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Learning disabilities and the new Mental Health Act

The new Mental Health Act 2007 creates more rights for people with learning disabilities through its amendment of the Mental Capacity Act 2005. It introduces safeguards for deprivation of liberty, both for patients lacking capacity in hospital and residents of care homes.

This is surely a good thing, and may finally end the confusion following the Bournewood case, where the case of a patient without capacity being kept in hospital was challenged.

However, despite changing the way mental disorder was defined in the Mental Health Act 1983 by abolishing references to categories of disorder, a person with a learning disability can still be sectioned if it is deemed they behave abnormally aggressively or seriously irresponsibly, without any signs of mental illness, unlike the rest of the general public.

Although this may at times provide a preferable alternative to the criminal justice system, many in-patients will remain in hospital purely on the grounds of some antisocial or criminal behaviour. They may well not pass a new 'appropriate medical treatment' test and often their original behaviour continues on the units, with little possible in the way of consequences to deter them.

The private sector has perhaps stolen a march on much of the National Health Service by creating expensive specialist services for these people. With the advent of the new Act, is it time to start catching up?

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Risk management in the digital age

The digital age is upon us. Television is changing (www.digitaltelevision.gov.uk/). Freeview channels are phasing in, reducing the dominance of familiar terrestrial channels. With choice expanding, in-patient services face a novel dilemma. Should they restrict access to new and widely available explicit materials or expose patients to them as part of normalisation?

When our in-patients requested Freeview boxes in their rooms we were surprised to learn that available content includes pornography channels (for 10 minutes, or longer with a subscription) and 'sex guides' with graphic imagery on unrestricted channels. While many secure units ban 18-certificate films, printed pornography and unrestricted internet access, we suspect they are unaware of this new source of explicit material.

Whether pornography is harmful is controversial. It probably increases risk of sexual violence for a predisposed minority (Seto *et al*, 2001) likely to be over-represented in secure mental health units. Sexually misogynistic content is likely to negatively affect self-esteem and mental state of those with sexual abuse histories, also more common among individuals with mental health problems (Spataro *et al*, 2004). It is accepted that access to pornography should be restricted for adolescents and children.

We are not arguing that pornography should be banned or is inherently wrong. Rather, we are concerned that it is available to vulnerable people without the awareness of professionals charged with their care. Television *is* changing. Our attitude must also change to ensure we are managing risks proportionately but effectively.

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SPATARO, J., MULLEN, P. E., BURGESS, P.M., *et al* (2004) Impact of child sexual abuse on mental health. Prospective study in males and females. *British Journal of Psychiatry*, **184**, 416–421.

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Schizophrenia and gender identity disorder

A 40-year-old man with a long history of schizophrenia was admitted to hospital after another relapse. He had stopped taking his medication and was behaving oddly – he was paranoid, agitated, self-neglected and had ideas of being controlled. He had two previous admissions with similar presentations. Interestingly, one of the early indicators of his relapse was his conviction of being of the opposite sex and tendency to dress as a female. He initially started wearing a wig with tights and a skirt, but with the worsening of his condition he ended up wearing a full female outfit with make-up. Before the admission he bought oestrogen tablets over the internet to develop secondary sexual characteristics. He even insisted on being admitted into a female ward.

During his stay as an in-patient, he expressed persistent discomfort with his gender and talked at length about different ways to change it. On each admission, the degree of his cross-dressing coincided with the severity of his primary illness. The more he looked like a female the more ill he was. Therefore, it became a useful indicator of his overall mental well-being. He was routinely treated with oral amisulpiride along with haloperidol depot, to which he always responded quite well. Once recovered, his gender dysphoria also disappeared.

Delusions of gender change have been noted among patients with schizophrenia (Borras *et al*, 2007); also, transsexualism could be a rare manifestation of schizophrenia (Manderson & Kumar, 2001) and very rarely schizophrenia leads to secondary transsexualism (Caldwell & Keshavan, 1991). To avoid diagnostic confusion, one must understand the relationship between such sexual manifestations and schizophrenia as it has implications for management and prognosis.

BORRAS, L., HUGUELET, P. & EYTAN, A. (2007) Delusional 'pseudotranssexualism' in schizophrenia. *Psychiatry: Interpersonal and Biological Processes*, **70**, 175–179.

CALDWELL, C. & KESHAVAN, M. S. (1991) Schizophrenia with secondary transsexualism. *Canadian Journal of Psychiatry*, **36**, 300–301.

MANDERSON, L. & KUMAR, S. (2001) Gender identity disorder as a rare manifestation of schizophrenia. *Australian and New Zealand Journal of Psychiatry*, **35**, 546–547.

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Rethinking risk to others in mental health services: final report of a scoping group

College Report CR 150, June 2008, £10, 49 pp.

This report focuses on risks posed to others and aims to stimulate further debate and research, as well as improvements in clinical practice and patient and public safety. It sets out current understanding of best practice and points to future action needed for further improvements.

The assessment and management of risk are integral to psychiatric practice. Over the last 10 years, the risk posed by mental health service users to others has been brought into the spotlight by the government and media as inquiries into serious incidents have suggested failings in the risk management of some patients with mental disorders.

All psychiatrists are conscious of the immeasurable impact of homicides and violence on victims, perpetrators and families, and recognise their responsibility to their patients and the wider public to use their professional skills to reduce risk.

The report describes key findings from a major survey of College members, and makes recommendations to improve the assessment and management of risk.

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Psychological therapies in psychiatry and primary care

College Report CR 151, June 2008, £10, 45 pp.

The aim of this report is to improve the provision of psychological therapies to people with mental and physical disorders in both primary and secondary care settings. It provides information and guidance about psychological therapies that should be useful to psychiatrists, general practitioners, employers and commissioners of services.

The report identifies key themes and principles, alongside ways to develop and maintain psychological services that meet satisfactory standards. It also sets out a number of benchmarks, with assessments of how well-recommended aims and standards are being accomplished. It provides advice for commissioners of the service.

In all settings, psychological therapies should be delivered by a workforce that is psychologically minded and trained in an appropriate range of psychological therapies. Key implications are set out for future medical training. The report may also assist those contemplating careers in general practice, or in psychiatry (which used to be known as 'psychological medicine') in weighing up the opportunities available for the holistic care of people with physical short- and long-term conditions as well as mental illness.

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Postgraduate training in psychiatry: essential information for trainees and trainers

Occasional Paper OP65, July 2008, £10, 56 pp.

This guide provides an overview of postgraduate training in psychiatry. It outlines the process of training for psychiatric trainees and so helps them meet the requirements of the curriculum. It will also be of help to those involved in training at all levels – educational supervisors, tutors, training programme directors, and heads of school. The guide is not intended to cover every detail and aspect of training, but it sets out standards across all psychiatric training. The standards have been developed from existing College guidance, including the *Basic Specialist Training Handbook* (2003) and the *Higher Specialist Training Handbook* (1998), as well as the Postgraduate Medical Education and Training Board's *Generic Standards for Training* (2006) and contemporary literature on postgraduate medical education. Further useful information can be found on the College website: www.rcpsych.ac.uk/training.aspx.

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