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Correspondence

BEHAVIOUR THERAPY

DEAR SIR,

I was particularly interested to read Dr. Oswald's report (January, 1965) on a fifty-four months follow up of a successfully treated mackintosh fetishist, because this is the type of patient I was concerned about in my letter of November, 1964, asking for a discussion of the criteria for diagnosing "mental illness" within the meaning of Section 26 of the Mental Health Act. If I am wrong in my interpretation, then it may be lawful to detain such a patient compulsorily, especially if a case can be made out for considering him a danger to others. He could thus be prevented from submitting himself to treatment such as Dr. Oswald has described, despite his wish to do so. In my view such detention would be unlawful. My opinion is certainly not shared by all other British psychiatrists, but I have been disappointed that no reasoned rebuttal of my argument has yet appeared.

F. P. HALDANE.

5 February, 1965.

[A reply to Dr. Haldane's earlier letter appears below.]

MENTAL ILLNESS UNDER THE MENTAL HEALTH ACT

DEAR SIR,

Since no other correspondent has so far ventured on a reasoned reply to Dr. Haldane's letter (November, 1964, p. 863) may I make my comments?

As Dr. Haldane says, the Law has its reasons; and these reasons do not have to be guessed at: they are clearly stated in the Report of the Royal (Percy) Commission and in the Parliamentary Debates on the Mental Health Bill, from which I will quote.

First, a few passages from the Report, on the meaning of "mental illness":

"The term mentally ill is applied to patients whose minds have previously functioned normally and who have become affected by some disorder, usually in adult life" (Para. 75).

"Mental illnesses, even of the same type, may vary in their severity. One person may overcome a mild depression without serious interruption of his normal life . . . another may be more deeply affected and unable to carry on . . . the first may pass unnoticed by his neighbours, they may describe the second as having a 'nervous breakdown' . . . but all are suffering from the same type of illness . . ." (Para. 80).

"Most mental illness is first brought to the attention of general practitioners . . . if not severe it may be treated by them" (Para. 89).

"The term 'mentally ill' is now generally used in everyday language . . . for patients who are certifiable as well as for others who are not" (Para. 182).

It will be seen that the Commission uses the term "mental illness" in its widest possible sense, and there is no question at all of limiting it to a departure from mental health of any particular degree.

Now, as to the conditions under which the use of compulsory powers is justifiable, the Report is equally explicit. They are (Para. 317, abbreviated):

(*a*) . . . reasonable certainty of a pathological mental disorder, and

(*b*) care cannot be provided by other means, and

(*c*) patient's unwillingness probably due to lack of appreciation of his condition deriving from the mental disorder itself, and

(*d*) either some prospect of benefit, or a need to protect others.

The Commission were confident that, if these criteria were adhered to, the medical profession could be trusted to use compulsory powers without any danger of abuse (Para. 325). They considered also that no formal definition was needed for *any* of the categories of mental disorder which they recommended, not even for the "severely subnormal" group; relying rather on "the consensus of opinion" regarding the individual patient (Para. 358).

Thus far the Royal Commission. The Government, however, felt that some more precise requirements were necessary (Mr. R. A. Butler in *Proceedings of N.A.M.H. Conference*, March 1958, p. 13). In drafting the Bill, they provided these in two ways. First, they introduced an intermediate requirement between the statement of the existence of a form of mental disorder and the declaration of the individual patient's needs; this, of course, was that the mental disorder, whatever its form, must be "of a nature or degree which warrants detention".

Secondly, they framed definitions for three of the categories used in the Act, but not for mental illness. As the Minister said in his introductory speech: "Mental illness needs no express definition in the Bill" (*Hansard*, 26 January, 1959, col. 710). And this was entirely in accordance with the general

opinion, for although there was much subsequent discussion in both Houses on the definitions of "severe subnormality" and "psychopathy", resulting in some amendments, not a single reference was made by any member to mental illness in this connection.

The position, therefore, seems clear enough. There is no such things as "mental illness within the meaning of the Act". The term is taken as one of common usage, in the same way as are such words as "mind", "intelligence", "disability", "exploitation", and others occurring in the Act. For the purpose of justifying compulsory treatment we are not required to worry about the borderline between illness and health, because we are concerned only with cases of such severity as to warrant detention. If the symptoms point to such severity, the Courts are not likely to pay attention to sophistries about "neurotic depression"; and this is in fact what happened in the case related by Dr. Haldane. It is to the criteria for the "degree of illness that warrants detention" that we need to address our minds, and here the circumstances justifying detention laid down by the Royal Commission provide a sure guide. For we can first ask ourselves whether the patient's condition is one in which these circumstances are liable to exist, and then secondly whether they actually do exist in the particular case. For instance, in the case of fetishism mentioned by Dr. Haldane in his second letter (above) it is very unlikely that condition (*c*) could be fulfilled.

It is a little surprising that Dr. Haldane should be inclined to revive the bogey of "heavy damages in the Courts" on account of some misinterpretation on our part, since the provisions of Section 16 of the Mental Treatment Act of 1930, re-enacted as Section 141 of the present Act, have for 35 years proved an effective safeguard against such disasters.

Psychopathic disorder, of course, presents a different problem, but here again the reasons for the present limited provision of the law are set out in the Royal Commission's Report; they do not lend themselves to summarizing.

Dr. Howard (January, 1965, p. 283) contends that the central scrutiny of admission documents should have been continued in order to ensure standardization of practice. This is in fact what the R.M.P.A. recommended (Memorandum of Evidence, in *Minutes of Evidence of the Royal Commission*, p. 291, Para. 200) and urged right through the passage of the Bill; but it is difficult to see how the Commissioners, had they been retained, could have evolved their own standard as regards psychopathy, for instance, unless (as in Scotland) they had also been given powers of personal visitation and enquiry throughout the period of detention.

Finally, may I comment on two points in Dr. Schmideberg's letter. If indeed any of our mental hospitals are worse than the worst prisons, they must be unfit to receive *any* patient, however insane. And I cannot imagine that anyone in this country would wish to use the McNaughton Rules—now nearly defunct—for purposes for which they were never intended. Their irrelevance to the problem of compulsory detention was emphasized in the Royal Commission's Report (Para. 152).

When concluding the oral evidence I gave before the Royal Commission as one of the team representing the R.M.P.A., I remarked that in the past the recommendations of Royal Commissions had often been forgotten and the resulting legislation subjected to fresh interpretations and commentaries without regard for the intentions of those who framed it; I expressed the hope that this would not happen now. Lord Percy replied: "I am afraid that always will be so". How right he was!

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POLARIZATION THERAPY IN DEPRESSIVE ILLNESSES

DEAR SIR,

Drs. Costain, Lippold and Redfearn are to be congratulated on their papers on electrical polarization published in the November, 1964 issue of the *Journal*. Clearly, if this procedure turns out to be effective in patients whose illnesses are resistant to antidepressants, E.C.T. and neuroleptic drugs, it will be a valuable addition to existing methods of treatment. In view of this, we read the three articles with interest; and we should like to comment on some data given in Table I on page 782 of the second paper (*Brit. J. Psychiat.*, **110**, 773–785).

It may be that because of the small number of patients included the authors have not felt it worth subjecting the results provided in Table I to statistical scrutiny. Nevertheless, if the data are examined from this standpoint, it would appear that improvement after polarization therapy is related to age, previous history, number of treatments given per week, and maximum current used. Specifically, factors associated with a favourable prognosis include: (1) age over 35; (2) a previous history of mental illness; (3) the administration of three or more treatments per week; and (4) the use of a maximum current greater than 100 μA.

In view of the foregoing, it is puzzling that these factors were not taken into account in designing the controlled trial reported in the third paper (*Brit. J. Psychiat.*, **110**, 786–799). The most likely explanation would seem to be that the small size of the sample