that Ingleby in his Introduction and in 'Understanding Mental Illness' was worth twenty of them, so I shall concentrate on him.

Ingleby says: '... the scientific image of psychiatry (is) a smokescreen; the real questions (are): whose side is the psychiatrist on? What kind of society does he serve, and do we want it?' 'Science had only confused the issue because its fundamental premise, that people were like things and could be studied in the same way as things, was degrading and far-fetched'. There is an 'inappropriateness of natural-scientific methods and concepts to the study of people.' The alternative is one of the 'interpretative' approaches: 'The simplest ... involves the view that so-called mental illnesses are actually meaningful responses to difficult situations, which a sympathetic application of commonsense can easily make intelligible.' And lastly 'if we are concerned about the oppressive aspects of our society we will take very seriously a theory which suggests that mental illness is a manifestation of them.'

So for Ingleby a textbook like Mayer-Gross, Slater and Roth is nothing but rubbish, and 'if ECT reduces the pain of events only by helping the patient to forget them, or if tranquillizers make people able to handle their emotions only by leaving them with no emotions to handle'—and that is what he believes—'then talk of a 'cure' becomes rather ironical.' So-called mental illness is a consequence of the way we live, of capitalism and class oppression and exploitation (and will only be cured by changing society), and the fact that the USSR still has schizophrenia and mental hospitals after a good half-century of non-capitalism is neither here nor there. Ingleby is a great man for brushing aside inconvenient opposition. He approves of a book by Laing and Esterson, *Sanity, Madness and the Family*, a detailed study of 11 psychiatric patients and their relations, and is angry at the oft-repeated criticism that these patients were not really schizophrenic. 'If psychiatrists fail to recognize the cases in this book as typical', he writes, 'it merely betrays how unsympathetically and superficially they are in the habit of perceiving their own patients.' That seems to me to come splendidly from a man without any psychiatric training or appropriate clinical experience.

What is astonishing about this book on psychiatry is its total disregard of the existence of *patients*. I thought that was what psychiatry was about, the touchstone of all theory and practice, before we got to the power-crazy jackboot-licking psychiatrists, or the philosophical debates about human individuality or economic determinism. But there is never a word about their numbers and individual varieties of behaviour, their ages, their actual desire to come into hospital, their satisfaction (sometimes) with their 'treatment', the difficulties psychotics can pose for relatives and neighbours, questions of suicide and alcoholism (which transcend class boundaries), the organic dementias ... not a single case history, not one real person. It is all in terms of high-flown debate, generalizations, assertions of non-facts; no practical results. It is obvious to me that Ingleby does not really know much about psychiatry, or what goes on in the clinic. And yet I rather like him; he reads widely, including out-of-the-way books, he writes quite well, he has some ideas to rub together, he can argue, his heart is often in the right place. But he floats in philosophic space, his feet never touch earth. I imagine him as dreadfully short-sighted, can't see the ground clearly, not quite sure whether that is a tree or a human being next to him; a bit cut off from life, perhaps, amid his books.

Why does one become an anti-psychiatrist? It is an emotional position, not an intellectual one, as far as my reading goes. Envy of the medical profession comes into it, because we get more pay than the non-medics and yet we don't have to be so intellectually brilliant. No need for first-class honours in our line, or even a degree at all: the Conjoint will do for a start. And then it also seems to me the way sociology is sometimes taught also comes in, with rather a contempt for mere data, whether from observation or experiment, but an emphasis on theory, argument, verbal play and disputation, a mediaeval scholasticism in modern dress. Perhaps the progressive intelligentsia is not really very interested after all in the deluded, demented or hallucinated, except as a convenient propaganda weapon in the political fight.

JOHN CRAMMER

Institute of Psychiatry
London SE5 8AF

Prevention of Psychiatric Disorders in General Practice. 1981. Royal College of General Practitioners. £3.

This document is the report of a sub-committee of the Royal College of General Practitioners Working Party on Prevention. The sub-committee is chaired by Professor Philip Graham, and among its other members are Professor George Brown and Dr Murray Parkes, as well as two general practitioners and a health visitor. The report is intended 'to provide a framework for preventive activity and to make specific suggestions in relation to particular psychiatric disorders'. It is almost exclusively concerned with primary prevention. As the document recognizes, this is not an area overendowed with research findings, and so inevitably some of the recommendations are less firmly based on scientific findings than is ideal.

As is to be expected, given the membership of the working party, the document takes a decidedly socially-orientated view of psychological disorder. Indeed, it could be argued that unless such a view is adopted the possibilities for prevention are limited. Crucial to any discussion of prevention is the notion of the 'at risk group'—that is, there are certain identifiable subgroups of the population who have a high risk for becoming ill. This report adopts two approaches to risk. Firstly, Parkes' (1971) concept of 'psychosocial transition'—that is, there are certain events in life which

require an individual to 'give up one set of assumptions about the world and adopt another', examples of which are leaving home in adolescence, losing one's job in adulthood, and retirement in older age groups. These times of transition are times of high risk for psychological disorder. Secondly, recognizing that not everyone undergoing a transition becomes ill, the report sets out a number of factors that are protective, and others that increase vulnerability to psychological disorder.

The principles of prevention are then described, under the headings of anticipatory guidance, supportive intervention, early treatment and referral. For the first two categories in particular, the emphasis is on practical guidance as to what the general practitioner can, and should, do.

Having discussed these general issues, the report deals separately with preventing psychological illness in childhood and adult life. Under the latter heading are included depression, parasuicide, problem drinking and functional deterioration in dementia. In each case, a number of specific recommendations are made. These are by and large, realistic: for example, it is recognized that, despite recent research effort, the opportunities available for the general practitioner to reduce vulnerability to depression are limited.

The final three sections of the booklet discuss organization, educational implications and research. A plea for further research is made, but in this case it should be taken more seriously than the obligatory statement that appears at the end of every research paper. There is a pressing need for more knowledge in this area, and it is to be hoped that this report will stimulate grant-giving bodies and researchers alike to devote some attention to this field. The report, however, is mainly directed to practising clinicians and general practitioners, and psychiatrists should not feel that there is therefore nothing in it for them. At present, hospital psychiatrists rarely see disorders in their early stages, and hence are not well equipped to deal with them. Given the continuing trend towards community psychiatry and the growing establishment of general practitioner-psychiatrist liaison schemes, early identification and preventive management of psychiatric disorder become increasingly important aspects of the psychiatrist's work.

PAUL WILLIAMS

Institute of Psychiatry
London SE5 8AF

The College

Towards a New Mental Health Act: Sections 60 and 65 and the European Commission of Human Rights

ROBERT BLUGLASS, Chairman, Special Committee of Council for the Review of the Mental Health Act

Section 65 of the Mental Health Act (restriction order)

The Mental Health Act 1959 empowers a Crown Court (but not a Magistrates' Court) to make a Restriction Order when a Hospital Order is made and if it appears to the Court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if released, that it is necessary for the protection of the public to do so. The Judge must hear oral evidence from one of the doctors recommending the Hospital Order.

The restrictions rescind the provisions relating to the duration, renewal and expiration of authority for the detention of patients as long as the Restriction Order is in force. The patient's case may be referred to a Mental Health Review Tribunal by the Home Secretary at any time for advice, and the patient may request him to do so after twelve months, after a further year and then at two-yearly intervals, but neither the patient nor his nearest relative may apply to the Tribunal directly. After recall from conditional discharge the patient may request an application to the Tribunal after six months.

Without the consent of the Home Secretary the patient may not be given leave of absence, be transferred to another hospital or to guardianship, or be discharged, and if given leave of absence the six-month limit on further detention (applicable to Hospital Orders under Section 39) does not apply. The Home Secretary also has power to recall a conditionally discharged patient at any time.

A Restriction Order ceases to have effect at the end of any period named by the Court (with limit of time). It can also be ended at any time by the Home Secretary, or the Home Secretary may discharge the patient at any time by warrant either absolutely or conditionally (and subject to requirements that he is under supervision and is liable to recall).

The patient may appeal to the Court of Appeal (Criminal