Psychiatric Bulletin (1993), **17**, 683–694

Correspondence

Community treatment and adults with moderate and severe learning disabilities

DEAR SIRS

In light of the College's consideration of community treatment (1987), the circulation by the Department of Health of Revised Proposals to the Code of Practice of the 1983 Mental Health Act (1993), and the recently published Mansell Report *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (Mansell, 1993), I wish to draw attention to adults with moderate and severe learning disabilities who have challenging behaviour with or without a mental health component living in community residential services that are not hospital facilities or mental nursing homes. They are likely to be registered under the Residential Homes Act 1984 with no guarantee of qualified staff.

Responsibility for these individuals lies with the staff and their management structure. Medical responsibility lies with the general practitioner. Referral to other professionals (i.e. learning disability teams, psychiatry, psychology) is dependent on individual need and cannot be assumed. Responsible Medical Officer (RMO) responsibility is a hospital concept and there may be confusion of responsibility between the general practitioner and an involved psychiatrist.

Experience with this client group suggests that they are unable to give consent, have ongoing problems and are not suitable for admission to most local psychiatric in-patient units. They nevertheless would fulfil the criteria of the Mental Health Act 1983 for compulsory hospital admission on the grounds of mental impairment or severe mental impairment. They require a safe secure environment where medication and appropriate management guidelines and programmes can be implemented and monitored. This has implications for staff numbers, training and registration status. Many individuals will be receiving long-term psychotropic medication and psychological treatments in a restricted domestic environment. If consent is given, it is unlikely to be "real" and consent may be refused. They do not receive the benefits or considerations that Parts IV and V and Section 121 of the Mental Health Act 1993 and the Code of Practice provide.

Issues of physical control or restraint, seclusion and greater security arise. There may be conflict with service managers and social workers, with differing interpretations of Guidelines issued by the Royal College of Psychiatrists and the Code of Practice.

Current proposals for Community Treatment Orders and revision of the Code of Practice will not be addressing this clinical area. Although the principle of "admitting to a service" in Community Treatment Order proposals is welcomed, my understanding is that they will be limited to people who have a mental illness and the issues of mental impairment or severe mental impairment will not be addressed.

In conclusion, I strongly urge that we consider adults with moderate and severe learning disabilities when formulating Community Treatment Orders. This is essential to the development of comprehensive good quality community psychiatric treatment, clarifying the types of hospital facilities that are genuinely required for this population and the feasibility of developing community psychiatric services within generic learning disability services, meeting the community training needs of doctors and improving our working relationship with primary care.

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The consultant psychiatrist and community care

DEAR SIRS

Dr Muijen has written a very important keynote paper (*Psychiatric Bulletin*, September 1993, **17**, 513–516).

With the recent expedition of the closure of mental hospitals, we are now engaged in delivering a re-organised psychiatric service, in the context of a radically re-organised national health service. Additionally, we have not, from the College, given guidance on the responsibilities of consultant psychiatrists since we responded to the enquiry into the

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