Review of Althaus's 'Treatise on Medical Electricity'. By Dr. NEATH (*Journal of Mental Science*, 1874, April).

When galvanism first came up it was regarded as a panacea for all ills and we may be sure that cases of mental disease did not escape this treatment. They were, however, very few, and chiefly cases of hysteria, epilepsy, catalepsy and those associated with paralysis. Nor is it surprising that mental disease should be thus neglected, for it is only quite recently we have come to look upon disease of the brain as a physical ailment or due to physical causes.

Duchenne, in 1850, was about the first earnest worker with this agent in insanity, and he was followed by Remak, Teilleux and Anzony. Dr. Arndt of Greifswald believes electricity is an invaluable remedy in many forms of insanity. He thinks that cause structured alterations of the brain matter are absent in the majority of cases, and where they are discovered they are more the consequences than the causes of disordered function. He considers the constant current to become, in course of time, the most important remedy at the disposal of the alienist physician.

CORRESPONDENCE

NEEDS OF THE MENTALLY HANDICAPPED

DEAR SIR,

I feel that the observations Dr. Shapiro makes in his letter (*News and Notes*, August 1974, p. 15) cannot be allowed to pass without comment. In the first place I must point out that it is not in fact Government policy that the severely handicapped should be cared for by a non-medical service. If it were, my letter (*News and Notes*, April 1974, p. 13) would have been unnecessary. In the current policy document (Command 4683) the concept of community care is applied only to the moderately and mildly handicapped, and although alternatives to the traditional subnormality hospital are postulated responsibility for the care of the severely handicapped is quite clearly placed with the Hospital Services.

I am in no way seeking to deny the very definite medical component to the study and care of the mentally handicapped, but what I am arguing is that this is neither sufficient in quantity nor of such a nature as to justify the present concept of mental handicap as an illness or to require that overall responsibility for care should remain with the medical profession. The medical needs of the majority of the mentally handicapped are no different nor any greater than those of the general population, and the medical problems particularly associated with mental handicap consist in the main of chronic conditions like epilepsy and cerebral palsy, which, while requiring periodic medical review, rarely require intensive medical treatment. Surveys of subnormality hospital populations (2, 3, 4, 5, 6) have all shown that less than 10 per cent of residents require active medical and nursing care on a day-to-day basis. The main needs of the mentally handicapped of all ability levels are for sheltered care, education, and social and occupational training, and it is these rather than outmoded traditional concepts which should determine the future development of services.

Dr. Shapiro's comments on the Danish and Swedish Services require substantiation. In a two months study tour of these services, during which I was able to speak with the mentally handicapped and their relatives and staff at all levels, I certainly did not encounter the grave doubts and misgivings in the system which he claims. Nor was it my perception that such doubts were expressed in the Third I.S.S.M.D. conference at The Hague to which he refers. Indeed, the contributions from both countries were virtually confined to the subject of sexuality and the mentally handicapped—an indication, surely of continuing progression towards the goal of normalization. Furthermore, what did emerge very clearly from the conference was that most other countries had taken a lead from the Scandinavians and were moving towards the development of similar patterns of care. It is a misrepresentation of the Swedish and Danish services to suggest that responsibility for the management of the mentally handicapped individual rests with a social worker or for that matter with any single discipline. The multidisciplinary team approach is well developed in both countries, with responsibility for care shared by the clinical psychologist, social worker, physiotherapist, teachers and care staff, and medical input provided as necessary by the relevant medical specialties (7, 8). The material excellence of facilities, adequacy of staffing and high financial input should not be allowed to mask a fundamental change in the philosophy of approach to care and the successful implementation of services based upon the needs and

rights of the mentally handicapped which is the real achievement of Sweden and Denmark.

The recent exposure of serious inadequacies in services for the mentally handicapped in this country has rapidly drawn attention to the more fundamental question of their appropriateness. The present degree of political and public interest in the problem of mental handicap provides a unique opportunity to establish a service better suited to the needs of the mentally handicapped and their families than is the present one. In grasping this opportunity we must not ignore the growing body of practical evidence in favour of a social rather than a medical model of care for the severely as well as the moderately and mildly handicapped.

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References

1. *Better Services for the Mentally Handicapped* (1971) Command 4683. H.M.S.O.
2. Tizard, J. (1964) *Community Services for the Mentally Handicapped.* London.
3. Pilkington, T. C. (1966) In *Report of Annual Conference.* London: N.A.M.H.
4. McKeown, T. & Teruel, J. R. (1970) *Brit. J. prev. soc. Med.*, **24**, 116.
5. Williams, C. E. (1971) *Brit. J. ment. Subn.*, **17**, 72.
6. Donaghue, E. C., Abbas, K. A. & Gal, E. (1970) *Brit. J. Psychiat.*, **117**, 531–2.
7. Day, K. A. (1973) The mentally handicapped in Sweden and Denmark. *Brit. J. Psychiat.: News and Notes*, Sept. p. 11
8. —— (1974) *Services for the Mentally Handicapped in Sweden and Denmark.* Mental Handicap Bulletin No. 13. London: Kings Fund Centre. June.

QUERIES FROM A DISTRICT PSYCHIATRIST

Dear Sir,

The following are questions which have been much in my mind for some time. I should be grateful if any of your readers would care to comment on some or all of them:

1. Morbid anger (unlike morbid anxiety, morbid depression and morbid elation) does not appear in psychiatric texts as a separate entity under the rubric of affective disorder, although it is generally admitted to be a potent psychopathological force. Should paranoid states be classified as affective disorders rather than schizophrenic ones?

2. In a case of shoplifting, how do you distinguish between obsessional impulse and failure to resist temptation? In these enlightened days of open door hospital management and the community care of mental illness, to what extent should psychiatric patients be considered subject to the usual forces of law and order, inside hospital and out?

3. It has been suggested that death by suicide in the course of mental illness should be certifiable as due to natural causes such as depression, in most cases without an inquest. What should happen in those comparatively rare instances of chronic mental disorder which are associated with determined suicidal intent using methods involving the safety of the general public, e.g. moving vehicles? Is it humane, or 'officiously striving to keep alive', to nurse such patients indefinitely in secure wards or hospitals?

4. Does readily available termination of pregnancy discourage the development of a sense of responsibility towards contraception? What should the medical profession's attitude be in this respect? Are there analogies perhaps to be drawn with toilet training, elementary hygiene and sanitary consideration for others? Can unsatisfied parental instincts (arising from a policy of population control) be satisfactorily displaced on to, or sublimated in, a general renaissance of interest in ensuring the future of our vulnerable and fragile cultural inheritance?

5. Allegations that consent to treatment was not properly obtained feature not uncommonly in claims for damages against members of the medical profession. How do you explain to a patient whom you are advising to have: (a) ECT; (b) a leucotomy the nature and purpose of these measures, and give him a sufficient understanding to enable him to exercise a choice in the matter? A patient who clearly understands the nature and effect of the treatment he requires for acute appendicitis to which he agrees, persistently signs the form of consent to operation 'Napoleon Bonaparte'. What is the correct procedure in these circumstances?

6. Should those who win or inherit fortunes of a size or complexity beyond their capacity to manage properly have their affairs put into the hands of the Court of Protection? Should the law be changed to enable this to be done?

7. How do you distinguish between clairvoyance and hallucination, thought transference and passivity feelings, pre-cognition and *avant vu*?

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WOMEN AND THE MEDICAL ASSISTANT GRADE

Dear Sir,

The publication in *News and Notes* for November 1974 of the Survey of Opinion on the Retention of