Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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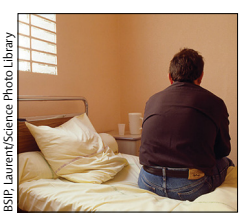
COVID-19 and involuntary hospitalisation: navigating the challenge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The COVID-19 pandemic has affected the psychiatric community in many ways. Aspects of psychiatric management and treatment have been addressed,[1,2] but legal and ethical aspects affecting clinical practice need equally to be considered.[3]

Physical distancing, isolation, and quarantine have become the worldwide mainstays of prevention of coronavirus spread. Although adhering to the constantly changing rules and regulations relating to COVID-19 is challenging for everyone,[4] it seems especially taxing for patients with psychiatric disorders. Increased anxiety, lack of insight, altered judgment, and dependence on others in everyday living, among other reasons, could interfere with their adherence to preventive measures. Thus, patients with psychiatric disorders might be more prone to violating the COVID-19 rules, leading to conflict with the authorities.

The problem of non-adherence to COVID-19 regulations has been addressed in several ways,[5] including forced isolation and hospitalisation.[6,7] Involuntary hospitalisation is a familiar concept to psychiatry. Since the beginning of the COVID-19 crisis, two of the authors (AG, RDS) have witnessed a noticeable number of patients referred for psychiatric evaluation after infringing COVID-19-related regulations. Thus, the following question arises: under what conditions does non-compliance with COVID-19-related rules justify psychiatric involuntary hospitalisation, and when might this extraordinary legal option be exploited in the service of public health?

Involuntary hospitalisation is generally restricted to patients who pose a proximate and serious risk to themselves or others. This basic tenet equally applies during pandemics. However, the COVID-19 crisis complicates risk assessment because even mundane behaviours could be considered dangerous. Moreover, the absence of data pertaining to the contagion risk of an individual in a specific situation makes it even harder to determine whether the evidence of dangerousness is clear and convincing, as required by minimum legal criteria for psychiatric involuntary commitment.[8]

In principle, higher levels of dangerousness might justify more restrictive means. Therefore, a higher level of restriction could be appropriate for patients with psychiatric disorders who are infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or who require preventive isolation (eg, because they are immunosuppressed), and who cannot adhere to preventive measures because of their acute disorder. Nevertheless, even in a high-risk situation, such as a patient with a psychiatric disorder who is infected with SARS-CoV-2, a psychiatric involuntary commitment might not be the most appropriate solution, especially in circumstances in which the patient is referred to a non-COVID-19 specialised psychiatric ward. Other therapeutic alternatives, as well as the possible risk to other patients on the psychiatric unit, should be considered.

COVID-19 might play a background role in patients' problematic behaviour (eg, a non-infected patient who repeatedly makes unwelcome physical contact with bystanders on the basis of a delusion of being able to convey supernatural protection against the virus). In this situation, the dangerousness derives from the psychotic behaviour but not from the risk of viral transmission. Thus, COVID-19-related exacerbation might justify an involuntary hospitalisation even in situations in which the patient is neither suffering from COVID-19 nor requires isolation.

However, in situations in which patients violate COVID-19 regulations due to chronic limitations that are secondary to severe mental illness, involuntary

commitment is not the most appropriate solution. This policy seems right even with regard to patients who place themselves in real danger by being in close proximity to a patient infected with SARS-CoV-2 (eg, a patient with diabetes and schizophrenia who does not fully understand the seriousness of the COVID-19 situation and frequently tries to visit her asymptomatic SARS-CoV-2-positive friend). In such situations, an involuntary hospitalisation is not likely to improve the patient's mental state. In fact, their ability to adhere to COVID-19 required distancing might be limited even on the psychiatric ward. There is no doubt that an intervention is required to protect these patients, but that alone does not justify involuntary commitment.

Situations that raise more ethical concern relate to individuals who are diagnosed with severe mental illness, are non-adherent to psychiatric follow-up, and possibly misuse alcohol or drugs. There is a high likelihood of these patients violating physical-distancing rules (eg, individuals who violate a quarantine to buy alcohol or drugs). Indeed, such behaviours could endanger other people and therefore they clearly require action by the relevant authorities. However, this risky behaviour is not related to an acute psychiatric condition. In such instances, not only is involuntary commitment unjustified, but had these individuals been involuntarily committed to a psychiatric ward, it would have constituted an abuse of the commitment law.

In sum, ensuring that the mechanism of involuntary hospitalisation is used appropriately during the COVID-19 pandemic is imperative to protect the interests of both patients and the community. Psychiatrists should not allow the involuntary commitment process to be exploited to ease COVID-19-induced public anxiety.

We declare no competing interests.

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