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Independent SAGE briefing note on use of punishments in the Covid response

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Summary

Blatant and visible violations of Covid-safe rules and guidance are relatively rare and probably less important in spreading infection than contacts that are within the current regulations (e.g. at workplaces). Punishment for blatant and visible violations may have a role in maintaining a sense of justice for the majority who are adhering, but evidence suggests that prioritizing punitive approaches can be ineffective or even counter-productive. Punitive approaches applied to the one area where adherence is low -- self-isolation -- also distract from the real causes of failure of adherence and the real solutions. Increasing public understanding about what self-isolation means and when it is required, plus providing adequate financial, material, practical and social support will be more effective in infection control than punishments.

Background

In recent weeks, the government press briefings and advertising campaigns have focused on 'rule-breaking' ('bending' or 'flexing') by the public. This was emphasized in the press conference led by Home Secretary Priti Patel on 12th January in which she was joined by the chair of the National Police Chiefs Council to emphasize that people would be caught and punished for activities such as organizing and attending gatherings. Parties and gatherings are clearly in breach of the rules but they are relatively rare and involve only a small number of people. But the same theme is evident in the current advertising campaign aimed at the general public, declaring that 'bending the rules costs lives'. The solution proposed has been to increase both sanction (greater fines for attending parties) and enforcement (more involvement of the police).

This emphasis on 'crime and punishment' is not new. Increased penalties and 'crackdowns' have repeatedly been proposed by the UK government as central to the fight against the pandemic. We have seen this in the case of self-isolation, for example, one area where we know levels of adherence are low, with just ~20% of those required to do so isolating completely for the full 10 days. In September 2020, a new fine of up to £10,000 was announced for failure to self-isolate. This approach makes sense only if there is adequate support and therefore if transgression is known to be wilful. We know from surveys that factors associated with not fully self-isolating include interpretation of symptoms, needing to go out to get provisions or for caring responsibilities and financial reasons: this suggests that greater punishment will not fix the problem.

In this briefing, we first explain why an emphasis on public rule-breaking as an explanation for current high infection and death rates is not supported by evidence.

Second, we explain why a disproportionate emphasis on threats and punishment is also *counterproductive* as a strategy for ensuring continued public engagement and adherence.

Crimes?

An unspoken premise of the current campaign against those who 'bend the rules' is that they are responsible for the high levels of infection and death we have seen since the beginning of January. But no evidence has been published by the government to demonstrate that a small number of individual rule-breakers are more responsible for the rise in cases than other established factors such as exposure in unprotected workplaces or other environments. Across different data sources, the evidence is that [adherence to most of the required protective behaviours has been very high](#) over the course of the pandemic. The self-report data for hand-washing, wearing face-coverings, and physical distancing, and the mobility data converge in suggesting that most people follow the rules most of the time.

The only protective behaviour which is out of line with this pattern is adherence to self-isolation. Across most of the surveys carried out, evidence suggests that [only a minority are fully self-isolating for the full 10 days required](#). Unlike hand-hygiene and social distancing, self-isolation requires support from others to be possible. This includes support from others in the community, in the form of shopping most obviously. It also requires material support in the form of an income and sufficient space. The lower adherence rates for self-isolation are less to do with psychological motivation than with the availability of resources.

It is true that while public adherence has been high overall, there have also been variations in levels of adherence. At certain points across the pandemic, [levels of adherence have gone down](#). But, crucially, *adherence tends to follow the regulations*. This means that, [in the lockdowns, people increased their adherence](#) to physical distancing and reduced the number of others they had contacts with.

Why, then, are some of us seeing people and cars on the streets? Mostly, these are people following the rules. The reason why there is more contact is because the rules have been more permissive and flexible than in lockdown 1. Lack of adherence is a minor issue. The real issues -- and the big levers that the government could pull to genuinely make a difference to levels of contact and levels of infection -- are the number of people who are not supported to work at home or [furlough](#), the number defined as 'critical workers' and hence the children in schools, and the number of people who need to self-isolate but cannot afford to. In addition, the government needs to properly enforce on employers the existing rules on safe workplaces. Instead, however, the UK government has instead focused on punishment. Next we review the evidence for the effectiveness of punishment, and coercive measures more generally, in public health contexts.

Punishments

Most people would agree there is a place for some level of sanction. In public health domains where there is recognition that lack of motivation is a factor, approaches based on restrictions and sanctions can be both effective and supported by the public. Examples include indoor smoking bans, tax increases on tobacco, and raising the age of sale of tobacco. And in the case of the present pandemic, most would agree that there should be sanction against the most egregious and deliberate rule-breaking. Indeed, public opinion would likely regard *lack* of punishment in such

cases as the real unfairness. The problem is where sanction or coercion is -- or is presented as -- the first rather than the last resort.

Evidence from other public health emergencies

There are various lines of evidence in research on other public health emergencies suggesting that use of coercion by the authorities can be counterproductive. A review of CBRN mass decontamination incidents found that relying on attempted force or threats can have a backfire effect. Instead of engaging with the process, casualties either engaged inefficiently or left the scene, which risked taking contaminants back to their communities. This and studies of successful management of decontamination suggest that a fundamental problem with use of coercion in public health settings is that it damages the relationship between public and professionals/authority, which means the public will listen and cooperate less, just when this is needed.

Two international historical examples of use of coercion in disease outbreaks further illustrate the problems.

During India's plague and flu epidemics of 1896-1919, 'drastic action' by the authorities, including summary powers, was used to strike down those they thought were a threat. Public responses included flight and a movement against these oppressive measures. The eventual solutions to the crisis included moving away from coercion and towards persuasion -- therefore relying instead on public cooperation.

More recently, accounts suggest that use of the military in Guinea, Liberia, and Sierra Leone in 2014 to enforce quarantine in the campaign against Ebola had the effect of creating anxiety, fear and lack of trust in, and alienation from, authorities just when the engagement of the public was needed.

Evidence from the Covid pandemic

In the Covid pandemic, a number of studies have compared legal sanction with other possible motivations for adherence to the behavioural regulations.

A survey carried out by the LSE in April 2020 found that social norms and a sense of 'we're all in it together' were stronger predictors of compliance with lockdown measures than legal compulsion. A survey of a representative sample in Germany found that the motivation to protect others was a more important reason for adherence than government mandate. Another survey in Germany found that enforcement crowds out voluntary support for a tracing app, vaccination and limiting contacts (but not for limiting travelling and wearing a mask). Research on the difficulty of following social restrictions among care-givers in the UK demonstrated that if rules were to follow community and social support values they would be more likely to be followed.

Where scientists participating in the UK advisory groups have examined the question of increasing financial penalties for non-adherence, they have explained the problems that can arise.

In April, [SPI-B](#) were asked to consider a government proposal for increasing the financial penalties imposed for failing to adhere to the regulations. They pointed out that the implicit assumption underlying the proposal was that 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. [In addition] there are equity issues … 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.

In August, scientists from SAGE subgroups and others published an [article](#) in which they modelled the effect of different measures on reporting symptoms and self-isolation, and argued that 'Legal enforcement' of self-isolation can create trade-offs by dissuading individuals from self-reporting' (p. 1) and 'Overall this [analysis] implies that policies such as fines, and police enforcement of self-isolation will have either little benefit or a negative effect' (p. 14).

Recommended alternatives to punishment

1, Education, information, communication
Evidence: In the case of self-isolation, one of the key reasons for failure of self-isolate for the full 10 days is [mild or receding symptoms](#). Another is [lack of clarity about the rules](#). This suggests that an improved information campaign needs to be part of the solution to the problem of failure of self-isolation.

2. Community engagement, participation, and co-production
Evidence: In past disease outbreaks, community engagement has been found to be essential in an effective response. This is shown for example in successful [responses to Ebola, the mobilization of the gay community in the campaign against AIDS](#) and [other disease outbreaks since 2000](#).

3. Support
Evidence: The fact that those most likely to not self-isolate for 10 days [tend to be people in low-income jobs](#) is evidence that there is insufficient financial support (rather than wilfulness being the problem). In some schemes in the USA, support for self-isolation includes free hotel accommodation, delivery of food, dog-walking, which have led to higher numbers of contacts being identified and [better rates of self-isolation than in the UK](#). Support can also help with adherence to other protective behaviours; examples include giving out free masks at supermarkets and making furlough easier to qualify for so that people can stay at home.

4. Solidarity
Evidence: Studies of effective [Covid response in other countries](#) (Norway, New Zealand) show how [messaging](#) and policies at the national and local level can facilitate solidarity across and within different social groups and explicitly help communities. These policies and messaging enable people to negotiate with each

other in their families, neighbourhoods and workplaces so we can create safer practices for all.

Conclusions

The assumption of public ill-will or lack of motivation is not supported by evidence. Surveys have shown that adherence is high on most protective behaviours; on those where it is lower, intentions to adhere are high and support is missing that would allow more of them to do it more consistently. What is more, assuming public ill-will can be a self-fulfilling prophecy. It leads to interventions that alienate the public, and diminish one of the key predictors of adherence - trust in the government. The alternative is to start from an assumption of goodwill, to inform and engage with the public to support them.

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