biological research was privileged in the higher items.

(b) Our findings about informed consent suggest that it is common for those recorded as of informal status on Department of Health statistics to report being coerced. The "hidden section" is well known to anyone working within psychiatry prepared to give an honest account of communications to patients. It is easy for clinicians to forget in their zeal to respond to those they deem to be ill that mental health law empowers professionals to operate a policy of preventive detention and detention without trial. Doctors may often believe that merely to identify mental illness is a good enough reason to treat it coercively. With such a cognitive set, it may be easy to overlook that locking people up against their will and without a trial (or merely having the power so to do) is hardly a conducive starting point for consensual decision making.

(c) Yes, physical treatments can be effective at symptom reduction. However, since the end of the 19th century it has been a rash psychiatrist who has claimed to "cure mental illness". Given the weak and contested evidence about the effectiveness of psychotropic medication yet the incontrovertible evidence about its iatrogenic effects, an ethical imperative exists to be open about the dangers of its use. For example, the difference in relapse between medicated and non-medicated (placebo) groups in the Northwick Park study was only 20%. In the first group 58% relapsed and in the second group 78% relapsed within two years. And yet, *all* of the recipients of major tranquillisers risk iatrogenic effects. Our anxieties are amplified when we look to the literature on polypharmacy, mega-dosing and irrational PRN policies, which potentiate iatrogenic effects and lead to unnecessary tardive dyskinesia, neuroleptic malignant syndrome and fatalities. When the latter occur among compulsorily detained patients, the cause for concern about human rights for those treated coercively with "dirty" pharmacological compounds becomes pressing. Shouldn't all users in every locality know about this picture when they are given neuroleptics?

(d) The very existence of a users' movement critical of what is currently delivered by services is testimony to the problems that the psychiatric profession faces. If patients are so grateful for what is offered, why do organisations like Survivors Speak Out exist and why do so many patients fail to comply with treatment? (The tautological explanation of the complainants being "mentally ill" is not a good enough answer to this question.) The emergence of a world wide new social movement, in protest against everyday theory and practice in psychiatric services, and the refusal of many patients to appreciate what is offered to them might indicate that some tough self-criticism, not bland reassurance, is required from the psychiatric profession.

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Diogenes syndrome

DEAR SIRS

Dr D. V. Coakley's letter (*Psychiatric Bulletin*, **16**, 111) characterising a patient as suffering from Diogenes syndrome and proposing management based on this 'diagnosis', over-estimates the validity of the syndrome. The term 'Diogenes syndrome' is unsatisfactorily defined and needs further study before one can assume that psychiatrists treating such elderly recluses are merely "agents of social control".

Patients conforming to the description are diagnostically heterogeneous. Indeed, half the population from which Clark *et al* (1975) coined the term 'Diogenes syndrome' and ascribed personality and intelligence characteristics was dementing or schizophrenic though this is never made explicit! Even otherwise 'normal' self neglecting patients can have unsuspected pathology for example frontal lobe dysfunction. As it stands 'Diogenes syndrome' is a blanket term for a variety of social, physical and psychiatric disorders. On its own it is neither helpful in predicting outcome nor suggesting treatment.

The case referred to by Dr Coakley (*Psychiatric Bulletin*, 1991, **15**, 574) does not appear to be just a case of a woman who lives in a dangerous building whom the authorities want "out of sight". While self neglect in itself should not be a reason for admitting people, its existence should make us look carefully for treatable mental illness and enable us to rescue these people from appalling living conditions. MacAnespie (1975) points out that response to treatment can be good and only repeated assessment at home can help take the often difficult decision whether a patient should be admitted.

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