Interpreting the Effectiveness of Involuntary Outpatient Commitment: A Conceptual Model

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Many experimental trials of community mental health interventions fail to develop testable conceptual models of the specific mechanisms and pathways by which relevant outcomes may occur, thus falling short of usefully interpreting what happens inside the experimental "black box." This paper describes a conceptual model of involuntary outpatient commitment (OPC) for persons with severe and persistent mental disorders. The model represents an attempt to "unpack" the effects of OPC by incorporating several interacting variables at various stages. According to this model, court-mandated outpatient treatment may improve long-term outcomes both directly and indirectly in several ways: by stimulating case management efforts, mobilizing supportive resources, improving individual compliance with treatment in the community, reducing clients' psychiatric symptoms and dangerous behavior, improving clients' social functioning, and finally by reducing the chance of illness relapse and rehospitalization. A randomized clinical trial of OPC is underway in North Carolina that will test the direct and indirect effects suggested by this model, using longitudinal data from the multiple perspectives of mental health clients, family members, and case managers.

As public mental health systems in the United States move inexorably toward managed care financing, the fate of vulnerable populations in the new era appears uncertain.[1] Critics wonder what will happen to persons with severe and persistent mental illnesses when local mental health authorities—driven by market forces and legislative reform of entitlement programs—increasingly assume the financial risk associated with each turn of the erstwhile "revolving

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door." One study of "worst recidivists" in 196 state hospitals found that this population (mostly persons diagnosed with schizophrenia, bipolar disorder, and personality disorders) had an average of 31 psychiatric admissions.[2] When the high costs associated with inpatient care for such patients can no longer be shifted, the question of how to prevent or limit hospitalization becomes more salient. To the extent that hospital recidivism may be attributed to noncompliance with outpatient therapies, new urgency arises in the challenges to improve clients' tenure in community-based treatment programs, and to the enhance the long-term effectiveness of outpatient treatment without adding to its cost.

In this light, some scholars of mental health policy are touting involuntary outpatient commitment (OPC) as a key strategy for serving uncooperative public mental health clients, especially those that may become violent or dangerous without treatment and require repeated involuntary hospitalization.[3–5] These scholars hope that extending the state's civil commitment powers to community-based treatment will effectively reduce hospital recidivism over time, and that this will conserve resources that may, in turn, be reinvested to expand and improve community care. And yet qualms about abridging civil liberties and increasing clinicians' liability have limited the use of OPC, even though most states now permit it by law.[4, 6–8] The primary sanction for noncompliance under OPC has been civil commitment to a hospital, which has lead to widespread skepticism about the effectiveness of this provision to slow the "revolving door."[9] Many who do support OPC would like to see the criteria broadened (as some states have done) to provide mandatory treatment *before* a client becomes dangerous to the point of meeting inpatient commitment criteria.[5, 10] Perhaps more significantly, as mental health administrators anticipate cutbacks in public funding for community-based services, they may have reason to be concerned about the short-term financial burden of providing court-mandated treatment.

Such dilemmas beg the basic question: can OPC really work, and if so, how? While a limited research base has accumulated on the short-term effects of OPC in improving compliance[11, 12] and reducing hospital recidivism,[13] the data are still out on whether, how, in which subgroups, and under what conditions this coercive approach to treatment may prove beneficial over time for people with severe mental disorders.[5] Meanwhile, policy debates about OPC are impoverished not only by inadequate empirical data, but by the lack of a testable conceptual framework that is sufficiently complex to interpret the way OPC operates in the real world.

This article outlines such a model, which was developed as part of a plan for a randomized trial of OPC and case management now underway in North Carolina (National Institute of Mental Health Grant R01MH48103 to M.S.S.). When the longitudinal findings from this study become available, they will provide the first comprehensive evaluation of the effectiveness of OPC from the point of view of persons with severe mental dis-

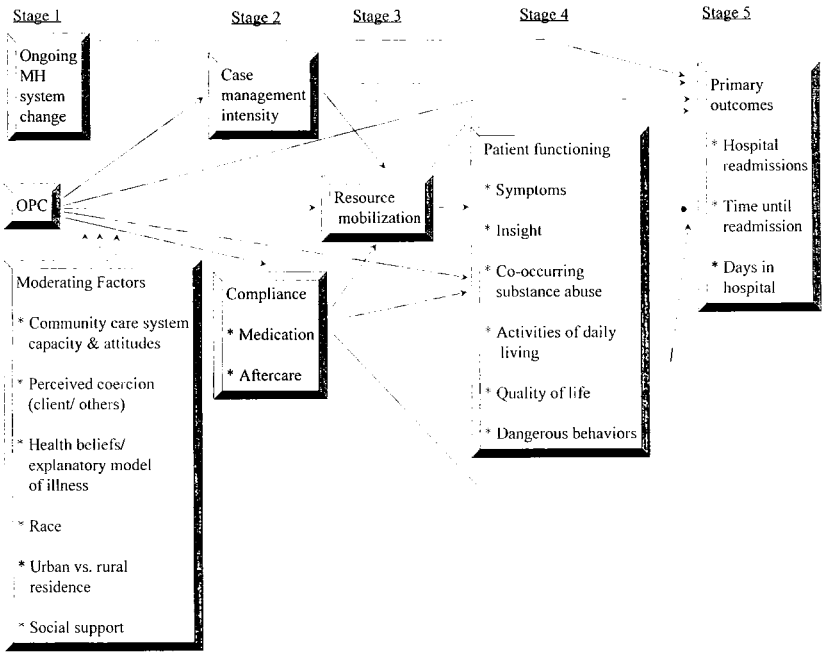

Figure 1. Direct, indirect, and moderating effects of involuntary OPC.

orders themselves, as well as from the perspective of their families and case managers and that of the rapidly changing public mental health systems responsible for serving them.

Conceptual Model

The conceptual model depicted in Figure 1 incorporates several direct and indirect mechanisms by which OPC may improve long-term outcomes for people with severe and persistent mental disorders. The primary independent variable in this model is the court order to comply with OPC, a formal, legally sanctioned use of coercion applied to the behavior of mentally ill individuals. However, the model also assumes that other less formal coercive influences may act simultaneously with the formal coercive force of OPC to shape the behavior of clients, caregivers, clinicians, case managers, and service systems as well.

The model suggests that OPC may exert its primary direct effect on the compliance behavior of the client through threat of force to be applied if the individual fails to comply with a regimen of outpatient treatment as mandated by the court. By changing compliance behavior, however, OPC may produce an indirect effect in any or all of the variables represented in the latter stages of the model. That is, improved compliance should lead to increased mobilization of community mental health resources and supportive services on the client's behalf (Fig. 1, Stage 3), which may then produce improvement in the patient's overall functioning (Fig. 1, Stage 4): decreased psy-

chiatric symptomology and comorbid substance abuse, improvements in self-care skills, improved quality of life, and reduced dangerous behavior. Finally, these changes in client functioning should be evident in decreased hospital readmissions, increased time between admissions, and a reduction in total days in the hospital.

Hence, by these pathways, OPC exerts key effects through improved client compliance with medications and aftercare. However, an equally plausible mechanism—and not a mutually exclusive one—posits that OPC succeeds through intensifying case management activity. Here the model suggests that the court order stimulates the service system to engage the client in treatment through more aggressive follow-up. These intensified efforts may also act as a lever to mobilize resources on the client's behalf; which may in turn lead to improvements in the client's social function and eventually to decreased reliance on repeated hospitalization. Also testable is a reciprocal relationship between case management intensity and compliance, whereby the case manager increases or decreases his/her efforts in response to the clients' varying level of compliance.

This conceptual model also examines a set of moderating factors that may alter the relationship between OPC and various outcomes. For example, the effects of OPC in preventing rehospitalizations may be greater in subgroups known to be especially noncompliant, "treatment-resistant," or under-served, such as racial and ethnic minority groups, rural residents, those who do not view themselves as mentally ill or needing treatment, and those with poor social support systems. Additional moderating factors include the capacity of relevant community care systems, providers' attitudes towards coercive treatment, and perceptions of coercion on the part of the client.

In summary, the model shown in Figure 1 suggests three central ideas as a framework for debate about the potential effectiveness of OPC. (1) Reduced hospital utilization is a *distal* outcome removed from OPC by several key intervening variables, or *proximal* outcomes, and is also likely to be affected by external systemic factors and historic trends. (2) In OPC, coercion acts as a two-edged sword by applying the power of law to mandate individuals' compliance with treatment, but also creating an obligation for case managers, clinicians, caregivers, and the mental health system in general to facilitate treatment. (3) At some level, OPC presupposes that community-based mental health programs have the wherewithal to provide adequate direct services as well as to enforce commitment orders. But by stimulating case management efforts, OPC may also act indirectly as a lever to mobilize other supportive and therapeutic resources in the community. Each of these themes will be discussed with respect to the terms depicted in the conceptual model.

Hospital Utilization: Relapse, Risk, or Resource? Readmission to a mental hospital is perhaps the most commonly studied outcome variable in mental health services research.[14] While often oversimplified as a proxy measure of illness relapse or treatment failure, the meaning of

hospital use for a conceptual model of OPC becomes more complex. Ideally, the effects of OPC on hospital utilization should be specified using several different measures: time until readmission, average length of stay, total number of admissions, and total number of inpatient days within a given period. Depending on individual circumstances and points of view, rehospitalization may be construed as a relapse of illness, a protection against harm, a treatment resource to which severely mentally ill people are entitled, a coercive or punitive response to deviant behavior, a curtailment of civil liberties, an exercise in social control, or a systemic financial liability. An adequately complex model of OPC must then take into account multiple meanings attached to readmission by persons at various points of intersection with the mental health service system, and must consider it as a phenomenon determined by a number of key factors.[15] For example, more aggressive case management under OPC may lead to earlier identification of relapse and foreshortened community tenure. In such a case, does earlier time to readmission reflect a failure of OPC? Probably not. Timely readmission, followed by successful inpatient treatment or rehabilitation, may actually be associated with fewer total admissions and inpatient days during the period following discharge. In short, an adequate view of the potential effects of OPC on hospital utilization should incorporate multiple measures of hospital use over time.

Being the primary dependent variable at Stage 5 in our model (Fig. 1), hospital utilization is affected most directly by the variables at Stage 4 that characterize patient functioning: psychiatric symptoms and level of insight, impairment in activities of daily living, quality of life, and dangerous behaviors. Dangerousness, in particular, as a chief criterion for involuntary civil commitment, is linked directly to rehospitalization. These facets of patients' experience often interact in complex ways. For example, progress in recovery from comorbid substance abuse may diminish the risk of violent behavior associated with intoxication. Gaining insight into one's mental illness may influence one to seek treatment voluntarily when necessary. However, rational judgment about such need for treatment is often impaired by psychotic symptomology, as are normal abilities to make functional decisions in other areas of life.

Ideally, the occurrence and length of hospitalization would be determined solely by need, being apportioned to all those (and only those) individuals who are so severely ill that they cannot safely survive outside the hospital; who cannot be treated adequately in an outpatient setting, but who could benefit from inpatient care; or who pose an imminent danger to others in the community. In reality, of course, the relationship between need and receipt of inpatient treatment is conditioned by other variables, which are represented at earlier stages in the model. At Stage 3 of the model (Fig. 1), the extent to which community services and resources have been mobilized on a client's behalf may directly influence decisions about hospital admission, or about whether and for how long an individual should remain in the hospital as an alternative. Such

decisions may also be affected by consideration of a client's level of compliance with medication and aftercare, as shown in Stage 2. Likewise at Stage 2, the intensity of case management efforts may influence whether or not appropriate clinical surveillance is in place at key junctures to identify and act upon emergent need for hospital treatment in a given case. Variables at Stage 2 and Stage 3 also affect hospital recidivism indirectly, by means of their impact in reducing symptoms and violence risk and improving social functioning and quality of life.

Finally, the presence of OPC may have both direct and indirect impact on rehospitalization—and the valence of such effects may be either positive or negative. For example, in some cases OPC precipitates hospital recidivism directly, insofar as failure to comply with outpatient treatment as legally mandated may prompt a subsequent civil commitment hearing resulting in rehospitalization. Lacking an OPC order in such instances, rehospitalization may not occur. Likewise, in some cases OPC will influence case managers and clinicians to be more vigilant in monitoring a client's course of illness. Thus, they will be more likely to detect a deterioration of a client's condition to the point where hospital treatment becomes indicated. Once again, without OPC in such situations, rehospitalization may not occur when appropriate.

On the other hand, the indirect effects of OPC for the most part operate in the opposite direction; insofar as OPC improves compliance with medication, it may indirectly improve symptoms, insight, and functioning, and lessen the risk of dangerous behaviors, making rehospitalization less likely. However, as implied above, these effects attributable to OPC may also be moderated by factors such as a client's social support system and the capacity of the local mental health program to provide treatment and to enforce OPC.

Importantly, external system changes and trends over time exert a significant influence on hospital recidivism, as well as on other key variables represented in the model; such exogenous effects may interact in unexpected ways with the particular characteristics of mentally ill populations in local areas. For example, in the early 1980s, a court-mandated fiscal incentive program dramatically reduced the mental hospital population in Texas over a four-year period of time. The program turned out to have much less impact in the southern border counties of the state where there is a high concentration of Mexican-Americans, resulting in a markedly greater reduction in inpatient utilization among non-Hispanic than among Hispanic origin patients.[16] It is interesting to speculate on how the cross-ethnic effects of "coercive treatment" might have been interpreted in Texas at that time.

In most states, "second-generation deinstitutionalization" continues in response to fiscal reforms, as well as mandates to provide treatment in the least restrictive setting appropriate to patients' needs. However, many scholars have argued that excessive zeal in continuing to empty state mental hospitals in the face of demonstrable failure of community mental health systems has simply perpetuated

the "revolving door" syndrome.[8, 17] Some studies have shown that well-funded model programs in the community—such as Assertive Community Treatment, supported housing, and halfway houses—can dramatically reduce hospital recidivism among persons with severe mental disorder.[18, 19] Others, however, suggest that the level of resources available for community mental health services is not particularly related to hospital readmission over time, because institutional recidivism primarily reflects the nature of severe and persistent mental illness. For example, Fisher *et al.*[20] found that a court-mandated increase in funding for community-based mental health programs in one region of Massachusetts was associated with lower state hospital population in that region. Over time, however, readmission patterns for individuals with severe mental disorders in the "resource-rich" area did not differ from those in other parts of the state.

In any event, changes in reimbursement systems for inpatient treatment can dramatically reduce hospital utilization, whether or not new funds are then made available for reinvestment in community-based services and whether or not such services in fact meet the needs of discharged patients. The relevant question persists, what happens to patients who are discharged after a much shorter stay, or who may be denied hospital admission due to factors unrelated to their psychiatric condition? One answer is that the strain on families and natural support systems may increase. For example, Thienhaus[21] studied referrals to community care settings for patients discharged from a geropsychiatric hospital after the average length of stay at the hospital was reduced 20 percent due to administrative changes in inpatient reimbursement. This study found that patients who "lacked natural support systems" disproportionately received referrals to more intensive, restrictive community care settings.

Along these same lines, Turner and Wan[22] used a small-area path analysis to show that certain social-environmental characteristics predict hospital recidivism independently of the presence of psychopathology and available health care resources; in particular, lower socioeconomic status and households headed by a female were significant correlates of readmission to state hospitals in Virginia over a six-year period. Similarly, Russo[23] followed a mentally ill population released from a maximum security hospital and found that criminal recidivism was more attributable to social marginality than to mental illness *per se*. Such findings would suggest that OPC is likely to exert its effect on institutional recidivism through a number of indirect pathways; and that such effects probably are subject to a variety of contingencies at the level of both micro- and macro-social systems. Using multiple measures of hospital utilization and a multistage longitudinal design, the conceptual model presented here provides a scheme for testing these complex effects.

Effects of Coercion on Individuals and Care Systems The second major idea underlying our conceptual model is that coercion cuts in more than one direction, affecting service providers and caregivers as well as clients; that perceived

coercion is likely to vary, independently of the fact of a civil commitment order; and that whatever the impact of formal, legal coercion, it is likely to play out in a social context in which informal coercion already abounds. The formal coercion of OPC may pale in comparison with other coercive elements in the client's life, such as threats of violence in an unsafe neighborhood. The meaning of OPC for given individuals may depend largely on their past encounters with more or less authoritarian (and more or less helpful) service providers, and with a range of quasicoercive experiences from financial dependence to guardianship to being transported to the hospital in a police cruiser. Such coercion is often viewed with ambivalence by mentally ill people and their family members alike.[24, 25] By incorporating measures of perceived coercion, our model of OPC provides a test of the felt impact of potential sanctions on the client's behavior.

The question of how to conceptualize coercion in a model of OPC is deceptively simple. On the surface, it seems logical to attribute to "coercion" all of the residual effects of the presence of OPC, after other covariates (such as case management intensity, service system capacity, etc.) have been taken into account. But the phenomenology of OPC as experienced in actual service settings contains subtle nuances. Contrasting frames of reference may define OPC as a lessening of coercion (i.e., as a less restrictive alternative to involuntary hospitalization) or as an increase in coercion (i.e., overriding a citizen's ordinary right to refuse mental health treatment in the community).[6, 26] Clients' knowledge of what exactly OPC legally requires and provides may vary considerably. The perceptions and definitions of the situation among various social actors around OPC may have different consequences or may achieve the same result for quite different reasons.

Consider, for example, a client who believes that OPC requires him to take medication as prescribed, and behaves as if this were true, even though forced medication actually is excluded from his state's OPC statute. Consider another client who is aware of his formal right to refuse medication as an outpatient, but nevertheless decides to comply after a clinician uses OPC to have him forcibly transported to the mental health center by a sheriff's deputy and then threatens involuntary hospitalization if the client does not take the medication. A third client on OPC simply disregards the order and never shows up for treatment because he believes it will never be enforced. A fourth patient on OPC becomes compliant because the court order creates a sense of obligation for a family member to remind him to keep appointments and to provide transportation for the client to get to the mental health center on schedule. Still another client complies with an outpatient regimen long after his OPC has expired, perhaps because he believes he is still required to do so, or perhaps because staying in treatment has given him better insight about his continuing need for treatment, or perhaps also because, while on OPC, a case manager became involved in his case and continues to closely monitor his progress and ensure that he stays in treatment.[11, 12, 27]

What all of these examples suggest is that *perceived* coercion must be considered conceptually (and measured) as a separate variable in a model of OPC—one that incorporates various facets of one's sense of autonomy, control, and influence and that may interact with both formal and informal pressures actually brought to bear on the behavior of mental health clients.[28, 29] Second, these examples illustrate that the coercive effects of OPC can move in different directions, spreading accountability and creating informal obligations and pressures felt by key actors in the mental health system and in the social network of persons with mental illness.

Resource Levels and Leverage The basic rationale underlying OPC assumes that noncompliance is a behavioral attribute of persons with mental disorder and that existing treatment is both efficacious and available. It hardly seems justifiable to legally compel people to use services that are not available, are demonstrably ineffective, or potentially even harmful. But therein lies the practical problem, as Fulop[6] has argued:

> It is ironic that advocates of [OPC] invoke this failure [of community care] as a justification for enforced treatment in the community to solve the "revolving door" problem when it is precisely this lack of community services that makes the implementation of [OPC] impossible. There are simply not enough community services to which people can be involuntarily committed.

And yet, some scholars have suggested just the opposite: that coercive treatment is necessary only because the community care system is inadequate. OPC becomes, rather, a device merely to maintain the floor of the system, ensuring minimal compliance with medication regimens (biological confinement) as a substitute for (unavailable) supportive services and therapies. This position is strongly reflected, for example, in the official statement of the National Alliance for the Mentally Ill on OPC: "The necessity of involuntary outpatient treatment is a tragic reflection of a treatment system which has failed to . . . provide effective treatment and services to individuals with the most severe brain disorders."[30] According to this view, in an ideal, integrated system of care, OPC would be superfluous because adequate resources would be readily deployed to ensure that mentally ill individuals are adequately supported, cared for, and treated in the community, effectively preventing their deterioration to the point of requiring forced protective intervention. In Tavolaro's[31] rendering:

> If adequate community care resources were available, it is quite likely that coercive intervention would not be necessary. . . . By offering real support in the community, many of the problems which preventive outpatient commitment is supposed to solve could be remedied through voluntary participation.

Stated in the extreme, Tavolaro's argument amounts to a virtually nonfalsifiable hypothesis, because it would have to be tested under almost utopian conditions. Moreover, it tends to skirt the possibility that psychotic illness may, by its very nature, impair someone's ability to voluntarily seek treatment, regardless of how rich or poor the service system may be. Even more to the point, the objection to OPC as merely a palliative remedy for an

inadequate community care system tends to ignore the potential for "leveraged" resources, which is central to our model: through its influence on case management, OPC may function as a lever to mobilize resources which otherwise would not be available to the client. In practical terms, this is precisely what clinicians have in mind when they discharge a patient on OPC "because they will get better followup in the community." When the level of resources is limited, leverage becomes more important; as a lever, OPC may indeed be applied more often to mobilize resources in community programs—from psychosocial rehabilitation services to supported housing—than to compel compliance behavior on the part of a client. Of course, to the degree that leverage occurs, OPC may be seen as a new entitlement, which raises a number of ethical and economic questions. However, such an entitlement may represent a justifiable use of societal resources, insofar as the recipients of OPC might otherwise incur greater costs to society as chronic hospital recidivists. In principle, that would be an empirically demonstrable argument.

Discussion

The conceptual model outlined in this article was designed primarily to guide a comprehensive empirical examination of the effectiveness of OPC by taking into account the multiple pathways and intervening mechanisms by which this legal intervention may (or may not) ultimately succeed in breaking the "revolving door" cycle of institutional recidivism for people with severe mental disorders. However, the model is also intended to stimulate discussion regarding some of the dilemmas and controversies inherent in the changing landscape of mental health services delivery in the United States. Part of the controversy surrounding OPC results from its being viewed from divergent perspectives that epitomize the positions of key stakeholders in mental health system reform; as such, these perspectives are illuminated by OPC but may also be instructive in broader ways.

Some civil libertarians and advocates for the mentally ill object to OPC as an unwarranted assault on the autonomy of people with psychiatric disabilities in the community. Mental health policy makers, on the other hand, may construe OPC as an innovation which makes possible a less restrictive, more normalized therapeutic environment for people who might otherwise be repeatedly confined to a mental hospital. Meanwhile, mental health clients themselves may in reality perceive OPC as no more coercive than the heavy-handedness and paternalism they experience from clinicians and caregivers as a matter of course. Thus, the degree to which OPC is seen as a punitive sort of "sentence" rather than as an entitlement to scarce resources may vary with the points of view of persons with mental disorder, their family members, and their service providers.

Indeed, the formal coercion of OPC occurs within the context of a range of less formal limits on the personal autonomy of persons with severe mental disorders. The constricted choices that are available to them in many areas of life, the sense of having little say in what

happens, the feeling of being too dependent on others, the fear of being vulnerable to harm or of being abandoned when help is needed—all of these experiences are relevant to discussions about the benefits versus costs of increased state coercion in the community treatment of mentally ill persons. Whether and under what conditions various sorts of limits are harmful, necessary, beneficial, or simply unavoidable, is a discussion that should be at the heart of mental health system reform and mental health services research. One prominent voice to be heard in such a debate is represented by the National Alliance for the Mentally Ill; "NAMI recognizes that involuntary outpatient commitment is a serious infringement on the personal autonomy of individuals with severe brain disorders and therefore takes the position that it should be considered only under extreme circumstances when other interventions are not available or appropriate."[30]

In the end, we believe that claims for the effectiveness of OPC will fall short as long as they are stated solely in the cost control metric of reduced hospital utilization,[13] rather than being demonstrated by meaningful improvement in the quality of life, the expansion of meaningful choices, and a less painful and prolonged course of illness experienced typically by persons with severe mental disorders in the community. The long-term promise of OPC is that by preventing costly hospitalizations, it will liberate funds from inpatient budgets to be reinvested in more effective community-based services. But in a world of shrinking entitlements to public resources, it is hardly obvious that "dollars will follow patients" as they go, especially for ongoing services to people who are already stigmatized as intractable, uncooperative, and dangerous. Given such realities, the use of legal coercion to outpatient treatment clearly will not, by itself, improve service systems that are already overburdened and underfunded. Coercion without resources is probably a strategy doomed to failure in the long run, however politically expedient at the moment.

Does this mean that OPC is a flawed policy? It is too soon to tell. Such a conclusion awaits the findings of research that will measure both the direct and indirect effects of OPC over time, and will show how both the formal and informal constraints on the behavior of mentally ill individuals interacts with the perceived obligations incumbent upon case managers, service providers, caregivers, and mental health systems in general. In the final analysis, it may turn out that the success or failure of OPC is primarily a function of the sustained involvement of case managers and the range of resources they are able to leverage, including inpatient treatment when appropriate, and may have little directly to do with the legal constraints of a civil commitment statute on the compliance behavior of individuals.

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