Why do people with mental handicap come to a psychiatrist?

DEAR SIRS

Today the statement that mentally handicapped people do not need psychiatry is often made. Like most generalisations it is true in the sense that it can be seen to apply to the majority of people with mental handicap. In practice mentally handicapped people continue to be referred to psychiatric consultation specialists and clinics. This letter presents a review of a six months analysis of the people newly referred to a psychiatric consultation service for mental handicap.

In the period studied, 1 January to 30 June 1987, one consultant psychiatrist was serving the whole population of 700,000 in the combined Leeds Western and Leeds Eastern Health Districts. As one consultant saw all the referrals to the mental handicap service, recording was consistent.

Eighteen new patients (ten male, eight female) who had not previously been seen by a psychiatrist in mental handicap, were referred in the period investigated. Nine of these referrals were in the 16 to 29 age group, confirming that this is a time of life during which mentally handicapped people, their families and carers, face difficulties. For example, mentally handicapped adolescents are reaching adulthood, adjusting from schools to training centres, trying to prove themselves and to test others, and their parents are growing older and are feeling the strain of years of caring for them.

One referral was aged under 16, three were in the 50 to 59 age group, one was over 60. Eleven patients (seven male, four female) were referred by family doctors, two men through the Community Mental Handicap Teams and five (one man, four women) from other hospitals and specialists. In terms of intellectual classification (ICD-9) three were profoundly, four severely, three moderately and eight (four male, four female) mildly mentally retarded. The high proportion (44%) of people with mild handicap reflected the expectation that the consultation service had a duty to receive all categories of mental handicap. Nine patients (seven male, two female) were referred on account of behavioural disorders. They exhibited what fashion now labels "challenging behaviours" with histories of aggressiveness, violence and self injury. Six (three men, three women) came for general advice and were welcomed as their referrals recognised that the psychiatric consultation service had a co-ordinating role in mobilising help, education and preventive action.

Three women were referred with the request for hospital admission. One was already in a hospital for mental handicap elsewhere. The others had been admitted to general hospital wards and were considered too dependent to return to existing community care facilities.

Of the 18 patients seen, six (two male, four female) suffered from epilepsy, a frequency of one in three, to be expected among a sample of mentally handicapped people. Remarkable was the frequency of medical conditions found in the patients examined. Specific disorders were autism, hydrocephalus, cerebral palsy, Sturge Weber Syndrome, Moebius Syndrome, dystrophia myotonica, fibrocystic disease and diabetes mellitus. One patient had hypothyroidism, epilepsy and a calcified meningioma. Another patient had mental illness co-existing with mental handicap.

This study indicated that the cases of mental handicap referred to a psychiatric consultation service presented their own distinct needs and challenges. These called for knowledge, understanding and experience on the part of the specialist. What is now called "The Psychiatry of Mental Handicap" or "Psychiatry in Mental Handicap" emerged as a specific area of psychiatric specialisation. It provided mentally handicapped patients, their family doctors and carers, with advice, assistance and services specifically intended to meet their needs.

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Section 37 of the Mental Health Act 1983

DEAR SIRS

Through your columns I wish to highlight what appears to be a serious anomaly in the Mental Health Act 1983.

Recently I had a patient under my care who was detained in hospital under Section 37 of the Mental Health Act. Within a few days of his being detained I received a letter from the Hospital Managers stating that the patient had applied to them to be discharged from hospital, and asking me to provide a psychiatric report.

I was naturally quite surprised as my understanding was that a patient on this order could not apply to the Mental Health Review Tribunal within the first period of detention. The Act states quite clearly that a patient detained in hospital under Section 37 may apply to a tribunal in the *second* six months of detention and has a further right within each subsequent period that the detention is renewed.

On querying the matter with the Managers I was told that although a patient could not apply to the MHRT within the first period of detention, he could do so to the Managers of the hospital. They also referred me to a booklet called *Hearing Patients' Appeals* published by the National Association of Health Authorities. According to this booklet, "A patient detained under Section 37 of the Mental Health Act can appeal to the Managers within the first six months of detention but can appeal to the MHRT only after that first six months."

I later discussed this matter with the Mental Health Act Commission. They agreed that the Act was somewhat ambiguous as to the question of whether a patient on a Section 37 could appeal to the Managers of the hospital within the first six months or not, but suggested that I speak to my Defence Society.

My enquiries with my Defence Society did not take me much further. They initially were quite certain that the patient could not appeal within the first six months. However, when I told them about the NAHA booklet they

advised me to furnish a psychiatric report to the Managers, but promised to follow up the matter further if I sent them a copy of this booklet.

I have since discussed this matter with my consultant colleagues, and all of them agree that there seems to be uncertainty, either in the Act, or in its interpretation.

It seems a discrepancy that a patient admitted to hospital by a court following evidence by two doctors, one of whom is "approved", cannot appeal to the MHRT within the first period of detention but yet can do so to the Managers of the hospital. The implications of this are that a panel of three Managers (who are usually neither medically nor psychiatrically trained, nor legally qualified), could discharge a patient detained under Section 37 within the first period of detention even though the MHRT cannot do so.

I would be most interested in hearing from colleagues who have had similar experiences, or who have any views on this matter. Of course, what would be most interesting to hear about would be if anyone has actually had a patient on Section 37 discharged by the Managers of the hospital within the first period of detention.

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Section 2 of the Mental Health Act 1983

DEAR SIRS

I would be grateful for space in the *Bulletin*, to share with the readership certain problems noted with Managers' Meetings and Mental Health Review Tribunals. These have to do especially with patients admitted under Section 2 of the Mental Health Act. As things stand, such patients are entitled to appeal against their detention during their first 14 days in hospital. Many go on to appeal *immediately*, and, as per procedure, such appeals must be heard within five days or so. The result is that the RMO finds himself preparing a report for the hearing, *before* he has the opportunity to make meaningful assessment.

That patients liable to be detained under the Act are free to appeal to *both* the Hospital Managers *and* the Mental Health Review Tribunal, only makes matters worse—because that situation calls upon the RMO to prepare two reports, and attend two hearings, whilst the assessment for which the patient was admitted is yet to be completed.

I would like to suggest that the Act be amended to read that patients detained under the provisions of Section 2 may appeal against their detention only if they are still detained *after* 14 days. This would give the RMO and his/her team the opportunity to carry out a clear-headed assessment of the patient, without rushing through matters in order to have a cogent viewpoint to offer the Hospital Managers or the Mental Health Review Tribunal. I would also suggest that the patients are permitted only *one* appeal during the period of their detention; thus, they may appeal to *either* the Managers *or* the MHRT, and not to both.

The question of course arises, what is the real status of the decisions of the Hospital Managers? If their decisions carry the same weight as those of the Tribunal, what is the point in appealing to two 'Courts' of equal authority to discharge or refuse discharge? If the decisions of the Managers are not of equal authority to those of the MHRT, what then is the purpose of the Managers' Meetings?

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Japanese psychiatry

DEAR SIRS

I feel it is my responsibility to comment on Dr Bourne's discussion of the current state of Japanese psychiatry (*Bulletin*, August 1987, **11**, 286) since I am the first and probably still the only Japanese member of the College.

Dr Bourne was right in stating that much remained to be done in Japanese psychiatry and that the present Mental Health Act should be reformed urgently. Unsatisfactory conditions of psychiatric in-patients in Japan have been reported from time to time by journalists and psychiatric professionals. The present movement of the reformation was precipitated by one of those reports, a scandal in a mental hospital. I am not qualified to discuss the scandal itself. The UN and ICJ (International Commission of Jurists), however, became aware of it and the condition of Japanese psychiatry and apparently urged the Japanese government to take action. A new bill now waits to be discussed in the current Diet extraordinary session, though it may not be without much debate before it is finalised and passed.

Here, I should like to emphasise the importance of psychiatric education both graduate and postgraduate, medical and paramedical. Dr Bourne quoted Mr Totsuka as saying that there is virtually no psychiatry in Japanese medical education and doctors wishing to specialise have to get their training outside the country.

Every medical school teaches psychiatry and has a psychiatric department. What Mr Totsuka meant to point out, however, is the inadequacy of the content of the postgraduate education. Although most university departments, mental hospitals and clinics seem enthusiastic in educating trainees, there exists no formal specialist qualification or examination. Nor is there any standard of curriculum of postgraduate education. It seems that only individual interest and a feeling of responsibility and devotion drives young physicians to acquire the necessary skills and knowledge. Those who are less interested in further education may be less likely to be capable of judging whether their skills and knowledge are adequate.

Improved as the new law may be, its purpose should and can only be embodied by those with specialist qualifications. Otherwise the new law may remain only as a source of red tape.

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