List of Participants

Name	Appointment
Dr G. Burton	Committee for the Safety of Medicines, DHSS
Dr S. Levine	Oldham & District General Hospital
Prof M. Lader	Institute of Psychiatry
Prof R. G. Priest	Registrar, Royal College of Psychiatrists
Dr T. Corn	The Wellcome Research Laboratories
Dr P. Tyrer	Mapperley Hospital
Prof H. L. Freeman	Editor, *British Journal of Psychiatry*
Dr S. A. Montgomery	Chairman, Programmes and Meetings Committee

Guidelines for regional advisers on consultant posts in hospital and community rehabilitation

The special problems of management posed by those suffering from chronic mental illness is linked to the need to develop facilities for care of patients outside hospital. With the move towards locally based psychiatric services it is vital that each district has a consultant whose responsibility lies in these fields. It is important to recall that much psychiatric illness becomes chronic.

These problems are the prime responsibility of the consultant in rehabilitation and community care. Such a post is an essential component of the District Service as described in the recent College report *Psychiatric Rehabilitation Updated*. (*Bulletin*, February 1987, **11**, 71).

Specifications for consultant posts in rehabilitation and community psychiatry should be tailored to suit local needs. Although there is a need for flexibility to reflect the particular organisation of services in any District, as a guideline there should be a minimum commitment of 0.2 FTE/100,000 total population. It is expected that the Regional Adviser will consult with the Specialty Regional Representative for Rehabilitation nominated by the Section for Social and Community Psychiatry.

(1) **The nature of the post**

(a) *Population to be served.* The population to be served should be clearly defined in terms of total (i) all ages and (ii) the number over 65. There should be a description of the catchment area in terms of geography and social structure and there should be comment on any sociodemographic or other features of the catchment population which create unusual service needs.

(b) *Organisation.* There should be a District Rehabilitation Committee or equivalent structure with representation from NHS, Local Authorities and relevant voluntary Sector agencies. This should be accepted by the statutory authorities as the prime source of advice for planning, developing and monitoring rehabilitation services. The consultant in rehabilitation should be the medical representative on this committee.

(c) *Facilities—general.* There should be a clear statement of the facilities in the hospital and in the community, both these will be the responsibility of the appointee and those, e.g. hostels, group homes, day centres, with which s/he will be expected to work but over which s/he will not have direct control. There must also be a clear statement of the development plans for the District and the role within these plans which the appointee is expected to fulfil.

(d) *In-patient facilities.* Most posts, though not all, will have in-patient beds. No post should involve work solely on long-stay hospital wards. If the post holder is responsible for long-stay wards, then it should be clearly stated that admission to these wards and discharge from them, is under the control of the rehabilitation consultant and that the beds are not available for admission to other consultants. In-patient beds must be supported by adequate occupational therapy and clinical psychology services.

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(e) *Day facilities.* The consultant should have responsibility for an adequate range of day care in the community. S/he should also have a liaison function for relevant non-NHS day care.

(2) Other responsibilities

S/he would have an advisory role in relation to social services and voluntary agencies especially for development. There must be a clear statement of the development plan for the District and the role of the appointee in the further development and implementation of these plans.

S/he should be involved in the training of both medical and non-medical staff in rehabilitation.

(3) Planning for the post

There should be a clear specification of the role of the consultant in relation to the work of his or her general psychiatry colleagues. The exact pattern of the work and delineation in patient care and other responsibilities from general catchment area teams may vary from District to District.

(4) Teaching and research

Teaching of both medical and other groups is likely to be a significant part of the post. Research should be encouraged as should links with academic departments of psychiatry. Some time for research should be available to the post if wanted.

(5) Consultant time

At least 50% of the consultant's time should be available for work outside the hospital wards with regular sessions at hostels, day centres, group homes and primary care settings. Sessions must be available for the advisory, training and planning work as well as clinical function.

(6) Non consultant medical staff

Trainee psychiatrists should have the opportunity of experience in rehabilitation, and the management of chronic mental disorder, within a rotational training scheme. It should be made clear that these posts will involve work outside the hospital as well as hospital based work. There is also a place for clinical assistant support.

(7) Other professional staff

In addition to the medical staff, the care team should consist of both hospital based and community psychiatric nurses and occupational therapists. There should be an identified commitment from clinical psychologist(s) and social workers. There should be close liaison with Social Services departments. The consultant should also have strong links with other remedial and educational services.

(8) Non-professional supporting staff

The consultant to be appointed must be assured of adequate physical bases both within the hospital and outside, and adequate secretarial support.

SECTION FOR SOCIAL AND COMMUNITY PSYCHIATRY

Approved by the Court of Electors 14 December 1987.

Elections to the Fellowship, 1988

The Members listed below have been elected as Fellows of the College by the Court of Electors:

Professor S. Acuda, Dr R. T. Allen, Dr C. G. Barrow, Dr M. S. Bethell, Dr J. C. D. Booth, Dr J. H. Brown, Dr M. W. Browne, Dr W. P. K. Calwell, Dr D. Cameron, Dr H. Chaudhry, Dr S. A. Checkley, Dr J. Chick, Dr J. P. Connaughton, Dr P. J. Cullen, Dr N. M. Desai, Dr M. Dhadphale, Dr P. H. Dick, Dr M. Entwisle, Dr G. Fisher, Dr E. Fottrell, Dr A. R. M. Freeman, Dr D. G. Fowlie, Dr M. E. Garralda Hualde, Dr R. D. Goldney, Dr N. Graham, Dr E. E. Gulland, Dr R. J. Hafner, Dr M. A. Halim, Dr F. Hassanyeh, Professor H. C. Hendrie, Dr R. Henryk-Gutt, Dr D. J. L. Huws, Dr A. B. Jack, Dr N. James, Dr I. Khan, Dr K. Khan, Dr K. Kuruvilla, Dr O. Kyaw, Dr B. Lake, Dr B. Lask, Professor R. J. Mathew, Professor P. E. Mullen, Dr K. N. Murray, Dr P. O'Farrell, Dr D. P. Ollerenshaw, Dr J. M. Pfeffer, Dr R. M. Philpott, Dr A. S. Powell, Professor S. I. A. Rahim, Dr D. J. Rampling, Dr E. H. Richards, Dr J. Ridley, Dr D. M. Riley, Dr A. B. Rolfe, Dr B. Rosen, Dr R. Seifert, Dr O. A. Sijuwola, Dr M. M. Slack, Dr O. J. Slowik, Dr E. D. Smith, Dr B. A. Snowdon, Dr D. Storer, Dr A. Y. Takriti, Dr E. Taylor, Dr R. Thaya-Paran, Dr B. K. Toone, Dr W. F. Tsoi, Dr R. Viswanathan, Dr D. S. Vorster, Dr P. Williams, Dr E. P. Worrall, Dr L. M. Zinkin

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