opinion & debate

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The point of principles: Commentary on . . . The Draft Mental Health Bill in England: without principles†

The request for this commentary arrived in the midst of (another) media frenzy about mental health services. You know you have a PR problem when tabloids and broadsheets agree on headlines, and both were full of the 'cannibal' case, which relegated the murder in Richmond Park (by an in-patient) to page three (*The Guardian*, *The Times*, *Daily Telegraph*, *The Independent*, etc., 16 March 2005).

I hate this as much as anyone who works in mental health, because a little smudge of each lurid headline rubs off on all our patients. Still, I am clear about where the problem lies, and there is no point in railing against the media and whining about stigma. Newspapers report these events because they are of massive and legitimate public interest, and it will be a sad day if any profession or government is ever able to stop them.

Such incidents serve to remind mental health services that, whereas some clinicians prefer to dwell only on the good, our profession also has to cater for the bad and the ugly. Uncomfortable as it may be for psychiatrists who prefer not to get closer to a prison than watching reruns of *Porridge*, mental health law has to permit doctors to operate at the sharp end. The challenge is to shape legislation that allows us to deal with the most challenging cases, while respecting principles that assume most treatment will be voluntary and confidential. How should we establish the principles to guide us in this difficult territory?

Thornicroft and Szmukler look for inspiration to various worthy publications, some of which have only marginal relevance to the dilemmas of compulsory treatment. Their approach reduces principles to buzz words that one is for or against: 'autonomy!', 'choice!', 'dignity!', 'participation!', 'motherhood!', 'apple pie!'. Okay, so I added the last two myself but they belong in the list and have as much meaning when applied to the patients mentioned above. Our national attention span may be 10 min and falling but complex issues are lost in such oversimplification. Perhaps they have taken minimalism too far. If life is so simple, why not just say the Bill is bad but we are good? Of course, we can all be on the side of the angels if we avoid the difficult questions. The principle at stake is not whether we, as a profession or as a society, value dignity, autonomy and choice. The tough choice is whose dignity, autonomy or choice takes precedence? That of the cyclist in Richmond Park, or that of the restricted patient? The central issue is conflict but, so long as we refuse to acknowledge its existence, well-intentioned publications provide no help in resolving it.

There are inevitable conflicts of principle and interest inherent in any mental health legislation. How does the paper of Thornicroft and Szmukler reconcile these conflicts? I see the following four principles running through the document, and all are contentious to say the least.

†See pp. 244–247 and 248–249, this issue.

'Doctor knows best'

What other principle underpins concern that a tribunal (with lay, legal and clinical representation) would have the power to override a doctor's decision to discharge a patient from compulsory treatment? Since when does a medical degree confer the ability or the right to decide what level of violence risk is acceptable in the community? My preferred words of principle here are 'Bristol!' and 'Shipman!' I assume the only lay support for this expression of naked professional self-interest will come from people who do not read the newspapers.

'Risks to self and risks to others are equivalent'

The authors see unfairness in the Bill's suggestion that the threshold for detaining people for their own protection should be higher than the threshold for detaining them to protect others. Yet the Bill's approach is consistent with the principles by which we all live. I may happily choose to engage in high risk activities, ranging from bungee jumping through skiing to unprotected sex, but I am not at all happy for somebody else to take those choices for me. Most doctors, whatever their specialty, are willing to tolerate patients gambling with their own health or safety, in a way that is not acceptable if the safety of another person is at stake. Why should psychiatry be different?

'The purpose of mental health law is to reduce stigma'

Am I the only psychiatrist to cringe with embarrassment every time I hear this statement? We already have lots of legislation to combat stigma, including human rights, disability, discrimination and employment law. The primary purpose of mental health law is to permit services to intervene and stop me from harming others or myself, should mental disorder impair my judgment to the extent that the usual psychological, moral and legal constraints no longer apply. Most patients will never find themselves in the position of being compelled to have treatment, but that is no reason to shy away from effective law to permit compulsory treatment of the minority for whom nothing else will suffice. It is not mental health law that stigmatises these patients, but the publicity that follows yet another mental health disaster.

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'Therapeutic benefit is always necessary to justify detention'

Let us suppose that the 'cannibal' or Richmond Park cases involved patients with treatment-refractory schizophrenia. Would any responsible psychiatrist decide not to detain them, given the risks involved? And what is the point in having principles if they are transgressed every day, in every clinic that detains patients with unresponsive mental illness?

The recent history of tribunal case law suggests that courts are also prepared to stretch the definitions of treatment and treatability to breaking point to avoid violating the common sense principle that one does not discharge dangerous mentally disordered people, whatever the prognosis. Many moral and practical difficulties surround the detention of patients who are unlikely to respond to treatment, but they cannot be solved by banal slogans. We have an obligation to do all we can to treat patients, but the right to detain a dangerous mentally disordered person cannot depend on a guarantee that treatment will be successful.

Opponents of the Bill also seem determined to forget that mental health legislation is permissive. It allows doctors to do what they think is correct and appropriate in the circumstances. No government can get around human rights legislation that gives clinicians the final say. Do the Bill's critics have so little confidence in their own profession that they believe doctors will become power crazy, once we remove the treatability condition attached to psychopathic disorder? It seems far more likely that doctors will still be left juggling too many patients and too few beds.

Conclusion

If my comments seem harsh, it is because they reflect disappointment and anger at a failure of leadership within British psychiatry over the issues of violence and compulsion. Better compliance with treatment is the most common factor identified by doctors as likely to have prevented homicides and suicides by patients (Appleby *et al*, 2001). That is no reason for a massive increase in the number of patients compelled to take their treatment, but it is a powerful argument for making sure that the law minimises obstacles to optimum clinical care. If we avoid the difficult issues in favour of politically correct platitudes, the politicians will take the lead, as they have done over the Dangerous People with Severe Personality Disorder (DSPD) initiative. Psychiatry is fast losing a political and public relations battle and our patients will suffer when we are further marginalised.

The liberal hysteria would be more understandable if our current mental health legislation was not among the best and most liberal in the world, in the way in which it deals with mentally disordered offenders. Mentally ill people can commit the most serious offences yet not spend a day in prison, with courts giving priority to their treatment and rehabilitation over any thoughts of punishment or retribution. We can be proud of this situation, but it will continue only if the courts and the public have confidence in our services.

Declaration of interest

None.

Reference

APPLEBY, L., SHAW, J., SHERRATT, J., *et al* (2001) *Safety First, Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Stationery Office.

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