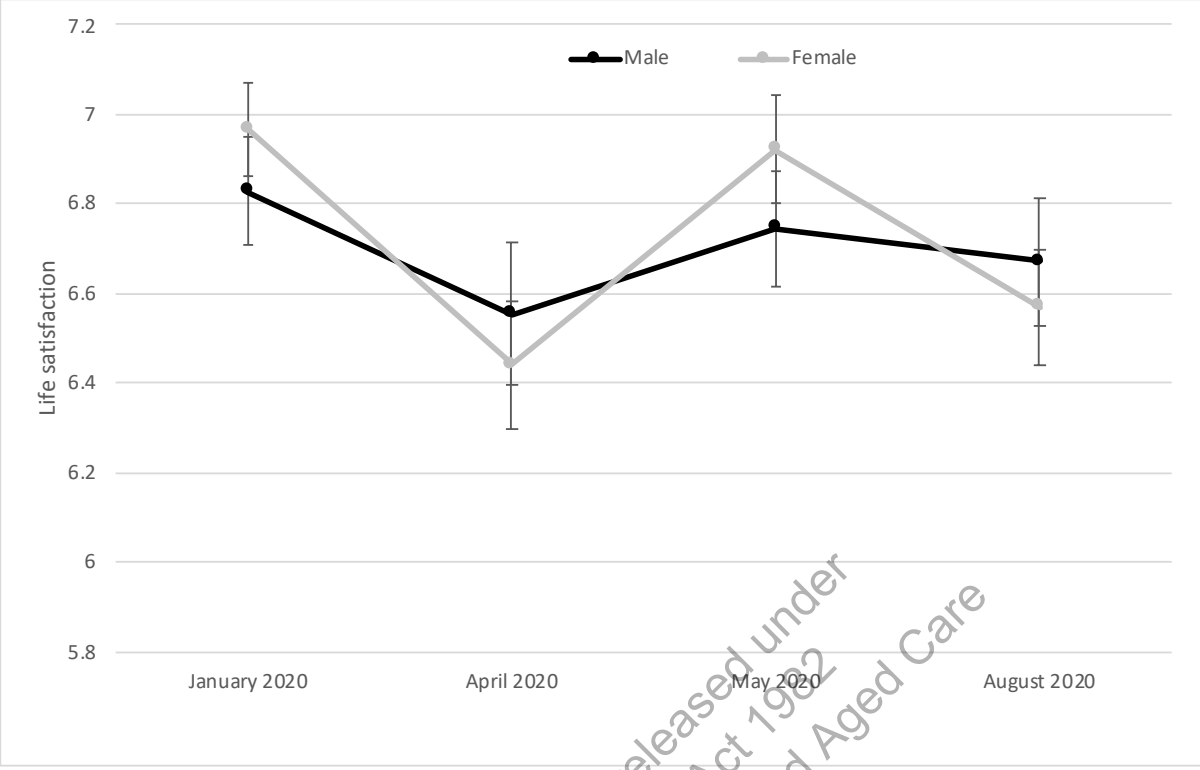
Notes: The "whiskers" on the bars indicate the 95 per cent confidence intervals for the estimate.

Source: ANUpoll, January April and August 2020 and Life in Australia Wave 35, February 2020.

5.3 Life satisfaction and satisfaction with the direction of the country

Life satisfaction continues to be highly volatile in Australia, particularly for females (Figure 11). For all Australians, in January 2020 life satisfaction averaged 6.90 on a scale of 0 to 10 (pre-pandemic, but during the Black Summer bushfires). Average life satisfaction declined substantially during the first wave of the pandemic in Australia (to 6.52 in April 2020) and then increased to 6.83 during May 2020 as infection rates had come down and physical distancing requirements had started to be eased. In August 2020, our most recent wave of data, life satisfaction had declined again to 6.62.

Figure 11 Life satisfaction by sex, January, April, May and August 2020



Notes: The "whiskers" on the lines indicate the 95 per cent confidence intervals for the estimate.

Source: ANUpoll, January, April, May and August 2020.

There has been a similar level of volatility in satisfaction with the direction of the country, although the early period of the pandemic had very different patterns than with life satisfaction. Between January and April 2020, there was a significant increase in the per cent of Australians who were satisfied or very satisfied with the direction of the country – from 59.5 per cent to 76.2 per cent. There was a further small increase between April and May 2020 (to 80.6 per cent), but a decline between May and August 2020 to a percentage slightly lower than during the first wave of infections (to 74.6 per cent).

5.4 Understanding the predictors of life satisfaction

With three waves of ANUpoll data now having been collected since the COVID-19 pandemic in Australia there is sufficient data available to understand the factors that are most strongly We now predictive of a person's subjective wellbeing during the COVID-19 period. Is it their views on how the country is going, their loneliness, their employment and hours worked, their income, or their level of housing stress? The short answer is that all of these things matter, but that they matter to different degrees and sometimes in surprising ways.

This section reports on the results of a linear, random effects model that exploits the longitudinal nature of the data and controls for time invariant characteristics to estimate the factors associated with life satisfaction (Table 5).[8]

Australians who were satisfied with the direction of the country had a life satisfaction value that was around 1.10 points (on a scale from 0 to 10) higher than those who were not satisfied. The effect of the lockdowns and the impact that is having on loneliness in particular also appears to be having an effect. Those who reported that they were lonely at least some of the

time had a level of subjective wellbeing that was 0.68 points lower than those who were not lonely.

There is a statistically significant relationship between hours worked and subjective wellbeing, but the relationship is complicated. The regression results show that those working 30 or more hours per week have the highest level of life satisfaction and that those working less than 30 hours per week have lower levels of life satisfaction. Those working very short part-time hours (1 to 9 hours per week) particularly low levels of life satisfaction, showing the challenge and stress of working part time during the COVID-19 period. Those who were employed, but worked zero hours per week had lower levels of life satisfaction than those working 30 or more hours per week, but the difference was not statistically significant due to relatively small sample sizes.

Those who were not in the labour force had lower levels of life satisfaction than those who were employed 30 or more hours. The lowest level of life satisfaction based on the employment variables, however, was for those who were unemployed, with a life satisfaction measure about 0.46 points lower than those employed 30 hours or more per week, and significantly lower than those who were employed but were not working any hours at the time of the survey. To the extent that the JobKeeper payments were able to maintain the employment link for those who otherwise would have become unemployed, this appears to have had benefits in terms of life satisfaction. The regression model includes income as an explanatory variable and hence the relationship between hours worked/employment status and life satisfaction is after controlling for differences in income.

While there is a clear relationship between labour market outcomes (hours worked and labour force status) and life satisfaction, the associations are much smaller than that between loneliness and life satisfaction.

The final measures in the model capture access to economic resources and financial stress. As income goes up, life satisfaction also goes up. However, the effect is non-linear. Specifically, there is a larger increase in life satisfaction for a $1 increase in income for those at the bottom of the income distribution than those at the top of the distribution. Given income has increased for those at the bottom of the distribution but declined for those at the top, the distributional changes during COVID-19 in Australia are likely to have had a buffering impact on wellbeing.

Where financial changes have potentially had a large negative impact on subjective wellbeing is through housing stress. We reported previously that there was a very large increase in the proportion of people who said they were unable to pay their rent or mortgage between April and May 2020 (from 6.9 per cent to 15.1 per cent). In our August 2020 data, we found that this measure of mortgage stress was reasonably steady between May and August (14.2 per cent at the end of the period). In our life satisfaction modelling, we show that those who were unable to pay their mortgage or rent had a significantly lower level of life satisfaction that those who could, controlling for income and other characteristics (0.23 points lower).

Taken together, the results presented in this subsection have shown that a large proportion of the variation in life satisfaction over the COVID-19 period was explained by variation in observed characteristics, and that these point to some of the potential policy effects and challenges in maintaining the wellbeing of the Australian population. Loneliness, which could be driven by the restrictions on social interaction, is a strong predictor of life satisfaction. Those who became unemployed during the period or who found it difficult to pay their mortgage have also been shown to have had lower levels of wellbeing. However, those who worked zero

hours, but still classified themselves as employed maintained a much higher level of wellbeing, with improvements in income at the bottom of the distribution also likely to have improved wellbeing.

Table 5 Factors associated with life satisfaction, April, May and August 2020

Independent variables	Coeff.	Signif.
Satisfied with direction of country	1.096	***
Lonely at least some of the time	-0.681	***
Employed, but worked zero hours	-0.099	
Worked 1 to 9 hours	-0.241	**
Worked 10 to 19 hours	-0.088	
Worked 20 to 29 hours	-0.123	*
Not in the labour force	-0.114	*
Unemployed	-0.459	***
Income (linear)	0.000308	***
Income (squared)	-0.000000044	
Unable to pay mortgage or rent on time	-0.229	***
Aged 65 to 74 years	0.506	***
Aged 75 years and over	1.028	***
May 2020 data collection	0.276	***
August 2020 data collection	0.066	*
Constant	5.789	
Sample size (number of observations)	7,320	
Sample size (number of individuals)	2,765	

Source: ANUpoll, April, May and August 2020.

Notes: Random effects linear regression Model. The base case individual is employed and worked 30 hours or more per week; Aged 18 to 64 years; and was interviewed in April 2020

Coefficients that are statistically significant at the 1 per cent level of significance are labelled ***; those significant at the 5 per cent level of significance are labelled **, and those significant at the 10 per cent level of significance are labelled *.

6 Comparing outcomes in Victoria with the rest of Australia

With the second wave of COVID-19 infections in Australia having largely been contained to the state of Victoria and the and the return to severe "lockdown" conditions in Victorian, comparison of changes in outcomes for the Victorian population compared to the experience in the rest of Australia provides new insights into impact of increases in the infection rate and lockdown on outcomes. In this section we show that, taken as a whole, outcomes in Victoria have worsened compared to the rest of Australia between May and August 2020.

In previous papers in this series where we have been able to track outcomes through time, geography has tended to be important at a structural level (capital city vs non-capital city, or rich vs poor areas), but there has not tended to be much divergence by State or Territory.

The basic empirical approach used in this section is to compare outcomes in Victoria in August with outcomes in the rest of Australia, for someone with the same outcomes in May 2020, and additional controls for a range of demographic and socioeconomic outcomes.[9] The model is estimated using the linked May to August 2020 sample. The lagged dependent variable is included to ensure that any pre-existing differences in outcomes between Victoria and the rest of Australia prior to the second wave of infections are taken into account. Demographically and socioeconomically, Victoria was not the same as the rest of Australia, and nor was it the

same in terms of many of the outcomes of interest The approach is similar to the widely used difference-in-difference model.

These results are summarised in Table 6 which shows the statistical significance of living in Victoria in August 2020 compared to living in the rest of Australia, as well as the direction of that difference. Select figures are also included in the remainder of this section to demonstrate the scale of the divergence in outcomes between Victoria and the rest of Australia. The detailed results of the model are presented in Appendix Table 1a (for the non-economic variables) and Table 1b (for the economic variables).

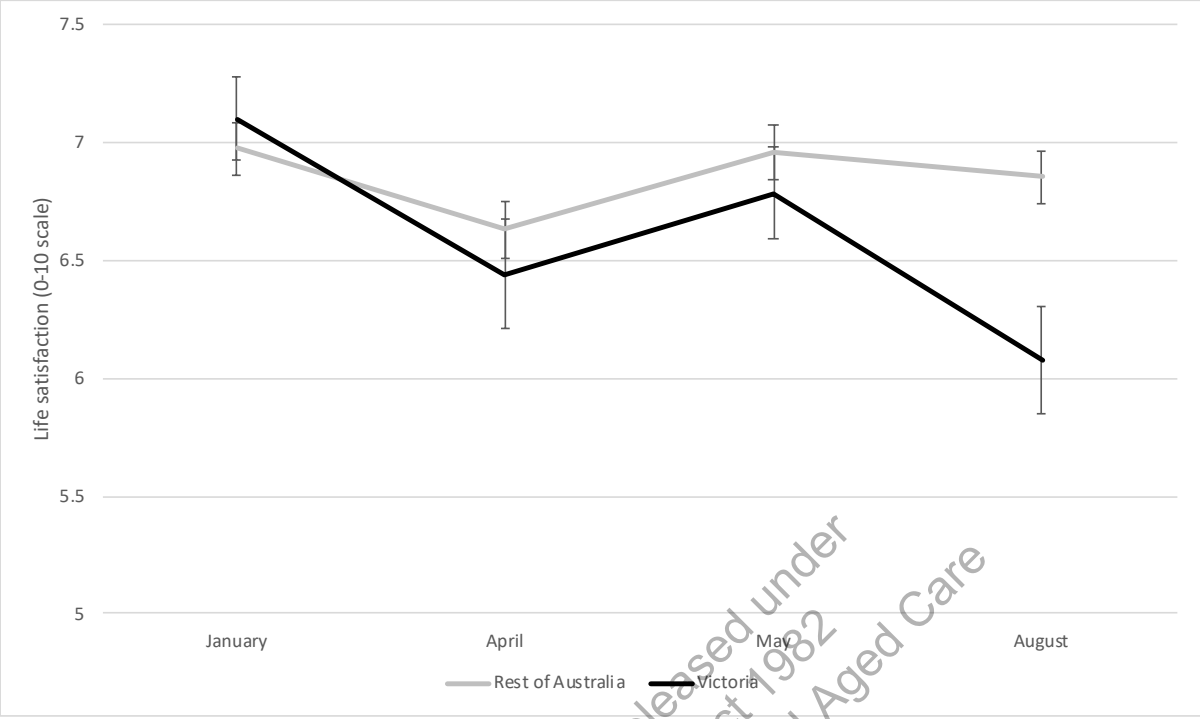
Of the 12 variables included in our analysis, there was strong evidence for a relative worsening in outcomes for six of the variables (that is, the variable for Victoria was significant at least the 5 per cent level of significance) and a further two variables where there is weaker but still convincing evidence (that is, significant at the 10 per cent level of significance only). There were no variables for which Victoria had improved relative to the rest of Australia between May and August 2020, and three for which the change in outcomes was the same for both Victoria and the rest of Australia.

Table 6 Relative changes in outcomes between Victoria and the rest of Australia, May to August 2020, controlling for baseline values and demographic/socioeconomic outcomes

Relative worsening in Victoria (5% statistical confidence level)	Relative worsening in Victoria (10% statistical confidence level)	No relative change	Relative improvement in Victoria
Psychological distress Loneliness Life satisfaction Satisfaction with direction of country Likely to be infected by COVID-19 Hours worked	Anxiety and worry due to COVID-19 Expected probability of losing one's job	Employed Household income per person Unable to pay rent or mortgage on time Difficult to meet expenditure on current income	

Looking at life satisfaction to start with, one of our key indicators of wellbeing in our tracking surveys, Victoria had slightly higher life satisfaction in January 2020 than the rest of Australia, though the difference was not statistically significant (Figure 12). It appears that there was a small divergence between January and April 2020 and then into May, though once again the difference is not statistically significant. Between May 2020 and August 2020, however, there was a significant and substantial divergence in life satisfaction, with values for the rest of Australia staying reasonably steady (6.96 in May 2020 down to 6.85 in August 2020) but very large and statistically significant declines for Victoria (6.78 in May 2020 down to 6.08 in August 2020).

Figure 12 Life satisfaction in Victoria and the rest of Australia, January, April, May, and August 2020



Notes: The "whiskers" on the lines indicate the 95 per cent confidence intervals for the estimate. Restricted to those who completed all four waves of data collection

Source: ANUpoll, January, April, May and August 2020.

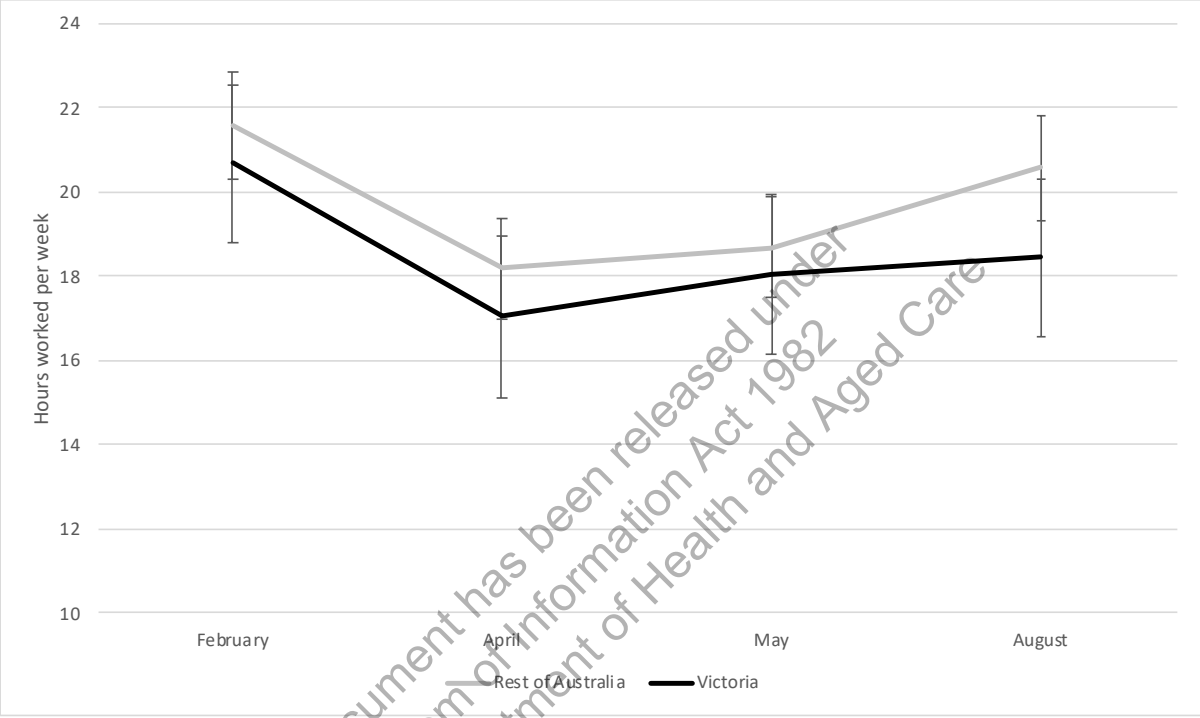
Psychological distress, a more negative measure of wellbeing, also worsened by more between May and August 2020 in Victoria compared to the rest of the country. In May 2020, the K-6 index was 12.06 in Victoria, already significantly higher than the value of 11.26 in the rest of Australia. Between May and August 2020, there was no statistically significant change for the rest of Australia (11.33), whereas the measure of psychological distress increased to 12.50 in Victoria.

These two findings were somewhat different to that reported by the ABS, with the ABS Head of Household Surveys quoted as saying "While Victoria has experienced the greatest surge in recent cases of COVID-19, our latest Household Impacts of COVID-19 Survey showed that the affects [sic] on how Australians are feeling are country-wide. In fact, the mid-August results were consistent across Australia with no significant differences reported by people in Victoria when compared to the rest of Australia."

The main reasons for the difference in our results compared to those of the ABS is that we make more extensive use of the longitudinal nature of our survey, and we have a significantly larger sample size (more than twice as large), which means that we are able to make more precise estimates for individual jurisdictions and population sub-groups. Indeed, for all six of the measures of psychological distress reported by the ABS in their survey, Victoria had a lower per cent of people in August 2020 who reported having those negative feelings 'none of the time.' However, the standard errors around these estimates from the ABS are too large to make definitive conclusions.

Not all the variables had as dramatic a divergence between Victoria and the rest of Australia between May and August 2020, though the 'difference-in-difference' was still both statistically significant and qualitatively important. For example, hours worked moved in a similar direction for Victoria and the rest of Australia between February and April 2020 (a large decline) and April and May 2020 (a small increase). Between May and August 2020, however, average hours worked in the rest of Australia increased significantly (from 18.7 hours per week to 20.6 hours per week), whereas for Victoria it has stayed more or less the same (18.0 hours to 18.4 hours).

Figure 13 Average hours worked in Victoria and the rest of Australia, February, April, May, and August 2020

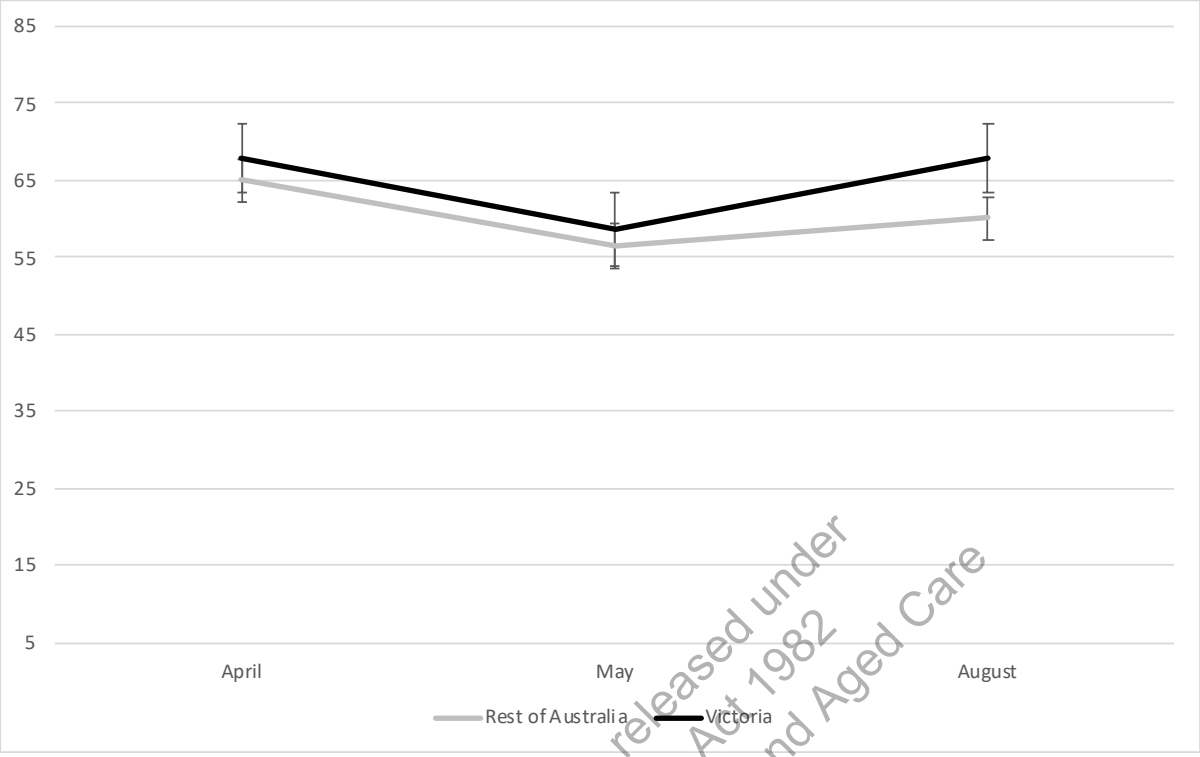


Notes: The "whiskers" on the lines indicate the 95 per cent confidence intervals for the estimate. Restricted to those who completed all four waves of data collection

Source: ANUpoll, April, May and August 2020 and Life in Australia Wave 35, February 2020.

For anxiety and worry, on the other hand, both Victoria and the rest of Australia experienced an increase between May and August 2020, albeit with a slightly larger increase for Victoria (from 58.9 per cent to 68.1 per cent) than for the rest of Australia (56.6 per cent to 60.2 per cent). Prior to the second wave of lockdowns, there was no statistically significant difference between Victoria and the rest of Australia in terms of anxiety and worry, but by August 2020 the difference was both larger and significant.

Figure 14 Anxiety and worry due to COVID-19 in Victoria and the rest of Australia, April, May, and August 2020



Notes: The "whiskers" on the lines indicate the 95 per cent confidence intervals for the estimate. Restricted to those who completed all four waves of data collection

Source: ANUpoll, April, May and August 2020.

7 Concluding comments

This paper provides estimates of how outcomes of the Australian population are tracking as the COVID-19 pandemic continues to impact in Australia. At the time of data collection in August 2020, while experiencing a second wave of COVID-19 infection, Australia still has moderate infection rates of COVID-19 and a low mortality rate relative to other comparable countries. Furthermore, the second wave of COVID-19 infections have largely been confined to Victoria. In response to the rising and relatively high infection rate in Victoria, from early August people living in metropolitan Melbourne have been subject to very stringent physical distancing and social isolation measures, with those in the rest of the State under less strict, but still quite stringent lockdown conditions.

This paper uses data collected as part of the ANU Centre for Social Research and Methods COVID-19 impact monitoring program. Surveys have been conducted with the same group of respondents in January and February just before the COVID-19 pandemic started in Australia and in April, May and August after the pandemic started to impact in Australia in major way. This is, as far as we are aware the only longitudinal survey of a large, representative sample of Australians with information from the same individuals prior to and during the Coronavirus pandemic.

We provide the first nationally representative population level estimates (as far as we are aware) of COVID-19 testing, showing that in August 2020 about one-in-five Australian adults

reported having been tested for COVID-19, up from about one-in-twenty in May and about one-in-fifty in April 2020.[10]

We show that anxiety and worry due to COVID-19 have increased since their low in May 2020, whereas measures of subjective wellbeing and psychological distress have worsened. Hours worked have increased across Australia since May 2020, but people who are employed are more worried about losing their job than they were in May 2020.

We provide the first longitudinal analysis of the effect of the second wave of infections and associated lockdown measures on the outcomes of Victorians, by comparing the relative change in outcomes for people from that jurisdiction to the change in the rest of Australia, controlling for other observable characteristics. We find a relative worsening in outcomes for Victoria compared to the rest of Australia between May 2020 and August for six key outcomes in particular: psychological distress; loneliness; life satisfaction; satisfaction with direction of country; expected likelihood of being infected by COVID-19; and hours worked.

We find smaller, but still statistically significant worsening in two additional outcomes: Anxiety and worry due to COVID-19; and the expected probability of losing one's job. We do not find any statistically significant effect on employment; household income per person; unable to pay rent or mortgage on time; and difficulty meeting expenditure on current income.

The COVID-19 pandemic continues to impact Australians physically, economically, and emotionally. Unlike in the earlier period of the pandemic, there has been a significant divergence in a range of outcomes between Victoria and the rest of the country. It is only with high quality, longitudinal data from a representative sample of the Australian population that we are able to monitor outcomes, identify those who are doing it toughest, and target support to those that need it most.

Appendix tables

Appendix Table 1a Relationship between living in Victoria and select outcome variables, controlling for lagged dependent variables

Explanatory variables	Psychological distress+		Loneliness*		Life satisfaction+		Satisfaction with direction of country*		Anxious and worried due to COVID-19*		Likely to be infected by COVID-19*	
	Coeff.	Signif.	Coeff.	Signif.	Coeff.	Signif.	Coeff.	Signif.	Coeff.	Signif.	Coeff.	Signif.
Lagged dependent variable	0.746	***	1.514	***	0.627	***	1.613	***	1.548	***	1.325	***
Victoria	0.448	***	0.228	***	-0.610	***	-0.313	***	0.153	***	0.226	***
Female	0.418	**	0.137	***	-0.184	***	0.015	***	0.305	*	-0.009	***
Aged 18 to 24 years	0.709	**	0.328	*	0.147	**	-0.248		-0.175	***	-0.092	
Aged 25 to 34 years	0.639		0.274	*	-0.066		0.033		0.076		-0.119	
Aged 45 to 54 years	0.112	*	0.119	**	-0.227		-0.116		-0.035		-0.128	
Aged 55 to 64 years	0.331		0.028		0.035	*	-0.113		-0.011		0.004	
Aged 65 to 74 years	-0.359		-0.154		0.101		-0.037		0.030		-0.359	
Aged 75 years plus	-0.330		0.178		0.358		0.025		0.002		-0.145	***
Indigenous	1.271		0.293		0.104	***	-0.130		-0.253		-0.105	
Born overseas in a main English speaking country	-0.078	*	-0.032		0.062		0.046		-0.118		0.049	
Born overseas in a non-English speaking country	-0.047		0.113		0.143		0.128		-0.069		0.059	
Speaks a language other than English at home	0.216		0.069		-0.121		0.385		0.112		0.148	
Has not completed Year 12 or post-school qualification	0.105		-0.128		0.130		0.053	***	-0.216		-0.103	
Has a post graduate degree	0.592		-0.170		0.122		-0.038		-0.045	*	-0.182	
Has an undergraduate degree	-0.068	*	-0.153		0.216		-0.044		-0.259		-0.127	
Has a Certificate III/IV, Diploma or Associate Degree	0.126		-0.087		0.028	*	-0.066		-0.148	**	-0.097	
Lives in the most disadvantaged areas (1st quintile)	0.100		-0.076		0.178		-0.064		0.118		-0.069	
Lives in next most disadvantaged areas (2nd quintile)	-0.560		-0.203		0.134		-0.013		0.198		0.006	
Lives in next most advantaged areas (4th quintile)	-0.354	*	-0.300	*	0.115		0.092		0.213	*	-0.006	
Lives in the most advantaged areas (5th quintile)	-0.244		-0.233	***	0.125		0.041		0.137	*	0.083	
Lives in a non-capital city	-0.272		-0.162	**	0.054		0.210		-0.068		-0.013	
Constant	2.690		-0.813	*	2.327		-0.573	**	-0.637		-0.777	
Sample size	2,765		2,769		2,606		2,767		2,770		2,598	

Source: ANUpoll, April, May and August 2020.

Notes: +Linear regression model or *Probit model. The base case individual did not live in Victoria; is female; aged 35 to 44; non-Indigenous; born in Australia; does not speak a language other than English at home; has completed Year 12 but does not have a post-graduate degree; lives in neither an advantaged or disadvantaged suburb (third quintile); and lives in a capital city. Coefficients that are statistically significant at the 1 per cent level of significance are labelled ***; those significant at the 5 per cent level of significance are labelled **, and those significant at the 10 per cent level of significance are labelled *.

Appendix Table 1b Relationship between living in Victoria and select outcome variables, controlling for lagged dependent variables

Explanatory variables	Employed*		Hours worked+		Probability of losing job+		Per person household income+		Unable to pay mortgage or rent on time*		Difficult meeting expenditure on income*	
	Coeff.	Signif.	Coeff.	Signif.	Coeff.	Signif.	Coeff.	Signif.	Coeff.	Signif.	Coeff.	Signif.
Lagged dependent variable	2.673	***	0.75	***	0.54	***	0.77	***	1.373	***	1.773	***
Victoria	-0.181	***	-1.54	***	3.22	***	-6.31	***	-0.135	***	0.017	***
Female	-0.093		-1.67	**	2.37	*	-28.25		-0.131		0.087	
Aged 18 to 24 years	-0.002		-0.16	***	-1.32		-47.81		0.075		-0.322	
Aged 25 to 34 years	-0.054		0.07		-1.24		38.47		0.084		0.004	
Aged 45 to 54 years	0.041		1.20		-0.04		-6.76		-0.094		-0.053	
Aged 55 to 64 years	-0.528		-2.84		0.75		33.27		-0.187		-0.042	
Aged 65 to 74 years	-0.968	***	-7.07	***	2.87		-42.50		-0.681		-0.046	
Aged 75 years plus	-1.488	***	-7.85	***	-16.82		-23.18	*	-0.858	***	-0.260	
Indigenous	-0.412	***	-0.43	***	4.44	**	-13.12		0.151	***	-0.066	
Born overseas in a main English speaking country	0.276		-0.23		3.51		2.83		0.090		-0.105	
Born overseas in a non-English speaking country	-0.429	**	-1.44		3.61		-23.54		0.401		0.210	
Speaks a language other than English at home	0.368	**	0.58		-0.27		1.53		0.061	***	0.082	
Has not completed Year 12 or post-school qualification	0.104	**	1.39		-6.50		-49.38		0.235		-0.087	
Has a post graduate degree	0.020		2.11		-6.51		11.79	*	0.025		-0.429	
Has an undergraduate degree	0.097		2.53	*	-7.18	**	49.37		0.053		-0.365	**
Has a Certificate III/IV, Diploma or Associate Degree	-0.021		0.93	***	-2.40	***	-17.89		0.335		-0.075	**
Lives in the most disadvantaged areas (1st quintile)	-0.325		-0.88		-0.04		-23.12		-0.162	**	-0.091	
Lives in next most disadvantaged areas (2nd quintile)	-0.288	*	-2.26		-0.05		18.95		0.032		-0.280	
Lives in next most advantaged areas (4th quintile)	-0.230	*	-0.89	***	-0.07		74.38		0.211		-0.149	**
Lives in the most advantaged areas (5th quintile)	0.027		0.19		1.34		21.44	***	0.012		-0.336	
Lives in a non-capital city	0.054		0.07		1.48		8.26		0.020		-0.070	**
Constant	-0.579		8.84		12.02		151.89		-1.569		-1.237	
Sample size	2,759		2,727		1,348		2,412		2,748		2,762	

Source: As for Appendix Table 1a.

Notes: As for Appendix Table 1a.

References

Aum, S., S.Y.T. Lee and Y. Shin (2020). "COVID-19 doesn't need lockdowns to destroy jobs: The effect of local outbreaks in Korea." *Working paper No. 27264*, National Bureau of Economic Research, Cambridge, MA.

Australian Bureau of Statistics (2020a). "Labour Force Survey, Australia, July 2020." *Catalogue No. 6202.0*, Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics (2020b). "Weekly Payroll Jobs and Wages in Australia, Week ending 8 August 2020." *Catalogue No. 6160.0.55.001,* Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics (2020c). "Australian National Accounts: National Income, Expenditure and Product, Mar 2020." *Catalogue No. 5206.0,* Australian Bureau of Statistics, Canberra.

Biddle, N., B. Edwards, M. Gray, and K. Sollis (2020a). "Hardship, distress, and resilience: The initial impacts of COVID-19 in Australia", COVID-19 Briefing Paper, ANU Centre for Social Research and Methods, Australian National University, Canberra.

Biddle, N., B. Edwards, M. Gray, and K. Sollis (2020b). "Tracking outcomes during the COVID-19 pandemic (May 2020) - Job and income losses halted and confidence rising", COVID-19 Briefing Paper, ANU Centre for Social Research and Methods, Australian National University, Canberra.

Biddle, N., B. Edwards, M. Gray and K. Sollis (2020c). "Initial impacts of COVID-19 on mental health in Australia." COVID-19 Briefing Paper, ANU Centre for Social Research and Methods, Australian National University, Canberra.

Borland, J. (2020). "The next employment challenge from coronavirus: how to help the young." *The Conversation*, 15 April

Foster, J. and R. Guttman (2018). "Perceptions of job security in Australia." *Reserve Bank of Australia Bulletin*, March: 1-21.

Gerino, E., L. Rollè, C. Sechi, and P. Brustia, (2017). Loneliness, resilience, mental health, and quality of life in old age: A structural equation model. *Frontiers in psychology*, 8, p.2003.

Hale, T., A. Petherick, T. Phillipsand and S. Webster (2020). "Variation in government responses to COVID-19." *Blavatnik School of Government Working Paper No. 31*.

Hamermesh, D.S., (2020). "Life satisfaction, loneliness and togetherness, with an application to Covid-19 lock-downs." *Review of Economics of the Household*, pp.1-18.

Kessler, R.C., G. Andrews, LJ. Colpe,E. Hiripi, D.K. Mroczek, S.L. Normand, E.E., Walters and A.M. Zaslavsky, (2002). "Short screening scales to monitor population prevalences and trends in non-specific psychological distress." P*sychological Medicine*, 32(6): 959-976.

Meagher, N., L. Carpenter, K. Marinkovic Chavez, M, Vasileva, C. MacDougall, L. Gibbs, D.J. Price and F.M. Shearer (2020). Distancing measures in the face of COVID-19 in Australia. Summary of national survey findings. Survey 2 Report, July 2020. Doherty Institute, Melbourne. https://www.doherty.edu.au/uploads/content_doc/Covid_report_2.pdf

Murphy, G.C. and J.A. Athanasou (1999). The effect of unemployment on mental health. *Journal of Occupational and Organizational Psychology*, 72(1), pp.83-99.

Phillips, B., M. Gray, and N. Biddle, (2020). "COVID-19 JobKeeper and JobSeeker impacts on poverty and housing stress under current and alternative economic and policy scenarios", COVID-19 Briefing Paper, ANU Centre for Social Research and Methods, Australian National University, Canberra.

Richardson, T., P. Elliott, and R. Roberts (2017). "Relationship between loneliness and mental health in students". *Journal of Public Mental Health*.

Schröder, M. (2020.) "Men lose life satisfaction with fewer hours in employment: Mothers do not profit from longer employment—evidence from eight panels." *Social Indicators Research*, https://doi.org/10.1007/s11205-020-02433-5

West, C.P., V.M. Montori and P Sampathkumar (2020). "COVID-19 testing: the threat of false-negative results." *Mayo Clinic Proceedings*, 95(6): 1127-1129.

Endnotes

1 https://ourworldindata.org/coronavirus-data#tests-cases-and-deaths

2 The February wave of data collection was conducted as Australian social Survey, in parallel with the European social Survey

3 Those aged 75 years or older are excluded from the regression model.

4 These results hold when we model the expected job loss in August 2020 as a function of expected job loss in May 2020, demographic, socioeconomic (including education) and geographic variables.

5 In seasonally adjusted chain volume terms.

6 The specific income question that we asked in February, April and May 2020 was 'Please indicate which of the following describes your household's total income, after tax and compulsory deductions, from all sources?' The income categories were: $0 to $24,554 ($0 to $472 weekly); More than $24,554 to $38,896 (more than $472 to $748 weekly); More than $38,896 to $52,884 (more than $478 to $1,017 weekly); More than $52,884 to $69,524 (more than $1,017 to $1,337 weekly); More than $69,524 to $88,452 (more than $1,337 to $1,701 weekly); More than $88,452 to $109,304 (more than $1,701 to $2,102 weekly); More than $109,304 to $134,784 (more than $2,102 to $2,592 weekly); More than $134,784 to $168,688 (more than $2,592 to $3,244 weekly); More than $168,688 to $222,300 (more than $3,244 to $4,275 weekly); or More than $222,300 (more than $4,275 weekly). Respondents are then asked to choose from one of ten income categories. These categories have been converted into a continuous income measure using interval regression. The natural log of the lower and upper bound of the income categories is the relevant dependent variable, and using the same demographic, socioeconomic and geographic measures in the regression equations up until now as explanatory variables. The predictions from the model are constrained to be in the same income category as they are observed to fall into.

7 The K6 comprises six items and has been widely used and validated in many epidemiological studies (e.g., Kessler et al., 2002).

8 We also control for those aged 65 to 74 years and aged 75 years and over, but drop other age variables or sex as they are not statistically significant.

9 Jurisdictional migration was not captured in the data, but is negligible between May and August.

10 There is some other survey data on physical distancing, but as far as we are aware none of been undertaken using a probability based national representative survey. For example the numbers reported by the Doherty Institute (Meagher et al. 2020) are from the non-probability YouGov online panel.

The Hon. Greg Hunt
Minister for Health
Minister.Hunt@health.gov.au

31 August 2020

Dear Minister

COVID-19 mental health risks and financial distress

We write seeking an urgent meeting to discuss the psychological distress, anxiety and depression associated with the elevated levels of financial hardship and uncertainty that millions of people now face as a result of COVID-19. With unemployment rising and a dramatic drop in incomes planned at the end of September, it is vital that the Federal Government assesses the mental health impacts before further decisions are made, particularly in the October budget.

In our discussions with service providers, people affected on the ground, health officials and the National Mental Health Commission, there is broad concern that financial hardship, and associated risks such as loss of one's home (whether rented or mortgaged), are undermining mental health.

An inadequate income and unemployment has a corrosive effect on people's mental health, causing psychological distress, anxiety, depression, and suicidal ideation. As set out in the attached ACOSS Briefing Note:

- Inadequate incomes, unemployment, loss of a sense of personal control and social support each risk corroding mental health and increase the risk of suicide.
- People who were unemployed or on Newstart/Youth Allowance were at least three times more likely to experience psychological distress, anxiety and depression than those in paid work. This difference is attributable to a combination of unemployment and inadequate income, and (closely related to these two factors) a lack of social support and a sense of personal control.
- People on low incomes are likely to have a far greater risk of high psychological distress. In 2011, more than one in four people in the lowest 20% of households by income had current psychological distress at a high or very high level, compared to one in 20 of those in the highest 20%.

- The onset of COVID-19 and related loss of jobs and incomes from February to April 2020 has increased psychological distress as well as the incidence of persistent depression or anxiety (which rose from 10% in 2017 to 19% overall in April 2020, to 29% among people who lost their jobs, and to 41% among those experiencing financial hardship). Among those who lost their jobs, 11% reported suicidal ideation.
- Subsequently, after the Coronavirus Supplement and JobKeeper Payment were introduced and lockdowns were eased, financial hardship among the lowest 10% by income fell from 60% to 46% and the proportion of people experiencing personal stress due to COVID-19 fell sharply from 43% to 24%.

The government is now considering a range of policies including the future of JobSeeker and other income support payments, and employment assistance for people who are unemployed.

Consistent with the government's COVID19 mental health strategy, the Federal Government must assess the direct correlation between financial hardship, unemployment and mental health. We would be grateful to discuss these issues in more detail with you as soon as possible. As you know, decisions are being made quickly on a number of fronts, and we wish to ensure that you are well briefed about the links between protecting people's mental health and preventing mental illness and suicidal ideation, and measures to ease financial distress.

Please contact Harry Lovelock, Director of Policy & Research at Mental Health Australia (harry.lovelock@mhaustralia.org or 0420 927 870) or Bill Gye OAM, CEO at Community Mental Health Australia (ceo@cmha.org.au or 0438 698 058) to arrange a meeting. We will be in touch with your office to follow up.

Yours sincerely,

Dr Leanne Beagley, CEO Mental Health Australia

Bill Gye. OAM, CEO Community Mental Health Australia

Gill Callister, CEO Mind Australia

Dr Cassandra Goldie, CEO Australian Council of Social Service

Attached: ACOSS Briefing Note