**BI Connect 2021 - COVDI-19 Behaviour Transcript. Recorded 4th November 2021.**

- [Simon] Hi, everyone. Welcome to the first of three sessions in BETA's BI connect, 2021 series. This is our second annual BI connect series. And I'm sure many of you participated last year. This year, we're exploring the application of behavioural insights to COVID-19, building on our series from last year. And I'm sure when we had that as our theme last year, we were all hoping it wouldn't be the theme again for 2021. And let's hope it's not the theme again for 2022, but who knows? Today's session is going to be on COVID-19 behaviour. A really fascinating topic. I'm Simon Gordon, the managing director of BETA. And before we get into the presentations, I'd just like to begin by acknowledging the Traditional Custodians of the lands on which we're all meeting today and pay my respects to their Elders past and present. I extend that respect to Aboriginal and Torres Strait Islander people who are online today. And also a special shout out to the Ngunnawal people on the land of which I'm on. So we have three speakers presenting their latest research today. Professor Kate Reynolds from ANU, Professor Ben Newell from UNSW, and Dr. Karen Tindall from the Behavioural Insights Team. So a really fantastic lineup. It's gonna be a pretty jam-packed session. So we're gonna go through each of those speakers and have a little bit of time for questions. As we did last year, we're gonna be using Slido. So if you have questions during the session, use Slido and you can also upvote any questions you like. I'm sure we're all very familiar with that now. We'll also have a little bit of time right at the end of the entire session to pull together any key themes, so keep voting right throughout. The event code is #BIConnect2021. Okay. So to our first speaker, Professor Kate Reynolds. Kate would be well known to all of you. She's a professor of psychology at the Australian National University. And some of you have probably gone through ANU psychology and had really close contact with Kate over the years. Her research is focussed on group processes and inter-group relations, including the impact of groups and group norms on individuals' attitudes, wellbeing, and behaviour. So a really fascinating stuff. I should add also that Kate is part of BETA's academic advisory panel. So we have the pleasure of hearing about this stuff regularly. Today, she'll be speaking about the importance of cohesion in predicting health behaviours, especially during the pandemic where collective effort was a major aspect of maintaining public health and continues to be. So welcome, Kate. Really looking forward to your presentation, hope the technology works and it's over to you.

- [Kate] Thank you. So it's very good to be here and to be talking to you about some of our recent research that we've been conducting at ANU. That was a very good introduction. So, thank you. There's not a lot, that I need to add, other than working out how to advance my slides. There we go. So this talk today is by myself and Diana Cardenas, a research fellow at the ANU. And it's part of a much larger team that have looked at COVID-19 through 2020. And we're doing some more survey work now in 2021. And again, like many researchers around the world, there's a lot to learn about crises and pandemics, such as COVID-19. The project is also part of what's called a grand challenge where ANU has funded complex and difficult areas of research that are difficult to fund from other sources. And this is part of a Social Cohesion Grand Challenge, which is an interdisciplinary team from across the ANU. You've heard a little bit about me already. A lot of the focus of the work that we're doing at ANU concerns behaviour change broadly defined. And I'm very happy to say, of course, that Karen Tindall was a member of our team. And some of the work that we're talking about draws on research that she conducted when she was a member of our group at ANU. Diana Cardenas has led much of this work to do with a representative survey of Australians through COVID-19. And much of the analysis and reporting has been led by her. And this is the work that we're going to be focussing on talking about today. In the abstract, I think we highlight and make it clear that to date, there's been an emphasis on individual factors in explaining behaviour change and compliance with health behaviours, that we've all needed to engage in in the context of COVID-19. But when it comes to a pandemic and we would say more broader than that as well, there is a real emphasis on people on a collective effort and people engaging in the same behaviours at the same time en masse, which raises this question of whether broader social factors may be important in understanding compliance with health behaviours, hand-washing, physical distancing and vaccination. And in this presentation today, we wanna talk about groups and behavior change more broadly, flag, very quickly, the health models that govern much of the work that is conducted in this area, including in the public policy domain. Make the case for social cohesion for these sociopolitical factors as being important in understanding health behaviour and behaviour more broadly. And then talk a little bit about the research. I plan to finish just after 10. So there's time for questions before the next speaker. So when we think about what we've witnessed and we're still witnessing in the context of COVID-19, we could see this as an exercise in mass behaviour change. Individuals have had to do new things to keep themselves, their loved ones and the community safe. There's been a range of new strategies by government and health bodies to bring about compliance. Quite often, we've seen incentives, safety messages, and fear, and there's a lot more that we could talk about in terms of how health officials have tried to encourage compliance. But I guess the question that we're asking more broadly is have we got the right model of the person at the centre of our efforts, with compliance and influence in the context of COVID, and also more broadly? Have we got the right model of the person in our theories of behaviour change and what could we learn about behaviour change more broadly by looking at our experiences through COVID-19? We're not gonna cover all answers to all of those questions today, and it's an ongoing enterprise, but I think, hopefully, enough of some questioning emerges that perhaps we need to develop a broader model of the person, in order to develop effective models of behaviour change. Some of you might've seen this before. I mean, often when we think about theories of behaviour change, these are the large dominant, sort of areas of work. You'd all be very familiar with incentivisation, making things attractive, dealing with barriers, making it easy and timely, and also social networks, and the role of interpersonal relations in affecting behaviour change. But really, when it comes to understanding some of the social and group processes that we're going to talk about here, some of the knowledge and models that we have are under conceptualised. So we can see here, the individual largely, individual drivers of behaviour change, but we can also see social and relational drivers of behaviour change. And I think that the point here is that the individualistic models really have been, are unable to account for common patterns of pro-social behaviour, in which people make decisions that better promote others, or their group interests rather than their own. And that's a broad conclusion that is increasingly common, both amongst academics and practitioners, that there may be a layer, or level, or tool, related to people's groups and group interests that needs to be better conceptualised and implemented. And I think we saw that in the context of COVID-19, very nicely put by Andrew Cuomo, the mayor of New York, who made this comment during the height of fatalities in New York. They're really making the point that we needed to focus on the we concept. So yeah, it's your life do whatever you want, but you are now responsible for my life. You have a responsibility to me. It's not just about you. We started saying, it's not about me, it's about we. Get your head around the we concept. It's not about you. It's about me, too. It's about we. And in the context of the pandemic, that idea has really come to the fore and emerges as being really important in understanding behaviour change, but how front and centre has it been in the way in which we've sought about bringing about our compliance. So these are two very high profile, well-known, well-researched models of health behaviours. They're well tested. And we're gonna talk about some of the variables that they're looking at. But when we focus on these models, it's very hard to see the we concept front and centre, in the way they might conceptualise a behaviour. And that is the area that we wanna really bring to the fore. And although we might know these things, quite often, it's not front of mind in terms of influence attempts, understanding theories of behaviour change and public policy responses and programmes. So I guess, we're looking to you a little bit to get some more insight into how we can raise the profile and showcase some of these insights a little bit more. So some of you will be familiar with this line of thinking that we really need to tap into the we concept. And there was a very developed theoretical approach, the social identity approach, which develops this idea. So the, we are social animals, we've learned to evolve and function in groups, a large part of the way in which we think about ourselves is connected to those group memberships. We can define ourselves, as Cuomo outlines, as individuals and as group members, we can shift in different situations and at different times between thinking of ourselves as individuals or as group members. And when we do think about ourselves as a group member, we internalise the group norms, the values and beliefs associated with that particular self-definition and willingly take on and engage with the values, norms, and behaviours of that group. And can do that in a very sustainable way. In different contexts, different selves become salient. And of course, in the context of COVID, we've really seen some of the national and local identities come to the fore. Some of the consequences of having a social identity or thinking about social identity at the centre of our models of behaviour change is that when social identity is relevant, we're acting in ways to advance group interests, we see other ingroup members, those that we see as similar to ourselves, like ourselves, as being valid sources of information, influential and persuasive. We seek agreement with those who are members of our ingroup, so we're trying to resolve differences, points of conflict. And that can create, what's referred to here as mutual influence and creative disagreement. We got new ideas emerge from engaging with ingroup members. And our experience of group processes means that when social identity is meaningful, we have a sense of shared purpose and understanding. We feel a sense of connection and belonging, and there is cohesion and support experienced by group members. Many of you I know, often draw on these kinds of insights to shape behavioural insights thinking, some of Cialdini's work on influence. You might be aware of his newest book on "Pre-Suasion". And of course, he had six areas which were critical to persuasion and in "Pre-Suasion", the most recent book he added the seventh, and the seventh is unity. And it's defined effectively as the sense of us, it's defined as a we concept. And he talks about the idea of people perceiving one another as being part of us and the idea that they're more likely to be influenced by others who they see in this way. So drawing very heavily on the idea of shared identity in understanding the influence process. So bringing these ideas to the fore in the context of COVID-19, we were interested in better understanding the role of group processes and ingroup norms would play in shaping compliance with COVID-19 recommended health behaviours, including vaccination, and also mental health. And we could think about social or group cohesion as capturing the qualities of a high functioning group, where individuals have trust and positive relations with one another. They have a sense of identification of belonging, and they have trust and confidence in the structures that allow the group to function. So we could think of those in terms of the political and social institutions if we're thinking about a national kind of group. These elements come to the fore in the concept of social cohesion. And within that, of course, is this idea of identification as being a part of a social cohesion thinking. When we look at broader research to do with social cohesion and health behaviours, there is a small but growing body of work, which is demonstrating over and above a range of other factors that we might consider to be important in explaining health behaviour. There is a role for a social cohesion dimensions. So here, there is work on whether people perceived the neighbours, when neighbours said that the people around them were friendly and trustworthy, young people were less likely to engage in risk-taking drinking. When people believe that their neighbours can be trusted and help one another, the same was true for smoking behaviour. So in a range of domains, there is evidence of links to health. We also know, including some work being conducted at ANU that people who identify with a group, and if the norms of that group are associated with particular behaviours, they are more likely to engage in those behaviours. So they could be things that we think are healthy, such as more likely to put effort and continuity into an exercise programme, or it could be associated with binge drinking and also to do with whether we will be vaccinated for a whole range of things including COVID-19. There's also some work in the context of pandemics, which is telling us that the sociopolitical factors, social cohesion dimensions are important. There was work on Ebola in Sierra Leone, where trusting government and trying to overcome and trying to build community trust was critical in terms of community members engaging in health behaviours. During H1N1, confidence in the Dutch government was related to intentions to get vaccinated. And during COVID-19, again, confidence in government was related to intentions to receive vaccines. So in a range of domains, we can see that these sociopolitical factors, the we concepts are important, but yet, there's a lack of work that looks at all of the individual and social factors in the one model, there's limited competitive testing of what might be the critical predictors of the health behaviours. And there's a lack of longitudinal work. And this is where we sought to explore some of these things in our own work. So united we stand, divided we fall. We were very focused on trying to measure some of the things that might drive the degree to which we're united. The social relations, social identification, and confidence in government at both the local, sort of state level, and also at the federal level. So two different types of our group memberships exploring those dimensions and looking at the relationship to physical distancing and hand hygiene. Controlling for a range of other demographic, health and COVID-19 related factors. So this survey was conducted across three waves. It's longitudinal with us starting with 3,030 participants with some attrition across the three waves. Our aim was a representative sample of Australians, and we broadly achieved that outcome. We surveyed the sample three times through last year. Wave one, just as many places were coming out of the first set of lockdowns. Wave two, where most people were out of lockdown, but Melbourne re-entered its lockdown and then through to wave three, where most areas are emerging from lockdown. So we've got some different times when the survey was taken, we measured social relations, help that is at both the neighbourhood and national level. How helpful people perceive others to be, how much trust they have, how safe they feel, whether people around them are following rules. Are there positive ethnic relations? Do they perceive that? Do they perceive that people are good at problem solving? Do they have positive social relations with others? The degree to which they identified with their neighbourhood and with Australia, and the confidence that they felt in federal and state governments. We measured physical distancing using five items and hand hygiene using four items within the survey. And here, I guess, is quite a critical dimension. We are also measuring and controlling for a range of the other variables, the individual factors in a way, that are seen to be important in terms of explaining health behaviour. Demographics, a range of health variables. Did someone have COVID, did someone close them have COVID? How did they perceive their own health leading into the COVID-19 pandemic? Do they know how to engage in these behaviours? What are their risk perceptions, more broadly? And some of those things, of course, feature in the common health behaviour models. Pre COVID-19 behaviours, to what degree did they engage in these kinds of behaviours, even leading into COVID-19? Were they washing their hands? Was there awareness, I guess, of hand hygiene and their political orientation? So we're running and I'm reporting here four regressions, where we're looking at both the local and national levels separately, and looking at the two behaviours of hand hygiene and physical distancing separately. This is the kind of, there's four of these slides. I'm trying to summarise and give you some insights into what we're doing and what we're finding. So the first point is that these are longitudinal models. So we're controlling for a lot of these dimensions at wave one. And then, we're looking whether the sociopolitical factors, neighbourhoods, social relations, identification, confidence in government are related to the COVID behaviour of interest. So this is what is predicting physical distancing at wave two based on the variables that we measured at wave one. And we can see that 23% of the variance in the behaviour is explained completely by the model. And we could perhaps come back to that and think, well, what aren't we measuring in a model like this? There are lots of things we are measuring. The individual factors that were significant, what people's age, whether they tested positive for COVID, their health at wave one, their risk perception at wave one, their self-efficacy at wave one, and their behaviour pre-COVID. So many of the dimensions that are in the dominant sort of models we're also finding evidence for. So that says that those models are relevant and useful in understanding behaviour. But we're also seeing over and above that, significant relations for some of the sociopolitical factors. So some of the social relations dimensions, and we included them all separately because not a lot of work has been done on these dimensions. And we wanted to see, well, which ones were important. Whether people perceive others as following the rules was important. Whether people felt there were positive interactions was important. We're also finding that some of these social relations dimensions are having a negative relationship. So the more likely you feel connected in some ways to those in your local area, the less likely you are to engage in the behaviour. And we've done some work that you could almost refer to as a dark side of social identification, is that when you feel very connected to others, you actually trust them more and you see them as less of a risk. So there is some interesting ideas there to talk about. This, at the national level for the same behaviour, which is physical distancing. And again, we can see a range of individual factors were significant and some of the sociopolitical factors including identification with Australia. So the more that people identified with Australia, the more likely they were to engage in physical distancing. There's effects there for political orientation with left leaning being more likely to engage in these behaviours. In relation to hand hygiene, again, at the neighbourhood level, we're seeing some of the individual factors emerge as being important, but also some of the sociopolitical factors, whether we perceive others to be helpful and identification with the neighbourhood. And with the same behaviour in the context of a national social identification with the nation is in this case, predicting people's willingness to engage in hand hygiene and also this negative relationship that we're seeing with whether people feel safe in the local area. So if we wanted to summarise this work, and there is a published paper led by Diana in political psychology highlighting these sociopolitical factors, we can conclude that the we concepts matters, mostly in terms of promoting the behaviours of interest, but the we concept also matters because it can be informative about why perhaps people aren't complying with certain behaviours. That individual and sociopolitical factors are predicting compliance. And I mean, this raises the broader question of whether we have a limited model of the person, or perhaps even the wrong model of the person. And we need to, that's at the centre of our theories of behaviour change, the theories of how in which we go about bringing about compliance and the methods of what we might use in policy and program settings that we might need to increase attention as a matter of urgency to social identity, social connection, and social norms, and bring these tools front and centre in terms of the ways in which we might understand behaviour change. So if we wanted to think through some implications, and of course, we're very interested in your thoughts and input here as well, is that this idea of social cohesion, which captures social identity and connection is a social glue that you never know when you might need. And yet, we can see that a neighborhood's and a nation where people perceived that cohesion was important in understanding how they kept themselves and communities safe during COVID-19. That strengthening social cohesion could be a wise investment in the context of increasing crises. So the idea that we're dealing with COVID now, we've dealt with bush fires in the past that there could be more things coming our way and that perhaps if we had stronger social cohesion, then we would be better able to prepare, respond and recover from such crises. That social cohesion shouldn't be seen as separate or independent from any efforts that are going on across government in the context of understanding security, hazard crisis preparedness and recovery, or efforts related to resilience. There's lots of programs of work that we're aware of across different government departments that would tap into some of those dimensions. But yet, from this and related work, social cohesion seems to be critical for the way in which people might respond in the context of crises and knowing how to strengthen social cohesion, of course, might be good for managing things like health compliance in the context of COVID or responsiveness in the context of bush fires. But of course, we also know that social cohesion is really important for individual and community prosperity, broadly defined. So there is a broader case that could be made about focussing on identity, shared identity, connection and cohesion for communities more broadly, so people can thrive. So I guess the concluding statement here leaving some time for questions is that our view is we do need to work harder to get our heads around the we concept. And it is in part about we, and that we might need help perhaps from people here and others to bring to the fore, a broader model of the person at the centre of the way in which we understand behaviour change. I have a few more slides that just sort of highlight some other work that we've been doing. We've looked at the same relationships in terms of vaccine, the same relationships in terms of mental health, finding evidence of the importance of social cohesion as we've defined it in this project, but very much over to you now to hear about your comments and questions. Thank you.

- [Simon] Hi there. Just having some trouble with the tech, trying to get to the questions. Thanks, Kate. That was super interesting. As always, even though I've heard some of it before, I still get a lot out of it every single time. We've got a couple of questions on Slido, they're kind of related, and then I've got an extra one, but if anyone has anything else that they wanna raise, as we're going, please chuck it on the Slido. So the first question says, it's very interesting about the me, we theory. During the pandemic, there was a lot of messaging about we're all in this together, which sometimes didn't resonate with different cohorts depending on what they were experiencing. Do you have advice and I guess, to policymakers about the timeliness of that type of message and how you might target it as well?

- [Kate] Yeah, great. Well, it was like that, wasn't it? I mean, very much in the early days of COVID-19 in Australia, I think we did learn a bit from what we saw happening in other countries and they're very much was a 'we are all in this together'. We had national cabinet, we had the sense in which government and leaders, political leaders were coming together to make joint decisions in our interests. And we did have a very common experience of lockdowns in the early setting. So we were really all in this together. My fear is that it didn't last as long as it could have in terms of ensuring the flow through to compliance and maximising behaviour change. So some of those things did break down, but also, our treatment of different groups of people in the context of outbreaks, and I'm working with the Scanlon Foundation on a broader exploration of this. And I know BETA is interested in it as well, but, there was a sense in which people could sense that there might be different treatment for different groups. And I think that slowly but surely, those experiences made people feel that perhaps we were less in an all together than they had imagined. So if anything, it speaks to being very mindful of those kind of actions in the context of a crisis like COVID-19 and having the we concept front and centre in terms of thinking about what we do, how we respond at all levels in order to maximise compliance. So that's a bit of a long answer, but I think we had it there. I think we lost it. I think we had pretty good outcomes in Australia, but we could learn how to maintain that if we're thinking of how we might deal with a crisis going forward. So, I can't hear you. I don't know if that's just me.

- [Simon] I'm sorry, my bad.

- [Kate] Yeah.

- [Simon] I was just saying, I think it's really interesting that you've used that term maintain, and there's something there about the, how long from a sort of temporal perspective, you can kind of maintain this group cohesiveness and you see it diminish over time. And I think with the study you're doing, trying to understand the things which, firstly, rally people faster, but then also kind of last over time will be a really interesting piece of work. We have another question, and this is going to the, I guess from the first wave of protective health behaviours around hand hygiene, et cetera, et cetera, to vaccinations. And the question is, does the we concept help explain why many anti-vaccination people are really difficult to shift because they strongly identify with the anti-vax group or perhaps they don't feel like they belong to the wider community for some reason?

- [Kate] Yeah, I think it's very good analysis. So that would speak to me about the need for social cohesion and connection, feeling respected and valued, and having hope, I guess, leading into crisis like this, trying to make that as strong as possible to minimise the emergence of these kinds of divisions. And of course, there's groups and people here who may well be studying polarisation and different attitudes around vaccination. But certainly, there is a school of thought that it is connection, that is often lack of connection in particular ways, that is driving people towards having different views, conspiracy theories and the like. And so there is something in there about social cohesion, more broadly, as an effort that all of us would engage in to minimise some of those divisions that can affect all of us in times of crisis.

- [Simon] Yeah. For me, personally, it's interesting. I grew up in Lismore, up on the North Coast, which is one of the anti-vax kind of strongholds in Australia. And I live in Canberra, which is one of the strongest pro-vax places. And it's also from a policymaker perspective. It just highlights to me how important it is for people to not just do things through the lens of Canberra, for instance, if I go and observe this in a place like Lismore, I'll be observing something very different. It's the same concept at play though. It's just seeing how powerful it can be in different ways. Okay. So we've got a few more questions here and we've got a little bit of time. Someone said they really liked the concept of social glue, but are there proactive and effective ways to increase this in times of non-crisis?

- [Kate] Yeah, absolutely. Right. So that's one of the things that we're trying to better understand in the program of work at the ANU. How might you strengthen social cohesion now? And what types of interventions that NGOs, community members, government, might put in place that can strengthen social cohesion? And that is a body of work. And of course, there's knowledge out there already. There's lots of practitioners and members of regional and other communities who could already speak to the things that they think are effective. It's about trying to distil that knowledge, marrying it with some of the insights we have about these theoretical models of human behaviour, and then working out, there's not going to be the same thing for the same place, but what are effective interventions? So some of the work we're doing is looking at the role of a business social enterprises and the way in which they serve to build social cohesion. 'Cause often they have a social purpose that the communities can get behind and rally around and value, and the role that they play in building social cohesion. There are other projects of work to do with refugee resettlement in regional areas, where they're doing a lot of work with the host communities in advance, of settlement, for example, to strengthen social cohesion, to build relationships such that those kinds of changes can be better sort of managed, I guess. So that's exactly what we think needs to be done. There's a lot already happening, but we would like to distil the knowledge that we've got and start to think about what are the things that can really serve to strengthen social cohesion now. And our view is that that's a very good investment, for when we face further crises.

- [Simon] And for everyone online, we will be having our third session on the topic of building back better, which I think this can kind of relate to like, what can we think about as we come out of this pandemic more generally. I've got one more question and it's a big one. It relates to, I guess, this sense potentially that we're on the cusp of a growing inequality in Australia. If we look at things like the housing market or the results of COVID, and we're sort of moving a little bit more in the next sort of decades towards the haves and the have nots, in a generational kind of transfer of wealth. And I was interested if you had any views on what we could maybe learn from somewhere like the U.S., where it feels like some of this is playing out a little bit over there, over the last decade or so. And so there is unity and there is cohesion, but it's starting to happen between fairly large subgroups in society.

- [Kate] I mean, part of the driver for this grand challenge was precisely because we could look to other countries overseas and we can see that without any kind of effort and dedicated sort of thinking around this, there's nothing that will prevent the same pathway for Australia. So we know social cohesion is fragile in key countries, internationally. We know that it has been on decline in Australia and drawing on things like the mapping social cohesion data. So what could we do now, as a matter of urgency, to ensure that we don't move in that kind of direction. And I think we do have things, we have stronger safety nets and the like, but there's a very clear message, isn't there, about and we saw it a little bit during COVID-19, where people felt they were supported in the time of need, in direct financial support, for them to navigate what was a very difficult situation. That not only built confidence in government, but also addressed some of these issues of inequality. And I think that there is some very good messaging and learning in that for what we might want for our society going forward.

- [Simon] Absolutely. We've got like one minute left. I feel like the news reader as we come up to the seven o'clock morning news. It's a tricky one. You're not going to be able to answer it in time. It's a question about theory. And it says, how did the ideas about social identity and cohesion relate to or differ from the idea of social capital. In 30 seconds or less, that's a PhD topic, obviously.

- [Kate] No. So, I mean, obviously they're highly related and they're overlapping, but our conceptualisation is that social capital is understood as being held by the individual. Right? I have resources. I have a network, I have support as an individual. Whereas, we see social cohesion as operating at that level, but also at the community level, I feel my community has trust. I feel my community has an ability to solve problems. So we would very much draw that distinction in order to better separate those two concepts and why both of those things might be important.

- [Simon] Great. Well, thanks so much, Kate. That was a really interesting bunch of questions that kind of is the end of your part for now, but don't worry, if you're online, and you've got further questions, you can still put them on Slido and we'll get to them in the final Q and A session. So Kate will be hanging around for that when we have all three speakers. So thanks so much. And now we're gonna try to do the little transition across to our next speaker. So we'll see how that goes.

- [Kate] Okay. Thank you everyone.

- [Simon] Thanks. All right. Our next speaker is Dr. Karen Tindall. Karen is the principal advisor at the Behavioural Insights Team, and she's also announced previously, she'll be moving to Canberra soon. So that's gonna be super exciting. It's gonna be fun having you around. Karen holds a PhD in political science from ANU and is an Adjunct Associate Professor at the University of Canberra. Today, Karen is going to be talking about something really topical to us here in Australia, and she'll be sharing experiences from the UK on public risk assessments of Coronavirus since the restrictions eased which is, I think, we've all probably catch in a little bit of that on the news, but to have a bit of a deeper understanding of it will be really fascinating. So in particular, Karen is gonna talk about how people understand Coronavirus risk, factors that affect their risk perception and how we can help people make more accurate risk assessments. So thanks, Karen, over to you. And I'm sure there'll be stacks of questions afterwards.

- [Karen] Brilliant. I look forward to it. Thank you, Simon. And before I start, I wanna say that Simon mentioned at the beginning of this webinar, Kate's impact in her position at ANU. And I just wanna say I am one of those very lucky individuals who benefited from Kate's brilliance and mentorship, as she was my post doc supervisor back in 2012, 2013. So I wanna thank her publicly for that, and also thank her for the excellent presentation this morning. It was really, really interesting and took me back so I look forward to hearing more about that too. In terms of what I'm gonna present today, as Simon mentioned, we have seen a lot in the news. In the last few weeks, there's been a lot of easing of restrictions in Australia, really interesting time. And it's a great time to look at how other countries have managed that challenge. So of course, each country faces a very unique set of circumstances. Australia is very different to the UK, Australia's situation now is very different to the UK's situation when restrictions eased. But it is useful to look at how they tackle these challenges and the behavioural science underlying that. So some of you might remember back in July this year, England had its so-called freedom day, and it was quite different to what's happening now, but has some commonalities. So for England, the freedom day was quite abrupt and mask-wearing indoors and social distancing wasn't mandatory anymore. Here in Australia, we've got a much higher vaccination rate. We've got lower cases and a slower easing of restrictions. But there are still really, really useful lessons that we can learn looking at how people understand risk, how people understand COVID risk and the commonality between the UK in July, at freedom day, and Australia now, is that more and more, there's going to be less, we're gonna be relying less on legislation and hard restrictions, and we're gonna rely more on people's judgement and behaviour about what they can and can't do and what they should do. And we're gonna be relying on them, on individuals and us, making decisions about the risk of catching and spreading COVID. And as we all know, from the behavioural sciences, humans do not calculate risk in a purely rational way, anything but. So it's a time for us to look at how people assess risk and see if there's ways to improve the accuracy of risk perception. And the importance of that is really twofold. So we don't just want to, we wanna manage the pandemic. So those who are high risk, really need to take preventative measures, but it's also a time to support economic recovery. And so we want those who are already at low risk or who have low risk profiles to engage safely in society. And so that's what I'm going to be talking about. One of the really key components about how people assess COVID risk is their understanding of how the virus spreads, how the virus transmits. If someone is well aware that it's an airborne virus and it spreads in crowded places and in poorly ventilated places, then that will hopefully shift their behaviour so they, for example, socialise outdoors. And the more that we know about what people's understandings of what the risks are and what behaviours are more risky than others, the easier it is for us to provide guidance to them and to building that behavioural insights perspective. So what I'm gonna do today is share findings from an experiment our UK team conducted in England about two weeks after that freedom day in mid July. And as Simon said, I'm gonna talk about how they understood the risk, behavioural factors that affected that risk perception and some approaches that we can take to help people make more accurate risk assessments. And to do that, what the team did was they ran an online experiment with a representative sample of 3000 adults in England. And so we looked at, as you can see in the slide, we looked at understanding of transmission, preventative measures, their risk perception against various different scenarios. We conducted a calibration exercise to ask them how confident they were about their own judgments on how Coronavirus spreads. We, then, assigned them, all participants were assigned to four different interventions that were ways of communicating risk, addressing different behavioural aspects of risk perception. And what was also really great was that the team had already run this experiment seven months prior. So they could look at how risk perception had changed over time. So that's what I'm going to present today. But I do wanna add a really important caveat, that when I said that it is a representative sample, it is an online representative sample. So it's not capturing those who are digitally excluded. It's not capturing those who don't complete online surveys. And it's important for us to keep in mind when interpreting the results. Also, we know that there's an intention-action gap. So the interpretations of stated behaviour or stated intention is that sort of at the edge of real behaviour. So I will talk you through particularly interesting findings. And so this finding, we asked people about the main ways that people catch Coronavirus. And what was really encouraging, what was really great, is that two thirds correctly identified that Coronavirus spreads mainly through close contact. But what was interesting was that 20% of people answered incorrectly and did so with high confidence. And what you can see is that there is a sizable minority that don't appreciate that Coronavirus is an airborne virus. And this leads them to underestimate the role of ventilation. And many continue to overestimate the importance of hand-washing. So we now know that Coronavirus spreads in crowded spaces and the evidence has built up that it transmits through the air. This was known in July 2021, when this trial was run and the government's guidance had started to point to and emphasise to that. But as you can see, when we asked people, a third of them failed to identify the close contacts, where it was a primary transmission route. And now this is not surprising because back in early 2020, definitely the concern was that Coronavirus spread through the large fluid droplets, the direct coughs and sneezes, and the really important risk reduction items at that time were washing hands, physical distancing, and wiping down surfaces. But people haven't updated their mental model of what the risky behaviours are and what the best mitigation strategies are. And so, here's another variant on that, is we asked respondents to select their top three specific behaviours for reducing Coronavirus risk, risk of catching or spreading. And as you can see, the face coverings and hand-washing were the most commonly cited specific measures for reducing Coronavirus risk. And people very much overestimated the importance of hand-washing, putting it even above getting a vaccination. And I think very pertinent here is that washing hands was twice as likely to appear in the top three behaviours as staying in a well-ventilated space. Now, I'm not saying that washing hands isn't important, but the preventative and mitigation behaviours need to update as we learn more about what works and doesn't work to help control the spread. So, okay, the next slide. So people haven't updated their mental model of Coronavirus risk and I think it is really difficult to shift a mental model this late in the game. And it's a difficult balance between not discouraging hand-washing, but really encouraging that people keep to ventilated spaces and meet outdoors. And while it does get mentioned, it doesn't have priority. And you can see this in the current guidance. The current government guidance is still very much mentioning hand-washing, but there's no mentioning there of well-ventilated spaces. So we really need to do a lot to help update that mental model. The next key finding that I wanna show you is some really good news. Well, good news, is that people have a pretty good sense of which social situations are riskier than others. So the relative risk of one situation versus another. And the way we found this out is presented participants with a social scenario, these little social scenarios, they represented relative low, medium, and high risk. So we've got three examples up there on the slide. Participants were randomly assigned to a scenario, obviously, not color-coded 'cause that would be cheating. And asked them to rate how likely someone would be to capture and spread Coronavirus. And so, as I said, participants were pretty good at what scenarios were riskier than others. So parks were safer than nightclubs, take-aways were safer than cafes. What was interesting was 'cause as I mentioned, they ran this experiment back in November 2020. And so they could see the shift over time. And in November 2020, 47% of people thought that the risk of someone catching and spreading Coronavirus in a crowded area, like a nightclub was almost certain. And in this experiment, it's only 28%. So the perception of absolute risk has gone down over time, which was interesting because in July 2021, positive cases were higher. So then, the question is why was that? And it may have been that it was quite a low death rate at the time. And there was also the vaccination campaign was in full swing. So people might've had a lower perception of risk, but unfortunately, we weren't able to dig into that. So it remains conjecture. So in summary, what I've shown you so far is that as restrictions were easing and as personal risk assessments and personal risk judgments were becoming more and more important, there was still a sizable minority that couldn't name the main way that the virus spreads. And so, this indicated that we needed to improve people's understanding of transmission to help them make more informed risk judgement. Now, this experiment has not been run in Australia, as far as I know, so we can't say what the current Australian public perception is, but I would be surprised if it was dramatically different. So you can see here that the UK government's emphasis on fresh air and ventilation was already playing a part in comms, more so than we saw in the current New South Wales, Victorian and federal guidance. And even though we're in a much better position now than England was in mid July, there's still a lot that we can learn about updating mental models of risk and risk reduction behaviours. So I'm going to go through very briefly a part of the experiment where we tested out a few different interventions to see if we could make design or present interventions that help people make more accurate risk perceptions. So there is a lot of research showing that people don't calculate risk in a purely rational way and there are different cognitive biases and heuristics that play a very big part in this, given this is a BI community of practice. I'm gonna give a shout out to some of my favourite work in the area. So if you're interested in risk perception, then I really highly recommend the work of Paul Slovic. He was a pioneer in this area and his work is not only excellent work, but very accessible. I also recommend Gerd Gigerenzer, his research and particularly his book, "Risk Savvy" is a good read. And then of course, the absolutely wonderful, David Spiegelhalter, he's a professor of the public understanding of risk at Cambridge University. He also has a really great podcast called "Risky Talk", that I highly recommend you all subscribe to. And he talks about COVID. He talks about public communication, public policy, and just generally, how to communicate risk well. It's super interesting. So risk calibration is a really tricky balance. We don't wanna just sort of across the board, increase people's personal sense of risk unnecessarily. We do wanna improve risk perception. We wanna improve risk perception amongst those with a high risk profile, so potential super spreaders. But we don't want individuals who are already engaging in safety behaviours. Those people that we call sort of strong compliers, they might be overly worried about Coronavirus. We want them to go and engage safely in society. And so it's trying to balance those two priorities. And so, at risk of playing BI bingo, I'll call out a few of the really interesting heuristics that are pertinent here to risk perception. So we've got the controllability heuristic. So when judging risky situations, we tend to see things as less risky if we're in control while doing them. So I think a really common example, nice example, is that in general, not in general, but people think driving is safer than flying because they are in the driving seat, but in terms of how safe it is to fly, it's 75 times more dangerous to drive than to fly. So control is a really big factor in how risky we judge a situation to be. So this could play out in lots of different ways with Coronavirus. If people don't feel in control when flying, so they drive instead, then if people think that they can't control whether or not they catch the current Coronavirus, then they might avoid social contact entirely. Even though, there are very effective ways to reduce risk, by vaccination, meeting outdoors. So we need to calibrate that sense of control. And then, of course, there is the delay, really interesting, the delay between the hazard and the impact. So it's really hard for us to judge how risky a behaviour is, such as spending time in an unventilated environment, when the link between the risky behaviour and the impact, i.e. testing positive for COVID, is not immediately apparent. We don't have that visible cue or feedback, like the hazard of a cliff edge when you're going for a bushwalk, you haven't got those cues. And then, there is habituation. So when a hazard is present for a long time, we tend to get used to it and perceive it to be less risky, even if the technical risk remains the same. And then, of course, there is the very well-known, the fan favourite, the availability heuristic, which absolutely wreaks havoc with our ability to judge risk accurately. So we tend to judge the likelihood of an event by how easily we can retrieve examples. An example of this in relation to COVID would be studies that have found that people overestimate the fatality rate and part of that would be due to media reporting on the much easier to recall dramatic news around deaths. And so how do we use our knowledge of this to make risk perception more accurate? Part of this online experiment that I'm talking about, the team tested ways to communicate risk and help people more accurately assess their risk. And the hypothesis was pretty simple, and it was, if people understand how Coronavirus spreads, the risk to themselves and effective mitigation behaviours, then they can individually make better judgements, better risk judgments. And so the team tested four interventions that were designed to improve risk perception. There was a WHO transmission video, which explains how the virus is transmitted and discusses six safety precautions. There was the Swiss cheese video, which describes how safety precautions need to be done in combination to most effectively prevent transmission of the virus. Then we had the personal risk score, where participants were told that they were either low, moderate, or high risk of catching and spreading Coronavirus. And this personalised risk score was based on their data on their recent social contacts and precautions that they took during those social interactions. So those three were particularly targeting that controllability heuristic. And then we had the local area heat map. Where participants were shown the number of COVID cases in their postcode, along with a heatmap of the county. And this risk communication strategy was designed to target that availability heuristic or the inaccuracy that comes from the availability heuristic. So participants saw one of these four interventions and were randomised to see one of the four, or they were randomised into the control group. The control group saw either no guidance at all, or they saw the standard UK government's guidance that was available at the time. And you saw a sort of extended version of that before. And what the team found was that all four of these interventions increased people's perception of the risk relative to those in the control group, the existing guidance or the no guidance. Which is really great, great for highlighting the hazard and really great for getting people to understand behaviours that'll mitigate risk. But as I mentioned before, we don't always wanna increase people's personal sense of risk wholesale and unnecessarily. We wanna improve people's risk perception and increase risk perception among potential super spreaders, those with a high risk profile and encourage them to engage in protective behaviours. But we want those with a low risk profile, and those who are already strong compliers not to get even more to increase their risk perception. And so to test that or to analyse that, the two groups, the strong compliers and the super spreaders, are particularly interesting to look at. And so the team broke down the results by strong compliers and potential super spreaders. And you can see that the intervention, the personalised risk score, that was the only one, that was the only intervention that shifted the risk perception in these groups in the desired direction. So all the interventions increased the sense of risk, but in that personalised risk score, it reduced risk perception among the already strong compliers, and it increased risk perception among the potential super spreaders. So really interesting, but don't get too excited because the effects of these interventions, they were significant, but they were modest. So it's not gonna solve the problem. There are big challenges, further challenges that we need to keep in mind is that those potential super spreaders, as we know, are disproportionately, likely not to engage with government messaging. And so reaching them is gonna be a challenge. And there's a need to identify better opportunities. The other thing to moderate your excitement about these results is that the personalised risk score, while great, did require information about individuals. So it's much harder to implement and disseminate as an intervention strategy. It's not impossible, but it's certainly challenging. So I will wrap up by summarising some of the recommendations that came from this work. The first is that when you want to get people to understand risk, it's really helpful to use metaphors, visually rich stimuli and not just written guidance. So the videos and the interactive maps were generally better at changing people's intentions to engage in those important preventative behaviours. The second is that the recommendation in England in July, and I would hazard a guess in Australia in November, is to emphasise the importance of socialising in well-ventilated spaces or outdoor spaces, as only one in five, considered that socialising in well-ventilated spaces was in one of the top three precautions they could take individually. And in a different part of the experiment, which I didn't present, they thought that outdoor environments were only slightly less risky than indoor environments. And then, the third recommendation would be to, in order to increase accuracy of risk perceptions among the high and low risk groups, personalised risk information, where possible, can be really effective, but it's the where possible that's the problem. And so that leads me to another important implication to consider. So we are relying here on individuals making judgments about risk and making individual decisions about precautions to take. But as we know, humans are not great at judging risk and not great at following through on even very, very good intentions. So if we want to get people out in society while also managing the spread of the virus, then a really good way to do this would be to keep finding structural and environmental ways to do it that don't require individual action. So there are some really nice examples that we've already seen. The perspex shields at cash registers and receptions don't require individual action. There's the wastewater detection, targeted wastewater detection that can identify outbreaks. And so if individuals aren't going to get tested in a particular area, we're not relying on those individual behaviours in order to help manage the spread. And then helping others to design environments to encourage the best protective behaviours. So for example, subsidies for businesses, for things that will encourage people to move outdoors like sun shades and umbrellas in cafes, or air filters, that sort of thing. So really, sort of taking a step back and thinking how we can design the problem out as best as we can. So I will wrap up there. And so I think just in sum, I will always advocate for more research on the public understanding of risk, but communications is just one piece of the puzzle. And it's really important that we think about designing the environment, that choice architecture, that gets talked about so much. We need to think of that piece of the puzzle as well. So with that, I will stop sharing.

- [Simon] Awesome. Thanks Karen. We've got around about five minutes for questions directly for you, and then, we'll go to the group. There's some tricky ones here, but I'm gonna start with a super easy one. Can you just repeat some of the resources you mentioned when talking about perceived risk, there was a couple of books and podcasts there.

- [Karen] Yes. Yes. So Paul Slovic, S-L-O-V-I-C, you'll see his name come up a lot in all the classic studies about public understanding of risk. Yeah, really, really great research. Gerd Gigerenzer, his book is called "Risk Savvy" and he has a really interesting take that's less about, his work is less about, he believes that it's easier to teach people to think deliberatively rather than rely on their automatic behaviours. And so really, really great perspective on that. And then the third name I wanted to call out was David Spiegelhalter. I can now see why this required repeating 'cause there's some pretty tricky names there, and his podcast is called "Risk Savvy". And if you look up the Centre for Communication of Risk and Evidence at Cambridge University, his work is really great. It distils something as tricky as probability into really easy to understand concepts and not so related to this, but he also has a really great book called "Norm Chronicles", which I really highly recommend.

- [Simon] Great. All right. That's a super list to go with and we're purchasing some of those for our BETA library. So thanks for that. Maybe one of those authors or others have touched on this. You said it's really hard for people to update their mental models. And we saw that in your research. Are there any examples from other contexts or historically where we think people have successfully updated their mental models that we could borrow from?

- [Karen] Oh, that's such, that's a great question. Sorry, go ahead.

- [Simon] If nothing comes to mind then you can keep thinking about it till we get to the group discussion. That's a tough one.

- [Karen] It is. Yeah. So nothing immediately comes to mind. And I think my impression is the reason for that is because it would probably be a combination of a whole lot of things. So you would need to look at what embeds something into someone's mental model and things like the availability heuristic is a classic wonderful example. So you need to have a look at examples where those heuristics have been understood and what's the word, not mitigated, but worked around. So yeah, I'll ponder that one a bit more, but yeah, nothing immediately comes to mind.

- [Simon] Cool. There's a question here, it says, when do you think cognitive overload comes into play with people feeling they need to be across the detail of multiple transmission modes. A few people experienced this. Are there any behavioural insights that could be used to make it easier for people to know how much they really need to know.

- [Karen] Hm, great question. Yeah. So people will fall back on those automatic behaviours, the cognitive biases and heuristics when they're faced with too much information, too little information, uncertainty, time pressure, or stress. And that's the basis of all the BI, much of the BI that we do. So in terms of how to give people enough information that they need, but not overwhelm them, it really is not trying to give too many calls to action at once, really working out where your big bang for buck is. And I think the Swiss cheese model video actually does quite a nice job of showing that the call to action is the combination. So I would, yeah, it's linked in the presentation, which I assume will be shared afterwards. So yeah, I think thinking about what the top call to action would be.

- [Simon] Maybe a practical kind of a way to think about this is, there's a question here around the challenge of explaining what a well-ventilated space is, as we'll shift explaining many, many spaces in a day, in a week and even in an hour. Is there a way, I mean, are we expecting everyone to kind of do a quick assessment, like it would have for security where you look around at the windows and check, or is there an easy way where we can just know whether something's well-ventilated?

- [Karen] That's a really great point. And what are the rules of thumb that people can use? Or what are the ways they can conceptualise it? So that at a glance, they can look at it and decide how risky it is 'cause of course, it's not binary. So it's assessing that, and actually since this research, I've found myself doing that too. I'll be in a big sort of garage shed and be actually, I know the roof is high. There's not that many of us in there, this I would consider is a well-ventilated area. So I think it is, hopefully people don't have to sit through my presentation in order to be able to decide that it's important to pay attention to these things. But I think your point about plain English and rules of thumb is a really important one.

- [Simon] Just one last question, because we're at time and we'll go to the whole group. But there's a suggestion here that, this is partly what explains why mask wearing is the highest protective health behaviour now in a lot of studies, because it's much easier to do as a small controllable personal action. So it's separating out some of these things where the choice architecture has to be done by others. And then you experienced that with the things that you can do, any observations on mask wearing in the UK and where that's at at the moment.

- [Karen] I don't feel like I know enough about what's happening at the moment in the UK to talk about mask wearing. But on the point of mask wearing, I think something that's really interesting is the visibility of it and the social norms that are associated with it. And I think more and more we'll see that people will walk into a space where they know, you know you're meant to be wearing a mask, but no one else is. And so you don't either. And I think that then brings in Kate's excellent work around social identity and who those influential people in the group are and how to identify them and make the best use of their influence.

- [Simon] That's a great little segue. So we might bring in Kate and Ben now for some group discussions. There were a bunch of questions that came in just on your presentation, Karen, but we might be able to touch on some of those. I'm gonna kick off with, I feel like what we're really great at in the behavioural sciences is explaining what happened after the event with behaviour and putting a theory to it. I'm gonna challenge you to sort of think forward a little bit to where Australia might be in a few months, and let's just set some parameters. Let's assume that it's sort of February, March, there's around about 5,000 cases a day, maybe 30, 50 people dying a day across Australia from COVID. Where do you, very broadly, what's your expectation from this point forward, and you can use your own location, Sydney or Canberra, on things like mask wearing, hygiene? How many of these things are gonna stick, what are the critical points gonna be where we might lose some of that protective health behaviour? And what can we do to try to maintain it? Tough first question.

- [Kate] I've got some comments, the questions are for us, yeah?

- [Simon] Yup. Go for it.

- [Kate] So I think, where Australia sits right now is that given the way we've managed the pandemic, we are fortunate in being able to learn and we have all along in a way from other countries. And I really think we need to bring to the fore some of the models that we know have been effective in practice, they've got to be very influential models. Japan is one, the Scandinavian countries are the other, and what's emerging, and of course, there's people who are experts in these particular health behaviours, but what is clear is that vaccine is not enough, that a whole range, a whole suite of behaviours need to continue. And the sooner we can start to make that clear, at the moment, we're focused on vaccine, vaccination rates, but we should also be really strongly communicating things about mask wearing, ventilation, as we've just heard from Karen, distancing, avoiding places that are of high density, they aren't at the forefront of people's thinking, and yet, they're gonna have to be for us to continue to prosper as well as we can through 2022 and onwards.

- [Simon] Any comments-

- [Kate] So I would say using our tools of influence, the things that we understand work in order to move people's mindsets from vaccinations and boosters to the behaviours that are gonna keep themselves and community safe.

- [Simon] Any comments from you, Ben, on that one?

- [Ben] Yeah. I think the point that Karen raised about the mask wearing and the change in norms around that is really important. And I do think that we will need to get that communication clearer and stronger and better because it will, very rapidly I think, if you're asking, what's it gonna like in March, I think that mask wearing will fall away, if it's not emphasised that this is still a useful measure to stop the spread. And I think just saying to people, it'd be a good idea if you did, until it reaches a real norm where it's the same as someone lighting up a cigarette on a bus, if the person's not wearing a mask, it's gonna be really hard to keep that going. So I think that messaging has to happen. And I think it is interesting talking about a shift in mental models and the sort of causal understanding of the mechanism. And you are asking, or one of the questions was about where has that happened? And I think to some extent, to take it away a little bit from COVID, that people's mental model of the causes of global warming is something where now a lot more people understand, maybe not the detailed chemistry of it, but the basic link between fossil fuel burning and an increase in the global temperature. And I think if you can get that across in the COVID sense of it spreads through the air, therefore, things that stop things from spreading through the air, like a mask or a breeze blowing through a room, as long as you're not directly downwind of that breeze, I guess, is going to be helpful. And so, yeah, I think we do just have to keep emphasising that until it reaches that norm. And I'd be interested in Karen and Kate's take, have much more knowledge of that social norm literature than me. I mean, what is the point at which it breaks through a threshold of, it's just the thing that everybody does now.

- [Simon] Any comments from you, Karen? Or you've touched on a lot of this in your presentation, but-

- [Karen] Yeah, I think I'll just re-emphasise that I'm such a big fan of designing the environment, mostly, because I'm just very lazy. So if I don't have to make the decision and the environment just does it for me, then that's my ideal. I'll let Kate speak to the norm point, but I'll just, I'm reminiscing back to a conversation that we had in 2012 that really struck me was when Kate was talking about the importance of top-down and bottom-up around cigarettes and the change in norms around smoking that it was both restrictions that were imposed from above that gave space for these shifts in norms from the sort of community group level. So I think that is very applicable here, but I'll ask Kate about her thoughts on that.

- [Kate] Yeah great. I was thinking, sorry-

- [Simon] Can I just ask before you go to that, and you might want to touch on some of these things, and there's a message here. There's question here also about the influence of advice and consistency of advice from experts. Two things which I'm hearing a lot at, or one thing I'm hearing a lot of at the moment is this idea of returning to normal. It's a phrase that gets used a lot as in like our lives are getting back to normal, but I'm interested to know how that might play out also in how people think about this. The other thing I'm hearing a little bit of is that in some respects, getting COVID will be inevitable. We're all gonna get it at some point. It's almost a matter of trying to time when you get it to be related to your vaccine. So I just want to sort of throw out both of those in the mix as newer developments that are sort of starting to also overtake the idea of just the risk of getting COVID. So sorry, I just wanna add that in and go to you first Kate and then any other comments from others.

- [Kate] Yeah, no. I mean, thanks for that. I was thinking about smoking in the context of that question of where have we updated our mindsets. Now, that did take a long time, but the surgeon general in the U.S. released a report of key factors that had driven the smoking rates down. So that's not just changing mindsets, that's actually changing behaviour and yeah, Karen remembers well, that's exactly right, that it was both of those things that mattered. You know, at the moment, when I walk into a shop, there is a sign outside that shop telling me that my mask must be worn, it's a requirement. It's a health requirement that when I walk inside, I'm wearing a mask. To some degree, if that is maintained itself in a consistent way across the country. I think it's already unravelling in some states compared to others, then those kinds of measures are gonna be the environment telling us what to do, Karen. But yeah, I think we do need to get consistent messaging. It would be great to get consistency, which we sort of have struggled with across the country. So that there's a sort of one set of behaviours that people need, that people know everyone is doing for as long as possible, to ensure that other people and themselves are safe. So sure. I might get COVID at some point, but if we all got COVID at once, there's a lot of people who that will put at risk. So those risk messages, for others, as well as ourselves, are still very real going forward. And the longer we leave it, the more likely it is people have boosters, we'll have other kinds of treatments. So there's huge advantages in not, again, letting this thing run that need to be really carefully communicated to people.

- [Simon] Ben, any comments there?

- [Ben] Yeah. I think the consistency in messaging is also something that you hear a lot and the challenge of different policies in different states and different jurisdictions is one that I don't see an easy resolution to at the moment, but I agree. I think that there is this change in returning to normal having to, I mean it sounds trite to say, it's a new normal or COVID normal, but I think that is important to emphasise. It's not like it was at the end of 2019. It's a different way of doing things and we will adapt to it and we will change to it and we will start to accommodate it and it won't be a, but it will take time. These things take time.

- [Simon] Yeah, for sure. We're just a couple of minutes over the scheduled finish, but I might just ask a couple more questions, if you can all stick around for a few more minutes. This might be one where you just say, that's too difficult and I'll have a think about it. There's a question here, it says, Kate challenges us to adopt better models of behavioural change, models that incorporate social identity and cohesion, are there any behavioural change models that the panel feels are stronger in this respect? Or are there other models that should be retired? It's a tough one on the spot. I should have given this as a Dorothy Dixer so you could prepare.

- [Kate] I think there has been work on, there's been a whole journal article on whether the theory of planned behaviour should be retired. Which stimulated a lot of discussion, a lot of mixed views, but I think what's interesting and what I would like to see going forward is that we use what we've seen with COVID to really test some of our theories of behaviour change. And I think it is not unlike other things that we're going to face going forward, and it's a good opportunity to dig in and refine, check, assess, develop our models of behaviour change. And I think we've seen that shift going on ever since the behavioural insights movement sort of began. It's always checking in around models of behaviour change. So certainly, I'd like to do more work in that area and collaborate with anyone who thinks that there is some interesting things to learn there.

- [Ben] I would-

- [Simon] Go, Ben.

- [Karen] Go please, Ben.

- [Ben] I was just gonna say that I think that one aspect that's under discussed in our model, certainly around the kind of nudge techniques, nudge toolkit is the element of social sense-making or interaction between the person making the policy change and the person who it's intended to. We know about things that, if you set a default it implies, it's the thing I'd like you to do. And so there are much broader aspects. I think of that kind of active interpretation of the person whose behaviour is trying to be changed, which we often, I think don't emphasise enough when we say people are irrational and they can't do this and they can't do that. And there's all these biases and heuristics. People are actually pretty smart and people are very sensitive to very quite subtle cues in the way that information is presented to them. And acknowledging that a little bit more and trying to think a bit more carefully about how people are thinking, the people that have been nudged are thinking, they're not just passive recipients of information. So yes, we might be lazy, and yes, changing the environment, the choice architecture, may facilitate certain things, but we're not all bumbling around with no brains in our heads, not knowing what to do. And I think that message needs to get across a little bit more strongly. There's this sort of self-fulfilling prophecy of, "Oh, you're hopelessly biased, let me sort it out for you", that we need to avoid.

- [Kate] Could I just quickly comment on that because I think that Steve Reicher who's been very involved in this sort of Sage network in the UK. I mean, he's got this whole notion that lots of the initiatives around COVID were driven by that view, that we would turn in, that we were driven by fear, that we wouldn't be able to think properly, that we wouldn't be able to know what to do. And yet, the more we brought people on the journey and gave them the right kind of information, the more they could act and make decisions. So there was a view at the centre of government in the UK has been argued to be the wrong view of the person, effectively.

- [Ben] Yeah. I completely agree. Yeah.

- [Simon] Karen, I'll give you the last word.

- [Karen] Yeah. I mean, I think that we need to choose the model of behaviour change based on the circumstances. So I definitely don't think we're all bumbling around and I am definitely lazy, but I only want those choices to be designed for me when I either don't care enough about the situation or when I'm too busy or when I want someone else to pass the information and make it plain English for me. We are very capable of thinking through challenges deliberatively but we've got limited hours in the day and limited situations where we can turn our attention to deliberative thought. And so those rules of thumb and shortcuts, they are a feature, not a bug of how we go through our day. So I think it's more about knowing how and when to switch into that deliberative mode so that we think through it carefully and also when it warrants people to do so. So I completely agree that the deliberative mode is incredibly important and that we shouldn't just be relying on behaviour change through automatic mechanisms by any means. But it's this shift where it used to be, we always thought, well not always thought, we believed that people would rationally think through every decision that we put in front of them. But if they get home at the end of the day and they receive a letter and they are tired and they don't care enough about the issue, then we shouldn't force them into that deliberative mode. So it's about picking and choosing when it's suitable. Sorry, that was quite a long answer, but it's something I feel very passionately about.

- [Simon] Right, yeah. I can tell, that's good. We're gonna finish the questions there. We've had a fairly active kind of group on Slido, just a couple of little comments to draw out. We asked about where mental models might have shifted. Someone has suggested smoking as the example where that could have happened with huge effort. And there's also been a suggestion to check out microcovid.org for a risk calculator. So that's one to have a look at. And I'm not sure if it's the same one I saw on the news the other day or not. But I saw there was one developed in Queensland, so that could be a similar one. That's all we've got time for, unfortunately. I feel like we could've gone on for a long time there. I'd just like to thank all of you for making the time this morning. Really fascinating presentations. There'll be an opportunity, I hope to engage with you all about some of the subject matter in other ways. 'Cause I know a lot of people kind of have follow-up questions and we'll probably get some of those. So we might be doubling back. For those who are on the line, the next BI Connect session will be on Thursday, the 18th of November. It's gonna be on another really interesting subject on COVID-19 misinformation. I'm sure we probably could have used these three speakers to talk about that for two hours, as well. There's a lot of thinking going on about it at the moment. We'll be hearing from Dr. Carissa Bonner from the University of Sydney and Matthew Nurse from ANU. So thanks again, everyone. Really enjoyed the presentations and the questions and look forward to the next BI Connect session.