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

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