columns

Personality disorder – a stigmatising diagnosis?

We were interested in John Gunn's anecdote (*Psychiatric Bulletin*, January 2007, **31**, 25–28) regarding a patient who had apparently been informed that he 'was a personality disorder' by the registrar. Professor Gunn's reply is worth quoting in full: 'I never use that term, I don't use that term in my clinic, it's not something I ever say to any patient.' This raises the questions: does Professor Gunn not believe in the diagnostic category, as seems to be implied (rather than not believing that this diagnostic category fits this person), or does he acknowledge the category but perceives the label as stigmatising? Either is interesting, given that the category itself is well recognised in both ICD–10 and DSM–IV, and is therefore likely to be used by at least some practising psychiatrists. If Professor Gunn perceives the term 'personality disorder' as stigmatising and/or unhelpful, would it not be better to discuss the possibility of this label being applied, and the grounds for its application, with the individual concerned, rather than distancing himself from the concept? Presumably the person to whom the label was applied remained the same person before and after the diagnosis. If psychiatrists genuinely believe in reducing the stigma still attached to mental illness in general and personality disorder in particular (Lewis & Appleby, 1988), is avoidance a rational way to deal with diagnostic labels perceived to be stigmatising? It seems that even among the most justly esteemed psychiatrists, the label personality disorder still elicits aversive responses. Perhaps psychiatric fear of personality disorder still needs exploring.

LEWIS, G. & APPLEBY, L. (1988) Personality disorder: the patients psychiatrists dislike. *British Journal of Psychiatry*, **153**, 44–49.

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Is the Mental Health (Care and Treatment) (Scotland) Act 2003 the least restrictive option?

The Mental Health (Care and Treatment) (Scotland) Act 2003 became effective in October 2005 but the paucity of literature and debate surrounding it has been disappointing. The Act changed mental healthcare delivery in Scotland, and its positive aspects are described elsewhere (Darjee & Crighton, 2004; Thomson, 2005). The Act has defined principles (e.g. interventions should involve the minimum restriction of the patient), but paradoxically introduced a number of new restrictions on patients.

The 'gateway order' in the 2003 Act is a 28-day short term detention certificate. Proponents suggest that this 28-day detention order with compulsory treatment is *less* restrictive than a 72 h (emergency) detention period with no compulsory treatment, as the latter gives no right of appeal.

Previously, it was common psychiatric practice to grant 'time off the ward'. Now formal suspension of detention is required before patients leave hospital grounds, even for short periods. The responsible medical officer may attach formal conditions to this.

The Act introduced the Mental Health Tribunal for Scotland which hears all applications for 6-month detentions. These formal and often adversarial hearings occur irrespective of patients' objections and can be an ordeal for many patients.

Administrative demands on services have increased significantly, diverting clinical resources from the majority of (informal) patients, thereby limiting their service provision.

We therefore propose that the 2003 Act does not fulfil the principle of minimum restriction.

DARJEE, R. & CRIGHTON, J. (2004) New mental health legislation. *BMJ*, **329**, 634–635.

THOMSON, L. D. G. (2005) The Mental Health (Care and Treatment) (Scotland) Act 2003: civil legislation. *Psychiatric Bulletin*, **29**, 381–384.

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Are old age services equipped to cope with immigrant elders?

As a trainee psychiatrist of ethnic origin, I wonder whether old age psychiatric services are aware of problems they are likely to face in the future and how they plan to adapt to them. Those migrants who came to the UK from India, Pakistan and Bangladesh in the late 50s and 60s are now reaching retirement age and consequently any mental health problems they experience would need to be addressed by old age psychiatry services. Some services may have had experience of treating the parents of these migrants, but not in the numbers they are likely to face.

Traditionally, elders have been cared for in older age by the extended family, who have been able to meet their cultural, social and physical needs. As the current generation of descendants becomes more integrated into Western society, the break up of the extended family is both evident and inevitable. There are also wider implications. Are there culturally sensitive and appropriate placements available for such people once they are discharged, if going home is no longer an option? Surely we need to plan ahead and address these issues which we are highly likely to face in the near future.

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Which medications for side-effects should be included on forms 38 and 39?

We recently surveyed the medication prescribed to 145 detained in-patients to determine which drugs for the side-effects of psychotropics were included on Mental Health Act forms 38 and 39 and which were not. Clinicians were largely in agreement that drugs for motor disorders, hypersalivation and antipsychotic-induced seizures should be included whereas drugs for constipation, dyspepsia and metabolic syndrome should not. There was, however, disagreement about inclusion of drugs for weight reduction. Neither the *Code of Practice* (Department of Health & Welsh Office, 1999) nor the *Memorandum* (Department of Health & Welsh Office, 1998) indicates which medicines should or should not be included on treatment authorisation forms. According to the Mental Health Act Commission guidance note for commissioners on consent to treatment, 'adjuvant medication without which the therapeutic objectives of alleviation of the symptoms of mental disorder . . . could not be achieved' should be included, but laxatives are specifically excluded (Mental Health Act Commission, 2002).

It appears that current practice regarding which drugs for side-effects to include or exclude has arisen haphazardly. The simplest solution would be to include none. The Mental Health Act is concerned with treatment for mental disorder and makes no mention of medications for side-effects.

DEPARTMENT OF HEALTH & WELSH OFFICE (1998) *Mental Health Act 1983. Memorandum on Parts I to VI, VIII and X*. TSO (The Stationery Office).

DEPARTMENT OF HEALTH & WELSH OFFICE (1999) *Code of Practice Mental Health Act 1983*. TSO (The Stationery Office).

MENTAL HEALTH ACT COMMISSION (2002) *Guidance for Commissioners on Consent to Treatment and Section 58 of the Mental Health Act*. Mental Health Act Commission.

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