The College

Mental Handicap—The Changing Scene: Implications for Higher Training

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A conference on the above theme organized by the Mental Deficiency Specialist Advisory Committee of the Joint Committee on Higher Psychiatric Training was held at the Institute of Psychiatry on 18 November, 1980 and chaired by Professor K. Rawnsley (Chairman, JCHPT).

Opening the conference, Dr K. A. Day (Honorary Secretary MDSAC) discussed the implications of the recent radical change in approach to the care of the mentally handicapped on the role and training of the specialist in mental handicap. It is now accepted that he is primarily a psychiatrist and that the psychiatric aspects of the care of the mentally handicapped and their families should be the main focus of his work and training—although an adequate experience of the whole spectrum of mental handicap is essential to carry out this role competently. Specialist training in mental handicap should be undertaken at senior registrar level after the trainee has had a thorough grounding in all aspects of psychiatry, preferably in a registrar rotational training scheme which included some mental handicap experience. The MDSAC guidelines for training programmes are set out in its 'Outline of Training Requirements' (see second report JCHPT). A satisfactory training scheme requires an active progressive hospital with a community-orientated approach linked to a comprehensive area service. It requires that the behaviourally disturbed and mentally ill mentally handicapped are identified and treated as separate groups; that there are good links with paediatric and child psychiatry units, with full involvement in family counselling; that there is active input into community facilities and good liaison and team work with other disciplines both within and without the hospital. Training schemes should be fully integrated with other senior registrar training schemes in psychiatry and offer continuing involvement in mainstream psychiatry. More academic posts in mental handicap are required and specialty tutors are needed in those areas with more than one post, to co-ordinate training schemes. Good senior registrar training schemes must be backed by adequate exposure to the subject at undergraduate and vocational training level if recruitment is to be improved. All trainee psychiatrists should do at least three months full-time in mental handicap. Some re-styling of the job and re-shaping of the services is necessary to enable the consultant to function affectively in his newly defined role. Joint appointments between mental handicap and general and child psychiatry are a logical accompaniment of changing approaches to care, and offer a sensible solution to the recruitment problem. Special training schemes for combined posts need to be developed and should not be too unwieldy or lengthy.

Trainees' views were presented by DR L. B. CAMPBELL (London). Thirty-nine senior registrar posts were identified and incumbents circulated with a questionnaire seeking a range of information including the proportion of time spent in mental handicap, proportion of time spent in hospital and community work, future career intentions and opinions regarding the feasibility of community care and the future role of the consultant in mental handicap both in hospital and community practice. Twenty replies were obtained (9 posts were unfilled at the time of the survey). Only seven senior registrars intended to seek a full-time consultant post in mental handicap, but a further ten indicated an interest in a joint appointment, generally in combination with child psychiatry. The majority of respondents thought that the future mental handicap hospital would be substantially smaller and offer a specialized service in the assessment and treatment of particular groups, including those with multiple handicaps and the behaviourally disturbed and mentally ill. Most expected the consultant to have a role within the community services as equal status professional rather than team leader. Among the expected skills of the future consultant, psychiatric treatment, teaching and research were the most commonly mentioned. Sixteen of the original twenty respondents replied to a follow-up questionnaire nine months later. Of these, nine remained in the same post, four had obtained consultant appointments, and three had moved into a different psychiatric specialty.

Essentially the overall opinions regarding the future role of the consultant remained unaltered. Furthermore those senior registrars who had indicated a firm commitment to mental handicap had either remained in a training post or had obtained a consultancy in the specialty. This, however, applied only to nine individuals in a total of 39 identified posts.

The afternoon session was devoted to a discussion of the roles of the paediatrician and child psychiatrist and the relative values of full-time and joint appointments. Discussing the contribution of the *paediatrician* DR D. MORRIS (London) identified three roles: diagnosis and developmental assessment; parental support; supporting and advising other professional workers. He saw an important role for the paediatrician in supporting staff in mental handicap hospitals but not as taking total responsibility for the children. He stressed the primary role of the paediatrician in making the diagnosis, conveying this to

parents and providing support in the early stages. Suspicions of deviations from the normal are onerous to manage for fear of arousing unnecessary anxiety and call for sensitive and delicate handling. Breaking the news of handicap is always a crisis requiring experienced skills and management as well as time, privacy and devotion. The paediatrician may become the 'named person' or co-ordinator to ensure effective communication with the other professionals involved. In the execution of these tasks the paediatrician recognizes parents as partners and the involvement of the rest of the family.

Speaking on the role of the *child psychiatrist* in the field of mental handicap DR W. L. WALKER (Bristol) drew attention to the fact that psychiatric disorders were three times as common in mentally handicapped children as in normal children, and to the recommendations of the Court Report for greater involvement of child psychiatrists in the care of these children and their families. He referred to a 'grey area' of expertise in which paediatricians, specialists in mental handicap and child psychiatrists might each see themselves as best qualified to assess and treat. Boundary disputes must be avoided.

The size of the problem is vast and there is increasing demand for skills in 'supporting the supporters' in the community with plenty of work for all. District handicap teams should be able to evaluate needs and share tasks appropriately. The child psychiatrist's role is the diagnosis of family interaction which has become maladaptive and the treatment of psychiatric disorders in the index child or the immediate family. Experience in the psychiatric problems associated with educational difficulties, developmental delay and mental handicap are now an integral part of the training of child psychiatrists. He saw many problems arising from child psychiatrists accepting responsibility for the long-stay care of the mentally handicapped children and in the development of joint posts. Combined training for both skills would be prolonged, and there was a danger of producing individuals whose training would be considered inadequate or unacceptable by both sub-specialties.

Arguing the case for the *full-time specialist in mental handicap*, DR YVONNE V. WILEY (Bristol) stressed the multiple problems of mentally handicapped people and their need for continuity of care throughout their lifetimes. The full-time specialist was the only person with an overview of the totality of services and the breadth of skills and experience sufficient to advise on and co-ordinate all aspects of care. She drew attention to the potential problems of a hand-over during the crucial period of adolescence if children and adult services were divided, and was concerned that emotional problems and mental illness could easily go unrecognized without the routine involvement of the psychiatrist. She commended the College memorandum on the role of the consultant psychiatrist in mental handicap (*News and Notes*, May 1974) and described his functions, which in addition to psychiatric care and family therapy included the very important roles of co-ordinating the work of the many other professionals involved and providing support and advice to community services. Mental handicap was the area of psychiatry which most fully utilized the combined skills of physician and psychiatrist. But it was possible to overstate the range of skills necessary.

The full-time specialist did not claim to be an expert in all areas which the work spanned but rather to have a wide enough base of knowledge to refer on where appropriate.

Speaking on 'Joint Appointments—The Scottish Experience', DR. A. H. REID (Dundee, Chairman MDSAC) emphasized the problems of recruiting good calibre consultants in mental handicap on a full-time basis—a situation which was now reaching crisis point. Many present consultants were approaching retirement, many senior registrar posts remained unfilled and a significant number of present senior registrars did not have appropriate higher psychiatric qualification or did not intend to remain in the specialty. The problem was compounded by inconsistency in our concept of the consultant's role in the field of mental handicap. The all-encompassing role was an illusion but we did have highly relevant skills to offer. Against the background of these problems and facts the Batchelor Report (1970) had recommended the establishment of joint posts between mental illness and mental handicap and that paediatricians and child psychiatrists should be increasingly involved in the care of mentally handicapped children. Despite the controversy this aroused joint appointments had proved workable and helpful in the East and now increasingly in the West of Scotland. There was greater stability for the service in having a wider range of skills to call upon, and damaging disputes as to who should look after borderline patients were obviated. Integrated and flexible training schemes could be developed with relative ease. A joint appointments system allowed the consultant concerned to focus more clearly on the essential skills he or she had to offer and facilitated the development of a more substantial contribution from other professionals. The system had enhanced research and brought senior psychiatric trainees of good calibre into contact with mental handicap. Joint appointments had much to contribute and could co-exist with full-time posts. They were here to stay and should not be dismissed as an interim or temporary measure.