SPI-B: Consensus Statement on Local Interventions

Date: 27 July 2020

1. The following SPI-B statement is provided to SAGE for their meeting on 30 July, to form part of the response to a commission received from MHCLG on 17 July. Paragraphs 4-6 summarise comparative analysis provided by ICJU. Paragraphs 11 (i) and (ii) draw on work by the SPI-B Policing and Security sub-group. All material has been signed-off by respective Chairs and officials.

2. This statement adopts the terminology 'area(s) of intervention' and 'local intervention(s)' *or* 'restriction(s)' rather than 'local lockdowns'. This is to provide consistency with the DHSC 'COVID-19 contain framework: a guide for local decision-makers' and to avoid the punitive framing of 'lockdown' – an issue which this statement addresses.[1]

QUESTION 1: SAGE is asked to provide a view on the adherence barriers for localised interventions

3. Behaviour change is more likely if people have the *capability*, *opportunity* and *motivation* to adhere to public health measures and these measures are perceived as *legitimate*. In the context of a local intervention, the following principles should be considered:
    - The capability of people to adhere to restrictions may be impeded if messaging from central government and local government is contradictory or not aligned. This can lead to confusion among people about how and what actions they need to take.
    - The opportunity of people to comply with restrictions may be undermined if the reintroduction of strict public health measures is not accompanied by a wide-ranging package of support. Without targeted support, pre-existing inequalities may make adherence impossible, in particular for vulnerable and already marginalised groups.
    - Motivation to comply with measures may increase alongside fear or worry, especially amongst population cohorts most at risk (for example, older adults or those who are clinically vulnerable). However, the need for the re-imposition of measures must be communicated carefully to manage the relationship between perceived risk and vulnerable group status. Clear communication is also required to explain re-imposition of measures if there is widespread perception that these were not effective when introduced in the first instance. The provision of information with clear instructions about what to do, what not to do, and what to expect will reduce uncertainty, prevent emergence of a sense of fatalism and increase the likelihood of compliance.
    - Legitimacy: As with national restrictions, there is a risk that legitimacy may be undermined if localised restrictions are viewed as arbitrary, incompetent and inequitable and this is likely to reduce adherence to public health measures and increase tension. Ensuring that measures are co-produced with local leaders and community stakeholders will help mitigate this risk and increase local confidence and buy-in into the wider process.

QUESTION 2: SAGE is asked to provide a view on what can be learnt from other countries that have implemented localised intervention measures.

4. In other countries, localised interventions are frequently used as part of a 'cluster-detection' approach to infection control in which a transmission cluster ('super-spreading event') can be defined as 5+ secondary infections from a single index case. Most comparators have incorporated some form of cluster-suppression into their responses to Covid-19, either since the outset of the pandemic to prevent widespread community

transmission (e.g. Japan, South Korea) or at different stages of the pandemic, adopting or readopting a cluster-based approach where community transmission is still present (e.g. Germany, Spain, Italy).[2]

5. Comparator countries use testing in a variety of ways to detect 'incident clusters' early and enable faster responses. Early identification is assumed to be critical to effective suppression of clusters.

6. Key learnings from the experience of other countries who have implemented local interventions include:
    - It is important that measures are implemented at the appropriate spatial scale to avoid accusations of disproportionality
    - The context of a specific country, and particularly the relative levels of trust in national and regional authorities, will impact the effectiveness of the response and whether it should be driven at the national or regional level. Whilst many Asian countries which are considered to have been effective at having controlled initial infections through national agencies - such as South Korea and Japan - others have effectively responded primarily at a regional/state level (such as Germany and Australia).
    - There is some evidence suggesting that the effectiveness of local intervention measures is related to how familiar a country is at implementing different regional measures and its wider ability in crisis response.

QUESTION 3: SAGE is asked to provide a view on possible wider effects and unintended consequences of localised interventions, including trust in government, public disorder, and social stigmatisation. In areas with vulnerable or marginalised communities, how can government ensure measures are equitable and non-discriminatory?

7. The effects of re-introduced restrictions are likely to differ according to an area's geography, demography and history. It is possible a local intervention might enhance local community solidarity when those affected feel they are all 'in this together'. Background levels of social capital may buffer communities against negative impacts of local restrictions.[3]

8. However, the reimposition of localised restrictions also carries various risks. Local restrictions may be experienced negatively and differentially across different demographic groups, and result in unintended consequences for community cohesion, racial inequality, public disorder and policing, and local economies. Potential effects may include:

9. **A divided nation:** Localised measures may undermine previous perceptions of shared adversity and collective spirit – 'we are all in this together' - and lead to feelings of isolation, fear, anger, stigmatization and shame for those living in the affected area.[4] These responses can damage trust in central and local government, and undermine adherence to wider health measures. Fear can lead to poor decision-making, inappropriate behaviours, and stigmatisation of certain populations, undermining the social cohesion[5]. Lack of trust could also result in an 'infodemic',[6] increased anxiety, spontaneous precautionary behaviours, and refusal to adopt recommended protective health behaviours.[7]

10. **Racial tensions and risk to social cohesion:** Marginalised and/or ethnic minority communities (e.g. BAME) which are already more susceptible to coronavirus due to wider structural inequalities may also be particularly vulnerable to the effects of local restrictions. These communities disproportionately live in crowded accommodation or multi-generational households and are more likely to be financially disadvantaged by restrictions (e.g. employed in sectors with no potential for furlough). Given the current epidemiological trend of transmission concentrations within BAME communities, there is the risk of racial stigmatisation and discrimination. This situation could be exploited by far and extreme right-wing groups.

11. **Social unrest**: Perceived inconsistency or unfairness in how and where restrictions are imposed could lead to social unrest and public disorder.

    (i) Recent political trends and volatility will influence perception and reception of local restrictions - following the recent Black Lives Matter protests, for example, there has been an erosion of police legitimacy and a marked increase in the frequency and severity of assaults on police officers. Community anger around perceived restriction inequalities would be directed at the police in most cases. Policing at locality boundaries will be resource intensive and may be a potential site of unrest, as people attempt to travel out or in. Risks of unrest may also be heightened in areas with a larger proportion of people from a lower socio-economic demographic, and where historical relations with the police make escalations more likely. Resultant civil disorder may also feed and be exploited by extremist groups, especially where local outbreaks and subsequent restrictions are perceived to map onto BAME communities.

    (ii) While these risks can be managed – no major disorder occurred in Leicester, for example, despite heightened local tensions – other local areas may not react in the same way. Effective risk mitigation will require: (i) intensive intelligence gathering on community relations and policy legitimacy; (ii) curtailing the use of the punitive and stigmatising term 'lockdown'; (iii) providing clear explanations for reintroducing restrictions to communities via early and substantial community engagement; (iv) assisting vulnerable and disadvantaged sections of the community; (v) engagement with national and local media to reduce stigmatisation; and (vi) local tailoring and minimisation of police engagement except in cases of persistent, flagrant or large-scale violations.

12. **Long-term economic decline**: While negative financial consequences are inevitable, longer term economic decline may result in areas affected by the reimposition of restrictions. In such cases, an area identified as a COVID 19 'hotspot' may become known as a place to avoid, leading to a reduction in travel to and through that area, depressing local finances through reduced business takings and local taxation. Intention to avoid travelling through or returning to a previously contaminated area has been noted in prior studies.[8] Moreover, an area that people do not want to visit will become an area in which people do not want to live. If families no longer move there or current residents move away, the area will suffer long term economic damage.

QUESTION 4: SAGE is asked to provide a view on specific measures to take to achieve public buy-in and compliance with such measures, including consideration of timing and form of announcements and messaging.

13. A local intervention requires a complex emergency response. Consideration will be needed to ensure that measures are applied throughout the response in an equitable way and to avoid unintended consequences. This applies to the early stages of national and local planning of the intervention, following on to how the measures are introduced in practice and how the exit from the intervention is managed.

14. To ensure public buy-in and compliance, different phases of the intervention should be planned with the following principles in mind:

15. <u>Emergency planning and preparedness</u>:
    - **Proportionality**: Measures should be implemented in a way that is equitable and takes into account the potential for restrictions to penalise marginalised social groups more heavily. This principle emphasises the need that measures implemented are commensurate to meet the targeted end and requires a balancing of risk. It encourages interventions that are risk-based and balanced, is important for the continued legitimacy of intervention measures, and will ease restoration of local confidence after the removal of restrictions.

- **Co-production with key local and community stakeholders**: While national guidance is needed on how to respond to a high incidence, plans must be adapted for the local context. Local planning for implementing interventions in specific areas should involve all key stakeholders and relevant local leaders in local government, civil society and the justice system at a meaningful and substantive level. Co-production of guidance and communication strategies can help to generate an effective collective response and locally salient messages explaining the rationale for measures; what community members should expect; and how community members can support each other.
- **Consideration of the impact on individuals and groups:** As stated earlier, a localised intervention may impact groups already facing structural discrimination and unequal access to resources more acutely. Specific measures should be in place to mitigate such as adverse impact (for example, tailored engagement with the white population in the area to counter-act adverse media reporting which may otherwise stigmatise local BAME groups). Specific measures should also consider the impact on groups of different ages and groups who will require additional support to comply with restrictions (e.g. people with disabilities or students/families with second language considerations).

16. Communications should be evidence-based, co-designed and piloted and should meet the following requirements:
    - **Avoid punitive language**: Terminology should emphasise care, not punishment. Given the punitive connotations of the term 'lockdown' which can be seen to emphasise blame, terms should be adopted that emphasise care, concern and support for the affected communities. Procedural justice and community development evidence stresses that local emergency measures should be framed not as something that is done **to** people, but **with** and **for** them.
    - **Consistency in messaging**: National and local messaging should be aligned and consistent. Contradictory messages are likely to lead to confusion and reduce the ability of people to adhere to the intervention.
    - **Culturally appropriate**: As set out in a previous SPI-B paper (*Public Health Messaging for Communities from Different Cultural Backgrounds*[9]), communications should be tailored to the target audience and reflect the diversity of the communities that are being impacted. Language should be sensitive and culturally appropriate.
    - **Transparent and user-friendly**: Evidence cited by communications should be transparent and user-friendly (clear and familiar) to legitimise measures enabling the public to understand when, why and how measures will be reintroduced. 'Infodemics' must be avoided by relying on a single authoritative source of information such as the Joint Biosecurity Centre. Legal clarity in decision-making is important: regulations to enforce local interventions should be published and clearly presented to the public before restrictions are re-imposed locally.
    - **Designated communicators** should be used to monitor social media, correct misinformation and provide updates as appropriate. Interactive tools or methods that engage should likewise be used.

17. Emergency response and recovery:
    - **Ensure secure access to key social services**: The provision of local health, social and mental health services should be highlighted to support the local population as they deal with short, medium and long term challenges. Access to support services will be key in enabling local communities to adhere to restrictions. Local authorities should lead evaluation and review of service provision, but also work with public health officers to communicate quickly with families, schools, businesses and the media with as much factual detail as possible and appropriate, using pre-established trusted channels on social media. Particular attention should be paid to secondary stressors (e.g., loss of income or exposure to media reports) that continue after the initial impact of an extreme event.[10]
    - **Provide clear criteria for an exit strategy:** Messaging that clearly sets out how and when the restrictions will be lifted will enable adherence and increase motivation. In contrast, a lack of guidance

on when restrictions will be removed creates a sense of disempowerment and has a disruptive impact. Trust can be built by the provision of factually correct, consistent, regularly updated information.[11]

- **Proportionality**: Measures should be implemented in a way that is equitable and takes into account the potential for restrictions to penalise marginalised social groups more heavily. This principle emphasises the need that measures implemented are commensurate to meet the targeted end and requires a balancing of risk. This is important for the continued legitimacy of intervention measures, and will ease restoration of local confidence after the removal of restrictions.
- **Co-production with key local and community stakeholders**: While national guidance is needed on how to respond to a high incidence, plans must be adapted for the local context. Local planning for implementing interventions in specific areas should involve all key stakeholders and relevant local leaders in local government, civil society and the justice system at a meaningful and substantive level. Co-production of guidance and communication strategies can help to generate an effective collective response and locally salient messages explaining the rationale for measures, what community members should expect, and how community members can support each other.
- **Consideration of the impact on individuals and groups:** A defined and explicit package of care for businesses, schools and families will remove resource-related barriers. Particular consideration needs to be given to impacts on groups already facing structural discrimination and unequal access to resources more acutely. Specific measures should be in place to mitigate such as adverse impact (for example, tailored engagement with the white population in the area to counter-act adverse media reporting which may otherwise stigmatise local BAME groups). Before measures are introduced, consideration should be given to the potential impact on groups of different ages and groups who will require additional support to comply with restrictions (e.g. people with disabilities or students/families with second language considerations).

References

[1] https://www.gov.uk/government/publications/containing-and-managing-local-coronavirus-covid-19-outbreaks/covid-19-contain-framework-a-guide-for-local-decision-makers

[2] It is thought that a cluster-based approach is less effective where community transmission is widespread. But several countries (i.e. Germany, Spain, Italy) are now attempting cluster suppression where community transmission is present.

[3] Engbers TA, Thompson MF, Slaper TF.2016. Theory and Measurement in Social Capital Research. Social Indicators Research 132:537-58

[4] WHO. 2018. Managing epidemics: Key facts about major deadline diseases. https://wwwwhoint/emergencies/diseases/managing-epidemics-interactivepdf 2018

[5] WHO. Managing epidemics: Key facts about major deadline diseases, 2018. http://www.who.int/emergencies/diseases/managing-epidemics-interactive.pdf

[6] Rogers MB, Pearce JM. Risk communication, risk perception and behaviour as foundations of effective national security practices. In: Akhgar B, Yates S, eds. Strategic Intelligence Management. Oxford: Elsevier Butterworth-Heinemann 2013.

[7] Rogers MB, Amlot R, Rubin GJ. Investigating the impact of communication materials on public responses to a radiological dispersal device (RDD) attack. *Biosecurity and Bioterrorism* 2013;11(1):49-58.

[8] Ibid.

[9] Presented to SAGE on 23 July 2020.

[10] Lock S, Rubin GJ, Murray V, et al. 2012. Secondary stressors and extreme events and disasters: a systematic review of primary research from 2010-2011. *PLoS Curr* 4 doi: 10.1371/currents.dis.a9b76fed1b2dd5c5bfcfc13c87a2f24f [published Online First: 2012/11/13].

[11] Rogers MB, Amlot R, Rubin GJ, et al. 2007. Mediating the social and psychological impacts of terrorist attacks: the role of risk perception and risk communication. *Int Rev Psychiatry* 19(3):279-88. doi: 10.1080/09540260701349373 [published Online First: 2007/06/15].