

A Qualitative Investigation into How the COVID-19 Crisis Shaped Ethical Challenges and Situational Vulnerability in Mental Health Care

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Abstract

During the COVID-19 pandemic, individuals receiving mental healthcare were frequently portrayed as especially at risk, yet what this vulnerability entails—and what ethical duties follow—depends heavily on how vulnerability is conceptualized. Traditional perspectives associate vulnerability with characteristics attributed to certain social groups, whereas situational and dynamic frameworks emphasize how institutional and societal arrangements create vulnerable positions. Despite this, the lived circumstances of users and patients across diverse psychosocial settings during the pandemic have not been thoroughly mapped or ethically examined through the lens of situational vulnerability. This study draws on a retrospective qualitative assessment of a survey capturing ethical difficulties encountered in multiple mental healthcare institutions operated by a major regional provider in Germany. The resulting material was evaluated using a dynamic, context-dependent vulnerability framework. Across service settings, ethically relevant patterns surfaced, including challenges in enforcing infection-control protocols, reductions or interruptions in mental health services to prioritize infection prevention, heightened social isolation, detrimental health consequences for users and patients, and obstacles in applying state-level and organizational regulations within local operational constraints. Viewing vulnerability as situational and fluid provides a means to pinpoint concrete contextual elements that intensified vulnerability among mental healthcare users and patients. These context-specific conditions warrant attention in the development of both statewide and local policies aimed at mitigating and responding to vulnerability.

Keywords: COVID-19, Mental health care, Vulnerability, Ethical challenges

Introduction

COVID-19 and the context of mental healthcare users and patients in germany

Public discussions about the societal repercussions of COVID-19 were extensive, yet the circumstances of people relying on mental healthcare services, those in forensic or psychiatric institutions under involuntary commitment, and residents of care homes or other mental

health facilities (hereafter: users and patients), received comparatively limited scrutiny [1-4].

Available empirical evidence shows that people with mental illness experienced disproportionate strain during the pandemic. Research has documented elevated infection rates, more severe disease trajectories, and increased mortality relative to the general population [5-9]. This is particularly notable in light of the already poorer baseline health status among those with severe mental illness, which the World Health Association links partly to systemic obstacles in accessing healthcare [10]. Moreover, individuals with mental illness reported substantially higher psychological distress than the general population during the pandemic [11].

Within Germany, several shifts in mental healthcare provision have already been observed under pandemic conditions. Service reductions—such as interruptions of

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day clinics, group therapy formats, and self-help groups—have been reported [12], and cancelled or delayed psychiatric appointments were associated with worsened depressive symptoms [12]. Practices surrounding involuntary commitment also changed during the pandemic [1, 13, 14]. Numerous psychosocial services struggled to maintain continuity of care while simultaneously enforcing infection-control requirements. In agreement with this, the 2020 report from the National Agency for the Prevention of Torture highlighted specific difficulties in mental healthcare environments, such as ensuring distancing and managing quarantine procedures [15]. Comparable challenges were noted in forensic psychiatric contexts [16]. Even as many public-health restrictions were lifted in other societal sectors, infection-prevention requirements remained in force within mental healthcare facilities.

People with mental illnesses were labeled a “particularly vulnerable group” [17] during these debates. The German Ethics Council’s statement on pandemic decision-making correspondingly references the “special” vulnerability of several social groups, including this population [18]. The precise meaning of such vulnerability, however, and the normative implications that follow, vary substantially depending on the conceptual framework employed.

Although vulnerability is widely invoked in both classic and contemporary bioethical discourse, conceptual ambiguity persists [19-21]. Debates have largely taken place within research ethics, public health ethics [22], and more recently, clinical practice [23] and aged-care contexts [24]. Traditional frameworks aim to define criteria for identifying vulnerable individuals, typically by grouping people who share characteristics that heighten risks of compromised consent capacity, exploitation, or unjust treatment. Ethical duties then often take the form of enhanced protection, modified consent procedures, or exclusion from research participation [22]. However, critics argue that categorizing entire groups as vulnerable purely on the basis of their characteristics can promote stigmatization, discrimination, paternalism, and a loss of perceived agency [22, 25-28]. Additionally, the routine exclusion of groups such as pregnant women or individuals under involuntary commitment from clinical trials has been criticized for producing inequities, as these populations may not benefit equally from advances in research [29, 30].

Dynamic understandings of vulnerability

In its report, the German Ethics Council adopts a situational, dynamic conception of vulnerability: vulnerability is not an intrinsic attribute of any group identified by particular traits, but rather emerges from concrete contexts — “social, political, economic or also environmental constellations or interactions” [18]. From this viewpoint, structural forces such as discrimination can create or exacerbate situational vulnerabilities.

This interpretation aligns with recent theoretical developments. Building on critiques of static, group-based models [31], Luna [32] and other bioethicists [26] have advanced a layered account of vulnerability applicable to research ethics, public health, and clinical practice. In this model, “layers” denote dispositional conditions that heighten the likelihood of harm or disadvantage in a given context; these layers can originate from internal factors (e.g., age, medical conditions) or external influences (e.g., social environments, policy frameworks, systemic discrimination). The proximate factors that bring a vulnerability into effect are described as “triggers.” Multiple vulnerability layers can coexist and be treated separately, while some layers may interact or cascade, producing additional vulnerabilities [26]. Luna argues that this approach is normatively valuable because it permits the derivation of ethical duties from the specific sources and triggers of vulnerability [26].

To our knowledge, no prior study has applied an ethical evaluation of situational vulnerability to mental healthcare users and patients during the COVID-19 pandemic.

This study

Here, we report findings from a retrospective qualitative analysis of a written survey documenting ethical challenges experienced during the COVID-19 pandemic, collected from nursing and medical directors and facility managers across a range of mental healthcare institutions operated by the Regional Association of Westphalia-Lippe (Landschaftsverband Westfalen-Lippe) in Germany. Our analysis describes the variety of challenges encountered across mental healthcare settings during the pandemic’s first year, taking into account that people with mental health conditions make use of diverse services — from outpatient care, day-structuring programs, and day clinics to inpatient psychiatric care, multiple residential and care-home models, and involuntary placements in psychiatric or forensic hospitals. The study has two aims: first, to provide an

exploratory inventory of ethical challenges linked to pandemic-driven changes in mental healthcare settings and practices; second, to assess those challenges through a dynamic, situational lens in order to identify multiple coexisting layers of vulnerability experienced by mental healthcare users and patients during the pandemic.

Materials and Methods

We performed a retrospective qualitative analysis of written survey documents. These materials were originally gathered by the internal working group “Ethical dilemmas in psychiatry during the COVID-19 pandemic in institutions of the Regional Association of Westphalia Lippe,” which was formed in spring 2021 to collect ethical problems arising during the pandemic and to produce practice-oriented recommendations as part of internal quality-improvement efforts. In early May 2021 the working group solicited reports of ethical challenges from nursing and medical directors and facility managers via a prestructured written questionnaire distributed by email, aiming to integrate frontline experiences into the discussion. Although the survey was primarily intended to inform the working group’s recommendations, the responses contained rich, detailed accounts of ethical dilemmas across multiple care settings; consequently, the authors opted to analyze the documents qualitatively to support an empirically grounded ethical assessment. The project received approval from the Research Ethics Committee of the Medical Faculty of Ruhr University Bochum (Reg. No.: 21-7290_BR). The authors adhered to the Standards for Reporting Qualitative Research set out by O’Brien *et al.* [33].

Data collection

Within Germany’s mental healthcare landscape, the Regional Association of Westphalia Lippe occupies a central role, operating a wide array of services that span eleven adult psychiatric hospitals, four hospitals for child and adolescent psychiatry, ten residential and care facilities for individuals with mental illnesses or disabilities, and six institutions providing forensic psychiatric care. At the beginning of May 2021, the working group initiated data collection by sending an email to every nursing and medical director across these hospitals, as well as to the managers responsible for the residential facilities and care homes. Each recipient was asked—after consulting their teams—to complete a

structured survey designed to explore ethical difficulties emerging in their specific care environments.

The message requested that the completed document be returned within four weeks, and follow-up reminders were issued first at the end of this period and then two weeks later. The purpose of the survey was clearly stated: to support facilities during the pandemic by offering ethically informed guidance aimed at strengthening both clinical and ethical decision-making.

Respondents were first asked to identify their role and type of mental healthcare setting. The rest of the instrument consisted of six broad areas addressing issues related to infection-prevention measures: (1) implications for guideline-recommended therapies, (2) the impact of contact restrictions, (3) the use and challenges of coercive practices, (4) obstacles arising during infection-control implementation, (5) experiences with vaccination programs, and (6) encounters with regulations issued at state, provider, and facility levels. The survey blended closed questions with spaces for open commentary, allowing participants to elaborate freely.

Of the 40 surveys distributed, 27 anonymized responses were returned (a 65% response rate). These included 8 from adult psychiatry services (submitted by 2 medical directors, 5 nursing directors, and 1 quality manager), 2 from child and adolescent psychiatry (1 medical and 1 nursing director), 6 from forensic psychiatric hospitals (1 medical and 5 nursing directors), and a combined total of 11 from residential facilities and care homes (5 and 6 respectively).

Data analysis

The study employed a qualitative content analysis following the approach outlined by Kuckartz [34], and the data were processed using the MAXQDA software package (MAXQDA 18 Standard Portable, VERBI Software GmbH, Berlin, Germany). The initial analytical work was carried out jointly by two researchers specializing in medical ethics and psychiatry: MF, a cis-female white physician with training in philosophy, and AW, a cis-female white medical student with a molecular biomedicine background and previous training as a peer support worker. Both researchers had completed methodological training in qualitative research at the Methods Centre of Ruhr University Bochum and possessed prior experience conducting qualitative investigations. Their work was overseen by JG—a cis-male white consultant in psychiatry and psychotherapy

with formal philosophical training—who had previously supervised several qualitative research initiatives.

Following the principles of structured qualitative content analysis described by Kuckartz [34], the team adopted a multi-stage analytic strategy aimed at systematically identifying and organizing themes within the survey responses. The procedure unfolded across seven distinct phases: (1) MF and AW independently examined each survey document, annotated them, and prepared summary notes; (2) after jointly coding an initial 20% of the material, and with guidance from JG, they developed a set of main categories that blended inductive insights drawn from the survey content with deductive elements informed by the working group's expertise; (3) the full dataset was then coded by MF and AW using this category system; (4) all excerpts assigned to the same category were re-examined together by MF and AW, after which broader thematic clusters were formulated collaboratively with JG; (5) the draft categories and overarching themes were subsequently reviewed in discussion with the entire working group; (6) MF and AW then recoded all survey materials; and (7) finally, the authors collectively selected those issues judged to be ethically significant for deeper discussion.

Informed by the ethical challenges emerging from the analysis and the broader debates concerning vulnerability during the pandemic, the authors chose to interpret the findings through the lens of a dynamic vulnerability framework [26, 32]. The team explicitly recognized that their own professional roles, social positioning, and familiarity with mental healthcare could shape how the material was understood. Because the research group represented a range of disciplines—including psychiatry, nursing sciences, health sciences, medical ethics, and philosophy—and brought both personal and professional experiences with mental healthcare, potential biases and implicit assumptions were openly examined and critically discussed throughout the project.

Results and Discussion

Analysis of the survey data revealed five ethically significant themes. Selected quotations, translated from German into English by the first author, are presented in italics.

Theme 1: challenges in enforcing infection prevention in mental healthcare settings

Participants described multiple obstacles in implementing infection control measures. Structural limitations often made social distancing and hygiene protocols impractical. Many psychiatric hospitals and residential facilities lacked proper isolation or quarantine areas with private bathrooms. In one psychiatric hospital, staff had to share toilet facilities with patients in quarantine due to building design constraints.

Room allocation posed additional difficulties. In a forensic psychiatric hospital, seclusion rooms—normally reserved for acute risk situations—were temporarily used to house new admissions awaiting confirmed negative COVID-19 tests: “The rooms were sparsely furnished with shared bathrooms and potential camera monitoring; patients had to endure minimal personal belongings and the constant feeling of being observed from outside” (forensic psychiatric hospital, nursing director no. 3). Overcrowding sometimes prevented patients from accessing standard rooms even after negative tests were available.

Staff also reported that infection control measures encroached on patients' rights. In some residential facilities, maintaining isolation required continuous one-on-one supervision, which was experienced as a significant intrusion on personal privacy.

Theme 2: limitation of mental health services to prioritize infection control

Another key theme was the reduction of psychiatric and therapeutic services in order to comply with infection prevention. During the early months of the pandemic, therapy provision was markedly decreased in many facilities. Group therapy sessions and cross-ward programs were suspended in psychiatric and forensic hospitals, reducing overall therapeutic opportunities. Assisted living facilities reported closures of day-structuring programs, essential for maintaining residents' daily routines: “The temporary closure of day-structuring programs caused confusion and disrupted routines; some residents struggled to reengage with services they had previously managed to follow consistently” (residential facility, facility manager no. 3). Physiotherapy, occupational therapy, and specialist consultations were also unavailable for extended periods in some settings. Daily care routines were additionally affected. Lockdowns made it difficult to provide regular meals in certain residential facilities: “It was challenging to ensure proper meals during lockdowns since snack bars and canteens were closed and cooking skills were lacking

among staff” (residential facility, facility manager no. 1). Communal dining, important for social interaction and reducing isolation, was often replaced by in-room meals. Critical therapeutic activities were suspended as well. Exposure training in home settings, crucial for discharge preparation and evaluating treatment outcomes in child and adolescent psychiatry, was halted. Leaves used for discharge planning or correctional relaxation in forensic hospitals were also restricted. Many facilities reported that outpatient follow-up and aftercare were severely limited due to reduced external service availability.

Theme 3: social isolation resulting from contact restrictions

All types of mental healthcare facilities reported changes in visitation policies and on-site access. The strictness of these measures varied considerably across institutions. In one psychiatric hospital, visits were largely permitted, whereas other hospitals enforced strict bans supported by security personnel. In a particularly restrictive psychiatric facility, “access to the grounds was blocked with temporary fencing, informational signs were displayed, and a complete ban on visitors to patient buildings was enforced; even the expansive hospital park could rarely be used freely” (psychiatric hospital, quality manager). Similarly, a forensic psychiatric facility reported severe limitations on social interaction: “considerable constraints on social contacts meant that some patients had not seen their relatives in person for over a year” (forensic psychiatric hospital, nursing director no. 1).

Theme 4: adverse health consequences for patients and residents

The reduction of therapeutic services and strict contact limitations had notable negative effects on patients’ wellbeing, manifesting differently depending on the care setting. In child and adolescent psychiatry, social isolation—especially from their home environment and relatives—was a primary concern, potentially contributing to hospitalism. Acute psychiatric units reported increased tension due to patients’ restricted movement. Nursing homes observed that isolation combined with reduced therapy led to declines in psychosocial functioning among residents with dementia, with some no longer recognizing family members. Social isolation was broadly described as “a major source of stress for many residents” (care home, facility manager no. 1). Among residents with mental

disabilities in residential facilities, both physical (e.g., weight loss) and psychological effects (e.g., depressive moods) were noted as a consequence of visiting restrictions: “The visitor ban resulted in increased withdrawal, depressive moods, refusal to engage in group or individual activities, and similar behaviors” (residential facility, facility manager no. 3).

Theme 5: conflicting and rapidly changing regulations across multiple levels

Staff frequently struggled with the complexity and variability of regulations issued at the state, provider, and local facility levels. The constantly changing guidelines often led to confusion, frustration, and resistance among employees. One facility manager noted: “Frequent short-notice changes and the temporary nature of regulations made it difficult to communicate correct guidelines consistently; in some cases, this caused staff to develop negative attitudes toward new rules and even refuse to implement them” (residential facility, facility manager no. 3). Respondents also criticized the lack of attention to the specific needs of mental healthcare populations, particularly in child and adolescent psychiatry: “Child and adolescent psychiatry was largely overlooked at the state level and only occasionally considered at the provider level” (child and adolescent psychiatry, medical director no. 1). Infection prevention measures were often modeled after somatic healthcare settings, neglecting the unique circumstances of psychiatric hospitals, such as long-term patient stays, social isolation, and heightened psychological stress during the pandemic: “Few regulations included practical references to everyday life” (psychiatric hospital, medical director no. 2). Nonetheless, participants highlighted the potential for facilities to adapt regulations individually, drawing on staff experience—for example, by implementing digital communication solutions to maintain contact between patients and relatives.

The COVID-19 pandemic posed unprecedented challenges for society, policymakers, hospitals, and mental healthcare institutions. Protective regulations had to be developed rapidly to safeguard the general population and groups particularly susceptible to severe outcomes from COVID-19. Within this context, mental healthcare facilities implemented a variety of infection prevention measures. Our findings highlight that these measures, although ethically necessary, led to significant unintended consequences in the provision of mental healthcare. The following discussion examines these

consequences through the lens of different layers of vulnerability.

Layers of vulnerability in mental healthcare during infection prevention

Our analysis revealed that facilities struggled to implement the recommended infection control measures effectively. Respondents expressed concerns that spatial limitations and structural characteristics of their institutions increased the risk of COVID-19 transmission, particularly before vaccines were available. This concern aligns with empirical evidence showing that residents of long-term care facilities face elevated infection risks [35], compounded by the generally poorer physical health of individuals with severe mental illness [10]. Thus, heightened susceptibility to infection due to living conditions and health status constitutes one layer of vulnerability.

Facilities were subsequently tasked with developing strategies to mitigate infection risks under challenging conditions such as overcrowding. In some forensic psychiatric hospitals, seclusion rooms—intended for acute psychiatric crises where immediate danger to self or others exists—were repurposed for quarantine during patient admissions. Such use is problematic, as these spaces are unsuitable for therapeutic purposes outside of emergencies. The National Agency for the Prevention of Torture explicitly rejects using seclusion rooms for quarantine or isolation [15].

To further reduce infection risks, contact restrictions were imposed across facilities. While effective in limiting virus transmission, these restrictions also caused social isolation and coincided with reduced therapeutic and day-structuring activities. Social relationships are central to the wellbeing of individuals, making such isolation particularly burdensome. The psychological effects reported by participants, including increased depressive symptoms and tension, correspond with international findings regarding the impact of quarantine on people with mental illness [11].

Institutional regulations on space usage, daily routines, and available resources further limited patients' ability to cope with these restrictions. Unlike the general population, who could structure their daily routines at home, individuals in mental healthcare—especially those with cognitive impairments—experienced constant supervision in long-term care settings to enforce contact restrictions. This intensive oversight potentially infringed on privacy rights; according to the Federal

Working Group of Community Psychiatric Associations [36], private bedrooms in long-term care should serve as “retreat and protective spaces.” Consequently, the limited autonomy to develop personal coping strategies and the unavailability of therapeutic interventions represented an additional layer of vulnerability, manifesting in adverse health outcomes and social isolation.

Mental healthcare institutions differ substantially from somatic hospitals. Nursing facilities and residential homes function as long-term residences for individuals with mental illnesses or disabilities [36], and psychiatric hospitals often host patients for longer durations than somatic hospitals. Individuals under involuntary commitment cannot choose whether or where to be hospitalized, nor can they defer psychiatric treatment [13, 14]. Voluntary patients also faced limited alternatives due to the reduction or suspension of community-based services during the pandemic [37].

Federal and state regulations at the start of the pandemic largely failed to account for the specific needs of mental healthcare settings. Fasshauer and colleagues [38] noted that only three of Germany's 16 states issued separate regulations for mental health facilities. Gomolla [39] emphasizes that neutral-appearing legal rules can unintentionally disadvantage certain groups, a form of indirect institutional discrimination. The lack of tailored guidance for mental healthcare settings likely contributed to the difficulties observed, effectively amplifying vulnerability.

In summary, efforts to reduce COVID-19 infection risks—a justifiable response to one layer of vulnerability—unintentionally created additional harms. These included increased psychological distress and negative health outcomes arising from contact restrictions and institutional structures that constrained patients' ability to adapt to new practices. The following section explores the ethical implications of these findings.

Implications

Our findings highlight that individuals receiving care in mental healthcare facilities were profoundly impacted by the COVID-19 pandemic. As noted by the German Ethics Council (2022), “Vulnerability is not merely a characteristic of affected individuals, but precisely the result of comprehensive constellations in which risk factors and protective factors interact in a complex manner. To a good extent, these constellations can also be influenced and produced.” Similarly, Victor and

colleagues emphasize our responsibility to “eliminate, mitigate, and avoid exacerbating vulnerability” [26]. In our study, we identified multiple layers and triggers of vulnerability affecting service users and patients during the pandemic. A dynamic conceptualization of vulnerability, as opposed to a static view, reveals that these vulnerabilities are not inherent to mental illness or psychiatric conditions but are shaped by regulations and institutional practices that did not account for the specificities of mental healthcare settings.

What are the implications of this for decision-making at different levels of governance—local facilities, healthcare providers, and state authorities? Luna [32] recommends prioritizing vulnerabilities according to the severity, likelihood, and potential cascading effects, while respecting the autonomy and preferences of those affected [26]. Our analysis demonstrated that applying uniform regulations designed for somatic healthcare to mental healthcare settings created disproportionate burdens on patients. We therefore recommend that state-level regulations be adjusted where necessary to reflect the particular needs of mental healthcare institutions and prevent indirect institutional discrimination.

At the provider level, our findings indicate that facilities benefited when regulations allowed flexibility to adapt practices to local conditions. At the facility level, organizational processes were shown to carry ethical significance. Local clinical ethics committees can support decision-makers by developing regulations that are both ethically defensible and practically feasible, while remaining within the framework of state guidelines and sensitive to identified vulnerabilities [40]. Additionally, involving service users and patients in decision-making ensures their preferences and autonomy are respected—a practice associated with improved outcomes according to recent literature [41].

Limitations

Several methodological limitations should be acknowledged. First, data were collected via a structured written survey. While the predefined format may have constrained responses, many participants used supplementary fields to provide additional context and elaborate on their experiences. We therefore believe that most relevant ethical challenges were captured.

Second, only senior staff members (medical directors, nursing directors, and facility managers) were invited to participate. Consequently, the perspectives of service users, patients, and non-executive staff were not directly

included. Since these groups are best positioned to report on their lived experiences during the pandemic, future studies should incorporate their insights.

Third, some limitations relate to our use of the dynamic vulnerability framework. Victor *et al.* [26] provide guidance on ranking different layers of vulnerability but offer limited normative direction for determining which layer is “most harmful,” particularly when addressing one vulnerability (e.g., heightened risk of infection) may exacerbate others (e.g., psychological harm from social isolation). Because the framework emphasizes respecting the preferences of those affected, stakeholder participation is essential for prioritizing vulnerabilities—a task beyond the scope of this study.

Despite these limitations, our study offers valuable insights into the challenges faced by diverse mental healthcare settings during the first year of the COVID-19 pandemic and demonstrates how a dynamic approach to vulnerability can inform ethical analyses in empirical research.

Conclusion

Our qualitative survey of executives across diverse mental healthcare settings—including psychiatric hospitals, residential facilities, and care homes—illustrates the complexity of ethical decision-making during the COVID-19 pandemic. Using the dynamic vulnerability framework, it becomes evident that patients’ and service users’ vulnerability is not inherently tied to their mental health conditions, but emerges from specific contextual factors, particularly material and regulatory conditions. Recognizing these layers of vulnerability allows decision-makers to address them in a targeted manner and mitigate their consequences. This perspective is valuable for both clinical and policy-level decision-making.

Unlike traditional approaches that label vulnerability as a fixed trait, the dynamic framework emphasizes that the experiences and preferences of those affected are essential when prioritizing and managing different layers and triggers of vulnerability, underscoring the importance of active stakeholder participation.

Our findings also indicate that mental healthcare institutions often lacked sufficient material and human resources during the pandemic to adequately protect residents and service users from situational or individual vulnerabilities. This aligns with what the German Ethics Council refers to as “structural vulnerability,” meaning

the institution's inability to fulfill its essential functions during a crisis [18]. Therefore, ensuring that mental healthcare facilities are adequately resourced—both in personnel and infrastructure—is crucial for delivering high-quality care during crises and beyond.

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