COVID-19, Civil Commitment, and Ethics

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The declaration of a national emergency concerning the COVID-19 outbreak on March 13, 2020, has created new challenges for the ethical practice of involuntary civil commitment in psychiatry. For individuals with serious mental illness (SMI), the risks associated with psychiatric hospitalization, as well as those associated with being in the community, are different. Court procedure itself is affected by the requirements of social distancing. Psychiatrists re-main responsible for translating what constitutes an imminent and serious risk to self or others in commitment petitions, with inadequate evidence about determinants of risk. Careful consideration of these matters and their impact is necessary to carry out the civil commitment process during the COVID-19 pandemic. We will specifically focus on non–substance-related civil commitment procedures involving involuntary psychiatric hospitalization during the pandemic.

Inpatient Psychiatric Treatment

Patients hospitalized on psychiatric units are at increased risk for exposure to COVID-19 due to high volumes of patients with frequent turnover, limited space, and communal living with shared facilities such as bathrooms, showers, dining rooms, and treatment areas.[1] The physical layout of inpatient psychiatric facilities and the milieu-focused treatment pose challenges to the delivery of care during a pandemic. Best practice consists of limiting admissions, testing patients for COVID-19 prior to arrival on the unit, screening staff, and creating isolation units for those patients who are positive or potentially positive.[2] Protocols continue to evolve, however, creating obstacles for front-line care.

Implementing infection-control protocols on an inpatient psychiatric unit also poses several challenges. Infection control or prevention has not been a prior focus of psychiatry. Patients may not practice good hygiene, wear masks, or social distance correctly.[3] Others may require hands-on interventions for safety, which does not allow for social distancing. Most psychiatric units have few single rooms, let alone isolation rooms. And like the rest of the world, access to personal protective equipment is limited on psychiatric units. In an effort to reduce contact and adhere to infection-control protocols, many inpatient evaluations, including day-to-day rounding, have been replaced by telepsychiatry visits. Typically, a nurse or mental health worker is present with the patient to facilitate the technology for the telepsychiatry visit. Group therapies have been greatly reduced or transitioned to videoconferencing. Virtual psychiatrist and group visits could arguably be done outside of hospitalization, similar to current outpatient visits, making the need for hospitalization an important consideration.

The reduction or elimination of the therapeutic milieu, an essential component of inpatient psychiatric treatment, undoubtedly affects inpatient treatment. Without such an integral component of treatment,

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psychiatric admissions during COVID-19 are largely containment measures with a focus on medication and in some cases electroconvulsive treatment (ECT). Early in the pandemic, there were concerns about ECT administration, including concerns about potential risk to patients from cross-contamination, risk to staff from aerosol-generating procedures, and redeployment of ECT teams.[4] In response to the pandemic, the American Psychiatric Association (APA) identified ECT as an "essential procedure in urgent clinical situations," which, if possible should be "maintained as an available treatment procedure for psychiatric patients clinically assessed as high risk without it."[5]

The concept of a multidisciplinary treatment team during the COVID-19 pandemic has also suffered casualties. The reduction in staffing (including the removal of residents and medical students, as well as occupational therapists, psychologists, and mental health workers) is a response to the need to limit patient exposures, maintain a healthy workforce reserve, redeploy essential personnel, and minimize nonessential use of limited personal protective equipment. The loss of support and observations offered by these disciplines can make it more difficult to evaluate a patient's progress, thereby delaying an expeditious discharge.

In evaluations, the requirement for both staff and patients to wear facemasks has resulted in unintended consequences. Some patients may have more difficulty developing rapport. Staff may have problems assessing a patient's mental status because facial expressions are literally masked. Thus, the overall therapeutic alliance may be compromised.

Shortly after the declaration of a national emergency, medical facilities, including psychiatric facilities, limited visitation policies. Policies vary from restricting all visitation to allowing a limited number of visits after screening protocols. The absence of a support person not only affects the wellness of the patient but also makes collaboration with the treatment team difficult, which further affects determinations of discharge readiness.

Additional challenges of discharge planning during COVID-19 include the lack of resources for continued care outside the hospital. Many residential facilities have closed admissions due to the pandemic. Community supports such as day treatment programs, partial hospitalization programs, outreach team home visits, and visiting nurse services are equally scarce or nonexistent. Family supports are also limited as families exercise social distancing and are unable to visit with recently discharged family members. This makes it more difficult to advocate for a less restrictive setting and may prolong hospitalizations.

Involuntary Commitment Criteria

Patients who meet criteria for involuntary inpatient psychiatric commitment may be uniquely affected by COVID-19. These patients appear to carry a baseline higher risk of COVID-19–related morbidity and mortality. Patients with SMI have a higher prevalence of multiple chronic medical conditions, including cardiovascular disease, acute and chronic pulmonary disease, obesity, diabetes, hypertension, metabolic syndrome, as well as infectious diseases such as hepatitis B, hepatitis C, and HIV.[6,7] Medical comorbidities of patients with SMI are more likely to be poorly managed in the community at baseline due to a complex interplay of individual patient, provider, and system barriers.[6] Patients with SMI are also more likely to smoke.[6,7] These same medical risk factors have been associated with more severe COVID-19 and increased mortality.[8,9]

SMI is also associated with multiple adverse social determinants of health including homelessness, unemployment, limited education, violence exposure, stigma exposure, poor treatment adherence, and deficits in social role functioning, which may also negatively affect COVID-19 disease transmission and outcomes.[6,10–12] Patients experiencing homelessness and SMI present a public health challenge. These patients are unlikely to have the private space, financial means, or community support that effectively isolating in the community requires. Patients from group-living environments like group homes or skilled nursing facilities similarly face structural barriers to social distancing and isolating.

With respect to the role of SMI in mediating COVID-19 transmission, lack of insight, altered judgment, cognitive impairment, or frank delusions may all lead to an increased risk of transmission.[13,14] In a study of a tuberculosis outbreak among patients with SMI, poor insight was linked to medication nonadherence and delayed diagnosis, which led to prolonged windows of infectivity.[15] A multivariate analysis of factors associated with court-ordered detention for tuberculosis treatment in New York found that mental illness was second only to substance abuse as the strongest independent risk factor for detention.[16]

While some kinds of psychiatric symptomatology may play a part in patients' refusals to wear face masks, perform hand hygiene, or adhere to social distancing guidelines, these behaviors may also reflect preferences unrelated to mental illness (similar to others in society). Parker *et al.*[17] highlight that assuming a relationship between psychiatric symptomatology and adherence to COVID-19 precautions risks discriminating against patients with SMI. And even when the behaviors are related to mental illness, they may be relatively static and unlikely remediable with acute involuntary treatment.[13]

Ethics Considerations

One ethics quandary faced by psychiatrists during the pandemic involves pursuing involuntary commitment for patients.[13,18,19] While the fundamental ethics tension between patient autonomy and beneficence/nonmaleficence in justifying involuntary commitment is unchanged, COVID-19 affects the calculus by reducing the potential benefit of inpatient treatment (related to the factors discussed above) and because the hospital represents a potentially risky environment. COVID-19 increases the cost of respecting patient autonomy when it means that patients may acquire and spread a potentially lethal disease. COVID-19 also challenges physicians to reconcile competing obligations to individual patients and the community with tradeoffs not only in terms of resource allocation but also privacy.

Autonomy

In justifying overriding patient autonomy, involuntary commitment petitions require that patients must pose an imminent risk of harm to themselves or others or be at risk of grave disability in the community. While state statutes vary, the Substance Abuse and Mental Health Services Administration (SAMHSA) recommendations note that harm does not require risk of violent behavior and that patients may be committable if "an individual is at risk for injury, illness, death, or other loss solely due to mental illness symptoms such as an inability to . . . satisfy his need for nourishment, personal, or medical care."[20] It remains unclear, however, how psychiatrists should take into account the risk of acquiring or spreading COVID-19. Gold *et al.*[13] described that patients were being sent for psychiatric evaluation after breaking COVID-19–related rules, leading to involuntary hospitalization. Psychiatrists relate having been asked how patients with SMI can socially distance in the community because of their psychotic beliefs or promiscuity during manic episodes. Another question raised is whether people with SMI have a right to think COVID-19 is a government conspiracy, like some others without SMI do. The fundamental question of what qualifies as an imminent and serious risk to self or others is modified by the current climate.

Disease severity in COVID-19 is highly variable; especially early in the pandemic, outcomes have been difficult to predict. At the same time, COVID-19 is highly transmissible and potentially lethal; current treatment is largely limited to supportive interventions. The interpretation of imminence is also relevant as we consider an infectious disease that is, based on available data, time-limited in course, unlike HIV, tuberculosis, or hepatitis, and is no longer dangerous for transmission after the passage of a few weeks.

Existing guidance related to the intersection of psychiatric illness and risk of spreading communicable disease is sparse. The APA offers guidance on psychiatrists' duty to protect others in the case of HIV. HIV is a limited analogy given its different route of transmission, among other factors; as noted by Gold *et al.*,[13] transmission of COVID-19 may happen during otherwise mundane behavior. The APA Position Statement on HIV and Inpatient Services noted that "if a patient engages, or threatens to engage in behavior that places other individuals at risk for potential HIV infection, the responsible physician should assure that appropriate steps are taken to control the behavior and, if necessary, isolate and/or restrain the patient."[21] Unfortunately, this guidance does not specifically address the involuntary commitment of patients whose mental illness increases their risk of dangerousness to others via HIV transmission. A 1989 survey of forensic practitioners reported that there was moderate agreement that "high risk behavior resulting in potential HIV transmission should be sufficient for invoking civil commitment based on dangerousness to others" (Ref. 22, p 648). Sub-sequent research has not updated these norms in light of marked changes in HIV's treatability and focuses more on the permissibility of breaching confidentiality and the duty to warn in the case of HIV-positive patients with mental illness.[23,24]

Perhaps increased restriction, such as commitment, may be conceptualized as appropriate for patients who are at increased risk for COVID-19 and who require quarantine, or who cannot adhere to preventive measures because of their psychiatric condition.[13] Justifying civil commitment for these circumstances is less clear when we have little evidence to evaluate dangerousness. To date we have inadequate knowledge about the risk of COVID-19 in psychiatric patients. Similarly, we do not have data about how a certain psychiatric condition may or may not affect compliance with infectious disease protocols. Although paternalism is embedded in the guidelines imposed by the national emergency, involuntarily hospitalizing psychiatric patients without evidence that they pose a substantial risk of harm to self or others is unethical, even during a pandemic.

Non-Maleficence and Beneficence

Ethical involuntary commitment during the COVID-19 pandemic must contemplate both non-maleficence when considering forcible restriction to a high-risk living environment and reduced beneficence from changes to the structure of inpatient treatment offerings. Recognizing the risk of disease spread in inpatient settings, SAMHSA guidelines for the care of treatment of mental and substance use disorders during the pandemic recommended that alternatives to inpatient treatment be used "to the greatest extent possible."[20] This guidance assumes that patients are not already in congregate living settings; residence in a group home, nursing facility, homeless shelters, or even multigenerational family homes could confer a similar or even greater risk of transmission.

Confidentiality

Physicians have an ethics responsibility to maintain the privacy of a patient's personal health information. Maintaining confidentiality during the COVID-19 pandemic requires a careful balance of patient privacy with public protection. Although advantageous in reducing the risk of transmission, the use of teleconferencing for patient interviews is not without cost. Many patients are either not able to navigate the technology due to inexperience or are not considered safe to be left alone with such devices. As a result, many patient interviews are not private, even sometimes including an information technology expert. Patients who are uncomfortable with this do not have many alternatives other than to wait for a trusted staff member to be available to assist them. Furthermore, truly obtaining informed consent for this technology during hospitalization is not entirely possible because patients typically are not offered alternatives.

During a pandemic, confidentiality can quickly erode both with regard to patient and staff health care information. Congregate settings like inpatient psychiatric units are particularly vulnerable due to the pressing need to identify who has contracted the virus to mitigate transmission. In some settings the safety and well-being of others takes precedence over patient privacy. For example, the Department of Health and Social Care for England allowed health care providers access to patients' COVID-19 status to reduce the risk of transmission.[25] Although the interests of public protection may outweigh patient privacy in some situations, the breach of confidentiality comes with its own maladies, such as stigmatization and discrimination.

Virtual Civil Commitment Proceedings

In 1993, a North Carolina federal court upheld a district court ruling that the use of videoconferencing for psychiatric civil commitment proceedings was constitutional.[26] The APA subsequently supported the use of videoconferencing in civil commitment hearings in 1998.[27] Over the past two decades, the introduction of telecourts and videoconferencing for judicial proceedings has steadily increased. The experience of the University of Michigan Mental Health System with telecourt hearings for civil commitment proceedings suggests a positive outcome, benefitting the safety and respect of patients as well as being a cost-effective measure.[28] Missouri implemented telecourt in 2010 for civil commitment with an average of 250 cases per year. They maintain that the use of videoconferencing has a positive effect by improving productivity, enhancing both patient and staff safety, and decreasing the need to be transported by deputies to hearings.[29] Legal challenges to such hearings revolve around due process arguments. In *Doe v. State*,[30] the Supreme Court of Florida ruled that individuals subject to commitment hearings have a right to a judicial officer physically present at the hearings. The court reasoned that the long-standing tradition of physical presence of judicial officers at trials and hearings is a fundamental right. The court concluded that videoconference hearings could only occur if agreed upon by all involved parties.

On March 29, 2020, the Judicial Conference of the United States temporarily approved both the use of video and telephone conferencing during COVID-19 for civil proceedings, including civil commitment hearings.[31] Although some jurisdictions were routinely using videoconferencing for civil commitment, today the majority of civil commitment hearings are conducted remotely. Unlike prepandemic telecourt, however, today's court hearings are largely virtual, with no one in the courtroom, including the judge and the courtroom personnel. Absent is the typical courtroom decorum. Due to the health care contact risks, the patient-client, attorneys, and witnesses are rarely in the same room.

The unique challenges of telecourt proceedings in the pandemic include the inability of attorneys to consult with the patient-client and witnesses contemporaneously. If an attorney wants to confer with a client or witness, the attorney has to request a recess. During the recess, the attorney and the other party confer in a separate videoconference room. Not only is this cumbersome, it alerts the judge that there is some problem or at minimum a miscommunication. Additionally, there is no way of knowing whether a witness is reading from a script. The presentation of evidence also poses a potential problem. Unlike courts that have been utilizing videoconferencing for civil commitment for some time and have established a protocol for transmitting evidence, courts that are new to the process have not. Thus, the ability to introduce evidence or cross-examine a witness regarding an entry in the medical record is not available.

Despite these challenges, there are some potential benefits to conducting hearings with videoconferencing, in addition to alleviating the risk of courtroom transmission of disease. Courts have more flexibility in scheduling hearings so that patients may have timely appearances. This flexibility may also allow witnesses who are unable to travel an opportunity to participate in the hearing. Without a clear end to the COVID-19 pandemic, the use of telecourt for civil commitment hearings is here to stay.

Legal Considerations

The ethics dilemmas we raise are not isolated to academia. As of July 2020, there were no state or federal cases that have addressed the question of involuntary civil commitment for patients with mental illness during the COVID-19 pandemic. In the Massachusetts Supreme Court case *Foster v. Commissioner of Correction (No. 1)*,[32] the court held that people who had been committed for involuntary treatment of substance use disorders were entitled to a new hearing to "take into account treatment limitations in the circumstances and to weigh the balance of potential benefits from treatment and the potential harms as a result of being held in wings of prisons and jails and other conditions of confinement during the pandemic" (Ref. 32, p 380). We anticipate that similar legal challenges may be mounted on behalf of patients who are involuntarily civilly committed for mental illness during this period.

The question of civil commitment for sexually dangerous or sexually violent persons related to the COVID-19 pandemic has also been raised in some jurisdictions.[33] Mr. Richard Meuse opposed temporary commitment at the Massachusetts Treatment Center as a sexually dangerous person on grounds related to the COVID-19 pandemic and requested the court release him to home confinement. Mr. Meuse argued that eight percent of inmates at the Massachusetts Treatment Center had tested positive for the COVID-19, and his underlying medical conditions of diabetes and high blood pressure put him at increased risk for severe symptoms and complications related to COVID-19. The court found that the risk of danger to children and the public if Mr. Meuse was not subject to temporary confinement outweighed Mr. Meuse's risk of developing COVID-19.

Conclusion

As psychiatrists consider civil commitment for patients who are a risk to themselves or others in the time of COVID-19, we must be thoughtful about the many ways that the disease changes the provision of care and to recalibrate continuously our attunement to patients' rights and safety risk.

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