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Exporting psychiatric skills*

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In early 1992, I spent five weeks at the Costina Hospital in Romania – an exchange visit organised by the West Midlands Regional Health Authority at the request of a charity known as Faure Alderson Romanian Appeal, based in London. The team who set off with me in a lorry, minibus and a Land Rover, included a residential social worker, a medical student who helped me with the assessment of patients and four other volunteers from the charity to help in an orphanage. The journey across Europe was confronted with difficulties at Romanian customs but we eventually managed to meet the Director of the Hospital we were visiting, after a week on the road.

The tasks before us were Herculean. The aim was to translate each patient's case-notes and social files into English, then complete physical and psychiatric assessments, with a view to deciding who could be housed in a half-way/rehabilitation home which the charity is proposing to start in the near future.

Costina is a large asylum, about 17 kilometres from the town of Suceava in the Region of Moldavia, one of the poorest parts of Romania, not far from the Russian border. The asylum houses 210 adults of both sexes, supposedly suffering from mental illness and/or mental handicap. It is a grey, concrete building, with the hot water supply restricted to only two hours per week. Patients bathe in the same bath water, if they are lucky, once a week. Men and women are housed in separate 'pavilions'. When housed in mixed blocks, illegitimacies and sexual exploitation were rife, and privacy was negligible. Some of the rooms were recently painted by volunteers from the charity. Even the right to an individual bed has recently been gained, due to the donation of separate mattresses by the charity. Prior to this, three or four patients used to share one dilapidated bed.

Similar to other mental hospitals in Romania, (Gath, 1991; Wilkinson *et al*, 1992) all the admissions are compulsory at Costina. Admission is arranged by the patient's family. The family approaches a local psychiatrist who provides them with a clinical certificate and a letter is sometimes obtained from a Social Inspector. These documents are then taken to the 'Inspectorate' at Suceava, who then arranges for the patient to be committed to Costina. Once 'interned' patients cannot discharge themselves, unless their relatives are willing to take them back and this must be with the Commissioner's permission. As one patient succinctly put it, he sees his future "only in the grave".

There is one psychiatrist, appointed a few months ago (after considerable difficulty), for the whole hospital. His visit to England for two weeks had given him some idea of psychiatry as practised in English hospitals and made him keen to change the system at Costina. There is also a Director of the Hospital who is a non-medical person. He had experienced resistance from many of the staff while trying to institute improvements. The staff consisted of about 130, with six nurses (classified as medical assistants), administrators, cleaners, gardeners and kitchen staff. Most staff have had no formal psychiatric training.

The information in the case-notes and social files was translated into English by a Romanian interpreter. Physical examinations were done by a Romanian born, Russian qualified doctor recently appointed by the charity, who used basic equipment (stethoscope, sphygmomanometer, ophthalmoscope and auriscope) which I had brought from England. The most common documented diagnosis in the case-notes was 'oligophrenia', similar to the labels given for children at orphanages (Gath, 1991). The old-fashioned terms such as idiocy, imbecility and encephalopath were still in use. The psychotropic medication available was mainly haloperidol. This was used only for a few days during the initial admission and stopped abruptly as it was in short supply. The disposable syringes and needles were re-used after boiling them in a small stainless steel steriliser.

Among the 40 patients (27 females and 13 males) assessed, although over a quarter (30%) suffered from mental illness such as schizophrenia and affective disorder, it was distressing to note that over one half (52%) had been admitted for physical and/or social reasons (e.g. a squint, deaf and mute). Some were brought up in orphanages and interned for lack of other facilities while others had been committed because of homosexuality, illegitimate pregnancies or political reasons.

A professor of economics and politics was labelled as 'schizophrenic' and the reason given in her case-notes was that she was not married at the

**An exchange visit to a psychiatric hospital in Romania, 2 February–12 March 1992*

Patients enthusiastically attending the art group.

age of 34 and thus, went insane. She is now totally debilitated.

One 40-year-old woman, who had six children, was interned at her husband's request with a diagnosis of "chronic alcoholism". Since her internment, her husband divorced her, married his mistress and became sole custodian of their children. Another very knowledgeable 70-year-old man had been a bodyguard for King Michael. He had problems with his legs and was 'interned' to Costina for treatment! Although showing no signs of mental illness and desperately anxious to return home, no-one could tell him whether his land or home still existed. The absence of a social worker meant that no social care was offered to patients and they were left to languish. (Wilkinson *et al*, 1992). Less than a quarter of the patients seen had learning disability, diagnosed after taking their education and social background into account. Some had never been to school, so it was difficult to assess their reading/writing skills. I used a rather simple, crude method to assess their domestic and social adaptive skills. Those labelled as epileptics received either phenobarbitone and/or phenytoin. New anti-convulsants were not in use. The type and frequency of seizures was not recorded. It was shocking to learn that none of the patients had a prescription card.

Little treatment is offered to patients. They mostly stay in bed, huddle in corners, pace around the corridor or look through the windows in vain. (Radhakrishnan, 1991; Wilkinson *et al*, 1992). Some knit but there is always a shortage of knitting wool.

When art groups were started, there was an overwhelming enthusiasm to attend and the patients waited eagerly near the door for our arrival. Some patients revealed excellent artistic talents and there was a remarkable improvement in patients who had learning disabilities. Initially, they merely scribbled but as time went on, they gained confidence and interacted in spite of the language barrier. Their drawings had identifiable objects and shapes. Many patients expressed a keen interest in reading, but there was a shortage of books and magazines.

There were abundant opportunities for staff training. While I talked about epilepsy, many staff attended and asked me lively questions. They gave the impression that they were willing to listen and learn (Wilkinson *et al*, 1992). I instituted a seizure chart, in the hope that this would raise the standards of record keeping. It was clear that there were enormous gaps in education for the staff and a lot remains to be done. In addition, I visited a school cum-orphanage for children with varying degrees of

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learning disabilities. It housed 250 boys and girls ranging in age from seven to 14 years. About three quarters of these children have known no other home, many are suffering simply from social deprivation, deafness and eyesight problems but labelled as children with learning difficulties.

The poverty of the country was reflected everywhere I visited. The market stalls were usually empty and there were some traders trying to sell a small pile of vegetables which were either rotten or withered.

At least a proportion of Western aid in the form of clothes and food seemed to be siphoned off or eventually ends up in the thriving black market.

The aim should be to make permanent long-term changes in modifying the general attitude towards people with mental illness and learning disability and to impart practical skills. Romanians should be helped to help themselves.

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Mental Health (Detention) (Scotland) Act 1991

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This Act, effective from 9 March 1992, contains amendments to the Mental Health (Scotland) Act 1984. It provides an extension to 28-day short term detention, requires sheriffs to hear applications for full detention within five days of their submission and authorises detention of patients until the outcome of such an application is known.

Background

Civil detention under section 18 of the Mental Health (Scotland) Act 1984 requires judicial approval from a sheriff, a legally qualified judge. This requirement is unique in mental health legislation in the United Kingdom. Judicial approval is commonly determined at a hearing in court at which the patient and the applicant (almost always a social worker) are legally represented. The process may take time.

Most s.18 applications are made in respect of patients who are already in hospital under short term detention (s.26). The latter lapses after 28 days and may not be immediately re-applied. Problems arise if the condition of a patient detained under s.26 deteriorates shortly before expiry giving insufficient time for an application under s.18 to be submitted and approved by a sheriff.

Early testing of this aspect of s.26 reached the House of Lords in *B v. Forsey (H.L) 1988 Scots Law Times, 572*. This confirmed that there was no authority under s.26 to detain beyond 28 days; that detention under a fresh s.26 was not immediately permissable; and that doctors could not rely on common law to detain patients until an application under s.18 was approved by a sheriff. The Mental Health (Detention) (Scotland) Act 1991 fills the defect in the legislation which the House of Lords identified in *B v. Forsey*.

Extension to Section 26

Where a patient is detained under s.26 (no application for s.18 having yet been made) and his mental condition changes such that continued detention is deemed necessary, then s.26A authorises detention