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Editorial

Hospitalisation and compulsion: the research agenda†

Tom Burns and Jorun Rugkåsa

Summary

Keown *et al*'s paper highlights the complex nature of social determinants of hospital admission and compulsory care. We review here how research into compulsion in mental health has progressed beyond epidemiological studies of rates of admission. There is now a wider recognition of the range of compulsory and coercive processes used and how they are experienced by patients. The results of recent studies have confirmed the importance of confronting the complexity that Keown *et al* have presented. They have also produced unexpected and intriguing findings that set the direction for future research.

Declaration of interest

T.B. and J.R. were the principal investigator and manager respectively of the OCTET CTO trial.

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Tom Burns (pictured) is emeritus professor of social psychiatry in the Department of Psychiatry at the University of Oxford. Jorun Rugkåsa is a senior researcher in the Health Services Research Unit at Akershus University Hospital in Norway and an honorary senior researcher in the Department of Psychiatry at the University of Oxford.

The study of hospital admissions by Keown and colleagues in this issue of the *BJPsych* is doubly welcome.[1] First, they take a refreshing approach by investigating links between the social characteristics of geographical areas and hospital admissions rather than just individual patient characteristics and outcomes. This way, they remind us how structural and social issues can shape mental health, and why the link between social deprivation and mental ill health is essential for both health service and broader social planning. Recent work on 'ethnic density'[2] has added weight to the conclusions from decades of research that social circumstances are not just associated with poor mental and physical health but important contributors to it.[3]

Their study is also welcome because it handles the issue of compulsion in a clear, rational manner, free of the polemic that has often characterised writing in this area. It is a serious scientific enquiry into a controversial yet necessary practice. Mental health legislation exists to ensure that effective intervention and treatment is promptly available for those who need it but do not recognise that need. It can also protect patients, and others, from harm and ensure humane treatment within the judicial system. Psychiatrists should be no more apologetic about the appropriate use of the Mental Health Act than surgeons should be about making incisions into our bodies.

The debate on striking the right balance between patient autonomy and the duty to provide care to those in need is still, however, far from settled. Indeed, it is likely to intensify given the 2008 UN Convention on the Rights of Persons with Disabilities (CRPD). This challenges practices that restrict people's liberty on the basis of their disability, which is commonly interpreted to include mental illness.

Compulsion in mental healthcare is increasing, not decreasing. Evidence from across Europe indicates a more or less universal increase although rates vary markedly, and inexplicably, across different countries.[4] With the international spread of community treatment order (CTO) legislation, the use of compulsory powers is now also common for out-patients. This expansion has stimulated the rise of systematic research to understand coercion more fully, beyond legal interpretations or comparisons of national rates of involuntary admission. The literature now addresses a number of new areas including: (a) establishing who is assessed for, and subject to, compulsion; (b) identifying distinct forms of informal pressurising practices and establishing their prevalence; (c) investigating patients' experience of coercion that may or may not correspond to their legal status; (d) establishing the effectiveness and outcomes of compulsion. We will attempt briefly to summarise some recent advances in these research areas.

Who is assessed and subject to compulsion?

Keown *et al*'s paper is an example of the increasing sophistication of enquiry into who is subject to compulsion.[1] It shows that high rates of compulsion result from combinations of factors, not single causes. The importance of age-related variables, and the reminder that we need to pay close attention to the context within which patients and services are placed, should be taken into account in future research. The AMEND study also broke new ground by investigating the likelihood of detention among those assessed under the Mental Health Act. A diagnosis of psychosis, the presence of recognised risk, female gender, level of social support and being assessed in London all predicted detention. Both AMEND[5] and Keown *et al*'s study,[1] found that ethnicity (long a focus of heated debate[6]) was not an independent predictor of detention.

Treatment pressures

New models have been developed for describing the wide range of pressures placed on patients to adhere to treatment without resorting to compulsion. Szmukler & Applebaum[7] suggest a hierarchy of such pressures rising from persuasion, interpersonal leverage ('do it for me'), inducements ('if you do it then I can . . . '), threats ('if you don't do it then . . . ') and finally legal compulsion. 'Leverage' is now commonly used to describe when some concrete benefit (accommodation, leniency from the court, etc.) is made explicitly contingent on adherence to treatment and is the most researched of these pressures. In US studies, around

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half of public mental health patients report it[8] and in Europe the same pattern of leverage has also been found, albeit at lower rates.[9,10] Links between these types of informal pressures and formal compulsion, patient characteristics and outcomes remain to be explored.

Patients' experience of coercion

Early studies reported that many patients who were in treatment voluntarily still felt coerced and, more surprisingly, a smaller number of involuntary patients did not feel restricted.[11] Research has benefited from the widespread use of the MacArthur Admission Survey by which patients rate their experiences of 'perceived coercion', 'negative pressures' and 'procedural justice'.[12] How compulsion is applied can modify the experience: patients who feel they had a say and that the process was fair (procedural justice) often report less perceived coercion.[10] Compulsion may also, contrary to expectations, not necessarily damage the therapeutic relationship.[13]

Does compulsion work?

The evidence base for the effectiveness of in-patient compulsion is meagre and understandably hard to obtain. Most jurisdictions require a doctor or magistrate to be convinced that compulsion is immediately necessary. Not surprisingly, no randomised trials have been conducted. Observational studies are also fraught with difficulties, and the literature gives no clear results. Systematic reviews of (by and large uncontrolled) studies indicate that a slim majority of patients (39–75%) report in retrospect that their involuntary admission 'was right' for them, whereas 10–47% still consider it unjustified.[14]

For out-patient compulsion (CTOs), there has been more research into its effectiveness and this has been extensively reviewed.[15] Before and after studies are of varying methodological quality and either use CTO patients as their own controls or compare outcomes with matched controls from the same service. Their sample sizes vary widely from a few dozen to several thousand patients and results are contradictory: in some studies relapse and admission to hospital is increased in the CTO group, in some it is reduced and there is no difference in others.[15] Three randomised controlled trials have been conducted and all clearly demonstrate no benefit in terms of both their common primary outcome (rate of readmission) and in a wide range of other measured outcomes.[15]

Future direction of research

There are undoubtedly many dimensions to admission rates and compulsory treatment that deserve attention and work is currently under way to explore a range of impacts. These include whether CTO use reduces the use of other coercive practices, whether there is evidence of a hierarchy of pressures being sequentially utilised by clinicians before compulsion is imposed, and how compulsion and coercion affect the therapeutic relationship. Qualitative work has demonstrated a range of responses to compulsion in both patients and their families. That patients all disapprove of compulsion and families all welcome it is not bourne out in these studies which report much more nuanced experiences.[16]

Improved understanding of the outcomes of coercion and how it affects those experiencing it are two key areas where research is urgently needed. Keown *et al*'s article directs our attention to factors that shape these experiences.[1] In demonstrating the links between in-patient treatment, both voluntary and involuntary, and several aspects of deprivation it highlights the need for structural issues to be included in future analyses. Investigating the mechanisms by which the specific characteristics of these deprived, urban areas affect the course of illnesses, the rate of admission to hospital and the use of compulsion is a daunting research challenge but one which may bring great rewards.

Tom Burns, DSc, Department of Psychiatry, University of Oxford, Oxford, UK; **Jorun Rugkåsa**, PhD, Health Services Research Unit, Akershus University Hospital, Lørenskog, Norway, and Department of Psychiatry, University of Oxford, Oxford, UK

Correspondence: Tom Burns, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, UK. Email: tom.burns@psych.ox.ac.uk

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