

## **Mandated Community Treatment: Beyond Outpatient Commitment**

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### **abstract**

Outpatient commitment, although often viewed as merely an extension of inpatient commitment, is only one of a growing array of legal tools used to mandate treatment adherence. The authors describe various forms of mandated community treatment. People with severe and chronic mental disorders often depend on goods and services provided by the social welfare system. Benefits disbursed by representative payees and the provision of subsidized housing have both been used as leverage to ensure treatment adherence. Many discharged patients are arrested for criminal offenses. Favorable disposition of their cases by a mental health court may be tied to participation in treatment. Under outpatient commitment statutes, judges can order committed patients to comply with prescribed treatment. Patients may attempt to maximize their control over treatment in the event of later deterioration by executing an advance directive. The ideologic posturing that currently characterizes the field must be replaced by an evidence-based approach. (*Psychiatric Services* 52: 1198-2005, 2001).

Mandating adherence to mental health treatment in the community through outpatient commitment is among the most contested issues in mental health law. Outpatient commitment refers to a court order that directs a person who has a serious mental disorder to adhere to a prescribed community treatment plan and to be hospitalized for failure to do so if the criteria for involuntary hospitalization are met. Although 39 U.S. jurisdictions have statutes that nominally authorize outpatient commitment, until recently few states made substantial use of these laws. With the 1999 enactment in New York State of “Kendra’s Law,” nationwide interest in—and controversy over—outpatient commitment has soared. In many states a take-no-prisoners battle is under way between advocates of outpatient commitment—who call this approach assisted outpatient treatment—and its opponents—who use the term “leash laws.”

Much of the strident policy debate on outpatient commitment treats this approach as if it were simply an extension of inpatient commitment, and places outpatient commitment within the same conceptual framework that has historically been used to analyze commitment to a mental hospital. In fact, however, outpatient commitment is only one of a growing array of legal tools that are being used to mandate treatment adherence in the community. Only in relation to these other forms of mandated treatment in the open community, rather than to the body of law and policy developed for confinement in an inpatient facility, can outpatient commitment be adequately understood.

The purpose of this article is to inductively elaborate a new and broader conceptual framework for the various forms of mandated community treatment. First, we review what is known about the variety of influences that are brought to bear on a patient’s choice of whether to accept mental health services in the community. Second, we discuss what needs to be known

about these various forms of mandated treatment so that their potential role in mental health law and policy can be properly assessed.

People who have severe and chronic mental disorders often interact with the social welfare system and with the judicial system. In both of these contexts, such individuals face loss of liberty, property, or other valued interests if they fail to adhere to prescribed treatment. The “leverage” (1) that is applied by these systems is typically accompanied by assertive community treatment, a mode of service delivery that itself blurs the distinction between voluntary and coerced treatment (2). Facing such pervasive constraints, patients may attempt to maximize their own control over the treatment they receive by executing advance directives in the event of later deterioration.

### **Mandated treatment involving the social welfare system**

People with mental disabilities may qualify under federal or state laws to receive monetary payments and subsidized housing. It appears that both of these benefits are being used as leverage to ensure that beneficiaries adhere to mental health treatment in the community.

#### *Money as leverage*

A recent survey found that 70 percent of the U.S. population believes that people with diagnoses of schizophrenia are “not very able” or “not able at all” to manage their money (3). Such beliefs underlie the inclusion of people who have mental disorders in programs that regulate the disbursement of social welfare benefits. For example, recipients of Supplemental Security Income or Social Security Disability Insurance may have a representative payee appointed to receive their checks. Representative payees can ensure that the individual’s basic needs are met by directly paying for rent and food. Of the 1.2 million people who receive disability benefits for a mental disorder, 45 percent have a representative payee (personal communication, Kennedy L, 2000).

A representative payee is usually appointed for people who have schizophrenia, people with a co-occurring substance use disorder, those with a history of mishandling money, or homeless persons (4,5). The representative payees are usually family members, but organizations often serve this function (6). Representative payee programs have been found to reduce the number of hospital days (7), to increase adherence to outpatient treatment (8), and to decrease homelessness (9). Patient satisfaction with these programs tends to be high (10).

A study that surveyed representative payee programs of mental health centers in Illinois found that disbursement was at least “moderately” contingent on avoidance of substance abuse in

71 percent of the programs—and was “tightly” linked in 31 percent of programs—whereas receipt of benefits was at least moderately contingent on adherence to mental health treatment in 55 percent of the programs and tightly linked in 17 percent of programs (11).

Similar results were found in Washington State (12). Thus disbursement of social welfare benefits to people who have a mental disorder through a representative payee is used frequently and appears to be associated with a variety of positive outcomes. In a majority of representative payee programs, some relationship exists between treatment adherence and receipt of funds; in a substantial minority of programs this relationship approaches quid pro quo status.

### *Housing as leverage*

A recent survey found that a person with a mental disorder who is living solely on disability benefits would not be able to afford the fair market rent for a “modest” efficiency apartment in any area of the United States (13). To avoid homelessness in this population, the government provides several housing options in the community for people with mental disorders that are not available to other citizens. Some of these programs are tenant based and provide vouchers for the difference between the market rate for housing and what the individual can afford to pay. Other programs are landlord based and offer incentives for landlords to rent to people with mental disorders at below-market rates.

No one questions whether landlords should be able to impose generally applicable requirements—such as not disturbing neighbors—on their tenants. The issue is whether landlords legally can—and whether they in fact do—impose additional requirements on tenants who have mental disorders and whether such requirements may pertain to treatment.

Many agencies that manage housing programs for people with mental disorders appear to consider the programs primarily as residential treatment and only incidentally as lodging (14). It is clear that landlords sometimes try to use housing as leverage. For example, the standard lease used by one provider of supported housing 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” (15).

More important, although some statutes may prohibit the use of housing as leverage to ensure treatment adherence, others do not. For example, the federal statute authorizing the Shelter Plus Care program explicitly states, “In addition to standard lease provisions, the occupancy agreement may also include a provision requiring the participant to take part in the supportive services provided through the program as a condition of continued occupancy” (16). The statute defines supportive services as including mental health treatment, alcohol, and other substance abuse services.

Although some patient advocates decry the linking of housing and services (17), a study of 118 people with mental disorders who were living in public shelters in Boston reported that 92 percent of these individuals wanted to move out of the shelter and into permanent housing, “even if they were required to continue taking psychotropic medication” as a condition of securing the housing (18).

Thus housing is sometimes used formally as leverage to ensure adherence to mental health treatment in the community and, much more often, may be used informally to the same end. Many people who have mental disorders appear to be prepared to accept services if such a trade-off is required in order for them to obtain the housing they want.

### **Mandated treatment involving the judicial system**

People who have severe mental illness are sometimes ordered to comply with treatment by judges or other decision makers in the legal system, such as probation officers. Even in the absence of a judicial order, people may agree to adhere to treatment requirements to avoid an unfavorable judicial order, such as incarceration or civil commitment to an inpatient facility. In these contexts, judicial authority to impose sanctions and curtail freedom provides the leverage for inducing treatment adherence in the community.

#### *Avoidance of jail as leverage*

Although informal procedures have long existed for dealing with mentally ill defendants who are charged with minor crimes (19), the important role that judges play in this area is now acknowledged with much less hesitation than it was in the past. In fact, a new type of criminal court—called, appropriately, a mental health court—has been developed that makes explicit the link between sanctioning and treatment in the community.

Adapted from the drug court model and often explicitly premised on notions of “therapeutic jurisprudence” (20,21), mental health courts give prominence to the role of the judge, who “plays a hands-on, therapeutically oriented, and directive role at the center of the treatment process” (22). In a mental health court, cases are heard on their own calendar, separate from other cases, and are handled by a specialized team of legal and mental health professionals. Emphasis is placed on implementing new working relationships among the criminal justice, mental health, and social welfare systems, particularly in supervising the defendant in the community.

About a dozen courts now refer to themselves as mental health courts (23). A bill to create 100 demonstration mental health courts across the country by 2004 (S.B. 1865) was signed into federal law in November 2000, although spending appropriation has not been enacted. There appears to be no lack of demand for these new courts. Of defendants who are given the choice of having their case heard by a mental health court or by a regular criminal court, 95 percent choose the mental health court (23).

Goldkamp and Irons-Guynn (22) found many differences among the four pioneering courts that they studied, so much so that it is clear that there is no single model for what constitutes a mental health court (24,25). These authors also addressed the extent to which the avoidance of jail is used as leverage: “Some observers see special courts as vehicles for ‘coerced treatment,’ a term with favorable and unfavorable connotations. The favorable use of the term suggests that the judicial role and application of sanctions and rewards contribute a valuable tool for keeping participants in treatment and increasing the chances for successful outcomes. The unfavorable reference alludes to the problems associated with forcing treatment upon individuals who have not voluntarily consented, from a due process perspective and from the perspective that treatment cannot be effective unless it is wanted” (22).

Mental health courts, in one of several forms, are likely to be established in an increasing number of communities. Where they exist, they seem to attract a large caseload of misdemeanor defendants with mental disorders who, when given the choice, prefer to receive mental health treatment in the community than to be incarcerated.

*Avoidance of hospitalization as leverage*



There are three types of outpatient commitment (26). The first is a variant of conditional release from a hospital: a patient is discharged on the condition that he or she continues treatment in the community. The second type is an alternative to hospitalization for people who meet the legal criteria for inpatient treatment: they are essentially given the choice between receiving treatment in the community and receiving treatment in the hospital. The third type of outpatient commitment is preventive: people who do not currently meet the legal criteria for inpatient hospitalization but who are believed to be at risk of decompensation to the point that they will qualify for hospitalization if left untreated are ordered to accept treatment in the community.

Two randomized controlled trials of outpatient commitment were recently published. The first—the Duke mental health study (27)—followed up patients who had been involuntarily hospitalized and given a court order for mandatory community treatment after discharge. Patients who were randomly assigned to the control group were released from the court order. For patients who were randomly assigned to the experimental group, the outpatient commitment order remained in effect for various periods, depending on whether a psychiatrist and the court believed that the patient continued to meet the legal criteria for outpatient commitment.

In bivariate analyses, the control and outpatient commitment groups did not differ significantly in hospital outcomes, although repeated-measures multivariate analyses showed that the likelihood of readmission was lower for the outpatient commitment group (27). However, when the data from the experimental group were disaggregated according to whether the patients had been subject to outpatient commitment for at least six months or for less than six months, strong differences emerged. The patients who had been under outpatient commitment for a sustained period had significantly fewer hospital readmissions and hospital days than control subjects.

Additional analyses showed that sustained outpatient commitment was associated with fewer hospital readmissions only when it was combined with a higher intensity of outpatient services—averaging approximately seven service events per month. The prevalence of violence toward other persons during the year after discharge was also significantly lower among the patients who had been subject to outpatient commitment for at least six months than among the control subjects and those who had received less than six months of outpatient commitment (28). Extended outpatient commitment was also associated with a lower rate of criminal victimization and arrest (29,30).

The second randomized controlled trial—the Bellevue study (31)—also followed up patients who had been hospitalized and given a court order for mandatory community treatment after discharge. A court-ordered outpatient commitment group was compared with a control group over a one-year follow-up period. Both groups received a package of enhanced services that included intensive community treatment.

No significant differences in number of hospitalizations and arrests or in other outcome measures were found between the control and experimental groups. A significantly smaller proportion of each group was hospitalized during the follow-up year than had been hospitalized during the previous year. The researchers concluded that enhanced services made a positive difference in the postdischarge experiences of both groups but that “the court order itself had no discernible added value in producing better outcomes.”

Thus it appears that the results of the only two randomized controlled trials of outpatient commitment agree that improving the availability and quality of mental health services leads to positive outcomes but conflict about the value added by legally mandating patients’ participation

in those services. Both of these studies had methodologic limitations that make it difficult to resolve this conflict (32,33).

### **Advance directives**

Faced with the possibility of undergoing mandated treatment if their condition deteriorates, patients may choose to specify their treatment preferences before a disabling crisis actually occurs (34). Some patient advocates see the use of an advance directive as an antidote to mandatory treatment orders. Others have touted the value of an advance directive as a means of binding oneself to future treatment—“self-mandated treatment”—by authorizing caretakers to override anticipated objections on the part of the patient. 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” (35).

Under the Patient Self-Determination Act of 1991, any hospital that receives federal funds must notify admitted patients of their right to create an advance directive. Usually advance directives pertain to medical care at the end of life. However, the 1991 act has given impetus to the creation of advance directives to promote self-determination during periods in which an individual is rendered incapacitated as a result of a mental disorder. Mental health advance directives, first proposed two decades ago as “psychiatric wills” (36), are permitted in all states, and 13 states have enacted specific statutes that authorize them (37).

Medical and mental health advance directives differ in an important experiential respect: because end-of-life care typically occurs only once, the individual is likely to have had little direct experience with being unable to make treatment choices. In contrast, because of the

episodic nature of mental illness, most individuals who have a severe mental disorder can be expected to accumulate experience on how best to manage the symptoms that impair their decision-making abilities (38,39).

Mental health advance directives take two basic forms. An instructional directive tells treatment providers what to do about treatment in the event that the individual becomes incapacitated—for example, which treatments the individual wants to receive or which facilities the individual wants to avoid (40). On the other hand, a proxy directive gives treatment providers the name of an individual whom the patient has designated to make treatment decisions in the event that he or she becomes unable to do so. Both types of directive can be combined in the same instrument (41).

Surveys conducted in the mid-1990s found that only a small percentage of patients with a mental disorder had completed a mental health advance directive (42). However, with concerted educational efforts, this situation could change radically. One study surveyed people with severe mental disorders who were receiving treatment in public mental health programs and informed them of their right to prepare a mental health advance directive (43). Thirty of the 40 patients who were surveyed chose to prepare a directive; 22 of these chose to designate a proxy decision maker, usually a family member.

None of the patients used the directive to refuse all treatment, although many used the directive to refuse some treatments—for example, electroconvulsive therapy. Almost all patients were satisfied with their advance directive. As one respondent stated, “It is a document that is my voice when I am not able to be.” However, 17 of 21 treatment providers surveyed expressed concern about how the directive would be implemented. They had little confidence that the advance directive would be accessible to clinicians in the event of a crisis.

Mental health advance directives might have a much broader application if they were more aggressively “marketed” to consumers, families, and providers. Technology may play a large role in making advance directives accessible. The recent development of a CD-ROM titled AD-Maker (44) and the online psychiatric advance directives now available from the Bazelon Center for Mental Health Law and from the Advance Directive Training Project may facilitate the use of these instruments. In this regard, New York State has embarked on a \$1 million educational campaign that has distributed 20,000 copies of educational materials on how to complete mental health advance directives (personal communication, Shaw M, 2001).

### **What we need to know about mandated community treatment**

To evaluate the role that mandated treatment may play in mental health law, we need to know how frequently leverage is used, how the process of applying leverage operates, and the outcomes of leveraged treatment. We also need a sharper understanding of the profound legal, ethical, and political issues that are raised when leverage is used to secure treatment adherence.

#### *Prevalence*

Basic descriptive information is lacking for many forms of mandated community treatment. Virtually everything we know about a given use of leverage comes from the experience of only one or two states. Part of the reason for this lack of even rudimentary data is that many forms of mandated community treatment have been implemented only recently. However, this state of affairs may also be a reflection of the sub rosa quality of many of these arrangements. The use of housing or social welfare benefits as leverage is clearly controversial and subject to legal

challenge, and advocates of these practices may consider it imprudent to bring empirical attention to such leverage.

Descriptive information is needed not only about the different types of mandated treatment but also about the joint use of two or more forms of leverage. Data on the overlap among the various forms of mandated community treatment we have described are essential for determining the prevalence of the use of some form of leverage to induce people to adhere to mental health treatment recommendations. An analogy may be the treatment of alcoholism, for which it has been stated that treatment adherence is governed by at least one of the “four Ls”: liver, lover, livelihood, and the law (45).

Alternatively, rather than a single form of leverage being applied to an individual who is reluctant to adhere to treatment, it may be that several forms of leverage are applied. If one form of leverage appears not to be producing treatment adherence, then another is tried, and then another, until adherence is achieved. To the extent that this leverage substitution occurs, eliminating one form of leverage will only increase reliance on other forms.

### *Process*

The central finding from a series of studies of inpatient hospitalization undertaken as part of the MacArthur coercion study (46) was that “the amount of coercion experienced is strongly related to a patient’s belief about the justice of the process by which he or she was admitted. That is, a patient’s beliefs that others acted out of genuine concern, treated the patient respectfully and in good faith, and afforded the patient the chance to tell his or her side of the story, are associated with low levels of experienced coercion.”

The authors referred to this process variable as procedural justice. In theory, one might expect that leveraged community treatment would be characterized by much more procedural justice than involuntary inpatient hospitalization, and thus that the people to whom it was applied should experience it as much less “coercive” than hospitalization. For example, financial management by representative payees is designed to be negotiated in order that the patient be involved as much as possible in decisions about how money is to be allocated.

Perhaps the best illustration of active participation by the mentally ill individual is the drafting of a mental health advance directive. Indeed, the very purpose of an advance directive is to memorialize the patient’s “voice” while he or she is competent to exercise that voice (47). If the results of the MacArthur coercion study are generalizable to the community, such practices should greatly reduce the individual’s experience of coercion. Whether they actually do so is yet to be determined.

### *Outcomes*

#### **Outcomes for people who have mental disorders.**

The proponents of mandated treatment believe that without leverage, many individuals would not adhere to mental health treatment (48) and thus would not achieve positive therapeutic outcomes. However, it is not yet clear that services that are effective when received voluntarily produce the same outcomes when they are received under duress.

Even if mandated treatment were shown to be effective, it is still not clear whether other, nonmandated treatment options could be equally effective. What proportion of people with serious mental disorders would, but for the use of leverage, consistently refuse to avail

themselves of clinically and culturally appropriate mental health services assertively provided in the community? The answer to this crucially important question is unknown.

The reason often given by family advocates for the claim that, without leverage, many people with serious mental disorders would not adhere to treatment is that mental illness negates the ability to make rational treatment decisions. There is no question that mental disorders can impair the competence of some of the people who suffer from them. In the MacArthur treatment competence study (49), of the patients who were hospitalized with a diagnosis of schizophrenia, approximately half had a significant impairment in at least one of the abilities necessary for making a competent decision about treatment. However, the number of these individuals who would continually refuse the offer of high-quality mental health treatment is currently unknown.

Patient advocates not only question the positive outcomes claimed for outpatient commitment but also claim that leveraged treatment will have a perverse effect on the use of services: people who might otherwise want to avail themselves of mental health services will avoid such services for fear of being forced to continue with them indefinitely or face inpatient hospitalization (50). Campbell and Schraiber (51) reported that 47 percent of all discharged patients surveyed in California answered yes to the question, “Has the fear of being involuntarily committed ever caused you to avoid treatment for psychological or emotional problems?” However, a disproportionate number of the former patients who were sampled in that study were members of the “survivor” movement. A similar outpatient-commitment survey, administered to a more representative sample of mental health consumers, would be valuable.

One putative outcome of mandated treatment is its effect on reducing violence in the community. Advocates of outpatient commitment have explicitly “sold” the approach largely by playing on public fears of violence committed by people who have mental disorders (4). As



stated by Jaffe (52), “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.”

Although playing the violence card may succeed in getting legislation enacted, the actual effect of outpatient commitment on reducing community violence is unclear, as we have mentioned. From any benefits that accrue as a result of tapping into public fear must be subtracted the costs of greater stigma toward people with mental disorders that may result from sensationalizing a real—but modest—relationship between mental illness and violence (53,54).

#### **Outcomes for the mental health system.**

It is also important to determine the outcomes of mandated treatment on the availability of mental health services in the community. It is often said that the use of leverage commits the system to the patient as much as it commits the patient to the system. However, it is not clear how true this bromide is. Are resources merely being shifted from voluntary cases to leveraged cases? If so, the apparent irony is that people who want services are denied them so that people who do not want services can receive them. Proponents claim that resources are in fact being appropriately prioritized toward patients with the greatest needs.

Alternatively, it may be that leveraged treatment actually leads to an overall increase in the resources allocated to mental health services. The extent to which any augmented funds are earmarked by the legislature for specific types of services—for example, inpatient beds—and the relative desirability of such services compared with other treatment needs are additional factors to be considered.

Outside the context of a legislative infusion of new moneys into the public mental health system, there is no apparent reason for a service that was previously unavailable to an individual who needed it to suddenly become available because the name of the service is written on a piece of paper as a mental health advance directive. Nor is “My landlord says I need this” likely to be a winning argument with intake workers in many overburdened treatment agencies. In the era of managed care, “Show me the money” may be the response of service providers.

However, the situation may be different in the case of outpatient commitment and mental health courts. Judges may play a critical role in forcing actors in the mental health, substance abuse, and criminal justice systems to work together in a more effective, less turf-protecting manner. When a judge calls a meeting, people tend to show up—and on time. Judges’ use of their bully pulpit may also get the attention of legislators in a way that traditional lobbying by special-interest mental health activists does not.

*Legal, ethical, and political questions*

Whatever its outcomes, is leverage legal? There is no shortage of people who assert that some of the forms of mandated treatment we have described violate existing statutes. For example, Allen (15) claims that “bundling” housing and services violates the Americans With Disabilities Act, the Fair Housing Act, and the Rehabilitation Act as well as numerous state landlord-tenant laws. Concerns about tort liability are also pervasive. For example, is a mental health professional likely to be sued if he or she provides the type of treatment specified in a patient’s advance directive under circumstances in which professional standards indicate that a different treatment is more effective?

Over and above the question of whether any given form of mandated treatment violates a specific statute, it has been claimed that mandated treatment is unconstitutional. The first case that challenged New York's outpatient statute asserted that the statute violates due process and equal protection rights because it permits treatment to be ordered "without a showing by clear and convincing evidence that the person to whom the order applies lacks the capacity to make a reasoned treatment decision." However, the court held otherwise: "Clearly, the state has a compelling interest in taking measures to prevent these patients who pose such a high risk from becoming a danger to the community and themselves. Kendra's Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness, and hospitalization continually repeat itself" (55)

Therefore, contrary to the claims of advocates on either side of the debate, it is fair to say that the legal status of many forms of mandated treatment is currently uncertain. It will take a number of years before it is clear from the courts which forms of leverage—and the manner in which they are operationalized—violate a state or federal statute or constitution. It is not at all unlikely that some state courts, relying on their statutes and constitution, will approve the same type of mandated treatment that other state courts, relying on their own sources of legal authority, have prohibited. As Berg and Bonnie (56) state, "The law in this area is far from settled. Community treatment providers should be aware of the relevant issues and should begin to shape their own guidelines, rather than wait for litigation and thereby surrender responsibility to the courts." When courts finally do address these issues, empirical research on the prevalence, process, and outcomes of given forms of leveraged treatment may play an important and perhaps decisive role.

Beyond questions of the legality of leverage remains the question of whether using jail, housing, hospitalization, or money to leverage treatment adherence—or insisting that a treatment decision made by an earlier “competent self” trump a treatment decision made by a later “incompetent self”—can be morally justified.

From one viewpoint, the operative moral concept in mandated treatment is a threat: “Adhere to mental health treatment in the community, or else you will be jailed or will become homeless.” From another point of view, the operative moral concept is an offer: “Before, you were facing the certain prospect of jail, or homelessness. Now, we are offering you a way to avoid that by adhering to mental health treatment in the community. Your choice.”

The clearest articulation of the distinction being made here is that of Wertheimer (57): “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 or present situation.”

However, with mandated community treatment, fixing the individual’s baseline is fraught with contention. The individual may see the funds that are sometimes used by representative payees as leverage for securing adherence to community treatment as “my money”—money that he or she is legally “entitled” to receive. Others may see such funds as “taxpayer’s money,” to be used as the government chooses to use it (56). According to this view, if a law currently prohibits the government from using disability benefits as leverage, that law can and should be changed, much as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L.

104-193)—passed by a Republican Congress and signed by a Democratic President—terminated 60 years of federal benefits to eligible mothers and children in the pursuit of “ending welfare as we know it.” What once was an entitlement no longer is.

People who have an expansive view of “welfare rights” or “housing rights” are likely to believe that the baseline against which mandated treatment is to be judged should be much higher than people who believe that the government’s obligations in the areas of welfare and housing are more circumscribed. The former group is likely to point out that only for people who are both mentally ill and poor can money or housing effectively function as leverage. The latter group is likely to advocate that the government use limited public resources to promote the public good and that getting treatment to people who need it falls squarely into this category.

Viewed in such a light, the resolution of some—although hardly all—of the controversies surrounding mandated community treatment may lie in the trade-offs inherent in the political process. What percentage of people who have mental disorders would adhere to treatment in the community if various forms of leverage were made sufficiently attractive? What percentage of the public would support increases in the resources available for mental health services in the community if they believed that leverage would be applied to ensure that the people most in need of services actually received them? The debate on mandated treatment would be enriched if answers to such questions were available.

## **Conclusions**

Commitment to treatment in the open community in the early 21st century bears little resemblance to commitment to an inpatient facility in the late 20th century. Commitment can be understood only in the context of a broad movement to apply whatever leverage is available to

induce engagement with mental health treatment in the community, a movement that includes the use of representative payees, subsidized housing, mental health courts, outpatient commitment, and mental health advance directives.

Other forms of leverage may exist as well—for example, continued employment used as leverage under the Americans With Disabilities Act. At least one court seems to think so (58). Little hard evidence exists on the pervasiveness of the various forms of mandated treatment for people with mental illness, how leverage is imposed, or the actual effects of using leverage for different types of patients with various types and severities of illness, or for various mental health systems.

The many vexing legal, ethical, and political questions surrounding mandated treatment have not been thoroughly aired. Yet there are a number of indications that mandated treatment is expanding at a rapid pace, not just in the United States but throughout the world (59). If mental health law and policy are to incorporate—or repudiate—some or all of these types of leverage, an evidence-based approach must rapidly come to replace the ideologic posturing that currently characterizes the field.

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