



Rapid Evidence Review

The immediate and medium-term social and psycho-social impacts of COVID-19 in New Zealand¹

May 2020

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Disclaimer

The views and interpretations in this report are those of the researchers and are not the official position of the Ministry of Social Development.

Readers should note that while the report has been through a quality assurance and proofing process, it has not been through the Ministry's full Publications Committee process, since the value and relevance of the report is considered tied to it being made promptly available.

Purpose and limitations of the report

This evidence review was produced at speed, between late March and late April 2020, for the purpose of informing the all-of-government COVID-19 response plan. It was not intended as an academic publication. This review was started as New Zealand entered Level 4 lockdown and completed as New Zealand moved into Alert Level 3, before it was known how long New Zealand would remain at each Alert Level. The literature and evidence cited was current at the time of review (late April 2020) but since then newer literature, evidence and data has emerged. This review will not be updated.

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Executive Summary

This rapid evidence review was commissioned and undertaken by the Ministry of Social Development to aid an all of government COVID-19 response planning and delivery.

The review identifies the likely immediate and medium-term social and psychosocial impacts of COVID-19 in Aotearoa New Zealand and responses to mitigate these impacts, and discusses how the impacts vary across different population groups.

An inductive approach was taken to identify immediate impacts and affected population groups from a literature review and then impacts were categorised into key impact domains. Medium-term impacts are likely to be an extension or exacerbation of immediate-term impacts and are dependent on the social and economic conditions under which Aotearoa New Zealand will be operating for the next 12 months (to April 2021).

Māori and COVID-19

The COVID-19 pandemic is expected to have disproportionately negative impacts on Māori, and particular sub-groups of Māori, who already face multiple, concurrent disadvantages. The structures and customs of Māori society are an asset in the COVID-19 response and recovery.

Māori knowledge and values can shape behavioural and cognitive responses that facilitate coping, recovery and wellbeing. Traditional cultural practices can strengthen resilience through a range of psychosocial mediators such as self-efficacy, social connectedness, confidence, safety, inclusion, social cohesion, empowerment, trust, reciprocity and collective preparedness.

Research on the mediators of psychosocial impacts for Māori during civil defence emergencies, evolving theory on the determinants of indigenous resilience, and academic discourse on the enablers of Māori transformation, support a COVID-19 response based on Mātauranga Māori principles.²

1. Social isolation and crowding may increase negative social and psychosocial outcomes

Immediate impacts:

The psychological impacts of quarantine³ and self-isolation⁴ include Post Traumatic Stress Disorder (PTSD), depression, stress and anxiety.

² Mana Motuhake: enabling Māori to make and enact decisions within whānau, hapū, iwi; Mana Taurite: addressing the underlying drivers of inequity; Mana Whakaora: strengthening capacity for long-term, collective wellbeing; Mana Māori: enabling mātauranga Māori service designs; Mana Tangata: prioritising equity in service planning and delivery nationally; Mana Whakahaere: responses that contribute to the Crown's obligations under *Te Tiriti o Waitangi*

³ *Quarantine*: refers to where a person is physically 'isolated' or 'quarantined', because they either have the infectious disease or have been exposed to it, to prevent infecting others (refer to Brooks et al, 2020). The restrictions on people's freedoms and activity is greater in 'quarantine' situations than the restrictions experienced by the general population under Level 4 'lockdown' in Aotearoa New Zealand.

⁴ *Self-isolation*: refers to the situation where people were asked to 'quarantine' themselves at home.

Loneliness (likely to increase while at alert level 4) can increase morbidity and mortality, depression and anxiety, and can impair cognitive performance.

People living in crowded households during lockdown may be at risk of poor mental health outcomes and increased family conflict and violence.

The likelihood of negative psychological effects may be exacerbated by additional stressors including financial loss, longer quarantine duration, infection fears, frustration, inadequate supplies, and inadequate information.

Medium-term impacts:

The psychological effects of quarantine can continue for several years.

Groups at higher risk of severe illness from COVID-19 are more likely to extend household isolation and may experience enduring impacts of isolation and loneliness.

The loss of jobs or businesses may result in or increase social isolation, disconnection and loneliness.

2. COVID-19, and the predicted recession, may negatively impact mental health

Immediate impacts:

Mental distress and illness can be triggered by significant life shocks such as a disaster or pandemic, job loss, or death of a loved one.

The pandemic may increase the incidence of a range of mental health conditions, especially anxiety, depression, PTSD, and substance use disorders.

Population groups at increased risk of adverse mental health impacts include those pre-existing mental health conditions, disabled people, health and essential workers.

Disrupted access to mental health support, or services being unable to meet a surge in demand, may worsen outcomes.

There is considerable evidence that job loss leads to poor mental health.

All of the above have potential to increase the risk of suicide (in the immediate and medium term). But 'potential' is not inevitable; the causes of suicide are complex.

Medium-term impacts:

Increases in unemployment are likely to lead to increases in material hardship and delays in realising previous aspirations (i.e. home ownership, starting a family), which may lead to poorer mental health.

3. COVID-19 may elevate risk factors for family violence

Immediate impacts:

Using unhealthy coping mechanisms (e.g. substance abuse) in the face of the pandemic, increases the risks of violence.

People may resort to controlling behaviours and violence in response to perceived loss of control and freedom during containment and social distancing.

Disease containment measures may disrupt social networks and supports that could otherwise reduce the risk of victimisation. Disease containment measures may also hinder a person's ability to leave abusive situations and access support services.

Medium-term impacts:

Prolonged economic stress related to pandemic restrictions and a likely economic recession, with potentially persisting adverse effects of the pandemic on mental health, may increase rates of family violence in the longer term.

Experiencing violence has medium and long-term effects on mental health.

4. COVID-19 is likely to have negative impacts on child wellbeing and development

Immediate impacts:

Children are at risk of harm as a consequence of stress on the adults in their lives.

School closures and restrictions on movements disrupt children's social supports, and mean the loss of a key protective factor against disadvantage and exposure to violence.

Adverse child experiences due to COVID-19 (e.g. economic insecurity, disruption to learning, lack of support networks, overcrowding, parental distress, and exposure to violence) are likely to have detrimental impacts on children's wellbeing.

Medium-term impacts:

Many of the psychosocial impacts on children are likely to manifest in the medium and long term rather than during a four-week Level 4 lockdown period.

The immediate risk of increased exposure to violence and abuse has medium and long-term consequences for child wellbeing and development.

Loss of employment is likely to see more children living in families experiencing material hardship. Children who experience material hardship have worse cognitive, social, behavioural and health outcomes both during childhood and during the life course.

Youth unemployment increases the risk of social exclusion and mental health issues. The effects of unemployment at an early stage in a career can result in employment scarring and negative impact life trajectory.

Impacts are likely to differ across population groups

Negative effects of COVID-19 on the total population are likely to reduce after lockdown has lifted, but adverse impacts will continue and increase for those in the following scenarios:

- Groups at risk of severe illness should they contract COVID-19 are likely to have to continue physical distancing and household isolation.
- Adults whose income has been lost or substantially reduced (and do not have immediately available alternatives) may experience financial / material hardship⁵ and the emotional loss of their livelihoods and status degradation.
- Adults in households where strain on financial and inter-personal resources exposes them to conflict, abuse or violence in their relationships.
- Children in households where resources are diminished or strained, exposing them to potentially stressful developmental environments such as material hardship and/or increased family conflict/abuse/violence.

The direct and indirect impacts of COVID-19 risks compounding pre-existing social and economic inequities. While the ways in which they are affected will differ, the population groups at higher risk of adverse social and psychosocial impacts in the immediate and medium terms include: Māori, Pacific Peoples, refugees and migrants, health workers, essential workers, people with existing physical and mental health conditions, people with disabilities, older people, young people (18-25 years), children, and women.

A range of strategies can mitigate negative impacts

Evidence suggests that mitigation efforts and resources should target those population groups most at risk and address structural and systemic inequities. In addition:

- A one-size-fits-all response to the pandemic may serve to exacerbate persistent health and socio-economic inequities.
- Responses need to be whānau centred, culturally informed, culturally appropriate and recognise diversity in communities, including location (e.g. rural or urban) age, gender, and whānau circumstances.
- Recognise the expertise and leadership in Māori and Pacific communities and ensure culturally specific approaches to reporting measures.
- Ensure that groups at high risk of adverse impacts are consulted and wherever possible involved in the decision-making process.
- Communications and responses should be targeted to the needs of different groups.
- Access to generous financial and other assistance and debt relief, and employment programs should be supported and resourced to meet increased demand.
- Access to timely mental health and addiction services should be supported and resourced to meet increased demand.
- Family violence services should be resourced to meet increased demand.
- Child-specific programming of intervention strategies should be ensured.

⁵ In scenario 1, Treasury forecasts in the best-case scenario unemployment rates of at least 9.5% without the fiscal stimulus proposed in scenarios 1a.

Introduction: scope, purpose, approach, limitations and definitions

The purpose of this rapid evidence review is to answer three questions (where the evidence allows). These focus on identifying, from the national and international evidence:

(1) what are the likely **immediate** and core social and psychosocial impacts of the COVID-19 crisis for the Aotearoa New Zealand population during the initial lockdown period (Alert Level 4) of 32 days, and mitigations to these impacts?

(2) what are the likely **medium term** social and psychosocial consequences of the crisis for the Aotearoa New Zealand population?

(3) what **mitigation responses could** reduce anticipated adverse social and psychosocial impacts for the Aotearoa New Zealand population, whānau and communities?

Approach: an inductive approach was taken to identify immediate impacts and affected population groups from a literature review and then impacts were categorised into key impact domains. The medium term social and psychosocial impacts have been identified as those influenced by i) the immediate impacts caused by disease containment measures and, ii) the social and economic conditions under which Aotearoa New Zealand will be operating for the next 12 months (to April 2021). Higher risk⁶ population groups were identified from the literature.

Limitations: the inductive approach taken for Part 1 of this evidence review has the limitation of potential publication bias. Another limitation of any rapid evidence review is that it is produced in a short amount of time. In this 'rapid' review it has not been feasible to appraise the quality of studies cited, although the authors have drawn on meta-reviews rather than individual studies where possible. Time constraints have also meant it has not been possible to detail every population group affected by every impact, and decisions to prioritise some populations groups have been made. Finally, the COVID-19 crisis in Aotearoa New Zealand is a situation evolving in real time. Where possible, data on the current or 'baseline' situation in Aotearoa New Zealand has been provided to help contextualise the findings of published literature.

Scope: the scope of this review is limited to the social and psychosocial impacts of COVID-19 in Aotearoa / New Zealand. Whilst interrelated, impacts on health and the health system, and the economy and criminal justice, are outside the scope of this review.

Definitions

Quarantine: refers to where a person is physically 'isolated' or 'quarantined', because they either have the infectious disease or have been exposed to it, to prevent infecting others (refer to Brooks et al, 2020). The restrictions on people's freedoms and activity is

⁶ *Higher risk* is defined, for purposes of this review, as those at higher risk of adverse social and psychosocial impacts of COVID-19 due to pre-existing physical and mental health conditions, disability, age, socio-economic disadvantage and structural and systemic inequalities.

greater in 'quarantine' situations than the restrictions experienced by the general population under Level 4 'lockdown' in Aotearoa New Zealand.

Self-isolation: refers to the situation where people in Aotearoa New Zealand were asked to 'quarantine' themselves at home.

Lockdown: refers to the restrictions that are required under Aotearoa New Zealand's COVID 19 Alert level 4 – 'Level 4: Lockdown'.⁷

Approach to medium-term impacts

In each section of this review the immediate-term impacts are followed by consideration of potential medium-term impacts.

Medium-term impacts are likely to be an extension or exacerbation of immediate-term impacts depending on the New Zealand population's exposure to social restrictions or an economic downturn. People who continue to be physically and socially disconnected from others due to pre-existing disadvantages, who become unemployed or lose businesses, and/or who experience material hardship, are likely to be negatively affected the most.

The scale of medium-term impacts is dependent partially on the length of time Aotearoa New Zealand stays in each of the four Alert levels.⁸

Assuming New Zealand transitions from Level 4 to Level 2 over a month (without the need to return to Level 4),⁹ then we would expect to see a reduction in the proportion of the population who experience social disconnection, isolation and/or crowding due to the COVID-19 crisis.

At Levels 3 and then 2, although restrictions on activity remain, many people can return to daily activities outside the household including work, education, recreation, and hobbies in the community. For those able to continue or return to their employment/businesses, (although their daily activities are modified compared with pre-COVID-19 activity), the impacts are not likely to substantially undermine their wellbeing in the medium-term.

However, this will not be the case for everyone, including:

- Higher risk populations who are at risk of severe illness should they contract COVID-19. They are likely to continue physical distancing and household isolation – thereby reducing their participation in daily activities and continuing their risk of negative impacts from their disconnection/isolation.
- People whose income has substantially reduced as a result of the crisis and are struggling financially and/or who are now experiencing material and /or psychological hardship.

⁷ <https://covid19.govt.nz/alert-system/covid-19-alert-system/#level-4-lockdown>

⁸ The country was in 'Level 4: Lockdown' for approximately five weeks and transitioned to 'Level 3: Restrict' on 28th April. If the shift to Level 3 is successful, then in an unknown period of time, New Zealand will shift to Level 2: Reduce' and then 'Alert Level 1: Prepare'. <https://covid19.govt.nz/assets/resources/tables/COVID-19-alert-levels-detailed.pdf>

⁹ This is akin to Scenario 1 in Treasury Report: *Economic scenarios* released on 14 April 2020. <https://treasury.govt.nz/information-and-services/new-zealand-economy/covid-19-economicresponse/information-releases>. The best-case scenario.

- People who have lost their employment¹⁰ or businesses altogether (and do not have immediately available alternatives) may be experiencing the emotional loss of their livelihoods and financial / material hardship and status degradation.
- Children in households where financial and inter-personal resources have been diminished or strained as a result of COVID-19, exposing them to potentially stressful developmental environments such as material hardship and/or increased family conflict/abuse/violence.
- Adults in households where financial and inter-personal resources have been diminished or strained as a result of COVID-19, exposing them to material hardship and/or conflict, abuse or violence in their relationships.

Within these groups, some may be more susceptible to longer-term consequences. These include young people whose intended educational or employment trajectories have been disrupted, children whose development has been affected by household poverty, and adults and children who may be subject to abuse and violence.

Social and psycho-social impacts of COVID-19

The range of likely immediate social and psychosocial impacts identified from the literature have been grouped into four domains:

- Social disconnection, isolation and crowding
- Mental health and wellbeing
- Family violence and domestic violence
- Child wellbeing, child development and child protection

However, it is important to note that impacts are linked and will likely have synergistic or additive effects.

Both the immediate and medium-term impacts of COVID-19 will be particularly severe for population groups already experiencing disadvantage and risks compounding existing socio-economic divides (OECD, 2020). Each impact section attempts to briefly identify population groups that may be at higher risk of adverse social and psychosocial impacts of COVID-19. A fuller breakdown of impacts by higher-risk population groups, as well as consideration of strengths and resilience, starts on p.48. Issues of inequity and marginalisation need to be considered in response planning, risk communication and community engagement strategies.¹¹

Before considering the social and psychosocial impacts within the four domain headings listed above, the evidence review first considers the impacts on Māori as well as Māori strengths and resilience.

¹⁰ In scenario 1, Treasury forecasts in the best-case scenario unemployment rates of at least 9.5% without the fiscal stimulus proposed in scenarios 1a.

¹¹ Useful guide by RCCE: COVID-19` [How to include marginalized and vulnerable people in risk communication and community engagement](#)

Māori and COVID-19

The Crown's obligations to protect Māori rights are derived from *Te Tiriti o Waitangi* and a number of international instruments for the protection of indigenous human rights (Durie, 2011). The COVID-19 pandemic is expected to have disproportionately negative impacts on Māori, and particular sub-groups of Māori, who already face multiple concurrent disadvantages^{12,13}. The psychosocial impacts arising from public health measures such as self-isolation and social distancing may also be disproportionate for Māori (Ministry of Social Development, 2016)(Lambert, 2013). There is widespread concern a one-size-fits-all response to the pandemic will serve to exacerbate persistent health and socio-economic inequities for Māori¹⁴.

Te Rōpū Whakakaupapa Urutā, a newly formed national pandemic group of Māori medical and public health experts, has called for a response based on the mātauranga Māori principles of **Mana Motuhake** (enabling Māori to make and enact decisions within whānau, hapū, iwi); **Mana Taurite** (addressing the underlying drivers of inequity) and **Mana Whakaora** (strengthening capacity for long-term, collective wellbeing)¹⁵. The Ministry of Health's Initial COVID-19 Māori Response Action Plan (April, 2020) is also grounded in mātauranga Māori concepts of **Mana Motuhake** (supporting iwi, hapū, whānau and Māori organisations to respond directly to the increasing health needs of their people); **Mana Māori** (enabling mātauranga Māori service designs); **Mana Tangata** (prioritising equity in service planning and delivery nationally) and **Mana Whakahaere** (responses that contribute to the Crown's obligations under *Te Tiriti o Waitangi*).

In signalling the relevance of mātauranga Māori responses to the COVID-19 pandemic, Māori health experts have drawn on research that considers the mediators of psychosocial impacts for Māori during civil defence emergencies, evolving theory on the determinants of indigenous resilience, and scholarly discourse on the enablers of Māori transformation.

Mātauranga Māori as a mediator of psychosocial impacts

Emergency management is vital in civil defence operations that seek community recovery and long-term resilience (Mooney et al 2011). In Aotearoa New Zealand, the effectiveness of immediate, post-disaster risk mitigation strategies is impacted by tensions that arise from confusing communications, civil servants gatekeeping information and resources, culturally insensitive leadership styles, disregard for local knowledge, and little investment in relationship-building with whānau, hapū, iwi who have **mana whenua** (Hudson & Hughes 2004; Hartnell 2012; Lambert & Mark-Shadbolt 2012; Thornley et al 2015, Kenney et al 2015). Lessons learned from Ngāi Tahu engagement in emergency management and recovery during the Christchurch earthquakes include the capacity of mātauranga Māori to improve emergency

¹² Ministry of Health (2018) Health and Independence Report. Ministry of Health.

¹³ Hobbs, M., Ahuriri-Driscoll, A., Marek, L., Campbell, M., Tomintz, M. & S. Kinghorn (2019) Reducing Health Inequity for Māori People in New Zealand. *The Lancet*. Volume 394, Issue 10209, P1613-1614

¹⁴ Te Rōpū Whakakaupapa Urutā (2020,13 April) COVID-19 Position Statement. Retrieved from <https://www.uruta.maori.nz/research-and-evidence> on 22 April 2020.

¹⁵ *ibid*.

management, and the theoretical underpinnings of mātauranga Māori as a mediator of individual and collective resilience.

The literature shows Ngāi Tahu was enabled to take a leadership role and the operationalisation of **mana motuhake** was a catalyst for more effective collaboration across agencies involved in establishing emergency infrastructure. This led to the mobilisation of inter-tribal networks that enabled better logistical co-ordination of social and material resources, identification of needs, dissemination of information, distribution of supplies and relocation of families, agencies, banks and community organisations (Lambert 2013, Kenney & Phibbs 2015). The Ngāi Tahu approach to emergency management was shaped by the concepts of **mātauranga Māori, kaupapa** and **tikanga**.

In collaboration with Ngāi Tahu, several theoretical models have been used to explore how traditional cultural practices can be adapted and applied to manage disaster-related risks, mitigate social impacts, and facilitate collective recovery (Kenney & Phipps 2015; Kenney, Phipps, Paton et al 2015).

This work has demonstrated that traditional cultural practices, or cultural technologies, can strengthen resilience through a range of psychosocial mediators such as self-efficacy, social connectedness, confidence, safety, inclusion, social cohesion, empowerment, trust, reciprocity and collective preparedness. Māori knowledge, values and cultural practices provide a scaffolding of inter-related actants that can shape behavioural and cognitive responses that facilitate coping, recovery and wellbeing. As an example, the operationalisation of mana motuhake enabled Ngāi Tahu to normalise traditional cultural practices which led to earthquake survivors, both Māori and non-Māori, being exposed to a range of cultural technologies for mitigating risk, such as aroha nui ki te tangata, kotahitanga, whanaungatanga, marae, manaakitanga and kaitiakitanga. In addition, Ngāi Tahu having the capacity and opportunity to express mana motuhake is essential for intergenerational transmission of cultural technologies and an important mechanism, therefore, for the long-term survival of whānau, hapū, iwi.

The value of incorporating indigenous knowledge in disaster management strategies has been recognized in the United Nation's latest global blueprint for reducing risks and building the resilience of nations and communities¹⁶. A recent study has shown around 190 iwi management plans (IMPS) have been lodged with local authorities throughout Aotearoa New Zealand but few have been adopted or acknowledged in any meaningful way by local and regional authorities or Civil Defence Emergency Management (CDEM) (Saunders, 2018).

Mediators of Indigenous resilience

Indigenous resilience is an alternative perspective to definitions that centre on indigenous disadvantage and individual capacity to overcome trauma or risk (Durie 2011). Indigenous resilience is re-configured as a search for success and centres on the collective capacity of families, whānau, hapū, iwi, communities and entire populations to

¹⁶ UN/ISDR (2007). *Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters. Extract from the final report of the World Conference on Disaster Reduction (A/CONF.206/6)*. United Nations, International Strategy for Disaster Reduction. Geneva. Retrieved from https://www.unisdr.org/files/1037_hyogoframeworkforactionenglish.pdf on 28 April 2020.

turn adversities into accomplishments. Although it is superimposed on historic trauma, Durie (2011) suggests indigenous success is broadly underpinned by two capacities:

- capacity to engage indigenous culture, networks and resources as well as global societies and communities – the two worlds in which indigenous people live and work
- capacity for autonomy and self-management – this is dependent on capacity for governance and management and is less likely when indigenous futures are premised on the aspirations of others.

Community resilience is key to effective disaster management and recovery. Thorndon and colleagues (2015) have identified the factors which fostered community resilience in communities that were impacted by the Christchurch earthquakes. Recovery from this disaster was more likely in Māori communities that were:

- bonded by whakapapa, whenua and whanaungatanga and have pre-existing infrastructure for collective action based on Māori values and worldviews such as mana whenua, marae, tribal organisations and trusted local leaders
- believe they have the power to influence decisions and actively engage in decision-making
- have survival skills and capacity for self-organisation, creative problem-solving and improvisation
- have relationships with central and local government agencies including Civil Defence as well as opportunities for funding, practical support and advocacy
- feel their knowledge, wisdom and priorities are acknowledged and respected.

In comparison, recovery was less likely in communities that were fragmented by conflict, divisions and powerlessness and had limited capacity for collective action due to material hardship and stressors. Key strategies for strengthening resilience in Māori communities include enabling the capacity for mana motuhake (collective decision-making, problem-solving and action), supporting the development of infrastructure, strengthening cultural identity, connectedness and capacity for self-development alongside greater devolution of powers and policies to reduce inequity.

An emerging body of evidence supports the 'Culture as Cure' hypothesis in which a strong Māori identity is a moderator of psychological distress and collective resilience. Empirical studies have identified the buffering effect of cultural efficacy and shown that capacity to navigate the Māori world can protect against the impacts of psychological distress (Muriwai, Houkamau & Sibley, 2015). The buffering effect may also be more pronounced among people who identify solely as Māori, compared with mixed Māori-European ethnicity (Muriwai et al, 2015).

Collective capacity to mobilize resources that support employment, income generation, education, health and social connectedness in sole-parent families have also been associated with the value that is placed on Māori cultural practices, such as manaakitanga, aroha and whanaungatanga (Waldegrave et al, 2016).

A strong positive Māori cultural identity is also known to mitigate the impacts of whānau violence for tamariki and rangatahi (Walters & Seymour, 2017). This study has highlighted the importance of interventions that are based on Māori cultural principles, provided by culturally competent practitioners and aim to strengthen collective whānau resilience.

Boulton & Gifford (2011) have questioned the value of continuing to use the notion of *resilience* to frame Māori experience alongside homegrown indigenous concepts like Whānau Ora that are grounded within a Māori worldview and aligned with Māori practice models embedded within existing health and social services. Their preliminary studies suggest the Whānau Ora practice model is strengthening the collective, indigenous resilience of Māori whānau, hapū, iwi.

Enablers of Māori transformation

Tā Mason Durie has been championing a transformational approach to Māori development for many years. Notwithstanding continuing inequalities between Māori and non-Māori, Durie has highlighted the gains and limitations of advancements achieved in recent decades, and the following additional transformations that are needed to sustain capability and build resilience for Māori until 2025 and beyond (Durie, 2005):

- extending the emphasis on access and participation in **education** to high achievement and quality outcomes
- strengthening **whānau resilience and capacities** to care for each other, create whānau wealth and engage in whānau planning, intergenerational transfer of knowledge and skills and the wise management of whānau estates
- developing **collaborations and clustered networks between Māori organisations** so that economies of scale can be realised and the best use is made of resources
- building **strong governance and leadership capacity** with the skillsets to lead the Māori paradigm with a future orientation and outcomes focus.

The COVID Level 4 lockdown has forced a nationwide transformation of lifestyles, from the hustle and bustle of daily life to an almost overnight, standstill. Regardless of demographics, financial position, employment status and place of dwelling, whānau and communities everywhere have had to abandon their usual modus operandi, accept uncertainty, and embrace virtual technologies for prayer, communication, learning, socialisation, shopping and working.

Te Pae Tata, MSD's strategy and action plan for Māori, contains three guiding principles for responding to obligations under *Te Tiriti o Waitangi*: **Hoatanga Rangapū** (act reasonably, honourably and in good faith towards Māori), **Tiakitanga** (recognise and provide for Māori perspectives and values and take positive steps to ensure Māori interests are protected) and **Whakaurunga** (enable and support Māori to actively participate in all matters that increase wellbeing). Beneath these principles, Te Pae Tata presents three areas of focus during 2019-2022: **Mana Manaaki** (earn the respect and trust of Māori), **Kōtahitanga** (genuine partnerships for greater impact) and **Kia Takatū Tātou** (to support Māori aspirations and long-term socio-economic development). Alongside All-of-Government actions to eliminate persistent health and social inequities, this discussion of the evidence on psychosocial impacts for Māori has identified a range of immediate, medium and long-term actions that could be aligned with Te Pae Tata focus areas to inform a work programme that fosters Māori recovery and transformation.

Principles	immediate	medium	long-term
Mana Manaaki earn the trust and respect of Māori	relationship building with marae, local, and community based organisations	disaster management plans are located in Māori worldviews	strong cultural identity
Kōtahitanga genuine partnerships with Māori for greater impact	establish workforce & capability canvass opportunities & aspirations, challenges & needs	understanding of cultural technologies iwi disaster management plans are integrated in local/regional/CDEM	autonomy and self-management conflict resolution empowerment
Kia Takatū Tātou supporting Māori aspirations and long term socio-economic development	blue-skies scoping of strategies to address hardship, housing and inequity	infrastructure for collective action, empowerment and development relationships with local authorities, funders & CDEM	

The Crown’s responsibility for resourcing as well as supporting Māori innovation

In celebrating ‘innovation’ and solutions achieved by Māori providers, there is a need to ensure Māori organisations/iwi/hapū are protected from further inequity. As the Te Rōpū Whakakaupapa Urutā Position Statement outlined, there’s been a huge expectation for Māori providers to provide ‘innovative solutions’ (which often translates into finding solutions to crisis and problems beyond the capability of government, and without extra financial resources), which subsequently relegates responsibility to Māori away from mainstream (or non-Māori) services. It is critical that Māori are provided with resource for the sharing of ideas and knowledge, and for taking government accountability into their own hands. Without such acknowledgement and resourcing, there is a risk of overworking frontline workers and Māori whānau who are pivotal in caring for the psychosocial needs of their communities.

SOCIAL DISCONNECTION, ISOLATION AND CROWDING

Social disconnection, isolation and crowding are likely to increase the risk of negative social and psychosocial impacts

COVID-19 Levels 4 and 3 has meant that the population of Aotearoa New Zealand has been asked to stay home and keep within small restricted social groups based on their household. Opportunities for social interactions are radically reduced. Work places, educational institutions, recreational groups and activities, community spaces, sports groups, churches, and other community groups have been closed or discontinued. For some, COVID-19 restrictions may also have led to more people living in the same household.

Changes in usual activities and living arrangements may mean that New Zealanders are experiencing social disconnection, isolation and loneliness on one hand while some may also be living in crowded housing arrangements. Literature indicates that people with these experiences are at higher risk of negative consequences for their physical and mental health, and social relationships. Disconnected and/or crowded households may mean children's developmental outcomes may be adversely affected due to living in stressful environments for extended periods of time. This may mean there is a reduced ability to maintain safe social spaces for children, family or whānau members at risk of family violence or other forms of social harm.

For those in quarantine

Specific disease containment measures such as quarantine can be traumatising.

Literature indicates that disease-containment measures such as quarantine and isolation can be traumatising to a significant portion of children and parents who experience it. For example, a study of 398 parents experiencing quarantine, showed the criteria for PTSD was met in 30% of isolated or quarantined children based on parental reports, and 25% of quarantined or isolated parents (based on self-reports) (Sprang & Silman, 2013b).

Brooks et al., (2020) reviewed studies on the psychological impact of quarantine. Most reviewed studies reported negative psychological effects including post-traumatic stress symptoms, emotional disturbance, depression, stress, difficulty sleeping, low mood, irritability, confusion, and anger. Several studies indicate that the psychological effects of quarantine can continue for several years. PTSD symptoms were apparent in some people after three years (Brooks et al.,2020).

Stressors that increase the likelihood of negative psychological effects include longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, and inadequate information. Post quarantine stressors include financial loss and stigma.

Some population groups are more likely to suffer the negative impacts of quarantine more than others. Existing vulnerabilities are intensified under these conditions. Māori are one of the population groups that already suffer greater levels of PTSD (Hirini et al., 2005; Wirihana & Smith, 2014). People with existing mental health conditions may experience greater stress through social isolation¹⁷ and are likely to have treatment for their conditions and management of recovery complicated under quarantine (Huremović, 2019).

Some studies suggested that **health workers in quarantine experienced greater impacts** (Brooks et al.,2020). For example, after being quarantined, in one study health workers were significantly more likely to report exhaustion, detachment from others, anxiety when dealing with febrile patients, irritability, insomnia, poor concentration and indecisiveness, deteriorating work performance, and reluctance to work or consideration of resignation. Another study indicated health-care workers also felt greater stigmatisation than the general public, exhibited more avoidance behaviours after quarantine, reported greater lost income, and were consistently more affected

¹⁷ <https://www.psychologytoday.com/us/blog/talking-about-health/202003/mental-health-in-time-pandemic>

psychologically: reporting substantially more anger, annoyance, fear, frustration, guilt, helplessness, isolation, loneliness, nervousness, sadness, worry, and feeling less happy.

For the general population in lockdown and those in quarantine

The effectiveness of social support may reduce over time, increasing risk.

Culturally appropriate social support is key to recovery from disasters (Mooney et al., 2011). Negative life events can erode functional characteristics of external social support, even when the structure of that support remains relatively intact. Within isolated and confined environments, everyone is experiencing the same stressors and resources necessary to provide support are stretched, albeit people respond to the same stressors very differently, shaped by experience, personality and previous responses to stress (Schneiderman et al., 2005). Even when not everyone experiences the same stressor or when resources are not taxed, satisfaction with support from family and friends also declines under conditions of isolation and confinement (Palinkas, Johnson, & Boster, 2004).

There are evidenced links between cultural identity and mental wellbeing,

particularly for Māori (Health Promotion Agency, 2018; Williams et al., 2018). The inability to carry out cultural practices or religious practices during social isolation – e.g. tangihanga – may negatively impact individual and collective mental wellbeing. To date however, cultural and religious groups, including Māori, have been very proactive in adapting to the circumstances (see p.42 for discussion of Māori and COVID-19).

Loneliness, which is likely to increase across the general population, influences a wide range of physical and mental health outcomes.

Objective isolation (relating to the *quantity* of social interactions) and perceived isolation (more closely relating to the *quality* of social interactions and often referred to as loneliness) both increase the risk of a range of negative effects. Perceived isolation (loneliness) predicts various outcomes beyond what is predicted by objective isolation (Cacioppo et al., 2011). With physical distancing, being on lockdown, and relying increasingly on technology to connect with others, there is a risk that loneliness will increase along with social isolation.

During lockdown most forms of interaction take place via the internet, with many services directing people away from human contact. According to New Zealand's 2018 census, at least 211,700 (21%) households (up to around 600,00 people, did not have access to internet.¹⁸ These households were predominantly Māori and Pacific, disabled people and those experiencing poverty. The effects of job loss and unemployment due to COVID-19 may mean people cannot retain the internet due to the connection costs.

Loneliness influences a wide range of emotional and cognitive processes and outcomes including increasing depressive symptoms, perceived stress, fear of negative evaluation, anxiety, anger, and diminishing optimism and self-esteem. It has also been associated with personality disorders and psychoses; suicide; impaired cognitive performance and cognitive decline over time; increased risk of Alzheimer's Disease; and diminished executive control (Hawkely & Cacioppo, 2020). The authors note that: "*One of the consequences of loneliness... is a diminished capacity for self-regulation. The*

¹⁸ <https://www.stats.govt.nz/2018-census/>

ability to regulate one's thoughts, feelings, and behaviour is critical to accomplish personal goals or to comply with social norms. Feeling socially isolated impairs the capacity to self-regulate, and these effects are so automatic as to seem outside of awareness." (Hawkely & Cacioppo, 2020).

A recent study affirmed the link between social disconnection, perceived isolation and depression and anxiety disorders in older adults (57-85 years) at (Santini et al., 2020).

Harris & Orth's (2019) recent review indicates that social relationships play a key role in shaping an individual's self-esteem. Social relationships and levels of self-esteem have a reciprocal relationship across the life span, reflecting a positive feedback loop. In addition, the interconnectivity of individuals and organisations contributes to the resilience of a community (Chandra et al., 2010).

Recent surveys indicate in the short-term people are reporting increased feelings of loneliness or depression/anxiety since before COVID¹⁹

Nearly a third of respondents reported an increase in feelings of depression/anxiety/sense of hopelessness (32%) or loneliness (29%) although 7% and 10% reported a decrease, respectively. Although all groups were affected, the reporting of increases in negative feelings was higher for younger women. Similarly, younger women and women with young children also reported increases in feelings of loneliness.

The risk of negative impacts from social disconnection, loneliness and household stress will reduce for many in the medium term – but not for all groups

Assuming Aotearoa New Zealand shifts to Alert Level 2 promptly after shifting to Level 3, many people will return to daily activities outside the household, (including work, education, recreation, and hobbies in the community), although some restrictions on activity remain. For many of those able to continue or return to employment/businesses, any negative impacts they experienced from social disconnection and loneliness under Alert Level 4 are likely to be ameliorated by their reconnection with social groups. However, this will not be the case for several groups of people in Aotearoa New Zealand.

Higher risk population groups, such as those with health conditions, with disabilities and/or in older age groups are likely to have to continue physical distancing and household isolation as they are at greater risk of severe health consequences from contracting COVID-19. These groups may continue to have reduced participation in a range of social activities, thereby maintaining their disconnection/isolation and risk of negative impacts across psychological, cognitive, self-regulation and physical life domains as described above (Evans et al., 2019; Hämmig, 2019; Hawkley & Cacioppo, 2010; Holt-Lunstad, 2017). Without efforts to reduce this isolation, feelings of disconnection and loneliness may be felt more acutely by these groups compared to those that are more able to physically reconnect with their social networks.

Another group at risk of continuing social disconnection and loneliness may be those who have recently **lost their jobs or businesses** (Pohlan, 2019). Pohlan (2019) concludes from her longitudinal study that "*job loss has particularly detrimental effects on the subjective perception of social integration, life satisfaction, access to economic resources*

¹⁹ Colmar Brunton (15 April 2020), Colmar Brunton Covid Times: Bubble Behaviours.

and an individual's mental health The effects of job loss are long lasting, grow more profound the longer the duration of unemployment and persist following reemployment." Job insecurity and job degradation also impacts on the sense of personal control and autonomy (Glavin, 2013), and this sense of loss of personal autonomy has a strong gendered response (Enarson, 2000).

Job loss may also lead to poverty, which has been found to negatively affect social life (Mood & Jonsson, 2016). They found poverty had more harmful effects for relations with friends and relatives than for social support; and more for political participation than organisational activity. Poverty measured by material deprivation appeared to have a greater influence on social outcomes compared with poverty measured by absolute or relative income. **Children in households experiencing poverty** are at increased risk of a range of negative life course outcomes.²⁰

Young adults may have been disconnected from anticipated education, training and employment opportunities. Although benefit recipients have increased across all groups, recent benefit recipients are more likely to be younger (in their 20s), non-Māori, have little or no recent benefit history, and have higher amounts of lost weekly income compared with recent benefit recipients in a similar period in 2019.²¹

Household crowding creates a range of social and psychosocial risks

In lockdown, people are in close social proximity (in household "bubbles") with the same people for long periods of time. Some of these households, using objective measures, may be crowded, or perceived as crowded. A range of literature links crowding, and particularly the perception of crowding, with higher risk of negative outcomes.

A range of studies found that crowding is associated with poor mental health, feeling physically and psychologically drained, having poor relationships in the home (both adult relationships and parent-child relationships), less responsive parenting and poorer child care, and child behavioural problems (Solari & Mare, 2012; Gove and Hughes 1983). The effect of crowding on mental health, social relationships and physical health was largely **related to the experience of excessive demands and lack of privacy** (Gove and Hughes, 1983).

Studies also indicate a range of negative effects for children and parents, including children's academic achievement and external behaviour problems (Solari & Mare, 2012). One study (in Bangkok) showed that household crowding increased marital instability and arguments, and parent-child tensions (Fuller et al., 1993). The relationship between crowding and children's behavioural problems is partially mediated by greater maternal stress, less sleep, and strained parent-child interactions (Marsh et al., 2019).

²⁰ <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/information-releases/weag-report-release/rapid-evidence-review-the-impact-of-poverty-on-life-course-outcomes-for-children-and-the-likely-effect-of-increasing-the-adequacy-of-welfare-benef.pdf>

²¹ Unpublished analysis by MSD April 2020, 'The shifting composition of Jobseeker work-ready grants during lockdown'.

There are factors that increase or decrease the likelihood of negative effects from crowding

Gove and Hughes (1983) found that **responses to crowding varied across cultures** in their USA sample, depending whether people were part of high-contact cultures or not. Similar findings are reported in New Zealand: perceptions and tolerance of crowding vary across cultures depending on cultural use and meaning of space (Gray, 2001). Gove and Hughes surmised that culture appears to play a role in regulating the levels of privacy and demands experienced and reactions to them, but some cultures appear to be more concerned with privacy while others more concerned with demands. Ability to regulate privacy and intrusion demands varies within household. Those in power within households are better able to regulate by use of space, parents of children may have less ability to privacy and intrusion from children, and “anonymously situated adults” who do not have clear roles within a household are less able to regulate.

The **effects of household crowding are increased when the neighbourhood is perceived as undesirable** but decreased when the neighbourhood is perceived as desirable. Similarly, Gómez-Jacinto & Hombrados-Mendieta (2002) found in their small study based in Spain, the effect of household crowding on psychological distress was increased when both household and residential crowding is high although there was a mild moderation effect from social support.

Some population groups are more likely to suffer the negative impacts of crowding more than others

New Zealanders who are poor are more likely to be living in crowded households. A 2018 report from Stats NZ found that people in crowded households were more likely to experience lower well-being on measures such as life satisfaction and material well-being; were significantly more likely to say they did not have enough money for everyday needs; were more likely to have postponed visits to the doctor because of costs; and were more likely to report housing problems (Stats NZ, 2019).

Stats NZ data from the 2013 Census on showed that crowding is highest for Pacific people (39.8 percent), followed by Māori (20.0 percent) and NZ’s Asian population (18.4 percent). People of Māori or Asian ethnicity were four times more likely to live in crowded homes than people of European ethnicity. Pacific people were around eight times more likely to be living in a crowded house (Stats NZ, 2019).

Literature suggests that while perceptions of overcrowding vary among Pacific peoples, depending on the indicator used, crowding is a serious concern (Schluter, P., Carter, S., & Kokaua, J., 2007). Proximity and concentration of deprivation and lack of opportunity can have an exponential effect (Salesa, 2017). Among Pacific peoples, there is an association between the prevalence of certain infectious diseases and crowding, between crowding and poor educational attainment, and between residential crowding and psychological distress (Ministry of Social Development, 2016; Statistics New Zealand and Ministry of Pacific Island Affairs, 2011).

Mitigations against social disconnection, isolation and crowding

Mitigations against social and psychological consequences of quarantine containment for people who have been quarantined

Huremović (2019) notes the importance of measures to reduce perceived isolation and to address uncertainties that may give rise to anxiety and despair, and the importance of specific measures for people with existing mental health conditions where these conditions are exacerbated by quarantine containment.

Brooks et al., (2020) suggest a range of strategies to mitigate the consequences of quarantine containment:

- Officials should quarantine people for no longer than required, and ensure personal liberty and agency are protected.
- Ensure essential supplies such as food and medicines are provided, and consider financial loss associated with quarantine.
- Consider strategies to address effects of stigmatisation (additional strategies are needed for increased risk of negative effects for health and support workers who are quarantined including perceived stigmatisation)
- Use clear lines of communication and messaging for both those in quarantine and the wider public:
 - provide clear rationale for quarantine and information about protocols.
 - Appeals to altruism by reminding the public about the benefits of quarantine to wider society can be favourable.
 - Within a Māori setting, drawing on the needs of the collective and on the concept of Mannaakitanga is likely to resonate more strongly; build on existing 'Protect our whakapapa' messaging.

Mitigations against social and psychological consequence of social isolation and being in household 'bubbles' leading to disconnection, loneliness or crowding situations for the general public in lockdown and for those isolated in the medium term due to being at risk of severe illness from contracting COVID-19.

Employ/share/reinforce messaging around strategies to increase social coherence within household "bubbles" - inference from study by Palinkas, (2003) and help empower people to cope with life in isolation (Smith and Barrett , 2020) by:

- being aware that adaptation takes time.
- establishing a routine to facilitate a sense of control.
- dealing with threat, danger and uncertainty by thinking about the positives and reflecting on actual risks, to provide perspective.
- dealing with monotony and boredom through a variety of pursuits and entertainment, including physical exercise.
- addressing low mood and motivation by acknowledging progress and focusing on and celebrating small achievements with a support network.

- dealing with the paradox of social proximity and separation by being tolerant of others and being tolerable oneself. Identifying an area of personal space, developing norms, ground rules, and managing expectations.
- using messaging and video calling platforms to maintain social connections, while also managing this over time to ensure effects are beneficial rather than negative – agreed content, call times etc.

The World Health Organisation also details a range of messages for different population groups to help address the psychosocial stress engendered by the COVID-19 crisis and responses to it.²²

Mitigations against loneliness among adults across a range of higher risk groups in the short and medium terms

- Increase the availability and awareness of online support, individual peer mentoring, and group psychosocial support interventions (Bessaha 2020).
- Group strategies can increase the number of social contacts, increase a sense of belonging, or mediate stress responses, and decrease loneliness.
- Individual strategies may allow for greater adaptability of interventions and decrease loneliness
- Use of technology in interventions targeting loneliness (e.g., online adaptation of a friendship enrichment program, virtual self-help group) may be valuable. Computer-delivered interventions may also improve feelings of social support, self-efficacy, and the ability to self-manage and adapt. However, computer-delivered interventions may also miss some of the most socially excluded groups due to inequity in internet and device access.
- Draw on examples of community led, cultural responses. For example, geographically isolated Māori communities have met the challenges of loneliness and isolation in collective, largely marae based, actions.

Mitigations against the effects of crowding

Reducing overcrowding in New Zealand requires long-term high level change to ensure the provision of quality affordable housing, including increasing the availability of social housing stock, and measures to ensure tenants are able to maintain tenancies. It is hard to address the social and psychosocial *effects* of overcrowding unless the root cause, i.e. the overcrowding itself, is addressed. There is a very little literature on strategies to mitigate to social and psychosocial effects of overcrowding, but strategies to mitigate against the effects of overcrowding during lockdown are likely to include:

- Access to remote psychological support
- Increased housing options and accommodation supports
- Strategies to reduce perceived excessive demand and lack of privacy.
- Culturally informed strategies that draw on community knowledge and expertise.

²² <https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf>

MENTAL HEALTH AND WELLBEING

There are likely to be negative impacts on mental wellbeing associated with COVID-19 and the predicted recession

Epidemics can negatively impact the mental health of the wider population as well as people with underlying mental health conditions

Mental distress and illness (including addiction) can be triggered by significant negative life shocks such as experiencing a disaster or pandemic,²³ job loss, trauma, relationship breakdowns, or the death of a loved one (especially if people cannot be with a dying loved one, if traditional funeral practices cannot be carried out, and family cannot come together): all possible and interrelated scenarios of COVID-19. Self-isolation, especially if prolonged, is likely contribute to poor mental health outcomes (Brooks et al., 2020b).

The pandemic increases the risk there will be a rise in the incidence of mental health conditions, especially anxiety, depression, PTSD²⁴ and substance use disorders (SUD). People may require more support or access to mental health treatment during this period.

People often under-react to familiar threats (e.g. flu) but novel, exotic threats such as Ebola or corona viruses can **increase anxiety in the wider population** – even when the actual risk of contracting it is low (Lu, 2015). Anxiety is contagious: it ‘rubs off’ on other people (Kerr & Bowen, 1988).²⁵ Research has found that people who are least able to tolerate uncertainty experience the most anxiety during a pandemic and are less likely to believe they could protect themselves (Taha et al., 2014). Others who are feeling anxious about the virus may over function (e.g. panic buy grocery items). The degree of anxiety a person feels may bear little relationship to their actual risk of contracting the virus. There is evidence that some of those with high levels of anxiety have a low risk of contracting the virus (Duan & Zhu, 2020; Miller et al., 1988; C. Wang et al., 2020).

COVID-19 could **increase the incidence of depression** due to increased environmental stress (e.g. isolation, social distancing, relationship stress, personal losses and extreme changes in daily life).²⁶

We are likely to see an increase in PTSD given that disasters can trigger PTSD. Given the scale of the COVID-19 epidemic it is likely some with PTSD will experience worse symptoms. PTSD can lead to depression, self-harm and suicide. As mentioned

²³ Experiencing a pandemic such as COVID-19 is inherently stressful. The mental health impact of the 2014-2016 Ebola epidemic had an impact on mental health outcomes in the general population of affected countries. Symptoms of PTSD and anxiety-depression were common after one year of Ebola response (Jalloh et al., 2018). Knowing someone quarantined for Ebola was independently associated with anxiety-depression. Perceiving Ebola as a threat was independently associated with anxiety-depression.

²⁴ Post-traumatic stress disorder (PTSD) is a psychological reaction to experiencing or witnessing a severely shocking event. This includes death or threatened death, actual or threatened serious injury, actual or threatened sexual violation.

²⁵ <https://www.anxiety.org/bowen-family-systems-theory-how-anxiety-spreads-affects-loved-ones>

²⁶ See *COVID-19 could lead to an epidemic of clinical depression, and the health care system isn't ready for that, either*. <https://theconversation.com/covid-19-could-lead-to-an-epidemic-of-clinical-depression-and-the-health-care-system-isnt-ready-for-that-either-134528>

previously there is also evidence linking quarantine with PTSD (Brooks et al., 2020). New cases of PTSD may emerge, especially among health workers responding to the pandemic, if the services become overwhelmed. Māori experience trauma in distinct ways – including historical trauma – that are linked to the experience of colonisation, racism and discrimination, negative stereotyping and subsequent unequal rates of violence, poverty and ill health (Pihama et al., 2018; Wirihana & Smith, 2014).

There may be an increase in **substance use disorders (SUDs)**. Problematic substance use is linked to the development of mental health problems. The more severe the problems with substance use, the greater the likelihood of co-existent mental disorder and increased suicide risk.²⁷ Stress and anxiety associated with the virus²⁸ may contribute to uptake of substances or relapse (Volkow, 2020). While it is maladaptive, substance use is a type of coping that is common following significant life shocks (e.g. loss of a family member, job loss, natural disaster). There may also be impacts of disrupted access to drugs for people who already use substances in a harmful way.

People with SUDs may be at greater risk of overdose if they consume new substances because their normal supplies are disrupted. People with SUDs may find it harder to access addiction treatment (e.g. methadone treatment, psychological therapies, support groups). Those in recovery will also be uniquely challenged by social distancing measures (e.g. psychological therapies, support groups).

With the closure of casinos and Class 4 gambling venues, and the cancellation of most sport, it is possible that there will be an **increase in harm from online gambling**. In particular this may be exacerbated by overseas-based websites or apps which do not have strong regulatory settings around spending limits or encourage help seeking, and which are heavily advertised through social media.²⁹

Frontline health workers may be at greater risk of developing mental health conditions. Studies show that front-line health care workers experience higher anxiety than the general community about contracting viruses during pandemics (Chua et al., 2004). Health workers responding to the pandemic may be at particular risk of developing depression. A meta-analysis of US military personnel who responded to the Ebola crisis found there was an increase in deployed service members returning with clinically significant problems, the most notable of which was depression (Vyas et al., 2016). Research emerging from other countries with COVID-19 suggests health workers are at increased risk of depression, anxiety and stress, burnout, PTSD, and isolation from family and other supports due to quarantine or contracting the disease (Chen et al., 2020; Kang et al., 2020). However, it is important to note that New Zealand has not yet

²⁷ Over half of youth suicides involve alcohol or illicit drug exposure. In NZ over 70% of people who attend addiction services have co-existing mental health conditions, and over 50% of mental health service users are estimated to have co-existing substance abuse problems (Government Inquiry into Mental Health and Addiction, 2018).

²⁸ People with SUD may have increased anxiety as they are likely to be more at risk of contracting the virus and suffering worse outcomes.

²⁹ Anecdotal evidence indicates that there may be an increase in online gambling:

<https://www.dw.com/en/coronavirus-and-online-betting-a-perfect-storm-for-gambling-addicts/a-53094333><https://www.bbc.com/news/uk-england-leeds-52212822>

Coronavirus: gambling firms urged to impose betting cap of £50 a day:

<https://www.theguardian.com/sport/2020/mar/22/coronavirus-gambling-firms-urged-to-impose-betting-cap-of-50-a-day>

experienced the same high levels of case numbers (and therefore necessary medical intervention) as the countries in the research cited above.

Poor and disrupted access to mental health care and addiction treatment may worsen mental health outcomes. People may experience delays in accessing treatment. Any increase in the incidence of depression and anxiety associated with COVID-19 is likely to place greater strain on already stretched mental health and addiction services. The Government *Inquiry into Mental Health and Addiction* and the OECD report on mental health and work reported that access to mental health services was inadequate, especially for people with common mental health problems such as depression and anxiety (*Government Inquiry into Mental Health and Addiction*, 2018; OECD, 2018). This report also made mention of the inadequacy of services for Māori and Pacific.

For those receiving treatment (e.g. face to face talking therapies) there may be disruptions to this treatment associated with self-isolation measures. Following the 2011 Japanese earthquake and tsunami the disruption of psychiatry care was associated with persistent adverse impacts on mental health amongst older people surveyed (Tsuboya et al., 2016).

There is considerable evidence that job loss can lead to poor mental health

COVID-19 is leading to job loss. Given the centrality of employment in people's lives³⁰ job loss is likely to increase the incidence of a range of mental health conditions, especially common mental health disorders (e.g. depression and anxiety) and SUDs. Unemployment and transitions into worklessness are associated with increased morbidity and mortality, worse self-rated health and reduced social activity and social support. This body of evidence is well established and includes systematic reviews and robust meta-analyses, although the direction of causality may still be contested (Curnock et al., 2016). The fear and insecurity generated by the anticipation of unemployment during a recession can also increase mental distress (Stroka, 2016).

Whilst both men and women suffer from loss of work, **there may be a gendered psychological response** (L. Jimenez & Walkerdine, 2011; Mooi-reci & Mills, 2012).

Some groups of men, for example older men in working class male dominated jobs, have a particularly hard time adjusting to worklessness and no longer being a breadwinner. They are also reluctant to take up jobs that don't fit with their role identity.³¹ There is significant research on those with managerial positions losing their jobs and the associated status degradation (Eby & Buch, 1994; Letkemann, 2002; McArdle et al., 2007; Schöb, 2013).

Youth entering the labour market during economic downturn, especially youth who are NEET (Not in Education, Employment or Training) and therefore already marginalised are

³⁰ Employment constitutes a central means through which individuals meet both the material and the psychosocial demands characteristic of life. Unemployment results in both material and psychosocial disadvantages to the individual (Shahidi, Siddiqi, & Muntaner, 2016).

³¹ Thompson, D. 2014 The Mysterious Rise of the Non-Working Man. *The Atlantic*.
<https://www.theatlantic.com/business/archive/2014/12/men-not-at-work/383755/>
<https://www.nytimes.com/2017/01/04/upshot/why-men-dont-want-the-jobs-done-mostly-by-women.html>

more likely than their older peers to suffer adverse effects of unemployment (see p.55 for fuller consideration of unemployment and young people).

While quick access to financial support will help reduce anxiety, the need for mental health and addiction support is likely to increase as a result of the job losses associated with COVID-19.

This may prove challenging as:

- there was already a need for more interventions targeting those with common mental health conditions (e.g. depression, stress, anxiety) (*Government Inquiry into Mental Health and Addiction*, 2018, Potter, Poulton, Gluckman, McNaughton, & Lambie, 2017).
- there are likely to be disruptions to existing services.

Many people are now taking up social assistance as a result of COVID-19 related job losses. Whilst the wage subsidy in Aotearoa New Zealand may be perceived very differently from other benefits since it is short term and is paid through employers rather than directly from a government agency, the transition from wage subsidy to job seeker benefits may be a difficult financial and mental-wellbeing transition. There is evidence that **receiving social assistance is associated with poorer mental health** (e.g. depression). This appears to be the case even after controlling for key demographic and socioeconomic characteristics (Shahidi, Ramraj, Sod-Erdene, Hildebrand, & Siddiqi, 2019). The direction of the causality is unclear (Curnock et al., 2016; F. V. Shahidi et al., 2019). However Australian research on sole parent benefit recipients suggests the stigma associated with welfare receipt contributes to poor mental health of welfare recipients (Butterworth et al., 2011). Research in New Zealand, including research drawing on the longitudinal Dunedin Multidisciplinary Health and Development Study in New Zealand, has also found that sole parents have worse mental health than parents in two parent households (Ministry of Social Development, 2010; Tobias et al., 2010). However there is also evidence that the **generosity of social assistance can positively influence mental health outcomes** (Leão et al., 2018; Shahidi et al., 2016, 2019). Adverse health related consequences of unemployment are less severe in countries where there is greater public support for the welfare state and, by extension, for those who depend on it (e.g. the unemployed) (Shahidi et al., 2016).

Loss of income associated with COVID-19 may mean that some people **lose their homes or experience greater housing instability**, with negative impacts on mental health. Home foreclosures have been shown to negatively impact mental health. Housing instability (e.g. eviction, loss of a home due to foreclosure, or otherwise being forced to move frequently) leads to high levels of stress that have adverse health consequences, especially for mental health (Lubell et al., 2007). Following the 2011 Japanese earthquake and tsunami the loss of a home was associated with persistent adverse impacts on mental health among older people surveyed (Tsuboya et al., 2016). A meta-analysis found that resettlement following the earthquake was associated with long term depressive symptoms (Ando et al., 2017). Following the Christchurch earthquake, homelessness was associated with poorer mental health, particularly through the loss of low-cost accommodation which, pre-earthquake, had largely catered for vulnerable people, such as single men with mental health/addiction problems (Goodyear, 2013).

Some may only be able to afford low-quality housing. Numerous studies have investigated the health of populations and their housing conditions, resulting in a body of evidence which reports strong associations between poor physical and mental health and low-quality housing (Thomson et al., 2013). Long periods of time in self-isolation in low quality housing will likely further reduce mental wellbeing.

For others the loss of income will mean housings costs will take up a greater proportion of their budgets. Financial stress associated with high housing costs is linked to poor mental health.

Some population groups will be more affected by loss of income than others

Loss of income through loss or reduction of a salary or increased housing costs will not impact population groups equally. Those already on low salaries (which includes many essential workers, including support workers), and those with irregular incomes, are more likely to be pushed into poverty or further into poverty. Data on 'in-work' poverty in New Zealand shows that 50,943 households (7% of total households in NZ) are both working and in poverty (Plum et al., 2019).³² Overrepresented in New Zealand's 'working poor' are single parents, Māori, Pasifika, disabled people, those with health problems and learning difficulties, and migrants (those from north-east Asia have the highest rates of in-work poverty).

Medium term mental wellbeing impacts

COVID-19 is likely to have medium- and longer-term impacts on the mental health of the general population

Social support and social connectedness are strong predictors of resilience and recovery for individuals and communities following trauma and disaster. However, the nature of an infectious disease outbreak is that people are asked to distance themselves from group settings and isolate themselves to reduce the risk of infection. Symptoms of PTSD, confusion, and anger are common among people forced to quarantine. Some studies have suggested these effects can be long lasting (Brooks et al., 2020b). For example, three years after the SARS outbreak, among health workers, alcohol abuse or dependency symptoms were associated with having been quarantined.

COVID-19 is likely to have increased anxiety in the general population (i.e. worry about contracting the virus, and/or worry about loved ones getting ill, and worry when experiencing related symptoms). The absence of a definitive treatment or vaccine for coronavirus will continue to exacerbate this anxiety in the medium term.

Many of the anticipated consequences of quarantine and associated social and physical distancing measures are themselves key risk factors for developing longer term mental health issues (e.g. self-harm, alcohol and substance misuse, gambling, domestic and child abuse, and psychosocial risks such as social disconnection, lack of meaning or anomie, entrapment, cyberbullying, feeling a burden, financial stress, bereavement, loss, unemployment, homelessness, and relationship breakdown).

Some groups are most at risk of longer-term mental health problems

Having a psychiatric history is associated with psychological distress after experiencing

³² Based on a 60% before housing costs poverty threshold.

any disaster-related trauma (Alvarez & Hunt, 2005; Cukor et al., 2011; Shah et al., 2020) and it is likely that people with pre-existing poor mental health need extra support during and after quarantine (Brooks et al., 2020b). There are some indications that children who experience substantial disruption following disasters (i.e. Hurricane Katrina) are more likely to develop mental health problems in subsequent years. Children who are already vulnerable are more at risk.³³

People who have contracted the virus and health care workers may be at risk of longer-term mental health problems

People who have had COVID-19 may be at risk of developing mental health problems in the medium to longer-term either because the experience was traumatic or because the virus has longer term impacts on the brain:

- Patients who survive severe and life-threatening illness were at risk of post-traumatic stress disorder and depression (Holmes et al., 2020).
- Post-infectious fatigue and depressive syndromes have been associated with other epidemics, and it seems possible that the same will be true of the COVID-19 pandemic.

There is some evidence health care workers may be at greater risk of developing mental health problems (Brooks et al., 2020b). Given the low levels of community transmission in New Zealand so far, health care workers here may be less at risk of longer-term mental health problems than those in countries with higher rates of transmission.

The economic impacts of the COVID-19 response are likely to contribute to poorer mental health outcomes in the medium and longer term

There is evidence that financial loss associated with quarantine (e.g. arising from people unable to work and having to interrupt their businesses with no advanced planning) can have long lasting effects on mental health. A recent review of mental health impacts of past epidemics found suffering financial loss as a result of quarantine to be a risk factor for symptoms of psychological disorders and both anger and anxiety several months after quarantine (Brooks et al., 2020b).

As the economic impact of the predicted recession associated with COVID-19 increases, there is likely to be a higher prevalence of mental health problems, including common mental disorders, SUDs, and ultimately suicidal behaviour (Frasquilho et al., 2016). A UK study found that individuals experiencing unemployment, who lost income, or were sick or disabled during the Global Financial Crisis were most at risk of experiencing poor mental health (Boyce et al., 2018). A Spanish study also found evidence of poor mental health outcomes for those experiencing job loss, especially where the unemployment is long-term (Farré et al., 2018). Several US studies have found that recessions increase risk of worse mental health—particularly depression and anxiety—and harmful coping behaviours such as risky alcohol and drug use. Risks appear to be greater for people with lower incomes or levels of education and without secure employment (Forbes & Krueger, 2019).

³³ See <https://www.theatlantic.com/health/archive/2020/03/what-coronavirus-will-do-kids/608608/>

The recent New Zealand mental health inquiry found that poverty, low incomes, low-status insecure work, and poor housing all contribute to poor mental health. International evidence indicates a recession is likely to exacerbate these contributors to poor mental health. Māori are disproportionately affected as they experienced higher rates of unemployment in previous recessions and currently have higher rates of poor mental health.³⁴

There may be an increased risk of suicide as a result of COVID-19 and the associated recession

While the causes of suicides are complex, risk factors include life shocks such as job loss and poverty associated with recession, increases in levels of debt, house repossession, relationship difficulties, alcohol misuse, pressures on those remaining in work and job insecurity, and cuts in mental health services (Barr et al., 2016; Coope et al., 2014; Corcoran, Griffin, Arensman, Fitzgerald, & Perry, 2015; Rambotti, 2020; (Haw et al., 2015).

Those most at risk of poor mental health outcomes associated with economic recessions include:

- Those who experience a loss of income through job loss or business closure. particularly if they need to take up social assistance.
- Those who fear they will experience a loss of income through job loss or business closure.
- Those experiencing housing instability or loss of a home.
- Those with existing mental health conditions, including addiction.
- Those already experiencing disadvantage in the labour market (e.g. people with health conditions, disabled people, those with low educational qualifications, low wage workers, young people entering the labour market).
- Those who are disabled and therefore already over-represented in experiencing poor mental health, and their carers.
- Evidence suggests association between the high rates of Māori suicide and blocked life trajectories, including career and job opportunities for young Māori (Coupe, 2000; Gallagher et al., 2008).

Internationally, concerns have been voiced about the risk of suicide increasing with the isolation of people alongside rising unemployment (Te Pou, 2020). There were increases in suicide among older people following the SARS epidemic and the Christchurch earthquakes (Te Pou, 2020). COVID-19 may precipitate risk factors for youth mental health and suicide, including disruptions or changes in whānau living arrangements or school circumstances; severe family problems; unemployment and financial uncertainty; social isolation or feelings of loneliness (Te Pou, 2020).

The risk of suicide associated with job loss and an economic downturn (mentioned above) is not only proximate to the current and medium-term situations. The psychosocial impacts of the pandemic may also result in an increase in suicide rates in the longer term. In New Zealand the rise in suicides among young men in the late 1980s

³⁴ *Government Inquiry into Mental Health and Addiction.* (2018).

and early 1990s suggested that they are particularly at risk from the flow-on from an economic downturn (Howden-Chapman et al., 2005). The failure to effectively address stressors on children will contribute to continued high suicide rates in future, given what is known about the links between suicidal distress and adverse childhood experiences/childhood trauma (this will be discussed in the next sections of the evidence review).

Mitigations against adverse mental health and wellbeing

Collectively building the social and economic foundations for psychosocial wellbeing is paramount. Positive mental wellbeing, healthy families and thriving communities cannot be achieved by the health sector alone. Initiatives that actively reduce the extent of harm caused directly or indirectly by COVID-19 and/or address the foundations on which mental wellbeing is built are crucial for the COVID-19 recovery. General mitigation strategies include:

- Provide tools and resources to support people to look after their own mental wellbeing (and to know where to get help when they need it) and the mental wellbeing of their whānau and those around them.
- Empower community-led solutions and to equip communities with the skills and resources to recognise and respond to mental distress and addiction issues.
- Ensuring access to online and telephone mental health support for people with common mental health conditions to meet need where face to face services are restricted and to deal with the expected increases in demand.
- Assisting people to activate their social networks, albeit remotely, is important. Limited social contact is associated not just with immediate anxiety, but longer-term distress.

Mitigation responses to increased anxiety and concern in the wider community about COVID-19

Effective, transparent, accurate communication about:

- promoting wellbeing and building resilience in a positive way – not just mitigating risks.
- the risks associated with the pandemic and what people should practically do will assist in reducing anxiety and support public health outcomes (Lu, 2015).
- the distinction between physical distancing and social distancing and the need to remain socially engaged as critical for community connectedness and wellbeing.
- encouraging people to reach out and remain connected with people who might be struggling
- The framing of health messages in the media influences levels of anxiety as well as take up of desired healthy behaviour (Sandell et al., 2013).

Mitigation responses to poor mental health among high risk groups

- Effective communication, as outlined above, should be targeted to the needs of different groups, including disabled people³⁵ and people with pre-existing health conditions, children and young people, Rainbow youth, people living with mental health and addiction issues, and new parents. It is important to be aware of potential cultural differences in responses to emergency situations (Weston et al., 2018).
- Ensuring access to online and telephone mental health supports as outlined above (applicable to all groups, high risk or not).
- Providing timely access to services, appropriate treatment and/or psychological support for those who are at risk of drug misuse including relapse.
- Monitoring the number of outlets selling alcohol in neighborhoods (New Zealand Government, 2018).
- Prioritise the suicide prevention strategy.³⁶ Accelerate the implementation of the action plan with a focus on community-based initiatives.
- Consider expanding existing pilot projects where there is evidence of effectiveness.

Medium-term mitigations

Medium-term recovery requires a tiered response to reflect diverse levels of need:

- **Collectively build the social and economic foundations for psychosocial and economic wellbeing:** Income, employment, housing, education, recreation, social connection, cultural identity, safe and healthy relationships, and many other factors impact on our wellbeing.
- **Empower community-led solutions** to ensure that whānau and communities have the resources they need to recover and adapt from this pandemic. Proactively create environments in which whānau and communities can thrive. This includes supportive schools and workplaces that prioritise mental wellbeing, green spaces in our neighbourhoods that are safe and accessible, affordable and connected housing and connection with wāhi tapu and places of significance. Equip communities with the skills and resources to recognise and respond to mental distress and addiction issues.
- **Equip people to look after their own mental wellbeing:** promote wellbeing for all New Zealanders, ensure relevance and reach for groups with specific needs, promote awareness of services, and enable access to practical self-help resources and tools.
- **Strengthen mental health and addiction supports in communities:** it is crucial to ensure timely access to primary and community supports where and when people need them. Increased access and choice of supports on an ongoing basis (as needs will be ongoing) is critical.

³⁵ Ministry of Health and ODI have provided information on covid-19 aimed at disabled people <https://www.odi.govt.nz/whats-happening/ministry-of-health-covid-19-update/>. See also WHO recommendations for communicating with disabled people <https://www.who.int/who-documents-detail/disability-considerations-during-the-covid-19-outbreak>

³⁶ <https://www.health.govt.nz/publication/every-life-matters-he-tapu-te-oranga-o-ia-tangata-suicide-prevention-strategy-2019-2029-and-suicide>

- **Support specialist mental health and addiction services:** The need for specialist mental health and addiction services may increase over the COVID-19 recovery period. For those people who have or develop more severe and enduring mental health and/or addiction issues, more access and greater choice of services is key. There is no one-size-fits-all approach. Providing access to free online and telephone support should be part of the mix (Shah et al, 2020).
- For mitigation responses to poor mental health outcomes arising from loss of jobs and income, see pp.54-55.

FAMILY VIOLENCE AND DOMESTIC VIOLENCE

Disasters and pandemics elevate known risk factors for, family, domestic and social violence.

Financial, material and psychosocial stressors related to COVID-19 and virus containment measures that restrict movement and access to supports are likely to increase the risk of conflict and violence. While the availability of robust research in the context of pandemics is limited, there is some emerging evidence linking infectious disease outbreaks to increased violence towards women and children, largely perpetrated by men (Fraser, 2020). There is an established and growing evidence base showing an increased prevalence of gender-based violence following natural disasters and other crises³⁷. This can be exacerbated by disrupted social networks and supports that may reduce the risk of conflict and family violence.

Though the circumstances of the current COVID-19 crisis are constantly evolving and there is uncertainty about how the pandemic will play out in the medium term, the likely increase in family violence during and immediately after the lockdown period has the potential to be exacerbated. Disaster literature also shows that the increases in domestic violence, sexual violence and child abuse increases not only in the immediate aftermath but also in the longer term during the rebuild and recovery phase (Campbell & Jones, 2010; Houghton, 2010; Molyneaux et al., 2020).

While impacts on conflict and domestic violence will depend on the severity of the ensuing economic downturn and the trajectory of the pandemic, the mechanisms described in literature are likely to be similar regardless of scenarios. However, impacts are not likely to be evenly distributed across society. Those with coping mechanisms, financial resources and social supports may experience different levels of susceptibility to adverse social and psychosocial impacts in the medium term.

While there are several fundamental differences between natural disasters and pandemics or disease outbreaks, understanding the pathways in which disasters impact

³⁷ Increases in family violence, including intimate partner violence, child abuse and sexual violence were found after a range of natural disasters (2016; Rezaeian, 2013; Seddighi et al., 2019) including the 2011 Christchurch earthquakes (Campbell & Jones, and civil defence emergencies in New Zealand (Houghton, 2010)

relational conflict and violence and potential mitigations provide learnings for responses to the COVID-19 pandemic (Peterman et al., 2020).

Disease containment measures that confine households and restrict movement create more opportunities for violence to be perpetrated through increased exposure to potential perpetrators, decreased freedom and privacy in confined conditions, and reduced access to external supports and social networks.

The advice for people to remain at home has implications for adults and children for whom home is not a safe place, but where physical, psychological and sexual abuse takes place. Family violence can encompass a broad range of controlling behaviours, primarily of a physical, sexual, and/or psychological nature which typically involve fear, intimidation and emotional deprivation. Family violence includes intimate partner violence (IPV), child abuse/neglect, elder abuse/neglect, parental abuse and sibling abuse ((Ministry of Social Development, 2002).

Current estimates find that one in three ever-partnered women in Aotearoa New Zealand experience physical and/or sexual IPV in their lifetime. This increases to 55% with the inclusion of psychological/emotional abuse (Family Violence Clearinghouse, 2017). Psychological abuse is most prevalent; despite using a narrow definition of psychological intimate partner violence, the *New Zealand Crime and Victims Survey* (NZCVS) found that in the last 12 months New Zealand adults were almost three times more likely to experience intimate partner psychological violence compared to other specific offences by intimate partners (including physical and sexual assault, harassment and threatening behaviour). Additionally, people who have experienced violence report similar levels of psychological distress regardless of the type of violence experienced (Ministry of Justice, 2020)).

Given the existing high rates of domestic violence in Aotearoa New Zealand, particularly psychological abuse, the consequences of COVID-19 are likely to have direct and indirect impacts on domestic violence rates. Overcrowded households are particularly at risk, with evidence from crisis settings (e.g. refugee camps and humanitarian assistance areas) where family members were in close contact under stressful conditions for long time periods were shown to be associated with increased violence against women and children (Peterman et al., 2020).

Evidence shows an increased prevalence of gender-based violence in the immediate and long-term, following a disaster event (Campbell & Jones, 2010; Parkinson, 2011; True, 2013a). Violence against women and girls is pervasive in pre-pandemic conditions and underreporting is likely to underestimate its true prevalence. Disasters have a direct impact on the major determinants of violence against women and girls, including family and community stress and psychological trauma, and financial insecurity (True, 2013 cited in Hedlund, 2016). Women, particularly young women are overrepresented in those who experience sexual violence (Ministry of Justice, 2019).

People experiencing violence may not be able to access support services or support networks and / or have difficulty accessing support services without the perpetrators finding out (UN Women, 2020).

Currently, requests for help have been decreasing in countries where movement is restricted, and/or where access to quality essential services is limited, or being administered differently, as a result of social distancing (e.g. counselling by phone, emails or other platforms). A domestic violence helpline in Italy and a women's shelter network in France reported a drop in calls because women found it hard to ask for help during lockdown. These examples highlight the vulnerability of women who cannot access resources to help them to cope with or escape from situations of violence. Women and girls at this time may not be able to access formal and informal support networks (UN Women, 2020). Within the home, violence can occur without scrutiny from those outside the household. There are disruptions to or breakdowns of the familial and community oversight or societal infrastructures that may have acted as pathway for detection of abusive behaviours and subsequent follow up or referral to services (Peterman et al., 2020).

In line with wider literature, in New Zealand informal networks are also an important source of support and disclosure for those experiencing violence. The NZCVS found that half of those who had experienced offences committed by family members sought help from other family, whānau, friends or neighbours (Ministry of Justice, 2019). Reduced access to informal supports through physical distancing and lockdown rules can put those already experiencing violence and those at risk of experiencing violence at even greater risk.

Decreases in disclosure of violence rates following a crisis event should not be taken as an indication that levels of violence are decreasing, but may suggest increased pressure on support services and the high rates of family violence that occur without being reported to Police (Campbell & Jones, 2010). In other countries however, there are already signs that family violence reports to Police, calls to helplines or use of helpline websites have increased.³⁸

Given the high levels of existing family violence in Aotearoa New Zealand previously outlined, there is no reason to think the situation will be different here. Services are closed due to lockdown. Emergency housing, finances and support services are less accessible during crises. There is also the risk that people may not be aware of services that are still operating during lockdown. In addition, disease containment measures impact the legal system which affect court proceedings, protection orders, separations/divorces/custody hearings (Peterman et al., 2020).

Social or cultural norms can silence and discourage people from seeking help, especially when the focus of a response may be on loss or practical recovery. Following the Black Saturday bushfire disaster in Australia, it was reported that responders excused/minimised violence, blamed violence on stress and chaos, overly empathised with those perpetrating violence, and advised people experiencing violence to put up with violent behaviour (Parkinson & Zara, 2013). Internationally, we have already seen this type of victim-blaming response, such as the 'stop nagging' public health campaign

³⁸ Godin, M. 2020. As Cities Around the World Go on Lockdown, Victims of Domestic Violence Look for a Way Out. Time Magazine. <https://time.com/5803887/coronavirus-domestic-violence-victims/>

in Malaysia (which has since been withdrawn). Unequal gender relations and patriarchal norms are factors that act to magnify risk factors of experiencing familial conflict or violence during times of crisis Peterman et al. (2020).

Disabled women are particularly at risk from violence

Despite the growing awareness of disability related abuse, there is a continued scarcity of evidence synthesising the increased risk of violence faced by disabled people, especially within the New Zealand context (Roguski, 2013). International systematic reviews are limited by this lack of well-designed studies and poor measurement standards of disability and violence, but have found that disabled children and adults, particularly those with mental health disorders, are more likely to be subject to any violence when compared with non-disabled children and adults (Hughes et al., 2012; Jones et al., 2012).

The studies suggest that increased vulnerabilities to abuse, particularly for disabled women, are likely due to risk factors such as increased isolation, disability-related dependencies, difficulties in identifying and defining abuse and persisting cultural or societal stigmas. Additionally there may be lack of support for caregivers (Hughes et al., 2012; Jones et al., 2012; Plummer & Findley, 2012). Without increased support and vigilance, the aforementioned risk factors are only likely to increase with COVID-19 containment measures and responses, highlighting the increased risk of violence for disabled people during this time.

Financial and material stressors during the four-week lockdown period may trigger violence

Similar economic consequences following natural disasters including negative impacts on income, job loss and financial hardship have been shown to be associated with increases in IPV risk (Biswas et al., 2010; Lauve-Moon & Ferreira, 2017; Molyneaux et al., 2020). Financial strain was reported as one of the primary reasons behind reported increases in domestic violence after natural disasters (Houghton, 2010). Even outside the context of crisis or disaster, almost one in three incidents of current-partner violence are suggested to be triggered by financial issues (Ministry of Justice, 2019). There is also evidence to suggest that anticipatory anxiety may have a negative impact on relationship dynamics (Peterman et al., 2020) .

Literature from post disaster contexts describes the mechanisms by which economic stress and insecurity is said to be associated with increased violence against women and children. These factors include: poorer access to health and legal services for women and children experiencing violence, those perpetrating violence being more likely to employ poor coping strategies, increased levels of acute and chronic stress (Peterman et al., 2020), insecure housing (Parkinson, 2011), and poor access to basic material needs (True, 2013).

Prolonged economic stress and income insecurity related to pandemic restrictions and an economic recession may increase rates of family violence.

The relationship between unemployment and domestic violence is not always clear and appears to be dependent on gender norms and power dynamics of particular cultural

contexts.³⁹ However, unemployment has been linked to significant emotional stress and poor mental health and mental disorders which themselves have been described as risk factors for gender-based violence including family violence.

Financial resources influence the ability for people to leave an abusive relationship or situation.

In the context of the COVID-19 the complex reasons that women may stay with abusive partners are likely to be compounded by the financial impacts of the pandemic. Despite messaging from NZ Police that it is ok to leave the house in situations where people feel in danger and are unable to contact emergency services⁴⁰, in the lockdown period people experiencing violence may not be aware of this. People experiencing violence may also be reliant on the perpetrators of violence for financial support and resources and lack the resources to leave the relationship. They may also return to abusive ex-partners for financial support and resources (Parkinson & Zara, 2013). Other reasons women may remain in abusive relationships include emotional attachment, psychological distress and the fear that separating from a partner will put themselves or their children's safety at risk (Peterman et al., 2020), worries which may be heightened during the pandemic.

Psychosocial stressors in the immediate term

- Evidence already exists linking increased stress as a risk factor for family violence (Parkinson, 2011). Within the context of a disaster the stresses from changes to living and employment situations, financial stressors, PTSD and alcohol abuse were also suggested to trigger increased violence (Parkinson et al., 2011).
- The use of unhealthy coping mechanisms by perpetrators, including substance abuse, increased debt and other risky behaviours that may arise from economic insecurity or virus-related mental health impacts are associated with higher risks of different forms of interpersonal violence, including family violence (Peterman et al., 2020).
- Additional coping mechanisms include increases in controlling behaviours and violence by perpetrators to compensate for the perceived loss of control and freedom experienced during social distancing (Phillips et al, 2009, cited in (Parkinson & Zara, 2013).
- People experiencing violence may not seek access to health services/support services due to increased fear and anxiety, either due to their permanent proximity to the perpetrator, fear of contracting the virus by leaving the home to access help and services, or fear they could be in trouble for breaching lockdown conditions, if they are not aware that it is okay to leave home to get help, or a combination of all of the above.

³⁹ See Schneider et al., 2016 and Peterman et al., 2020). Bhalotra et al. (2019) explored differences in male and female unemployment using data from 31 countries and found that a 1 percent increase in male unemployment was associated with a 0.50 percentage point (pp) (2.5 percent) increase in physical IPV for women. Increases female unemployment are associated with decreases in IPV by similar magnitudes (0.52 pp or 2.75 percent). In contrast, Anderberg et al. (2016) examined the relationship between unemployment in the United Kingdom during the recession and found that increases in male unemployed decreased rates of IPV and increases in female unemployment increased IPV.

⁴⁰ NZ Police. 2020. "Your safety still comes first" <https://www.police.govt.nz/news/release/your-safety-still-comes-first-%E2%80%93-police-message-people-facing-family-harm>

Anxiety and fear related to the virus itself can be used by perpetrators to justify coercion and control through scare tactics or misinformation, withholding safety items (e.g. hand sanitiser, soap, protective masks), or if available, limiting access to vaccines (Peterman et al., 2020).

Psychosocial stressors in the medium term

The adverse effects of the current pandemic on mental health described previously such as PTSD, depression, anxiety, suicidality sleep difficulties; and substance abuse (Brooks et al., 2020) may persist in the long term following a pandemic. These factors are shown to increase risk of violence against women and children (Trevillion et al., 2012), effects of which could continue after the immediate crises of the pandemic ends (Peterman et al., 2020). Molyneaux et al., (2020) reported associations between post-disaster experiences of IPV and PTSD and depression up to three years after the Black Friday Australian bushfires. Furthermore:

- Unemployment has been linked to significant emotional stress and poor mental health and mental disorders which themselves have been described as risk factors for gender-based violence, including family violence (Devries et al., 2013).
- Impacts of domestic violence on the mental and physical health on those experiencing domestic violence may reduce their ability to respond and recover in the context of a disaster or crisis.
- Use of unhealthy coping mechanisms can continue after the crisis event. Increases in alcohol, drug use and aggressive behaviours were reported during the rebuild phase of the Christchurch Earthquake (Campbell & Jones, 2010). As previously mentioned, these behaviours are linked to increased prevalence of family violence. Unhealthy coping mechanisms may be further fuelled by disruption to support services such as alcohol and drug treatment centres.

Population groups at increased at risk of experiencing violence:

Family violence is an issue that affects New Zealand families and whānau across the spectrum of socioeconomic status, culture, class and background (Ministry of Social Development, 2002). However, violence statistics show that some groups are more at risk, in particular: women and Māori and those experiencing material hardship. After the Christchurch earthquakes low-income families and others dependent on low-cost and/or social housing did not receive assistance comparable to the level of need, contributing to rising rates of negative outcomes, including family violence (Hedlund, 2016).

Previous experiences of non-physical abuse or IPV before a disaster increase the likelihood of IPV following a disaster event (Molyneaux et al., 2020), for both men and women (Coker et al., 2006; *Victorian Bushfires Royal Commission Final report summary*, 2009) and women specifically (Anastario et al., 2009; Fredman et al., 2010; Harville et al., 2011).

People who lack resources to access services, including phones, internet and transport also face increased risk. In addition, indigenous and ethnic population groups, sex workers, other marginalised populations (including the LGBTQI+ community) as well as those living with disabilities, also may have intersectional risks for experiencing increased violence during and after the events of COVID-19 (Peterman et al., 2020).

Other forms of generalised violence that may occur during pandemics, including elder neglect and abuse, online child solicitation, child abuse, despite the limited research that is currently available, (Peterman et al., 2020).

Social conflict and violence

In previous pandemic situations people infected with disease and/or those exposed to infectious groups, such as frontline healthcare workers, were exposed to higher levels of discrimination (Brooks et al., 2020a).

Women make up a large percentage of the frontline healthcare workforce. There have been increased reports of both physical and verbal attacks on healthcare workers in China, Italy and Singapore.

Discrimination of minority ethnic groups from countries where infectious disease may have originated or xenophobia have been previously reported in African communities (Madhav et al., 2017) or even those perceived to be of African descent during the Ebola epidemic, (Van Bortel et al., 2016), and Asian-Americans during the SARS epidemic (Person et al., 2004). Fear and anxiety fuel discrimination which may manifest through blame, shunning or isolation. This can lead to racial abuse/hate crimes (Peterman et al., 2020)

- Media reports of reports of physical attacks on ethnic Asian people in predominantly White countries, and some government officials' mis-characterizations of SARS-CoV-2 as the "Wuhan" or "Chinese virus"
- Fear of getting tested/seeking medical advice despite displaying clinical symptoms (Person et al., 2004)

Media reporting and headline and fear mongering during the SARS epidemic were shown to contribute to stigmatising attitudes within the wider public (Person et al., 2004)

Mitigations against family, domestic and social violence

Mitigations to address likely increased demand for services and support frontline work in the context of pandemic response:

- Consistent, multi-level messaging (not only from NZ Police) that people experiencing violence can and should leave home to seek help during a period of lockdown.
- Ensure that frontline domestic violence services are well resourced to support an increased demand for services, including phonedlines and outreach centres (Peterman et al., 2020).
- Recognise the need to sufficiently resource those agencies working with specific communities: kaupapa Māori service, Pacific services, migrant and ethnic community services, LBGTQI+ communities.
- Consider innovative ways for people to access help. Ensure there are free or reimbursable online and text options and that these ways of getting help are made widely known. Draw on international cases, for example in France help centres have been set up at essential shops and a code word that can be used to ask for help at

pharmacies has been promoted or the app created in Italy that enables women to ask for help without needing to make a phone call.⁴¹ In China social media was used to provide resources and raise awareness of violence as a risk during lockdown with the social media hashtag #AntiDomesticViolenceDuringEpidemic (United Nations, 2020).

- Encourage people to access informal and virtual support networks where possible.
- Take a proactive collaborative approach across different agencies that may be involved in the response to COVID-19 as was demonstrated by the Canterbury Family Violence Collaboration⁴² which supported the community to effectively respond to increases in family violence after the Christchurch earthquakes (Campbell & Jones, 2010) Actively consider women, and women at risk of experiencing domestic violence in the interventions designed to support the COVID-19 response (Molyneaux et al., 2020).
- Involve women and women's services and agencies in response planning. Policies and responses that do not consult women or include them in decision-making are at risk of being inefficient or even causing harm (United Nations, 2020).
- Support those who already have a high risk of experiencing family/domestic violence during the lockdown and establish systems to collect as accurate as possible records of violence.
- Strengthen and leverage off informal community outreach connections that have been established through COVID-19 lockdown period (for example, organisations delivering food parcels).
- Ensure information/training/tools are available for people experiencing violence, communities and support services delivering COVID-19 responses to detect signs of family violence, particularly in the context of the lockdown restrictions (Parkinson & Zara, 2013). For example, police in the United Kingdom have extended the call to courier drivers and postal workers who may interact with people who are potentially experiencing violence to look out for and report signs of violence.⁴³

Mitigations to address financial and social vulnerabilities:

- Ensure financial and social supports are available for people experiencing violence to access emergency and safe housing, transport and emergency supplies (Houghton, 2010). Maintaining social safety nets to allow financial independence for those experiencing violence to have the resources to leave abusive relationships.

⁴¹ "European countries develop new ways to tackle domestic violence during coronavirus lockdowns"
<https://www.nbcnews.com/news/world/european-countries-develop-new-ways-tackle-domestic-violence-during-coronavirus-n1174301>

⁴² The *Canterbury Family Violence Collaboration* is made up of 45 Government and NGOs. Campbell and Jones (2016) identified four success factors of the taskforce in delivering multi-dimensional, evidence-based package of system-level, whole-of-community interventions . 1. A common agenda and compelling reason for collaboration. 2. An open support system and structure. 3. They built on pre-existing strengths, which in this case was a strong history of connectedness among family violence organisations in the region, and the shared experience of the earthquake. 4. Strategic collaborations and sharing of findings.

⁴³ Lythgoe, G. 2020. "Police express support to domestic violence victims in Cumbria during self-isolation".
<https://www.thewestmorlandgazette.co.uk/news/18333834.police-express-support-domestic-violence-victims-cumbria-self-isolation/>

- Ensure resources are available so a household's basic needs (for example, food, water, shelter, warmth) are met to reduce the stressful conditions that may exacerbate risks of domestic/family violence (Hedlund, 2016).
- Ensure communication and messaging to those experiencing violence, those perpetrating violence, communities, support services and agencies is clear and co-ordinated (Parkinson & Zara, 2013):
- Clearer messaging and sharing of pathways around seeking support and available resources.
- Clear messages from government that family violence and sexual violence are still being taken seriously to counter potential perceptions that Police are too busy to deal with family violence call outs (Houghton, 2010).
- Clear messages that people experiencing violence can leave their homes to seek help. Establish a clear way for Government services and frontline workers to communicate. (Pauly et al., 2016).
- There is some evidence suggesting that in high income countries women's employment and earnings is a protective factor against violence (Peterman, 2020).
- Previous disaster responses have suffered from a lack of gendered data collected in mitigation responses (True, 2013). Ensure that data collected on COVID-19 response initiatives includes good enough samples of women and that the data can be disaggregated by gender.
- Ensure that responses to increases in domestic violence include targeted mental health and support, to reduce the increased burden of poor mental health that people experiencing violence may be exposed to.
- Ensure there is funding, training and support for first responders to expand and maintain quality support throughout the crisis, and to establish such services in rural or resource-low settings, where they do not already exist (Peterman et al., 2020).

CHILD WELLBEING, DEVELOPMENT AND PROTECTION

COVID-19 is likely to have negative impacts on child wellbeing, child development, increase the risk of harm and reduce protections for children

Infectious diseases like COVID-19 can disrupt the environments in which children develop. Disruptions to families, friendships, daily routines and the wider community can have negative consequences for children's well-being, development and protection. In addition, measures such as quarantine and self-isolation used to prevent and control the spread of COVID-19, can expose children or increase child exposure and intensity to safety and care and protection risks. (The Alliance for Child Protection in Humanitarian Action, 2019). Children and families who are already facing socio-economic disadvantage, social exclusion, those who live in overcrowded settings and those already experiencing or witnessing violence, are particularly at risk.

Many countries around the world are expecting and planning for considerable increases in children entering the care and protection system, with impacts expected to last at least 10 years with significant increases in financial contributions to child welfare.

Research from the United Kingdom indicates that adverse child experiences (ACEs) relevant in the COVID-19 context - including economic disadvantage, disruption to learning, lack of friend and family support networks, overcrowding, parental mental health problems and exposure to violence - have adverse impacts on children's subjective wellbeing (The Children's Society, 2017). The same research found that children who experience disadvantages in multiple life domains have the lowest wellbeing. A recent study in New Zealand found that ACEs in early childhood also negatively impact on cognitive performance and school readiness outcomes (Walsh et al., 2019)⁴⁴ International studies have strongly associated ACEs with early childhood academic performance and behavioural problems (M. E. Jimenez et al., 2016), and with behavioural problems and health conditions in later childhood and adolescence (Hunt et al., 2017; Slack et al., 2017).

Many of the social and psychosocial impacts on children are likely to manifest in the medium and long term rather than immediate term during the four-week lockdown period.⁴⁵ As such, the immediate and medium-term impacts are considered together within each sub-domain of impact on children.

Evidence suggests that disease containment measures such as quarantine and self-isolation have enduring effects on child and adolescent psychological well-being.

Quarantine and other disease prevention measures such as school closures and restrictions on movements disrupt children's routine and social support. Recent analysis in the current COVID-19 context has highlighted the psychological stressors on children resulting from disease containment measures, including fear of catching the disease, frustration and boredom, lack of in-person contact with classmates, friends and teachers and lack of personal space (Brooks et al., 2020b).

In a US study of children who had been quarantined or isolated during pandemics, 30% demonstrated symptoms that met the overall threshold for PTSD and showed significantly higher rates of PTSD symptoms on all subscales; this is almost four times higher than the estimated prevalence of PTSD in the general population. The children in this study met the criteria for PTSD at rates closer to children who have experienced disasters and other serious traumatic events (Sprang & Silman, 2013a).

Disease containment measures also risk separating children from parents and carers due to the need for a caregiver to isolate/quarantine apart from their children due to either contracting the virus or being at risk of contracting the virus in the line of their work or

⁴⁴ Walsh et al. (2019) study using the *Growing Up in New Zealand* study cohort found statistically significant associations were found between a child's experience of ACEs and their performance in cognitive tests administered at 54 months of the GUINZ study.

⁴⁵ This evidence review explores the 'medium term' impacts defined as one year after the Alert Level 4 lockdown period. The impact of adverse child experiences from COVID-19 on adulthood is beyond the scope of this review. However, evidence is clear that cumulative disadvantage and severe and persistent abuse has lifelong consequences.

shared custody arrangements. Disease containment measures also place new stressors on parents and caregivers who may have to find new childcare options or forgo work (Alliance for Child Protection in Humanitarian Action, 2019).

Children’s fears in pandemics and disasters are often misunderstood and underestimated

A child’s age and developmental stage influences their comprehension of illness and causality: fear of separation from or loss of family due to the virus and fear of catching the virus themselves (irrespective of the likelihood), and self-blame for the consequences, can cause psychological distress in children (Dalton et al., 2020).

There is evidence to suggest that parents and carers underestimate the impact of pandemics and disasters on children (Earls et al., 1988; Pfefferbaum et al., 2014; Pfefferbaum & North, 2008) and / or that children not fully display their distress (McFarlane et al., 1987; Shaw et al., 1995, cited in Pfefferbaum & North, 2008).

Children are at risk of harm as a consequence of the stress on adults in their lives.

As parents are the closest and most important source of support for children during the COVID-19 crisis, the level of stress which they are under and their ability to cope is paramount for child well-being (OECD, 2020).

There is a significant amount of evidence indicating that parental distress significantly affects their children’s distress following disasters (Earls et al., 1988; Kelley et al., 2010; Pfefferbaum & North, 2008; Norris et al., 2002; Sprang & Silman, 2013). Sprang and Silman’s 2013 study of children in isolation and quarantine reported many parents and children simultaneously met the PTSD criteria. A study of children’s fear reactions to the 2009 swine flu epidemic found that parent’s transmission of threat information was positively associated with children’s fear and that this link remained significant when controlling for other sources of information (i.e., media, friends, and school) or direct experience with the disease. Results also showed that threat information as provided by the parents played a role in the association between parents’ and children’s fear (Remmerswaal & Muris, 2011).

Children and parents who have pre-existing mental conditions before a crisis are likely to see their conditions worsen due to increased levels of stress and / or lack of access to Mental Health and Psychosocial Support (MHPSS).

Children are among those most at risk of psychological trauma and behavioural difficulties but they may not appear immediately during the outbreak or disaster (Fothergill, 2017; Oranga Tamariki, 2020; Schonfeld & Demaria, 2015)

Evidence from previous disasters suggests the psychological impacts on children are likely to manifest in the aftermath of a disaster. A study into the effects of the 2011 Christchurch earthquakes on children reported significant levels of behaviour problems

and PTSD symptoms in the children who entered school after the earthquakes (Liberty et al., 2016).⁴⁶ Among the effected cohort, the only significant predictor of a higher number of PTSD symptoms was younger age at the time of the earthquakes. Anecdotally, district health authorities reported an increased demand for specialist mental health services for children and youth usually 3-6 months after the adult demand.

There are some early signs that New Zealand children affected by the Christchurch earthquakes in-utero exhibited behavioural problems and anxiety at age 5 (Stillman & Menclova, 2019). These findings are corroborated by a meta review of several studies which suggests pregnant mothers experiencing mental stress and reduction in LMC care and usual support systems can negatively impact the health and wellbeing of the developing child in utero and infancy (Gragnic-Philippe et al., 2014).

Adolescents are already a high-risk group for mental health issues

According to the World Health Organisation (WHO), mental health is one of the leading causes of disability among adolescents globally. One in six children aged between 10 and 19 suffer from mental health issues which accounts to 16% of the global burden of disease for that age range. Suicide is the third leading cause of death in 15-19-year-olds.⁴⁷

School closures mean the loss of a key protective factor against disadvantage, exposure to violence and mental health risks.

Schools serve as a protective factor against social disadvantage (and negative outcomes associated with social disadvantage). Schools provide extracurricular activities, positive relationships and mentors, steps on a path to employability, and may be a source for free school meals (Kelly & Hansel, 2020; Liu & Miller, 2020).

Schools can serve as a protective factor for vulnerable children against home violence, abuse and neglect by keeping children away from adverse family environments (Ferguson et al., 2013; G. Wang et al., 2020). Schools also provide societal oversight and are often the first to identify the possibility that the child is experiencing family harm and provide a referral pathway to support and child protection services for children experiencing or witnessing violence (Kernic et al., 2002).

Schools also protect children by providing a respite away from home where the parent(s) has mental health issues or misuses substances. Schools also serve as a de facto mental health system for children, often providing referral to mental health services while also providing mental health services for children (Golberstein et al., 2020).

There is an immediate risk of increased exposure to violence and abuse.

Pandemics such as COVID-19 and measures taken to control the spread of disease drastically alter the environment in which children live, therefore increasing their susceptibility to abuse, neglect, violence, exploitation, psychological distress and

⁴⁶ Seventy per cent of the post-quake children had at least one symptom of PTSD. One in five exhibited all classic symptoms of PTSD. This incidence of significant levels of PTSD was double the rate of the children surveyed before the quakes.

⁴⁷ <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>

impaired development (Alliance for Child Protection in Humanitarian Action, 2019). Children in isolation will not have access to protection provided outside the family due to closer of services, care facilities and education sector.

Increased exposure to violence includes sexual violence, and increased exposure to abuse includes both physical and emotional abuse. This increased exposure may result from caregivers and other adult family members becoming increasingly distressed, a sense of support and belonging to a community being disrupted and the use of dysfunctional coping mechanisms to cope with the challenging environment (UNICEF, 2020, cited in Sistovaris et al., 2020).

Increased exposure to violence and abuse can also result from reduced contact with family and therefore family protection. There is also an increased risk of neglect, as distinct from abuse. School closures may mean an increase in the time vulnerable children spend unsupervised if parents cannot make alternative childcare arrangements or work from home (Friedman & Billick, 2015).

Further, the possibility that children are not at school and therefore spending more time online during the COVID-19 crisis has the potential for increased exposure to harmful online content, online bullying and inaccurate messaging about the pandemic / current situation (eSafety Commissioner, 2020; NCA, 2020). Increased online child abuse behaviour during the COVID-19 crisis has already been detected in Europe (UN Women, 2020).⁴⁸

The immediate risk of increased exposure to violence and abuse has medium – long term consequences

There is substantial evidence linking exposure to violence and abuse in childhood with negative impacts on a range of life domains in both the immediate term, later childhood, adolescence and through adulthood.

In the shorter term, Kernic's study found that children's exposure to maternal interpersonal violence was significantly associated with the occurrence of poor academic performance, school health concerns and behavioural issues (Kernic et al., 2002). An evidence review by Harold (2011) summarised that:

"Children who have experienced domestic violence are at increased risk for an array of emotional and behavioural problems, 40% of children from families characterised as "domestically violent" exhibit clinically significant behavioural problems (vs. 10% of children from families not considered domestically violent). Such children are at increased risk for internalising symptoms, externalising problems, decreased cognitive functioning, including IQ deficits, decreased social competence, and are at elevated risk for post-traumatic stress disorder."

(Gordon, 2011)

⁴⁸ See also: <https://www.theguardian.com/world/2020/apr/02/coronavirus-lockdown-raises-risk-of-online-child-abuse-charity-says>

The COVID-19 outbreak presents specific challenges for the well-being of children with disabilities.

During school closures, children with disabilities are more likely to miss out on education. For instance, the suitability of remote learning depends on children's individual needs and schools' ability to provide tailored tuition. They also face considerable disruptions to therapeutic services that are critical for supporting the development of communication and social-emotional skills and helping children cope better at school and at home. In particular for children with higher needs, disruption to schooling and respite care placements have the potential to push some families into crisis. Moreover, the presence of a sibling with a disability in the home will compromise parents' abilities to meet the new demands of home schooling for other children and managing heightened levels of family stress (OECD, 2020).

Children and youth who were socially excluded before the outbreak already have increased risks and more limited support.

Groups of socially excluded children and youth include those already living on the street, those in conflict with the law (including those in detention) and Rainbow youth who may be in confinement with unsupportive family members and have less access to usual supports.

Some children will experience greater impacts than others during COVID-19 due to existing socio-economic inequities.

A United Nations article identifies that children are at risk of becoming amongst its biggest victims from the effects of the pandemic, which will have profound effect on their wellbeing. These harmful effects of the pandemic will not be distributed equally with children from the poorest counties, poorest neighbourhoods and those already disadvantaged or vulnerable bearing the most damaging effects. This group as well as increasingly more children will also slip into poverty, have worsened situations for learning, increased threats to basic needs and health, and have increased risks for their safety and protection (United Nations, 2020a).

Children from low socio-economic households are at a disadvantage for continuing their study and learning at home. The success of interim educational measures implemented during school closures, for example remote learning, depends on the quality of children's home learning environment. Important factors include home educational resources, availability of space, parental level education, parents' fluency in language of school instruction, and parents' digital competencies, but also parents' engagement with schools (OECD, 2020).

New Zealand's 2019 child poverty figures report that about 15% of children (about 168,500) are living in households below the 50% median poverty line⁴⁹ and about 13% of children are living in households that have experienced material hardship. Employment has never been a guaranteed protection against child poverty: from 2007 to 2018, about 40% of children in poverty were living in working households where under-employment and low and inadequate wages are a feature, and rates of working poverty

⁴⁹ This figure is the BHC figure – the percentage of children living in households with less than 50 percent of the median equivalised disposable household income before housing costs are deducted, for the 2017/18 base financial year). The AHC figure (after housing costs are deducted) is higher at around 21% (about 235,400). <https://www.stats.govt.nz/information-releases/child-poverty-statistics-year-ended-june-2019>

are nearly doubled for Māori and Pacific households (Plum et al., 2019). The economic fallout from COVID-19 via lost or diminished parental earnings is likely to push more children into poverty because we are likely to see more families joining the group of 'working poor' or families that are already 'working poor' becoming poorer.

A systematic review exploring the impact of macroeconomic crises on families (predominantly two-parent families) found that resulting economic stress was linked to negative changes in family dynamics, particularly on marital relationships and parenting practices (Fonseca et al., 2016).

There is strong evidence both from New Zealand and internationally that children and adolescents who experience persistent poverty and material hardship have worse cognitive, social behavioural and health outcomes both during childhood and adolescence and during life course (Ministry of Social Development, 2018; see also Dominick, 2018).

Mitigations to adverse child wellbeing and development and child protection risks

The United Nations (2020) highlights that the risks and impacts from the pandemic can be minimised for children by governments, policy makers, social welfare systems and services responding with:

- Prioritising the restoration of all areas of the child protection system as quickly as possible with the plan to increase capability, including the speed at which cases move through the system.
- Adaptation of physical distancing and lockdown strategies for children in care and out-of-home care.
- Expand child protection services and programmes to reach the most vulnerable children in communities for prevention and potential increase in demand for child placements.
- Prioritising the continuity of child-centred services and ensure prevention services have a focus on equity of access.
- Introduce and expand support respite care to caregivers.
- Introduce and expand practical support services to parents and caregivers to help them care for children.
- Build resilient and adaptable service delivery system and practices to better withstand the next or other forms of crisis.
- Preparing for what may lie ahead for child welfare systems.⁵⁰ Being prepared for uncertain changes and significant increases ahead for sudden and protracted shift in demand for children needing out-of-home care as a result of abuse and neglect is critical. Preparedness for social welfare systems is about:

⁵⁰ See article: <https://chronicleofsocialchange.org/child-welfare-2/looking-ahead-the-nations-child-welfare-systems-after-coronavirus/41738>

- extending and adding prevention services and resources with the public expenditure for parents/ caregivers/ families to prevent many children unnecessarily entering care.
- introducing guidelines for professionals to making hard decisions on life and death decisions for children when there are no services or a lack of services and care systems to support children needing out-of-home care.
- reducing the risk of harm for children as a result of decisions made and improving their wellbeing.
- reducing the length an out-of-home care.
- working on culture of acceptance that some decisions will lead to a loss of life and where there is a culture of forgiveness.

The *Alliance for Child Protection in Humanitarian Action* (2019) also lists a number of **child protection strategies**:

- Ensure there is child-specific considerations and programming of intervention strategies. Increased collaboration and coordination across all sectors required. Consult children, adolescents and community members and groups in the design of interventions (Hedlund, 2016).
- Reduce parental stress which has adverse influence on child development (Evans & Schamberg, 2009).
- Strategies recommended by WHO to help children deal with stress during COVID-19 (Inter-Agency-Standing-Committee, 2020)
- Train health, education, child services and MHPSS staff on COVID-19 related child protection risks. Conduct remote age and gender appropriate awareness raising.
- Contact children in families with histories of abuse.

Other evidence for mitigations to adverse child wellbeing and protection suggests:

- Messaging: build on things that have young people have expressed as being positives from the lockdown experience, for example increased focus on self-care, slower pace of life, increased sense of community, positive impact on environment.
- Communication: consideration of a child's developmental stage is crucial to ensure that communication is effective and neither underestimates or overestimates their understanding; listening to what children believe about COVID-19 transmission is essential (Dalton et al., 2020).
- Adapt existing referral pathways to facilitate:
 - Access to family counselling and drug treatment programmes.
 - Shared care arrangements, foster families. This is particularly important where relationships between parents is poor. However, shared care can also be a source of anxiety for children and it should not be assumed that shared care is a default protective mechanism.
- Schools focus on enhancing personal development (Liu, & Miller, 2020). Prioritise a focus on wellbeing in primary and secondary schools.
- Consider further expansion of nurses and social workers in schools.

- Further expand healthy relationships programmes at schools, and encourage and enable safe opportunities for children and young people to talk about family violence that might be occurring at home.
- Strengthen services for children with mental health issues.
- Ensure ongoing quality perinatal support, including home visits for parents and their babies.
- Develop targeted messaging for young people and support peer-to-peer messaging, encouraging children and young people to speak out.
- Lessons from the Christchurch earthquake response and recovery include:
 - Develop wellbeing messages aimed specifically at families and carers.
 - Child and youth response measures need to include a focus on adults with an eye on prevention of harm to children and young people, as well as creating a safety net and services for them after harm has been caused.
 - Limit the financial pain as much as possible.

Impacts and mitigation responses to COVID-19 by different population groups across Aotearoa NZ

Pandemics are experienced by groups differently. The range and intensity of impacts is likely to differ substantially across population groups within the New Zealand population, with COVID-19 expected to exacerbate existing inequalities.

The list of population groups below is not exhaustive. This review focuses on the population groups likely to be at higher risk of adverse social and psychosocial impacts from COVID-19 due to pre-existing physical and mental health conditions, disability, age, socio-economic disadvantage and structural and systemic inequities..

It is important to note that whilst belonging to a higher risk group means a person or population is statistically more *likely* to experience adverse impacts, being at higher risk is not a *determinate* of any impact. In addition, the concept of intersectionality means that those who fall into more than one group are likely to be more at risk (Cormack et al., 2020; Smith et al., 2019). It is also important to recognise that people, whānau and communities who may be considered higher risk in one or some aspects can also exhibit strengths and resilience which need to be factored into mitigation responses.

Due to the constraints of time it has not been possible to consider every possible group at higher risk, for example it has not been possible to include the prison population and prison workers within the scope of this review.

Summary table of population group specific impacts and mitigations

Population group	Mitigations and responses should:
<p>Māori:</p> <ul style="list-style-type: none"> • face existing health and social inequities compared to non-Māori • may face impacts on individual and collective mental wellbeing due to inability to carry out cultural practices 	<p>Incorporate the following principles of Mātauranga Māori to support resilience, recovery and transformation:</p> <ul style="list-style-type: none"> • Mana Motuhake - enable Māori to make and enact decisions within whānau, hapū, iwi. • Mana Taurite - address the underlying drivers of inequity • Mana Whakaora -strengthen capacity for long-term, collective wellbeing • Mana Motuhake - support iwi, hapū, whānau and Māori organisations to respond directly to the increasing health needs of their people • Mana Māori - enabling mātauranga Māori service designs • Mana Tangata - prioritise equity in national service planning and delivery. • Mana Whakahaere -contribute to the Crown’s obligations under Te Tiriti o Waitangi <p>Support Māori to foster community resilience by:</p> <ul style="list-style-type: none"> • use of traditional cultural practices or technologies • enabling collective decision-making, problem-solving and action • supporting the development of infrastructure • strengthening cultural identity, connectedness and capacity for self-development.
<p>Tamariki</p> <ul style="list-style-type: none"> • Children are among those most at risk of psychological trauma, but impacts may not be apparent immediately • Children are at risk of harm as a consequence of adults’ stress • School closure means loss of key protective mechanisms • Risk of increased exposure to violence and abuse • Children’s fears in pandemics are often misunderstood and underestimated 	<p>Prioritise restoration and expansion of the child protection system.</p> <p>Prioritise the continuity of child-centred services</p> <p>Ensure there are child-specific considerations and programming of intervention strategies.</p> <p>Consider further expansion of nurses and social workers in schools</p> <p>Strengthen mental health services for children</p> <p>Develop child and young people friendly messaging</p> <p>Prepare child welfare system for what may lie ahead:</p>

<ul style="list-style-type: none"> • Adolescents are already a high risk group for mental health 	<ul style="list-style-type: none"> • extend and add prevention services • introduce guidelines for professionals making hard decisions where there are no services. • Reduce length of out of home care
<p>Pacific peoples:</p> <ul style="list-style-type: none"> • share many existing health and social inequities faced by Māori, in particular, a disproportionate burden of long-term physical and mental health conditions • are particularly overrepresented in overcrowding statistics 	<p>Ensure messaging is:</p> <ul style="list-style-type: none"> • available in Pacific languages <p>Support Pacific communities by:</p> <ul style="list-style-type: none"> • enabling Pacific community leaders • using culturally specific and appropriate approaches and reporting measures • promoting maintenance of community and cultural connectivity
<p>People experiencing social disadvantage: are less able to deal with unanticipated events because they are:</p> <ul style="list-style-type: none"> • exposed to markers of adversity associated with a range of negative outcomes including: <ul style="list-style-type: none"> ○ unemployment or income insecurity ○ material hardship ○ housing issues ○ benefit receipt • more likely to face more severe and long-lasting impacts during an economic downturn 	<p>Increase and ensure comprehensive employment support is available throughout all stages of obtaining employment, from job search to post-placement support.</p> <p>Increase and ensure generous financial and other assistance is available and promoted for those most at risk through:</p> <ul style="list-style-type: none"> • in-work financial assistance • wage subsidies • employers Subsidies for community and local government agencies • self-employment assistance <p>Increase training opportunities for job-seekers</p> <p>De-stigmatise services and benefits, and promote more constructive interpersonal interactions</p> <p>Continue to widen access and capability to digital technology, so that more people are able to engage and stay connected and to help reduce digital divide inequities.</p>
<p>Young people (18-25 years) are more at risk from changes in labour market conditions as they</p> <ul style="list-style-type: none"> • may be disconnected from current or anticipated education, training and employment opportunities. • face increased risk of “employment scarring” with negative long-term consequences for transitions into 	<p>See mitigations in section above.</p>

<p>adulthood and future labour market participation</p> <ul style="list-style-type: none"> • young people (and adolescents) are already at higher risk of poorer mental health and the crisis may increase risk factors • there are higher rates of suicide amongst this age group, and Māori males are overrepresented 	
<p>Older people (with and without care dependencies):</p> <ul style="list-style-type: none"> • are at greater risk of severe or fatal health consequences from contracting COVID-19 . • have a high risk of experiencing neglect, abuse or violence • are more likely to face existing social disconnection, isolation, loneliness • face reduced access to health services or providers • are at risk of elder abuse (particularly financial abuse) 	<p>Support continued outreach and contact through local community organisations.</p> <p>Consider innovative alternative interventions rather than digital/online options.</p> <p>Ensure messaging is:</p> <ul style="list-style-type: none"> • tailored to particular living situations that apply to older people • also targeted to the people that support older people <p>Targeted and proactive support for grandparents raising grandchildren.</p>
<p>Refugees and immigrants:</p> <ul style="list-style-type: none"> • may have extensive social and psychosocial needs due to <ul style="list-style-type: none"> ○ existing trauma from home countries ○ fear of or actual increased discrimination, racism or xenophobia • may have limited community resources 	<p>Provide COVID messaging in an accessible format</p> <p>Support and encourage cultural competency in public health preparedness and response and communication</p> <p>Recognise existing resilience within communities</p> <p>Prioritise initiatives that address cultural bias and racism</p>
<p>Disabled people:</p> <ul style="list-style-type: none"> • face existing poor social outcomes • may experience disruptions to services they are dependent on • face a higher risk of experiencing abuse and violence 	<p>Provide ongoing care and therapeutic support for disabled people– including support or respite for caregivers.</p> <p>Work with disabled people and disability service providers to:</p> <ul style="list-style-type: none"> • identify actions for the continuation of services and priority access to protective equipment • identify fiscal and administrative measures
<p>People with long term health conditions</p>	<p>Provide timely access to services, appropriate treatment and/or psychological support.</p>

<ul style="list-style-type: none"> • are at greater risk of severe health consequences from contracting COVID-19 • may face health service disruption • have a higher risk of experiencing negative impacts on mental health • face longer term social isolation and physical distancing 	<p>Ensure and improve access to online and telehealth support.</p>
<p>Frontline health and disability workers:</p> <ul style="list-style-type: none"> • are more likely to experience negative psychological impacts due to <ul style="list-style-type: none"> ○ increased risks of exposure to virus ○ actual or perceived stigmatisation ○ work place stressors (e.g. inability to save lives during the pandemic) 	<p>Address effects of stigmatisation in health care workers, particularly those who have been quarantined.</p> <p>Reduce specific work-place stressors, including early intervention and awareness training.</p> <p>Introduce supports for general welfare of medical staff.</p> <p>Provide specialised psychological support for medical staff.</p>
<p>Essential workers:</p> <ul style="list-style-type: none"> • Are more likely to be low paid or casual workers • may face increased stress levels due to: <ul style="list-style-type: none"> ○ Increased pressure at work ○ Increased exposure to disease ○ Potential increased abuse from public 	<p>Consider additional or fully supported leave options implemented for all essential workers.</p> <p>Leverage off increased awareness and valuing of essential nature of these often poor paid roles to promote debate around fairer/living wage to help reduce inequities.</p>
<p>Women:</p> <ul style="list-style-type: none"> • are more at risk from negative mental health impacts due to <ul style="list-style-type: none"> ○ increased caregiving or caring responsibilities ○ overrepresentation in health workforce exposed to patients with the virus • face an increased risk of gender-based violence, in particular family and sexual violence which in turn increases likelihood of negative social and psychosocial impacts 	<p>Apply a gender lens in response planning.</p> <p>Encourage people to access informal and virtual support networks wherever possible.</p> <p>Ensure family and sexual violence support services are sufficiently resourced to continue service provision and to support increased demand.</p> <p>Ensure that frontline responses to family harm or violence incorporate targeted mental health support for both victims and perpetrators.</p> <p>Ensure adequate collection and analysis of gendered data on the effects of the current pandemic on women.</p>

Pacific peoples

Pacific people share many of the same health and social inequalities as Māori, including “frequent and disproportionate challenges around poverty and lack of opportunity” (Salesa, 2017). They are at higher risk of more rapid COVID-19 spread given their vulnerabilities, and experience harm from not accessing care as service models shift from face-to-face to virtual / telehealth. Pacific people are the most overcrowded population in New Zealand, communities tend to be highly urbanized, and have a disproportionate burden of long term physical and mental health conditions (Pasifika Futures, 2017). Many in Pacific communities have poor access to telehealth and other options for remote access to health and social care.

Despite a recent pre-COVID decrease in Pacific unemployment rates, the unemployment rate for Pacific people still remains disproportionately high when compared to the national unemployment rate, at 11.1% versus 5.7% respectively between 2008 and 2016. During the financial crisis of 2008 to 2012 all ethnic groups saw an increase in unemployment, however, Pacific people were most affected (Pasifika Futures, 2017). Employment is the primary driver of income levels for Pacific people; increased levels of unemployment due to economic downturn is likely to disproportionately impact Pacific people (and Māori). In addition, more recent decreases in unemployment amongst New Zealand’s populations have been driven by higher employment in industries that are typically lower paid and, in some cases, likely to be hit hard by a recession, such as utilities and construction, transport, warehousing, IM and communications, and accommodation and food services (Pasifika Futures, 2017).

New Zealand’s Pacific population has families in the Pacific who will also be experiencing the impact of the pandemic on their incomes and access to goods. Cultural practices such as tithing and sending money home to support families, may become increasingly important.

However, the Pacific communities also have shown resilience in the face of adversity. Community and cultural connections are very important to Pacific wellbeing and may mitigate against some adversities including poor mental health (Ataera-Minster & Trowland, 2018). Strong structures and high levels of connectivity built around leaders, elders and the church are an important asset in mitigating negative social and psychosocial impacts and in messaging around the virus.

Despite entrenched disadvantages, Pacific communities have continued to innovate in multiple fields across business and culture (Salesa, 2017). Pacific communities evidenced strong adaptability during lockdown, for example by holding services and community meetings online.

Mitigations

- Clear, consistent and values-based messaging and support in Pacific languages
- Recognition of the expertise and leadership in Pacific communities (strong youth-led leadership, both faith-based and community organisational).
- Using culturally specific approaches to mitigating adverse impacts on mental wellbeing, and culturally appropriate reporting measures (Manuela & Sibley, 2015; Tiatia-Seath, 2016; Tiatia-Seath et al., 2017).

Socio-economic disadvantage through lack of resources

International research indicates that “socially disadvantaged groups have fared the worst of any population during influenza pandemics”.⁵¹ This includes those who are already experiencing socio-economic disadvantage as well as marginalised minorities. People living in poverty have little room for error or capacity to deal with unanticipated ‘shocks’ or adverse events in a family’s life.

Under lockdown, households may experience increases in household expenditure, particularly for power and food (where food was previously provided elsewhere, such as schools, work or community groups). During the four-week lockdown period there has been a reported increase in use of foodbanks and food parcels, with the Salvation Army distributing four times as many food parcels in the week up to 14 April 2020 compared to a month earlier in the week up to 17 March 2020 (The Salvation Army, 2020).

Poverty and material hardship: the New Zealand context

Several measures of poverty and material hardship are used in New Zealand to reflect the economic living circumstances of New Zealand households. Recent estimates indicate that around 10% of the whole population of New Zealand was living in poverty in 2018 using the 50% median equivalised disposable household income before housing costs (BHC) are deducted and around 16% of the whole population after housing costs are deducted.⁵²

Using the BHC measure, this rate is nearly double for Māori and Pasifika households. Disabled people are also overrepresented among low income groups; in June 2019, their median weekly income was \$392 (compared with \$749 for non-disabled people).⁵³ New Zealand’s 2019 child poverty figures report around 15% of children (168,500) living before the 50 per cent median poverty line and around 13% of children are living in households that have experienced material hardship.⁵⁴

Working is not a guaranteed protection against poverty. **Using the 60% of median BHC measure**, research on ‘in-work’ poverty in New Zealand found that almost 51,000 households (7% of total households) are both working and in poverty (Plum, et al., 2019; Perry, 2019).⁵⁵ Between 2007 to 2018, about 40% of children in poverty were

⁵¹ When the H1N1 virus (also known as ‘swine flu’) swept the globe in 2009, researchers in the United Kingdom found that mortality rates were three times higher in disadvantages neighbourhoods compared to more affluent areas (NSW Government, 2020).

⁵² <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/household-incomes/household-incomes-1982-to-2018.html>

⁵³ Perry, B. (2019). *Household incomes in New Zealand: Trends in indicators of inequality and hardship 1982 to 2018*: <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/household-incomes/household-incomes-1982-to-2018.html>

⁵⁴ <https://www.stats.govt.nz/information-releases/child-poverty-statistics-year-ended-june-2019>

⁵⁵ Plum et al. figures based 60% before housing costs (BHC) poverty threshold, in line with international practice. Perry, 2019 figures on in-work poverty rates for New Zealand are round 7-8 % using either a relative BHC 60 measure or a relative AHC 50 measure, with not much change in the last 10 years.

living in working households, and rates of working poverty are nearly doubled for Māori and Pacific (Plum et al., 2019). Also overrepresented in New Zealand's 'working poor' are single parents, disabled people, those with health problems and learning difficulties, and migrants (migrants from north-east Asia have the highest rates of in-work poverty)(Plum et al., 2019).

The impact of COVID-19

The most significant effect of recessions on people's income is job loss. It is likely that the COVID-19 crisis will increase the number of households with incomes below standard poverty lines or living in material hardship through loss or reduction in wages and employment. Not everyone whose earnings have reduced in the COVID-19 crisis will necessarily experience a large increase in material hardship. Some people will be able to draw down their savings, get assistance from family and friends, or have an income source through a partner. But there will also be people who do not have these backstops and may also be in significant financial strife because of pre-committed expenditure, for example on housing and consumer debt such as loans for vehicle purchase.

Those who are already on low incomes (which includes many essential workers including support workers), and those with irregular incomes, are more likely to be pushed into poverty and material hardship. Material hardship data from the Global Financial Crisis years 2007 – 2013 shows that changes to the general state of the economy (wages and employment especially) had a rapid and noticeable impact on those who were not at the deepest levels of hardship but 'just getting by'. The households in this category can have their actual day-to-day- living conditions significantly changed by even modest changes in income (Perry, 2019). The Salvation Army has reported concerns of new groups of people and whānau entering financial hardship in the first 28 days in the lockdown: many people receiving food parcels are first-time users of our foodbank services (The Salvation Army, 2020).

Mitigations

- Provide access to generous financial assistance and debt relief to mitigate the impacts of poverty. Income is a key social determinant of health. More generous schemes can provide a protective buffer against the adverse health-related consequences of unemployment and income reduction (Gunnell & Chang, 2016; Leão et al., 2018; Rambotti, 2020; Reeves et al., 2014; Shahidi et al., 2016, 2019)
- There is strong evidence that suitable work improves mental health. Re-employment has been found to lead to improved self-esteem, improved general and mental health, and reduced psychological distress (Curnock et al. 2016).
- Strengthen efforts to match unemployed with emerging work opportunities and provide greater support for retraining opportunities.
- Recognising that poverty has negative impacts on cognitive functioning will be important (Daminger et al., 2015; Sheehy-skeffington & Rea, 2017).

- Initiatives aimed at assisting those on low incomes should:
 - reduce or eliminate the costs of poverty, e.g. the difficulty applying for financial assistance (Daminger et al., 2015).
 - build an adequate cushion of time, money, attention, and other critical resources as a prerequisite for escaping poverty. People living in poverty have little capacity to deal with unanticipated shocks or adverse events in a family's life.
 - empower people by de-stigmatizing services and benefits, promote more constructive interpersonal interactions, and put decision making back in the hands of families (Daminger et al., 2015). Institutions need to ensure they work in favour of, rather than against, the psychosocial processes of their users (Sheehy-skeffington & Rea, 2017).

Other mitigations may include:

- Case management and job search assistance (i.e. reminders, kiosks etc)
- Increased provision of one off and ongoing in-work financial assistance (e.g. employment and work readiness assistance, raising the cash asset test for AS), and more extensive provision of information about financial assistance when in work ('Better off in Work' info).
- Wage subsidies for highly at risk job seekers.
- Industry specific short-term training for job seekers.
- Subsidies for community and local government agencies to employ those most at risk of long term employment.
- Self-employment assistance (for a small group of people with previous experience who have business plans).

Incorporate recommendations from the Welfare Expert Advisory Group's report which include principles to guide the design and operation of the welfare system.⁵⁶

Young people (18 – 29 years)

There is evidence for considering young people aged between approximately 18 – 29 as a high risk population group in the context of COVID-19. Previous recessions have seen a sharp rise in unemployment in New Zealand, with young Māori and Pacific peoples especially disproportionately affected.⁵⁷ Research in New Zealand found that cohorts of young people who enter the labour market during periods of high overall unemployment experience different outcomes around transitions into adulthood (Rea & Callister, 2009). These transitions include leaving home and school, getting a job, forming relationships, and having children.

There is plentiful evidence linking temporary disadvantages in the labour market during young adulthood with substantial lifetime impacts on range of wellbeing outcomes. Being unemployed when young leads to higher likelihood of long-term 'scarring' later in life in terms of subsequent lower pay, higher unemployment and reduced life chances (Bell & Blanchflower, 2011; McQuaid, 2017; McQuaid et al., 2014). These findings were echoed in a recent study that investigated the midlife impacts of those graduating during a

⁵⁶ <http://www.weag.govt.nz/weag-report/whakamana-tangata/>

⁵⁷ Unemployment for those aged 20-24 rose from 7% - 12% between June 2008 and June 2009. In comparison, unemployment for those aged 40-44 rose from only 2.4% to 3% (Rea & Callister, 2009).

recession (Schwandt & Wachter, 2020). Youth unemployment and the duration of unemployment throughout adulthood is also associated with elevated levels of psychological distress around mid-life (Daly & Delaney, 2013).

Young people with NEET status (not in educational, employment or training) may be more disadvantaged in terms of both gaining and maintaining employment and the type of employment they can secure. A study in Scotland using longitudinal analysis over 20 years found that young people NEET status experience long term 'occupational scarring' (Ralston et al., 2016).⁵⁸

Besides the risks from labour market conditions and employment scarring, there is also emerging evidence that people aged 18-25 suffered the effects of the initial four-week lockdown period. Data from Colmar Brunton's COVID-19 survey series that explored 'bubble behaviours' in New Zealand found that people aged 18-29 (of both genders) were one of the groups that experienced the largest negative change in life satisfaction, and the greatest increase in loneliness (especially young women) (Colmar Brunton, 2020). These findings correspond with data from pre-COVID-19. New Zealand's 2014 General Society Survey found that those aged 15-24 had the highest levels of loneliness (16.8%) of all age groups, with women more likely to report higher levels of loneliness than men.⁵⁹

Mitigations

Increase support for NEETs and young people on the cusp of their careers.

See mitigations against poverty and employment on pp.56.

Older people (with and without care dependencies)

Data on COVID-19 cases clearly shows that older are the most at risk from contracting COVID-19 as the group with the highest fatality rates. There are other important risk factors to consider alongside susceptibility to contracting the virus. A recent report by the United Nations (2020) *Policy brief: The Impact of COVID-19 on older persons*⁶⁰ provides a good overview of the impacts of COVID-19 on older people and identifies a range of policy and programme responses.

Older people who are single and living alone and / or struggling with lack of income, poor heating and warm clothing may be particularly at risk. In addition, older people may also be at risk during the COVID-19 crisis due to:

- Having difficulty caring for themselves and depend on family or caregivers, and services are withdrawn.
- Not always able to go to the health services, the services provided are not adequate for older people, or health services are rationed.

⁵⁸ 'Occupational scarring' is defined as long periods of time spend in lower paid occupations and the impact on future earning prospects. Ralston et al also found that the effects of NEET status on occupational scarring are variable by level of education and gender.

⁵⁹ <http://www.socialreport.msd.govt.nz/social-connectedness/loneliness.html>

⁶⁰ https://www.un.org/sites/un2.un.org/files/un_policy_brief_on_covid-19_and_older_persons_1_may_2020.pdf

- Language and communication barriers: older people not understanding the information and messages provided or unable to follow the instructions.
- Restrictions on visitors in residential care facilities inducing or exacerbating loneliness and isolation. This also applies to older people not in care facilities who have likely been in isolation for longer.
- Family who are suffering financial hardship taking advantage of older people (a form of elder abuse).
- Residential care facilities for older people no longer have external eyes and ears ensuring elder abuse is not occurring by staff who will also be under significant strain.
- Older people being targeted by increased cyberattack activity, as reported internationally.
- Older people being targeted by door knockers offering to do their shopping, giving COVID-19 testing in the homes, as reported internationally.
- Digital exclusion – most information resources and services have moved online
- Loss of employment – increased discrimination as unemployment rates rise
- Increased ageism and discrimination – some of which may have been exacerbated by initial messaging and the ongoing use of terms such as 'elderly' and 'vulnerable'.
- Older people lacking confidence – being able to reintegrate into their activities/society, going out again, driving – feeling safe – especially when they see unsafe practices all around them. Grandparents raising children have increased social and economic pressures.

Mitigations

Specific interventions required for older people during this time include⁶¹:

- Supporting local community organisations to continue to reach out to their membership with phone trees as a way of checking on each other and breaking the isolation. Computer interventions are not necessarily appropriate for this population group who sometimes struggle with banks, social services and other organisations who are mainly digital these days.
- Tailor messages and make them actionable for particular living conditions (including assisted living facilities), and health status.
- Engage older people and address their specific feedback.
- Develop specific messages to explain the risk for older people and how to care for them, especially in homecare. Target family members, health care providers and caregivers.

⁶¹ Mitigations and some risks listed are drawn from *COVID-19: How to include marginalised and vulnerable people in risk communication and community engagement*: https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2020/03/COVID-19_CommunityEngagement_130320.pdf

- Draw on examples of community led, cultural responses. For example, geographically isolated Māori communities, through collective largely marae based actions, have ensured their kaumatua have their food and other needs met, whilst observing distancing protocols.

Refugees, immigrants and ethnic groups

Refugees and some immigrant communities are likely to experience worse impacts of COVID-19 due to different and extensive social and psychosocial needs, including existing trauma from home countries which increases mental health requirements, chronic underlying health conditions, overcrowded housing, limited material resources, language and cultural barriers which impede access to services and understanding public health communications. Refugees may have limited community resources to draw upon.

Stigma, racism and xenophobia: persons whose culture or country of origin are identified as the source of a pandemic may fear negative social outcomes as much as the disease itself. This risk is greater if media stories repeatedly associate the origin of an outbreak with specific or well-defined ethnic, geographic, or cultural profiles (Truman et al., 2009).

Mitigations

- Refugees and immigrants need clear, accessible, timely and targeted COVID-19 related messaging and advice, in a form and language that they can access and understand. Some communities may prefer to respond to verbal and audio communication and messaging, for example through community language radio. It may be preferable for information to be communicated through community groups or NGOs who already have expertise in supporting refugees (e.g. the Red Cross).
- A literature review of pandemic response amongst immigrants and refugees also highlights the need for cultural competency and understanding of connections between religious or cultural beliefs and health practices are critical in public health preparedness and response (Truman et al., 2009).
- It is important to consider that refugees and immigrant communities many have already lived through crisis and, whilst they may suffer from negative effects of crisis, are also adaptive and resilient as result.

Disabled people

Disabled people are likely to experience disability-specific impacts as well similar types of psycho-social impacts to non-disabled people but on a magnified level. Disabled people as a group already have poorer social outcomes across a wide range of measures including income, housing, employment, wellbeing and health (Murry,2019). Any additional impact will lead to even poorer outcomes.

Disabled people may also be disproportionately impacted by the outbreak because of disruptions to the services they rely on. Their families and whānau can also be affected

with the increased burden of supporting their disabled family member due to support workers being unavailable or being able to cover the costs of care⁶². Caring for a disabled family member can be stressful and disrupting support networks can create significant increased stress on the family unit in some cases (Ward, 2015).

Mitigations

- Provide good quality information targeted to the needs of disabled people
- Provide ongoing care and therapeutic and learning support for neuro-diverse children and those with disabilities – including support/respite for caregivers
- Provide accurate information which makes the distinction between physical distancing and social distancing. Encourage people to remain socially engaged as this is critical for community connectedness and wellbeing.
- Work with the disability service providers to identify actions for the continuation of services and priority access to protective equipment
- Undertake targeted measures for disabled people and their support networks
- Work with disabled people and their representative agencies to rapidly identify fiscal and administrative measures
- Work with the disability service providers to identify actions for the continuation of services and priority access to protective equipment

Ministry of Health and the World Health Organisation have provided information and guidance on COVID-19 for disabled people.⁶³

People with long term health conditions

People with long term health conditions (physical) are likely to experience health specific impacts as well as similar types of impacts to those without long term health conditions. People with long term health conditions already have poorer social outcomes across a wide-range of measures including income, housing, employment and wellbeing.

People with chronic physical health conditions are at greater risk of poor mental health than those who do not have a physical health condition. People with chronic health conditions are likely to face an additional risk of developing a mental health problem or worsening an existing one because of heightened fear of contracting the virus and any stress associated with maintaining their physical health in lockdown. Following the SARS epidemic in Hong Kong, the presence of pre-existing chronic health conditions was a significant predictor of PTSD among people who recovered from SARS (Mak, et al., 2012).

Like disabled people, those with long term health conditions are likely to be disproportionately impacted by COVID-19 because of disruptions to services they rely on.

⁶² Evidence is considerable that having a health condition or disability imposes additional costs on individuals and families. Families with a disabled child or a child with significant health conditions have lower income, living standards and higher levels of social exclusion (Melnichuk et al, 2018; Wynd, 2015).

⁶³ <https://www.who.int/who-documents-detail/disability-considerations-during-the-covid-19-outbreak>
<https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-information-disabled-people-and-their-family-and-whanau/covid-19-getting-disability-support>

Mitigations

- Provide quality information targeted to the needs of people with pre-existing health conditions
- Provide accurate information which makes the distinction between physical distancing and social distancing. Encourage people to remain socially engaged as this is critical for community connectedness and wellbeing
- Offer technology enabled mental health services
- Continuing to address the social determinants of poor mental and physical health.
- Provide additional financial and proactive, practical support to grandparents raising grandchildren.

Frontline health and disability workers

Frontline health and disability workers include health and disability support staff and carers as well as doctors, nurses and other medical staff.

Studies from recent COVID-19 contexts and past epidemics show that health workers are at increased risk of depression, anxiety and stress, burnout, PTSD, and isolation from family and other supports due to quarantine or contracting the disease (Chen Q et al., 2020; Kang L et al., 2020; McAlonan, G. et al., 2007). Other studies show that front-line health care workers experience higher anxiety than the general community about contracting viruses during pandemics (Chua et al., 2004). The inability to save lives during COVID-19 has been predicted to take its toll physically and mentally on nursing staff (Jackson et al., 2020). Some studies indicate that healthcare workers are more likely to experience worse psychological effects from being in quarantine (Brooks et al., 2020b).

Mitigations⁶⁴

- Strategies to reduce specific work-place stressors, including early intervention and awareness training.
- Supports for general welfare of medical staff.
- Provide specialised psychological support for medical staff.

Essential workers

Essential workers include carers, supermarket staff, prison staff, transport drivers, refuse collectors and cleaners. Some of these essential worker jobs are low paid and casual. Essential workers may face increased stress levels related to changes at work, increased exposure to the disease and the potential increased levels of abuse from members of the public.

Mitigations

- Consider additional or fully supported leave options implemented for all essential workers.

⁶⁴ For a full list of recommended mitigations see: <https://psychscenehub.com/psychinsights/mental-health-challenges-healthcare-workers-during-covid-19-pandemic-management-strategies/>

- Leverage off increased awareness and valuing of essential nature of these often poor paid roles to promote debate around fairer/living wage to help reduce inequities.

Women

Women may face greater mental health risk where they are the primary caregiver, either as sole parents or within a relationship. Women are also more likely than men to be family carers for disabled people, older people, and people with long term health conditions - and therefore risk carer burnout.⁶⁵ Women make up a large amount of the health workforce. Division of labour in a relationship may increase the daily workload, including childcare / supervising children's education, home activities e.g. laundry, and maintaining pre-lockdown employment activities.

Women are likely to be more exposed to the economic downturns driven by COVID-19 because of its impact on sectors with high female employment workforce, combined with the impact of school closures on working mothers (Ministry for Women, 2020; Olmstead-rumsey et al., 2020). Data from New Zealand's Household Labour Force Survey shows that women have been more severely affected by past crises and labour market shocks than men, with diverse groups of women being affected (Ministry for Women, 2020).

Women and children are already at a higher risk of experiencing family violence pre-lockdown and this is anticipated to increase during lockdown as people are unable to remove themselves from family violence situations, which may produce ongoing trauma.

Women who fall into multiple groups experiencing existing inequalities may feel the combined effects of factors such as race, age, sexuality and disability with gender (Ministry for Women, 2020).

Mitigations

- Apply a gender lens in response planning.
- Encourage people to access informal and virtual support networks wherever possible.
- Ensure family and sexual violence support services are sufficiently resourced to continue service provision and to support increased demand.
- Ensure that frontline responses to family harm or violence incorporate targeted mental health support for both victims and perpetrators.
- Ensure adequate collection and analysis of gendered data on the effects of the current pandemic on women.

⁶⁵ As cited in Ministry for Women's 2020 report: *2018 Census data shows us that more women perform unpaid work than men*. Of Census respondents who had looked after children in their household in the previous four weeks, 57.5 percent were women. Of Census respondents who had looked after ill or disabled people in the household, 60.8 percent were women.

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