Easing restrictions on activity and social distancing: comments and suggestions from SPI-B [1 April 2020]

This paper summarises key points from discussions in SPI-B concerning: 1) timing and options for easing restrictions; 2) methods of promoting and maintaining adherence to changing restrictions; and 3) some specific comments about the new suggestions for increasing adherence that are contained in the 27 March draft framework for social distancing.

1. Timing and options for easing restrictions

Any decision around changing restrictions should take into consideration the current context. Adherence to the measures currently in place is high. The daily YouGov survey commissioned by the Cabinet Office for the 29-30 March suggests that only 13% of the population are going to their place of work as much as usual, 84% have entirely stopped seeing members of their family who do not live with them and 91% have entirely stopped seeing friends. Even among those who report still doing these activities, most report having cut it down a little or a lot. These data are backed up by other objective indicators including travel and mobile phone data. We are aware that modelling colleagues estimate that the changes already in place have probably reduced R to below 1. There is evidence that these behavioural changes began to appear in mid-March and steadily improved over time.

There is robust theory and evidence that adherence is likely to be high as long as (i) perceptions of the risk of Covid-19 to self and others are high, (ii) the perceived effectiveness of restricting activity is high, iii) confidence in your ability to restrict your activity is high (e.g. if there is adequate support and access to essential supplies), and (iv) the perceived costs (e.g. unemployment, financial insecurity, loneliness, boredom etc) to self and others of adhering are not too high.

There was consensus that current high levels of support and adherence to existing restrictions are likely to be maintained in the short to medium term, for as long as it is evident that Covid-19 poses a serious risk that cannot be managed in any other way. Introducing additional and more coercive measures (i.e. further restriction of activity) risks undermining this support, the high levels of adherence at the moment are likely based on a sense of community cooperation. Coercive measures should only be considered if adherence is seen to drop to low levels and they can be clearly justified on public health grounds (i.e. infection rates that are overwhelming the health system and measures that are clearly effective in counteracting this). If additional measures are to be used then they must be clearly explained and accompanied by appropriate support for communities and individuals to minimise psychological, social and financial harm.

Alternating current restrictions with substantial easing of restrictions would need to be very carefully explained in advance, if required. If strict restrictions are retained for months and then abruptly eased and people are told it is safe to resume social contact they will expect this to mean that the risk of infection has ceased or significantly reduced. If there is then an increase in infection rates that necessitates a reintroduction of restrictions this is likely to be seen as a serious failure of policy and trust in public health advice will be lost, leading to lower adherence to advice to restrict or to resume activity. There are also many practical barriers for the community in stopping and restarting some activities that need to be considered (e.g. hiring and furloughing staff, arranging childcare). Prolongation or reintroduction of measures will also disproportionately affect those on low incomes, potentially leading to community tension.

To avoid these problems we would advocate trialling easing restrictions very gradually when epidemiologically indicated while clearly explaining why these particular activities are being resumed and how risks must be controlled if these activities are to be maintained. This will also allow an opportunity to gather epidemiological evidence about the impact of easing the restriction and be used to provide evidence to the public about the impact of that restriction. To maintain public trust and support it will be important to have acceptable and equitable criteria for selecting which activities can be resumed. For example, it may be difficult to justify easing restrictions solely for economic activities without any easing of restrictions for low risk activities with significant social and psychological benefit.

The process should be accompanied by openly monitoring the effects on behaviour and infection rates, so that the public will be reassured about safety and will understand if restrictions can or cannot be eased further, and that this will be based on everyone resuming activity in a safe way. There is evidence that public acceptance of public health advice is increased when the advice is seen to be clearly based on evidence – and so there is likely to be better adherence to maintaining restrictions or resuming activity if the effects on infection rates are tracked and publicised. The timescale before review should be clearly communicated.

2. Developing clear and comprehensive guidance for resuming activity

Guidance must explain exactly which activities can be resumed by whom, why, when, and in what way in order to support appropriate adherence.

While simple rules are easiest to follow, gradually resuming activity cannot be covered by a simple rule such as 'stay at home'. Guidance and its implementation needs to be flexible and comprehensive enough to allow for a) the enormous variety of relevant activities and available resources to reduce risk, b) differences in risks to and from people (for example, if they are in an at risk category) and households, and c) the possibility that restrictions may well need to be changed and selectively re-imposed in future. It will therefore be necessary to engage in intensive public health education to help people understand what activities are high-risk and how risks can be mitigated.

We can draw on existing methods and mechanisms to do this, including:

a) applying health and safety legislation and procedures to explicitly address coronavirus infection control (e.g. risk assessment of working practices and methods to improve them to manage risk). There are examples where activities that are currently allowed possibly should not be (e.g. employing people in high risk environments who are themselves vulnerable or living with people who are vulnerable), while other activities could be made more safe (e.g. through better hand hygiene facilities or physical distancing).

b) encouraging people to use the same methods to assess, avoid and manage risk outside the workplace, including understanding and applying principles of minimising links between social networks.

c) extending public health campaigns to provide in-depth, effective implementation guidance using established motivational behaviour change techniques (e.g. as recommended by the SPI-B Implementation sub-group) and providing structural and social support for implementation. For example, methods that have been used successfully for helping people understand how to implement other behaviour changes (such as healthy eating) include providing a 'traffic light' list of

examples of high (avoid), medium (do rarely and carefully) and low (do freely) risk activities and 'modelling' stories describing how other people like themselves in similar situations have overcome barriers to implement guidance successfully.

d) working intensively and rapidly with community members to identify barriers and facilitators to adhering to changes in restrictions on activity and to optimise communication of the guidance in terms of accessibility and acceptability to all sectors of the population.

e) doing rapid pilot trials of easing restrictions (e.g. in particular locations that have a lower level of infection in the community), using real time monitoring facilities to track effects on behaviour, contacts and likely or actual transmission.

3. Specific comments about new suggestions for improving adherence within the Framework (27 March)

The Framework proposes four new suggestions for increasing adherence, numbered as options 17 to 20 that SPI-B have not commented on before. These focus on: 17) increasing the financial penalties imposed; 18) introducing self-validation for movements; 19) reducing exercise and/or shopping; 20) reducing non-home working.

We have reservations about options 17 to 19. First, we are unclear what the evidence base is that the targeted behaviours are a substantial contribution to disease transmission, particularly given the high adherence rates currently observed in the community. Is there evidence, for example, that exercise conducted more than 1km away from the house leads to higher rates of transmission than exercise conducted within 1km of the house? Indeed, for this option, there is a risk that reducing the ability of people to apply some flexibility in choosing where to exercise will increase risk by preventing people from spreading out in nearby open space. Tightening restrictions without clear epidemiological need may lose support among people who have been attempting to adhere.

Second, the implicit assumption underlying options 17 to 19 is that people lack motivation to adhere to current guidance. This may apply to some specific subgroups (the example of young men has been given), but broadly the current levels of adherence we are witnessing suggest this is not the issue.

Third, there are equity issues within options 17 to 19. Any flat rate financial penalty will have a higher impact on poorer households, while the assumption that printing and completing paperwork is straightforward for all households can also be challenged. The assumption underlying restrictions on shopping frequency is that people can afford to buy in larger quantities. The risk of tension arising as the police are required to start penalising those who are not adhering should also be factored into considerations.

With regards to option 20 (reduce home working), this appears to offer more room to reduce contacts in the community, given that 13% of those polled by YouGov report still going to their place of work as much as usual. However, the success of this strategy is contingent on financial support reaching those who are furloughed in a timely manner, or else there is a risk of tension resulting for a lack or equity in this measure.

We would also propose two additional suggestions that might be considered.

First, we note that the new suggestions proposed in the Framework are based on additional restrictions, barriers or punishments. We recommend that HM Government also consider the role of

rewards and facilitations in improving adherence. Rapid research will be needed to inform this – what are the reasons why people are finding it difficult to adhere to current advice? But as examples, consideration could be given to providing quicker access to financial support so that people do not feel compelled to attend work or free home entertainment or on-line education (in partnership with industry bodies) to provide an alternative to leaving home when bored.

Second, we note that the additional suggestions largely operate at the level of the individual. We recommend that consideration also be given to ways to reduce disease transmission at a more organisational level. Are health and safety guidelines adequate (and adequately enforced) to ensure that where people do attend work, the risk of disease transmission is minimised by, for example, allowing sufficient breaks and facilities for hand hygiene, staggered office hours to reduce rush hour use of public transport, or enough space and guidance to allow within-work physical distancing?