3 Mandated psychiatric treatment in the community – forms, prevalence, outcomes and controversies

John Monahan

University of Virginia School of Law, 580 Massie Road, Charlottesville, VA, 22903, USA

Treating people with mental disorder who do not want to be treated for mental disorder has always and everywhere been the most contentious issue in mental health law. For centuries, unwanted treatment took place solely in mental hospitals. What has changed in recent decades is the locus of unwanted treatment. What was once hidden from sight in closed institutions has increasingly shifted into plain view in the open community.

Outpatient commitment – a civil court order requiring a person to adhere to psychiatric treatment in the community, at the risk of being hospitalized if the order is defied – has grown rapidly in the past two decades, being adopted in Australia in 1986, in Israel in 1991, in New Zealand in 1992, in Ontario, Canada, in 2000, in Scotland in 2005, and in England and Wales, Taiwan and Sweden in 2008 [1]. But perhaps nowhere has outpatient commitment grown as fast, and with as much controversy, as in the United States. Since New York State introduced the first modern outpatient commitment statute in 1999, many other American jurisdictions

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have followed suite with new or strengthened laws, including California in 2003; Florida, Michigan and West Virginia in 2005; Illinois, Idaho and Virginia in 2008; and New Jersey and Maine in 2010 [2].

Much of the strident policy debate on outpatient commitment treats it as if it were simply an extension of inpatient commitment, viewing it within the same conceptual and legal framework historically used to analyse commitment to a mental hospital. Increasingly, however, it is becoming apparent that concepts developed within an institutional setting do not translate well to the much more open-textured context of the community. It was for good reason that Goffman [3] famously described mental hospitals as 'total institutions': a single source supplied an individual's lodging, administered welfare benefits, maintained order and provided treatment. In the community, in contrast, one source supplies an individual's lodging (a housing agency), another administers benefits (a welfare agency), a third maintains order (the criminal justice system), and a fourth provides treatment (the mental health system). Outpatient commitment, rather than being seen as a diluted form of mental hospitalization, may be better considered as one of a growing array of legal tools from the social welfare and judicial systems being used as 'leverage' to ensure adherence to psychiatric treatment in the community [4].

This chapter does four things. First, it illustrates a new and broader perspective on requiring adherence to outpatient mental health services, called 'mandated community treatment'. Second, it provides estimates of the frequency with which various forms of leverage are applied to psychiatric outpatients in the United States, as well as of the use of psychiatric advance directives. Third, preliminary empirical findings on the outcomes attributable to the different forms of leverage are summarized. Finally, the chapter addresses two controversial issues that often arise in discussions of mandated community treatment: the extent to which the use of leverage amounts to 'coercion', and the role of culture in understanding people's views of the legitimacy of mandated community treatment.

3.1 The forms of mandated community treatment

It is primarily through the social welfare and legal systems that leverage can be applied to people with mental illness to increase the likelihood that they will adhere to treatment in the community. People with serious mental disorder may qualify under American law to receive assistance from the social welfare system. Two forms of assistance for which some people with mental illness qualify are financial benefits and subsidized housing. In addition, people with serious mental disorder are sometimes required to comply with treatment by judges or by other officials acting under judicial authority (e.g. probation or parole officers). Even without a formal

judicial order, people with mental illness may agree to adhere to treatment in the community in the hope of avoiding an unfavourable resolution of their case, such as being sentenced to jail, or being committed to a mental hospital.

3.1.1 Money as leverage

Recipients of government disability benefits in the United States typically receive checks made in their own names. The law, however, provides for the appointment of a 'representative payee' to receive the checks if it is determined to be in the beneficiary's best interests to do so. For example, a representative payee might be appointed for a beneficiary who is in a coma, or who is a young child. An estimated one million Americans with a mental disability also receive federal government benefits through a representative payee [5]. Some of these people with mental disability who have a representative payee appointed for them believe that there is a quid-pro-quo relationship between their adherence to outpatient treatment and their receipt of what they consider to be 'their' money [6]. For example, the patient brochure on representative payee services used by one state agency states: 'You are receiving benefits based on the mental health and physical problems that you have. The Social Security Administration requires that you be involved in mental health services and work with your program so that you will feel better' [7].

3.1.2 Housing as leverage

A recent survey of the United States reported that 'there is not one state or community in the nation where a person with a disability receiving [federal disability] payments can afford to rent a modest... one-bedroom or efficiency housing unit' [8]. To avoid widespread homelessness, federal and state governments provide a number of housing options in the community for people with mental illness. No one questions that property owners can impose generally applicable requirements – such as not disturbing neighbours – on their tenants. However, proprietors sometimes proactively impose the additional requirement on a tenant with mental disorder that he or she be actively engaged in treatment [9]. Agencies that manage housing programmes for people with mental disorders may consider the programmes primarily as 'residential treatment' and only incidentally as lodging. For example, the standard lease used by one housing provider reads, 'Refusing to continue with mental health treatment means that I do not believe I need mental health services... I understand that since I am no longer a consumer of mental health services, it is expected that I will find alternative housing. I understand that if I do not, I may face eviction' [4].

3.1.3 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 [10]. For example, Chapter 18, Section 3563 of the United States Code states that a federal court may impose as a condition of probation that an offender 'undergo available medical, psychiatric, or psychological treatment'. In addition to this general provision of treatment as a condition of probation, an entirely new type of criminal court – called, appropriately, a 'mental health court' – has been developed that makes even more explicit the link between avoiding criminal punishment and accepting treatment in the community. Adapted from the drug court model, a mental health court offers the defendant intensely supervised outpatient treatment as an alternative to jail [11].

3.1.4 Hospitalization as leverage

Outpatient commitment, as described above, refers to a court order directing a person with a serious mental disorder to adhere to 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. There are three types of outpatient commitment in use in the United States today. In the first type, *conditional discharge*, a psychiatric inpatient continues to meet commitment criteria, but is offered hospital discharge on the condition that he or she continue with treatment in the community. In the second type, *alternative to hospitalization*, a person in the community meets inpatient commitment criteria, but is offered outpatient commitment in lieu of admission to a psychiatric hospital. In the final and most controversial type, *preventive commitment*, a person does *not* meet inpatient commitment criteria, but is believed to be deteriorating to the point that – unless treatment in the community is obtained – he or she soon will qualify for involuntary hospitalization [7].

Only two randomized clinical trials of outpatient commitment exist [12,13], and these two American studies reached opposite conclusions. A third randomized clinical trial, in the United Kingdom, is currently under way [14]. One review of 72 studies undertaken in six countries concluded that 'it is not possible to state whether [outpatient commitment] orders are beneficial or harmful to patients' ([15]; but see [16]). This lack of agreement in the data has not kept advocacy groups from making unequivocal empirical judgments (see Table 3.1 comparing the views of the leading American patient advocacy group, the Bazelon Center, and the leading American family advocacy group, the Treatment Advocacy Center).

Table 3.1 American advocacy groups' opposing views of existing data on outpatient commitment (OPC).

Issue	Bazelon Center [17,18]	Treatment Advocacy Center [19,20]
Overall research findings	'The studies, relatively few in number, clearly show that [OPC] confers no benefit beyond access to effective community services – access that is too often nonexistent on a voluntary basis.'	'Studies and data from states using AOT[a] prove that it is effective in reducing . . . homelessness, arrests and incarcerations, victimization, and violent episodes.'
Bellevue outcome study	'The findings are conclusive. . . The study provides strong evidence that outpatient commitment has no intrinsic value.'	'[T]he authors acknowledged that a "limit on [the study's] ability to draw wide-ranging conclusions is the modest size of [the] study group." . . . Additionally, nonadherence to a treatment order had no consequences.'
Duke outcome study	'[T]he Bazelon Center's analysis. . . find[s] weaknesses in the North Carolina study.'	'[T]he Duke Studies are the largest and most respected of the controlled examinations of assisted outpatient treatment (AOT). The Duke Studies proved the remarkable benefits of assisted outpatient treatment.'
Effect on hospital admissions	'Statements that outpatient commitment reduces hospital admissions or hospital stays are often based on data from four published studies, all flawed.'	'Several studies have clearly established the effectiveness of AOT in decreasing hospital admissions.'
Effect on treatment adherence	'Statements that increased compliance with psychiatric treatment can be attributed solely to the effect of outpatient commitment are normally based on data from two studies – both flawed.'	'AOT has also been shown to be extremely effective in increasing treatment compliance.'

[a] The Treatment Advocacy Center refers to outpatient commitment as 'assisted outpatient treatment' (AOT).

3.1.5 An antidote to leverage

Usually, advance directives pertain to medical care at the end of life. But changes in American law have given impetus to patient advocates to promote the creation of advance directives for psychiatric treatment. These directives allow competent persons to declare their preferences for mental health treatment, or to appoint a

surrogate to make decisions for them, in advance of a crisis during which they may lose capacity to make reliable health care decisions themselves [21]. Many patient advocates as well as clinicians see the use of a psychiatric advance directive as an antidote to, or at least an attenuation of, treatment mandated by others. As one commentator stated, 'The advent of advance directives for psychiatric care offers an unprecedented opportunity to reconcile, or at least accommodate, the opposing values represented by proponents of involuntary interventions, on the one hand, and by civil libertarians, on the other' [22].

3.2 The prevalence of mandated community treatment

How often are given forms of leverage – singly or in combination – imposed on people with mental disorder to get them to adhere to treatment in the community? Since the total amount of leverage used, and the distribution of different types of leverage, will vary across locations even within the same country, it is important to study people with mental disorder in a number of different sites. One study in the United States selected five sites that were diverse in terms of region, population and the density of mandated treatment programmes: San Francisco, CA; Chicago, IL; Tampa, FL; Worcester, MA; and Durham, NC. Over 1000 adults currently in outpatient treatment for a mental disorder with a publicly supported mental health service provider for at least six months were surveyed [23,24]. Amongst the key findings of this study were that approximately half of all outpatients – 44 to 59% across the five sites, with a mean of 51% – have experienced at least one form of leverage over the course of their lifetimes. Half of *these* patients have experienced two or more different forms of leverage. The most common forms of leverage were treatment in order to obtain subsidized housing (32% of all patients) and to avoid going to jail (23%), and the least prevalent forms of leverage were treatment to obtain disability benefits (12%), and to avoid inpatient mental hospitalization (i.e. outpatient commitment; 15%). A consistent picture emerged of leverage being used more frequently for patients – particularly younger males – with more severe, disabling and longer lasting psychopathology, with a pattern of multiple hospital readmissions, and with previous intensive outpatient service utilization. Substance abuse increased the likelihood of all forms of leverage except housing, since housing programmes often bar substance abusers.

In addition, recent American work has addressed the use of child custody as leverage to assure that parents with mental illness adhere to outpatient treatment [25], education as leverage to increase the likelihood that university students with mental illness will adhere to outpatient treatment [26], licences as leverage to induce professionals (e.g. physicians, lawyers and airline pilots) with mental illness to accept outpatient psychiatric services [27], and employment as leverage to secure the adherence of (non-licensed) employees with mental illness to outpatient

treatment [28]. (For research mandating children with mental illness to adhere to treatment, see [29].)

In addition to providing data on the epidemiology of various forms of leverage, recent studies [23] also reported that 7% of all outpatients had completed a psychiatric advance directive, but two-thirds of all outpatients stated that they wanted to complete an advance directive, but did not know how to do so. Significantly higher demand for psychiatric advance directives was found amongst outpatients who were female and nonwhite, who had a history of self-harm, arrest and decreased personal autonomy, and who felt pressured by others to take medication [30].

3.3 The clinical and societal outcomes associated with mandated community treatment

What are the demonstrable impacts of mandated community treatment on individual patients subject to it, 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 [7]. Regarding the effects of given forms of mandated treatment on the community, one putative outcome of mandated treatment is its effect on reducing violence. Advocates of outpatient commitment have explicitly 'sold' the approach largely by playing on public fears of violence committed by people who have mental disorders [31–33]. As stated by Jaffe (quoted in [7]),

> Laws change for a single reason, in reaction to highly publicized incidents of violence. People care about public safety. I am not saying it is right, I am saying this is the reality. . . So if you're changing your laws in your state, you have to understand that. . . It means that you have to take the debate out of the mental health arena and put it in the criminal justice/public safety arena.

Much research to answer these questions is in progress, but the evidence to date is suggestive rather than conclusive. Whatever the measurable outcomes of mandated community treatment may be, the cost at which these outcomes are obtained is a crucial consideration for policy makers [34]. Initial substantive findings, from one American project, the MacArthur Research Network on Mandated Community Treatment, include the following:

3.3.1 Money as leverage

- Patients assigned a representative payee are more likely than other patients to experience 'financial coercion' to participate in outpatient treatment, and also more likely to adhere to outpatient treatment [35].

- Both consumers *and* their representative payees demonstrate deficiencies in the basic arithmetic abilities necessary to create a simple budget, and this often leads to conflict [36].
- Having a family member act as a representative payee doubles the likelihood of the patient engaging in family violence. The more a patient interacts with a family member who is a representative, the more likely the family violence [37].

3.3.2 Housing as leverage

- Housing is often used in combination with money as leverage, because it is usually property owners, rather than clinicians, who impose adherence to treatment as a requirement of obtaining housing, and the proprietors require that they be named representative payee in order to ensure that the rent gets paid [9].
- The use of housing as leverage often increases patients' perceived coercion [9].
- Housing programmes that do *not* require treatment as a condition of occupancy (called 'Housing-First' programmes) are becoming increasingly common and achieve a level of patient satisfaction with housing and with treatment comparable to that of programmes that use housing as leverage to obtain treatment adherence [38].

3.3.3 Jail as leverage

- Speciality probation agencies that have smaller and exclusively mental health caseloads, and that use problem-solving strategies rather than threats of incarceration, are more effective than traditional probation agencies in reducing the risk of probation violation [39]. New paradigms for reducing recidivism amongst probationers are emerging [40].
- When given a choice, 95% of mental ill defendants in one Florida county chose to have their cases heard in a mental health court rather than in a regular criminal court, and the defendants who chose a mental health court reported much less experience of coercion, and were much more satisfied with the court process, than were mentally ill defendants in the criminal court [41].
- In the18 months following enrolment in a mental health court or in a usual criminal court, defendants with a mental illness whose cases were processed in the mental health court had fewer arrests and fewer days incarcerated than defendants in the usual court group. Defendants who 'graduated' from the mental health court had lower rearrest rates than defendants who failed to complete the mental health court process [42].

3.3.4 Hospitalization as leverage

- African Americans were more likely than whites to be involuntarily committed for outpatient psychiatric care in New York State. However, candidates for outpatient commitment are largely drawn from a population in which African Americans are overrepresented, that is, psychiatric patients with multiple past involuntary hospitalizations in public mental health facilities. Whether this overrepresentation under court-ordered outpatient treatment is racially discriminatory depends on one's view of whether outpatient commitment is best seen as providing increased access to treatment in a setting that is less restrictive than hospitalization, or whether it is best seen as a deprivation of personal liberty [43].
- While patients were under an outpatient commitment order, they experienced a substantial reduction in psychiatric hospitalizations and were more likely to consistently receive psychotropic medications. If the outpatient commitment order was in effect for one year or longer, these benefits continued after the order had expired [44].
- Patients on outpatient commitment felt neither more positive nor more negative about their experience with psychiatric treatment than did voluntary patients. More specifically, there were no significant differences between patients on outpatient commitment and voluntary patients in perceived coercion, the therapist–patient alliance, treatment satisfaction or life satisfaction [16].

3.3.5 Psychiatric advance directives

- Approximately half the mental health professionals in one survey agreed that psychiatric advance directives are helpful to patients. Clinicians have more positive attitudes about psychiatric advance directives when they correctly recognize that they are not required by law to honour a directive in which a person refuses appropriate psychiatric or psychological treatment. However, a majority of clinicians have practical concerns about getting access to psychiatric advance directives in a crisis. Other concerns include the problem of inappropriate treatment requests in psychiatric advance directives [45].
- There are important differences amongst patients, family members and clinicians on several aspects of psychiatric advance directives: 44% of patients (compared to only 14% of family members) believe that patients should be able to change an advance directive 'even when they are ill'. Three-quarters of patients believe that a psychiatric advance directive will help them avoid unwanted treatment, but only one-quarter of clinicians agree [46].
- Patients can complete a psychiatric advance directive with a one-hour facilitation session, but otherwise do not complete them: 79% of the patients randomly assigned

to have someone help them complete a psychiatric advance directives actually completed one, compared to only 6% of the subjects in the control group who had to complete the directive on their own [47]. The completion of a psychiatric advance directive is associated with significant reduction in the use of coercive interventions such as police transport, involuntary commitment, seclusion and restraints, and involuntary medications during mental health crises [48].

3.4 Controversial issues

Few issues in contemporary mental health policy are as contested as mandated community treatment. One argument often raised in opposition to the use of leverage to secure treatment adherence in the community 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 leverage is imposed and the social agency doing the imposition, and that mandated community treatment is therefore properly seen as coercive. A second and related argument often raised in international debates on mandated community treatment is that the findings of the existing research – even if those findings are empirically valid in the legal and social culture in which they were generated – may not be generalizable to other legal and social cultures.

Bonnie and Monahan [49], in response to the first of these two arguments, propose that framing the debate primarily in the vocabulary of 'coercion' has become counterproductive and that reframing it in the language of 'contract' may allow for new insights and invigorated discussion. They base their position on the work of Wertheimer [50], who has stated that the ability to obligate oneself by creating a binding contract is an important aspect of freedom. 'Voluntariness – and, in particular, the absence of coercion', according to Wertheimer, is 'a necessary condition of obligations grounded in agreement'. How is one to determine which contractual decisions are voluntary and which are the product of coercion? Wertheimer formulates the underlying issue as follows:

> The standard view of coercive proposals is that threats coerce but offers do not. And the crux of the distinction between threats and offers is that A makes a *threat* when B will be *worse off* than in some relevant baseline position if B does not accept A's proposal, but that A makes an *offer* when B will be *no worse off* than in some relevant baseline position if B does not accept A's proposal. On this view... the key to understanding what counts as a coercive proposal is to properly fix B's *baseline* [50].

Building on Wertheimer, Bonnie and Monahan [49] make distinctions amongst different types of leverage. They argue, for example, that 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 treatment as a condition of probation (or in a mental health court) the legal baseline is going to jail to serve the sentence for the crime of which the person was convicted. In using jail as leverage, they 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. [49]

On the other hand, using hospitalization as leverage in (preventive) outpatient commitment is 'unambiguously coercive'. Preventive outpatient commitment involves no choice at all. In preventive outpatient commitment, the person does *not* currently meet the statutory criteria for inpatient hospitalization, but rather is predicted to meet those criteria in the future if untreated in the community. In the use of jail as leverage, the individual's options are being *expanded* – from one option (jail) to two options (jail or treatment in the community). In preventive outpatient commitment, however, the individual's options are being *constrained*: before, the individual had two options (adhere to treatment or do not adhere to treatment in the community); now, the individual has only one option (adhere to treatment in the community). The individual is not being 'offered' anything in consideration for adhering to treatment in the community. In preventive outpatient commitment, therefore, the contract model does not apply.

A person's 'baseline' condition, however – from which one determines whether accepting outpatient treatment is in response to a coercive 'threat' or to a non-coercive 'offer' – is difficult to establish without taking into account cultural factors. This leads to the second controversy: are findings on mandated community treatment generated in one cultural context generalizable to other cultural contexts?

For example, one large and representative survey of attitudes toward outpatient commitment found the American public to be evenly split in their views – with 49.1% agreeing that people with schizophrenia 'should be forced by law to. . . get treatment at a clinic or from a doctor' and 50.9% disagreeing with this statement [51]. The researchers found that respondents' support of or opposition to outpatient commitment bore no significant relationship to self-rated political liberalism–conservatism.

Kahan *et al.* [52], in a large Web-based survey of American adults, tried to go beyond left–right political ideology to explain public views of mandated community treatment in cultural terms. Using Douglas' theory of 'cultural cognition'[53], they

found that outpatient commitment was supported by people who are *hierarchical* and *communitarian* – that is, people who value authority, who trust experts, and who believe that securing conditions of societal wellbeing is a societal duty that takes priority over individual interests. People who are *egalitarian* and *individualistic* – that is, people who resent stratification, who distrust authority, and who place the prerogatives of individuals ahead of those of the collective – were more likely to oppose outpatient commitment. Because on many issues egalitarian and communitarian orientations converge on liberal policy stances, and hierarchical and individualistic orientations on conservative ones, they believe that it is not surprising that public opinion on outpatient commitment bears little relationship to conventional liberal and conservative ideological categories (see also [54]).

If such results can be found within one (American) culture, what are the prospects for generalizing research finding across cultures? In many cultures, the (competent) individual is taken to be the autonomous decision maker. In other cultures, the family plays a much stronger role in decision-making [55]. In some legal systems, housing or disability benefits are a matter of 'right' and cannot be used as leverage to promote treatment adherence. In other legal systems, housing or disability benefits are discretionary programmes that the government can provide or withhold, subject only to the political process [56]. Differences in the provision of mental health care itself – whether such care is publically available as part of a national health service, or is available if, and only if, one has private insurance – can make an enormous difference in the frequency and the manner in which outpatient treatment can be 'mandated' [34].

3.5 Conclusion

Unwanted institutional treatment for mental disorder remains a crucially important clinical, legal, moral and fiscal issue throughout the world. Early in the twenty-first century, however, unwanted treatment in the community is replacing unwanted institutional treatment as a growing object of controversy. Unwanted community treatment may take many forms, with negative events, such as incarceration or hospitalization being avoided, or positive events, such as placement in subsidized housing or the receipt of disability benefits, being obtained, contingent on whether a person adheres to outpatient treatment. A majority of patients in public-sector outpatient mental health treatment in the United States have experienced the application of at least one – and often more than one – of these forms of 'leverage'. Research on the outcomes associated with mandated community treatment is in its infancy, but there are suggestions that, if properly implemented, it may have value in increasing treatment adherence. Different forms of mandated community treatment may raise different legal and moral issues, and these issues are likely to vary greatly

in different political and cultural contexts. One necessary but not sufficient prerequisite to the success of any form of mandated community treatment in any country is the ready availability of evidence-based mental health services. What the government of Scotland concluded when it recently initiated community treatment orders is true more broadly:

> Where society imposes an obligation on an individual to comply with a programme of treatment or care, a parallel obligation is imposed on health and social care services to provide safe and appropriate services and ongoing care. [57]

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