CORRESPONDENCE

NORMS FOR STAFFING OF PSYCHIATRIC SERVICES: CHILD PSYCHIATRY

DEAR SIR,

On page 6 of *News and Notes* for December 1973, the above Memorandum refers to the psychiatric staffing of child psychiatric services in 1970/71 having increased to 183 hospital-employed consultants, consisting of 149 full-time equivalents. It should be made quite clear that this figure includes Regional Hospital Board employment, which may be child guidance clinic based and not hospital based. In the area served by the North East Metropolitan Regional Hospital Board, with which I am associated, the overwhelming majority of child consultant psychiatric sessions worked are in child guidance clinics, and it would not surprise me to learn that this was the case in most, if not all, Regional Hospital Boards throughout the country. There is at present a strong move at ministerial level to place child psychiatric services, other than advisory ones, within the hospital setting (something which one might regard as clinically undesirable and economically impractical) and it becomes all the more important therefore that the current state of child psychiatry be accurately represented in such memoranda as appear.

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[On checking with the authors of the Memorandum, it appears that the figure of 183 consultants does refer to all those employed by Regional Hospital Boards, whether working in hospitals or in clinics. —EDS.]

NEEDS OF THE MENTALLY HANDICAPPED

DEAR SIR,

Underlying the conclusions of the recent conference on the future role and responsibilities of the specialist in mental handicap (*News and Notes*, December 1973) is the assumption that the care of the severely handicapped is primarily a medical responsibility. Yet there is growing evidence from many sources indicating that a medical model of care is no longer appropriate. Sweden, in particular, has demonstrated that the severely handicapped can be successfully cared for to their advantage by a non-medical service, and that small residential homes are a viable and superior alternative to a large institution. The Swedish service is now well established, being nearly 20 years old, and continues to evolve in the direction of greater integration of the severely handicapped with the community: it is simply not true to say that it is too young for effective evaluation. Nor are questions of economics and organizational differences valid arguments against a principle of care. The medical aspects of care which dominate our current thinking have been exaggerated. In practice doctors and nurses working with the severely handicapped are far more concerned with their basic care and training than with medical and nursing care, and we strive to turn our hospitals into homes.

A single specialty responsible for the long-term care is an intrinsic part of the medical model, but the mentally handicapped as a group present such a wide spectrum of medical needs that these can never be adequately covered by one specialist, however well trained. The psychiatric needs of the behaviourally disturbed and the physical needs of those with multiple handicaps are poles apart. Functional division within the medical model is no real solution, and one can appreciate the reluctance of paediatricians and other specialists to accept an overall responsibility for mentally handicapped children and physically handicapped adults. The problem will remain so long as the provision of residential care is a medical responsibility. The much-emphasized coordinating role of the specialist in mental handicap has been forced upon him by a system of care which unnecessarily complicates the multi-disciplinary nature of the subject.

The psychiatric needs of the mentally handicapped and their families were rightly stressed by the conference. It has been claimed that the size of the problem is sufficient to justify a separate subspeciality, but needs have been artifically inflated by the inadequacies of our present service and should fall substantially as these improve. This has certainly been the case in Sweden and Denmark. Disturbed behaviour is so often a reaction to abnormal and overcrowded living conditions and antisocial behaviour the result of poor training and lack of community facilities. How many parents would develop pathological reactions or mismanage their children if they received adequate support and counselling from the start? There is nothing unique about the psychiatry of mental handicap and no reason why it could not eventually be undertaken by child and adult psychiatrists.

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