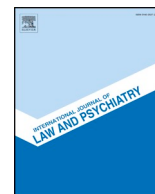




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Under which conditions are changes in the treatment of people under involuntary commitment justified during the COVID-19 pandemic? An ethical evaluation of current developments in Germany



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ABSTRACT

The COVID-19 pandemic poses significant challenges in psychiatric hospitals, particularly in the context of the treatment of people under involuntary commitment. The question arises at various points in the procedure for and process of involuntary commitment whether procedural modifications or further restrictive measures are necessary to minimise the spread of COVID-19 and protect all people involved from infection.

In the light of current developments in Germany, this article examines under which conditions changes in the treatment of people under involuntary commitment are ethically justified in view of the COVID-19 pandemic. Among others, we discuss ethical arguments for and against involuntary commitments with reference to COVID-19, the use of different coercive interventions, the introduction of video hearings, an increased use of video surveillance and interventions based on the German Infection Protection Act.

We argue that strict hygiene concepts, the provision of sufficient personal protective equipment and frequent testing for COVID-19 should be the central strategies to ensure the best possible protection against infection. Any further restrictions of the liberty of people under involuntary commitment require a sound ethical justification based on the criteria of suitability, necessity and proportionality. A strict compliance with these criteria and the continued oversight by external and independent control mechanisms are important to prevent ethically unjustified restrictions and discrimination against people with the diagnosis of a mental disorder during the COVID-19 pandemic.

1. Introduction

The global pandemic caused by the coronavirus SARS-CoV-2 has had a major impact on the European continent (World Health Organization, 2020). Germany, the most populous country in the European Union, is also affected by the pandemic. Current data from the European Centre for Disease Prevention and Control show that the official number of laboratory confirmed cases of coronavirus disease (COVID-19) in Germany is among the highest in Europe (European Centre for Disease Prevention Control, 2020). The Robert Koch Institute, the German government's central scientific public health institution, currently reports 181,196 cumulative reported cases of COVID-19 in Germany, including 8,489 related deaths (Robert Koch

Institute, 2020a; as of 30 May 2020). A more detailed examination of the spread of the virus reveals differences, some of them significant, between the 16 German states. North Rhine-Westphalia and Bavaria are among the states affected most severely. There have been 37,910 laboratory-confirmed cases currently reported in North Rhine-Westphalia, the most populous German state with 17.9 million inhabitants, which corresponds to an incidence of 211 per 100,000 inhabitants. Bavaria, the largest German state in terms of area, has officially reported 46,854 laboratory-confirmed cases, an incidence of 358 per 100,000 inhabitants (Robert Koch Institute, 2020a; as of 30 May 2020).

The measures taken to contain the COVID-19 pandemic have led to considerable restrictions of the basic rights of the population in Germany and other countries worldwide. These restrictions initially

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took place at a local level, such as the closure of schools and public institutions in the district of Heinsberg in North Rhine-Westphalia.¹ On 20 March 2020, Bavaria was one of the first German states to impose “social distancing” measures as public restrictions.² This was followed a few days later by a corresponding nationwide regulation.³ Although these measures have been gradually relaxed since the beginning of May^{4,5} they are to be reinstated as soon as the number of new infections in a city or district exceeds a certain level.⁶ Both the Robert Koch Institute and leading virologists in Germany expect a second wave of the disease in the coming autumn/winter.^{7,8}

Early on, the German Ethics Council drew attention to ethical problems associated with the COVID-19 pandemic in an ad hoc recommendation (German Ethics Council, 2020). In that report and in further medical and ethical position papers from the German-speaking countries, the situation in somatic medicine and especially the problem of triage situations in the case of insufficient treatment and ventilation capacities were discussed (Bioethikkommission, 2020; Deutsche Interdisziplinäre Vereinigung für Intensiv- und Notfallmedizin, 2020; German Medical Association, 2020; Swiss Academy of Medical Sciences, 2020). However, the COVID-19 pandemic and the restrictions it has brought about have also led to major changes in psychiatric hospitals, especially regarding the people under involuntary commitment. Several studies on psychological and psychiatric aspects of the COVID-19 pandemic have been published since the beginning of the pandemic (Bohken, Schömig, Lemke, Pumberger, & Riedel-Heller, 2020; de Girolamo et al., 2020; Frank et al., 2020; Gunnell et al., 2020; Petzold, Plag, & Ströhle, 2020; Pfefferbaum & North, 2020; Röhr et al., 2020). Some publications deal specifically with the special situation of people under involuntary commitment in psychiatric hospitals (Brown, Ruck Keene, Hooper, & O'Brien, 2020; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2020; Gulati, Dunne, & Kelly, 2020; Gulati, Fistein, Dunne, Kelly, & Murphy, 2020; National Association of Psychiatric Intensive Care & Low Secure Units, 2020; Ruck Keene, 2020; Russ, Sisti, & Wilner, 2020; Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2020; Zhu et al.,

2020). A German perspective on the implications of the COVID-19 pandemic for the treatment of people under involuntary commitment is still missing.

People under involuntary commitment are highly affected by the COVID-19 pandemic for several reasons. Firstly, unlike voluntary patients, people under involuntary commitment cannot choose not to be hospitalized on account of the court decision. This means that they cannot make their own, autonomous decisions about their medical treatment and the associated risk-benefit ratio during the COVID-19 pandemic. Secondly, due to the acute and substantial danger to self or others that underlies the involuntary hospitalization, treatment cannot be postponed, as is the case, for example, with elective procedures in somatic medicine. Thirdly, many people under involuntary commitment have an increased risk of severe COVID-19 complications due to the higher incidence of medical comorbidities and increased cigarette consumption in people with severe mental illness (Compton, Daumit, & Druss, 2006; Schneider, Erhart, Hewer, Loeffler, & Jacobi, 2019), and the generally higher age of people with dementia.

A central ethical challenge during the COVID-19 pandemic is to bring the rights and interests of individuals and groups into an ethically appropriate relationship with the rights and interests of others and society as a whole (German Network Public Health COVID-19, 2020). This has the following implications for the group of people under involuntary commitment in psychiatric hospitals. First of all, psychiatric hospitals should, just like general hospitals, contribute to containing the COVID-19 pandemic. At the same time, all people in psychiatric institutions (i.e. voluntary and involuntary patients and mental health professionals) must be protected as well as possible against infection with SARS-CoV-2. Finally, any (additional) intervention affecting the rights of people under involuntary commitment must be proportional and ethically justified (European Committee on Prevention of Torture Inhuman or Degrading Treatment or Punishment, 2020).

Although each of the goals mentioned above is likely to meet with broad consensus, tensions between them can arise in clinical practice. In such situations, mental health professionals need normative support to be able to make ethically justified decisions in individual cases. In response to the COVID-19 outbreak in Germany, several proposals for changes in the treatment of people under involuntary commitment have been discussed among stakeholders. Our paper examines under which conditions changes in the treatment of people under involuntary commitment are ethically justified in view of the COVID-19 pandemic. In this way, we want to support practitioners involved in the treatment of involuntary patients in striking an ethically sound balance between infection control, on the one hand, and the protection of the already restricted basic rights of people who have been committed, on the other. Our considerations are based on perspectives from clinical psychiatry, medical ethics and law, as we are convinced that real clinical and normative challenges in relation to the treatment of people under involuntary commitment can only be answered by means of an interdisciplinary approach. We refer to the mental health laws of the two German states of Bavaria (BayPsychKHG)⁹ and North Rhine-Westphalia (PsychKG NRW)¹⁰ in our article. However, our findings also have implications for involuntary commitments on other legal bases in the national and international context.

2. Involuntary commitment with reference to COVID-19

In times of the pandemic, the question arises to what extent prevention of SARS-CoV-2 infections could serve as a justification for the involuntary commitment of people with mental disorders in psychiatric

¹ Nach Corona-Fällen: Schulen und Kindergärten im Kreis Heinsberg bleiben geschlossen. (2020). *Aachener Zeitung*. Retrieved from https://www.aachenerzeitung.de/lokales/heinsberg/kreis-heinsberg-zieht-konsequenzen-aus-corona-fall_aid-49192025, accessed on 30 May 2020.

² Update: Bavaria and Saarland become first German states to impose lockdowns. (2020). *The Local*. Retrieved from <https://www.thelocal.de/20200320/bavaria-becomes-first-german-state-to-impose-lockdown>, accessed on 30 May 2020.

³ Coronavirus: What are the lockdown measures across Europe? (2020). *DW*. Retrieved from <https://www.dw.com/en/coronavirus-what-are-the-lockdown-measures-across-europe/a-52905137>, accessed on 30 May 2020.

⁴ Coronavirus: Germany reopens shops as lockdown is relaxed. (2020). *BBC*. Retrieved from <https://www.bbc.com/news/world-europe-52557718>, accessed on 30 May 2020.

⁵ Explained: Here's Germany's plan for post-lockdown life with coronavirus. (2020). *The Local*. Retrieved from <https://www.thelocal.de/20200506/whats-germanys-plan-for-post-lockdown-life-with-coronavirus>, accessed on 30 May 2020.

⁶ Merkel urges virus vigilance; Germany loosens border checks. (2020). *The New York Times*. Retrieved from <https://www.nytimes.com/aponline/2020/05/13/world/europe/ap-eu-virus-outbreak-germany.html>, accessed on 30 May 2020.

⁷ Germany's Robert Koch Institute warns of further waves of coronavirus. (2020). *CGTN*. Retrieved from <https://www.nytimes.com/aponline/2020/05/13/world/europe/ap-eu-virus-outbreak-germany.html>, accessed on 30 May 2020.

⁸ Germany's Covid-19 expert: 'For many, I'm the evil guy crippling the economy'. (2020). *The Guardian*. Retrieved from <https://www.theguardian.com/world/2020/apr/26/virologist-christian-drosten-germany-coronavirus-expert-interview>, accessed on 30 May 2020.

⁹ <https://www.gesetze-bayern.de/Content/Document/BayPsychKHG?AspxAutoDetectCookieSupport=1>, accessed on 30 May 2020.

¹⁰ https://recht.nrw.de/lmi/owa/br_text_anzeigen?v_id=1000000000000000086, accessed on 30 May 2020.

hospitals on the basis of mental health laws. Should people with mental disorders who, say, spit on the street, do not wear a community mask in a supermarket or do not observe distance rules be admitted involuntarily to a psychiatric hospital? These and related cases were discussed in Germany at the beginning of the COVID-19 pandemic.

From an ethical and legal perspective, the involuntary commitment of a person is permissible only if the following necessary conditions are satisfied:

1. The person poses an acute and substantial risk of harm to self or others on account of his or her mental disorder.
2. The person lacks mental capacity.
3. The involuntary commitment is a suitable means to remove the risk of harm to self or others.
4. The involuntary commitment is a necessary means to remove the risk of harm to self or others in the sense that there are no less restrictive alternatives with which the same result can be achieved.
5. The impact of the involuntary commitment is proportional in relation to the impact of the risk of harm to self or others.

We will refer to these criteria for ease of exposition as (1) the risk criterion, (2) the capacity criterion, (3) the suitability criterion, (4), the necessity criterion and (5) the proportionality criterion. Involuntary admission to a psychiatric hospital should be considered only if all these criteria are met.

There will, of course, still be situations during the COVID-19 pandemic in which people with a mental disorder who lack mental capacity will have to be committed based on the mental health laws to avert acute and substantial risk of harm to self or others. From our own clinical experience in the last months, we know of cases that gave us the impression that some stakeholders outside the hospital were inclined to lower the threshold for involuntary admission in view of the COVID-19 pandemic in order to minimise a supposedly increased risk of infection for third parties due to the challenging behaviour of people with mental problems. It is clear, however, that it is not ethically appropriate to lower the threshold for involuntary commitments to a psychiatric hospital during a pandemic. Mental health laws are not legal instruments of infection control and may not be misused for these purposes.

We believe that the criteria for involuntary commitment mentioned above will be met only in rare cases where the prevention of the spread of COVID-19 is the primary motivation to arrange an involuntary commitment. We believe, for example, that the criteria are not met in cases where people with mental disorders who exhibit no concrete symptoms of COVID-19 and who have had no contact with people with COVID-19 spit on the street, do not wear a community mask in a supermarket or do not observe distance rules. In what follows, we will give a brief explanation of each of the criteria for involuntary commitment, using concrete examples where necessary to illustrate our claims.

2.1. The risk criterion

According to the mental health laws of the German states, particularly those of North-Rhine Westphalia and Bavaria, involuntary commitment to a psychiatric hospital is permitted only if a person poses an acute and substantial risk of harm to self or others on account of a mental disorder (Sec. 1 PsychKG NRW; Art. 5 BayPsychKHG). The threshold for risk to self or others is high in German mental health laws. According to the mental health law of North Rhine-Westphalia, for example, the risk of harm to others must have impact on the “significant rights of others” (Sec. 11 para. 1 PsychKG NRW) and the event must be either “imminent” or it should be the case that “its occurrence, though unpredictable, can nevertheless be expected at any time due to special circumstances” (Sec. 11 para. 2 PsychKG NRW). It is widely accepted that so-called “challenging” behaviour due to agitation during a psychotic episode or an increased drive during a manic episode, does not as

such entail a high enough risk to self or others to meet the risk criterion. Accordingly, it is unlikely that people with mental disorders who manifest no concrete symptoms of COVID-19 and have had no contact with people with COVID-19 meet the risk criterion by failing to comply with social distancing measures. In such cases, the risk seems latent and low to moderate rather than acute and substantial. Involuntary hospital admission would, therefore, be unjustified in these cases. We will assess cases in which the risk criterion does seem satisfied below.

2.2. The capacity criterion

According to German mental health laws, people can be hospitalized involuntarily only if they lack mental capacity regarding the decision at hand (“*Einsichts- und Steuerungsfähigkeit*”, mentioned explicitly in Art. 5 BayPsychKHG).¹¹ According to a widely accepted model, people have mental capacity to make a treatment decision if and only if they are able to understand the information about the potential consequences of their decision, appreciate that this information applies to their own situation, rationally process this information and communicate a treatment choice (Grisso & Appelbaum, 1998; Scholten & Vollmann, 2017). Involuntary hospitalization can be justified based on the mental health laws of German states only if a person lacks mental capacity. If a person with a mental disorder and confirmed COVID-19 has mental capacity, on the other hand, involuntary interventions based on the German Infection Protection Act can be considered under special circumstances. We discuss these circumstances further below (section 4.4).

2.3. The suitability criterion

We think that the suitability criterion is not satisfied in most of the cases in which COVID-19 serves as the primary motivation to arrange an involuntary commitment. Involuntary commitment is unlikely to be a suitable means to remove the risk of infection in most cases, as infections with COVID-19 may also occur on psychiatric wards. It is likely that locked psychiatric wards entail an increased risk of infection, since crowding is a familiar phenomenon on locked psychiatric wards and the wards are not designed for quarantine measures (Zhu et al., 2020). Moreover, we observed earlier that people under involuntary commitment, as a group, are at an increased risk of severe COVID-19 complications due to medical comorbidities, high cigarette consumption or advanced age. It would, thus, seem that involuntary admission to a locked psychiatric ward will increase rather than decrease the risk of infection.

That said, the question whether the suitability criterion is satisfied must be answered on a case-by-case basis. Clinicians are sometimes confronted with cases that are ethically complex. One case would be a person in a manic episode who has had contact with a person with confirmed COVID-19 but refuses to test for COVID-19 and does not comply with the order of home quarantine. On the premise that this person lacks mental capacity, the question can be raised whether involuntary hospital admission would be a suitable means to reduce the risk of infection with SARS-CoV-2.

The answer to this question depends on contextual factors. In the case given, involuntary admission to a psychiatric hospital would put other people on the psychiatric ward at a relatively high risk, as delineated above. This risk would have to be smaller than the aggregate risk incurred by other people in the case where the person is not

¹¹ The criterion that the person must lack mental capacity is mentioned explicitly in the Bavarian but not in the North Rhine-Westphalian mental health law. However, based on decisions of the German Federal Constitutional Court (“*Bundesverfassungsgericht*” = BVerfG), this criterion applies to involuntary commitments under the mental health laws of all German states (BVerfG, decision of 10 July 1981, Az. 2 BvR 1194/80).

hospitalized. This could be the case if the person has a lot of social contacts in the community, for example, if he or she moves around the city, goes to supermarkets and shops without wearing a community mask and so on. On the other hand, if the person stays in a relatively small area and keeps distance from others, involuntary admission to a psychiatric hospital would not reduce the risk of infection and would hence not be a suitable intervention. Instead of arranging an involuntary commitment, mental health professionals should offer support in the community, and local authorities should stay in contact with the person and regularly offer testing for COVID-19.

An even more challenging case would be a 65-year-old man with Korsakoff syndrome who lives in a nursing home and has difficulties keeping distance from others and adhering to basic hygiene rules, such as washing hands regularly. Would it not be suitable to admit the person to a psychiatric hospital in order to protect the other nursing home residents, considering that nursing homes are a high-risk setting for COVID-19? Although it might be understandable that some professionals in a nursing home would favour an involuntary admission to a psychiatric hospital in this situation to protect other residents from infection, an involuntary commitment would, in most cases, only shift the problem to a different setting. Similar to nursing homes, wards in geriatric psychiatry are high-risk settings for COVID-19, as they are specialised in the treatment of older people with mental problems and challenging behaviour. Moreover, involuntary hospitalization brings with it additional risks, particularly increased social contacts during the transport to the hospital and, as the involuntary commitment is necessarily temporary, back to the nursing home. Finally, changes to the environment of a person with Korsakoff syndrome would most probably increase rather than alleviate the challenging behaviour, while there are no treatment options available in the psychiatric hospital which are not also available in the nursing home. For these reasons, involuntary admission to a psychiatric hospital is not a suitable measure to reduce the risk of infection in the present case. Instead, all efforts to reduce infection risks should concentrate on the nursing home itself, and the Robert Koch Institute provides detailed recommendations on how this can best be achieved (Robert Koch Institute, 2020b).

2.4. The necessity criterion

Even in cases where involuntary commitment is a suitable means to reduce the risk of infection, it need not be a necessary means. In many cases, involuntary hospital admission is not necessary to remove the risk of infection, given the availability of less restrictive alternatives by means of which the same result can be achieved. A police order is a case in point. There can be cases, however, where people ignore an order or are unable to comply with it due to a lack of mental capacity. Before the option of involuntary commitment is considered, supported decision-making should be provided to enable the person in question to oversee the consequences of his or her choices and behaviour better (Penzenstadler, Molodynski, & Khazaal, 2020; Scholten & Gather, 2018). If that strategy is of no avail, professionals could apply a range of so-called “treatment pressures” to motivate the person to comply with the order. Treatment pressures are communicative interventions by means of which mental health professionals provide service users with incentives in order to increase treatment compliance. Notable examples are persuasion, interpersonal leverage and inducement (Szmukler & Appelbaum, 2008). Only if all less restrictive alternatives prove unsuccessful can the option of involuntary commitment be considered.

2.5. The proportionality criterion

A suitable and necessary intervention need not be proportional. Even if we were to assume that an involuntary commitment is a suitable and necessary means to remove the risk of the spread of COVID-19 infections in a given case, it is unlikely that the proportionality criterion is met. An involuntary commitment is a very severe restriction of a

person's liberty. If such an intervention is to be permissible, it should remove a risk of harm to self or others of considerable impact and probability. This is reflected in the high thresholds for risk to self or others in German mental health laws which we have described above. Take the case of a person with a mental disorder who does not adhere to social distancing measures, but who manifests no symptoms of COVID-19 and has had no contact with people with COVID-19. In this case, the restriction of liberty entailed by the involuntary commitment would seem disproportional compared to the reduction of the risk of harm to others which could be achieved by means of the intervention.

The picture is different when we assess the example of a person suffering from schizophrenia with confirmed COVID-19 who, based on a delusional belief, attempts to infect other people by spitting in their faces. Here, it could be argued that the risk of harm to others is substantial and that an involuntary commitment would be both necessary and proportional. As detailed above, however, we are not convinced that the involuntary commitment would be a suitable measure to remove the risk of harm to others, as it puts the other people on the ward at risk. In response, it might be proposed that the person should be placed in isolation in order to reduce the risk of infection on the ward (Brown et al., 2020). We will discuss the issue of the choice of coercive measures on the ward in the following section.

In sum, if an involuntary commitment is considered for reasons related to COVID-19, mental health professionals and other stakeholders involved should assess carefully whether the relevant criteria are satisfied in the case at hand. All people involved are called upon to maintain the high threshold for involuntary admissions to psychiatric hospitals to avoid an unjustified unequal treatment of people with mental disorders. It would be unacceptable discrimination if a person with a mental disorder were to be admitted to a psychiatric hospital because of behaviour for which a person without a mental illness would merely be given a police warning or fined (Scholten, Gather, & Vollmann, in press).

3. Opting for different coercive measures

According to the mental health law of North Rhine-Westphalia, coercive measures include seclusion, physical restraint and mechanical restraint. Mechanical restraint is the coercive measure most used in Germany, followed by seclusion (Steinert & Schmid, 2014). Coercive measures are permissible only if they are suitable, necessary and proportional to remove an acute and substantial risk to self or others. Each measure may only be maintained for as short a time as necessary (BVerfGE 145, 293).

Individual 1:1 care provided by a mental health nurse is usually regarded as a less restrictive alternative to the coercive measures regulated by the law. Furthermore, it is supposed to help to minimise highly restrictive interventions, such as locked ward doors (Gather, Scholten, Henking, Vollmann, & Juckel, 2019). Continuous 1:1 care (“*persönliche Bezugsbegleitung*”) is also constitutionally required for any mechanical restraint since a decision of the Federal Constitutional Court in 2018 (BVerfGE 149, 293–346). There are various reasons for this requirement: A person who is mechanically restrained as ultima ratio is in an absolutely exceptional situation that requires appropriate care. Only professional care of the highest quality can ensure that a restraint only lasts as long as it is actually necessary. The fact that 1:1 care requires a lot of personnel resources might also guarantee that mechanical restraint is only used as a last resort. In addition, the requirement also considers protection aspects, because a situation that is (life-)threatening for the person restrained can be recognised immediately and a reaction can be made quickly. These constitutional requirements have now been implemented in the mental health laws (Sec. 20 PsychKG NRW; Art. 29 BayPsychKHG).

All coercive measures involve comparatively close physical contact, and the people who have been committed involuntarily often resist. Therefore, these interventions represent an increased risk of infection

with SARS-CoV-2, and the question arises as to whether changes in the use of coercive measures are ethically necessary to protect the person under involuntary commitment and the mental health professionals involved.

Since coercive measures are, in any case, only permissible in situations where they are absolutely necessary to avert an acute and substantial danger, refraining from using a coercive measure is not an option under those circumstances. It may be asked, however, whether mental health professionals should be allowed to deviate from the normative requirement of the least restrictive alternative in pandemic times in order to choose the alternative with the lowest risk of infection. Should, for instance, mental health professionals opt for seclusion instead of 1:1 care?

Such a switch to a more restrictive intervention could only be ethically justified if the advantages regarding infection protection outweighed the disadvantages associated with the more restrictive measure. From the point of view of the person affected by the intervention, this will hardly ever be the case. Even for mental health professionals, the more restrictive intervention would probably often not be associated with a lower risk of infection, because most restrictive measures, such as mechanical restraint or seclusion, require very close physical contact when being applied against a person's will.

A generally higher risk of possible infection during a pandemic is not a sufficient reason to deviate from the normative principle of the least restrictive alternative without a sound ethical justification in each individual case. It is important at this point to minimise the overall risk of infection through a differentiated hygiene concept and the provision of sufficient personal protective equipment. As far as staff protection is concerned, an additional attempt should be made to deploy employees with a higher risk of severe complications caused by COVID-19 (e.g. due to pre-existing or chronic diseases) in areas of the hospital where there is less contact with people showing challenging behaviour or where distance rules can be observed better.

Here we can return to the extreme case of the person with schizophrenia and confirmed COVID-19 who lacks mental capacity and, based on a delusional belief, attempts to infect other people by spitting in their faces. As mentioned in the previous section, it might be argued here that the person should be involuntarily admitted to a psychiatric hospital to remove the risk of infection of other people on the street and, furthermore, that the person should be placed in isolation to remove the risk of infection of other people on the ward. Supported decision-making, treatment pressures, 1:1 care, voluntary medication or voluntary isolation in a single bedroom with unlocked doors would be less restrictive alternatives in such a case. However, if we assume that these and other conceivable alternatives are of no avail, a coercive intervention such as seclusion or mechanical restraint seems necessary to protect others. Furthermore, since spitting by a person with confirmed COVID-19 poses an acute and substantial risk of harm to others, the intervention can be regarded as proportional, especially considering that many people treated on acute psychiatric wards have risk factors of severe complications associated with COVID-19.

However, whether seclusion or mechanical restraint are suitable means to remove the risk of harm to others can be questioned. We should consider that mental health professionals should stay with the person in a small room for extended periods of time in order to give support and monitor the person's health status as well as the potential impact of the coercive intervention. If the person spits, screams or sings loudly, the coercive intervention alone appears insufficient to remove the risk of harm to others. Mental health professionals working on the ward will be exposed to the risk of infection and hence other patients who stay on the ward will be indirectly exposed to this risk as well. This seems to hold true even under the assumption that mental health professionals have protective equipment at their disposal, as it is questionable whether this equipment is sufficiently protective in the case of such challenging behaviour as described above.

Mental health professionals have a right to be protected against known and foreseeable risks, and the situation described above is known to bring with it a high risk of infection with SARS-CoV-2. Furthermore, the situation in this case is significantly different from other situations in health care, as COVID-19 patients on intensive care units or elsewhere usually do not exhibit such challenging behaviour and do not try to infect other people intentionally. So, how should the mental health professionals on the ward act in this situation to reduce the risk of infection?

The question might arise in clinical practice whether involuntary medication with an antipsychotic and/or sedative drug would be ethically justified. The mental health laws of North Rhine-Westphalia and Bavaria allow involuntary medication with the primary goal of protecting others, albeit under strict conditions (Sec. 18 PsychKG NRW; Art. 20 BayPsychKHG). However, based on a decision of the Federal Constitutional Court (BVerfGE 128, 282–322; 129, 269 ff.), there is a broad consensus among legal scholars that involuntary treatment for the benefit of third parties is unconstitutional (Henking & Mittag, 2013, 2014). In line with the decision of the Federal Constitutional Court, the Central Ethics Commission at the German Medical Association argued that a risk of harm to others can typically be averted by liberty restricting measures (e.g. mechanical restraint or seclusion) and, therefore, does not justify involuntary medication (Zentrale Ethikkommission bei der Bundesärztekammer, 2013). The underlying rationale is, thus, that involuntary medication to reduce the risk of harm to third parties is impermissible because involuntary medication is not necessary to reduce this risk.

We acknowledge that this holds true for most cases of physical aggression. However, the situation is different in the case under discussion. In this case, the acute and substantial risk of contracting COVID-19 cannot be averted or substantially reduced by means of mechanical restraint or seclusion of the person. If the latter are not sufficient to remove or substantially reduce the risk of harm to others, it could be argued that involuntary medication is necessary to achieve this end. Moreover, since involuntary antipsychotic and/or sedative medication will probably alleviate the person's agitated state and reduce the associated behaviour (i.e. spitting, screaming and singing loudly), it seems a suitable means to reduce the risk of harm to others. Finally, since the risk of harm to others in the situation without involuntary medication would be both acute and substantial, it might be argued that involuntary medication would also be proportional. It might, thus, be argued that involuntary medication would be suitable, necessary and proportional in the case under discussion and could hence be regarded as ethically justified, despite the fact that the primary aim of the medication is to avoid harm to others rather than harm to self.

Several objections could be raised to this line of argument. Firstly, one could argue that medication is necessarily a part of treatment and that treatment should always be for the benefit of the patient and never for the benefit of third parties. In this view, involuntary medication should be considered as a protective measure (i.e. a form of "chemical restraint") rather than a medical intervention in the case under discussion (Henking & Mittag, 2013, 2014, 2015). One could retort here by saying that the medication could help the person to regain mental capacity and to understand the situation better, which could reduce the psychotically motivated urge to spit and allow for a voluntary isolation in a single bedroom with unlocked doors, which would in turn release the person from the burden of being secluded or mechanically restrained. It should be noted, however, that this rejoinder is insufficient to take away the worry that the primary motivation for the involuntary medication is the protection of others.

Secondly, one could object to the proposal to proceed with involuntary medication to protect third parties by saying that an encroachment of the right to bodily integrity by invasive means (e.g. involuntary medication) is always morally worse than an encroachment of the right to bodily integrity by non-invasive means (e.g. seclusion and physical restraint). One could retort here by saying that

mechanically restraining a person in an agitated state over a long period of time imposes a higher burden on the person than subjecting them to involuntary medication, as the tranquilizing effect of involuntary medication can relatively quickly make mechanical restraint unnecessary (German Association for Psychiatry, Psychotherapy and Psychosomatics, 2014).

Although this intricate dispute must be resolved, doing so is obviously beyond the scope of this paper. We have attempted to lay down the criteria that could guide a discussion about these issues. It should be noted that the case we have discussed here is an extreme and rare case. We believe that the right ethical answer in most cases can be found by adequately applying the criteria proposed.

4. Other changes proposed

Several other proposals for changes in the treatment of people under involuntary commitment have been discussed among German stakeholders in response to the COVID-19 pandemic. In this section, we discuss the proposal to modify legal hearings (4.1), prolong involuntary commitments (4.2), replace 1:1 care by video surveillance (4.3) and arrange involuntary commitments based on the Infection Protection Act (4.4).

4.1. Modifications of the hearings

Under German mental health laws, involuntary admissions to a psychiatric hospital take place upon application by the relevant regulatory authority and require a court decision. Before the decision regarding involuntary commitment is issued, the person concerned must be personally heard by a judge in the psychiatric hospital (a so-called in-person hearing). At the hearing, a guardian ad litem (“*Verfahrenspfleger*”) must be present whose task it is to protect the rights of the person concerned.

It would be ethically inappropriate to extend the initial commitment period in order to reduce the risk of infection, even if the aim of the extended duration is to avoid a renewed examination of the requirements with another in-person hearing. A hearing should not be less frequent or shorter than necessary in pandemic periods to give the people concerned sufficient opportunity to understand all the relevant aspects of the commitment procedure and to articulate their views. The procedural law applicable to commitment procedures provides for a hearing as an expression of the right to be heard. The individual should not merely be the object of the proceedings but should have his or her own say in order to be able to influence the proceedings and their outcome (BVerfGE 9, 89; 55, 1; 57, 250; 84, 188; 86, 133; 89, 28; 107, 395). From an ethical point of view, hearings are a central element of procedural justice, which, in addition to its high normative importance, has a strong influence on the level of coercion that people under involuntary commitment experience subjectively (Szmukler, 2018, pp. 174–175).

We are aware that the issue of protection against infection is particularly relevant in hearing situations, given that several people usually stay in the same room for a certain period of time. Furthermore, judges and guardians ad litem come to the hospital from outside and are usually responsible for several wards and institutions, on account of which they have comparatively many social contacts. However, instead of lowering the legal and ethical standards of procedural justice, psychiatric institutions should ensure that suitable hygiene concepts and protective measures reduce the risk of infection for everyone involved. This includes, for example, sufficiently large and well-ventilated rooms, maintaining sufficient distance, providing disinfectants and personal protective equipment, instruction in their hygienically correct use and low-threshold testing for COVID-19. The provision of sufficient protective equipment against infections must have a high priority not only from a clinical point of view but also for ethical reasons (Fenton, 2020; Schuklenk, 2020).

In the context of hearings, there is also a current discussion about switching to video hearings in certain cases to minimise personal contact. On 15 May 2020, the Bundesrat (i.e. the parliament, which consists of representatives of the governments in each state) passed a law proposal which would make it possible to replace face-to-face in-person hearings with video hearings (Deutscher Bundesrat BR-Drs. 211/20, 2020). The German Bundestag (i.e. the national Parliament of the Federal Republic of Germany) still has to approve the law proposal. The latter explicitly pursues the goal of protecting “vulnerable people” in commitment procedures and requires that the German Bundestag has declared an epidemic situation of national importance. As long as the epidemic situation persists, video hearings can be allowed in special cases in which the risk of infection cannot be countered by other measures, according to the law.

In principle, such a law, which is limited to times of epidemics, can be a good way of contributing to infection protection for all people involved in a hearing. In certain areas, for example in forensic psychiatry, positive experiences have already been made in recent months with a switch to video hearings that are permitted under the condition of the prior voluntary consent of the people concerned. However, in view of the situation in acute psychiatry, several ethical aspects need to be considered. People under involuntary commitment are usually in an acute mental crisis, often highly psychotic or alcohol- or drug-intoxicated. For many of them, a video hearing will hardly be possible against this background. Others may be processing the image and sound transmission in light of their delusions and may be convinced that they are being filmed or observed from outside. There is also the concern that the people affected might behave differently in front of a camera than they would in a face-to-face conversation. Such considerations must be scrutinized when weighing up the individual case. Video hearings are unlikely to be justified in situations where the risk of infection is very low under observance of a strict hygiene concept and there are no concrete indications that the person has COVID-19 or has been in contact with people with COVID-19. In such situations, the disadvantages of video hearings for the person concerned outweigh their advantages in terms of minimising the risk of infection.

To justify a switch to a video hearing, it would also have to be made plausible for what reason the person affected is classified as “vulnerable” to infection with SARS-CoV-2 (e.g. due to a serious previous illness of the lungs) and to what extent the video hearing actually promises additional “protection” that outweighs the disadvantages. It could be the case, for example, that a person prefers a video hearing him- or herself to avoid additional personal contact to reduce the risk of infection. A further advantage of the video hearing could be that people who have been committed involuntarily can recognise the face and facial expressions of those involved in the hearing and, thus, gain more confidence than if a hearing is held with people wearing protective clothing.

4.2. Prolonging the involuntary commitment

Involuntary commitments under mental health laws must be terminated as soon as their requirements no longer apply (Sec. 15 PsychKG NRW; Art. 27 BayPsychKHG). Whether an acute and substantial danger to self or others continues to exist must be checked and documented daily. From a legal and ethical point of view, regular review is an important instrument to reduce the restriction of freedom to a minimum. It is important to ensure that this review is carried out with due care during the COVID-19 pandemic. A discharge before the end of the period of involuntary commitment originally set by the judge contributes not only to a lower restriction of freedom but also to higher infection control, since the fewer people who are detained in a psychiatric hospital for longer than absolutely necessary, the lower the risk of infection within the institution for all concerned.

If it is decided to maintain or even prolong the commitment of people with mental disorders, the justification must be based solely on

the assessment of acute and substantial danger to self or others and not be mixed up with general considerations of infection control. If there are concerns about protection against infection, for example, because a person with a mental disorder does not consistently adhere to certain hygiene rules, continued commitment in a psychiatric hospital would only be ethically appropriate if all ethical criteria mentioned above are met. As has already been explained, such situations are likely to be rare.

4.3. Video surveillance instead of 1:1 care

Another proposal being discussed among psychiatrists in Germany is the use of video surveillance to minimise personal contact in the treatment of people who have been committed involuntarily. Video surveillance could, for example, replace 1:1 care, which requires mental health professionals to stay in close contact with people in an acute mental crisis over an extended period of time. The admissibility of video surveillance is regulated differently in the various German states. While video surveillance in connection with coercive measures is explicitly prohibited in North Rhine-Westphalia (Sec. 20 PsychKG NRW), it is, in principle, permissible in Bavaria (Art. 29 BayPsychKHG). Should psychiatric hospitals rely on video surveillance increasingly during the Covid-19 pandemic and even reinstate it in North Rhine-Westphalia?

It is helpful to consider the background to the ban on video surveillance in North Rhine-Westphalia to assess the proposal from an ethical perspective. The ban on video surveillance in North Rhine-Westphalia was issued in 2011 under pressure from associations of mental health service users after they objected to video surveillance to relieve the burden on staff (Landtag NRW Drs. 15/3275, 2011). The invasion of privacy and the associated control and monitoring were not considered proportional. Video surveillance represents a serious infringement of the right to informational self-determination (*“Recht auf informationelle Selbstbestimmung”*, comparable to the right to privacy) of people under involuntary commitment and is likely to be processed in a delusional manner, especially by people with acute psychosis. These considerable disadvantages would have to be counterbalanced by a strong benefit in terms of protection against infection in order to justify video surveillance ethically. However, the real benefit of an increased use of video surveillance seems to be rather small. The person concerned would still have to be contacted personally on several occasions, and it seems much more suitable and even more promising to reduce the infection risk by a strong hygiene concept including personal protective equipment and low-threshold testing for COVID-19. Personal protective equipment can usually be worn during 1:1 care and the distance recommended in the current pandemic situation can be maintained. The inside of buildings can be ventilated, and the measure can – at least partially – be carried out in an outdoor area.

Furthermore, the replacement of 1:1 care by video surveillance is contrary to central ethical arguments in favour of 1:1 care. Even if 1:1 care undoubtedly serves purposes of surveillance and security, at least to some extent, the normative and therapeutic core of 1:1 care lies in the intensified attention and care for the person concerned, including continuous monitoring of the vital parameters of a person under mechanical restraint. For this reason, the common German expression for the intervention is 1:1 care (*“1:1 Betreuung”*) rather than 1:1 observation or surveillance. The term *“Sitzwache”* (permanent watch), long used in connection with mechanical restraint, has been replaced by the term *“persönliche Bezugsbegleitung”* (continuous 1:1 care). A re-introduction or increased use of video surveillance would jeopardize this ethical progress of recent years, while marginally, if at all, contributing to the protection against infection.

4.4. Interventions based on the German Infection Protection Act

The German Infection Protection Act (*“Infektionsschutzgesetz”*;

IfSG)¹² serves to protect the general public, aims to combat communicable diseases and allows the authorities to restrict the freedom of individuals to achieve this goal. The Infection Protection Act applies to all people in Germany, irrespective of whether they have a mental disorder. One possible restrictive measure is the order not to leave one's own home (Sec. 28 IfSG). According to Sec. 30 para. 1.2 IfSG, the authorities can order a “separation” (*“Absonderung”*) in a hospital or a suitable facility if the person concerned does not adhere to or is expected not to comply with the order. It is irrelevant whether non-compliance with the order is intentional or due to circumstances beyond the person's control. If the person concerned does not follow the corresponding order, he or she may even be liable to prosecution.

From a legal and ethical point of view, it is important that, in the case of interventions under the Infection Protection Act, the reason for separation lies exclusively in the violation of quarantine orders. Furthermore, people may not be treated differently in measures under this Act simply because they have a mental disorder.

We are aware of one case in which patients with mental capacity who were voluntarily treated in a psychiatric hospital had to remain in quarantine in the hospital for 14 days by order of the relevant authority instead of being discharged into home quarantine. This happened after they had had contact with an asymptomatic person who tested positive for COVID-19 once, and the stay on the ward was maintained after their own negative testing. Such unequal treatment based on the presence of a mental disorder is ethically unjustified. This policy constitutes an inadmissible form of discrimination by imposing a relative disadvantage on people simply because they have a mental disorder (Scholten, Gather, & Vollmann, in press).

5. The necessity of control mechanisms

The experiences and considerations described above highlight the importance of independent control mechanisms to identify and remedy unjustified restrictions of basic rights. The mental health laws provide for so-called visiting commissions, which visit every psychiatric hospital once a year or once every two years without prior notice, check the compliance with legal standards and make suggestions for improvements, as a control instrument (Sec. 23 PsychKG NRW; Art. 37 BayPsychKHG). A similar objective is pursued by the Joint Commission of the States of the National Agency for the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was established under the Optional Protocol to the UN Convention Against Torture. Commission representatives visit places where people are deprived of their liberty, including psychiatric hospitals. From an ethical point of view, it seems important that the work of these external commissions continues in pandemic times and that explicit attention should be paid to changes in the context of the COVID-19 pandemic. The work of such independent commissions should be seen by all those involved as an opportunity to find an ethically appropriate balance between infection control and the restriction of freedom.

6. Conclusion

The COVID-19 pandemic poses significant challenges in psychiatric hospitals and particularly in the context of the treatment of people under involuntary commitment. We have tried to show that the question arises at various points in the procedure for and process of an involuntary commitment whether procedural modifications or further restrictive measures are necessary to minimise the spread of COVID-19 and whether these modifications are ethically justified. The issue of the appropriate balance between infection control measures and additional restrictions of the basic rights of people under involuntary commitment is essentially an ethical one.

¹² <https://www.gesetze-im-internet.de/ifsg/>, accessed on 30 May 2020.

We have argued that strict hygiene concepts, including the provision of sufficient personal protective equipment and frequent testing for COVID-19, should be the central strategy to provide the best possible protection against infection for all people involved. Psychiatric hospitals that treat people under involuntary commitment should, therefore, be given high priority in the allocation of these products and testing capacities for COVID-19. Any additional restriction of the rights of people under involuntary commitment, even in exceptional times of a pandemic, requires a legal and ethical justification in each individual case in strict compliance with the principles of suitability, necessity and proportionality. These justifications must not merely refer to blanket and vague attributions of “vulnerability” and interpret restrictions not only as positively connotated measures of infection “protection” but must also integrate the actual dangers of the virus and the negative effects of additional restrictions into the ethical weighing. In this context, it is important to differentiate between situations with a more abstract risk of infection and those with a concrete risk of infection (e.g. suspected or confirmed COVID-19 cases).

The maintenance of external and independent control mechanisms is of great importance, especially in pandemic times, to identify unjustified restrictions of the rights of people under involuntary commitment. The identification and prevention of unequal treatment of people with the diagnosis of a mental disorder compared to people without such a diagnosis should be part of these examinations in order to prevent discrimination. External control mechanisms should ideally be complemented by the self-reflection of the various people involved in the process of involuntary commitments, such as public officials, judges and mental health professionals. The aspiration should be to critically reflect together on the approaches and experiences made so far in order to arrive at ethically justified decisions in the ongoing COVID-19 pandemic.

Declarations of Competing Interest

None.

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