MENTAL HANDICAP*

On 15 June 1976 the Chairman of the Mental Deficiency Section read a statement to Council, expressing that Section's serious concern about the grave situation facing services for the mentally handicapped and the future of the specialty (*News and Notes*, October 1976, p 1). Council set up a Special Committee under the Chairmanship of the President to investigate the situation and prepare comments and recommendations for its consideration. The result is this Memorandum which Council has approved. The members of the Special Committee were Drs V. Cowie, A. Fairburn, Professor P. Graham, Drs W. A. Heaton-Ward, L. Hersov, T. Lawlor, W. R. McKibben, Professor D. Pond, Dr D. Primrose, Professor G. Russell, Drs B. Scally and A. Shapiro.

Copies of the Memorandum have been sent to the DHSS, the Scottish Home and Health Department, the Standing Mental Health Advisory Committee, the Central Health Services Council, and to various organizations concerned with Mental Handicap. The Divisions have also been asked to give consideration to the Memorandum.

1. Care needs of the mentally handicapped

The great majority of the mentally handicapped population reside at home or close by (at least until their parents get too old or die) using local special schools, hostels and adult training facilities and the medical and social services available to the general public. Some of them may require short-term residential care away from home from time to time. A minority require long-term hospital care, and the following categories of patients are generally accepted as appropriate for hospital admission:

the profoundly subnormal and those with multiple handicaps requiring specialized care;

the mentally handicapped with severe behaviour disorders (e.g. hyperactivity or violence), personality disorders or superimposed psychiatric illness, some having forensic implications.

It is often overlooked that people prone to unaesthetic behaviour need privacy and space around them. However, those with cogent reasons for long-term admission are at present having to compete for places with 'social' admissions because of the lack of local authority group houses and hostels.

The trend of survival into adult life of persons with multiple handicaps and of very low ability reflects improved medical care; hospitals also have a mounting geriatric population of the lesser handicapped (in England the over 65s in mental handicap hospitals increased by 8·5 per cent from 5,490 to 5,956 over the three years from 1970 to 1973) (1). Because of this longer survival and of bed reductions in adult wards, children in long-stay units cannot move on as they grow older. As a result there is a serious shortage of beds both for children and adults at present in the community who really need long-term residential care and for short-stay accommodation to provide family relief during the school holidays.

Recommendations

i. Future planning of a broad spectrum of community provision is strongly endorsed.

ii. Services should

(a) be concerned with every aspect of the person's needs: assessment, education, social, vocational and recreational training, psychiatric treatment and care;

(b) provide continuity throughout the handicapped person's lifetime within one closely linked multi-disciplinary system;

(c) be clustered for easy accessibility in the locality;

(d) be considered medically as a branch of maintenance medicine and thus developmental rather than episodic in concept.

iii. The use of mental handicap hospital beds for crises and for short-term planned care for family relief is strongly supported.

iv. Present hospital units should be maintained and upgraded and not run down until the matching community provision meets the need.

v. The needs of an increasing geriatric age group and the need for more children's accommodation must be remembered.

2. The medical components

Mental handicap work involves a network of co-operating professionals, and there is a need for flexibility when operating this network.

Paediatricians are rightly very frequently involved in the first identification and early management of the mentally handicapped, especially the severely handicapped, from the maternity unit onwards. In some areas they have better facilities than any other specialty for the elaborate biochemical, chromosomal, genetic and other technical investigations which are

* The terms mental deficiency, mental handicap, mental subnormality are used interchangeably.

often needed, if only as a routine screening before a firm diagnosis is reached.

Those families still doubtful about psychiatric involvement may prefer to deal with the paediatric team for continued counselling, and most are extremely grateful for crisis and 'family relief' admission into acute paediatric beds, especially for the under-fives.

In addition, it should be said that family unease about psychiatric involvement is minimized by good relations between paediatrician and psychiatrist. It should be noted, however, that patients with severe mental subnormality are unfortunately not always acceptable to paediatricians for admission into paediatric beds, even when the patient is still under 5 years of age. This is often because once in hospital, discharge may be long delayed for lack of other facilities.

Child psychiatrists undertaking responsibilities for mentally handicapped children are moving towards even closer working with both the preventive services and the child developmental specialists being trained nowadays by paediatric teams operating multiple handicap assessment centres. Developmental paediatricians and paediatric neurologists are able to offer developmental and neurological tests which discriminate the finer details of handicap. Together with other professionals they offer longitudinal data on the growth and progress of a child, together with advice to other clinicians, teachers, speech therapists, physiotherapists, and clinical psychologists.

The reference in the Court Report (2) to those psychiatrists who possess skills with children, both with and without mental handicap, does not adequately represent their contribution, which in some areas is historical and already highly developed. On the other hand, the report tends to over-estimate the current willingness and interest of child psychiatrists in mental handicap.

Because of his limited ability to communicate his needs and monitor his own progress, the severely handicapped person living at home requires special sympathy and skill from his general practitioner and other members of the primary health care team. General practitioners are already providing the day-to-day routine medical care of patients in many mental handicap hospitals.

The full medical assessment of any mentally handicapped child must include investigations of his sight, hearing and speech, which often require highly specialized techniques and which should lead to subsequent treatment by both medical and paramedical specialists. Investigation and treatment of motor disabilities require the services of orthopaedic consultants and physiotherapists.

The Role of the Psychiatrist

An important requirement, entailing skilled investigation and great experience, is to identify, wherever possible, the cause of the child's mental handicap and to make reliable predictions on life span, further development and possible deterioration. In some cases this will have been done already by the paediatrician either alone or in consultation with a consultant psychiatrist in mental handicap. Discovery of a genetically determined disorder imposes a heavy responsibility on the family. The psychiatrist's subsequent involvement depends on the mentally handicapped person's treatment needs and those of his family, who may require considerable help in dealing with their own anxieties and conflicts concerning their mentally handicapped member. This is one of the most important elements of the psychiatrist's role.

The prevalence of psychiatric disorder in its broadest sense has been estimated to be as high as 60 per cent of the existing population of mental handicap hospitals (3). The often atypical presentation of mental illness in the mentally handicapped, and their often idiosyncratic response to drugs used in their treatment, require the services of the psychiatrist specially trained in this field.

The psychiatrist is also particularly concerned with the diagnosis and treatment of the wide range of manifestations of epilepsy and disturbed behaviour associated with brain damage or developmental abnormality.

There is an important forensic component in the psychiatrist's role in examining mentally handicapped offenders and advising the courts on their disposal. This involves a highly skilled judgment of the chances of a recurrence of the offence and of the risk to the public of care in the community or in an open hospital, far more difficult than in the case of many offenders of normal intelligence. The psychiatric staff of mental handicap hospitals have been far more ready to admit mentally handicapped offenders than their colleagues in mental illness hospitals, and some consultants in the mental handicap field see the treatment of such patients as an important part of their role.

Psychiatrists are involved in the treatment of short-stay patients and increasingly of day patients.

Full-time psychiatrists in the subnormality service are the backbone of the psychiatric aspect of the service and supply continuity of care in hospital services, often throughout a mentally handicapped person's life. They are active in reforming and upgrading under-funded and overcrowded long-stay hospital units, and ensuring that hospital units develop according to the needs of the area. Most of

the medical advances in rehabilitation have been the work of this group of consultants.

For three years, since the re-organization of the National Health Service, Area Joint Care Planning Teams and county planners have relied heavily on the advice of the consultants in post on local needs. Where such guidance is unavailable, administrators have tended to produce generalized propositions based on DHSS models rather than tailored plans to meet local needs.

Some job descriptions for consultant posts now reflect the suggestion of the Secretary of State (4), in a statement to a conference of the National Society for Mentally Handicapped Children, that appointments should serve the needs of an Area or District in collaboration with other professionals as well as providing services to clinics and long-stay units.

No matter how intensive the medical or non-medical support, the families of mentally handicapped patients run the risk of psychiatric stress, and the psychiatrist's training makes him particularly suitable to treat and counsel families under emotional and psychological stress.

There are a large number of psychiatrists in variously combined posts who bring to the task of providing a psychiatric service to the mentally handicapped a wide experience, the most numerous being child psychiatrists. These share much common ground with the specialist in mental handicap and are able to bring to the job skills with families and with teachers, as well as sophistication in working with pre-school children and with child care residential and field-worker personnel.

The child psychiatrist's energies are also geared to building up or maintaining a child psychiatric service for those with a normal range of ability, and it should be clearly recognized that no economies result from combined posts. General psychiatrists in combined posts tend to visit isolated mental handicap units and to offer occasional psychiatric back-up from their own wards, rather than offering a comprehensive service. However, they bring to the post ready-made specialist field-worker contacts in mental health as well as a regular involvement in hostels, lodgings and other rehabilitation schemes.

Recommendations

i. 'Ways must be found to retain services and utilize to the full the experience of those at present professionally employed in the mental handicap service' (2)—this recommendation of the Court Report is strongly endorsed.

ii. One of the most effective measures in achieving a comprehensive psychiatric service for the mentally handicapped in a locality is the appointment of a highly trained, enthusiastic consultant in mental handicap.

The consultant psychiatrist should be involved in the delineation and improvement of standards in the handicap hospitals, and in monitoring standards. Leadership has many advantages when given from a medical viewpoint.

His membership of the local psychiatric division ensures that medical manpower plans and other developments reach District Management Teams and are known to the Area Community Specialist in the same way as are establishments and funds for acute services.

iii. The consultant should take the lead in establishing the milieu on which a therapeutic community can when appropriate be based.

iv. Whilst applauding the establishment of the National Development Group, it is regretted that the DHSS has not filled the vacant post of Consultant Medical Adviser in Mental Handicap, since there could be a place for both. This should be put right.

v. Combined posts in mental handicap and child or adult psychiatry may be valuable, but such posts do not and cannot bring about economies of consultant time. Organization of psychiatric services depending heavily on combined posts will need to pay particular attention to continuity of care between child and adult services.

3. Medical manpower and training

It is proposed that:

i. the existing number of full-time consultant posts in mental handicap forms a minimum which should be maintained;

ii. all other psychiatrists, in training and in consultant posts, should be given an opportunity to widen their skills in order to fit in effectively with local mental handicap schemes should they later wish to do so;

iii. a small nucleus of extra training posts in mental handicap should be immediately created, whose effect will be felt and can be assessed at a later stage. This could lead to an increase in the nucleus of whole-time consultants, linked with the creation of further training posts as necessary.

The mental handicap service is at present seriously understaffed medically because training schemes have been unattractive and ineffectual, and a vicious circle arising out of uncertainty about the future of the specialty has affected recruitment—which has not been adequate even to fill existing consultant posts. It will be seen that the recommendation of 240 consultants, each to provide a service for a population

of 200,000 contained in the Royal College of Psychiatrists' document *'Norms' for Medical Staffing of Psychiatric Services: Mental handicap* (5) has been far from achieved (see Table).

The Approval Exercise of the Royal College of Psychiatrists stresses the desirability of trainees having some experience in mental handicap prior to taking the Membership Examination (M.R.C.Psych.), but this is not mandatory. Approval teams are currently commencing visits to mental handicap hospitals to determine whether they are suitable for pre-Membership training purposes. Training programmes are being considered by the Joint Committee on Higher Psychiatric Training for those who wish to specialize in mental handicap.

Consultant and Training Posts in Psychiatry (1976)

The following Table shows the number of staff in Mental Handicap, Child Psychiatry, Adult Psychiatry. As far as Mental Handicap is concerned there are only 136 consultants in post, although the establishment is 167.

	Mental Handicap		Child Psychiatry		General (adult) Psychiatry	
	Total	'British'	Total	'British'	Total	'British'
Consultants	136		238		1057	
Senior Registrars	19	(4)	69	(45)	247	(161)
Registrars ..	22	(5)	28	(17)	623	(231)
Senior House Officers ..	5½	(1)	4	(2)	516	(212)

'British'—people born in Great Britain, Northern Ireland and Eire.

The numbers indicate staff in post, not establishment. The 238 consultant child psychiatrists represent 207 w.t.e. consultant posts. There is a negligible number of psychiatrists in mental handicap who are not full-time.

Recommendations

i. *Structure of medical service*

The medical service should consist broadly of two parts. The first will be manned by a cadre of highly specialized consultants (at present, the consultants specifically designated as primarily responsible for the mentally handicapped), providing facilities in hospitals and in the community. It is mainly to them that the profession will look for the development of teaching and research in their discipline and for future academic growth. The second part of the service will include the care provided by other psychiatrists, namely child psychiatrists and general (adult) psychiatrists, who will need to acquire the necessary skills and knowledge to care for the mentally handicapped. This part of the service will be mainly based in out-patient departments and in the community. The primary aims must therefore be:

(a) to maintain and strengthen the cadre of consultants in mental handicap who at present are facing a serious fall in the recruitment of men and women of sufficiently high quality;

(b) to provide training for future generations of child psychiatrists and general psychiatrists who hitherto have had little or no opportunity to obtain clinical experience in this field.

A study of relevant statistics for 1976 (see Table) reveals why so many serious problems have arisen in the provision of skilled medical personnel to care for the mentally handicapped.

It will first be noted how few (19) senior registrar posts are available to train future consultants in mental handicap who now number a mere 136. The fact that only 4 of the 19 senior registrars in 1976 were British underlies how little interest is being taken in mental handicap by younger trainees from this country.

In marked contrast, the future of child psychiatry seems promising for the renewal and expansion of existing consultant posts (238 at present). (Forty-five of the 66 senior registrar posts in this sub-specialty are at present occupied by British trainees.) There has been virtually no increase of consultants in post in mental handicap in recent years because of a lack of suitably trained senior registrars, and little growth in senior registrar posts because of the awareness that it would not be possible to recruit British doctors to these posts anyway. Moreover, the small numbers of training posts in mental handicap at more junior levels (27 registrar and senior house officer posts) must explain in large measure why clinical experience in this field has not become more widely available to psychiatrists who would wish to work eventually in child psychiatry or general psychiatry. It also explains why it is difficult to incorporate such experience in rotating schemes at registrar level at a period of training when the future psychiatrist needs to have as broad a clinical experience as possible and at a time when he is still relatively uncommitted to his future specialty within psychiatry.

If it were possible to provide every trainee in psychiatry with clinical experience in the form of a supervised service commitment in mental handicap when he is at registrar (or SHO) level, two benefits

would ensue; the majority of psychiatrists would be better equipped than at present with the skills needed to care for the mentally handicapped, no matter what field of psychiatry they eventually selected, and the recruitment of psychiatrists into the specialist field of mental handicap would show improvements in both number and quality.

ii. *Registrar Posts*

In planning for future consultant posts irrespective of specialty, the DHSS and the Central Manpower Committee have based their tentative calculations on the number of British trainees required to fill these posts as they arise, partly through death or retirement, partly through expansion of the service. In our case, the exercise is somewhat different, because we are planning to provide future general and child psychiatrists with a basic experience in mental handicap. These psychiatrists all pass through the pool of registrars in general psychiatry in the early stages of their training. For our purposes we may concentrate on the 1,100 or so registrar posts (see Table). Provision should be made for these 1,100 doctors to obtain a basic experience in mental handicap by rotating through such posts during their training which may be considered to last at least three years. The basic experience in mental handicap should be *not less than three months*. With these figures in mind, the theoretical requirement of registrar (and SHO) posts in mental handicap is approximately 90 (1,100 divided by 12), compared with the 27 existing posts.

Ninety posts may be an underestimate because some trainees would spend more than three months in mental handicap, but it is a reasonable figure to aim at. Indeed, it will not be realistic to aim at reaching this target in less than five years, and as a first step it is proposed that 20 new registrar posts in mental handicap should be established and linked to existing general rotating programmes. These posts must be additional ones, and not taken from general psychiatry, because the service and training requirements would not withstand any depletion, and experience has clearly taught that rotational programmes cannot be extended to include new disciplines unless additional posts are provided.

In subsequent years, and in the light of experience, it should be possible to add further to these training posts in mental handicap and aim at the target of 90 posts. If this policy could be implemented, the majority of general and child psychiatrists would be equipped to treat their mentally handicapped patients, and a substantial number of recruits would come forward wishing to devote the remainder of their psychiatric careers to the specialized field of mental handicap.

iii. *Senior Registrar Posts*

Additional senior posts will be needed in response to the anticipated improvement in recruitment, and in order to retain a cadre of well-trained consultants in mental handicap and possibly add to their number if the opportunity arises. In order to establish a number of senior registrar posts commensurate with other fields (e.g. adult psychiatry) it would seem appropriate to aim at *five to ten additional* posts.

The first five of these should be made available within one or two years of the additional registrar posts being established (thus giving time for more registrars to obtain the relevant experience). Another five posts will probably be required two or three years later.

Future planning will clearly depend on overall development in the psychiatric services for mentally handicapped patients, and there might be a case for further expansion of senior registrar posts in the light of experience.

iv. *Academic posts*

At all university medical schools there is need for the appointment of a teacher in mental handicap to ensure adequate teaching at under-graduate level. Since such teaching involves psychiatrists and paediatricians it is liable to be neglected unless one consultant or equivalent academic is specially charged with responsibility for organizing this teaching.

Further development should include the establishment of at least one medical professorial chair in mental handicap in the UK with the creation of other academic posts of appropriate status—such as Readers and Senior Lecturers—in a number of centres.

While it is unlikely that a small academic department will by itself cover a wide field of mental handicap research, and accepting that neurochemical and biochemical research already have a strong impetus in some existing centres, the opportunity to collaborate in psycho-social aspects of mental handicap should be reinforced.

Summary of Recommendations

1. That basic experience in Mental Handicap be given as part of a rotational training scheme at registrar level.
2. That 20 new registrar posts providing clinical experience in mental handicap be established as soon as possible and incorporated within existing rotation programmes at registrar and SHO level. Further registrar posts in mental handicap to be provided in subsequent years in the light of experience, up to a possible target of 90.

3. That 5 senior registrar posts in mental handicap be established within two years of the above recommendation being implemented and that a further 5 posts be created two or three years later.

4. That the Royal College of Psychiatrists Manpower Sub-Committee give immediate attention to Recommendations 2 and 3 above with a view to encouraging their implementation.

5. That University medical schools appoint a teacher in Mental Handicap at an appropriately senior level who would be concerned with both postgraduate and undergraduate teaching in mental handicap.

6. That research in the field be encouraged at all academic centres.

7. That a medical Chair in Mental Handicap be established immediately.

References

1. DHSS Statistical Research Series No. 12. Psychiatric Hospitals and Units in England: HMSO, 1976.
2. *Fit for the Future*. Report of the Court Committee on Child Health Services, 1977.
3. Primrose, D. A. (1971) A survey of 500 consecutive admissions to a subnormality hospital from 1st January 1968 to 31st December 1970. *British Journal of Mental Subnormality*, **27**, 25–8.
4. Secretary of State's statement to the Conference of the National Society for Mentally Handicapped Children on 26 February 1975.
5. 'Norms' for medical staffing of psychiatric services: mental handicap, *British Journal of Psychiatry, News and Notes*, December 1973.

APPENDIX

Combined Posts:

Those combined posts described to the College Committee originally considering this subject seemed to have three factors in common which made for success:

(i) an enthusiastic Consultant in mental handicap in the position;

(ii) early contact with mental handicap at registrar level where there was University involvement in the training scheme; and

(iii) a successful local pattern of parallel working with non-psychiatric services for the mentally handicapped.

Examples in Areas in which combined posts have been operating:

Avon, with one million population clustered in commuter towns near two cities twelve miles apart, one having a medical school and the other a strong postgraduate teaching centre, has 10 consultants working in mental handicap.

Of the 8 in combined posts (all with child psychiatry) two see their jobs as essentially in mental handicap, 6 allocate equal time and energies successfully, undertaking responsibility for up to 300 in-patient beds as well.

Dundee, with its compact grouping around a mental handicap hospital, a university hospital and a mental illness hospital, has been particularly successful.

Edinburgh, where the mental handicap component has been found to work only when it comprises a major commitment.

Lanarkshire, where a trial of combined appointments was successful in its community and residential short-term care aspects, but not on the institutional and long-term care side. This area is reverting to full time posts.

North and West Somerset are completely covered through combined posts.

In one Health District of 250,000 population two combined-post child psychiatrists spend three sessions each in an in-patient children's psychiatric unit, four clinic or community child psychiatry sessions and three sessions in mental handicap, sharing 280 long-stay beds between them.

It is characteristic of their area that the adult mental illness service is well staffed, the paediatricians are prepared to be heavily involved in subnormality in children, there is an excellent special education service and the social services department has a strong tradition of working constructively in mental handicap.

A common factor with *North East Somerset* (130,000 population) is perhaps the low-stress rural community.

In this Health District a similarly combined post consultant covers both specialties single handed but has in addition two medium sized long-stay units and very strong involvement with the primary care services.