Health Care Compliance Principles and the Judiciary

David Wexler
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David B. Wexler
The University of Arizona
James E. Rogers College of Law

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H. ENHANCING COMPLIANCE

When an offender agrees to a rehabilitation plan that will likely reduce risk, the court's concern will shift in part to questions of compliance. How judges can enhance compliance is given full coverage in this selection by Wexler, which reviews in considerable detail the psychological literature on compliance with healthcare advice and then applies those principles in the context of the conditional release of insanity acquittees. It should come as no surprise that the compliance principles are highly consistent with Clark's point, made earlier, regarding active client involvement and participation.

Of course, as is typical for the readings in Part II, the relevant therapeutic jurisprudence principles transcend the legal context in which they are illustrated. The principles for enhancing compliance, for example, can find a fit, to a greater or lesser degree, in many legal contexts besides the conditional release of insanity acquittees. Other contexts include reentry courts, probation and parole, outpatient commitment, domestic violence protective orders, and family safety plans.

Health Care Compliance Principles and the Judiciary
by David B. Wexler

The medical profession has long known that patients often fail to comply with prescribed treatment regimens. Increasingly, the health care compliance problem has attracted the attention of psychologists interested in understanding, predicting, and improving patient compliance. Now, Donald Meichenbaum and Dennis Turk have marshalled the literature and have published a book entitled Facilitating Treatment Adherence: A Practitioner's Guidebook. The book presents a set of principles designed to help the medical profession increase patient treatment adherence.

The book does not deal with the legal system at all. And although it discusses the research on compliance and noncompliance by mental health outpatients (particularly those diagnosed as having schizophrenia, bipolar dis-
order, and alcoholism), it cannot be classified as a book specializing in mental patient compliance. Nonetheless, the Meichenbaum and Turk principles have the potential of making a substantial contribution to the field of mental health law. The purpose of the present chapter is to demonstrate how health care compliance principles might be used by the judiciary and the legal system to increase the medication and treatment compliance of a very worrisome group—conditionally released insanity acquittees.

More specifically, the chapter will suggest how, consistent with psychological principles of health care compliance, insanity acquittee conditional release hearings might be restructured, and how the judicial role in such hearings might be altered, so as to enhance the probability of adherence by the patients eventually granted conditional release. As such, the topic falls squarely within the research agenda of therapeutic jurisprudence.

Before turning to the health care compliance principles, we had best review briefly the law and practice regarding insanity acquittee conditional release. It is that body of law that will ultimately be scrutinized for its ability to accommodate and exploit the Meichenbaum and Turk principles.

The Legal Landscape

Commitment

In a distinct minority of jurisdictions, insanity acquittees are committable only through the generic civil commitment procedure. As such, the duration of their confinement and the mechanisms for their securing institutional passes and conditional and unconditional releases are no different from those governing civilly committed mental patients who have not had contact with the criminal justice system. For that group, trial visits, conditional release, and even ultimate release are usually within the unilateral discretion of the hospital authorities, unscrutinized by the courts.

Far more common, however, especially since the Hinckley verdict, are “special” commitment systems governing the commitment, duration of confinement, and release (conditional or otherwise) of insanity acquittees. Some jurisdictions regard an insanity acquittal as sufficient grounds for automatic commitment; others require a fresh judicial inquiry into the acquittee’s present mental condition and likely future dangerousness. Once committed, the acquittee might constitutionally face a potentially indefinite confinement period. A number of jurisdictions, however, limit the confinement of the acquittee to the maximum sentence that could have been imposed had a conviction, rather than an insanity acquittal, followed the criminal trial. In those jurisdictions, at the expiration of the “hypothetical maximum criminal sentence,” the insanity acquittee would have to be released or, if warranted by
the acquittee's current mental condition and predicted dangerousness, civilly committed under the applicable generic civil commitment code.

Even more pertinent for purposes of the present chapter are the provisions governing release, particularly conditional release and shorter-term institutional leaves, variously referred to as passes, trial visits, and furloughs. The states invariably allow the acquittee and his or her attorney to file, at specified intervals, a petition for release and a request for a judicial hearing. Typically, the acquittee will bear the burden of persuasion at the release hearing.

Further, whenever the superintendent believes the acquittee is ready for conditional or unconditional release, a hospital-initiated petition for release may be filed. In progressive jurisdictions, a period of conditional release will usually precede an application for outright release. Indeed, under a “graduated release” model, even conditional release is typically preceded by passes or trial visits. Under modern statutes, particularly those passed post-

_hinckley_, even short-term hospital absences ordinarily require court approval, especially if the acquittee is to enter the community unaccompanied by public officials.

When a superintendent files a petition for an acquittee's conditional release, some jurisdictions require a court hearing on the matter, while others permit such a hearing on the court’s own motion and require a hearing only if the prosecuting attorney objects to the proposed conditional release. In any event, a study of the District of Columbia practice concludes that “although holding a court hearing is optional, some form of hearing occurs in virtually all cases, to make a record, test the opinion of the Hospital and wisdom of its recommendation, and to assure protection for the public.” That same study concludes that, in the “vast majority of cases,” the court will concur with the hospital’s recommendation. When a conditional release is granted, the court will order the acquittee to comply with certain conditions. Under the federal statute, for example, the court shall

(A) order that he be conditionally discharged under a prescribed regimen of medical, psychiatric, or psychological care or treatment that has been prepared for him, that has been certified to the court as appropriate by the director of the facility in which he is committed, and that has been found by the court to be appropriate, and

(B) order, as an explicit condition of release, that he comply with the prescribed regimen of medical, psychiatric, or psychological care or treatment.

Typical conditions that have been imposed by courts relate to taking medication (perhaps in the presence of another), to living in a particular household, to keeping weekly outpatient therapy appointments, and to attending Alcoholics Anonymous meetings. Failure to comply with the conditions can,
of course, lead to revocation and rehospitalization, typically triggered by a due process hearing.

Jurisdictional Matters
When courts are charged with making conditional release decisions, a jurisdictional issue also arises. Typically, the criminal court—which becomes the committing court when a defendant is acquitted by insanity—has jurisdiction over conditional release matters. Under some schemes, however, jurisdiction is vested in the probate court of the county in which the hospital is located. These jurisdictional niceties are skirted in a state like Oregon, where release and conditional release decisions of committed insanity acquittees reside in an administrative body known as the Psychiatric Security Review Board.

Administrative Model
Oregon's highly regarded Psychiatric Security Review Board is composed of five members (a psychiatrist, psychologist, lawyer, parole expert, and a member of the public). By majority vote, the Board elects a chair and conducts other business. Much of its business consists of making insanity acquittee conditional release decisions. The Board holds hearings, retires to deliberate, makes findings, and, within 45 days of the conclusion of a hearing, issues written notice of its decision.

The administrative model of the Psychiatric Security Review Board is the chief competitor to the traditional model, which vests insanity acquittee release decisions in the hands of the judiciary. Later, the discussion returns to this issue and, indeed, to virtually all the legal material presented in this section. Now, however, it is time to turn to the psychological principles of health care compliance.

Health Care Compliance Principles
This section will set forth those health care compliance principles discussed by Meichenbaum and Turk that have potential relevance to the insanity acquittee conditional release process. In the current section, the principles will be discussed without reference to the legal system. Integrating the psychology and the law is the task of the ensuing sections.

As noted earlier, Meichenbaum and Turk deal in part with mental patients, but their volume covers the full gamut of health care patients and professionals. The principles they propound have apparent general applicability to both physical and mental health compliance. This section will assume the accuracy and efficacy of the principles, which were derived from an extensive review of the research and clinical literature. Further research is obviously needed, but that is typically the case. From a therapeutic jurisprudence perspective, it should be highly instructive to regard those principles as tentatively true, and to examine how the legal system might be reshaped to accommodate them.
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Adherence Process

One of the most important reasons for nonadherence is the failure of the health care professional (HCP) to instruct the patient adequately about the treatment regimen. Indeed, although physicians seem not to commonly acknowledge it, “the behavior of the HCP plays a critical role in the adherence process.” Nonadherence is promoted when the HCP is distant, looks and acts busy, reads case notes during the interview, uses jargon, asks patients questions calling for “yes or no” answers, cuts off the patient, does not permit patients to tell their stories in their own words, fails to state the exact treatment regimen or states it in unclear or technical terms, adopts a moralizing, high power stance, fails to sit at the same keel as the patient, keeps a desk between the HCP and the patient, and terminates the interview abruptly. By contrast, Meichenbaum and Turk advise HCPs to introduce themselves, to avoid unexplained jargon, and to elicit patient suggestions and preferences.

The patient’s active involvement in negotiating and designing the treatment program is of tremendous importance to adherence and favorable outcome. Even giving a patient a choice over some of the more minor details—such as the form of medication and the scheduling of injections—can have salutary effects.

To promote patient adherence, the HCP should linguistically cast the treatment program in a manner that capitalizes on the patient’s involvement and agreement. For example, directive terminology such as “What you are to do is…” should be replaced by a softer, more bilateral statement, such as “So what you have agreed to try is…” Adherence will be further nurtured if the HCP has high prestige and is perceived to be competent, attentive, practical, and to be motivated by the best interests of the client.

In questioning a patient, the compliance literature also suggests the HCP needs to achieve a delicate balance with respect to the nature of self-disclosure requested of patients. Thus, “seeking high self-disclosure or asking patients about material that they would not usually share with other family members or friends” seems detrimental to adherence. In contrast, a moderate (rather than low) level of self-disclosure, focusing both on personal strengths and weaknesses, seems to increase perceived self-efficacy and the patient’s adherence. A particularly profitable avenue of HCP questioning relates to the patient’s past compliance efforts: “What kinds of things in the past have you tried that were unsuccessful? How is what you have agreed to do now different?”

Relatedly, it is profitable for the HCP to raise mild counterarguments about the patient’s prospective compliance. When the HCP indicates to the patient certain obstacles and drawbacks to compliance, the patient will have an opportunity to minimize and counter the HCP’s arguments, thus “fostering the patient’s sense of control, commitment, and degree of hope.” A patient presented with mild counterarguments to compliance who nonetheless announces to a prestigious HCP his or her intention to comply will be “an-
chored" to the compliance decision by anticipated disapproval from the HCP and by anticipated self-disapproval.

Involving significant others—such as family members—in the treatment process is also likely to enhance patient adherence. Family members aware of the treatment regimen can encourage, remind, and prod the patient, and can help the HCP assess patient compliance. One suggested technique for involving significant others is for the HCP to bring in family members and to have the patient personally explain to them the nature of the illness and the proposed treatment.

So long as the patient is agreeable to the involvement of certain family members, their presence and participation is likely to be beneficial. Greater patient adherence has been found, for example, among patients accompanied to evaluations by family members than among those patients who attended those evaluations alone.

When an HCP has a patient explain her medical problem and agreed upon course of treatment to family members, the active patient participation provides an opportunity to "assess her comprehension, to elicit a public commitment, and to strengthen her adherence-related attitudes."

One reason why the presence of significant others enhances patient compliance is that "public commitment leads to greater adherence than does private commitment." In addition to the motivational power of anticipated self-disapproval and the anticipated social disapproval of the HCP, discussed above, a patient who has previously made a commitment to significant others will be anchored to compliance by their anticipated disapproval as well. Thus, Meichenbaum and Turk note that "insofar as patients can be encouraged to inform one or more people (in addition to the HCP) of their intentions to follow the treatment regimen, there is an increased likelihood of adherence."

Behavioral Contracting

When negotiating a course of treatment with a patient, HCPs can profit from the behavior modification literature regarding "behavioral contracting." Such "behavioral" or "contingency" contracting "capitalizes on the patient-HCP relationship by actively involving the patient in the therapeutic decision-making process and by providing additional incentives (rewards) for achievement of treatment objectives."

The relevant literature seems to suggest that behavioral contracting works best when the contract is individually tailored to the particular needs and desires of a given patient, when it defines the target behavior expected of the patient with specificity, when it spells out the positive and aversive consequences that will attach, respectively, to compliance and to noncompliance, when significant others (rather than the HCP alone) deliver the consequences, when the contracts include the "specific dates for contract initiation, termination, and renewal," when the patient's commitment is solicited
in both oral and written form, and when the contract is “signed by at least two parties as well as other interested and relevant” ones.

Unfortunately, despite evidence of short-term benefits flowing from behavioral contracting in the health area, the long-term benefits have yet to be established. There is evidence that health-related behavioral changes “are maintained only for the duration of the contract, and after its termination or when the treatment contract is withdrawn the patient may stop performing health-related behaviors (e.g., pill taking, diet, exercise).”

Some principles may be invoked to lessen the chances of disappointing post-termination results. For example, during the contract period itself, “the greater the continuity of care whereby patients can see the same HCP upon repeated visits, the greater the likelihood of adherence.” The HCP should not abruptly terminate treatment but should instead gradually wean the patient from the process. While doing so, the HCP should help the patient make “self attributions” about successful behavioral changes. It is best that patients attribute beneficial changes to themselves rather than to external events or persons.

HCPs and Compliance

Interestingly, although Meichenbaum and Turk devote much of their volume to patient nonadherence to HCP recommendations, they close with a discussion of why HCPs themselves might not adhere to the recommendations set forth in the book: Patients should take their advice or simply suffer the consequences of noncompliance; the principles simply will not work with their particular patient populations; the recommended procedures are too complicated and numerous; there is simply no time in day-to-day practice to implement the procedures; the system does not support frills like adherence counseling; and, finally, they cannot make use of the principles because most HCPs are not mental health professionals and accordingly have not been trained in psychological techniques of adherence.

Meichenbaum and Turk provide powerful counterarguments to the anticipated HCP reluctance to implement the recommended health care compliance principles. Thus, although the procedures many seem a bit complicated initially, they will soon require less attention and will in the long run improve the quality of service. At the early stages, the HCP can use checklists as memory prompts. Finally, with regard to clinical skill, the authors note that “no great amount of specialized training” is ordinarily required to use the recommended enhancement techniques.

Applying the Health Care Compliance Principles in the Insanity Acquittee Conditional Release Process

To varying degrees, health care compliance principles can be invoked in a variety of legal contexts—such as insanity acquittee conditional release, parole, probation, and outpatient civil commitment. The only example to be considered here, the insanity acquittee conditional release process, is the
legal mechanism most suitable for incorporating the health care compliance principles. In fact, to maximize the potential application of the health care compliance principles, the insanity acquittee conditional release process will itself be discussed in a somewhat limited legal and geographical context.

From a legal perspective, only hospital-initiated conditional release petitions are examined, and not conditional release claims triggered by patients over the objection of the hospital. As a practical matter, hospital-initiated petitions are the most viable ones—the ones that typically lead to conditional release rather than to continued hospitalization.

Geographically, for reasons of efficiency, security, and transportation, the recommended principles will be easiest to implement if the hospital, the criminal court where the insanity acquittal occurred, and the acquittee’s home community fall within the same general area. In that case, the inconvenience to the hospital, to the community facility, and to the patient and patient’s family will not be great even if a series of conditional release hearings is held.

The Courts’ Role in Adherence

With the above limitations and caveats in mind, let us turn our attention to the means by which a court versed in the health care compliance principles might exploit those principles to increase the adherence behavior of a patient proposed by the hospital for conditional release status. Such hospital-initiated cases are likely to lead to conditional release (whether the prosecutor supports or opposes the hospital’s recommendation), and in this relatively low stress context the court might rather comfortably see its role as facilitating as well as predicting compliance.

It is important to recognize, however, that courts might sometimes increase eventual patient adherence not by simply deferring to the hospital’s conditional release recommendation but by truly scrutinizing hospital-initiated conditional release petitions for their conformity to the health care compliance principles. To the extent that HCPs may themselves fail to comply with the recommended procedures for facilitating treatment adherence, as Meichenbaum and Turk worry they often will, courts can encourage HCP compliance by denying (or deferring action on) hospital petitions that demonstrate insufficient use of the fundamentals of treatment adherence.

The use of some of the fundamentals will be easier for courts to monitor and oversee than will others. Courts may not have much control over the give-and-take of doctor-patient office dialogue, for example, but they can—through the actions of denial and deferral—encourage the hospital, patient, and community facility to negotiate, prepare, sign, and submit with the judicial petition a rather specific behavioral contract setting forth the terms and conditions of the proposed conditional release.
The Conditional Release Hearing

Once the behavioral contract is "signed by at least two parties [the patient and the hospital] as well as the other interested and relevant parties [the community facility and perhaps family members]," the court can use the contracts as the basis of a judicial conditional release hearing, and can view the hearing as somewhat akin to (but far less routinized than) the framework of a Federal Rule of Criminal Procedure 11 hearing held to approve a previously negotiated plea agreement. Rule 11 hearings require a dialogue with the defendant in open court to assure that the defendant understands and agrees to the plea. Similarly, the conditional release hearing can actively involve the acquittee—to test the patient's understanding of the treatment regimen and to insure that the patient agrees with it and has input into its design.

The court can structure and shape the conditional release hearing so as to invoke a number of other important health care compliance principles—principles that may or may not have been used by the HCP when negotiating the plan with the patient. For example, the hearing will serve as a forum for the patient to make a "public commitment" to comply with the treatment regimen. That way, the commitment will be made not only to the HCP, but also to a high-status judicial official and to any significant others—such as family members—whose presence at the hearing has been approved by the patient.

A conditional release hearing can also provide an excellent opportunity for the court to seek from the patient the appropriate level of self-disclosure, particularly regarding past unsuccessful compliance efforts and the extent to which the current treatment plan differs from any earlier, unsuccessful ones. The hearing is also an ideal forum for presenting the patient with "mild counterarguments" to compliance, enabling the patient to counter those arguments and accordingly to become "anchored" to the compliance decision.

Where the hospital-initiated conditional release petition is unopposed by the prosecution, the judge might personally elicit the patient self-disclosure and might personally express concern in the form of "mild counterarguments." Where the hospital's petition is opposed by the prosecution, those matters will naturally fall to the prosecuting attorney.

As a result of matters ventilated at the hearing, the behavioral contract may be somewhat revised before it is finally approved by the court. When the agreement is finally approved, however, the patient's commitment will have been solicited both orally and in writing, and the other important behavioral contracting principles (e.g., individually tailored, specific regarding expected patient behavior and positive and aversive consequences, involvement of significant others, specification of termination or renewal dates) will have been attended to as well.

In terms of court approval of the conditional release, the statutes—especially the federal one—convey the flavor of a court ordering a passive acquittee to be "conditionally discharged under a prescribed regimen of..."
treatment that has been prepared for him," and ordering "as an explicit condition of release, that he comply with the prescribed regimen." Despite the unfortunate linguistic flavor of the statutes, a court is free to follow the more therapeutic course and to conceptualize and frame the conditional release as an agreement ("So what you have agreed to try is...") rather than as an order ("What you are to do is...").

A Model of Judicial Behavior

Indeed, to the extent that the court is in some sense shaping or approving the release conditions, the court is itself an HCP, and the judge should therefore attend to the HCP behavioral factors thought to enhance patient adherence. For instance, the judge can make sure to introduce himself or herself to the patient, can be attentive, can avoid using legal or medical jargon, can allow the patient to tell his or her story without undue interruption, can make sure the patient understands the precise treatment regimen, and can even sit at the same level and at the same conference table as the patient—perhaps in a mental health facility conference room rather than in a courtroom.

The suggested model of judicial behavior is remarkably similar to the model employed in some jurisdictions by judges presiding at civil commitment hearings. In the civil commitment context, that model has been criticized as appearing "confusingly like a treatment conference..." The criticism is well taken in a context, like civil commitment, where the state is seeking to deprive an individual of liberty and where the model might lead us to relax our due process guard. In the insanity acquittal context, however, the acquittedee has already lost his or her liberty, and following the hearing on the hospital-initiated conditional release petition, the acquittedee is likely to regain a taste of liberty. In that context, it seems somewhat less crucial to maintain traditional judicial formalities. In any event, there is of course no inherent conflict between maintaining judicial decorum and treating an insanity acquittedee respectfully; nor is there an inherent conflict between being competent, expert, and of high prestige and nonetheless being motivated by the acquittedee's best interest.

Initial Patient Reentry Transitions

In order to enable the insanity acquittedee to reenter the community gradually, and to allow the relevant authorities to keep close tabs on the patient's adjustment, it is probably best that the acquittedee first return to the community not under conditional release, but under the authority of very brief passes or furloughs. In fact, such leaves, which by statute increasingly require court approval, should perhaps be used, much more than they currently are, as a partial substitute for conditional release.

For example, after laying the conditional release groundwork by according an acquittedee a series of brief furloughs, a court might be inclined to grant the acquittedee conditional release status. Instead of granting a full-blown con-
The court might grant the acquittee a longer, time-limited furlough. The furlough could be issued according to a behavioral contract obliging the acquittee to follow an agreed-upon therapeutic program, and compliance could be rewarded by renewal of the furlough. In all other respects, the agreements and hearings could follow the suggestions given above for the conditional release process.

By using a series of furloughs as a precursor to conditional release, the court may be able to tap some additional health care compliance principles. Furlough termination and renewal dates can be noted with great precision, and the acquittee can have some input into the appropriate duration—and renewal date hearing—of each furlough. Significant others can be nominated by the patient to monitor compliance and to appear and testify at follow-up (renewal) hearings. The follow-up hearings will provide a type of “continuity of care,” especially if the same judge is able to oversee the acquittee’s community adjustment. The fade-out from furlough to full-fledged conditional release can be gradual, giving the court an opportunity to help the patient make “self-attributions” about the patient’s continual progress. Further monitoring, follow-up, and fading-out can and should of course occur during the period of conditional release proper.

If the health care compliance techniques are brought by the judiciary into the insanity acquittee furlough and conditional release process in the manner described above, the therapeutic value of that process may be enhanced without treading upon values of justice. Of course, the law in some jurisdictions will make it easier than in others for the judiciary to import the health care compliance principles. Accordingly, the next section briefly assesses the ability of various legal schemes to accommodate the compliance principles.

The Law and the Health Care Compliance Principles

Certain legal schemes stand out as frustrating the application of the health care compliance principles to the insanity acquittee conditional release process. For instance, those states that process insanity acquittees through the civil commitment system typically leave release, conditional release, and furlough matters to the hospital itself; the courts accordingly play no role in such matters and therefore lack leverage to urge the adoption of appropriate adherence techniques. Almost as bad—in terms of lack of leverage—are special insanity acquittee commitment laws that nonetheless mandate the court to order release in the absence of objection from the prosecution. And even worse are legal systems where insanity acquittees fall under special commitment laws but where those laws are read as not even authorizing conditional release.
The Courts’ Active Involvement

Laws favorable to the use of principles expressed here are those requiring court approval even of furloughs, and those authorizing or even requiring conditional release hearings. Jurisdictionally, it is probably best if release matters are heard in the original commitment court, rather than in the probate court of the county where the hospital is located. Such a resolution, although not taking advantage of any specialized knowledge that probate courts located in the vicinity of the hospital might develop, spreads the judicial work load more equitably, appears not to lead to harsher treatment of insanity acquittces, and will make more feasible the holding of follow-up hearings at which the most important witnesses should be the patient, the community treatment facility staff, and the patient’s family. Of course, as a practical matter, such hearings will be easiest to conduct when, as noted earlier, the committing court, hospital, and the patient’s home community are all located in the same area.

Recommended Period of Control

Because of the behavioral contracting data suggesting diminished treatment adherence after the expiration of the contract period, the period a releasee can be held on conditional release ought not to be too short. On the other hand, the indefinite control over an insanity acquittee is probably not necessary, and may be countertherapeutic if its prospect leads defendants not to assert the insanity defense in the first place. State control over an acquittee for the period of the “hypothetical maximum criminal sentence” should be sufficient, especially since persons acquitted by insanity of very serious crimes will be under state control for a long-term, and perhaps for a lifetime.

Administrative Model

Curiously, Oregon’s administrative model—the Psychiatric Security Review Board—does not fare very well when scrutinized from the perspective of the compliance principles. The Board may perform exceptionally well in terms of monitoring and in terms of other important areas beyond the scope of the present chapter. The model seems to fall short, however, in terms of its potential for inducing compliance through the hearing process itself.

The Board, composed of five members, might have some difficulty departing sufficiently from formality to play the HCP role described earlier. Further, following the hearing, the Board is expected to deliberate in closed session and, by majority vote, to reach a decision and later issue its findings and order. Such a model does not comport ideally with the model developed earlier in the chapter: a single judge holding a hearing to review a previously negotiated agreement, questioning the patient about the agreement, putting the final touches on it, extracting from the patient a public commitment to comply, setting a follow-up hearing at which the same judge will preside, and, in the presence of the patient, entering an order approving the patient’s temporary future period to be extended to b
temporary release according to the terms and conditions set out in the agreement. Given the attractiveness of the PSRB in other respects, a worthwhile future project would be to consider ways in which the PSRB could be modified to better incorporate health care compliance principles.

Conclusion

This exercise in therapeutic jurisprudence demonstrates which legal structures square best with importing health care compliance principles into the insanity acquittee conditional release process and, even more, demonstrates how courts can restructure the process and the hearings to facilitate treatment adherence. In their text, Meichenbaum and Turk express the fear that, for a variety of reasons, HCPs themselves will not comply with the recommendations. In this chapter, the issue of HCP noncompliance has been partly finessed, for courts can exert compliance leverage over a hospital seeking to conditionally discharge an insanity acquittee. Only one major issue seems to remain: Will courts comply?

Courts may resist for reasons similar to those given by HCPs: Patients should adhere or else suffer the consequences; the principles will not work on a population of insanity acquittees; the procedures are too complicated and numerous; there is no time in day-to-day courtroom practice to implement the procedures; the system does not support frills like adherence-enhancing strategies; and, finally, courts cannot make use of the principles because judges are not mental health professionals and accordingly have not been trained in psychological techniques of adherence.

The responses given by Meichenbaum and Turk to the HCPs are similar to those that can be given to the courts: the procedures may seem complicated at first, but, after a hearing or two, should require less attention; in the long run the modification in procedures should improve patient adherence and thus better serve society; manuals and checklists can be used to introduce courts to the procedures and principles; and, finally, no particularly specialized training is necessary to implement the procedures.

Just as “the behavior of the HCP plays a critical role in the adherence process,” it is probable that, like it or not, the behavior of courts plays a critical role in the adherence behavior of conditionally released insanity acquittees. Ultimately, of course, the issue is an empirical one. Ideally, the judicial role in influencing patient compliance is a matter that should receive careful empirical examination.

Notes

1. A familiarity with the compliance literature and with the legal reality should serve to keep the prosecutor’s behavior within the bounds of restrained advocacy. True, if the prosecution is very forceful, the hospital’s conditional release petition may be denied. Typically, however, the courts will follow the hospital’s conditional release recommendation despite the prosecutor’s objec-
tion. If conditional release is, in any event, likely, and if high, as opposed to moderate, patient self-disclosure lessens the prospects of adherence, a prosecutor who seeks anything more than moderate patient self-disclosure runs the risk of contributing to the conditionally released patient’s noncompliance.

2. Presumably, in cases where the hospital itself petitions for the patient’s conditional release, the patient will be cooperative, have insight into his need to adhere to treatment conditions, and have had input into the shaping of the conditions. Under those circumstances, the patient should identify with the plan to a sufficient degree so that psychological “reactance” (reacting against the proposed conditions) will be avoided. See S. Brehm & J. Brehm, Psychological Reactance: A Theory of Freedom and Control (1981).

3. The agreement may require the acquittee to live in a particular place, attend an outpatient clinic on a weekly basis, and take prescribed medication—perhaps in the presence of others. Positive reinforcers of a “bonus” variety can be dispensed by family members so as to capitalize on the “immediacy effects” that flow from promptly reinforcing appropriate patient behaviors. Under the principle of “response cost,” the patient might even agree to part with items of his own—items that can be earned back from family members by engaging in appropriate behavior. Patient lawyers can play an important role in negotiating such “side agreements” with family members and in working with the hospital to present a forceful petition for conditional release.

Key References