Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

Mental health and incapacity legislation

I enjoyed the article by Dawson & Szmukler (2006) because I like to keep up to date with legal and ethical issues in mental health. However, their claim for equivalence between mental and physical diseases sits uneasily with scientific papers published in the *Journal*. Shaw *et al* (2006) found that schizophrenia had a prevalence of 5% in perpetrators of homicide, compared with 1% in the general population. I would love to see comparable figures for the prevalence of hypertension, multiple sclerosis, leprosy etc., but meanwhile we have a problem. The Ritchie report on the inquiry into the care of Christopher Clunis reveals capacity's dark side by showing how psychiatrists repeatedly brought a patient to the point at which he could make his own decisions, then left him to fend for himself (Ritchie *et al*, 1994). Perhaps the best way for services to reduce the stigma and discrimination associated with psychiatric illness is to reduce the 5% figure? Somehow, I cannot see capacity-based legislation playing a lead role in achieving that objective.

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

Ritchie, J., Dick, D. & Lingham, R. (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. TSO (The Stationery Office).

Shaw, J., Hunt, I. M., Flynn, S., *et al* (2006) Rates of mental disorder in people convicted of homicide: a national clinical survey. *British Journal of Psychiatry*, **188**, 143–147.

A. Maden Department of Forensic Psychiatry, Academic Centre, West London Mental Health NHS Trust, Southall, Middlesex UB1 3EU, UK. Email: a.maden@ic.ac.uk

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Psychiatric patients can be treated involuntarily even if they possess the mental capacity that would render the involuntary treatment of a medical patient illegal. Dawson & Szmukler (2006) describe this as a form of discrimination and propose that the relevant legislation be 'fused' so that, like medical patients, most psychiatric patients could be treated involuntarily only if they lacked mental capacity. I see a number of advantages to using mental capacity as a legal criterion (Buchanan, 2002, 2005). I suspect, however, that Dawson & Szmukler's solution encourages its own form of discrimination. Under the proposals, 'non-forensic' patients could be treated involuntarily only if they lacked mental capacity. However, 'forensic' patients would be liable to a different, and easier-to-meet, set of criteria.

Underlying the distinction seems to be an assumption that the duties of doctors are different in respect of mentally disordered offenders. Some of the patients that forensic psychiatrists treat, Dawson & Szmukler write, are 'not . . . under treatment primarily for their own benefit, but for the protection of others' (p. 508). This seems to mistake a difference in emphasis for something more significant. First, benefiting patients and protecting others are not mutually exclusive. Second, treatment directed to both of these ends is not limited to forensic psychiatry. Third, where a tension does exist the position is straightforward. Exceptional cases notwithstanding, a doctor's primary responsibility is his patient's well-being. Ethical guidelines make no distinction in this regard between 'forensic' and other patients (Gunn & Taylor, 1993; Bloch & Green, 2006).

If capacity principles are to govern the coercion of psychiatric patients, I am not convinced that any 'forensic exception' is necessary. In England and Wales the important area is the hospital order under section 37 of the Mental Health Act 1983 (945 cases in 2004, 288 with restrictions). Here Dawson & Szmukler have two suggestions. The first would replace the hospital order with something like the present 'hospital direction' under section 45A of the Act. The second would sanction the involuntary treatment of a patient with mental capacity for a period 'proportionate to the seriousness of the offence' if a court thought that this would reduce reoffending. Presumably, the same treatment would be clinically indicated in many cases but the suggested criteria do not require this. Psychiatrists have complained that the hospital direction requires them to declare patients 'fit for punishment' (Mullen *et al*, 2000). The second suggestion implies the use of compulsory psychiatric treatment to achieve a legal end.

Instead, if capacity is to govern involuntary psychiatric treatment, why not make the passing of a hospital order, with or without restrictions, dependent on the patient consenting (or, if the patient lacks capacity, dependent on treatment being in their best interests)? The law could then permit re-sentencing if the convicted defendant changed their mind (or regained capacity and refused treatment), when the situation would be similar to the breaching of a probation order with a condition of treatment. The initial decision to give consent would often be difficult especially where the offence was serious and the choice lay between a substantial prison term and indeterminate detention in hospital. However, I am not clear that a competent defendant should be prevented from making it, particularly if the interim hospital order under section 38 of the Act remained available for cases where the psychiatrist was unsure whether to offer treatment or the patient was unsure whether to accept.

Because adherence is often partial there would still be cases where the doctor's subsequent decision that a failure to participate in treatment amounted to withdrawal of consent could be seen as declaring the patient 'fit for punishment'. Such a scheme would also have to overcome objections that section 37 of the Act already provides an efficient way of getting treatment to people who need it, resources permitting. However, by making court-ordered treatment dependent on consent, it would bring the management of those with psychiatric illness more into line with that of patients elsewhere in medicine. Moreover, it would do so without replacing one form of discrimination with another.

Bloch, S. & Green, S. A. (2006) An ethical framework for psychiatry. *British Journal of Psychiatry*, **188**, 7–12.