professionals ($Z = -2.46$, $P = 0.016$) and special programmes for children ($Z = -1.92$, $P = 0.055$) and refugees ($Z = -2.26$, $P = 0.024$) were available. The Gini coefficient was not significantly associated with mental health being part of the primary healthcare system, availability of acute treatment for mental disorders in primary care, availability of community care, involvement of non-governmental organisations in mental health, and special programmes for the elderly.

Discussion

The findings of this study, using a different methodological approach, are consistent with the findings reported in the *Lancet* series of papers (Jacob *et al*, 2007; Patel *et al*, 2007; Saraceno *et al*, 2007; Saxena *et al*, 2007). The current findings were that higher GDP was associated with the presence of national mental health policy, national substance misuse policy, mental health legislation and a mental health information-gathering system, mental health being part of the primary care system, treatment for mental disorders being available in primary care, availability of community care, involvement of non-governmental organisations in mental health, higher percentage of the health budget spent on mental health, and greater density of psychiatric beds, psychiatrists, psychiatric nurses, psychologists and social workers. Additionally, albeit previously unreported, broadly similar associations were observed with greater income inequality (measured by the Gini coefficient). Thus, in addition to the socio-economic status of countries, the degree of income inequality may also influence the development and delivery of mental health services. This is an important observation because it does not necessarily follow that lower socio-economic status implies greater income inequality.

The challenge for international organisations, including the WHO, the World Psychiatric Association and the World Bank, and for national governments, is to encourage fair and equitable mental healthcare budgetary provision and the development of national mental health policies, including mental health legislation, with effective national implementation programmes in both LMICs and in countries with greater income inequality. This will require political will to give mental healthcare priority and support through satisfactory funding, although it may be difficult to achieve owing to poor socio-economic status, income inequality and different healthcare sectors competing for scarce resources. Otherwise, vulnerable patients with mental disorders, who are more likely to be at the receiving end of the effects of poor socio-economic status and greater income inequality, will continue to suffer in silence. The recent initiative by the *Lancet* (Horton, 2007) will no doubt assist in meeting this challenge.

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SPECIAL PAPER

Fairness, liberty and psychiatry

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According to Beauchamp & Childress (2001) the fundamental principles of biomedical ethics include 'justice'. But how do we approach 'justice'? Justice may be thought of in relation to an individual or society. An individual may be just or unjust. Justice in society may be thought of as 'retributive justice' (fair punishment), 'civil justice' (fair recompense), 'distributive justice' (fair shares) or 'social justice' (a fair social contract for citizens of a society).

The present paper introduces *A Theory of Justice* (1972), written by John Rawls (1921–2002), which looks at social justice. Because Rawls' first principle of justice is the 'liberty principle', some thoughts on liberty are also offered. The aim is not to be comprehensive but to stimulate further interest and debate in these issues among psychiatrists. A more extensive summary of Rawls' theory has been provided by Ikkos *et al* (2006).

John Rawls' theory of justice

The two fundamental principles of social justice, according to Rawls, are the 'liberty principle' and the 'difference principle':

- according to the liberty principle, 'Each person [should] have equal right to the most extensive system of equal

basic liberties compatible with a similar system of liberty for all'.

- according to the difference principle, 'Social and economic inequalities are to be arranged so that they are both: to the greatest benefit to the least advantaged … and attached to offices and positions open to all under conditions of fair equality of opportunity'.

The term 'fair equality of opportunity' means that everyone should be given an equal opportunity to succeed in society, irrespective of status at birth.

Rawls was a *prima facie* egalitarian. He believed that inequality in society was morally objectionable and that some people should not get more because of an accident of birth. He believed that all individuals should share equally in 'primary social goods'. His primary social goods include: rights, liberties, opportunities, powers, income and wealth, and a sense of one's worth. Although an egalitarian, Rawls stated that inequality is morally justifiable when, according to the difference principle, it promotes the welfare of the least well off in society.

When making specific policy decisions, principles of social justice may appear to be in conflict with each other. Rawls believed that a fair social contract would reflect the following 'priority rules' in attempting to work through such conflict:

- the first priority rule – the priority of liberty – stipulates that liberty can be restricted only for the sake of liberty
- the second priority rule – the priority of justice over efficiency and welfare – is lexically prior to the principle of efficiency and to that of maximising the sum of advantages; and fair opportunity is prior to the difference principle.

The first priority rule is self-explanatory, but what about the second? What Rawls seems to be saying is:

- the welfare of the least advantaged in society should take precedence over efficiency
- all individuals must be treated fairly and their legitimate interests must not be sacrificed in the pursuit of the welfare of the least advantaged.

Liberty

If liberty is the foremost principle that underpins social justice, then psychiatrists need to have some understanding of what it is. This section summarises four approaches to liberty.

One approach is to equate it with unencumbered expression of one's will or volition according to one's nature. The 17th-century English Enlightenment philosopher Thomas Hobbes (1588–1679) adopted such a definition (see Pink, 2004, ch. 4). The problem with this approach is that one person's unencumbered freedom may restrict that of another.

A second approach is to think of liberty as the autonomous exercise of choice on the basis of free will. The most influential discussion of autonomy is that of the 18th-century German Enlightenment philosopher Immanuel Kant (1724–1804). Kant identifies human dignity with autonomy. Rawls' emphasis on liberty as fundamental to social justice is predicated on this identification. Rawls' theory is strongly influenced by Kant but not identical with it. Autonomy as defined by Kant is a highly complex concept (Wood, 1999). According to Kant, autonomy is dependent on 'free will'. Free will, in turn, depends on the capacity to make choices. Furthermore, according to Kant, the truly autonomous subject does not make choices according to his or her own nature or volition, but according to the 'moral law', which Kant takes to be objective in the same way as the laws of physics are. True autonomy, according to Kant, is an act of free choice in accordance with the moral law. To be free, Kant says, is to do the right thing when you have a choice to do the wrong thing. To be free also requires the capacity to act against one's nature. We can see now that Kant's definition of human freedom is diametrically opposite to Hobbes' freedom.

A third approach is that of George Agich (1993), a contemporary American medical ethicist. He contrasts autonomy as defined by Kant with what he calls 'actual autonomy'. Agich argues that the autonomy that matters in everyday life is not that of deliberating and making choices but that of spontaneous action. According to Agich, 'identification, the ability to reflexively recognize as one's own the constituents of an action, is logically prior to freedom…. Expressions of autonomy are thus enactments of who the individual is as she is becoming.' In contrast to Hobbes, who emphasises the free expression of one's nature, Agich points out that education and training may enhance one's freedom by enlarging the scope and range of the kind of activities that one may do and identify with.

Perhaps the best-known discussion of liberty in the 20th century was that of Isaiah Berlin (1909–97). He proposed a distinction between 'positive liberty' and 'negative liberty'. Positive liberty is the 'freedom to…'. Positive freedom may be the freedom to express one's volition (e.g. Hobbes) or make autonomous choices (e.g. Kant) or be educated to do more things one feels good about doing (e.g. Agich). As we have seen, the promotion of positive liberty for some may place the liberty of others at risk. Berlin was particularly interested in negative liberty, therefore. Negative liberty is 'liberty from…'. Berlin (2002, p. 41) summarised his thoughts as follows:

> The extent of a man's negative freedom is, as it were, a function of what doors, and how many, are open to him; upon what prospects they open; and how open they are. The formula must not be pressed too far, for not all doors are of equal importance…. Consequently the problem of how an overall increase of liberty in particular circumstances is to be secured … can be an agonising problem, not solved by any hard and fast rule.

Implications for psychiatrists

If we follow Kant, Rawls and others, we may accept that liberty is at the heart of human dignity and social justice.

In relation to psychiatric practice, liberty is a complex and neglected topic. Relevant issues include freedom, freedom of expression, free will, free choice, autonomy as defined by Kant, actual autonomy as defined by Agich and negative liberty as defined by Berlin. Education and rehabilitation may be vital in promoting the liberty of our patients. Conversely, the absence of these, as well as treatment, may limit their liberty and autonomy, often unfairly.

Restriction of liberty is consistent with a fair social contract, but can be justified only on grounds of liberty itself. It cannot be justified on other grounds. Psychiatrists must

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never participate in coercive forms of treatment that are not fair to the individual patient.

Where restriction of the liberty of a patient is necessary, arrangements must be fair to the patient in ways that maximise his or her liberty (and dignity) and do not subsume these to considerations of efficiency. Where restriction of the liberty of a psychiatric patient is being considered for the protection of others, the restriction should be proportionate to the threat and respectful of the liberty and dignity of the patient.

We have thus far focused on liberty in light of the primary importance of the liberty principle. The 'difference principle', however, is also important for psychiatrists. Its emphasis on ensuring the best outcome for the worst off in society puts psychiatrists in a strong position to advocate greater funding for public mental health services. Indeed, it can be said that the fairness of any society can be assessed in large part by the social outcomes of people with intellectual disability or mental illness.

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NEWS AND NOTES

Contributions to the 'News and notes' column should be sent by email to: Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk

College mental health leaflets in other languages

Over the past couple of years the College has had huge support from members and staff to translate the College mental health leaflets into 14 different languages. There are well over 100 translated leaflets available to the public, in paper form and on the College website. The web pages for the Arabic series, coordinated by Dr Sabry Fattah, attracted over 44 000 visits in 2008. The pages with Farsi translations attracted 32 000 visits and these leaflets are also hosted on the website of Mashhad University of Medical Sciences, Iran. The College is collaborating with Dr Syed Ahmer and Prof. Murad Khan at the Department of Psychiatry, AKU, Karachi, who have organised the translation of many College leaflets into Urdu, and are printing them for free distribution in Pakistan.

In Europe, in 2008 the mental health information page of the College website had 14 000 visitors viewing the French leaflets and 13 000 reading Polish translations. The College is now planning to extend this exciting and challenging work in 2009 and welcomes more volunteers to help with translations.

News from the Pan-American Division

The Pan-American International Division of the Royal College of Psychiatrists has again organised an international symposium at the American Psychiatric Association's annual meeting in San Francisco in May 2009, for members of the College from around the world. The symposium, entitled 'The effects of city life on mental health around the world', is on Tuesday 19 May, 2–5 p.m., in the Moscone Center, Room 122, Exhibit Level North. The presenters are from Cairo (Nasser Loza), Mexico City (Elena Medina-Mora), Mumbai (Amresh Shrivastava), São Paulo (Paulo Menezes), Singapore (EE-Heok Kua) and Australia (Helen Herrman). Rachel Jenkins (London) will be the discussant and Nigel Bark (New York City) is chair.

That same evening (6–8 p.m.), the Pan-American Division and the College will have their annual reception (check the venue in the Directory of Allied Meetings). All members and friends of the College are very welcome.

The Pan-American Division's session at the Royal College's 2009 annual meeting in Liverpool is on 2 June, 9.45–11 a.m. entitled 'A fair deal in North America?' It will feature 'Stigma in Canada' (Roumen Milev), 'Services in the Bronx' (Nigel Bark) and 'Cross-border training in Mexico' (Richard Swinson).

The next steps for Kenya

Following a situational needs analysis in Nairobi, a 5-day working conference, 'Working with children and young people with mental health problems in the juvenile justice system', was hosted by the Royal College of Psychiatrists. Participants were drawn from various disciplines, including the police and judiciary, probation officers, special-needs teachers, psychiatrists, nursing staff from the Mathari Hospital, social workers and children's department staff and administrators from the Ministry of Health. Throughout the week, a number of recurring themes emerged:

- there is a need for systematic training in recognition of mental health problems in young offenders across all agencies and at all levels of staffing
- there is a need for formalised systems of inter-agency collaboration
- child protection services have to be developed
- protocols for all agencies have to be produced.