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Correspondence

The changing role of the consultant in mental handicap

DEAR SIRS

I read with interest Dr Nwulu's article 'Consultant jobs in mental handicap: dead end posts?' (*Bulletin*, July 1988, **12**, 279–281) but I considered that it did not do justice to the positive contribution that specialists in mental handicap are making at the present time. This prompted me to record from day to day what my job entailed for a period of three months. I see adult mentally handicapped patients from the whole County of Cornwall, population 450,000, a large geographical area of small towns and villages. There remain 150 in-patient beds in three units, 25 and 35 miles apart with 60 places in the health authority supported domestic homes established under the care in the community programme. During the period of the study I had no junior medical support, although the physical needs of in-patients were met by GP clinical assistant sessions.

(a) Twenty-one per cent of my time was spent discussing clients with a wide range of other professionals and carers. Outside of hospitals, one half of my professional contacts were with social service staff: social workers, hostel and adult training centre personnel. I met relatives, managers of private residential homes and landladies. Health Service staff I talked to included GPs, other psychiatrists and consultants in other specialities, hospital and community nurses, psychologists, physiotherapists, occupational therapists, a speech therapist and a dentist. I also spoke to policemen and a solicitor. As might be expected, this discussion often centred on behavioural and emotional difficulties but I was also able to alert people to the physical and psychological effects of medical conditions on their clients, e.g. hypothyroidism in Down's Syndrome, epilepsy, sight and hearing disorders etc.

(b) A further 20% of my time was spent in direct contact with patients, 65% of contacts were with out-patients, 65% of all contacts were with mildly handicapped as opposed to moderately or severely handicapped patients. The presenting complaint was behavioural or psychiatric in 71% of cases, epilepsy and its associated problems in 16% and the remainder had other physical ailments. Interestingly, mildly handicapped patients were more likely to present with behavioural and psychiatric complaints (87%) whereas the more severely handicapped patients more often presented with physical illness or epilepsy (65%). Overall the commonest presenting complaint was psychiatric disorder in mildly handicapped patients (60%).

(c) I am a member of the Mental Handicap Management Team and committee meetings took 7% of my time. Only 1% was devoted to teaching or research but this will increase shortly when a senior registrar is allocated to me. Seventeen per cent of my day was spent in my office, telephoning, dealing with correspondence etc.

(d) I was surprised to find that a third of my working day was spent behind the wheel of my car. This is perhaps the unfortunate result of community care, the geography of Cornwall and my wish to see people in their own setting.

What of my job satisfaction? I appreciate the move away from the supervision of the physical and institutional care of in-patients to a situation which makes better use of my psychiatric training, but dealing with six community teams, five adult training centres, three social services hostels, supported domestic and residential homes and three hospital units is demanding. In-depth assessment and the development of close working links with other professionals is difficult in this setting.

The other problem I share with Dr Nwulu is that of the treatment of mildly mentally handicapped people with behavioural and psychiatric disorders. While services for the more severely handicapped have improved and we are successfully caring for even the most handicapped people in domestic settings, the services for the mildly handicapped have not improved. Traditionally adult training centres and hostels catered for mildly handicapped clients. Many of these have now moved out to sheltered employment and lodgings. Those with superimposed psychiatric difficulties who have failed in less sheltered settings are now out of place in ATCs and hostels which now deal with more severely handicapped clients.

Dr Nwulu and Dr Cooke (*Psychiatric Bulletin*, October 1988, **12**, 452) have proposed specialist treatment units and I fully support these suggestions.

Such units should not only have in-patient facilities but also provide a base for a multidisciplinary team devoted to the treatment of psychiatric and behavioural disorders in any setting. Whether such units should treat both severely and mildly mentally handicapped people or whether separate units for the treatment of mildly handicapped people perhaps attached to general psychiatric facilities should be established is open to debate. As yet few units exist and evaluation of different patterns of service should be evaluated, perhaps co-ordinated, by the College.

I have witnessed great changes in the pattern of services during the 15 years that I have been a

consultant in mental handicap. Our psychiatric expertise is becoming increasingly recognised but as community care develops there is some uncertainty about our future role which will continue until specialist treatment facilities are established which will make the best use of our time and expertise.

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What should registrars and senior registrars learn about mental handicap?

DEAR SIRS

Registrars and senior registrars assigned to work in mental handicap for the first time can feel at a loss. Their work does not necessarily assume the patterns that general and acute commitments automatically impose. In mental handicap, patients' problems often tend to be long-term, to involve a range of disciplines and services and to be less immediately responsive to therapeutic interventions. At a hospital for mental handicap, trainees will be faced with large numbers of patients, only some of whom intermittently or continuously have psychiatric disorders and needs.

It is, therefore, especially important to give the trainees some structure and purpose to their clinical activities, duties and experience, which can add flesh to the skeleton of broad objectives that the Royal College of Psychiatrists (1985) has outlined. Mental handicap has the advantage of encompassing a reasonably distinct body of knowledge and practice. This makes it possible to compile a checklist of subjects of which trainees need to be aware, and with which they can plan to gain familiarity. A package of training could be devised, to be treated as flexible, tailored to the requirements of individual trainees related to their previous studies of the topics involved and whether they are at registrar or senior registrar level.

For example, trainees could aim to cover the following topics. The headlines are broad so that detail can be expanded under each item.

(a) Background

Outline of history of mental handicap and services, terminology, definitions, conceptions, criteria, prevalence, classification, aetiology, epidemiology, clinical features of the more common conditions, prevention – primary, secondary, tertiary.

(b) The health care of people with mental handicaps

General medical care – susceptibility of people with mentally handicapping conditions to particular medical disorders. Specialist needs – physical disabilities, epilepsy, sensory handicaps, speech and communication difficulties, conduct and behaviour disorders, profoundly mentally and physically handicapped people – physiotherapy, mobility and orthopaedic help, nutritional needs and advice.

(c) Life, family and community processes and services

The problems, needs and provisions associated with mentally handicapped people and their families and carers from infancy, through childhood and adolescence to adult life and old age; child development and assessment; primary care and community mental handicap teams; options in residential care, education, training, work, leisure and recreation, rehabilitation, individual programme planning and resettlement. Planning of services; mental handicap registers; contributions of voluntary agencies.

(d) The psychiatry of mental handicap

Psychoneurotic and psychotic disorders in mentally handicapped patients, classification, differences in presentation of mental illness in mental handicap. Epilepsy and mental handicap. Autistic syndromes. Dementia in mentally handicapped people. Challenging behaviours. The Mental Health Act and mental handicap – mental impairment. Forensic mental handicap – mentally handicapped offenders, interrogation of mentally handicapped persons, reports to Courts, 'difficult to place' patients, intensive care and special needs cases, visits or residential period for experience at a special hospital.

(e) Clinical practice

History-taking, examination, formulation of reports. Out-patient clinics, community visits, in-patient reviews, case conferences, monitoring of medication, consent to treatment issues.

(f) General

Timetable, text books, mental handicap journals, reading lists on mental handicap, management involvement, research opportunities.

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Reference

ROYAL COLLEGE OF PSYCHIATRISTS (1985) (Section for the Psychiatry of Mental Handicap) Registrar training in mental handicap. *Bulletin of the Royal College of Psychiatrists*, **9**, 206.