

Patient-Centered, Recovery-Oriented Psychiatric Care and Treatment Are Not Always Voluntary

Jeffrey L. Geller, M.D., M.P.H.

Explicitly coercive measures are sometimes necessary in the care and treatment of psychiatric patients. The author describes how use of such measures is not antithetical to patient-centered, recovery-oriented practice either in inpatient or outpatient settings. Citing a definition widely used by advocates to describe the overarching goal of recovery—“a full, meaningful, and self-determined life in the community . . . regardless of psychiatric status”—the author draws parallels between coercive measures taken by society to prevent and treat citizens’ dangerous behaviors, such as speeding and public inebriation, and coercive interventions to address dangerous behaviors of psychiatric patients, such as harm to self or others. Society applies coercive interventions to address dangerous behaviors, not psychiatric status. (*Psychiatric Services* 63:493–495, 2012; doi: 10.1176/appi.ps.201100503)

Principles of patient-centered, recovery-oriented practice in psychiatry (1) include the centrality of the individual with mental illness in the process of treatment planning and implementation; shared decision making with an “autonomy rheostat” depending on the capabilities of the person with mental illness; reasoned risk taking that extends the margins of

the scope of functioning; and the cooperative extension of the boundaries of psychiatric care to include health and wellness, mindfulness, social engagement, and employment. The psychiatrist’s option to employ coercion when necessary is an integral component of functioning in this recovery-oriented paradigm and staying focused on recovery goals. But coercion must be used in a way that counteracts patients’ frequent perception that such practices are dehumanizing (2). If a person with serious mental illness becomes psychotic and dangerous, how can one honor the principles of recovery-oriented practice to achieve recovery goals without use of involuntary interventions?

This Open Forum examines use of coercion in inpatient and outpatient settings and calls on clinicians to focus on how to use involuntary interventions in the context of a recovery-oriented process to achieve recovery goals.

Case examples

Case 1

June, a 34-year-old woman with schizophrenia and a history of trauma, including sexual assault by her father from age 5 through 19, accrued 22 psychiatric admissions between the ages of 25 and 30, all of which were through involuntary emergency detentions. At age 30, June and her recently assigned outpatient psychiatrist discussed this pattern of admissions to hospitals that she “hates.” In the context of discussing shared decision making and advance directives, the two agreed on what leads to hospital admissions, what conditions would warrant a psychiatric admission and

when an admission would be involuntary, what contact the outpatient psychiatrist would have with June during her hospitalization, and how June and her psychiatrist would process each hospitalization after discharge. Between the ages of 31 and 34, June had two psychiatric admissions. At her first appointment after turning 35, June told her psychiatrist, “You know what makes the difference, Doc? I know you act with me whenever you can and act for me only when you have to. We are in this together, even if you lock me up once in a while.”

Case 2

Jeremiah is a 74-year-old man with a 55-year history of schizophrenia, whose most recent stay at a state hospital lasted for nine years. He was discharged to a lovely senior citizen garden apartment complex with two other state hospital patients of his generation. During the first two weeks he repeatedly ran off, sometimes climbing out of his first-floor bedroom window, attempting to return to the state hospital. He said he “hated” what others were telling him was a “normal lifestyle” in the community; he preferred his “retirement in the state hospital.” He did not want to be “forced” to be in the apartment. He insisted that his discharge and placement were “involuntary.” He could find no advocate to assist him to return to the state hospital. Within a month, he committed a crime (picked all the tulips in a city park and threw them at a police officer) and was admitted to the state hospital, this time as a forensic patient. On admission he said, “It’s sad this is what it took to get me back here.”

Dr. Geller is affiliated with the Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Ave. North, Worcester, MA 01655 (e-mail: jeffrey.geller@umassmed.edu).

Inpatient treatment

Patient-centered care and treatment in a psychiatric hospital means that treatment, habilitation, and rehabilitation are constructed, implemented, and monitored with continuous, meaningful patient and staff input to the maximum extent possible. Patients define their problems and goals with assistance from staff, and interventions are designed and provided by staff with input from patients to address each patient's achievement of his or her goals in an effort to resolve problems impeding resumption of the individual's role as a participating member of his community (3). Both patients and staff recognize that factors outside their control, such as forensic commitment, have an impact on this process and that achieving a clinical status the court believes warrants discharge may take time, which will delay community (re)integration. In these cases, further goals to be achieved in the hospital need to be developed by the patient, assisted by staff.

Patient-centered care does not mean that under the banner of "patients' rights," inpatients can do whatever they choose or go anywhere in the hospital they deem appropriate at any time. Patients have myriad rights, but one of them is not to make up rules for themselves as they see fit. They don't have this right outside the hospital, so why would they have it in the hospital?

It is not antithetical to patient-centered care and treatment to use seclusion or restraint. Minimizing the use of these practices is a worthy and long-held goal (4,5), along with minimizing other interventions that restrict free movement, such as putting people behind locked doors on psychiatric wards or holding people against their will in hospital emergency departments. But the notion that we can eliminate all coercive interventions by using our current array of psychopharmacologic agents, psychotherapies, and rehabilitation interventions is without precedent (6). The gyrations that staff would have to go through to achieve zero coercion would be considerably less patient centered, less safe, and less honest than the level of care they can provide

through the judicious use of effectively monitored coercive interventions.

Is it patient centered to assist a patient to move from a hospital to a nominally more integrated setting? Only if that is what he or she wants. If it's not, then it's not patient centered. If a patient in a newly constructed state hospital indicates he wants to stay because no place he can live will ever be as nice as the state hospital, then under a model that honors the patient-centered approach he stays, at least for now. But inpatient beds are a scarce resource, so staff would work with the patient to shift his assessment of community benefits. Coercive discharge is rarely effective (7). The decision to remain a hospital patient can be a perfectly rational one, made in an informed decision-making process, but it need not be the final one.

Inpatient studies have found evidence that involuntary patients' perception of coercion has a much stronger impact on their satisfaction with treatment than the documented use of coercive interventions (8). Thus using the patient-centered approach of ensuring that the patient is an informed participant should decrease the feeling of being coerced.

A major quandary in patient-centered care and treatment is the all-too-common scenario in which individuals articulate what they want and then conduct themselves in a manner that precludes their getting it. For example, an inpatient says he wants to leave the hospital as soon as he can, but he regularly assaults the staff. In this fundamental disconnect, staff must take the lead to be patient centered for the patient until he can be patient centered on his own behalf, and then staff can follow. Involuntary treatment is the patient-centered treatment of choice in such cases: it is treatment in which the patient is participating to the maximum extent possible.

Outpatient treatment

Questions surrounding coercion and involuntariness are not put to rest when individuals with serious mental illness reside outside hospitals in what is euphemistically called "the community." Coercive interventions, with

little or no review by anyone other than a physician or a treatment team or administrator, are rampant in entitlement programs; they include leveraged housing (for example, "If you want to live in this residence, you have to take your medication as prescribed and go to a day program"); representative payeeships; "bargained" psychopharmacologic regimens (for example, "You take your antipsychotic and you can have a benzodiazepine"); waiver of civic responsibilities (for example, jury duty); treatment "contracts" through Individual Service Plans; and threats of emergency detention (for example, civil commitment) (9).

We need to recognize that coercion and involuntary care and treatment are, within reasonable degrees, in the eye of the beholder. For example, pursuant to the U.S. Supreme Court *Olmstead* decision, states must provide care to persons in the most integrated setting appropriate to an individual's need. However, it would be incorrect to conceive of this as a set of fixed-step residential options, graded from least to most integrated by type of setting. One person may experience detention in a state hospital as involuntary, whereas another may experience discharge from a state hospital as involuntary.

In the community there are structured forms of involuntary commitment, referred to as outpatient commitment or assisted outpatient treatment, such as the program in New York State. In these programs individuals are legally committed to treatment because they cannot make a valid "commitment" to treatment themselves. Clinical guidelines have existed for this form of intervention for two decades (10), and its effectiveness has been documented (11). The fear that this effective, involuntary community intervention will expand beyond the targeted population has been allayed (12).

Community-based paralegal and legal commitments often serve as the foundation for patient-centered care and treatment. It is difficult, if not impossible, for patients to be patient centered if they cannot find their center because their thinking is so obscured by psychosis that a fundamen-

tal sense of reality is lost. A strong case could be made that failure to use coercion or involuntary treatment in such instances is an abandonment of patient-centered care and treatment—and may even be an abandonment of the patient.

As in inpatient studies, outpatient studies have shown that perceived coercion is a key parameter. Informing patients about the need for a coercive intervention and the process used can decrease perceptions of coercion (13). Such efforts are central to working on recovery goals.

Service system issues

It is unfortunate that those who define and advocate for recovery either fail to acknowledge, or fail to address, the role of coercion in recovery. In doing so, they exacerbate the very issues they claim to be ameliorating. For example, the extensive materials on recovery on the Web site of the Substance Abuse and Mental Health Services Administration (SAMHSA) (www.SAMHSA.gov) present no discussion of coercion as an aid to meeting recovery goals. The SAMHSA materials include the following statement: “What advocates are promoting now is a full, meaningful, and self-determined life in the community—the same kind of life that all of us want, regardless of psychiatric status” (14).

SAMHSA is exactly right on this point. A person who repeatedly gets stopped for speeding loses his or her license and must attend classes to get it back (treatment). A bartender refuses to serve more drinks to a patron who becomes inebriated (prevention). Someone who disrupts a public event is removed from the venue (treatment, behavior modification). If you park illegally, the car is towed and you get fined, and you must pay the fine to get the car back (treatment and prevention). If a person behaves in a way that is dangerous to others,

and the danger can be mitigated by psychiatric treatment, the person gets treatment. The treatment is focused on preventing further episodes of the dangerous behavior. It is coercion in the same way that others in the community are subjected to coercion. It is not coercion because of “psychiatric status”; it is an intervention to address behavior. Just as we all experience.

Coercion, as described in this Open Forum, is not about withholding from individuals with psychiatric disorders “the dignity to fail” (15). Rather, it’s about safety, and in that way, it’s about respect.

Conclusions

Rather than focusing on the elimination of every aspect of coercion and involuntary treatment in psychiatry, we might do better to focus on how to use involuntary interventions in the context of a recovery-oriented process to achieve recovery goals. Coercion is rampant and used with little thought in medicine—treating patients in emergency departments without their informed consent, requiring treatment for tuberculosis in the primary care physician’s office, and restraining patients with movement disorders in nursing homes. Psychiatry is not alone in the use of involuntary interventions. Because any patient could view any intervention as coercive (2), it is best to acknowledge coercion when it is used. It is time for psychiatry to develop methods for humane, respectful, recovery-oriented involuntary interventions to specifically achieve recovery goals and teach them to the rest of medicine.

Acknowledgments and disclosures

The author reports no competing interests.

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