The College

Psychiatric Services for Mentally Handicapped Adults and Young People

Psychiatric disorder is a common complication of mental handicap. Whilst there are few detailed studies of psychiatric morbidity in mentally handicapped people, recent epidemiological surveys indicate that approximately 50% of mentally handicapped people in hospital and in contact with services in the community have suffered from psychiatric symptoms or behavioural problems sufficient to require specialist advice. All forms of psychiatric disorder are seen although the pattern differs somewhat from that in the general population and there is a high frequency of behaviour disorders.[1,2,3]

Because of the unique features attending the occurrence, nature, diagnosis and treatment of psychiatric and behaviour disorders in mentally handicapped people, a **specialised service** is required, organised and staffed by appropriately trained and experienced doctors, nurses and other staff who have a wide knowledge of the general field of mental handicap.[4]

A specialised psychiatric service for mentally handicapped people and their families should have three main functions:

1. Prevention of psychiatric and behaviour disorders;
2. diagnosis and treatment of psychiatric and behaviour disorders;
3. counselling and support for families and other carers.

Both research studies and clinical experience indicate that psychiatric and behaviour problems arising in the mentally handicapped are frequently a consequence of family psychopathology or abnormal living environments and lifestyles. Intervention at the point of diagnosis and family therapy are therefore essential components of the service and psychiatrists and other staff have a key role to play in the general planning and development of services for mentally handicapped people.

Support and counselling for carers, both relatives and professionals, to assist with the general management of a problem or shed light on any family or institutional dynamics which are maintaining a particular problem is an essential component of the service. Another important role is to increase awareness in families and those professionals in face to face contact with mentally handicapped people of the high prevalence of psychiatric morbidity and its manifestations in the mentally handicapped thus facilitating early referral to specialist services for advice and treatment.

The vast majority of mentally handicapped people with psychiatric disorder and behavioural problems can be treated in the community and a full range of out-patient services, domiciliary support, consultative input into local authority facilities and work with Community Mental Handicap Teams forms the bedrock of the service. Some patients will require in-patient treatment and each health district and local authority should have a clearly established plan for those requiring specialist in-patient services or a residential component to the amelioration of their disorder. Provision is required for the following groups:

(i) Acutely and chronically mentally ill;
(ii) mildly mentally handicapped people with personality problems;
(iii) mentally handicapped offenders;
(iv) severely mentally handicapped people with behavioural problems;
(v) the elderly mentally handicapped with psychogeriatric problems;
(vi) mentally handicapped people whose epilepsy poses special problems.

The total number of **acute and long-stay treatment beds** required to provide a service for the mentally ill mentally handicapped, those with severe behaviour problems and offenders has been estimated at 0·25 beds per 1,000 population.[5] There is no universal agreement about how psychiatric treatment beds are best provided. The general trend is towards developing comprehensive regional or sub-regional units based on existing mental handicap hospitals but in some health districts 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, bearing in mind the comparatively small number of patients requiring in-patient care at any one time and the need to provide for a full range of psychiatric problems and intellectual levels. However, it is generally felt that small locally based units will be unable to meet all needs fully and that some base hospital facilities will always be required. Ideally, specialised psychiatric services for mentally handicapped people should be integrated with the other psychiatric specialities as part of a comprehensive psychiatric service to a locality.

Specialised regional medium secure units are also required for the small number of mentally handicapped patients who require conditions of security beyond that which can be provided in psychiatric units for the mentally handicapped but who do not require the facilities of a special hospital.[6] These include both the mildly and severely mentally handicapped who have committed serious offences or exhibit dangerously violent propensities towards themselves and others and who experience has shown are not appropriately placed in medium secure facilities for the mentally ill. Such units should also provide rehabilitation facilities for certain

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patients from special hospitals. It is impossible to calculate with accuracy the number of places required because of lack of data—10 places per million population has been suggested.[7]

Consultant psychiatrists working in the service should be appropriately qualified and have completed a three years vocational training course in psychiatry in an approved centre and have held a senior registrar or equivalent academic post in an approved training scheme for a period of normally not less than three years.[8] Three types of consultant post are recognised and distinguished by the requirements of training and service responsibilities.[9]

Nurses working in psychiatric services for the mentally handicapped should have a basic training in mental handicap but receive additional training in psychiatry. Nurses currently working in the service should be given opportunities to receive the necessary additional training and qualifications in the psychiatric aspects of care through attendance at special courses or secondment to mental illness hospitals. Psychiatric nurses who have received additional training in mental handicap are also acceptable in the service. More emphasis should be given to psychiatric aspects of care in mental handicap nurse training both at basic and post-basic levels.

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Hospital Beds for Psychiatric Patients

Members write to the College asking for guidance on planning services for psychiatric patients, and in particular on the desirable level of provision of hospital beds. At the request of the Executive and Finance Committee I am publishing the following information, based on a letter that I wrote to Regional Advisers:

A frequent complaint is that Regional Health Authorities are applying a rigid norm of 0·35 beds per thousand population for planning for psychiatric in-patients. I have seen this figure used repeatedly and it seems to derive from figures given by Robertson in his guide to regional planners and quoted by Professor J. K. Wing at the DHSS/RCPsych conference last year.[1] I have prepared the following simplified table from Professor Wing's paper:

Number of occupied beds per 100,000 population required in 1991

		Short-stay (up to 1 year)	*Long-stay (over 1 year)*
(A)	Under 65 (mainly functional mental illness)	35	32
(B)	Over 65 (functional mental illness)	18	21
(C)	Over 65 (organic dementia)	7	27

It will be seen that the figure of 35 per 100,000:

1. Ignores patients staying for more than one year. Strategies vary, but many DGH units are expected to 'consume their own smoke' and continue to look after their own new long-stay patients.
2. Ignores patients over 65 years of age. Those elderly patients who suffer from dementia are sometimes catered for under a different heading, but I have found that Health Authorities are prone to forget about patients over 65 years of age with functional mental illness.