Te Hiringa Mahara
Mental Health and Wellbeing Commission

COVID-19 Impact Insights Paper #8

Wellbeing impacts of the COVID-19 pandemic

June 2023

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A report issued by Te Hiringa Mahara - Mental Health and Wellbeing Commission.

Te Hiringa Mahara wishes to recognise the valuable contributions to the content and preparation of this report from the community organisations we have engaged with over the last year, and who provided input to each of our previous COVID-19 insights reports. We also want to thank the reviewers of each of those source reports, and our colleagues at the Social Wellbeing Agency for reviewing this report.

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Te Hiringa Mahara – the Mental Health and Wellbeing Commission – was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

For more information, please visit our website: https://www.mhwc.govt.nz/
The mission statement in our Strategy is “clearing pathways to wellbeing for all.” Te Hiringa Mahara acknowledges the inequities present in how different communities in Aotearoa experience wellbeing and that we must create the space to welcome change and transformation of the systems that support mental health and wellbeing. Transforming the ways people experience wellbeing can only be realised when the voices of those poorly served communities, including Māori and people with lived experience of distress and addiction, substance or gambling harm, are prioritised.

Te Hiringa Mahara - Mental Health and Wellbeing Commission (2023). **Wellbeing impacts of the COVID-19 pandemic**. Wellington: New Zealand.

Summary

The COVID-19 pandemic has seen huge change and disruption to communities across Aotearoa. The pandemic has highlighted and exacerbated many inequities in wellbeing in Aotearoa, but it also highlighted the strength, resilience, and resolve of communities to support wellbeing.

Across a series of short reports[1], we have explored the wellbeing impacts for Māori, for older people, rural communities, for Pacific peoples, for people at risk of family violence across a range of communities, and have seen parallels in the face of other crises. This paper draws on these reports and wider research to highlight the wellbeing impacts of the pandemic, and to learn from them. This paper does not evaluate the Government's COVID-19 response – it highlights the shared and unique wellbeing impacts of the pandemic, for people who experience greater challenges to wellbeing across Aotearoa.

Many of the challenges faced in the pandemic were not new – but were made more starkly visible for a lot of communities. We have seen and described this in our previous reports: the pandemic has exacerbated and amplified many inequities in mental health and wellbeing outcomes, and in access to services and supports. It has seen racism and discrimination increase, and it has affected the wellbeing of different communities in different ways. It has particularly affected the wellbeing of people who belong to several underserved communities, compounding the impact for those who experience intersecting disadvantage.

While there are many shared challenges, different communities across Aotearoa also face unique challenges. Different populations in Aotearoa have unique mental health and wellbeing needs, and, in times of crisis, require support tailored to meet these. Accessing and understanding information about the pandemic was challenging for some communities, contributing to increased fears and anxiety. While largely successful, the approach to vaccination did not work for all communities; and the latter stages of the pandemic have impacted communities differently.

Wellbeing inequities, as well as different social, economic and cultural needs, mean that a one-size-fits-all approach is inadequate for many populations in Aotearoa.

Such an approach can be seen as inadequate to support Māori wellbeing, and does not reflect Te Tiriti partnership. In the face of this, and building on existing history and knowledge, iwi, hapū, and whānau Māori exercised rangatiratanga, providing practical support for themselves and others through the pandemic. Māori responses to the pandemic were grounded in tikanga Māori and mātauranga Māori, and built on

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[1] This paper is the last in a series of eight short, focused insights reports that highlight key elements of the wellbeing impacts of the pandemic in Aotearoa. For the rest of the series, please see our website https://www.mhwc.govt.nz/our-work/covid-19-insights/

established networks and relationships. In this way, Māori-led responses were agile and adaptive in protecting the health and wellbeing of communities.

In the face of similar inequities and needs, the strengths, resourcefulness, and contributions of many communities were evident as they engaged in opportunities to improve wellbeing for themselves and others. Our COVID-19 reports have repeatedly highlighted that while communities sought to meet unique needs, common strengths were evident across their responses. These include a strong sense of connectedness and belonging, clear leadership, innovative practices and collaboration with and between services and government agencies.

Where government decision-makers and agencies have been able to draw on these community strengths, support communities' self-determination, and strengthen these common enablers, they have been able to better support wellbeing together.

Te Hiringa Mahara has drawn on the findings, across our reports and wider community engagement and research reported here, to call for **new or better ways of working with communities**:

- Recognising the value and exercising of rangatiratanga, and giving Māori, iwi, hapū and whānau the freedom and resources to act in the way that best meets their wellbeing needs.
- Where government continues to provide services, planning them in partnership with Māori, meaning government responses are informed by tikanga and matauranga Māori.
- Employing high-trust models for working with communities, enabling community-based providers and communities to spend more time and energy supporting local wellbeing, in ways that work for them.
- Recognising and consulting those groups who often have poorer wellbeing outcomes, and including their community leaders and members in planning and decision-making.

Communities have drawn on their own knowledge, resources and networks for wellbeing, supported by a range of common enablers, including trusting support from government, having resilient social infrastructure, and being able to use digital infrastructure to be innovative. This means there are some **practical actions or enablers that can support wellbeing**:

- Funding and assistance for marae to maintain the capacity to provide practical support to their communities will support wellbeing now, and in the face of future crises.
- Government resources to support the sustainability and resilience of other community organisations and social hubs who provide wellbeing support, will protect wellbeing now and enable preparedness for the next crisis.

- Ongoing investment in bridging the ‘digital divide’ will support connection and wellbeing, especially when other social connections are unavailable, such as during ‘lockdowns’.
- Continuing investment in accessible, responsive, and ongoing comprehensive trauma and distress support, which will support communities in the future, in general and during times of crisis.

Improving wellbeing requires understanding the wellbeing of individuals, whānau, and communities, and the unique challenges experienced by different communities and people who intersect them. To understand the needs and wellbeing experience of many populations, **investment in high quality research and data is needed**:

- High quality research and data will support iwi and Māori responses and will help build the trust needed for partnership. Greater emphasis needs to go into sharing relevant information and supporting Māori research and researchers to address these concerns, including upholding Māori data sovereignty.
- We experience wellbeing differently, based on a variety of factors. If we are to improve wellbeing for all, we need better disaggregated data and research to understand wellbeing for different communities, including people with lived experience of distress or addiction, Pacific and Asian peoples and the ethnic communities that make up these groups.

Introduction

The COVID-19 pandemic disrupted the daily lives of millions in unprecedented ways. As COVID-19 began spreading around the world in January 2020, it overwhelmed health care systems and caused widespread loss of life. The extraordinary crisis required an extraordinary response, and Aotearoa New Zealand's government took measures to combat coronavirus transmission, including international border closure, national and regional lockdowns, contact tracing, face mask mandates and societal restrictions.

Beyond the health repercussions of the virus itself, these response measures also presented a challenge to the economic, social, and public systems and processes that support wellbeing in Aotearoa.

Over the last year, Te Hiringa Mahara has sought to better understand the impact of the pandemic on wellbeing in Aotearoa. To do this, we have produced a series of seven papers, embracing whanau-level, community-level, non-health-system concepts of wellbeing and wellbeing enhancement (instead of "services" and "service delivery"), which have contrasted narratives of failure and deficit with community examples of success and narratives of individual experience with community worldviews; and focused on outcomes for Māori and other populations.

This eighth report draws together the key findings of those seven previous reports, with additional evidence-based literature and engagement with communities, to highlight the shared and unique wellbeing impacts of the pandemic so far, and to call attention to the common things we have learned from this to improve wellbeing.[2] In doing so, this report necessarily repeats some content from those past reports – this is because that information bears repeating, and informs the shared findings and calls for action across our reports and across communities.

These reports have not, and cannot, evaluate the overall pandemic response, but they provide a view on how wellbeing has been impacted and, importantly, how government decision-makers, agencies, and communities can work together to support wellbeing in Aotearoa.

He Ara Oranga Framework

Individually, we each have a sense that our wellbeing is made up of a great many factors – some concrete and material, some intangible but no less important. Taken together, as in our He Ara Oranga wellbeing outcomes framework (see Appendix 1), we know that people need to have their rights, dignity and tino rangatiratanga fully realised, need to feel safe, valued and connected to communities and cultures, and

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[2] All references cited in this report are from Aotearoa unless otherwise specified in the text.

people need resources, skills, resilience, hope and purpose for the future. This understanding of wellbeing has guided our COVID-19 insights series.

The first paper in our series[3] showed that media coverage on the mental health problems contributed to by the pandemic was largely concentrated on the changes to people's work, education, and lifestyle, the material impacts of this, and loneliness. In general, coverage of mental health in the pandemic focuses on the material resources and services that people have access to, and stresses that emerge when these are lacking. These are important elements, but this narrow framing misses out other wellbeing elements that we know are important to mental health in Aotearoa, including:

- rights, dignity and tino rangatiratanga;
- tikanga and culture;
- whānau skills and resilience;
- connection and value;
- and having hope, purpose and community self-determination.

Further, by universalising the impacts of the pandemic, some media narratives may be counter-productive to understanding wellbeing – a sense of 'we are all in this together' may be beneficial for rallying together a public health response, and for encouraging empathy, but if our understanding of the peoples' experience of wellbeing is monolithic, we miss the opportunity to understand and subsequently support greater wellbeing for different communities.

This wider understanding of wellbeing was reinforced through the rest of the series of papers, as people and communities we engaged with described the challenges they faced, and the actions they took to support the wellbeing of their whānau, families and communities. The importance of understanding different communities was similarly reinforced, as a variety of experiences and concerns were highlighted. While our series of short papers cannot canvas the full breadth of wellbeing and communities' responses to it, it highlights some key ways that communities have supported wellbeing, and can be enabled to further support wellbeing in the future.

In acknowledgement of Māori as tāngata whenua and Te Tiriti o Waitangi partners, this paper turns first to highlight findings about Māori responses to the pandemic. It then looks at the experiences of other communities in Aotearoa, to gain insight into the wellbeing impacts of COVID-19 on communities and their responses to this. The paper concludes with calls to action to support communities' wellbeing.

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[3] COVID-19 Impact Insights Paper #1 [Media reporting of COVID-19 and mental health and wellbeing]

Māori responses supported wellbeing in the pandemic

For Māori, wellbeing is greater than the individual, inextricably linked with whānau and the wider community. Oranga is a Māori concept, broader and more encompassing than wellbeing, that reflects a Māori upbringing, a Māori way of being and talks to a persons' connection or lack of connection to their whānau, hapū, iwi and whenua. The impact of alienation from their whenua and hapū/iwi, urbanisation, the impact of legislation and government policies have all contributed to the inequity faced by Māori.

In communities across Aotearoa, Māori did what they have always done to look after themselves and one another, and to support their wider communities. Our paper focusing on Māori exercising tino rangatiratanga during the pandemic[4] highlighted how Māori-led responses to the pandemic were vital to protecting the wellbeing of whānau and communities.

While the COVID-19 pandemic was widely touted as 'unprecedented', by the media, politicians and social commentators, Māori were only too familiar with the devastating impact of introduced diseases (Cram, 2021; Ngata, 2020; Te One & Clifford, 2021). Through colonisation experiences, Māori were severely impacted by typhoid, smallpox, influenza, measles, tuberculosis and other outbreaks, suffering considerably worse in all cases, than urban, non-Māori (Kawharu, 2020). Knowledge has been passed down through generations to today, so that when COVID-19 reached Aotearoa the devastating impact of previous introduced diseases were at the top of mind for many Māori (Boulton et al., 2022; Ngata, 2020).

Just as the experience of introduced infectious disease is not unfamiliar to Māori, neither is the experience of responding rapidly to protect and support communities. In the following sections we outline key ways that Māori responses to COVID-19 supported wellbeing; grounded in mātauranga Māori, building on established relationships and whānaungatanga, and being agile to protect health and wellbeing in changing environment.

A one-size-fits-all approach is not adequate and does not reflect Te Tiriti partnership.

While effective at preventing the spread of COVID-19 in Aotearoa, the government's pandemic response was challenged by Māori, who identified flaws or gaps in the nation-wide pandemic responses from the beginning (Devine et al., 2021; King et al., 2020; Kukutai et al., 2020; Reweti et al., 2022). Māori leaders were critical of the 'one size fits all' approach that was taken, in light of the specific needs of Māori, who face "stark, persistent, and increasing health inequities in Aotearoa" (Whitehead et al.,

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[4] COVID-19 Impact Insights Paper #6 Exercising rangatiratanga during the COVID-19 pandemic

2022, p.54). Serious concern was expressed that the government's approach to COVID-19 lacked acknowledgement of their positions as Te Tiriti o Waitangi partners and of Māori rangatiratanga (Reweti et al., 2022).

Some Māori leaders were critical of the decision-making approach and viewed the response as being overly 'top down' and 'one size fits all', without having followed tika processes such as deliberative face-to-face decision-making, and inclusion of leaders in a respectful manner (Morgan et al., 2022). As a result of this, major opportunities to consider and incorporate a range of Māori views and leadership, as well as some serious inequities such as those experienced in the current health system, were missed.

These approaches to decision-making had practical implications for Māori, for example in the inability to participate in tangihanga. Restrictions on gatherings prevented Māori from conducting timely customary funeral rites with support from kaumātua and whānau (Moeke-Maxwell et al., 2020). While there was general acceptance of the guidelines, many also felt that the Government had imposed restrictions with little regard to the practices and attitudes of Māori (Dawes et al., 2021; Moeke-Maxwell et al., 2020).

Māori exercised rangatiratanga, supporting themselves and others through the pandemic.

From the outset of the pandemic, Māori identified and managed risk, with iwi and hapū responses protecting the health and wellbeing of their people, and serving to off-set some of the pre-existing inequities in support.

Almost 50 roadside checkpoints were developed, resourced and led by iwi/Māori, staffed by volunteers, and often operated with co-operation of NZ Police (Cram, 2020; Pihama & Lipsham, 2020; Stanley & Bradley, 2022). The checkpoints provided an additional layer of protection for entire communities, including Māori and non-Māori residents (Ngata, 2020; Te One & Clifford, 2021). Checkpoints were also invaluable for communicating information, and contributing to a sense of trust, between government agencies and community (Rewi & Hastie, 2021).

Many iwi, hapū, marae, Māori hauora and social providers, organisations and community groups organised and delivered essential resources to members of the community, Māori and non-Māori, on the largest scale seen in recent history (Cassim & Keelan, 2022; McMeeking & Savage, 2020; Te One & Clifford, 2021). Many initiatives were marae-based and supported by Māori and non-Māori businesses (Cram, 2021), with priority given to members of the community facing greater challenges, such as kaumātua, low-income earners, those who were more isolated geographically, or had pre-existing health conditions (Te One & Clifford, 2021). Through rapid mobilisation and leverage of existing networks, areas of need were identified, and resources accessed and distributed (McMeeking & Savage, 2020), including kai, information, and essential items as well as support such as direct donations and financial support, transport and linking whānau with government agencies (Boulton et al., 2022; Cassim & Keelan, 2022). In rural areas, some Māori organisations and iwi used their allocated customary seafood catch or locally produced food to provide sustenance to communities (APEC SOM Steering Committee on Economic and Technical Cooperation, 2021; Cram, 2021; McMeeking & Savage, 2020).

While older people were recognised as being particularly at risk of the effects of COVID-19, kaumātua were also at the centre of community resilience during lockdown, collaborating with whānau to mitigate the impacts of the lockdowns and restrictions on travel and gatherings (Keelan et al., 2021). Kaumātua were active in looking after others through the coordination, creation and delivery of kai and care packs to others, and engaged in online initiatives.

The impact of marae being closed during lockdown was keenly felt and the inability to tangihanga together was particularly hard (Dawes et al., 2021; Moeke-Maxwell et al., 2020). Māori responded in innovative ways, using networks to support and strengthen communities through a range of media and forums, such as online mental health services, peer support phonelines, social and spiritual initiatives, phone calls checking in on people, and pop-up clinics in smaller rural communities (Manuirirangi & Jarman, 2021). Online innovations enabled Māori to maintain whanaungatanga through use of digital technology and online spaces, to build and maintain connections, share knowledge and support (Cassim & Keelan, 2022; Waitoki & MacLachlan, 2022). This helped ensure Māori maintained regular contact with community members, and karakia, tangihanga, and cultural workshops were conducted online (Cram, 2021; Te One & Clifford, 2021). Digital platforms provided a way for people to keep busy, to learn different skills, to connect with others or for pleasure and amusement (Waitoki & MacLachlan, 2022).

Māori-led actions continued to protect the community as the pandemic unfolded. These included establishment of Te Roopū Whakakaupapa Urutā, a National Māori Pandemic response group of Māori health experts, to focus on the wellbeing of Māori and provide a Māori voice (Pihama & Lipsham, 2020); advocating, promoting and actively supporting COVID-19 vaccinations (Reweti et al., 2022); and opting to keep all Kohanga Reo closed (Te One & Clifford, 2021), to continue protection of their communities. Through Whānau Ora Commissioning Agencies, Māori guided the allocation of Government funding, made available to support Māori.

Māori ways of being and connecting were enablers of success.

At the outset of the pandemic, in early March 2020, “most crystal balls would have predicted that Māori would experience disproportionately higher rates of infection and mortality from Covid-19; some commentators were forecasting a mortality rate twice that of non-Māori” (McMeeking & Savage, 2020, p.36). However, in that first wave, Māori had remarkably low rates of infection, and even as numbers rose when the Delta variant entered the country, Māori responses continued to protect and support Māori communities. Throughout the pandemic, and especially during lockdown, Māori communities repeatedly demonstrated innovative means of resilience, through distributed leadership, localised self-determination, and care, empowered by the strength of their connections and relationships (Carr, 2020; Kukutai et al., 2020; Manuirirangi & Jarman, 2021; McMeeking & Savage, 2020).

Māori responses to the pandemic were grounded in tikanga Māori and mātauranga Māori.

A tikanga-centred approach meant a focus on oranga, the health and wellbeing, of the collective, rather than on the individual. Led by values such as mana, manaakitanga, kaitiakitanga, whanaungatanga and rangatiratanga, Māori communities looked out for and took care of each other.

While lockdowns and restrictions on travel and gatherings presented significant challenges to tikanga Māori, marae across Aotearoa developed pandemic plans that adapted tikanga and kawa to the challenges that were presented (Cassim & Keelan, 2022). Kaumātua had frontline and leadership roles in adapting tikanga, seen in hapū and marae committees temporarily closing their marae; in new approaches to tangihanga, despite the huge personal and spiritual impacts this had; and in many changes to the way people interacted in kanohi ki to kanohi, 'face-to-face', settings, to prevent the spread of disease.

> "… we did what it takes and we still do and we'll continue to do that because that's what Māori providers do. That's what Māori do. Even when you're not in this game, it's kaupapa Māori, it's tikanga, it's kawa." (Ali Hamlin-Paenga, CE, Ngāti Kahungunu Whānau Services, 2022b)

The Māori response built on established networks and relationships.

Māori know their own. Relationships and networks were of key importance throughout the COVID-19 response (Manuirirangi & Jarman, 2021). Established community networks, relationships and social capital enabled Māori to gather information and data about whānau health and wellbeing, distribute resources and provide care and support, often prioritising those who were most vulnerable or faced particular challenges, including kaumātua and those who live rurally. Māori networks played a critical role in conveying COVID-19 related information to communities, ensuring access to the government public health messages, and prioritising reaching parts of the community that can be hard to reach. Social networks within their communities supported kaumātua who live in relatively isolated rural areas, providing access to important resources such as food, income, and health care.

> “The critical insight is that Māori networks can and do unlock resources that would otherwise not have been available for community relief.” (McMeeking & Savage, 2020, p.38)

The Māori response was agile and adaptive in protecting the health and wellbeing of communities.

The speed, scale and purpose of Māori mobilisation should not be surprising. Māori have had much experience of rapid mobilisation, for example, in response to crises and disasters, and within iwi to organise and support tangihanga. Communities being self-reliant and resilient, particularly in the face of government unwillingness or inability to respond to community needs, is part of the colonial legacy (McMeeking et al., 2020).

> “It's a kaupapa Māori response [...] We're agile. We move. We don't need a set of rules to be able to respond. We can adjust our policies really quickly because we only have to ask ourselves.” (Ali Hamlin-Paenga, CE, Ngāti Kahungunu Whānau Services, 2022a)

Communities across Aotearoa worked to support wellbeing

The pandemic highlighted and exacerbated many existing inequities.

From the outset of the pandemic, there were concerns about particular communities being at greater risk of contracting COVID-19 and of having poorer health outcomes once they had caught it. It was anticipated that Māori and Pacific peoples would experience inequitable outcomes and more significant long-term consequences (Andersen et al., 2020; Smith et al., 2021). Older people, people with underlying health conditions particularly those with compromised immunity and high-risk medical conditions, were identified as being at greater risk of severe health consequences, with socioeconomic deprivation, gender, inequitable access to healthcare and increased occupational exposure to the virus identified as increasing vulnerability to COVID-19 (Department of the Prime Minister and Cabinet, 2020). International research also showed that people with “experience of mental health and addiction issues” had a higher likelihood of infection with and poor outcomes from COVID-19, including higher risk of hospitalisation and higher risk of dying, “up to twice as high for people with experience of mental health and addiction issues and even higher for certain diagnoses and people with more complex needs” (Te Pou, 2021, p.6).

Wellbeing inequities have been exacerbated and amplified by the pandemic responses, besides those health inequities related directly to the virus.

Self-reported wellbeing was, for most people in Aotearoa, about the same or better following the first national lockdown in June 2020, compared to 2018 (Webber et al., 2022). However, communities who faced wellbeing challenges before COVID-19 reached Aotearoa continued to, and for many the challenges worsened as the pandemic went on. Communities and advocates underscored that many of the challenges faced in the pandemic were not new – they were just made more starkly visible for a lot of communities. We have seen and described this in previous reports on the experiences of Māori, Pacific peoples,[5] older people[6] and rural populations[7]. We have seen the impact on people at risk of family violence,[8] and have seen parallels in the face of other crises[9].

Our ongoing engagement with communities points to an exacerbation of inequities experienced by people with lived experience of distress, disabled people, people with lived experience of addiction, Asian peoples, rainbow communities and others.

In surveys, people with lived experience of distress reported increased risk of psychological distress and anxiety, consumed more alcohol and were more likely to have experienced suicidal thoughts than before the pandemic (Bell et al., 2022); one in three people with lived experience of distress thought that their mental health had been worse than usual during the first lockdown, while one in six participants reported it was better than usual (Every-Palmer et al., 2020). People with lived experience of distress also reported poorer relationships with people in their bubble, reduced social contacts and greater loneliness, as well as higher levels of health and financial concerns (Bell et al., 2022). In addition to these concerns, community advocates point to the challenges for people of having less access to support people outside of the bubble. For some people this meant an abrupt stop to seeing support workers in person, for others, there was a sense of damage to trust and connection within support relationships.

The pandemic exacerbated existing inequalities for disabled people, too, such as mental health outcomes and access to health services, and created some novel health challenges including access to Personal Protective Equipment and testing (Independent Monitoring Mechanism, 2021). Disabled people were more likely than non-disabled people to face barriers accessing, and to delay seeking, healthcare, during lockdown and through into 2022, due at least in part to fear of contracting

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[5] COVID-19 Impact Insights Paper #7 Pacific connectedness and wellbeing in the pandemic

[6] COVID-19 Impact Insights Paper #2 The wellbeing of older people in Aotearoa

[7] COVID-19 Impact Insights Paper #3 Impact of COVID-19 on the wellbeing of rural communities in Aotearoa

[8] COVID-19 Impact Insights Paper #4 COVID-19 and safety in the home

[9] COVID-19 Impact Insights Paper #5 Supporting wellbeing after a crisis

COVID-19 (Health Quality & Safety Commission, 2021; Ministry of Health, 2023), and in 2022 had four times the risk of hospitalisation and 13 times the risk of COVID-19 attributed mortality compared with the rest of the population (Ministry of Health, 2023)

Disabled people and advocates told us that mental distress, which was already an issue for disabled people, increased with the pandemic. There were increasing rates of loneliness and high levels of anxiety, and poorer happiness and family wellbeing (Stats NZ, 2021). While mental distress increased for everyone in 2021, the increase was notably more for disabled people, from an already high 27% to almost 33%, compared with non-disabled people who saw a one percent increase in feeling high distress to 9% (Woodbury, 2023). While there is no specific data for tāngata whaikaha Māori or disabled Pacific peoples, the gap between good and poor health for these groups is almost certainly greater, given higher rates of disability, and intersecting effects of ableism and racism (Woodbury, 2023).

Advocates expressed concern about the limited availability of mental health services to support disabled people. As the pandemic progressed, distress continued to be generated for disabled people around availability of appropriate support, barriers to accessing help and healthcare, lack of accessibility in the community, financial strain, isolation and loneliness, lack of emotional support and lack of timely communication of information (Ministry of Health, 2023; Woodbury, 2023).

Racism and discrimination experienced in the home, online, and in the community increased.

Our report on safety in the home noted increases in racism and discrimination experienced in the home and online. There is also further evidence of that outside the home. Pacific, Māori, Asian, disabled, and older people reported increases in discrimination (Jaung et al., 2022; Nielsen, 2021; Webber et al., 2022, Liu et al., 2022). Nearly 40% of Asian participants in one large 2021 study reporting experiences of racism (Juang et al., 2022). Reports of racism included subtle 'othering' of Asian people , verbal attacks and micro-aggressions in public places, social media and mainstream media racism, and violent racial attacks (Belong Aotearoa, 2020; Chen, 2021; Liu et al., 2022).

Variations in the discrimination experienced was determined by ethnicity, age, and region (Liu et al., 2022). High school and tertiary students, new migrants with temporary visas, and those living in rural areas were more likely to report racism (Juang et al., 2022).

Community advocates told us of increased bullying of Asian people since COVID-19 arrived, with new migrants, in particular, trying not to attract attention. Chinese and Korean older adult migrants in one study described being careful not to breach any rules, in order to not be singled out or blamed in any way for the pandemic (Koh, 2023). Similarly, Pacific peoples reported being careful to follow rules after media reports of the COVID cluster in South Auckland church community.

Communities are not homogenous and inequities exist within and across communities.

In addition to the challenges faced by particular groups, we have seen that negotiating multiple, intersecting identities can increase challenges (such as experiencing discrimination or exclusion) and compound the adverse impacts of the pandemic.

For example, one research study found a significantly higher prevalence of anxiety and depression among tāngata whaikaha Māori (Māori with disabilities) who had COVID-19 than non-disabled Māori, yet less mental health support was received (Russell et al., 2023).

The Youth Pulse Check survey found that during the first national lockdown young people who also “identified as LGBTQI+, Māori, Pacific or having a disability were more likely to report feeling unsafe within their bubbles than other population groups” (Ministry of Youth Development, 2020, p.11).

During the 2020 national lockdown, reports of family violence increased dramatically. Over the lockdown period, police figures showed a 22% increase in investigations (Masselot & Hayes, 2020), while Women's Refuge reported a 20% increase in calls related to domestic violence (Foon, 2020). Some communities were at particular risk of harm or faced barriers to accessing support,including women, disabled people, children and young people, older people, and migrants.

A one-size-fits-all approach is inadequate for many communities

Just as the pandemic has shone a light on existing inequities, it has also highlighted that the underlying differences between communities require different responses to best support wellbeing. Mental health, addiction, and wellbeing challenges are complex during times of crisis; the challenges vary by location, by community, and by individual and whānau. Consequently, communities have stressed that a one-size-fits-all response is not adequate.

Our reports, like in the Māori wellbeing section above, have highlighted challenges faced by older people, rural communities and Pacific peoples; similar challenges are faced by other groups.

Different populations in Aotearoa have unique mental health and wellbeing needs, and require support tailored to meet these.

Across our reports, we have seen that barriers to accessing appropriate information and support impacted on Māori, Pacific peoples, and older people, and some elements of the pandemic response were less readily applicable to the realities of rural living. We have also seen that keeping people safe requires a range of safe, accessible options. Many other communities across Aotearoa have experienced similar challenges.

Advocacy groups told us that mental distress increased for Asian peoples since the outset of the pandemic. As well as the racism and discrimination described earlier, there were other causes of increased distress. For example, some older people were anxious about catching COVID-19, so stayed home, struggling with accessing food and becoming increasingly socially isolated. Some families experienced conflict with young people using gaming to connect with peers and becoming violent when asked to stop. Advocacy groups told us that the need for mental health support for children and older people increased, as did the calls from Asian people to helplines, but that many Asian people find it difficult to connect with existing services and mental health professionals due to language difficulties and lack of cultural competency.

Refugees are a population who have specific needs. Advocacy groups told us of the increased mental distress experienced by refugees who arrived in Aotearoa with trauma, and can then face discrimination and difficulties navigating the system, encountering a lack of cultural understanding when accessing basic health service, and for some isolation is an issue. Advocates have told us of receiving more calls over the pandemic from refugees with high needs, complex issues and calling for psychiatric support. With the borders closed, former refugees and asylum seekers were anxious, stressed and worried about families and situations in their home countries.

Community advocates also told us of the anxiety experienced by disabled people and their fear of catching COVID-19. Lack of suitable transport options and concerns about social distancing led to many people staying home and self-isolating. This meant that disabled people had variable access to essential goods, services and spaces, and accessing health care became more difficult during lockdown and associated Alert Levels (Health Quality Safety Commission, 2021; Independent Monitoring Mechanism, 2021). Disabled people also experienced inequitable access to education, justice and legal services, and disabled people in places of detention encountered barriers, particularly around access to information, communications, and essential services (Independent Monitoring Mechanism, 2021).While the Government response created serious challenges, there was little opportunity for disabled people to participate in decision-making and many felt that groups were primarily for consultative purposes and often an afterthought (Independent Monitoring Mechanism, 2021).

Three quarters of the young people who participated in the Youth Pulse Check survey reported managing okay to extremely well (Ministry of Youth Development, 2020). However, many young people felt disconnected from friends and whānau, with a lack of social interaction, and without the support of social and cultural events (Ministry of Youth Development, 2020).

Some young people reported feeling isolated, stressed, anxious and depressed during Alert Level 4, in one study, with concerns about “living in toxic environments” in bubbles with people they do not get on with, family violence, discrimination, and accessibility, with some experiencing digital exclusion on a significant scale (Webb et al., 2022). Life was particularly difficult for some, with nearly half of the disabled young people participating, and over a third of rainbow young people and those who felt unsafe in their bubble reported not managing well during lockdown (Webb et al., 2022). But the diversity of young people’s experiences is reflected in another study, in which some rainbow young people and former refugees thought life was worse during lockdown, while other young people, particularly Māori, Pacific and disabled young people, thought life was better (Office of the Children’s Commissioner, 2020).

There is very little data to help understand the experience of rainbow communities, but some studies with rainbow young people indicated that they experienced a high level of mental distress (Radford Poupard, 2021; Webb et al., 2022), with at least a third in one study reporting “they were not managing well” (Radford Poupard, 2021). Young people experienced depression and anxiety, loneliness and isolation, with some not feeling safe in their bubbles and difficulties accessing mental health support (Radford Poupard, 2021).

Accessing and understanding information about the pandemic was challenging for some communities, contributing to increased fears and anxiety.

Providing timely and accurate information about the pandemic was a key part of the Government response. However, information was not always easily and immediately accessible for some communities, including Māori and Pacific peoples, people with disabilities, and migrants and former refugees for whom there were linguistic barriers.

Migrant peoples were impacted by confusion about COVID-19 information (Belong Aotearoa, 2020; Koh, 2023). Advocacy groups told us of confusion and difficulties experienced by Asian people accessing information, contacting government agencies and booking vaccinations, because of challenges with language. There was also confusion about the restrictions on support for some temporary migrants, such as international students (Belong Aotearoa, 2020). Ethnic social media platforms, such as WeChat, were often a source of misinformation and generated more confusion and anxiety for people.

Asian communities need culturally appropriate services and support to overcome linguistic barriers. While much information is translated into other languages, this was not always accurate or updated in a timely way, nor was it being promoted through ethnic media channels to ensure that it reached the Asian population. Advocates told us that many Asian people who cannot speak or understand English were struggling to find the information they needed, and communities were working really hard to make sense of – and translate - the information.

> “Migrants don’t know what support is available. Nobody tells them exactly what opportunities they have or how exactly they get it. They refer them from place to place without giving the exact answer. If they are referred to online websites still they cannot understand the way they get support.” (Survey respondent, Belong Aotearoa, 2020)

While largely successful, the approach to vaccination did not work for all communities.

Vaccination prioritisation, based on age and physical health conditions, exacerbated health inequities for people with lived experience of mental distress or addiction, Māori and Pacific peoples (Te Pou, 2021). This is amplified for those groups who also experience compounding COVID-19 risk factors, such as socioeconomic deprivation and physical health comorbidities (Te Pou, 2021). Although some people with lived experience of distress were included in Priority Group 3 for vaccine access (those with a diagnosis of severe mental illness or in contact with specialist mental health and addiction services) the vaccination rates were well below those of the general population (Every-Palmer et al., 2022). This may be because people did not realise that they were a priority group for vaccinations, and “furthermore, structural discrimination embedded within the health system makes accessing physical healthcare, including vaccinations, more challenging” (Every-Palmer et al., 2022, p.133).

Community advocates also noted that there was apprehension about vaccination for people who had been forcibly treated in the mental health system, and online disinformation targeted toward communities that resulted in scepticism and people opting out of government funded health initiatives.

The latter stages of the pandemic have impacted communities differently.

As the pandemic progressed, the response to it was also adapted, with many people welcoming a loosening of safety measures. However, participants in one study suggested that as the pandemic unfolded, there was a shift from a communal sense of caring shown early on, the sense of ‘we are all in this together’, to people being focused more on themselves (Russell et al., 2023). For some people, particularly older people and disabled people, the relaxing of safety measures led to increased anxiety.

Our previous report discusses how older people appeared to do better than others during the initial lockdown and elimination phases, but as the pandemic progressed, older people were not doing as well, with increased anxiety as COVID-19 cases increased and safety measures reduced. Similarly, the COVID-19 elimination strategy, including border closures, restrictions and the work of health staff, was hugely successful in keeping disabled people safe over the first two years of the pandemic (Baker & King, 2022; Woodbury, 2023). But, as the pandemic progressed, inequities continued to be evident. By 2022, high vaccination rates combined with self-isolation meant disabled people were slightly less likely to get COVID-19 than non-disabled people, but were more likely to die if they did (Ministry of Health, 2023). Data from a Manatū Hauora and Whaikaha study also suggested that disabled people living in residential care in 2022 were eight times more likely to be hospitalised and 47 times more likely to die from COVID-19 than non-disabled people (Woodbury, 2023).

Risk increased for disabled people and tāngata whaikaha Māori following the reduction in public health measures and the emergence of the Omicron variant and widespread transmission (Baker & King, 2022). Communities told us of ongoing anxiety for disabled people about catching COVID-19 and concerns that, as it spread, there would be less support available for families. Accurate and accessible disability-specific information has been hard to find, and disabled people have experienced barriers to accessing support (Baker & King, 2022).

For people with disabilities, there are intersecting and compounding issues that put them at greater risk, including "lower rates of employment, lower income, housing insecurity, biases of the community, and reliance on public transport put disabled people at increased risk for poor service outcomes" (Good et al., 2022, p.832). With the 'traffic light' system that excluded lockdowns introduced and the borders reopened, many disabled people and their whānau felt 'hidden' (Good et al., 2022) and decided that the safest option was to self-isolate from the wider community (Baker & King, 2022). Community advocates have told us that for disabled people the anxiety is still there about not wanting to go out and contract COVID-19, and that "if you feel like the world doesn't think you exist, then there will be impacts on mental distress."

> "The difference between a nationwide lockdown and a community needing to use self-imposed lockdown to mitigate risk means that supports that should be in place are not in place and life becomes even more challenging and isolating for disabled people in contrast to the increased freedom and community participation others are enjoying."
> (Submission to the Inquiry into the Support of Disabled People and Whānau During Omicron, Baker & King, 2022, p.27)

Similar to the experiences explored for other communities in our previous papers, isolation has a range of potential impacts for disabled people, including loss of community, practical support and physical contact, reduced independence, and challenges with technology. People with disabilities also experienced particular challenges to isolating safely, with some people not able to afford to stock up on food or medication, not having suitable housing situations for self-isolating, disruptions in support and education, and problems connecting with usual health services (Baker & King, 2022).

> "After the lockdown had finished there was a great sense in the media that we were celebrating, we were healing, and we were moving on. But for me and my peers that wasn't necessarily the case. A lot of the struggles we had faced during Covid were not reflected and so there was almost a sense or feeling that we were being forgotten." (Aigagalefili Fepulea'i-Tapua'I, Head girl of Aorere College, in Fa'alii-Fidow, 2020, p.352)

Communities took action to support themselves and others through the pandemic

Our COVID-19 reports have repeatedly highlighted the resilience and contributions of communities as they engaged in opportunities to improve wellbeing for themselves and others. Through listening to communities we have identified common strengths evident across communities' responses to the pandemic. These include a strong sense of connectedness and belonging, clear leadership, innovative practices and collaboration with and between services and government agencies.

Connectedness and community leadership are key components of wellbeing that have supported communities over the COVID-19 pandemic.

The connectedness of rural and Pacific communities, for example, enabled them to come together to both receive and provide support to one another and remain strong during times of social distancing and physical isolation. The pandemic highlighted that connectedness, to culture and community, is an important strength of Māori and Pacific communities, and is key to supporting health and wellbeing, and addressing inequitable wellbeing outcomes.

We have explored the role of kaumatua in shaping Māori responses previously. Similarly, Pacific community and church leaders supported the work of government agencies during the pandemic and were key partners in ensuring community resilience and recovery after the first lockdown. Trusted community leaders were 'bridge' people for Asian communities too, particularly in supporting older migrants who faced greater language and cultural challenges (Koh, 2023).

Community organisations have drawn on their existing social capital, knowledge and resources to swiftly pivot and act to support communities.

Across our reports, we have seen the high degree of social capital already present to support communities. All community advocates we engaged with pointed to the importance of grass roots community organisations in knowing what the need is, to a greater extent than government. Disability advocates, older people organisations and Pacific community groups, amongst others, pointed to the need to respond quickly to support communities, for example with food parcels, welfare checks and connecting people directly with support services and government agencies. Going through government agencies was perceived as requiring too much time and 'jumping through hoops'.

Community organisations have played a critical role throughout the pandemic, providing specifically tailored information to communities about the Government response and regulations, COVID-19 testing and vaccinations. We have seen examples of this in culturally-relevant translation and presentation of information; and in disability advocates hosting online events to support vaccination and set up vaccination sites with environments adapted to support people with sensory needs. Communities have also provided much needed information to Government, identifying needs and how to best address these.

Innovation has been a key feature of communities' responses to pandemic challenges.

Rural communities, for example, are well experienced at being innovative given the challenges posed by geographical isolation. While rural services, including health, housing and transport, have been impacted by the COVID-19 pandemic, rural advocates pointed out that people were used to pulling together and supporting each other in times of crisis and in the face of adverse events. Innovation and transformation, flexibility and collaboration were evident features of rural hospital and health service responses to the pandemic (Miller et al., 2020; Nixon et al., 2021).

Similarly, innovation among Pacific health and social service providers flourished as they worked collaboratively with agencies, including DHBs and public health units, becoming a bridge between the community and government agencies. Pacific health service providers played an integral role in supporting communities throughout the pandemic, communicating with families, providing information and social, emotional and practical support. High trust models enabled providers to establish flexible, adaptive responses that allowed them to better meet the needs of their communities.

Innovation was also evident in the responses of Pacific church communities. Faith and spirituality are key components of Pacific wellbeing, with communities connected through faith-based networks. Many churches were well prepared to respond, and lockdown provided an opportunity to transform how they did things to further support families, such as adapting digital platforms for service delivery. From the outset of the lockdowns, church, community and social events swiftly moved to online platforms, enabling people to stay connected.

People with lived experience of distress led their own innovative community responses, for example, through the Ngātahi Ora project funded to support establishment of peer support services and lived experience communities to enable fully informed choice around vaccines and address access barriers to vaccination for people with lived experience, considering vaccine uptake inequities. Lived experience communities point to peer support wellbeing initiatives, which were set up to support people with lived experience of distress, such as the online Whakatau Mai wellbeing sessions, by Changing Minds, and the 1737 peer support phone line.

Rainbow organisations, too, pivoted to provide online services during lockdowns, experiencing a large increase in the number of young people seeking support with multiple and complex issues (Radford Poupard, 2021).

Some key enablers or forms of infrastructure supported communities' wellbeing.

Through their responses to the pandemic, communities have shown that they know what is best for their own. They have drawn on knowledge, resources and networks to support wellbeing, but we have seen a range of common factors that also supported their responses, including trusting support from government, having resilient social infrastructure, and being able to use digital infrastructure to be innovative.

Trusting, supporting, and listening to communities supports greater wellbeing, both in a crisis situation and more generally

Communities have told us that it is essential that they are listened to and involved in planning and decision-making, and that not doing so has resulted in poor wellbeing outcomes for communities who face greater inequities and barriers to accessing support (Government Inquiry into Mental Health and Addiction, 2018).

Trust was emphasised by community advocates and service providers as being key to supporting wellbeing. Organisations and providers who are trusted by their communities can reach people that government agencies are unable to, identify needs and provide the kind of support that is needed to effectively meet these needs. Communities and community-based providers described how swift and responsive funding and resourcing from Government enabled them to provide support where it was needed, pivoting as necessary and repurposing funding to meet identified needs.

During the pandemic, we saw how a range of high-trust approaches worked, enabling community organisations and providers to support households with necessities and food, digital technology to enable connectivity, and accommodation. Community organisations are well placed to respond to changing needs, and empowering and involving communities in planning is key to reaching people safely and quickly. Across different groups we have heard that it is the grass roots organisations who know what the needs are. For example, Pacific providers described how it enabled them to support households with necessities and food, digital technology to enable connectivity, and accommodation. Asian advocates told us how smaller community groups have tailored their services to meet community needs, while working on shoestring budgets. In the early days of the pandemic funding and resources were more readily available for community-based organisations, rather than the usual procurement processes favouring larger, mainstream providers.

Communities have shared with us the effectiveness of a high-trust model. These high-trust models will work outside of the pandemic too, enabling communities and providers to spend more time and energy supporting local wellbeing, in a way that works for them.

It is important that the support, particularly mental health services, are not time limited in their provision. There is a risk after any crisis that as the immediate need diminishes, attention and support will reduce. We know that the ongoing impacts will be long-lasting, and that experiencing multiple 'shocks' or crises compounds the impact and can contribute to cumulative and collective trauma – in recent months, communities had already been hit hard by COVID-19, and then by the North Island floods and/or Cyclone Gabrielle. We know that preparing for future crises will require ongoing support.

A sense of community and resilient social infrastructure is essential to help prevent many of the worst mental health, addiction, and wellbeing effects of the crises like the pandemic.

Social hubs, such as marae, schools, churches and libraries, acted as key places for the sharing of information, food, resources, and personal support for many people during the pandemic. This same value has been seen in response to other crises, such as earthquakes and severe weather events.

Inversely, the closure of places which act as social hubs had large impacts on communities. This is particularly seen in rural communities, but also where other communities rely on a limited number of such spaces for support. For example, in one rural community we considered, the library hosted a range of activities including a knitting club, book club and a fall-prevention exercise group, as well as being a safe and warm space for people experiencing distress and homelessness, and providing support with filling out government forms, printing and photocopying. Its closure during lockdown periods had a range of detrimental wellbeing effects on the people who relied on it.

Connectedness is critical for wellbeing – when this is not possible face to face, digital connection is an important means of staying connected.

Digital provision of support, services, information, and education were all important elements of the pandemic response. We have already seen that communities adapted many of their own processes to provide support and connection online.

Some communities were well prepared for digital connectivity prior to the pandemic. For example, the numbers of 'tech-savvy' older people were on the rise prior to the pandemic (Amundsen, 2020), and some older Asian people were already familiar with using technology for digital connection to stay connected with family members outside of Aotearoa (Koh, 2023). For older people, technological skills were often learnt with the support of younger family members (Dawes et al., 2021; Prigent et al., 2022).

However, some communities face particular challenges with accessing or using digital technology. For example, low income households are disadvantaged, with a recent survey finding that only around two thirds (69%) of those living in state or social housing reported having access to the internet, compared with 91% reporting access across all of the respondents (New Zealand Government, 2021).

Difficulties with connective technology or poor connectivity also impacts the mental health and wellbeing of rural people (Federated Farmers of New Zealand 2022), and increases the risk that people will struggle to get help, advice and support. Public libraries are a source of free WIFI for people without access at home, including those in rural areas, however the closure of these during lockdowns removed that source of connection.

Some groups of young people struggled early on in the pandemic with digital connectivity. As well as for rural young people, difficulties accessing a device, WIFI internet and/or data were reported by Māori and Pacific young people, young people with disabilities, recent migrants and former refugees, and rainbow young people (Ministry of Youth Development, 2020).

For many communities who were able to access and use digital technology, this enabled connectivity and provided some relief in light of the restrictions on travel and gathering, and experiences of self-isolation. Social services, churches and community groups pivoted to meet the needs of communities online. One community advocate noted that for some people with lived experience of distress moving many services online was a good thing, making processes much simpler. One study reported that socially and economically marginalised communities who had earlier not used digital technologies started using them during lockdown to stay connected, and to secure access to fundamental services (Elers et al. 2022).

It is hard to understand the needs and wellbeing experience of many populations, because data and research are lacking.

A recurring theme throughout our previous reports and community engagement is the challenge of meeting community wellbeing needs when there is not adequate research to understand these. For many groups, such as disabled people and people with lived experience of distress or addiction, there is recognition of the health and service access challenges they face, but a lack of data and published research on the impact of COVID-19 on their wellbeing or on communities responses to this.

> “Without disability data, health inequities and social injustice are perpetuated … and disabled people will continue to be excluded from policy decisions which affect their health and well-being.” (Perry et al., 2020, p.112)

Research on the impact of COVID-19 on the wellbeing of other populations is also limited. For example, rural communities are a significant and important group in Aotearoa, but of the little published information that exists, most is focused on the farming sector and communities, with less focused on other parts of the rural community.

The lack of research is particularly apparent for Pacific and Asian peoples, for whom there is very little ethnic-specific research and data. Understanding and supporting pan-Pacific and Pan-Asian approaches is valuable, given shared values, common interests, and cultural similarities. In the regional areas of Aotearoa, and locations where these populations are lower, this is particularly helpful. However, each Pacific and Asian community is different, and where they can identify their own needs and are supported to respond appropriately, wellbeing is even better supported.

There are other communities whose wellbeing, and the impact of the pandemic on this we know very little about. Prior to the pandemic, loneliness and social isolation was identified as an important narrative in the experience of veterans in Aotearoa, for a number of reasons including managing the transition to civilian life, adverse childhood experiences for some, the mobile and transient nature of employment in the forces, experiences of trauma and posttraumatic stress injury, and loss of identity, community and culture leading to feelings of alienation in civilian world (Austin et al., 2020). Recognising that veteran loneliness and isolation was likely to be exacerbated during the COVID response, Veteran Affairs contacted more than 8,000 veterans by phone at least once during the first national lockdown, including calling 3,000 veterans on ANZAC Day to check on their wellbeing (Austin et al., 2020). A follow-up survey showed this had been helpful and appreciated. (Veterans' Affairs, 2020), but further research on the wellbeing of veterans in Aotearoa is very limited.

People in prisons are another group we know little about. The Ombudsman's key observation was that prisons responded to the COVID-19 pandemic in a well-resourced, balanced, and efficient manner, despite the complex challenges of managing prisoners at this time. The media reported strict lockdown protocols within institutions at the beginning of the pandemic, with individuals confined to cells between 20 and 22 hours a day, outside visitors suspended, along with any outside materials by family members or friends (RNZ, 2020). Correction officials provided phone cards to people in institutions, however, there were reports that the lines to use the phones were long and there were not enough to meet demand (Murray & Kras, 2020).

These glimpses into the experiences of communities highlight the need for further research to better understand their wellbeing experiences, including the impact of crises such as the pandemic on wellbeing. While community members and advocates have told us of ways in which communities responded proactively to the challenges presented by the pandemic, our review has also highlighted the lack of documented evidence around this, underlining the need for further research from a strengths-based community perspective.

Calls to Action

Government agencies need to trust, support, and listen to communities

Throughout the pandemic, communities across Aotearoa have displayed the expertise, passion, resources and networks to support wellbeing. They have the trust of the people they work with, and deep knowledge about priorities for action and the best way to achieve outcomes. Where government decision-makers and agencies draw on these community strengths and support communities' self-determination, they have been able to better support wellbeing together.

- For Māori in particular, this means recognising the value and exercising of rangatiratanga seen through the pandemic, and giving iwi, hapū and whānau the freedom and resources to act in the way that best meets their wellbeing needs.
- During the pandemic, we saw how a range of high-trust approaches worked, including to support households with necessities and food, digital technology to enable connectivity, and accommodation. These high-trust models will work outside of the pandemic too, enabling communities and providers to spend more time and energy supporting local wellbeing, in a way that works for them.

- The Government has a duty to protect tino rangatiratanga, and to uphold its Te Tiriti o Waitangi obligations. Where government continues to provide services, decision-making must be done in partnership with Māori in accordance with Te Tiriti o Waitangi and inclusive of Māori leadership. This will see government responses informed by tikanga and matauranga Māori.
- Likewise for other communities, this means recognising and consulting those groups who often have poorer wellbeing outcomes, and including their community leaders and members in planning and decision-making. Communities of belonging, whether based on geography, identity, ethnicity, or any other shared experience, need to make their own choices, have resources, and be trusted to develop solutions for themselves.

Key enablers to wellbeing need improvement or support

Building on the recognition of the strengths of communities across Aotearoa, there are some practical actions or enablers that can be seen to support wellbeing.

- Marae are the centre of many Māori communities, and key enablers of wellbeing for many whānau. Funding and practical support for marae to maintain the capacity to provide practical support to their communities will support wellbeing now, and in the face of future crises.
- Similarly, recognising the wellbeing-supporting role of community organisations and social hubs, government resources can support their sustainability and resilience now, so that they are well positioned to be both responsive during recovery, and ready for the next crisis.
- Online connectivity provides an important way of keeping people safe and connected to support, but many communities struggled with access to both essential services and technology during the pandemic. Ongoing investment in bridging the ‘digital divide’ will support connection and wellbeing, especially when other social connections are unavailable, such as during ‘lockdowns’.
- We have seen increases in need for accessible, responsive, and ongoing trauma and distress support in the pandemic and other crises – continuing investment in this safety net will support affected communities in the future.

Better data and research are needed

Improving wellbeing requires understanding wellbeing – including connection, hope, rights, self-expression, Māori oranga, cultural needs, and self-determination – of individuals, whānau, and communities. It also means looking at the unique challenges experienced by different communities, and people who intersect them, and considering the broader context of people’s lives.

- High quality research and data will support iwi and Māori responses and will help build the trust needed for partnership. Incomplete data makes it challenging for national and local government to understand how communities are affected, and lack of access to data can restrain the activities of Māori organisations and providers. Greater emphasis needs to go into building the appropriate system and in sharing relevant information, and supporting Māori research and researchers to address these concerns, including upholding Māori data sovereignty.

- We experience wellbeing differently, based on a variety of factors. If we are to improve wellbeing for all, we need better disaggregated data and research to understand wellbeing for different communities, including older people, rural populations, people with lived experience of stress and distress, Pacific peoples and the ethnic communities that make up this group.

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Methodology

The overall aim of the COVID-19 Impact Insights series of reports was to explore and gain understanding and insights into the wellbeing impacts of COVID-19 on people in Aotearoa. This final report aimed to draw together findings from the previous seven reports and wider research to highlight and learn from the wellbeing impacts of the pandemic. To do so, the following questions were addressed:

- What are the key impacts of the COVID-19 pandemic, including shared and unique impacts, on the wellbeing of people across Aotearoa, particularly those communities who experience greater challenges to wellbeing?
- What can we learn from the COVID-19 pandemic about ways of better supporting the wellbeing of communities in Aotearoa?

The methodology involved collecting and analysing evidence from literature and community engagement, and integrating this with findings from our previous reports (also based on literature reviews and community engagement).

Rapid literature review

The rapid review was undertaken to identify and review research literature that was relevant to the questions being addressed in this project and could thereby contribute to the development of evidence-informed actionable insights. The rapid review was conducted over a three-month period (from 13 March to 7 June 2023) using the following methods.

1.1 Literature searching and selection

Literature was selected using the following inclusion criteria:

- Focus on impact of the COVID-19 pandemic on wellbeing; AND
- Focus on the experiences of populations identified as experiencing wellbeing inequities (as identified in He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction[10] except those focused on in previous reports (Māori, Pacific peoples, older people, rural communities); AND
- Evidence based studies, reports, briefing papers.

A comprehensive search was conducted of electronic databases: APA PsycInfo <2002 to February Week 3 2023>, adapted for Medline, Scopus, Index New Zealand, NZ Research. The websites Google and Google Scholar were also searched.

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[10] Māori; Pacific peoples; Refugees and migrants; Rainbow communities; Rural communities; Disabled people; Veterans; Prisoners; Young people; Older people; Children experiencing adverse childhood events; Children in State care

Search strategy: Database searches were conducted between 13 March and 1 May, with supplementary searches (drawing on reference lists, government department websites) conducted in May and June 2023. Searches were conducted using combinations of the following keywords.

("2019-ncov" or "ncov19" or "ncov-19" or "2019-novel CoV" or "sars-cov2" or "sars-cov-2" or ("sarscov2" or "sarscov-2" or "Sars-cORonavirus2" or "Sars-cORonavirus-2" or "SARS-like cORonavirus*" or "cORonavirus-19" or "covid19" or "covid-19" or "covid 2019" or "novel coronavirus" or omicron); (zealand or aotearoa or Māori or tamariki or whanau or iwi or marae or kaumatua); (rangatahi or teen* or adoles* or "young adult*" or "young people" or "young person*" or youth); (tamaiti or tamariki or kohungahunga or child* or toddler* or infant* or "first 1000 day*" or "first 2000 day*" or baby or babies or preschool* or pre-school* or parent* or school* or kura); (child protection service or “foster care” or out of home care or “looked after child” or “state care”); (mental* and (ill* or disorder* or health); (anxi* or depress* or psychiatric); (bipolar or schizophrenia or (feeding and eating disorder*) or anorexia or bulimia or borderline personality disorder or obsessive-compulsive disorder or dissociative or psychosis); (disab* or autis* or asperger* or "down syndrome" or "downs syndrome" or "down's syndrome" or blind or "visually impaired" or "partially sighted" or deaf or "hearing impaired"); (Disabled Persons/ or whaikaha); (prisoner* or inmate* or offender*); (correctional facilities or jail* or prison* of incarcerat*); veteran*; (rainbow* or takatapui or queer or gender diverse or intersex or lgbt* or lesbian* or bisexual* or transgender* or “sexual minority” or homosexual* or gay or SOGIESC); (migrant* or immigrant* or refugee*)

The searches were inclusive of grey literature, with unpublished studies and reports also captured through the electronic search processes. In addition, a form of snowballing took place, whereby further references were identified from reference lists and searched for.

1.2 Screening, mapping and coding

Following the searches, the abstracts were screened according to the selection criteria. The full text of any potentially relevant papers were then retrieved for closer examination. The papers were collated in a comprehensive Excel database, which included mapping information such as title, author, date, type of document (journal article, briefing paper etc), methods used in the study, sample description and keywords.

1.3 Data analysis

A thematic analysis was undertaken which involved a) generating initial codes into a coding framework, by identifying recurring factors, b) recording data (text from the papers) to each code, c) collating codes into potential themes, and d) reviewing and refining themes through iterative analysis.

While the methodology involved a thorough search and analysis, there were several limitations. The searches were limited to documents available in the English language, published since 2015. While the search process followed a well-defined, structured process there may be relevant documents that have been missed or were not available in the period these were collected.

In addition to the literature accessed through the search processes, literature previously accessed for other reports in the series was also directly referred to in the report. In total, 63 papers from Aotearoa were included in the review: 36 journal articles and 27 other reports, briefings etc.

Community engagement

A critical component of the report was engagement with advocacy groups to ensure that the views and voices of communities are included, and to ground the report in lived experience. Information was sourced from notes taken during face-to-face engagement between Te Hiringa Mahara and community advocacy groups, as well as online hui and talanoa, and email communication, with community members, leaders and community-based service providers for the previous reports.

The final stage of the analysis involved writing up the themes in this report, followed by a review process.