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Ambivalence about community treatment orders[☆]

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1. Introduction

The trend to endorse the use of outpatient commitment, or community treatment orders (CommTOs) (the terms are equivalent), seems to be gathering momentum. There is now some empirical evidence and a significant body of clinical opinion to suggest that CommTOs can affect clinical outcomes when properly established, resourced, and sustained. Their range has been extending in North America to cover New York and Ontario, for instance. Their introduction is actively under consideration in England and Wales (Department of Health, 2000). They are used extensively in Australia and New Zealand (Dawson, 1991; Dawson & Romans, 2001; Power, 1999; Vaughan, McConaghy, Wolf, Myhr, & Black, 2000). It seems CommTOs are now politically acceptable in many places.

The general question we wish to pose about CommTOs is why, despite this gathering momentum, there remains such widespread ambivalence about their use. In addition, what are the reasons for this ambivalence? Does it flow only from the inadequate and conflicting nature of the evidence concerning their efficacy, or is the problem more fundamental and less easily resolved?

2. The empirical evidence

Certainly, there are problems with the existing evidence and with the empirical approaches taken so far. The few studies conducted have produced conflicting results (Appelbaum, 2001; Ridgeley, Borum, & Petrila, 2001). There are also serious difficulties in finding ethical and

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lawful research designs that isolate the effect of the CommTO for independent study when its implementation is deeply enmeshed with the infrastructure of the community mental health system and with adequate enforcement of the statutory scheme (Dawson, King, Papageorgiou, & Davidson, 2001; Swartz et al., 1997).

The four main methods used to evaluate this form of treatment delivery all have significant limitations.

Many of the studies have adopted a before-and-after approach: comparing, for instance, rates of hospitalization in the years before and after patients were on the CommTO (Rohland, Rohrer, & Richards, 2000; Zanni & de Veau, 1986). The results often showed substantial reductions in inpatient stays in the later period. However, as Appelbaum (2001) has observed, these studies do not control for the effects of any intervening period of inpatient care, or for the associated social interventions, which may provide an alternative reason for the better patient outcomes at the later time. Nor do they take into account the changing character of the community mental health system or the fact that better tolerated and more effective medications may become available.

A second approach has been to follow and compare patients discharged to a CommTO with patients discharged to voluntary outpatient care (Hiday & Scheid-Cook, 1989). The difficulty with many of these studies is that the groups followed are not randomly assigned, so they may not be comparable. In Appelbaum's (2001, p. 348) words, there is "the possibility that patients with a better prognosis might have been selected for involuntary outpatient treatment, thus biasing the findings in favor of the intervention." It is possible, for instance, that patients whose treatment would be more acceptable to community mental health staff are advanced by clinicians for CommTOs. This is a potentially researchable question.

A third approach, attempted by Geller, Grudzinskas, McDermeit, Fisher, and Lawlor (1998) in Massachusetts, is to follow and compare two groups of paired patients who have been carefully matched on numerous relevant criteria—diagnosis, age, gender, previous admissions, etc. One group would then be treated under the CommTO, or an equivalent legal regime, the other offered voluntary outpatient care. This approach seems more likely to produce two otherwise similar groups for comparison, but the doubt will remain whether the two groups have been accurately matched on other relevant criteria (e.g., likely response to medication, or effective social support). These further differences between the two groups might explain why some patients, and not others, were placed under compulsory outpatient treatment in the first place, and would again bias the findings. Only 19 pairs were matched in the Massachusetts study, in any case, providing limited statistical power; no significant differences in outcome were found.

In these circumstances, it is not surprising that Swartz et al. (1995) in North Carolina recommended use of the prospective, randomized controlled trial to try to measure the impact of outpatient commitment in a more definitive manner. Two such studies have now been conducted, in New York and North Carolina.

The New York study was conducted under clear legislative authority, reducing the potential legal problems (Policy Research Associates, 1998). However, this was an attempt to evaluate a pilot scheme only. At the time of the study, this scheme was not fully embedded in the available clinical and social service structures, nor was adherence to outpatient

treatment rigorously enforced (Telson, Glickstein, & Trujillo, 1999). Thus, considerable doubt remains whether the compulsory and voluntary groups were really treated any differently and it is not surprising that no significant variations in outcome were found (Appelbaum, 2001; Steadman et al., 2001).

In North Carolina, a fully embedded statewide scheme was studied, although more resources were injected into the community mental health system in the relevant region during the period of the research. The patients in the trial were recruited at a state hospital, then assigned to continue under the outpatient commitment regime or to discharge to voluntary outpatient care. The two groups were then followed for a year to see whether outcome differences emerged (Swartz et al., 1999). This was a remarkable experiment. Its authors have argued that its results demonstrate that sustained use of outpatient commitment, when combined with intensive treatment, can reduce inpatient stays and the prevalence among such patients of violence, arrest, and victimization (Hiday, Swanson, Swartz, Borum, & Wagner, 2001; Swanson et al., 2000, 2001; Swartz et al., 1999).

Even this study has limitations. Although necessary for ethical and legal reasons, the significance of the study was reduced by the exclusion from random assignment of patients known to have recently engaged in violence. In addition, the validity of the comparison between the two groups is thrown into doubt by attrition from the compulsorily treated group of those patients who were subsequently released from compulsion through the operation of the mandatory review procedures prescribed by the legislation, of which they could not be deprived. Release of some patients following those reviews inevitably led to their being dropped from the compulsory outpatient group. This, in turn, meant that assignment of the two groups still being followed was no longer fully random after the first reviews occurred; this may be the reason why differences in outcome between these two groups gained in significance as the length of time patients spent under outpatient commitment increased. Szumukler and Hotopf (2001, p. 654) have suggested that the study's results may therefore reflect "a bias in which involuntary outpatient commitment was selectively extended when it seemed to be helping the patient."

The researchers have argued in response that any such bias arising from attrition from the compulsorily treated group is likely to be in the opposite direction, because those patients for whom the order was extended were likely to be "at higher baseline risk for hospitalization" (Swartz et al., 2001, p. 655). On that view, attrition through discharge from the compulsorily treated group might be expected to elevate progressively rates of hospitalization in those who remained under the order. Yet, the opposite outcome was found: extended use of outpatient commitment, combined with intensive treatment, appeared to reduce rates of hospitalization in comparison with the voluntarily treated group.

The problem is that we do not know why some patients were discharged from the compulsorily treated group or why their orders were not extended when they expired. Both the factors identified by the critics and by the researchers may be at work, albeit with opposite effects. Therefore, it is still legitimate to reach the conclusion that attrition through discharge from the outpatient commitment group undermined the initial randomization.

Identification of this limitation in the research is less a criticism of the methods adopted in North Carolina than an inevitable feature of a naturalistic experiment conducted with an

ongoing statutory scheme. However, it throws a cloud over the results. Thus, there is still no entirely convincing empirical study of the effectiveness of CommTOs, even in a single jurisdiction. Perhaps there never will be.

Even if an ideal study was conducted, there would still be the further problem that its results could not be readily generalized to other jurisdictions, with different populations and culture, different legislation, and different service delivery and reimbursement systems, many of which are also in a state of flux.

To take the North Carolina example again: the statutory regime studied there offered limited means for enforcing outpatient medication without consent, the study was conducted in a largely rural area, and the patients in both arms of the trial were offered intensive community treatment. It would not be safe to generalize the results of such a study to another jurisdiction where the statute contained different enforcement provisions. Nor could its results be readily applied to a large urban area or to a situation in which more limited community services were available, as is often the case.

There are therefore many problems with the existing empirical database, although the groups in North Carolina, New York, and Massachusetts have made considerable efforts to improve it. It was these kinds of difficulties that led the authors of two recent literature reviews to conclude: “The lack of empirical evidence about the comparative effectiveness of involuntary versus voluntary treatment is troubling—decisions may be influenced more by advocacy than by fact” (RAND, 2001, p. 4), and “It appears that it is not research evidence that is the driving force behind the possible introduction of compulsory community powers” (Pinfold & Bindman, 2001, p. 270).

Appelbaum (2001) and Geller (1986a, 1986b, 1990) are nevertheless right to emphasize that many other current practices in psychiatry lack definitive empirical support (as in medicine in general), and that in this common situation we should not ignore experienced clinicians’ support for compulsory community care. However, lack of definitive empirical support is still a major source of many people’s ambivalence concerning CommTOs.

3. Beyond empirical evidence

We wish to emphasize, however, that even if these empirical questions could be resolved, ambivalence about CommTOs would still continue, due to the presence of other conceptual and evaluative difficulties that cannot be resolved through empirical means. These difficulties concern such matters as the meaning of liberty for the severely mentally ill and how to weigh the success of CommTOs on some criteria—such as reduced rates of hospitalization—against their negative impact on other criteria—such as increased levels of perceived coercion on the part of patients, or increased fear of coercion on the part of service users in general (Geller, 1986a; MIND, 1999; Mulvey, Geller, & Roth, 1987).

Further, we must balance the degree of satisfaction expressed by different participants in the process—by clinicians, patients, families, judges, etc.—whose opinions often conflict; and we have to cope with the relative and equivocal nature of the evaluations often made. A common view, for instance, is that use of CommTOs is more desirable than prolonged

inpatient care, or more desirable than unnecessary imprisonment, which may both be alternatives, but less desirable than a voluntary therapeutic alliance. Is such an equivocal assessment of CommTOs to be taken as a positive or negative judgment overall?

There is also the wider concern—expressed in the current law reform debate in England—that introducing CommTOs may have negative implications for the mental health system in general, e.g., that it may legitimize the provision of inadequate community services or expand the scope of compulsion to new groups of patients (MIND, 1999; Pinfold & Bindman, 2001).

To summarize, ambivalence about CommTOs arises from all the following concerns:

- the inadequate and conflicting evidence concerning their efficacy;
- the ethical, legal, and other methodological problems with the research designs;
- the existence of conflicts between potential criteria of success and between different stakeholders' perspectives;
- the absence of any definite criterion of overall success;
- the relativity of the judgment that CommTOs are better than *X* but worse than *Y*;
- the codependence of CommTOs on the community mental health infrastructure;
- widespread concern that their use is less than optimal.

We would add to these sources of ambivalence a further set of difficulties for the evaluation of CommTOs that arise from certain paradoxes that are consistently observed and that have no obvious resolution. In our view, the persistence of these paradoxes, or conundrums, provides an additional source of doubt, or this is an alternative way to describe the conflicting phenomena frequently observed.

To illustrate this, we will discuss three sets of paradoxical or ambiguous phenomena, which we will call:

- Paradoxes of design
- The dilemma of discharge, or the paradox of success; and
- The puzzling case of volunteers for compulsion.

4. Paradoxes of design

This is our name for the many ways in which CommTO legislation may be designed in a self-defeating fashion from the start, i.e., in a manner that ensures its failure or nonuse.

An example of this self-defeating approach is the phenomenon observed with the legislation in some jurisdictions that only patients who do *not* meet the legal criteria for use of the CommTO may be considered suitable candidates for treatment under this regime (Geller, 1986b).

The legal criteria for use of CommTOs vary in the different jurisdictions, but if they include the requirement of an imminent threat of serious harm to self or others, and that requirement *is met*, then arguably such persons should remain in inpatient care. They would therefore be ineligible for the CommTO regime. If, on the other hand, they do *not* meet that

requirement, then arguably they should be fully discharged from compulsion, as the statute would demand. In such a case, either there would be no suitable candidates for the CommTO or all those on the order would be unlawfully compelled. The presence of this paradox would help explain why some CommTO statutes are very lightly used.

This problem is not universal, and we do not think it is a significant problem in New Zealand, but it has been identified as an obstacle in those jurisdictions that adopt imminent risk of harm to self or others as a necessary condition of outpatient commitment or which apply the same tight legal criteria to outpatient commitment as are applied to compulsory inpatient care (Allen & Smith, 2001; Appelbaum, 2001).

The recent CommTO legislation in Ontario may partly illustrate this problem, although in a slightly different form. The criteria for use of CommTOs in Ontario seem to have been drawn so narrowly, perhaps with a view to surviving constitutional challenge, that the consent of the patient (whenever competent), or of a substitute decision-maker, is required before treatment under the CommTO may proceed, even when the patient meets the other criteria for compulsory care.¹ This consent requirement might prevent the use of CommTOs with those patients for whom many clinicians would consider them most helpful: those who will *not* consent to the sustained administration of outpatient medication, but again relapse and require inpatient care. The Ontario statute, while showing an admirable degree of respect for patients' autonomy, might then go virtually unused. Such a paradoxical situation is likely to generate considerable ambivalence about the value of that statutory scheme.

These examples concerning the criteria for use of CommTOs illustrate the more general problem we are calling the paradox of design: the problem that CommTO legislation may be subverted from the start. There are numerous other policy errors that may have the same effect:

- failure to provide in the legislation any practical means of ensuring compliance with medication by those under involuntary treatment;
- imposing overly cumbersome procedural requirements on clinicians, either when a CommTO is to be made or reviewed, or when clinicians are convinced outpatient status should be revoked;
- exposing clinicians unnecessarily to the threat of liability for the conduct of compulsory outpatients whose actions they cannot effectively control;
- requiring an unaffordable or unavailable level of services to be delivered to compulsory outpatients.

A major lesson we draw from the literature is that if the CommTO regime is not well designed and properly resourced from the start, it is probably not worth having, and advanced sensitivities to patients' civil liberties are probably better expressed through total opposition to CommTOs than through support for an unenforceable and overly bureaucratic statutory scheme.

¹ Brian's Law, Mental Health Legislative Reform Act, 2000, s 33.1(4)(f) (Ontario).

5. Avoiding paradoxes of design: The New Zealand approach

In our view, New Zealand has avoided many of these difficulties, but only through enacting legislation that some people will consider overly coercive and that might not survive constitutional challenge in North America.²

The civil commitment criteria in New Zealand are sufficiently broad to cover patients suitable for extended periods of outpatient care. To be treated compulsorily as an in- or outpatient, the person must present an “abnormal state of mind (whether of a continuous or *an intermittent* nature)” (our italics). This must be “characterised by delusions, or by disorders of mood or perception or volition or cognition,” and it must be “of such a degree that it poses a serious danger to the health or safety of that person or of others” or “seriously diminishes the capacity of that person” for self-care (Section 2). Involuntary treatment must also be “necessary.” Further criteria then apply to compulsory *community* care. It must be shown that outpatient treatment would be appropriate and available, and that the social circumstances of the patient in the community would be adequate (Section 29). These criteria have been broadly interpreted by the judiciary and review tribunals to cover patients whose history clearly suggests they would relapse if not required to accept medication under the CommTO regime: *Re PT* [2001] New Zealand Family Law Reports 79–87.

The New Zealand statute has clear mechanisms of enforcement.³ It states that the effect of the CommTO is to “require the patient to attend. . .for treatment” by a designated outpatient service and “to accept. . .treatment” as directed by the responsible clinician. Staff members are authorized to enter the patient’s place of residence “at all reasonable times. . .for the purpose of treating the patient.” If patients do not comply, they may be taken to an outpatient clinic for treatment to be administered or returned to inpatient care. The police may be called to assist the health professionals if required. Throughout, such force may be used as is “reasonably necessary in the circumstances,” although in practice the use of force to administer medication in outpatient settings is said to be very rare. There is no need for an immediate formal hearing on the revocation of outpatient status, although the patient remains entitled to an independent review at six monthly intervals before a court or tribunal. This is undoubtedly a powerful and potentially intrusive regime.

Under this scheme, there is considerable flexibility for clinicians to move patients rapidly between in- and outpatient status without excessive administrative burden. In effect, the order is for involuntary treatment, with clinicians deciding where that treatment should occur. There is no evidence that the existence of this regime has expanded the number of those subject to compulsory treatment as a whole, as the total number of patients under compulsion has remained relatively stable in New Zealand for many years ([Ministry of Health, annual publication](#)).

Much of the work of monitoring patients under such orders is performed by assigned “keyworkers,” often experienced psychiatric nurses, who visit patients at their place of

² Mental Health (Compulsory Assessment and Treatment) Act 1992 (New Zealand).

³ Mental Health (Compulsory Assessment and Treatment) Act 1992 (New Zealand), Sections 28, 29, 40, 41, 122B, as amended in 1999.

residence. This may permit the development of a long-term therapeutic alliance, which might not otherwise be maintained.

In addition, there are few liability concerns for community clinicians in New Zealand, as a statutory system of no-fault insurance covers all personal injuries caused by medical malpractice, and there is no entrenched bill of rights that might permit a direct constitutional challenge to the CommTO regime.

In these somewhat unique circumstances, there is no major organized opposition to the use of CommTOs in New Zealand, even from patient advocacy groups, and most psychiatrists appear to consider them a useful strategy for managing transitions between hospital and community of long-term patients with psychotic disorders (Dawson & Romans, 2001).

6. The dilemma of discharge and the lack of a definite criterion of success

A further dilemma, or paradox, may arise in relation to the decision to discharge a patient from a CommTO. It arises because there is no definite criterion of success in compulsory community care.

The dilemma concerning discharge can be stated in the form of a question: is long-term use of the CommTO, without the patient's readmission to inpatient care, to be considered a *successful* or an *unnecessary* (and therefore overly *coercive*) form of intervention? On one view, such long-term use of the order is a resounding success, because inpatient care is being avoided, a primary aim. On another view of the same situation, however, the order is being extended unnecessarily, because the patient has now *achieved* community stability, so should be fully discharged.

A paradox is presented because the longer the order extends without the patient's readmission, the more successful and the more unnecessary the order seems to be. How can the correct moment for discharge be determined when there is no decisive criterion of overall success?

Numerous different criteria can be used to measure the success of CommTOs:

- improved quality of life, mental health, or social functioning of patients
- fewer days inpatient care
- fewer compulsory admissions
- increased compliance with medication
- increased contact with health professionals
- fewer incidents of harm or victimization
- reduced levels of perceived coercion on the part of patients
- reduced levels of substance misuse
- earlier identification of relapse
- increased satisfaction with care, on the part of patients, families, carers, the police, etc.

In individual cases, use of the order may appear to succeed on some criteria but fail on others. The patient may spend less time in hospital but experience a higher level of coercion.

Or there may be earlier identification of the patient's relapse, but more time spent in hospital as a consequence. Is use of the CommTO in such cases to be considered a success or failure overall?

The dilemma of discharge illustrates this problem at a particular point in the process. One responsible clinician, interviewed in our research into CommTOs in southern New Zealand, said of the discharge decision:

Some of my patients are elated when finally discharged. They say: "At last, I'm finally free." Does this mean the order has been used successfully, or for too long? It was a success in that the patient could be discharged and so experience this elation. But that elation indicates how coerced the patient had felt under the CommTO. Should they have been discharged earlier? What are the indicators for overall success?

The lack of a definite criterion of success leads to ambivalence in the psychiatrist concerning the discharge decision, and it can lead to conflicting interpretations of the same phenomenon: long-term use of the CommTO without readmission to inpatient care.

The clinician is not bound to accept the patient's sense of coercion as a decisive indicator for discharge. However, the patient's preferences should still be weighed against the other treatment objectives, and the clinician may then be left with the dilemma that the CommTO appears to succeed on some criteria, but fail on others, and there is no authoritative process of reasoning to indicate when continued use of the CommTO is beneficial as a whole.

7. Volunteers for compulsion

A third conundrum concerns the puzzling position of those patients who appear to embrace CommTOs as a form of advance directive for compulsory care. There are some patients who seem to consent, although not always at the outset, to treatment under the compulsory regime. However, why should they be compelled if they are genuinely volunteers?

This paradoxical situation seems to arise partly from the ambivalent or fluctuating attitude of some patients to their treatment and partly from the ambiguous character of the CommTO, which may have both advantages and disadvantages for the patient.

Not all patients are positive about CommTOs, of course. Some remain strongly opposed. In interviews, patients have said they feel stigmatized, under supervision, restricted, dictated to, and that it was "mainly negative really, but it saved my life." Other patients have limited understanding of their position, or of the order's significance, and some deny they are on the order at all.

Nevertheless, there are some patients who appear to be volunteers for compulsion. They have said the CommTO is: "part of my personal risk management plan," "a protection," "to ensure I get admitted," "to guarantee services," "to stop me getting too unwell," "to keep me safe," "you know if you flip out they will put you in the hospital," "you have care straight there," "you move through the system in a tighter circle," and "I like how it is worded, a *community* treatment order, because it is the people around you who are helping you."

Some health professionals have also described the CommTO as a “flag,” a “sign,” or a “ticket”—to rapid readmission or to prioritization within scarce services, which both patients and their families value. It may be said that an *order* should not be required for this purpose; but what if the order does have the effect of giving priority within scarce services to those whose treatment has been found, in the past, to be most urgently required? Perhaps CommTOs focus the attention of clinicians on the most severely ill patients, even if they are difficult to treat.

Some orders therefore appear to be made with the consent of patients or the order is not opposed. There are also patients who do not wish to be discharged from the order and do not apply for formal reviews, even when fully aware of their entitlements.

This situation illustrates the complexities of freedom and choice and the problem of defining patient liberty in compulsory community care. It is clear from our interviews that *some* patients do *not* view complete discharge from the CommTO as the least restrictive option *for them*. They value being held metaphorically in a system of protection and support.

These complexities were well displayed by the first patient interviewed in our current research, a qualitative study of the use of CommTOs in Otago. The man interviewed was in his late thirties, with a long psychiatric history and a diagnosis of paranoid schizophrenia. He had been considered very difficult to treat in the past, had a history of dangerous substance misuse, had been under the care of the forensic service, and at one point had spent 6 ½ years in continuous inpatient care. At the date of interview, he had passed through an extended period under a CommTO. He had then been completely discharged. Now he was living independently, although receiving continuing outpatient care. Here are some extracts from an interview with him concerning use of the CommTO.

The order is just a back up, for reassurance from the health system, so they know you are still there and focused on being good in the community, to make sure that you are doing well and feeling comfortable about the order. I would have been a loose cannon and still drinking and smoking dope all the time.

It puts pressure on in a polite way. They said you have to stay at [a supervised group home] clean for a year, so I got into glass blowing and art work and things that my mind would enjoy.

Lots of my friends, as soon as they are off the order, they think they're free and they just go and do their thing. That is OK, everyone's got their freedom of choice, but it can be disruptive to your mind as well. . .

Question: Did you feel like you had to take the medication because you were on the CommTO?

Patient: Not just because of that effect, because I was frightened of having delusions again and hearing voices.

Question: Do you think the CommTO helped you to stay on medication? Or was it more your choice?

Patient: It was their choice. But their choice was to give me encouragement and insight into my illness.

Question: So you were happy to take that medication?

Patient: Yes, because I was in a state, getting right out of it and taking mind-altering pills. So thumb screws now on, pull your weight, and compulsory treatment order. If you don't pull your weight you are going to be stuck on the order and you are going to a place to reform, and getting sick again. At their choice and at their time—capacity to be cured.

The patient's ambivalence towards treatment and much of the ambiguity of the CommTO are captured in that interview, even in the final sentence. The patient says it was largely the health professionals' choice that he should receive medication, at least initially, and the time frame for his treatment was under their control. But, in his view, the CommTO had successfully delivered to him—on a compulsory basis—the “capacity to be cured.” Compulsion was part of the process whereby he had attained his current stability, and he was now fully discharged from compulsory care.

This material illustrates:

- the relative and ambiguous character of freedom for severely mentally ill persons and the capacity of the CommTO both to advance and to limit their freedom, in different respects or at different times in their lives;
- how the CommTO may be experienced as much as a commitment of the mental health professionals to the patient, as of the patient to them;
- the close integration of the CommTO with the delivery of community care, i.e., its relations with adequate community housing and finance, medication compliance and enforcement, meaningful occupation, and forced abstinence from substance misuse;
- what [Geller \(1995\)](#) describes as the structural and motivational aspects of the CommTO regime.

This case appears to illustrate how, in some cases, the CommTO may act as a buttress, or a prop, or may lock into place a service delivery structure, which might not otherwise be maintained, but which has its consequences only through the services delivered ([Swanson et al., 1997](#)).

8. Conclusion

We believe these conundrums show that important aspects of the CommTO phenomenon may be subject to radically different, even contradictory, interpretations or judgments, although CommTOs share this characteristic with much of the rest of psychiatry and with medicine in general. Empirical research—of either a quantitative or a qualitative kind—cannot resolve the fundamental ethical and political conflicts this form of treatment delivery presents. Only through evaluative judgments can we determine the priority to give to different criteria of success in compulsory community care, or decide whether to promote positive over negative liberty on the part of the mentally ill. Because reasonable people can disagree on such judgments debate about the value of CommTOs is bound to continue.

There is still much to be learned from the research and further research strategies to pursue. The quantitative studies have forced hard thought about potential criteria for success, and about how to measure in naturalistic settings whether compulsion has an independent effect. The more sophisticated studies carefully track the link between compulsion and the delivery of services. They contextualize the research by examining the quality and nature of the services patients actually receive. The current studies indicate the need to examine how CommTOs may promote patient access to scarce services and how they may give priority to those who are most at risk or most unwell.

There is a need for comparative work to identify best practices across jurisdictions, for qualitative work on patient, family, and clinical perspectives, especially patients' views of how CommTOs affect their freedoms, and for further work on downstream decisions in the CommTO process, such as the revocation, extension, and discharge decisions.

Ultimately, even careful research will not determine the policy debates. Their resolution lies in the political domain. However, research can help shape the context in which political decisions are made.

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