# *Correspondence*

## *Section 136*

DEAR SIRS

In the light of Rassaby and Roger's paper on "Psychiatric referrals from the police..." (*Bulletin*, March 1987) our interpretation of Section 136 may be of interest. These thoughts came out of discussions as to how we could best, and most legally, cope with a move to stop patients detained under Section 136 being taken direct to a distant mental hospital. Assessment was to take place in the Accident and Emergency Department of the local DGH (Charing Cross) which also has a Psychiatric Department.

During the course of the discussions two aspects became clearer.

(1) The act quite clearly states that the person is being detained "For the purpose of enabling him to be examined by a registered medical practitioner *and* to be interviewed by an approved social worker and of making any necessary arrangements for his treatment or care" (our emphasis). It seemed good practice that this should if possible be a joint assessment, that it should occur *as soon as possible*, and that "Arrangements for his treatment and care" implied more than merely deciding whether to admit or not. A further implication seems to be that once this joint assessment had been made, powers to detain under Section 136 are void and that any further compulsory detention would have to be under Section 2 or 4 of the Mental Health Act, except in those very rare circumstances where the doctor and social worker felt a further period of assessment was necessary before they could decide what needed to happen to the patient.

(2) It seemed to us that there is a clear administrative distinction between detention in a place of safety and admission to hospital. The patient is detained at the hospital in the Accident and Emergency Department. At times they may need to be admitted to the psychiatric ward because they are not containable in the Accident and Emergency Department. This is a separate decision and again, once the joint assessment has been made, further detention, if necessary, would be under other sections of the Mental Health Act.

The practical significance of this is that the local duty Approved Social Worker has to come in to assess such patients. The positive result is that decisions are taken much more quickly, reducing unnecessary detention to a minimum; there is a joint psycho-social assessment rather than merely a medical one and thus, hopefully, the consideration of a wider range of options than just to detain or not. We believe the patients involved get a better service.

SAM BAXTER
*Consultant Psychiatrist*
JOHN CHAMBERLAIN
*Group Principal Social Worker*
*Charing Cross Hospital (Fulham)*
*London W6*

## *Community psychiatry!*

DEAR MARGE

I am in a desperate state—can you help me? I'm 32, and over the past two years, since I became a consultant, I've fallen victim to the charismatic religious cult called 'Community Psychiatry'. Their followers are nicknamed 'Loonies' (derived from the Latin word for 'Moonies'), and now I am one.

Typically it started in a small way, and I thought I could handle it. But, after weeks of brainwashing, which they called 'normalisation', I felt so virtuous, so good, so modern, ... so smug.

At weekends I went to religious meetings called 'workshops'. The congregation was composed of people from all professions. There were doctors, nurses, clinical psychologists, social workers, and many other ageing hippies.

The religion is quite simple really, and is probably why it is so seductive. Basically, all that is good is in the 'community' (heaven), and all that is evil is in 'hospital' (hell). Our churches are called Community Mental Health Centres, and they are open to anyone, without the need of a referral letter. Unfortunately, they are not open after 5 or at the weekends, so if anyone needs help at these times, they can go to Hell (sorry hospital).

Our commandments are these:

(1) Though shalt not speak in clear terms, but instead use words like 'needs', 'enable', 'catalyse', 'facilitate', and 'restructure'. Remember, in psychiatric politics the Word is mightier than the meaning.

(2) Thou shalt not use science. 'Community Psychiatry' needs only faith, not proof.

(3) Thou shalt not covet thy consultant's power, nor his salary, nor his office, nor his Volvo.

(4) Thou shalt not commit adultery (except during a residential psychotherapy workshop).

(5) Thou shalt not utter the words 'illness' or 'patient'.

(6) Thou shalt use less drugs and ECT. This would *prove* that 'community psychiatry' is better than hospitals.

As a disciple, I was charged with the task of spreading the Word. Our work has been made easier by some disciples joining the Health Advisory Service and the Mental Health Act Commission. Daily, I prayed for the courage I needed to preach to evil and obdurate colleagues, but unfortunately many of them (including Professors, who should know better) remain unrepentant. After a while I found myself talking in a strange language, calling patients 'consumers', 'users', or 'clients', quite indiscriminately. Eventually, I couldn't think for myself, without a multidisciplinary team around me to facilitate and catalyse my helping skills. All my 12 years of medical education suddenly seemed irrelevant. I became very confused. Was I in a 'beehive' or a 'network'? Was I a key-worker, a drone, a Queen, a catalyst, a resource, or what? What were my individual needs? All these questions whirled around my head—my role had become completely blurred. I was completely cognitively destructured.

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Disgusted with myself, I gave up my office, wore polo-necked sweaters, and asked the 'consumers' to call me Vic. I felt compelled to beat myself with leather thongs every time I thought of the 'medical model'. Every night I chanted passages either from the Draft Code of Practice or our latest HAS report. I so much wanted to be liked by everyone, I was willing to give up everything.

But Marge, how can I escape? I am desperately unhappy. All they want me for now is to write prescriptions, and be on-call at night. They despise me. Can you please consult your multidisciplinary team, and ask the key worker to send me an individual care plan—soon!

Dr (sorry) VIC HARRIS

*Birch Hill Hospital*
*Rochdale*

P.S. I've just remembered. I do hope I'm in *your* sector.

## *Part-time training in psychiatry*

DEAR SIRS

I was interested to read a brief guide to the options available, prepared by a working party of the Collegiate Trainees' Committee, (*Bulletin*, April 1987, **11**, 137).

All my training in psychiatry has been carried out on a part-time basis, initially as a part-time supernumerary Registrar funded by the Welsh Office, and more recently as a Senior Registrar working part time in an established full-time post.

I am writing to draw your attention, and that of your readers, to this option which was described as available in Scotland but was not so described for England and Wales, that is the option of applying for a full-time post and then of requesting at interview to work on a part-time basis. I did this with the support of the Clinical Tutor at these hospitals and the support of the Consultant for whose post I was applying. I am now in post (part-time).

This seems a logical way of achieving part-time training. The Joint Committee for Higher Psychiatric Training holds the view that Senior Registrar training positions should not be used for routine provision of services. It seems appropriate therefore that such posts should be offered to the most suitable candidate even if this person is only able to work part-time.

MOLLY McGREGOR

*Mental Impairment Evaluation and Treatment Service*
*Bethlem Royal Hospital,*
*Beckenham, Kent*

## *Asylum of Leros*

DEAR SIRS

Lawrence Durrell's description of Leros as a gloomy, shut-in sort of place, with fjords full of lustreless water as cold as a polar bear's kiss[1] did this pretty Greek island an injustice. Some of these remarks, however, aptly describe the asylum of Leros, which for many years (and perhaps for centuries) has served as a depository for undesirable social misfits including convicts, political dissidents and, now, incurable psychiatric patients from the whole of Greece. The current asylum population of 1350 includes about 300 'children'. Many are mentally handicapped and some have multiple disabilities. Over 90% are poor and illiterate. They are looked after by one psychiatrist, one social worker, a few nurses and several hundred unqualified persons known as guards; there are no psychologists, no occupational therapists, physiotherapists, speech therapists, or teachers. The general policy is one of containment; the patients are fed, cleaned and kept quiet, and physical restraint is used. The classic features of institutionalism are evident throughout, and the patients exist in a socially impoverished, restricted environment, with no stimulation, occupation or other remedial activity. They seldom have any personal possessions and hardly any links with their areas of origin or with the outside island community.

In 1984, a project team headed by Professor Ivor Browne was appointed by the EEC. The team's report[2] made clear urgent recommendations for the assessment of the asylum's population, the initiation of programmes for training and rehabilitation, the transfer of some patients to hospitals near their families and the resettlement of others in suitable community accommodation, as well as for the development of trained staff teams. The report also stressed the importance of combining these programmes with plans for alternative economic developments for the islanders who are dependent on the asylum for their livelihood. During the last three years, there was very little uptake of the allocated EEC funds, and nothing has changed since the report's publication. There are powerful and complex political, cultural and economic reasons for this inactivity, and, meanwhile, hundreds of disabled people continue to live within "the most serious example of human misery and suffering in the Greek psychiatric problems".[2]

At the recent First European Meeting on Deinstitutionalisation and Vocational Rehabilitation held in Leros, professional workers from Greece and from other EEC member countries joined in pressing for immediate changes. The awareness of this situation by British psychiatrists, and their support (perhaps by writing to the Greek Minister of Health) may well assist in achieving results.

M. Y. EKDAWI

*Netherne Hospital*
*Coulsdon, Surrey*

REFERENCES

[1]DURRELL, L. (1978) *The Greek Islands*. London: Faber & Faber.

[2]COMMISSION OF THE EUROPEAN COMMUNITIES (1984) *Reform of Public Mental Health Care in Greece*. Brussels.

## *Culture-bound disorders*

DEAR SIRS

It was interesting to read the letter on multiple personality disorder (MPD) by Ray Aldridge-Morris in the May *Bulletin*. In my opinion, multiple personality disorder is an

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