Quarantine or physical isolation, used for centuries to contain the spread of infection, isolates those who have (or may have) been infected by a contagious disease to control or limit contamination. The COVID-19, a novel coronavirus first reported in Wuhan, China in late 2019, has rapidly spread across the globe becoming a pandemic. Modern quarantine strategies have been imposed globally in an attempt to curtail the spread of the COVID-19 infection including short- to medium-term lockdowns, voluntary home curfew, restriction on the assembly of groups of people, cancellation of planned social and public events, closure of mass transit systems, and other travel restrictions. These restrictions imposed because of the COVID-19 outbreak, have caused significant disruption globally, and to individuals, families, communities, and whole countries. They have affected much (if not all) of the world’s population; drastically altering what is familiar, and complicating aspects of daily life that were previously simple and uncomplicated. For many people, daily life is changed dramatically, and the “normal” ways of life as we know them are suspended indefinitely.

Imposed quarantine or isolation is an unfamiliar and unpleasant experience that involves separation from friends and family, and a departure from usual, everyday routines. Many usual activities are prohibited, and in some settings, such as in corrections and other prison contexts, isolation is a form of punishment or censure. Isolation is known to cause psychosocial problems, especially for those recognised as vulnerable. While all humans are at risk of psychological harm when kept in isolation, the most vulnerable in these situations are children and adolescents, older
adults, minority groups, those from lower socio-economic groups, females, and people with pre-existing mental health conditions (Perrin, McCabe, Everly & Links 2009).

Changes to the usual ways of life can make people feel anxious and unsafe—feelings of being unsafe can be associated with the disease-fear contagion nexus, for example, not knowing the cause or progression of the disease and outcomes, rumours and misinformation that can lead to discrimination against or marginalism of people of specific descent. The need for social support is greatest in times of adverse situations and events such as the current pandemic; hence, severing social support as part of an imposed quarantine or isolation strategy can threaten an individual’s sense of connectedness and may take a considerable toll on mental health (Hawryluck et al. 2004).

The serious outcomes associated with isolating large numbers of people in quarantine means that such decisions are only made in the most serious of situations. Social isolation associated with quarantine can be the catalyst for many mental health sequelae; even in people who were previously well. These can include acute stress disorders, irritability, insomnia, emotional distress, mood disorders, including depressive symptoms, fear and panic, anxiety and stress because of financial concerns, frustration and boredom, loneliness, lack of supplies and poor communication (Bai et al. 2004; Hawryluck et al. 2004; Cava et al. 2005; Desclaux et al. 2017; Brooks et al. 2020). Moreover, the longer a person is confined to quarantine, the poorer the mental health outcomes; specifically, symptoms of posttraumatic stress disorder (PTSD), avoidance behaviour and anger may be seen (Brooks et al. 2020). Longer times in quarantine are particularly associated with increasing symptoms of PTSD, which may indicate that quarantine itself can be perceived and experienced as a traumatic event (Hawryluck et al. 2004). Other stressors associated with quarantine can include irregular or less supply of usual supplies, such as food items and medication, and restriction of routine daily activities (Brooks et al. 2020).

The negative mental health impacts do not simply stop but continue following the quarantine period. Following the Severe Acute Respiratory Syndrome (SARS) health crisis, a range of avoidance behaviours such as reduced direct contact with other people and crowds, less social contact, avoiding enclosed and public places, not returning to work (Marjanovic et al. 2007); and long-term behavioural changes, for example, excessive handwashing, were reported post-quarantine (Reynolds et al. 2008). Health workers who had been quarantined reported negative
sequelae, including adverse mental health outcomes, for example, post-traumatic stress disorder, and feelings of isolation, depression, anxiety, loneliness and helplessness (Reynolds et al. 2008).

In this current situation, health personnel are likely to experience emotional distress associated with a number of factors; including the scale of disease and death they are encountering; shortages of staff and essential resources including personal protective equipment; grief; and, moral distress associated with care rationing and other factors (Jackson et.al. 2020). In addition to working in unsafe, under-resourced and morally distressing situations, health personnel face emotional distress caused by clinical uncertainty associated with lack of clinical guidelines, ambiguity about the trajectory of the pandemic, and concerns about short and longer-term outcomes of the outbreak (Smith et al. 2020).

For people with an existing mental health condition, isolation presents more severe problems (Goodman et al., 2001), and can exacerbate feelings of anxiety and anger (Jeong et al. 2016). People with severe mental illness are likely to be also affected by (previous) existing social isolation and other social issues compounding their vulnerability such as homelessness, loneliness and poorer physical health. Homelessness puts people at risk of a range of poor health outcomes (Wilson et al. 2019) and these risks are likely to be aggravated in a pandemic. Many people with a serious mental illness will experience an exacerbation of their pre-existing symptoms as a result of a disaster (Math et al. 2008). In addition, they have a higher risk of developing PTSD after a traumatic event (Goodman et al. 2001). People in treatment for a range of conditions such as alcoholism and other similar issues may also be vulnerable to set-backs and additional complications arising from enforced social isolation. Many people in these vulnerable groups rely on supports and programs that may be lost or interrupted due to restrictions associated with COVID-19. Getting people safely through the pandemic is the immediate aim – subsequently there will need to be a major effort and targeted resources to ensure services that will allow people to maintain or return to optimal functioning are quickly re-established (Milligan & McGuinness, 2009).

During this time of global pandemic, it is so important to continue to advocate for those in the community who are particularly vulnerable – those who are facing this pandemic with all of the stress and uncertainties around it - in the context of considerable existing mental health and associated social challenges. Our role as advocates for those who are unable to speak or be
effectively heard has never been more important, and now more than ever, it is crucial that we continue to work collaboratively and with determination to ensure that all people are kept as safe and possible within the constraints of the current situation. Our patients, clients and the communities we serve are depending on us.

References


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