The College

Mental Handicap Services—The Future

(Approved by Council in January 1983)

Over the past few years a number of policy statements concerning the needs of people with mental handicap have been published.[1,2,3,4,5,6]

The purpose of the present document is to review these in the light of their implications for the evolving practice of psychiatry and the training of psychiatrists in mental handicap.

The changes that are currently taking place in the care of the mentally handicapped and the movement towards the community which will affect the manner in which psychiatric care is provided are noted and strongly endorsed. These trends are identified in the references. The living needs of mentally handicapped people as a whole are social and educational in nature and those needs should be met in non-hospital environments. Nevertheless the medical and psychiatric needs of the mentally handicapped and their families will also require considerable Health Service input.

(1) In considering future planning for the mentally handicapped population the particular difficulties of this group must be borne in mind, i.e. the wide range of disorders, the variety of combinations of disorders within individuals and the chronic nature of most of the difficulties encountered.

(2) Because of the extremely heterogeneous nature of the mentally handicapped population, particularly those with more severe handicaps and those with multiple handicaps, a correspondingly wide variety of services is needed. A major defect of many of the previous planning documents was failure to recognize this problem with the result that models were produced based on a predominantly unitary pattern of care which, consequently, excluded many categories of mentally handicapped persons. It is, therefore, important to emphasize that no single form of provision can provide for the needs of the entire range of the mentally handicapped.

(3) A further consequence of the heterogeneous nature of the population is that service implications must reflect the needs of this population, i.e. the many different professions involved, all of whom should be trained in modern approaches to the speciality and the consequent financial implications of this.

(4) The modern approach to the care of the handicapped emphasizes improvements in every sphere of their being with the main emphasis on enhancing behavioural, educational, social and occupational skills, improvements in their physical and psychological well being and provision of leisure and stimulation. This is in contrast to the purely custodial approach with its consequent loss of morale in care staff and lack of development of patients. At present families and communities rightly expect a better standard of care, improved facilities and specific therapies for their particular needs. The standard of staff is also likely to improve with better and more interesting working conditions.

(5) In order to supply a variety of provisions it is necessary to develop an integrated service involving close and flexible co-operation between Health, Social Services, Education and other services. If this is to be a realistic aim the legislation covering these areas should make their responsibilities obligatory rather than permissive. If this is not done Local Authorities may be subject to political and financial pressures which could adversely affect the number of mentally handicapped persons for whom they should accept responsibility.

Range of services required

As pointed out in paragraph 2, a wide variety of services is needed because of the wide range of problems and age scatter found in mental handicap, e.g. behaviour disorders, psychiatric disorders, perceptual disorders, physical disabilities, including epilepsy, neuro-muscular disorders, etc. Depending on the prevalence of the respective disorders, specialized units may be needed on a District or Regional basis. A comprehensive range of services would include:

1. Day Centres of various kinds, both in community and in the hospital, would be needed. Provision must also be made for short term, medium term and respite care
2. Domiciliary services and community support teams
3. Hostels
4. Community units and group homes
5. Part Three accommodation
6. Fostering and adoption
7. Residential schools, special schools, child development and assessment centres
8. Voluntary services including village communities, e.g. care
9. Specialized hospital units (see section below)
10. Semi-secure units
11. Special high security hospitals

The role of the hospital service in the care of the mentally handicapped

Health Services in the future will provide a specialist role in the care of the following groups of mentally handicapped people: mentally ill, behaviourally disturbed, elderly with psychogeriatric problems, certain offenders, those with perceptual disorders with additional psychiatric disorder present, and severely multiply handicapped with high

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nursing dependency needs.

Specialized services should include in-patient facilities for short-term and long-term care, day services including out-patient clinics, community nursing, family therapy and consultancy services to Social Services and Education.

Future planning should provide for relatively small, locally based specialized hospital units which act as resource centres for the catchment area population since this allows for easier involvement of family and friends and the advantages of frequent visiting to the patient as well as the facilitation of the teaching of management techniques to family members. It also allows for easier turn-round of patients and better integration with other services such as Education and Social Services, as well as better social integration and acceptance within the local community.

It is important to recognize that mental handicap hospitals will continue to have a major commitment in the provision of long-term residential care for many years to come. It is therefore essential to ensure that adequate staffing and facilities are provided to enable this role to be properly fulfilled. As the level of dependency of patients in hospitals rises there will be a corresponding need for an increase in resources.

In the United Kingdom widely differing patterns of care have evolved depending on finance, geography, training and the availability of various professional skills. This is particularly so in the field of mentally handicapped children. There has been a sharp fall in the number of mentally handicapped children in long-term hospital care and this is a tendency that is very much encouraged. This trend has led to a changing pattern of care for mentally handicapped children with a greater involvement by paediatricians and child psychiatrists. This has occurred on a variable basis nationally and in many areas the Specialist in Mental Handicap still plays a central role. Many of these factors are unlikely to change greatly in the near future and it is to be expected that the present wide variations in patterns of care are likely to remain for some time to come.

Establishment

The recent establishment of academic posts in mental handicap is welcomed. However, a majority of University Departments of Psychiatry still do not have such appointments. Academic posts are viewed as essential for the enhancement of undergraduate and postgraduate training in the specialty and the fostering of research.

The current patient/consultant ratio varies enormously in different parts of the country and in some areas the levels of staffing are highly unsatisfactory (Appendix). Attempts should be made to rationalize the situation and achieve the College norm of 1:200,000 population.

Nature of multidisciplinary teams

Perhaps the most efficient way of creating these various services and providing continuous flexible follow-up for patients would be through District based multidisciplinary teams. These should be mainly of two types: (a) teams whose main objective would be planning; (b) teams which would be basically clinical in function.

All of these services should be properly financed and supported and should be flexibly integrated in terms of patient referral and acceptance for optimal efficiency and cost effectiveness. They should be staffed by people in adequate numbers with proper training in the special problems of the mentally handicapped. There should be a written operational policy covering the various services to help clarify the particular functions of each resource and also to create easy mechanisms to facilitate the movement of mental handicap people from one type of facility to another as their needs change.

Planning teams

Planning teams should be widely representative, and should include representatives from Health, Social Services, Education and Voluntary Bodies, and be concerned with all aspects of future planning of services, allocation of resources, identifying needs and clarifying relationships between professional bodies.

Multidisciplinary teams

Multidisciplinary teams should consist of practitioners in all the disciplines involved with mentally handicapped people. Implicit in the nature of the multidisciplinary teams is the idea that the various members would carry a greater degree of individual responsibility than sometimes happens. The multidisciplinary team should always involve the services likely to be concerned with the particular patients, i.e. Health, Education, Social Services and Voluntary Organizations. The function of the multidisciplinary team is to be involved in the assessments of the mentally handicapped and provide continuing service to the family on a developmental rather than episodic basis and help co-ordinate other services involved. Access to this team should be as direct and uncomplicated as possible. Ultimately, however, the multidisciplinary approach from the medical point of view is a process of consultation, the final responsibility resting with the consultant.

For optimal efficiency a 'key worker' for every family should be decided upon. This person would accept the main continuing responsibility for contact with the family and liaison with all the services involved.

Training programmes should be organized to offer experience in mental handicap to those in other branches of medicine, including general practitioners, paediatricians and community physicians.

The role and training requirements of psychiatrists in the mental handicap service

The primary role of the consultant psychiatrist in mental handicap is the provision of psychiatric care for the mentally

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handicapped and their families. In addition to practising his normal skills he has to accept overall co-ordinating responsibility for the mentally handicapped people under his care and to offer advice for those in the community where this is needed. He should ensure that appropriate medical, surgical, psychiatric and other care is provided, that a sensitive response is made to the needs of the family, to help in the rehabilitation process, to help develop the best potential of the individual and to help create the best possible environment for the mentally handicapped wherever they may be living or working.

As increasing numbers of the mentally handicapped people live in the community the consultant psychiatrists in mental handicap will become increasingly involved in providing a service to local authority, voluntary and domiciliary services.

Consultant psychiatric services to the mentally handicapped can be delivered in two ways: either on the basis of a full-time appointment or on the basis of a joint appointment linking the psychiatric care of the mentally handicapped adults with the general psychiatric service, and the psychiatric care of mentally handicapped children with the mainstream child psychiatric services. Each model of care has advantages and disadvantages and neither is mutually exclusive. Calibre and commitment are more important than contractual details and neither model should be held as superior to the other.

Health Authorities should be encouraged to develop a range of consultant psychiatric appointments including full-time and joint appointments linking mental handicap with the general and child psychiatry services.

The consultant psychiatrist in mental handicap should have had a core training at registrar level. This training would include a wide experience of general psychiatry with rotational experience in mental handicap (ideally for a minimum of six months), child and family psychiatry, forensic psychiatry and some experience of behavioural and assessment techniques.

To accommodate different ways of delivering the service, and the differing training requirements, the JCHPT should be encouraged to re-examine its training requirements for senior registrars in mental handicap.

It is important to emphasize that training in management skills, e.g. co-ordinating multidisciplinary teams, co-ordination of services, etc., should be included in all training programmes.

Conclusions

The heterogeneous nature of the mentally handicapped population and the multiplicity of their problems requires a wide variety of skills and services to deal with these efficiently. At present there are a large number of patients in mental handicap hospitals who do not have psychiatric problems and are the proper responsibility of other services. Mentally handicapped people, like others, need services which are social and educational in nature but some of them and their families have a variety of problems which require psychiatric services and other medical services. The psychiatrist with a special training in mental handicap would be in the best position to provide the clinical and management input. The training of such psychiatrists must cover the core areas described as well as particular sub-specialties in order to provide a flexible service. The environment of all staff and patients must be of a high standard to improve both the quality and numbers of professionals who work for the mental handicap service.

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APPENDIX: SOURCES OF INFORMATION

England and Wales

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Scotland

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Wales

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Northern Ireland

Establishment and population: Dr R. J. Millar, Department of Health and Social Services, Northern Ireland

Republic of Ireland

Establishment and population: Dr M. Mulcahy, The Medico-Social Research Board, Dublin.

Statistical analysis: Dr G. Carter, Bristol

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Appendix

Establishment of consultant psychiatrists in mental handicap in the United Kingdom and the Republic of Ireland in relation to the population

United Kingdom and Republic of Ireland	Consultant establishment	Population	Population per consultant	Royal College of Psychiatrists' recommendation: 200,000 per consultant
1. South West Thames RHA	19	2,906,000	152,947	
2. Republic of Ireland	21.4*	3,400,000	158,879	
3. South Western RHA	18	3,029,000	168,278	Less than 200,000
4. East Anglia RHA	11	1,863,000	169,364	
5. Northern Ireland	8	1,510,000	188,750	
6. Scotland	21.2**	5,142,000	242,547	More than 200,000
7. West Midlands RHA	17	5,161,000	303,588	
8. Mersey RHA	8	2,458,000	307,250	
9. Wales	9	2,807,000	311,900	
10. Oxford RHA	7	2,340,000	334,286	
11. North West Thames RHA	10	3,460,000	346,000	More than 300,000
12. Trent RHA	13	4,517,000	347,460	
13. North East Thames RHA	10	3,772,000	377,200	
14. Northern RHA	8	3,087,000	384,750	
15. South East Thames RHA	9	3,544,000	393,778	
16. Wessex RHA	6	2,744,000	457,334	More than 400,000
17. Yorkshire RHA	7	3,577,000	511,000	More than 500,000
18. North West RHA	7	4,339,000	619,857	More than 600,000
London PG Teaching Hospitals	3			
Total	212.6			

* Establishment includes 23 consultants of whom there are 3 wholetime paediatricians in mental handicap, 4 joint appointments with maximum sessions in mental handicap (3 joint child psychiatry and 1 mental illness).

** Establishment includes 16 wholetime posts and 12 joint appointments with mental illness, of total 52 sessions in mental handicap weekly (5.2 wholetime).

Obituary

JOHN LEWIS CAMERON, formerly Director of Research and Training, Chestnut Lodge Research Institute, Rockville, Maryland, USA.

Dr. J. L. Cameron died on 1 January 1983, in Gaithersburg, Maryland, at the age of 60.

After graduating in 1950 from Glasgow, he began a career in psychiatry under the guidance of Dr. Angus MacNiven, Physician Superintendent of Glasgow Royal Mental Hospital and Professor T. Ferguson Rodger of the Department of Psychological Medicine, University of Glasgow. His aptitude for clinical work was quickly recognized and he was appointed to a post in the Department of Psychological Medicine based at the Royal Mental Hospital. After four years' work, which culminated in a series of publications on depressive and schizophrenic psychoses, he decided to specialize in the psychotherapeutic treatment of these conditions. This necessitated his leaving Scotland for the United States. In 1956 he obtained a post at Chestnut Lodge Sanitarium, Rockville, Maryland. This enabled him to undertake a training at the Washington Psychoanalytic Institute.

In the following years Iain Cameron won the confidence and trust of his American colleagues. His talents as a clinician and teacher were recognized by his appointment as Clinical Professor of Psychiatry at the Georgetown University Medical School, Washington, DC in 1966. In 1968 he was appointed Director of Training and Research at Chestnut Lodge. During his tenure of this post he initiated and supervised a number of research projects. In recognition of this and his own published work, he was, in 1972, appointed a Consultant to the Institute of Mental Health, Bethesda. Ill-health led to his retirement in 1980. This afforded him the opportunity to pursue a life-long interest in Gaelic language and culture. In 1981 he founded a branch of An Comunn Gaidhealach (America) for the advancement of Gaelic culture. TF

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