

Mandated Community Treatment: Applying Leverage to Achieve Adherence

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Treating people with mental disorder without their consent always has been the defining human rights issue in mental health law. For centuries, unwanted treatment took place in a closed institution, a mental hospital. What has changed is that in recent years the locus of involuntary treatment has shifted from the closed institution to the open community.

Much of the strident policy debate on outpatient commitment, a civil court order requiring a person to adhere to mental health treatment in the community, treats it as if it were simply an extension of inpatient commitment, viewing it within the same conceptual and legal framework historically used to analyze commitment to a mental hospital. Increasingly, however, it is becoming apparent that concepts developed within a closed institutional context do not translate well to the much more open-textured context of the community. It is for good reason that mental hospitals have been described as total institutions: a single source supplies an individual's lodging, delivers benefits, maintains order, and provides treatment. In the community, however, one source supplies an individual's lodging (a housing agency), another delivers benefits (a welfare agency), a third maintains order (the criminal justice system), and a fourth provides treatment (the mental health system). Outpatient commitment is better seen as only one of a growing array of legal tools from the social

welfare and judicial systems now being used as leverage to ensure treatment adherence in the community.¹

Leverage From the Social Welfare System

Persons with serious mental disorder may qualify under current law to receive certain social welfare benefits. Two benefits to which some are entitled under current laws are disability benefits and subsidized housing.

Money as Leverage

Recipients of federal disability benefits typically receive checks made in their names. The Social Security Act, however, provides for the appointment of a representative payee to receive the checks if it is determined to be in the beneficiary's best interest to do so. Some patients who have a representative payee (or a more informal money manager) believe that there is a *quid pro quo* relationship between their adherence to treatment and their receipt of what they consider to be their money.²

Housing as Leverage

Recent surveys have found that there is not a single city or county in the United States in which a person with a mental disorder living solely on disability benefits can afford the fair market rent for an efficiency apartment. To avoid widespread homelessness, federal and state governments provide several housing options in the community for individuals with mental disorder. No one questions that landlords can impose generally applicable requirements, such as not disturbing neighbors, on their tenants. However, landlords sometimes proactively impose the addi-

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tional requirement on a tenant with mental disorder that he or she be actively engaged in treatment, with eviction as a possible sanction for failure to be so engaged.³

Leverage From the Judicial System

People with severe mental disorder are sometimes required to comply with treatment by judges or by other officials acting in the shadow of judicial authority (e.g., probation officers). Even without a formal judicial order, patients may agree to adhere to treatment in the hope of avoiding an unfavorable resolution of the case, such as being sentenced to jail or committed to a hospital.

Jail as Leverage

Making the acceptance of mental health treatment in the community a condition of sentencing a defendant to probation rather than to jail has long been an accepted judicial practice.⁴ In addition, a new type of criminal court, called appropriately, mental health court, has been developed that makes even more explicit the link between criminal sanctions and treatment in the community. Adapted from the drug court model, a mental health court offers the defendant intensely supervised treatment in the community as an alternative to jail.⁵

Hospitalization as Leverage

Outpatient commitment, as described herein, refers to a court order directing a person with a serious mental disorder to comply with a prescribed plan of treatment in the community, under pain of being hospitalized for failure to do so if the person meets the statutory criteria. Outpatient commitment, in this view, is properly seen as only one of several forms of leverage used to assure adherence to treatment and not as the sum and substance of involuntary treatment in the community.⁶

Psychiatric Advance Directives

One way to establish a person's preferences regarding future treatment, should the person become unable to make or to communicate those preferences in the future, is for the person to mandate the preferred treatment him- or herself. Usually, advance directives pertain to medical care at the end of life. But a 1991 federal law has given impetus to mental health

advocates to promote the creation of advance directives for psychiatric treatment.⁷ These directives allow competent persons to declare their preferences for mental health treatment or to appoint a surrogate decision maker in advance of a crisis during which they may lose the capacity to make reliable health care decisions themselves. (A National Resource Center on Psychiatric Advance Directives has recently been created. See <http://www.nrc-pad.org>.)

The Prevalence of Leverage

How often are the given forms of leverage, singly or in combination, imposed on people with mental disorder to compel them to adhere to treatment in the community? Since the total amount of leverage used and the distribution of different types of leverage vary across sites, it may be important to study people with mental disorder in several different locations. In one study,⁸ five sites were selected that were diverse in region, population, and the density of mandated treatment programs: San Francisco; Chicago; Tampa, FL; Worcester, MA; and Durham, NC. Over 1,000 adults currently in outpatient treatment for a mental disorder with a publicly supported mental health service provider for at least six months were surveyed. Among the key findings of this research were these: Approximately half of all patients—44 to 59 percent across the 5 sites—have experienced at least one form of leverage. Half of these patients have experienced two or more different forms of leverage. The most common forms of leverage are obtaining subsidized housing (32% of all patients) and avoiding jail (23%), and the least prevalent forms of leverage are obtaining spending money (12%) and outpatient commitment to avoid hospitalization (15%).

In addition, a fairly consistent picture emerges of leverage being used more frequently in patients with more severe, disabling, and longer lasting psychopathology, a pattern of multiple hospital readmissions, and intensive outpatient service utilization. Substance abuse increases the likelihood of the use of all forms of leverage except housing, since housing programs often bar substance abusers. Across the sites, only 4 to 13 percent of participants had completed a psychiatric advance directive; however, between 66 and 77 percent reported wanting to complete one if given assistance.⁹

The Clinical and Societal Outcomes Produced by Mandated Community Treatment

What is the demonstrable impact of mandated community treatment on individual patients and on their communities? Regarding patients, hypothesized outcomes range from decreased symptoms of mental disorder as a result of improved treatment adherence to decreased voluntary help-seeking because of patients' fears that treatment will be made involuntary. Regarding the effects of mandated treatment on the community, some family advocates expect a decrease in violence brought about by patients' being more closely monitored, while some patient advocates speculate that already inadequate treatment resources will be shifted away from people who want treatment and toward people who do not. Much research to answer these questions is in progress, but the evidence so far is suggestive rather than definitive. Whatever the measurable outcomes of mandated community treatment, the cost at which these outcomes are obtained is a crucial consideration for policy makers.¹⁰

The Legality and Morality of Mandated Community Treatment

A national dialogue is taking place on the legality and morality of allowing deprivations such as jail or hospitalization to be avoided, and rewards such as money or housing to be obtained, contingent on adherence to treatment. As an illustration, Bonnie and Monahan¹¹ have suggested that framing the legal debate on mandated community treatment primarily in terms of coercion has become counterproductive and that the debate should be reframed in terms of contract. Language derived from contract law often yields a more accurate account of the current state of the law governing mandated community treatment, is more likely to be translated into a useful descriptive vocabulary for empirical research, and is more likely to clarify the policy concerns at stake than is the currently stalemated argument based on putative rights. Their hope is that adopting the language of contract may help to identify those types and features of mandated community treatment that are genuinely problematic (e.g., the preventive outpatient commitment of people who do not qualify for inpatient hospitalization), rather than perpetuating the

unhelpful and misleading assumption that all types of leverage necessarily amount to coercion.

Controversies

Few aspects of contemporary mental health policy are as contested as mandated community treatment. Two points, in particular, are often raised in opposition to the use of leverage to secure adherence to treatment in the community. The first posits that a person's freedom to choose to enter a leveraged agreement to accept treatment is specious, given stark power imbalances between the individual on whom the leverage is imposed and the social agency that imposes it. Bonnie and Monahan, in response to this charge, make a distinction among different types of leverage. They argue, for example, that using hospitalization as leverage in (preventive) outpatient commitment is "unambiguously coercive" (Ref. 11, p 497), but that using jail as leverage for people who have pled or been found to be guilty of a crime is not properly seen as coercive at all. This is so because in preventive outpatient commitment, the individual's legal baseline, in the terms used by Wertheimer,¹² is to remain free to decide whether to accept treatment in the community, whereas in treatment as a condition of probation (or in a mental health court) the legal baseline is to go to jail to serve the sentence for the crime of which you have been convicted. In using the criminal justice system as leverage, Bonnie and Monahan argue:

The key question. . . is whether the prosecutor's proposal is best construed as a "threat" to put the defendant in jail if he or she fails to adhere to treatment in the community, or as an "offer" of treatment in lieu of jail. According to Wertheimer, the prosecutor's proposal would be a "threat" if the defendant would be worse off than in his or her baseline position if the defendant does not accept the proposal, whereas it would be an "offer" (expanding choice) if the defendant would be no worse off than in his or her baseline position if the proposal is not accepted. [If] incarceration were an available sentencing option, as it is in the usual case, probation conditioned on medication compliance is properly regarded as an "offer," and the agreement is valid. [We] think the agreement is valid even if the court would not otherwise have had the authority to require treatment because the agreement still represents a choice by the defendant between jail and leveraged treatment in the community—a hard choice, perhaps, but not an unconscionable one [Ref. 11, p 491].

A second point often made in opposition to mandated community treatment is that it is doomed to be ineffective, given that many forms of leverage explic-

itly preclude the involuntary administration of psychotropic medication on competent patients.

In fact, as the quotation just given indicates, taking psychotropic medication can be a requirement of some forms of mandated treatment—for example, treatment as a condition of probation. Title 18, § 3563, of the United States Code, states that “the court may provide, as further conditions of a sentence of probation. . .that the defendant. . .undergo available medical, psychiatric, or psychological treatment.” If the probationer with a mental illness does not adhere to prescribed medication, however, he or she cannot be forcibly medicated in the community. Rather, for breaching the probation agreement, the patient can be returned to jail or prison to serve the original sentence.

It is true that under New York State’s Kendra’s Law (New York Mental Hygiene Law § 9.60) and similar preventive outpatient commitment statutes, psychotropic medication cannot be administered involuntarily under the commitment order, or even during a mandatory evaluation period, in the absence of an emergency. But these orders still have some teeth. For example Swartz *et al.*¹³ report that “persons reporting a history of [outpatient] civil treatment mandates also reported more pressures from treatment personnel. . .to adhere to prescribed medication,” with an odds ratio for pressure to take medication of 2.3 (Ref. 13, p 348). As a result of these pressures, the likelihood of adherence to treatment with psychotropic medication can increase, even if the involuntary administration of medication in the community is explicitly precluded by the outpatient commitment statute.

Conclusions

Contrary to the confident claims of advocates on either side of the debate, the legal status of many forms of mandated treatment is currently uncertain.

Given the recent origins of many kinds of leverage, it will be some time before we know which will survive constitutional or statutory challenge. As courts and legislatures begin to address these concerns, empirical research on the prevalence, outcomes, and costs of given types of mandated treatment may play an increasingly important role in legal, policy, and clinical deliberations.

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