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reviews

Maudsley Discussion Paper 10. Mental Health Law – Discrimination or Protection?

By George Szmukler & Frank Holloway. London: South London & Maudsley NHS Trust. 2000. 21 pp. £4.00 (pb).

On what basis is it justifiable to treat people with mental health problems differently to those with physical health conditions? Szmukler and Holloway's views will be well-known to readers of the *Bulletin* (see, for example, *Psychiatric Bulletin*, November 1998, **22**, 662–665), but this discussion paper (written before the Government's White Paper was published) gives the clearest account yet of their position: not only is mental health law discriminatory, the situation is actually getting worse. Moreover, there is no logical or factual justification for it.

The authors start by showing that mental health law has historically oscillated between the two poles of a medical 'best interests' model on the one hand and a legalistic 'dangerousness' approach on the other; our present law represents a slight retreat from the paternalistic 1959 Act. They then look at the 'Bournewood gap' and the Richardson Committee's proposals, largely disregarded by the Government. They consider the plans for compulsory treatment and find them wanting. So far, so familiar.

The most intriguing part of the paper is the thesis that current legislation poses two key questions the wrong way round. The questions are, first, does the person have a mental disorder? Second, is he or she dangerous? Addressing them in this order inevitably leads to the treatment of people with mental health problems on a different basis from the rest of the population. However, if the questions are reversed, the question of dangerousness can be approached in the same way for all; the disorder then becomes a factor in determining how to address the dangerousness. It follows that, if the first question is answered in the negative, there is little justification for compulsory intervention. This analysis is a most helpful contribution to the current debate.

The authors finish by considering compulsory treatment in the community: they have no objections to its use where the patient lacks capacity and the treatment is in his or her best interests. If it is applied as an alternative to hospital admission, or to facilitate earlier discharge, the order must be time-limited, based on recovery of capacity. It should not be used for the protection of others.

The paper concludes with a plea for placing compulsory treatment on a firm ethical basis. As we now know, the White Paper, with its stress on best interests, represents a move back towards paternalism. Let us hope that Parliament will bring some ethical rigour to its own discussions in due course.

Simon Foster Principal Solicitor, Mind

Stigma Videotape

By the Royal College of Psychiatrists. London: Royal College of Psychiatrists. 1990. 14 minutes. £5.00.

With a cheerful piano accompaniment by Nicholas Medtner (at times sounding like the arguably more appropriate Charles Alkan) and punctuated by some catchy rock lyrics, this 14-minute videotape takes off from the previous College cinema short on the same topic. Like the earlier film this attempts to argue the propinquity of mental illness: if not you, then your mother or your lover. Unlike the previous shorter one, this new update largely eschews images of cinematic horror and madness that at a previous showing Lewis Wolpert and others had argued were counterproductive in our attempts to confront stigma.

Instead we have a largely Whiggish perspective: once regarded with superstitious fear, mental illness is now amenable to a scientific knowledge and control in which the College is fully involved. Some of its fast-moving montage depicts past human cruelty – Nazi executions of civilians and electroconvulsive therapy (Eh? Electroconvulsive therapy is not a therapy?). This upbeat science sweeping away prejudice has problems with the very non-understandability of psychopathology. Here it is a disease as illustrated by various brain scans, and addiction too is just a disease. Best left to the experts, yet some human sympathy won't go amiss. But surely, one of the reasons 'insanity' still provides one of our most enduring tropes, not least in the cinema, is its ready illustration of unintelligibility, alterity, and its awkward position between naturalistic and voluntaristic ways of understanding. Hardly the fault of the filmmakers: we still do not have a model of psychosis that makes any sense in terms of popular knowledge. Nor, with the fading of the anti-psychiatric approach (which at least offered some model of insanity as a response to not unintelligible social conditions), are we likely to get that soon? The neurobiology of schizophrenia is still too distant from commonsense understanding. By contrast, a broken leg (which the film offers as a counterpoint) is apparently approachable through knowledge of a broken stick or something similar. Not so a 'broken mind' as it is called here.

It might be felt that the producers could have gone for one illness as an intelligible model (say depression), rather than collecting together psychosis, addictions, eating disorders, dementia and the psychoses. (Do we really think a unitary model for all these will emerge?) But, reliance on the one, apparently intelligible, pattern of depression as a general model might have been regarded as dishonest. In short, we have here a succinct and humane little film that is unlikely to do any harm (not least to the reputation of psychiatry). Whiggish? Certainly, but none the worse for that.

Roland Littlewood Professor of Anthropology and Psychiatry, University College London

Recent Advances in Understanding Mental Illness and Psychotic Experiences. A Report by the British Psychological Society Division of Clinical Psychology

By The British Psychological Society. Leicester: British Psychological Society. 2001. 82 pp.

This is a readable booklet marshalling current psychological thinking on psychosis, produced by a working party set up by the British Psychological Society, including several of the most renowned professors of clinical psychology in Britain today.

It will be found provocative by psychiatrists, because it constantly strives to drive a distinction between the way psychologists conceive of psychosis and the perspective of doctors.

Psychiatric propositions about biological causes are critically assessed, for example the dopamine hypothesis is dismissed as relying too heavily on arguments about dopamine-influencing medication, which the booklet asserts is like arguing that headaches are caused by lack of aspirin.

It tries instead to emphasise a dimensional rather than categorical or medical model approach to psychosis.

While the booklet rigorously and scientifically argues its case for a more psychological perspective, the key issue is what proportion of people with psychosis treated in the health service would really benefit from its recommendations. For

https://doi.org/10.1192/pb.25.11.454-b Published online by Cambridge University Press

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example, would the kind of person admitted to an adult acute ward really benefit from more cognitive behavioural therapy and less medication and coercion, as opposed to the kind of person normally referred to a psychologist in an out-patient department?

It is difficult to escape the sense that this report has been put together by a group of well-meaning academics, who do not on a daily basis have to manage schizophrenia, or take decisions with profound legal implications, as clinical psychiatrists must.

Indeed the true empirical test begging to be instituted following this comprehensive report, would be for a group of daring psychologists to set up an acute ward and community service based solely on these psychological principles. This would help us all to see how far one can really take this kind of psychological model in the real world.

Raj Persaud Consultant Psychiatrist, The Maudsley Hospital, London

miscellany

Harrogate–Zomba Mental Health Link

In May 2001 members of the Harrogate Health NHS Trust visited the Zomba Mental Health hospital in Malawi. The focus of the visit was to familiarise the team with the psychiatric services available in Zomba and look at the medical input provided. The situation within the hospital and in the community is very poor. There is no consultant psychiatrist attached to the hospital and medical input is provided by a clinical medical officer whose level of training is lower than that of a UK medical practitioner. In the whole country there are five qualified psychiatric nurses and no plans have been made for after their retirement, which is imminent. Medication is haphazard and supplies limited. The patients are accommodated in poorly maintained wards.

While much of what was seen during the visit was disheartening, there was a great desire by all the staff to change things for the better. A visit to Harrogate by staff from the Zomba Mental Health hospital is planned for late 2001, with a view to exploring links with York University and the possibility of further training for nursing staff from Malawi. The need for medical input is clear, but the Ministry of Health in Malawi has been unsuccessful in recruiting psychiatrists to take up the post. However, they are very keen to discuss the possibility of recently retired consultants from the UK taking an interest in the development of their service and perhaps assisting them in this. Those who would like to explore this option or obtain additional information regarding the establishment of a further link should contact Dr Dympna Ryan, Consultant Psychiatrist, Briary Wing, Harrogate District Hospital, Lancaster Park Road, Harrogate HG2 7SX (tel: 01423 553 683).

Overseas Working Group in Child and Adolescent Mental Health

The Royal College of Psychiatrists set up an Overseas Working Party chaired by Dr Bob Kendall. The final report of the working party recommended, among other things, setting up an Overseas Working Group in Child and Adolescent Mental Health. Accordingly such a working group has been formed with a view to undertaking the following tasks:

(1) To identify key people and networks associated with Child and Adolescent Mental Health in various countries, to contact them in order to assess the training needs in their networks and to co-construct training programmes that can be cascaded further.
(2) To explore the possibility of designing a core multi-disciplinary training pack in child and adolescent mental health that would be relevant and applicable in a variety of countries.
(3) To encourage and connect all those interested in helping with such ventures through Focus Newsletter, Faculty Newsletter, the College website, etc.
(4) To explore the possibility of using some of the unfilled specialist registrar posts or creating some other short-term clinical training experiences in the UK for overseas professionals.

The main aim of the group is to look at how the College may support and facilitate the development of child mental health services by providing resources and support for multi-disciplinary training. It was felt that key people and networks in a variety of countries should be approached with a view to developing dialogues that will be fruitful to all concerned so that they can learn from each other's experiences. The respondents can comment either from their local, regional, national and/or supranational perspectives. To help structure their responses a few questions, such as the following, should be listed:

(1) Are there any child mental health services in existence? If no, what would help to develop such services. If yes, where are such services currently located (i.e. within what type of facilities e.g. paediatrics, maternal and child health, psychiatry, specialised resources in very remote tertiary settings or more widely available?)
(2) What is the mental health training currently available in your context/country that is child specific and for what disciplines? Is the training pre/post registration? Are there child mental health inputs into post-graduate psychiatry and/or paediatric programmes?
(3) What is your view of the objectives of the College Overseas Group? Do you consider that such a group could have a useful input to meet your country's training needs?
(4) What do you think about the idea of having access to a modular training content? If it seems useful, does it need to be in a printed format only or would the facilities to use video material accompanying a printed manual be available? If not, is this because of the need for content to be translated into local languages and/or lack of technology or resources?
(5) Is there a need for direct contact-based clinical experiential training? How and where can it be best organised and for what period?

The Overseas Working Group in Child and Adolescent Mental Health would be extremely grateful for any suggestions and relevant contacts in different countries, including low income countries, who could be approached for the above. Readers may also be able to comment on the above issues themselves and pass on this request to other relevant associations encouraging them to respond. Those interested in helping this important venture in any way (e.g. creating links abroad, helping with designing training packs, providing training, creating training places) should contact the Honorary Secretary, Dr Kedar Dwivedi, 8 Notre Dame Mews, Northampton NN1 2BG (tel: 01604 604 608; fax: 01604 604 531).

Special Interest Group in Gay and Lesbian Mental Health

Despite advances in rights for gay men and lesbians in British society, a homosexual orientation is still the object of stigma and discrimination. A Special

https://doi.org/10.1192/pb.25.11.454-b Published online by Cambridge University Press