2. *Guidelines for Regional Advisers on Consultant Psychiatrist Posts in Mental Handicap*

Changing concepts and patterns of care for the mentally handicapped over the last decade have resulted in a considerable transformation in the role and responsibilities of Consultant Psychiatrists in Mental Handicap. It is now accepted that the primary role of the consultant is the provision of psychiatric services for the mentally handicapped and their families. Regional Advisers should find the recently published College document, 'Mental Handicap Services—The Future',[1] which defines this role in detail and spells out the related service needs, of considerable assistance.

Regional Representatives in Mental Handicap have been appointed by the Section for all Divisions. Regional Advisers are requested to consult their local Regional Representative about all job descriptions (both old and new) and, if necessary, the Chairman of the Section.

Uncertainties during the transitional period of the last few years have led to certain developments which the Section considers undesirable. Some Health Districts, for example, have sought to provide a psychiatric service for the mentally handicapped and their families on the basis of two to three sessions per week from a consultant working in the community without in-patient facilities. Others have decided to dispense with consultants in mental handicap altogether and provide psychiatric cover from the existing generic services. Neither is acceptable to the Section, which believes emphatically that psychiatric provision for this group of patients requires properly trained and experienced doctors and other staff, and an appropriate range of in-patient and other facilities. Confusion has also arisen over the role of multidisciplinary admissions and discharge panels. Whilst these are considered to be wholly appropriate in respect of decisions about residential care, they are not appropriate in relation to admissions and discharges to a psychiatric unit for treatment where such decisions are the responsibility of the consultant psychiatrist.

Types of post

Three types of consultant posts are recognized and distinguished by the requirements for training and service responsibilities: (i) whole-time (or maximum part-time) consultant posts in the psychiatry of mental handicap; (ii) joint appointments with at least 50 per cent and preferably a majority of sessions in mental handicap; and (iii) Special Interest Posts with a minority of sessions (usually two to four in mental handicap).

Specialist training in mental handicap is required for appointment to a consultant post with whole-time commitment to mental handicap and for a joint post. Consultants with a special interest should have had a substantial, but not an extensive, specialist training in mental handicap.

Mental handicap can be combined in joint appointments with most other psychiatric specialties, dependent upon local needs, the most appropriate being general psychiatry, child psychiatry, and forensic psychiatry. Consultants holding joint appointments should never be expected to be responsible for the organization and development of more than one specialist service.

Consultants responsible for the organization and development of the clinical service should either hold a post with a total commitment to mental handicap or a joint appointment in which the majority of sessions are in mental handicap and the consultant's primary responsibility for mental handicap is made clear. Only in exceptional circumstances should the responsibility for organizing and developing services rest with the consultant with a special interest appointment.

The present DHSS/College recommended consultant establishment in mental handicap is a minimum of one whole-time equivalent consultant per 200,000 of the population. Consultants should not be expected to carry a greater work load.

This figure is currently under review and the ratio is likely to be substantially decreased, having regard to the changing role of the consultant psychiatrist in mental handicap.

Treatment beds

In order to function effectively a consultant needs access to psychiatric treatment beds. These should preferably be provided in the form of a specialized unit or units. The total number of acute and long-stay beds required to provide a service for the mentally ill, mentally handicapped, those with severe behaviour problems and mentally handicapped offenders has been estimated at 0.25 beds per 1,000 population.[2]

It has been estimated that a further 0.75 health beds per 1,000 population is required for the care of the profoundly and multiply handicapped. There is no universal agreement about how treatment beds are best provided. The general trend is towards developing sub-regional units based in existing mental handicap hospitals, but in some areas treatment beds are being provided in small, locally-based hospital units. Neither style of service has been evaluated. The essential criterion is whether or not a viable service can be provided on a local basis, bearing in mind the comparatively small number of patients requiring in-patient care at any one time and a need to provide for a full range of psychiatric problems and intellectual levels.

Non-consultant medical staff

There should be an adequate number of non-consultant staff associated with each consultant post. These may be at senior registrar, registrar or clinical assistant level, according to the nature of the service.

Supporting staff and other facilities

There should be an adequate establishment of trained staff from other disciplines including nurses, clinical psychologists, the remedial professions, etc.

Adequate office accommodation and secretarial staff, including a full-time personal secretary, should always be available.

Job description

New patterns of care for the mentally handicapped are evolving at different rates and in different ways in different parts of the country. There have also been serious recruitment problems in the past which have left a substantial number of posts chronically vacant. It is, therefore, impossible to be totally dogmatic about job descriptions for consultant posts which are constantly being adapted to meet local needs. However, the following general principles should be applied:

(a) The primary role, namely the provision of a psychiatric service to the mentally handicapped and their families, should be clearly stated in the contract, which should also indicate the facilities available or to be developed to enable this duty to be properly discharged.

(b) Job descriptions should delineate the catchment area which should be of reasonable size, the position regarding in-patient facilities (whether they are in local mental handicap hospital or elsewhere or still in the planning stage) and the whole range of other services to which he will have access or for which he will be responsible. This should include sub-regional and regional services for the mentally handicapped to which he may have access.

(c) When a consultant is appointed to a large hospital his responsibilities in relation to long-stay residents and his role and responsibilities in developing a specialized psychiatric service should be clearly defined. Where a service is primarily community based the number of psychiatric treatment beds available and the role and responsibilities of the consultant in relation to any locally based hospital units or community units should be clearly stated.

(d) Administrative responsibilities including the planning machinery for mental handicap services and membership of medical committees should be specified together with any teaching responsibilities and associated local honorary university status. An adequate number of sessions should be allocated to teaching and administrative duties.

(e) Special attention should be paid to the problems of isolation attendent upon the appointment of a district base single-handed consultant. There should be close working contact with other consultant psychiatrists both in mental handicap and other psychiatric specialties.

References

[1]Royal College of Psychiatrists (1983) Mental handicap services—The future. *Bulletin of the Royal College of Psychiatrists*, **7**, 131–134.

[2]Day, K. A. (1983) A hospital based psychiatric unit for mentally handicapped adults. *Mental Handicap*, **11**, 137–140.

Management of Deliberate Self-Harm in Children and Young People

The Child and Adolescent Psychiatry Specialist Section wishes to draw the attention of child and adolescent psychiatrists to the DHSS Circular HN(84)25 LASSL(84)5 dated December 1984 for the following reasons:

1. This circular was prepared by a multidisciplinary working group formed by the Royal College of Psychiatrists at the invitation of the DHSS.
2. Para 2, (6) deals with children and young people who have taken an overdose.
3. This paragraph recommends that wherever possible a child and adolescent psychiatrist and other appropriate members of the team should not only take part in the assessment and management of young people under 16 but also *help to draw up local policy*.
4. Para 2, (4) states that each district or hospital should have a clearly laid down policy or code of practice agreed by clinical consultants, consultant psychiatrists, and other relevant staff. It also says that the DHA should set up local multidisciplinary groups, in order to formulate appropriate policies.
5. The Section suggests that any child and adolescent psychiatrist who has not been consulted about future arrangements in their own district for the management of such children and young people should make their views known to the local multidisciplinary group which is considering this matter.

Election to the Fellowship

Candidates for election to the Fellowship are considered annually by the Court of Electors.

Candidates may not make a personal approach to the College for election, *but must be nominated by two sponsors, who must be Fellows of the College.*

Sponsors should *apply in writing* to the Registrar for the relevant forms. Completed nominations should be submitted to the Registrar by 30 September in any year, for consideration by the Court at its meeting the following February.

Eligibility of nominees

a. Candidates must either be Members of the College by Examination of more than five years standing, or Members who have been granted exemption from examination.

b. The Fellowship is ordinarily awarded to a Member for unusual distinction in teaching, research, and/or administrative ability, or for exceptional service to patients, especially where the supporting services have been inadequate. Sponsors are therefore asked to indicate any factors which go beyond the carrying out of consultant or academic duties by the candidates of their choice.

All sponsors and all successful candidates will be notified by letter of the decision of the Court of Electors.

Individuals elected to the Fellowship become entitled to use the designation FRCPsych after they have paid the prescribed registration fee.