overall costs while offering a very limited prospect of any long-term change in his behaviour.

In summing-up, I feel that compulsory treatment of Munchausen patients cannot be legally, ethically, clinically, or financially justified. However, I agree with the authors that such persons have tended to be neglected, if not rejected, and more efforts should be made to engage them in voluntary treatment which can then be properly assessed for its efficacy and cost-effectiveness.

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AUTHORS' REPLY: Although the central theme of our paper was that of resources wasted by dysfunctional medical systems, Dr Black's sweeping assertions cannot go unchallenged. We continue to believe that detention could be legally justified under the category 'psychopathic disorder'. This is defined in the Mental Health Act 1983 as "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned". There is ample evidence that our patient displays these features. As a result of his disorder, he has sustained numerous physical injuries of such severity that his safety is endangered and his health impaired. He has assaulted people and behaved dangerously (e.g. running in traffic), making him a risk to others. In addition, Dr Black points out correctly that compulsory treatment must be likely to alleviate the condition or prevent a deterioration. The authors are aware of two periods of detention during which his behaviour significantly improved, and although he is treatment-resistant this is not the same as an inability to benefit from any therapy.

The philosophical debate regarding whether a person's behaviour is volitional or determined is familiar in respect to Munchausen patients. One danger in such an approach is that patients deemed responsible for their unpleasant actions can easily be treated punitively or rejected, as sometimes happens to patients who harm themselves. One objective of our report was to avoid the traditionally polarised, moral view but, rather, to take a pragmatic perspective. Furthermore, simply because an individual behaves in an apparently wilful manner does not exclude him or her from having a psychiatric disorder, and one that might respond to treatment.

We agree with Dr Black that a central aim would be to improve quality of life, but we do not advocate detention merely to avoid straining the public purse. However, more effective use of resources might achieve both these results and is always desirable. Since the patient has profited in the past from relatively unstructured therapy, it is not unreasonable to suggest that he might improve with the treatment programme described. There is evidence that patients can show clinical improvement without actively participating in a behavioural therapy programme. Moreover, most detained patients (and this patient in particular) cooperate to some degree in their treatment. We do not argue that continuous hospitalisation for this case, or for Munchausen patients in general, is either necessary or appropriate.

The authors have not presented a full economic evaluation of this man's treatment. In view of the expense of forgone opportunities to public services and private individuals, the underestimate of direct costs to the National Health Service, and indirect costs (e.g. the halting of a rail network), it is probable that this patient consumes more resources than would be needed to attempt to treat him. It is one of the central tenets of health service contracting that expenses are concentrated "in one area" as this practice improves clinical services and accountability. Under the previous system, the dispersal of costs led to their being obscured and encouraged a therapeutically nihilistic approach.

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Mental disorders and adaptive behaviour in people with Down's syndrome

SIR: We read with interest the two related articles by Collacott *et al* (*Journal*, November 1992, **161**, 671–674) and by Collacott (*Journal*, November 1992, **161**, 675–679), reporting the occurrence of psychiatric disorders and changes in adaptive behaviour in people with Down's syndrome. Although the articles enhance our understanding of mental disorders in people with Down's syndrome, there were a few methodological flaws in both studies.

The authors fail to say whether the diagnosis of Down's syndrome was cytogenetically confirmed or not and, if so, of what type. Just as people with a

learning disability are not a homogenous group, neither are people with Down's syndrome. The chromosomal origin of Down's syndrome is an important variable which every study of people with Down's syndrome must account for.

Psychiatric disorders of people with a learning disability should no longer be studied as a "group phenomenon", and every effort must be made to compare their psychopathology based on aetiological/syndrome groups. Problems inherent in the study of behaviours of heterogenous groups in developmental psychiatry are well documented in a recent article by O'Brien (1992).

Another important source of error in both studies was that the psychiatric diagnoses were made without due consideration to the observation that this population has a higher risk of developing insidious medical illnesses, such as sensory impairment and thyroid dysfunction. These impairments can present as a psychiatric symptom leading to errors in clinical diagnosis. There is no mention of the nature of, and figures for, coexisting medical conditions in either of the studies.

In the second article an attempt is made to equate "regression in adaptive functioning" in the elderly Down's syndrome subjects with the "development of Alzheimer's disease". Not all elderly people who lose skills have dementia. Without a full medical screen, in particular for hypothyroidism and sensory loss, both of which will lead to loss of skills and subsequent regression, a probable diagnosis of Alzheimer's disease is untenable.

In the first article there is a statement that "Heaton-Ward (1977) had found a prevalence of 3.4% ... similar to that of 32.2% found by Reid (1972*a*,*b*)". Review of the papers by Reid (1972*a*,*b*) shows the actual percentage to be only 3.2%.

We recommended that no psychiatric diagnosis should be made for people with Down's syndrome/learning disability without a full medical screen first, as these people are at higher risk for developing related psychiatric conditions. The authors of both articles deserve commendation for their industry and contribution to the literature but, in view of the flaws in the studies, the conclusions that they have arrived at should be accepted with reservation.

HEATON-WARD, W. A. (1977) Psychosis in mental handicap. *British Journal of Psychiatry*, **130**, 525–533.

O'BRIEN, G. (1992) Behavioural phenotype in developmental psychiatry; measuring behavioural phenotypes – a guide to available schedules. *European Child and Adolescent Psychiatry* (suppl. 1), 1–61.

REID, A. H. (1972*a*) Psychosis in adult mental defectives. I: manic-depressive psychosis. *British Journal of Psychiatry*, **120**, 205–212.

— (1972*b*) Psychosis in adult mental defectives. II: schizophrenic and paranoid psychoses. *British Journal of Psychiatry*, **120**, 213–218.

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AUTHORS' REPLY: We wish to thank Drs Prasher & Krishnan for the interest that has been shown in our two studies (Collacott *et al*, *Journal*, November 1992, **161**, 671–674; Collacott, *Journal*, November 1992, **161**, 675–679) which investigated different psychiatric aspects of people with Down's syndrome. While they highlight one error, clearly typographical in origin, we are puzzled by some of their criticisms.

The plethora of characteristics typical of Down's syndrome renders the diagnosis essentially a clinical one. The overwhelming majority of cases of Down's syndrome are due to trisomy 21 (93–96%). Hence, in studies of a large size, such as ours, the chromosomal origin of the syndrome loses relevance. Additionally, cases of mental illness and Alzheimer's neuropathology have been reported in translocation and mosaic Down's syndrome individuals (Crapper *et al*, 1975; Lai & Williams, 1989; Reid & Aungle, 1974; Reid *et al*, 1978). Conversely, there is no evidence to suggest that such individuals sustain a different pattern of mental disorders than those with trisomy 21.

The study of psychopathology in groups of people with specific causes for their learning disability clearly provides a different kind of information to that gained from studying a heterogeneous group of people with learning disability from diverse causes. The former may provide information that becomes relevant to clinical practice and the assessment and treatment of individuals, whereas the latter may delineate the extent of problems and needs in whole populations, and may have an influence on service planning. Our study has tried to address the former issue, rather than the latter, by studying people with Down's syndrome. For the purpose of describing rates of psychiatric disorders, a comparison control group is, of course, necessary due to the lack of standard diagnostic criteria for psychiatric illness in people with learning disabilities.

Regrettably, we must disagree with the statement that in people with Down's syndrome/learning disabilities, the first step in making a psychiatric diagnosis is a "full medical screen". In clinical practice, psychiatric diagnosis requires the taking of a full history, under the usual standard headings (from both patient and collaterally, from an informant), a