NOTE

The rising tide of compulsory admissions: is any remedy available?

Sonia Johnson
Mental Health Sciences Unit, University College London, Charles Bell House, 67-73 Riding House St, London, W1W 7EY, s.johnson@ucl.ac.uk

The UK has achieved some success in shifting mental health care from institutional to community settings, but with one important and disappointing limitation. Compulsory admissions have risen steadily over the past two decades in the UK and in some other countries undergoing similar deinstitutionalisation processes.[1,2] Possible service-related explanations include shortages of acute beds, resulting in delayed admissions and early discharges of people who remain unwell,[1] increasingly risk-averse clinicians,[3] patients' reluctance to be admitted to crowded and unpleasant wards,[4] and the closure of long-stay wards, resulting in more people with severe illnesses residing in the community. Candidate societal contributing factors include rises in social exclusion and isolation, or in substance misuse among the mentally ill,[5,6] and a decline in deference that could make patients less inclined to do as professionals instruct.[7]

We have insuffi cient data to allow us to assess these potential explanations. Still more pressing is the need for an evidence-based remedy for this worrying rise in compulsory admissions. Unfortunately, provision of alternatives to admission, such as intensive home treatment, does not by itself reduce compulsory admissions.[1,2,8] As such, the fi ndings of two studies by Tom Burns and colleagues[9] and Graham Thornicroft and colleagues[10] published in *The Lancet* are of considerable importance. The authors present high-quality assessments of two contrasting strategies for attempting to turn back the rising tide of compulsory admissions.

The OCTET study[9] is remarkable as a randomised trial of a new legal power (legislation is rarely tested so rigorously). Supervised Community Treatment Orders (CTOs) were introduced in England and Wales in 2008 through the addition of new sections to the 1983 Mental Health Act.[11] People detained for treatment in hospital under the Mental Health Act can be placed on a CTO on discharge. Conditions with which they are expected to comply vary, but very often include contact with a mental health team and adherence to medication. If conditions are breached, they can be recalled to hospital. The purpose of CTOs is to allow a group of patients with a history of frequent compulsory admissions to be safely and eff ectively managed in the community. The findings of the OCTET study indicate that CTOs have no eff ect on patterns of admission—this outcome should not be surprising, since it replicates the limited international evidence.[12] Some methodological limitations are identified by the authors: however, the continuing rise in compulsory admissions throughout England since the introduction of CTOs is congruent with the trial's findings.[13]

Can the continuing availability and use of CTOs now be justified? In my clinical practice, CTOs have on occasion seemed the most promising strategy within available resources for stabilising certain frequently admitted people who are diffi cult to engage and seem to present a substantial risk. Higher than anticipated levels of use suggest other clinicians feel the same. However, clinical impressions unsubstantiated by evidence cannot be suffi cient to justify CTOs. A strong respect for civil liberties is imperative for professionals entrusted with coercive powers, and arguments that CTOs infringe human rights seem persuasive if benefi ts cannot be shown.[14] The large amounts of senior professional time currently invested in CTO implementation also need to be clearly justifi ed. Thus, the case for urgent review of this legislation, both at government level and within the professions involved in CTO use, is now strong. If the continued use of CTOs is contemplated, further evidence regarding their eff ect will need urgently to be sought, for example through large-scale collation and analysis of routine data already recorded since their introduction. Such analyses could allow comparisons over a longer period between groups of otherwise similar patients managed with or without CTOs.

The CRIMSON trial[10] assessed a contrasting and less contentious strategy for reducing compulsory admissions, this time through joint crisis plans, intended as a means of engaging patients and professionals in active joint planning for future crises. An exploratory trial raised hopes with a signifi cant finding of reduced compulsory admissions.[15] Unfortunately, this result was not replicated in the subsequent multicentre trial. Chance could explain the earlier finding, but the authors make a persuasive case from the study's qualitative component that patchy implementation and lack of real commitment are more likely culprits. Indeed, one meeting between patients and professionals is unlikely to be sufficient to counteract a culture of professional dominance in decision making where this prevails.

These two excellent papers provide no clear means of turning back the slowly rising tide of compulsory admissions. Regarding future strategies, the door remains open for further attempts to reduce compulsory admissions by engaging service users more eff ectively in decisions about their care. However, widespread implementation might require a substantial cultural shift in relationships between patients and professionals. An important question is whether the long-established but little evaluated UK Care Programme Approach is really a useful framework for fostering greater equality and collaboration between service users and staff . More engaging and acceptable continuing community care, as seems to be provided by Early Intervention Services,[3] might in itself reduce compulsory admissions, and could also be a fruitful context for joint crisis plans. Making inpatient environments less aversive and improving the quality of staff-patient alliances in this setting could also result in less need for compulsory admissions. We do not yet know whether changing relationships between staff and patients can reverse the continuing rise in compulsory admissions, but, with the apparent failure of CTOs, we need to keep trying.

The author has no confl icts of interest.

References

[1] Keown P, Weich S, Bhui KS, Scott J. Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988–2008: ecological study. *BMJ* 2011; **343:** d3736.

[2] Wierdsma AI, Mulder CL. Does mental health service integration aff ect compulsory admissions? *Int J Integr Care* 2009; **9:** e90. http://www.ijic.org/index.php/ijic/article/viewArticle/324/646 (accessed Feb 28, 2013).

[3] Schizophrenia Commission. The abandoned illness. London: The Schizophrenia Commission, 2012.

[4] Jones J, Nolan P, Bowers L, et al. Psychiatric wards: places of safety? *J Psychiatr Ment Health Nurs* 2010; **17:** 124–30.

[5] Tew J, Ramon S, Slade M, Bird V, Melton J, Le Boutillier C. Social factors and recovery from mental health diffi culties: a review of the evidence. *Br J Social Work* 2012; **42:** 443–60.

[6] Crawford V, Crome IB, Clancy C. Co-existing problems of mental health and substance misuse (dual diagnosis): a literature review. *Drugs Educ Prev Pol* 2003; **10:** 1–74.

[7] Rowe R, Calnan M. Trust relations in health care—the new agenda. *Eur J Public Health* 2006; **16:** 4–6.

[8] Johnson S, Nolan F, Pilling S, et al. Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *BMJ* 2005; **331:** 599–602.

[9] Burns T, Rugkåsa J, Molodynski A, et al. Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet* 2013; published online March 26.

[10] Thornicroft G, Farrelly S, Szmukler G, et al. Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial. *Lancet* 2013; published online March 26.

[11] Rugkåsa J, Burns T. Community treatment orders. *Psychiatry* 2009 **8:** 493–95.

[12] Kisely SR, Campbell LA, Preston NJ. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Syst Rev* 2011; **2:** CD004408.

[13] Health and Social Care Information Centre (Government Statistical Service). Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, Annual fi gures, England, 2011/12. https://catalogue.ic.nhs.uk/publications/mental-health/ legislation/inp-det-m-h-a-1983-sup-com-eng-11-12/inp-det-m-h-a-1983- sup-com-eng-11-12-rep.pdf (accessed Feb 28, 2013).

[14] Khurmi S, Curtice M. The supervised community treatment order and the Human Rights Act 1998. *Adv Psychiatr Treat* 2010; **16:** 263–71.

[15] Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szmukler G. Eff ect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. *BMJ* 2004; **329:** 136.