1.5.3 Coercion in Psychiatric Rehabilitation

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Learning Objectives

1. To appreciate the ethical problems of using coercion in psychiatric rehabilitation
2. To recognize an alternative to coercion in psychiatric rehabilitation and its grounds

Case

Mr. Smith is a 38-year-old single, unemployed man who lives on his own in subsidized housing. He has been an outpatient of yours for the last year or so, and he also has a community case manager who has known him for the last decade or so. He has been diagnosed with schizophrenia, paranoid type, since he was 19 years old, and he has also been diagnosed with cannabis abuse since he was 25 and with non-insulin-dependent diabetes mellitus for the last two years (with no history of hypo/hyperglycemic coma). He is treated with oral antipsychotic medication and a low-sugar diet and has declined other treatment suggestions such as depot (injectable) antipsychotic medication and oral hypoglycemics. He is considered capable of consenting to treatment but not of managing his finances, for which the public guardian and trustee is the substitute decision-maker. Lately he has had an exacerbation of auditory hallucinations and related death wishes without suicidal intent. The identified trigger to this exacerbation is an increase in his cannabis intake due to peer pressure. The identified trigger for many of his previous psychiatric exacerbations, some of which have led to hospital admissions, is non-adherence to antipsychotic medication. Mr. Smith does not have a history of physical aggression or suicidal acts. Although Mr. Smith insists on maintaining his subsidized housing as he likes his independence, his case manager approaches you with the request to collaborate with her in creating and implementing a plan to coerce Mr. Smith into moving to a group home, where his adherence, substance use and diabetes can be monitored closely and addressed. She states that, with your support, the public guardian and trustee could be convinced to discontinue Mr. Smith's payment for subsidized housing and to divert it to group home payment.

Questions

1. Should Mr. Smith be supported in maintaining his subsidized housing, and if so, on what grounds?
2. If Mr. Smith should be supported in maintaining his subsidized housing, to what extent, if at all, is that qualified by potential benefits for him of living in a supervised setting such as a group home?
3. What is the characterization of the notion of therapeutic coercion, and to what extent, if at all, is it compatible with psychiatric rehabilitation?
4. What may be a sound alternative to the case manager’s approach, and what may be the grounds for such an alternative?

Discussion

Q1. Should Mr. Smith be supported in maintaining his subsidized housing, and if so, on what grounds?

Housing is a basic human need, and it is therefore a fundamental goal in psychiatric rehabilitation, which strives to assist people with psychiatric disabilities to achieve their goals in life by enhancing and maintaining their skills and supports.1 The law is silent on such matters. The well-known principles of bioethics, namely, respect for persons (and autonomy or self-determination), beneficence (and non-maleficence) and justice (or fairness to all involved), are relevant to psychiatric rehabilitation as they are to other areas of psychiatry and health care.2 Respect for Mr. Smith would require respecting his choice to maintain his subsidized housing. As respect for persons is considered a central principle of contemporary bioethics, at least in ordinary clinical circumstances, coercing Mr. Smith into moving to a group home may be unethical. In addition, psychiatric rehabilitation is associated with a client-centred and recovery-oriented approach, which assists patients in working toward their own goals in life, so that coercing Mr. Smith into moving to a group home may not be clinically sound, at least within a rehabilitation framework. This case highlights that clinical decision-making may extend beyond considerations of treatment to considerations of
Q2. If Mr. Smith should be supported in maintaining his subsidized housing, to what extent, if at all, is this qualified by potential benefits for him of living in a supervised setting such as a group home?

A non-supportive living environment can be detrimental to a person's well-being and/or health. This is true in general of work, leisure and social environments, but perhaps even more so for residential environments. It is clearly the case for persons who are homeless, whose life expectancy is decreased due to the difficult settings they reside in. Thus, housing can be beneficial for a person. This is perhaps even more likely for persons with psychiatric disabilities, who are more vulnerable than the general population, so that residential supports may be needed to uphold their well-being and/or health. In the case of physical disabilities, such supports are mostly physical, such as ramps for people who use wheelchairs. In the case of psychiatric disabilities, such supports are mostly social, such as caregivers — professionals, family members and others — to assist in accomplishing activities of daily living that are generally important, such as healthy eating and medication intake. Supervised housing settings such as group homes can provide such supervision. This type of support is grounded on the principle of beneficence.

In the case of Mr. Smith, where the principle of beneficence clashes with the principle of autonomy, which of these two principles should prevail? For Mr. Smith, taking antipsychotic medications and closely monitoring and treating his diabetes and substance abuse could clearly be beneficial to his health. Yet it would disrupt his self-determination. Admittedly, his self-determination could also be disrupted by non-adherence to treatment and by substance abuse, as at an extreme these may result in stupor, yet this is unlikely in his case (based on his history). It is commonly agreed (and legislated) that when a person's safety is at serious risk due to his mental illness, beneficence outweighs autonomy, but that otherwise, a person's choice is to be respected. This has been discussed and demonstrated in the context of psychiatric rehabilitation. Therefore, the extent of risk to Mr. Smith's safety due to living in subsidized housing rather than in a group home, and its relation to his mental illness, have to be assessed. Not adhering to antipsychotic medications may cause Mr. Smith an exacerbation of his psychiatric symptoms, and possibly suicidal ideation, but probably not suicidal acts (according to his history). Not closely monitoring and treating his diabetes may cause Mr. Smith complications, but his diabetes seems to be mild enough so as not to have caused him coma in the past, in spite of his self-neglect. His substance abuse has caused him exacerbation of psychiatric symptoms, to the point of past psychiatric hospital admissions, but without aggression or suicidal acts. Perhaps even more important is the fact that Mr. Smith's insistence on maintaining his subsidized housing (rather than moving to a group home) is not related to his mental illness but rather to his wish to be independent, which is a very common and normal wish. Thus, as there does not seem to be serious risk to Mr. Smith's safety in maintaining his subsidized housing, and as his wish to maintain his subsidized housing does not seem to be related to his mental illness, autonomy trumps beneficence in his case. In other words, the potential benefits for him of living in a group home should not qualify the support for him in maintaining his subsidized housing.

Q3. What is the characterization of the notion of therapeutic coercion, and to what extent, if at all, is it compatible with psychiatric rehabilitation?

Coercion is the restriction or modification by one party of another party's range of choice or actual choice, through various means, such as emotional extortion, intellectual manipulation and more; use of physical force is considered distinct from coercion by some. For instance, the use of threats can be regarded as coercive, as in the threat to hospitalize an individual if he or she does not adhere to prescribed treatment; this is illustrated in community treatment orders. Coercion assumes involuntary participation by the coerced party. Coercion differs from offering (otherwise unavailable) alternatives, as a result of which the range of choice is expanded; this is illustrated in developing countries, where offering otherwise unavailable HIV/AIDS treatment as part of clinical research can be considered ethical. Coercion also differs from persuasion, in which the goal of each party is to get the other party to accept a particular statement, using as premises only statements that the other party is committed to in advance; this is manifest in truth-seeking critical discussion. Therapeutic coercion is coercion aimed at helping the coerced party, specifically at helping a patient. As noted above, psychiatric rehabilitation works toward achieving patient's goals by skills training and providing supports; hence, patient choice and offering alternatives are central in psychiatric rehabilitation. Coercion is not usually compatible with psychiatric rehabilitation, but when safety is at serious risk due to a person's mental illness coercion and use of physical force may be necessary.

Q4. What may be a sound alternative to the case manager's approach, and what may be the grounds for such an alternative?
A sound alternative to coercion in psychiatric rehabilitation is to engage with the person in communication about potential challenges to his or her success in environments of the person's choice. This approach has been studied and formulated as assessing and developing readiness for psychiatric rehabilitation. The process is non-confrontational and explores the person's perceived need to change, commitment to change, self-awareness, awareness of living environments and closeness to others. The grounds for this process can be argued to be situated in a dialogical approach to bioethics, where discussion of ethical problems goes beyond the standard bioethical principles to engage the person in ethical dialogue on his or her goals, using communication strategies that may be adapted to the needs of people with schizophrenia and other serious mental illnesses who may have impairments that make it particularly difficult for them to engage in such dialogue. The outcome of engaging Mr. Smith in such a process may be to secure his consent to be supported by outreach staff in his subsidized housing.

Conclusion

Coercion is not usually compatible with psychiatric rehabilitation. When safety is at serious risk — such as a likely risk of death — due to a person's mental illness, coercion and use of physical force may be acceptable. Otherwise, a mentally ill person's goals should be respected as much as possible in clinical decision-making. When these goals are considered unreasonable, engagement in dialogue with that person regarding his or her goals is recommended, as reflected in the process of rehabilitation readiness assessment and development. The above requires prudent clinical and ethical decision-making that is contextualized and conducted in an accountable manner, as is true for all medical decision-making.

Generally, mental health challenges are complex and related outcomes are commonly determined in part by social factors such as poverty and discrimination. As part of that, mental health services require an interprofessional approach and call for person-centered care even for the most seriously mentally ill individuals. Recovery is now recognized as the ultimate goal of mental health care, although it sometimes raises challenging ethical questions. Physicians and others providing care to people with mental illness can benefit from identifying and addressing ethical issues pertaining to their involvement with these individuals.

References