that they were mentally ill but did not accept it; they fully appreciated the importance of information given to them, but they reasoned that treatment would be harmful. They expressed a choice to have no treatment, even if it left them homeless. Do they have capacity? I do not know. However, their lack of insight into a dangerous, harmful mental illness makes compulsory treatment appropriate. Whether they have capacity is an entirely academic consideration; it is neither measurable nor relevant.

Rejection

Supposing these patients were also known to be difficult to treat because of histories of substance misuse and previous violence when in hospital. A capacity test gives an over-stretched and reluctant mental health service an opportunity to reject the patient and passively facilitate entry to the criminal justice system. Indeed Doyal and Sheather recommend that mentally ill people who threaten others but are believed to retain capacity should be referred to the police.¹ They do not say if, how, or where treatment for these people should be provided.

Conclusion

Patient autonomy is of the utmost importance in medical practice. But it is a fact of life that detained psychiatric patients lose autonomy. This is why the whole process of compulsory detention must be governed by sophisticated legislation that provides for scrutiny by independent statutory bodies. Crucial decisions about compulsory treatment cannot turn solely on an assessment of capacity. A capacity test will lead to delay or rejection in doctors' implementation of compulsory measures of care. Is (self inflicted) death with human rights preserved a more desirable outcome than compulsory treatment?

Competing interest: DC is a medical member of the Mental Health Tribunal for Scotland.

- 1 Doyal L, Sheather J. Mental health legislation should respect decision making capacity. *BMJ* 2005;331:1467-9.
- 2 Scottish Executive. *Mental Health (Care and Treatment) (Scotland) Act 2003*. Section 57(3)(d). London: Stationery Office, 2003.
- 3 Scottish Executive. *Mental Health (Care and Treatment) (Scotland) Act 2003: code of practice*. Vol 2. Edinburgh: Scottish Executive, 2005.
- 4 Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G, et al. Prevalence and predictors of mental incapacity in psychiatric in-patients. *Br J Psychiatry* 2005;187:379-85.

Commentary: Who benefits from the new act?

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Depriving someone of their liberty is one of the most serious actions that a state can take. To do this when someone has committed no crime is more serious still. If, in addition, the state then administers chemical and physical treatments that carry a substantial risk of disabling, and sometimes irreversible, damage, it must have the best possible justification for doing so.

The government's proposal to replace the current mental health act gives us an opportunity to assess whether the proposed legislation is fit for purpose. An analysis of the issues around capacity suggests it leaves much to be desired in that respect.¹ This is important, but it is not the only way in which the current proposal fails to justify the denial of basic rights.

Misnomer

What is proposed (and, in fact, what we currently have) is not a mental health act but a compliance with treatment act. This was made explicit by Paul Boateng, who, when he was parliamentary under secretary of state for health, said that: "Non compliance can no longer be an option"² (though this quote is partial in both senses, and I will complete the sentence and put it in context later). The underpinning assumption is that doctor knows best and that patient has no right to decide otherwise. I want to set out the view from "the other end of the needle." At this point I should declare my primary interest: I have twice been detained under the current act and have no wish to score a dubious hat trick.

What's wrong with what we have?

Plenty of evidence shows that mental health services are failing particular groups. One report found: "Black people see using mental health services as a degrading and alienating experience" and that "Service users expressed fears about being admitted to hospital and most strikingly a fear that involvement with mental health services could eventually lead to their death."³ In addition, a recent Cochrane review found no strong evidence that compulsory treatment reduces use of health services or improves patients' social functioning. It also concluded that a lack of data made it impossible to assess the effect on costs, mental state, and other aspects of patient or carer satisfaction.⁴ And, finally, the government has clearly said that the proposed legislation does not introduce a new power of preventive detention.⁵

The legislation therefore needs to offer something really important to offset these existing and potential problems. One principle that would make an important difference is that of therapeutic benefit. This is the idea that compulsion can be justified only if the resulting treatment will help the person forced to take it. This is not a particularly radical notion. Like capacity, it forms one of the principles of the Scottish legislation (though the term benefit is used). Therapeutic benefit also forms part of the notion of reciprocity recommended by the expert committee² and the Mental Health Alliance (a coalition of 75 mental health organisations from the professional, voluntary, and service user sectors). The amendment of the proposed conditions for compulsion to include therapeutic

benefit is one of the recommendations of the joint committee on the draft mental health bill.

What Paul Boateng said was:

But if there is a responsibility on statutory authorities to ensure the delivery of quality services to patients through the application of agreed individual care plans, so there is also, increasingly, a responsibility on individual patients to comply with their programmes of care. Non compliance can no longer be an option when appropriate care in appropriate settings is in place. I have made it clear to the field that this is not negotiable.²

In short, he is stating the case for reciprocity. So in the light of the evidence and apparent alignment of professional, political, and voluntary sectors, has the government responded positively? Not quite. The initial response to the joint committee is as follows: "We do not agree that compulsion should be limited to those cases where the benefit of treatment will be expressed by an improvement to the patient's condition, or by preventing deterioration."⁶

I have struggled and failed to come up with a sensible definition of benefit that doesn't include improvement or prevention of deterioration and hope that this and the subsequent argument that, "In some cases, treatment may need to be given even though the nature of the patient's condition means that the treatment is unlikely either to improve it or to prevent it worsening" becomes unsustainable as the legislation progresses.

Compulsion should be unnecessary

If services really are improving, as the government claims, and if we are to have the range of attractive and effective services that a patient led NHS offers, then there should be little or no need for compulsion. Non-compliance should always remain an option until the therapeutic benefit of any intervention is clearly proved. The principle of therapeutic benefit is vital to the integrity and credibility of mental health services. Without it, people will continue to fear services, they will avoid seeking and receiving the help they need, and the risk of harm will be increased; those who work in mental health will find their relationships with their service users more strained, and society will have failed to strike the right balance between personal autonomy and protecting people in need.

Competing interests: None declared.

- 1 Doyal L, Sheather J. Mental health legislation should respect decision making capacity. *BMJ* 2005;331:1467-9.
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- 4 Kisely S, Campbell LA, Perston N. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Syst Rev* 2005;(3):CD004408.
- 5 Department of Health. *Improving mental health law—towards a new mental health act—summary*. London: DoH, 2005.
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Anatomy lessons for the bird brained

One afternoon when I was slaving in the anatomy dissection hall, teaching preclinical students the nuances of human anatomy, a sparrow darting across the hall got knocked down by a ceiling fan. The avian crash evoked shrill shrieks from damsels, and soon a few wet hankies were doing the rounds. I scurried over to investigate the "fall of the sparrow," welcoming the brief respite from my onerous chores. The little bird was senseless with eyes shut, a little heart weakly thumping, and oozing blood. Ministering to the avian patient, I became aware that among the crowd of sighing students was one face that seemed a wee bit more senile—oops, my professor.

Arms akimbo, he peered down through his bifocals and gravely commented, "To treat the injured, one needs to be thoroughly versed in the basic medical subjects, such as, say, anatomy." He paused before continuing, "If I was a postgraduate student in anatomy, like you are now, and this happened, I would love to dissect the bird . . . learn some basic stuff—such as that the sparrow, *Passer domesticus*, displays corpora bigemina, not corpora quadrigemina. Anyway," he muttered audibly, "imbeciles wouldn't know birds had bigemina, when they don't know that humans had quadri."

The throng quickly melted. Thus it came about that I ended up dissecting the sparrow, to display the odd configuration of its midbrain dorsum—and, because of

the sparrow's fall, I was assigned a dissertation on bird embryology as part of my masters degree.

I was condemned to handle 300 eggs of the white leghorn, drilling and injecting them, day in and day out. I smelt of eggs, like stale egg shampoo—and for someone who had never touched an egg in his life, thanks to an orthodox vegetarian upbringing, the egginess of the exercise was galling (from the Latin *gallus*, in this case).

However, I later became recognised as something of an expert in ornithology, even receiving a gold medal for my project, and became proficient enough to dash off articles to ornithological websites and magazines. It's as if Shakespeare wrote "there's a special providence in the fall of a sparrow" in *Hamlet* just for me.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. Please submit the article on <http://submit.bmj.com> Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.