Correspondence

Reality of the concept of organic psychiatry

DEAR SIRS

I would suggest that it is now time for the segregation of mental handicap, and the stigma that goes with it, to be removed once and for all from our highly scientific, advanced and progressive society. As the sub-specialty of mental handicap (now mental infirmity) is concerned with the organic state of the brain, it could be renamed 'organic psychiatry'. In this way greater justice will be done to the 'Cinderella' of psychiatric practice, opening up a vast area for research and the understanding of human intellectual development and behaviour.

In the meantime the confusion continues unabated. The DHSS uses the term 'Mental Handicap'. The Royal College of Psychiatrists justifiably, though belatedly, terms it the 'psychiatry of mental handicap' which I suspect is not fully accepted by the DHSS. In medico-legal matters, the term 'mental infirmity' is applied. It seems to be that there is no communication or agreement between the custodians of the service for mentally handicapped people. This could easily be obtained if the psychiatric service of mental handicap is regarded as a sub-specialty of 'organic psychiatry' and the social care of mentally handicapped and normal people is entrusted to a 'Care Service' based in each District and separate from any psychiatric service.

Such measures would: remove prejudice against mentally handicapped people; bring uniformity to the concept; enhance the research and understanding of organically based psychiatry and up-grade the treatment and care given in each hospital; give mentally handicapped people the opportunity to remain in society being cared for by specially trained staff; remove the present confusion regarding the terminology of mental handicap; and allow the Government to save money, as a hospital-based service (which is unnecessary) is more costly than a District-based 'Care Service'.

Refusal to change and the continuation of unscientific practice will be regarded as unforgivable by future generations. A change in the terminology would bring the sub-specialty within the auspices of psychiatry and the resultant interest and enthusiasm would bring new hope to the practice of psychiatry, thereby breaking down the barrier that now excludes mentally infirm people.

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Mental Health Review Tribunals

DEAR SIRS

For Dr Anne Farmer (*Bulletin*, February 1984, **8**, 23–24) to suggest that a psychiatrist might opt for Section 3 of the new Act rather than Section 2 in order to allow time to prepare a proper Tribunal report is treading on very dangerous ground indeed.

She describes an old lady in a general hospital who is deeply deluded. She is a recluse, and some three years before had been admitted to a general hospital under the provisions of the National Assistance Act suffering from malnutrition and hypothermia. Now she refuses admission to a psychiatric hospital and one may presume she is totally without insight. She was, therefore, admitted under Section 2 of the Act and subsequently discharged by a Tribunal within the 28-day period on the grounds that she was no longer a danger to herself. The Tribunal expressed the hope that she would remain informally.

I am puzzled to know why a Section 2 was considered at all. The diagnosis was in no doubt. She was a very sick woman who was obviously going to need more than 28 days compulsory treatment for her psychiatric illness. She fulfilled the criteria of Section 3 in that she suffered from mental illness of a nature or degree which made it appropriate for her to receive medical treatment in a hospital, and it was necessary for her to receive such treatment in the interests of her health.

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Services for people with mental handicap

DEAR SIRS

The letter by Mr Russell on 'Mental handicap services—the future' (*Bulletin*, December 1983, **7**, 224) prompts me to put my thoughts on paper regarding, firstly, the role of consultant psychiatrists in mental handicap. These are: (i) The prevention of abnormal psychological stress to the person with handicap by the modification of abnormal and stressful lifestyles. (ii) The diagnosis and treatment of psychiatric illness. (iii) The support of caring groups, including families in whom there is collective psychopathology. (iv) Participation in drawing out personalized programmes of care on a multidisciplinary team basis. The team should consist of the patient and his family and those care workers best able to help with his problem.

Secondly, the chief roles that the hospital plays in the mental handicap service at the present time are: (i) To provide intensive supervision and treatment for people with handicap who are mentally ill. (ii) To provide children and adults with periods of short-term care for medical, nursing, clinical, psychological, dental and social reasons. (iii) To provide homes for a substantial number of people who have been in hospital all their adult lives.