

Licit Substance Use in Physical Rehabilitation Settings

Brynne McArthur, Alexandra Campbell and Andria Bianchi

Volume 5, Number 2, 2022

URI: <https://id.erudit.org/iderudit/1089791ar>

DOI: <https://doi.org/10.7202/1089791ar>

[See table of contents](#)

Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

[Explore this journal](#)

Cite this document

McArthur, B., Campbell, A. & Bianchi, A. (2022). Licit Substance Use in Physical Rehabilitation Settings. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, 5(2), 124–128. <https://doi.org/10.7202/1089791ar>

Article abstract

The purpose of this commentary is to consider circumstances under which it may be ethical to permit patients to use licit substances in rehabilitation contexts. While the content of this commentary may be transferable to other healthcare spaces, our focus on rehabilitation is based on some important distinctions that exist between rehabilitation and acute care spaces.

© Brynne McArthur, Alexandra Campbell and Andria Bianchi, 2022



This document is protected by copyright law. Use of the services of Érudit (including reproduction) is subject to its terms and conditions, which can be viewed online.

<https://apropos.erudit.org/en/users/policy-on-use/>

This article is disseminated and preserved by Érudit.

Érudit is a non-profit inter-university consortium of the Université de Montréal, Université Laval, and the Université du Québec à Montréal. Its mission is to promote and disseminate research.

<https://www.erudit.org/en/>

COMMENTAIRE CRITIQUE / CRITICAL COMMENTARY (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Licit Substance Use in Physical Rehabilitation Settings

Brynne McArthur^{a,b}, Alexandra Campbell^c, Andria Bianchi^{a,d,e}

Résumé

L'objectif de ce commentaire est d'examiner les circonstances dans lesquelles il peut être éthique de permettre aux patients de consommer des substances licites dans des contextes de réadaptation. Bien que le contenu de ce commentaire puisse être transposé à d'autres espaces de soins de santé, l'accent mis sur la réadaptation est fondé sur certaines distinctions importantes qui existent entre la réadaptation et les espaces de soins aigus.

Mots-clés

consommation de substances psychoactives, réadaptation, réduction des méfaits, centré sur la personne, centré sur le patient

Abstract

The purpose of this commentary is to consider circumstances under which it may be ethical to permit patients to use licit substances in rehabilitation contexts. While the content of this commentary may be transferable to other healthcare spaces, our focus on rehabilitation is based on some important distinctions that exist between rehabilitation and acute care spaces.

Keywords

substance use, rehabilitation, harm reduction, person-centred, patient-centred

Affiliations

^a Bioethics Department, University Health Network, Toronto, Ontario, Canada

^b School of Rehabilitation Sciences, McMaster University, Hamilton, Ontario, Canada

^c Centre for Clinical Ethics, Unity Health Toronto, Toronto, Ontario, Canada

^d KITE Research Institute, Toronto Rehabilitation, Toronto, Ontario, Canada

^e Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada

Correspondance / Correspondence: Andria Bianchi, andria.bianchi@utoronto.ca

CASE

Courtney was recently in a motor vehicle accident, resulting in spinal and upper extremity fractures. After the accident, she was admitted to an acute care hospital and then transferred to an inpatient unit at a physical rehabilitation centre. As part of Courtney's rehabilitation, her clinical team recommends a number of therapies, and she consents to all recommendations. Courtney has a good support network of friends who visit frequently and take her outside for fresh air. On one occasion, a clinician sees Courtney with her friends. The group appears to be drinking alcohol and smoking cannabis. Although both alcohol and cannabis are legal substances in this rehabilitation centre's jurisdiction, the centre does not permit patients to use substances during their inpatient journey regardless of whether they are legal or consumed off-property. The clinical team approaches Courtney after being informed of the staff member's observations, and in response to the team's queries, Courtney states that alcohol and cannabis are a regular part of social activities with friends. She communicates good knowledge of the risks and knows where to seek support if ever needed. Courtney also expresses frustration upon learning of the rehabilitation centre's position/prohibition of patients consuming these legal substances, especially since she will consume them post-discharge.

INTRODUCTION

Cases such as Courtney's occur in rehabilitation and acute care settings; patients sometimes remain on or leave hospital premises to engage in licit (e.g., smoking cigarettes) and/or illicit (e.g., using heroin) activities. The response of healthcare organizations to these activities differ depending on 1) whether there exist relevant policies, 2) staff members' values and beliefs, 3) clinical contraindications, and/or 4) the patient(s) involved. The purpose of this commentary is to consider circumstances under which it may be ethical to permit patients to use licit substances in rehabilitation contexts.¹ While the content of this commentary may be transferable to other healthcare spaces, our focus on rehabilitation is based on our professional experiences and some important distinctions that exist between rehabilitation and acute care settings. Furthermore, there is reason to believe that substance use may be prevalent for at least some populations within a rehab context.

In the first part of this commentary, we discuss physical rehabilitation and person-centredness. We then introduce the topic of substance use and consider why some patients may want to use licit substances. In the third section, we consider whether a harm-reduction approach to care and substance use may be apt for rehabilitation contexts. Ultimately, we suggest that it may be ethical to allow patients in rehabilitation to use licit substances in some circumstances.

¹ We focus our attention on legally-permitted substances since ethics considerations, rather than legal considerations, are what require scrutiny. However, our focus on licit substances is not meant to suggest that the use of illicit substances is necessarily unethical.

REHABILITATION AND PERSON-CENTREDNESS

Rehabilitation centres provide therapeutic techniques that aim to improve function and reduce disability for people with various physical and cognitive impairments (congenital and acquired). People of any age may require rehabilitation at any time and for many reasons, such as when recovering from surgery, illness, motor vehicle accidents, etc. Although outpatient and addiction rehabilitation centres exist, this commentary focuses on inpatients receiving support for anything other than substance use itself.²

The primary goal of rehabilitation is to reduce disability and improve and/or regain functioning through methods that promote independence and autonomy (1). A person-centred philosophy is at the core of rehabilitation, where each patient is regarded as a person who has goals, values, and beliefs that extend beyond hospital walls. A person-centred approach to care is important for all healthcare facilities to implement, though it may be particularly important for rehabilitation since a primary goal is to increase independence prior to discharging back home/to the community. A patient's rehabilitation journey and care provision will likely depend on their individual values, beliefs, and post-discharge preferences. For instance, if a person with a new physical disability values living in and wants to be discharged to a two-storey home with stairs and no main-level washroom, then the rehabilitation team may develop recommendations based on this goal; they may spend substantial time on stair-climbing, ensure that all at-home supports are in place to mitigate falls, etc. Person-centred care involves maintaining a holistic view of patients and empowering them to participate in decisions about care provision and discharge planning so their values and goals can be realized.

SUBSTANCE USE AND INPATIENTS IN REHAB

A common practice within all inpatient medical settings is to strongly discourage or require that patients abstain from all substance use, regardless of whether legal constraints exist. "Substance use" is an umbrella term that describes "the use of drugs or alcohol... [including] cigarettes, illegal drugs, prescription drugs, inhalants and solvents" (2).³ Using any substance brings with it potentially detrimental health consequences, so the intention of prohibiting substance use or encouraging abstinence may be good. For instance, we know that smoking cigarettes causes approximately 80% of deaths from chronic obstructive pulmonary disease (COPD), leads to an increased likelihood of developing cataracts, cancer, etc. (4). Because of consequences related to smoking cigarettes, it seems reasonable that a healthcare facility may want to prohibit patients from smoking. Similarly, known short-term and long-term health effects about cannabis may influence organizations to ban or discourage its use (5). Additionally, some substances may lead to consequences that pose barriers for a person's care plan. For instance, if fatigue is a consequence of substance use, then one may be less willing to participate in therapeutic activities that require energy after using the substance.

Promoting patients' overall health is a sensible goal for any health facility. Typically, when a person who uses substances is in a healthcare setting that does not permit such use, the clinical team may propose options to help them abstain. Depending on the type of substance and potential consequence(s) of stopping, these options may include smoking cessation support (e.g., nicotine replacement therapies), opioid agonist therapies (e.g., buprenorphine, methadone), counselling, peer support, etc. From some perspectives, providing patients with options to help manage withdrawal symptoms may be considered one way to promote patient involvement and autonomous decision-making in a way that aligns with person-centredness. Additionally, supporting abstinence may seem to align with principles of beneficence and non-maleficence.

However, suppose that in the above-mentioned case, Courtney tells the clinical team she plans to continue to smoke cannabis off-hospital property even if they have a conflicting view; she makes an autonomous and well-informed decision to continue to use a legally permissible substance and *not* to abstain in accordance with clinical recommendations. In this scenario, threatening discharge or failing to offer support would oppose what it means to provide person-centred care. A person-centred approach would presumably involve acknowledging Courtney's plan to smoke cannabis both during and after her rehabilitation admission, working with her to explore how cannabis may influence her rehabilitation goals, and establishing mutually agreed upon parameters about when she can use cannabis so that it will not interfere with her therapy (e.g., after completing strenuous activities in the therapy gym). Additionally, a person-centred approach may involve taking on certain risks and teaching new skills. For instance, if Courtney's substance use puts her at a greater risk of falls, and if this is a risk that she wants to take, then the team may decide to teach her how to fall safely, how to get up, explore whether her home environment should be altered to reduce possible harms, etc. Insofar as person-centred care is an ethical philosophy to prioritize in rehabilitation, then working in accordance with Courtney's overall goals and values is important.

In addition to person-centredness, an abstinence-only philosophy may lead to unintended and avoidable harms. According to a 2018 study, abstinence as a form of substance use management can motivate patients to find alternative, potentially dangerous ways to use substances, or they may refuse to receive care altogether (6). Having an abstinence-only policy can also influence a person's recovery since it may result in early discharge (e.g., patients discharging against medical advice or staff discharging patients who use substances against the policy), risky substance use behaviour, and stigma from staff toward

² This commentary argues that it is ethically defensible to permit patients to use licit substances while receiving rehabilitation. Permitting licit substance use for a person receiving rehabilitation support for licit substance use (e.g., smoking cessation) would be in contradiction to the goal of that type of rehabilitation.

³ It is important to note that a person who uses substances does not necessarily have a substance use disorder (SUD). According to the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), 11 criteria are relevant to a SUD diagnosis; a person must meet two or more criteria within twelve months in order to be diagnosed (3).

those using substances (7). Furthermore, if abstinence is required and a withdrawal plan is managed without appropriate expertise, then withdrawal symptoms and pain can cause substantial distress for all (8). Finally, we know that requiring (undesired) abstinence can cause challenging dynamics to arise amongst patients and staff (7).

It may be the case that most health facilities assume that in-hospital abstinence will extend into discharge. However, short-term interventions for substance use, such as abstinence during a hospital admission, are insufficient for generating long-term behavioural change (8). Therefore, ceasing substance use while receiving rehabilitation is unlikely to alter the patient's post-discharge behaviour; this means that a patient's performance in rehabilitation may not adequately reflect their functioning in the real world. As described in Courtney's case, she explicitly informed her care team that alcohol and cannabis are a regular part of her and her friends' lives. It is unlikely that she will maintain abstinence post-discharge regardless of the rehabilitation centre's policy. Ultimately, substance use alters thinking and behaviour, so if Courtney receives rehabilitation while sober, but uses substances when discharged, then her ability to perform certain activities and the activities' level of risk may differ from what the clinical team witnessed.

While these questions and complexities related to substance use likely exist in any healthcare setting, the challenges with prohibiting licit substance use are even more important to consider for rehabilitation contexts. Rehabilitation is supposed to prepare people to live as independently as possible and to offer care that aligns with their individual goals, values, and preferences so they can successfully and meaningfully transition to the community. If a person will presumably engage in legally permitted activities post-discharge, including substance use, then it may be worthwhile for clinical teams to consider what these activities will look like in the community *during* their time in rehabilitation. A person who commences "new" activities post-discharge (e.g., substance use) may encounter unanticipated challenges that interfere with their meaningful and successful transition home.

HARM REDUCTION AND REHABILITATION

Requiring patients to abstain from licit substance use means that individuals such as Courtney may: 1) continue to use substances in a discrete and potentially dangerous way, 2) experience interpersonal conflict with team members, 3) experience pain if a careful withdrawal management plan is not established, and 4) fail to have a safe and successful discharge. Furthermore, an abstinence-only model fails to respect differing perspectives on licit substance use and the various lifestyles that people may autonomously choose to pursue post-discharge, preventing person-centred care from being fully realized.

If the goal of rehabilitation is to provide person-centred care to all who may benefit, then a harm-reduction approach may be a suitable alternative to abstinence-only policies. Harm reduction is a philosophy of care that aims to reduce harms associated with a particular behaviour; for the purposes of this paper, harm reduction refers to mitigating potential harms that come with continuing to use licit substances during inpatient rehabilitation treatment (9). Implementing a harm-reduction approach in rehabilitation would involve: 1) encouraging inpatients to be transparent about licit substance use, 2) offering support about when and/or how to use substances during rehabilitation and post-discharge, and 3) providing counselling for patients who want to abstain. The goal of a harm-reduction approach would be to minimize harms in relation to substance use while also enabling patients to gain the many benefits that come from rehabilitation. This approach would enable patients to receive rehabilitation in a manner that accords with their goals and values, and empower the clinical team and patient to prepare for a successful and safe discharge.

One response may be that patients who use any substance will not benefit from rehabilitation. However, this claim is unwarranted, as demonstrated by a spinal cord rehabilitation program in British Columbia (9). This spinal cord program implements a harm-reduction approach for inpatients with (licit and illicit) alcohol/drug dependencies who are unable or unwilling to abstain from use. If a patient wants to abstain from substance use, then the program offers withdrawal and abstinence support since "abstinence... is recognized as the ideal basis of health" (9). However, the program responds to the fact that abstinence is not a realistic option for many patients. Ultimately, the main goals of this program are to reduce conflict between patients and staff (which can stem from differing responses related to substance use), increase the number of completed rehabilitation programs for those with substance dependencies, and maintain a relationship with patients post-discharge (9). Upon achieving these goals, the program predicts that patients experience less harm, staff have a better work environment, and the health care system incurs fewer costs (9). Other research also suggests that the use of harm reduction in hospital settings has the potential to improve hospital care retention, promote patient (person)-centredness, and reduce harms associated with substance use (7).

In addition to the above, a further concern about permitting patients to use licit substances may be that inebriated patients will become unruly or aggressive toward others (e.g., staff, patients). This possibility is problematic since staff have the right to work in a safe environment and other patients' safety, care, and well-being is a priority. In response, we would suggest that the possibility of unruliness or aggression does not justify prohibiting substances. However, it does mean that education and an open dialogue amongst patients and staff will be an important part of care planning. For instance, as part of their discussion, perhaps Courtney and her care team could discuss whether the possibility of unruliness, aggression, or disruption may result from her desired substance use while in rehabilitation. The team, including Courtney, could then explore whether any strategies exist to lessen this possibility. In some cases, perhaps especially if disruptive behaviours do result from substance use, negotiating a plan that involves managed substance administration from hospital staff could be considered (6).

The reduction of harm, a more efficient and appropriate use of health care resources, and the development of supportive therapeutic relationships are all ethically significant consequences of implementing a harm-reduction approach in rehabilitation. An additional benefit is that this approach is *truly* person-centred. Given the prevalence of licit substance use in Canada (10) and globally (11,12), abstaining from substances will not be a realistic goal for everyone, nor does it take into account an individual's autonomous choice of if, when, or how they may want to abstain.

It is particularly important to consider the need for a harm reduction strategy with respect to substance use in physical rehabilitation contexts/amongst people who may require rehab. Although there exists minimal information on the topic of substance use and rehabilitation specifically, existing literature suggests that at least some patients who may require physical rehabilitation are more likely than the general population to use substances; this literature mostly focuses on patients with spinal cord injuries. For instance, a 2019 study which reviewed de-identified patient health records to examine spinal cord injury and substance use found that people with spinal cord injury have an increased likelihood of alcohol use disorder, cannabis use disorder, opioid use disorder, and nicotine use disorder (13). Another study found that “[p]ersons with disabilities [generally speaking] are at a disproportionately greater risk for substance abuse problems than members of the general population” (14). This same study found that the prevalence of substance use in the United States for people with traumatic brain and spinal cord injuries, in addition to those with mental illness, approached or exceeded 50% (14). Increased prevalence of substance use amongst persons with disabilities is acknowledged in some disability-related resources as well (15).

Ultimately, if a patient is unable or unwilling to abstain from using licit substances while in physical rehabilitation, then proposing options beyond abstinence allows clinicians to honour the duty to provide beneficial care while also reducing harm. It is also worth noting that people who use substances are at a higher risk of being admitted to a hospital or rehabilitation centre for substance-related injuries, so introducing a method that may reduce the risk of future injury would benefit both the patient and the healthcare system (6).

CONCLUSION

Overall, implementing a harm-reduction approach in rehabilitation would promote patient autonomy and independence, reduce potential harms from substance use and those incurred from not receiving rehabilitation, provide patients who use licit substances with benefits of rehabilitation, and influence the development of positive therapeutic relationships. Furthermore, if a person plans to use a substance post-discharge and if the substance has the potential to influence their health (e.g., to increase fatigue, risk of falls), then it makes sense to incorporate this reality as part of their inpatient care. Practicing rehabilitation skills in a manner that better mimics the home environment is essential to person-centredness and successful discharge planning. Ultimately, while some parameters may need to be established in order to ensure that patients can meaningfully participate in rehabilitation, a “zero tolerance” policy may not always be the most effective or most ethical.

Reçu/Received: 13/09/2021

Remerciements

Les auteurs tiennent à remercier Jessica Babineau pour son soutien dans l'analyse documentaire initiale.

Conflits d'intérêts

Deux des auteurs (Bianchi et Campbell) travaillent pour des réseaux hospitaliers financés par des fonds publics qui comprennent des établissements de réadaptation. Les opinions exprimées dans ce commentaire ne sont pas nécessairement celles de leurs employeurs.

Publié/Published: 13/06/2022

Acknowledgements

The authors would like to acknowledge Jessica Babineau for supporting the initial literature review.

Conflicts of Interest

Two of the authors (Bianchi and Campbell) work for publicly funded hospital networks that include rehabilitation facilities. The opinions stated in this commentary are not necessarily those of their employers.

Édition/Editors: Anne Hudon & Aliya Afddal

Les éditeurs suivent les recommandations et les procédures décrites dans le [Code of Conduct and Best Practice Guidelines for Journal Editors](#) de COPE. Plus précisément, ils travaillent pour s'assurer des plus hautes normes éthiques de la publication, y compris l'identification et la gestion des conflits d'intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d'excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE [Code of Conduct and Best Practice Guidelines for Journal Editors](#). Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal's standards of excellence.

Évaluation/Peer-Review: Charlotte Royeen

Les recommandations des évaluateurs externes sont prises en considération de façon sérieuse par les éditeurs et les auteurs dans la préparation des manuscrits pour publication. Toutefois, être nommé comme évaluateurs n'indique pas nécessairement l'approbation de ce manuscrit. Les éditeurs de la [Revue canadienne de bioéthique](#) assument la responsabilité entière de l'acceptation finale et de la publication d'un article.

Reviewer evaluations are given serious consideration by the editors and authors in the preparation of manuscripts for publication. Nonetheless, being named as a reviewer does not necessarily denote approval of a manuscript; the editors of [Canadian Journal of Bioethics](#) take full responsibility for final acceptance and publication of an article.

REFERENCES

1. Institute for Work & Health (IWH). [New World Health Organization guidelines on rehabilitation tap into Institute synthesis](#). 2017.
2. HealthLinkBC. [Substance Use](#). 2021.
3. Hasin DS, O'Brien CP, Auriacombe M. [DSM-5 criteria for substance use disorders: recommendations and rationale](#). American Journal of Psychiatry. 2013;170(8):834-51.
4. Centers for Disease Control and Prevention. [Health Effects of Cigarette Smoking](#). 2020.
5. Government of Canada. [Health Effects Of Cannabis](#). 2021.
6. Brooks HL, Kassam S, Salvalaggio G, Hyshka E. [Implementing managed alcohol programs in hospital settings: A review of academic and grey literature](#). Drug and Alcohol Review. 2018;37(1):S145-S155.
7. Cortina S, Kennedy MC, Dong H, et al. [Willingness to use an in-hospital supervised inhalation room among people who smoke crack cocaine in Vancouver, Canada](#). Drug and Alcohol Review. 2018;37(5):645-52.
8. Haber PS, Demirkol A, Lange K, Murnion B. [Management of injecting drug users admitted to hospital](#). Lancet. 2009;374(9697):1284-93.
9. Young JM, Fish WM, Browne A, Lawrie RS. [Using a harm reduction approach with clients who have alcohol/drug dependencies in a spinal cord rehabilitation program](#). Journal of Spinal Cord Medicine. 2002;25(2):81-87.
10. Health Canada. [Canadian Tobacco, Alcohol and Drugs Survey \(CTADS\): summary of results for 2017](#). 2021.
11. World Health Organization (WHO). [Substance Abuse](#). 2021.
12. Peacock A, Leung J, Larney S, et al. [Global statistics on alcohol, tobacco and illicit drug use: 2017 status report](#). Addiction. 2018;113(10):1905-26.
13. Graupensperger S, Corey JJ, Turrisi RJ, Evans MB. [Individuals with spinal cord injury have greater odds of substance use disorders than non-sci comparisons](#). Drug and Alcohol Dependence. 2019;205:107608.
14. Smedema SM, Ebener D. [Substance abuse and psychosocial adaptation to physical disability: analysis of the literature and future directions](#). Disability and Rehabilitation. 2010;32(16):1311-19.
15. National Rehabilitation Information Center. [Substance Abuse and Individuals with Disabilities](#). 2011;6(1).