



OPEN LETTER

Why it's time to stop saying "mental illness": A commentary on the revision of the Irish Mental Health Act [version 1; peer review: 1 approved, 1 approved with reservations]

Malcolm MacLachlan ^{1,2}, Rebecca Murphy¹, Michael Daly ¹, Philip Hyland ¹

¹Department of Psychology and Assisting Living & Learning Institute, Maynooth University, Maynooth, Co Kildare, Leinster, W23 F2H6, Ireland

²HSE National Clinical Programme for People with Disability, Health Service Executive (HSE), Parkgate Street, Dublin 8, D08 YFF1, Ireland

V1 First published: 19 Mar 2021, 4:28
<https://doi.org/10.12688/hrbopenres.13235.1>
 Latest published: 19 Mar 2021, 4:28
<https://doi.org/10.12688/hrbopenres.13235.1>

Abstract

The Irish Mental Health Act (2001) is undergoing revision. In 2014 an Expert Review Group recommended that the term currently used in the act "mental disorder", should be replaced with the term "mental illness". We argue that the proposed change, while well intentioned, contradicts the internationally adopted terminology of "mental disorder" used by the United Nations, World Health Organisation and European Commission. The term "mental illness" is atavistic, it implies an unsupported cause, it contravenes the United Nations Convention on the Rights of Persons with Disabilities (UNCPRD), and it is associated with concerns regarding stigma and reduced self-efficacy. Furthermore, the term "mental illness" is not used in any internationally accepted diagnostic or classification system in the mental health field. While any term used to describe mental health problems, may be contested, Ireland should not revert to using archaic terminology. In accordance with international best practice, and perhaps in lieu of a willingness to accept more progressive alternatives, Ireland should continue to use cause-neutral terminology, such as "mental disorder", in the revised Mental Health Act.

Keywords

mental illness, mental disorder, psychosocial disability, Mental Health Act, Ireland, UNCPRD

Open Peer Review

Approval Status

	1	2
version 1		
19 Mar 2021	view	view

1. **Geoffrey L. Dickens** , Northumbria University, Newcastle, UK

Sarah Bisp, Northumbria University, Newcastle, UK

Benjamin Ajibade , Northumbria University, Newcastle, UK

2. **Graham W. Mellso**p, University of Auckland, Auckland, New Zealand

Any reports and responses or comments on the article can be found at the end of the article.

Corresponding author: Malcolm MacLachlan (all.institute@mu.ie)

Author roles: **MacLachlan M:** Writing – Original Draft Preparation; **Murphy R:** Writing – Review & Editing; **Daly M:** Writing – Review & Editing; **Hyland P:** Writing – Review & Editing

Competing interests: No competing interests were disclosed.

Grant information: Health Research Board Ireland grant number COV19-2020-025

The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Copyright: © 2021 MacLachlan M *et al.* This is an open access article distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

How to cite this article: MacLachlan M, Murphy R, Daly M and Hyland P. **Why it's time to stop saying "mental illness": A commentary on the revision of the Irish Mental Health Act [version 1; peer review: 1 approved, 1 approved with reservations]** HRB Open Research 2021, 4:28 <https://doi.org/10.12688/hrbopenres.13235.1>

First published: 19 Mar 2021, 4:28 <https://doi.org/10.12688/hrbopenres.13235.1>

Disclaimer

The views expressed in this article are those of the author(s). Publication in HRB Open Research does not imply endorsement by the Health Research Board of Ireland.

In their classic work “Models for Mental Disorder”, psychiatrists [Tyrer & Steinberg \(1998\)](#) indicate that among the central tenets of the disease model are that “mental pathology is also accompanied by physical pathology” and that “the causes of physical and mental pathology in psychiatric illness are all explicable in terms of physical illness” (p. 10). They go on to state: “[a]lthough laboratory and other independent tests are not available to confirm the clinical findings...[t]he examination of the mental state is the mental equivalent of the physical examination” (p. 13). This remains the essence of the disease model from which the concept and term “mental illness” arises. In essence, the presence of a distressed mental state or *dis-ease*, is taken as evidence of the presence of a diseased physical state.

Just as in 1998, there are still no “laboratory tests or other biomarkers” to support the idea that mental health problems are disease-like states that express themselves through “illness” ([Bhugra et al., 2017](#); [Kapur et al., 2012](#)). This is not in any way to deny the legitimacy of the distress or the disruption to life that those with mental health problems suffer. It is perhaps surprising that no recognised biological marker of mental health problems exists given the extremes of human experience and behaviour that are apparent in conditions as varied as bipolar disorder, schizophrenia, obsessive compulsive disorder, or anxiety. Yet, repeatedly, and despite the attempts of many brilliant psychiatric researchers (e.g. see [Kendler & Schaffner, 2011](#)), no evidence for a neurobiological cause of mental health problems has yet been found ([Harrington, 2020](#)), and assumptions about psychotropic drugs as disease-specific interventions continue to be contested (e.g. [Götzsche, 2020](#); [Moncrieff, 2020](#)).

The importance of biological research

This is not to say that biological based research on mental health problems is without value, or prospects (e.g. [Mongan et al. 2021](#); [Strawbridge et al., 2017](#)); or that important discoveries are not to be found in such research (e.g. [Brückl et al., 2020](#)). However, until we find evidence to suggest otherwise, it seems reasonable to assume that the usual range of biological functioning is sufficient to produce a great variety of mental and behavioural experiences. We are definitely not suggesting that research should cease looking for biological causes or concomitants of mental health problems; nor that we should necessarily stop using psychotropic drugs, which can effectively suppress unwanted ‘symptoms’, experiences, or behaviours for many people with mental health problems.

Cause-neutral terminology

The language we use should not however imply and/or promise a causality where evidence for such a cause is absent. How language is used, its metaphors and allusions, influence how people understand their own experiences and the world

around them and how they are treated by others ([Bruffee, 1986](#); [Schultz, 2017](#); [White, 2018](#)). In such a contested, nascent field, it is surely judicious, respectful, humble, and honest to use *cause-neutral* terminology; that is, terminology which does not imply a physical cause, a psychological cause, a social cause, or any other cause; language that does not privilege one perspective over another. [Kendler \(2014\)](#), in arguing for the importance of clarifying causal processes in “psychiatric science” suggests that “[t]olerance for diversity and humility come with scientific maturity”. Indeed, the imposition of what [Kendler](#) calls “fervent monism” has been argued to unjustifiably diminish legitimate alternative perspectives ([Deacon, 2013](#)).

Implications of “illness”

At the same time, it is important to recognise that the linking of mental and physical illness is often well-meaning. For instance, such an attribution has the potential to reduce victim blaming/stigma or to increase help-seeking by reducing perceived personal responsibility for ‘symptoms’. Unfortunately, it seems that such an emphasis on illness has in fact been more linked with increased discrimination and reduced perceived personal control over one’s mental health ([Pescosolido et al., 2010](#); [Read et al., 2006](#)). An extensive empirical literature has examined the implications of holding biological illness explanations of mental disorders and the “mental illness is an illness like any other” approach to reducing stereotypes which has been described as an “unequivocal failure” in reducing stigma ([Deacon, 2013](#)). For instance, a review of anti-stigma initiatives in relation to schizophrenia concluded that “diagnostic labelling as ‘illness’, are both positively related to perceptions of dangerousness and unpredictability, and to fear and desire for social distance.” ([Read et al., 2006](#)). Another meta-analysis of 25 studies confirmed these trends ([Kvaale et al., 2013](#)). Experimental studies have found that presenting people with biogenetic illness explanations for mental disorder increased perceptions of dangerousness and decreased their perceived recovery prospects ([Bennett et al., 2008](#); [Walker & Read, 2002](#)). A meta-analysis examining trends in public attitudes towards “mental illness” found that biological models of mental disorders have been increasingly endorsed in recent decades, but that this has not been coupled with a reduction in social acceptance of those individuals with such disorders ([Schomerus et al., 2012](#)). Taken together these findings suggest that diagnostic labelling of mental health problems as “illness” is unlikely to reduce mental health stigma and may in fact result in the opposite.

Review of the Irish mental health act (2001)

[The Irish Mental Health Act \(2001\)](#) is in the process of revision and has received input from a range of stakeholders, including an Expert Review Group (ERG), which reported on its recommendations for revisions to the act in 2014. This group made many useful recommendations. However, the [ERG \(2014\)](#) also recommended that the existing term in use in the Act, “mental disorder”, should be replaced with the term, “mental illness”. Confusingly, the ERG suggests that the term ‘mental disorder’, “reflects a strongly medical model approach to mental illness” (p16). However, in attempting to diverge from the language of

the biomedical model, they have instead reinforced it through the use of ‘mental illness’ terminology; where “mental illness means a complex and changeable condition where the state of mind of a person affects the person’s thinking, perceiving, emotion or judgement and seriously impairs the mental function of the person to the extent that he or she requires treatment”. (p. 17). Compared to the existing [Mental Health Act \(2001\)](#) this definition is actually very similar: with “complex and changeable” added, and with reasons for treatment “in the interest of others” being dropped. Interestingly then, the proposed definition of “mental illness” does not refer to any biological process, which one might imagine is a pre-requisite for the use of “illness” terminology. So, even in its own terms, the proposed definition for the Irish Mental Health Act is not viable.

While the stated intention of the ERG to separate the “definition of mental illness from the criteria for detention” is welcome and appropriate, there is no reason why the same effect cannot be achieved by distinguishing between the definition of “mental disorder” and the criteria for detention. At the most fundamental level, the act is about “Mental Health”. The suggestion that the archaic phrase “mental illness” be used in place of “mental disorder” not only ignores current best practice but is atavistic by referring to a nomenclature that is less and less used, including in psychiatry. This retrograde step would make Ireland an outlier on the international landscape, while instead we should be aligning with best practice in international human rights and international public health. We now outline below just what that is.

United nations statements

In the 2019 recommendations of the *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* ([United Nations Human Rights Council, 2019 A/HRC/RES/42/16](#)), Dainius Pūras (a Professor of Psychiatry) submitted in accordance with Human Rights Council resolutions 6/29 and 33/9 ([United Nations Human Rights Council, 2007](#); [United Nations Human Rights Council, 2016](#)):

[O]bstacles exist that impair the provision of mental health care and hinder the realization of the right to health ([United Nations Human Rights Council, 2017 A/HRC/35/21](#)). Such obstacles include the overuse of the biomedical model to define emotional distress and a medical hierarchy that can result in coercion that is detrimental and dehumanizing to patients, as well as providers of mental health. Power asymmetries between medical specialties, between doctors and other health-care workers, and between doctors and users of services, create additional barriers to the realization of the right to health (p. 18).

The Special Rapporteur argued that the use of terminology which privileges a medical model, in the absence of any evidence to support it, is inappropriate and that such a stance is contrary to the [UNCRPD \(2006\)](#). Ireland ratified the UNCRPD in 2018 and is now obliged to report to it. As the UNCRPD does not use biologically-orientated terminology, Ireland would be in contravention of the convention should it revert to using

“mental illness” as terminology in the revised Irish Mental Health Act.

The Annual report of the *United Nations High Commissioner for Human Rights*, 2017, specifically addressed the theme of mental health and human rights. The term “mental illness” is not used anywhere in the document; rather the phrases repeatedly used are “[u]sers of mental health services”, “persons with mental health conditions” and “persons with psychosocial disabilities”. For instance, it is stated that:

Mental health is not merely a health or medical concern, it is very much a matter of human rights, dignity and social justice. The overview of the challenges facing persons with mental health conditions and those with psychosocial disabilities indicates that fundamental changes are necessary in current approaches to the protection of their rights and how that protection is implemented in policy ([UNHCHR, 2017](#), p. 11).

The High Commissioner for Human Rights concludes:

Consequently, in meeting their obligation to achieve the full realization of the rights of persons with mental health conditions, users of mental health services and persons with psychosocial disabilities, States should align the policy and legal framework with human rights norms, develop and implement rights-based strategies and plans, and share technical expertise and other resources, such as good practice norms. (p.18).

If Ireland were to return to using “mental illness” within its Mental Health Act, it would be failing to align policy with prevailing human rights norms; such as the UNCRPD, the Statements of the High Commissioner for Human Rights, and the Statements of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ([United Nations Human Rights Council, 2019 A/HRC/RES/42/16](#)).

World health organization (WHO)

The World Health Assembly officially adopted the International Classification of Diseases 11th Revision (ICD-11) in 2019 ([World Health Organization, 2019](#)). This system of classification and diagnosis does not use the term “mental illness”. The “ICD is the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of diseases, disorders, injuries and other related health conditions” ([World Health Organization, 2020](#)). The scope of the ICD is therefore very broad conceptually and has been developed to be used internationally, throughout the world. Indeed, from 2022, all countries will be required to report their health statistics using ICD terminology. The terminology used within the revised Mental Health Act should therefore be consistent with the terminology with which we will be required to report our mental health statistics. WHO uses the term ‘mental disorders’ and defines them thus:

Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse ([World Health Organization Mental Disorders, 2019](#)).

While not the same, this definition is very close to the proposed Irish definition of “mental illness”. The WHO definition of mental disorder was carefully crafted by an international expert committee specifically to move away from disease models due to a lack of supporting evidence for this approach. Importantly, the WHO position is not ideological or aligned to any professional discipline, rather it is based on the international evidence and deliberately does not privilege one causal model (e.g., disease) over any other causal model. As with all mental health classification systems, it is descriptive rather than explanatory.

WHO’s Mental Health Action Plan 2013–2020 ([World Health Organisation, 2013](#)) does not use the term “mental illness”. In different places, it variously uses the terms “mental disorder” or “mental health problem” or “psychosocial disability”. In fact, it repeatedly uses the phrase “people with mental disorders and psychosocial disabilities”. Its glossary of terms does not define “mental illness”. The current WHO Europe website on “Key Terms and Definitions in Mental Health” ([Euro WHO, 2021](#)) defines “mental disorders” but does not define “mental illness”. Historically, some have argued that the term “illness” should be retained for more severe problems. Severity and causality are, of course, distinct. WHO does not use the terms “illness” even for more severe conditions. For example, it defines schizophrenia as “[a] severe mental disorder, characterized by profound disruptions in thinking, affecting language, perception, and the sense of self”. It defines depression as “a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration”.

European commission

All European Commission (EC) documentation in this area uses “mental disorder” or “mental health problem” terminology. The Council of Europe in Parliamentary Assembly 2019 refers to “persons with mental health conditions or psychosocial disabilities” ([Council of Europe, 2019](#)). The EU Joint Action on Mental Health and Wellbeing seeks to “champion mental health as a European public health priority and to develop tools to support Member States in improving conditions for the prevention, diagnosis and care of mental disorders in their countries.” ([Caldas de Almeida, 2016](#)). No EC documentation uses “mental illness” terminology.

DSM

Traditionally, the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association had adopted a stronger

disease model orientation than the WHO equivalent (ICD). However, its most recent edition, the DSM-5, does not use the term “mental illness”, it does not define mental illness, and has explicitly been revised to use cause-neutral terminology. Thus, it is not possible to be “diagnosed”, or classified, as having a “mental illness” using either of the classification systems available to mental health professionals around the world.

Conclusion

In being critical of the term “mental illness” and suggesting retention of the term “mental disorder” in the revised Irish Mental Health Act, we are also aware that the latter term may also be contested; and that some experts-by-experience question the legitimacy of implying “disorder” in conditions that are often patterned – ordered – in recognisable ways. Beresford notes that “[t]erminology has become a battleground” ([Beresford, 2019](#); p. 35) on which different ontologies are paraded and contested. We therefore also appreciate that the terminology utilised within international human rights legislation is not necessarily universally accepted and can be argued to be culturally encapsulated ([MacLachlan, 2006](#)). We acknowledge that any linguistic and philosophical framing of human suffering - especially by those who have not experienced it - is likely to be problematic and contested. With that realization our intention is to urge Irish alignment with international progression in this field, rather than reversion to an outlying discourse.

The revised Mental Health Act could also consider using terms such as “mental health problems”, “mental health difficulties”, “mental health conditions” or “psychosocial disabilities” – all used to some extent in the international documents cited above. However, in lieu of a willingness to embrace these - perhaps more progressive terms - we should not be regressive. The term “mental disorder” has at least the benefit of not privileging one ontology over another. As Faulkner and Kalathil argue “[t]he definitions we work with are not just a matter of academic clarity, they are tied up with funding decisions and policy priorities” ([Faulkner & Kalathil, 2012](#); p.27). The revision of the [Mental Health Act \(2001\)](#) should reflect our policy priorities. Ireland should not replace the existing and internationally adopted terminology of “mental disorder” with terminology that: implies an unsupported cause; is atavistic; is associated with concerns regarding stigma and beliefs about personal coping efficacy; is contrary to the UNCRPD; and is not actually viable within any current mental health, psychiatric, or psychological diagnostic or classification system.

Data availability statement

No data are associated with this article

Author contributions

MM wrote the first draft and RM, MD and PH all contributed revisions and to the final draft.

Acknowledgments

We are grateful to Anastasia Campbell for editorial support on writing this article.

References

- Bennett L, Thirlaway K, Murray AJ: **The stigmatising implications of presenting schizophrenia as a genetic disease.** *J Genet Couns.* 2008; **17**(6): 550–559.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Beresford P: **Including Our Self In Struggle.** *Canadian Journal of Disability Studies.* 2019; **8**(4): 31–59.
[Publisher Full Text](#)
- Bhugra D, Tasman A, Pathare S, et al.: **The WPA-Lancet Psychiatry Commission on the Future of Psychiatry.** *Lancet Psychiatry.* 2017; **4**(10): 775–818.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Brückl TM, Spoomaker VI, Sämann PG, et al.: **The biological classification of mental disorders (BeCOME) study: a protocol for an observational deep-phenotyping study for the identification of biological subtypes.** *BMC Psychiatry.* 2020; **20**(1): 213.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Bruffee KA: **Social Construction, Language, and the Authority of Knowledge: A Bibliographical Essay.** *College English.* 1986; **48**(8): 773–790.
[Publisher Full Text](#)
- Caldas de Almeida J: **A new Framework for Action on Mental Health and Wellbeing.** *Ec.europa.eu.* 2016; [Accessed 3 February 2021].
[Reference Source](#)
- Council of Europe Parliamentary Assembly: **Ending coercion in mental health: the need for a human rights-based approach.** Resolution 2291. 2019.
[Reference Source](#)
- Deacon BJ: **The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research.** *Clin Psychol Rev.* 2013; **33**(7): 846–861.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Euro WHO: **Key terms and definitions.** 2021; [Accessed 3 February 2021].
[Reference Source](#)
- Expert Review Group: **Report of the Expert Review Group on the Review of the Mental Health Act 2001.** Dublin: Department of Health. 2014.
[Reference Source](#)
- Faulkner A, Kalathil J: **The Freedom to be the Chance to Dream: Preserving User-led Peer Support in Mental Health. Commissioned by Together.** 2012.
[Reference Source](#)
- Gotzsche PC: **Long-term use of antipsychotics and antidepressants is not evidence-based.** *Int J Risk Saf Med.* 2020; **31**(1): 37–42.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Harrington A: **Mind Fixers: Psychiatry's troubled search for the biology of mental illness.** New York: W.W. Norton & Co. 2020; **49**(2): 212–214.
[Publisher Full Text](#)
- Kapur S, Phillips A, Insel T: **Why has it taken so long for biological psychiatry to develop clinical tests and what to do about it?** *Mol Psychiatry.* 2012; **17**: 1174–1179.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Kvaale EP, Gottdiener WH, Haslam N: **Biogenetic explanations and stigma: A meta-analytic review of associations among laypeople.** *Soc Sci Med.* 2013; **96**: 95–103.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Kendler KS: **The structure of psychiatric science.** *Am J Psychiatry.* 2014; **171**(9): 931–938.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Kendler KS, Schaffner KF: **The dopamine hypothesis of schizophrenia: an historical and philosophical analysis.** *Philosophy, Psychiatry, & Psychology.* 2011; **18**(1): 41–63.
[Publisher Full Text](#)
- MacLachlan M: **Culture & Health: A Critical Perspective Towards Global Health.** 2nd ed. Chichester: Wiley. 2006.
[Reference Source](#)
- Mental Health Act. 2001.
[Reference Source](#)
- Moncrieff J: **A straight talking introduction to psychiatric drugs.** (2nd Ed) Monmouth: PCC Books. 2020.
[Reference Source](#)
- Mongan D, Föcking M, Healy C, et al.: **Development of Proteomic Prediction Models for Transition to Psychotic Disorder in the Clinical High-Risk State and Psychotic Experiences in Adolescence.** *JAMA Psychiatry.* 2021; **78**(1): 77–90.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Pescosolido BA, Martin JK, Long JS, et al.: **"A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence.** *Am J Psychiatry.* 2010; **167**(11): 1321–1330.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Read J, Haslam N, Sayce L, et al.: **Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach.** *Acta Psychiatr Scand.* 2006; **114**(5): 303–318.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Schomerus G, Schwahn C, Holzinger A, et al.: **Evolution of public attitudes about mental illness: A systematic review and meta-analysis.** *Acta Psychiatr Scand.* 2012; **125**(6): 440–452.
[PubMed Abstract](#) | [Publisher Full Text](#)
- Schultz W: **Explaining Depression in Clinical Settings: Shortcomings and Dangers of Simplified Analogies.** *Ethical Hum Psychol Psychiatry.* 2017; **19**(1): 51–64.
[Publisher Full Text](#)
- Strawbridge R, Young AH, Cleare AJ: **Biomarkers for depression: Recent insights, current challenges and future prospects.** *Neuropsychiatr Dis Treat.* 2017; **13**: 1245–1262.
[PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Tyrer P, Steinberg D: **Models for Mental Disorder: Conceptual Models in Psychiatry.** (3rd Ed) Chichester: Wiley. 1998.
[Reference Source](#)
- United Nations Human Rights Council: **The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.** A/HRC/RES/42/16. 2019.
[Reference Source](#)
- United Nations High Commissioner for Human Rights: **Report on Mental Health and Human Rights.** 2017.
[Reference Source](#)
- United Nations: **Convention on the Rights of Persons with Disability.** Geneva: United Nations. 2006.
[Reference Source](#)
- United Nations Human Rights Council: **Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General.** A/HRC/34/1. 2017.
[Reference Source](#)
- United Nations Human Rights Council: **Right of everyone to the enjoyment of the highest attainable standard of physical and mental health.** Resolution 6/29. 2007.
[Reference Source](#)
- United Nations Human Rights Council: **The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.** Resolution 33/9. 2016.
[Reference Source](#)
- Walker I, Read J: **The differential effectiveness of psychosocial and biogenetic causal explanations in reducing negative attitudes toward "mental illness".** *Psychiatry.* 2002; **65**(4): 313–325.
[PubMed Abstract](#) | [Publisher Full Text](#)
- White K: **The social construction of mental illness.** In BMZ Cohen (Ed) *Routledge International Handbook of Critical Mental Health.* New York: Routledge. 2018.
- World Health Organisation: **Mental health action plan 2013 – 2020.** 2013.
[Reference Source](#)
- World Health Organisation: **World Health Assembly Update, 25 May 2019.** 2019.
[Reference Source](#)
- World Health Organisation: **Mental disorders.** 2019.
[Reference Source](#)
- World Health Organisation: **International Statistical Classification of Diseases and Related Health Problems (ICD).** 2020.
[Reference Source](#)

Open Peer Review

Current Peer Review Status:  

Version 1

Reviewer Report 18 January 2022

<https://doi.org/10.21956/hrbopenres.14397.r31233>

© 2022 Mellso G. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.



Graham W. Mellso

University of Auckland, Auckland, New Zealand

The authors have written a polemic about proposed new Irish legislation relevant to treatment compulsion in psychiatry. To do so they have selected references to use which facilitate their argument, as is entirely appropriate. There are many possibilities for readers to question them or argue about their selection, interpretations, or views. I will refer to five.

Firstly, that this whole interest in new mental health legislations is international and is occurring within two relatively academic contexts: the 2008 UN convention to which they refer and a number of recent publications attempting to throw light on the question of the efficacy of compulsory treatment in psychiatry.

Secondly, they set up a straw man by quoting one old paper by Tyler which proposed a concept of disease which many would argue with. They stretch that to argue that biologic contributions are necessary for an illness concept. I would argue only that whatever word is used, the core is a change in mental state. Legislations don't usually specify particular diagnoses but if one intention in modern legislations is to reduce compulsion, in line with the UN convention which has virtually universally been agreed to by all nations, then whatever word is used should at least convey the seriousness of the change in mental state.

Thirdly, they do not emphasise that the 2008 UN convention is not preoccupied with the semantics of illness/disorder/disease etc., but is primarily focused on maximizing the autonomy of all health service users by respecting consent to treatment whatever the problem is.

A fourth point is that they argue that the 11th revision of the ICD does not use the word illness, skipping over the fact that it has the word disease in its title.

I make my fifth point from the perspective of someone who was involved in the developments of DSMs 3, 4, and 5 as I have concerns about their DSM summary. In contrast to their statements, I do not agree that the earlier DSMs placed greater emphasis on biologic aetiologies than did the earlier ICDs. I would also think it worth noting that the DSMs are products of the American

Psychiatric Association particularly aiming to facilitate invoicing for provided services in the USA. While DSMs 3 & 4 have been very influential in many countries, DSM 5 has been very widely criticized, including within the USA by the authoritative NIMH.

In conclusion, my points are not intended to be exclusively in favour of any particular semantic, but rather to suggest that whatever word is used does convey the gravity of the mental state where any treatment compulsion is being considered. The Act may choose to give specific diagnostic guidance to either inclusion or exclusion, as has been done in many legislative efforts worldwide.

Is the rationale for the Open Letter provided in sufficient detail?

Yes

Does the article adequately reference differing views and opinions?

Partly

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Partly

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Psychiatric epidemiology, education, classification, and forensic. Also a number of publications researching or commenting on mental health treatment compulsion legislation in a number of countries. I am not familiar with the present or proposed Irish legislation.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Reviewer Report 15 July 2021

<https://doi.org/10.21956/hrbopenres.14397.r29689>

© 2021 Dickens G et al. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.



Geoffrey L. Dickens 

Department of Nursing, Midwifery and Health, Northumbria University, Newcastle, UK

Sarah Bisp

Department of Nursing, Midwifery and Health, Northumbria University, Newcastle, UK

Benjamin Ajibade 

Department of Nursing, Midwifery and Health, Northumbria University, Newcastle, UK

OPEN LETTER

Why it's time to stop saying "mental illness": A commentary on the revision of the Irish Mental Health Act

Peer review by Geoffrey L. Dickens (Professor), Sarah Bisp (Lecturer), and Dr. Benjamin Ajibade (Senior Lecturer)

All: Department of Nursing, Midwifery, and Health, Northumbria University

Preamble

We read MacLachlan *et al.*'s (2021) open letter with considerable interest. The authors scrutinize and set out their case against the replacement of the term 'mental disorder' with 'mental illness' in the new Irish Mental Health Act. We are three UK-based mental health nurse academics, all recently employed at Northumbria University, and have accepted the task of peer review of the open letter as a team development exercise and arising from our own interest in the topic. Reviewer GLD has published both systematic review and primary research studies related to the use of nomenclature ('patient', 'consumer', 'service user', 'client') to refer to people who use mental health services (Dickens & Picchioni, 2012¹; Dickens *et al.*, 2011²). Before we commence we should state our own intentions about the terms we will use. In this we have been influenced by the UK-based mental health charity Mind who use the term 'mental health problems' but recognize that some people with such 'problems' may find terms including 'poor emotional health', 'mental health issues', or 'mental illness' more helpful for identification, description, and explanation of their experiences both to themselves and others (www.mind.org.uk).

Further, the use of the term 'disorder' with specific reference to people who are diagnosed with a personality disorder is also dealt with pragmatically by the charity: to paraphrase, some find it unhelpful or upsetting if their condition is labelled a disorder, feeling that it invalidates the traumatic experiences that may have influenced the way that they interact with the world; others, however, find that a diagnostic label of personality disorder helps them to identify and explain their experiences, and to seek support. We feel similarly that language can and should be understood and used flexibly. In addition, all the proposed terms from 'illness' to 'disorder' to 'problem' are being used to refer to an extensive range of complex behaviours, thoughts, feelings, and experiences. In such circumstances, the use of any single term is likely to be contestable from any number of perspectives. We tend to use 'mental health problems' but we do not assume that the use of any of the other terms is inherently inferior.

On the whole, we found MacLachlan *et al.*'s (2021) assertion that 'mental illness' has a fixed connotation as a biologically determined phenomenon to be less convincing than other views (e.g., Ventriglio *et al.*, 2017³) which note the subtle distinction between 'illness' and 'disease'.

Nevertheless, theirs is a legitimate and well-argued position and is appropriate for this open letter. Interestingly, terminological controversies are not unique to 'mental illness'. We noted above differing views on the use of the term 'personality disorder' and, perhaps most notably, a number of commentators have made similar pronouncements about the terms 'patient', 'client', 'service user' or 'consumer'. Various perspectives have been offered including that 'patient' places an individual in a 'sick role' and promotes dependence (Neuberger, 1999⁴), while others defend or promote its use from the position of encouraging belief in mental health problems as an illness like any other (Tallis, 1999⁵). My [GLD] own experience of conducting research in this area (Dickens *et al.*, 2011²) – a study of terminological preference in a secure, forensic hospital population – was that a spiritedly disputed subject in staff meetings ('patients' vs. 'service users') was met with – bar some notable exceptions – much less interest by the people about whom the terms were applied. For the record, the term 'patient' was the most preferred, though not by a majority. In an alternative vote run off more than 60% of respondents preferred 'patient' as either their first or second choice. However, patients' views were mixed and there was little sense that the issue was of great import. We wonder if that might turn out to be the case here. Despite the author's palpable fear that the use of the term 'mental illness' will prove disastrous, could it be that the way in which mental illness is *defined* in the Act, rather than simply the *fact* of its use, means that its use will not be deleterious?

Detailed report

Is the rationale for the Open Letter provided in sufficient detail?

The rationale is clearly set out, however, the proposed definition of 'mental illness' and the current definitions used in the Irish Mental Health Act are not included in the letter. For non-Ireland based readers including ourselves, such information would have been useful but further information is freely available which does give a more comprehensive background. A search on The College of Psychiatrists of Ireland (College of Psychiatrists of Ireland, 2018⁶) website quickly provides this information plus links to the Expert Review Group (ERG) report (Mental Health Commission,⁷) and College recommendations for the revision of the Act. For instance, the Commentary on Report of Expert Group Review of the Mental Health Act 2001 highlights a number of discussion points that are not mentioned in MacLachlan *et al.*'s letter (College of Psychiatrists of Ireland 2016⁸). Notably, the College and Law Committee agree that the revised Irish Mental Health Act should be fit for purpose and compatible with the European Convention on Human Rights; that they recommend a reformulation of the principle of 'best interests'; and that further clarity is required on the definition of 'Consultant Psychiatrist' regarding who can be appointed as the 'Inspector' (College of Psychiatrists of Ireland 2016⁸). Any use of the Act would – or should – of course, be deeply embedded in the individual's care and treatment, where their own unique set of circumstances would be known to those involved.

On page three of the ERG's Commentary Report, they state that: "mental illness means a complex and changeable condition where the state of mind of a person affects the person's thinking, perceiving, emotion or judgement and seriously impairs the mental function of the person to the extent that he or she requires treatment." (College of Psychiatrists of Ireland, 2016⁸ p.2)

The report also includes the note of the Law Committee: "We would note in passing the definition makes no reference to the fact that mental disorders are part of a constellation of disorders of the brain that manifest in neurological, mental health and substance use disorders." (College of

Psychiatrists of Ireland, 2016⁸ p.2).

In our view, including this information in the original letter and cross-referencing to the Quality Framework review and Mental Health Commission to clarify the rationale and justification for the use of the term 'mental illness' as opposed to an alternative term would have been useful.

A more holistic view is evident on page 4. of the Commentary Report, where the Law Committee identifies that treatment goes beyond medication and interventions are considered to stem from mutually respectful therapeutic relationships, which incorporate not only psychopharmacology but also psychological and behavioral approaches.

Does the article adequately reference differing views and opinions?

Alongside the proposed revision of the Irish Mental Health Act is a Public Consultation of the Quality Framework for Mental Health Services (Mental Health Commission⁷), the website states that the consultation is open until 5th July and aims to gain views from as many stakeholders as possible.

This Consultation is being led by the Mental Health Commission and forms part of the wider reform of Mental Health Service across Ireland. The revision of the Irish Mental Health Act falls under this revision. The foreword from the Chairman of the Mental Health Commission speaks of empowerment, high standards, and focus on recovery (Mental Health Commission⁷).

In my role as peer reviewer [SB], it has certainly been beneficial to have read the letter alongside the wider supporting information available. Within the ERG Commentary Report, it is noted that the Law Committee expresses their own reservations at the composition of the ERG itself, stating 'We consider that the lack of representation of medical professionals working in the areas of Child and Adolescent Mental Health significantly detracts from the credibility of any of the recommendations made in this area by the Expert group.' The report also states that there were concerns about a lack of representation from General Practice (College of Psychiatrists of Ireland, 2016⁸). With this in mind, although the Quality Framework and Mental Health Commission may have offered a consultation with stakeholders, this in itself does not guarantee that response is truly representative.

Further reading around the topic of 'terminology' and definitions of Mental Disorder vs mental illness – only seems to highlight further complexity and challenge (Bingham & Banner 2014⁹; Bolton 2001¹⁰; Stein *et al.*, 2010¹¹), and leads us to suspect that this particular debate will continue for a long time to come and be revisited multiple times.

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

MacLachlan and colleagues base their opposition to the proposed change on two key premises. First, that use of the term 'mental illness' flies in the face of all current practice globally, and second that use of the term 'mental illness' necessarily implies an unsupported cause, namely that the associated thoughts, feelings, behaviours, and experiences are the result of a biological or disease process. We will address these two premises in turn.

That the proposed change is out of step with current practices is indisputable. MacLachlan *et al.*

marshal evidence from United Nations, World Health Organization, and European Commission to demonstrate this. They also note that the term 'illness' is not used either in DSM5 or ICD-10 (though somewhat ironically they do not provide the non-abbreviated title: International Classification of *Diseases* (our italics) and Related Health Problems). To be fair, however, the conditions listed in ICD-10 Chapter V (F00-F99) are largely labelled as 'disorders'. Note, however, that senile dementia Alzheimer's type is specifically labelled in ICD-10 as a disease and, despite MacLachlan *et al.*'s protestations elsewhere, is diagnosable – at least for research purposes – through biomarkers ante mortem (Morris *et al.*, 2014¹²). This is a quibble, however, and we accept that the proposed changes are contrary to the current direction of travel.

MacLachlan *et al.*'s claim that the term 'mental illness' necessarily implies biological causation deserves more scrutiny, however. The authors' objection might be more strongly supported if the proposal were to use the term 'mental disease'. While the terms 'illness' and 'disease' are not entirely distinct, Ventriglio *et al.* (2017)³ suggest subtle differences. Disease inherently deals with pathology and is the business of medical doctors who are trained to identify and treat it. Illness, on the other hand, is experienced by patients as a deleterious impact on their broader wellbeing including their physical functioning but also on emotional and social lives. 'Mental illness' also offers the prospect of remission or recovery, temporary or permanent: after all, as with other conditions, mental health problems may ebb and flow. An individual who experiences debilitating depression periodically may be mentally well for long periods between isolated nadirs. Does not the idea of periods of time interspersed by periods of illness and health make as much sense as such expanses populated by order and disorder?

The authors then bolster their case through an account of research into the mental disorder-related stigma. Much is made by MacLachlan *et al.* of findings from the survey and experimental studies about the use of biological explanations of mental disorders and the relation of that to public attitudes. Most notably they point to Schomerus *et al.*'s (2012)¹³ meta-analysis of survey studies finding that, while public attitudes have increasingly shown increased support for biological explanations, this has not been matched by decreases in stigma. Indeed, much is made of the isolated cases where increases in stigma have been found, and little time is spent highlighting the improvements made in terms of help-seeking behaviours which might result from these changing attitudes. Indeed, it is of interest that improvements in terms of help-seeking have occurred despite studies suggesting that they are consistently negatively related to stigma (Clement *et al.*, 2014)¹⁴. None of this is to say that we are suggesting that a slavish devotion to biological aetiological models is warranted, but this section of the letter may have been strengthened by a little more balance and critique of this body of literature. We also note that the ecological validity of the hypothetical, highly constructed vignette-based experimental studies which inform mental health stigma-related research has been highlighted (Angermeyer *et al.*, 2004)¹⁵. One issue emerging from this discussion seems to be that the various advantages and disadvantages of public attitudes to mental health problems on a nature-nurture axis are complex and may differ depending on inter alia the sort of mental disorders examined, demographic characteristics of the actors involved, and other influences.

Is the Open Letter written in accessible language?

The letter is written engagingly and with clarity

Where applicable, are recommendations and next steps explained clearly for others to follow?

The authors make clear recommendations. We suggest that the involvement of expert-by-experience representation should be central to decision-making.

References

1. Dickens G, Picchioni M: A systematic review of the terms used to refer to people who use mental health services: user perspectives. *Int J Soc Psychiatry*. 2012; **58** (2): 115-22 [PubMed Abstract](#) | [Publisher Full Text](#)
2. Dickens G, Langé A, Picchioni M: Labelling people who are resident in a secure forensic mental health service: user views. *Journal of Forensic Psychiatry & Psychology*. 2011; **22** (6): 885-894 [Publisher Full Text](#)
3. Ventriglio A, Torales J, Bhugra D: Disease versus illness: What do clinicians need to know?. *Int J Soc Psychiatry*. 2017; **63** (1): 3-4 [PubMed Abstract](#) | [Publisher Full Text](#)
4. Neuberger J: Do we need a new word for patients? Lets do away with "patients". *BMJ*. 1999; **318** (7200): 1756-7 [PubMed Abstract](#) | [Publisher Full Text](#)
5. Tallis R: Do we need a new word for patients? Commentary: leave well alone. *BMJ*. 1999; **318** (7200): 1757-8 [PubMed Abstract](#)
6. College of Psychiatrists of Ireland: Mental Health Legislation. 2018. [Reference Source](#)
7. Mental Health Commission: Public consultation on quality framework for mental health services. [Reference Source](#)
8. College of Psychiatrists of Ireland: Commentary on Report of Expert Group Review of the Mental Health Act 2001. 2016. [Reference Source](#)
9. Bingham R, Banner N: The definition of mental disorder: evolving but dysfunctional?. *J Med Ethics*. 2014; **40** (8): 537-42 [PubMed Abstract](#) | [Publisher Full Text](#)
10. Bolton D: Problems in the Definition of 'Mental Disorder'. *The Philosophical Quarterly*. 2001; **51** (203): 182-199 [Publisher Full Text](#)
11. Stein DJ, Phillips KA, Bolton D, Fulford KW, et al.: What is a mental/psychiatric disorder? From DSM-IV to DSM-V. *Psychol Med*. 2010; **40** (11): 1759-65 [PubMed Abstract](#) | [Publisher Full Text](#)
12. Morris JC, Blennow K, Froelich L, Nordberg A, et al.: Harmonized diagnostic criteria for Alzheimer's disease: recommendations. *J Intern Med*. 2014; **275** (3): 204-13 [PubMed Abstract](#) | [Publisher Full Text](#)
13. Schomerus G, Schwahn C, Holzinger A, Corrigan PW, et al.: Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatr Scand*. 2012; **125** (6): 440-52 [PubMed Abstract](#) | [Publisher Full Text](#)
14. Clement S, Schauman O, Graham T, Maggioni F, et al.: What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychol Med*. 2015; **45** (1): 11-27 [PubMed Abstract](#) | [Publisher Full Text](#)
15. Angermeyer MC, Matschinger H, Corrigan PW: Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey. *Schizophr Res*. 2004; **69** (2-3): 175-82 [PubMed Abstract](#) | [Publisher Full Text](#)

Is the rationale for the Open Letter provided in sufficient detail?

Yes

Does the article adequately reference differing views and opinions?

Yes

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Yes

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Mental health nursing

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.
