Patient Experiences of Autonomy and Coercion While Receiving Legal Leverage in Forensic Assertive Community Treatment

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Abstract: Legal leverage is broadly defined as the use of legal authority to promote treatment adherence. It is widely utilized within mental health courts, drug courts, mandated outpatient treatment programs, and other intervention strategies for individuals with mental illness or chemical dependency who have contact with the criminal justice system. Nonetheless, the ethics of using legal authority to promote treatment adherence remains a hotly debated issue within public and professional circles alike. While critics characterize legal leverage as a coercive form of social control that undermines personal autonomy, advocates contend that it supports autonomy because treatment strategies using legal leverage are designed to promote health and independence. Despite the controversy, there is little evidence regarding the impact of legal leverage on patient autonomy as experienced and expressed by patients themselves. This report presents findings from a qualitative study involving six focus groups with severely mentally ill outpatients who received legal leverage through three forensic assertive community treatment (FACT) programs in Northeastern, Midwestern, and West Coast cities. Findings are discussed in the context of the self-determination theory of human motivation, and practical implications for the use of legal leverage are considered.

Keywords: autonomy, coercion, forensic assertive community treatment, legal leverage, motivation, self-determination theory, treatment adherence

A man convinced against his will is of the same opinion still.
—anonymous

INTRODUCTION

Treatment refusal is common among persons with severe mental illness who live in community settings. A recent review of antipsychotic medication adherence in schizophrenia found that approximately half of all outpatients were nonadherent.[1] Refusal rates are likely even higher among those who are arrested and incarcerated. In a study conducted within a large urban county jail, for example, researchers found that 92% of severely mentally ill inmates had histories of medication nonadherence prior to their arrest.[2] Mentally ill persons may refuse psychiatric treatment for a variety of reasons, including a concern about treatment side effects, a perceived lack of treatment effectiveness, and the fear of being stigmatized. Moreover, some individuals with severe mental illness are not aware that they are even ill.[3] When those who refuse treatment also engage in criminal activity or prove dangerous to themselves or others, they may become candidates for intervention strategies involving *legal leverage*.

Legal leverage is the process of using legal authority to engage individuals with mental illness or addiction who become involved with the criminal justice system into needed treatments and services.[4,5] It is utilized in various settings to promote engagement in treatment. These include mental health courts, drug courts, pretrial service programs, police-based jail diversion programs, mandated outpatient-treatment programs, and conditional release programs. Probation and parole officers also utilize legal leverage in the community supervision of individuals with severe mental illness or drug addiction. Although the source of legal authority may differ from one setting to another, the aim remains the same: to prompt ill individuals at risk of incarceration, poor health, or other harmful outcomes to accept treatment.

Despite its widespread use, legal leverage is one of the most contentious topics in the mental health field today.[6–10] At the heart of the controversy lies the question whether legal

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leverage promotes or undermines personal autonomy. In bioethics, autonomy is defined as "self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice."[11(p99)] Proponents of legal leverage believe that the intervention supports autonomy by promoting engagement in treatments and services designed to improve health, wellness, and the ability to live independently. Critics counter that legal leverage, however well intentioned, is still fundamentally coercive and disempowering. While concern about the impact of legal leverage on autonomy has emerged mainly from sources outside of the health care field, clinicians are increasingly recognizing and appreciating the importance of autonomy. Standards of medical professionalism[12] and biomedical ethics[11] now require health care professionals to consider patient autonomy and social justice of equal importance to length and quality of life. Patient autonomy has also received legislative support. The Patient Self-Determination Act was passed by Congress in 1990 as the first federal law to ensure that all health institutions inform patients that they have the right to refuse medical treatment.[13]

In light of the increasing attention to questions concerning autonomy and legal leverage, what does the empirical literature tell us about legal leverage and how it affects autonomy? A search of the Medline database from 1946 to the present, combining the keywords autonomy and legal leverage, revealed no articles. In considering this dearth of findings, it is necessary to recognize that a language for conceptualizing and studying the relationship between legal leverage and autonomy has yet to fully emerge. For example, the term *legal leverage* is often used interchangeably with the term *coercion*, and the term *coercive* is often used synonymously with *forced*, *compulsory*, *mandated*, and *involuntary* to describe treatment. This common parlance blurs the distinctions between efforts to engage a person in treatment, the person's perception of those efforts, and the treatment itself.

Wild and colleagues[14] have made an important distinction between legal leverage, which is *an external form of social pressure*, and coercion, which is *an internal perception* of being controlled or influenced against one's will. One does not necessarily lead to the other. The landmark MacArthur Coercion Study demonstrated that perceptions of coercion among psychiatric patients who were involuntarily hospitalized depended on whether patients felt that they were given a "voice" and treated with respect during the commitment process.[15,16] Subsequent studies involving outpatient populations have suggested that perceptions of coercion are more strongly related to features of the treatment being delivered, including the quality of the therapeutic alliance, than to the degree of pressure applied.[17–21] Research has also shown that perceptions of coercion may be heightened by paranoia and other acute psychiatric symptoms.[22] Acute symptoms are common among patients entering outpatient treatment programs directly from jail, where mental illness is often untreated. These findings suggest that a clear distinction must be made between the following factors in order to examine the relationships between them: (1) legal leverage, (2) an individual's perceptions of the leverage process, (3) the treatment that an individual is being leveraged to receive, and (4) an individual's mental status. The findings also suggest that perceptions of legal leverage may be determined, in part, by how legal leverage is applied.

If perceptions of legal leverage are related to how it is applied, then how can it be applied to minimize perceived coercion, maximize personal autonomy, and promote motivation for treatment? In this article we consider patients' personal experiences and reflections regarding legal leverage as gathered from focus groups with severely mentally ill adults enrolled in *forensic assertive community treatment* (FACT) programs. Results are discussed in the context of *self-determination theory* (SDT),[23,24] which provides a guide as to how legal leverage might be utilized most effectively to promote active participation in treatment. Based on this theory and the findings of the study described below, we propose that legal leverage can be applied with varying degrees of respect for a person's psychological needs and that differences in degree will undermine or enhance patient autonomy and motivation for treatment.

METHODS

Six focus groups were conducted with severely mentally ill adults enrolled in three FACT programs located in three mid-sized Northeastern, Midwestern, and West Coast cities during 2009 and 2010. One study site was a university-affiliated outpatient mental health clinic, and the two other sites were public outpatient mental health clinics. The three sites were similar in size, staff composition, and hours of operation. All focus groups were conducted at the clinics themselves, where the study participants received their outpatient mental health services. Focus groups were convened as part of a National Institute of Mental Health–funded study to standardize and test the FACT model, an adaptation of the assertive community treatment (ACT) model. ACT has long been recognized as the gold standard of care for preventing hospitalization among persons with severe mental illness who experience difficulty engaging in standard outpatient treatment.[25] Although ACT is effective at reducing hospitalization rates, it has not been found effective at reducing criminal recidivism.[26] To prevent arrest and incarceration, FACT modifies the ACT model by incorporating intervention strategies that target risk factors for criminal recidivism and by developing criminal justice partnerships for the purpose of utilizing legal leverage to promote treatment engagement.[27–29]

Focus groups were conducted with the aim of learning how clients themselves experience legal leverage and if there are ways to more effectively promote their active participation in treatment. All focus group participants had either received or were receiving legal leverage in the form of judicial monitoring at the time that the focus groups were conducted. In general, these individuals entered their FACT programs as

an alternative to incarceration or as a condition of release in exchange for their agreement to accept treatment and to attend regular hearings with a judge.

Study inclusion and exclusion criteria were that all subjects must be aged 18 or older, be currently enrolled in a FACT program, and have an Axis I diagnosis of a severe mental illness. Subjects were required to have an adequate command of English to understand study materials and instructions. In addition, all subjects were required to have an adequate capacity to provide informed consent (in the opinion of their respective FACT program directors). The study was reviewed and approved by the University of Rochester Medical Center institutional review board.

Prospective focus group participants were identified and recruited by their respective FACT program directors. Patients who expressed interest were then invited to meet with study staff members before the first focus group, and they were given the opportunity to learn more about the study and to ask questions. Study staff members were not involved in the patients' treatment, and they informed all potential subjects that study participation was voluntary. Study staff members then obtained written informed consent from all interested individuals, and each research subject received a $20 grocery store gift card for study participation.

Subjects were 31 adults between the ages of 18 and 65, with 17 (55%) women and 14 (45%) men. Racial and ethnic demography of the subjects was 19 (61%) Caucasian, 8 (26%) African American, 2 (6%) American Indian, and 2 (6%) Asian. Twenty-six (84%) were non-Latino, and 5 (16%) were Latino. All subjects were diagnosed with a severe mental illness; the most common diagnoses were bipolar disorder, schizoaffective disorder, and schizophrenia. Approximately 80% of all subjects suffered from co-occurring substance use disorders in addition to their Axis I diagnoses.

Focus groups comprised approximately ten participants each and were conducted in two 90-minute sessions on consecutive days at each FACT program by two of the authors (JSL and DJ). Groups were audio recorded, and a flip chart was used to keep track of participants' comments and questions and to help guide the group discussions. Each focus group began with introductions, a statement about the purpose of the group, a reminder about confidentiality, and encouragement to share personal experiences, thoughts, and opinions. Areas of questioning for each group were as follows:

Day 1 focus groups:
- participants' general experiences within their respective FACT programs
- how their experiences compared to previous treatment and courtroom experiences
- aspects of the program that they found most helpful and least helpful

Day 2 focus groups:
- why participants entered their respective FACT programs, and their perceptions of coercion at that time
- participants' feelings and perceptions related to receiving ongoing judicial monitoring
- participants' feelings and perceptions about their treatment
- participants' feelings and perceptions about program clinicians and criminal justice staff

Focus groups were recorded, and the recordings were transcribed for qualitative analysis with NVivo 8 software. Qualitative analysis of focus group data was conducted according to the principles of grounded theory.[30] Content analysis of the qualitative reports and narrative data was conducted by four doctoral-level staff: a psychiatrist and two psychologists with research experience, and a trained qualitative researcher who supervised the analysis process. The rating team identified a total of 101 themes through consensus, which were subsequently coded and annotated, and then labeled, indexed, and classified using the software program to facilitate data retrieval. This process resulted in the identification of 14 themes that were judged by the rating team as relevant to understanding how legal leverage was experienced by focus group participants:

- accountability (being held responsible for one's actions)
- autonomy (feeling free to make one's own decisions)
- choice (having options or alternatives)
- coercion (feeling controlled against one's will)
- engagement (active involvement with a pursuit or activity)
- practical supports (helpful people, places, and things)
- motivation sources (factors that compel, drive, or inspire an individual to act)
- recovery (the process of healing from mental illness or addiction)
- personal relationships (close and meaningful connections with others)
- roles and responsibilities (tasks, duties, and activities for which an individual is accountable)
- voluntariness (the extent to which an activity or agreement can be entered into freely)
- treatment (the role of medications, counseling, and health services)
- trust (the role and importance of believing in others)
- turning points (situations or circumstances that prompted changing one's life in a significant and positive way)

Based upon the review of pertinent themes and associated participant comments, the authors derived a series of observations relating to how legal leverage is experienced by focus group participants.

RESULTS

The findings from the qualitative analysis of the focus group data are presented below, including the number of

participant responses (when possible) and illustrative participant comments. It is noteworthy that participants varied in their ability or willingness to address the focus group questions, with some participants being more engaged, active, and articulate than others. Furthermore, the response count does not capture nods of assent or other nonverbal communications that occurred in the groups. Nonetheless, these data provide a general sense of the frequency and force of some of the most resonant reflections and opinions that were shared.

Focus group participants generally agreed that legal leverage provided a strong incentive to enter FACT treatment programs but differed regarding the extent to which they perceived the process as coercive. While 32% of participants (10 of 31) framed their decisions to enter treatment as largely compelled, 52% (16 of 31) indicated that their decisions also reflected personal choices. In addition, focus group comments suggested that autonomy at the time of program entry was affected by factors over and above legal leverage, including the presence of mental illness and co-occurring addiction. Participants' comments often reflected at least some level of awareness of having an illness, with 65% (20 of 31) explicitly endorsing that severe mental illness and co-occurring addiction had diminished their personal autonomy. This latter group also recognized that restrictions imposed through legal leverage may ultimately improve their autonomy by helping them gain greater control over the personal circumstances that had influenced their lives. Participants' comments on these points often appeared more nuanced and complex than bluntly framed positions either for or against legal leverage:

- My mess started when I was 13. An older man had sex with me, and I started drinking. The years went by, I started using drugs, and I got pregnant when I was 16. When I lost the baby, that messed up my head pretty bad. I started snorting Oxys, and it just got worse and worse. Then I caught a felony indictment for selling drugs, and that's when they tried to put me in drug court. I tried it for a minute, but it just wasn't working. They were trying to deal with the drug problem, but the real problem was in my head. Well anyway, my parole officer was breathing down my throat, so I threw up my hands and quit reporting to him. They finally caught up with me, and I was ready to just go do my time. I was looking at five years in prison, but they offered me a plea to come here. Then this lady from pre-sentencing, she assessed me, and I guess she thought I needed it. That's pretty much what got me in. Anyway, now I'm loving it because they deal not just with your drug problem but also with your mind.
- I stole a VCR back in 1991 and went to prison for 15 years. I got drunk and didn't know what I was doing, so my addiction had something to do with it. I wish I had somebody tell me I had to go to treatment back then.
- I could have gotten AIDS selling my body for crack. I'd get in the car with "Joe the Slasher"; I just didn't care. I was getting tired of my life the way it was. I was damn near 40 and still on the streets. Then I got arrested and sent to jail. The inmates were so mean. It made me want to have my life, my own personal life back. So I came to the program. I have to thank the team here for giving me clozapine. I think I'm doing the best I've ever done now. I haven't been hospitalized in a long time, and I've got my own place.
- I could either go to prison and get worse because that's what was going to happen, or I could change my life around, and that's what I wanted. I was tired of being incarcerated, and I was tired of degrading myself. I would literally go down the street in tears because everybody else had a life, and I didn't. I chose a better life because I felt myself committing slow suicide.

Of those who initially felt forced into treatment, approximately half continued to resent the process and to accept treatment begrudgingly, if at all. For these individuals, the experience of legal leverage may indeed be one of coercion and reduced autonomy as they struggle with the structure and rules of their respective programs:

- The legal system is all into my case—the parole officer makes sure that I come to program. It's made me more rebellious if anything. I know what I gotta do, and I don't need somebody telling me.
- I'm grown, and you can't tell me I have to take medication when I know I don't, so they locked me up.
- I'm tired of my probation officer trying to nickel and dime me here on violations. I told him, just lock me up right now, and I'll do a year and a half in the county jail, and then be done with you.

Eleven of 31 focus group participants (35%), however, expressed that their initial perceptions of external control and coercion changed over time. Beyond simply adhering to treatment, these participants reported becoming actively engaged in their own care over the course of involvement in their respective programs. Participants' comments suggest that this shift in behavior was accompanied by a shift in perception from feeling externally controlled toward becoming internally motivated. These participants were able to identify personally important reasons to engage in treatment beyond the presence of legal leverage:

- If I don't come here, I do eight years in prison, so yeah, it's a big incentive to coming here every day. But what starts out as me doing this to stay out of prison, after a while, it just becomes your life. I don't think any more like "Oh man, I've got to go to group." If problems arise during the week or on the weekend, you want to come in

here every day and talk about what's going on in your life. It helps me become more responsible and learn how to live.
- I didn't want to talk to anybody because I was paranoid, and I needed help, so they put me here. Now I keep coming because it keeps me out of trouble.
- I'm off probation now. Keeping away from drugs, my mental health and stuff like that, that's what keeps me in treatment.
- It was a no-brainer to enter the program, but what keeps me here is I want to be sober and to have my life back.
- In the beginning it was the thought of prison that made me come here. When I first came here, I just wanted to get it over with. But after I had been here for a bit, I really enjoyed coming here, and it's helped me a whole lot. I don't really think about the prison stuff now.

Most focus group participants framed their participation in treatment as attributable to many factors in addition to, or in place of, legal leverage. One prominent theme across all groups was the role of participants' relationships with FACT program judges and clinicians. Participants appeared willing to accept treatment along with judicial monitoring if offered with caring, empathy, and concern—which they described as often missing in their lives:

- My caseworkers wanted to see where I camped by the river, so I took them there. Halfway down the mountain, one of them lost her footing. She landed on her rump, slid the rest of the way down, and I helped her up. I never had any caseworker ever want to see where my camp was, they'd just take my word for it. But they wanted to know where they could find me, so I showed them. And all that made me think that if they went the extra mile to do that, well then these people really care.
- What really shocked me is that the judge knew about me. I thought he don't know what's going on, he don't know about my doctors, my suicide attempts, my hepatitis, but he knew everything. I wasn't just another number in there. He knew about me and talked to me in a way that made me feel like I wanted to make this change; I want to work this program.
- The staff here shows me a sensitive side, like a caring side that I've never experienced in my life. They want to help us, and they know we're human, and they know we need help. You still have your consequences, sometimes you might go to jail. But they still work with you, they just try to get you stable and try to help you understand your mental illness and your addiction.
- We're in here because we have serious problems that could mean the end of our lives. They seem genuinely concerned and caring, and I've never been around stuff like that, where people care, you know what I mean? I'm used to being around people who don't care about you, and you're not supposed to care about them.

Participants' comments suggested that FACT staff members' skill in addressing participants' health issues in a way that promoted motivation for treatment was critical. Moreover, the providers' ability to facilitate the perception of having a choice or being able to decide for oneself appeared important to the participants:

- My probation office told me that she's not going to put me in jail, but if I want to, I can put myself in jail.
- When I started treatment I wasn't ready, which, you know, makes a difference. But they met me right at that point, they came to my level.
- My doctor doesn't really give you orders, he listens, and he makes you feel like it was your own idea.
- The judge will give you a heads up, tell you what you need to work on, you know. Other judges will be like, OK, here's 90 days in jail.

In addition to having trusting relationships with skilled providers, participants consistently expressed the need to learn basic living skills in order to transition successfully from incarceration and homelessness to living in the community. Participants often reflected on how their sense of confidence never developed or how it was diminished from years of repeated vocational, educational, and social failures due to severe mental illness and co-occurring addiction. Eleven of 31 participants (35%) suggested that involvement in their respective programs allowed a new or renewed sense of confidence in their ability to care for themselves and to accomplish their goals:

- Eighteen months ago, going to prison would have been a whole lot easier than trying to get my life together because that's what I knew. I'd been to jail, been to prison. I didn't know how to do what I'm doing now.
- Our goals are little things to some people but big things to us, like your hygiene or maintaining housing.
- I went to prison when I was 18 years old, I was basically a kid, and I had to adapt to that type of environment. When they let me out of prison, I was like a dog just let out of a cage. I ran wild because I didn't know how to succeed out there.
- I had nothing before I got into this program. Because of this program I got a place, money to get what I need, my clothes, do my laundry, my dental hygiene, whatever. I wouldn't be able to do any of this if it wasn't for the program.

Seventy-four percent (23 of 31) of participants acknowledged that the structure provided by ongoing judicial monitoring in combination with appropriate treatment and

support services provided a springboard for their personal growth and recovery. Program structure appeared to initially stabilize patients who were unable to stabilize themselves when their lives were out of control:

- They don't have unrealistic expectations. Realistically, I've been using and abusing 20 years, and that's what I know. They're not going to expect me to change overnight. This program is teaching me how to live with mental illness without street drugs. The program kept me structured until I could get some structure on my own.
- I'm not sure if it's the drug testing every week that keeps me clean, or if it's actually me, but the way this program works with the judge being so interactive with you, it helps.
- They're not just going to throw you into a fast food restaurant and say "See ya." People with mental problems sometimes can't be around a lot of people, so they'll put you in an environment that you'll be able to do alright in. You can choose which work environment you feel the most comfortable in, so you'll want to give it a try.
- As soon as I'm off probation, I'm going to find myself at a very important point in my recovery. I'm not going to have anyone to answer to anymore, and it's not like I'm not going to have access to anything I want. So, yeah, I'm worried about it, but as long as I do the things that they're teaching me to do and have my support group and everything else, I should be fine. I fear my not being held accountable anymore for anything. I won't have anybody to answer to, and I've had the structure for a long time with people kind of guiding me down this road. Am I going to use all these tools I'm learning, or am I going to toss them to the side? I don't know.

DISCUSSION

Study findings suggest that the experience of legal leverage varies widely among adults with severe mental illness. Some focus group participants perceived the legal leverage process as consistently coercive, whereas others reported feeling less coerced and more autonomous over time. The finding that perceptions of coercion and autonomy may change over time is significant and counters simple characterizations of legal leverage as either coercive or noncoercive. Indeed, for some study participants, coercion and caring appeared to be two sides of the same coin. As explained by one focus group participant who was required to report to a judge each month, "If she didn't care about you, she wouldn't bother with this." In addition, focus group findings suggest that "choice" was already constrained, making it a complicated issue for focus group participants even before receiving legal leverage in their respective FACT programs. The majority had suffered losses of health or freedom due to the combined impact of mental illness, addiction, poor choices, and lack of social supports or other resources prior to program entry. Facing the prospect of continued suffering and incarceration, and even the possibility of early death, program entry may have seemed the best among a diminishing menu of options.

Study findings also suggest that treatment programs using legal leverage may sometimes need to limit personal autonomy to ensure public safety as well as to protect patients themselves. This dynamic was evident from participants' descriptions of behaviors that harmed themselves or others, and also from statements by some that they felt forced to accept treatment. Since legal leverage ultimately aims to promote voluntary and active participation in needed treatments and services, however, perceived coercion should be viewed as an undesirable *side effect* of such intervention. As with certain medication side effects that are sometimes unavoidable but always undesirable, perceptions of coercion should be minimized when possible.

The experience of legal leverage appeared to be affected by a complex array of factors within this sample of FACT program clients, including psychiatric symptoms, varying awareness of illness, drug and alcohol use, readiness for change, and treatment effectiveness. Two factors emerged with special prominence, however, in all focus group discussions: the role of relationships with clinicians and criminal justice staff, and the role of program structure. The importance of these two intervention elements, along with the finding that perceptions of coercion and autonomy can change over time, raises the possibility that such change might be facilitated with appropriate intervention. Rather than continuing the current debate over the use of legal leverage, the more relevant question in health services today may be *how* to use leverage in ways that minimize coercion while promoting autonomy and engagement in treatment. As previously noted, there is little research evidence with which to address this question. In the absence of empirical data, we turn for guidance to a theory of human motivation called *self-determination theory*. Based on this theory and study findings, we propose that legal leverage can be applied in ways that will either undermine or enhance patient autonomy and, ultimately, motivation to engage in care.

An Overview of Self-Determination Theory

Self-determination theory provides a useful framework for interpreting focus group findings and for considering how legal leverage may be applied most appropriately and effectively. A substantial body of experimental and theoretical literature exists concerning SDT that is relevant to understanding the relationships between legal leverage, autonomy, and engagement in treatment. SDT is a general theory of human motivation that describes how social and clinical interactions can either thwart or support personal autonomy, and how autonomy can promote engagement in treatment. According to SDT, all people share basic psychological needs for *autonomy* (i.e., feeling free to do things for themselves), *competence* (i.e., feeling able to accomplish their desired goals), and *relatedness* (i.e., feeling warmly and positively

related to others). SDT posits that people are naturally motivated and that when these basic psychological needs are supported by the social environment (including teaching, parenting, coaching, health care, and criminal justice environments), people feel energized to grow, to address personal challenges, and to be healthier. When these basic needs are thwarted or undermined, however, individuals become unmotivated or they rebel against those they perceive to be controlling them.

Over 1000 scientific papers have been published providing empirical tests of SDT in different settings and across different cultures, including health care, education, employment, parenting, and interpersonal relationships.[31–33] Within health care, six randomized, controlled studies have examined the impact of perceptions of autonomy on long-term abstinence from tobacco,[34,35] on physical activity,[36,37] and on dental plaque and gingivitis.[38,39] Results show that when the health care environment supports people's psychological needs, including the need for autonomy, they have greater engagement in treatment. Research has also shown that clinicians can be trained to provide greater support for autonomy and that this process results in patients experiencing greater personal autonomy [40] and greater engagement in care.[31]

Central to the experience of personal autonomy is an individual's perception of who is causing a given behavior—whether it is one's self or another person. This perception includes whether individuals feel that they are fully engaged in a behavior because they want to or because they are being forced because of some external contingency. Feeling forced or controlled is associated with disengagement and low levels of motivation.[31,41] Individuals who perform certain behaviors only because they feel forced are unlikely to continue them once the contingencies are removed.

By contrast, behaviors that are autonomously motivated are those that an individual values as personally meaningful and important. Behaviors that are autonomously motivated, however, do not always begin that way. New behaviors that are important to an individual but not intrinsically fun or interesting typically start out being experienced as controlling. With support for autonomy and structure from the surrounding environment over time, new behaviors may gradually become experienced as increasingly autonomously motivated through the process of *internalization*. This process—through which perceptions of autonomy naturally change over time—is of key importance in adopting health-related behaviors. According to SDT theory, internalization of health-related behaviors can be promoted by eliciting and acknowledging patient values and perspectives, providing a menu of effective options, supporting patient initiatives, providing a rationale for why a particular recommendation has been made, and being nonjudgmental.[34,41–43]

Legal Leverage in the Context of Self-Determination Theory

A key study finding is that perceptions of coercion and autonomy changed over time for some focus group participants, along with their level of engagement in treatment. From the standpoint of SDT, the shift from feeling forced into treatment to becoming an active and willing participant is consistent with the process of internalization. Whether treatment is perceived as coercive or as autonomously motivated over time may ultimately depend on the skill of service providers and also the willingness of patients to engage. The providers who prove to be most successful at promoting engagement may be those who convey to patients that, in the end, they are in charge of their own health, treatment, and recovery. Based on study findings, and consistent with the SDT model, provider attitudes and behaviors that can support patients' autonomy and motivation to participate in legally leveraged treatment may include the following:

- being empathic but clear about the rules and expectations
- providing patients with a rationale for expected behaviors
- eliciting and acknowledging patient perspectives
- offering patients reasonable choices when possible
- supporting patient initiatives when safe to do so
- minimizing control when possible
- remaining nonjudgmental
- being positive that each patient can succeed

The majority of focus group participants reported that the FACT program structure helped them transition from being out of control "into having an actual life," as stated by one participant. This observation suggests that legal leverage may help provide structure that allows autonomous motivation to become internalized over time. Another study participant, however, reported that "you get from level one to level two by doing what you're supposed to do," suggesting that some participants felt compelled to move along in a passive and formulaic manner. Based on study findings, and consistent with SDT theory, it may be beneficial if programs can provide structure in ways that support patients' basic desire for autonomy, for meaningful relationships, and for a sense of competence. The need for competence was evident among focus group participants, who consistently expressed the need to learn basic living skills and to gain confidence in their ability to care for themselves. Service providers might enhance their patients' sense of competence by partnering with them to develop realistic program goals and expectations, taking into account each individual's level of impairment. Autonomy might be supported through the use of clearly written participation contracts that spell out program expectations and benefits, enabling patients to make fully informed decisions prior to program entry. In addition, program structure can be used to build relationships by scheduling both regular individual meetings with patients and team meetings for patients to review their progress together with program clinicians and criminal justice staff.

Some focus group participants reported feeling harassed or unmotivated by the criminal justice staff members who

monitored their treatment adherence. This finding is consistent with a central tenet of SDT theory—that individuals will be less willing to follow directions from those with whom they lack a positive relationship. Alternately, focus group participants discussed how their motivation for treatment was enhanced by working with judges and other staff members whom they perceived to be caring, supportive, and knowledgeable. These observations suggest that programs utilizing legal leverage to engage patients in treatment should avoid undermining patients' psychological needs by being overly punitive, impersonal, or dismissive of patients' preferences. Such adverse outcomes can result if legal authority is applied by criminal justice staff members from a solely "get tough on crime" perspective. Likewise, similar outcomes might result if clinicians see their role in the legal leverage process as simply reporting behavioral problems to criminal justice staff rather than working to engage patients in appropriate person-centered treatments and services.

Optimal implementation of legal leverage appears to require an active partnership among clinicians, criminal justice staff, and patients themselves. For clinicians and criminal justice staff, having a consistent approach is key. Yet, since these professional groups typically have different priorities (i.e., promoting patient health versus protecting public safety, respectively), partnership development may require explicit discussion and the development of shared values and goals. Examples include believing in treatment as a legitimate alternative to punishment, using problem-solving rather than punitive approaches to behavior problems when possible, and embracing patient health and public safety as complementary, rather than competing, goals. Consistent with study findings that patients' autonomy can be impaired by mental illness and addiction, optimal use of legal leverage may also require a willingness to utilize clinically informed decision making. In this process, criminal justice decisions about how to address a given patient's behavior problems are informed by clinician input about the patient's condition, possible therapeutic options, and overall progress.

Several study limitations to this qualitative study should be noted. As previously mentioned, the percentages and numbers of responses reported here are based upon only those patients who chose to share their opinions during focus group discussions. For example, more than 10 subjects may actually have felt that their entry into treatment was entirely compelled, but only 10 of 31 shared those feelings during focus group discussions. Another limitation is the cross-sectional nature of the study. Longitudinal studies are needed to examine how patient perceptions of coercion and autonomy actually change over time, the factors associated with such changes, and the relationship of those changes to health and public safety outcomes. An additional limitation is that no health or safety outcomes were assessed in this study. Finally, this study examined only a small sample of individuals who were enrolled in FACT programs. The process of how legal leverage is applied in FACT may differ from that found in other legal leverage-based treatment approaches. Patients in this study were offered treatment as an alternative to incarceration or as a condition of release prior to FACT program entry. Because this type of legal leverage *increases* individuals' available options (i.e., from jail only, to jail *or* treatment), it may be inherently less coercive than other leverage-based interventions that may serve to *decrease* individuals' options.[44]

CONCLUSIONS

Patients' experiences of autonomy and coercion while receiving legal leverage appear to be affected by multiple factors, including how legal leverage is applied. Consistent with SDT theory, study findings suggest that perceptions of coercion can be minimized and active participation in treatment can be promoted by applying legal leverage in ways that support patients' basic psychological needs: to be one's own person, to feel able to accomplish one's goals, and to have positive relationships. Focus group findings suggest that these basic needs can be supported even in the context of legally leveraged treatment and that supporting these needs may allow internalization of motivation to occur over time. Applying legal leverage in a supportive manner is consistent with current standards of biomedical ethics, medical professionalism, and aspects of Western legal codes, and may lead to improved engagement in treatment. Quantitative research is needed to further examine the relationships between patient experiences of autonomy and coercion, engagement in care, and health and safety outcomes in legal leverage-based treatment interventions.

Declaration of interest: Drs. Lamberti and Weisman are cofounders of Community Forensic Interventions, LLC, a company that provides training and technical assistance services related to the forensic assertive community treatment model.

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