social research

Scottish Government
Riaghaltas na h-Alba
gov.scot

HEALTH AND SOCIAL CARE

Research Findings
No. 147/2021

Covid-19 Support Study: experiences of and compliance with self-isolation Research Findings

Introduction

Self-isolation is a well establised approach in transmissable disease prevention. The primary reasons for asking individuals to self-isolate during the COVID-19 pandemic have been to interrupt the spread of the virus, reduce community transmission and save lives. Scotland's approach to self-isolation, laid out in the Test, Trace, Isolate, Support Strategy[1] and the Test and Protect Programme[2] is for those with, or potentially at risk of developing, COVID-19 to be identified and asked to self-isolate, while offering support for them to do so successfully.

> **Self-isolation** refers to the approach under the Test and Protect system whereby individuals are asked to remain at home or in managed isolation (see below) for a period of 10 days from: the onset of symptoms (or longer if the symptoms have not gone), contact from Test and Protect or return from international travel. Those asked to self-isolate should not leave their house/accommodation unless this is solely to get or return a COVID-19 test and should not receive visitors from outside their household. Where possible, those self-isolating should try to maintain physical distancing from others within their household who have not been advised to self-isolate.

This research is intended as a response to SAGE's identification, in September 2020, of the need for better, and regular, data on adherence to self-isolation across the UK[3,4]. The combined strength of a large survey of those asked to self-isolate along with in-depth qualitative exploration allows the Scottish Government and its partners to better understand common and distinct experiences, incentives and barriers to compliance, as well as how support can be targeted in the best possible

[1] See https://www.gov.scot/publications/coronavirus-covid-19-test-trace-isolate-support/
[2] See https://www.nhsinform.scot/campaigns/test-and-protect
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925133/S0759_SPI-B__The_impact_of_financial_and_other_targeted_support_on_rates_of_self-isolation_or_quarantine_.pdf
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/931005/S0762_Fifty-seventh_SAGE_meeting_on_Covid-19.pdf

way for specific groups. This knowledge will inform policy and practices to improve the Test and Protect system and support high levels of compliance that will ultimately ensure that the population of Scotland can be protected.

The specific aims of this research were to:

- Measure compliance rates, including the extent of compliance (from full non-compliance to full compliance).
- Measure understanding of self-isolation guidance.
- Provide in-depth information on the experience of isolation.
- Provide in-depth information on barriers and support to comply with the requirement to self-isolate.

This research is to be published at a point at which advice and rules around self-isolation are due to change. The findings here remain vital to understanding the experience of self-isolation and supporting those asked to self-isolate as long as this remains a crucial part of the response to the Covid-19 pandemic.

Methods

Study design

A quantitative online survey (with the option of telephone completion) and qualitative telephone/video interviews were identified as the most appropriate and feasible means of meeting the study objectives and to generate a robust evidence base to inform policy.

The populations of interest were three key groups in the Test and Protect system:

1. Index Cases: Those asked to self-isolate after testing positive for COVID-19
2. Contact Cases: Those who had been in close contact with someone who tested positive for COVID-19
3. International Travellers: Those arriving into Scotland from outside the UK

Index and Contact cases in the Test and Protect system were eligible to take part if: they were 16 or older; had not travelled in the last 14 days; their onset of symptoms fell in the relevant fieldwork period; they were on/close to Day 8 of isolation on a day when invitations were issued and consent for Test and Protect to allow future contact for research purposes was given.

International Traveller cases in the Test and Protect system were eligible to take part if: they were 16 or older; were not using a Home Office email address; they were on day 8 of their official self-isolation period on a day when invitations were issued and they had given consent for Test and Protect to allow future contact for research purposes.

Quantitative survey

- 59,734 invitations to take part in an online survey were issued directly by Test and Protect via either SMS or email.
- Three waves of fieldwork were carried out between March and June 2021. A total of 4325 Test and Protect cases took part in the survey with response highest for International Travellers. The number of participants that took part in each wave were: Wave 1= 917, Wave 2=1748, Wave 3=1660 with response ranging from 7% in Wave 1 to 9% in Wave 3. While there were similarities between the sample profile and the profile of Test & Protect cases over the same period, some groups were under-represented in the survey. These were male Index and Contact Cases; 16-24 year olds and those living in Scotland's most deprived SIMD quintile.
- The survey was opt-in and is therefore not representative of everyone asked to self-isolate, but only of those who took part in the research.

Qualitative interviews

- In total, 30 survey participants who took part in Wave 1, and who consented to being re-contacted for a follow-up interview, took part in an in-depth telephone[5] interview in April/May 2021.
- Purposive sampling was conducted in order that survey participants were contacted to be interviewed based on sampling criteria including: survey defined compliance with self-isolation requirements; case type; sex; age; ethnicity; area deprivation; employment status; and receipt of Local Authority support.

Compliance with the requirement to self-isolate

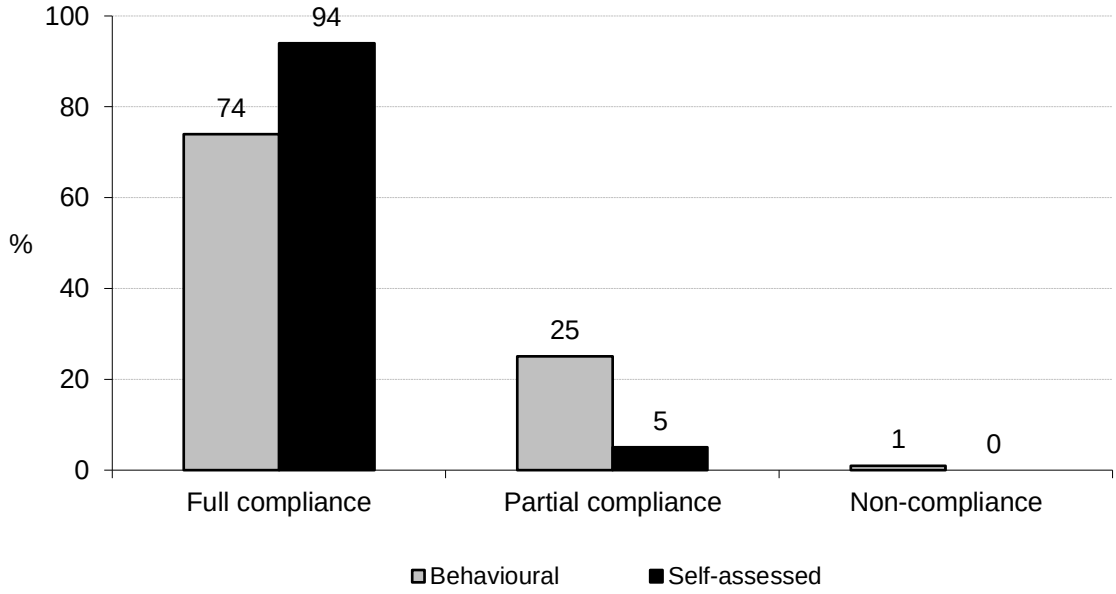
Full compliance with self-isolation requirements was high amongst survey participants of all case types (Index Cases, Contact Cases, International Travellers). Qualitative findings indicated that people complied with self-isolation requirements in order to protect the wider population by reducing the transmission of COVID-19. While self-isolation was challenging for some, on the whole qualitative respondents recognised the importance of complying with the requirement to isolate. However, variance between self-assessment of compliance and the behavioural measure of compliance[6] suggests that some participants may have lacked the knowledge, willingness and/or capability to self-isolate successfully: 94% of Index and Contact Case participants self-assessed as being 'fully compliant', but looking at specific behaviours this was in fact 74%, while 91%

[5] No one opted for the video interview format.

[6] Behavioural compliance is a derived measure of compliance based on how soon an individual started to self-isolate after being advised to do so, whether or not they left their home/accommodation during this period and how long they were able to self-isolate for. A participant who complied with all of these measures is described as 'fully compliant'. Someone who complied with some, but not all, is described as partially compliant and a participant who did not comply with any is described as non-compliant.

of International Travellers self-assessed as ‘fully compliant’, but this was 70% when looking at behaviours (Figure 1.1).

Figure 1.1 Behavioural and self-assessed compliance with self-isolation (%, All Index and Contact Case participants)



Across case types there was high compliance with all elements of the self-isolation requirement. However, compliance with the requirement to isolate for 10 days, the requirement to remain at home during self-isolation, and the requirement to avoid close contact with people from outside the household declined across the fieldwork period for Index and Contact Cases.

Compliance with different elements of self-isolation varied by case type. For example, Contact Case participants were significantly more likely than Index Cases to begin isolating either immediately or in advance of being advised to do so. Qualitative Contact Case respondents shared that they were often contacted by employers, schools or personal contacts to inform them of positive test results in that location prior to contact tracing from Test and Protect. Therefore, Contact Cases were sometimes notified in advance that they would be required to self-isolate.

Index Case participants were significantly more likely that Contact Cases to isolate for the correct number of days and to stay at home. Furthermore, International Travellers in managed quarantine were significantly more likely than those isolating at home to comply with the requirement not to leave home/accommodation during isolation and to avoid contact with people from outside their household.

Non-compliance

Instances of non-compliance with self-isolation requirements were low across all case types although this is likely, in part, due to the opt-in nature of the survey. However, there was evidence that participants undertook a number of activities

before beginning self-isolation, or during self-isolation, which were not permitted under self-isolation requirements. These included: going to the shops for groceries, toiletries or medicine; going for outdoor recreation or exercise; going to work, school or university; and going out for a planned medical appointment. Qualitative interviews uncovered that other non-compliant activities people did during isolation included: dog walking; driving members of their household to get a COVID-19 test or to go to work; putting the bins out; going outside to smoke; and delivering groceries to a neighbour who was also self-isolating. Index Cases were more likely than Contact Cases to carry out non-compliant activities prior to starting self-isolation (except outdoor recreation).

Knowledge of rules and guidance

Understanding of self-isolation requirements, including what activities were and were not permitted during the self-isolation period, was high among all case types. However, there was some ambiguity about whether leaving self-isolation for a planned medical appointment; to care for a vulnerable person; for outdoor recreation; or to get or return a COVID-19 test was allowed or not. Men were significantly more likely than women to think that attending a planned medical appointment and helping a vulnerable person were allowed while self-isolating. Those aged 16-24 were more likely than other age groups to think that attending a planned medical appointment was allowed during self-isolation.

Qualitative findings reiterated that some people did not fully understand the self-isolation requirements and highlighted a number of areas they would like further information and guidance on such as: permitted tasks during self-isolation; extended isolation periods; requirements for International Travellers; when and how often they should be tested for COVID-19; and how to self-isolate within households with other occupants who did not have to isolate. Respondents thought clear information and guidance addressing these issues should be developed and communicated to everyone asked to self-isolate.

There was a clear statistically significant association between knowledge of self-isolation requirements and compliance with the requirements to isolate straight away, isolate for 10 days, and remain at home during self-isolation for all Index and Contact Case participants. This was not the case for International Travellers – irrespective of whether or not they knew the number of days a positive COVID-19 case should isolate for, around three-quarters fully complied with their own self-isolation.

However, knowledge of self-isolation requirements did not guarantee compliance (Figure 1.2). A number of qualitative interviewees knowingly breached self-isolation requirements to carry out a number of activities (including those listed above). Respondents perceived these to be minor infractions which could not be avoided and they took steps to minimise risk to others while undertaking these tasks (for example, by walking their dog very early in the morning or late at night).

Figure 1.2 Whether knew activity was allowed or not by whether individual activities were undertaken (%, All Index & Contact Case participants)

Activities	% who knew activity not allowed but undertook activity	% who thought activity was allowed/were not sure but undertook it
Outdoor recreation	13	49
Medical reason (e.g. doctor/hospital/dental appointment)	3	12
Take children to/from school	1	8
Provide help for vulnerable person	0	3

Attitudes & experiences of self-isolation

Agreement that self-isolation is an effective strategy against the spread of COVID-19 was high across all case types, and among Index and Contact Cases in particular (92%). Agreement was high across all age groups but support increased with age. Overall agreement with the effectiveness of the self-isolation strategy was lower among International Traveller participants (81%) with agreement higher among those self-isolating at home than among those in managed accommodation. The majority view was that the individual is not best placed to decide on whether isolation was required or not, though this was lower among International Travellers (70% compared with 83% of Index and Contact Cases), particularly those in managed isolation.

There was some evidence of a relationship between endorsement of the self-isolation strategy and compliance with the requirement to self-isolate among all case types, with strong supporters of the strategy more likely to fully adhere to self-isolation – although the causal nature of that relationship remains unclear. Support for the rules around international travel were lower with around six in ten International Travellers agreeing that the rules would help limit the spread of COVID-19 and variants of it, while two in ten disagreed. Agreement that international travel restrictions are effective was significantly higher among those who agreed that self-isolation was effective in preventing the spread of COVID-19 than among those who disagreed that this was the case.

Half of those who took part in the survey expressed that the experience of self-isolating had impacted negatively upon their mental health. There was evidence of an association between compliance and perceived impact on mental health, with partial compliers more likely than those that successfully completed their isolation to cite that the experience had impacted negatively upon their mental health. Repeated experience of having to self-isolate was also associated with negative mental health impacts, and among International Travellers the detriment to mental health was more acute among those in managed isolation. International Travellers found hotel quarantine both financially and emotionally challenging. Qualitative

respondents felt that allowing International Travellers who live in Scotland to self-isolate at home rather than quarantine in hotels would assist them both financially and emotionally.

Across all case types, the burden on mental health appeared greatest for young people (aged 16-24) and declined with age. The challenge that self-isolation posed for young people appeared to extend beyond the psychological, with significant proportions also expressing that the experience had various financial impacts as well. While young people (aged 16-24) were most likely to cite self-isolation impacting upon their employment and income, this was by no means unique to them with around three in ten of all participants reporting negative impacts on these. Those living in Scotland's two most deprived SIMD quintiles were more likely than those living elsewhere to state lost income and/or job loss/missed work opportunities as a result of the need to self-isolate. Across the board, the most commonly cited implications for finances were paying for online deliveries not normally needed and paying more than normal for groceries.

Testing

Nearly all Index and Contact Case participants had been tested at least once, with Contact Cases more likely than Index Cases to have been tested multiple times. International Travellers were more likely to have been tested multiple times than Index and Contact Case participants.

Index and Contact Case participants who tested positive on their most recent test were more likely to comply fully with self-isolation than those who tested negative.

Over the fieldwork period, the proportion of participants getting tested at a local walk in/drive through testing site decreased while home testing increased. Qualitative interviewees who undertook testing at home commented that the instructions for testing were clear and easy to understand.

Vaccination

Half of Index and Contact Case participants and just over a third of International Travellers had received at least one dose of vaccine at the time of completing the survey. However, no statistically significant association between compliance with the self-isolation regulations and vaccination status was observed for any case type.

A high level of intended future compliance with self-isolation regulations (82%), even once vaccinations had been given, was reported amongst Index and Contact Cases, though this decreased with age. A significantly lower proportion (61%) of International Travellers said they would also self-isolate again in the future once fully vaccinated if requested to do so (which was even lower for those aged 16-24), but one-in-five reported it was unlikely they would.

Qualitative findings illustrated that vaccinations were perceived to be a way to protect themselves and others by reducing the risk of catching and transmitting

COVID-19 and the best way to control COVID-19, get through the pandemic and ease COVID-19 restrictions.

Support during self-isolation

A fairly high level of awareness of formal support existed among Index and Contact Case participants, with over half indicating that they were offered the option of their Local Authority contacting them and just under a quarter being offered online support. Qualitative findings indicate that while people were aware support was available, they were not always able to recall who was offering the support or what kind of support was available.

Uptake of Local Authority support was relatively low among Index and Contact Cases (14%), but was higher among those with a limiting long-term illness (28%) and those with lower household incomes (23%). The majority declined Local Authority support because they did not need any additional support, some of whom were receiving the support they needed from family, friends and employers. In the qualitative interviews respondents also said they declined formal support because they did not know what support was available or they were concerned that accepting support would be taking it away from those who needed it more.

Where support from formal sources was accessed this primarily related to financial and practical support such as the Self-Isolation Support Grant, support paying bills, accessing grants and benefits or practical help with food deliveries. Around a third of Index and Contact Cases who accepted Local Authority support were interested in the Self-Isolation Support Grant. While interest was high, the proportion applying for the grant was low (8%), though higher among those living in Scotland's two most deprived SIMD quintiles (13% compared to 5% living elsewhere). The main reasons for not applying for the grant were perceived ineligibility (50%) or lack of knowledge about the grant (21%), with the latter more likely among those on lower incomes. There was a greater emphasis on access to additional information (28%) among International Travellers than on accessing help with practical support (such as food deliveries) and/or financial help (12% and 9% respectively).[7]

It is encouraging to note that the majority of survey respondents who accessed formal support felt that their needs had been met and that access to such support was particularly likely among several potentially vulnerable groups including those who did not have informal support from friends, family and neighbours, those on lower incomes and those with a limiting long-term illness. However, it is recognised that self-isolation can provide challenges for individuals from a range of personal circumstances and that increasing awareness of what is available remains central to the efforts to support those in this situation. Qualitative respondents provided a range of ideas as to how this could be achieved. Suggestions included: providing everyone who is isolating with a written list of sources of support and relevant contact details (available in a range of formats); improving the accessibility and clarity of guidance available on relevant government and NHS websites; and

[7] Though International Travellers are not offered proactive outreach from their Local Authority to self-isolate they can contact they Local Authority directly or via the National Assistance Helpline.

offering resources to help people look after themselves physically and mentally during isolation.

Qualitative findings also highlighted that there may be inconsistency in the support offered to different groups in different areas, and proposed ways of addressing this. For example people suggested: ensuring the same support is available regardless of where you live in Scotland; widening the eligibility of the Self-Isolation Support Grant; and providing additional support for those with caring responsibilities.

However, among all case types, some confusion remains around the formal support offer, with the study data highlighting that scope remains to increase awareness of the formal support on offer to those asked to self-isolate, modify what the various formal support sources can offer and how these might be accessed.

Around eight in ten Index and Contact Case survey participants reported having the support of friends, family or neighbours, a higher proportion than among International Travellers (around six in ten) – influenced by a lower proportion of those in managed isolation being able to access such support. In addition to offering practical support such as food/medicine deliveries, dog walking and taking children to school, emotional and mental health support were also provided by informal sources, particularly where these could be accessed by online technology and platforms such as social media.

How to access background or source data

☒ may be made available on request, subject to consideration of legal and ethical factors. Please contact socialresearch@gov.scot for further information.

This report is available on the Scottish Government Publications Website (http://www.gov.scot/Publications/Recent)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80201-269-9
Published by the Scottish Government, August 2021

Produced for the Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS919187 (08/21)