handicapped people was inappropriately placed with that for people suffering from mental illness. The intention of the Act was to provide that only mentally handicapped people whose condition was associated with 'abnormally aggressive or seriously irresponsible conduct' would remain liable to admission under Sections 3, 37, 47 and 48. In general terms, all mentally handicapped people remain liable to admission to hospital under the shorter term sections, in particular Section 4 and Section 2. This was a very messy way of half achieving the underlying objects, but at the time the legislators thought this was the only option open to them.

The use of guardianship in relation to mentally handicapped people is another issue. I have looked through the debates of the Special Standing Committee in the House of Commons and I can find no mention of any consideration of the limitation of this power to 'mentally impaired' and 'severely impaired' people. My own recollection is that it never occurred to any of those involved in the passage of the Mental Health Act to query its application to only that group of mentally handicapped people.

I agree with Dr Singh that consideration must be given to those problems. My own view is that there seems little evidence for the need to extend the long-term detention sections of the Act to all mentally handicapped people and that as far as guardianship is concerned there is an urgent need for hard evidence as to whether the powers actually possessed by the guardian would be useful and appropriate in many circumstances where they are inapplicable at the moment. The 'rights' to which Dr Singh referred must mean not only the rights to protection but also the rights to take risks that all of us regard as an ordinary part of our life. What we really need is an entirely separate legislation which can be tailored to particular needs of mentally handicapped people.

WILLIAM BINGLEY
Legal Director

MIND
22 Harley Street, London W1

Psychiatry of mental handicap services

DEAR SIRS

Recently D. A. Spencer argued in your columns that Divisions of Psychiatry should be watchful to preserve the roles of consultants of mental handicap services in those places where it is proposed to adopt a service model based on principles of 'normalization' (*Bulletin*, January 1985, **9**, 14).

The City of Sheffield is, as far as I can discover, the only place where there is a published strategy to transfer the care of intellectually impaired people from the health service to the local authority. It must be made clear that Sheffield plans do not envisage anything other than a continuing and active role for the consultant psychiatrist. Indeed, she is a very committed and active member of the Joint Team of Officers that has the responsibility of translating the strategy into actuality. The longer this Team works at its task, the more convinced we become that if the opportunities of intellectually impaired people are to be maximized, the combined skills of all those professional groups currently working in the mental handicap services will be required in abundance. Our aim is not to offload such patients from a hard-pressed service, but to enable all intellectually retarded people in this city to play a full part in its life.

P. HUTCHINSON
Chairman, Joint Team of Officers

Redvers House
Union Street, Sheffield

Physical activity for the mentally handicapped: A unit of learning

DEAR SIRS

Physical activity is important in the development and maintenance of good physical health and mental well being. Such activities are especially important to the mentally handicapped where development of physical movement and co-ordination helps create activity, invigorates and improves the quality of life. The feelings of well being and of achievement also improves self-esteem and the socialization of the handicapped and aids integration not only between themselves but also with the community.

The term physical activities should be interpreted widely and include any physical activities that aid the mentally handicapped to develop their full potential and acquire maximum independence and use of their leisure time.

Within the hospital service many units have developed active programmes, not only of traditional activities but also of adventure-type projects such as rock climbing, potholing, sailing, etc, as well as local and regional sports days. National and international olympics have been held successfully.

Everyone caring for the handicapped needs to have knowledge of the resources available in the community, locally and nationally. In particular, nurses should have some knowledge of how physical achievement can enhance the quality of life for mentally handicapped persons, and be equipped with some of the necessary skills needed to provide relevant physical activities.

Towards this end a unit of learning for staff caring for children and adults with mental handicap has been devised by Barbara Norris, Lecturer in Physical Education, University of East Anglia, working as a part-time member of staff of the Disabled Living Foundation. The unit of learning has been approved by the English National Board for Nursing, Midwifery and Health Visiting. The learning unit is intended to provide 40 hours' tuition during the three-year nurse training. Its syllabus includes: (i) the concept of an active life style, with relevance to the division of work and recreation in the life of a mentally handicapped person; (ii) movement as an integral part of child development and growth; (iii) physical activities as a stimulator for language development; (iv) the physiological benefits arising from regular physical activity; (v) the resources available in the community. Practical work includes activities based on music, ways of promoting large body movement in water therapy and swimming.

This brief note has been prepared to advise psychiatrists of the existence of such a unit of learning and where possible to stimulate its use in the nurse training curriculum and promote such activities in their clinical practice.

H. HUNTER

Balderton Hospital
Balderton, Nr Newark, Notts

Psychiatry in decline

DEAR SIRS

Dr Morrison has voiced the thoughts of many psychiatrists on the future of their specialty (*Bulletin*, January 1985, **9**, 4–7). The public has never had a confidence in psychiatrists equal to that placed in other medical practitioners. However, they were prepared to put their trust in them. Over the past twenty years, as Dr Morrison points out, an unease and suspicion about psychiatrists and their practice has increasingly appeared. Can this change be attributed to the emergence within the population of 'damaging paranoid forces'? I believe that Dr Morrison identifies the real cause when he says that, 'it is the very nature of psychiatry that undermines our purpose.'

I have held the view for many years that the majority of our colleagues have refused to acknowledge the true nature of mental life and the disturbances which affect it. The wish that pathological mental events could be simply and easily influenced for good has triumphed over reality. Mental events have an inherent resistance to change as is evidenced in perseverative phenomena at the conceptual as well as the sensorimotor level and in the compulsion to repeat. As we have now learned, this inertia, which is so much a feature of mental pathology, cannot be speedily overcome by chemotherapy, by brief or sometimes prolonged psychotherapy, by behavioural methods or by social intervention.

The general public came to believe that psychiatrists possessed remarkable therapeutic powers. Psychiatrists were idealized. Great expectations were aroused. These expectations have not been met and a serious disillusionment with psychiatrists has set in. There is a turning to others who encourage these unrealistic expectations. It is disillusionment with psychiatrists, not paranoid anxieties, which has led to the present disenchantment on the part of the public.

Eleven years ago (*News and Notes*, September 1974, 11) I expressed the fear that great damage had been done to psychiatry because of the erosion of the clinical tradition caused by enthusiasm for natural science methodology and an uncritical advocacy of biochemical theories of mental illness. This damage has been increased by the down-grading of mental hospital practice and the promotion of district hospital and community psychiatry. A generation of psychiatrists has been deprived of the clinical knowledge which was second nature to those of earlier years. The resulting lack of confidence has been sensed by other professions and by the general public enhancing innate fears and doubts about the competence of psychiatrists. It is unrealistic to believe that these attitudes can be quickly halted or reversed. They will certainly not be changed by lectures, confrontations or polemics. Mental illnesses and the problems they present will remain. A commitment to serious clinical work may give psychiatrists the opportunity to regain what has been lost.

THOMAS FREEMAN

Hollywell Hospital
Antrim, Northern Ireland

DEAR SIRS

As Secretary and Finance Officer of the Mental Health Act Commission, I am puzzled by the reference in 'Psychiatry in Decline' (*Bulletin*, January 1985, **9**, 4–7) to second opinion psychiatrists earning 'more than £600 a day'.

The Commission provides a second opinion service through some 100 appointed doctors (twenty-one Commissioner doctors and an outside panel of about eighty). During its first year the Commission arranged 2,200 second opinions. Each one costs £46.35 (the standard exceptional consultation fee) plus any incidental travel/subsistence expenses. With a policy of trying to arrange for a second opinion speedily (within two working days for ECT cases), doctors are not often asked to see more than one patient a day.

M. ROWLANDS

Mental Health Act Commission
Hepburn House
Marsham Street, London SW1P 4HW

Training in community psychiatry

DEAR SIRS

I was interested to read Hugh Freeman's article (*Bulletin*, February 1985, **9**, 29–32) on training in community psychiatry.

I would like to call attention to the paragraph about Dingleton which says that the 'philosophy practised there may be more acceptable to doctors preparing to work in the community' than to those training for hospital practice. Mention is also made of broadly based psychotherapy training there which is in contrast with most psychotherapy training.

I understand that the principle of democratization, as described at Henderson, has provided some inspiration for their approach. This is also true of my own training at John Conolly Hospital in Birmingham. Democratization seems to me to be about sharing responsibility. A shift of responsibility from the hierarchical structures of many mental hospitals to other workers and towards patients living independently in the community also seems central to community psychiatry.

Working therapeutically with all types of psychiatric patient requires extensive and effective support for the workers to deal with such phenomena as countertransference, apathy and the projections of severely damaged and regressed personalities.

Development of group skills in multidisciplinary settings may be seen as a partial solution to the problems of meeting this need. The personality growth which may result from a sharing of responsibility, if the group is working, I suggest is essential to good training in community psychiatry.

Resistance from the established order is to be expected and faced. It is not surprising that academic psychiatry and the