

Mental illness is different and ignoring its differences profits nobody

*Tom Burns*¹

Szmukler, Daw and Dawson have produced a detailed and carefully worded proposal for a new approach fusing mental health and capacity legislation. In practice their proposal abolishes separate mental health legislation. It aims to ensure that compulsory care for the mentally ill is provided, when needed, according to the same principles as in severe disabling physical disorders (e.g. toxic confusion states, acute head injury, dementia). Their proposal derives from two strongly held and clearly presented principles – respect for the autonomy of the psychiatric patient and removal of what they consider the stigmatising discrimination between mental and physical illness. Capacity becomes the threshold for considering any compulsory detention or treatment.

Their paper is in two parts. It starts with an introduction outlining the principles behind the proposed ‘fusion’ legislation and an overview of its practice. This is then followed by an extensive preliminary draft of their model statute in eight parts. These eight parts contain a detailed presentation of the mechanics and definitions of the processes of the statute; they cover details such as the different proposed orders, safeguards, operation of tribunals and even details of the transfer of patients to hospital. Drafting legislation is a complex and tricky undertaking and they appear to have made an excellent start.

I will restrict my commentary to their introduction. This reflects my primary sphere of competence as a clinical academic psychiatrist, not a lawyer. It is also my experience that few, if any, clinicians ever read the details of legislation. Most familiarise themselves ‘on the job’ with the mechanics of those parts of the Act they regularly use. They learn what they have to sign and complete in order to achieve what they have already clinically decided on. Gaining any understanding of the principles of the Act is usually through exposure to where it restricts their clinical decisions. Such learning is via simple, practical requirements such as confirming ‘treatability’ or ‘danger to others’ in the detention of specific individuals.

Where I describe ‘what psychiatrists do’ it is based on my direct experience of practice in the UK and in a range of international jurisdictions where I have worked alongside colleagues. These include various European countries, the USA, New Zealand and Australia and also in India and Hong Kong – in no way a scientific sample. However, I have been impressed by the strikingly similar decision-making processes and declared professional values of psychiatrists; this despite widely differing social and healthcare contexts and a range of mental health legislations. It will be clear that I do not believe that mental illnesses are ‘simply social constructs’ but have a consistency and reality beyond our diagnostic manuals and legal definitions. It is the nature of mental illnesses and their treatments that shape mental health legislation: not mental health legislation that shapes mental health practice (other than at the edges).

¹ Professor of Social Psychiatry, University of Oxford, Warneford Hospital, Oxford, OX3 7JZ tom.burns@psych.ox.ac.uk

My critique of this proposal is contained in four questions.

Is the case advanced for the importance of treating mental illness and physical illness in exactly the same manner convincing?

Does the proposed law accurately reflect and address the ethical challenges faced daily in mental health practice – will it provide a useful and accessible guide to the practitioner?

Does the proposed law bring greater clarity to our understanding of the nature of mental illness and how society can best relate to it?

Does the proposed law reduce ethical confusion in mental health practice; in particular can it reduce the risk of moral jeopardy?

Despite important insights and obvious merit I believe that, on balance, it fails on three of these four tests.

1. Is the case advanced for treating mental illness and physical illness in exactly the same manner convincing?

Szmukler and colleagues consider that differences in how mental and physical health care are delivered constitute unacceptable discrimination ‘..that separate legislation authorising the civil commitment of ‘mentally disordered’ persons is unnecessary, and discriminatory...’, ‘..this ‘two-track’ approach is inconsistent with general principles of health care ethics....’. They advance no specific reason why treating mental illnesses and physical illnesses differently is unacceptable or damaging. They rely on the implication that to discriminate between them is inherently unjust. Why should this be so?

Psychiatry is not a subspecialty of medicine in the same way that dermatology or nephrology derived from internal medicine. It did not arise from a necessary division of labour, driven by a rapidly expanding body of knowledge and skills. Its history is one of *convergence* with general medicine rather than *emergence* from it. Indeed the terms ‘mental illness’ and ‘mental patient’ have been in use for less than half of psychiatry’s existence.

Modern mental health care is a product of the Enlightenment, most commonly identified with the emergence of moral therapy. This is dated from Pinel’s striking off the chains from the Paris lunatics in 1793 and the opening of the York Retreat in 1796 by the Tukes, an English Quaker family. Both emphasised the irrelevance of the then current medical nostrums; the Tukes strove actively to keep physicians out of asylums for the following 30 years. The term ‘Psychiatry’ was first coined by Johann Reil in 1808 (from *psyche*, mind and *iatros* doctor) to stress its empirical rather than theological provenance^{2,3}; Reil was mainly concerned to codify psychotherapeutic approaches⁴. Only as late as 1930 in the UK were the terms ‘lunatic’ and ‘asylum’ officially replaced by ‘mental patient’ and ‘mental hospital’.

These earlier terms (and practices) do not indicate any ignorance of the physical basis of many mental illnesses. Asylum doctors were in no doubt of the organic origins of disorders such as General Paralysis of the Insane, alcoholic dementia and Pellagra. These constituted a significant proportion of their patients. Recognising substantial overlap between physical and mental illnesses but also essential difference has never been impossible. Ignoring these differences, or using terminology that obscures them, does not

2 Ellenberger HF. *The discovery of the unconscious: the history and evolution of dynamic psychiatry*. New York: Basic Books; 1970.

3 Mameros A. ‘Psychiatry’s 200th birthday’. *British Journal of Psychiatry* 2008 Jul;193(1):1-3.

4 Reil J. *Rhapsodies on the Application of the Psychic Cure Method to Mental Disorders*. Halle: Curtsche Buchhandlung; 1803.

make them go away. Whether the similarities between mental and physical illnesses are greater or less than their differences is more a philosophical than empirical issue. However few would deny it is an issue. The degree to which mental illness and physical illness have to be treated exactly alike in legislation has to be argued, not simply assumed from the similarity of the terms.

2. Does the proposed law accurately reflect and address the ethical challenges faced daily in mental health practice – will it provide a useful and accessible guide to the practitioner?

The UK's tortuous ten year attempt to update the *Mental Health Act 1983*, resulting in the 2007 amendment,⁵ can be interpreted in two ways. One is as a failure of resolve to properly grasp the principles of the primacy of autonomy, using capacity as the threshold for compulsion, as outlined here and originally proposed by Richardson's expert committee⁶. The other is that the proposals were rejected as judged not to adequately address common, and serious clinical challenges, and to run the risk of unacceptable and unforeseen consequences.

Szmukler and colleagues comment '...protecting the autonomy of patients with capacity is not the only important ethical principle....another concerns the need to protect other people...'. They are certainly right that protecting autonomy is not the *only* important ethical principle. Indeed it is the failure to explore the full range of important, and well recognised, principles of medical ethics that is so strikingly absent from this analysis. All ethical decisions include the need to balance several, often equally important and frequently conflicting principles (e.g. Liberty, Equality, Fraternity). In medical ethics respect for autonomy, beneficence, non-maleficence and justice are generally considered to be a minimal ethical framework for decision making and analysis⁷. These may often be in conflict. Amartya Sen argues for humility and an empirical approach to derive an area of 'circumscribed congruence'⁸ for making moral judgements about competing claims for different individual freedoms⁹.

For most clinicians beneficence is at least as important as respect for autonomy. After all getting people better is the main purpose of medical care. Virtually all difficult decisions about coercion in mental health involve balancing the potential for beneficence against the overriding of autonomy for an individual patient. It is the silence of Szmukler et al's (and Richardson's) proposals on this tension that renders the capacity argument inadequate to many clinical readers. For example only with the most tortuous logic can the compulsory detention of a distraught adolescent intent on suicide because of a broken love-affair be justified in terms of capacity. However few psychiatrists would hesitate to use it if they 'had to'; beneficence so clearly overwhelms autonomy in this situation. Most compulsion is used in individuals with established, fluctuating psychotic illnesses. Patients with schizophrenia are usually detained because the doctor thinks that treatment will significantly enhance their well-being, not because they are at immediate risk of dying or hurting others.

We may dress decision up as risk, and sometimes have to. In some jurisdictions the language of risk has replaced that of therapeutic benefit. However, only the most disingenuous observer will believe that risk

5 *Draft Mental Health Bill, Session 2004–05, Volume 1, HL Paper 79-1, HC 95-1, House of Lords House of Commons Joint Committee on the Draft Mental Health Bill, (2005).*

6 Department of Health. *Report of the Expert Committee: Review of the Mental Health Act 1983.* London: Department of Health; 1999.

7 Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press; 2001.

8 Sen A. 'What Theory of Justice?' 7 A.D. May 30; Sheldonian Theatre, Oxford:OPHI Conference <http://ophi.org.uk/subindex.php?id=video0>; 2007.

9 Sen A. 'What do we want from a theory of justice?' *The Journal of Philosophy* 2006;CIII(5):215-38.

assessment has genuinely replaced therapeutic considerations in the doctor's decision making. Where the legislation requires 'risk of harm' for compulsory admission I have watched psychiatrists emphasise suicidality (particularly when access to beds is restricted) whilst making exactly the same clinical decision where I use benefit to health as the justification. Neither of us is in any doubt that we are both making our judgements in exactly the same way based primarily on beneficence.

This proposal fails to engage with the central role of beneficence (indeed paternalism) that has always lain at the heart of psychiatric practice. The distortions of judgement and lack of personal choice in some mental illnesses complicate the assessment of beneficence in a way that is unique. Isaiah Berlin, in his essay *Two Concepts of Liberty*¹⁰, proposes that sometimes 'liberty from' (i.e. autonomy from intrusion) has to be compromised to ensure the 'liberty to' (i.e. capacity to do, as Sen would use it). Nowhere is this dilemma more sharply drawn than in the practice of mental health and is explored in the next section.

3. Does the proposed law bring greater clarity to our understanding of the nature of mental illness and how society can best relate to it?

One of the great advantages of this proposal is that emphasising the careful assessment of capacity puts something of a brake on psychiatry's seemingly inexorable expansion. As 'mental illness' has been replaced by 'mental disorder' the concept has been diluted to the point where psychiatry's conceptual coherence and social legitimacy are seriously challenged. This is even more so as mental disorders are currently defined almost exclusively in terms of international classifications such as DSM IV¹¹ and ICD 10¹² where reliability completely overshadows validity. Requiring capacity for the detention of patients could force a necessary debate, for example, on the vexed issue of 'personality disorders', and the increasing long-term detention of 'PD' patients for public safety. The definition of incapacity presented by Szmukler and colleagues (despite the proposal that it be '...sufficiently flexible ... [for] ... the complex and subtle forms of incapacity found in some mental disorders.') would clearly preclude the detention of personality disordered individuals even without a 'treatability' test.

However this does not address the fundamental nature of mental illness. It is the impaired appraisal of the self and world with their impact on the individuals' behaviour that are central. Mental illness implies a *changed* state, a distancing from the normal self. Mentally ill patients are 'alienated' not so much from society but alienated from their normal selves. Treatment has always been aimed at '*restoring to reason*'. Severe developmental impairments and personality disorders can lie at the absolute extreme of social deviance and disability but we do not consider them mental illnesses.

When we speak of mental illness we implicitly use the concepts of first and second order desires clarified by the American philosopher Harry Frankfurt¹³. Frankfurt considers the defining characteristic of a human being ('personhood') that they can have desires or wishes about their wishes. Unlike non-humans we 'can want to want'. The alcoholic wants to drink (a first order desire) but he also wants to not want to drink (a second order desire).

The legitimacy of psychiatry as a discipline (and mental illness as a concept) rests on believing this, and believing that we can make reasonably meaningful judgements about an individual's second order desires.

10 Berlin I. *Two Concepts of Liberty*. Oxford: Clarendon Press; 1958.

11 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (Fourth Edition)*. Washington DC: American Psychiatric Association; 1994.

12 World Health Organisation. *The ICD-10 Classification of Mental and Behavioural Disorders*. Geneva: World Health Organisation; 1992.

13 Frankfurt HG. 'Freedom of the Will and Concept of a Person'. *Journal of Philosophy* 1971;68(1):5-20.

In short we believe we can construct an understanding of a person's 'healthy' state of being and contrast it with their current 'ill' state. The justification for over-riding their current declared wishes is that we believe that it is likely that when not ill they would think and act differently. Often this judgement has to be made without prior acquaintance with the individual and may be based on a current diagnosis from which it is extrapolated. This judgement balances the two liberties that Berlin distinguished¹⁴ as his 'liberty from' and 'liberty to'. Just and moral action often requires us to make a judgement about what people are capable of and would want to do as we weigh up their dilemma ('.. to offer political rights or safeguards....to men who are ...underfed and diseased is to mock their condition..')¹⁵. Decisions are made on a judgement of how the individual is now, compared to how we hypothesise they are 'normally'; rounded judgements are not made ahistorically solely on the dimension of their current capacity.

Obviously such judgements are not perfect – a significant proportion of patients (though not all by any means) persist in disagreeing with their treatment when recovered¹⁶. Continued disagreement is more common when recovery is only partial¹⁷. Szmukler and colleagues are also right that risk and consequences should enter into the equation but surely wrong to give them such prominence. It is striking that the only reference to treatment benefit is in the paragraph outlining the use of compulsion for dangerous but capacitous individuals.

In a laudable drive to reduce stigma and discrimination against the mentally ill this proposal risks blunting and obscuring our already limited understanding of what mental illness is. While this may bring some short-term gains the poor fit of the legislation with the reality of mental illness can only, over time, begin to chafe and distort practice. Mental illness has never been an easy concept. However, retreating from its complexity and substituting simpler, more easily quantified proxies, carries real risks for the profession and society and thus risks for patients.

4. Does the proposed law reduce ethical confusion in mental health practice; in particular can it reduce the risk of moral jeopardy?

Emphasising capacity certainly may reduce some of the ethical risks in psychiatry. This is particularly pressing in its involvement in the long-term incarceration of individuals with unacceptable personality disorders or sexual, addictive and violent behaviours. This is much to be welcomed. On balance it remains unclear whether or not the current proposal is an advance. The test will be whether capacity (backed up by risk) will serve better over the long term than the concept of mental illness (with its implication of impaired judgement and a distinction between the ill and normal self) in the hard, ethically ambiguous cases that will inevitably confront any legislation.

The concept of mental illness has certainly been abused both by the profession and by external agents (governments, pharmaceutical companies etc). Would we be better served by a sharper distinction between mental illness and mental disorder or should we accept (as here) mental disorder but with a clearer threshold for coercion? The former approach offers no short-term solution (mental illnesses inevitably require constant negotiation about their boundaries). It is also out of favour with a hard-line evidence-based approach that emphasises reliability and science rather than validity and the 'craft' nature

14 Berlin I. 'Two Concepts of Liberty'. Oxford: Clarendon Press; 1958.

15 Berlin I. 'Two Concepts of Liberty'. Oxford: Clarendon Press; 1958.

16 Priebe S, Katsakou C, Amos T, Leese M, Morriss R, Rose D, et al. 'Patients' views and readmissions 1 year after involuntary hospitalisation'. *British J Psychiatry* 2009;194(1):49-54.

17 Katsakou C, Priebe S. 'Outcomes of involuntary hospital admission – a review'. *Acta Psychiatr Scand* 2006 Oct;114(4):232-41.

of professions. Capacity is a reasonably objectively defined threshold, likely to achieve high reliability and durability.

The down-side of this otherwise very attractive proposition is evident in the paper. Having started off with a clear definition of capacity, the authors then fall back on the need for a flexible definition to cover the 'complex and subtle' forms of incapacity in mental illness. They avoid potential practices that might equate treatment with punishment. However their implied ethical hierarchy in which beneficence, justice and non-maleficence seem secondary to autonomy and risk remains of concern. It distracts attention from the moral jeopardy of indeterminate psychiatric incarceration of individuals who neither have a mental illness nor any reasonable prospect of effective treatment.

Conclusion

The desire to create coherent, intellectually satisfying legislation to cover compulsory treatment in mental health is not new. I would argue that the messiness of mental illnesses, in particular the need for a high order, and inevitably speculative, judgement about a patient's 'normal self' defeats this admirable intention. The diagnosis of mental illness demands both a careful narrative and a descriptive framework and defies a simple cross sectional 'check list' approach. Current diagnostic manuals give a misleadingly optimistic impression as clinicians still use narrative thinking acquired in their professional training but use the check-list approach to improve reliability. This improved reliability has, however, been at the cost of a staggering increase in the number of people diagnosed.

A more robust MHA based solidly round capacity would initially improve consistency of practice. However, a reliance on a simple threshold (and one that will undoubtedly be stretched as expedient) and the removal of a professional judgement about whether the patient has an identifiable illness (not a disorder) and is no longer their normal self will probably lead to an increase in compulsion, not a reduction. We should not forget that (at least in the UK) it was the profession's stubborn refusal to bend the act to detain non mentally-ill, dangerous individuals that stimulated the most sustained pressure to change it.