COMPULSORY COMMUNITY TREATMENT? I. ONTARIO STAKEHOLDERS' RESPONSES TO "HELPING THOSE WHO WON'T HELP THEMSELVES"

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ABSTRACT

This paper explores the highly controversial issue of compulsory treatment of allegedly mentally disordered persons within the community. In light of American literature on the subject, we examine and contrast the positions and arguments of a variety of Ontario stakeholders. This is done through content analysis of 224 submissions to the Ontario Ministry of Health in response to its "Discussion Paper Towards Community Mental Health Services Legislation of January 1990" which addresses the specific question: "Should the legislation include provisions for out-patient commitment/compulsory community treatment?" Our purpose in this paper is not to determine the desirability or undesirability of compulsory community treatment (CCT) as such, but to examine Ontario positions as a first and necessary step in the process of acquiring perspective on the issue.

Compulsory community treatment (CCT) has been called, in the United States, "a popular proposal" (Wilk, 1988, p. 580), an "increasingly attractive and seemingly necessary strategy" (Mulvey, Geler, & Roth, 1987, p. 572), "a nationwide movement" (Wilk, 1988, p. 133), "gaining popularity across the country" (Stefan, 1987, p. 288). Yet, it has, simultaneously been described as a subject about which there is minimal awareness, much ambivalence (Miller & Fiddleman, 1984, p. 147), and considerable confusion (Mulvey et al., 1987, p. 573).

CCT or community commitment¹ refers "to the legal and psychosocial process whereby an allegedly mentally disordered person is forced to undergo mental health treatment or care in an outpatient setting" (Keilitz & Hall, 1985, p. 378). Realistically speaking, treatment or care generally means medication (Scheid-Cook, 1991a, 1991b), but it may also include attendance at out-patient clinics, participation in individual or group therapy, educational and vocational activities, supervision, monitoring and/or case management, an obligation to stay in a recommended living situation, the non-use of alcohol and of illegal drugs, and money management (Lamb, Weinberger, & Gross, 1988; McCafferty &

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Dooley, 1990).² Ideally, CCT promises a careful monitoring of treatment at regular intervals and the detection of early signs of relapse (Bursten, 1986). Of course the CCT orders are assumed to be "in the patient's interest," in other words, for the purpose of "helping those who cannot or will not help themselves."

On the current mental health policy agenda in most American states, either as a *fait accompli* of the 1980s or a policy proposal for the 90s (for excellent surveys of state statutes governing CCT, see Keilitz & Hall, 1985; McCafferty & Dooley, 1990; Miller, 1992),³ CCT is increasingly debated by concerned stakeholders in Canada as a promising or as a dreaded possibility. While there is a recent and growing literature on the American responses to the concept and practice of CCT (see Geller, 1990, and Keilitz, 1990, for two excellent literature reviews), no systematic survey of the Canadian arguments has come forth on this highly controversial issue. The purpose of this paper is to fill this gap as we examine and contrast the positions expressed on CCT by Ontario interest groups involved in the mental health service environment.

In January, 1990, the Ontario legislative sub-committee of the provincial community mental health committee, responsible for the elaboration of a comprehensive mental health care system as provincial policy, distributed across the province a *Discussion Paper Towards Community Mental Health Services Legislation* asking for responses to 14 specific questions on such issues as centralization/decentralization; consumer, family, and community involvement in the planning, co-ordination, and delivery of services; guaranteed right to services; and quality control. This was done in a spirit of consultation and partnership, asking those who felt concerned to express their particular viewpoints on these questions "before we begin drafting legislation" (1990, p. 1). Question number 13 was of particular interest to us as it specifically asked if legislation should include provisions for "compulsory community treatment" or "out-patient commitment."

The sub-committee received 327 submissions from a wide spectrum of stakeholders from across the province. These submissions were presented in written and/or verbal form during eight public consultation meetings conducted by the sub-committee across Ontario. Presentations which were exclusively in oral form were retrieved from the court transcripts of each meeting. Of the 327 submissions, 28%, that is 103 submissions, did not address question 13 and are listed under N/A on Table 1. This left us effectively with 224 responses on the specific issue of CCT.

In the following pages, we will first examine question 13, identifying some of its strengths and weaknesses in relation to our specific purposes. We will then turn our attention to the responses provided. Our purpose, in this first paper, is not to discuss the desirability or undesirability of CCT as such nor to suggest whether or not it should be implemented here, but rather to examine Ontario stakeholders' positions and key arguments on the issue. In other words, we have attempted to provide answers to the following questions: Where do Ontario stakeholders stand on the controversial issue of CCT? Who is for and who is against? What are the key arguments on each side of the issue? Is there any form of polarization, any consensus to be observed?

Furthermore, in order to add some perspective, we have compared, whenever the literature permits, Ontario stakeholders' responses with the positions expressed in existing studies by their American counterparts who are already involved in the implementation of CCT legislation.

QUESTION THIRTEEN: IMPOSED LIMITS BUT FRUITFUL QUESTION

Question 13 is an attempt at surveying, in a broad but unstandardized fashion, Ontario's opinions on the issue of CCT. Respondents are all, in one way or another, stakeholders who have chosen to take advantage of the opportunity to influence policy makers by convincing them of the logic and rightfulness of their positions. As respondents, however, they are self-selected and from our research standpoint, they do not represent the full scale of interest groups in the mental health field. As self-identified stakeholders, on the other hand, they are the ones who poured their souls into this because it mattered. They are the ones who wanted to and who, in fact, must be heard.

Our study is also bound by certain limits imposed by the particular wording of the question:

"Should the legislation include provisions for out-patient commitment/compulsory community treatment?"

One option would be not to introduce out-patient commitment or compulsory community treatment.

Another option would be to provide for conditional release or certificate of leave from hospital.

A third option would detail out-patient commitment. If a certificate-of-leave or out-patient commitment is to be considered in Ontario, it is recommended that this be included in the *Mental Health Act*, and not in the Community Mental Health Services legislation (Ontario legislative sub-committee, 1990, p. 9).

It is not certain whether the last statement, that "if a certificate-of-leave or out-patient commitment is to be considered in Ontario, it is recommended that this be included in the *Mental Health Act*," is a statement, an actual recommendation from/for policy makers, or a question open for consultation. Most people simply chose not to address it. Another problem is that the third option, to "detail out-patient commitment," is too general and imprecise. As a whole, in attempting to be brief and stay simple, Question 13 does not identify nor define the full range of possibilities from which Ontario legislators and respondents might ultimately have a choice, and which must be considered when one seeks to adopt a procedure such as this one.

In fact, looking at the American experience, there are, at present, four approaches to the concept of community commitment: (a) conditional release, (b) post-hospital mandatory outpatient treatment, (c) substitute for confinement, and (d) preventive commitment.

Conditional release or trial release, occurs when the hospital releases a patient to the community on the condition of compliance with an outpatient treatment plan and where the individual remains on the hospital rolls until the com-

TABLE 1
Respondents by Their Position on the Issue of CCT and Organizational Categories

Category	Total	Yes	No	Def.	N.A.
Political	2	0	1	0	1
NDP health critic	1	0	1	0	0
Aldersperson	1	0	0	0	1
Official Network	22	4	6	3	9
District health councils	16	4	3	1	8
Departments of public health	2	0	2	0	0
Government ministries	4	0	1	2	1
Advisory, co-ordinating, planning committees	12	2	4	1	5
Hospitals total	28	5	9	10	4
(a) General	17	4	6	4	3
(b) Psychiatric	11	1	3	6	1
Community programs total	32	11	9	3	9
Treatment/clinics	11	5	3	0	3
Counselling	7	2	1	1	3
Case management	3	0	2	1	0
Social and vocational rehab.	8	3	2	1	2
Multi-component	3	1	1	0	1
Public health units	2	0	0	1	1
Housing total	16	1	9	6	0
Housing authorities	5	1	1	3	0
Housing programs	7	0	6	1	0
Supportive housing coalition	4	0	2	2	0
Groups and associations providing related services (e.g., employment, legal, geriatric, school boards, AIDS advocacy, police, substance abuse, district health coalitions)	17	1	4	3	9
Advocacy groups (e.g., self help/consumer)	21	0	15	0	6
Professionals association, corps., unions total	20	2	4	7	7
Social workers	4	0	0	4	0

mitment period is completed. Such procedures have a history of use by institutions in the United States and in Canada and are analogous to parole in the criminal justice system (for instance, section 21 of the Ontario Mental Health Act [1980] provides for a conditional leave of absence).

Post-hospital mandatory outpatient treatment such as passed in 1981 by the Tennessee legislature, differs from its civil predecessor in that it starts at the time of the actual discharge and may be renewed periodically in order to prevent recurrence of the acute illness. In both cases, the persons generally targeted are those

TABLE 1 (continued)

Respondents by Their Position on the Issue of CCT and Organizational Categories

Category	Total	Yes	No	Def.	N.A.
Case management group	1	0	1	0	0
Psychological association	4	1	1	0	2
Psychiatric association	1	0	1	0	0
Occupational therapists	1	0	1	0	0
Family physicians	1	0	0	0	1
Nursing association	3	1	0	0	2
Union (OPSEU)	5	0	0	3	2
Volunteer organization total	19	2	10	1	6
CMHA	10	0	7	1	2
Manic Depressive Assoc. of Tor.	3	0	2	0	1
Canadian Schizophrenic Assoc.	1	1	0	0	0
Alzheimer Society	2	1	0	0	1
Addiction Research Foundation	1	0	0	0	1
Addiction Programmes Fed.	1	0	1	0	0
Assoc. for Community Living	1	0	0	0	1
Interested groups not providing services (e.g., multi-cultural, academic, universities)	8	0	0	3	5
Families/organizations of families	31	16	2	4	9
Personal/individual total	97	7	49	9	32
(a) Consumer/users	77	4	45	5	23
(b) Service providers	20	3	4	4	9
Total submissions	327	51	122	51	103
Total addressing CCT	224	51	122	51	
%		23%	54%	23%	

Legend

Total: Total submissions responding to Discussion Paper.

Yes: Respondents who support CCT for Ontario.

No: Respondents who oppose the introduction of CCT.

Def.: Respondents who defer their conclusions on CCT.

N.A.: Those submissions that do not address Question 13 of the discussion paper regarding CCT.

referred to as recidivists, the chronic, revolving-door population whose behaviour pattern fits Appelbaum's (1986) description:

Following their last hospitalization, they continued for a time taking their medication and attending outpatient therapy sessions. Soon, however, they came to question the value of treatment and convinced that ill effects would not ensue, stopped their medications. Within a few months, they had de-compensated and again required inpatient care (p. 1270).

Substitute for confinement is also known as direct involuntary commitment to outpatient treatment. Necessitating a civil commitment court hearing, direct involuntary commitment to outpatient treatment allows the patient who normally would be involuntarily hospitalized, to remain in the community while undergoing treatment. This is done without initial hospitalization. This option is not clearly detailed in question 13. Substitute for confinement is analogous to probation in the criminal justice system.

Finally, preventive commitment (Stefan, 1987), is similar to "substitute for confinement" in that it is done through a judicial hearing without initial hospitalization. It is, however, administered under looser legal standards and relaxed criteria and concerns "individuals who do not meet the statutory standard for involuntary hospitalization but who, it is asserted, are mentally ill, are unable to voluntarily seek or comply with treatment, and need treatment in order to prevent deterioration that would predictably result in dangerousness to self or others or grave disability" (Wilk, 1988, p. 133).⁴ By 1990-91, 35 American states permitted initial commitment to out-patient treatment (Miller, 1992), that is, CCT without prior hospitalization.

In all four cases, CCT is legislated on the conviction that its candidates are incapable of making competent decisions concerning treatment and that forcible treatment is in their best interest. Without it, it is maintained, decompensation and dangerousness to self or to others is certain; with it, it is contended that the person can remain in the community and thus enjoy "the least restrictive alternative"⁵ in civil commitment.

Statutes which legislated explicit outpatient commitment, in the United States, have not always established explicit procedures for dealing with non-compliant outpatients. When dictated in the form of a court order, refusal to comply to CCT has been seen to constitute contempt of court and in some instances, it has meant jail.⁶ While rehospitalization, with or without a judicial hearing, has been the usual response to noncompliance, "a growing number of states now authorize taking noncompliant patients to an outpatient treatment facility instead of to a hospital" (Miller, 1992, p. 80). The use of physical coercion in the administration of medication is itself the object of much debate (Miller, 1992).

While question 13 does not display the entire range of legal approaches currently adopted elsewhere, it is nevertheless sufficient to elicit from concerned stakeholders responses which indicate where they stand on the general issue.

YES? NO? UNDECIDED? ANY CONSENSUS?

The expressed goal of any form of interest group consultation is for policy makers to see if there is "some kind of consensus out there." When looking at the totality of respondents who have addressed the issue ($N=224$), we note that 23% ($N=51$) give an unequivocal "yes" to question 13, while a majority of 54% ($N=122$) respond "no." On the other hand, 23% ($N=51$), have been placed under the category "deferred" because they are either unable or unwilling to take a firm stance. They are likely to comment on the advantages and disadvantages of the practice, to rightfully stress the complexity of the question, to emphasize the dif-

difficulties of implementation and enforcement, and to finally conclude that there is a need for further research, or, in some cases, that it pertains to the Mental Health Act (MHA, 1980) and not to the community mental health legislation.

In fact, only 44 (19.6%) out of all 224 respondents actually said that CCT should pertain to the MHA. Numbers are small and not all of them were positively inclined toward CCT. In fact, this represents 29.9% of those who said "yes" to CCT, 13.9% of those who said "no," and 23.7% of those who were classified as "deferred." The others simply did not address the issue.

Question 13 did not clearly identify the four possible approaches to CCT as presently known. We have, however, attempted to see what, in particular, the categorical "yes" respondents had in mind when giving their verdict. While respondents never actually attempted to systematically "detail out-patient commitment," nevertheless, within the 51 "yes" answers, there were nine references to what was defined above as "conditional release"; 17 references to what, in essence is "post-hospital mandatory out-patient treatment," and 12 to "substitute confinement." Most interestingly, there were 36 references (70.5%) to what we have defined above as "preventive commitment," as a possible function of CCT. (Some referred to more than one of the types identified above.)

All in all, we must conclude at this point that there isn't an overall or overwhelming consensus to be found on the issue of CCT in Ontario. One would be justified in saying that slightly less than one fourth of Ontario stakeholders are clearly in favour and that a large proportion of these refer to community commitment without prior hospitalization, especially as a form of prevention. For another quarter (23%), the issue is not clear cut. These are people who are not yet convinced one way or the other—and who could ultimately be convinced, one way or the other. Above all, the data suggest that the opposition to CCT is already, and would likely be, forceful, should such legislation be introduced.

Who Says Yes, Who Says No, and Who's Uncertain? And Why?

In order to see if there are any identifiable clusters of stakeholders in favour of or against CCT, we have distributed our 224 respondents according to 14 categories which best represent their personal or organizational status within the field of mental health. Generally speaking, Table 1 does not spontaneously trig-

TABLE 2
Respondents who Support CCT by the Specific Types of CCT Indicated

Type of CCT	Total Number*
Substitute for confinement	12
Conditional release	9
Post-hospital mandatory treatment	17
Preventive commitment	36

* Some respondents refer to several of the types identified above.

ger the reader's sociological imagination with scores of excitingly obvious conclusions. Except for families, advocacy groups, and consumers, it is indeed difficult to immediately identify ready battalions of interest groups on either side of this issue. Yet, there is much to say when one looks more closely.

The Political Network: One Lonely Voice

It is highly significant that only one of Ontario's politicians saw fit to respond to the sub-committee's call for input on CCT. David Reville, M.P.P., and then NDP health critic, now personal advisor to Premier Bob Rae, was already a known advocate for the rights of persons afflicted with mental health problems. His argument is based on "personal experience" as he states in the Ontario Legislative Assembly: "I believe I am right because I got back most of the power I lost because of my mental health problem and it was not my treatment that helped me to do that" (1989, p. 2322). It is also based on the principle of the least restrictive alternative, a principle which would be offended with the passage of CCT legislation.

First recognized in 1975 by the United States Supreme Court in a landmark case which legislated that mental patients had to be kept in the least restrictive setting necessary for their well-being, this principle has usually provided the conceptual underpinning for arguments in favour of, not against, CCT. Community commitment, they argue, is "the least restrictive alternative to civil commitment" (Hiday & Goodman, 1982; Hiday & Scheid-Cook, 1989; Miller, 1982; Miller & Fiddleman, 1984). The same principle is now being used to justify two contradictory positions. Compared to inpatient civil commitment, CCT as outpatient commitment is maintained to be the least restrictive alternative; but, compared to voluntary community treatment, CCT is understood as not being at all the least restrictive alternative since it deprives someone of the right to refuse treatment.

The Administrative Network— District Health Councils

We have located under the category "provincial administrative network" those authorities, departments, and offices which occupy responsible administrative positions within the mental health system. Even though they are key advisory players in the system, half of the 16 responding District Health Councils chose not to address the issue. The four who responded positively stated, as sole comment, that "compulsory treatment should be included in the Mental Health Act (1980) and other criminal code laws, not in community mental health legislation"—thus suggesting a "yes" to the principle but a refusal to deal with it in this brief. The three who said "no" said so in no uncertain terms: "We are convinced the voluntary relationship between the client and the service should remain"; "the terms 'out patient' and 'compulsory' are incompatible"; "the potential for infringement on rights and for abuse would out-weight potential benefits," and "legislation on this issue is not considered the solution to an acknowledged problem."

Planning and Coordinating Committees

We have entered in this category, alliances, groups, or committees funded through the Ministry of Health, and whose primary responsibility is to plan and co-ordinate regional or local mental health services. These groups do not actually provide mental health services but are, in their attempts at rational planning, regularly confronted with the needs of deinstitutionalization, shortages of resources, observed homelessness, and unbalanced services. Would outpatient commitment which "theoretically" promises to bring relief to the chronic revolving-door problems, be received favourably here? Of the 12 planning committees who responded, five did not address the question. The two who said "yes," said so as long as there are clearly adhered to rules and safeguards. One of them made a clear difference between "principle" and "practice," stressing that while in principle, treatment should be voluntary, in practice, in certain extreme circumstances, it may constitute the least restrictive manner of providing care, as long as it is done after careful consultation with the individual and as long as it requires application to a hospital review board, with right of appeal that either party could initiate. The four who said "no," call CCT a "form of leash law" with "far greater potential for damage than for benefit," "a regressive step," "unenforceable," "impossible." For all planning committees, the actual meshing of implementation and enforcement procedures with the fundamental respect for human rights is a very real stumbling block. All in all, we can reasonably conclude, that CCT would presently not receive an enthusiastic support from Ontario groups whose primary responsibility is to evaluate needs and "rationally coordinate" resources in their region or community.

Hospitals

It is often stated by defendants of CCT that its legislation would solve the problems of hospitals having to deal with revolving-door, decompensating, and returning clients. Empirical studies of the American experience, using readmission rates as "criterion of success," suggest, in one case, that outpatient commitment was ineffective (Bursten, 1986); and in another, that it was effective for a relatively small, select group of involuntary patients (Keilitz, 1990). In most other instances, the conclusions are that it appeared to provide an effective alternative to continued hospitalization for at least some patients (Hiday & Goodman, 1982); that it was effective in reducing inpatient stays (Van Putten, Santiago, & Berren, 1988) and in preventing unnecessary readmissions (Band, Heine, & Goldfrank, 1984; Geller, 1986a,b; Schneider-Brauss, 1986; Zanni & De Veau, 1986), in diverting patients from inpatient to outpatient care and in maintaining compliance with treatment (Hiday & Scheid-Cook, 1987, 1989, 1991), and finally, in increasing the voluntary use of aftercare services and continuing treatment even after commitment (Van Putten et al., 1988). Furthermore, Miller and Fiddleman (1984) found that hospital clinicians were more likely than community clinicians to endorse CCT, to agree that community staff have an obligation to provide outreach services to patients who do not come voluntarily for treatment and that treating chronic patients should be a community centre's primary responsibility. The American Psychiatric Association (APA) reported that hospital clinicians were also more likely than community clinicians to view psychotropic medica-

tions as necessary for treatment and to agree that they should be administered involuntarily if clinically indicated (APA, 1987).

One might expect, then, that hospital representatives would largely be in favour of CCT in Ontario. One might also expect that psychiatric hospitals would be more likely to accept it than general hospitals as they traditionally deal with the more chronic, institutionalized clientele. Respondents, however, did not display this kind of consensus.

Out of 28 general and psychiatric institutions, four did not address the issue. Ten could not give a definite answer, six of which were psychiatric hospitals. Only one psychiatric hospital, but four psychiatric departments within general hospitals, were in favour of CCT within carefully defined limits: when patients present a danger to others as well as to themselves, to ensure compliance with treatment and avoid deterioration.

The reference to dangerousness as a criterion for CCT poses a number of logistic problems. Currently accepted as the necessary and sufficient condition for inpatient commitment in Ontario and other provinces, a patient deemed dangerous would now be able to return to or remain in the community on the condition that he or she would comply with treatment. As the present legislation stands, the same person, if committed in the hospital and if recognized competent/capable, can refuse treatment. The same person, committed to CCT would not be able to do so. While in theory, "potentially dangerous individuals for whom there is no treatment could be held under civil commitment indefinitely" (Brouillette & Paris, 1991, p. 285), in practice, this is a very real problem. Would CCT then be defined as preferable to civil commitment because it imposes treatment on potentially violent or suicidal people? How would this be justified to the community? Wouldn't CCT under these conditions, exacerbate the climate of fear which surrounds the question of dangerousness? Or would CCT be seen as a form of protection?

The nine hospitals which were opposed to CCT used the terms "unadvisable," "unreasonable," "opposed to a human rights point of view," "impossible to police," "a further burden to out-patient services," "a cause of serious dilemma for the care giver," "alters the focus of community mental health services," "ultimately detrimental to the system," and "untenable to administer." Questions of concern were: "Would there be adequate protection for practitioners and agencies against legal recourse if harm occurs?" Or again, "What penalty would be imposed if the order is defied?"; "Would we then confine this person to an institution?" One hospital concluded: "This would only serve to increase the pressure on already limited hospital psychiatric beds and require an increased financial commitment to programming by the Ministry of Health."

Community Programs

Some American studies show a "lack of receptiveness" (Miller, 1985), much hesitation and resistance on the part of clinicians and counsellors within community clinics with regards to CCT. In fact, advocates of CCT have felt that this resistance has "undercut the success of mandated outpatient programs for acutely ill patients" (Bursten, 1986, p. 1258). American clinicians and counsellors, ac-

According to these studies, object to the fact that they are compelled to accept clients and in fact, that they have little, if any input into the decisions to commit patients to their care (Miller, 1985). They are said to worry about client loads increased beyond capacity. They complain that the reciprocal relation between clients and service providers is at risk of becoming an adversarial one where both distrust each other's motives and intentions. They object to the idea that this relationship will become mediated by the client's lawyer, and state that clinicians will be forced to predict dangerousness with no particular skills to do so. They argue that lawyers and clinicians will turn against each other as they struggle over the allocation of available resources, and finally, they object to being, themselves, compelled to use force, threats, or coercion (Appelbaum, 1986; Appelbaum & Roth, 1988; Mulvey et al., 1987; Wilk, 1988).

Yet, in her interviews with the primary clinicians for 115 individuals on CCT in North Carolina, Scheid-Cook (1991b) found a completely different picture. Clinicians found OPC (out-patient commitment) helpful primarily because it provided greater social control over the patient.

They reported that OPC was "in general a good thing because it gives some leverage over a relatively refractory treatment population." One psychologist put it more bluntly when he stated the OPC "is another way to twist their arm" (. . .) Clinicians viewed OPC as "therapy, it gives you the freedom to go fetch somebody, as a way to get them there (the community mental health centre) for treatment." What works about OPC is the threat of further court appearances or the sheriff coming to their house. The single most common complaint about OPC was that . . . clinicians "wished there were more teeth to enforce compliance" (p. 68).

On the basis of this literature it was difficult to know what to expect on the part of Ontario's community programs toward CCT. Only 32 (18.4%) out of a possible 174 mental health programs (other than housing) funded by the Ontario Community Mental Health Branch of the Ministry of Health actually presented briefs to the sub-committee. Of these, nine did not address the issue; three could not give a firm answer; nine were against, but 11 were in favour. Keeping in mind that numbers are small and respondents self-selected, it is still notable that more community programs who chose to respond were in favour than against. This was specifically the case for treatment centres/clinics, where five are in favour, three against. On the "pro" side, the most compelling argument is what they call a humanitarian argument: "loss of lives can be prevented." Against it, opponents stress the importance of the voluntary nature of treatment in the community. It is the absence of coercion which, for them, is truly humanitarian.

Three of the six responding social and vocational rehabilitation centres stood firm on the need to protect those who will not protect themselves: "While the emphasis on patient's rights is commendable . . . their lack of insight into their illness has caused them to not seek help, or to refuse it, because they are not aware they are seriously ill." Two programs offering case management feel they do not need this extra power to accomplish their task.

One counselling program for women conducted its own survey with 32 of its clients with surprising results: 31% of these clients decided that it would be "a good law for them" and 40% actually decided that it would be "a good law for

people they knew," while we know that as a whole, only 23% of all respondents to question 13, felt certain that CCT was a good idea. The authors of the brief nevertheless opt against CCT, emphasizing instead the need for a wide range and choice of support, resources, and service providing client-directed rehabilitation responding to local needs defined at the local level by consumers, service providers, family members, and interested community members.

Housing

One would expect other stakeholders involved in the provision of housing to share the firm position held by one large metropolitan housing authority for whom CCT "will mean increased ability to help potentially successful clients to maintain their housing, or, if necessary, in a positive fashion assist with the transition to a more appropriate housing form." Legislation, they say, "should reflect the theme: rights with responsibilities."

This housing authority, however, stands alone. For others, CCT is not a "user friendly system." As for individual housing programs and housing coalitions, CCT, they argue, would undermine the operation of an effective housing program"; "it is contrary to the basic philosophy and objectives of supportive housing"; "it would, in essence, be creating mini jails in the community"; and "would be undesirable, inappropriate, and cost prohibitive."

Groups and Associations Providing Related Services

In this category we have located 17 groups offering such services as legal, alcohol, and substance abuse services; youth employment counselling; police; etc. There is very little comparable American information on such groups. We therefore cannot say whether the stance of one of Ontario's community legal services is typical or not. The authors of this brief speak of "the danger of indefinite attachment to the institution"; they express their concern that "this option may become virtually a compulsory step to full discharge" and "that people may end up in the category of committed outpatients for long periods of time and possibly forgotten"—thus raising the issue of time limits, an issue which is rarely referred to in the American literature. While registering their opposition to CCT, the authors conclude that the problem requires broader social, political, and economic solutions and necessitates a recognition of the right to receive services and thus of the responsibility to offer them.

The American police force shows considerable resistance to CCT for one basic logistical reason: they do not like getting involved in the mechanisms of enforcement (Miller, 1988). Would CCT also be a source of frustration for the Ontario police force? The only police response from Ontario is consistent with Miller's observations, though it concentrated exclusively on the difficulties the police experience with the implementation of inpatient commitment under the existing Mental Health Act (1980).

Advocacy Groups—Survivors and Consumers

Here, there is consensus: all say "no" to community commitment. Arguments supported by personal histories of painful experiences are consistently prefaced by an expression of profound doubt concerning the beneficial effects of

medication. They are also based on an unquestionable belief in a person's fundamental right to choose. The bottom line is: "To force a person to take chemicals is a violation of that person's rights under the Charter of Rights and Freedoms." As well, CCT is deemed antipodal to another key principle and an inspiring source of motivation: empowerment. Thus, in direct contrast with CCT as "helping those who won't help themselves," they propose "taking control over our own lives" in developing ways to "help each other help ourselves."

Professional Groups, Associations, and Unions

We expected, once again, that professional groups and associations would be highly concerned by the issue—as major gate-keepers, service providers, and potential enforcers. However, of the 20 responding professional groups and associations, seven (one third) did not address the question. We expected that some professional groups would approach the issue as the American Psychiatric Association did and recommend substantive criteria and guidelines for the implementation of CCT (Miller, 1988; Miller, Luskin, Starett, Bloom, & Weizel, 1988; Rubenstein, 1985). We also expected that others, as shown in a National Institute of Mental Health study (Owens, 1985, p. 38), might, on the contrary, express reluctance at being asked to treat unwilling patients and see this as an additional burden which would jeopardize good working relations, threaten their professional integrity in judicially determining their caseload, force them into a policing role, and pose serious questions regarding liability for patient behaviour (Geller, 1986a,b; Wilk, 1988). In fact, two respondents were positively inclined, four negatively, and seven could not give a definite answer.

The key argument in support of CCT for one visiting nurses' association refers to the "potential abdication of responsibility" of the professional when clients decompensate in the community. In other words, it is clearly in line with the belief in the system's duty to "help those who cannot/will not help themselves." For an academy of psychology, CCT offers a more benign and less drastic alternative while promoting the linkage of the marginal person to "the beneficial treatment." Treatment here was not synonymous with medication, however, but with "a more psychosocial approach to therapy which is broader and more relevant to the individual's life."

The arguments, from Ontario professionals who oppose CCT are clearly in line with the arguments of their American counterparts. Yet, while American social workers feared that they would become "nothing more than medication monitors" (Wilk, 1988, p. 136) and wondered how much "forgiveness" a therapist could allow a patient before reporting the problem to the court and warned of "staff demoralization" (Wilk, 1988, p. 136), here in Ontario, responding social workers find themselves torn between the ethical principles of the profession and situational contingencies, between principles and practice. They recommend that the issue of outpatient committal be deferred pending further discussions and study.

The only voice from any psychiatric association came from a northern Ontario city. Contrary to their American colleagues of the APA, these psychiatrists prefer to do without CCT. It is their belief that creative referral and competent intake processes can accomplish the same end as well as having a range of services

available in a catchment area, greater numbers of case managers to provide follow-up, and greater responsiveness on the part of the Ministry of Health to the needs of the discharged psychiatric patient and their care-providers.

As for unionized employees, their briefs deplore the many failings of the Mental Health Act (1980) which, in its present form "makes it harder than ever before, for the mentally ill to get help when they want it and need it." They are demanding a "broader" MHA. On CCT, however, there is no specific position.

Volunteer Organizations, Societies, and Foundations

Among the 19 volunteer groups and associations, the "no" position is also quite compelling. Arguments refer to the Charter of Rights and Freedoms (1982), to the psychosocial philosophy of rehabilitation, to the difficulty and to the cost of implementing and monitoring, to the change in relationship between consumers and the community, and especially here, to the impact on municipal zoning practices for group homes (requiring, they maintain, a change from residential to institutional both for purposes of municipal by-laws and under the Fire Code pursuant to the Fire Marshall's Act). It is argued that hospitals are for this sort of thing and not the community. They also warn against the possible abuse of the MHA, in forcing (re)hospitalization for "misbehaving or non-compliance," in other words as punishment and not because of dangerousness to self and others.

The real solution: a better balance between hospital and community; more outreach services; greater client involvement in the planning, evaluation, and distribution of services, with contracts on a more informal basis if the consumer is agreeable.

One "yes" comes from a local branch of a Schizophrenia Foundation, stressing that mentally ill persons who are allowed to wander around in the community are not acceptable to the citizens. There is always the risk of a patient being a danger to himself or others, and of the destruction of property. Legislation, they say, should be included in the Mental Health Act (1980) and enforced by those who are charged with keeping the law. This position is shared by families and organizations of families.

Families and Organizations of Families and Friends

Families, everyone agrees, are ultimately the ones who "bear the daily burden of noncompliant patients who are unable to meet the current strict criteria for inpatient hospitalization" (Wilk, 1988, p. 134). They are routinely believed to be the strongest supporters and lobbyists for CCT "because of their repeated frustrations in getting treatment for their loved ones before extreme deterioration occurs" (Korr, 1988, p. 748). In practice, family members or neighbours were indeed more likely to be the petitioners (68.7%) for CCT in North Carolina than physicians, law officers, or social service workers (24%) (Scheid-Cook, 1987, p. 177). Their support, from everyone's point of view, is qualified as "understandable" (Wilk, 1988, p. 4).

Of the Ontario families and organizations of families and friends who address the issue, 65.2% are in favour of CCT. This is remarkably similar to an Oregon study of family members' opinions about civil commitment where 63%

were in favour of CCT—but “although family members favoured outpatient commitment in theory, a large majority felt it would have been impractical in their relative's case at the time of the last commitment” (McFarland, Faulkes, Bloom, Hallaux, & Bray, 1990, p. 540). In other words, in times of crisis, families still preferred inpatient civil commitment—with “broader criteria” (1990, p. 540)—to outpatient commitment. They favoured “mandatory outpatient treatment or medication after involuntary hospitalization but were not enthusiastic about outpatient commitment without hospitalization” (1990, p. 537).

The position of the Ontario Friends of Schizophrenics is already well known. For them, CCT is an *essential* feature of a community-focused system. It must be implemented for community-based mental health services to become an effective alternative to hospital-based care. Without it, they conclude, the most seriously ill will continue to be no one's responsibility. “Arguments put forward by civil libertarians are very seductive,” says June Beeby, the organization's executive director . . . “but the reality of it is that adhering to that principle causes terrible suffering” (Swainson, 1992, p. C3). In other words, CCT would clearly be “helping those who cannot/will not help themselves.”

Personal/Individual

Primary consumers are the key stakeholders in this issue and as we would expect, the most vociferous against it. Of the 52 consumers who specifically addressed the issue, 83.3% were against CCT. The four consumers who were “in favour” had adopted the bio-psychiatric discourse: “Bio-chemical ills can *only* be treated by chemicals” (personal statement). They told their personal stories: Properly adjusted medication brought back happiness, self-control and the ability to exercise will power. It saved their lives. CCT could make sure that others, like them, are helped by taking their medication.

The consumers who oppose CCT are skeptical and denounce the system's reliance on medication/overmedication. They oppose coercion for what it has done to them: “As a result of forced drugging I am now a tranquilizer addict” (personal statement). They oppose it in the name of human rights, personal autonomy, and human dignity. They assert their ability to know and to judge the effectiveness of medication: “You may not always know what's good for you, but you always know that if something definitely hurts you, it is probably definitely bad for you” (personal statement). They speak of social control and oppression: “Leash laws are jail with no bars.” They see CCT as a “cop out for government to provide sufficient funds to community support services” (personal statement).

The better way? Freedom of choice in a balanced system—repeatedly quoting Simmons' recent book (1990)—which would offer the full range of services in the community: housing, crisis centres, day centres, workshops. “If we are to break the swinging-door syndrome, then we must teach life skills, financial management skills, etc., not this watered-down version of take your meds, attend day care, and everything will be all right” (personal statement).

These “survivors” are true believers of community based mental health services as a voluntary and involved partnership.

DISCUSSION

In asking their 14 questions, the members of the Ontario legislative subcommittee on mental health were asking Ontario stakeholders "to help us further develop our thinking on these issues before we begin drafting legislation." In a democracy, we are told, "the people ultimately call the shots" (Borovoy, 1988, p. iv). The theory says that the majority rules, and in the case of CCT, a 54% majority of those who chose to answer question 13, says "no" to its explicit legislation. This is very clear. Among those who say "no" there is a broad spectrum of stakeholders, all involved with the system in a variety of capacities, but the groups which most uniformly oppose the legislation are the consumers themselves and their advocates. This is also very clear.

But the question cannot be so easily discarded. A bit less clear is that among the 46% left, there are as many who are "undecided" as there are who say "yes." In addition, 28% of the stakeholders who have sent submissions to the subcommittee in response to its list of questions have chosen not to tackle with Question 13.

We all know that the way a question is asked influences the nature of the responses received. As spelled out, Question 13 implies an absolute answer which must be justified through a statement of principles: "Should the legislation include provisions for out-patient commitment/compulsory community treatment?" The options proposed hinted at a possible distinction within categories of CCT, but did not suggest that the distinction may be between the variety of people in need. Had the question been: "Are there instances when CCT could be appropriate," or "For whom could compulsory community treatment be appropriate?" would all 54% who said "no" to Question 13 have also answered "none" or "nobody"? The results of the small in-house survey referred to earlier permit us to doubt it. Respondents in this case showed a higher rate of acceptance than the respondents to Question 13. Their question, however, did not ask for "absolutes," or for a decision based on general principles, but dealt with real "instances": Yourself or people you know—who could benefit from it. Their answers were thus "situational," "pragmatic." Could there have been, even, from the point of view of those who answered "no," some "situational" instances whereby CCT, with strict criteria for eligibility, guidelines for implementation, and procedural safeguards (Geller, 1990) would be appropriate? What about those who were uncertain or even those who chose not to tackle the issue?

Objectively speaking, it is possible that a different question might provide policy makers with a different perspective on opinions concerning the desirability of CCT. The problem is not purely academic or hypothetical, it pertains directly to one of the key complaints expressed by parents that there is a very real difference to be made between principles and reality. Arguments put forward by opponents of CCT are very "seductive" says June Beeby, executive director of the Ontario Friends of Schizophrenics (Swainson, 1992, p. C3). "It sounds great, but the reality of it is that adhering to (such) principles causes terrible suffering. We just cannot tolerate children not being helped because of some abstract principle" (Swainson, 1992, p. C3). It is also this opposition between principles and reality which constitutes the major stumbling block for those who cannot make up their minds and have been classified as deferred. More research, they say, is needed.

When looking at the arguments in favour of CCT and at the arguments against, it soon becomes apparent that they reflect, first and foremost, the fundamental opposition which pervades in the entire field of mental health between the bio-medical/social-control mindframe versus the survivor/client-centred/anti-psychiatry one. On the specific issue of CCT, one side calls upon the basic principle of *parens patriae*, the other calls for empowerment. One uses the language of social responsibility and humanitarianism, the other, the language of human rights. One speaks of "helping those who will not help themselves," the other speaks of personal autonomy, the right to choice and self-directedness.

The opposition between these two paradigms is present to some extent, and rather unevenly so, within every category of stakeholders identified here; but it is most evident in the polarization of views between families and consumers/survivors/advocates. They, as we know, are the key stakeholders on this issue. They are the ones who stand to be the most personally affected by the legislation, the ones who must live with the very real anguish and turmoil but, who, even while living under the same roof, do not share the same vantage point on the overall experience. Their positions, each arrived at from painfully lived realities, appear irreconcilable.

Ultimately, the choice to be made may depend on their respective ability to lobby, to organize, and to convince. For this, it will also depend on the strategic alliances with and between other stakeholders who, for their own reasons, will favour or oppose CCT should it ever become a formal policy proposal.

When all is said and done, however, the choice will likely depend on policy makers' conception of what is the most ethically and politically correct stance for the times. At that level, we venture to say that CCT might not be considered very palatable here in Canada where the language of current policy documents in the entire field of human services features such concepts as partnership and empowerment, self care and mutual help, all of which are explicitly defined in opposition to the concepts of control and coercion (Boudreau, 1991a,b). Spelled out most clearly and for the entire country, in the federal discussion document, *Mental Health for Canadians: Striking a Balance* (Health and Welfare Canada, 1988), this language calls for "the provision of a legal context in which people's human rights are protected" (p. 14), where "inequities are reduced" (p. 13), where "people's empowerment grows" (p. 14), where those who are disadvantaged are "given a greater voice" (p. 14), and where coping is enhanced through "the support and reinforcement of efforts of family, caregivers and health professionals, by putting in place a broad range of practical and psychosocial resources that they can count on" (p. 17). In a sense what such government-produced documents call for is very much in tune with what stakeholders on the "no" side in Ontario have argued as alternatives to CCT: a balanced mental health system with appropriate housing, work, educational programs, advocacy, and client-operated initiatives; and the development of "partnership" relationships between mental health professionals and psychiatric survivors.

While Canadians and Americans are probably more alike than any other two peoples on earth, they are also very dissimilar in many ways. As David V.J. Bell (1992) mentions, "what we do depends on what we think and feel and believe" (p. 1) and political actions reflect and involve elements of a political culture.

Canadians and Americans of today, if we believe Seymour Martin Lipset (1990), still march to a different drummer, as did the rebels and loyalists, the Whigs and the Tories two centuries ago. That so many American states have turned to explicit CCT in the 1980s and continue to do so, while Canadian legislators have not (yet) featured it on their political agendas, may reflect differences in the magnitude of the population in need. It may also reflect the fact, as Marmor and Gill (1989) put it, that since the mid-1970s, the mental health treatment system in the U.S. has faced budgetary famine and that "it is likely that the profound mismatch in need and spending for mental health programs will continue indefinitely" (1989, p. 459). It may also reflect different political cultures. Very few, however, agree on what this really is (Bell, 1992) and the subject deserves more than a few tentative suggestions. Nevertheless, that the United States have one of the weakest sets of welfare provisions in the developed world and that none of the states have ever elected a social democratic government, might give us some insights into the values of the privileged. That the United States still defines itself as *the* land of opportunities and achievement, while the highly visible human landscape of its inner city streets gives evidence of the contrary, might also help us understand its acceptance of a moral mandate to "help those who refuse to help themselves." Would we grossly and unforgivably caricature if we quoted here Lipset's (1990) observation (p. 128) that Canada emphasizes the greater value of societal relationships while Americans emphasize achievement of "ends" with "less" concern for the social appropriateness of "means" (p. 98)? Can we interpret the acceptance of programs which cut welfare benefits to people who don't accept workfare as demonstrating a greater readiness in American states for punitive action toward noncomplying citizens? Can we legitimately relate the fact that Americans are more fearful than Canadians of "walking the streets of their community" and of being unprotected after dark (Lipset, 1990, p. 94) to their willingness to accept coercion as a means to decrease "dangerousness"? Could the political clout of the medical lobbying which has consistently prevented the introduction of a universal health insurance plan, throw additional light on the various states' choice in favour of traditional medical knowledge and professional psychiatric expertise on CCT? Finally, the fact that the United States has adopted during the 1980s a more aggressive neo-conservative and welfare cost-cutting path than Canada in response to its fiscal crisis could also be part of a multifaceted ideological, political, and economic explanation.

Is this to say that a political discourse in the Canadian context favouring explicit legislation on CCT as a solution to the problems associated with deinstitutionalization is an unlikely prospect? The very real problems which CCT purports to address in the name of "helping those who will not help themselves" dictate that we take a closer look at the collision of views at stake, at the legal and procedural complexities involved, as we wonder whether CCT is truly "the best possible alternative."

NOTES

1. This is usually referred to in the American literature as involuntary outpatient commitment (IOC) or simply as out-patient commitment (OPC). Because the term "outpatient" is likely to suggest "post-hospital treatment" while some forms of community commit-

- ment do not require prior hospitalization, we prefer the terms compulsory community treatment (CCT) or simply community commitment (CC).
2. In fact, CCT orders, as they exist in various American states, can provide "either general guidelines for treatment regimens and conditions, or place the individual in the care of a specific individual or facility that assumes responsibility for a treatment plan" (McCafferty & Dooley, 1990, p. 277).
 3. By 1988, Miller reports that every state except New York (because of expected resistance from civil libertarians) permits some form of outpatient commitment. Miller also reports that it is as yet underutilized. McCafferty and Dooley in 1990 specify that legislation on IOC varies from state to state. A number of state laws specifically list IOC, others use more vague statutory language, specifying only that the treatment ordered must be "the least restrictive alternative." States, in increasing numbers, they say, are now passing laws to authorize it as such, to enhance or further refine its use. See McCafferty and Dooley (1990) for a detailed overview of current and pending state legislation.
 4. This approach is particularly dependent on the highly debated assumption that dangerousness can be reliably predicted (McCafferty & Dooley, 1990). North Carolina was the first state to implement preventive commitment in 1983; by 1987 Hawaii, Georgia, and Tennessee had followed suit, allowing preventive commitment of an individual based on the likelihood that, without forced treatment, the person will soon be committable (because dangerous to self or others). In 1987, Stefan specified that dozens of other states were considering this type of legislation while in 1990, McCafferty and Dooley indicated that no other states had considered it.
 5. The doctrine of the least restrictive alternative, or least restrictive environment or setting, refers to the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services (The President's Commission on Mental Health, 1978).
 6. In 1987 an Indiana patient, found "gravely disabled based on his dangerous behavior due to chronic paranoid schizophrenia," had been sentenced to jail for contempt in refusing to take his medication. The sentence was suspended when he agreed to take his medication. In 1989, the same process occurred and the patient was sent to jail for nearly one month where he continued to refuse medication. An Indiana appeals court affirmed the lower court decision incarcerating and holding a mental patient in contempt of court for willfully failing to take his medication. But finally, the Indiana Supreme Court held that it was inappropriate to jail someone subject to outpatient commitment instead of involuntarily committing him for not taking court-ordered medication on a regular basis (Tarpley, 1991).

RÉSUMÉ

Cet article explore la question très controversée du traitement dans la communauté imposé de façon préromptoire aux personnes dont on prétend qu'elles connaissent des problèmes mentaux. À la lumière de la littérature américaine sur la question, nous examinons et comparons les positions et les arguments de différents groupes d'intérêt, à partir de l'analyse de contenu des mémoires soumis au Ministère de la santé de l'Ontario en réponse à son «Document de travail en vue d'une législation des services de santé mentale dans la communauté» (janvier 1990). Ce document posait de façon spécifique la question suivante: «La législation devrait-elle prévoir des dispositions pour l'engagement non volontaire dans un traitement externe communautaire?» L'intention de cet article n'est pas de déterminer si le traite-

ment communautaire non volontaire est une mesure désirable ou non, mais de considérer les positions exprimées en Ontario comme une première étape nécessaire pour acquérir une certaine perspective sur la question.

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COMPULSORY COMMUNITY TREATMENT? II. THE COLLISION OF VIEWS AND COMPLEXITIES INVOLVED: IS IT "THE BEST POSSIBLE ALTERNATIVE"?

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ABSTRACT

This paper pursues our exploration of the highly controversial issue concerning the compulsory treatment of allegedly mentally disordered persons within the community. We contrast, in their most basic arguments, the discourses which proponents and opponents of CCT characteristically construct for the specific purposes of convincing policy makers of the rightfulness of their respective positions and of ultimately influencing the legislative choices to be made. We identify key practical questions which have to be addressed in order to further our thinking on the issue and suggest that what today's mental health system unequivocally requires is real commitment on the part of government to make a greater political, organizational, and financial commitment to effective partnership models and to a balanced mental health system.

INTRODUCTION

The question of compulsory community treatment (CCT) or community commitment (CC) provides the perfect platform for the display of the great disparity of opinions and views prevalent in the field of mental health. As today's policy makers are bracing for the future and exploring new directions for mental health services (Taube, Mechanic, & Hohmann, 1990), CCT's relevance as a key, critical, and controversial issue cannot be underestimated. Already adopted, either as a specific form of legislation or in implicit statutory terms in all American states except New York,¹ CCT requires close, informed, and critical examination before it is allowed to become an explicitly legislated part of the Canadian mental health landscape.²

Best defined as "the legal and psychosocial process whereby an allegedly mentally disordered person is forced to undergo mental health treatment or care in an outpatient setting" (Keilitz & Hall, 1985, p. 378), CCT is imposed with or without prior hospitalization,³ depending on state legislation. It is imposed on individuals who are deemed mentally ill, are said to "have no insight into their condition and would not voluntarily comply with treatment considered necessary to prevent overt psychosis and potential dangerousness" (Scheid-Cook, 1991a,

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p. 43), yet who are capable of surviving safely in the community with supervision and treatment. While increasing in visibility, CCT has been presented by those who are convinced of its benefits as a "response to the problems created by deinstitutionalization" (Geller, 1986a, p. 295), "an effective alternative to compulsory inpatient treatment and a way to catch those who are falling between the cracks" (Wilk, 1988, p. 133), "a strategy to alleviate homelessness" (Mulvey, Geller, & Roth, 1987, p. 572), "the least restrictive alternative in civil commitment" (Hiday & Scheid-Cook, 1989, p. 52), a "creative process" (Greenley quoted in Isaac & Armat, 1990, p. 311), and an answer to "the frustration over the inability to maintain uncooperative patients in the community" (Appelbaum & Roth, 1988, p. 408).

And yet, from a much less enthusiastic standpoint, it has been understood as a proof of the failure of community based mental health services and "a dysfunctional legal response to a service system vacuum" (Schwartz & Constanzo, 1987, p. 1329), "an imperfect solution" (McCafferty & Dooley, 1990, p. 277), a sure way "to pit clinicians and patients against each other" (Appelbaum & Roth, 1988, p. 409), the future source of "legal quagmires" (Leong, 1987, p. 694), a "widening of the net of coercive state control" (Stefan, 1987, p. 288), and a procedure that holds the potential for the creation of a therapeutic state (Stone, 1985).

As illustrated in our earlier examination of Ontario stakeholders' responses to the "promising or dreaded possibility of CCT" in their province (Boudreau & Lambert, 1993), proponents and opponents of CCT basically agree that there are in society some people who are chronically mentally disturbed and who encounter severe problems in functioning and remaining effectively in the community. From that point on, however, they lock horns on what they consider to be "the facts" and the conceptually correct "principles" which must guide our society's response to these problems.

Our purpose in this second paper is, thus, to pursue our discussion of CCT as we contrast, in their most basic arguments, competing values and definitions of the situation, the fundamentally incompatible discourses which proponents and opponents of CCT contrast in order to convince. We outline some of the practical questions which will also have to be addressed should Canadian policy makers seriously consider introducing CCT legislation and conclude that perhaps what today's mental health system truly requires is not community commitment in the form of CCT, but real commitment to a balanced and effective community-based mental health system.

DECONSTRUCTING THE ARGUMENTS: DIFFERENT STARTING POINTS, DIFFERENT CONCEPTIONS OF "INSIGHT"

Bleicher (1967) indicated that "some people are deprived of their liberties in an attempt to give them psychiatric care. Occasionally, others are deprived of psychiatric care in the attempt to guard their liberties" (p. 93). This dilemma has been proclaimed "the focal point of the ongoing debate for the ensuing three decades" (Mulvey et al., 1987, p. 571). In light of current discussions surrounding CCT, we must disagree: this is not the true "dilemma" of today. Bleicher's dilemma is trapped in a certain mindscape which suggests that

psychiatric care is a "desirable good" of which one could be "deprived." It is the same mindscape which is at the foundation of arguments in favour of CCT: in order to help those who cannot or will not help themselves, the system is deemed justified in compelling patients to "benefit from" treatment of which they risk being "deprived" because of their "lack of insight" into their illness. It is assumed that patients who show insight into their illness accept medication (generally synonymous with psychiatric treatment). Insight means compliance (Scheid-Cook, 1991b). The effectiveness and desirability of psychiatric care is here understood as a basic "fact" around which the "pro CCT" conceptual and moral argument is constructed. Belief in psychiatric care, belief in—or putting one's hopes in—medication, is the starting point of an approach which prompts people to accept the idea that "helping those who will not help themselves" is an act of benevolent coercion and not alienation.

For those who reject Bleicher's (1967) premise altogether; for those, thus, who emphasize the personal risks involved in taking psychiatric medication and who do not take the reasoning and effectiveness of the biopsychiatric model as a fact, a choice to refuse psychiatric intervention is *not* a choice which involves being "deprived" of such services. It is a choice which means being "saved" from the most commonly experienced side effects of medication, such as "dry mouth, excessive sleepiness, lack of energy and slowed down feelings, restlessness and tremors" (Scheid-Cook, 1991b, p. 74) and other "serious physical, emotional and cognitive distress" (Brooks, 1980, p. 183) caused by psychiatric medication. The emphasis here is not on the psychiatric medication's effectiveness in preventing mental deterioration leading to rehospitalization, but on its shown side effects "which could interfere with the person's ability to function normally in the community" (Scheid-Cook, 1991b, p. 74). Promoted here is a different kind of "insight": psychiatry is "toxic" (Breggin, 1991) and psychiatric drugs are hazards to the brain (Breggin, 1983).

Their starting point is thus very different: CCT is an authoritarian form of social control, of psychiatric and legal abuse, and a breach of their basic right to liberty and security as emphasized in section 7 of the Canadian Charter of Rights and Freedoms (1982):

s. 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Yet, the highly prized "right to be let alone," to be "as free as any other citizen" once released from hospital, along with the established "right of involuntary inpatients to refuse treatment," are metaphorically translated, from a pro-CCT standpoint, as: "dying or rotting with one's rights on" (Appelbaum & Gutheil, 1979; Gutheil, 1980). Liberty, they say, is a treasure to be guarded but not worshipped (Mulvey et al., 1987, p. 574). Proponents of CCT, thereby consider it society's responsibility to force treatment upon those who, "because of the nature of their illness," refuse it.

A focus on individual rights versus one on the system's responsibility, a social control versus a medical model of interpretation, a bio-psychiatric versus an anti-psychiatric perspective, a civil libertarian versus a paternalistic or *parens patriae* conviction: the collision of views is categorical.

HIGHLY PRIZED CONCEPTS, OPPOSING VANTAGE POINTS

In deconstructing their respective arguments, it becomes clear that each side approaches today's many highly prized concepts from very different vantage points. One of these concepts is the principle of the least restrictive alternative. The doctrine of the least restrictive alternative refers to the objective of maintaining the greatest degree of freedom; self-determination; autonomy; dignity; and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services (Hiday & Goodman, 1982). Compared to inpatient civil commitment, outpatient commitment is maintained to be the least restrictive alternative. It allows the person deemed mentally ill greater liberty than if hospitalized. Compared to voluntary community treatment however, compulsory community commitment is not at all the least restrictive alternative. It is primarily a means of controlling and of depriving someone of his or her liberty even in one's "natural milieu." In other words, if the argument focuses on the locus of treatment—hospital or community—CCT is the least restrictive. But if one's argument focuses on the level of intrusiveness and on the level of choice in treatment, CCT is not necessarily the least restrictive alternative. In some of its dimensions, it may even be more restrictive than inpatient civil commitment. Indeed, contrary to inpatient commitment, which, in most legislations recognizes the right to refuse treatment, including psychosurgery, electroconvulsive therapy (ECT), and psychoactive drugs, unless shown incompetent, CCT, by definition⁴ denies such right and holds the potential to monitor and control a patient's entire life; place of residence, presence in day clinics, the consumption of alcohol, the acceptance of case management, etc. (Anderson, Hogarty, & Reiss, 1980; Falloon et al., 1982; Mulvey et al., 1987). Ultimately, the de facto choice for the unwilling participant in psychiatric services may very well be between hospitalization without medication and controlled community living with forcibly injected medication.

Another key concept in this discussion, interpreted in two very different ways, is continuity of care. From a "pro" side, CCT becomes part of a helping strategy which would facilitate the passage from institution to community and solve the continuity, that is, the "drop out" and the "no show" problems. Well managed continuity of care is in fact considered to be the system's and the providers' responsibility to their clients and to their families, and CCT is one strategy to live up to this responsibility.

In the language of those who oppose CCT, continuity of care, imposed or not, is another "institutionally" tinted concept which extends the hospital's tentacles into the community (White, 1992), thereby raising the danger of indefinite submission and attachment to the medical institution. As an opponent to CCT says, "CCT transforms one's private home and personal sanctuary into a mini-institution" (personal statement from an Ontario survivor).

The disagreement over continuity of care stems largely from the different meanings each side attributes to the term "community" and to the relationship community entertains with hospital. For those who speak in favour of CCT, this relationship is understood in terms of a "link," a "continuum." For those who oppose CCT, this relationship is that of a "split." For the former, the hospital is a

central and accessible part of the community; it is, as one Ontario respondent put it, "a pulse point" in the community. For the latter, hospital and community are opposites, the community is the alternative to the institution. On the pro side, the consumer's identity is that of an "in-patient" in the hospital and an "out-patient" in the community, and CCT guarantees the return to the hospital if the patient stops acting as a conforming patient. On the opposing side, community represents citizenship, freedom, normalcy, and not patienthood. Community and compulsory treatment are therefore antipodal, contradictory concepts. Community comes associated with liberty. Affordable and adequate housing, work and sheltered workshops, life skill supports, crisis centres, drop-in centres, self-help, mutual help, and talking therapies are, on the pro CCT side, intermediary services which ideally will complement compulsory medication. On the side of those who oppose CCT, these services are the essential alternatives (White & Mercier, 1989).

Continuity of care is also increasingly used synonymously with the concept of case management (Krauss, 1989, p. 283), an essential component of CCT. Ideally, CCT promises a careful management of treatment permitting the enforcement and regular monitoring of individualized plans as well as the detection of early signs of relapse (Bursten, 1986). The concept of case management from the standpoint of those who refuse CCT is in itself unacceptable terminology as it transforms persons with mental problems into cases to be managed and helpers into brokers. It is an intrusion into one's personal space. Basically, what they say is: "We are not cases and you are not managers" (Everett & Nelson, 1992, p. 49). From that vantage point, CCT is a "leash law" which deprives one of his or her own personal responsibility to make choices (even bad ones). The helper's responsibility, as they see it, is to see people's strengths, not deficits; to empower, not control; to facilitate partnership, not the management of cases. And partnership, by the very nature of the word, excludes coercion and the presence of all-powerful managers (see on partnership: Boudreau 1991a,b). In fact, from the survivor's viewpoint, partnership requires professionals to move over (Church, 1992).

Paradoxically, both sides make their claim in the name of autonomy. Both sides would agree with Borovoy's statement that "the exercise of autonomy is essential to the experience of dignity . . . and a sense of dignity requires some control of one's destiny" (1988, p. iv). From the "pro" standpoint, CCT provides the chronically ill patient with a chance to live "autonomously" in his or her community as it is meant to avoid decompensation, loss of control, the possible breakdown of one's living conditions, and a decline in one's quality of life. For the other camp, however, autonomy through forced treatment is nonsensical. It is another contradiction in terms. Forced treatment is an insult to one's integrity, one's dignity. "Autonomy" here means that the person is the author of his or her own personal decisions; one is a free agent. It means that dropping out, refusal to take prescribed medications, and missed appointments in many instances are signs of one's personal agency and must be recognized as such. It means that instead of compelling a person to undergo treatment or exercising some form of punishment for disobeying treatment orders, one must inquire about, respect and address the reasons which motivate a person's decision not to comply. These may include the experience of disturbing side effects, the fear of tardive dyskinesia and

thus be the result of the person's own "cost-benefit" evaluation. Reasons may also include the absence of a support system, the prohibitive cost of transportation or medication, discouraging living conditions or absence of a home base, absence of family support or of child care, or personal humiliation at being forced into something against one's will. Non compliance may also be motivated by the strong desire to cope by oneself with one's problems or again by the conviction that the system just does not offer what the client really needs (see White, 1992, on non compliance, personal agency, and continuity).

Individual reasons for non-compliance have been addressed in psychiatric terms as "defect in insight," "intentional, involuntary behavior" (McEvoy, Appelbaum, & Apperson, 1989; McEvoy, Apperson, & Appelbaum, 1989; McEvoy, Freter, & Everett, 1989) or "volitional disability" (Ferrell, Price, & Gert, 1984). When advocates of CCT speak of rates of "recidivism," "drop-out," or "no-show," this is the language they speak. As Scheid-Cook (1988) reports: "Despite the patient's obvious resistance to medication, the clinicians expressed little or no concern about the causes of this resistance, or about whether the medication actually helped patients attain stability within their communities" (p. 168). In fact, North Carolina's clinicians expressed "little sympathy for the patient's troubles (related to the side effects of their medication)" (Scheid-Cook, 1991b, p. 74).

Compliance being the primary concern, free will and personal agency does not enter into consideration as the assumptions they make about mental illness lead them to discount patient claims (Holstein, 1987). On the other hand, neither do dangerousness, threats of violence, and severe psychoses appear to be taken into consideration in the anti-CCT discourse on autonomy and personal agency. These blind spots in their respective arguments mean they are talking past each other. One is largely concerned with the severely dysfunctional, potentially dangerous, or self-destructive individual, spouse, sons or daughters, who, they maintain, could remain in the community under strict chemical control. It is a purely functional stance which requires a strict definition of criteria for the identification of "appropriate cases." The other is concerned with chronically disturbed individuals, as a collectivity or as fellow survivors, who are at risk of being caught in the CCT net. It is a defensive stance, inspired by a profound distrust in the system and which, in principle, does not allow room for the possibility of so-called "appropriate cases."

Within the first mindscape it is nonsensical to speak of the individual who does not comply, as a personal, autonomous agent; within the other, it is a must. Within the first mindscape, what the individual needs is management, monitoring, and control. Within the other, what the individual desires is some assistance and extra support in establishing and pursuing his or her personal agenda; it is understanding and empathy; it is respect, recognition, and personal empowerment, not the threat of hospitalization, rehospitalization, or even jail.

Opponents see a clear flaw in the logic of threat which underlies CCT. Presumably, a person who is able to understand and respond to this threat by complying to treatment is therefore presumed to be able to make a good, sensible choice. If this person is seen as sensible enough to wish to avoid the threatened punishment, why is he or she not accepted as sensible enough to decide whether or not to conform to treatment of his or her own volition? In a certain sense,

there is a recognition of the individual's power to make a decision, as long as it is in relation to that threat only.

Also part of the conceptual argument for and against CCT is the concept of prevention, but again from two different vantage points. CCT is defined as prevention because it promises to "forestall anticipated deterioration, which could result in a person's meeting the stricter standards for commitment to a hospital" (Wilk, 1988, p. 133). From the opposite standpoint, what is needed is "prevention," indeed, but of drug dependency and of its hazardous side effects. It is the prevention of an early or continued stigmatization and psychiatricization of the individual and this in his or her own living environment. It is also prevention of the possible overuses and abuses which might ensue should CCT be legally permitted, where the burden of proof might be placed not on the professional who wants to impose it, but on the individual consumer/survivor who opposes it.

Cost-effectiveness is another one of today's highly valued concepts which finds its way in the discourses over CCT. From a pro-CCT standpoint, it is deemed extremely expensive for the system and a loss of valuable professional energies to regularly readmit people in hospital who after release habitually stop taking their medication and "decompensate." From the standpoint of those who oppose CCT, however, its so-called cost-effectiveness is the product and could ultimately become the cause of a cop-out on the part of government against providing the full range of services indispensable for a balanced community-based mental health system. "It may be used as a rationale for decreasing the already minimal funding for outpatient services" warns an American psychiatrist (Leong, 1987, p. 694). Fennell, in Great Britain (where CCT is not adopted but under consideration), also warns that community treatment orders might provide the underpinning of a system of community care "on the cheap" (1992, p. 229). Addressing these very real worries, a study of Washington State's expanded inpatient commitment law insightfully concludes "... if a state legislature is determined to expand dramatically the reach of the involuntary civil commitment system, it must at the same time appropriate adequate additional resources if it is to have any hope of achieving the therapeutic purposes sought" (Durham & LaFond, 1985, p. 444).

This leads us finally, to the term "humane," also a favourite of the pro- and anti-CCT discourses and also a chameleon-like concept whose meaning depends on the vantage point from which it is displayed. Repeatedly, among Ontario and American proponents, CCT is said to be the only humane solution to the current abandonment or dumping of chronically mentally disordered persons. The alternative to CCT, they say, is continued homelessness, distraught families, dangerousness, violence, suicide, needless pain, and suffering. The alternative according to the anti-CCT discourse is a more "humane" system offering a broad spectrum of community services voluntarily selected; it is not a "leash law" which contradicts one's most fundamental human rights, where compliance is policed and chemically tested⁵ and where rehospitalization or even prison become the threat and punishment. Leash laws, as the term suggests, are not for human beings, they are "inhumane."

It is very clear that a fundamental disagreement over proper terminology and over the meanings which lay behind key concepts has dominated discussions over CCT. The end result is truly representative of the content of the discourses which

compete in the entire field of mental health. When these two discursive strategies meet, each taking on the uneven quality of "partly convincing truths" the end result is tricky to disentangle. Adding to the ethical, moral, and paradigmatic choices to be made here, there are, as well, a number of procedural issues which must be taken into consideration when making the decision of whether or not to introduce CCT legislation. First and foremost amongst these issues is the establishment of reliable criteria for appropriateness.

THE ESTABLISHMENT OF CRITERIA FOR APPROPRIATENESS

Policy makers will see the identification of strict and reliable criteria for appropriateness, is a *sine qua non* condition for the adoption of any form of CCT. Proponents recommend the procedure generally for "patients" who meet certain criteria such as a history of multiple hospitalizations, a good response to medication, low insight, a failure to comply with voluntary outpatient treatment, and frequent and severe relapses (Band, Heine, & Goldfrank, 1984; Mulvey et al., 1987). Anti-CCT lobbyists in the United States argue that these criteria have been based on partisan measures. They claim not only that the standards used are insufficient to justify CCT, but that these standards themselves are subject to too much interpretation to be valid. Studies show, indeed, that the selection of candidates for CCT is marked by unpredictability and arbitrariness. When Scheid-Cook (1987) questioned if the people targeted and actually affected by CCT were indeed the people who met the criteria for appropriateness, she found that:

OPC (outpatient commitment) was explicitly designed for chronically mentally ill, revolving-door patients with a history of medication refusal that predictably results in mental deterioration and the potential for dangerous behavior. Most ordered to OPC meet at least one of these criteria, although few meet them all (p. 173).

Miller and Fiddleman (1984) found statutory guidelines alone were not sufficient to prevent inappropriate placements: judges were in fact ordering OPC against the explicit recommendation of hospital and community mental health centre (CMHC) staff. All this is not reassuring and led such people as Geller (1990), a strong advocate of CCT, to work on elaborating refined criteria for the careful selection of potential involuntary patients as a necessary condition for the proper use of CCT. On the basis of his analysis of a number of case studies, Geller developed 10 sequential guidelines that can help clinicians identify patients who are appropriate for CCT. These include:

1. an interest on the part of the patient in living in the community; but
2. previous failures to remain; 3. a degree of competency necessary to understand the stipulations of his or her involuntary community treatment;
4. the capacity to comply; 5. demonstrated efficacy of the treatment when used properly by the patient in question; 6. treatment must be such that it can be delivered on an outpatient basis, (is) sufficient for the patient's needs and (is) necessary to sustain community tenure; 7. the treatment can be monitored by outpatient treatment agencies; 8. the outpatient treatment system is willing to participate in delivering the treatment and enforcing compliance; 9. the public sector inpatient system must support the outpatient system's participation; and 10. non dangerousness⁶ when complying with the ordered treatment (Geller, 1990, pp. 751-753).

Furthermore, the degree of competency necessary to understand the stipulation of the CCT (guideline 3) is deemed different from the competency necessary to give informed consent—for if there is informed consent, there is no need for CCT. Geller adds:

To require candidates for involuntary outpatient treatment to demonstrate the competency necessary for informed consent would have the paradoxical effect of demanding a level of competency that in many jurisdictions would enable them to exercise the right to refuse treatment (1990, p. 751).

Nevertheless, it is highly unlikely one could consistently discern and standardize such a distinction between "levels of competency." Knowing that "the competency parlance is full of value contradictions and global assertions which disguise social and community interests" (Weisstub, 1990, p. 31), knowing "that we do not have the tools currently to understand the deeper levels of subjective appreciation or emotional and intellectual compatibility tied to the decision to accept a treatment" (Weisstub, 1990, p. 31), one cannot underestimate the complexities involved in ascertaining that the uses of CCT will always be appropriate—even with an extremely refined set of criteria.

A PLETHORA OF PROCEDURAL AND LEGAL COMPLEXITIES

Since 1985, a few American authors have extensively surveyed the entire spectrum of statutes and procedures on CCT as enacted in the various American states, emphasizing the great variety in modalities from state to state, the blurred definitions, the lack of standardization, the complex court procedures, as well as the myriad of legal and practical questions and precisions which must be dealt with for the smooth and effective implementation of CCT (Hinds, 1990; Keilitz & Hall, 1985; McCafferty & Dooley, 1990). In their decision as to whether or not to adopt CCT, Canadian policy makers would have to consider these and many other legal and procedural questions: What establishment will be responsible for ordering CCT: commitment courts, mental health boards? Of whom will they be constituted? How many should there be in the province and how will they proceed? Who will be allowed to petition and through what process? What would be the rules and statutory procedures for the actual ordering of CCT? Would it necessitate prior hospitalization or is preventive CCT also acceptable? What would be the standards for invoking outpatient commitment? What about the "dangerousness" standard which is deemed necessary by American courts where CCT statutes based solely on standards of "in need of treatment" or "in the best interest of the patient" have been struck down (Hinds, 1990, p. 403)? What about the questionable "anticipation of future dangerousness" as a standard? On what basis can the now recognized "right to refuse treatment" be abrogated? How is this compatible or incompatible with the Canadian Charter of Rights and Freedoms and with existing provincial mental health legislation? When is CCT clearly "the least restrictive alternative"? What forms of treatment can/should be included in the court order? Who develops the initial outpatient treatment plan: the original inpatient facility, the outpatient facility, the physician responsible for outpatient care, or all three in cooperation (as in several states)? Is consultation with the patient included (as in the Texas statute)? What must the treatment plan in-

clude?⁸ What rules and procedures are to be enacted to monitor compliance: "regularly scheduled testing of blood medication levels, compulsory meetings with the outpatient psychiatrist or a required frequency of meetings with support workers" as suggested by Geller (1990, p. 753)? How is enforcement for noncomplying patients to be carried out? By whom? What is the role of the police in this process? Can they legally use force to bring the person to submit to monitoring tests and to medication (Schmidt & Geller, 1989)? Can a person who is violating his or her CCT orders but does not seem to pose any immediate danger be forcibly medicated or rehospitalized? What kinds of threats can be used against non-compliant patients: hospitalization or rehospitalization, forced medication through injection, implying the use of physical force (prohibited in some states such as North Carolina and Hawaii), jail for contempt of court (held as inappropriate by the Indiana Supreme Court in *Tarpley*, 1991)? Are these threats legally enforceable (doubtful according to many such as Hinds, 1990)? But isn't enforcement, according to the logic of CCT, a *sine qua non* requirement for effectiveness? How much teeth does the legislation need to have to be "effective"? How much discretion is the physician or institution responsible allowed to have in carrying out the order? Who is liable should a patient under CCT, become dangerous and violent, or commit suicide (Birch, 1992; McMahon, 1992)?⁹ What procedures must be enacted to change and/or revoke CCT when necessary? What about the patient's right to counsel? to advocacy? What procedural safeguards must be adopted against erroneous decisions, overzealous and abusive imposition of treatment? How will one distinguish between "punitive action" and "treatment action"? Are there maximum time limits for CCT? Will periodic reviews, as in many jurisdictions in the United States, be obligatory? What new human resources would have to be injected in the system to set up, implement, and regularly evaluate the system? What would be the financial implications of the entire exercise? Would it not be better spent in strengthening community-based services? And last but not least, in light of "the imprecision of psychiatric diagnoses and improper use of medications (as well as the history of institutional abuses of the mentally handicapped) and vague standards allowing professional judgements about patients' 'need' for treatment and 'inability' to make the 'correct' decision" (Hinds, 1990, p. 406), how can one feel confident enough to so drastically expand the state's and the psychiatric system's powers over the individual?

These are only some of the questions which immediately come to mind and need contemplating as Canada's policy makers "further their thoughts on the issue." "Perhaps the greatest error in implementing this policy," we are told, "is to underestimate its complexity" (Mulvey et al., 1987, p. 582).

To what extent is Canada willing to invest its legal resources and energies in sorting out the entire panoply of procedures related to CCT and what would be the return for this investment?

REPORTED EFFECTIVENESS

What do we actually know of the effectiveness of CCT? As yet, very little. Convinced CCT advocate and researcher, Dr. Jeffrey Geller, admits that "social control through the use of coercive outpatient treatment protocols demands demonstration of its efficacy beyond what exists to date" (1992, p. 92).

One must look critically at the existing attempts to verify the effectiveness of CCT where implemented. While earlier studies reported no clear data regarding the outcome of involuntary outpatient treatment (Miller & Fiddleman, 1984; Roth & Appelbaum, 1982), studies of "effectiveness" published in recent years have generally and increasingly reported an apparent "success" measured in terms of declining readmission rates (Keilitz, 1990), reduced inpatient stays (Van Putten, Santiago, & Barren, 1988), prevention of unnecessary readmissions (Band, Heine, Goldrank, 1984; Geller, 1986a,b; Schneider-Brauss, 1986; Zanni & De Veau, 1986), diverting patients from inpatient to outpatient care and maintaining compliance with treatment (Hiday & Scheid-Cook, 1987, 1989, 1991), reduced levels of dangerousness (Sensky, Hughes, & Hirsch, 1991a,b), and finally, increased voluntary use of after-care services and continued treatment even after commitment (Van Putten et al., 1988).

These "effectiveness" studies tell us, in other words, that CCT "generally" meets the system's needs for lower hospital census and slower revolving-door admissions of chronic patients, thus, presumably reducing some mental health costs (Scheid-Cook, 1991a). They, however, tell us very little about how individual needs were met: those of the therapist in the exercise of his or her practice and especially those of the client in remaining in the community. They tell us absolutely nothing about individual satisfaction and quality of life.

Scheid-Cook's follow-up studies (1987, 1991a,b) in seven North Carolina counties are more worrisome than enticing as they reveal that (a) the extent and nature of enforcement as well as the understanding of CCT's purpose varies from therapist to therapist, from CMHC to CMHC; (b) therapists use their own discretion in enforcement (one entry reads: "while I could have moved in January to have Mr. ____ picked up for examination, I opted not to . . . because he remained non-psychotic even though off hospital meds." However, it concludes with: "This person was committed soon after in New York where he was found wandering around psychotic"); (c) clinicians generally used milder persuasion (letters and telephone calls) rather than harsher compliance methods (calling the sheriff); (d) the majority of patients receive psychiatric medication as the "bottom-line" form of treatment for all CCT patients, rather than alternative treatments, even though 90% experience problems with side effects; (e) patients are likely to be male, middle-aged, black,¹⁰ single, unemployed, from rural or small towns, have less than high school education, have a primary diagnosis of schizophrenia, and been dangerous in the week prior to becoming commitment candidates; (f) generally clinicians found OPC helpful "because it gives some leverage over respondents"; and (g) clients themselves often liked going to the CMHC and felt that it was better than hospitalization. All in all, Scheid-Cook concludes that CCT "worked" because it provided both the power of social control (for the therapist) and greater individual liberty (for the patient) (Scheid-Cook, 1991a,b). In other words, CCT emerged as the middle-range solution between the total social control of hospital commitment and the total liberty of community living.

One must wonder, however, if such control and such restrictions on liberty are absolutely essential in order to achieve the basic goals pursued by CCT: low readmission rates and greater lengths of stay in the community.

FOR TRUE COMMITMENT: COMMITTED "OUTPATIENTS" OR A COMMITTED COMMUNITY SYSTEM?

The search for an accurate perspective on CCT would require us to see to what extent the recorded "successes" of CCT are actually caused by the compulsory nature of treatment or by the fact that with CCT, it is not just the client who is committed, but also the treatment team. In North Carolina, for instance, community centres that had the most "success" encouraged the compliance of patients under CCT through an aggressive search for appropriate local resources and through active, involved, and frequent staff contact:

They created new positions or hired new personnel to monitor and supervise patients who were committed to outpatient treatment; kept contact with the state mental hospitals, the courts, and sheriffs; made home visits; and provided services needed to maintain the patients in the community. Not all of the centers were rich in resources and programs, but they aggressively reached out to patients. They located other community programs to supplement what they lacked and found housing, transportation, part-time and full-time employment, training, recreation, child care and money for medication (Hiday & Scheid-Cook, 1989, p. 58).

Appropriate housing, jobs and skill training, educational programs, recreation, child care, home visits: isn't it likely that these are the determining factors of "success" and not the compulsory nature of the "treatment"? Controlled evaluative studies of continuous care teams in the intensive outpatient treatment of chronically mentally ill patients (Arana, Hastings, & Herron, 1991) as well as studies of ACT, or Active (Assertive) Community Treatment programs (Bond et al., 1990; Mowbray, 1990; Stein & Test, 1980), which focus "on the practical, here-and-now life concerns of persons with serious and persistent mental illness" (Bond et al., 1990, p. 866), report similar successes in reducing the frequency of crises as well as readmission rates and decreasing the frequency and duration of hospitalization while at the same time, facilitating the development of long-term supportive therapeutic relationships. Some studies have also found clients involved in such programs have greater satisfaction with services (than the control groups), better vocational outcomes, fewer legal problems, and/or fewer psychiatric symptoms (Olson, 1990). Continuous care teams, ACT, as well as the growing variety of consumer-controlled/client-operated frameworks for support and neighbourhood mutual-aid projects involving "natural helpers" (Guay & Chabot, 1992) do not necessitate CCT as a coercive tool, but they depend on human contact, assertive involvement and persistent outreach on the part of the community workers (be they professionals or survivors) in the person's natural milieu. They feature, among other things, a primary reliance on *in vivo* assistance and training of clients in the major areas of client functioning (social, residential, vocational, etc.), "attention" to psychotropic medication, and a heavy emphasis on teamwork and/or partnership. Such models of practice require commitment indeed, but toward the person in need. They require thrust, not threats. They also require determined, genuine, and undeviating government investment in community mental health. In other words, what today's mental health system unequivocally requires is real commitment.

CONCLUSION

Perhaps Canada's "political will" will decide to put the issue of CCT on the back burner with the conclusion that in this tricky exercise of balancing advantages and weighing risks, the risks are much more convincing. Perhaps today's "political will" will decide that it is time to give "true deinstitutionalization," "building community support for people" (Graham, 1988), and "partnership" a real chance before adopting drastic and questionable legal and coercive procedures. For above the conceptual entanglements and colliding positions around CCT, one must not ignore the growing expressions of faith on the part of survivors, family members, service providers, mental health service planners, and administrators alike in the development of effective and workable partnership models within a strengthened community-based mental health service system. This will also require the federal and provincial governments to follow through, politically and financially, with their recent commitment to a balanced mental health system. This suggestion is not new (CMHA, 1991; Health and Welfare Canada, 1988; Simmons, 1990) and even in our restricted economic times, it is well worth listening to. CCT is simply not "the best possible alternative"!

NOTES

1. Miller reports (1988) that every state except New York (because of expected resistance from civil libertarians) permits some form of outpatient commitment. McCafferty and Dooley (1990) specify that legislation on Involuntary Outpatient Commitment (IOC) varies from state to state. A number of state laws specifically list IOC, others use more vague statutory language, specifying only that the treatment ordered must be "the least restrictive alternative." States, in increasing numbers, say the authors, are now passing laws to authorize it as such, to enhance or further refine its use.
2. Section 21 of the Ontario Mental Health Act (1990) provides for a conditional leave of absence which implicitly could allow for some form of CCT analogous to parole in the criminal justice system. No data is available, however, on the extent to which this provision is used to force compliance in taking medication or in continuing treatment across the province.
3. See Boudreau and Lambert (1993) for a detailed exposé of the four possible forms of CCT as presently in effect in various American states.
4. Hinds (1990) notes that
although some commentators assume the right to refuse treatment is necessarily sacrificed during outpatient commitment, this proposition, they say, is not self-evident. Arguably, if a patient will unequivocally refuse outpatient treatment, he is not a suitable candidate for outpatient commitment. . . . Although a patient who is likely to comply with outpatient treatment arguably does not need involuntary commitment, some patients are more likely to comply if they are obligated to do so under a court order (p. 369).

Hinds cites Arizona state legislation whereby "outpatient commitment may be ordered only if the court finds that the patient will follow a prescribed outpatient treatment plan" and Tennessee legislation, which states that "patients may be discharged to outpatient treatment if the patient is likely to participate in outpatient treatment with a legal obligation to do so; and the patient is not likely to participate in outpatient treatment unless legally obligated to do so" (p. 369). Presumably, we are to understand

from this questionable argument, that a person can be forced into treatment if he or she is willing to comply to it, in a sense voluntarily, and that therefore this does not sacrifice his or her right to refuse treatment.

5. According to Mulvey et al. (1987), "the most efficient and valid way to monitor compliance with a chemically based treatment program is to use methods such as regular depot injections or blood tests" (p. 576).
6. We need not review here the literature which raises profound doubts on the ability to demonstrate and predict dangerousness and on the procedures to establish incompetence (for an excellent discussion of this, however, see Ewing, 1991; Hiday, 1990; and McMahon, 1992). We will not review either the abundant literature which stresses the imprecision of psychiatric diagnoses and the history of improper use of medications. These are all important points to consider when "furthering our thoughts" on CCT.
7. It is important to know also that some outpatient statutes abrogate the right to refuse treatment on the basis of past histories and anticipated future needs (Hinds, 1990), and not on the basis of incompetence.
8. In Nebraska, for instance, the treatment plan must contain: a statement of the nature of the specific mental and physical problems and needs of the subject (sic), a statement of the least restrictive treatment conditions necessary to achieve the purposes of the board's order, and a description of intermediate and long-range treatment goals, with a projected time table for their attainment (see Hinds, 1990).
9. Geller (1992) reports that some states have introduced statutes that grant limited immunity to psychiatrists treating patients under outpatient commitment orders.
10. Information on characteristics of CCT patients is very inconsistent, limited, and may be related to the demographic composition of the state from which the statistics are taken (e.g., predominance of blacks in North Carolina). Band et al. (1984), for instance, found CCT patients in the District of Columbia were more likely to be females with a diagnosis of schizophrenia and bipolar affective disorder. Male outpatients, when compared to committed female outpatients, were more likely to have been married, be younger, have a greater number of readmissions, and were likely to be diagnosed as suffering from schizophrenia, schizoaffective disorder, bipolar affective disorder, or alcohol-related pathology.

RÉSUMÉ

Cet article poursuit l'étude de la question très controversée du traitement non volontaire dans la communauté des personnes dont on prétend qu'elles connaissent des problèmes mentaux. Nous mettons en opposition les principaux arguments avancés par les promoteurs et les opposants du traitement communautaire non volontaire pour convaincre les décideurs politiques de la justesse de leurs positions respectives et influencer la législation à venir. Nous identifions des questions pratiques de base à considérer avant de poursuivre la réflexion sur la question. Nous suggérons que ce dont un système de santé mentale a besoin sans équivoque est un engagement réel de la part du gouvernement quant à une implication politique, organisationnelle, et financière accrue en vue de modèles de partenariat efficaces et d'un système de santé mentale équilibré.

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