Isolation on psychiatric wards during covid-19

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The **conundrum**

And an over-simplistic question…

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Isolation of patients in psychiatric hospitals in the context of the COVID-19 pandemic: An ethical, legal, and practical challenge

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ABSTRACT

Psychiatric inpatients are particularly vulnerable to the transmission and effects of COVID-19. As such, healthcare providers should implement measures to prevent its spread within mental health units, including adequate testing, cohorting, and in some cases, the isolation of patients. Respiratory isolation imposes a significant limitation on an individual's right to liberty, and should be accompanied by appropriate legal safeguards. This paper explores the implications of respiratory isolation in English law, considering the applicability of the common law doctrine of necessity, the Mental Capacity Act 2005, the Mental Health Act 1983, and public health legislation. We then interrogate the practicality of currently available approaches by applying them to a series of hypothetical cases. There are currently no 'neat' or practicable solutions to the problem of lawfully isolating patients on mental health units, and we discuss the myriad issues with both mental health and public health law approaches to the problem. We conclude by making some suggestions to policymakers.

1

There are no **good** legal solutions to the problem.

Mental health legislation to enforce public health: ‘psycholegal gymnastics’

OR

Public health legislation: entirely inappropriate for use in psychiatric settings in its current form

2

The MHA likely provides authority to isolate patients where there is a link between their refusal to do so and a mental disorder.

But with some important caveats.

Some initial caveats

- Very narrow scope – answering a very specific question;
- Does not attempt to discuss issues relating to testing, PPE, or even isolation for the protection of the patient (shielding);
- Has little to say about how Restrictive Practice (RP) policies integrate with Infection Prevention & Control (IPC) policies;
- Infection control (a clinical issue) should come first – this discussion is secondary to that (and other) considerations;
- Anglocentric; and
- Isolation is awful!

Structure of paper / presentation

- COVID-19 on MH units: the health problem
- The legal background: human rights, common law, MCA, MHA, PH law
- Case vignettes: semi-practical worked-examples
- Discussion (in the paper):
  - Departure from MHA CoP
  - MH or PH law?
- Conclusions

COVID-19 on MH units

- Disease characteristics: highly contagious, potential for asymptomatic transmission
- Environmental characteristics: close communal living
- Patient characteristics: comorbidities, vulnerabilities, behaviours, medications

Managing transmission risk

- Shut-off unit cf. Scottish care homes
- Quarantine

- Discharge
- Cohorting / designated wards
- Isolation

- Informed by infectious disease specialists. Starting point will be clinical science, and the local IPC policy.

Legal background

- NHS Legal Guidance 30 March 2020 (v1)

"Providers need to develop appropriate strategies to manage this safely to protect patients and staff from transmission and risk of physical injury within legal constraints, including their obligations under the Human Rights Act (1998)…

…colleagues should determine appropriate use of the relevant legal framework on a case-by-case basis, with reference to organisational ethics committees and support from medicolegal colleagues as required."

Human rights engagement

- Positive obligation:
  - Article 2 – right to life
- Negative obligations
  - Article 3 – freedom from torture/inhuman/degrading treatment
  - Article 5 – right to liberty
  - Article 8 – right to a private life

*NHSE legal guidance: 'key human right that is at risk when considering the management of people who will not self-isolate is the Right to **Liberty** which is a non-absolute right. This means that any restriction on this right has to be lawful, necessary and **proportionate**'*

Common law

- Such steps that are ‘necessary and proportionate to protect others from the *immediate* risk of significant harm’
- Legitimate only in the *very* short term
- No procedural safeguards → risk of arbitrary use

MCA 2005 / DoLS

- Best interests to be isolated?
- Objecting mental health patients → MHA

MHA 1983

- Ancillary powers upon detention, including:
  - **Implied power** to seclude a patient within a hospital as a ‘necessary ingredient flowing from a power of detention for treatment’; and
  - The power to seclude as an aspect of the power to provide **medical treatment** under s.63.
- Colonel Munjaz
- Chapter 26: seclusion is “*the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others*”
  - *Reviews (risk, mental / physical health), observation (particularly in light of behavioural disturbance) & engagement, room specifications*
- Segregation

Public health legislation

- Coronavirus Act 2020
  - If a person has been assessed by a PHO and the officer has reasonable grounds to suspect that the person is potentially infectious, they can require the person to remain in a specified place in isolation from others for a specified period, initially up to 14 days.
  - Failure to comply with the requirement gives rise to a criminal offence.
  - Appeal is to the Magistrates' Court.
  - Powers can’t be delegated to health/care providers → PHO or police officer present to enforce it.
  - No (public) accompanying guidance akin to CoP on review/observation/engagement of individual in isolation.

Updated guidance

Department of Health & Social Care

Guidance

The Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19) pandemic: additional guidance

Updated 10 June 2020

If someone who lacks relevant capacity needs to be isolated because they have symptoms and are not following public health advice

When a person who lacks relevant mental capacity is suspected or confirmed to have COVID-19, and they are presenting with symptoms, it is essential that the individual follows public health advice to prevent the spread of the disease and receives the necessary care available through the NHS and other care services. Outside of cases where the Mental Health Act (1983) (MHA) is relevant, those caring for the person should explore the use of the MCA as far as possible for care and treatment moving forward.

When a person who lacks relevant mental capacity is suspected to have COVID-19 but does not have classic symptoms of the disease or is vulnerable to contracting COVID-19 and should follow public health advice (for example, to self-isolate), every effort should be made to ensure that they are supported in order to be able to understand what is being asked of them and therefore make the decision for themselves. This includes requesting the support of the relevant carers, family and friends.

For individuals who lack the relevant capacity, the first options to explore are the MCA and/or the MHA. In some circumstances, it may be appropriate to seek further advice from Public Health England. In England, on the use of restrictions, please contact your local health protection team (HPT). In Wales, there is information about COVID-19 by Public Health Wales and contact details for the HPT.

Public health legislation (2)

- Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 – 26 March 2020
- Can’t leave main residence without reasonable excuse
- Don’t apply to bedrooms on MH wards

Case vignettes

(no cohorting available)

1. Caroline

Caroline has been admitted voluntarily ('informally') due to concerns that she is experiencing a relapse in her bipolar affective disorder. She understands that she's unwell, that her erratic behaviour in the community was putting her at risk, and was distressing to her family. She understands the need for treatment, and appears to be able to consent validly to an informal psychiatric admission. She has begun coughing and has had a documented fever of 38.5C. She doesn't think that she has COVID-19, and believes that even if she did, the media has over-blown the risks, and that she shouldn't self-isolate in her bedroom. A viral swab has been sent but there is a 2–3 day wait for results. There is no capacity to 'cohort' patients.

- MCA?
- Common law?
- Validly consenting?
  - Blanket rule – e.g. isolate if suspected COVID-19

2. Owen

Owen has a long history of paranoid schizophrenia which has been in remission for over a decade. He usually has a supportive network of friends and carers, he has a voluntary job three days a week, and attends a day centre the other two. Since the COVID-19 outbreak, almost all of his usual support disappeared. He became anxious and started taking a reduced dose of his clozapine. He was detained under s.3 of the MHA 1983 after being found wandering in a state of self-neglect outside his flat. On admission he was found to have a fever, though he appears otherwise physically well. He appears distracted and profoundly thought disordered. He is neither aggressive nor violent. He seems incapable of engaging in a conversation around isolation and repeatedly tries to leave his bedroom. In order to prevent him from doing so, he has been placed by staff on 1:1 observations, and his bedroom door is intermittently being locked.

- Public health legislation?
- Seclusion?
  - Arguable, but probably cogent reasons to depart from the letter of the CoP
- Engagement & ‘offsetting measures’

3. Vaughn

Vaughn is a 36 year old man with diagnoses of schizoaffective disorder (currently well-manged on a depot antipsychotic) and antisocial personality disorder (ASPD), currently detained under s.37/41 on a medium secure forensic unit. He's developed a new continuous cough, and says that he must have got it from staff as they're the only people who enter and leave the otherwise locked building. He thinks he probably has COVID-19 but says he doesn't care if he gives it to other patients or staff, and says it is his right to use the TV lounge as much as he wants. He quickly became aroused and threatening when told that he should be self-isolating. He is unlikely to be discharged as he is in the midst of offence-related psychological work, and has not yet had leave granted by the Ministry of Justice, due to a succession of violent incidents on the ward.

- Seclusion?
- Police?
- Public health legislation?

4. Ines

Ines is a 46 year old lady who is severely depressed and detained under S3 of the MHA 1983. She displays profound psychomotor retardation and very rarely leaves her room. She is provided meals in her room. She is mute, and appears distracted. It is not possible to engage her in conversation and it is not clear that she understands that given her new cough, she presents an infection risk to others and is being asked to self-isolate. Nonetheless, she 'passively complies', never trying to leave her room. Crucially, if she did try to do so, she would be stopped.

- What *is* the question?
  - DoLS analogy
  - Additional deprivation of liberty?
  - Issue of proportionality

5. Dave

David is a 52 year old man who's been admitted voluntarily following a highly risky suicide attempt. He's recently lost his job, separated from his wife and family, and been made homeless. He has no support network. He is clinically depressed and consented validly to inpatient admission on this basis, recognising that until his mood improves and he has accommodation, he would present a very significant risk to himself if he weren't admitted. He develops a cough and fever and, being aware of the government guidance, is happy to self-isolate in his en-suite bedroom on the ward. He says he's happy to be prevented (by locking his door, if need-be) from leaving his room for the next 14 days.

- Voluntary self-isolation
- Voluntary patient: Importance of clarity of choice: isolate or discharge
- Detained patient: coerced (Analogy: *de facto* detention)? Psychological benefit of being offered the choice
- Ulysses clauses

Public health vs. mental health law

MHA – points of departure from CoP

- Duration of likely seclusion
- Specifications of room
- Infection control implications on review type/frequency
- Increased emphasis on engagement / offsetting measures

Also would need to cover (as a care plan):

- Compliant patients who lack capacity
- Voluntary isolation

Including frequency of reviews, etc.

MHA - other arguments

- *'but for'* covid-19 would not be secluded, therefore not for mental but for physical/public health.
- NHSE Legal Guidance v2 *"For currently detained patients, providers should not impose blanket restrictions, but* ***the use of the MHA may offer authority for enforcing social distancing and isolation of symptomatic patients****. It is vital these powers are used with regard to the principles of the MHA Code of Practice."*

Public health law

- Disability neutral (less discriminatory)
- Useful where no good link between MI and inability to isolate
- Means of appeal
- Avoid deviating from CoP
- Avoids watering down MHA
- Intellectually honest

- Practical difficulties
- Unclear application for those lacking capacity / SMI
- Criminal paradigm
- Inability to delegate powers – police presence on wards
- Interface with MHA

Conclusions

- The *right* questions…
- Plea to DHSC for clear and practical guidance.
- Until this is provided, consider updating/writing policies and discussing these with the CQC / seek legal advice.
- IMPORTANT: isolation policy is only one small part of a provider's response to reducing restrictive practice in this context:
  - Crucial that the IPC policy uses evidence / testing to allow least restrictions
  - Trusts must do what they can to provide cohorting arrangements (*strong* ethical mandate for this)
  - PPE and testing
  - Reporting framework
- Worst case scenario…
- Lasting lessons – how to better engage with patients in seclusion, how to approach the issue of isolation more flexibly.

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