

# Ethical Issues in Mobile Psychiatric Treatment with Homebound Elderly Patients: The Psychogeriatric Assessment and Treatment in City Housing Experience

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Unique and challenging ethical difficulties arise during mobile psychiatric treatment of elderly patients. This article outlines and analyzes five of these challenges that have been encountered during nearly 20 years of experience with the Psychogeriatric Assessment and Treatment in City Housing Program in Baltimore, Maryland. The ethical challenges reviewed are: establishing the treatment contract versus the right to refuse treatment, protecting confidentiality versus patient protection, protecting autonomy versus asserting beneficence, treatment termination versus open-ended treatment, and cost versus benefit of care. Ethical challenges with homebound elderly patients are unique because of patient characteristics as well as features of the treatment environment. *J Am Geriatr Soc* 54:843–848, 2006.

**Key words:** psychiatric home care; ethics; mobile treatment; geriatric psychiatry

Mobile treatment services, an evolving mainstay of public health over the past century, are becoming important sources of geriatric medical care.<sup>1,2</sup> With the advent of de-institutionalization of the mentally ill, mobile psychiatric treatment has emerged as an important modality of care delivery to chronically ill psychiatric patients unable or unwilling to access care through community mental health clinics.<sup>3</sup> Homecare delivery programs are becoming an important source of medical care for the geriatric population but are still evolving and not yet widely available.

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DOI: 10.1111/j.1532-5415.2006.00706.x

The treatment setting may influence the application of bioethical principles. This may be due to factors inherent in the framework within which the care occurs, such as the forensic, military, or employment setting. Alternatively, this alteration may be due to patient characteristics such as age or cognitive capacity. In mobile psychiatric treatment with older people, a unique blend of patient characteristics and environment creates a distinct set of ethical challenges.<sup>4</sup>

This report grows out of nearly 20 years of experience providing outreach psychiatric treatment to homebound elderly individuals in Baltimore City public housing. This report describes and analyzes some of the common ethical challenges that have been encountered.<sup>5,6</sup>

## THE PATCH PROGRAM

The Psychogeriatric Assessment and Treatment in City Housing (PATCH) Program, a nurse-based community outreach program that identifies and treats elderly psychiatric patients not receiving care because of inability to access psychiatric services for reasons of physical or psychiatric illness, has been previously described.<sup>7</sup> The PATCH program, which services residents of Baltimore City public housing high-rise buildings, combines elements of the Assertive Community Treatment and the Gatekeeper models (Table 1).<sup>8,9</sup> The referral method yielded a cohort with high rates of psychopathology<sup>7,10</sup> (Table 2) and a mean age  $\pm$  standard deviation of  $73.1 \pm 8.7$ .<sup>6</sup> Many newly referred patients' medical conditions were so severe that urgent medical attention was necessary. Furthermore, the severity of behavior problems was such that many of the referred residents were facing eviction. A randomized, controlled trial demonstrated that this program could reduce psychiatric symptoms in the patients it served.<sup>6</sup>

## METHODS

A consensus process among the PATCH clinicians was used to identify five important ethical issues commonly encountered in mobile psychiatric treatment with elderly patients. Ethical issues thought to be unique to this setting were

**Table 1. Psychogeriatric Assessment and Treatment in City Housing (PATCH) Program Characteristics**

Variable	PATCH Program	Details
Setting	Patients' apartments	Goal of transition to outpatient setting
Case finders	Apartment building workers	Managers Janitors Postal workers Garbage collectors Security personnel
Reasons for referral	Observed symptoms	Sadness Psychosis Disruptive behavior Neglect of apartment Not paying bills Hoarding food/trash
Composition of treatment team	Multidisciplinary	Psychiatric nurse Geriatric psychiatrist Social worker

sought. Brief case vignettes felt to best illustrate these issues are presented in Table 3.

## RESULTS

### Ethical Challenges

#### *Establishing the Treatment Contract Versus the Right to Refuse Treatment*

In traditional psychiatric practice, the doctor-patient relationship is established voluntarily, usually at the initiative of patients or their families, and can be terminated at the request of the patient. Once terminated, efforts to return the patient to the clinician's practice are usually inappropriate.

In mobile treatment, in contrast, the treatment team seeks out the patient, usually at the initiation of a third party, although upon occasion the patient is self-referred. Typically, neither patient nor their families initially seek out the treatment. Initial contact with the resident is often met with refusal to participate in the program, but further attempts at enrollment are usually made. Although actual evaluation and treatment are not initiated without consent, the PATCH nurse does not usually accept initial refusals.

This deviation from traditional practice is justified for a number of reasons. First, clinical experience with this population suggests that the initial refusal is often based upon

misinformation, depression, paranoia, dementia, concern about stigma from being labeled a psychiatric patient, ingrained social isolation, or a reflexive avoidance of the unfamiliar. With repeated exposure to the nurse, the initial hesitation often wanes. Moreover, patients' initial refusals are not viewed a priori as reflecting an autonomous decision. The high rates of significant cognitive impairment found in newly referred patients, many of whom are ultimately found, after appropriate clinical assessment, to lack decisional capacity, support this approach.

Second, the significant percentage of patients referred to the program in an emergency or near-emergency situation justifies the assertive approach to establishing a treatment relationship, because the chance of identifying an extremely ill or vulnerable resident is significant. These two factors taken together place PATCH referrals somewhere in the continuum between usual outpatient treatment, in which treatment refusal may be accepted, and an emergency situation when the patient lacks decisional capacity, in which refusal is not accepted.

Many assumptions that support a less-assertive approach in general clinical settings are not applicable to the homebound elderly mentally ill. The fact that many PATCH patients ultimately do want treatment, but their symptoms prevent their obtaining it belies the idea that, if patients wanted treatment, they would initiate it. The high prevalence of cognitive impairment, severe affective disorder, and psychosis in this patient population undermines the belief that treatment refusal is an autonomous expression of free will. The assumption that someone else besides the clinician would intervene if the situation were truly urgent is also not true. Many patients in this population live in near-complete isolation from family, friends, religious organizations, medical practitioners, or other sources of support, protection, and emergency referral. The outreach clinician may be the only person in the patient's environment with the ability and willingness to perceive the gravity of the clinical situation and intervene.

### *Protecting Confidentiality Versus Patient Protection*

Mobile psychiatric treatment presents several challenges to the protection of confidentiality, an important component

**Table 2. Frequency of Psychiatric Diagnoses and Functional Impairment in the Original Psychogeriatric Assessment and Treatment in City Housing Sample**

Variable	Percentage
Met $\geq 1$ DSM-III-R diagnoses	89
Previously undiagnosed*	63
Unable to perform $\geq 1$ activities of daily living	21
Needed assistance with instrumental activities of daily living	54

\* Of those who now met Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) diagnostic criteria for a mental illness.

**Table 3. Common Ethical Challenges Encountered in Mobile Psychiatric Treatment of Homebound Elderly Patients**

Ethical Challenge	Clinical Example	Approach to Resolution
Establishing the treatment contract versus the right to refuse treatment	Uncooperative manic or paranoid patient who is refusing evaluation, noncompliant with medications, and wandering the streets	Assess safety Rapidly collect further information Assess decisional capacity Consider emergency petition
Protecting confidentiality versus patient protection	Patient with personality disorder, gross neglect of personal/apartment hygiene, leading to neighbors inquiring of treatment team about progress	Maximize discretion in visibility of home visits Do not disclose personal information Encourage neighbors to take a pragmatic, problem-solving approach, rather than an adversarial one
Protecting autonomy versus asserting beneficence	Patient with chronic schizophrenia and long-standing desire to live independently, now unable to safely manage medications	Explore options for supervising medication administration at home Consider patient preference in choosing new living arrangement
Treatment termination versus open-ended treatment	Alcohol-dependent patient repeatedly refusing to engage in alcohol treatment	Assess commitment to treatment Explain treatment options as well as consequences of not engaging in treatment Assess safety Provide contact information for alcohol treatment programs Consider discharge from mobile treatment
Cost versus benefit of care	Medically complex and illiterate patient with depression, mild cognitive impairment, and no family involvement, requiring weekly visits for a year	Assess patient needs and available resources Maximize patient enrollment in available social service programs Recall that ideal care may be expensive and that investing heavily in supportive living now may produce large monetary savings later Enroll patient in program that provides broad range of services and not only billable ones

of the physician–patient relationship generally,<sup>11</sup> and a cornerstone of the relationship between a mental health practitioner and the patient.<sup>12</sup> Building staff, who serve as primary “case finders,” refer patients to PATCH. Once the treatment relationship is established, clinicians must not provide information to that referral source unless mobile treatment participation is a prerequisite to staying an eviction order, in which case communication between clinician and building management is required. This requirement is explained to the patient, and attempts are made to obtain consent for its occurrence. In other cases, after an appropriate clinical evaluation, the patient is found to lack decisional capacity including providing consent or refusing contact with clinicians. If there is no identified surrogate decision-maker, the clinician is guided by acting in the patient’s best interest and must communicate with building management, family members, and social service agencies to facilitate proper care.

Two further challenges to confidentiality commonly arise. First, insofar as many building residents know the PATCH team, the home visit itself identifies the resident as a psychiatric patient, despite attempts to maximize discretion. Many patients are unwilling to be seen anywhere but in their apartments, even when office space is available within their building. The second is the fact that neighbors may approach the clinician to inquire about a patient’s welfare or to provide information they think will be clin-

ically useful. In this circumstance, the clinician has to balance confidentiality protection with trying to foster a genuine interest in the patients by individuals who could function as a social net in the place of the family or community that many PATCH patients lack.

Confidentiality in geriatric care is generally more complex than with younger adults. A care team often delivers treatment of elderly individuals, leading to the question of whether all team members should be privy to the same information. Because geriatric care often involves many family members, with whom diagnosis and treatment must be formulated and implemented, questions about confidentiality frequently arise.<sup>13</sup>

Certain cases present a particularly difficult dilemma. The evaluation may not yet have proceeded to the point where a competency determination can be made, yet safety concerns may already be present that should be addressed promptly. Clinicians must balance the potential for harm should the patient lack decisional capacity and not receive proper treatment with the risk of harm from violating patient confidentiality. A competent patient’s refusal to break confidentiality must be respected unless the clinical situation is deemed to be an emergency.

***Protecting Autonomy Versus Asserting Beneficence***

Many ethical systems hold that individuals should generally be free to make personal decisions for themselves, a position

adopted by modern American medical ethics. A cornerstone of medical ethics is beneficence, the obligation of health professionals to act in their patients' best interest. Although these values sometimes overlap, scenarios when they appear to conflict are common. For instance, some patients have significant cognitive impairment or other psychiatric symptoms but are not clearly incompetent. The treatment team may believe that the patient would be much happier, healthier, and protected in a supervised setting, although the patient refuses to consider this option. These scenarios require a careful balance between respecting the patient's wishes and appreciating the dangers that isolated, medically complex, and psychiatrically ill patients may face.

The approach in PATCH entails multiple steps that are repeated and refined over time with each patient. The first consideration is usually safety. Patients in immediate danger (malnutrition, dehydration, neglect of medical conditions, or reckless behavior) are hospitalized, voluntarily or involuntarily. If the situation does not entail immediate danger, a therapeutic alliance is formed, and attempts are made to build a supportive social network involving family, community resources, and social service agencies, in addition to treating the primary psychiatric condition. Safety is regularly assessed, because patients' medical and psychiatric conditions often fluctuate. The recommendation to live in a more-supervised setting is repeated if still applicable. Patients' wishes to remain living independently are placed in the context of their other goals (longevity, medical health, social contact, participation in religious ceremonies, being symptom-free), and the patient may make a decision considering all factors.<sup>14</sup>

Although PATCH strives to support and actualize a patient's desire to live independently, when the team believes that a patient would be better served in a different living setting, this recommendation is made and restated over time in an attempt to obtain informed consent from the patient to move forward with the recommendation. This approach raises certain ethical questions about the propriety of making and pursuing such a recommendation when the patient did not request the PATCH service and may initially have resisted it, but given the significant vulnerability of this population, the lack of social support available to most of them, and the high prevalence of significant medical and psychiatric morbidities, an assertive approach that emphasizes beneficence is justified.

#### *Treatment Termination Versus Open-Ended Treatment*

PATCH treatment can be terminated in one of three ways: once the patient transitions to outpatient treatment, when the clinicians feel that the patient will not benefit from further PATCH treatment, or upon patient request. The first two circumstances can present ethical challenges. Most patients derive substantial emotional and pragmatic benefits from regular contact with the PATCH team. The amount of support exceeds that usually available in traditional outpatient treatment, in length and frequency of visits, and in breadth of psychosocial problems addressed. Clinician-initiated termination of treatment may have a negative emotional effect on the patient and potentially lead to a sense of abandonment.

There are a number of valid ethical justifications for the withdrawal of this level of support. When patients transi-

tion successfully to traditional treatment, they usually consider this to be an achievement of improved health and independence. Even when patients prefer the convenience of home treatment, the limited nature of the PATCH resource justifies restricting the service to those truly requiring it. Finally, when the patient is clearly not benefiting from the treatment (e.g., gross noncompliance for reasons other than symptoms of the illness itself or lack of willingness to pursue substance abuse treatment), continued treatment may be considered inappropriate clinical care or even harmful if it enables patients to avoid taking responsibility for their care. This may be particularly relevant for patients whose primary diagnosis is substance abuse or a personality disorder. This problem is approached proactively by regularly reviewing cases as a group and defining explicit treatment goals.

Some patients will accept medical and psychiatric services only when delivered by the outreach team, even once target symptoms have substantially improved, because the factors that initially led them to avoid outpatient psychiatric treatment persist. Therefore, some patients are kept in the program beyond the time in which they meet technical entrance criteria. For such individuals, a slow taper of mobile treatment services is attempted by continuing it while transitioning them to care in more-traditional outpatient settings. Finally, because mobile treatment patients may have difficulty expressing their wish for termination, the mobile treatment clinician looks for signs of ambivalence about treatment or the desire to terminate treatment.

#### *Cost Versus Benefit of Care*

Attention to the appropriate use of resources is a necessary component of the medical ethic. Mobile treatment programs are expensive, do not yet have proven cost effectiveness, and often cannot use traditional fee-for-service reimbursement models. Even when payment is available, multiple nurse visits may be necessary before a billable service can be rendered. Furthermore, many services provided, such as coordinating medical appointments, organizing medications, and trying to mobilize a social network, are time consuming and do not qualify as a billable home-care visit. Nonetheless, such services are an absolute necessity for this vulnerable and disadvantaged patient population. Grant funding or capitated programs are thus the preferred funding mechanism for such programs, because they allow for the provision of a broad scope of necessary services and not just billable ones.

Most patients requiring PATCH have a combination of characteristics rendering them particularly vulnerable and in need of intensive services. It is the combination of characteristics rather than any one of them alone that creates the unique need served by PATCH. First is the presence of a major mental illness, often schizophrenia, bipolar disorder, major depression, or dementia. Second is a high prevalence of cognitive impairment, either from dementia or lifelong cognitive impairment. Third is the high prevalence of complex and often-neglected medical conditions requiring coordination of multiple medications and physicians. Fourth, and in many ways most important, is the nearly complete lack of significant family or other social support. These factors together contribute to the social isolation, lack of integration into social services, inconsistent medical care,

significant poverty, and tenuous nutritional status faced by most PATCH patients.

## DISCUSSION

This article outlines and briefly analyzes five ethical dilemmas commonly encountered by the PATCH team while delivering mobile psychiatric treatment to homebound elderly patients. These dilemmas reflect unique features of the patients, their residential settings, and the expertise of a treatment team that focuses on the severely mentally ill with significant medical comorbidity. Different ethical dilemmas would likely unfold with different patients, in other settings, and when cared for by treatment teams with professionals from other disciplines.

It is reasonable to ask whether the challenges raised by mobile psychiatric treatment differ significantly from those confronted in the office setting. There are several important differences. First, as described in the second ethical challenge, the home setting creates certain realities related to confidentiality, as well as clinician allegiance, that are not typically encountered in the traditional office setting. Second, the percentage of referred patients who turn out to lack decisional capacity but are completely isolated and without easily identified individuals to provide support is higher than in most care settings. This combination leads to unique and challenging ethical dilemmas. Third, the high prevalence of medical and social comorbidity in this patient population often leads to scenarios that require immediate intervention in ways that favor beneficence over autonomy concerns. Failing to intervene may have irreversible consequences in terms of the patient's health or even life, outcomes that are not implausible given the medical and psychiatric complexity of the population. Although the approach can be paternalistic at times, attempts are always made to consider the wishes of the patient.

In traditional outpatient settings, these concerns are infrequent or rare. The presence of family or community allows for medical decisions to be made by the patient with meaningful input by family or community members or by legal surrogate decision-makers when the patient lacks decisional capacity. These decisions may be made based upon known previous wishes of the patient or upon what the family believes is in the patient's best interest. The great isolation from family or community of the patients described in this article makes this kind of shared or surrogate decision-making impossible. The treatment team must often make recommendations without the benefit of input from a wider circle of involved individuals, relying instead on patient preference, clinical judgment, and the input of social service agencies. With patients who are unable to make their own decisions, and in the absence of involved family or friends who might provide resources to improve the safety of the home environment, safety concerns often drive decision-making.

There are certain similarities between the PATCH program and consultation/liaison psychiatry. In both settings, contact with the patient is usually initiated at the request of a third party, a party that often comes to the psychiatric consultation with its own objectives for the evaluation. Thus, the establishment of a therapeutic alliance may be more challenging than in a typical office setting. Moreover,

the psychiatric clinician must be able to disentangle the objectives of the referring individual (e.g., eviction, transfer of the patient to another service) from what is truly in the best interest of the patient.

In the course of the routine practice of mobile treatment, particularly mobile psychiatric treatment, it is useful to identify the particular ethical tensions present in each case and include them in the case formulation. This encourages clinicians to explicitly consider all the relevant factors in the case and may lead to creative solutions that address varying concerns. Holding regular team meetings at which these clinical and ethical dilemmas are discussed and at which input is encouraged from all team members is one important approach. Consulting with knowledgeable colleagues, including formal ethics or clerical consultation, is another option, particularly when difficult dilemmas are encountered. Finally, issues of resource allocation need to be addressed at the societal level.<sup>15</sup> It is not known whether providing mobile psychiatric outreach treatment is more or less expensive than not providing it, but the service provided is unique and valuable to this underserved special-needs population.

## ACKNOWLEDGMENTS

The authors acknowledge Mary Tlasek-Wolfson for her participation in the early years of the project.

**Financial Disclosure:** Supported by a grant from Baltimore Mental Health Systems and the State of Maryland Department of Health and Mental Hygiene.

**Author Contributions:** David M. Blass and Peter V. Rabins: study design and concept, data acquisition and analysis, preparation of initial manuscript draft and revisions. Rebecca M. Rye, Beatrice M. Robbins, Mary M. Miner, Sharon Handel, and John L. Carroll: study design and concept, data acquisition and analysis, preparation of manuscript revisions.

**Sponsor's role:** None.

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