FRONTLINE PERSPECTIVES

Peer Reviewed

Ethical Challenges on an Inpatient Involuntary Psychiatric Unit in the Time of COVID-19

Gwen Levitt DO DFAPA
Attending Psychiatrist and Director of Research - Department of Psychiatry District Medical Group, University of Arizona Medical School, Mayo Clinical College of Medicine and Science, and Midwestern University, USA

Abstract

Ethical challenges with respect to autonomy, beneficence, non-maleficence, and justice can occur in the treatment of involuntary psychiatric inpatients related to the management of COVID-19. Patient autonomy can be challenged by COVID-19 testing, quarantine, infection control policies, and limitations on discharging patients to the community. During a pandemic, the obligation of beneficence includes providing treatment while ensuring that patients follow infection control protocols. Non-maleficence may be challenged by holding patients in a high risk setting for infection and by restrictive measures such as seclusion, restraints, and forced medications related to aggression displayed by patients refusing to quarantine. Justice can be tested when hospital bed capacity is reduced to accommodate quarantined patients or when discharges are delayed due to quarantine for COVID-19. Even after over two years, the ethical issues brought up by the COVID-19 pandemic remain difficult to balance.

Key words: ethics, involuntary psychiatric patients, COVID-19

Introduction

The four pillars of ethics, autonomy, beneficence, non-maleficence, and justice must hold up the roof of human dignity. Involuntary psychiatric hospitalization has always challenged the core concepts of medical ethics which, in turn, has generated laws and statutes to protect the rights of

those civilly committed to psychiatric facilities. The COVID-19 pandemic posed new ethical challenges for involuntary patients as confinement occurs in what is inherently a high-risk setting for contagious illness with patients residing in communal settings while on psychiatric units. Psychiatric units are designed to encourage social interaction via communal dining, group activities, and common areas (Li, 2020). In addition, rooms are typically multi-bedded, and patients and staff often move about the facility for activities and for safety issues. All these factors can impact the ability of a psychiatric hospital to mitigate a highly infectious illness.

This paper describes policy and procedure changes enacted by a large urban involuntary psychiatric facility (over 300 beds) to safeguard the health and safety of patients and staff during the COVID-19 pandemic. A new set of challenges and the impact on ethical principles related to these changes will be outlined.

Infection Control

Infection control policies (ICP) are critical for preventing the transmission of communicable illnesses (Peters et al., 2018). During the COVID-19 pandemic, the inpatient psychiatric hospital in which the author works made many ICP changes:

- **Restriction of personal visits:** The hospital prohibits visitors including outpatient care teams who assist in planning patients' discharges. Teleconferences are utilized for treatment planning, mental health court, and attorney consultations.
- **Admissions Observation Units and admission protocols:** The facilities designated Admissions Observation Units (AOU) are used to quarantine one patient per room for all admissions. (The AOU change decreased the hospital's capacity by 30 beds.)

  Initially, patients were transferred off the AOU after testing negative for COVID-19. With learning of the 14-day viral incubation period, false negative test results early in the infection, and observing patients convert from negative to positive after several days, quarantine continued for 72 hours, and patients must remain symptom-free.

- **Preventive measures by staff:** Hospital staff are required to a wear a mask and face shield when in patient care areas. Staff were asked to take their temperatures and by clocking in attesting that they are asymptomatic. Video/teleconferencing replaced in-person meetings.

  AOU and "COVID-positive unit" staff wear full personal protective equipment (PPE). Videoconferencing is utilized to evaluate quarantined patients.

- **Preventive measures for patients:** Social distancing was encouraged throughout the facility (CDC, 2020). Common areas were reconfigured to create space for social distancing. Group activities were halted. Meals were delivered to the units rather than using the dining hall.

Utilization of electronics: Cell phones, normally prohibited, are provided in quarantine areas with pre-selected internet sites to utilize for calls and entertainment.

Impact of Infection Control Measures

ICP are designed to protect all patients and staff in the communal setting but come at the expense of privacy and comfort for the individual patient.

- **Acute illness and cognitive impairment:** Acute psychiatric symptoms and cognitive impairments can interfere with patients' abilities and/or willingness to follow ICP (Hernández-Huerta et al., 2020; Luykx et al., 2020, Yao et al., 2020; Smith & Lim, 2020; Moreno et al., 2020). To avoid ingestion of hand sanitizer by patients, psychiatric facilities use non-alcohol-based hand sanitizers which are ineffective against COVID-19 (Berardi et al., 2020) forcing the facility to change products. Psychiatric patients may have issues maintaining personal hygiene and require reminders to perform these tasks. Patients may become anxious or suspicious when staff members attempt to assist them with activities of daily living (Wang et al., 2020). Constant redirection from staff to follow ICP can be annoying to patients (and staff) but may also trigger patients to become anxious or paranoid, and to respond with negative behaviours.

  A recent study found that 78.4% of inpatients on a COVID-19 triage unit were non-compliant with infection control measures. Even with education, only 44.9% began wearing a mask (Williams et al., 2021).

- **Impact of use of PPE:** Face masks obscure the mouth, muffle the voice, and impersonalize the wearer impacting personal interactions (Bojdani et al., 2020). Patients with cognitive or hearing impairments may struggle to hear and understand staff wearing a mask. Some patients may not be able to identify who is speaking (Wang et al., 2020). A mask can make it hard to interpret the objective emotions of the wearer. (Pal et al., 2020). Full PPE can create uncertainty and fear in a psychiatric patient (Veluri, 2020). Patients may not like the feel of the mask or simply refuse to wear it. Again, constant directives from staff may cause patients to experience undue anxiety or agitation.
- **Quarantine:** Movement of patients on and off quarantined units is restricted and impacts admissions and discharges.
- **Confinement**: Being confined to one room can cause agitation or aggression. If a patient refuses to quarantine, he/she could be placed in a locked room, a form of restraint, which necessitates constant observation. While quarantined, patients are often confined with other peers who they may not otherwise choose to spend time with and/or who may be engaging in disruptive or concerning behaviour due to their mental illness. Staff interaction is decreased as they do not enter rooms unless necessary. Since there often is not a shower in the room, bathing occurs via a cumbersome process to maintain ICP.
- **COVID-19 testing:** Testing for COVID-19 is critical for identification, tracking, and containment (Van Beusekom, 2020). Testing is mandatory and if a patient refuses, quarantine continues for 14 days or until tested, if the patient refuses to be swabbed.
- **Remote interviewing:** Staff monitor, and at times hold, the cellphone video device during interviews to help patients utilize them correctly and safely. This close contact creates a higher risk for transmission. Some patients are suspicious of the technology, believing the interview may be recorded or broadcast. Due to the device's small screen, providers can see only the patient's face making it difficult to assess physical issues such as abnormal movement. Noise causes significant interference during interactions (e.g., people speaking nearby and rustling of PPE gowns). For some patients, locating the source of the voice is disorienting and frightening.

Prior to the pandemic, patients met with their providers in small interview rooms that

cannot accommodate social distancing and have limited ventilation. During the pandemic, COVID-negative patients are interviewed in the larger dayroom or at bedside which interferes with privacy causing somepatients to be unwilling to disclose information. Without direct observation by family and outpatient teams, the ability to ascertain treatment response and/or readiness for discharge is impacted.

Legal proceedings must be conducted in a private area that is free from interruption. So these activities had to be conducted via videoconference and take place in the interview rooms which are confined spaces Sstaff must be present to supervise the patient making it impossible to maintain social distance. Legal advocates meet with patients, but often not in private and/or using teleconferencing. This may impact patients' understanding of these complex processes.

- **Treatment limitations**: Group activities are limited in size and scope to accommodate ICP. Quarantined patients are given activity items such as word games, colouring projects, reading materials, cards, and puzzles to occupy their time. Daily assessments and psychotherapy are completed by videoconferencing , at bedside, or from the doorway to the room for quarantined patients, neither of which provides privacy. Similarly, these activities occur in the patient's room or in the common areas for patients not on quarantine. Psychological testing cannot be accomplished in quarantine. Physical and occupational therapy are very limited and non-urgent medical tests are often delayed until the patient is no longer quarantined.
- **Electroconvulsive therapy** (ECT) is significantly impacted by ICP and is frequently interrupted by quarantines (Espinoza 2020). ECT is restricted during COVID-19 surges due to reduced bed availability in medical areas and staff shortages.
- **Bed shortages**: Bed availability for new admissions is limited by COVID testing, creation of the AOU and the inability to move patients on to quarantined units. Staff shortages due to illness, burn-out, and resignations also cause administration to halt admissions and close units to maintain safe levels of patient-personnel staffing ratios. While patients who can continue to quarantine after discharge may leave, no new patients can be admitted to a quarantined unit. This causes a further decrease in available beds.

- **Discharge:** Most community placements decline to accept quarantined patients irrespective of a negative COVID test. Some patients have a home but lack the necessary space or are simply unwilling to quarantine after discharge. While waiting for quarantine to end, patients remain confined, prolonging their potential exposure to COVID-19.
- **Legal process:** In civil commitment proceedings, due process requires various legal procedures, filings, and deadlines. Legal documents are provided to patients and can contain legal jargon and descriptions of the behaviours that led to hospitalization (which often can be upsetting to patients). Patients having access to legal counsel to assist in this process is affected. With consultation occurring virtually, the patient's ability to interact effectively with counsel and counsel's ability to ensure their client's understanding of the process may be limited.

Ethical Challenges

The response to COVID-19 and ICP present a host of ethical challenges for involuntary psychiatric patients.

- **Involuntary placement:** Beneficence outweighs patient autonomy in the civil commitment process. It is the clinician's ethical obligation to do what is in the best interest of the patient to treat an acute mental illness and avoid deterioration and/or reduce risk of harm to self and others. States created procedures for civil commitment involving judicial review to protect patient autonomy within the context of involuntary treatment (Anfang & Appelbaum, 2006). Non-maleficence and beneficence are impacted by placing an involuntary patient in an environment that is high-risk for contracting a serious communicable disease such as COVID-19.
- **Court proceedings:** Court proceedings can be intimidating. The adaptations undertaken to decrease risk of infection, while necessary, negatively impact engagement in the processes intended to protect patient autonomy and thereby challenge the goals of beneficence and non-maleficence.
- **Bed availability:** As the region's only acute, involuntary psychiatric facility the bed loss widely impacted local medical and psychiatric emergency rooms and hospitals. Acute psychiatric patients are left without the intensive psychiatric care they require, but also

filled urgently needed emergency and medical beds. Patient autonomy is affected in several manners. Patients requiring emergency psychiatric services are often involuntary and cannot opt for alternative care or be discharged. Once admitted, patients are immediately quarantined to be cleared of COVID-19 and have limited access to therapeutic, recreational, and social activities.

Beneficence is challenged as patients are placed on a psychiatric hold, not receiving needed mental health care in an emergency room or medical bed and are unable to leave the hospital.

Justice is not served as patient backlogs limit the ability of others from accessing scarce medical and psychiatric resources. Hospitals suffer financial losses when insurers refuse reimbursement for services rendered to patients awaiting transfer because they are not requiring medical interventions.

Indirectly, non-maleficence is impacted both because necessary psychiatric care is delayed, and the patient is confined to an environment where risk of COVID-19 transmission is high.

- **Quarantine and ICP measures:** Quarantine impacts autonomy in perhaps the most fundamental regard: inhibiting a patient's freedom to move about. This restriction of freedom is compounded for an involuntary patient who is being held on a locked unit and cannot opt for an alternative.

  Psychiatric hospitals strive to provide therapeutic environments that promote stabilization and development of healthy coping skills. Medication management alone, which is the main modality of treatment while in quarantine, is not typically adequate to fully treat a patient whose symptoms are so severe as to warrant involuntary hospitalization. While quarantine does protect the health of a group of patients, the quarantine environment is far from therapeutic on the individual level thus non-maleficence and beneficence are hampered

  Enforcing ICP curtails patient autonomy. In some respects, these protective measures are coercive in the inpatient setting because if a patient refuses to comply, he/she may be quarantined.

Quarantine isolates the individual which can be detrimental to their well-being, especially those with serious mental illness. Quarantine severely limits a patient's access to the phone, media, visitors, and other pro-social activities. The principal of beneficence takes precedence and non-maleficence becomes a two-sided coin; quarantine is meant to protect patients from infection, but the isolation can be psychologically detrimental.

- **Crisis management: Crisis measures** also impact autonomy, non-maleficence, and beneficence. A patient who refuses to abide with quarantine requirements poses a challenge for staff. When verbal redirection fails, staff may have to intervene to stop a patient from leaving quarantine possibly causing agitation or violence. If the latter occurs, staff may need to seclude, restrain, and/or medicate the patient against his/her will. In addition to the risk of physical injury, staff also risk viral exposure through the direct contact inherent in these processes.
- **Privacy and confidentiality:** Privacy and confidentiality are an inherent part of ethical care and lack of one or both is maleficence. Patient autonomy dictates protection of privacy. The use of video/teleconferencing for interviews and court has the potential to violate patient confidentiality and privacy as patients are supervised by staff while handling electronic devices, and they may also be quarantined with other patients and have no privacy. In-person assessments are similarly problematic, taking place from the doorway of a shared room or in open dayrooms.
- **Discharge planning:** Quarantine frequently impacts discharge planning and timing and can unnecessarily extend the length of stay. Extending the length of stay for a stable patient impacts autonomy. Patients cannot access more varied outpatient treatment options thus challenging beneficence. Patients become demoralized by an extended stay which can prompt a regression of a previously stable state which could be seen as maleficence. The inability to admit new patients creates a burden on needed medical or emergency beds and impacts costs when insurers refuse to reimburse for care of patients no longer meeting criteria for continued hospitalization. This added financial strain negatively impacts justice.

Discussion

The American Medical Association's Code of Ethics states, "A physician shall recognize a responsibility to participate in activities contributing to the improvement of community and the betterment of public health." This is expanded further to say that physicians "support mandatory quarantine and isolation when a patient fails to adhere voluntarily." While quarantine and isolation are critical components of infection control, such restrictive measures should not be taken lightly. All inpatients are subject to the same rules and expectations and employing these in a uniform manner is perhaps the only equitable way to approach enforcement of ICP. Patients who are unwilling or unable to follow protocols can require a disproportionate amount of time and staff resources.

Aristotle said, "Nothing hinders us from doing or choosing something that makes us have control." Many believe free will is an American right and this notion has been the basis of caustic public debate surrounding COVID-19 in the United States. People have various beliefs about masks, vaccinations, social distancing, shelter-in-place, and quarantine. Local and state governments have varied widely in the level of precautions mandated in the community.

The level of precautions taken in a hospital are not optional and are more restrictive, given the vulnerability of medically compromised patients and known potential for hospital-acquired infections. Protecting patients from infection is an example of beneficence but sacrifices autonomy when forced. The ethical challenges occur when deciding on the appropriate response to take with patients who are unwilling or unable to follow ICP. Staff can request that a quarantined patient remove themselves from common areas, but the patient can refuse to comply with the request. Forcing a patient to remain in his/her room involuntarily constitutes a seclusion. Balancing how far staff should go to ensure that a patient remains quarantined at the risk of instigating an aggressive response is difficult to gauge. Where the line is drawn to address the uncooperative person while protecting other patients and staff is a challenge. That line may need to move in response to those who are unwilling as opposed to those patients who are unable to adhere to ICP.

The ethical responsibility to protect psychiatric inpatients from infection is arguably even greater when hospitalization is forced. The duty of non-maleficence seems straightforward in principle, but in practice clashes with autonomy when patients are involuntary and compelled to comply with ICP. As elaborated above, the level of infection risk in a psychiatric facility may be even greater than

a medical hospital given the communal setting. Thus, the level of precautions taken is expected to be commensurately higher to protect patients from contracting infection.

It has been posited that quarantining the seriously mentally ill can, in some cases, be beneficial particularly for those who engage in high-risk behaviours, are at risk for severe illness or death from COVID-19,or are unable to comprehend the seriousness of the pandemic and safety measures. These vulnerable patients might be best protected, as would the public, by quarantining the patient via civil commitment as a preventative measure (Sorrentino et al., 2020). It is conceivable that inability or refusal to follow safety measures could be construed as being a danger to self, a danger to others, or at risk of deterioration under civil commitment statutes. Thus, beneficence outweighs patient autonomy.

Conclusions

Psychiatric professionals are faced with daily ethical dilemmas when providing care to mentally ill patients when pursuing civil commitment, seclusion, restraints, and/or forced medication. These responsibilities have been counterbalanced in each state by a framework of laws and statutes to protect autonomy and prevent undue infringement on patient rights. Legal due process aids in balancing patients' desires and best interests with their need for treatment. COVID-19 has placed the spotlight on the ethical impact of infection control measures in an inpatient setting. The lack of clear-cut answers for many questions reflects the complexity that persists even after two years of the pandemic. As medical professionals, we have an important role to play not only to ensure our patients are cared for but also to refrain from doing harm in providing care. It is hoped that sharing these ethical challenges that the author has encountered will contribute to the collective knowledge base regarding how ICP impacts daily life on a psychiatric unit. The pandemic has given us reason to pause and take a fresh look at the admonishment of the Hippocratic Oath to "Do no harm".

References

American Medical Association Code of Ethics. Accessed at topics/ama-code-medical-ethics.

Anfang, S. A., & Appelbaum, P. S. (2006). Civil commitment--the American experience. Isr J Psychiatry Relat Sci. *43*(3), 209-218.

Berardi, A., Perinelli, D. R., Merchant, H. A, Bisharat, L., Basheti, I. A., Bonacucina, G., Cespi, M., & Palmieri, G. F. (2020). Hand sanitisers amid COViD-19: A critical review of alcohol based products on the market and formulation approaches to respond to increasing demand. *International Journal of Pharmaceutics*, *584*, 119431. https://doi.org/10.1016/j.ijpharm.2020.119431

Bojdani, E., Rajagopalan, A., Chen, A., Gearin, P., Olcott, W., Shankar, V., Cloutier, A., Solomon, H., Naqvi, N. Z., Batty, N., Festin, F. E. D., Tahera, D., Chang, G., DeLisi, L. E. (2020). COVID-19 pandemic: Impact on psychiatric care in the United States, a review. *Psychiatry Research*, *289*, 113069. https://doi.org/10.1016/j.psychres.2020.113069

CDC. Medical Isolation of Confirmed or Suspected COVID-19 Cases. (2020). Accessed November 10, 2020 at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

Espinoza, R. T., Kellner, C. H., & McCall, W. V. (2020). Electroconvulsive therapy during COVID-19: an essential medical procedure: Maintaining service viability and accessibility. *The Journal of ECT*, *36*(2), 78-79. https://doi.org/10.1097/YCT.0000000000000689

Hernández-Huerta, D., Alonso-Sánchez, E. B., Carrajo-Garcia, C. A., & Montes-Rodrígueza, J. M. (2020). The impact of COVID-19 on acute psychiatric inpatient unit. *Psychiatry Research*, *290*, 113107-113107. https://doi.org/10.1016%2Fj.psychres.2020.113107

Li, L. (1010). Challenges and Priorities in Responding to COVID-19 in Inpatient Psychiatry. *Psychiatric Services*, *71*(6), 624-626. https://doi.org/10.1176/appi.ps.202000166

Luykx, J. J, Vinkers, C. H., Tijdink, J. K. (2020) Psychiatry in times of the coronavirus disease 2019 (COVID-19) pandemic: An imperative for psychiatrists to act now. *JAMA Psychiatry*, *77*(11), 1097-1098. https://doi.org/10.1001/jamapsychiatry.2020.1225

Moreno, C., Wykes, T., Galderisi, S., et al. (2020).How mental health care should change as a consequence of the COVID-19 pandemic. *The Lancet Psychiatry*, *7*(9), 813-824. https://doi.org/10.1016/S2215-0366(20)30307-2

Pal, A., Gupta, P., Parmar, A., & Sharma, P. (2020). 'Masking' of the mental state: Unintended consequences of personal protective equipment (PPE) on psychiatric clinical practice.

Psychiatry Research, *290*, 113178. https://doi.org/10.1016%2Fj.psychres.2020.113178

Peters, A., Otter, J., Moldovan, A., Parneix, P., Voss, A., & Pittet, D. (2018). Keeping hospitals clean and safe without breaking the bank; Summary of the Healthcare Cleaning Forum 2018. *Antimicrobial Resistance & Infection Control*, *7*(1), 132. https://doi.org/10.1186/s13756-018-0420-3

Smith, B. J., & Lim, M. H. (2020). How the COVID-19 pandemic is focusing attention on loneliness and social isolation. *Public Health Research & Practice*, *30*(2). https://doi.org/10.17061/phrp3022008

Sorrentino, R. M., DiCola, L. A., & Friedman, S. H. (2020). COVID-19, Civil Commitment, and Ethics. *J Am Acad Psychiatry Law*, *48*(4), 436-441. https://doi.org/10.29158/jaapl.200080-20

Van Beusekom, M. Studies. (2020). Hand sanitizers kill CVOID-19 virus, e-consult appropriate. Accessed June 16, 2020 at https://www.cidrap.umn.edu/news-perspective/2020/04/studies-hand-sanitizers-kill-covid-19-virus-e-consults-appropriate.

Veluri, N. (2020). Are masks impacting psychiatric inpatients' treatment? *Psychiatry Research*, *293*, 113459. https://doi.org/10.1016%2Fj.psychres.2020.113459

Wang, H., Li, T., Barbarino, P., Gauthier, S., Brodaty, H., Molinuevo, J. L., Xie, H., Sun, Y., Yu, E., Tang, Y., Weidner, W., & Yu, X. (2020). Dementia care during COVID-19. *Lancet*, *395*(10231), 1190-1191. https://doi.org/10.1016/s0140-6736(20)30755-8

Williams, R., Tweed, J., Rebolledo, L., Khalid, O., Agyeman, J., & Pinto da Costa, M. (2021). Patient adherence with infection control measure on a novel ‘COVID-19 triage” psychiatric in-patient ward. *BJPsych Open*, *7*(4), e131. https://doi.org/10.1192/bjo.2021.968

Yao, H., Chen, J. H., & Xu, Y. F. (2020). Patients with mental health disorders in the COVID-19 epidemic. *The Lancet Psychiatry*, *7*(4), e21. https://doi.org/10.1016/S2215-0366(20)30090-0

Acknowledgements: Sara Ashurst MD
Funding Source: None
Competing Interests: None
Address for Correspondence: Gwen_Levitt@dmgaz.org
Publication Date: April 7, 2023