Correspondence

Draft Code of Practice

DEAR SIRS

I wonder if I might add my pennyworth to the no doubt voluminous correspondence on this matter (Comments of the Royal College of Psychiatrists on the Mental Health Act 1983 Draft Code of Practice, *Bulletin*, August 1986, **10**, 194–195).

In general I very much agree with the sentiments expressed—in particular that "the Code should enable staff to act energetically in the best interests of the patients". I have seen more harm done recently through acts of omission—particularly failure to use Section 3 of the Mental Health Act effectively and to prescribe adequate doses of medication—than through acts of commission.

May I, however, through your columns, express my strong reservations regarding the comment that "the provisions of the Code should be attainable within present manpower and financial constraints." It is of course very important that the recommendations of the Code should be realistic. On the other hand it would be a pity if the recommendations were to be too much constrained by fluctuating political and fiscal factors, particularly as there is so much variation throughout the country between regions and even within regions. Surely it would be better to determine an appropriate and feasible standard of care as practised, say, in the best of our centres of excellence and put this forward as an appropriate ideal to be aimed at nationally. The more deprived districts might not at present be able to achieve this ideal. However if this was put forward as a standard of practice to be aimed at the responsibility would then lie clearly with the Health Authorities to provide resources to enable such practices to be carried out in reality. It would of course need to be made clear in the Code of Practice that where standards fall below the recommended ideal due to lack of resources that the responsibility would be with the Health Authority rather than with individual practitioners to rectify the situation.

T. PASTOR

The Acre & Homefield
Worthing, West Sussex

Consultant staffing figures

DEAR SIRS

I find the consultant staffing figures quoted in the paper 'The Role, Responsibilities and Work of the Child and Adolescent Psychiatrist' (*Bulletin*, August 1986, **8**, 202–206) surprising. In Norway we are using as a basis for further proposals the staffing levels proposed by the WHO, which are for one team of minimum four members for each 40,000 population. When due allowance is made for the geographical problems in providing the service, the suggestions are that appropriate coverage in Norway will be a minimum of one team for every 30,000 population (that is total population).

The poverty of the British Health Service becomes apparent when the only figures to be mentioned are for irreducible minimums rather than what is required to give an adequate coverage and so some support for those areas which are prepared to challenge the dominance of somatic disciplines in the tight defence required for service development. I am uncertain that the figures quoted would enable a conscientious consultant to fulfil his responsibilities as itemised in the paper.

It is because of the special problems encountered by child psychiatrists in defending budget proposals that the WHO suggestions are so potentially valuable. From outside Britain one sees too many signs of Health Service workers 'giving up'. I hope that these suggestions for the consultant coverage in child psychiatry can be made a touch more enterprising. It is here that the evaluative research of clinical practice suggested in the paper has such an important part to play, along with research into the evaluation of the other consultant responsibilities mentioned.

SIMON WILKINSON

Per Lasons Vei 17
Kolbotn, Norway

Non accidental injury to adults with mental handicap

DEAR SIRS

1. There are clearcut guidelines regarding cases of child abuse and professional staff working with children know how to respond to a situation. In the case of adults with mental handicap (especially moderate to severe) the situation is not so clear. These people, although chronologically adults, mentally remain vulnerable like children.

2. Non accidental injury is defined as a situation where there is definite knowledge or reasonable suspicion that the abuse was, or may be inflicted (or knowingly not prevented) by any person having custody, charge or care of the person. This would include the following categories:—

(a) Physical injury.
(b) Administration of poisonous substances.
(c) Severe or persistent physical neglect.
(d) Medical diagnosis of non-organic failure to thrive.

https://doi.org/10.1192/pb.10.11.317 Published online by Cambridge University Press