# Correspondence

## Compulsory admission and suicide

Sir: John Crammer (*Psychiatric Bulletin*, December 1998, **22**, 769–770) used three case histories of patients dying by suicide to illustrate care issues. Psychological autopsies, I believe, are an essential part of modern care – not to mention research – and his reference to them is to be applauded. However, the dreaded 'retrospectroscope' is notorious for deception. If a suicidal patient is told to 'turn right' and they shortly after kill themselves, then it can appear that they should have been told to 'turn left'. Similarly outpatients who kill themselves, in retrospect, may appear to have had indications for in-patient care.

Despite the vogue for outcome-orientated medicine and audits of critical incidents, I am unaware of any reasonably scientific research examining the efficacy of either in-patient care or involuntary admission in respect of suicide prevention. However, Crammer suggests the establishment of a commission on the use and limits of compulsion in medicine with community involvement including churchmen, lawyers, trade unionists and more. The inference is that more involuntary care may reduce suicides.

I have no doubt that on occasion both hospitalisation and involuntary care are life-saving. However, I also suspect that at times these measures are harmful. Therapeutic relationships may be damaged and the mode of care may deter patients from seeking help in the future. The price of reducing short-term risk may be that of increasing long-term risk. In addition, paternalistic care can foster regression. I suspect that establishment of the commission as called for by Crammer may be a wonderful exercise in democracy producing yet more overly simplistic recommendations that head us in the wrong direction. However, a strong case can be put for rigorous scientific investigation of the efficacy of both in-patient care and involuntary care for suicidal people. Further, I will be presumptuous and suggest the question should not be 'Do these measures help?' but instead 'For which types of patients and under what circumstances do these measures have beneficial and negative effects?'

CHRIS CANTOR, *Senior Research Psychiatrist, Nathan Campus, Griffith University, Brisbane, Queensland 4111, Australia*

## Nature or degree

Sir: Gralton (*Psychiatric Bulletin*, February 1999, **23**, 114) makes an important point in regard to Mental Health Review Tribunals. This same point was recently the subject of a judicial review.

A patient suffering from paranoid schizophrenia and detained under Section 37/41 Mental Health Act 1983 was refused a conditional discharge by a tribunal. At the time it was said that he was not suffering from positive or negative symptoms of his paranoid schizophrenia. The responsible medical officer argued that the patient did suffer from a mental disorder of a nature, but not of a degree, which warranted his continuing detention in hospital. The tribunal agreed and refused his discharge.

In R. *v.* Mental Health Review Tribunal for South Thames region ex-parte Smith (*The Times*, 9 December 1998), the court considered an appeal against the refusal of the tribunal to discharge the patient. The court rejected the appeal. It was said that it was lawful to continue to detain someone in hospital if the nature of the mental disorder continued to warrant it. Although the patient's condition was thought to be in remission, and therefore the degree of the condition did not warrant continuing detention, the nature of the illness meant that he would be liable to relapse and this was sufficient in itself to warrant continuing in-patient treatment.

I would suggest that this judicial review has gone a long way to clarify this frequently debated point.

MARTIN LOCK, *Consultant Forensic Psychiatrist, Three Bridges Regional Secure Unit, Uxbridge Road, Southall, Middlesex UB1 3EU*

Sir: Szmulker & Holloway (*Psychiatric Bulletin*, November 1998, **22**, 662–665) provide a provocative contribution to the current debate on reform of mental health legislation. Their anti-discriminatory stance in arguing for an Incapacity Act to apply equally to patients with mental and physical disorders is attractive.

However, its effect would be to deny to patients treatment which any reasonable layperson would say was desperately needed. The proposed definitions of incapacity they quote, that is, being unable by reason of mental disability to make a decision on the matter in question or being unable to communicate a decision, are tests of "understanding not wisdom" (Law Commission,