Medicine, Science and the Law
2022, Vol. 62(4) 275–282

DOI: 10.1177/00258024221086054
journals.sagepub.com/home/msl


COVID-19 Vaccination in those with mental health difficulties: A guide to assist decision-making in England, Scotland, and Wales

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Abstract

There is currently no specific guidance addressing vaccine hesitancy in those with mental health difficulties in the United Kingdom. This is particularly problematic when one considers that individuals with serious mental illnesses are at greater risk of infection and have poorer health outcomes for a range of reasons. There are also many individual and system level barriers to vaccination in this group. When an affected adult lacks the capacity to make a decision for themselves, it often falls to healthcare professionals to make a decision on that person's behalf and in their best interests. This article explores this matter with regard to the law in practice in the English and Welsh, and Scottish, jurisdictions and consider this with relevance to the safest approach that doctors and other healthcare professionals should take in working with patients for whom mental disorder may impact on decision-making capacity. The article focuses on psychiatric inpatients, including those who are detained involuntarily, to consider whether, and in what circumstances, COVID-19 vaccination should be given to individuals who cannot or do not consent.

Keywords

Medical law, legal system, law, human rights, COVID-19, vaccination

Introduction

Vaccination as a means to mitigate the impact of the COVID-19 (severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)) pandemic on society will rely upon sufficient voluntary uptake of an effective vaccine and the achievement of herd immunity. Whilst a sizeable majority of individuals with mental health difficulties are likely to agree to vaccination,[1] there is currently no specific guidance addressing vaccine hesitancy in this population.[2] This is particularly problematic when one considers how individuals with serious mental illnesses (SMI) are at greater risk of infection and have poorer outcomes for a range of reasons, including pre-existing physical health co-morbidities and greater socioeconomic deprivation.[3–5] Previous work has shown it to be difficult to overcome individual and systemic barriers to vaccination more generally in this group, but also that active interventions from professionals and services can help.[6]

When an adult with a mental health difficulty lacks the mental capacity to make a decision for themselves, it often falls to healthcare professionals to make a decision on that person's behalf in their best interests. The requirement to act in accordance with the individual's best interests exposes tensions that feed into wider contemporary issues regarding COVID-19 vaccination: for example, debates on personal autonomy versus societal responsibilities and the increasing influence of (organised) anti-vaccination sentiment.[7,8]

A recent editorial by Sediqzadah et al. argued that from an international perspective—the authors compared Canadian and UK legislative frameworks—involuntary psychiatric admission for the purpose of infectious

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disease control may be warranted depending on the individual's behaviour, risk profile, and whether efforts to support them in the community have been exhausted.[9]

In this article, we explore the law of the jurisdictions of England and Wales and Scotland in order to form a view as to the safest approach that doctors and other healthcare professionals should take to working with patients whose mental disorder may impact on decision-making capacity. We focus on psychiatric inpatients, including those who are detained involuntarily, to consider whether, and in what circumstances, COVID-19 vaccination should be given to individuals who cannot or do not consent.

COVID-19 infection in the psychiatric population

Two cohort studies (one UK-based and one USA-based)[3,4] have found that the presence of a psychiatric diagnosis is associated with increased risk of COVID-19 infection. A 2021 systematic review and meta-analysis[5] comprising 1,469,731 patients with COVID-19 (of whom 43,938 had mental disorders) found that the presence of any mental disorder was associated with a twofold increased risk of COVID-19 mortality (OR 2·00 [95% CI 1·58–2·54]), that the odds of hospitalisation were increased (OR 2·24 [1·70–2·94]), and that COVID-19 mortality was associated with exposure to antipsychotics (OR 3·71 [1·74–7·91]), anxiolytics (OR 2·58 [1·22–5·44]), and antidepressants (OR 2·23 [1·06–4·71]).

These studies have implications for patients detained involuntarily in psychiatric hospitals, where social distancing may be difficult. In 2019/2020, the annual detention rate in England was 91.8 per 100,000 of the population for men and 84.4 for women.[10] Further, there have been at least anecdotal reports of reduced adherence to social distancing and mask-wearing by some inpatients in part due to their mental illness and lack of understanding of, or unwillingness to engage with, such regulations. There may also be particular implications for patients detained in secure settings where length of stay is considerably longer than in general adult settings.[11,12] Conversely, hospital settings offer opportunities for engagement, education, examination, testing, and treatment that cannot be easily matched in community settings.

Coercion in public health: the legal context

In the United Kingdom, mandatory vaccination is not generally legally permissible under public health law. (COVID-19 vaccine mandates for health and social care staff have been introduced in England; discussion of this issue is beyond the scope of this article.)

In England and Wales, mandatory medical treatment and vaccination are explicitly prohibited by The Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008 ('the PHA 1984').[13] The executive power to make regulations under sections 45B and 45C of the PHA 1984 is subject to section 45E which provides that any regulations cannot require a person to undergo medical treatment. 'Medical treatment' includes vaccination and other prophylactic treatment.

The situation in Scotland is similar. The Public Health (Scotland) 2008 Act ('the PHSA 2008')[14] provides health boards with various powers that may be exercised on application to a sheriff for the purposes of public health protection, including medical examination, detention, and quarantine. Importantly, however, the Act makes no reference to treatment, vaccination, or immunisation. None of these can be mandated.

The Coronavirus Act 2020 ('the CVA 2020'),[15] which was enacted in March 2020 to grant emergency powers to the UK Government to manage the COVID-19 pandemic, does not change the legal position in respect of mandatory vaccination in any of England, Wales, or Scotland. Indeed, Schedule 19 paragraph 3 expressly clarifies that Scottish Ministers may not use their powers to make health protection regulations to require an individual to undergo medical treatment, and specifies that this includes 'vaccination and other prophylactic treatment'.

UK Legislation is compatible with its international human rights law obligations.[1] In *Solomakhin v Ukraine*,[16] the European Court of Human Rights (ECtHR) held that mandatory vaccination interferes with a person's right to integrity protected under Article 8 of the European Convention on Human Rights (ECHR): the right to respect for private and family life, home and correspondence. However, and importantly, Article 8 ECHR is a *qualified* right. Interference may be permissible if it is in accordance with the law, it pursues a legitimate aim, and meets the tests of necessity and proportionality. The ECtHR concluded in *Solomakin* that compulsory vaccination may be permissible if 'justified by the public health considerations and necessity to control the spreading of infectious diseases in the region'. In *Vavřička v Czech Republic*,[17] the ECtHR held that a policy of mandatory childhood vaccinations fell within the margin of appreciation enjoyed by the state to pursue the legitimate aims promoted by a duty to vaccinate.

COVID-19 vaccination and the assessment of mental capacity

In consequence of their mental disorder, psychiatric inpatients may suffer impairment to their decision-making capacity[2]. In a 2008 study[18] of 350 consecutive people admitted to psychiatric wards at the Maudsley Hospital in London, an estimated 60% of these people lacked mental capacity to make decisions on treatment, with the proportion varying markedly according to diagnosis. There are, however, no data available concerning psychiatric inpatients' capacity to decide whether to receive COVID-19 vaccination.

In England and Wales, and Scotland, the Mental Capacity Act 2005 ('MCA 2005')[19] and the Adults with

Incapacity (Scotland) Act 2000 ('AWIA 2000')[20] respectively govern the law on decision-making capacity for people aged 16 years and over. Although the provisions of these legal regimes differ in form and detail, in both jurisdictions the following principles apply to clinicians:

1. They must presume capacity (unless incapacity is established).
2. They must support decision-making by taking all practicable steps to involve people in making decisions for themselves.
3. They cannot treat someone as lacking capacity merely because of a view that they are making an unwise decision.
4. They must act on behalf of a person lacking capacity in their best interests or benefit, involving the individual and any family, carer, or significant person who knows them well, including when that person might ask to be vaccinated.
5. They must, when making a decision on behalf of another person, ensure the use of the least restrictive option. This includes considering whether it is possible to act in a way that would interfere less with the person's rights, or whether there is a need to act at all.

It is unlawful to impose vaccination over a valid refusal of treatment.[21] Other things being equal, if an individual has mental capacity in respect of the decision of whether to receive COVID-19 vaccination, it will be unlawful to administer a vaccine without their consent. However, we shall discuss a possible exception to this rule arising from mental health law below.

Best interests, benefit, and COVID-19 vaccination

Healthcare professionals have an obligation to advocate for and promote best practice and guidance for their patients, including around vaccination. In the circumstances in which a person with a mental disorder lacks decision-making capacity in respect of COVID-19 vaccination, healthcare professionals will need to consider whether vaccination is in the best interests or for the benefit of the patient. In England and Wales, best interests is a statutory principle set out in sections 4 and 5 of the MCA 2005. Section 1(5) of the Act sets out the principle that:

> Any act done, or a decision made, under this Act or on behalf of a person who lacks capacity must be done, or made, in his best interests.

The drafters of the AWIA 2000 explicitly rejected a best interests test, considering it wrong to employ the construct for adults when best interests was developed in the context of child law, instead opting for the notion of benefit.[22] The AWIA 2000 states:

> There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention.

In principle then, psychiatric patients in both jurisdictions can lawfully be vaccinated if they lack capacity to make a choice and vaccination is deemed in their best interests or, in Scotland, will benefit them in a way which cannot otherwise be achieved. Whether COVID-19 vaccination is in any one individual's best interests (and therefore lawful) is a question that must be answered in light of the specific factual circumstances of each case. A blanket policy of vaccination in respect of detained patients who lack capacity is unlikely to be justifiable. This is because there is a broad range of perspectives on vaccination in society, and as such we cannot expect that COVID-19 vaccination will be 'best' for an individual viewed through the prism of their own wishes and feelings, or beliefs and values, as the legislation requires. As the Court of Protection notes in *Wye Valley NHS Trust v B*, incapacity is not an 'off-switch' for an individual's rights and freedoms.[23]

There have been a number of Court of Protection decisions over the course of the COVID-19 pandemic that exemplify the requirement to assess whether vaccination is in an individual's best interests from their own personal perspective.

In *E (Vaccine): LB Hammersmith and Fulham v W,*[24] which considered whether an 80-year-old resident of a care home who suffered with dementia, Hayden J held:

> In determining what would be in Mrs E's best interests, I am required by section 4(6) MCA 2005 to consider, so far as is reasonably ascertainable, her past and present wishes and feelings, the beliefs and values that would be likely to influence her decision if she had capacity, and any other factors she would be likely to take into account if she were able to do so. Mrs E had, prior to her diagnosis of dementia, willingly received the influenza vaccine and is also recorded as receiving a vaccination for swine flu in 2009. I consider the fact that, when she had capacity, Mrs E chose to be vaccinated in line with public health advice, to be relevant to my assessment of what she would choose in relation to receiving the Covid-19 vaccine today.

SS v LB Richmond upon Thames and SWL CCG concerned an 86-year-old individual with a diagnosis of dementia.[25]

SS's medical records—which went back to 1997—contained an unambiguous record of her declining both seasonal influenza and pneumococcal vaccines, while simultaneously setting out her engagement in responsible and proactive care and treatment arranged by the GP surgery and hospital outpatient departments. Hayden J found:

> Capacitous individuals facing a frightening pandemic might very well take a different view of a vaccination which

> restores them to their liberty than, for example, a decision not to take a flu vaccine. Ultimately, the forensic tapestry can only be woven from the available thread. However, it must be borne in mind that even though a capacity to weigh and balance the decision in focus has long disappeared, SS has nonetheless consistently and volubly opposed the vaccination. SS's reality is undoubtedly delusional, but that does not stop it being her reality. This has to be both recognised and respected.

Hayden J also found that the trust SS placed in her carers threatened being undone by the forcible administration of the vaccine. His judgement included the opinion of a team leader at the care home:

> (…) she thought that SS would look to her carers for help. They would not be able to intervene; that would be distressing for both parties. Moreover, in her analysis it would most likely dismantle the tentative trust that had been established over the months and in consequence of sensitive and determined professional effort. I find this reasoning to be measured and persuasive.

Information as to vaccination preferences and practice was central to the outcome in both these cases. As such, it is important to keep good records about vaccination. If it is not already common practice, it will be important for practitioners to consider the opportunity they have to enquire with patients as to their future wishes in respect of COVID-19 vaccination or vaccination in the context of pandemic or endemic disease. This is especially the case should repeat vaccinations at regular intervals become clinically indicated.

History may not always be there to guide the way in respect of an individual's preferences and values. In such cases, it will be necessary to construct the individual's point of view from the evidence provided by carers and personal relations. In *NHS Tameside & Glossop CCG v CR*,[26] HHJ Butler considered whether it was in the best interests of CR to have a COVID-19 vaccine. The court was unable to consider CR's past and present wishes due to his lifelong severe learning disability, autism, and epilepsy suffered. Therefore, the views of professionals engaged in caring for him and interested in his welfare, as well as the views of his immediate family, assumed prominence in the determination of his best interests, in line with sections 4(6)(b) and (c) of the MCA 2005.

The objections to vaccination advanced by CR's father were held to 'have no clinical evidence base' (insofar as they relied on the debunked association between MMR vaccination and autism). On the contrary, the medical evidence supported vaccination, and CR had previously responded without objection to the medical intervention of a blood test ('the use of something sharp'). In light of these factors, the Judge found that CR would have considered 'the evidence-based advantages of having a vaccination' if he were able so to do, and declared that it would be lawful to provide a COVID-19 vaccine to CR, but only if it could be administered without physical intervention (the use of force).

Re A (Covid-19 vaccination)[27] considered the issue of sedation provided in order to make vaccination less distressing. The CCG (the Clinical Commissioning Group) had applied to the Court of Protection for authorisation to administer a covert sedative medication and two doses of the Astra-Zeneca COVID-19 vaccination, and a booster in a few months' time, to a man in his thirties, AD. AD who had diagnoses of moderate learning disability, Down's syndrome, and autism was clinically extremely vulnerable to COVID-19. AD had a history of refusing healthcare intervention and would say 'no' when introduced to a healthcare professional. It was considered that he held an objection to the COVID-19 vaccination as when an easy-read social story had been read to him concerning the COVID-19 virus and vaccination, he shook his head and said 'no'. AD's mother opposed vaccination on various grounds, including a broad set of vaccine misinformation garnered from the Internet.

In supporting the application (though deferring the issue of a booster dose for a future application), HHJ Brown made clear that the court was not authorising the administration of the vaccine using force. AD could receive a sedative (temazepam, given covertly in a drink) in advance of the vaccination, which would also have the effect of preventing memory formation. If the sedative did not work, then vaccination would be cancelled and rearranged. Vaccination would take place in the home and would not require AD to travel to a medical setting. The person administering the vaccine would not be part of AD's care team, and would leave immediately after administering the vaccine.

The lesson we might draw from this case is that covert administration is not in principle ruled out by the best interests' analysis. Sedation may be an element of a combined vaccination intervention that makes a procedure that would otherwise be contrary to an individual's best interests lawful—because it reduces distress (and possible pain) and the harms associated with resistance. Of course, covert administration may be problematic for a number of reasons. In many cases, it can be anticipated that the individual will learn of and understand what has happened to them. That discovery is likely be distressing and may jeopardise the relationship the individual has with those working with them. Of course, it may be the case that an individual who lacks capacity is likely to accept sedation and vaccination as an alternative to vaccination alone, and as such covert sedation should only be considered in cases in which it is the least restrictive alternative.

Vaccination without consent under mental health legislation

Patients detained under the provisions of either the Mental Health Act 1983 ('the MHA 1983')[28] or The Mental Health (Care & Treatment) (Scotland) Act 2003 ('the MHCTSA

2003')[29] may be treated compulsorily—that is, without consent to or over a valid refusal of treatment—for a mental disorder or the effects of a mental disorder. However, the legal permission to treat without consent does not include treatment for physical illness unless the said illness is the cause or result of the individual's mental disorder.

The MHA 1983 and the MHCTSA 2003 define medical treatment in an almost identical way as comprising: nursing, psychological intervention, specialist mental health habilitation, rehabilitation, and care.

The courts have interpreted treatment for mental disorder broadly. In *B v Croydon Health Authority*, Hoffman LJ interpreted medical treatment for the purposes of the MHA 1983 as including ancillary acts:

> nursing and care concurrent with the core treatment or as a necessary prerequisite to such treatment or to prevent the patient from causing harm to himself or to alleviate the consequences of the disorder.[30]

In this case, force-feeding was held to be both a prerequisite for being able to engage with other forms of treatment, and treatment for the manifestation of the mental disorder.

It is difficult to interpret vaccination as treatment for the symptoms of mental disorder. The refusal of vaccination may be a manifestation of a mental disorder, for example, in individuals who suffer with paranoid delusional thinking. However, it is not a direct treatment for this symptomatology.

It might be argued that vaccination is an ancillary treatment insofar as it facilitates treatment or alleviates the consequences of mental disorder. In respect of treatment facilitation, residency in an inpatient facility, as well as treatment in a group or any treatment involving close proximity, may be relevant. While mitigating steps of wearing face coverings, of social distancing, and of good ventilation may assist, they may not always be practicable or may be insufficient depending on the evolution of the virus. If patients are unable to participate in treatment because of vaccine refusal, then this may set back their progress towards discharge. In respect of alleviation of the consequences of mental disorder, the uncomplicated administration of vaccination may help in the resolution of the beliefs arising because of the mental disorder. It is perhaps difficult to predict the approach of the courts in respect of either of these matters should they arise for legal resolution. In general, use of the MCA 2005 or AWIA 2000 seems a more appropriate and legally less risky approach.

Advance decision-making

In England and Wales, the MCA 2005 makes provision for legally binding advance decisions to refuse treatment. An advance decision must be made at a time when an individual has capacity and it must be valid and applicable to the circumstances. If an advance decision to refuse treatment is valid and applicable, it has the effect of a contemporaneous refusal of treatment by an adult with capacity. If the question of treatment arises and a clinician is not satisfied that an advance decision is valid or applicable in the circumstances which present, the clinician will not be legally liable in the event that they provide treatment. An advance decision can be withdrawn or altered at any time if the individual has capacity.

In Scotland, common law governs advance refusals of treatment outside of the specific framework and context of the MHCTSA 2003. There is a lack of authoritative Scottish case law on advance refusals. It is plausible that the Scottish courts would employ a similar approach to the validity and applicability of advance refusals as the Court of Protection in England and Wales.

Clearly, an advance decision may be made in respect of COVID-19 vaccination. It is plausible that the greater level of detail in respect of the kinds of vaccines refused or the circumstances in which the vaccine is refused, the greater the likelihood that there exist grounds to hold an individual's advance decision inapplicable. Overriding refusal of vaccination may be more likely to create a risk of legal liability for clinicians.

The MHCTSA 2003 provides a legal framework for recognition of 'advance statements' where a patient is subject to a Compulsory Treatment Order. The detained patient can

Advance decision-making and the MCA 2005

Is there incapacity?	The advance decision will not be applicable to a matter at the material time if the person who made it has capacity to give or refuse consent.
Is the advance decision valid?	An advance decision will not be valid: If the decision was withdrawn when the individual had capacity. If the individual subsequently acted in a way clearly inconsistent with the Advance Decision remaining his/her fixed decision. If the individual has subsequently made a lasting power of attorney that confers on the donee the power to take the *same* medical decisions as the Advance Decision.
Is the advance decision applicable?	An advance decision is not applicable if: Treatment is not that specified in the advance decision. Any circumstances specified in the advance decision are absent. It is believed that circumstances not anticipated by the individual at the time of making the advance decision now exist that would have made a difference to their decision.

make an advance statement both to refuse certain treatments as well as to specify interventions they would welcome or accept. However, this advance statement regime is not binding on the clinician and relates only to treatment for mental disorder as defined by the Act. As we have argued above, vaccination would not normally be such a treatment.

Advance decisions, advance directives, and advance statements are still uncommon. In 2014, The House of Lords Select Committee on the MCA 2005 heard evidence that no data were collected concerning the making of advance decisions to refuse treatment but that research has found that only 3% of the public had made an advance decision.[31] The proportion of psychiatric inpatients with such decisions in place may be higher.[32]

Disagreement between proxy decision-makers

One of the authors has had recent and helpful experience of a recent (unreported) application before the Court of Protection in England. The vignette below provides an anonymised description of the application made.

> P is a middle-aged man who has developed early-onset dementia on a background of moderate intellectual disability. He has physical health problems and lives in supported accommodation. A learning disability psychiatrist found him to lack capacity with regard to a decision to be vaccinated—as he was neither able to understand, nor use nor weigh, the relevant information.
>
> P has two brothers. One favours vaccination but lives abroad and is not considered his ordinary carer. The other is strongly opposed on the basis that a) the seriousness of COVID-19 infection has been exaggerated and b) that the risks of the novel vaccine are as-yet unknown and may exacerbate P's existing physical illnesses. Of note, P willingly accepted vaccinations for seasonal illnesses in the past, and has no difficulties with needles.
>
> In view of disagreement about treatment from the family, the Trust—following a 'best interests meeting'—decides to seek a declaration from the Court of Protection that vaccination is in P's best interests.
>
> Had there been consensus between the family and the treating clinicians, a decision to vaccinate would have been made by his Consultant Psychiatrist following the requirements of section 5 of MCA 2005 which relates to 'acts in connection with care or treatment' for a person who is reasonably believed to lack mental capacity for a specific decision.

In Scottish cases on similar facts where the family members in disagreement are welfare proxies (they may either hold a welfare power of attorney or be welfare guardians), the Mental Welfare Commission for Scotland (MWC)[33] have advised practitioners to instigate the section 50 process of the AWIA 2000. This places a duty on the MWC to appoint an independent 'nominated practitioner' who makes a determination. The medical treatment (in this scenario, COVID-19 vaccination) can go ahead if the nominated practitioner determines that this is the right course of action. To date, this as far as the MWC has had to go and cases have been resolved at this level. If either party disagreed the next step would be to go to the Court of Session for a determination.

If the family member(s) in disagreement did not have specific powers, then the usual processes of the AWIA 2000 would govern the actions that follow.

The ethics of COVID-19 vaccination in psychiatric settings

A key issue relating to vaccination for COVID-19 is the question of how to balance risks to the individual and risks to others. A common thread running through both the legal and ethical reflections in this paper is that of 'proportionality'.[34] The Nuffield Council on Bioethics reported in 2007 that the most intrusive policies are likely to be justifiable only if the benefits of the outcomes are favourably weighted against any loss of liberty. They concluded:

> In general, public health policies should use the least intrusive means to achieve the required public health benefit. Directive vaccination approaches that go further than simply providing information and encouragement to take up the vaccine may, however, be justified on the basis of minimising risks of harm to others, or protecting the health of children and other vulnerable people. A case-by-case assessment will always be required.[35]

Targeted and general vaccine mandates have been introduced in several jurisdictions, including England where all care home workers, and anyone entering a care home, have needed to be fully vaccinated, unless they are exempt under the regulations.[36] Compulsory vaccination against COVID-19 is not necessarily harder to justify, ethically speaking, than other measures that have been introduced for the purposes of infectious disease control during the Coronavirus pandemic, such as restrictions on freedom of movement and association.[37] In shared living environments (including locked mental health units), where there may be a greater risk of viral transmission (to physically vulnerable persons), the relevance of others' physical health evidently merits greater consideration.

However, we will not dwell on the justifications for compulsory vaccination that focus on the protection of the rights and freedoms of others. Capacity law requires that the focus is primarily on the best interests of the patient. For as long as data supports the safety and efficacy of the vaccines used, including as boosting doses,[38] vaccination against COVID-19 will be in most individuals' self-interest

However, while vaccination confers significant harm-reduction, particularly for the vulnerable population in question, forcible injection under restraint is self-evidently distressing. Though an individual may lack capacity regarding a specific decision, this is not an *'off switch for [their] rights and freedoms',*[23] and indeed their considered or deeply held views must be promoted and respected—albeit expressed wishes may demand careful interpretation in light of clinical, historical, and other contextual factors.

In the absence of a clearly expressed wish or preference against vaccination, we would argue that vaccination is likely to be in the best interests of a person who lacks capacity and they should be supported to receive it. However, in cases where the individual who lacks capacity is actively opposed to vaccination *and* refusing it, a rigorous approach to the assessment of best interests must then be adopted, including attention paid to the physical risk of harm from COVID-19 (e.g. if the patient has obvious risk factors such as obesity, chronic inflammatory conditions, and previous lung disease). In such cases, where COVID-19 infection might present a serious risk to wellbeing and life, then consideration should be given to vaccination against the person's wishes. The benefits of this intervention would need to be weighed against the level of restraint needed to give it (which might cause significant distress and/or harm to the patient or those administering the vaccination), the effect upon the quality of the future therapeutic relationship, and the impact and significance of the immediate and possible side-effects suffered, with fatigue and pain being the most common local and systemic adverse events suffered.[38]

The degree of restraint—or measures taken to avoid the use of force, such as (possibly covert) sedation—will depend on a number of factors, including the patient's mental state, their values and wishes (past and present), and the degree to which they might resist. Certainly, the decision would need to weigh in the balance individual and external factors that would be different for each case, including (and for example) the number of unvaccinated patients and staff coming into the patient's vicinity who might place the patient at risk of infection and the extent to which risks could be mitigated in other ways, e.g. with the use of personal protective equipment (PPE).

A further challenge is that ethnicity is amongst the factors that contribute to harm from COVID-19, with consistent data showing that those from black and minority ethnic groups are at higher risk of greater illness severity.[39–41] This has led to focused educational campaigns to encourage individuals from such backgrounds to receive the vaccine.[42] There are also stark inequalities in detention statistics across mental health services for people from different ethnic backgrounds, and in particular for black African-Caribbean people. NHS Digital's MHA 1983 annual figures from 2020–21[43] set out that amongst the five broad ethnic groups, known rates of detention for the 'Black or Black British' group in England were over four times those of the 'White' group. In the context of psychiatric care, this opens up the problematic possibility that enforced treatment based upon perceived risk:benefit ratio might lead to greater impositions on individuals from minority backgrounds.

Conclusion

In this article we considered the legal frameworks applicable in England and Wales, and Scotland, to the issue of COVID-19 vaccination of individuals, including those who lack capacity, in inpatient psychiatric settings. We showed how the law requires a person-specific and fact sensitive approach to the vaccination of individuals who lack decision-making capacity. We engaged with the difficult and uncertain issue of whether vaccination can be imposed under mental health law. We outlined the relevant law in respect of advance refusals of treatment and how it might apply in a situation where COVID-19 vaccination is offered. We described the procedures applicable in the context of disagreement between proxy decision-makers. Finally, we briefly raised some ethical considerations relevant vaccination in this setting for this vulnerable population.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors would like to thank West London NHS Trust and Broadmoor Hospital for their financial support in making this article freely accessible by all.

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Notes

1. The European Convention on Human Rights and the European Court of Human Rights exist separately from the European Union. The Supreme Court's relationship with the Strasbourg Court is not, therefore, changed by the UK's exit from the European Union.
2. Capacity is time and decision-specific, and not a 'general' finding.

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