


Limits of remote working: the ethical challenges in conducting Mental Health Act assessments during COVID-19

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ABSTRACT

COVID-19 has created additional challenges in mental health services, including the impact of social distancing measures on care and treatment. For situations where a detention under mental health legislation is required to keep an individual safe, psychiatrists may consider whether to conduct an assessment in person or using video technology. The Mental Health (Care and Treatment) (Scotland) Act 2003 does not stipulate that an assessment has to be conducted in person. Yet, the Code of Practice envisions that detention assessments would be conducted face to face in all circumstances. During the pandemic, the Mental Welfare Commission for Scotland, a statutory body with a duty to promote best practice of the Act, has been asked whether it may be acceptable and indeed preferable for some assessments to be conducted via video technology. Where an assessment is needed to determine if a patient needs to be detained, and where there is a need for social distancing or the need for 'shielding', remote assessments may in some circumstances be preferable. In this article, we outline the modification of the Mental Welfare Commission's previous outright rejection of virtual assessments as the pandemic progressed and discuss the ethical and legal issues the possibility of remote assessments has exposed. We also discuss the limits and when a virtual assessment is not considered ethical. As the pandemic moves from a state of emergency into a 'new normal' in psychiatric services during second, or subsequent, waves, the use and place (if any) of remote assessments for detention needs to be considered.

INTRODUCTION

AB is a 46-year-old unemployed man with a diagnosis of schizophrenia and an autoimmune condition, living in shared accommodation. When COVID-19 emerged in Scotland, AB became increasingly unwell with relapse psychosis symptoms previously well controlled. AB's access to a local support group for people who experience hearing voices was limited as it was forced to close. There were concerns about the need for a detention. As AB was shielding, due to underlying vulnerabilities, and lived in shared accommodation where a resident had tested positive for COVID-19, the appropriateness of a face-to-face assessment for a detention was questionable. The supported accommodation staff were concerned about the idea of a psychiatrist and social worker visiting to conduct a face-to-face assessment under the Mental Health

(Care and Treatment) (Scotland) Act 2003 ('the Act'). A care staff member suggested conducting the assessment on their mobile phone using Zoom. The psychiatrist contacted the Mental Welfare Commission for Scotland ('the Commission'), a statutory organisation with a duty to promote best practice as regards the operation and the observance of principles of the Act, for advice about whether this was permitted under the law.

The above case raises practical questions about: (A) whether an assessment can be done remotely and under what conditions, and (B) provisions in the Act and the Code of Practice regarding mental health assessments and whether these need amending during a pandemic. The ongoing need for social distancing during COVID-19 raises new questions about the value of face-to-face assessments and whether human contact in the context of a complex assessment for detention can be replicated on a two-dimensional screen. Clinical issues also include the role of smell or touch and, more widely, remote assessments alter the nature of the doctor-patient relationship. Ethical issues include the balancing of human rights duties and safeguarding rights to an individual, versus the duties to the wider state.¹

In discharging its duty to advice on best practice of the Act, the Commission operates an advice line that provides guidance on legal and ethical issues to practitioners. The above case, for which demographic and clinical details have been changed to protect anonymity, came to the attention of the Commission through the advice line and illustrates the limitations of remote mental health assessments. This article describes the ethical considerations the Commission applied to reach a revised view on remote assessments.

AMENDMENTS TO THE ACT IN RESPONSE TO COVID-19

During the early stages of the pandemic, the Scottish Government prepared for the potential implementation of emergency legislation in order to cope with pressures on health services. Schedule 9, part 2 of the Coronavirus Act 2020 (UK) ('the Coronavirus Act') made amendments to the Act to provide for, for example, a longer period for detaining patients.² A summary of amendments the Coronavirus Act made to civil detentions, in the event they would be needed, is provided in [box 1](#).



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Box 1 Amendments to civil detentions as per the Coronavirus Act, Schedule 9, part 2

Nurse's holding power

Extended from 3 hours to 6 hours.

Emergency Detention Certificate (EDC)

A 72-hour period of detention. Extended from 72 to 120 hours.

Short-Term Detention Certificate (STDC)

A 28-day period of detention in hospital. Can be granted by an approved medical practitioner (AMP) without consent of a mental health officer (MHO) and can be renewed once and with this 'second certificate', which can be granted before the expiry of the first certificate, a short-term detention can last up to 56 days rather than 28 days. An approval by an AMP for a second certificate needs to record the reasons why it has been impracticable to apply for a CTO.

Compulsory Treatment Order (CTO)

A 6-month period of detention in hospital, or of compulsory treatment in a community setting. Application can be made with a single AMP recommendation rather than two, set aside conflict of interest other than those relating to familial relationship, medication can be given after 8 weeks on request of a designated medical practitioner (DMP) review by an AMP even without the DMP having issued a certificate, suspension of mandatory CTO reviews and mental health tribunals to be able to include two rather than three members.

The passing of the Coronavirus Act was swift in the face of the pandemic, but concerns about potential issues relating to safeguarding patients' rights were raised and continue to be raised in mental health and human rights literature.^{3,4} Politically, the provisions extending detentions and limiting safeguards remain contentious. In Scotland, the Equalities and Human Rights Committee of the Scottish Parliament has explored these issues as part of its ongoing inquiry.⁵ The widespread shortages of workforce the Coronavirus Act was designed for have fortunately not transpired and developed measures were not 'triggered'. However, the ability to trigger these currently remains in statute and could be implemented at ministerial discretion. The changes were designed with workforce shortages rather than social distancing in mind.

Delivery of care throughout the National Health Service has changed during the pandemic and the 'new normal' has forced us to explore how mental health services can operate in socially distanced ways. With continuing need for restrictions and 'lock-downs' it poses questions about what healthcare we can deliver remotely. On 30 July 2020, Matt Hancock, the Secretary of State for Health and Social Care in the UK Government,¹ reported that 'only 3% of doctors before going into this crisis offered video consultations. That is now 98%'.ⁱⁱ While indicating that most health services have moved to remote modalities, it also highlights that some consultations are not, and perhaps should not, be undertaken remotely. We believe most mental health assessments for detention fall into this category.

ⁱMr Hancock's responsibilities extend only to England as health and social care are devolved.

ⁱⁱBBC Radio 4 Today programme, 30 July 2021 (this programme is no longer available online).

Little ethical or legal guidance exists on this aspect of mental healthcare, though a recent article regarding involuntary commitment in Germany during the pandemic noted the need for individual assessment of legal and ethical justifications. Furthermore, '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' (p 8).⁶

The ways in which services have had to adapt have resulted in ongoing uncertainties about how ethical rapidly adopted new processes are. The ethical guidance published by the Scottish Government on 29 July 2020 set out the need for establishing regional ethical advice and support groups to guide decisions around necessary changes to care provision.⁷ This guidance did not specifically address mental health services or the challenges arising from conducting mental health assessments for patients who may require detention under the Act. However, the guidance refers to using existing mechanisms to seek ethical advice, including directing practitioners to the Commission.

CHANGING POSITION AROUND REMOTE ASSESSMENTS

The Commission's view prior to the pandemic was that assessments should take place face to face. However, in certain and limited situations a remote assessment might be permissible. During the course of the pandemic, the Commission's view remains that assessments for Emergency Detention Certificates, Short-Term Detention Certificates (STDCs) and new Compulsory Treatment Orders (CTOs) ought to be face to face. The renewal of a CTO, conversely, might be preferably undertaken remotely with the consent of the patient for this assessment to take place 'virtually'. This repositioning supported the possibility of patients who have existing relationships with psychiatrists to have assessments undertaken remotely, such as the renewal of CTOs. While the Commission position is not a legal view, it has influence on the sector. Participation in this process is key as the method of assessment should not be forced on the patient, but respect the patient's preferences. Participation through actively sought consent is the most important factor—this prevents the situation where someone with reduced cognitive abilities and unable to consent to a video assessment might have their detention renewed without them being seen face to face.

New considerations

The new position leads to new considerations; what factors might a patient or service user be reasonably expected to take into account when consenting to a remote assessment? How would a professional demonstrate consent to participate in this process and how would that participation impact on decision-making to recommend ongoing detention? In what ways are remote assessments different, both materially and subjectively, from 'normal' face-to-face assessments? We are still in the process of considering how we work in these ways and take forward changes that the pandemic has necessitated or accelerated.

Differences in approaches to the use of remote technology are now emerging. In England and Wales, the lawfulness of remote assessment arose for decision in the case of *Devon Partnership NHS Trust v Secretary of State for Health and Social Care NHS Commissioning Board*.⁸ Under the relevant provisions of the Mental Health Act 1983, applications for detention can only be made by someone who has 'personally seen' the patient in a recent 14-day period, and the supporting medical recommendations

must come from practitioners who have ‘personally examined’ the patient. The Court concluded that for the purposes of interpretation, the context should not be as of 1983, since that Act had merely been a consolidating statute; the relevant time was 1959, the date of the preceding Act. Seen in that light, physical attendance on the patient was a necessary part of both concepts, and remote assessment did not fulfil the statutory criteria. Any change to the law in England and Wales would be for Parliament.

In Scotland, wording identical to that examined in the *Devon* case formed part of the equivalent provisions in the Mental Health (Scotland) Act 1984, but was not repeated when the Act was passed in 2003. The Act refers only to requirements for applicants to ‘interview’ the patient, and that two medical practitioners shall each conduct a ‘medical examination’, without specifying modality. The Commission took the view that the guidance provided remained fit and proper and emphasised the need for determination of modality to be informed by the above considerations and, crucially, adding considerations of a competently made choice to have a remote examination in the specific circumstances. We explore this further in subsequent sections.

There may also be United Nations Convention on the Rights of People with Disabilities challenges to the view that consent for participation in a remote assessment is required when linked, as above, with cognitive abilities as this position may be seen as discriminatory and preventing those with limited capacity from participation. Despite the ‘relaxing’ of the position around assessments for renewals of CTOs the Commission did not go further. The Commission continues to hold that assessments for new detentions must be done face to face. In the following section, we consider the evidence and ethical considerations that underpinned the changed position on virtual assessments in Scotland.

THE EVIDENCE AND ETHICS OF TELEPSYCHIATRY FOR DETENTION

While mental health services have had to adapt and use remote technology, little evidence exists for how this modality works in the context of detentions. A recent review of the limited evidence on the use of telehealth for psychiatric emergencies suggested that it can be cost-effective, reduce admission rates and length of hospitalisation, increase confidence of professionals, has validity similar to face-to-face care and has been evidenced as satisfactory among patients and practitioners.⁹ The review also showed that implementation to date has primarily been areas with higher needs, such as rural locations or in large emergency departments. However, evidence for treatment of patients with severe mental illness is scarce, and many services exclude patients who are suicidal.⁹ Furthermore, a systematic review of trials of telehealth services for individuals with severe mental illness included interventions such as medication adherence, patient education and self-management. The authors concluded that ‘not all technology is effective, depending on the outcome of interest’ and some interventions did not have better outcomes than nurse-based interventions and had lower acceptability.¹⁰

While the evidence suggests telehealth may be beneficial for some conditions, in some circumstances and for some interventions, the personal contact may be essential in specific situations like assessment for detention. We believe that the interaction in face-to-face situations during a mental health consultation is vital. Establishing rapport and a good relationship between patient and psychiatrist is key for optimal treatment,¹¹ yet individuals with severe mental disorders might have more difficulties in accessing, for example, online therapy.¹²

In developing guidance as the pandemic progressed, there was no firm evidence base to draw on to inform the ethical dilemmas that transpired regarding conducting remote assessments.

Evidence gathered by the Commission

The Commission routinely and continuously gathers information from people with lived experience to inform its approach to issues in the mental health sector. This information is anonymised and reported on the Commission website.¹³ Information gathered about teleconsultations during the lockdown indicated varying views. Generally, people preferred face-to-face contact, but felt that video consultations are ‘better than nothing’. Some described anxiety about the process as they did not think professionals could adequately assess how they were feeling and acting. The virtual presence of a professional in their own home made them feel unsafe. Some people were also very wary of the technology, uncomfortable with etiquette and practical problems that can occur when using it. Confidentiality was a concern for some individuals and they described having had practitioners’ family members coming into the room during the assessment. Others described feeling safer with a virtual assessment, as they saw their home as a safe haven. Some people described how remote assessments were helpful when they lacked energy or motivation to leave their home and that it removed the discomfort they felt about being assessed in person when they felt too unwell.

Royal College of Psychiatrists’ guidance

The challenges presented by the need for social distancing and limiting contacts by both patients and clinicians have been reflected in considerations from the Royal College of Psychiatrists (RCPsych). An important aspect of these challenges is ensuring that individual needs are not secondary to collective needs.¹⁴ The public health duties around social distancing, however, must be balanced against the needs for robust safeguards against infringements of a person’s autonomy. The RCPsych also provides recommendations for remote consultations, which are encouraged where safe and appropriate to limit contact between patients and clinicians. Normally, remote consultations should be an addition to, rather than substitute for, in-person consultation. The RCPsych guidance acknowledges that judgements about in-person consultations being default may not be possible under current circumstances.¹⁴ However, the RCPsych guidance does not directly address detention assessments remotely.

CURRENT LEGAL SITUATION IN SCOTLAND

For medical examinations relating to assessments under the Act, the accompanying Code of Practice appears to refer to in-person interviews.¹⁵ Importantly, if the patient refuses to consent to the examination, ‘the medical practitioners and the Mental Health Officer (MHO) will need to decide whether they have each been able to carry out a good enough assessment’.¹⁵ In case reports we have studied, the use of telepsychiatry in these circumstances was not challenged by legal representatives. It is not possible to say what the outcome would have been had these assessments been challenged. In these cases, it appeared that either the service user was previously known to the psychiatrist and/or that the service user agreed to the interview by remote link. Therefore, an interview in person must be considered to be the envisaged method of examination. An interview by remote video link must be regarded as an exceptional situation. It would be a matter for the Mental Health Tribunal Scotland to decide whether evidence gathered based on a remote interview is sufficient to meet the necessary criteria for authorising a detention.

Exceptional circumstances could be construed as instances where transport difficulties and/or time restrictions and/or impracticalities for the patient or healthcare worker to travel exist. For example, a patient from a remote island admitted to a hospital on an STDC on the mainland may choose to have their general practitioner from their island assess them for a CTO report by video link. If the position therefore is that assessments should be conducted in person, with assessments by video or telephone only permissible in exceptional circumstances, we can start to explore the factors to be taken into account in deciding whether to proceed with video or telephone assessments for detention.

FACTORS TO BE CONSIDERED IN UNDERTAKING A VIRTUAL ASSESSMENT UNDER THE ACT

The individual's capacity to consent to a virtual assessment must be considered in conjunction with the reasons to consider a telephone or video assessment. During the pandemic, these reasons may include the desire to reduce infection transmission by minimising physical movement of people. This is a particular concern if the professional will be entering into an environment otherwise free from COVID-19. Other considerations include the availability of professionals who could see the person face to face, if the person is shielding and whether the person can consent to a professional who has prior knowledge of the individual undertake the assessment.

Factors which may encourage telephone or video assessments may include the availability of the digital technology, especially for the patient, and its reliability; the lack of adequate personal protective equipment (PPE); and perhaps importantly, the patient's sense of whether an assessment conducted remotely is thorough and fair. Clearly, there will be no moral justification for conducting digital assessments merely for the convenience of professionals. However, what if the patient insists on a digital assessment, citing infection risk as the reason, even when professionals are able to attend in person?

These factors, and several others, will interact in a complex way to help guide the decision—and there will be circumstances in which all indicators point to carrying out an assessment by telephone or video, but a decision is made that an assessment in person is still required. Each case will turn on its own merits, and at different times, different factors will take primacy. For example, if the individual is already deprived of their liberty, such as when the assessment is for transfer from a custodial setting to hospital, and the clinical presentation requires an urgent transfer, and arranging an in-person assessment will introduce a severe delay, an argument could be made for carrying out a video assessment, possibly even if the patient declines to consent. But in these cases, the clinical urgency will be high, and the risk of delay will be a significant risk to life or limb. Another consideration must be the availability of support and follow-up after the assessment. If the assessment results in a detention, this includes practical issues to ensure that the individual is informed of and understands their rights and a safety mechanism for conveyance to the place of detention is in place.

Considerations going forward

As noted, for example, in Germany, justification for detention against infection control measures needs to be individually assessed.⁶ An oversight group involving stakeholders

from across the sector led by the Commission was constituted and remains poised and ready to provide oversight on use of any emergency provisions that may need to be triggered. However, currently the Act and its requirements remain the legal framework governing detentions. Prior to the pandemic, the issue of whether or not the Act allows for assessments to be made remotely had been raised only rarely. However, during the early phases of the pandemic and again in the winter of 2021 with the resurgence of cases these exceptional circumstances are occurring more often. During this 'new normal' it is therefore imperative to ensure that patients' rights are safeguarded, while also recognising that innovative approaches have been helpful to patients and those important to them. These approaches need to be available for use where appropriate.

A revised position has been published by the Commission, stating that in some cases remote assessments may be preferable rather than a second choice. Three considerations guide the decision on modality: (1) criteria for detention must be fully assessed regardless of assessment modality; (2) new detentions should normally continue face to face while second CTO reports or extensions of a CTO or Compulsion Order could preferentially be conducted virtually by a professional familiar with the patient's history, if the individual being assessed provides informed consent to this; and (3) patient participation and consent for remote technology is vital to minimise distress. The latter is an important consideration in remote assessments, as evidence of patient experience of detention under mental health legislation in general is that distress and lack of participation are commonly described by those with lived experience.¹⁶

With the issues that the pandemic has presented to psychiatry and mental health services, future training of mental health professionals should include how to conduct assessments under mental health legislation and provide treatment using online platforms, to be prepared for similar situations in the future.¹⁷ Research into outcomes and impact of virtual assessments is also needed to inform future clinical practice.

CONCLUSIONS

In the case described above, the Commission view was that this person required to be assessed face to face, with appropriate PPE, and necessary local health protection arrangements. Without an existing relationship with the patient, or a renewal of a CTO, the Commission regarded it a case where a virtual assessment would not address key considerations and an in-person assessment was more appropriate. While evidence for the use of telepsychiatry in general is promising, its use for detention is lacking and has many ethical issues. The COVID-19 pandemic has made it necessary for clinicians to adapt to remote ways of working in order to protect themselves and their patients, but as we argue there are limits to working remotely in mental healthcare and treatment. In this article, we have outlined the challenges which led the Commission to 'relaxing' the view on face-to-face assessments and where a 'red line' is considered to sit. Continuity of care and patient participation are key principles to guide these decisions, of which the latter is enshrined in the Act. The Commission will continue to review its position on socially distanced operation of the Act, particularly as services remobilise, and any potential need for triggering the measures of the Coronavirus Act. We stress that the 'relaxation' is not a lowering of standards but

an attempt to harness aspects of our technological response to the pandemic that have been accelerated and that we may wish to retain in a post-COVID world.

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REFERENCES

- 1 European Court of Human Rights. *European convention on human rights*.
- 2 Coronavirus act act 2020 2020.
- 3 Davies R. What does the coronavirus act 2020 mean for mental health nursing? | nursing times. Nurs. times, 2020. Available: <https://www.nursingtimes.net/roles/mental-health-nurses/what-does-the-coronavirus-act-2020-mean-for-mental-health-nursing-24-04-2020/> [Accessed 27 Aug 2020].
- 4 Stavert J, McKay C. Scottish mental health and capacity law: The normal, pandemic and 'new normal'. *Int J Law Psychiatry* 2020;71:101593.
- 5 Scottish Parliament. Impact of COVID-19 pandemic on Equalities and human rights, 2020. Available: <https://www.parliament.scot/parliamentarybusiness/CurrentCommittees/114975.aspx> [Accessed 3 Sep 2020].
- 6 Gather J, Juckel G, Henking T, et al. 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. *Int J Law Psychiatry* 2020;73:101615.
- 7 Scottish Government. COVID-19 guidance: ethical advice and support framework, 2020. Available: <https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2020/04/coronavirus-covid-19-ethical-advice-and-support-framework/documents/covid-19-cmo-ethical-advice-and-standards-3-april-2020/covid-19-cmo-ethical-advice-and-sta> [Accessed 27 Aug 2020].
- 8 Devon Partnership NHS Trust v Secretary of State for Health and Social Care. [2021] WLR(D) 62, [2021] EWHC 101 (Admin). Available: <https://www.bailii.org/ew/cases/EWHC/Admin/2021/101.html>
- 9 Reinhardt I, Gouzoulis-Mayfrank E, Zielasek J. Use of Telepsychiatry in emergency and crisis intervention: current evidence. *Curr Psychiatry Rep* 2019;21(8):6–13.
- 10 Lawes-Wickwar S, McBain H, Mulligan K. Application and effectiveness of telehealth to support severe mental illness management: systematic review. *JMIR Ment Health* 2018;5(4):e62.
- 11 Priebe S, McCabe R. Therapeutic relationships in psychiatry: the basis of therapy or therapy in itself? *Int Rev Psychiatry* 2008;20(6):521–6.
- 12 Athanasopoulou C, Välimäki M, Koutra K, et al. Internet use, eHealth literacy and attitudes toward computer/internet among people with schizophrenia spectrum disorders: a cross-sectional study in two distant European regions. *BMC Med Inform Decis Mak* 2017;17(1):136.
- 13 Mental Welfare Commission for Scotland. What people tell us, 2020. Available: <https://www.mwscot.org.uk/policy-and-research/what-people-tell-us> [Accessed 14 Sep 2020].
- 14 Royal College of Psychiatrists. Digital - COVID-19 guidance for clinicians, 2020. Available: <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians> [Accessed 27 Aug 2020].
- 15 Scottish Executive. Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 2 – civil compulsory powers (parts 5, 6, 7 & 20).
- 16 Akther SF, Molyneux E, Stuart R, et al. Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open* 2019;5(3).
- 17 Jurcik T, Jarvis GE, Zeleskov Doric J, et al. Adapting mental health services to the COVID-19 pandemic: reflections from professionals in four countries. *Couns Psychol Q* 2020;8(3):1–27.