



COVID-19 Lockdowns: a Public Mental Health Ethics Perspective

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Abstract

States all over the world have reacted to COVID-19 with quarantines of entire cities, provinces, and even nations. Previous studies and preliminary evidence from current lockdowns suggest that emergency measures protecting the public's physical health by dislocating individuals, families, and social networks could well be causing a devastating public health crisis of mental ill-health in the months and years to come. This article is the first to take a public mental health ethics perspective in examining these lockdowns, the lodestar of which is the right to mental health, rooted in the concept of human dignity. Even the strictest lockdowns are not necessarily unethical but are prone to damage mental health disproportionately, with vulnerable and disadvantaged populations being at particular risk.

Keywords Public mental health · Right to mental health · Public health ethics · COVID-19 · Lockdowns

Introduction

What not long ago seemed like a remote public health emergency in China has now become a seemingly unstoppable pandemic. States all over the world have grappled with the explosive surge of confirmed coronavirus disease 2019 (COVID-19) cases, with healthcare systems being stretched to the brink of collapse. This global public health emergency has given rise to a strong, perceived demand for states to take drastic, liberty-limiting prevention and containment measures, despite the fact that most of these states are signatories to a range of international human rights instruments, including the International Covenant on Economic, Social and Cultural Rights (ICESCR). One measure that was praised as highly effective by the World Health Organization (WHO), and yet is also the

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most restrictive of personal liberty, is the kind of mass quarantine that has become known as the ‘lockdown’. In its contemporary form, the lockdown might be said to be an ‘invention’ of China, when in January 2020 it imposed a stunning, unprecedented lockdown of almost 60 million people in Hubei province.

Other countries, even liberal democratic ones, quickly followed suit (Kickbusch et al. 2020). Italy became the first European country to impose a nationwide lockdown on its entire population, starting with a lockdown imposed on the northern regions on 8 March 2020. At the height of its restrictions, the lockdown shut down all shops apart from groceries and pharmacies and confined citizens to their homes. The Italian lockdown was then extended twice. This was later followed by countries like India, Spain, France, and the UK—all liberal democracies—where stay-at-home orders were put in place. The orders in Spain and France were extended beyond their initial 15-day period, and the British lockdown was indefinite in the context of a historic state of emergency, with restrictions only being eased after more than 7 weeks. India launched the largest nationwide lockdown human history had ever seen: on 24 March, Prime Minister Narendra Modi requested all 1.3 billion Indians to stay home for 3 weeks to slow down COVID-19 transmission. With the latest resurgences of COVID-19, countries that have eased restrictions are once again considering resorting to the use of lockdowns.

With such drastic measures having been imposed so widely and on such short notice, the concern is that the COVID-19 precedent, which permitted the suspension of a wide range of human rights in a desperate attempt to curb the spread of the pandemic, is a dangerous one. Insufficient thought has been given to the effects of the policies that have been put in place. In particular, the effects of these measures on the right to mental health are being overlooked, next to the harm done to the freedoms of movement, residence, assembly, and association. It is therefore timely that this article brings a human rights-based, public mental health ethics perspective to bear on the current wave of COVID-19 lockdowns, which may not be the last. A human rights approach to public health ethics clarifies the links between disasters and crises like pandemics and violations of common denominators of human entitlements, while also addressing broader changes needed to defend physical and mental public health (Mann 1996). This article extends its applicability to the burgeoning field of public mental health ethics, which studies ethical challenges pertaining to the promotion of mental health and the prevention of mental and substance misuse disorders in populations (Silva et al. 2018). Section 2 sketches briefly the legal and moral dimensions of the right to mental health in its individual and population dimensions. Section 3 uses existing studies on the psychology of quarantines to expound on the harms likely inflicted by coercive lockdown measures on the mental health of communities and in particular on vulnerable and disadvantaged populations. Section 4 summarizes our findings and identifies measures that can be taken to better ‘respect, protect and fulfil’ (UN Committee on Economic, Social and Cultural Rights 2000) the right to mental health.

The Right to Mental Health

In the words of the Universal Declaration of Human Rights, the ‘inherent dignity’ and ‘worth of the human person’ (Preamble) can be regarded as the ultimate foundation of the right to ‘health and well-being’ (Article 25). There is a broad consensus in the international community that a legal right to mental health exists (Hessler 2008). The Preamble of the

Constitution of the WHO, itself a multilateral treaty, proclaims the ‘highest attainable standard of health’, defined as ‘a state of complete physical, mental and social well-being’, as a fundamental right of every human being ‘without distinction of race, religion, political belief, economic or social condition’. Article 12 of the ICESCR, which most countries have ratified, obligates the signatory to take whatever reasonable steps are necessary to realize the right to mental health alongside physical health ‘to the highest attainable standard’ through prevention, treatment, and control and to create conditions conducive to access to mental health services. The right to mental health has been recognized implicitly or explicitly in several regional human rights conventions as well: Article 11 of the European Social Charter, which requires the ‘highest possible standard of health attainable’, and Article 16 of the African Charter on Human and People’s Rights, which enshrines ‘the best attainable state of physical and mental health’.

It can scarcely be disputed that governments have an obligation to advance the common good and public interest, including to eliminate grave and preventable risks to the physical and mental health of their people. This means that governments are duty bound to guard the mental health of citizens, who therefore have a corresponding right to mental health that is enforceable against the state (Wilson 2016), although whether this right should be enforced by courts or by other means are separate questions that will not be considered in this article. The existence of a legal right to mental health does not in itself prove that a moral right to mental health must exist, though the former can assist in the interpretation of the latter, as well as avoid scepticism about its practicality (Wilson 2016). Framing mental health as a right informs officialdom that mental ill-health undermines the common good, inflicting moral damage on citizens that could be mitigated by the provision of adequate mental health measures (Green 2000). It reminds all concerned that the whole community has a moral duty to respect people living with mental ill-health as having human dignity and as entitled to health and well-being as anyone else (Molas 2016).

The fact that some states have not ratified the ICESCR on the basis that its content, including the right to mental health, should be considered optional policy choices rather than inalienable rights (Riedel 2020) cannot alter two basic truths. First, given less than a minimally tolerable level of mental health, many citizens will be unable to meaningfully exercise civil and political rights like the freedom of speech, freedom of conscience, and the right to vote and stand for elections. Consequently, if governments are unwilling to discharge their duty to fulfil basic mental health needs, they will have stultified the democracy-enabling rights of an unknown proportion of the populace (Gostin 2001). Secondly, neglect of the right to mental health is in important ways neglect of the right to physical health; the two cannot be prescinded from each other (Molas 2016). There is a broad consensus inside and outside the WHO that mental ill-health is a risk factor for communicable as well as non-communicable diseases and a contributory factor to accidental as well as non-accidental injuries. For instance, persons with mental disorders are at more risk of vulnerability to at least some infectious diseases (Prince et al. 2007).

Violating the Right to Mental Health: the COVID-19 Lockdowns

The right to mental health can be violated by the state in two basic ways. First, the government can implement policies that are systemically harmful to individuals’ mental health (Gable and Gostin 2009). These policies are likely not intended to harm the mental

well-being of citizens but instead take the form of other restrictions on fundamental human rights (Liao 2019). To violate individual rights to life, liberty and equality, and human dignity in general is more likely than not to cause anxiety, depression, and stress (Gable and Gostin 2009). Everything ranging from torture, rape, and cruelty to privacy invasions, discrimination, and denial of equal opportunity can yield negative effects on mental health (Gable 2014). It follows that the rigorous safeguarding of human rights can ameliorate risk factors affecting mental health in countless ways, and the achievement of the right to mental health in fact demands the protection of other human rights.

Secondly, the government can fail to take steps necessary and appropriate to the state's obligation to protect public mental health at all times, including during an emergency (UN Committee on Economic, Social and Cultural Rights 2000). In the context of the large-scale COVID-19 lockdowns that have been implemented all over the world, the primary concern is not with the inevitable risks to mental health caused by the pandemic itself, but rather that in implementing an ill-planned, drastic response to the emergency in the interests of the physical health of their citizens, the response itself results in preventable hazards to public mental health that cannot be considered consistent with states' obligations to respect, protect, and fulfil the right to mental health. A lockdown that has left survivors mentally unhealthy is not necessarily unjustifiable from a public mental health ethics perspective, insofar as the responsible authorities have taken real steps to substantially neutralize threats to population mental health by effective *ex ante* prevention and *ex post* intervention measures. Consider this issue in the context of the earliest COVID-19 lockdowns that the world has ever seen. China, where the outbreak originated, has neither an established, nationwide mental healthcare system nor a public mental health emergency response infrastructure and workforce to provide humanitarian psychiatric intervention during lockdowns (Duan and Zhu 2020). No evidence could be found that, in their haste to lock down Wuhan, the authorities gave sufficient, or indeed any, thought to public mental health.

While the precise psychological effects of the unprecedented lockdowns on each of the populations of various countries are admittedly still unknown, it is still possible to derive useful insights from studies of previous quarantines, including that during the severe acute respiratory syndrome (SARS) outbreak in 2002–2003 and Ebola in 2014–2016. These quarantines provide us with useful insight into the types of effects that lockdowns may have on mental health, even if they occurred on a much smaller scale than the current lockdowns. In a comprehensive review of 24 studies on the psychological impact of quarantine, Brooks and others (Brooks et al. 2020) found that most of these reported a series of adverse psychological effects, the impact of which was wide ranging, substantial, and in some cases long lasting. The quantitative studies which examined individuals who had been under quarantine found a generally high prevalence of symptoms of psychological distress and disorder. Qualitative studies reviewed, in turn, reported many other negative psychological responses, such as confusion, fear, anger, grief, numbness, and anxiety-induced insomnia. In conducting their review, the authors also identified several stressors during quarantine that were demonstrated to have contributed to these negative psychological responses. While caution is needed when attempting to draw direct parallels to the current situation, the scale of which arguably renders it qualitatively different to any previous quarantine studied, it is likely that these stressors are equally at work in the current situation, if not more.

The first stressor was the length of the quarantine, with one of the reviewed studies showing that those quarantined for more than 10 days showed significantly higher post-traumatic stress symptoms than those quarantined for less than 10 days (Brooks et al. 2020). This is likely to be a significant stressor for individuals subjected to the current lockdowns, many of which were either put in place for an indefinite period of time or extended beyond the original period, the uncertainty of which was likely to be a source of additional anxiety at the time. Another identified stressor was the inadequacy of basic supplies, which was reported by reviewed studies to be a source of frustration, as well as anxiety and anger up to 4 to 6 months after release (Brooks et al. 2020). This is likely to be an important stressor during the current lockdowns too. In Jordan, citizens were initially not allowed to leave their homes at all; emergency hotlines were, as a result, reportedly overwhelmed, and people were stranded without food until finally permitted to leave home for essentials. Panic-buying, in some cases due to inadequate information from the government, has made it difficult for many families to procure essential supplies. Other stressors include fears of infection both of self and others, frustration and boredom, and inadequate information, all of which appear to be occurring during the current lockdowns. Financial loss, together with the resulting symptoms of anxiety and anger, which was identified by Brooks and others (2020) as a post-quarantine stressor, is likely to be a much more pressing and ongoing matter in current circumstances, given the lengthy, and in some cases indefinite, duration of the lockdowns and the extended unpaid leave that many employees have been forced to accept.

Adding to the increased mental health risk to all subjected to such measures is an additional troubling aspect—the disproportionate effect that the violation of the right to mental health will have on vulnerable and disadvantaged populations. Low-income families, for example, who are subjected to stay-at-home orders or advised not to leave their homes except for essential activities have often been confined to very small spaces for lengthy periods at a time. It can be reasonably presumed that the psychological risks of living within tight spaces would be gravely exacerbated if one has no choice but to remain in the small space, often with family members, for most of the day, with no end in sight. For low-income families, school closures have meant that their children no longer receive the school meals that they heavily depend on (Lancker and Parolin 2020), highly likely a source of anxiety for parents and children alike.

Those with pre-existing mental disorders are particularly vulnerable in such circumstances: one study reviewed by Brooks and others (2020) reported that a history of mental illness was associated with anxiety and anger for up to 4 to 6 months after the quarantine period. Fear of hospitals and clinics in the wake of such an experience has likely affected the willingness to access timely mental healthcare. In addition, individuals with mental disorder have not been able to engage in many of the usual recommendations for maintaining good mental health, such as socialization, which will then likely have detrimentally impacted on their mental state. There are many other similarly vulnerable and disadvantaged groups. Lockdowns have kept those with abusive family members confined in the same living space as their abusers. The situation may have been worsened by the anxiety and frustration generated by the lockdowns themselves: abusers may be more prone to abuse under the stressful conditions. The elderly and the disabled may be more likely to suffer difficulties procuring essential supplies such as groceries and masks, in particular during panic-buying, due to issues with mobility.

Single parents have been left with very few alternatives when faced with the closure of childcare facilities while continuing to work from home. The homeless, not able to enjoy even the privilege of house arrest, have been confronted by the threat of prison or involuntary hospitalization in the face of strict disease containment measures (Tsai and Wilson 2020). These predicaments are all likely to leave these groups with a range of adverse psychological reactions: fear, anxiety, anger, and frustration.

Discussion and Conclusion

The deployment of drastic lockdowns is politically understandable given that COVID-19 has, as at end-July 2020, resulted in over 17 million confirmed cases and claimed more than 673,000 lives on all inhabited continents. Evidence regarding whether these measures are the most efficacious from a public health perspective, however, is far from conclusive (Hsiang et al. 2020). A handful of East Asian jurisdictions—Hong Kong, Japan, South Korea, Macau, and Taiwan—initially proved remarkably adept at slowing down COVID-19 transmission without resorting to the kind of coercive lockdowns deployed in mainland China and in parts of Europe, Asia, and South America (Legido-Quigley 2020), although Hong Kong, Japan, and South Korea have seen a resurgence of cases in recent months due to various reasons. From the perspective of public mental health ethics, the justifiability of such extreme measures cannot be taken for granted, even if ultimately shown to have been effective in saving large numbers of lives. Even if the quarantine of all persons within a particular geographical area is ethical on the grounds that it significantly reduces risk of harm to others (Nuffield Council on Bioethics 2020), consideration ought to be given to how lockdowns can be implemented with the least possible limitation on the internationally enshrined legal right to mental health. This has deep metaphysical roots in the notion of human dignity; it is in many ways a prerequisite to the meaningful enjoyment of many other rights. The lockdown is not a homogeneous measure but one that could admit of a variety of formats. In the extreme, coercive, restrictive, indefinite lockdowns of hundreds of thousands of people can cause significant damage to public mental health by adding to anxiety, depression, and stress and by failing to fully integrate quarantine measures with the provision of adequate humanitarian psychological first aid services, accurate health information, and baseline socio-economic security, especially for vulnerable groups. The irony of the deployment of emergency powers in the name of protecting the physical public health by displacing individuals, families, and social networks is its potential to cause a public mental health crisis, if not a devastating epidemic of mental health effects that will dwell for years in affected populations (Hodge et al. 2010).

Whether to deal with the recurrence of COVID-19, which remains likely unless a reliable vaccine is made available globally, or some other future emergency, governments everywhere, single handedly or through multilateral cooperation, ought to make the most of their available resources to gradually implement ‘the full realization’ of the right to mental health by ‘all appropriate means’, according to Article 2 of the ICESCR. To prevent or at least ameliorate the risks to mental health caused by their lockdown measures, governments need to design measures that target identified risks to mental health, beginning with the systematic integration of mental health emergency preparedness into their public health emergency planning and response. This should include

formation of disaster response teams specifically trained in handling the mental health needs of vulnerable populations. To address general public mental health needs, governments should disseminate accurate, updated information about the epidemic and quarantine policies, recommend prudent measures in the event of a lockdown, and reinforce a culturally appropriate sense of solidarity (Brooks et al. 2020). Other measures for targeting the disadvantaged groups identified above include providing shelters for those who would be at greatest risk if confined to a home setting; providing timely, supportive financial compensation measures; and providing outreach support services for both psychiatric care and daily needs, such as the procurement of supplies.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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