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# Ethical Considerations in Balancing Use of Seclusion and Restraint With Risk of COVID-19 Exposure: Recommendations for Youth Inpatient Psychiatry Units

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**T**he onset of the COVID-19 pandemic has presented unique challenges for inpatient psychiatry units (IPUs). IPUs, especially those caring for children and adolescents, rely heavily on milieu group programming to provide care and supervision for patients, and have had to adapt unit policies and procedures to maintain a therapeutic milieu while minimizing COVID-19 transmission.<sup>1</sup> Simultaneously providing care while preventing transmission of COVID-19 within IPUs is a formidable task, and many IPUs face the additional challenge of treating youth who have been exposed to, or are actively infected with, COVID-19. In addition, given the need to prevent transmission of COVID-19, recommendations include “mandatory quarantine and isolation when patients refuse to adhere to guidelines,”<sup>2</sup> potentially leading to the use of restraint when patients attempt to leave isolation; thus a conflict between the potential risks of enforcing infection prevention policies in order to reduce virus transmission and best practices of eliminating seclusion and restraint (S/R) creates an ethical dilemma for IPUs.

Brown and colleagues’ recommendations for management of patients who have COVID-19 or require isolation because of exposure include discharge home, cohorting exposed patients in a separate “isolation” milieu with personal protective equipment (PPE)–clad staff, and in-room isolation.<sup>3</sup> Testing all patients for COVID-19 in the emergency department allows their infection status to influence admission decisions; there are some patients who may benefit from voluntary inpatient care but, when diagnosed with COVID-19, are able to safely discharge home to allow isolation in a more comfortable environment. For COVID-19–positive patients whose presenting mental health concerns require imminent hospitalization, options will vary from facility to facility. IPUs in a hospital may

have access to a special isolation unit (SIU) on a medical floor, or may have negative airflow rooms within their IPU for patients to stay the current Centers for Disease Control and Prevention (CDC) recommended duration of quarantine.<sup>4</sup> Psychiatry can remain the primary service for these patients and provide modified and individualized versions of the group therapy content. Patients can be discharged home prior to completing their quarantine if they are deemed safe to do so, or transferred to the IPU, out of isolation, if they continue to meet criteria for inpatient psychiatric care when their quarantine ends. When multiple patients are exposed, they may be cohorted into a closed subsection of the unit, thereby limiting the potential for more widespread exposure. These patients can spend time in the subsection rather than being confined to their rooms, and all staff don appropriate PPE whenever they are in these patient areas. Patients placed in isolation are confined to their rooms with a staff member monitoring them through the door window from outside and facilitating their care needs. If patients must leave their room to use the bathroom, they must minimize their time outside the room and wait until the space is clear of other patients and staff have donned PPE before exiting.

These are reasonable recommendations for many patients, and yet IPUs may benefit from further recommendations to guide practice as additional challenges arise. Many patients must quarantine in isolation for all or most of their admission, which limits their ability to engage in milieu activities and treatment. Patients may struggle to cope with isolation and boredom, losing interest in the limited available options for activities. When patients are unable to maintain isolation, hospitals’ infection prevention departments have recommended the use of physical restraint to enforce isolation in rooms. However, the policy was designed for individual hospital rooms rather than a milieu

environment, directly contrasting with IPU's trauma-informed approach of minimizing S/R and requiring staff to restrain patients who do not otherwise meet the IPU's threshold for restraint—a last resort in case of imminent safety risk to self/others that cannot otherwise be safely managed. Importantly, this threshold for use of S/R is consistent with federal Centers for Medicare and Medicaid Services (CMS) regulations that are in place to ensure protection of patient rights.<sup>5</sup>

Being quarantined in an IPU bedroom places additional strain upon a youth's mental health while already in crisis. These patients may struggle to manage impulses, tolerate frustration, communicate effectively, comprehend their situation, adhere to their treatment plan, and/or maintain their safety. These symptoms make it particularly difficult for this patient population to cope with and adhere to strict respiratory isolation. S/R has several significant risks to youth patients: it is traumatizing to the entire milieu, subjects patients to re-experiencing previous traumas, disrupts the therapeutic alliance between patients and staff, causes physical harm, and has even proved fatal.<sup>6</sup>

Staff are also affected by S/R. During a restraint, staff are at increased risk for injury, COVID-19 exposure (as PPE may become dislodged or removed), and associated emotional trauma from both. They must deviate from their training regarding the IPU's restraint policy during a high-stress time. Prior to the pandemic, youth who identify as Black, indigenous, and people of color (BIPOC) have suffered significant trauma and/or are neurodivergent were at greater risk for S/R. As a result of the increased risk of COVID-19 exposure and infection for marginalized populations,<sup>7</sup> hospital restraint policy may worsen these disparities; it thus undermines the IPU's commitment to providing antiracist and trauma-informed mental health care.<sup>8</sup>

The above issues forced us to examine the ethics of enforcing quarantine in isolation for youth admitted to the IPU, given the known significant risks of S/R, in context of our goal of providing trauma-informed antiracist mental health care to all of our patients. Clinicians from multiple disciplines (Psychiatry, Psychology, Pediatrics, Ethics, Infection Prevention) examined the issue together, considering the harms to individual patients, IPU patients, staff members, and the community at large related to COVID-19 infection, isolation, and use of S/R. In addition to the previous requirement of wearing appropriate PPE when providing care to these patients, the group developed the following recommendations for minimizing harms to all parties.

1. Reduce the number of IPU patients requiring isolation because of COVID-19 exposure based on available data, as it may lead to an overall reduction in need for S/R and

allow more patients to access milieu and group therapy. For example, at the time of the ethics consultation, our hospital data indicated that the risk of transmission from asymptomatic, PPE-wearing staff to patients was very low. As a result, these exposures did not warrant isolation.

2. When patients do require isolation, the low risk of transmission from fomites enables the use of regularly cleaned alternative spaces, thus minimizing the time that patients are confined to 1 space.<sup>9</sup> If a patient can be kept 6 feet away from other patients and staff, in a designated safe space, they may be able to de-escalate without the need for restraints,<sup>10</sup> an approach that is consistent with the IPU's standard approach with escalated patients.
3. Additional strategies to mitigate boredom while a patient is in isolation can include more consistent access to family members through virtual visits, and hospital programming through television, tablets, books, and virtual music therapy. Our hospital has iPads that have been locked to allow access only to specific applications, limiting the need for staff supervision of tablet use.
4. Patients can be engaged in parallel group work in order to maintain access to therapeutic materials and treatment.
5. Patients in isolation can be incentivized to adhere to isolation guidelines by implementing positive-reinforcement behavior modification plans, tailored to meet an individual patient's needs.
6. Our patient rooms do not lock (patients are able to leave at any time). Given this, we approved a policy to allow staff to hold their foot on the door (thus secluding the patient) to allow staff members to don the appropriate PPE should the patient attempt to leave their room. Patients should be immediately allowed out of their room after staff have donned the appropriate PPE.

Ultimately, the challenges faced by IPUs during this global pandemic highlight the potentially competing ethical theories of principlism and public health ethics. Principlism, commonly used in medical ethics, considers 4 principles and their impact on individual patients: beneficence, non-maleficence, autonomy, and justice. Alternatively, public health ethics focuses on the greater population and is informed by utilitarianism, where the best course of action is one that results in the greatest aggregate good. Although these theories may at times conflict, both support that for pandemic care in IPUs, the most ethical course of action is one that minimizes harm to both individuals and the milieu and that considers the relative risks of COVID-19 exposure and risks of S/R to both patients and staff. All of the aforementioned risks are real and impactful, both in the

short and long term. Moreover, minimizing individual harm may increase the risk of harm to others if exposed to COVID-19. The relative risks may vary from patient to patient. However, this new approach of reducing the need for isolation in low-risk exposures, allowing cohorting of exposed patients rather than imposing individual isolation, and offering a more flexible approach to de-escalation serves to lower the risk of harm to individual patients without creating or increasing the risk of harm to others.

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