models can successfully address issues of hidden confounding in the absence of appropriate design. Although enthusiasts in the social and behavioural sciences have used structural equation models and 'causal models' interchangeably for many years, their naïvety has frequently brought structural equation modelling into disrepute. Pearl's book covers structural modelling in the appropriate way, but many readers of this journal will find it a bit heavy going. We do indeed plan to publish on these issues in much greater detail in the near future.

Declaration of interest

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Jonathan Green, Division of Psychiatry, University of Manchester, Oxford Road, Manchester M13 9PL, UK. Email: jonathan.green@manchester.ac.uk; **Graham Dunn**, Health Methodology Research Group, University of Manchester, UK

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The most undeserving poor?

The Secretary of State for Work and Pensions, James Purnell, proposes removing payment of benefits from unemployed persons with addiction to crack cocaine and heroin.[1,2] The proposed Green Paper[3] sets a remarkable precedent in terms of official, inter-agency response to that common mental disorder described as 'drug addiction'. It focuses on benefits (to an estimated 267 000 individuals in England alone) for those 'dependent on drugs' or 'problematic drug users'.[4] Little attempt is made to distinguish between degrees of dependence or recreational use. The Green Paper claims that 'this is around three-quarters' of all the people who are 'dependent on these drugs'.[3]

It states 'we believe that drug misuse is a serious cause of worklessness and that individuals have a responsibility to declare it and take steps to overcome it' (section 2.40). At present only 0.05% of people on jobseekers allowance declare an addiction.[3]

All applicants will be required 'to declare whether they are addicted to heroin or crack cocaine' (section 2.39) with investigations for fraud against those who 'mislead' and they will 'be required to enter treatment' (section 2.41–2.43). Proposals include new powers to force agencies such as 'drug workers' (section 2.38) to disclose clinical information. It seems inevitable that at least forensic and prison doctors will have to 'share information', and National Health Service psychiatrists will become complicit in informing job centres as part of multidisciplinary teams.

Given the known morbidity of addiction,[5] we know of no other psychiatric disorder that excludes citizens from access to statutory services!

For practising clinicians, the proposed legislation strikes at the core of the doctor–patient relationship, destroying medical confidentiality and grossly interfering in treatment. Therapy is often episodic and incremental but in future doctors will hesitate to end an episode of failing treatment for fear of depriving their patients of food and sustenance. How will clinicians establish working relationships with their patients while simultaneously policing the state benefit system? Politicians, high on prejudice, are driving a coach and horses through the subtle art of treatment. Where is the dissenting outcry from the profession and the Royal College of Psychiatrists? If doctors do not speak up for their most vulnerable patients, who will?

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2 Purnell J. Welfare reform webchat. Tuesday 22 July 2008 (http://www.number10.gov.uk/Page16402).

3 Secretary of State for Work and Pensions. *No One Written Off: Reforming Welfare to Reward Responsibility*. Department of Work and Pensions, 2008.

4 Hay G, Bauld L. *Population Estimates of Problematic Drug Users in England who Access DWP Benefits: A Feasibility Study*. TSO (The Stationery Office), 2008.

5 Caan W. The nature of heroin and cocaine dependence. In *Drink, Drugs and Dependence. From Science to Clinical Practice* (eds W. Caan, J. de Belleroche): 171–95. Routledge, 2002.

Woody Caan, Anglia Ruskin University, East Road, Cambridge CB1 1PT, UK. Email: a.w.caan@anglia.ac.uk; **Mervyn London**, Drug and Alcohol Service, Cambridgeshire and Peterborough Mental Health Trust, Cambridge, UK.

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Wake-up call for British psychiatry: responses

The paper by Craddock *et al*[1] and the subsequent eLetters illustrate the variety of opinions that attracted me to psychiatry. I work in a multi-agency service and our assessments and interventions can be carried out by professionals in Mind, in social services and in the National Health Service (NHS). In our service we share responsibilities. This allows me (a consultant psychiatrist) to pursue a resurgent interest in psychopharmacology, treatment adherence and the harm caused by side-effects of medication. Although I appreciate the academic endeavours in biomedical science, I believe it is very important to contextualise them for non-academics. Randomised controlled trials don't speak to clinicians as well as naturalistic studies. I have noticed that some of my psychiatric colleagues (and myself at times) shy away from precise diagnosis, acutely aware of how diagnoses are deliberately used to stigmatise people by individuals outside mental health services (as well as within). This is happening at a time when case definitions are becoming important to health service managers. Perhaps some psychiatrists are uncomfortable in their traditional territory. However, if psychiatrists step back too far, then others will move in. I expect that senior managers, rather than other clinicians or service users, are likely to move into the spaces that we vacate. Psychiatrists should not support the replacement of 'doctor knows best' with 'manager knows best'. New Ways of Working may end up doing exactly that. Instead of being a shot in the arm, it may be a shot in the foot. Four trusts in the north of England are already constructing their own diagnostic systems to use alongside or instead of existing diagnostic schemes as a currency for payment by results. Assigning patients to pseudo-diagnostic 'care clusters' could be something all staff do, not just the doctors. If psychiatrists step back from diagnosis, then diagnosis may change from a clinical concept with an associated evidence base, to a financial planning tool. There are other drivers of change too. In the prevalent atmosphere of anxiety and blame, risk assessment, not diagnosis, is now arguably the main gateway into acute mental health services. This means that some very ill people may have to wait for treatment, while people who seem to be at acute risk are attended to first.

Times change and if psychiatrists of any persuasion want to retain some influence they have to put up, not shut up; so well done for making the biomedical case. Biomedical psychiatry complements psychosocial psychiatry and is uniquely part of

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