Over the past decade, the Research Network on Mandated Community Treatment — funded by a major grant to the University from the John D. and Catherine T. MacArthur Foundation — has produced almost 200 peer-reviewed articles studying whether — and, if so, how — to induce people with mental illness to accept psychiatric treatment in the community. This research was conducted in collaboration with colleagues at Harvard, Columbia, Duke, and the University of California.

Network director John Monahan — who has appointments in the Law and Medical schools and the Psychology Department — testified before the House Judiciary Committee on a bill that created a $50 million program to support services for people with mental illness in the justice system. Citing our research, New York state’s highest court unanimously upheld a statute for court-ordered treatment. Similarly, the World Health Organization relied on our research in describing the outcomes of mandated treatment in the community.

Treating people with mental illness who do not want to be treated is one of the most contentious issues in mental health law.

For centuries, unwanted treatment took place 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 community.

Outpatient commitment — a court order to adhere to prescribed treatment in the community — can best be understood in the context of a movement to apply whatever “leverage” is available to induce people with serious mental illness to become engaged in treatment. The mentally ill are often dependent upon goods and services provided by social welfare agencies, including disability benefits and housing. Their access to these goods and services is often tied to their being in treatment. Similarly, people with mental illness are frequently arrested for criminal offenses. Lenient disposition of their cases may be tied to treatment participation.

How often is leverage imposed on the mentally ill to get them to agree to receive treatment in the community? The MacArthur Network surveyed over 1,000 adults currently in outpatient treatment with a public mental health service provider at five sites across the United States, and found that 51 percent have experienced at least one form of leverage.

Different forms of leverage raise different legal and moral issues. One prerequisite to the success of any form of leverage is the ready availability of evidence-based mental health services in the community.

Does the use of leverage work in getting people to treatment and in producing other positive outcomes? Consider these three findings:

Specialty probation that uses smaller caseloads and problem-solving strategies, rather than threats of incarceration, are much more effective than traditional probation in reducing the risk of probation violation by probationers with mental illness.

When patients are under an outpatient commitment order, they experience a substantial reduction in psychiatric hospitalizations and in arrests (see graphic). If the outpatient commitment order is in effect for at least one year, benefits continue after the order ends.

A survey revealed that most four-year colleges in Virginia have procedures for involuntary student withdrawal for mental health reasons. Virtually all of these colleges require the student’s agreement to continue in outpatient treatment as a condition of re-admission to college.