Preferred policy options to assist post-COVID-19 mental health recovery: A population study

Karin Hammarberg | Thach Tran | Maggie Kirkman | Heather Rowe | Jane Fisher

Abstract

The aim of this study was to gauge the opinions of people in Australia about policies to help them recover from the consequences of COVID-19 pandemic and its associated restrictions. An anonymous online survey of people aged 18 years and older in Australia was available from 1 July to 31 August 2020. It included 16 proposed policies which respondents rated as ‘Not at all helpful’, ‘Somewhat helpful’, or ‘Very helpful’ in assisting them recover from the COVID-19 restrictions. In all, 9220 people completed the survey. The most endorsed policy was ‘To have a publicly available plan about management of future pandemics’ which was rated as ‘very helpful’ by 46.1% of respondents. Four other policies were rated as ‘very helpful’ by more than 30% of respondents: two related to mental health support, one to individual financial support for living expenses, and one to support for community organisations. Government preparedness for future pandemics and support for mental health, individual finance, and community organisations should be policy priorities in the post-COVID-19 recovery phase. The findings can guide policy development to support people in Australia as they recover from COVID-19 and the restrictions that have been imposed to control its spread.

KEYWORDS

COVID-19, mental health, policy, population, recovery
KEY POINTS

- An anonymous online survey of preferred policy options to assist post-COVID-19 mental health recovery was launched in July 2020.
- More than 9000 people completed the survey.
- Almost half of the respondents reported that having a publicly available plan about management of future pandemics would be ‘very helpful’.
- Two policies related to mental health support, one to financial support, and one to support for community organisations were endorsed as ‘very helpful’ by more than 30% of respondents.
- Government preparedness for future pandemics and support for mental health, individual finance, and community organisations should be policy priorities in the post-COVID-19 recovery phase.

1 INTRODUCTION

The mental health consequences of the COVID-19 pandemic and its associated restrictions have been significant around the world. A systematic review of studies of the effects of COVID-19 on psychological outcomes published up to May 2020 reported high rates of symptoms of anxiety, depression, post-traumatic stress disorder, psychological distress, and stress during the COVID-19 pandemic in the general populations of China, Spain, Italy, Iran, the United States, Turkey, Nepal, and Denmark (Xiong et al., 2020). The risk factors associated with these distress measures included female gender, younger age group (≤40 years), having a chronic or psychiatric illness, being unemployed, a student, or frequently exposed to social media or news about COVID-19.

In Australia, the first confirmed case of COVID-19 was identified in late January 2020 (Australian Government, 2020). Although the spread of the virus was initially slow, by late March increased cases and hospitalisations prompted the government to order national lockdown measures to slow the spread. Measures included staying at home except for a few specified reasons, working from home if possible, physical distancing, limiting in-person interactions, avoiding visits to residential aged care facilities, limiting attendance at weddings and funerals, cancelling travel, and online learning from home replacing attendance at educational institutions.

Containment of COVID-19 restricted freedom to socialise, work, conduct business, participate in cultural activities, and attend milestone events such as weddings and funerals. As in other countries, these multiple losses caused widespread disenfranchised grief and exacted a heavy toll on people’s mental health and well-being in Australia (Fisher & Kirkman, 2020). Poor mental health has adverse consequences for quality of life and physical health, as well as for people’s social and economic participation. The pandemic has reinforced unfortunate truths about the social determinants of health: the hardships caused by restrictions on freedom are inflicted unequally on citizens. Women, young people, and people who are socially disadvantaged experienced a heavier toll (Fisher et al., 2020).

Four days after the COVID-19 restrictions were implemented in April 2020, our group launched a short, anonymous online survey of people living in Australia aged at least 18 years to estimate population prevalence of clinically significant symptoms of depression and generalised anxiety. It included questions about demographics and experiences of COVID-19 and the associated
restrictions. Two widely used standardised psychometric instruments were incorporated to assess symptoms of depression and anxiety: The Patient Health Questionnaire 9 (PHQ-9) (Kroenke et al., 2001) and the Generalised Anxiety Disorder Scale 7 (GAD-7) (Spitzer et al., 2006). More than 13,000 people completed the survey which showed that, in the first month of COVID-19 restrictions, more than one in four had clinically significant symptoms of depression (PHQ-9 ≥ 10) and more than one in five had clinically significant symptoms of anxiety (GAD-7 ≥ 10), at least double the rates found in prior surveys conducted in a non-COVID time (Fisher et al., 2020). A smaller study conducted around the same time identified similar estimates of clinically significant symptoms of depression and anxiety (Dawel et al., 2020).

The United Nations (2020) recommends that all countries plan a response to the mental health consequences of the pandemic. Commentary about Australia’s response has called for increased healthcare services, including treatment of serious mental illness (McGorry, 2020) and ‘low intensity’ telehealth and online programs (Christensen, 2020) for people who are at risk of mental health problems or have mild symptoms. However, these necessary services are only part of the solution. Just as public health responses to COVID-19 have been crucial to protect Australians’ physical health, public mental health initiatives will be essential for full social and economic recovery. Indeed, the first of the three U.N. recommendations for post-COVID-19 recovery is to apply a ‘whole-of-society’ approach to promote, protect, and care for mental health (United Nations, 2020).

Public mental health is the art and science of enhancing mental health and well-being and preventing mental illness (The Lancet Editorial, 2016). It requires organised efforts and informed choices of public and private organisations, communities, and individuals. Mental health is profoundly influenced by the circumstances of people’s lives; risks and protective factors accumulate throughout the life course. Risks include exposure to adverse childhood experiences, violence, poverty, displacement, stigma, and discrimination. Conversely, mental health is supported by inclusive communities, gender equality, social and economic resources, and healthy relationships (Carbone, 2020). Public mental health is underpinned by human rights principles and a commitment to reducing mental health inequalities.

Like public health, public mental health relies on understanding the nature and distribution of the social and environmental determinants of mental health; applying universal evidence-based strategies to address modifiable risks; monitoring and evaluation; prioritising promotion, primary prevention, and early intervention; regulation and governance to influence policy; and employing participatory approaches that empower people, especially disadvantaged groups (State of Victoria, 2021). This requires a whole of government approach and the participation of civil society, industry, and communities (Global & Women’s Health, 2021).

Although Australia has experienced fewer COVID-19 infections and deaths than most other countries, the social and economic consequences of the pandemic have been significant, particularly for those who are socio-economically disadvantaged and marginalised. O’Sullivan et al. (2020) assert that the government’s policy responses will have long-term impacts across all areas of social and economic life, including on social equality and cohesion. They argue, therefore, that strong community engagement and participation are essential in developing policy responses (O’Sullivan, Rahamathulla, & Pawar, 2020).

To inform the development of recovery policy, the aim of this research was to gauge the opinions of people in Australia about policies to help them recover from the consequences of the COVID-19 pandemic and its associated restrictions.
2 | METHOD

This study was approved by Monash University Human Research Ethics Committee (2020-24080-45948). An anonymous online survey of people aged 18 years and older in Australia was available from 1 July to 31 August 2020. At that time, restrictions had eased in Australia except in Victoria where stringent restrictions were in place because of rapidly rising numbers of people infected with the virus. The survey repeated the questions from the survey we conducted in April 2020 (Fisher et al., 2020). In addition, 16 potential policies to help people recover were listed and respondents were asked whether each policy would help them recover from the COVID-19 restrictions; response options were ‘Not at all helpful’, ‘Somewhat helpful’, and ‘Very helpful’. The proposed policies were created using expert opinion and analysis of almost 14,000 responses to an open-ended question in the April survey.

Sociodemographic information collected was sex (female, male, non-binary), age, country of birth, place of residence, main occupation, and living situation.

2.1 Data management and statistical analysis

Data on Australian State, urban/rural residence, and Socioeconomic Indices for Areas (SEIFA) (Australian Bureau of Statistics, 2013) were derived from each respondent’s postcode using the most recent Australian Bureau of Statistics data (Australian Bureau of Statistics, 2019).

Population proportions and 95% confidence intervals of responses to questions about whether each policy would help respondents to recover from the COVID-19 restrictions were estimated, adjusting for differences in socio-demographic characteristics between the sample and the Australian population. The adjustments were made using weights for proportions of age groups, genders, SEIFA deciles, and states in the sample and the corresponding information in the population (Australian Bureau of Statistics, 2019).

A ‘heatmap’ was created to illustrate the proportions of people who endorsed each policy as ‘Very helpful’ for them, stratified by gender (female, male, non-binary), age group (18–29, 30–59, 60, and higher), place of residence (urban, regional/rural), and SEIFA groups (lowest 60%, highest 40%) simultaneously. The proportions were grouped as <10%, 10%–19%, 20%–29%, 30%–40%, and >40%.

Only complete data were included in analyses. The analyses were conducted using STATA Version 16 (StataCorp., College Station, TX).

3 | RESULTS

In all, 9220 people completed the survey. Just over half resided in Victoria, more than two thirds identified as women, and one quarter was born overseas (Table 1).

3.1 Most and least helpful policies

The weighted proportions of respondents who rated the proposed policies as ‘very’, ‘somewhat’, and ‘not at all’ helpful are shown in Table 2. The most emphatically endorsed policy was ‘To have
| State                        | n   | %   |
|-----------------------------|-----|-----|
| Victoria                    | 4844| 52.5|
| New South Wales             | 1796| 19.5|
| Queensland                  | 972 | 10.5|
| Western Australia           | 530 | 5.7 |
| South Australia             | 533 | 5.8 |
| Tasmania                    | 240 | 2.6 |
| Australian Capital Territory| 261 | 2.8 |
| Northern Territory          | 44  | 0.5 |

| SEIFA quintiles          | n   | %   |
|---------------------------|-----|-----|
| Quintile 1 (Lowest socio-economic position) | 858 | 9.3 |
| Quintile 2                | 1022| 11.1|
| Quintile 3                | 1362| 14.8|
| Quintile 4                | 2158| 23.4|
| Quintile 5 (Highest socio-economic position) | 3820| 41.4|

| Gender                    | n   | %   |
|---------------------------|-----|-----|
| Female                    | 6434| 69.8|
| Male                      | 2726| 29.6|
| Non-binary                | 60  | 0.7 |

| Age group                 | n   | %   |
|---------------------------|-----|-----|
| 18–29                     | 1348| 14.6|
| 30–39                     | 1758| 19.1|
| 40–49                     | 1763| 19.1|
| 50–59                     | 1871| 20.3|
| 60–69                     | 1592| 17.3|
| 70+                       | 888 | 9.6 |

| Living situation                             | n   | %   |
|-----------------------------------------------|-----|-----|
| On your own                                   | 1811| 19.6|
| With only your partner/your partner and children/adult family members | 6434| 69.8|
| With children and without a partner           | 340 | 3.7 |
| In a shared house with non-family members/Other | 635 | 6.9 |

| Born overseas                               | n   | %   |
|---------------------------------------------|-----|-----|
| 2246                                        | 24.4|

| Main occupation                           | n   | %   |
|-------------------------------------------|-----|-----|
| A paid job                                 | 5511| 59.8|
| Doing unpaid work caring for children/dependent relatives only or unemployed | 903 | 9.8 |
| Student                                    | 1038| 11.3|
| Retired                                    | 1768| 19.2|

Abbreviation: SEIFA, Socio-economic Indices for Areas.
TABLE 2 Population proportions\(^a\) (%) of the opinions about whether the proposed policies would help the respondent recover from the COVID-19 restrictions (sorted by highest to lowest proportions of ‘very helpful’)

| Policy                                                                 | Very helpful | Somewhat helpful | Not at all helpful |
|------------------------------------------------------------------------|--------------|------------------|-------------------|
| To have a publicly available plan about management of future pandemics  | 46.1         | 37               | 16.9              |
| Financial support for living expenses                                  | 33.9         | 38.5             | 27.5              |
| Additional support for community organisations (e.g. Men's Sheds, community choirs, sports clubs, environmental groups) | 32.0         | 39.7             | 28.3              |
| Access to face-to-face counselling with a mental health professional    | 30.5         | 38.3             | 31.3              |
| A GP asking me about my mental health                                   | 30.1         | 42.5             | 27.4              |
| Training for employers to manage employees' mental health needs during the transition from working at home | 28.7         | 35.2             | 36.1              |
| Information about how to manage my emotional well-being                | 28.6         | 48.4             | 23                |
| Access to telehealth for my physical health needs                      | 27.3         | 44.6             | 28.1              |
| A public statement of recognition, appreciation and thanks from the Prime Minister to people in Australia for limiting the spread of COVID-19 by following the restrictions | 26.8         | 38               | 35.1              |
| Access to telehealth counselling with a mental health professional     | 25.7         | 40               | 34.3              |
| Free access to mobile apps and online programs to help me manage my emotional well-being | 25.2         | 40.1             | 34.7              |
| Information about how to resume my work and social life safely         | 22.4         | 52               | 25.6              |
| More affordable childcare                                               | 21.5         | 23.9             | 54.5              |
| Public ceremonies or events to acknowledge what we have given and done together to limit the spread of COVID-19 | 20.5         | 38.2             | 41.4              |
| Individual help and support to find a job                              | 18.3         | 29.3             | 52.4              |
| A GP asking me about my use of alcohol                                  | 13.8         | 32.6             | 53.7              |

\(^a\)Post-stratification weighted by: State, Socio-economic Indices for Areas decile, gender, and age.

A publicly available plan about management of future pandemics’. Almost half of the respondents rated this as likely to be ‘very helpful’ in their recovery from the COVID-19 restrictions. Four other policies were rated as ‘very helpful’ by more than 30% of all respondents: two related to mental health support, one to individual financial support for living expenses, and one to support for community organisations.

Nine policies were rated as ‘not at all helpful’ by more than 30% of respondents. Four of these were rated as ‘not at all helpful’ by more than 40% of respondents. They concerned more affordable childcare, individual support to find a job, public ceremonies to acknowledge people’s sacrifices during the pandemic, and general practitioners (GPs) asking about alcohol consumption.
TABLE 3 ‘Heatmap’ of the ‘Very helpful’ policies by gender, age, region, and SEIFA subgroups

| Policy                                                                 | Gender     | Age groups (in years) | Place of residence | SEIFA |
|------------------------------------------------------------------------|------------|-----------------------|--------------------|-------|
|                                                                        | Female     | Male                  | Non-binary         | 18-29 | 30-59 | 60+ | Urban | Regions | Rural | Low | High |
| To have a publicly available plan about management of future pandemics | 51.9       | 46.2                  | 61.4               | 47.9  | 45.4  | 46.3 | 46.0  | 46.3    | 44.4  | 48.6 |
| Financial support for living expenses                                | 34.9       | 32.7                  | 32.6               | 41.5  | 35.5  | 25.2 | 33.7  | 34.2    | 34.7  | 32.8 |
| Additional support for community organisations                        | 37.4       | 26.7                  | 33.3               | 33.9  | 33.4  | 29.0 | 32.7  | 31.1    | 31.2  | 33.3 |
| Access to face-to-face counselling with a mental health professional  | 35.9       | 24.8                  | 50.9               | 41.1  | 33.2  | 17.4 | 32.0  | 28.2    | 28.6  | 33.2 |
| A GP asking me about my mental health                                 | 34.4       | 23.7                  | 38.6               | 40.6  | 36.5  | 21.5 | 30.2  | 29.9    | 29.6  | 30.7 |
| Training for employees to manage employers’ mental health needs       | 32.7       | 24.6                  | 38.6               | 35.8  | 32.3  | 16.4 | 31.0  | 25.3    | 26.0  | 32.6 |
| Information about how to manage my emotional wellbeing               | 35.7       | 21.4                  | 33.3               | 35.2  | 36.0  | 20.9 | 30.1  | 26.3    | 25.7  | 32.8 |
| Access to telehealth counselling with a mental health professional    | 33.2       | 22.2                  | 38.6               | 30.3  | 28.5  | 23.7 | 27.4  | 27.1    | 26.5  | 28.4 |
| A public statement of recognition, appreciation and thanks from the Prime Minister to people in Australia for limiting the spread of COVID-19 by following the restrictions | 29.7       | 24.0                  | 22.8               | 28.8  | 25.4  | 28.0 | 27.0  | 26.6    | 26.2  | 27.7 |
| Free access to mobile apps and online programs to help me manage my emotional wellbeing | 30.8       | 26.3                  | 49.1               | 33.5  | 29.6  | 13.6 | 26.7  | 24.2    | 24.5  | 27.5 |

SEIFA: Socioeconomic Indices for Areas; Low SEIFA: lowest 60%; High SEIFA: highest 40%.

Colour codes: > 40% ‘Very helpful’
30 – 40% 20 – 26% 10 – 19% < 10%

3.2 Demographic differences in policy preferences

Differences between subgroups in their policy preferences are shown in the heatmap (Table 3) which displays the proportions rating the policies as ‘very helpful’ by gender, age, place of residence, and socioeconomic subgroups. Having a publicly available plan for managing future pandemics was universally the most endorsed policy. Apart from people aged 60 years and older, financial support for living expenses was rated as ‘very helpful’ by between one third and half of people in all subgroups. Respondents identifying as women or non-binary rated more policies as ‘very helpful’ than respondents who identified as men. Similarly, higher proportions of respondents in the youngest and middle age groups reported that the suggested policies would help them recover than those in the oldest age group. It is notable that higher proportions of people living in urban and more socioeconomically advantaged areas endorsed some policies as very helpful than did people from regional and rural areas and less advantaged people. Five proposed policies relating to mental health support were endorsed by more than 30% of people who identified as women or non-binary and by people in the youngest age group.

4 DISCUSSION

The findings of this population study can be used to guide policy development to support people in Australia as they recover from COVID-19 and the restrictions that have been imposed to control its spread. They indicate that needs and policy preferences vary between population groups and that targeted policies may be needed to optimise their benefits.
This study has strengths and limitations. Strengths include the large sample, which was broadly representative and weighted to reflect the Australian population, and that the proposed potential policies were informed by expert opinions and data from analysis of free-text comments from respondents to survey 1. A limitation is that the list of suggested policies was restricted in the interest of survey brevity. Other policy suggestions may have rated more (or less) highly than those offered.

Although there is potential for the virus to resurface, Australia’s successful management of the pandemic allows federal, state, and local governments to focus on the transition from the acute to the recovery phase of the pandemic. One of the first steps towards recovery is to ensure universal access to and uptake of COVID-19 immunisation. Governments are implementing a staged immunisation program that will reduce the risk of future restrictions. However, to counter the significant economic and mental health consequences of the 2020 restrictions, well-designed recovery policies are also needed. Fakhruddin et al. (2020) argue that, for the recovery to be effective, the policy response needs to be comprehensive and combined with an improved data ecosystem between the public health system and the community where ‘communities feed information into the public health system and the feedback loop offers a fast and direct way to provide people with details of potential actions they can take’ (Fakhruddin, Blanchard, & Ragupathy, 2020). Others contend that policies should address the social determinants of health and promote social solidarity as this will improve population health, economic performance, and management of future pandemics (Lynch, 2020).

In this survey, the most popular proposed policy across all demographic categories was for a publicly available pandemic management plan. This is particularly notable because a key recommendation after the H1N1 pandemic in 2009 was that a comprehensive plan for managing pandemics be developed for the whole of Australia (Department of Health & Ageing, 2011). Had this recommendation been implemented then, it is likely that Australia’s response to the COVID-19 pandemic would have been more swift, better coordinated among the commonwealth and state and territory governments, and therefore more efficient and effective. That this policy was prioritised by survey respondents over all others suggests that they believe a well-prepared country with detailed plans of action and established infrastructure is most likely to protect its citizens from many of the other problems for which solutions are now being sought. It supports the argument made by others that governments need to change the mindset from ‘if’ to ‘when’ future pandemics will occur (Fakhruddin et al., 2020).

The policy suggestion to increase support for community organisations also received strong endorsement. Strengthening community organisations would afford opportunities for local communities to provide mutual support through shared experiences which in turn benefits mental health: the contribution to mental health of organisations such as Men’s Sheds (Kelly et al., 2021), choirs (Moss et al., 2017; Williams et al., 2018), sports clubs (Eime et al., 2010; Jenkin et al., 2018), and environmental working groups (Pich, 2020) is well documented.

The gender and age differences in policy preferences suggest that targeted recovery policies are also needed. Respondents who identified as women or non-binary and respondents in the youngest age group were more likely than those who identified as men and people in the older age groups to endorse receiving financial support to help with living expenses. This is unsurprising because women and young people were more likely than other groups to have experienced job loss and financial hardship as a result of COVID-19 restrictions (Kabatek, 2020; Wood et al., 2021). Women were also less likely than men to receive JobKeeper, the government financial support for maintaining a connection to the workplace, because it excluded short-term casual positions, occupied in the hardest-hit industries mostly by women (Wood et al., 2021). The age gradient for
the support of this policy is likely linked to the greater loss of job and income by younger groups and greater proportion of people over the age of 60 who are not reliant on employment for living expenses. O'Sullivan et al. argue that continued financial support for vulnerable groups may be needed to avoid exacerbating existing inequalities (O'Sullivan et al., 2020).

More than one third of respondents who identified as women or non-binary and those in the youngest age group reported that policies relating to mental health support would benefit their recovery. Results of the first survey showed that people in these groups were more likely than those in other groups to experience clinically significant symptoms of depression and anxiety (Fisher et al., 2020). In the case of women, this was in part explained by their disproportionate burden of unpaid work such as home schooling and caring for dependent family members: they shouldered an extra hour each day more than men of unpaid work, on top of their existing heavier load (Hammarberg et al., 2020; Wood et al., 2021). In addition to policies that directly support mental health, policies to reduce the burden on women of unpaid work are likely to benefit their mental health. With regard to the mental health needs of young people, the authors of an OECD report based on surveys from 90 youth organisations from 48 countries recommend government initiatives to promote inclusive and fair recovery for all generations (OECD, 2020). They include providing targeted policies and services for the most vulnerable youth populations, including young people not in employment, education, or training; young migrants; homeless youth; and young women, adolescents, and children facing increased risks of domestic violence.

Some suggested policies were supported by fewer than half of respondents. They included provision of more affordable childcare, which is surprising given economists’ arguments that childcare should be made cheaper to enable more women to do more paid work and to drive economic recovery (Wood et al., 2020). We can only speculate that women caring for young children, who could benefit from such a policy, were less likely than other women to complete the survey because of limited discretionary time. The suggestion that GPs ask about alcohol use was also unpopular, despite the finding that about one in five respondents to survey 1 reported drinking more alcohol than before the pandemic (Tran et al., 2020). Unwillingness to be asked about alcohol intake by a GP could arise from perceived stigma or respondents’ self-assessment of alcohol intake as unproblematic. Nevertheless, other policies to address the adverse social and health effects of excessive alcohol consumption appear to be warranted.

5 CONCLUSION

Although Australia has experienced fewer COVID-19 infections and deaths than most other countries, the social and economic consequences of the pandemic have been significant, particularly for those who are socio-economically disadvantaged and marginalised. To address this, federal, state, and local governments now need to focus on the transition from the acute to the recovery phase of the pandemic. This study found that for people in Australia, the preferred policy options for the post-COVID-19 recovery phase are government preparedness for future pandemics and support for mental health, individual finance, and community organisations.

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CONFLICT OF INTEREST
The authors declare no conflict of interest.

ORCID
Karin Hammarberg https://orcid.org/0000-0002-5988-5865

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