to move rapidly towards an integrated, centrally funded, community based service before even beginning to offer the sort of care needed by a developing nation reeling from years of injustice and conflict.

It is simply not good enough for the SPSA to mouth good intentions. A starting point could be an urgent and thorough review of the psychiatric training programme. Trainees should be discouraged from commencing private practice the day after completing their MMed(Psych). A further period of training, perhaps equivalent to the British senior registrar level, should be introduced. During this time, trainees should commit themselves to a period of academically supervised community based service. This would make post-apartheid South African psychiatrists not only more aware of the needs of the population, but also, safer doctors.

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Mental handicap – by any other name

DEAR SIRS

The problem nowadays referred to as 'mental handicap' must be in a strong position to claim the distinction of being the human condition which has had the most names applied to it.

During the 20th century there has been a continuing search for more acceptable expressions which are free from stigma and do not devalue the affected individual, and may seek to inspire new hope and enlightenment. The result so far is some 30 and more different terms which have been used at various times.

Old 'archaic' terms: oligophrenia, hypophrenia, amentia – 'simple primary amentia'.

Mental Deficiency Act 1913: mental defective – idiot, imbecile, feeble-minded or moron.

Mental Health Act 1959: subnormality, subnormal (severe)

Mental Health Act 1983: mental impairment

International Classification of Diseases: mental retardation – borderline (ICD-8), mild, moderate, severe, profound (ICD-9).

Education: educational subnormal (ESN), learning difficulty (severe LD), under-achiever.

Children: exceptional, unusual, different, special.

Others: mental handicap (Royal Society for Mentally Handicapped Children and Adults, 1955, Mr R. H. S. Crossman, Health Minister 1970). More recently – mental handicaps. Developmental handicap, developmental disability, developmental impairment, developmental psychiatry, defectology, retardology, high grade or low grade defect, 'one in a hundred', 'strangers in their own country', under-intellectualisation, intellectual insufficiency, intellectual disability, diminished people (Bernstein), cognitive impairment.

A reaction to the quest for new nomenclature is the 'no name' school of thought which argues that any name is a label which, by branding people as 'handicapped', perpetuates their treatment as handicapped.

The older terms which conveyed the disgust, fear, intolerance and impatience that mental deficiency formerly evoked have given way to euphemisms, some so obvious that they draw the attention they strive to escape. Some expressions may reflect 'out of sight, out of mind' defence mechanisms. They try to avoid the reality that mental handicap is a fact of life by being neutral or general, and hope to solve the problem of mental handicap by pretending that it does not exist.

A range of titles is found to describe services, for example, mental handicap services, mental handicap division or unit, services for people with mental handicap(s) or for learning difficulty(ies). Also seen have been 'howler' expressions such as 'mentally handicapped nurses', and 'mentally handicapped hospitals', and a few years ago a medical journal published an advertisement for a 'Consultant Psychiatrist (Mentally Handicapped)'.

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Teaching in mental handicap

DEAR SIRS

Many registrars feel less than satisfied with their teaching experience in mental handicap. Why is this? The mental handicap hospital still expects the doctor to visit all the villas (wards) daily, and to have 24-hour on call, with instant access to the doctor (medical model). The registrars get frustrated by seeming to have to do more GP work than "real psychiatry".

Our own attitude should focus on psychiatry, and we need to explain by day to day contact with patients and case conferences the links between physical symptoms, mental illness and behaviour. Mentally handicapped people often somatise their problems. Someone who cannot talk, cannot talk about their delusions/hallucinations but a change in behaviour can reveal them. It takes time to learn how to communicate with some mentally handicapped

people, perhaps six months or more for those with no speech (how many consultants are fluent in makaton?).

Do we pay enough attention to the emotional aspects of mental handicap? Do we address the emotional stress of dealing with profoundly handicapped physically disabled individuals? How can you build up a meaningful psycho-therapeutic relationship with someone who spits and bites? (Unwillingness to engage in therapy for registrars may be as a result of their unconscious rejection feelings.) We need to recognise these feelings.

Registrars should have a range of experience in mental handicap and be involved in the care of patients with challenging behaviour, learning how this challenges the service. Training should include experience in case conferences, community homes, out-patient clinics, resettlement, forensic/prison visits, adult training centres, drug reviews, psychotherapy with the mentally handicapped, management of epilepsy and community mental handicap teams (CHMTs). Visiting community homes, and learning to support the staff there and 'drinking tea' with the residents, should be an integral part of training. The CMHT is also valuable teaching, although this can feel like wasted time if there are endless meetings talking about patients you do not know, or administrative matters. Do registrars go on home visits with the community nurses? There should be time spent with patients families learning how to support and counsel them. A few basics to community psychiatry are: long-range bleep, good secretarial support, map, car, dictating machine. How many registrars get all these?

How to give registrars community experience in mental handicap while still covering the on-call for the large hospital can be overcome. Also, we need to ensure that registrars learn to recognise and treat mental illness in mental handicap.

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Mental Health Review Tribunals

DEAR SIRS

I am concerned about the continued reduction of psychiatric services on financial grounds and the persistent demand for cost improvements. One area to look at for savings might well be the Mental Health Review Tribunal system.

The 1983 Mental Health Act introduced the concept of Mental Health Review Tribunals and the right of patients' legal representation. These hearings I would suspect cost at least £1,000 a time, yet the patient can obtain legal representation no matter how hopeless his chances are.

The normal position with regard to Legal Aid is that it can only be obtained if there is a reasonable chance of success but the Mental Health Review Tribunal system ignores this.

It would be interesting to know the cost of the hearings and what savings might accrue should Legal Aid be restricted to those hearings where the patient has some hope of success.

I appreciate the fact that someone has to decide whether or not the patient has the likelihood of discharge but this should not be too difficult a problem to overcome.

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Seclusion of psychiatric patients

DEAR SIRS

I read with great interest the statement on the seclusion of psychiatric patients (*Psychiatric Bulletin*, 1990, **14**, 754–6) and support most of the statements therein. However, I was concerned by the very strict definition of seclusion which you use. In our hospital, we define seclusion as "the enforced isolation of any patient". This includes situations where, for instance, a patient is locked alone in a confined courtyard, or a disabled patient is shut in an unlocked room from where they are unable to exit unaided, despite the door being technically unlocked.

The reasons behind this broadening of the definition were, of course, to eliminate the loopholes in the procedures whereby alternative methods of de facto seclusion could be used to circumvent proper procedures. We feel that using our broader definition, all potential situations of isolation are covered by proper procedures, and subject to proper control.

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Transcultural misunderstandings

DEAR SIRS

The article by Appleby & Beaton (*Psychiatric Bulletin*, November 1990, **14**, 671–673) was both interesting and informative. The area of communication effectiveness is of vital importance in psychiatry, where comprehension of the patient's history is central to the diagnostic process. This particular problem was brought to our attention recently when a man, of Central American origin, was transferred to our hospital on certificates, for treatment of a 'paranoid psychosis with auditory hallucinations'. As the patient spoke Spanish, a colleague interviewed him