COVID-19 and women's mental health in 2021: Observations from Alliance members

In September 2021, the Women's Mental Health Alliance (Alliance) asked its members to report their observations of the ongoing mental health impacts of the COVID-19 pandemic. Alliance members reported that women's mental health was still being impacted by COVID-19 and associated public health restrictions.

Clinicians and advocates have observed an increase in women's mental distress during the current (2021) Victorian lockdown. Below are some key issues that Alliance members have observed in women's mental health during 2021 in Victoria.

This summary is not intended to provide a comprehensive overview of the current/ongoing impacts of COVID-19 on women's mental health and should be read together with more thorough policy briefings published by the Alliance in 2020, as well as 'This Conversation is Not Over': Women's Mental Health During the COVID-19 Pandemic (Gender Equity Victoria 2021) and Left Behind: Migrant and Refugee Women's Experience of COVID-19 (Gender Equity Victoria and Multicultural Centre for Women's Health, 2021).

With thanks to Women with Disabilities Victoria (WDV), Multicultural Centre for Women's Health (MCWH) and the Australian Muslim Women's Centre for Human Rights (AMWCHR), the summary has a particular focus on the experiences of women with disabilities, migrant women and Muslim women.

General deterioration in mental health

Issues affecting women's mental health reported by Alliance members include: loneliness and social isolation; fear, anxiety and nervousness; helplessness and lack of self-efficacy; lack of support; and an escalation in alcohol use.

In Area Mental Health Services, clinicians have noticed that women with serious existing mental illness are deteriorating and presenting to services later.

Health practitioners who do not specialise in mental health (for example, gynaecologists) are reporting that women are turning to them for mental health support. This reflects both a deterioration in mental health among women, as well as lack of access to mental health services. This is putting pressure on other health practitioners, including GPs, to manage increased demand and more complex presentations.

The Multicultural Centre for Women's Health (MCWH) has noted that mental health, isolation and financial insecurity have been the most pressing issues for the migrant and refugee community during COVID-19 lockdowns.

The Australian Muslim Women's Centre for Human Rights (AMWCHR) has noted an increase in the complexity of case work among their clients, requiring increased time with clients which has, in turn, has doubled their waitlist. They also noted a huge increase in callers during the Afghanistan crisis, with callers wanting to know how to apply for humanitarian visas for their friends and relatives, as well as worry about their own visa status. The precariousness of Temporary Protection and Safe Haven Enterprise visas has a negative impact on the mental health of Afghan refugees in Australia.

Young women's mental health

A significant body of evidence is emerging regarding the impacts of the pandemic on young women's mental health, including a rise in presentations for eating disorders and self-harm. Data from the Australian Institute for Health & Welfare shows that rates of ambulance attendance in Victoria for self-harm, suicidal ideation and suicide attempts increased sharply between 2018 and 2020 and were significantly higher for young women (aged below 25 years) than for young men.[1]

The proportion of young women with psychological distress has also increased from 22.4% in 2012 to 34.1% in 2020 (compared with an increase from 12.6% in 2012 to 15.3% in 2020 for young men).[2]

While much of this data relates to young people's experiences in 2020, Alliance members observe that these impacts are continuing. For example, Area Mental Health Services clinicians have noticed an increase in presentations by children and adolescent girls to Emergency Departments with self-harming behaviours in 2021, leading to an increase in adolescent mental health inpatient unit admissions.

Increased anxiety

Clinicians at Jean Hailes for Women's Health highlight an increase in anxiety among women, including at generalist (not women's health-specific) clinics. One clinician has noted that over 50% of her patients are reporting issues with anxiety (across all ages).

In the past few months, migrant and refugee women living in Victorian regions with high rates of COVID-19 have reported increased anxiety and stress about sending their children to school, particularly VCE students who have not been vaccinated.

Increases in eating disorders

Jean Hailes for Women's Health, Eating Disorders Victoria (EDV) and Area Mental Health Services have also seen a rise in eating disorder presentations among women. Those in Area Mental Health Services note a rise in new eating disorder presentations.

EDV has described an unprecedented increase in presentations and relapses of eating disorders, estimating a tripling of cases, and a doubling and tripling of demand for EDV's

[1] Australian Institute of Health & Welfare (2021) Ambulance attendances: suicidal and self-harm behaviours, Suicide & self-harm monitoring data [website].
[2] Psychological Distress in Young People in Australia 2012-2020, Mission Australia and Black Dog Institute, 2021

peer and clinical services. Females make up 70% of cases. This is consistent with data from the National Mental Health Commission which shows a 25% to 50% increase in the number of people being treated for eating disorders during the COVID-19 pandemic, including both relapses and new diagnoses.[3]

EDV notes that eating disorders can have a sudden onset but take time to treat and anticipate that there will be increased demand for their services for at least two years. While EDV welcomes the surge funding to meet increased demand, this needs to be extended beyond June 2022 to at least 2023.

Family violence reducing access to support, including mental health services

Recently published findings from an ANROWS survey found that 1 in 4 women who experienced physical or sexual violence during the pandemic did not seek help on at least one occasion due to safety concerns. 1 in 3 of the women who reported barriers to help-seeking did not seek help from police, government or non-government services at all during the previous twelve months.[4]

Clinicians from Area Mental Health Services report that family violence is being used to prevent women getting the psychiatric care they need.

Area Mental Health Services clinicians also report that telehealth has made it more difficult for women to disclose family violence. Similarly, Specialist Family Violence Advisors have reported that perinatal services providing telehealth have noted significant barriers to family violence screening and response, as they are unable to determine whether the perpetrator is in the room or listening to the call. Family violence support is critical during the perinatal period, as there is an increased risk of violence escalation.

Women with Disabilities Victoria are concerned that women with disabilities who experience family violence during lockdown will not be able to come forward for supports until after lockdown. Barriers to accessing family violence services have been exacerbated during lockdowns, which may have significant long-term impacts on women's physical and mental health. The perception of women with disabilities as ‘burdens’ has been evident in the public discourse around prioritisation for COVID treatment, which further reduces women with disabilities’ sense of belonging and value. The burden archetype is a reinforcing factor in the high rates of gender-based violence experienced by women with disability.

MCWH collaborates with ethno-specific and migrant women’s family violence response services in metropolitan and regional areas. These partner organisations have reported an increase in the number of migrant and refugee women who are seeking or being referred for assistance for family violence. Barriers to service access for migrant and refugee women

[3] As COVID lockdowns roll on, eating disorders are surging and wait times are blowing out ABC Online 31/08/21

[4] Boxall, H., & Morgan, A. (2021). Intimate partner violence during the COVID-19 pandemic: A survey of women in Australia (Research report Issue 3, October 2021). ANROWS

have been exacerbated by COVID-19 restrictions, and there are concerns that migrant women will continue to experience severe and prolonged violence.

Men's behaviour change programs have been unable to hold in-person meetings during lockdowns, negatively impacting a service's ability to assess and manage risk with perpetrators and victim-survivors. Further, without the perpetrator leaving the home to attend a weekly program, victim-survivors still living with the perpetrator have been unable to experience any time away, negatively impacting their mental wellbeing and self-care and safety strategies.

Increased demand for perinatal services, with higher rates of mental distress

Area Mental Health clinicians report an increase in demand for perinatal mental health services, noting that Hospital in the Home models of have worked well with this cohort.

Perinatal mental health clinicians at the Masada Early Parenting Centre (Ramsay Health) note that the pandemic is impacting clinical services. For example, visitors are not allowed and women cannot leave the Unit once admitted, which is unsettling for them. They are also only able to see their partners if their partners are also willing and able to be inside for the full five-day program. A higher than usual level of anxiety, increased mistrust, irritability and anger has been noticed among the women admitted. Over 700 women approached the Masada Early Parenting Centre for care in the three months to September 2021.

MCWH reports that COVID-19 lockdowns and border closures have reduced migrant and refugee women's access to support, which has exacerbated perinatal mental health issues. Migrant women with short length of residency, those who are socially isolated, and those experiencing financial hardship are particularly at risk.

Public discourse around COVID negatively affecting the mental health of women with disabilities

Public discussion about rising demand for health care due to COVID-19 has involved talk of de-prioritising people with disabilities for health care. Women with Disabilities Victoria report that this discourse has had a psychological impact on women with disabilities, leading to them feeling de-valued and turning away from news reports as a coping mechanism.

Public discussion about COVID patients with 'underlying conditions' suffering the most – without explanation of which underlying conditions are being referred to or how they interplay with COVID – has increased fear among women with disabilities. Some feel that this discourse 'blames the victim' for having an underlying condition rather than addressing barriers to access to preventive and protective measures. At the same time, women with disabilities highlight a lack of understanding of the risks they face if they have an underlying condition and contract COVID. This is exacerbated by lack of equitable access to vaccines for people with disabilities and support workers (despite being a priority group), resulting in fear, reduction and/or loss of services, and health risks.

Barriers to accessing mental health services among Muslim women

Structural barriers to navigating and accessing mental health and other services – including a reduction in face-to-face outreach support – has contributed to increased isolation, anxiety and stress among Muslim women.

Advice regarding the mental health impacts of COVID has directed people to their GP. However, many refugee and migrant families do not have a regular GP. Without an established relationship with a GP, there may be a lack of trust, resulting in fewer opportunities for prevention or early intervention in mental health.

The AMWCHR reports that there is a low level of mental health literacy among many Muslim women. There are many different Muslim communities from all over the world, with different understandings of mental health and wellbeing. Stereotypes of mental illness are pervasive, and there can be a tendency to minimise and dismiss mental health concerns. Refugee women may also dismiss experiences of racism and trauma (or family violence) in Australia when compared with experiences in their country of origin.

Stigma and shame around COVID also mean that there is a fear of getting tested and vaccinated among Muslim women.

Lack of availability of mental health and other supports

As noted above, health professionals working outside mental health are reporting that women are turning to them for mental health support because the huge demand for mental health support has meant there is no availability among psychologists.

Specialist Family Violence Advisors have also reported that throughout lockdowns, victim-survivors and perpetrators have been attending Area Mental Health Services and emergency departments when they were unable to access other in-person services, such as family violence and alcohol and other drug support.

Victim-survivors of family violence on temporary visas have been unable to access mental health supports as they are not eligible for government services such as Medicare. This means that their mental health needs were unmet at a time when the frequency and severity of family violence has increased, including first time experiences of family violence.

Women with disabilities have also reported a reduction or loss of therapeutic supports. Peer and formal supports break down during disasters, and this has serious impacts on daily living for people with disabilities, including increased social isolation. For example, support workers are no longer able to come into homes to help with eating, personal care and parenting supports. At the same time, access to external services becomes more difficult due to travel restrictions, fear and anxiety, and lack of access to vaccination – especially since disability services have been places of high infection risk during COVID-19.

Service innovations

Access to the internet has been important during lockdown for connecting with social networks, employment, and all kinds of essential services and information. However, many women with disabilities do not have access to the internet due to a range of factors including financial pressures, literacy levels, technology experience levels and issues with dexterity, hearing and speech. The internet can also present safety risks such as scams and technology-facilitated gendered violence. The Self Advocacy Resource Unit (SARU) received a grant to breach this digital divide, providing smart-tablets to people with disabilities. Regular self-advocacy groups gave participants opportunities to practise using tablets and access the internet safely. This approach has empowered many women with disabilities to maintain social connections and access information during the pandemic.

With the pandemic removing opportunities for face-to-face community outreach, AMWHRC offered digital literacy training for Muslim women, allowing them to engage online. Online support removed transport barriers and women remain highly engaged overall. However, the transition to digital services initially resulted in a drop in engagement among young women, who were reluctant to spend more time online. To address this, AMWCHR engaged young women via Instagram and set up a counsellor texting service so they can contact counsellors in the way that works best for them. These service adaptations have been successful.

The Workforce of Multilingual Health Educators (WOMHEn) project (coordinated by Gender Equity Victoria and MCWH) employed 50 women across 10 metropolitan and regional services, with a linguistic diversity of 20 different languages, to provide in-language education on COVID-19, mental health and other women's health issues. Almost 100 sessions have been conducted, reaching over 1800 migrant and refugee women. The WOMHEn project has demonstrated the value of a coordinated, preventative health education and promotion workforce that can provide place-based in-language support to migrant and refugee women in their own communities.[5] The health educators themselves report that the program supported their own mental health by empowering them and giving them financial independence and a sense of optimism.

Recommendations

The Alliance reiterates and builds on the recommendations made in its October 2020 policy brief on the impacts of COVID-19 on women's mental health, in particular recommendations to:

- Ensure women's equal representation in all COVID-19 response planning and decision making, including investing in specialist women's organisations working with

[5] Gender Equity Victoria and the Multicultural Centre for Women's Health (2021). Left Behind: Migrant and refugee women's experiences of COVID-19; Information about the WOMHEn project can be found here: WOMHEn: Workforce of Multilingual Health Educators.

women affected by multiple forms of discrimination and disadvantage, to support gender analysis of crisis response and recovery planning (*Recommendation 1(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 (*Recommendation 3(b)*). In addition, the universal public health approach must meet *Disability Discrimination Act* obligations.
- Support perinatal mental health by expanding access to appropriate, affordable support services for women during pregnancy and after a baby's birth (*Recommendation 3(f)*).
- Invest in workforce development to ensure the mental health workforce is equipped to support women who have experienced gendered violence (*Recommendation 3(h)*). This investment should include capacity-building to support mental health workers to fulfil Multi-Agency Risk Assessment and Management (MARAM) responsibilities.
- 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 and women with disabilities, including by challenging racism and ableism and embedding cultural safety in service delivery (*Recommendation 3(i)*)
- 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 (*Recommendation 3(j)*)
- 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 (*Recommendation 4(a)*) Geographic barriers to service access for Aboriginal and Torres Strait Islander women should be addressed.

In addition, we call for:

- An extension of surge funding for mental health and family violence response services beyond June 2022 to address the anticipated 'long tail' of COVID impacts
- Investment in research to understand the increase in psychological distress, self-harm and suicidality in young women and develop and implement relevant programs and supports

- Implementation of the recommendations for building an adequate supply of skilled mental health workers who are able to deliver trauma-informed, gender- and culturally responsive mental health support, at both state and national level, outlined in the Alliance's submission to the National Mental Health Workforce Strategy
- Dedicated funding for specialised mental health services for Muslim women and communities, which take a whole-of-family approach reflecting their collective culture, delivered by organisations like AMWCHR which have the requisite cultural knowledge and trust of the community
- Ongoing investment in mental health services to offer comprehensive culturally and linguistically appropriate support and case management to migrant and refugee women
- The removal of residency restrictions and making support services available to migrant and refugee people on all visa categories in Australia to avoid a multi-tiered system in which certain groups of residents and citizens have access to more support than others.
- Responses to the pandemic to be informed by the Social Model of Disability, which recognises that disability is socially constructed through the design of the physical environment, ableist attitudes, inflexible communication and social norms. Information and support during disasters must address the barriers to health and wellbeing for people with disabilities imposed by these structures.
- Dedicated funding for multilingual and ethno-specific organisations such as MCWH to facilitate innovative, tailored education and mental health promotion interventions, delivered by trained bilingual health educators (as in the WOMHEn project).

We also highlight the recommendations in publications from Gender Equity Victoria and Multicultural Centre for Women's Health: 'This Conversation is not over': Women's Mental Health During the COVID-19 Pandemic and Left Behind: Migrant and Refugee Women's Experiences of COVID-19 .