

'Community care': 'Team without a captain'

DEAR SIRS

I believe there is little objection in principle to providing comprehensive mental health care through a community based team. Once a principle is agreed by a multidisciplinary team the next step is to organise a Community Mental Health Centre outside a psychiatric hospital, as the philosophy of community care would suggest.

I have had an opportunity to sit through meetings where the two teams of the consultants have over the last two years been trying to achieve this aim. The experience has been an eye opener for myself, and I would like to share this with the readers of the *Bulletin*.

One of the stumbling blocks appeared to be lack of understanding, commitment and enthusiasm towards the project by the management. In general one starts setting up a service in two ways. The first, is the approach through management, and has the advantage in that it controls resources. The process unfortunately is cumbersome and bureaucratic, but if it works it enhances the process and the object can be achieved quicker. On the other hand, the basic idea of the service could evolve from the multidisciplinary team who then take the project to the management. One obvious problem with this would be to get the resources for the project. Each member of the multidisciplinary team is answerable to his own managers and this in itself creates problems when the community mental health team wishes to provide service in a certain way which may clash with the traditional system of each discipline. This emphasises the importance of involving the managers of the disciplines which ultimately may contribute to the success of the project.

One of the difficulties in a large multidisciplinary team is that there may be more than two representatives of each discipline and hence an issue cannot be resolved by counting the number of raised hands but it has to be decided on the weight of a certain argument; therefore it has to be reached by consensus. This causes problems in its own sense as it results in disappointment in the multidisciplinary team. There is a general feeling of reluctance to elect a manager, or a leader, or a captain from one of the disciplines. Unless this is resolved, community mental health teams are in danger of being a team without a captain and would end up in disarray and chaos.

The moral finally is that before one embarks on such a project one needs to give deep thought to the various pros and cons, in designing the service realistically and mostly to see whether it will be beneficial

for the patients in the long run and not only to please one's ideals.

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Premenstrual syndrome in mentally handicapped females

DEAR SIRS

The article by Browne & Ellis (*Psychiatric Bulletin*, 13, 363–365) identifying the existence of the premenstrual syndrome in mentally handicapped females prompts me to report on a small prospective study undertaken in our hospital.

A group of 13 females of reproductive age with marked behavioural problems was identified. Ages ranged from 19 to 38 with a mean of 27 years. Behaviour patterns exhibited included screaming, verbal aggression, ripping of clothes, self mutilation and aggression directed at others or inanimate objects. Level of mental handicap varied from mild to severe.

The subjects were monitored by care staff on a daily basis on a simple three part scale identifying agitation, aggression or aggression requiring seclusion. This first phase was for three months, pyridoxine 100 mg daily was then prescribed and monitoring continued for a further three months. Other relevant information, for example illnesses, fits, medication changes, outings and visits were also recorded.

One of the participants had primary amenorrhea and three other subjects had secondary amenorrhea following previous oral contraceptive therapy. The behavioural charts for these subjects did not reveal any cyclical pattern to their behaviour and there was no change on their behaviour while taking pyridoxine.

The remaining nine females all showed a pre or perimenstrual escalation in their disturbed behaviour. Six of this group (67%) showed a marked overall improvement in behaviour although a pre/perimenstrual pattern remained albeit with a major reduction in number of disturbed episodes.

Behaviour disturbances in the mentally handicapped can be attributed to a number of factors. Only recently, has the premenstrual syndrome been considered as a factor although its significance in the normal population has been acknowledged for some time. The cause of premenstrual syndrome remains unknown and a wide variety of treatments are currently in use.

Pyridoxine, the main form of Vitamin B₆, has been used for a number of years as a treatment for premenstrual syndrome sufferers. It is important in several metabolic processes including neurotransmission and oestrogen may disturb its function.

Premenstrual syndrome should not be forgotten as a causative factor in behaviour disturbances in mentally handicapped females of reproductive age and if its existence is suspected appropriate treatment should be instituted. Although its specificity of use and optimum dosage remain obscure, pyridoxine is one of the potential therapies available.

C. M. TYRIE

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Consent and the mentally handicapped

DEAR SIRS

I have recently been involved in the care of a woman with mental handicap, where some apparent confusion has arisen as to whether parents have the right to give consent on behalf of their offspring. The case concerns a 29-year-old woman with moderate mental handicap and a manic-depressive psychosis, circular type. During a period of hospitalisation, prophylactic treatment with lithium was commenced, following appropriate investigation. The clinical judgement of the Responsible Medical Officer was that the patient was not able to give informed consent. The parents were informed of the change of treatment the following day. They expressed immediate alarm at the use of such a "toxic drug" and insisted that the treatment be stopped at once.

Lithium was discontinued and the parents interviewed. Despite detailed explanation by senior staff about the medical aspects of the therapy, the parents were unwilling to accept reassurance that lithium was appropriate or safe. The parents insisted that they had the right to decide on their daughter's treatment and would not consent to the use of lithium. There has followed an unresolved dispute involving the parents, consultant, hospital administrators and Health Authority, as to who has the right to provide consent. Advice has been sought from the Welsh Office.

The important issues about consent and the mentally handicapped have been touched upon by G. C. Kanjilal (*Psychiatric Bulletin*, February 1989, 13, 82-83). In his article, Dr Kanjilal describes current practices. These include the process whereby, "The parents are kept fully informed and when available, give the consent instead (of the patient). However, in an emergency the consultant gives the consent and obtains the parents' consent as soon as practicable". Dr Kanjilal then addresses the validity of such consent, should there be disagreement between the consultant, multidisciplinary team or parents.

My view of this matter concerns the very essence of consent. Consent has been defined as "voluntary agreement or acquiescence in what another proposes or desires". This description has a very personal flavour. I would contend that once the age of

majority has been reached, it is not possible for valid consent to be given by one person on behalf of another. If a patient is unable to give informed consent, doctors generally like to have the agreement of colleagues and relatives when embarking on treatment, but this agreement does not amount to consent (Bicknell, 1989).

People who are mentally ill or handicapped may assent to treatment without necessarily having much reasonable insight into its nature or implications. Such compliance does not really constitute informed consent. Nobody else has the legal authority to provide consent. The Mental Health Act bestows only the power to treat in the absence of consent, although this may not itself be appropriate unless there are other grounds for its use (Browne, 1985). In the absence of informed consent, the need for agreement from all parties is paramount.

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The Costs of Hospital Closure: Providing services for the residents of Darenth Park Hospital

DEAR SIRS

We would like to congratulate Professor Glennerster (*Psychiatric Bulletin*, March 1990, 14, 140-143) on his clear and lucid evaluation of the two settings. We are particularly pleased to see the use of marginal costs and opportunity costs in his analysis. While we appreciate that this is a difficult area to give justice to, we do however feel that the analysis would have been more meaningful if benefits were included in the equation.

We find it surprising that the opportunity cost has only been analysed in terms of capital costs. It does not seem that it has taken into account the cost of possible loss of trained staff, as well as spacious grounds and recreational facilities.

We note the relatively small expenditure on health authority services. We wonder how did the use of these services relate to the availability as well as identification of need by health service providers (Bouras & Drummond, 1989).