



# the columns

## correspondence

### 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 Bournemouth 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?

**Tom Picton** Taylor Centre, Queensway House, Essex Street, Southend-on-Sea SS1 2NY, email: tom.picton@southeast-trust.nhs.uk

doi: 10.1192/pb.32.8.316

### Risk management in the digital age

The digital age is upon us. Television is changing ([www.digitaltelevision.gov.uk/](http://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.

SETO, M. C., MARIC, A. & BARBAREE, H. E. (2001) The role of pornography in the etiology of sexual aggression. *Aggression and Violent Behavior*, **6**, 35–53.

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.

**\*Philip Baker** Locum Consultant in Forensic Psychiatry, Female Services, Essex Forensic Mental Health Service, Runwell Hospital, Wickford SS11 7XX, email: philip.baker@doctors.org.uk,

**Paster Venan** Specialist Trainee in Forensic Psychiatry, Runwell Hospital

doi: 10.1192/pb.32.8.316a

### 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.