There were no associations between length of Section and identity of RMO, or length of Section and male or female sex.

Forty-eight detentions in the first group falling to 27 in the second included emergency powers; 14 and 11 respectively remained unconverted, 7 and 5 owing to expiry. A trend towards more Section 3s approached statistical significance ($P=0.103$).

During the first study period 55 patients stayed on voluntarily, this fell to 40 in the second period. Three-quarters of rescinded Section 3 patients were discharged the same day. Twenty per cent of Section 3s lasted less than 28 days in the first period and this rose to 36% in the second.

Approximately half the Section 2s in both groups expired. Just over half of all Section 2 patients remained in hospital voluntarily, most after their Section expired. Thirteen per cent of the first group of Section 2s lasted less than one week; this fell to 8% in the second group.

During both periods there was a trend ($P<0.09$) for females versus males to remain in hospital voluntarily.

On the results of this small survey, rates of use of emergency powers and very short Section 2s showed some improvement; other aspects of practice remained unchanged or conformed less to the guidelines.

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The role of the consultant in mental handicap

DEAR SIRS

The papers and letters regarding the role and responsibility of consultants in mental handicap in the *Psychiatric Bulletin* seem to be never-ending and another one would not make matters worse, hence this letter. I must declare that I am not at all against ongoing appraisal of one's role and responsibility; in fact I consider it to be healthy. Nevertheless, one can be forgiven for asking a few basic questions. Why have there been so many papers and letters? Is there a need for them? Has any other sub-speciality in psychiatry merited such a discussion, and if not, why not.

One of the reasons must be that it is not only those of us practising in this speciality who do not have a definite view about our role and function but other specialists in psychiatry do not either. While some of us feel strongly that we should confine ourselves to psychiatry of the mentally handicapped, others see us having a much wider role, including the traditional work in a hospital; some are content to deal with adults, leaving the children to child psychiatrists and paediatricians. Perhaps a case could be made for behaviour problems with or without criminality to be dealt with by forensic psychiatrists, physical problems by GPs and physicians, and problems of old age by psychogeriatricians. If this happens, one wonders what the consultant in mental handicap would be left to do. If other professionals and managers follow suit, surely they can be forgiven. In fact I well remember a manager at a conference organised last year by the College's Section of Psychiatry of Mental Handicap, who openly said, "What you consultants should be dealing with is just a few cases of mental illness, a few behavioural problems and some Section cases".

Mental handicap appears to be the field where everybody is an expert, and where it is questioned whether the expertise of psychiatrists is needed, perhaps with some justification.

Another reason put forward is that we are practising at a time of change from hospital care to community care, and we must adapt our role accordingly. The fact that hospital care will continue, albeit on a much reduced scale, is not properly considered, neither is the fact that it will take time before the last of the present hospital population is found alternative placement.

The multidisciplinary context in which psychiatrists in general, and those of us practising mental handicap in particular, find ourselves must be another factor. Why cannot psychologists, social workers, educationalists, nurses and so on work on their own, taking on more and more responsibility and authority, and deal with referrals direct rather than with the knowledge and approval of consultants in mental handicap? Why cannot Community Medical Officers deal with them also?

Questions about the role of consultants in mental handicap have been asked since Mrs Barbara Castle, then Secretary of State for Health and Social Services, produced her White Paper in 1975; among her proposals was one to probe the role of consultants in mental handicap. As a consequence, this matter was discussed at the Mental Deficiency Section meeting (as it was then called) of the Royal College of Psychiatrists in 1976/1977, and a paper was published in the *Bulletin* on 'The Responsibilities of Consultants in Psychiatry within the National Health Service' in September 1977. The responsibilities were under 14 items, and included those of clinician (specialist), co-ordinator, leader, adviser, arbiter, and provider of services. We are aware that the consultant cannot be all these at the same time and that he has a different role in different areas, even within the NHS. His role is primarily that of a clinician (specialist) and adviser with regard to those in Social Services and Education, for example. Yet the discussion continues.

We are frequently being asked to define our workload more precisely. We are criticised for taking on

other professionals' roles, especially those of psychologist, social worker, and educationalist. Can we really cordon ourselves off from these? Does not the practice of psychiatry extend to some, or all, of these at one time or another?

While I cannot see an end to the discussion, and am conscious of adding fuel with this letter, the following issues need to be addressed and dealt with unequivocally as far as the consultant's responsibility within the NHS is concerned.

(a) *The ultimate responsibility:* Here the consultant has professional, ethical and legal responsibility which cannot be devolved. Other disciplines within the NHS are not so clearly legally defined.

(b) *Responsibility with authority:* While most people acknowledge the responsibilities vested in consultants, consultants are rarely given the authority to pursue their responsibility.

(c) *Consultants and multidisciplinary teams:* Once again the roles of each must be clearly defined. It must be recognised "that the legal, professional, ethical, diagnostic and prescriptive responsibilities of the medical profession cannot be delegated to a multidisciplinary group when treating an individual patient." (Royal College of Psychiatrists, 1977).

(d) *Workload of consultants:* Whether we should confine our work to the psychiatry of mental handicap or extend it needs to be decided. My own view is that we should extend our role and emulate those in the academic departments of mental handicap who do not confine themselves to psychiatry and take on a much wider role of dealing with neuro-psychiatry and other areas of mental handicap, including paediatric and geriatric care. Obviously there has to be a change in emphasis in the training of future consultants with this in mind. I would also suggest that we are called consultants in mental handicap and not by other names currently used.

(e) *Role as an expert, leader, co-ordinator, arbiter, adviser and provider of services:* A consultant is the first to recognise that he cannot undertake all these roles at the same time and he has to be accommodating and helpful to members of other disciplines; the others must accept and respect his role and responsibility. We all have roles to play; let us define them and not work at variance.

(f) *Consultant and managers:* With the new managers, whose jobs depend upon achieving specific targets by certain dates, there is an 'unease' about each other's role. Most managers see consultants as standing in their path and a confrontational attitude results. It is the duty of management at all levels i.e. Region, District and Unit, to see that a consultant's 'somewhat different' if not special role and responsibility is upheld.

It was interesting to note from *Hansard* (27 April 1989) that when the closure of mental hospitals was debated, Lord Henley, on behalf of the Government, stated "the question of discharge of a patient into the community is entirely a matter for the consultant psychiatrist who must be happy that the patient will benefit from a more independent living environment." It is time that the DHSS gave an undertaking on the role and responsibility of a consultant in mental handicap in the NHS with the clarity of the foregoing statement.

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Reference

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Day care of the elderly mentally ill by voluntary workers

DEAR SIRS

In 1986 our 50 place day hospital for the treatment of elderly mentally ill patients was under pressure because of the lack of therapeutic day facilities in the community for recovering or recurrent mentally ill elderly people. The local council offered day care mainly for those patients suffering from dementia, but it was without social stimulation and was unacceptable to most of the functionally mentally ill. Age Concern was well established in Tameside, providing day centres for the physically disabled.

Health Service funding, initially for three years, was provided to enable Age Concern to open two day centres in ordinary community buildings to provide social stimulation and rehabilitative activities to patients referred from the day hospital. These buildings are not suitable for the day care of severely demented patients. The main staff are trained volunteers with one and a half community programme trainees and a project co-ordinator. There is also a joint management panel and ongoing support from a consultant, community nurse, health administrator, social worker and local Age Concern director and adviser. The first centre opened in November 1986 and four days a week are now available with a weekly attendance of 60 members. Initially, training courses have been provided by Health and Age Concern staff for volunteers. Close liaison has developed with the