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Letter

Race and mental capacity: no panacea

Joe Gough

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The recent Mental Health Bill contains among its core concerns the need to address racial inequity in use of the Mental Health Act and a wish to emphasise patient autonomy and capacity more strongly. Although these are important and admirable goals, there is a risk of walking into a quagmire of unstudied problems. Few studies have examined the relationship between mental capacity assessment and race. There are, however, strong reasons to suspect that it is not a panacea – and that it only appears as such because of a lack of study.

It has been well established that ethnic minorities are more likely to experience coercive pathways into care (although perhaps the largest evidence review on this topic found less evidence regarding Roma, Gypsy and Irish Traveller and Chinese groups).[1] Existing work, however, has focused on the use of involuntary detention under the Mental Health Act. Detention under the Mental Health Act has different requirements from those set out in the Mental Capacity Act. Such detention requires that the detained individual have a diagnosis of mental illness, as well as a 'risk-based' requirement that the person pose a risk to themselves or others. One possible explanation of the greater use of detention under the Mental Health Act is therefore the stereotyping of ethnic minorities, especially Black people, as more dangerous than White people.

One might therefore think that the general concern about coercive care cannot be generalised to the use of mental capacity legislation. The Mental Capacity Act, after all, is not 'risk-based' in the same way. Instead, it proposes a functional test: one has the capacity to make a certain decision if and only if one can understand, retain, and use and weigh the information relevant to that decision and communicate one's decision to others.

However, dangerousness is not the only stereotype around ethnic minorities. Ethnic minorities, and especially Black people, are often seen as less intelligent – a stereotype with a deep history, closely tied to the history of intelligence testing.[2,3,4] This stereotype may influence assessments of whether individuals meet the requirements of the functional test described above, especially in relation to criteria 1 and 3. 'Stereotype threat' may mean that people perform worse on the relevant cognitive tests as a result of their awareness of this stereotype.[5] It is also worth noting that stereotypes of low intelligence deserve more general study in relation to capacity – similar stereotypes may, for example, influence treatment of the elderly and other groups likely to be seen as less intelligent by clinicians, such as those with lower-prestige accents.

One might hope that clinicians have been trained so as not to be influenced by such stereotypes. However, this would not help with the problem of 'stereotype threat', in which the effect is mediated by the patient's awareness of the stereotype. Such a hope is also undermined by evidence of ethnic inequalities in healthcare in general, and in the use of the Mental Health Act in particular. As such, the generally higher rate of use of coercive methods on ethnic minorities and the existence of relevant stereotypes about ethnic minorities that may influence capacity assessment both provide reasons for concern about false negatives in capacity assessment: cases where individuals are denied capacity, despite in fact having capacity.

There is also a risk of false positives. In a false positive case, a person is asserted to have capacity despite lacking it. Capacity assessments are protective as well as coercive: being denied capacity is not always a bad thing, and it may be life-saving. Affirmations of a patient's capacity sometimes serve as an expression of the assessor's view that a patient is not worthy of help and treatment – as a denial of concern for the patient.[6,7] Ethnic minorities are frequently recipients of reduced empathy and seen as less legitimate victims of wrongs – they are also, for example, seen as less affected by pain.[8]

We therefore need to worry about both false positives, based on a lack of concern for ethnic minorities, and false negatives, based on negative stereotypes about the intelligence of ethnic minorities and willingness to apply coercive treatment to them. There is independent evidence of such duality in medical practice around psychiatric illness in ethnic minorities. For example, in the treatment of Black people with schizophrenia, some treatments such as talk therapy are less likely to be offered, whereas other treatments – in particular, highly invasive ones – are more likely to be offered.[1] Owing to the dual risks of both false positives and false negatives, fine-grained comparison and study are needed.

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Declaration of interest

None.

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Psychiatry in literature

Common medical dilemmas, Franz Kafka version

Alistair Stewart

Among Franz Kafka's stories, which have been subjected to many interpretations, there is one entitled *A Country Doctor*, an unsettling rush of events with the vertiginous inevitability of a bad dream. The tale, at the same time mundane and unearthly, describes a succession of dilemmas and challenges which, if only in the imagination, will be familiar to many doctors, albeit in a heightened, vivid and feverish form.

To start with, an urgent night visit through the snow to a family home some miles distant (I am not sure how many doctors still do this, but some psychiatrists certainly do). The visit made more complicated because of problems with transport – here it is the lack of a horse, but it could be a car that will not start. The unknown consequences that might flow from a hastily improvised arrangement to solve such a difficulty.

The anxious and caring family. The patient who asks to be allowed to die. The nagging awareness of the tension between our duty to them and our responsibility to those we have abandoned at home. An initial finding that nothing is wrong with the patient and that they might be better for getting out of bed. The sense of being poorly paid but still being eager to help the poor people: 'It is easy to write prescriptions, but beyond that it is difficult to come to an understanding with people . . . once again I have been troubled for no good reason, I am used to that, the whole district makes me a martyr to my nightbell.'

The disappointed family who urge you to reconsider, and the reluctant admission that yes, there is more to this case. An awful discovery. A terminal diagnosis. The patient who asks, can you save me? 'This is how people are in my part of the world. Always asking the doctor to do the impossible. They have lost their old religion; the priest sits at home, tearing to pieces his vestments from the mass; but the doctor is meant to arrange everything with his delicate surgical hand.'

Then the reckless willingness, in the last resort, to go along with untested, unorthodox measures, which are perhaps a little less familiar: 'And they come, the family and the village elders, and undress me; a school choir with the teacher at its head stands before the house and to a very simple melody sings the following "Undress him, then he will do the healing, and if he doesn't, then kill him, he's only a doctor, he's only a doctor".'

After all that, to have one's efforts angrily rejected by the patient, who then relents and seeks comfort from the offer of some meaningless reassurance: 'Is it really so, or are you deceiving me in my fever?' 'It is really so, you have my word of honour as a medical officer.'

Then leaving the patient to their fate, and ending up worrying about getting old, and some other doctor stealing your practice.

All uncomfortably close to the bone!

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