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Ethical and Clinical Considerations During the Coronavirus Era

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The practice of child and adolescent psychiatry is evolving during an unprecedented global health catastrophe, the coronavirus disease 2019 (COVID-19) pandemic. As child and adolescent psychiatrists grapple with COVID-19's enormous medical, educational, social, and economic toll, a mental health crisis is co-occurring. Pre-existing disparities are recognized as contributors to the disproportionate impact of the COVID-19 pandemic on racial and ethnic minorities.¹ The magnitude of COVID-19's effects on child and family mental health has yet to be fully revealed. Child and adolescent psychiatrists are in a unique position to address this mental health crisis. Child and adolescent psychiatrists must stay up-to-date regarding federal, state, local, and institutional mandates, regulations, and policies informed by the Centers for Disease Control and Prevention² and other public health institutions, while also navigating the ethical dilemmas unique to child and adolescent psychiatry during the coronavirus era.

The Hastings Center (Garrison, New York) describes health care's ethical framework as shifting from pre-pandemic "patient-centered practice" to pandemic "public-focused" care "to promote equality of persons and equity in distribution of risks and benefits in society."³ The American Academy of Child and Adolescent Psychiatry (AACAP) Code of Ethics⁴ provides the foundation for critical thinking and ethical decision making when addressing the mental health of children, families, and communities related to the COVID-19 pandemic. This shift to pandemic "public-focused" care creates ethical tensions. As child and adolescent psychiatrists treat youth and families within the context of the greater society, an examination of some ethical dilemmas intensified by this pandemic is warranted.

GENERAL CONSIDERATIONS

As information continues to unfold about COVID-19's transmission, susceptibility to illness, preventive measures,

interventions, and age-related clinical presentations,² looming child and family mental health challenges are noted due to the burdens of extended isolation in close quarters, economic loss, and disrupted educational and psychosocial environments. Child and adolescent psychiatrists more so than family medicine physicians, pediatricians, and other pediatric subspecialists, are adept at collaborating with the many family, community, and governmental agencies that serve youth.

Systems that serve children, such as education, child protective services, family courts, juvenile justice, and religious, cultural, and recreation sectors, have endured closures, reduced access, delays, and shifts in service delivery from in-person to virtual. Unlike other medical professional codes of ethics, the AACAP Code of Ethics⁴ leads with the developmental perspective. Child and adolescent psychiatrists should "strive to optimize the emotional, cognitive, social, and physiological development of all children and adolescents" and bring this perspective to a host of child-serving institutions.⁴ In the course of treatment, child and adolescent psychiatrists commonly coordinate, collaborate, and advocate for services provided by these institutions. Given the inherent constraints of such institutions, child and adolescent psychiatrists may find themselves advocating on behalf of vulnerable populations and for specific services for individual patients.

Ethical tensions in pediatric psychiatric treatment include shifting to greater crisis care, allocation of scarce resources, prioritization of treatment modalities, and utilization of stepped care models to reach the greatest number. Ensuring the safety of patients and staff working in pediatric psychiatric treatment settings requires planning, resources, funding, policy, and operational changes, which are often exigent for organizations. Infection control and mitigation procedures have necessitated some inpatient and residential facility closures, service reductions, or admission policy changes resulting in decreased access and/or delays in care.

Ethical quandaries escalate as COVID-19 infection spreads, pitting patients' access to care against maintaining the safety of health care workers, their families, and the larger community.⁵ Inequities among those who must work in person versus those permitted to work virtually can exacerbate their role and pay differentials across staff, deteriorating a treatment team's solidarity. Direct care staff, paid less than other professionals, are expected to be physically onsite, sometimes working overtime to cover scheduling gaps. Frontline staff may be confronted by emotionally dysregulated children who shout, bite, spit, and hit, behaviors that heighten the risk of viral spread. Risks intensify when frazzled staff encounter scared, irritable, and lonely youth coping with family worries, visiting restrictions, and canceled community outings.

During times of heightened moral distress, health care organizations dedicated to pediatric psychiatric care need to proactively promote staff morale. This can be accomplished by ensuring COVID-19 infection preventive measures, increasing infection control and prevention training, attending to staff wellness, enhancing staff support, and providing scheduling flexibility. Recognizing staff efforts in visible ways, increasing onsite leadership presence, and providing regular, transparent communication with staff are also meaningful actions when staff are experiencing heightened demands and fears of contagion. Addressing the needs of staff who suffer similar pandemic challenges as patients and families in treatment is critical to safe, quality care delivery. Child and adolescent psychiatrists as treatment team leaders can tap into their psychoeducational skills to assist both patients and staff with the recognition and management of their COVID-19 pandemic-related stress. Virtual visitations and therapy, trauma-informed care, and modified therapeutic, educational, and recreational programming can promote positive interactions between youth and staff.

VULNERABLE POPULATIONS

Individuals with autism spectrum disorder and intellectual and other developmental disabilities have additional COVID-19 infection risk factors, including pre-existing medical conditions, and are at risk for deadlier infections than the general population.^{6,7} Disrupted routines and services are often poorly tolerated. Further complicating coronavirus containment, these youth are more likely to reside in congregated care settings with shared living spaces and staff rotating on-and-off shifts. Moreover, understanding or practicing preventative measures and communicating symptoms may be challenging for these youths.

Similarly, youth in residential and forensic settings are more susceptible to communicable diseases. Physically coercive interventions, such as restraints, seclusion, or

involuntary psychotropic medications, which are sometimes used in these settings, pose physical and emotional risks. In the face of youths' intensified irritability and frustration over missing family visits and loss of off-campus activities, measures to address unsafe behaviors may surge and hamper COVID-19 pandemic containment efforts. In response, residential treatment settings have incorporated virtual platforms for both family visits and therapy. However, technology cannot replace the lost opportunities for youth and families to practice prosocial skills at home. Paused or limited therapeutic leave time for youth in residential treatment can result in discharge planning delays.

Educational disparities encountered by vulnerable youth necessitate specialized interventions. Child and adolescent psychiatrists should advocate for the continued provision of special education services through local school systems, public and private. Child and adolescent psychiatrists should also advocate whenever possible for effective public policies, such as funding streams to support group home, residential, and forensic settings to ensure safe, quality care.

FAMILY VIOLENCE

A sequitur of stay-at-home orders, social distancing, and key community agency closures is increased risk of family violence, including abuse or neglect of children, adult partners, and elders. Child victimization and domestic violence can fester unrecognized in settings of mass illness, layoffs, financial hardships, food insecurity, and close quarters with limited or no contact with outside support systems.⁸ Emerging evidence supports a rise in substance use during this pandemic,⁹ adding to the already known contributions of substance use to family violence. Overhearing, witnessing, or directly experiencing any form of family violence is detrimental to child mental health.

Health care professionals, teachers, guidance counselors, clergy, bus drivers, coaches, and daycare providers play key roles in suspecting and reporting child maltreatment. These professionals also may act as de facto reprieves from abusive or neglectful home environments. During quarantining, at-risk children can be hemmed in homes with perpetrators of violence. Additionally, pandemic precautions can provide more unsupervised screen time, thereby increasing their contact risk with online predators.

Diminished contact or no contact with mandated reporters plus insufficient staffing in child protective organizations can lead to under-recognition and under-reporting of suspected child maltreatment.⁸ Accurate, real-time data are crucial for proper identification, optimal responses, and best outcomes for maltreated children. As of this writing, there is no statistical evidence of a pandemic spike in child maltreatment in the United States.

Child welfare systems have been urged to create new approaches and mechanisms for prevention, surveillance, reporting, and interventions, yet the development and effectiveness of such strategies are unknown at this time. Child and adolescent psychiatrists should exercise their influence in leadership and supervisory positions to increase health care access, expand maltreatment prevention efforts, and promote mental health advocacy whenever possible.

TELEPSYCHIATRY INNOVATIONS

Medical distancing (a form of social distancing) includes limiting, whenever possible, patient visits to health care facilities and health care provider contacts with hospitalized patients. It also involves patients avoiding or delaying medical care. Unfortunately, avoiding and delaying prompt diagnosis or treatment of developmentally time-critical elective health care services can have substantial, enduring negative sequelae. This issue has ignited a medical paradigm shift from the “traditional” clinical practice to telehealth practice.

Amid medical distancing needs, the demand for telepsychiatry has grown. Temporary changes to institutional policies and state and federal telehealth regulations have fostered telepsychiatry’s expansion.^{10,11} However, a number of clinical and ethical considerations remain. Younger children and those with disabilities may not tolerate a telepsychiatry platform or may only engage for a limited time. Younger children frequently require adult assistance and supervision while accessing such technology. Some staff interventions, behavioral redirection, and modeling, as well as therapeutic experiences in group therapies in afterschool, partial, and other programs, are challenging to approximate virtually. Justice and equity issues arise when not all families, clinicians, clinics, or school-based mental health services have internet or necessary equipment for telepsychiatry. Privacy concerns have been addressed to some extent by tools compliant with the Health Insurance Portability and Accountability Act of 1996; however, privacy away from parents and siblings can be more challenging, especially for families with smaller living quarters. The risk of hackers (eg, “Zoom-bombing”) disrupting telepsychiatry sessions further threatens confidentiality.

The direct-to-patient approaches require child and adolescent psychiatrists to obtain updated consent for telepsychiatry visits, often necessitating payment discussions with families. Such conversations may raise questions from families regarding the fiduciary relationships between child and adolescent psychiatrists and families. Telepsychiatry must be explained in a developmentally appropriate manner to youth, and assent or consent must be documented as stipulated by the institution and jurisdiction in which care is rendered.

Telepsychiatry increases access and continuity of care; allows for safe observation of facial expressions; saves

families’ travel time and cost; and provides supplementary diagnostic information, as children and families are seen in their own homes. As telepsychiatry expands, child and adolescent psychiatrists should promote equitable mental health care when possible, especially when public safety, community health, and just allocation of limited resources are involved.⁴

THE “NEW NORMAL”

Chasms between the needs of youth with psychiatric disorders and dedicated resources available for their care predated the COVID-19 pandemic. The COVID-19 pandemic has widened these gaps and compels the health care system to reassess the access, delivery, and practices of medicine and apply this knowledge to produce sustainable improvements.

Public health experts predict that lifestyles and health care delivery will be reshaped by the COVID-19 pandemic. As society emerges from protracted pandemic adaptations, home life, education, recreation, interpersonal relationships, and public interactions will be reassessed. Psychiatric epidemiology, diagnosis, treatment care levels, service delivery modes, and goodness-of-fit of patients with provider discipline will face scrutiny. Research and clinical care must collaborate with updated evidence-based care during and after the COVID-19 pandemic. Child and adolescent psychiatrists must champion ethical precepts that inform best practices in the “new normal” state, such as addressing access to care issues and other inequalities. Child and adolescent psychiatrists must maintain the profession’s integrity by not abandoning ethical precepts and scientific principles during this pandemic and beyond.

CONCLUSIONS

The COVID-19 pandemic threatens child and family mental health while amplifying our sense of responsibility to one another. Child and adolescent psychiatrists have ethical responsibilities to practice in a manner that minimizes health care-related COVID-19 transmission; educates youths and families about COVID-19 prevention and health practices; provides care for the most vulnerable in society; helps prevent and mitigate child maltreatment; and promotes pandemic and post-pandemic access and continuity of care.

The ethical principles in the AACAP Code of Ethics⁴ supports child and adolescent psychiatrists in their numerous roles and efforts on behalf of individual youth and families, vulnerable populations, communities, and systems in which child and adolescent psychiatrists serve. A number of relevant ethical principles that guide child and adolescent psychiatrists’ practices during the coronavirus era have been highlighted, including consideration of development,

nonmaleficence, beneficence, autonomy, confidentiality, advocacy, equality, equity, and justice.⁴ In specific situations, ethical principles may conflict, creating tensions regarding priorities and actions. Child and adolescent psychiatrists use ethical principles as a foundation for decision making and tailor their decisions based on risk-benefit assessments.⁴

There is much to be learned from COVID-19's direct, indirect, and short- and long-term toll on child and family mental health. As child and adolescent psychiatrists identify child and family mental health needs, the importance of recognizing and fostering resilience of youth, families, caregivers, and communities has been underscored. Individual resilience is interconnected to the effectiveness of organizations and systems that serve youth. Child and adolescent psychiatrists can draw upon their knowledge of youth, family, and systems to strengthen protective factors and promote resilience while maintaining hope that pediatric patients with psychiatric illness can meaningfully thrive, consistent with their developmental potential. Child and adolescent psychiatrists can advocate for quality education and adequate community resources. This can be accomplished by supporting youths' secure attachments to caregivers, their evolving autonomy, their problem-solving and coping skills, their sense of self-efficacy, and their faith, hope and belief that life has utmost meaning.¹²

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REFERENCES

- Moore JT, Ricaldi JN, Rose CE, *et al.* Disparities in Incidence of COVID-19 Among Underrepresented Racial/Ethnic Groups In Counties Identified As Hotspots During June 5–18, 2020–22 States, February–June 2020. *MMWR Morb Mortal Wkly Rep.* 2020; 69:1122–1126.
- Center for Disease Control and Prevention. COVID-19. Published 2020; <https://www.cdc.gov/coronavirus/2019-ncov/index.html>. Accessed November 9, 2020.
- Berlinger N, Wynia M, Powell T, *et al.* Ethical Framework for Health Care Institutions and Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic: Managing Uncertainty, Safeguarding Communities, Guiding Practice. March 16, 2020; <https://www.thehastingscenter.org/ethicalframeworkcovid19/>. Accessed November 9, 2020.
- American Academy of Child and Adolescent Psychiatry. Code of Ethics. Published September 16, 2014; https://www.aacap.org/App_Themes/AACAP/docs/about_us/transparency_portal/aacap_code_of_ethics_2012.pdf. Accessed November 9, 2020.
- Greenberg N, Docherty M, Gnanapragasam S, *et al.* Managing mental health challenges faced by health care workers during covid-19 pandemic. *BMJ.* 2020;368:m1211.
- Turk MA, Landes SD, Formica MK, *et al.* Intellectual and developmental disability and COVID-19 case-fatality trends: TriNetX analysis. *Disabil Health J.* 2020;13:100942.
- Eshraghi AA, Li C, Alessandri M, *et al.* COVID-19: overcoming the challenges faced by individuals with autism and their families. *Lancet Psychiatry.* 2020;7:481–483.
- Abramson A. How COVID-19 may increase domestic violence and child abuse. *American Psychological Association*, April 8, 2020; <https://www.apa.org/topics/covid-19/domestic-violence-child-abuse>. Accessed November 9, 2020.
- Czeisler MÉ, Lane RI, Petrosky E, *et al.* Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. *MMWR Morb Mortal Wkly Rep.* 2020;69:1049–1057.
- Centers for Medicare & Medicaid Services. Physicians and Other Clinicians: CMS Flexibilities to fight COVID-19, November 4, 2020; <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>. Accessed November 9, 2020.
- American Psychiatric Association Committee on the Psychiatric Dimensions of Disaster and COVID-19, Committee on Telepsychiatry, and Council on Healthcare Systems and Financing. Support for permanent expansion of telehealth regulations after COVID-19; 2020; <https://www.psychiatry.org/File%20Library/Psychiatrists/APA-Guidance-Permanent-Expansion-COVID-19-Telehealth-Regulations.pdf>. Accessed November 9, 2020.
- Masten AS. Resilience from a developmental systems perspective. *World Psychiatry.* 2019;18:101–102.

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