

Outpatient Commitment. Some Reflections on Ideology, Practice and Implications for Research

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Introduction

Over the recent years, increased attention has been paid to non-compliance by mentally disordered patients living in the community with outpatient treatment.¹ To deal with this problem many countries are now revising relevant legislation, to introduce a broader base for involuntary treatment in the community.² This paper focuses both on the problems concerning the ideology and implementation of involuntary outpatient treatment, and on some of the research problems related to the evaluation of both the efficacy and effectiveness of outpatient commitment.

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1 Dennis, D. L., & Monahan, J., (Eds.) (1996) *Coercion and aggressive community treatment - A new frontier in mental health law*. New York: Plenum Press; Dennis, D. L., (1999) *Tracing the development of outpatient commitment. An annotated bibliography*. In *Coercion in mental health services - international perspectives. Research in community and mental health* (eds J. P.

Morrissey & J. Monahan), pp. 209-229. Stamford, Jai Press Inc; Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) *Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals*. *American Journal of Psychiatry*, 156, 1968-1975.

2 Department of Health (UK) (1999) *Reform of the Mental Health Act 1983- Proposals for consultation Green Paper: Department of Health*. London; Department of Health, Norway, (1999) *Lov om etablering og gjennomføring av psykisk helsevern (psykisk helsevernloven) 2. juli 1999, nr 62 (Mental Health Act 1999*. In Norwegian)

One of the most striking features to be found when reviewing the literature on involuntary outpatient treatment is the many and often complex criteria put down in the legislation concerning outpatient commitment.³ This applies both to the criteria authorising the use of outpatient commitment orders and to the circumstances in which coercive powers may be used. Another feature is the proliferation of names used to describe different variants of outpatient commitment. Names such as involuntary outpatient commitment, aggressive community treatment, assisted community treatment, involuntary community treatment, community treatment order, conditional discharge, preventive commitment and more can be found in the literature. Whilst such variations in both nomenclature and content is not surprising, given the diversity of legal approaches to compulsory assessment and treatment as a whole, we use the term outpatient commitment (OC) in this paper to cover *all* forms of involuntary outpatient orders, regardless of such orders' potential to sanction involuntarily treatment of patients in the community.

Different models and solutions

The statutes authorising OC are usually found in the mental health legislation, but in some jurisdictions outpatient commitment is dealt with through guardianship or competency-based statutes.⁴ In principle there are two OC models, one being OC as *a condition of leave or discharge*, the other being OC invoked as an *alternative to hospitalisation*. In practice the first model is by far the most common, while OC without any preceding inpatient period is mostly found in more recent legislation.⁵ However, within these two main models, a variety of legal approaches have been utilised in practice. Important issues (among others) in this respect concern the responsibility for overseeing OC and whether the criteria for OC should be different from those authorising inpatient civil commitment or not. Regarding the criteria for OC, more lax criteria (compared to the civil commitment criteria applying to in-patients) have been introduced in certain jurisdictions.⁶ In some places there is a requirement that the patient must at some time have received inpatient treatment before an OC order can be issued, while no such requirements exist in other jurisdictions. Criteria such as previous non-compliance, dangerousness, a previous

3 Appelbaum, P. (1988) *Assessing the NCSC guidelines for involuntary civil commitment from the clinician's perspective*. *Hospital and Community Psychiatry*, 39, 406-410; Geller, J. L. (1995) *A biopsychosocial rationale for coerced community treatment in the management of schizophrenia*. *Psychiatric Quarterly*, 66, 219-35; Hiday, V. A. (1996) *see note 3 above*; Smith, C. A. (1994) *Use of involuntary outpatient commitment in community care of the seriously and persistently mentally ill patient*. *Issues in Mental Health Nursing*, 16, 275-84.

4 Geller, J. L., McDermeit, M., Grudzinskas, Jr., et al (1997) . *A competency-based approach to court-ordered outpatient treatment*. *New Directions for Mental Health Services*, 15, 81-95; Slobogin, C. (1994) *Involuntary community treatment of people who are violent and mentally ill: A legal analysis*. *Hospital and Community Psychiatry*, 45, 685-9.

5 Department of Health (UK) (1999) . *Reform of the Mental Health Act 1983- Proposals for consultation*

Green paper: Department of Health. London; Department of Health, Norway, (1999) *Lov om etablering og gjennomføring av psykisk helsevern (psykisk helsevernloven) 2. juli 1999, nr 62 (Mental Health Act 1999. In Norwegian)* ; New York State Assembly. (1999) *New York State Bill A08477*. New York May 21, 1999; Power, P. (1999) *Community treatment orders: The Australian experience*. *The Journal of Forensic Psychiatry*, 10, 9-15; Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) *Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals*. *American Journal of Psychiatry*, 156, 1968-1975.

6 Torrey, E. F., Kaplan, R. I. (1995) *A national survey of the use of outpatient commitment*. *Psychiatric Services*, 46, 778-784; Swanson, J. W., Swartz, M. S., George, L. K., et al (1997) *Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model*. *Journal of the American Academy of Psychiatry and Law*, 25, 5-16.

positive treatment outcome etc. can also be found in some legislation. In addition all of the above mentioned criteria can be combined in various ways.

It seems that there are different forms of theoretical justification underpinning the two models described above. While the justification for OC following a hospital admission usually focuses on preventing relapse, the justification for OC as an alternative to hospitalisation is based more on a desire to comply with the “least-restrictive-measurement” ideology as reflected in ethical codes and international law.⁷ It is important to be aware of these differences because of the impact they may have on the level of coercion employed in the delivery of mental health services. While a focus on relapse prevention will tend to add further coercion to the existing inpatient coercion, outpatient commitment as an alternative to hospitalisation may have the potential to reduce the total amount of coercion in psychiatric care.⁸ What will happen in practice remains to be seen, and will among other things depend on the impact of empirical evidence, not as yet available, on the effectiveness of OC.

Procedures and outpatient commitment

To add to the complexity, it should also be remembered that procedural rules are of importance when different versions of outpatient commitment orders are evaluated. Relevant in this context are questions such as who decides to impose outpatient commitment and how is the OC decision made? Moreover, who is in charge of outpatient care? Who is entitled to enforce the law? What measures can be applied? A helpful enlightening example can be found by considering the newly passed Norwegian mental health act (still not in force). The new law authorises OC without any prior hospital admission. At the same time, the decision as to whether patients can be made the subject of an OC order or not, rests with the mental hospital located in the catchment area where the patient lives, and the responsibility for treatment rests with the same hospital. The statutes further states that “knowledge about the course of the disorder based on the patient’s symptoms and experiences from earlier episodes is required to the point where it is no doubt about the treatment needed by the patient”.⁹ It is therefore extremely unlikely that the OC order can be imposed on patients who are not familiar to the hospital staff, i.e. patients who have never previously been admitted. Thus it can be seen that even if an order with the power to commit a patient without a prior hospitalization episode exists, it is in practice virtually impossible to use such an order because of the procedural rules.

Another factor contributing to the confusion about OC is the variation in coercive powers provided by different OC orders. The most important question in this context is whether or not the law authorises forced treatment in the community. Again it may be helpful to give an example. It is repeatedly claimed that the English Mental Health Act 1983 (as currently applied in England

7 Council of Europe. (1950) *The European Convention for the Protection of Human Rights and Fundamental Freedoms*; Council of Europe (1983) *Recommendation R(83)2. Legal Protection of Persons Suffering from Mental Disorders Placed as Involuntary Patients*; Council of Europe. (1996) *For the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention of Human Rights and Biomedicine*; United Nations. (1948) *Universal Declaration of Human Rights*; United Nations. (1991) *Principles for the Protection of*

Persons with Mental Illness and for the Improvement of Mental Health Care; United Nations. (1996) *International Covenant on Civil and Political Rights*; World Psychiatric Association. (1996) *Declaration of Madrid*.

8 Peay, J., (2000) *Reform of the Mental Health Act 1983: Squandering an opportunity*. *Journal of Mental Health Law*, (3), 5-15.

9 Section 3 in the provisions on OC in the new Norwegian Mental Health Act.

and Wales) lacks OC orders, in spite of the fact that the 1983 Act sanctions conditional discharge of certain offender patients. Also, the Mental Health (Patients in the Community) Act 1995 (which amended the 1983 Act) authorises civil patients to be involuntarily taken from their homes to see their therapists or case managers.¹⁰ But because this legislation does not entail any powers to treat patients against their will, and because it is unclear how the power to convey patients can be enforced, scholars assert that outpatient commitment orders do not exist in England. A similar confusion about the existence of OC orders is reported from the US.¹¹

Competency, patients' autonomy and mandatory community treatment.

In our opinion the greatest ethical dilemma connected with OC concerns the question of what to do when patients function well enough so as to not to require inpatient care, but at the same time are believed to be likely to be non-compliant with treatment in the community? The answer to this question depends on answers to a number of other questions, such as: What are the reasons for non-compliance? Is it lack of insight as a product of mental disorder, or is it the poor quality of the treatment and services offered to the patient? Another issue is whether patients who function well enough to live in the community can at the same time can be incompetent as regards their ability to consent to treatment? We have not been able to find any study assessing the competency to consent to treatment for patients receiving outpatient commitment orders. Except for patients admitted purely for evaluation purposes, it would be expected that the mental state of most patients would show substantial improvement between admission and the time of readiness for discharge. Patients receiving an OC order, without any inpatient period, are likewise expected to function better than those committed as inpatients. There is some empirical evidence to support this. In the study by Swartz et al.¹², patients subjected to outpatient commitment had a Global Assessment of Functioning (GAF) score close to 50, while civilly committed inpatient populations usually score around 30 at intake.¹³ In these circumstances how can (continuing) compulsion be justified?

Some jurisdictions have tried to solve this problem by introducing wider criteria for OC compared to criteria for inpatient civil commitment. Though this would establish a legal base for forced treatment of relatively well functioning (but expectedly non-compliant) patients in the community, it would be violating the principles laid down in international law as well as all international recommendations and guidelines applying to the treatment of mental patients.¹⁴ It would also represent a reversal of the trend towards increased autonomy for mental patients evident over the last few decades (with the possible exception of the 1990s).

10 Eastman, N. (1997) *The mental health (patients in the community) Act 1995: A clinical analysis*. *British Journal of Psychiatry*, 170, 492-496.

11 Miller, R. D. (1985) *Commitment to outpatient treatment: A national survey*. *Hospital and Community Psychiatry*, 36, 265-7.

12 Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) *Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals*. *American Journal of Psychiatry*, 156, 1968-1975.

13 Poulsen, H. D. (1999) *Perceived coercion among committed, detained and voluntary patients*.

International Journal of Law and Psychiatry, 22, 167-175; Nichol森, R. A., Ekenstam, C., Norwood, S. (1996) *Coercion and the outcome of psychiatric hospitalization*. *International Journal of Law and Psychiatry*, 19, 201-217.

14 Slobogin, C. (1994) *Involuntary community treatment of people who are violent and mentally ill: A legal analysis*. *Hospital and Community Psychiatry*, 45, 685-9. See above note ; Ferris, R. J., (in press) . *Community treatment programs in Europe and the United Kingdom that have proven effective in preventing violence by the mentally ill in the community: Administrative, organizational and clinical aspects*.

Other jurisdictions apply wide criteria for both inpatient and outpatient commitment (e.g. mental disorder, mental illness etc. without any requirements for the disorder to be of a particular nature or degree of severity). If additional power to treat patients involuntarily in the community is incorporated in such legislation the same objections as those mentioned above will apply. But even countries where apparently strict commitment criteria apply may manage to establish a legal basis for OC by introducing a wide interpretation of the basic legal requirements. That is the case in Norway, which has had OC orders since 1961. The legal criteria are such that OC can only be imposed on patients suffering from a "Serious mental disorder", usually understood as synonymous with a psychotic condition. In a Supreme Court verdict of 1993, however, the court ruled that patients who were taking antipsychotics would have manifested psychotic symptoms if they were not taking medication. Thus they were legally to be regarded as still suffering from a serious mental disorder so long as they were taking antipsychotic medication(s), and could accordingly be placed under an OC order, in spite of a lack - for the time being - of any sign of psychotic symptoms. Thus the patient is being coerced to receive continuing treatment with medication in the absence of overt psychotic symptoms, because of a presumption that serious mental disorder persists, and despite the fact that most patients will have retained competency to accept or refuse treatment.¹⁵ This problem is not unique to Norway, but represents a fundamental problem regarding OC legislation and its implementation.

The underlying question is how far is it ethically (and legally) justifiable to deprive patients of their right to make treatment decisions (or to reject treatment)? Even if experience shows that the decisions patients make are poor and probably not in their best interests, should we not respect their right to make bad decisions as we usually do in physical medicine? Irrationality and incompetency are not the same. The former may be evidence of the latter, but it is illogical to permit those with physical illnesses to make irrational decisions, but not to permit those with mental illnesses to make rational decisions. Where the treatment of mental illness is concerned, the competency of the individual patient will be crucial. But by introducing excessively strict competency standards before mental patients are allowed to make treatment decisions, we will certainly run the risk of violating their autonomy. The problem has been pointed to by others¹⁶, but the solution seems to rest partly on balancing empirical evidence not yet available against value-based attitudes towards patients' right to self-determination.

Mandatory community treatment and allocation of resources

Another matter concerning OC is whether or not legislation authorising OC should include quality of care requirements or not. Though the argument that benefits including high quality care, free services etc. should be offered to those subjected to involuntary treatment seems sound, it

15 Hoyer, G. (1995) *Tilbakeslag for psykiatriske pasienters autonomi og rettssikkerhet (A set-back in autonomy and legal rights of mental patients. In Norwegian)*. Lov og Rett, 21, 151-167.

16 Smith, C. A. (1994) *Use of involuntary outpatient commitment in community care of the seriously and persistently mentally ill patient. Issues in Mental Health Nursing*, 16, 275-84; Geller, J. L., McDermeit, M., Grudzinskas, Jr., et al (1997). *A competency-based*

approach to court-ordered outpatient treatment. New Directions for Mental Health Services, 15, 81-95; Tavolaro, K. B. (1992) *Preventive outpatient civil commitment and the right to refuse treatment: Can pragmatic realities and constitutional requirements be reconciled? Medicine and Law*, 11, 249-67; Geller, J. L. (1986) *The quandaries of enforced community treatment and unenforceable outpatient commitment statutes. Journal of Psychiatry and Law*, 14, 149-158.

often leads to the paradox that services sought on a voluntary basis are compromised.¹⁷ An extreme and paradoxical scenario might see insightful patients lining up eagerly hoping to be committed in order to get access to affordable and acceptable services, because the rest of the services offered on a voluntary basis are too expensive or suffer from a lack of resources. Thus the voluntary treatment alternative will remain less attractive. Involuntary commitment figures will rise artificially, and the positive effect of coercion will most likely be overestimated in outcome studies, as long as a sufficient number of patients formally receiving services under a coercive order are in reality highly motivated to accept the services offered. This potential for skewed quality of care by the introduction of OC orders (or coercive orders in general), should at least call for a close monitoring of the services for such effects.

Outpatient commitment in practice

Even though OC orders have existed for many years in some countries, little is known about how such orders work and to what extent they are used. Generally the utilisation rate of such orders is described as low.¹⁸ Even if this is an accurate generalisation, the variation in the use of coercive orders between countries and jurisdictions is reported to be substantial.¹⁹ More than 40 states in the United States probably have some kind of outpatient commitment statutes²⁰, though there seems to be some difficulty in determining whether such statutes exist or not in a given jurisdiction. This is reflected in the figures reported in the literature: for example Torrey and Kaplan²¹ reported that 35 states had OC orders, while Miller²² found that 42 states had such orders. In Europe, OC orders exist in the majority of the European states. Exceptionally Denmark and Italy have no form of OC, but there may be other countries where this is the situation. The reason for this uncertainty is a complete lack of reviews on OC in Europe. The information on European conditions referred to in this paper is based on an unsystematically performed survey including a selected sample of European countries compiled by Ferris²³ supplemented by information from Finland and The Netherlands. This survey did also reveal that the coercive power of the OC order varied considerably between countries. Of those countries in Europe reporting they had some kind of OC order, approximately half also had the power to treat patients forcibly in the community.

17 Burns, T. (1996) *Community supervision orders for the mentally ill: Mental health professionals' attitudes*. *Journal of Mental Health UK*, 4, 301-308.

18 Hiday, V. A. (1996) *see note 3 above*; Swanson, J. W., Swartz, M. S., George, L. K., et al (1997) *Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model*. *Journal of the American Academy of Psychiatry and Law*, 25, 5-16; Mohan, D., Thompson, C., Mullee, M. A. (1996) *Preliminary evaluation of supervised discharge order in the south and west region*. *Psychiatric Bulletin*, 22, 421-423; Miller, R. D., Fiddleman, P. (1984) *Outpatient commitment: Treatment in the least restrictive environment?* *Hospital and Community Psychiatry*, 35, 147-151

19 Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) *Can involuntary outpatient commitment reduce*

hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals. *American Journal of Psychiatry*, 156, 1968-1975; Hiday, V. A. (1996) *see note 3 above*; Miller, R. D. (1992) *An update on involuntary civil commitment to outpatient treatment*. *Hospital and Community Psychiatry*, 43, 79-81.

20 Miller, R. D. (1992) *note 19 above*.

21 Torrey, E. F., Kaplan, R. I. (1995) *A national survey of the use of outpatient commitment*. *Psychiatric Services*, 46, 778-784.

22 Miller, R. D. (1985) *note 11 above*.

23 Ferris, R. J., (in press) . *Community treatment programs in Europe and the United Kingdom that have proven effective in preventing violence by the mentally ill in the community: Administrative, organizational and clinical aspects*.

Most jurisdictions in both Australia and New Zealand have put in place OC orders including the power to treat patients on an involuntary basis in the community.²⁴

In a recent overview of papers on outpatient commitment in the United States published between 1982 and 1998, 67 papers were identified.²⁵ However, only 22 of these papers were based on original empirical data, and of those, nine were based on data from one state (North Carolina). The most commonly used end-points of the included empirical studies were frequency of re-hospitalisation and the consumption of hospital days during the follow-up period. Though many studies found a reduction in hospital use by those on OC orders²⁶, similar reductions in re-hospitalisation have been found in studies exploring the effect of community treatment programs where patients were not subjected to outpatient commitment orders.²⁷ It is thus impossible to conclude that this outcome can be attributed to the coercive order per se. Nonetheless, some policy-makers refer to the scientific literature as if the efficacy of coerced community orders already had been proven. The preamble to the newly passed so called "Kendra's Law" on outpatient commitment in the state of New York, reads as follows: "Thirty-nine states have laws providing for court-ordered treatment for mentally ill outpatients with histories of failing to comply with prescribed care, and studies show that outpatients subjected to such laws have fewer psychiatric admissions, spend fewer days in hospitals and fewer incidents of violence than similar outpatients not subjected to Court-ordered treatment".²⁸ What makes this statement most remarkable is that prior to the passing of Kendra's Law, the New York Legislature in 1994 passed a bill to establish both a three years pilot project of involuntary outpatient treatment, and a research study to determine the effectiveness of the program was ordered as a part of that bill. In contrast to what was noted in the preamble to Kendra's Law, the actual research report concluded that the outpatient commitment

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- 24 Power, P. (1999) *Community treatment orders: The Australian experience*. *The Journal of Forensic Psychiatry*, 10, 9-15; Mclvor, R. (1998) *The community treatment order: Clinical and ethical issues*. *Australian and New Zealand Journal of Psychiatry*, 32, 223-228.
- 25 Dennis, D. L., (1999) *Tracing the development of outpatient commitment. An annotated bibliography*. In *Coercion in mental health services - international perspectives. Research in community and mental health* (eds J. P. Morrissey & J. Monahan), pp. 209-229. Stamford, Jai Press Inc.
- 26 Swartz, M. S., Swanson, J. W., Wagner, R. R., et al (1999) *Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severe mentally ill individuals*. *American Journal of Psychiatry*, 156, 1968-1975; Fernandez, G.A., Nygard, S. (1990) *Impact of involuntary commitment on the revolving door syndrome in North Carolina*. *Hospital and Community Psychiatry*, 41, 1001-1004; Geller, J. L., Grudzinskas, A. L., McDermeit, M., et al (1998) *The efficacy of involuntary outpatient treatment in Massachusetts administration*. *Policy in Mental Health*, 25, 271-285; Hiday, V. A., & Scheid-Cook, T. L. (1989) *A follow-up of chronic patients committed in outpatient treatment*. *Hospital and Community Psychiatry*, 40, 52-59; Hiday, V. A., & Scheid-Cook, T. L. (1987) *The North Carolina experience with outpatient commitment: A critical appraisal*. *International Journal of Law Psychiatry*, 10, 215-23; Van Putten, R. A., Santiago, J. M., Berren, M. R. (1988) *Involuntary outpatient commitment in Arizona: A retrospective study*. *Hospital and Community Psychiatry*, 39, 953-958; Zanni & DeVeaue, (1986) *Inpatient stays before and after outpatient commitment*. *Hospital and Community Psychiatry* 37: 941-2; Sensky, T., Hughes, I., Hirsch, S. (1991) *Compulsory psychiatric treatment in the community I. A controlled study of compulsory community treatment with extended leave under the mental health act: Special characteristics of patients treated and impact of treatment*. *British Journal of Psychiatry*, 158, 792-799; Munetz, M. R., Grande, T., Kleist, J., et al (1996) *The effectiveness of outpatient civil commitment*. *Psychiatric Services*, 47, 1251-1253; Munetz, M. R., Grande, T., Kleist, J., et al (1997) *What happens when effective outpatient civil commitment is terminated? New Directions for Mental Health Services*, 15, 49-59.
- 27 Marshall, M., Lockwood, A. (1998) *Assertive Community Treatment for People with Severe Mental Disorders*. 1998; *Cohrane Library*. Issue 3. Oxford: Update software
- 28 New York State Assembly. (1999) *New York State Bill A08477*. New York May 21, 1999
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order had no added value related to treatment outcome.²⁹ Thus it seems that the introduction of broad outpatient commitment statutes primarily is driven by public concern about mental patients living in the community, and to a lesser degree on empirically based evidence about how OC works.

If we turn to the *content* of outpatient commitment, very few papers describe the kinds of measures and treatment that patients on OC orders are subjected to. We have been able to identify only one paper based on data from Victoria (Australia) where this kind of data has been recorded. In this study it was found that 98% of the patients on an OC order were receiving forced medication, and for more than 50%, this was the only treatment they received. About 44% of the total sample received counseling or psychotherapy in addition to drugs.³⁰

Implications for research

A number of interesting research questions remain to be answered. First, we need more descriptive studies on how OC orders work.³¹ In particular, we need studies exploring how the orders are enforced (who enforces the law and what do they exactly do? Do they use physical force? Do they inject medication by force in patients' homes? And so forth). Other areas where research is needed include competency evaluations of those placed under OC orders, as well as clinical assessments in relation to the legal requirements underlying OC orders. It would also add important knowledge if prospective studies exploring clinical predictions of need for OC orders could be performed.

The impact of OC orders on the patient-therapist relationship is also a critical aspect to take into account when the benefits and costs of imposing OC are being analysed. Finally the great variations in the use of OC both within and across jurisdictions is another area where research efforts could produce a better understanding of matters influencing the use of such orders.³²

Research problems

As in most studies trying to explore the effectiveness of a particular intervention, studies on OC should carefully consider the kind of end-points that would be appropriate to use. One Australian paper is relatively critical of all American studies in this respect, claiming that "Overseas research, and in particular United States' scholarship, has tended to concentrate on treatment compliance and readmission rates as primary indicators of the "success" of OPC... .Such simple success measures can be criticised for their lack of consideration of patients' needs, and for relying solely on indicators which emerge from a restricted and fiscally derived model of public policy evaluation".³³ In our opinion this critique is not entirely fair, neither is it constructive. The question is whether the kind of outcome measures mentioned are valid measures of success or failure? Based on research on civil commitment, there are reasons to reconsider in particular the use of re-hospitalisation as a

29 Policy Research Associates Inc. (1998), *Research study of the New York City involuntary outpatient commitment pilot program; Final report*. Delmare, NY

30 McDonnel, E., Bartolomew, T. (1997) *Community treatment orders in Victoria: Emergent issues and anomalies*. *Psychiatry, Psychology and Law*, 4, 25-3624.

31 McIvor, R. (1998) *The community treatment order: Clinical and ethical issues*. *Australian and New*

Zealand Journal of Psychiatry, 32, 223-228.

32 Hiday, V. A. (1996) See note 3 above; Miller, R. D. (1992) *An update on involuntary civil commitment to outpatient treatment*. *Hospital and Community Psychiatry*, 43, 79-81; Power, P. (1999) *Community treatment orders: The Australian experience*. *The Journal of Forensic Psychiatry*, 10, 9-15.

33 See above note 30.

measure of failure.³⁴ It could as well be taken as an indication of success provided the re-admission is voluntary and the result of a process where the final decision rests with the patient. Furthermore, there seems no reason to believe that patient-therapist relationship variables like “voice”, “procedural justice”, “fairness” etc. are of less importance in outpatient settings compared with those that apply to patients being civilly committed as inpatients.³⁵ The lesson from inpatient civil commitment studies, namely that legal status is an extremely poor measure of coercion, seems to be overlooked in many studies on OC which rely on comparisons made between those legally on an out-patient commitment order to those who are not.

Another problem to be addressed concerns comparisons between OC and alternatives. If you compare patients on OC orders to those civilly committed as inpatients in randomised trials, the conclusions that can be drawn from such studies are limited. You can compare the course of the mental illness between inpatient and outpatient treatment programs, but the question on the effect of adding coercion to outpatient treatment programs cannot be answered. The justification for OC is based on the underlying assumption that it is the coercive power per se that will make the difference compared to outpatient programs offered on a voluntary basis. To answer this question OC programs can only be evaluated in comparison with other non-coercive programs. In the last case careful attention should be paid to the kind of outpatient treatment chosen as comparison. There is for instance some evidence that high quality assertive community treatment (ACT) programs (i.e. well staffed, low caseload per staff, 24 hours outreach service etc.) actually improve outcome³⁶ compared to other voluntary outpatient treatment programs. But should OC programs always be compared to “state of the art” programs, (or theoretically even better programs), or is it methodologically sound only to ensure that the OC group and controls receive the same treatment in the community (even if this treatment is lacking in quality and quantity)? If patients on OC orders are doing better than voluntary outpatients when both groups are offered a standard treatment program, it is not certain that the same result could be demonstrated if the outpatient treatment program offered was the best conceivable program ever. So even in randomised studies where both groups get the same treatment (except for the involuntary/voluntary dimension), one must be aware of the potential impact of the quality of the actual treatment program. Unfortunately, the possibility of carrying out randomised controlled trials in this field seems remote. Most studies must take place in naturalistic settings with the inherent problems of selection bias. Ethical oversight of studies often adds to the problem by imposing requirements (which may vary between different ethical review boards) for informed consent, and thus excludes the more disturbed patient from studies. Security and safety concerns may also limit the possibility of including potentially dangerous or suicidal patients in randomised studies, both groups who are at great risk of being subjected to civil commitment.

34 Draine, J. (1997) *Conceptualizing services research on outpatient commitment*. *Journal of Mental Health Administration*, 24, 306-315.

35 Lidz, C.W., Hoge, S. K., Gardner, W., et al (1995) *Perceived coercion in mental hospital admission*. *Archives*

of General Psychiatry, 52, 1034-1035; Hiday, V. A., Swartz, M. S., Swanson, J. et al (1997) *Patient Perceptions of Coercion in Mental Hospital Admission*. *International Journal of Law and Psychiatry*, 20, 237-241.

Other important issues regarding research on OC

This paper has not discussed matters such as the introduction of mental health advanced directives (MHAD) in relation to OC orders, though MHAD may have the potential to resolve some of the problems related to treatment refusal.³⁷ Another topic, also not discussed, is the variation in existing competency tests. As competency is one of the major theoretical and practical issues relating to the implementation of OC programs, it would be appropriate to scrutinise such tests and establish their reliability and validity through research. Nor has the time scale of OC orders been scrutinised. When is the appropriate time to cancel OC orders (presuming that such orders have been effective)³⁸, and what criteria should be employed? Equally, how long is the appropriate follow-up time in studies looking at the effect of OC programs, just to mention some questions related to time.

Conclusion

Even if some studies suggest that OC orders reduce re-hospitalisation rates, it has not been established that this effect can be attributed to the use of coercive orders *per se*. The increased emphasis on involuntary outpatient treatment raises a series of value based questions about fundamental issues such as patients' autonomy and its potential erosion by the introduction of broader coercive measures in a community setting. As most of the arguments both for and against OC orders are not empirically based, and as mandatory community treatment is likely to increase in the years to come, priority should be given to research on the effectiveness and efficacy of mandatory community treatment. Whilst the design and implementation of such studies are likely to be problematic in respect of both the ethical and logistic issues raised above, they are certainly needed in order to help us understand the consequences of our choices regarding mandatory community treatment.

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36 Marshall, M., Lockwood, A. (1998) *see note 27 above.*

37 Srebnik, D. S., & LaFond, J. O. (1999) *Advanced directives for mental health treatment. Psychiatric Services, 50, 919-925; Backlar, P. (1997) Ethics in community mental health care. Anticipatory planning for psychiatric treatment is not quite the same as*

planning for end-of-life care. Community Mental Health Journal, 33, 261-268.

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