

*'Community care': 'Team without a captain'*

DEAR SIRS

I believe there is little objection in principle to providing comprehensive mental health care through a community based team. Once a principle is agreed by a multidisciplinary team the next step is to organise a Community Mental Health Centre outside a psychiatric hospital, as the philosophy of community care would suggest.

I have had an opportunity to sit through meetings where the two teams of the consultants have over the last two years been trying to achieve this aim. The experience has been an eye opener for myself, and I would like to share this with the readers of the *Bulletin*.

One of the stumbling blocks appeared to be lack of understanding, commitment and enthusiasm towards the project by the management. In general one starts setting up a service in two ways. The first, is the approach through management, and has the advantage in that it controls resources. The process unfortunately is cumbersome and bureaucratic, but if it works it enhances the process and the object can be achieved quicker. On the other hand, the basic idea of the service could evolve from the multidisciplinary team who then take the project to the management. One obvious problem with this would be to get the resources for the project. Each member of the multidisciplinary team is answerable to his own managers and this in itself creates problems when the community mental health team wishes to provide service in a certain way which may clash with the traditional system of each discipline. This emphasises the importance of involving the managers of the disciplines which ultimately may contribute to the success of the project.

One of the difficulties in a large multidisciplinary team is that there may be more than two representatives of each discipline and hence an issue cannot be resolved by counting the number of raised hands but it has to be decided on the weight of a certain argument; therefore it has to be reached by consensus. This causes problems in its own sense as it results in disappointment in the multidisciplinary team. There is a general feeling of reluctance to elect a manager, or a leader, or a captain from one of the disciplines. Unless this is resolved, community mental health teams are in danger of being a team without a captain and would end up in disarray and chaos.

The moral finally is that before one embarks on such a project one needs to give deep thought to the various pros and cons, in designing the service realistically and mostly to see whether it will be beneficial

for the patients in the long run and not only to please one's ideals.

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*Premenstrual syndrome in mentally handicapped females*

DEAR SIRS

The article by Browne & Ellis (*Psychiatric Bulletin*, 13, 363–365) identifying the existence of the premenstrual syndrome in mentally handicapped females prompts me to report on a small prospective study undertaken in our hospital.

A group of 13 females of reproductive age with marked behavioural problems was identified. Ages ranged from 19 to 38 with a mean of 27 years. Behaviour patterns exhibited included screaming, verbal aggression, ripping of clothes, self mutilation and aggression directed at others or inanimate objects. Level of mental handicap varied from mild to severe.

The subjects were monitored by care staff on a daily basis on a simple three part scale identifying agitation, aggression or aggression requiring seclusion. This first phase was for three months, pyridoxine 100 mg daily was then prescribed and monitoring continued for a further three months. Other relevant information, for example illnesses, fits, medication changes, outings and visits were also recorded.

One of the participants had primary amenorrhea and three other subjects had secondary amenorrhea following previous oral contraceptive therapy. The behavioural charts for these subjects did not reveal any cyclical pattern to their behaviour and there was no change on their behaviour while taking pyridoxine.

The remaining nine females all showed a pre or perimenstrual escalation in their disturbed behaviour. Six of this group (67%) showed a marked overall improvement in behaviour although a pre/perimenstrual pattern remained albeit with a major reduction in number of disturbed episodes.

Behaviour disturbances in the mentally handicapped can be attributed to a number of factors. Only recently, has the premenstrual syndrome been considered as a factor although its significance in the normal population has been acknowledged for some time. The cause of premenstrual syndrome remains unknown and a wide variety of treatments are currently in use.

Pyridoxine, the main form of Vitamin B<sub>6</sub>, has been used for a number of years as a treatment for premenstrual syndrome sufferers. It is important in several metabolic processes including neurotransmission and oestrogen may disturb its function.