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PLC or TLC: Is outpatient commitment the/an answer?

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Abstract

The lively debate over mandated community treatment in general and outpatient commitment laws (OPC)[1] in particular has raised many issues. At its core, the debate is over how and to what extent laws should be formulated to persuade, leverage or coerce (PLC) persons with severe mental illness[2] living in the community to comply with medications that mental health professionals believe they need. The alternative to PLC is what we call TLC (tender loving care): a strategy of using benefits – improved patient-centered treatment, entitlements and service delivery, including assertive outreach – rather than penalties or conditions on access to services, to induce compliance. We examine three aspects of the debate: (1) the empirical case for the need for OPC court orders to maintain revolving-door severely mentally ill persons in the community; (2) the normative argument over whether such orders constitute coercion, and, if so, whether that coercion is justifiable; and (3) the incentives such orders create to leverage community providers to augment resources and tailor treatment and services to entice patients to become willing participants in the management of their disorders.

1. Introduction

The deinstitutionalization movement of the past four decades has led to the virtual elimination of long-term hospitalization[3] of persons with severe mental illness. Considerations of cost, advances in symptom control by medication, recognition of the iatrogenic effects of institutionalization, and concern for civil liberties have transformed public mental hospitals into acute care facilities (Morrissey & Goldman, 1986). Even voluntary patients are denied admission, or discharged before they wish, absent evidence of threat of imminent harm to themselves or others (Morrissey & Goldman, 1986). Treatment and care-giving needs of persons with severe mental illness beyond acute crisis intervention are administered, if at all, in the community or the criminal justice system (Ditton, 1999; Mechanic, 1999; Teplin, 1990).

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[1] For simplicity's sake, we use the term, outpatient commitment (OPC). Other names for this regime include: community treatment orders (CTO) in Australia, Canada and New Zealand; assisted outpatient treatment (AOT) in New York.

[2] The term, severe mental illness, encompasses persons with schizophrenia spectrum, major mood and other psychotic disorders.

[3] Exceptions are hospitalization for persons found incompetent to stand trial or not guilty by reason of insanity and persons found to be sexually violent predators.

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Community treatment has been plagued by a shortage of resources and coordination of relevant care-giving agencies and providers (Bloche & Cournos, 1990). Discharge planning between hospital and community is often absent or incomplete. Persons with severe mental illness fall out of, or never enter, community treatment systems — in some measure, because of lack of insight or lack of will; in further measure, because systems fail to engage them and address their needs. Many find themselves homeless, in marginal neighborhoods, and at heightened risk for crime victimization and for substance abuse (Draine, Salzer, Culhane, & Hadley, 2002; Hiday, 1997; Hiday, Swartz, Swanson, Borum, & Wagner, 1999; Silver, 2000). As a result, they are at risk for not only involuntary rehospitalization, but, more commonly, criminal arrest, conviction, and jail or prison — more frequently and for longer periods than their non-mentally ill counterparts (Broner, Lattimore, Cowell, & Schlenger, 2004; Ditton, 1999; Hiday & Wales, 2003). Their care in jails and prisons has all the deficiencies of long-term hospitalization and more (Beck & Maruschak, 2001; Teplin, 1990).

Into this breach have come a variety of state policies aimed at persuading/leveraging/coercing (PLC) patients — and sometimes treatment providers — into continuing community treatment and care.[4] Proponents of these policies believe the population of persons at risk is composed primarily of those with deficits of rationality or will to accept treatment (Appelbaum, 2003; Geller, 2006). Opponents believe this population consists primarily of those whom the system, for reasons of resource shortages and bureaucratic balkanization, has failed to engage, through positive inducements (TLC) rather than threats, in voluntary treatment (Allen & Smith, 2001). In fact, no one knows (Ridgely, 2003). The naturalistic setting for testing these competing claims — a state that is providing adequate treatment and services to all persons with severe mental illness who want it, and with additional resources to spare for involuntary patients — does not exist.

Outpatient commitment (OPC), attracting most of the controversy, may take one of four forms. The first and oldest is conditional release from involuntary hospitalization, where a patient whose condition has improved is released from the hospital on conditions of staying in treatment and not becoming dangerous. Noncompliance results in rehospitalization under authority of the continuing hospitalization order. The second, less restrictive alternative to hospitalization, evolving in the 1960's and 1970's, may occur at the time a patient is found to meet the criteria for involuntary hospitalization, or after some period of hospitalization, if it is determined that the patient can be treated safely in the community. Again, noncompliance may result in rehospitalization by authority of the original hospitalization order.[5] The third is preventive OPC,[6] in which a patient not meeting the criteria for forced treatment or involuntary hospitalization, but at risk for doing so, is court ordered to comply with a regimen of community treatment. Penalties for noncompliance vary. Fourth is the use of court-ordered community treatment under guardianship law.[7]

Although random control trials of OPC are difficult and few, one such study of one form of OPC has suggested that outpatient orders, combined with regular service use, increase medication adherence and quality of life, and reduce hospitalization, criminal arrests, crime victimization, caregiver burden, and substance abuse compared with matched voluntary controls offered comparable services (Hiday, 2003). But how and why OPC "works" is less clear. How much and what sort of PLC is sufficient for what levels of success with which patient subgroups? Does/can PLC "take," such that successful outcomes can be maintained over a substantial period after PLC is removed? And would the provision of higher levels of treatment and services (TLC) erode the difference in outcomes between matched OPC and voluntary patients?

Beyond the questions of what works lie a series of normative questions about OPC to which empirical research can provide no answers (Morse, 2006). When are various regimes of PLC simply illegitimate coercion? How greatly do we value individual autonomy for a population which, for the most part, meets legal criteria for competence to make their own treatment decisions (Grisso & Appelbaum, 1995)? What state interests are sufficient to overcome a legally competent person's disagreement with medical advice? What percentages of false positives and false negatives should we tolerate?

Critics argue that coercion of severely mentally ill persons, including OPC, is a cynical political cover for avoidance of the more daunting task of providing the kind of coordinated treatment and services (TLC) for which a patient might reasonably volunteer (Flug, 2003). But answers for how one moves the political process to seriously address that task typically reduce to appeals for empathy. OPC and other forms of PLC should be evaluated not only for their impact on the patient, but also for their effect on other patients, and on providers and the legislators that fund them. Will OPC

[4] These policies include: representative payee; housing benefits; outpatient commitment; mental health courts; and advance directives (Monahan et al., 2001). These are sometimes referred to in a group as mandated community treatment. Although all but advance directives include a penalty or threat to reduce services, there are important differences among them.

[5] Some jurisdictions require a new hearing for rehospitalization.

[6] See, e.g., N.C. GEN. STAT. s 122C–263 (Supp. 1993), enacted in 1983.

[7] Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983).

augment the state's commitment to providing treatment and services, or merely lead to reallocation of limited resources away from those who want them?

We turn first to the empirical literature on OPC for clues about its efficacy and on what makes it "work."

2. The empirical literature

Published empirical studies of OPC date from 1982 (Hiday & Goodman, 1982), when a far broader range of persons with severe mental illness were being hospitalized than today.[8] Over the first dozen years or so, study samples included a broader range of diagnostic types and functioning levels than those of the last 10–15 years, which focused on persons with severe mental illness, many of whom were revolving-door patients. This is because OPC laws of the earlier period, mostly of the less restrictive alternative variety, were met with skepticism that persons meeting involuntary hospitalization criteria for dangerousness could be treated safely in the community and that treatment could be effective for persons who would not seek it voluntarily (Miller, 1987; Mulvey, Geller, & Roth, 1987). Hence clinical and legal decision-makers tended to select for outpatient treatment patients who were lower risks for noncompliance and for causing harm. And researchers focused on the questions of whether these patients would become dangerous with consequent rehospitalization, and whether they would cooperate with treatment.

The early studies, all non-experimental, observing outcomes under the usual operation of the law and treatment, found that patients placed on OPC could be maintained safely in the community: few needed to be rehospitalized during the commitment period (Hiday & Goodman, 1982); none committed serious harm or was victim to it (VanPutten, Santiago, & Berren, 1988); they were no more likely to be rehospitalized, involuntarily hospitalized, have longer stays when hospitalized, be dangerous or be arrested than were other civil commitment patients held and released after their hearings or after a period of involuntarily hospitalization (Hiday & Scheid-Cook, 1987); they were less likely to have disruptive symptoms than patients released after 72-hour emergency holds and after involuntary hospitalization (Greeman & McClellan, 1985); and they were less likely to be hospitalized and more likely to have shorter stays after being placed on OPC orders than they were before their orders (Fernandez & Nygard, 1990; Zanni & deVeau, 1986). Noncompliance occurred; but patients placed on OPC were more likely to comply with medication and scheduled appointments than other patients brought into the civil commitment process but not put on OPC (Greeman & McClellan, 1985; Hiday & Scheid-Cook, 1987), and were more likely to use mental health services voluntarily after their orders expired (Hiday & Scheid-Cook, 1987; VanPutten et al., 1988). A recent study covering the first 4 years of the operation of Israel's OPC law asked the same questions as these earlier studies. Defining success as avoidance of involuntary hospitalization, it found that more than three-fourths of patients in several districts were successful during the 6 months of their OPC orders and in the following 6 months. Among these, three-fourths were fully compliant; the other fourth "needed the help of their families to comply" (p. 700, Durst, Teitelbaum, Bar-El, Shlafman, & Ginath, 1999).[9] Only one early study reported ambiguous findings, with one sample of OPC patients having lower rehospitalization rates than its matched comparison and a second sample having equivalent rates with its comparison (Bursten, 1986).

Taken together, this first set of studies supports the hypothesis that OPC can positively affect treatment compliance and safety in the community. But the support is not solid because of a likely selection bias in favor of OPC, with patients selected for OPC on the basis of traits thought predictive of low risk such as employment, family support and no history of violent acts, whereas comparison patients with less favorable indicators remained hospitalized for a period before release (Hiday & Goodman, 1982).

As hospitalization became restricted to more severe cases, OPC increasingly targeted severely mentally ill persons who do not comply with treatment in the community, deteriorate, become dangerous and revolve in and out of public mental hospitals and jails. Samples of later studies, thus, consisted entirely or predominantly of persons with severe mental illness (mostly schizophrenia spectrum disorders with lower functioning and often with co-occurring substance abuse). Research questions turned to whether patients do any better treated in the community under orders than treated without them. These studies also eliminated the confounding derived from comparing patients selected for OPC with

[8] Although psychotropic drugs, community care, budgetary priorities, and the civil rights movement had brought about significant declines in mental hospital populations and lengths of stay in the 1960's and 1970's in the U.S., later attempts by managed care to control costs and continuing budget cuts imposed more strict limits on in-patient treatment; thus, involuntary hospitalization of that earlier period, and consequently the early studies of OPC, included a substantial proportion of persons with diagnoses and levels of harm less serious than found after these newer financial constraints (Durham & LaFond, 1992; Hiday, 1977, 2003).

[9] It is notable that this study viewed voluntary hospitalization as a positive outcome.

patients by-passed in the selection by comparing the OPC group's hospital experience while under orders *and receiving treatment*[10] with their own hospital experience during a comparable period of time prior to issuance of the orders. All found reduced hospital admissions and reduced hospital days for those admitted (Erickson, 2005; Frank, Perry, Kean, Sigman, & Geagea, 2005; Geller, Grudzinskas, McDermeit, Fisher, & Lawlor, 1998; Greenberg, Mazar, Brom, & Barer, 2005; Munetz, Grande, Kleist, & Peterson, 1996; O'Brien & Farrell, 2005; O'Keefe, Potenza, & Mueser, 1997; Ozgul & Brunero, 1997; Preston, Kisely, & Xiao, 2002; Roland, Rohrer, & Richards, 2000; Sensky, Hughes, & Hisch, 1991; Vaughan, McConaghy, Wolf, Myhir, & Black, 2000). Although solving the problem of selection bias, these before- and-after studies still presented a methodological problem. They could not discern whether the recorded successes were caused by OPC itself or by concurrent system changes such as hospital closings, increased outpatient services, introduction of assertive community treatment or new supported housing, or just by regression to the mean.

Some of this second set of studies avoided that methodological weakness by evaluating the declines in admissions and bed days in relation to matched comparison groups.[11] These findings are mixed. Geller and colleagues (1998) found OPC patients in Massachusetts had significantly greater reductions in admissions and days hospitalized than a comparison group matched on demographic and clinical characteristics, but had no greater reductions than another comparison group matched on prior inpatient use. Researchers examining the outcome of all persons placed on CTO's in the first year of Western Australia's new CTO law reported in two papers that CTO orders do not make a difference in reducing hospitalization (Kisely, Xiao, & Preston, 2004; Preston et al., 2002). Even though persons on CTO's had fewer hospital admissions and bed days than in the prior year and even though CTO patients received more outpatient services while under orders than a first comparison group matched on eight demographic, diagnostic and service use characteristics, their declines were not significantly different (Preston et al., 2002). Using two new comparison samples (one matched on a different set of characteristics from the first comparison group and one matched on hospital discharge date) and adding new data allowing controls for *any* criminal offense and conviction, their second paper reported these same patients on CTO's had a greater risk of readmission than either comparison group in survival analysis and a greater risk than their matches in multivariate analysis (Kisely et al., 2004). More recently, Pollack, McFarland, Mahler, and Kovas (2005) also reported OPC patients had higher utilization of mental health services than other patients discharged without orders; and they found no difference in re-hospitalization or arrests during the follow-up. In a study of all patients in one catchment area in New South Wales, Australia, Vaughan and colleagues (2000) found that their comparison group matched on demographic, clinical and utilization characteristics had a level of illness severity too much lower than the CTO sample to permit meaningful evaluation of comparative hospital experiences. Looking more closely at the rehospitalized CTO group, they reported that intervention occurred more quickly, leading to shorter duration of noncompliance and disturbed behavior during CTO placement. The ensuing hospitalizations were shorter, less likely to be involuntary, and with less police involvement than they were earlier.

Studies using matched comparison samples address the problem of confounding due to concurrent system changes or regression to the mean; but they create another problem. While matching attempts to make groups as alike as possible on factors that could explain outcome differences between them, it often fails to achieve matches on the mix of factors which clinicians actually use in their decision making. For instance, neither Western Australia analyses controlled violent behavior[12] or clinician's view of patient risk, factors which could have made the difference in outcomes. In these later studies, physicians were likely to select patients for OPC because their risk of noncompliance and dangerousness was greater than those discharged without orders (McKenna, Simpson, & Coverdale, 2006; Vaughan et al., 2000).

To overcome such confounding from naturalistic studies requires random assignment to experimental and control conditions. But because of their expense and substitution for court and clinical decisions, only three random control trials (RCT) of OPC have been conducted. One in Victoria, Australia, found most patients on CTO's improved in multiple measures; but knowledge of this study's design, measurement, and analysis is limited as it was only briefly described in

[10] Data from one study (Roland et al., 2000) indicate that some patients ordered to community treatment received no services; and another (Preston et al., 2002) did not state or give data showing that all received services.

[11] While solving the problem of confounding by concurrent changes, this matched comparison group technique reintroduced the problem of selection bias; but by this time, selection bias was unfavorable to OPC (see below).

[12] The Western Australia study's control of criminal offenses and convictions did not control violence because most offenses of persons with severe mental illness are not violent (Hiday & Wales, 2003).

an editorial (Power, 1999). Another RCT in New York City[13] of a trial OPC law found no statistical difference in multiple outcomes between experimental and control groups of persons with severe mental illness (Steadman et al., 2001). However, in execution of its sophisticated design, crippling technical difficulties arose through no fault of the researchers. First, there were significantly more substance abusers in the OPC group despite randomization. Because substance abuse is a major risk factor for negative outcomes among persons with severe mental illness (Hiday, 2006; Steadman et al., 1998; Swanson et al., 2000), one would expect the OPC group to have poorer outcomes. Second, the sample size ($N=142$) was too small to obtain significance even when trends were clearly apparent between the OPC and control groups. Third, there was confusion among subjects concerning their legal status, with many control subjects thinking they had been ordered to follow treatment plans. Last, with the law being so new, enforcement mechanisms were not in place; therefore, noncompliance with orders could not be sanctioned. Although a number of reviewers conclude otherwise, these technical difficulties preclude a judgment that the NYC study demonstrates that OPC made no difference in outcomes. Indeed, the finding that the OPC group was no worse on any measure than its control when it had significantly more substance abusers suggests that OPC worked better than treatment with no order.

The third RCT, the North Carolina study, sampled involuntarily admitted, severely mentally ill persons 18 years or older, representative of revolving-door patients[14] in the public mental health system ($N=313$). They were recruited from patients in the admissions unit of a state mental hospital and the psychiatric units of three general hospitals serving catchment areas of participating community mental health programs who were court ordered to outpatient commitment. By agreement with clinicians and courts, researchers then randomly removed half of the sample from their orders. To address the question of whether OPC worked better than treatment without orders, members of both experimental and control groups received individually based treatment and case management. Those in the control group could not be placed on any future OPC for one year. The experimental group members remained on their initial orders (up to 90 days) and, in cases of persistent noncompliance with scheduled appointments, would be picked up by police to be taken to their outpatient treatment facility for persuasion to compliance. Mutually established "no-show" protocols with participating community mental health programs for both OPC and non-OPC groups minimized chances of subjects' falling through the cracks and receiving no treatment. Subjects who were rehospitalized could have OPC orders reinitiated (Swartz et al., 1999).

An exception to randomization occurred at termination of initial OPC orders when clinicians and courts determined which patients should have their orders renewed (a first extension of 180 days, further extensions of 1 year), thus creating nonrandom variability in length of OPC. This deviation from randomization may have worked against obtaining positive results for OPC for two reasons: the legal criteria for OPC would lead clinicians and courts to renew orders for those seen as having a greater risk of noncompliance, deterioration and dangerousness.[15] A second exception to randomization occurred in order to include violent persons yet satisfy public safety and liability concerns: subjects with a recent history of serious assault involving weapon use or physical injury to another person were required to undergo an initial period of OPC. These subjects ($N=67$) were able to be included in multivariate analyses with the randomized sample by a statistical control. Structured interviews with each subject, a collateral, and case manager at baseline and at 4, 8, and 12 months[16], as well as hospital, mental health center and state arrest records provided the data (Swartz et al., 1999).

With its larger sample, the North Carolina study was able to control for possible sociodemographic and clinical confounders in multivariate analyses. This study's first four papers reported that outcomes did not vary between OPC and control groups taken as a whole. But when OPC subjects were grouped by those whose orders were and were not extended for a total of at least 6 months, subjects with extended orders had significantly fewer hospital admissions and days when readmitted, fewer acts of broadly defined violence and better treatment adherence in the follow-up year (Swanson et al., 2000; Swartz, Swanson, Wagner, Burns, & Hiday, 2001; Swartz et al., 1999). Their analyses indicated that extended OPC had its effects only when combined with more frequent services (three or more services a month, with a mean of seven). For a subgroup who were double recidivists, that is who had a history at baseline of multiple

[13] The criteria and procedures of the New York trial outpatient commitment law were essentially the same as those of North Carolina and the research design of the New York City study was essentially the same as that of the North Carolina RCT of outpatient commitment which will be described below.

[14] Defined as diagnosis of schizophrenia, schizoaffective disorder, other psychotic disorder, or major affective disorder; disorder duration of one year or more; significant functional impairment in activities of daily living; and intensive treatment in past 2 years.

[15] Statistical analysis showed that those with lower insight and a history of medication noncompliance were more likely to receive extended OPC (Swartz et al., 1999).

[16] Experimental group members were followed even if their orders lapsed.

hospitalizations and arrests and/or violent behavior, extended OPC significantly reduced arrests over those in the control group and those with OPC lasting less than 6 months (Swanson et al., 2001).

In contrast to the first four outcome reports which dichotomized the OPC group and reported positive results occurring only after 6 months under orders, three later papers of the North Carolina study measured OPC by days under orders and reported that increasing duration of OPC led to significantly lower criminal victimization (Hiday, Swartz, Swanson, Borum, & Wagner, 2002a), better quality of life (Swanson, Swartz, Elbogen, Wagner, & Burns, 2003), and increased treatment adherence (Elbogen, Swanson, & Swartz, 2003). An eighth paper found OPC reduced perceived caregiver strain; but whether extended orders were necessary is unclear: bivariate analysis indicated less caregiver strain with increased days under orders; but multivariate analysis used only the dichotomized measure (Groff et al., 2004). Finally, a ninth paper reported mixed effects on homelessness, with a finding of less homelessness for those on OPC only at the four month assessment and only among those with severe functional impairment (Compton et al., 2003).

Although the North Carolina study attempted to equalize treatment by assuring that both experimental and control groups received individualized treatment and case management, case managers gave more frequent reminders of the consequences of treatment noncompliance and provided more active case management to OPC than to control subjects (Swartz, Wagner, Swanson, Hiday, & Burns, 2002). Most of their analyses controlled frequency of services to account for variation in treatment; but frequency is only a rough measure of treatment quality. Furthermore, because OPC subjects who had their orders renewed also received more services and more types of services, it may be that case managers who provided higher quality care were the ones who both renewed client orders with extensions to 6 months or more and insured that clients received more services. This raises the question of whether it was OPC or the better quality care which made the difference in outcomes. On the other hand, it may be that OPC had the effect of making quality providers attend to the needs of these difficult-to-treat, revolving-door patients when they otherwise would not have (Hiday & Scheid-Cook, 1987; Swanson et al., 1997).

The North Carolina study provides the most comprehensive analysis of OPC; and despite its weaknesses, it provides the most solid support that OPC works better than treatment-as-usual to produce desired outcomes. Combining its results with those of all other studies and weighing their weaknesses gives substantial empirical evidence that OPC can work to maintain a significant proportion of revolving-door, severely mentally ill persons in the community. This evidence is all the more persuasive because of its coming from various jurisdictions with different laws, enforcement mechanisms, and mental health systems in Australia, Canada, England, Israel, and the United States. That some nonrandomized studies found no lower hospitalization rates (or even higher rates) for OPC groups does not weaken this conclusion because of unfavorable selection bias in those studies. Persons assigned to OPC instead of being discharged without orders can be expected to be of greater risk. The severity and fluctuating nature of their illness, the common co-occurring substance abuse, the physical and social disadvantages of their lives and the inability to find medication which limits both positive and negative symptoms without unacceptable side effects presage periods of exacerbation of symptoms and crises when hospital placement may be the best treatment location. Theoretically, the closer monitoring under such orders should lead to earlier intervention before the crises and deterioration become severe. Such intervention may require hospitalization; but that hospitalization should result in shorter stays. Vaughan and colleagues (2000) found just this effect in New South Wales, Australia.

OPC studies assume not only that monitoring impacts outcomes positively but also that treatment provided under OPC orders, that is mandated treatment which otherwise would not be received, produces positive outcomes. Although most studies indicate that subjects receive more services while on OPC than they did before and more services than comparison subjects, they do not test causality, that is they do not test how and why OPC works. The one exception is the North Carolina study which found regular services were necessary for OPC to reduce hospitalization, treatment nonadherence, violence, and arrests. It also reported that OPC produces its positive results through increasing medication compliance and reducing substance abuse (Hiday et al., 2002a; Swanson et al., 2000, 2003). But are these the mechanisms through which OPC works in other mental health and legal systems? Some studies suggest that they are (Dawson, 2005; O'Reilly, Keegan, & Elias, 2000; Romans, Dawson, Mullen, & Gibbs, 2004; Scheid-Cook, 1991). Also, despite advances in measuring perceived coercion (Hiday, Swartz, Swanson, Borum, & Wagner, 2002b; Lidz et al., 1995; McKenna et al., 2006), we do not know how much and what sort of PLC is sufficient to produce desired outcomes, and for which patient subgroups.

More importantly, we do not know whether OPC would be necessary to maintain difficult-to-treat, severely mentally ill persons in the community if comprehensive, assertive, safe, effective, patient-centered care were provided (Committee on Crossing the Quality Chasm, 2006). We know little of what constituted the treatment given to patients in OPC studies, much less whether it was quality care; yet we know from other studies that care delivered is often different

from evidence-based treatment (Committee on Crossing the Quality Chasm, 2006; Watkins, Burnam, Kung, & Paddock, 2001). Even the North Carolina study told us little about treatment, reporting only that all subjects received case management and individualized treatment, that there was an adherence protocol, and that OPC was more effective in some analyses when there were "regular" services; but these services were less than once a week for many, a frequency not likely to provide supports needed by revolving-door, severely mentally ill persons. It appears that the PLC of the OPC order made a positive impact over and above treatment-as-usual. But if comprehensive, assertive safe, effective, and patient-centered care were provided, what proportion of the difficult-to-treat, revolving-door persons with severe mental illness would need that PLC? To answer that question, we need to examine four assumptions underlying OPC laws.

Assumption 1. Noncompliance with treatment is the reason severely mentally ill persons deteriorate to the point of meeting criteria for involuntary hospitalization.[17]

Research has demonstrated that persons with severe mental illness who have poor medication adherence have more psychiatric symptoms, more frequent psychotic episodes, more episodes of violence, more emergency room visits, more frequent rehospitalizations and more frequent involuntarily hospitalization (Dixon, Weiden, Torres, & Lehman, 1997; Olfson et al., 2000; Rittmannsberger, Pachinger, Keppelmuller, & Wancata, 2004; Svarstad, Shireman, & Sweeney, 2001; Swanson et al., 2000; Swartz et al., 1998; Verdoux et al., 2000). And among severely mentally ill persons who revolve in and out of psychiatric inpatient facilities, medication noncompliance is a major cause of rehospitalization (Swartz et al., 1998; Vaughan et al., 2000; Weiden & Glazer, 1997). We can thus say that noncompliance with treatment is a major reason that severely mentally ill persons deteriorate to the point of meeting involuntary hospitalization criteria. We cannot say from this evidence that it is *the* reason because underlying Assumption #1 is a second assumption which must hold.

Assumption 2. Treatment with medication works, that is, a medication regimen will prevent deterioration and consequent behavior leading to the necessity of hospitalization.

Numerous studies of conventional antipsychotic drugs have shown efficacy in preventing relapse and in reducing the positive symptoms of schizophrenia, the most common diagnosis of involuntary patients. But these drugs have little impact on negative symptoms and accompanying cognitive disabilities, and they can have adverse side effects on motor functions, cognition, sexual desire/functioning, and physical comfort (Hummer et al., 1999; Keith et al., 2004; Lieberman et al., 2005). Newer atypical antipsychotic drugs control positive and negative symptoms better while reducing the unpleasant and dangerous motor side effects (Keith et al., 2004). There is also evidence that they reduce aggressive behaviors, including physical assaults, in patients with schizophrenia spectrum disorders (Krakowski, Czobor, Citrome, Bark, & Cooper, 2006; Swanson, Swartz, & Elbogen, 2004), although their effects on cognitive functions are not as clear (Hoff & Kremen, 2003), and sexual disturbances still occur in a substantial minority (Hummer et al., 1999).

These medication studies all demonstrate significant improvements in reducing the symptoms accompanying severe mental illness; but not everyone is helped. Medication studies have high dropout rates and high drug discontinuation rates from inefficacy of the medication and intolerability of side effects (Lieberman et al., 2005; McEvoy et al., 2006; Stroup et al., 2006). Among revolving-door patients, medication nonresponse is a major reason for relapse and re-hospitalization (Weiden & Glazer, 1997). Thus, although medication works to reduce symptoms and improve functioning in varying degrees for many persons with severe mental illness, the assumption that treatment works for all revolving-door patients is not valid. Accordingly, the previous assumption that noncompliance is the reason patients with severe mental illness deteriorate to the point of meeting criteria for involuntary hospitalization is also not valid for some proportion of persons with severe mental illness.

Assumption 3. Persons with severe mental illness who do not comply with treatment, especially medication, are making irrational treatment decisions and must, therefore, be incompetent.

Based on the previous discussion of the first two assumptions, persons with severe mental illness whose disorders are nonresponsive to prescribed medication and who decide not to comply for this reason might well be making a

[17] Some preventive OPC laws require that "based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness" N.C.GEN.STAT. s 122C–263 (d) (1) c. (Supp. 1993), enacted in 1983. See also Dawson (2005).

legally competent decision, meeting the four abilities of capacity for making treatment decisions: understanding and appreciating the benefits of treatment, reasoning about whether to accept treatment, and communicating a choice (see Appelbaum & Redlich, 2006). Assumption #3 is, thus, not valid for such persons; but what about those for whom medication is efficacious?

Noncompliance rates are so much higher than incompetence rates that incompetence cannot be the reason for noncompliance. Studies report high rates of noncompliance with antipsychotic medication regimens, approaching 50% among outpatients with schizophrenia during the year after hospital discharge (Verdoux et al., 2000; Weiden & Olfson, 1995; Zygmunt, Olfson, Boyer, & Mechanic, 2002) and ranging to 90% in some samples, depending on the measures and samples (Nose, Barbui, & Tansella, 2003). Noncompliance among all persons with severe mental illness is probably greater than rates found in study samples because persons who are resistant to treatment tend to drop out of studies or never join; thus, they do not get counted (Zygmunt et al., 2002). In contrast to high rates of noncompliance, studies report comparatively low rates of legal incompetence on each of the four standards to make medical decisions among persons with severe mental illness (Grisso & Appelbaum, 1995). Appelbaum and Redlich (2006) reported mean scores on the four abilities of treatment decisional capacity of persons with severe mental illness in public health sector outpatient treatment to be well above the midpoints on each scale, where higher scores indicate greater decisional capacity. Given that the proportion of persons with severe mental illness who are incompetent is much smaller than the proportion which does not comply with medication, Assumption #3, that persons with severe mental illness who do not comply with medication are incompetent, is not valid for many of them.

Besides incompetence and medication nonresponse, there are numerous other explanations for noncompliance, some of which are intentional, and some, not. Intolerance of adverse side effects, substance abuse, poor alliance with treatment staff, families who do not become involved in treatment, social network problems, disorganized thoughts, lack of insight[18] and disorganized living conditions can individually or in combination lead a patient not to adhere to a prescribed medication regimen (Committee on Crossing the Quality Chasm, 2006; McEvoy, Appelbaum, Apperson, Geller, & Freter, 1989; Olfson, Marcus, Wilk, & West, 2006; Olfson et al., 2000; Rittmannsberger et al., 2004; Svarstad et al., 2001; Swanson et al., 2000; Swartz et al., 1998; Velligan et al., 2006; Verdoux et al., 2000; Weiden & Glazer, 1997). Recently attention has been paid to severely adverse physical side effects such as obesity, diabetes, and heart disease which may accompany the atypical antipsychotic drugs (Kleinfield, 2006; McEvoy et al., 2006; Stroup et al., 2006). As in the case of patients whose illness is nonresponsive to medication, a patient who chooses not to adhere to a medication regimen, which brings such severe side effects because of those side effects, may be making a treatment decision within the standard of legal competence. Assumption #3 is, thus, invalid for some proportion of non-compliant patients.

Assumption 4. There are no alternatives to OPC for severely mentally ill patients who do not seek or comply with treatment voluntarily which are less restrictive; the only way to get such patients to comply is to order them into treatment.

Psychosocial treatments have been shown to improve medication adherence by addressing factors which reduce medication compliance, such as poor therapeutic alliance, substance abuse, physical problems, unemployment, poor social functioning, poor or antitherapeutic social networks, and lack of insight (Chambless & Ollendick, 2001; Compton, Rudisch, Thompson, & Owens, 2006; Dixon et al., 1997; Mueser et al., 2002; Nose et al., 2003; Zygmunt et al., 2002). Strategies which encourage severely mentally ill persons to participate in their own treatment can lead to improved therapeutic alliances, cooperation in finding more effective and tolerable medication regimens, and medication compliance, which ultimately lead to better illness management and less involuntary hospitalization (Committee on Crossing the Quality Chasm, 2006; Henderson et al., 2004; Mueser et al., 2002). Such strategies include psychoeducation, cognitive–behavioral programs, relapse prevention, coping skills training, and crisis cards. Because components of their environment often negatively affect treatment adherence and illness course, programs designed to change family interaction (psychoeducation, behavioral therapy and problem solving for families) and conditions of living, especially housing, can have a positive impact on treatment adherence, illness course and other outcomes including dangerousness, arrest, and involuntary hospitalization (Mueser et al., 2002; Rosenheck, Kasprow, Frisman, & Liu-Mares, 2003; Zygmunt et al., 2002). Assertive community treatment (ACT) and intensive case management which

[18] Lack of insight, a medical construct, is sometimes equated with legal incompetence or seen as defining incompetence; but the two terms are distinct conceptually and analytically. Appelbaum and Redlich (2006) separate the two concepts in their analysis of predictors of various forms of mandated community treatment. They find only one significant correlation between the four abilities and insight (with reasoning, personal communication with authors).

address both environmental and individual factors in nonadherence, and which combine integrated dual diagnosis treatment with a patient-centered approach seem to offer the most benefit through improving patients' environments with readily available social support networks and stable housing, as well as by offering psychosocial services (Bond et al., 2001; Dixon et al., 1997; Mueser, Bond, Drake, & Resnick, 1998; Solomon & Draine, 1995; Stein & Test, 1980; Tsemberis & Eisenberg, 2000). These assertive programs also provide close monitoring such that problems with treatment and life situations can be corrected before reaching the stage of needing involuntary hospitalization. Depot medications can assist in these programs for those whose noncompliance is accidental or unintentional because of disorganized thoughts or disorganized living conditions (Elbogen et al., 2003; Swartz et al., 2001; Vaughan et al., 2000). In sum, there are alternatives to OPC to obtain compliance with treatment among revolving-door, severely mentally ill patients. Unfortunately, resources to provide these quality services are seldom available.

3. Normative issues: leverage of the patient or coercion?

Even if we are convinced from empirical research that the leverage OPC orders apply to patients produces a net good — less hospitalization, less harm to self and others, a better quality of life on average, etc. — distinct normative questions must be addressed. These concern the limits we believe it is right to place on the power of the state to coerce individual choices and behaviors. Those limits are determined, in part, by the value we place on individual autonomy, including whether we value it as an end in itself. Even the consequentialist must account for the value people place on autonomy, and the cost of coercion, in totting up the costs and benefits, pecuniary and otherwise, of a coercive measure. But how is individual autonomy affected by OPC, and under what circumstances does OPC amount to coercion? When it does constitute coercion, when is that coercion justified?

Although OPC may constrain autonomy in multiple ways — including liberty of movement (e.g., order to attend treatment), arrest[19] by police or other state officials for noncompliance, non-consensual entry into one's residence, non-consensual searches (e.g., urine tests) — we believe that the heart of the matter, for proponents and critics alike, is the scope of the individual's autonomy to make medication choices.

Coercion in OPC, to the extent present, is usually not literal, as it is in the case of forced medication. In the latter, the person receives medication, whether he agrees or not. In the former, the person is usually given a choice between compliance and some other undesirable consequence (e.g., arrest; hospitalization). The other undesirable consequence operates to constrain that choice, as persuasion, leverage, or coercion to comply. To the extent the state has no independent justification for administering that other undesirable consequence, the choice offered can be said to be coercive (Bonnie & Monahan, 2005). Thus there is a normative difference between the state denying a free car to an unapologetic smoker in a program to award free cars to persons who quit smoking, and the state confiscating the smoker's existing car for his failure to quit. The latter is arguably coercive.

What complicates the analysis of coercion is the problem of baselines. In the example, the smoker has no right to a free car, but has a right to keep the car he owns. But does he have a right to smoke, contrary to medical advice and risking harm to himself and others? Under the prevailing normative, as well as legal, view he does; many would argue he should not. But should the state enact a law prohibiting smoking, there is little in U.S. constitutional law to stop it. And car forfeiture is already a sanction in many U.S. drug enforcement cases. Once the legal baseline has been altered, what would opponents of such a law argue?

Apart from a set of empirical arguments — that the law is ineffectual; that it creates costly side effects — their arguments would be normative. First, they would argue for a strong version of autonomy — the right to make one's own decisions about one's tastes and preferences, including decisions others would regard as irrational, psychologically abnormal, driven by chemical imbalances in the brain, or self-defeating, so long as one met a minimal standard of decisional competence. Second, they would argue that the state has an insufficient interest to trump autonomy — that the net harms caused by leaving the behavior to less constrained choice[20] are insufficiently great, and/or insufficiently probable, and/or insufficiently imminent. Third, they would argue that the law creates an unacceptable number of false positives — smokers whose conduct is the result of a competent choice and will not cause

[19] The law of arrest, derived from the Fourth Amendment of the U.S. Constitution, makes no distinction, as empirical researchers tend to do, between arrest for criminal booking and arrest to be transported to a mental health facility. Indeed, what starts as one may easily become the other.
[20] The smoker's choices might already be constrained by such laws as tobacco taxes, rules against smoking in public places, etc.

anyone harm. In short, they will argue that the normative baseline for what constitutes coercion should be the one prevailing before the law was passed.

For persons with severe mental illness who are non-compliant with medication, the state may well be within its constitutional powers to shift the baseline for assessing unlawful coercion by passing OPC statutes. Indeed some courts have so ruled.[21] But that does not settle the normative debate as to where the baseline *should* be struck.[22] Those preferring some pre-existing legal baseline refer to OPC statutes as net widening.

The pre-existing common law baseline for medication decisions by persons with any illness was to respect their choices unless they had been found to lack decisional competence.[23] If incompetent, a substituted judgment would be made. In theory, the substitute decision-maker had to attempt to replicate the judgment the patient himself would have made if competent,[24] so as to respect the patient's tastes and preferences. Where the state is the substitute decision-maker, acting under *parens patriae* authority, the theory calls for the same autonomy-focused standard.[25] Many jurisdictions, however, because of the practical difficulties of determining the patient's wishes, set a "best interests of the patient" standard for substituted judgment, which often reduced to the judgment of treating professionals.[26] Where a competent or substituted judgment refusal of medication created a sufficient risk of harm to justify involuntary hospitalization, such literally coercive confinement could be employed to leverage the patient's compliance.[27] So long as the patient refused medication and failed to improve, he could be kept in the hospital. Finally, certain risks of harm to self or others or threats to the order of the confining institution would justify forcible medication in the face of a competent refusal.[28]

Net widening — the expansion of the state's legal power to exercise coercion over patients' medication decisions, redefining what once was coercion into merely leverage as a matter of law — is implicit in all four forms of OPC. Expansion may take two forms: (1) increasing the class of persons subject to leverage/coercion; (2) increasing the period of time over which the state's leverage/coercion may be exercised.

Net widening in both forms is explicit in OPC statutes of the third type (preventive OPC). Persons not found incompetent to refuse treatment and/or not yet meeting the risk criteria required for forced medication or involuntary hospitalization may be subject to court orders to comply with outpatient medication (Bonnie & Monahan, 2005). In essence, these are persons who are judgment-impaired but not incompetent by pre-existing standards and/or *likely to be likely* to cause harm or become gravely disabled. As a statistical matter, one can expect false positives (leveraging/coercing compliance orders to persons who are competent to object[29] and/or will not cause harm or become gravely disabled[30]) to increase and false negatives to decrease. Net widening is greatest in this form of OPC, both because the class may include those whose present episode of symptoms has yet to make them incompetent to refuse medication or

[21] See, In re K.L. , 806 N.E.2d 480 (N.Y. 2004).

[22] At the risk of belaboring the point, constitutional and normative arguments overlap on this issue, but are not co-extensive. The death penalty is currently constitutional in the U.S.; whether it is immoral is a distinct question. See generally Seidman (2001).

[23] The fact that many states have, at times in the past, equated a finding of mental illness with a finding of incompetence, does not contradict the theoretical premise. It is more common today, given greater sophistication about mental illness and the controversy about psychotropic medications, for courts to treat competence as a distinct legal construct. Most persons with severe mental illness are competent under one or more versions of that construct (Grisso & Appelbaum, 1995).

[24] See, e.g., In Re Guardianship of Roe, 421 N.E.2d 40 (Mass. 1981).

[25] See Note (1974) at 1218–19.

[26] Id. See also Appelbaum and Schwartz (1992) analyzing this and related rules as a problem of error costs.

The Supreme Court has embraced "professional judgment," a variant of "best interests" that also gives weight to the interests of the treating professionals, as the minimally required constitutional standard in certain cases involving institutionalized patients. See Youngberg v. Romeo, 457 U.S. 308 (1982) (institutionalized developmentally disabled); Washington v. Harper, 494 U.S. 210 (1990)(prison). For a critique of this rule, see Stefan (1992).

[27] Where inpatient commitment is based, explicitly or implicitly, on the patient's incompetence to make medication decisions, forced treatment is authorized if it meets the criteria for substituted judgment. See Appelbaum (1988) for a more complete discussion of the varying legal approaches.

[28] See, e.g., Washington v. Harper, 494 U.S. 210 (1990) (threat to prison order); Rogers v. Commissioner of Mental Health, 458 N.E.2d 308, 321–22 (1983) (imminent threat of harm to self or others).

[29] If one assumes some number of false positives — erroneous overrides of competent medication refusals — among involuntarily hospitalized patients, one would expect that number to increase as the class of persons subject to involuntary orders increases.

Overrides can be erroneous (false positives) in two ways: (1) competent persons may be found incompetent; (2) in substituting judgment for a person found incompetent, we may err in assessing what he would have decided if competent. The latter error is even more likely under a substituted judgment standard of "best interests of the patient" or "professional judgment."

[30] The increase in false positives of this type will be least in OPC that focuses on patients with a lengthy history of cycling into non-compliance and ensuing harmful conduct. See Gerbasi, Bonnie, and Binder (2000).

at sufficient risk of harm to warrant hospitalization, and because there is no obvious time limit for their commitment.[31] In theory, these patients may be subject to a lifetime of OPC orders.[32]

For the other three forms of OPC, net widening is implicit, in two ways.[33] First, although the person has been found to meet the criteria for inpatient commitment (or guardianship) in the current episode of symptoms, the length of that commitment (or guardianship) may be extended where part or all of it can occur without hospitalization. Availability of this less costly option removes a powerful incentive for the state to keep commitments brief — only so long as incompetence is clearest and/or risk of harm is substantial and imminent. And the determination that community treatment is possible necessarily includes an assessment of lowered risk, such that the literal coercion of confinement is not deemed necessary.[34]

Second, there may be net widening of the class of persons found initially committable, for similar reasons. Decision makers faced with the choice between involuntary hospitalization or no action may be more parsimonious in committing, given the costs of hospitalization, both to the state and to the patient, than they would be where community treatment is an option.[35] Criteria relating to competence and risk of harm are not so precise as to be impervious to shading in consideration of the available placements. Even though commitment laws in many jurisdictions do not require a formal finding that the risk posed by the patient is such as to make full hospitalization necessary, that is the criterion as a practical matter where OPC is not available.[36]

The assertion of net widening — that the legal baseline for assessing coercion has been moved by OPC — depends crucially on the sanction for noncompliance with community treatment. Where the sanction is literally coerced medication or hospitalization, then we have indeed widened the net. We have given less scope to the autonomy of patients to make their own treatment decisions, lowered the level of state interest required for forced medication and/or hospitalization, and increased the rate of false positives. To fail to view this model of OPC "within the same conceptual and legal framework as commitment to a mental hospital"[37] would lead to analytical confusion.

Similarly, if the sanction is arrest for forcible return to an outpatient treatment facility for some brief period, there is net widening, albeit with less dramatic consequences; persons not fitting the criteria for emergency hospitalization would not otherwise be subject to such constraints on their treatment choices.

On the other hand, if forcible return or inpatient hospitalization can only occur when the pre-existing criteria of emergency or inpatient commitment are met, then the OPC order more resembles a referral for voluntary treatment with an advisory that the state will be watching to see whether the patient deteriorates to the point of meeting those criteria. Whether or not the order has any practical effect, there is no normative effect, unless: (1) noncompliance with OPC creates an evidentiary advantage (e.g., gives rise to a presumption) for the state in making its case for involuntary hospitalization; or (2) the order creates an arguably unnecessary legal record and public distribution of same that conveys stigma or actual civil disabilities.

[31] What some clinicians describe as "fluctuating competence" (Appelbaum, 1994) — a cycling of judgment capacity in many patients between normal and poor — however accurate phenomenologically, does not lend itself to time-limited legal rules. In effect, the class is likely (but not certain) to experience periods of legal incompetence over the course of community treatment — which treatment may be a lifetime affair.

[32] Those who have suggested limits — e.g., Saks' one-shot six-month order (Saks, 2003) — are undercut somewhat by empirical studies finding limited benefit from such orders, as well as by the recurring nature of impaired, as opposed to incompetent, judgment.

Many statutes have set time limits for OPC orders, but new orders may be entered whenever statutory criteria are met.

[33] Employing the language of contract, Bonnie and Monahan (2005) reach substantially the same conclusion with respect to OPC in its conditional leave and alternative to hospitalization forms. However, despite its many attractions, we are dubious about the utility of the contract metaphor in assessing PLC generally for a variety of reasons, not the least of which are: (1) the great inequality of bargaining power between the patient and the state; (2) the necessary ambiguity of the obligations undertaken (cf., Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981)); and, most importantly, (3) the near absence of remedies for the patient should the state fail to perform its part of the bargain.

[34] In the early days of OPC as an alternative to hospitalization, proponents had to convince skeptics that these strategies would not overly increase risk of harm in the community (Hiday, 2003; Mulvey et al., 1987).

[35] This is a particular risk with OPC statutes of the second type (alternative to hospitalization). When they originated, the length of hospital stays may have made these statutes liberty enhancing. In an era of greatly restricted hospital budgets, they have the potential to expand the class subjected to involuntary orders.

[36] In Massachusetts, under Rogers, it is emergency involuntary medication that is subject to net widening in this manner. For non-emergencies, involuntary medication in both inpatient and outpatient settings is possible only on a judicial finding of incompetence and that the choice to medicate is the one the patient would have made if competent. See generally, Furlong (1995).

[37] See, Monahan, Swartz, and Bonnie (2003) at 29.

Some believe that a naked judicial order for compliance may be enough to persuade some otherwise non-compliant patients to stay in treatment (Swanson et al., 1997). It may also be the case that such orders have some impact on providers, making them more attentive to providing attractive, consistent and coordinated services tailored to the patient's needs (Dawson, 2005; O'Reilly, 2004; Swanson et al., 1997). Such orders are normatively benign, so long as the patient understands that the order carries no sanction and is not deceived to believe that it does (Borum et al., 1999; McKenna et al., 2006).

To say that net widening has occurred[38] is not to conclude the normative argument, only to frame it. Each version of OPC must be evaluated normatively for its constriction of patient autonomy, its claim of state interest in that constriction,[39] and its expansion of false positives. Empirical evidence of lives improved by OPC, including testimonials of patient gratitude after the fact,[40] may inform the normative discussion but cannot substitute for it.

4. Leveraging providers

If, as we believe, a shortage of resources for and lack of bureaucratic coordination in the delivery of needed treatment and related services is a significant cause of medication noncompliance for persons with severe mental illness, then OPC should also be evaluated for its PLC impact on providers, as well as on patients (Monahan et al., 2001). We turn here to some speculations as to the effects of OPC on provider behavior.

In a world of limited resources, community mental health providers must practice triage, both as to which patients to take on and as to the extent of services provided each patient. The least costly patients are those who require only medication, and who keep all appointments. To the extent patients require other services, particularly services which must be coordinated with other agencies (e.g., housing), or to the extent they are non-compliant, requiring proactive monitoring, they become more costly to serve.[41]

Persons with severe mental illness have no leverage, no entitlements, to influence those decisions other than by noncompliance. Noncompliance imposes costs on providers which, at the margin, will result in dropping the patient. That is not to say patient perceptions of their interests are necessarily ignored; only that when perceived interests of patients and providers conflict, patients lack leverage. Thus, even the choices of legally voluntary patients are constrained. They must take what is offered or go unserved.

Any system of OPC has the effect of shifting a portion of triage decision-making from mental health providers to a judicial process. To the extent that process is acting on petitions by those same providers, they retain substantial control over decision-making, subject only to the veto power of the judge.[42] To the extent courts grant petitions coming from the police, from family members, or from other members of the community, there will be a queuing effect, in which professionals will have to diminish existing patient rolls or services to provide for patients not of their choosing, and possibly services not of their choosing.[43] The impact of these patients on the providers' cost structure will be discounted to the extent the order and any monitoring undertaken by the court increase patient compliance. But to the extent the court imposes monitoring obligations on the providers, the costs to providers of these new patients will be increased.

Patient leverage may increase, but only for those whose refusals of treatment have made them sufficiently judgment-impaired and/or dangerous to qualify for an order.[44] Their ability to negotiate the terms of their treatment, either with the judge at the hearing or with providers concerned about achieving the court's goals, may increase in some measure.

[38] More precisely, the OPC law has created the potential for net widening to occur. Whether net widening occurs in practice may have more to do with budgetary and bureaucratic issues. Many OPC statutes have gone virtually unused.

[39] We concur with Saks (2002) that equal protection for persons with severe mental illness should be a part of this analysis.

[40] It is important to the normative analysis not to conflate patient gratitude after the fact with what the patient wished, or would have wished if competent, at the time his non-compliance was overriden. Nor can patient perceptions of coercion be the normative measure of coercion. Otherwise, the occurrence of coercion would depend entirely on a patient's sense of entitlement.

[41] See Gerbasi et al. (2000) at 136–38 for the lengthy list of services, including proactive case management, that the APA recommends for inclusion in OPC programs.

[42] In inpatient commitment, hospitals typically exercise considerable control over decisions to admit and retain, once the initial petition has been filed.

[43] See note 41, supra.

[44] Thus Andrew Goldstein, whose act of homicide gave rise to Kendra's Law (New York's OPC law), wouldn't have been committed were that law in place. He sought treatment, was rebuffed, then decompensated and killed before any potential petitioner noticed.

To the extent they are represented by competent counsel, their leverage will increase. The patient's leverage derives from whatever prestige the court has with the providers, and from the fact that the court's goal, dictated by the statute, is to reduce the risk of involuntary hospitalization and harm.[45] Those goals may be shared already by community providers, but not necessarily, as those are goals for which they are rarely held accountable by law. Thus, community providers who come to share the court's goals, and who lack the power to medicate forcibly, will have an incentive to negotiate with non-compliant OPC patients over the terms of their treatment.

Court involvement in triage decision-making comes with several handicaps. First, the court never sees cases in which voluntary applications for treatment or requests for particular treatment and services are rejected. Second, the cases it does see are those brought to it by assorted petitioners, and are not a random sample of persons most at risk for hospitalization or causing harm if left untreated. Third, the judicial process itself imposes costs, not only to the judiciary and patients, but also to the budget of treating professionals who must participate and write reports (Appelbaum & Schwartz, 1992). Fourth, judges have no training in mental health triage decision-making; nor does the legal decision they are called upon to make require that overall system impact be addressed.[46]

The question then is whether judicial involvement of the sort called for by OPC statutes will improve triage decision-making. To even begin to answer that question, one must determine what constitutes optimal triage, a necessarily normative and political question. Is it a process that creates the optimal reduction in costs of crime[47] and involuntary hospitalization,[48] as OPC statutes seem to imply? Is it a process that provides the greatest response to persons who affirmatively choose the treatment and services available?[49] Is it a process that provides at least minimal, even if sub-optimal, treatment to the greatest number of sufferers? What is the goal? Many of the recently enacted North American OPC statutes have been inspired by spectacular homicides committed by decompensating patients — Kendra's Law, Laura's Law, Brian's Law — which have the effect of shouting down any serious debate about what our priorities should be.[50]

Then there is the difficult empirical question of the extent to which judicial involvement advances these priorities, the answer to which is likely to vary between jurisdictions and over time. There is a wide range of competence and commitment among both courts and community treatment providers, even within a given state, and a wide range of incentive structures for doing the "right" thing. For example, in a jurisdiction where community treatment providers don't exercise proactive case management and generally shun the more high-risk patients, a charismatic crusading judge might do much to rearrange priorities.

OPC is most likely to have positive effect where accompanied by a significant and reliable long range budget commitment to improving resources for treatment and services.[51] If new patients and services are paid for with new funds, then there will be no impact on triage decision-making. And to the extent well-funded OPC programs reform treatment and service delivery — e.g., by leveraging greater coordination among service providers; listening more to patients — there may be spillover benefits in treatment and service delivery to voluntary patients. Service providers, like most people, respond better when there are carrots and not just sticks.

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[45] Judges who have noticed that the revolving door often deposits these same patients in the criminal justice system, at significant expense to courts, prosecutors and corrections departments, have expressed interest in utilizing OPC as a tool for reducing criminal dockets (Personal communication with Judge Brent Moss, 7th District Court, Idaho). Indeed some OPC statutes make this an explicit objective. See, e.g., N.Y. Mental Hyg. Law s9.60 (c)(4)(i) (McKinney, 2002) (requiring proof that the patient's noncompliance with treatment has, at least twice within the past 36 months, necessitated "hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility"). The recent development of mental health courts in the U.S. has been inspired, in part, by judicial awareness of the effect of revolving-door patients on the criminal justice system (Moore & Hiday, 2006). That experience in turn may give rise to greater use of OPC to reduce criminal arrests and prosecutions, regardless of whether that goal is formally dictated by the OPC statute.

[46] Some OPC regimes require the consent of the community provider before a new patient is assigned. See, e.g., Mental Health Act of Ontario ss 33.4–5. One should be reluctant, however, to assume that the answer to "is there space?" will be the same whether the person asking is a judge or a homeless voluntary patient off the street.

[47] See note 45 supra.

[48] Gerbasi et al. (2000) at 135–36.

[49] See Morse (1982). While not quite endorsing this position, Saks (2002) urges parsimonious use of commitment in service of this priority.

[50] Whatever the merits of OPC, observers generally agree that it is not a cost-effective strategy for reducing the homicide rate (Appelbaum, 2001).

[51] Inducing said legislative commitment may, for some states, be as simple as making judges, rather than health and welfare departments, the responsible decision-makers for the management of increased patient rolls and services, as well as tying the funds to savings in the criminal justice system. Legislators inclined to view health and welfare spending as "soft" or a "giveaway" and/or skeptical as to the efficacy of their health and welfare bureaucracies may view judges as more hard-headed managers, focused on community safety, and with less bureaucratic turf to protect.

5. Concluding observations

The message of the U.S. Army to young adults is: "Be all that you can be." The message of the onset of severe mental illness is: All that you can be is quite a bit less than you probably had in mind. Coming to terms with that reality can be a long and difficult journey. When medications work, they generally don't cure, in the sense of restoring the premorbid self. They often work poorly, or can't be tolerated, and have to be changed.[52] They carry side effects that damage both the body and self image. Sufferers often become isolated from friends, the workplace, and even families. There are many reasons to give up, and some do.

If OPC in any of its forms is to "take," such that coercion is not forever, it must provide treatment and related supports that put the patient in a position to manage his own condition and to have the desire to do so (Morey, Vogel-Scibilia, & Herz, 2002). Without the security of knowing that basic needs will be reliably met, and a sense that he can be a master of his own fate, the patient will have little stake in compliance.[53] Many of the critics of the use of coercion believe that a treatment system that provided a realistic chance of achieving those objectives, and that dealt proactively with reluctant or ambivalent patients, would run out of money before it would run out of voluntary clients. They fear that involuntary patients will displace voluntary ones, who will then be at risk of becoming involuntary patients. They worry that the availability of tools of coercion will incentivize the state to postpone difficult reform of unintegrated service systems and to scale back psychosocial services, leaving only the medication needed to keep a lid on crime and hospitalization costs. They worry that the revolving door will simply stop, a quarter turn from opening on the other side.

It is an unfortunate fact of political life that the principal leverage persons with severe mental illness have with legislators is the threat that they will cost the state even more if their treatment needs and aspirations are not met.[54] Thus critics of coercion believe that expansion of coercion will reduce that leverage. They worry that a minimal standard of decisional competence coupled with substituted medication decisions that the patient would have made if competent — a normative stance with which they are comfortable — will morph to a looser standard of impaired competence coupled with substituted decisions serving, in the main, the interests of those in authority.

To the extent coercion is minimized and community treatment funded to provide a realistic chance of making persons with severe mental illness willing partners in managing their own lives, the gap between critics and proponents of OPC will diminish.

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[52] See previous discussion of Assumption #2.

[53] This is the lesson of empirical research comparing housing first programs with programs offering housing conditioned on acceptance of proffered treatment. See Tsemberis and Eisenberg (2000). The latter is a form of PLC that falls on the persuasion/leverage side of the coercion line, insofar as the patient has no entitlement, constitutionally or by statute, to housing. See Bonnie and Monahan (2005). But in housing first programs, housing becomes a statutory entitlement, resulting in more patients choosing both housing and treatment.

[54] For a full discussion of the political powerlessness of persons with severe mental illness in shaping mental health policy, see Bloche and Cournos (1990) at 389–90, 393–98.

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