Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

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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.

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doi: 10.1192/bjp.190.2.176

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.

Buchanan, A. (2002) Psychiatric detention and treatment: a suggested criterion. *Journal of Mental Health Law*, **6**, 35–41.

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Mullen, P., Briggs, S., Dalton, T., *et al* (2000) Forensic mental health services in Australia. *International Journal of Law and Psychiatry*, **23**, 433–452.

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doi: 10.1192/bjp.190.2.176a

Authors' reply: Dr Buchanan notes that we allow an exception to 'pure' incapacity principles where a *serious* offence has been committed by a person with a mental disorder. We would allow the involuntary treatment of this narrowly defined subgroup of forensic patients under certain conditions, even if they regained capacity, to prevent harm to others. Buchanan believes this would discriminate unfairly between these patients and non-forensic patients. We are not convinced, however, that this would involve unjustified discrimination, because the commission of a serious offence constitutes a significant difference between their positions.

Nevertheless, Dr Buchanan's suggestion that convicted offenders might be given a choice, on disposition from the court, of accepting imprisonment or consenting to treatment in hospital deserves serious consideration. However, we think a time limit should still be placed on the period during which a patient could be treated in hospital on this basis. That time would be proportionate to the seriousness of their offence. Otherwise, the patient who accepts hospitalisation and treatment initially, but later refuses treatment when they regain capacity, would face return to court for resentencing for an indeterminate period. Or, if the patient were to make a rapid recovery with treatment, would discharge very soon after a serious offence be politically acceptable?

Professor Maden, as we understand it, fears that the legislation we propose would not reduce homicides by people with mental illness, but we have little knowledge of the effect of mental health laws on rates of serious offending. What is most likely to reduce rates of violence is early access to effective treatment. Our proposal would allow involuntary treatment for the right reasons at the right time, and it may permit intervention sooner than under the 1983 Act. Some people with personality disorders who pose a risk of harm to others may not meet our incapacity test, and the transitional position of such persons who are already detained in our mental health facilities would have to be addressed. However, on balance, we think our proposals are likely to reduce violence overall, by allowing earlier access to effective treatment for persons who are incapacitated, regardless of the cause.

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Violence and psychiatric morbidity

Coid *et al* (2006) reported an important cross-sectional survey of 8397 persons in UK households and found that psychosis was independently associated with a sixfold increase in the reporting of five or more violent incidents. Given the controversy and sensitivity over the stigma associated with psychiatric illness, particularly concerning public perceptions of links between psychosis and violence, this kind of result is prone to generate misleading impressions.

In a recent comprehensive review Hiday (2006) points out that surveys of this type are prone to exaggerate the contribution of mental illness and other diagnostic labels to violence as a result of several methodological weaknesses. The first is associated with the issue of comorbidity. It was not clear from the presentation of their data whether Coid *et al* were able to investigate the comorbidity of psychosis and other diagnostic categories and violence. It is possible that once comorbid substance misuse, personality disorder or other issues were taken into account, the unique contribution of psychosis to violence might have diminished dramatically (Hiday, 2006).

There is an even more fundamental problem that underpins violence surveys of this type: a neglect of the confounding factor that those with mental illness are more likely to reside in violent neighbourhoods and this could be the key predictive variable, not the illness itself. The term now used to describe the places where most people with severe mental illness live is 'socially disorganised communities', and these combine a multiplicity of factors that promote violence completely independently of psychiatric dysfunction (Silver *et al*, 2001). Features of these environments include chronic disabling poverty, few employment prospects or educational opportunities, decaying buildings and few amenities. In these neighbourhoods families and similar social institutions have broken down, leaving most individuals devoid of traditional social guidance and control (Swanson *et al*, 2002).

Living and growing up in such environments is possibly the key variable that predicts violence, not the mental illness of the individual (Hiday, 2006). Community household surveys such as that reported by Coid *et al* (2006) represent a unique opportunity to explicate the contribution of ecological factors when violence appears to be linked to mental illness. It would therefore be useful in terms of advancing the debate over the link between violence and mental illness if a wider theoretical background to such analyses could be encouraged in the future.

Coid, J., Yang, M., Roberts, A., *et al* (2006) Violence and psychiatric morbidity in the national household population of Britain: public health implications. *British Journal of Psychiatry*, **189**, 12–19.

Hiday, V. A. (2006) Putting community risk in perspective: a look at correlations, causes and controls. *International Journal of Law and Psychiatry*, **29**, 316–331.

Silver, E., Mulvey, E. P. & Monahan, J. (2001) Assessing violence risk among discharged psychiatric patients: toward an ecological approach. *Law and Human Behaviour*, **23**, 235–253.

Swanson, J. W., Swartz, M. S., Essock, S. M., *et al* (2002) The social–environmental context of violent behavior in persons with severe mental illness, *American Journal of Public Health*, **92**, 1523–1531.

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Authors' reply: We do not want our finding of a sixfold increase in reporting five or more violent incidents in persons with psychosis to give a misleading impression regarding the association of violence with mental illness. This was the only finding suggesting increased risk and means that there is a small subgroup of people with psychosis who are repeatedly violent. The real message of our paper should have