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Assisted Outpatient Treatment Services and the Influence of Compulsory Treatment

To the Editor: The article by Swanson et al. (1) in the December 2013 issue reports reduced inpatient care and costs with the New York assisted outpatient treatment program. Assisted outpatient treatment comprises two distinct components: enhanced multidisciplinary community outreach service and court-ordered compulsion to comply with treatment. Unfortunately, the article fails to adequately distinguish these two components or set either of them in their full research context. The result is that many readers will draw the wrong conclusions.

Coordinated multidisciplinary mental health care with outreach to psychotic patients has been researched thoroughly for over 3 decades, repeatedly demonstrating reduced rates of relapse and hospital readmissions (2). In this respect, the reported results are good news for severely ill New Yorkers but no news for those familiar with the literature.

Swanson et al. comment that opposition to assisted outpatient treatment arises from a range of consumer advocates and stakeholder resistance, omitting the resistance stemming from the absence of convincing evidence for their effectiveness. None of the three published randomized controlled trials of compulsory community treatment (3–5) found an advantage in their stated primary outcome of reduced readmissions. In addition, there are nearly a dozen controlled before and after studies (6) of the form. These are predominantly drawn from two large databases: New York, with 3,576 individuals in assisted outpatient treatment and 2,025 matched comparison subjects (7), and Victoria, Australia, with 8,879 individuals in assisted outpatient treatment (community treatment order) and 16,694 matched comparison subjects (8). Australian practice does not actively privilege intensive treatment for individuals in assisted outpatient treatment, and their findings are the opposite of those in New York. The Australian assisted treatment was associated with significantly increased admissions.

International findings support the authors' conclusions that reductions in hospital admissions need well-funded and coordinated community services. However, the findings also currently indicate that coercion itself does nothing to reduce readmissions, and this study does not alter that conclusion.

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Response to Burns

To the Editor: Professor Burns' claim that three randomized trials have now failed to find any benefit for involuntary outpatient commitment in reducing hospitalizations is debatable. The first trial (1), conducted in North Carolina in the 1990s, found that patients randomly assigned to outpatient commitment had a significantly reduced monthly risk of hospitalization (odds ratio=0.64, 95% confidence interval [CI]=0.46–0.88, $p<0.01$). Moreover, hospitalization was not the only outcome that mattered in the North Carolina study; the outpatient commitment group was also significantly less likely than the comparison group to experience criminal victimization over the 12-month follow-up (2) (23.5% and 42.4%, respectively; $p<0.01$).

The second trial, an evaluation of New York State's pilot program for assisted outpatient treatment based at Bellevue Hospital (3), reported null findings but was hampered by implementation challenges and methodological limitations that may have biased its results. The Bellevue study's protocol problems ranged from an imbalance in randomization (significantly more substance abusers were assigned to the experimental group) to an unclear distinction between court-ordered treatment and voluntary participation in the assisted outpatient treatment program (participants often did not know which arm of the study they were in) to inadequate statistical power.

The third trial, the Oxford Community Treatment Evaluation Trial (OCTET), was recently completed in the United Kingdom by Professor Burns and colleagues (4). The OCTET study compared community treatment orders to a form of conditional release (Section 17 Leave), described by the authors as "two forms of mandatory outpatient care." While the control group participants experienced fewer days under compulsory treatment with no worse outcome, the OCTET study's design did not permit a comparison to truly voluntary care. As a result, we do not believe that these three randomized trials are fully comparable, nor do they definitively address questions about the effectiveness of such mandated treatment programs.