TAKING ISSUE

Can Psychiatry Learn From Tuberculosis Treatment?

Medication compliance is a major problem for schizophrenia and bipolar disorder, both of which have one-year median noncompliance rates of 40 percent or higher. The consequences of noncompliance include a recurrence of symptoms, which may lead to homelessness, misdemeanors followed by jailing, and occasionally violent behavior. Medication noncompliance is also a major problem for tuberculosis, which has a similar one-year median noncompliance rate of 40 percent or higher. The consequences of symptom recurrence include progressive disease, possible death, and spreading of the disease.

To increase medication compliance for tuberculosis, public health authorities in several states have introduced directly observed therapy (DOT) programs. An outreach worker visits patients twice weekly or more to watch them take their drugs. Compliance with medications is rewarded with food supplements, fast-food vouchers, transportation tokens, movie passes, clothing, and sometimes money, with increased rewards for increased compliance. An important element is the personal relationship between outreach workers and patients; workers often act as surrogate siblings or uncles or aunts in single-parent households.

People with active tuberculosis who refuse to participate in DOT can be involuntary hospitalized and treated. In New York City between 1993 and 1995, an average of eight detention orders a month were issued, with a peak of 47 patients involuntarily treated at any one time. According to city health officials, the credible threat of involuntary treatment is an important reason for DOT's success. Under DOT, the city's tuberculosis rate decreased 55 percent between 1992 and 1997.

Major problems with DOT include its cost of approximately $400 per patient per month, the safety of outreach workers in high-crime neighborhoods, staff stress and turnover, and the issue of infringement of civil liberties for patients involuntarily detained. The costs must be weighed against the savings in preventing hospitalizations and the spread of disease.

Although some psychiatric programs use outreach in their treatment of schizophrenia and bipolar disorder, they do not incorporate graduated incentives such as used in DOT. Furthermore, a credible threat of involuntary treatment, essential for the success of DOT, is often missing in psychiatric programs.

In New York City, 11 percent of patients involuntarily treated for tuberculosis also had schizophrenia. Some were a danger to themselves and others for both conditions. Their tuberculosis could be treated, but not their schizophrenia. Is there something inherently different in brains and lungs? Or is it that our brains are not thinking clearly?—E. FULLER TORREY, M.D., and JUDY MILLER, B.A., *Stanley Foundation Research Programs, Bethesda, Maryland*

Psychiatric Services (formerly *Hospital and Community Psychiatry* [*H&CP*]) was established in 1950 by Daniel Blain, M.D. It is published monthly by the American Psychiatric Association for mental health professionals and others concerned with treatment and services for persons with mental illnesses and mental disabilities, in keeping with APA's objectives to improve care and treatment, to promote research and professional education in psychiatric and related fields, and to advance the standards of all psychiatric services and facilities.