National Coalition for Mental Health Recovery

Involuntary Outpatient Commitment – Citations and Abstracts

Introduction

Under Involuntary Outpatient Commitment (IOC), a person with a serious mental health condition is mandated by a court to follow a specific treatment plan, usually requiring the person to take medication and sometimes directing where the person can live and what his or her daily activities must include.

Research on the effectiveness and impact of this practice, which involves compulsory treatment, raises concerns about the negative effects and the necessity of this approach. The following abstracts summarize some of this research. For more information on these citations or involuntary outpatient commitment, contact media@ncmhr.org.

Citations and Abstracts

Allen, M., & Smith, V.F. (2001). Opening Pandora's box: The practical and legal dangers of involuntary outpatient commitment. *Psychiatric Services, 52*(3): 342-346.

> Abstract: Policy makers have recently begun to reconsider involuntary outpatient commitment as a means of enhancing public safety and providing mental health services to people deemed to be noncompliant with treatment. The authors review the therapeutic claims for outpatient commitment and take the position that there is insufficient evidence that it is effective. They offer arguments that outpatient commitment may not improve public safety and may not be more effective than voluntary services. The authors further point out that **outpatient commitment may undermine the delivery of voluntary services and may drive consumers away from the mental health system.** The authors conclude that outpatient commitment programs are vulnerable to legal challenge because they may depart from established constitutional standards for involuntary treatment.

Burns T, Rugkåsa J, Molodynski A. et al. (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial, *Lancet 381*:1627-33.

> Background**:** Compulsory supervision outside hospital has been developed internationally for the treatment of mentally ill people following widespread deinstitutionalisation but its efficacy has not yet been proven. Community treatment orders (CTOs) for psychiatric patients became available in England and Wales in 2008. We tested whether CTOs reduce admissions compared with use of Section 17 leave when patients in both groups

receive equivalent levels of clinical contact but different lengths of compulsory supervision.

Methods: OCTET is a non-blinded, parallel-arm randomised controlled trial. We postulated that patients with a diagnosis of psychosis discharged from hospital on CTOs would have a lower rate of readmission over 12 months than those discharged on the pre-existing Section 17 leave of absence. Eligible patients were those involuntarily admitted to hospital with a diagnosis of psychosis, aged 18—65 years, who were deemed suitable for supervised outpatient care by their clinicians. Consenting patients were randomly assigned (1:1 ratio) to be discharged from hospital either on CTO or Section 17 leave. Randomisation used random permuted blocks with lengths of two, four, and six, and stratified for sex, schizophrenic diagnosis, and duration of illness. Research assistants, treating clinicians, and patients were aware of assignment to randomisation group. The primary outcome measure was whether or not the patient was admitted to hospital during the 12-month follow-up period, analysed with a log-binomial regression model adjusted for stratification factors. We did all analyses by intention to treat. This trial is registered, number ISRCTN73110773.

Findings: Of 442 patients assessed, 336 patients were randomly assigned to be discharged from hospital either on CTO (167 patients) or Section 17 leave (169 patients). One patient withdrew directly after randomisation and two were ineligible, giving a total sample of 333 patients (166 in the CTO group and 167 in the Section 17 group). At 12 months, despite the fact that the length of initial compulsory outpatient treatment differed significantly between the two groups (median 183 days CTO group vs 8 days Section 17 group, $p<0{\cdot}001$) the number of patients readmitted did not differ between groups (59 [36%] of 166 patients in the CTO group vs 60 [36%] of 167 patients in the Section 17 group; adjusted relative risk 1·0 [95% CI 0·75—1·33]).

Interpretation**: In well-coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty**.

Kisely, S. R., Campbell, L.A., and Preston, N. J. (2011). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. DOI: 10.1002/14651858.CD004408.pub3

Background: There is controversy as to whether compulsory community treatment for people with severe mental illnesses reduces health service use, or improves clinical outcome and social functioning. Given the widespread use of such powers it is important to assess the effects of this type of legislation.

Objectives: To examine the clinical and cost effectiveness of compulsory community treatment for people with severe mental illness.

Search Strategy: We undertook searches of the Cochrane Schizophrenia Group Register 2003, 2008, and Science Citation Index. We obtained all references of identified studies and contacted authors of each included study.

Selection Criteria: All relevant randomised controlled clinical trials of compulsory community treatment compared with standard care for people with severe mental illness.

Data Collection and Analysis: We reliably selected and quality assessed studies and extracted data. For binary outcomes, we calculated a fixed effects risk ratio (RR), its 95% confidence interval (CI) and, where possible, the weighted number needed to treat/harm statistic (NNT/H).

Main Results: We identified two randomised clinical trials (total n = 416) of court-ordered 'Outpatient Commitment' (OPC) from the USA. **We found little evidence that compulsory community treatment was effective in any of the main outcome indices:** health service use (2 RCTs, n = 416, RR for readmission to hospital by 11-12 months 0.98 CI 0.79 to 1.2); social functioning (2 RCTs, n = 416, RR for arrested at least once by 11-12 months 0.97 CI 0.62 to 1.52); mental state; quality of life (2 RCTs, n = 416, RR for homelessness 0.67 CI 0.39 to 1.15) or satisfaction with care (2 RCTs, n = 416, RR for perceived coercion 1.36 CI 0.97 to 1.89). However, risk of victimisation may decrease with OPC (1 RCT, n = 264, RR 0.5 CI 0.31 to 0.8). In terms of numbers needed to treat (NNT), it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest. The NNT for the reduction of victimisation was lower at six (CI 6 to 6.5). A new search for trials in 2008 did not find any new trials that were relevant to this review.

Conclusions: **Compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. People** receiving compulsory community treatment were, however, less likely to be victims of violent or non-violent crime. It is unclear whether this benefit is due to the intensity of treatment or its compulsory nature. Evaluation of a wide range of outcomes should be considered when this type of legislation is introduced.

Molodynski, A., Turnpenny, L., Rugkasa, J., Burns, T., & Moussaoui, D. (2014). Coercion and compulsion in mental healthcare—An international perspective. *Asian Journal of Psychiatry, 8*: 2-6. DOI: http://dx.doi.org/10.1016/j.ajp.2013.08.002

Background: Coercion has always existed in psychiatry and is increasingly debated. The 'move into the community' in many countries over recent decades and the evolution of community services have substantially altered the locus of coercion. In many countries psychiatric services remain poorly funded and patchy. Substantial differences between regions and countries in the provision of services, the role of the family, and the wider economic and political climate are likely to lead to different sources and experiences of coercion.

Discussion: This paper explores a number of factors that may affect the prevalence and type of coercion in psychiatric services and in society and their impact upon those with severe mental illnesses. Differences in service provision are explored and wider societal issues that may impact are considered along with relevant evidence.

Conclusions: Coercion is commonly experienced by those with severe mental illnesses but is poorly understood. The vast majority of research relates to High Income Group countries with developed community services and formal mental health legislation that adopt the so-called 'medical model'. **Further research and collaboration is urgently required to increase our understanding of these issues, which are difficult to define and measure. An evidence base that is relevant worldwide, not just to a small group of countries, is needed to inform training and the care of all patients.** A particular focus must be expanding our knowledge and understanding of coercion in cultures outside those where such research has traditionally taken place to date.

Ridgely, M., Borum, R., and Petrila, J. (2001). The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. RAND Institute for Civil Justice. Retrieved from: http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1340.pdf

Summary: Many states use civil commitment — a statutorily created and court-ordered form of compulsory treatment — to compel people with mental illness who become gravely disabled or dangerous to themselves or others to undergo treatment. In the last decade, many states have amended or interpreted their existing civil commitment statutes to allow for involuntary outpatient treatment. Such a law has been proposed for California. At the request of the California State Senate, the authors conducted a systematic literature review on involuntary outpatient commitment; examined the experience of eight other states including statutory analysis and in-depth interviews with attorneys, public officials, and psychiatrists; and analyzed California administrative data for all persons served by California's county contract mental health agencies. They found that involuntary outpatient commitment, when combined with intensive mental health services, can be effective in reducing the risk of negative outcomes. But whether a court order in and of itself has any effect is an unanswered question. However, **there is clear evidence that intensive community-based voluntary mental health treatment can produce good outcomes**. There are no cost effectiveness studies that compare the relative return on investment in developing an involuntary outpatient treatment system or focusing all available resources on developing state-of-the-art treatment systems. Either approach would require a sustained commitment by California policymakers.

Rowe, M., (2013). Alternatives to outpatient commitment. *J. of Am. Acad. Of Psychiatry and the Law,41*(3): 332-336.

Conclusions: On balance, after more than 20 years of mandates and programs, outpatient commitment remains a costly, coercive, and unproven approach. **More promising, and proven, practices are available. Through building on such practices and increasing the availability of services, effective mental health care can be provided to persons**

with serious mental illness who are not presently receiving care, including the very small percentage of those among this group who are at risk of violence toward others.

Steadman, H., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., and Robbins, P. 2001. Assessing the New York City Involuntary Outpatient Commitment Pilot Program. *Psychiatric Services. 52*(3): 330-336. DOI: http://dx.doi.org.ezproxyles.flo.org/10.1176/appi.ps.52.3.330

Objective: The study evaluated the effectiveness of a three-year outpatient commitment pilot program established in 1994 at Bellevue Hospital in New York City.

Methods: A total of 142 participants were randomly assigned; 78 received court-ordered treatment, which included enhanced services, and 64 received the enhanced-service package only. Between 57 and 68 percent of the subjects completed interviews at one, five, and 11 months after hospital discharge. Outcome measures included rehospitalization, arrest, quality of life, symptomatology, treatment noncompliance, and perceived level of coercion.

Results: On all major outcome measures, **no statistically significant differences were found between the two groups**. No subject was arrested for a violent crime. Eighteen percent of the court-ordered group and 16 percent of the control group were arrested at least once. The percentage rehospitalized during follow-up was about the same for both groups-51 percent and 42 percent, respectively. **The groups did not differ significantly in the total number of days hospitalized during the follow-up period**. Participants' perceptions of their quality of life and level of coercion were about the same. From the community service providers' perspective, **patients in the two groups were similarly adherent to their required treatments.**

Conclusions: All results must be qualified by the fact that no pick-up order procedures for noncompliant subjects in the court-ordered group were implemented during the study, which compromised the differences between the conditions for the two groups, and that persons with a history of violence were excluded from the program.