

MANDATED
COMMUNITY
TREATMENT:
A BROADER
FRAMEWORK
FOR A REASONED
DISCUSSION

*A Policy Brief from the
John D. and Catherine T. MacArthur Foundation
Initiative on Mandated Community Treatment*

Many people with symptoms of mental disorder willingly seek treatment. But a certain percentage holds back. Some don't believe the treatment will work; others can't accept the side effects; still others may, because of their illness, not be competent to make decisions.

How should we deal with those people in our communities who suffer from severe mental illness, yet do not adhere to the treatment that is offered to them?

Few questions draw more strongly on the feelings that make us human: our desire for dignity and autonomy, our empathy and compassion—and our fear. Because of the depths of feeling it arouses, as well as the legal and ethical issues it raises, the question of mandated community treatment has polarized stakeholders in the sphere of mental health.

On one side is a passionate consumer movement—people who have received mental health services, supported by civil libertarians—who say, “If we break the law, punish us as you would anyone. But like anyone, we have the right to make our own treatment choices.” On the other side are equally passionate family members, clinicians, and others who seek laws to compel treatment for at least some who refuse it. While some hope that these laws will lead to increased resources for mental health services, their arguments also play on the public's fear of violence by the mentally ill. It was such fears that led to the enactment in New York State of “Kendra's Law,” named for the young woman who was pushed in front of a subway train by a man who had sought help, but who failed to take the medication prescribed for his mental illness.

Kendra's law authorizes the most clearly coercive form of mandated community treatment: involuntary outpatient commitment—that is, a court order for a person, who is not charged with a crime, to comply with a prescribed outpatient treatment plan or be sent to an inpatient facility; there he or she will be examined to determine whether hospitalization is required. While most states have similar laws on the books, until recently they were rarely used. It is the current push to strengthen and enforce involuntary commitment laws—prompted both by a few highly publicized cases of violence and by severe cutbacks in mental health services—that has led to the current impassioned debate over mandated treatment.

“The debate is an important one, and it deserves a thorough and rational hearing,” says John Monahan, a psychologist and professor at the University of Virginia School of Law. “For that very reason, it's essential that we take into account not only outpatient commitment, strictly defined, but the full array of legal, administrative, and social tools that are used as leverage to get people to accept outpatient treatment.” Those options—and the articles, studies, and reports describing them—have been reviewed in detail by the MacArthur Foundation Initiative on Mandated Community Treatment, which Monahan directs. (See the September 2001 issue of *Psychiatric Services*.)

BROADENING THE CONCEPT: THE TOOLS OF LEVERAGE

Monahan points out that leverage may be more widely used than is acknowledged, since it's generally done informally and has been sparsely studied. The MacArthur Initiative identified five major approaches: two that work through the social welfare system, two that use the judicial system, and one—advance directives—that can be viewed as “self-mandated” treatment.

1. *Money as leverage.* People with a serious mental disorder often qualify for government disability benefits such as Supplemental Security Income or Social Security Disability Insurance. While most of these people receive the benefits directly, in some cases a “representative payee”—a family member or a social service agency, a case manager or a therapist—is appointed to receive the check and use it for the benefit of the qualified individual. Two studies have found that representative payees frequently use disability benefits as leverage, agreeing to distribute the money in return for treatment adherence or related behavioral goals, such as avoiding alcohol and drugs.

2. *Housing as leverage.* Because disability benefits fall far short of real-world housing costs, the government provides a variety of housing programs for people with mental disorders. The agencies that manage these programs sometimes require tenants to accept mental health treatment or other services, and to avoid substance abuse. But the legal policy governing this “bundling” of housing and services is inconsistent: some forms of federal housing assistance ban it, while others allow it. As a result, housing is used as leverage both formally and, much more often, *informally* to get people to adhere to treatment.

3. *Avoidance of jail as leverage.* The vast majority of crimes committed by people with mental disorders are minor ones. Recognizing that jails aren’t equipped to deal with these defendants, judges sometimes refer them to mental hospitals or put them on probation under outpatient psychiatric care. Recently, a handful of jurisdictions have formalized such procedures in “mental health courts,” establishing a new working relationship among the criminal justice, mental health, and social welfare systems. While there is no single model, mental health courts generally are staffed by specialized teams of legal and mental health professionals and provide more intensive supervision in the community than do regular criminal courts.

4. *Avoidance of hospital as leverage.* With the large-scale deinstitutionalization of the 1960s and the more recent growth of managed behavioral health care, long-term inpatient commitment has become rare. In its place, most states have instituted outpatient commitment. Outpatient commitment may be used as a form of conditional release from a hospital, as an alternative to hospitalization, or preventively, for people who don’t currently meet the legal criteria for inpatient hospitalization but are considered at risk of doing so. Some “assertive community treatment” programs may also be viewed as leverage; even if outpatient commitment is not formally invoked, advocates feel the programs imply that failure to adhere to the recommended treatment will result in hospitalization.

5. *Advance directives.* Faced with the eventual possibility of some form of mandated or negotiated care, patients may choose to specify their treatment preferences before a crisis arises. Mental health advance directives—modeled on those now common in end-of-life medical care—are permitted in all states and specifically authorized in 13. Like medical advance directives, there are two types: *instructional directives* that specify which treatments or facilities the patient does or does not want; and *proxy directives* that designate someone to make treatment decisions if the patient is unable to do so.

THE ISSUES IN CONTEXT

Evaluating the role that mandated treatment should play in mental health law and policy invokes issues ranging from outcomes to economics, from psychological concerns to legal, ethical, and political questions. Few of these questions have clear answers today. Nevertheless, Monahan emphasizes, "it's imperative that we gather what information is available and consider the issues in light of the full spectrum of approaches to mandated treatment, so that patients, families, and policy makers can make informed choices while research continues."

Is mandated treatment necessary?

This is really a double-edged question: Is mandated treatment necessary for the welfare of the patient? And is it necessary for the safety of the community?

Most people—but not all—view treatment as a humanitarian imperative. They believe, and research confirms, that people with serious, untreated mental disorders are more likely than others to be homeless, ill nourished, and victims of crime and violence. Still, much of the current rhetoric demanding treatment is fueled by a perceived threat not to people with mental disorder themselves, but to those around them—a risk that research shows to be drastically overstated.

The MacArthur Community Violence Study, for example, has found that in the absence of substance abuse, people with mental disorders are no more likely to commit violent acts than are others in their communities. (They are, however, more likely to be abusing drugs or alcohol.) Some groups, including members of the MacArthur Initiative, are working to develop improved tools for assessing an individual's risk of violence. In the meantime, we lack good information on whether mandated community treatment reduces violence in the community—or, for that matter, whether the public focus on violence increases the stigma of mental disorder and discourages people from seeking *voluntary* treatment.

On the other hand, what if treatment were made more acceptable—and readily available—on a voluntary basis? Would many more people with serious mental disorders seek out and adhere to treatment in the community? Would mandated treatment become superfluous? Or would impaired decision-making ability or other factors continue to deter many individuals from seeking treatment? It's impossible to say at this point: all too often, such services are *not* available—and the lack of access is only getting worse.

How are the different types of mandated treatment currently applied?

In a perfect world, this would be the starting point for assessing the impact of different types of leverage. Unfortunately, there is little descriptive data available. Some forms of mandated treatment, such as mental health courts and advance directives, are simply too new and the numbers too small; others, such as outpatient commitment, have only recently been seriously implemented. But others—notably, the use of housing or social welfare benefits as leverage—remain undescribed in large part because they are controversial, possibly subject to legal challenge, and are often used informally and without documentation.

As a result, we know very little about when, where, how, and in what combinations or sequences the different forms of mandated community treatment are used. "It may be the case that if one form of leverage doesn't work for an individual, then another is tried, and another, until one works," says Monahan. "In that case, it would be extremely valuable to know which ones are seen by patients as more coercive, as well as which ones are more effective."

Does mandated treatment work?

Here, again, we need to consider several issues: Does it work, clinically and socially, to improve the lives of people with mental disorders? Which approaches work best, and for whom? And will mandating treatment work, as some suggest it will, to make mental health services more available in the community?

We know that many people with severe and persistent forms of mental disorder can be helped by medications, psychotherapies, and social services. Still, it is by no means clear that services that produce positive outcomes in a voluntary setting will have the same effect when they're mandated. The research so far is inconclusive: for example, some studies have found that representative payee programs reduce hospital days, increase adherence to treatment, and decrease homelessness; others have found problems with the program when the same person serves as therapist or case manager and representative payee. Studies of outpatient commitment also have found positive outcomes; but other studies question the extent to which this is due simply to improving the availability and quality of mental health services.

What's more, some patient advocates suggest that in the context of mandated treatment, people who *want* to make use of outpatient mental health services may avoid those services, for fear they may be forced to continue using them. Again, we don't have the data to answer this question.

Some people have argued that mandated treatment "commits the system to the patient"—increasing mental health services in the community, or at least prioritizing the use of services from lower need cases to those in greater need. Others counter that services are merely shifted, not prioritized, and that any new infusions of resources into the system tend to be short-term responses to high-profile incidents.

"It does seem doubtful that new resources would appear merely in response to demands from landlords, representative payees, or advance directives," Monahan says. "On the other hand, judges may play a critical role—through mental health courts or outpatient commitment—in getting the attention of legislators in ways that mental health activists have not." But, he adds, there is some concern that this use of the judicial system may also result in "overcommitting" the system, widening the net of social control over people with mental disorders.

Are leveraged approaches to mandated treatment legal?

The law governing what can be used as leverage is unsettled. For example, while landlords can clearly impose certain requirements, such as paying rent, on all residents, can they impose additional requirements—such as treatment—on particular residents? Even in the case of advance directives, the law remains untested. Will clinicians be sued for not following a patient's directives—or for following them when professional standards suggest a different treatment? How will the issue of competence play out in this context, or in the context of mental health courts?

When the courts do begin to address the many complex issues involved in mandated treatment, they will need a reliable body of empirical research to draw on. Even so, it's likely that judgments will differ from court to court, since statutes are in conflict and constitutional issues that bear on the right to make unfettered treatment decisions have yet to be decided.

"Definitive legal judgments are not likely to be close at hand," says Monahan. "In the meantime, we can't afford to let the system grind to a halt. Providers need to fashion their own best practices in an atmosphere of rational, informed discussion."

Is it right?

At the heart of the debate over mandated treatment is its ethical core: Can using money, housing, hospitalization, or jail—or insisting that a decision made by an earlier “competent self” trump a decision by a later “incompetent self”—be morally justified?

The question hinges, in part, on the highly subjective concept of coercion. Whether a patient experiences a particular form of leverage as coercive depends on many factors. One is whether the option is seen as a threat (“Not accepting treatment will make me worse off.”) or merely as the offer of a new alternative (“I won’t be any worse off if I don’t accept treatment.”). That in turn depends on where the baseline—the standard for comparison—is set.

Determining the baseline, however, is fraught with contention. For example, consider disability payments used by a representative payee as leverage to secure treatment. The beneficiary may view these funds as “my money.” Others, however, may see the funds as “taxpayers’ money,” to be used in the beneficiary’s best interests—as the representative payee sees those interests.

Another factor that plays a role in the perception of coercion is “procedural justice.” “In studies of inpatient commitment,” Monahan explains, “when patients felt the process by which they were committed was a fair one—that others acted out of genuine concern, treated them respectfully and in good faith, and gave them the chance to tell their side of the story—they were much less likely to feel coerced.”

Does the same principle apply to mandated outpatient treatment? Research suggests it might. In housing programs, for example, one study showed that the more choice people felt they had, the more successful their community tenure. Other forms of leverage may offer even more opportunities for procedural justice: the negotiated money management of the representative payee program; the slower pace and interactive process of the mental health courts; and the drafting of a mental health advance directive, which may be the best example of allowing individuals to express their preferences and participate in treatment decisions.

Still, there are political questions that further complicate the ethical issues. For example, to what extent are welfare and housing benefits “rights” or “entitlements”? Those who believe they are may well object to using them as leverage. In any case, these are effective as leverage only for people who are poor as well as mentally disordered; is that just? And looking at the larger political picture, would the American people be willing to spend more on mental health resources in the community if they believed those services went to the people most in need of them?

MOVING AHEAD

Whatever one’s position, it’s clear that mandated treatment, as carried out in the U.S. today, bears little resemblance to the institutional commitment of a few decades ago. Today’s options include a wide range of “leverages” used to encourage, persuade, or coerce—depending on your point of view—individuals to accept mental health treatment in the community.

We have many more questions than answers about these forms of leverage, how they are used, and what the effects are. And there are troublesome legal, ethical, and political questions to be addressed. Yet mandated treatment *is* being used, and its use appears to be expanding. Mental health law and policy must address these thorny issues not in heated ideological debate, but from a foundation of empirical evidence, reason, and humanity.

*This Policy Brief was written by Giudi Weiss, a freelance writer who lives in Chicago. The citation for the full article is Monahan, J., Bonnie, R., Appelbaum, P., Hyde, P., Steadman, H., and Swartz, M. (2001). Mandated community treatment: Beyond outpatient commitment. *Psychiatric Services*, 52, 1198-1205. It can be found on the web at <http://macarthur.virginia.edu>. For additional copies of this brochure, write to jmonahan@virginia.edu.*