RESPONSE

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Attorneys Honig and Stefan present an elegant discourse on their concerns about involuntary outpatient treatment. Unfortunately, in much of the material they cover, they examine only one face of Janus. As one individual who has treated in- and outpatients, voluntary and involuntary, and another who has been the recipient of in- and outpatient psychiatric treatment, the two of us wholeheartedly endorse Attorney Honig and Stefan’s points that “a decision to refuse treatment with antipsychotics . . . might represent a sound medical decision;” values of self-determination, empowerment, meaningful society roles, and the absence of stigma and discrimination are laudable and desirable; frontline clinicians would much rather engage persons in treatment than make them involuntary patients; appropriate care is much more than medication compliance alone; an integrated community system of care and treatment is fundamental to effective outpatient treatment; the success of outpatient commitment (“OPC”) needs to be measured not just in service utilization data, but also in quality of life outcomes; and any intervention, OPC not excepted, should be evaluated from a risk-benefit perspective with an analysis of all significant and reasonably foreseeable harms included.

We take exception to other of Attorneys Honig and Stefan’s proclamations, such as that proponents of OPC like ourselves “suggest that OPC is necessary because it is the only effective means of containing dangerous mentally ill individuals while permitting them to continue to live in the community;” “recent studies have found that many commonly-prescribed psychiatric medications have . . . questionable efficacy;” and any involuntary treatment undermines long-term self-determination.

As can be seen, we have considerably more agreement than disagreement with Attorneys Honig and Stefan on the principles underlying beneficent, effective outpatient treatment. This, however, has little to do with the current state of the evaluation of OPC.

Attorneys Honig and Stefan correctly indicate that the more recent studies are an improvement on the earlier studies, which almost uniformly
found OPC a clinically efficacious modality of treatment. Yet, even the newer studies could be improved. To make sweeping generalizations from these nascent research efforts is premature rejection, especially when based largely on methodological criticisms. Such a position follows the observation that a conclusion is simply the point at which we get tired of thinking.

Without providing a lengthy analysis (since the information can be found directly in the source material), we simply point out that in order to conduct the research that eventually produced distinct and assorted positive outcomes for OPC in North Carolina, the researchers excluded from randomization those individuals who might have benefited the most from OPC, i.e. exclusions based on inability to give informed consent, certain diagnoses, certain degrees of violence. And, the inconclusive analysis of the New York experience cited by Attorneys Honig and Stefan was

1. E.g., Gustavo A. Fernandez & Sylvia Nygard, Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina, 41 Hosp. & CMTY. PSYCHIATRY 1001, 1003 (1990) (median readmissions decrease from 3.7 to 0.7 per 1,000 days); Virginia A. Hiday & Teresa L. Scheid-Cook, The North Carolina Experience with Outpatient Commitment: A Critical Appraisal, 10 INT’L J. L. & PSYCHIATRY 215, 229 (1987) (over six months, thirty percent medication refusal versus sixty-six percent absent orders); Robert A. Van Putten et al., Involuntary Outpatient Commitment in Arizona: A Retrospective Study, 39 Hosp. & CMTY. PSYCHIATRY 953, 957 (1988) (“almost no patients” without orders voluntarily maintain treatment in mental health system versus seventy-one percent who do in group with orders); Guido Zanni & Leslie deVeau, Inpatient Stays Before and After Outpatient Commitment, 37 Hosp. & CMTY. PSYCHIATRY 941, 942 (1986). (readmissions decrease from 1.81 to 0.95 per year).

2. Jeffrey W. Swanson et al., Psychiatric Impairment, Social Contact, and Violent Behavior: Evidence from a Study of Outpatient-Committed Persons with Severe Mental Disorders, 33 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 886, 889 (1998); Jeffrey W. Swanson et al., Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness?, 28 CRIM. JUST. & BEHAV. 56, 161, 162 (2001); Jeffrey W. Swanson et al., Involuntary Out-Patient Commitment and Reduction of Violent Behavior in Persons with Severe Mental Illness, 176 BRIT. J. PSYCHIATRY 324, 325 (2000); Marvin S. Swartz et al., The Ethical Challenges of a Randomized Controlled Trial of Involuntary Outpatient Commitment, 24 J. MENTAL HEALTH ADMIN. 35, 40 (1997); Marvin S. Swartz et al., New Directions in Research on Involuntary Outpatient Commitment, 46 PSYCHIATRIC SERVICES 381, 384 (1995); Marvin S. Swartz et al., A Randomized Controlled Trial of Outpatient Commitment in North Carolina, 52 PSYCHIATRIC SERVICES 325, 326 (2001); Marvin S. Swartz et al., Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?: Findings From a Randomized Trial with Severely Mentally Ill Individuals, 156 AM. J. PSYCHIATRY 1968, 1969 (1999); Marvin S. Swartz et al., The Perceived Coerciveness of Involuntary Outpatient Commitment: Findings From an Experimental Study, 30 J. AM. ACAD. PSYCHIATRY & L. 207, 209 (2002).

3. The Bellevue Hospital Center Outpatient Commitment Pilot Program was considerably less vigorously controlled than the North Carolina experimental design.

4. Henry J. Steadman et al., Assessing the New York City Involuntary Outpatient
severely criticized by, among others, those who actually conducted the treatment and reached very different conclusions.5

Attorneys Honig and Stefan leave out any discussion of a competency-based approach to OPC rather than a dangerous-based approach.6 The former either dispels or alleviates many of their concerns about deprivation of choice, autonomy and liberty without due process.

Finally, Attorneys Honig and Stefan fail to even consider clinical issues around OPC7 or, when they do so, present only one side. Attorneys Honig and Stefan indicate that research should “evaluate the impact of OPC on the service delivery system—how using coercion affects service providers . . . .” Well they should, but should they not also study the impact upon service providers of bearing witness to individuals who could have a substantially improved quality of life but are instead involuntarily subject to severe psychiatric symptoms that lead to death in such ways as freezing on a street corner, jumping from a bridge, or with a gun in their mouth.

Commitment Pilot Program, 52 PSYCHIATRIC SERVICES 330 (2001). It should be noted that the authors specifically warned that their study “results must be interpreted cautiously” because of limitations in the study design. They also point out that there was a substantial difference for people who had court orders. “The median number of days of hospitalization during the period was 43 for the experimental group and 101 for the control group. Although this difference is substantial, a standard non-parametric statistical test of significance . . . showed that the two distributions were not significantly different. If we had recruited twice as many subjects for the study, this difference in hospital days would have attained the .05 level of significance.” Id. at 331, 333.


And, heed is due the impact on caregivers from impotently watching those needlessly living on the street, eating lunch from a dumpster, and wearing vermin-infested clothing. We would modify Attorneys Honig and Stefan’s conclusion to underscore our point of view. Our desire to provide mental health treatment to some people who do not want it must not be constrained, for to do so may violate their rights. Our task now is to determine just who such people are, and then to deliver to them state of the art treatments that maximize effectiveness and minimize side effects to the greatest extent of our knowledge.