tive symptoms or severe residual anhedonia, or in a patient with an anxiety disorder despite increased avoidance behavior, or in a patient with schizophrenia despite high levels of negative or cognitive symptoms. Functioning or distress are often not taken into account when defining an (in)adequate response, while, in some patients with schizophrenia, learning to cope with a treatment resistant hallucination can significantly decrease distress and hence improve quality of life[5].

The reason why most definitions of treatment resistance require two previous unsuccessful treatment episodes is also unclear. The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial documented that, with each treatment step, an incremental gain in the response rate is observed, but there is also an incremental dropout rate and a higher and faster rate of relapse[6].

Furthermore, in defining treatment resistant schizophrenia, only pharmacotherapy is considered, while, in defining treatment resistant anxiety disorders, both pharmacotherapy and psychotherapy are taken into account. It is remarkable that, in treatment resistant depression, psychotherapy or neuromodulation (except electroconvulsive therapy) are most often not considered.

The fact that outcome in trials with treatment resistant patients provide different results depending on whether the two treatment episodes with inadequate response were both retrospective or whether one was retrospective and the other one prospective further documents the difficulty in obtaining a homogeneous patient population.

The recommendation that each of the two treatment episodes should have lasted "at least six weeks" is understandable from both a trial design and a clinical point of view, since few non-responders within the first six weeks will respond later, but again is far away from daily practice: health insurance databases show that a third treatment step is on average started after 43 weeks, which is important to take into account, since duration of an illness episode predicts outcome[7].

It is understandable that classification attempts are now moving away from two categories (non-resistant or resistant) versus staging and "levels of resistance" approaches. These are based on number of treatments (with different treatments getting differential weights), episode duration and symptom severity.

More fundamentally, it has been suggested that the expression "treatment resistance" is "devoid of empathy"[8]. Indeed, the expression seems to blame the disorder or even the patient: for example, a lay press article mentioned that a new antidepressant "can cause rapid antidepressant effects in many people with 'stubborn' depression"[9].

Finally, the concept of "treatment resistance" stems from an acute illness model with remission or cure as the goal. Unfortunately, not all patients with psychiatric disorders can reach that symptom-free goal. That's why the use of the more collaborative expression "difficult to treat" psychiatric disorders could be preferred.

This expression may fit better with the recurrent or chronic nature of some psychiatric disorders. Achieving a meaningful life in spite of limitations can be(come) the ultimate treatment goal. This also resonates with the "recovery" movement, which identifies regaining personal control and establishing a personally meaningful life, with or without residual symptoms, as the objective to pursue.

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Factors facilitating or preventing compulsory admission in psychiatry

A large majority of mental health professionals have a positive attitude towards compulsory admission of people with mental disorders, when some conditions specified by the law are present[1]. However, most professionals are not aware that the circumstances under which compulsory admissions actually occur worldwide are very different, as reflected by the wide variation of the numbers of these admissions in the various countries[2], which cannot be explained by clinical variables.

The factors which impact on the threshold for compulsory admissions, either facilitating or preventing them, can be classified into three levels: a macro-level, including the wider societal perspective and the national legislation; a meso-level, including the organization of mental health care and in particular the implementation of intervention strategies aimed to reduce those admissions; and a micro-level, including the socio-demographic and clinical features of the affected persons as well as the attitudes of their caregivers.

At the macro-level, the assumption that people with severe mental disorders, in particular schizophrenia, are unpredictable and dangerous is still widespread in the general population in many countries. This is the background on which national mental health legislations often identify the risk of harm to others as the main criterion for compulsory hospitalization, in order to ensure protection of the general public. The threshold for perceived danger may vary substantially from context to context and from professional to professional, and this will ob-

viously influence the likelihood of involuntary hospitalization.

In most mental health laws, compulsory hospitalization also serves the purpose of protecting a person with a mental disorder from self-harm. However, the conceptualization and perception of self-harm may again vary substantially from context to context and from professional to professional, so that compulsory admission may be restricted to an imminent and/or serious danger or otherwise focus on possible long-term threats to the affected person's mental and/or physical health. This, again, may affect the rate of involuntary admissions.

Finally, the formal procedural act, i.e., which legal authority takes the responsibility for the involuntary hospitalization, such as an independent authority or the medical system itself, and the safeguards that are provided, including the right by the patient to oppose the decision, also contribute to set the threshold for compulsory hospitalization.

At the meso-level, the organization of the mental health care system is a crucial factor affecting the rate of compulsory admissions. Continuity of care, and in particular an effective integration between the inpatient and outpatient components, is likely to be a crucial factor. However, a meta-analysis of randomized controlled trials of "integrated treatment" (actually including only one study on crisis resolution teams, two studies on integrated treatment in first-episode schizophrenia, and one study on psychoeducation combined with focused monitoring) found no significant reduction in the risk of compulsory admissions[3].

This meta-analysis also found no significant risk reduction in two studies on compliance enhancement (focusing respectively on treatment adherence therapy and on financial incentives for improving adherence to antipsychotic treatment), and three studies on "community treatment orders" (i.e., orders for the patient to receive involuntary treatment in the community)[3].

Why these strategies are ineffective remains unclear. Most of the above studies were conducted in Anglo-Saxon countries, and it is possible[4] that in those countries certain staff characteristics facilitate compulsory admission, such as weekend working, burnout and lack of contact with other services. In other cultural settings with less distressing service characteristics, similar intervention strategies might be more successful[5].

In some countries, a significant increase in compulsory admissions has been observed during the process of deinstitutionalization[2], which has revived the old debate on whether community mental health care facilitates "revolving door", i.e. repetitive – including involuntary – hospitalization as a consequence of too early discharge from inpatient units into the community. However, the above increase seems to reflect a more general increase in psychiatric service use rather than a failure of community psychiatry[2].

At the micro-level, it has been repeatedly documented that persons who are male, younger, unemployed, from an urban environment, from lower social classes, and from a diverse ethnic and linguistic background, are at higher risk of compulsory hospitalizations[6]. However, most of these risk factors are likely to be proxies, standing for social exclusion and isolation, which, in a complex interaction with clinical features, may facilitate compulsory admissions.

A potentially effective approach for users to prevent compulsory admissions are advance statements. These are documents which allow persons at risk to state their future treatment preferences in the case they will not be able to make considered decisions. A meta-analysis of four randomized controlled trials on advance statements[3] found a statistically significant and clinically relevant 23% reduction in compulsory admissions in adult psychiatric patients. Advance statements are currently advocated also by international bodies, such as the World Health Organization[7].

On the other hand, user-held records (i.e., the person holding the information about the course and care of his/her illness) have been found to have no significant effect on compulsory admissions in three randomized controlled trials versus treatment as usual[8].

Whether the involvement of caregivers in treatment planning may have an impact on compulsory hospitalizations remains unclear. The caregivers' appraisal of compulsory admissions is in general quite favorable[9], as they are regularly the first line who have to cope with patients' acute episodes and carry most of the associated burden. As such, their attitude might, at least in part of the cases, facilitate compulsory admissions, although this issue has never been explored systematically.

From the above synthetic review, it is clear that the literature on factors facilitating or preventing compulsory admissions in psychiatry is more speculative than based on empirical findings, and that the few data available are often controversial and of difficult interpretation. Moreover, cross-cultural studies are very rare, although they may be extremely useful to clarify several aspects. Given the high clinical and ethical relevance of the issue, further research in this area is obviously warranted.

It is likely that many of the factors we have briefly considered contribute with a small effect to facilitate or prevent compulsory admission, and that interventions will need to be likewise differentiated and take place at different levels.

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