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Mental health and incapacity legislation

The laudable aim of Dawson & Szmukler (2006) of eliminating discrimination against those with mental illness by a fusion of mental health and incapacity legislation may not be achievable with their proposals. They address the ethical difficulties of treating 'patients with fluctuating mental conditions who temporarily regain their capacity after medication, and again refuse necessary treatment'. They suggest that 'where the patient has been treated involuntarily on several occasions with a positive response, and a sustained course of treatment is again considered necessary, sustained resumption of capacity on the part of the patient might be required for the patient's refusal to be honoured'.

In my opinion this highlights two issues. First the authors fail in their aim to stop the discrimination against patients with mental illness who retain capacity. In their proposed legislation they suggest permitting the coercive treatment of patients with mental illness despite the presence of capacity but decry this principle in the Mental Health Act 1983. Second their proposal of using a past history of successful coercive treatment to allow further treatment is unworkable. It is impossible to implement for new patients as no previous history of successful treatment can be demonstrated.

Dawson, J. & Szmukler, G. (2006) Fusion of mental health and incapacity legislation. *British Journal of Psychiatry*, **188**, 504–509.

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Dawson & Szmukler (2006) raised a number of interesting points but assumed that general medical patients who lack capacity and object to medical intervention have as serious consequences for their actions as those that refuse psychiatric care. However, we believe that for psychiatric patients objection to intervention could increase risks to self and others. This justifies involuntary treatment under the Mental Health Act 1983. Studies have shown that mental disorder is a risk factor for violent offending in the community (Monahan *et al*, 2001).

Earlier intervention in mental disorders as a result of using 'incapacity criteria' will not confer any advantage, as the Mental Health Act 1983 already makes provision for such early intervention (allowing detention on the basis of the nature or degree of the disorder). Nature in this context represents the pattern of the disorder, allowing for earlier application of the Act.

Finally, we believe that returning patients who have mental disorder and capacity to prison because they refuse hospital treatment is wrong. The prison health services are at best basic (Wilson, 2004). It seems unethical to return vulnerable patients to an environment which can exacerbate their mental disorder and even increase their risk of suicide (Shaw *et al*, 2004).

Monahan, J., Steadman, H., Silver, E., *et al* (2001) *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence*. New York: Oxford University Press.

Shaw, J., Baker, D., Hunt, I. M., *et al* (2004) Suicide by prisoners: national clinical survey. *British Journal of Psychiatry*, **184**, 263–267.

Wilson, S., (2004) The principle of equivalence and the future of mental health care in prisons. *British Journal of Psychiatry*, **184**, 5–7.

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Authors' reply: Dr O'Muirithe notes that we propose a modified legal test, based on sustained resumption of capacity, to cover people with fluctuating mental disorders and a history of successful treatment who recover for short periods and then refuse treatment. We take this approach because we doubt the wisdom of immediately ceasing treatment of patients whose resumption of capacity may be temporary and whose sustained treatment is required. This approach also avoids the potential for an 'infinite regress' of resumptions and losses of capacity.

Nevertheless, when he argues that this requirement of sustained resumption of capacity is discriminatory, Dr Muirithe forgets that the legislation we propose applies to incapacity owing to any condition. This test would therefore apply as much to elderly patients with confusion hypertension and cardiac failure, as to those with a post-ictal confusional state, or to those recovering from a manic episode. We accept this is a compromise of pure capacity principles, but one which is required in practice.

Drs Adeshina & Sule note the ethical problems in the decision to return a convicted person to prison from hospital if they recover capacity and refuse treatment (i.e. to decide that the patient is fit for punishment unless they accept treatment). Psychiatrists make similar decisions when returning offenders to prison who have gone to hospital for acute treatment, and when they inform the authorities that a patient has 'breached' the treatment conditions of probation or parole. However, the matter remains troubling. So we also offered an alternative: that forensic patients with capacity may be treated involuntarily, for a limited period, when they have committed acts constituting a serious crime, are suffering from a serious mental disorder that contributed significantly to those acts, and effective treatment could reduce the risk of its recurrence. However, this would also compromise pure capacity principles.

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