Psychiatric Bulletin (1993), **17**, 683–694

Correspondence

Community treatment and adults with moderate and severe learning disabilities

DEAR SIRS

In light of the College's consideration of community treatment (1987), the circulation by the Department of Health of Revised Proposals to the Code of Practice of the 1983 Mental Health Act (1993), and the recently published Mansell Report *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (Mansell, 1993), I wish to draw attention to adults with moderate and severe learning disabilities who have challenging behaviour with or without a mental health component living in community residential services that are not hospital facilities or mental nursing homes. They are likely to be registered under the Residential Homes Act 1984 with no guarantee of qualified staff.

Responsibility for these individuals lies with the staff and their management structure. Medical responsibility lies with the general practitioner. Referral to other professionals (i.e. learning disability teams, psychiatry, psychology) is dependent on individual need and cannot be assumed. Responsible Medical Officer (RMO) responsibility is a hospital concept and there may be confusion of responsibility between the general practitioner and an involved psychiatrist.

Experience with this client group suggests that they are unable to give consent, have ongoing problems and are not suitable for admission to most local psychiatric in-patient units. They nevertheless would fulfil the criteria of the Mental Health Act 1983 for compulsory hospital admission on the grounds of mental impairment or severe mental impairment. They require a safe secure environment where medication and appropriate management guidelines and programmes can be implemented and monitored. This has implications for staff numbers, training and registration status. Many individuals will be receiving long-term psychotropic medication and psychological treatments in a restricted domestic environment. If consent is given, it is unlikely to be "real" and consent may be refused. They do not receive the benefits or considerations that Parts IV and V and Section 121 of the Mental Health Act 1993 and the Code of Practice provide.

Issues of physical control or restraint, seclusion and greater security arise. There may be conflict with service managers and social workers, with differing interpretations of Guidelines issued by the Royal College of Psychiatrists and the Code of Practice.

Current proposals for Community Treatment Orders and revision of the Code of Practice will not be addressing this clinical area. Although the principle of "admitting to a service" in Community Treatment Order proposals is welcomed, my understanding is that they will be limited to people who have a mental illness and the issues of mental impairment or severe mental impairment will not be addressed.

In conclusion, I strongly urge that we consider adults with moderate and severe learning disabilities when formulating Community Treatment Orders. This is essential to the development of comprehensive good quality community psychiatric treatment, clarifying the types of hospital facilities that are genuinely required for this population and the feasibility of developing community psychiatric services within generic learning disability services, meeting the community training needs of doctors and improving our working relationship with primary care.

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The consultant psychiatrist and community care

DEAR SIRS

Dr Muijen has written a very important keynote paper (*Psychiatric Bulletin*, September 1993, **17**, 513–516).

With the recent expedition of the closure of mental hospitals, we are now engaged in delivering a re-organised psychiatric service, in the context of a radically re-organised national health service. Additionally, we have not, from the College, given guidance on the responsibilities of consultant psychiatrists since we responded to the enquiry into the

outbreak of infection at Stanley Royd's hospital in 1986.

There are several reasons why the responsibilities and roles of consultants should be reconsidered. Dr Muijen has written about some of them.

In recent months we have received many letters from members on aspects of these, e.g. on the distance from an acute or non-acute unit that medical staff can be resident, where medical responsibility lies for patients who are referred to or by non-medical colleagues, and perhaps most seriously, when is it appropriate for managers to decide which patients can be discharged so that an even more seriously ill patient can be admitted.

The report of the CMO's working group on specialisation indicates that postgraduate medical training should be structured, with a clear end-point. This implies that we know what we are training people to do. What is consultant work in psychiatry? Dr Muijen has challenged some aspects of *Mental Health of the Nation* and trainees have been telling us for years that training for work in "the community" is not our strong suit.

Mental Health of the Nation shows the levels of consultant manpower required to run an adequate service. But isn't further work required to examine the requirement for other grades of staff, both medical and non-medical? Such calculations can only be made when both the responsibilities and the numbers of consultants have been determined. While I agree with Dr Muijen that professional responsibilities must be discussed and identified in a multi-professional framework, and we maintain and try to improve our relationships with colleagues, there is an urgent need for us to clarify what our unique contribution to the psychiatric service is.

It has been agreed by the Executive and Finance Committee that I should chair a small working group which will produce a policy statement as quickly as possible setting out the core responsibilities of consultant psychiatrists and their role in the NHS. I hope that it will also be possible to produce additional information which is specifically relevant to each psychiatric specialty.

As Dr El-Komy says in his letter below, Council has recently produced a short statement on medical responsibility when a patient is referred by a non-doctor to a colleague who is also non-medical (*Psychiatric Bulletin*, April 1993, **17**, 251). This did not extend to referrals made to non-medical members of the multidisciplinary team by general practitioners, and should be.

I hope that most members of the College agree with Dr Muijen that "consultant psychiatrists, often represented by the Royal College of Psychiatrists, should take an active part in developments, and should be recognised as representing the best interest of the consumers i.e. their patients".

There is much concern in the public arena at the time of writing about standards of practice in medicine and we are developing a vigorous programme of continuing medical education in psychiatry.

I hope that this piece of work which we are now embarking on will facilitate even higher standards of care for psychiatric patients being delivered than at present, and that members and fellows will write to me with their views in order that the working group can be as well informed as possible. It will not surprise readers to learn that colleagues at the Department of Health are interested that we are embarking on this and wish to see the outcome.

FIONA CALDICOTT
President

Medical responsibility in the case of patients referred to non medical staff of a mental health unit or trust directly from non-medical services

DEAR SIRS

I read with interest the long overdue statement by the Royal College of Psychiatrists regarding medical responsibility (*Psychiatric Bulletin*, April 1993, **17**, 251). This issue has been a matter of concern among the consultant and medical staff in the West Dorset Mental Health NHS Trust. However, the statement has not clarified an important matter relating to referrals made by general practitioners to individual members of the mental health team, who may have no previous knowledge of the patient and bypassing the appropriate consultant. Some members of the team are working more or less independently to provide a specialised service, e.g. psychodrama, behavioural cognitive therapy etc., and it might be asked whether a particular member will be the most suitable person to deal with a patient with a psychiatric illness in need of a different treatment approach.

I think further clarification is needed of this important issue which I believe poses a problem not only in West Dorset but in other districts.

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Problems of the special hospitals

DEAR SIRS

I welcome the interest shown in the future of Ashworth Hospital by Dr C. M. Green (*Psychiatric Bulletin*, April 1993, **17**, 243). As there has been no response from your other readers to the report of