Commentary: The Search for a Formula to Relate Competence, Coercion, and Mandated Treatment

Albert J. Grudzinskas, Jr., JD

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The article entitled "The Perceived Coerciveness of Involuntary Outpatient Commitment: Findings from an Experimental Study" offers an important evolution in an area that informs the mental health law and policy debate on mandating treatment.[1] Swartz *et al*., and in particular the John D. and Catherine T. MacArthur Foundation, are to be commended for their continued commitment to understanding the impact of the violence-competence-coercion triad on development of mental health policy. It is, however, the promise of an elaboration of the generated data, which the authors suggest may be available, that offers the most hope for answering difficult questions. It is hardly news that persons subject to outpatient commitment (OPC) perceive themselves to be coerced. It is important that analysis of the data gathered demonstrate a link between a greater level of perceived coercion and poor insight into illness (among others). If, as the authors suggest, further analysis can contrast the perception of coercion among persons who improve and do not improve under OPC, then as the authors hypothesize, we may be able to determine whether some lost autonomy is to be tolerated if outcomes improve.

Society yearns for simple black-box solutions to difficult problems. If the subject is guilt or innocence, we turn to lie detectors, breathalyzers, and DNA testing. When the problem is mandated treatment of any kind, we seek algebraic-like equations so that subjective moral judgments can somehow assume a mantle of objective justification. The ability to determine with some degree of uniformity, when and to what degree coercion is appropriate (if ever) in the treatment of disease, and in particular the treatment of mental illness, has long been a goal of behavioral science literature and research. We seek a formula to predict appropriate levels of coercion by factoring a risk/benefit analysis, with elements of violence risk-potential assessment and an allowance for competency. The result could then be considered while applying the appropriate standard of proof: "the degree of confidence our society thinks [the decision maker] should have in the correctness of factual conclusions for a particular type of [decision]."[2] High risk of violence potential, coupled with treatment demonstrated to be efficacious for this individual, may, for example, require proof of incompetency to be supported by only a fair preponderance of the evidence and may tolerate some level of coercion. Low risk coupled with a moderately effective treatment regimen may require proof of incompetency beyond a reasonable doubt and may tolerate little loss of autonomy. If not justifying the means, this would at least allow the clinician some comfort level when making the decision to intrude on personal autonomy.

From 1955 to 1998 the state hospital inpatient population in the United States dropped from its peak census of approximately 559,000 to 57,151.[3] There are many factors that contributed to this decrease. Some of the most salient of these include the introduction of effective pharmacotherapy in the 1950s, the amendments to the 1935 Social Security Act that created supplemental security disability income (SSDI) in 1956, Medicaid and Medicare in

Mr. Grudzinskas is Assistant Professor of Psychiatry in Law, Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA. Address correspondence to: Albert J. Grudzinskas, Jr., JD, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Room S7-802, WSH-8C, Worcester, MA 01655. E-mail: al.grudzinskas@umassmed.edu

1965, and supplemental security income (SSI) in 1972[4] and the belief that treatment in the community is preferable to hospitalization whenever feasible.[5,6] As a result, the overwhelming majority of individuals served by state mental health agencies today are treated in less-secure environments than in traditional inpatient settings.[7] Treatment in the community in many cases leads, as the article suggests, to high rates of relapse and rehospitalization.

The temptation is to forgo some degree of autonomy in exchange for a promise of treatment compliance and improved outcome. The justification to limit autonomy and impose mandated mental health treatment stems from either the exercise of the state's *parens patriae* role or the exercise of the state's police power. The problem is that the first often ignores the oft-quoted dissenting admonition of Justice Brandeis:

> Experience should teach us to be most on our guard to protect liberty when the Government's purpose is beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.[8]

The suggestion of the Resource Document on Mandatory Outpatient Treatment that "the imposition of such treatment should be ordered by a court only after a hearing. . ."[9] addresses the second justification. The requirement of a court hearing enforces the point that mandating treatment in the community entails a loss of liberty that, although distinct from civil commitment, nonetheless involves a loss of a constitutionally guaranteed substantive right. Only when the State can show a compelling interest and such loss is accompanied by procedural due process protections can we accept the result. The U.S. Supreme Court in *O'Connor v. Donaldson* held that "a finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely. . . ."[10]

Similarly, our legal system is founded on the principle of autonomy for individuals, particularly in making decisions that principally affect their own lives.[11] The Massachusetts Supreme Judicial Court considering the issue observed that "his own good, either physical or moral is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others to do so would be wise, or even right."[12, 13] Nine years earlier, Judge Bazelon wondered, however: "How real is the promise of individual autonomy for a confused person set adrift in a hostile world?"[14] His inquiry foreshadows Chief Justice Burger's pronouncement that, "One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma."[2]

If, as the article suggests and its underlying study found, sustained OPC combined with frequent services can improve some outcomes, then we must still ask whether obtaining this improvement is worth the price of the increase in coercion. We must also decide which factors are the operative ones. Is coercion required, or would frequent services alone be sufficient? A recent randomized study concluded that enhanced services made a positive difference in the postdischarge outcomes (including differences in number of hospitalizations and arrests) in both a court-ordered OPC group and a control group. The researchers found that "the court order itself had no discernible added value in producing better outcomes."[15] Measuring the perception of coercion allows us to consider the impact on those persons whose opinion on coercion matters most (in this context): the person being coerced.

This assumes that we are all talking about the same phenomenon. What is coercion? Does perceiving coercion when a person is delusionally paranoid actually mean that coercion has occurred? On what grounds do we justify the use of coercion? An important question to resolve is whether the coercion has any measurable effect on the improvement noted. Swartz *et al.* correctly point out that further analysis is necessary to contrast coercion among persons who improve and do not improve under OPC, to test whether some lost autonomy is to be tolerated if outcomes improve.

Another component of the equation is the matter of competency. What is competency? Are sliding scales of competency required? Or is it simply that the competency assessment actually entails a multivariate clinical assessment of capacity in a variety of different realms? Because these decisions often involve a legal process, it is important to remember that competency is a legal concept. It can be formally determined only through legal proceedings.[16] In his provocative editorial, "Donut Shop Diversion Program," Jeffrey Geller, MD,[17] wonders why we don't offer a choice of "weight reduction clinic or jail" to

overweight individuals who try to enter donut shops. He argues that we would be reducing obesity, decreasing health care costs, saving hospital beds, and improving the quality of life of the overweight citizenry. He points out that informed consent is hardly the issue. Many persons with mental illness are capable of giving informed consent. The finding by Swartz *et al*. that "individuals with lower insight or awareness of illness during the study period felt more coerced" suggests that perhaps a link exists between perceived coercion and competency if competency is measured in terms of insight into illness.

Legal history is replete with examples of the legal, and often the criminal justice, system's being brought to bear on the system of care for the mentally ill. As early as 1676 for example, a statute of the Massachusetts Bay Colony authorized town selectmen to care for those deemed dangerously distracted so that they not "dumify others."[18] The system of care most frequently used was commitment to the local jail.

The article raises two additional questions that we discovered but were unable to address in our analysis of a competency-based system of outpatient treatment in Massachusetts.[19] The first is the question of enforcement of the pick-up orders by law enforcement and transport of the subjects to treatment. Our quasiexperimental study found that records were not sufficiently well documented to assess the number of times the authority was actually used. Anecdotal evidence, however, showed that the orders were only sporadically used in the three-year period we observed. It would be helpful if the authors could review the (we hope) more elaborate records in North Carolina to determine whether the threat of the order or its actual use are in any way associated with compliance with treatment. Additionally, because we were studying an event that occurred naturally without our structuring it, we could not assess the impact of increased activity by case managers on compliance with treatment. This problem may also have an impact on the process. Swartz *et al*. point to the involvement of case managers as an element in perceived coercion, but did the contact, apart from its compulsive element, have a positive effect when no coercion was perceived?

Much unfinished work remains in this area, but the important extension of the knowledge base and the promise of more to come from these researchers bodes well for those persons we seek to serve.

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References

1. Swartz MS, Wagner HR, Swanson JW, Hiday VA, Burns BJ: The perceived coerciveness of involuntary outpatient commitment: findings from an experimental study. J Am Acad Psychiatry Law 30:207–17, 2002
2. Addington v. Texas, 441 U.S. 418 (1979) (quoting In re Winship, 397 U.S. 358 (1970))
3. Center for Mental Health Services: Additions and resident patients at end of year, state and county mental hospitals, by age and diagnosis, by state, United States, 1998. Rockville, MD: the Substance Abuse and Mental Health Services Administration, 2000
4. Grob GN: The Mad Among Us: A History of the Care of America's Mentally Ill. New York: The Free Press, 1994
5. Appelbaum PS: Least restrictive alternative revisited: Olmstead's uncertain mandate for community-based care. Psychiatr Serv 50: 1271–2, 1999
6. Mazade N, Glover R, Hutchings G: Environmental Scan 2000: issues facing state mental health agencies. Admin Policy Ment Health 27:167–81, 2000
7. Lamb H: The new state mental hospitals in the community. Psychiatr Serv 48:1307–10, 1997
8. Olmstead v. U.S., 277 U.S. 438, 478 (1928)
9. Gerbasi JB, Bonnie RJ, Binder RL: Resource document on mandatory outpatient treatment. J Am Acad Psychiatry Law 28:127–44, 2000
10. O'Connor v. Donaldson, 422 U.S. 563, 575 (1975)
11. Winick BJ: The Right to Refuse Mental Health Treatment. Washington, DC: American Psychological Association, 1997
12. Mill JS, Gray J (editors): On Liberty and Other Essays. New York, NY: Oxford University Press, 1998
13. Brophy v. New England Sinai Hospital, Inc., 497 N.E.2d 626, 638 (1986)
14. Bazelon DL: Institutionalization, deinstitutionalization and the adversary process. Columbia Law Rev 51:897–907, 1975
15. Steadman H, Gounis K, Dennis D, *et al*: Assessing the New York City involuntary outpatient commitment pilot program. Psychiatr Serv 52:330–6, 2001
16. Appelbaum PS, Grisso T: Assessing patients' capacities to consent to treatment. N Engl J Med 19:1635–8, 1988
17. Geller JL: Donut shop diversion program [editorial]. Psychiatr Serv 52:1559, 2001
18. Brakel SJ, Parry J, Weiner BA: The Mentally Disabled and the Law (ed 3). Washington, DC: American Bar Association, 1986
19. Geller JL, Grudzinskas AJ, McDermeit M, Fisher WH, Lawlor T: The efficacy of involuntary outpatient treatment in Massachusetts. Admin Policy Ment Health 25:271–85, 1998