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Dr Mike Freelander MP
The Chair
House of Representatives Standing Committee on Health, Aged Care and Sport
PO Box 6021
Parliament House
CANBERRA ACT 2600

By email: Health.Reps@aph.gov.au

Dear Chair

Inquiry into Long COVID and Repeated COVID Infections

This submission from Relationships Australia National Office responds to Terms of Reference 2 and 4. It expresses our concern that people experiencing long and repeat COVID, and their families and carers, may face diverse obstacles limiting their access to timely mental health, psycho-social and relationship services and supports to enable their fullest participation in education, employment and society. Only through such participation do we receive the manifold benefits of social connection and mitigate the risks of isolation, loneliness and intersecting disadvantages that can affect people restrictive long-term health conditions.

It is important to emphasise that many of the concerns and recommendations we articulate in this submission apply to many people who live with restrictive long-term health conditions, disabilities, and other barriers to participating fully in community life. This includes people living with conditions that are ‘invisible’, or which have fluctuating intensity, as well as those living with intersecting disadvantage and circumstances of vulnerability. We have elsewhere made recommendations about how to better support people living with poor mental health and people living with disabilities.[1] The recommendations made in this submission focus on the needs and priorities of people living with long and repeat COVID.

PART 1 BACKGROUND

1.1 About Relationships Australia

Relationships Australia is a federation of community-based, not-for-profit organisations with no religious affiliations, which has served people living in Australia for over 70 years. Our services are for all members of the community, regardless of religious belief, age, gender, sexual orientation, lifestyle choice, cultural background or economic circumstances.

Relationships Australia services include individual, family and couples counselling, children’s services, services for victims and perpetrators of family violence, services to people experiencing harms related to gambling and use of

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[1] See our submissions about mental health policy and programme responses, and policy and programme interventions to support people living with disability, at https://relationships.org.au/what-we-do/#advocacy

alcohol and other drugs, dispute resolution, and relationship and professional education. We aim to support all people to live with positive and respectful relationships and receive the benefits of nurturing relationships and inclusive, welcoming and flourishing communities.

1.2 Our concerns about long and repeat COVID, and the risks they pose

This submission is grounded in our experience and expertise as community-based providers of mental health services, as well as relationship services. Mental ill health, and the adequacy of clinical and community-based services to maintain and restore good mental health, were prominent policy concerns before the onset of the pandemic. The uncertainties surrounding COVID-19 itself, and the constraints on social, commercial and recreational activities imposed to counter its transmission, have exacerbated not only the suffering of those already struggling with their mental health and that of their loved ones, but also the exigent demands under which health and social services were already buckling.

Research undertaken by bodies including the Australian Institute of Criminology and the Australian National Research Organisation for Women's Safety[2] has confirmed the observations of Relationships Australia practitioners: from early in the pandemic, individuals and families began to present with an increased range of such co-morbidities and increased intensity of those co-morbidities. Our practitioners noted first onset of domestic and family violence, and increases in harmful gambling, alcohol and other drugs.

Relationships Australia is concerned that, in the absence of decisive and large scale intervention now, long and repeat COVID will lead to enduring entrenchment of these issues for families struggling not only with COVID, but also with the social, financial, and child development sequelae of the pandemic. In the context of this Inquiry, we are particularly concerned with risks that:

- people experiencing long or repeat COVID may lose protective social connections, leading to loneliness, which bears its own significant risks to physical and mental health
- people experiencing long or repeat COVID will face discrimination, stigma and other mistreatment
- people already living with marginalisation, complex trauma or other circumstances of vulnerability, and who develop long or repeat COVID, will suffer compounding disadvantages
- co-morbidities, including misuse of substances, poor mental health, harmful gambling, poverty, and housing and employment precarity, will lead to relationship breakdowns, family separation, and domestic and family violence (DFV), including abuse and neglect of older people; poor mental health has long been acknowledged as a co-morbidity with domestic and family violence[3]
- people experiencing long or repeat COVID will face barriers in accessing appropriate supports and accommodations, to which they have rights under the Convention on the Rights of Persons with Disability, noting:
    - the dispersal of our population and geographic inequity across service provision
    - the need for culturally safe services

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[2] See, for example, Morgan A & Boxall H, 2022; Boxall H & Morgan A 2021. ; Boxall H & Morgan A 2021; Morgan A & Boxall H, 2020; Boxall H, Morgan A & Brown R, 2020 ; see also information about the DAHLIA Study: https://www.anrows.org.au/project/domestic-abuse-harnessing-learning-internationally-under-covid-19-the-dahlia-19-study/

[3] See, for example, the Interim and Final Reports of the Family Law Council on Families with Complex Needs and the Intersection of the Family Law and Child Protection Systems: https://www.ag.gov.au/families-andmarriage/family-law-council/family-law-council-published-reports ; Boxall H, Morgan A & Brown R, 2021.

  - the potential for online services, while recognising the impact of the digital divide among particular cohorts,[4] and
  - long waiting lists for certain health and social services, and
- workforce burnout, which was an issue before the pandemic, and has been substantially exacerbated by it (noting that many health care providers are living with the sequelae of COVID themselves, or in their family members and communities), will continue to affect service capacity.

This Inquiry presents a window of opportunity for policy-makers to make recommendations leveraging and supporting:

- protective social connections and positive relationships to counter the risks to physical and mental health posed by social isolation and loneliness, and
- access to effective therapeutic interventions, as well as individual and systemic advocacy.

1.3 Recommendations from Relationships Australia

Evidence base

1 Fund research projects (including longitudinal studies) to explore the nature and prevalence of long and repeat COVID and on their impacts on individuals, families, society and the economy.

2 Collect data on services provided to people experiencing long and repeated COVID, their families and carers, to develop robust data on long and repeated COVID and their impacts and on the efficacy of interventions.

Social connection

3 Commission research into barriers to social connection for people with long and repeat COVID, their families and carers.

4 Support research, education and public awareness campaigns to:
- foster and maintain social connection, especially for people living with disability (including long and repeated COVID), and
- prevent and reduce risk of stigma and discrimination in health care, employment, education, cultural, social and recreational activities.

5 Commission the development of materials, tailored to workplaces, that explore and explain what we know about long and repeated COVID, and how workplaces should support people experiencing long or repeat COVID (including rights and responsibilities under occupational health and safety, industrial relations and anti-discrimination legislation). Such materials will need to be updated as knowledge and understanding of long and repeated COVID evolve.

6 Ask the Australian Human Rights Commission to explore barriers, faced by people experiencing long and repeated COVID, to exercising rights under the Convention on the Rights of Persons with Disability, in particular (but not limited to):
- Articles 19, 29, 30 - to live independently and be included in the community, to participate in political and public life, and to participate in cultural life, recreation, leisure and sport (respectively)

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[4] See Australia's Digital Inclusion Index at https://www.digitalinclusionindex.org.au/digital-inclusion-the-australian-context-in-2021/

- Article 24 – education
- Article 25 – health
- Article 26 – habilitation and rehabilitation
- Article 27 – work and employment, and
- Article 28 – adequate standard of living and social protection.

Service delivery

7 Ensure that people with long or repeat Covid, their family members, carers and service providers have access to holistic and integrated health and social services, noting the need for:

- universal service and accessibility, which embraces geographic equity, as well as the imperative that lack of financial means should not be a barrier to seeking or providing services[5]
- a spectrum of mental health services, recognising the value of family and relationships services and community-based services to supporting good mental health
- a variety of mainstream providers, Aboriginal Controlled Organisations and culturally safe providers
- flexible and blended service modes, including outreach support, drop-in services, and telephone, online and face-to-face counselling
- tailored case management services (including interagency care plans), navigational support, and up to date online service directories and service maps that are available for users and professionals seeking to make referrals, and
- dedicated counselling services which:
    - recognise the uncertainties surrounding the trajectory of long COVID and repeated COVID, and
    - are person-centred and trauma-informed.

8 Design services according to principles including:

- full involvement of people with lived experience throughout design, delivery and evaluation, including in identifying outcomes and metrics
- ‘no wrong door’ - holistic and integrated design from and around the needs of users, not driven by existing legal, jurisprudential, administrative, funding or single-disciplinary structures, distinctions and hierarchies; the use of virtual and physical hubs should be explored
- ‘front-loading’ costs through prevention, early intervention, capacity-building within families, and follow up
- pathways and services that are proportionate to families’ needs and resources (ie not a ‘one size fits all’ journey with the expectation that expensive tertiary services are always the ‘gold standard’), and
- that there is no wrong door and, as an enabler of this principle, that service integration and collaboration happen invisibly to clients.

9 Establish funding arrangements that:

- provide stability and certainty to providers, which will support:
    - recruitment and retention of appropriately skilled and qualified workers, and

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[5] Relationships Australia has previously observed that family law and family relationship services have long provided timely and effective help to clients with high rates of disadvantage within a universal framework.

    - the development of trusting relationships with service providers, which is a prerequisite for effective therapeutic engagement, particularly in communities and cohorts which have experienced intersecting disadvantage and inter-generational trauma
- take into account escalating costs of providing services, arising from increases to CPI, to interest rates, and to utilities including fuel and power, and
- properly reflect the even greater costs in providing services to rural, regional and remote areas, whether through outreach or permanently based services.

1.4 Overarching principles

1.4.1 Commitment to human rights

Relationships Australia contextualises its services, research and advocacy within imperatives to strengthen connections between people, scaffolded by a robust commitment to human rights. We acknowledge Australia's engagement with multilateral instruments and fora that promote the recognition, protection and vindication of human rights. We encourage policy-makers' acknowledgement of intersectionality and the value of lived experience as fundamental to applying human rights frameworks to day to day life.

Our commitment to human rights also underpins our advocacy for universal accessibility to expert services, in which social and financial disadvantage are not barriers. This commitment also requires geographical equity in service availability. Relationships Australia recognises that there are fewer resources available to people in rural, regional and remote areas, and that they live with pressures, complexities and uncertainties not experienced by those living in cities and regional centres.

As a corollary to our commitment to human rights, Relationships Australia regards ageist and ableist attitudes as pervasive and as root causes of violence and abuse against, and neglect and exploitation of, older people and people living with a disability. Such attitudes will potentially affect people living with long and repeat COVID. The ageism that pervaded discourse, policy formation and service delivery responses to COVID is well-documented.[6] We note, too, the evidence submitted to the Committee that there appears to be an association between long COVID and sex.[7] If this is the case, then gendered stereotypes might also affect how people experiencing long COVID are perceived and treated.

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[6] See, for example, the 2020 statement from Australian's Age Discrimination Commission, the Hon Dr Kay Patterson AO, available at https://humanrights.gov.au/about/news/ageism-and-covid-19 , and the statement by the United Nations Independent Expert on the enjoyment of all human rights by older persons, 30 September 2021, available at https://www.ohchr.org/en/press-releases/2021/09/pandemic-exposes-ageism-and-age-discrimination-society-says-un-expert .[both accessed 14 November 2022]

[7] Including evidence from Dr Irani Thevarajan, Professor Catherine Bennett, and Professor Greg Dore.

1.4.2 Commitment to promoting social connection

What is loneliness?

Loneliness is a public health concern which has been linked to physical health risks, such as an increased risk of heart disease, [8] and is a precursor to poorer mental health outcomes, including increased suicidality.[9] Loneliness is a complex social problem stemming from dissatisfaction with our relationships, a lack of positive and respectful relationships, or both of these. It is often caused by experiences of exclusion due to structural and systemic social realities that form obstacles to participation in social, economic, cultural and political life. We are invested in supporting respectful and sustainable relationships within families, throughout communities. Relationships Australia is uniquely positioned to speak on isolation and loneliness as we have clinical experience supporting clients who experience loneliness, have conducted pioneering research into who experiences loneliness (eg Mance, 2018), and manage a social connection campaign, Neighbours Every Day (https://neighbourseveryday.org/), which encourages and supports social connection to end loneliness. This is a nation-wide intervention which develops social capital and inclusion in neighbourhoods and communities across Australia.[10]

A social model of loneliness

The connections between respectful relationships, human rights, mental health and loneliness are inextricable. As such, it is also important to establish an understanding of loneliness within a social model. Loneliness is usually understood as a subjective state, a set of complex and upsetting feelings when an individual's social needs are unmet; this is distinct from the objective state of being alone or socially isolated (Heinrich & Gullone, 2006).

A pioneering study investigating the social model of loneliness found that social structures, not disease processes, disempowered people living with disability (specifically, older cognitively impaired people) leading to social exclusion and loneliness. Traditionally, there have been assumptions that the biological manifestations of cognitive impairment lead to a loss of social resources, as sufferers become unable to maintain their former social lives. Burholt and colleagues (2017) explored the effect cognitive impairment had on older people's pathway to loneliness, identifying evidence that our social-structural understanding of disability significantly impacts social resources. This research established that it was the social environment's treatment of cognitive impairment that limited social resources and in turn led to loneliness, rather than the biological experience of dementia (Burholt, 2017). Establishing a social model of loneliness highlights how the social environment, and its

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[8] Heinrich L & Gullone E, 2006; Holt-Lunstad J, Smith T, Baker M, Harris T & Stephenson D, 2015; Mance, P, 2018; Valtorta, N., Kanaan, M., Gilbody, S., Ronzi, S., & Hanratty, B., 2016.

[9] Calati, R., Ferrari, C., Brittner, M., Oasi, O., Olié, E., Carvalho, A. F., & Courtet, P, 2019; McClelland, H., Evans, J. J., Nowland, R., Ferguson, E., & O'Connor, R. C, 2020; Mushtaq, R., 2014. The campaign Ending Loneliness Together has released a guide that explains how community organisations can use validated scales to measure loneliness: https://endingloneliness.com.au/wpcontent/uploads/2021/08/AGuideto-Measuring-Loneliness-for-Community-Organisations_Ending

[10] Evaluations of the Neighbour Day Campaign (the previous name of Neighbours Every Day) have found enduring evidence of greater social connection, increased wellbeing and reduced loneliness following involvement in the campaign (Cruwys et al., 2021; Cruwys et al., 2020; Cruwys et al., 2019; Long & Lim 2018). Over several years, these evaluations have demonstrated that greater neighbourhood identification is associated with better mental wellbeing. This occurred in part due to greater perceived access to neighbours' support and a reduced sense of loneliness. While not traditionally considered a mental health intervention, social connection campaigns such as Neighbour Day provide innovative, low-intensity opportunities for people to increase their community-based social connection with tangible outcomes.

incumbent assumptions, can produce poorer mental health and wellbeing outcomes for those living with disability.

These insights have clear and alarming implications for people who become isolated in the course of experiencing (or a loved one experiencing) social, occupational, educational and financial disruption due to long or repeat COVID.

Interventions that support social connection

Policy, regulatory and service interventions that strengthen connections and reduce isolation are the most promising and feasible avenues for reducing risks of neglect, abuse, exploitation, and other mistreatment of people who face structural and systemic barriers to their full participation in society, including people experiencing disability or restrictive long-term health conditions.[11] Without policy interventions now, people living with long or repeat COVID may (unnecessarily) become lonely, and suffer its adverse consequences. The narrative should shift away from language centred on the impairment of individuals, and towards creating a more supportive social environment to benefit everyone. Research indicates:

- that the adverse impacts of social isolation and loneliness include increased risk of becoming a victim or perpetrator of abuse, as well as pervasive negative effects on mental and physical health, and
- the protective impacts of safe and healthy family relationships, and of social belonging and connection in both preventing violence, abuse, neglect and exploitation, and mitigating its impacts.[12]

1.4.3 Commitment to clarity, transparency and accountability in legislation, regulation, systems and processes

Fragmentation of legislation, services and programmes is a burden that is routinely imposed on clients of Relationships Australia, by virtue of factors including Australia's federated structure and bureaucratic organisation within jurisdictions. We consistently advocate that it should be lifted, as far as possible, from the shoulders of those least equipped to bear it; for example, in navigating the health, aged care and disability systems, as well as the family law, family violence and child protection systems.

Nor should the burden of fragmentation be 'delegated' to hard-pressed service providers. Currently, contending with bureaucratic silos is a major challenge associated with providing effective health and social services. Relationships Australia is committed to work collectively with local and peak body organisations to deliver a spectrum of prevention, early and tertiary intervention programs with people at all points of the lifespan.

Fragmentation dramatically curtails equitable access to support services.[13] The following systemic issues compound the burdens of fragmentation for clients and providers:

- tendering processes which encourage competition, rather than collaboration, between services
- reporting, evaluation and evidenced-based requirements that varies across funders and programmes, even within jurisdictions
- lack of, or inadequate, efforts to support joint planning, place-based consultation processes, sharing research and learning, and building collective capacity of the sector

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[11] See Dean, A., 2018; Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G, 2010; citing also Hamby, S., Smith, A., Mitchell, K., & Turner, H., 2016; Pillemer, K., Burnes, D., Rifn, C., & Lachs, M. S., 2016.

[12] See, for example, references cited at section 2.4 within.

[13] See https://relationships.org.au/what-we-do/#advocacy

- lack of online directories and service maps to support up to date referral practices
- funding arrangements that divert resources from service delivery to red tape that neither delivers effective accountability nor enhances client outcomes
- short-term funding arrangements that constrain workforce recruitment and retention
- long delays in giving effect to funding announcements, and
- data collection where data seemingly goes into a black hole and are not leveraged to continuously improve service delivery, even where 'partnership approaches', as with DEX, ostensibly operate.

1.4.4 Commitment to valuing lived experience

The expertise and insights deriving from lived experience should be at the heart of policy making and programme design. This is particularly critical in the context of COVID, in which we are all – experts or not - learning as we go. Governments, service providers and researchers must genuinely, consistently and continuously engage with consumer, advocacy and self-help groups to develop and deliver effective service responses.[14]

1.4.5 Commitment to prevention and early intervention strategies

Relationships Australia is committed to prevention and early intervention services across all of our programmes. Relationships Australia provides various universal and targeted mental health services, including prevention and early intervention services. For example, we work around the country in suicide prevention, often in collaboration with other service providers, peak bodies, governments and alliances. When clients need specialised supports beyond our professional expertise, we provide warm referrals.

As we enter our fourth year of living with COVID, there is a clear policy window in which we can, for people experiencing long or repeat COVID and their families, pre-empt many long-term adverse consequences that have unnecessarily afflicted others experiencing restrictive long-term health issues, including:

- stigma, discrimination and othering, particularly where health issues are not well understood by researchers, health care providers and broader society, or which cause 'invisible' or fluctuating symptoms and impairments
- isolation and loneliness
- family and other relationship breakdown, as well as domestic and family violence, and
- restriction of everyday activities, including employment, education, and participation in social, cultural, recreational and other community activities.

These consequences affect entire families and communities. They impoverish broader society by depriving it of participants' fullest potential contributions. It is a matter of urgent public importance to mitigate the adverse impacts of long or repeat COVID, through measures recommended in this submission.

1.5 Relationships Australia's work in the mental health sector

The relationship between healthy relationships and good mental health is bi-directional. A person's mental health is intrinsically linked to the health of their social connections, and strong family and social relationships play foundational roles. As we learn to live with COVID, it has never been more vital to leverage the power of

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[14] See Relationships Australia's *Mental Health Statement*, 2015, which is located at www.relationships.org.au/national/submissions-and-policy-statements/mental-health-statement/view.

connection to improve mental health, including by creating continuity between community-based care and other mental healthcare in Australia.

Relationships Australia became a national member of Mental Health Australia in 2014, in recognition that, through our universal and our targeted services, we see a far higher number of people with poor mental health than in the wider population. Recent studies have identified high rates of poor mental well-being in clients accessing family and relationship counselling and mediation services.[15] In research findings published in 2012, a high proportion of clients accessing individual counselling (17.6%), individual education (15.6%) and couple counselling (13.7%) services reported very high psychological distress. Lower proportions of family dispute resolution mediation (9%) and couple education (5.7%) clients reported very high psychological distress. These rates are two to five times higher than those reported for the Australian population. Relationships Australia South Australia conducted an audit of over 3,200 files from 2013-2018, and found that a significant proportion of clients reported mental health concerns, along with violence and harm to children.

1.5.1 Specialist mental health services

Relationships Australia specialist mental health services have included:

- Aboriginal Social and Emotional Wellbeing
- Access to Allied Psychological Services
- ACT Therapeutic Program for children and young people
- Better Access to Mental Health Care
- Carers Northern Territory
- Children’s Therapeutic Team (Urban and Remote)
- COPE Mental Health and Wellbeing
- Family Mental Health Support Services (pre-2012)
- Gay Men’s Health South Australia
- headspace, across various states and territories
- Heal and Connect
- Healing Foundation
- Holding People Together (for children and young people)
- Partners in Recovery
- Mental Health First Aid
- MOSAIC Blood Borne Viruses Support Services South Australia
- Northern Territory Government Employee Assistance Counselling
- Northern Territory Police Fire and Emergency Psychological Services
- Northern Territory Stolen Generations Aboriginal Corporation
- Open Arms (formerly Veterans and Veterans Families Counselling Service)
- Past Adoption Support and Find and Connect services
- Problem Gambling Support and Prevention Services
- Rural Primary Health Services
- SCIL Living with Autism
- Strength to Strength (for children and young people)
- Tasmanian North West Suicide Prevention – trial site (which has a focus on older people)
- Tasmanian Suicide Prevention Community Network

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[15] See eg Petch J, Murray J, Bickerdike A and Lewis, P, 2014.

- Unplanned Pregnancy Support
- Victims of Crime Counselling and Support
- family and relationships services funded by the Commonwealth Attorney-General's Department and the Department of Social Services
- services to support people affected by the Royal Commission into Institutional Responses to Child Sexual Abuse
- services to support people affected by the Royal Commission into the Detention and Protection of Children in the Northern Territory
- services to support people affected by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
- services for Forgotten Australians
- services for culturally and linguistically diverse people
- Speak Up! StayChatTY, and
- support services for people in the LGBTIQ communities.

Relationships Australia also supports organisations and programmes including Beyond Blue, headspace, Children of Parents with a Mental Illness, the National Mental Health Consumer and Carer Forum, Child and Adolescent Mental Health Services, and Suicide Prevention Australia.[16]

1.5.2 Relationship services as a pathway to better mental health and wellbeing

We consider our family and relationship services to be an integral part of the mental healthcare landscape of Australia, although their value is under-recognised. They can help individuals and families to strengthen and repair their relationships and ultimately support mental health and wellbeing. Family systems research considers:

- the demographics of marriage and family
- the powerful effects of relationships and aspects of human wellbeing
- ways of understanding multi-generational transmission of risk, and
- characteristics of relationships such as conflict, attachment, communication, gender roles and, importantly, family violence.

Research supporting the efficacy of specific couple and family therapy and partner-assisted approaches for treatment of mental illness presentations includes:

- evidence that family-based therapies are as effective as individual cognitive-behavioural therapy and psychodynamic therapy in the specific treatment of major adolescent depression (Carr, 2009)
- evidence that family work is essential (though rarely funded) to assist recovery from trauma (Dwyer and Miller, 2012), and
- promising results for Attachment-Based Family Therapy (ABFT) with depressed and suicidal adolescents (Diamond, 2014; Diamond, Diamond & Levy, 2014; Kissil, 2011; Shpigel, Diamond & Diamond, 2012).

Family relationship services should be leveraged to their full potential, as integral components of a holistic service response to long or repeat COVID and its psycho-social co-morbidities, because:

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[16] See Relationships Australia's *Mental Health Statement*, 2015, which is located at www.relationships.org.au/national/submissions-and-policy-statements/mental-health-statement/view.

- mental disorders have significant, potentially devastating effects on individuals and family, and may be both a cause and a consequence of relationship difficulties
- many common mental disorders go undiagnosed and untreated
- many disorders are chronic or recurrent and often call for long-term management, far beyond acute care
- much of the care provided for people with mental disorders is informal care provided by family members, and
- 'vulnerable' family groups in family relationships services often have a greater risk of mental health problems than average.[17]

Beyond GP-referred, Medicare funded, psychological treatment services, there is an apparent gap in services targeting interventions for a middle group whose mental health issues are not severe enough to warrant acute care and hospital services, but whose symptoms are nevertheless debilitating for them, their families and carers, leading to disruption in workforce and education participation, as well as social isolation and family conflict. Mental illness often ripples through families and can affect the safety and support needs of all family members. Family relationship services can meet the needs of those who would otherwise not be able to access mental health support.

PART 2 LONG AND REPEATED COVID AND ITS EFFECTS ON SOCIAL CONNECTION AND RELATIONSHIPS

2.1 Long or repeat COVID can disrupt connection, leading to social isolation and loneliness

People experiencing long or repeat COVID will be at heightened risk of also experiencing social isolation, stigma, discrimination, relationship breakdown, and disconnection from everyday activities including employment, education, and recreation. Each of these can, in themselves, lead to poor mental health; experiencing long or repeat COVID may compound the risks.

In November 2022, Relationships Australia published an analysis of data collected in our nationally representative Relationship Indicators survey. This revealed that a range of external pressures over the past six months have placed significant strains on relationships, including mental health pressures (22.1%) and economic pressures (20%), both of which have been exacerbated as a result of the COVID pandemic.[18]

Understanding of the nature and prevalence of long COVID and repeat COVID will evolve as the virus itself evolves and as immunity profiles shift. Interventions adopted now will potentially need to be refined and re-scaled many times. Accordingly, it is vital to implement measures now to ensure that scientists, clinicians, service providers and policymakers have access to the best possible data.

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[17] Elly Robinson, Bryan Rodgers and Peter Butterworth, FRSA conference, Sydney, November 2009.

[18] See https://relationships.org.au/relationship-indicators/

Evidence base - recommendations

1 Fund research projects (including longitudinal studies) to explore the nature and prevalence of long and repeat COVID and on their impacts on individuals, families, society and the economy.

2 Collect data on services provided to people experiencing long and repeat COVID, their families and carers, to develop robust data on long or repeat COVID and its impacts and on the efficacy of interventions.

2.2 Positive relationships protect good mental health

The ability to create and sustain strong and positive relationships is a foundational aspect of good mental health (Foresight Mental Capital and Wellbeing Project, 2008). Conversely, a lack of supportive relationships can exacerbate mental ill-health (Beyond Blue, 2014). For example, poor social connectedness is correlated with:

- higher levels of depression and anxiety (Beyond Blue, 2014; Wang et al, 2018; McDonald, 2018; Davidson, 2013; Rubin & Mills, 1998; Nangle et al, 2003)
- lower levels of self-worth (Qualter & Munn, 2002) and life satisfaction (Goodwin, Cook & Yung, 2001), and
- poor subjective wellbeing (Chipuer, Bramston & Pretty, 2003).

Conversely, research has highlighted how certain groups are supported by increased social connection and its tangible effects in promoting good mental health (Beyond Blue, 2014; Mance, 2018; McIntosh, 2016).

Improved outcomes could be achieved with expanded services, such as couple and group interventions. More broadly-applied services would assist families, carers and friends to help their loved ones’ recoveries, and support them where their own mental health has been negatively affected.

2.3 Supportive communities and social capital protect mental health

There are significant mental health and wellbeing benefits gained from living in, and engaging with, supportive communities (Stafford, De Silva, Stansfeld & Marmot, 2008; Ziersch, Baum, MacDougall & Putland, 2005). Community engagement enhances subjective wellbeing, and neighbourhoods with outgoing and sociable cultures enhance collective wellbeing (Evans & Kelley, 2002). This is because social capital, a measure of the quality and quantity of social relationships, is a protective factor in the wellbeing of individuals and communities (De Silva, McKenzie, Harpham & Huttly, 2005). Social capital encompasses concepts such as trust, reciprocity, and social cohesion (Whitley & McKenzie, 2005). Numerous studies have found a positive association between social capital, mental health and the wellbeing of individuals, families and communities (Álvarez & Romaní, 2017; Oshio, 2015; Stafford et al, 2008).

The mental health landscape could be enhanced by interventions and group-based programs which build supportive and connected communities. Examples of group work across the Relationships Australia federation include:

- suicide prevention community networks
- activity programs with fathers and children
- community information sessions on the abuse of older people
- cultural engagement for Aboriginal and Torres Strait Islander people
- services for Forgotten Australians
- National Redress Scheme support services
- forced adoption support services
- post adoption support services

- find & connect support services, and
- support groups for those involved in the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

While therapeutic environments vary widely, the subjective and collective mental health and wellbeing benefits of group work and community-based interventions are similar. They work by increasing individuals' social capital, and consequently, their capacity for trust, reciprocity and social cohesion. These outcomes are fundamental to all group and community-based work Relationships Australia does, and can be transformative for people living with restrictive long-term health conditions, including long or repeat COVID. Offering diverse, capacity-building supports, including individual, family, community and population-based services, will support the mental health and wellbeing of those experiencing long or repeat COVID.

2.4 The role of informal support in fostering and maintaining social connection

Researchers have also attempted to evaluate social support systems as supporters of health and well-being, finding that they can have a protective role against:

- becoming a victim or perpetrator of abuse (Huang, Son & Wang, 2010; Herrera et al, 2008)
- physical ill-health (House, Landis, and Umberson, 1988)
- substance abuse and misuse (Pettersen et al, 2019)
- stress and reduced self-esteem (Ozbay et al, 2007)
- mental ill-health and poor wellbeing (Productivity Commission, 2020)
- loneliness (Relationships Australia, 2018; AIHW, 2019), and
- suicidality (Productivity Commission, 2020, p 150).

Those experiencing long or repeat COVID, theirs families and carers, potentially face each of these risks.

Research on risk and protective factors is rarely definitive. Of course, social support systems cannot guarantee protection from these experiences. Significantly, much of the protective factor research examines individual-level causes, rather than investigating social and environmental factors that lead to these experiences. Causation can be difficult to conclude. Yet, through our services to people affected by the Disability Royal Commission, for example, we have identified that informal support systems can mitigate pervasive physical, attitudinal, communication and social barriers to social inclusion. While the individual experience of each client is unique, the need for social connection and support is ubiquitous, and the benefits plain.

2.5 Discrimination, stigma and othering

Discrimination, stigma and othering interfere with relationships and connections to family, friends, workplaces, community and culture. People experiencing mental ill-health often experience discrimination. Prejudice and discrimination interfere with restoration of good mental health. Stigma and discrimination also affect families, carers and support persons.

Relationships Australia organisations offer family and relationship services as general population services, offering opportunities to counter stigma. Family therapy has a long tradition of engaging diverse families and communities. The understanding and conduct of health professionals towards people experiencing long or repeat COVID will be critical, noting that the lived experience of people with mental illness is directly affected by not only the skill, but also the attitudes and behaviours, of staff.

Evidence suggests that longer-term anti-discrimination and anti-stigma initiatives have more success than short-term measures in reducing the experience of discrimination by people living with a mental health difficulty. Relationships Australia has engaged with several campaigns to counter discrimination and stigma, including EveryAGE Counts, Racism. It Stops With Me, and the marriage equality campaign.

Regular and well-targeted public campaigns are needed. Strengthening community understanding helps build people's capacity to identify and better understand the early signs of mental distress; however, we note that improvements in community understanding and mental health literacy are not necessarily associated with a reduction in discriminatory behaviour and stigmatising attitudes.[19] Other supports are also necessary to promote a society that includes and supports, rather than excludes or demeans. A key element of reducing institutional and individual discrimination is to strengthen community understanding.

Social connection - recommendations

3. Commission research into barriers to social connection for people with long and repeat COVID, their families and carers.

4. Support research, education and public awareness campaigns to:
    - foster and maintain social connection, especially for people living with disability (including long and repeated COVID), and
    - prevent and reduce risk of stigma and discrimination in health care, employment, education, cultural, social and recreational activities.

5. Commission the development of public awareness materials, tailored to workplaces, that explore and explain what we know about long and repeated COVID, and how workplaces should support people experiencing long or repeat COVID (including rights and responsibilities under occupational health and safety, industrial relations and anti-discrimination legislation). Such materials will need to be updated as knowledge and understanding of long and repeated COVID evolve.

6. Ask the Australian Human Rights Commission to explore barriers, faced by people experiencing long and repeated COVID, to exercising rights under the Convention on the Rights of Persons with Disability, in particular (but not limited to):
    - Articles 19, 29, 30 - to live independently and be included in the community, to participate in political and public life, and to participate in cultural life, recreation, leisure and sport (respectively)
    - Article 24 – education
    - Article 25 – health
    - Article 26 – habilitation and rehabilitation
    - Article 27 – work and employment, and
    - Article 28 – adequate standard of living and social protection.

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[19] Reavley N J and Jorm A F, 2011.

PART 3 SERVICE RESPONSES

3.1 Integrated, holistic services with no 'wrong door'

Lack of integration is often experienced by clients as gaps in service. Gaps between early intervention and prevention services and secondary or tertiary services lead to attempts to 'push' clients between services if their needs cannot be met. In many cases, this risk is managed informally by having good relationships between service personnel. At other times, however, these gaps are where vulnerable people fall through, and miss out on vital services. Fragmentation also imposes on service providers heavy burdens of, for example:

- duplicative regulation and compliance activity, including performance reporting
- cumbersome communication channels and opaque referral pathways
- disjointed and process-laden attempts at 'co-ordination', and
- conflict between client need and program guidelines and scope (and lack of flexibility to work with program parameters to meet clients' evolving and emergent needs).[20]

An integrated system means no wrong door for clients and a consistent approach to case management. Case management approaches deliver improved outcomes for clients, but are resource intensive. Relationships Australia is exploring approaches which allow some users to self-serve, to improve and expand service reach in a cost effective way, while maintaining intensive face-to-face services for those clients requiring a higher level of care. Individualised interagency care plans that go with the client would also be very helpful. Protocols must define roles, procedures to negotiate gaps, and short, medium and long term strategies for supporting clients, particularly those with severe and complex health issues.

While many local community services networks are well connected, links between the medical and community services sectors are less robust. Services rely on local knowledge and there are few contemporary service maps that can be used to identify the services in the region. Medical professionals, within and beyond government, have patchy understanding of the strengths of community services organisations, like Relationships Australia, and peer workers, in facilitating pathways for people with multiple needs, and providing ongoing support and follow-up. The absence of consistent approaches often leads to crisis situations and presentations to what may appear to be the only alternative – busy Emergency Departments.

Case navigation models have proven effective in health settings. One example is the Patient Navigator Service offered by the Peter MacCallum Cancer Centre. There are also online navigation approaches, such as the Counterpart Navigator App, supported by the Victorian Government. Continuity in navigators, where practicable, would be optimal to support the development of trusting relationships with users who have ongoing and complex needs.

Clients need smooth connections and continuity. Services should be easy to navigate, with transitions that are invisible to clients. Key elements include:

- warm, supported referrals
- flexible service delivery
- multi-layered options; for example, when working with Forgotten Australians and members of the Stolen Generation, therapeutic treatment or healing may need to occur over multiple domains, such as trauma

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[20] For example, some of Relationships Australia member organisations administer more than 50 funding sources from which they are to provide services – often, to the same clients.

from child sexual abuse, feelings of abandonment, loss and grief through separation from family, loss of culture, country and identity

- safe, welcoming and accessible physical locations[21]
- mechanisms to accommodate intermittent, but long-term, needs for care
- transitional pathways for young clients as they ‘age out’ of services targeting children and young people, and into adult services
- triage and stepped care at point of entry
- services provided at the earliest opportunity, rather than in response to crises
- clearly defined and agreed pathways through the support system (including to system exit)
- collaborative approaches between specialist family relationships services and mental health treatment services, which could help to manage the complex interplay between interpersonal relationships and health
- implementation of collaborative care that optimises the role played by all providers (including peer workers, case managers, mental health nurses, GPs, psychologists, psychiatrists, housing workers, case managers, employment support workers and others), and
- duration or intensity of care and support that is based on routine reassessment and review, rather than on arbitrary caps on service offerings.

3.2 Hub approaches

Widespread implementation of multidisciplinary hubs could be leveraged to enhance geographic equity and universal access for people experiencing long or repeat COVID, their families and carers. We have advocated for hub-based service approaches (which could include both physical and virtual hubs) across a range of policy and programme domains. For example, in our submission to the Productivity Commission’s inquiry into mental health, we supported the establishment of integrated service hubs to address the fragmentation of mental health services (Relationships Australia submission 103).[22] We addressed the challenges and costs associated with establishing multidisciplinary hubs, and concluded that they can be overcome through the pragmatic qualities of successful hubs as outlined by the Productivity Commission, including:

- commitment from leadership
- staff buy-in and willingness to embrace change
- regular monitoring and evaluation of service effectiveness
- learning from previous co-location initiatives, and
- agreements to clarify roles and responsibilities (Productivity Commission 2020, p 363).

Hubs could be incorporated into existing place-based services and facilities. For example, placing hubs in schools would use pre-existing infrastructure situated in a familiar environment. They would provide access to hard-to-reach communities, such as children from CALD and Aboriginal and Torres Strait Islander backgrounds, children experiencing family violence and children and young people unaware of, or unable to access, other mental health services such as headspace centres. Using pre-existing institutions for new hub locations reduces the necessity

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[21] Such as the ‘Meeting Place’ established by Relationships Australia Northern Territory, staffed by counsellors and Aboriginal and Torres Strait Islander Cultural Advisors, and which was an outdoor refreshment area for people attending hearings of the Royal Commission into Institutional Responses to Child Sexual Abuse.

[22] Available on the Productivity Commission website at https://www.pc.gov.au/__data/assets/pdf_file/0005/240197/sub103-mental-health.pdf and on the Relationships Australia website at https://relationships.org.au/wp-content/uploads/Productivity-Commission-2013-The-Social-and-Economic-Benefits-of-Improving-Mental-Health-2013-Response-to-Issues-Paper.pdf .

for advertising, heavy recruitment and infrastructure costs. Since schools, hospitals and universities are already understood as hubs for educational and health purposes, incorporating a spectrum of mental health care and preventative measures within them is less arduous, less costly and likely to be more palatable for potential users.

Relationships Australia has also engaged with several services and networks which encourage integration at the service level. For example, Indigenous Community Links, to support Aboriginal and Torres Strait Islander community members and their families by providing links and referrals to a range of mainstream and Indigenous services, such as welfare and social support, employment, family violence, health (including drug and alcohol services), legal, child care and housing. Services also encourage the development and fostering of relationships with other service providers by promoting access and pathways to their services, including through the provision of Internet access.

The Tasmanian Suicide Prevention Community Network (TSPCN) is a network of community members, service providers, organisations and government representatives who are working together to reduce the rate and impact of suicide in Tasmania. The TSPCN is supported by a Suicide Prevention Facilitator and the LGBTI Project Officers. These positions have been funded by the Department of Health and Human Services (DHHS) and staff are located at Relationships Australia Tasmania, which is funded to auspice the TSPCN. Relationships Australia also provides therapeutic services to headspaces. Relationships Australia Western Australia, Relationships Australia Victoria, and Relationships Australia Canberra and Region each have overall management and co-ordination of a number of headspace centres. Other models which focus on integrated services delivered by Relationships Australia include Partners in Recovery (funded by the Department of Health and Ageing) and Family Mental Health services (DSS).

3.3 Challenges in achieving geographic equity

Funding and accountability measures do not reflect the significant challenges faced by providers serving regional, rural and remote communities. For example, a practitioner located in the Perth servicing the Peel region of Western Australia conducts monthly outreach trips to remote areas. The travel time cannot be captured or reflected, no-shows cannot be replaced, and limitations on scheduling (due to the realities of outreach) makes the service less accessible. Face-to-face services will continue to be needed in these communities as online service delivery is not a panacea for population dispersal.[23]

Worker burnout is also a heightened reality in rural, regional and remote communities, exacerbated by cascading natural disasters disproportionately affecting regional areas.

3.4 Serving people who are culturally and linguistically diverse

Help-seeking can be hindered by limited availability of inclusive services to provide culturally sensitive interventions, services and interpreters.[24] Balancing the importance of mainstreaming disability with the need to provide tailored services for groups with intersecting vulnerabilities is of particular concern when planning, designing and providing support for people from culturally and linguistically diverse backgrounds (CALD). People from CALD backgrounds face difficulties in accessing information, isolation and difficulty in connecting with services that meet their cultural needs. Like ageist beliefs and practices, racist beliefs and practices have also

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[23] Relationships Australia has consistently advocated for greater digital inclusion, including in the recent consultation by the Australian Communications and Media Authority on Consumer vulnerability: expectations for the telco industry

[24] Sawrikar P and Katx I, 2008.

been much in evidence since the onset of the pandemic,[25] and particular care should be taken to ensure access to culturally safe services for people from CALD backgrounds who experience long or repeat COVID, including by:

- obtaining bilingual carers, advocates and other supports, for service referral and provision
- navigating cultural stigmas around disability (which may extend to long and repeat COVID), and
- responding sensitively to fears of mistreatment stemming from histories of violence and exploitation by governments, agencies and institutions, and other service providers.

Funders can inadvertently constrain providers' ability to provide culturally appropriate services. For example, if outcomes and metrics do not:

- account for the extensive role that familial support systems play in some CALD communities – for example, the key role grandparents and other extended family members play in supporting child and young people, the influence of young and middle-aged adults in family dynamics, and
- recognise community diversity, and diverse epistemologies, and therefore cannot leverage the knowledge and strengths of communities, families and individuals.

The numbers of people accessing the NDIS who identify as CALD go some way to quantifying the extent to these barriers may come to apply to people experiencing long or repeat COVID. While an estimated 23% of Australians are from CALD backgrounds, only 7% of NDIS participants at the end of 2017 identified as CALD (Settlement Services International, 2019). Services, especially mainstream services, have been shaped by a history of colonisation and imperialism (Dittfield, 2020). While equitable access to services for all Australians is integral to inclusion, social work is a profession based on concepts, problems and solutions which have marginalised and obscured Indigenous knowledge systems (as distinct from modern Western knowledge systems).[26]

3.5 Universal access - encouraging blended face to face/online models of care

During 2020, a significant proportion of Relationships Australia's service offerings were moved online to adhere to physical distancing and lockdown laws. While many of our programs have offered blended models of care for some time, some services are more challenging to offer in safe online versions. The rapid digitalisation brought about by the pandemic no doubt accelerated community acceptance of, and comfort with, online health care. Further, research has shown that access to services during lockdowns was essential to building resilience among people who access psychosocial support services (Wellways, 2021).

When implemented correctly, online programs have an unmatched potential for outreach. For example, easily accessible interventions such as Family Connect, an online step-by-step skills and discussion based programme, teaches children and parents social competence, problem-solving skills and autonomy. This program was developed by Uplifting Australia and gifted to Relationships Australia in 2021. It offers evidence-based strategies which families can work through independently.[27]

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[25] See, for example, Doery, K., Jones, R., O'Connor, M., Olsson, C., PhD, Guo, S., Harriott, L., Priest, N, 2022; Tan, X., Lee, R., & Ruppanner, L, 2021 ; the statement by Australia's Race Discrimination Commissioner, Chin Tan, 8 April 2020, available at https://humanrights.gov.au/about/news/racism-undermines-covid-19-response .

[26] Indigenous here refers to knowledge developed within societies, independent of, and prior to, the advent of the modern scientific knowledge systems.

[27] Available at https://www.familyconnect.org.au/

Nevertheless, many barriers to digital service delivery, which we have identified in previous submissions, persist. For example, socioeconomic issues limit people's use of online services, including:

- functional illiteracy
- lack of access to safe and private spaces from which to access online services
- financial disadvantage limiting access to technology
- lack of knowledge about what is on offer and how to access it
- digital divides in at-risk populations including older Australians, CALD communities and Aboriginal and Torres Strait Islander communities,[28] and
- distrust and/or dislike of digital services for communities with entrenched stigma around mental health care.

Cultural realities may also make online service provision inappropriate. While face-to-face care may not completely assuage concerns about cultural safety, engaging face to face with local practitioners can support greater confidence and willingness to seek support. Further, engaging with local practitioners offers greater scope for increasing numbers of Aboriginal and Torres Strait Islander mental health workers and expanding the role of Aboriginal and Torres Strait Islander controlled mental health services. Aboriginal and Torres Strait Islander people access services at lower rates (Australian Human Rights Commission, 2015). Research finds that Aboriginal and Torres Strait Islander people with disability are often cared for within their extended family, rather than by service providers. This is true across remote, rural and urban Australia (AbSec 2020). This, coupled with a legacy of fear and mistrust of services, can place pressure on kinship systems and pose barriers to choosing alternative supports. Relationships Australia also recognises the historical traumas caused by mainstream services to people who live with disability who also identify as Aboriginal and/or Torres Strait Islander. We believe that any services for Aboriginal and Torres Strait Islander peoples with disability, especially mainstream and non-ACO specialist disability services, must continually work to centre the importance of Country, culture and community.

Online services cannot yet be regarded, indiscriminately, as an adequate substitute for face to face delivery. In our experience, digital services are at their best when they are understood as a supplementary support for robust in-person offerings, rather than an alternative solution to entrenched healthcare issues, including barriers emerging from social determinants of health. There are constituencies for whom online programs are unsuitable, inappropriate or unwelcome, and the use of such programs as a cost-cutting measure must be guarded against.

3.6 The role of community-based treatment, care and support

The potential role for community-based treatment, care and support in Australia's mental health landscape has been well-recognised in recent years,[29] and could enable invaluable tailored support to people experiencing long or repeat COVID, as well as the broader community. When more medicalised care is required, we bridge service gaps by providing warm referrals and/or being located within hub-based care models.

There is real and unmet need for properly-resourced community models of mental health. In our experience, community mental health services are often better received by clients in regional and remote areas, as well as those from vulnerable or disadvantaged client groups (eg those on low income). General counselling, community mental health models, peer workers and the engagement of family members and carers should sit alongside, and

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[28] See Australia's Digital Inclusion Index at https://www.digitalinclusionindex.org.au/digital-inclusion-the-australian-context-in-2021/

[29] For example, the Victorian Royal Commission, 2021, the Productivity Commission (2020), and the National Suicide Prevention Officer (2020).

collaborate with, medical models and provide early intervention pathways and choice for clients seeking to access mental health services. Further, properly-resourced community-based services can alleviate pressures on tertiary services, including emergency departments, to which people often default if they are unaware of other options, or other options are otherwise inaccessible.

3.7 Stable funding

Relationships Australia notes the widely-shared predilection for establishing short-term pilot programs to meet contemporary exigencies, and then de-funding such services (whether evaluated as successful or not). Such approaches inhibit the establishment of trusting therapeutic relationships, employment and retention of skilled and experienced staff, and investment in vital infrastructure.

Given the unknown trajectory of long and repeat COVID, recommendations to government around funding mechanisms should be framed around sustained, long term investment in services. Short term pilots, and other short term funding arrangements, leave clients and workers vulnerable. Worker shortages are already endemic across health and social services, and funding uncertainty only exacerbates that.

Clients and community groups consistently express disappointment at the 'here today/gone tomorrow' approach which characterises short-term funding commitments. Relationships Australia has observed elsewhere that the constant rolling out of new, short-term programs imposes significant administrative burdens, potentially distracting time and energy, as well as money, from service provision. These cycles lead to worker and client fatigue, distrust, and little long term benefit to users.

Relationships Australia acknowledges that this is very challenging within the constraints of budget and election cycles, and needs to ensure appropriate accountability for public money. It would require commitment from leaders to communicate and persuade as to the benefits of such longer cycles as are needed to disrupt (and ultimately halt) cycles of entrenched disadvantage and dysfunction and reap the far-reaching and multidimensional socio-economic benefits of doing so.

Relationships Australia welcomes recent attention to this issue by government and its commitment to working with the community sector on a blueprint for achieving more stable and secure long-term funding which is adequate to meet rising demand for services.

Service delivery - recommendations

7 Ensure that people with long or repeat COVID, their family members, carers and service providers have access to holistic and integrated health and social services, noting the need for:

  - universal service and accessibility, which embraces geographic equity, as well as the imperative that lack of financial means should not be a barrier to seeking or providing services[30]
  - a spectrum of mental health services, recognising the value of family and relationships services and community-based services to supporting good mental health
  - a variety of mainstream providers, Aboriginal Controlled Organisations and culturally safe providers

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[30] Relationships Australia has previously observed that family law and family relationship services have long provided timely and effective help to clients with high rates of disadvantage within a universal framework.

- flexible and blended service modes, including outreach support, drop-in services, and telephone, online and face-to-face counselling
- tailored case management services (including interagency care plans), navigational support, and up to date online service directories and service maps that are available for users and professionals seeking to make referrals, and
- dedicated counselling services which:
    - recognise the uncertainties surrounding the trajectory of long COVID and repeated COVID, and
    - are person-centred and trauma-informed.

8 Design services according to principles including:

- full involvement of people with lived experience throughout design, delivery and evaluation, including in identifying outcomes and metrics
- ‘no wrong door’ - holistic and integrated design from and around the needs of users, not driven by existing legal, jurisprudential, administrative, funding or single-disciplinary structures, distinctions and hierarchies; the use of virtual and physical hubs should be explored
- ‘front-loading’ costs through prevention, early intervention, capacity-building within families, and follow up
- pathways and services that are proportionate to families’ needs and resources (ie not a ‘one size fits all’ journey with the expectation that expensive tertiary services are always the ‘gold standard’), and
- that there is no wrong door and, as an enabler of this principle, that service integration and collaboration happen invisibly to clients.

9 Establish funding arrangements that:

- provide stability and certainty to providers, which will support:
    - recruitment and retention of appropriately skilled and qualified workers, and
    - the development of trusting relationships with service providers, which is a prerequisite for effective therapeutic engagement, particularly in communities and cohorts which have experienced intersecting disadvantage and inter-generational trauma
- take into account escalating costs of providing services, arising from increases to CPI, interest rates, and utilities including fuel and power, and
- properly reflect the even greater costs in providing services to rural, regional and remote areas, whether through outreach or permanently based services.

PART 4 BROADER SOCIAL RESPONSES TO LONG AND REPEAT COVID

4.1 The importance of supporting employment and education participation by people experiencing long and repeat COVID

Relationships Australia recognises the important role work environments and secure employment play in the mental health of all Australians. Research shows that opportunities to socialise in the workplace can positively affect mental health (Tinson 2020; Productivity Commission, p 172). The disruptions to work-life during COVID-19 brought about economic losses and changes to work-based relationships which challenged people financially, socially and emotionally. A poll conducted by Relationships Australia found that 63% of respondents experienced changes to their mental health in response to changes in their working conditions during April of 2020 (Fisher, 2020). Furthermore, Relationships Australia found that those respondents who agreed that their workplace was part of their social life were far more likely to experience changes to their mental health following these workplace disruptions. Pre-pandemic research showed that workplace social networks were found to be so effective that they improve the perceptions people have of their jobs (Tinson, 2020).

As we continue to live with COVID, and more people experience long and repeat COVID, workplaces will need to consider the mental health of workers. This will require a combination of approaches. Good mental health in the workplace is affected by the health of one's relationships, both at work and in other aspects of life. In Relationships Australia's submission about the development of the National Workplace Initiative, we emphasised the need for a two-pronged approach, by creating workplace cultures that:

- understand mental ill-health – including awareness, intervention, support and recovery, and
- recognise the benefits of mentally healthy workers and prioritise mental health – including ensuring accessibility and support for people living with a disability, promoting diversity and other initiatives designed to enshrine inclusion.

To support people experiencing mental health issues associated with long or repeat COVID, it will be important to unify and clarify people's understanding of mentally healthy workplaces, giving them a language to speak about the subject consistently and confidently. Although it is improving, people's understanding of their own mental health and the concept more generally remains confused and somewhat taboo. Bringing the discussion into the workplace will help to demystify these concepts and normalise the discussion of mental health.

The workplace can be a locus of discrimination and stigma. In our work with people engaging with the Disability Royal Commission, our practitioners have heard many accounts of employers discriminating against people with disability. This can be particularly acute in regional areas. For example, clients often express frustration that regional employers can engage in:

- increased stereotyping and stigma
- limited alternative options (forcing the client to 'put up with' discrimination, exploitation, abuse or unfair dismissal), and
- reputational risk affecting future employment and additional costs associated with fighting unfair dismissals in regional locations (such as limited access to advocacy, travel costs and loss of work).

Relationships Australia invites the Committee to make recommendations to mitigate the risk that people experiencing long or repeat COVID might face similar obstacles; see, in particular, recommendations 3-6.

4.2 Systemic institutionalised neglect and past experiences with trauma at the hands of the system

As an absolute minimum, Australian society has a moral obligation to ensure that those who experience long or repeat COVID never suffer the systemic institutionalised neglect and mistreatment that has been inflicted upon others who have lived with disability. This ubiquitous experience with structural barriers has, shamefully, been part of the systemic institutionalised neglect experienced by those living with disability. The universality of these experiences, and other historical experiences of neglect and exploitation has left this cohort deeply traumatised by the system.

> *The common thread is that all these clients have come to our service feeling there is no space or way through for them in "the system". In their contact with government agencies and community services, they have experienced being labelled, discriminated against, dismissed, unacknowledged, discredited, and disempowered. As a result, these people have developed psychological symptoms such as anger, fear,*

> *anxiety, depression, hopelessness, suicidality, etc. Of course, there might have been other life events impacting their mental health, however, their experience of the system has often been central to their current state of distress and suffering.*
>
> - ***Program manager, Relationships Australia***

We cannot allow this experience to be repeated for people experiencing long or repeat COVID. Relationships Australia hopes that recommendations emerging from the Disability Royal Commission will be implemented, to the benefit not only of people experiencing long or repeat COVID, their families and carers, but also society as a whole, which flourishes best when it is inclusive, welcoming and values each person.

CONCLUDING REMARKS

Thank you again for the opportunity to participate in this inquiry. We look forward to seeing the outcome of this inquiry in the final report. Should you require any clarification of any aspect of this submission, or would like more information on the services that Relationships Australia provides, please contact me (ntebbey@relationships.org.au) or Dr Susan Cochrane, our National Policy Manager (scochrane@relationships.org.au).

Yours sincerely,

Nick Tebbey
National Executive Officer

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