

# Mandated Treatment In The Community For People With Mental Disorders

Treating people without their consent has always been the defining human rights issue in mental health law.

by **John Monahan, Marvin Swartz, and Richard J. Bonnie**

**PROLOGUE:** The process of deinstitutionalizing people with mental illness in the United States—now a half-century in the making—has manifested itself in a dramatic decline in the populations of state and county mental hospitals: from more than half a million in 1950 to about 50,000 today. At the same time, the ranks of jails and prisons are swelling with a rising number of inmates with serious mental illness, to the point where a person with a serious mental illness is about five times more likely to find himself incarcerated rather than admitted.

The juxtaposition of declining treatment and increasing incarceration rates among people with mental illness has led to considerable criticism of the deinstitutionalization movement for failing to follow through on promised community-based treatment. But the tide could be turning. Backed up by research that confirms that treatment can reduce violence in people with major psychiatric disorders and fueled by several high-profile cases of violent crimes committed by people with severe mental illness, mandated community-based treatment has now taken center stage in this drama. But the issue remains controversial, as it pits public safety concerns against the rights of individuals.

The following paper explores the context within which coerced community treatment has arisen and seeks to break the impasse between advocates and opponents by placing mandated treatment within the larger conceptual framework of health care quality. The authors are all part of the Research Network on Mandated Community Treatment, a MacArthur Foundation-funded project designed to evaluate programs in which mentally ill patients are instructed by the courts to get community-based treatment. John Monahan, the network's director and a clinical psychologist, holds the Doherty Chair in Law at the University of Virginia, where he is also a professor of psychology and psychiatric medicine. Marvin Swartz is a professor and head of the Division of Social and Community Psychiatry and codirector of the Services Effectiveness Research Program in the Department of Psychiatry and Behavioral Sciences at Duke University. Richard Bonnie is the John S. Battle Professor of Law; a professor of psychiatric medicine; and director of the Institute of Law, Psychiatry, and Public Policy at the University of Virginia.

**ABSTRACT:** Commitment to community-based mental health treatment bears limited resemblance to commitment to treatment in a closed institution. It can be better understood in the context of a broad movement to apply leverage to induce treatment engagement, a movement that includes use of the social welfare and justice systems and psychiatric advance directives. Understanding “mandated community treatment” in all of its forms can be advanced by viewing it within the framework of health care quality as recently outlined by the Institute of Medicine, particularly along the dimension of patient-centeredness.

**R**EQUIRING ADHERENCE to community-based mental health treatment is now the single most contested human rights issue in mental health law and policy. Although forty U.S. jurisdictions have statutes nominally authorizing outpatient commitment (a legal order to adhere to prescribed community treatment), until recently few states made substantial use of these laws. With the 1999 enactment in New York State of “Kendra’s Law” and the 2003 enactment in California of “Laura’s Law,” both statutes named after young women killed by people with untreated mental illness, national interest in outpatient commitment has soared. Many states are now experiencing a take-no-prisoners battle between advocates for “assisted treatment” (the more benign term preferred by the proponents of outpatient commitment) and advocates against “leash laws” (the less benign term used by its opponents).

In this paper we first describe the mental health policy context within which coerced community treatment has arisen. Second, we provide an account of the current uses of outpatient commitment and other forms of “mandated community treatment” and how these practices came to be. Finally, we place mandated treatment within the larger conceptual framework of health care quality recently proposed by the Institute of Medicine (IOM), a framework more conducive to reasoned policy deliberation than that often reflected in the current polarized debate.

### **The Context Of Coercion In The Community**

Almost every U.S. community has a subpopulation of mentally ill people who manifest complex problems in multiple areas of life and who come into contact with a variety of public agencies and institutions—including community mental health centers, public hospitals, substance abuse treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities. The growth of this population, often termed “revolving-door patients,” is attributable to increasingly restrictive criteria for involuntary inpatient commitment, limited availability of effective inpatient care, a paucity of effective community-based services, and a lack of other needed community supports. Many of these patients derive little benefit from available treatment programs because they often do not adhere to medication regimens or keep scheduled appointments, may abuse substances, and tend to live in impoverished, dangerous environments with inadequate social supports.

Much of the debate on treatment mandates, or the use of coercion in treatment, assumes that treatment mandates represent a coordinated policy to tighten social controls on people with serious mental illness. It is more useful to understand these mandates as a set of convergent responses to the common challenges facing the diverse agencies and institutions serving this population. While many critics cogently argue that the scarcity of appropriate treatment and rehabilitation/habilitation resources is the fundamental cause of poor treatment outcomes, poor adherence to even scarce treatment programs is equally problematic. It is not surprising that diverse agencies and institutions have developed similar strategies to address the common problem of treatment nonadherence. However, it is also important to recognize that treatment mandates arise from quite different contexts.

### **The Varieties Of Mandated Community Treatment**

Treating people with mental disorders without their consent has always been the defining human rights issue in mental health law. (This same historical debate has been largely absent in substance abuse treatment, however, and the ubiquitous use of coercion in substance abuse treatment is largely uncontested.) For centuries, unwanted treatment for mental disorder took place in a closed institution—a mental hospital. What has changed is that now the locus of involuntary treatment has shifted to the open community.

Much of the strident policy debate on outpatient commitment treats it as simply an extension of inpatient commitment and views it within the same conceptual and legal framework as commitment to a mental hospital. We believe that outpatient commitment should be seen in the context of a growing array of legal tools now being used to improve treatment adherence in the community. In this way, outpatient commitment can be adequately understood, and informed policy decisions on whether to promote or oppose its adoption can be reached.<sup>1</sup>

■ **Conditional release.** Of course, many states in the past have explicitly or implicitly permitted “conditional release” from inpatient commitment as a way to move committed patients into the community while assuring appropriate follow-up and treatment adherence. Sometimes conditional release was treated as a form of “leave”—the patient remained on the census and could be returned to the hospital at any time during the period of conditional release. In addition, some states allowed so-called split commitments, reserving some of the commitment time for an outpatient period of observation after hospital discharge. In either instance, these forms of conditional release were reserved exclusively for patients who met inpatient commitment criteria.

■ **Preventive commitment.** Beginning in the 1990s, commitment laws permitted outpatient commitment as an alternative to inpatient commitment. More recently, states have used outpatient commitment as a preventive procedure, allowing a court order before a psychiatric crisis that would be needed to meet inpatient commitment criteria. These latter uses of commitment law represent a departure

from the historical use of inpatient commitment.

As noted, the preventive use of outpatient commitment is one of several forms of mandated community treatment. People with severe and persistent mental disorders are often dependent upon goods and services provided by social welfare agencies, including disability benefits and housing. Their access to these goods and services may be tied to treatment participation. Similarly, many people with severe and persistent mental disorders often find themselves arrested for criminal offenses. Lenient disposition of their cases may be tied to treatment participation. In each of these contexts, the targeted patients face loss of liberty, property, or other valued interests if they fail to comply with prescribed treatment. Facing such pervasive constraints on “free choice,” patients may attempt to maximize their own control over the treatment they receive in the event of later deterioration by executing advance directives; paradoxically, they may choose to authorize treatment even over their subsequent resistance. Each of these forms of leverage is described in more detail below.

### **Mandated Treatment In The Social Welfare System**

People with disabilities, such as those associated with a serious mental disorder, may qualify under current federal or state laws to receive certain social welfare benefits, such as income supports and subsidized housing.

■ **Money as leverage.** Because people with mental disorders sometimes have cognitive deficits that impair their ability to manage money, the Social Security Administration (SSA) may appoint a representative payee to manage clients’ disability benefits. A representative payee can be either an agency or a person who is paid directly by the SSA and through whom a recipient can gain access to his or her disability payments. Some estimates indicate that about half of those receiving disability benefits for mental disorders use representative payees.<sup>2</sup>

The system of representative payees arose out of concern that vulnerable people might be victimized or might not use public funds appropriately. Thus, the system was designed to protect such people while serving the fiduciary interests of the government. Informally, some representative payees have construed the payee role as more broadly supervisory and have made access to some funds contingent on treatment adherence. One survey in Chicago indicated that the majority of patients who have a representative payee believe that there is a relationship between their adherence to treatment and whether they receive funds, and a large minority believes that this relationship approaches *quid pro quo*.<sup>3</sup> Other studies have correlated the presence of representative payees with decreased homelessness, victimization, and days spent in psychiatric hospitals and increased participation in treatment.<sup>4</sup> Clearly, representative payeeship is an informal tool of mandated treatment—to apparent benefit—but it arose because of government’s concern about the appropriate use of public funds.

■ **Housing as leverage.** A survey conducted in 2001 found that in not a single

U.S. city or county could a person with a mental disorder living solely on disability benefits afford the fair market rent for a “modest” efficiency apartment.<sup>5</sup> The only alternative to subsidizing housing for many people with severe and persistent mental illness, therefore, is homelessness. To avoid this outcome, the government provides a number of housing options in the community for people with mental disorders that it does not provide to other citizens. Of the 600,000 Americans with disabilities who in 2001 resided in housing subsidized by the federal Department of Housing and Urban Development (HUD), approximately one-third qualified for this subsidy because of a mental disorder.<sup>6</sup>

No one doubts that landlords can impose generally applicable requirements on their tenants. The issue is whether landlords legally can and in fact do impose additional requirements on tenants with mental disorders and whether any such requirements can pertain to treatment. The slim research literature on this topic finds that subsidized housing sometimes is used formally and much more often may be used informally as leverage to assure adherence to mental health treatment in the community.

Many agencies that manage housing programs for people with mental disorders appear to consider the programs to be primarily “residential treatment” and only incidentally lodging.<sup>7</sup> For example, the standard lease used by one group providing 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 alternate housing. I understand that if I do not, I may face eviction.”<sup>8</sup> While it appears that the intent is to leverage treatment adherence through the offer of housing, the more general rationale offered by providers is that given the limited housing resources available, existing housing slots must be reserved for people participating in treatment and likely to benefit from treatment-affiliated housing. They also argue that allowing residence by nonadherent people disrupts the treatment of other clients. One recent randomized study, however, found that a program that allowed the tenants of subsidized housing to control whether or not they receive services—compared with a program that linked housing to treatment adherence—reduced homelessness without increasing psychiatric symptoms or substance abuse.<sup>9</sup>

## **Mandated Treatment In The Judicial System**

People with severe mental disorders can be ordered to comply with treatment by judges or by other officials acting in the shadow of judicial authority (such as probation officers). Even in the absence of a judicial order, patients might agree to adhere to treatment requirements to avoid an unfavorable judicial order such as a sentence of incarceration.

■ **Avoidance of jail as leverage.** Making the acceptance of mental health treatment in the community a condition of sentencing a defendant to probation rather

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than to jail has long been an accepted judicial practice, and one that can affect many defendants. Of the 3.8 million U.S. defendants who were convicted and sentenced to probation in 2002, 8–12 percent (300,000–450,000 people) were estimated to have a serious mental disorder. In addition, a new type of criminal court—called, appropriately, a “mental health court”—makes even more explicit the link between sanctioning and treatment in the community.

Mental health courts focus on the nonviolent mentally ill offender who has had repeated contact with the criminal justice system. Adapted from the drug-court model, a mental health court differs from a regular court in several respects: Cases are heard on their own court calendar, separate from other cases, and are handled by their own specialized team of legal and mental health professionals; emphasis is put on implementing new working relationships between the criminal justice system and the mental health and social welfare systems; and defendants appearing before mental health courts generally receive intensive supervision in the community. Mental health courts appear to be spreading rapidly across the country. There was but one operating mental health court in 1997, but by 2002 there were thirty-three, with at least ten additional courts set to begin operation.<sup>10</sup>

Mental health courts arguably use avoidance of incarceration to mandate treatment. However, closer examination reveals great variability in their operations. For some courts, the key motivation appears to be to reduce jail crowding, and they give relatively less attention to assuring treatment participation. Other courts, by use of frequent status hearings, follow the subject’s treatment participation and apply sanctions for nonadherence. These latter courts more directly use the court to mandate treatment.

■ **Avoidance of hospitalization as leverage.** Outpatient commitment, as described above, refers to a court order directing a person with a serious mental disorder to comply with a community treatment plan, under pain of being hospitalized for failure to do so, if the person meets the criteria for involuntary hospitalization.

Outpatient commitment was conceived as a less restrictive alternative to involuntary hospitalization for people at risk of being dangerous or gravely disabled without treatment. It arose as a recognition by the courts that noncompliance with treatment was a common cause of repeated involuntary hospitalizations and thereby a barrier to less restrictive treatment alternatives. By using the moral authority of the court, outpatient commitment was envisioned as a means to reduce relapse, reduce involuntary hospitalizations, and improve the effectiveness of outpatient care by improving treatment adherence.<sup>11</sup>

In New York State, Kendra’s Law mandates adherence to mental health treatment in the community for those who meet a number of statutory qualifications,

including that the person is suffering from mental illness and “because of mental illness is unlikely to participate voluntarily in recommended treatment and... needs assisted outpatient treatment to prevent a relapse or deterioration which would likely result in serious harm to the person or others.” From the time it was enacted in December 1999 through June 2003, 7,983 people in New York State have been evaluated for outpatient commitment under Kendra’s Law, of whom 2,602 were committed and another 1,913 “voluntarily” agreed to adhere to treatment in the community before a judgment was rendered.<sup>12</sup>

■ **Advance directives.** One way to establish a person’s preferences regarding future treatment, should the person become unable to make those decisions or to communicate those preferences in the future, is for the person to “mandate” his or her preferred treatment in an advance directive. Usually, advance directives pertain to wanted or unwanted medical care at the end of life. But a 1991 federal law has given impetus to mental health advocates to promote the creation of psychiatric or mental health advance directives to promote self-determination during periods of incapacitation because of mental disorder. All fifty states permit psychiatric advance directives, and fifteen have enacted specific statutes to promote them.

Psychiatric advance directives can also be applied as leverage in the form of “self-mandated” treatment.<sup>13</sup> However, the origin of these advance directives is more clearly associated with the patient self-determination and empowerment movements than with treatment mandates. In fact, much of the enthusiasm for these legal tools is based on their ability to help the person avoid coerced treatment.

## **Mandated Treatment And Health Care Quality**

Recent health policy literature abounds with reports of efforts to define and measure health care quality. Yet the developing concepts and frameworks typically omit any consideration of coercion or therapeutic leverage. In fact, use of coercion—a core problem in mental health care and also in other health contexts, including infectious disease control and geriatric care—seems to be viewed as extrinsic to any health care quality assessment.

Mental health practitioners and policymakers uniformly assume that coercion and therapeutic pressure are sometimes needed to help people recover or avoid deterioration; presumably, some practices are likely to work better than others do—because they are more effective or because they are more respectful of patients’ values and wishes, or both. Where do these questions fit into a quality framework? In our view, mandated treatment should be brought, to the greatest extent possible, within standard paradigms of health care quality.

■ **IOM framework.** We illustrate these points by commenting on the IOM framework for assessing health care quality outlined in a recent series of reports.<sup>14</sup> The IOM framework has two major dimensions. One dimension concerns consumers’ perspectives on health care needs. The most directly relevant consumer perspectives on health care are getting better (recovering from an illness) and living with ill-

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ness and disability (“getting help with managing an ongoing, chronic condition or dealing with a disability that affects function”). In the mental health context, the first perspective might simply be termed “recovery,” and the second, “support.”

The other dimension of the IOM framework consists of four components of health care quality: patient-centeredness (health care that establishes a partnership among practitioners, patients, and their families), safety, effectiveness of care, and timeliness of care. Consumers are morally entitled to care that satisfies all of these components and, depending on the legal basis for their care, may be legally entitled to such care as well. Inadequate investment in mental health services by government bodies and restrictively “managed” private systems can prolong suffering and disability or even endanger the patient or others, by closing the door to timely and effective treatment. Even when services are adequately funded, however, quality of care could be compromised by inadequate respect for the patient. A key conclusion of the IOM report is that patient-centeredness is an independent, freestanding component of health care quality. That is, it is a crucial aspect of high-quality care in its own right, even if it affected no other aspect of health care.

■ **Patient-centeredness.** Patient-centeredness is the component of quality to which treatment mandates are most relevant. Yet, because the criteria for this component emphasize respect for patients’ preferences and other indicators of patient autonomy, any use of coercion or leverage would seem to signify “poor” care on this component of quality. But surely such a characterization is misleading and incomplete. Under some circumstances, typically involving patients with impaired decision-making capacity, respect for the patient’s express wishes is ethically and legally unthinkable. In such cases, overriding the patient’s wishes could be regarded as “patient-centered” care in the most fundamental sense.

Two solutions to this puzzle are possible. Recognizing that trade-offs among the four quality components are sometimes necessary, one possibility is to say that effectiveness or timeliness of mandated interventions can sometimes trump patient-centeredness. This formulation would be consistent with the standard ethical and legal accounts of mandatory treatment by highlighting the inevitable tension between beneficence and autonomy.

However, we prefer a second possibility, which is to broaden the concept of patient-centeredness to include mandated care under certain circumstances. In our view, patient-centered care aims to promote patients’ engagement in their own treatment to the maximum extent consistent with their abilities. Similarly, using incentives and disincentives to facilitate and promote adherence to treatment is patient-centered care to the extent that these interventions are experienced by patients as being clinically grounded in a caring therapeutic relationship.

We do not want to be understood as devaluing the core understanding of patient-centeredness as a component of quality assessment—in most situations, health care should be independently judged according to whether patients view it as having respected their wishes and having “empowered” them to become actively engaged as decisionmakers in their own care. However, not all patients with a mental disorder are capable of achieving such an autonomous role.

The “competence” of people with a mental disorder to make treatment decisions has been studied extensively in the context of involuntary treatment in hospitals. Results indicate that patients hospitalized with a mental disorder—particularly schizophrenia—more often show deficits in their decision-making competence than do patients hospitalized for a medical illness.<sup>15</sup> But competence has yet to be systematically addressed in the very different context of mandated treatment in the community. What does patient-centeredness imply when treatment decisions are made by a guardian or other surrogate decisionmaker for patients who are determined, under the law, to lack decisional competence? What is expected from health care providers for patients whose ability to make treatment decisions is impaired, even though they have not been found to be “incompetent” by a court? These complex questions need to be addressed, not only in relation to the meaning of patient-centeredness as a component of quality, but also in relation to the ethical and legal legitimacy of mandated community treatment.

Our view is that good clinical care requires a more assertive approach in situations of compromised autonomy. In these situations, the quality of the care should be independently judged according to whether it is experienced by patients as having been necessary, respectful, and motivated by beneficence.

■ **Safety.** One of the dominant legal concerns in mental health care relates to the nature and scope of the clinician’s obligation to prevent the patient from harming someone else. In fact, concern about the risk of violence to third parties is at the heart of the debate about mandated treatment (in hospitals or in the community). Should measures of high-quality mental health care include items relating to violence risk assessment and risk management? As usually described, the “safety” component of quality relates to protecting the patient from iatrogenic injury—that is, reducing medical errors. But what if the clinician fails to take appropriate precautions to reduce the risk of harm to third parties? Would a health care organization that systematically fails to protect other people from dangerous patients be rated poorly on the safety component of a health care quality report card?

It is possible to characterize the risk of health care to third parties as being conceptually extrinsic to the “quality” of clinical care. Not every consequence of health care needs to be incorporated into a quality framework. The idea of quality could be sensibly limited to patients, including those exposed to infections (or violence) in hospitals, but not family members exposed to infections (or violence) by contagious (or dangerous) patients outside the hospital.

On the other hand, who would be willing to take this analysis to its logical ex-

treme, saying, in effect, that failing to take well-established steps to prevent the spread of an infection is irrelevant to the quality of the health care system? There is no doubt that such incompetence would breach a duty owed to the population.

■ **Effectiveness.** How does patient adherence fit into judgments about the effectiveness of care? Medications or other interventions that have proved efficacious in clinical trials will not be effective in practice if patient compliance is poor. Accordingly, in any thorough assessment of health care quality, one indicator of ineffectiveness of care will be poor compliance rates, and improved compliance rates would presumably provide a useful measure of increased effectiveness. As a result, a question of great interest is how improved compliance can be achieved. It is unfortunate that instruments of therapeutic leverage, including incentives and disincentives as well as mandates, are not often mentioned in studies of interventions that aim to facilitate treatment adherence. Rectifying this omission is especially important in the context of mental health care.

■ **Timeliness.** Under the IOM formulation, the definition of “timeliness” of care assumes that patients are seeking care; the measures of quality relate to whether care is available and provided to the patient when needed. As noted earlier, it is hard to know how to deal with recalcitrant patients within this framework. A mental health services system that routinely deploys outreach services to identify patients who are not seeking care and that hospitalizes many patients involuntarily under broad commitment criteria might rank high on “timeliness” but low on patient-centeredness because it is unnecessarily authoritarian. However, it is also possible that such a system could rank more highly on patient-centeredness if the clinically aggressive (and timely) interventions are experienced by patients as being carried out in a respectful and caring manner.

**C**OMMITMENT TO TREATMENT in the community in the early twenty-first century bears little resemblance to commitment to treatment in a closed institution in the middle and late twentieth century. It can only be understood in the context of a broad movement to apply whatever leverage is available to induce patients’ engagement with mental health treatment in the community, a movement that includes the use of the social welfare system, the judicial system, and psychiatric advance directives. Little hard information exists on the pervasiveness of the various forms of mandated treatment for people with mental disorders, how leverage is imposed, or what the measurable outcomes of using leverage actually are. The many vexing legal and ethical questions surrounding mandated treatment have not yet been thoroughly aired. The need for further thought is illustrated by the difficulty of incorporating mandated treatment into the IOM health care quality framework. If policymakers and practitioners in mental health care are to embrace—or to repudiate—some or all forms of mandated community treatment, an evidence-based approach must soon replace polemics.

**NOTES**

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