

# 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.<sup>1</sup> 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%.<sup>2</sup> 28% of women have experienced loneliness, compared with 16% of men.<sup>3</sup>

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.<sup>4</sup>

The escalation in mental health issues among women is due, at least in part,<sup>5</sup> 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).<sup>6</sup>

Overall, women accounted for 61% of job losses in Victoria between February and July this year.<sup>7</sup> 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.<sup>8</sup>

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.<sup>9</sup> Migrant and refugee women and Aboriginal and Torres Strait Islander women are also over-represented in the industries most affected by COVID-19.<sup>10</sup>

### **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.<sup>11</sup>

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.<sup>12</sup> 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%).<sup>13</sup>

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.<sup>14</sup> 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.<sup>15</sup>

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.<sup>16</sup>

### **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.<sup>17</sup> Given women make up 75% of all health professionals and 88% of nurses and midwives in Australia,<sup>18</sup> and that Personal Protective Equipment is reported to be ill-fitting for women,<sup>19</sup> 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.<sup>20</sup>

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.’<sup>21</sup>

### **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.<sup>22</sup> 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.<sup>23</sup>

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,<sup>24</sup> 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.<sup>25</sup> 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.<sup>26</sup> 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,<sup>27</sup> 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:<sup>28</sup>

- 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 (VMIAAC) 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.<sup>29</sup> Though this was lower than the percentage of male respondents who identified that their mental health was worse during the second wave, VMIAAC 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.<sup>30</sup> 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.<sup>31</sup>

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.<sup>32</sup> Anger expressed as self-harm is a common presentation among Victorian women.<sup>33</sup>

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.<sup>34</sup>

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'.<sup>35</sup> This is consistent with existing evidence that suggests that the frequency and severity of family violence – including sexual violence – increases during emergencies.<sup>36</sup> 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.<sup>37</sup>

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.<sup>38</sup> 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.<sup>39</sup> 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.'<sup>40</sup>

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.<sup>41</sup> There have also been reports in the community of women facing increased pressure regarding dowry payments which may put them at risk of violence.<sup>42</sup>

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.<sup>43</sup>

### **Young women**

Survey data shows young women are reporting higher levels of mental distress than young men (24% compared to 21%).<sup>44</sup> 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.<sup>45</sup> Though sex-disaggregated data is not publicly available, we know that women are over-represented in hospital presentations for self-harm overall.<sup>46</sup>

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%).<sup>47</sup>

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%).<sup>48</sup> 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.<sup>49</sup> 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.<sup>50</sup>

### **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.<sup>51</sup> 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<sup>52</sup> 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%).<sup>53</sup>

At the same time, we have seen a resurgence of deep-seated ageist attitudes.<sup>54</sup> 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.<sup>55</sup> 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,<sup>56</sup> 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,<sup>57</sup> 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.<sup>58</sup> 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.<sup>59</sup> 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.<sup>60</sup> 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).<sup>61</sup>

## **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.<sup>62</sup>

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.<sup>63</sup> 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,<sup>64</sup> 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).<sup>65</sup> As of August 2020, 15% of women reported receiving the Coronavirus Supplement, compared to 11% of men.<sup>66</sup> 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.<sup>67</sup> However, the plans to reduce it are creating undue stress for single mother households.<sup>68</sup>

Further distress is often caused by the eligibility requirements and compliance obligations for income support, such as mutual obligations.<sup>69</sup> 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.<sup>70</sup>

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.<sup>71</sup>

### **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.<sup>72</sup>*

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.<sup>73</sup>

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:<sup>74</sup>

- 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.

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<sup>1</sup> 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.

<sup>2</sup> Australian Bureau of Statistics, [4940.0 – Household Impacts of COVID-19 Survey, 7 – 17 August 2020](#), Australian Bureau of Statistics, Canberra.

<sup>3</sup> Australian Bureau of Statistics, [4940.0 – Household Impacts of COVID-19 Survey, 7 – 17 August 2020](#), Australian Bureau of Statistics, Canberra.

<sup>4</sup> Information provided by Prof Jayashri Kulkarni, Director of Monash Alfred Psychiatry Research Centre (MAPrc), August 2020

<sup>5</sup> 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.

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- <sup>6</sup> 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;
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- <sup>54</sup> Brooke J and Jackson D (2020). [Older people and COVID-19: Isolation, risk and ageism](#). Journal of Clinical Nursing.
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- <sup>73</sup> 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).
- <sup>74</sup> 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.