Meeting the Mental Health Needs of Adults with a Mild Learning Disability

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Executive summary (incorporating recommendations)

It is generally recognised that people with learning disabilities have a higher rate of psychiatric disorder than the general population. Ninety-eight per cent of people with a learning disability function in the range of mild learning disability.

The principle of normalisation and Government policy in the UK state that, wherever possible, people with learning disabilities should use mainstream mental health services. However, mainstream mental health services currently lack the resources, skills and expertise to manage this group of patients. Although there are not many examples of good practice either in the UK or elsewhere, intensive case management and collaborative systems of care appear to be beneficial for people with mild learning disabilities.

The following recommendations are made to facilitate a collaborative system of care for this group of patients.

Recommendations

At local level

1. Each district should have protocols to meet the mental health needs of adults with mild learning disability, jointly agreed between learning disability services, adult mental health services, primary care trusts and social services. Managers of learning disability services should make sure that the needs of this group are on the agendas of partnership boards and local implementation groups for the National Service Framework for Mental Health. Consultants in the psychiatry of learning disability should ensure that there is a mental health service available for them.
2. There should be protocols to share expertise and resources such as day activities, respite, therapy groups, rehabilitation facilities and outreach teams. Regular clinical meetings between learning disability and mental health teams could allocate resources and draw up care plans.
3. Trusts providing psychiatry of learning disability services should ensure that the Royal Collage of Psychiatrists' guidelines regarding staffing levels are implemented (i.e. one full-time equivalent consultant psychiatrist in learning disability per 80 000 population).
4. Many people with mild learning disability can benefit from psychological treatments. Learning disability professionals should work with other mental health colleagues specifically to meet this need.
5. There should be representation from learning disability service providers on National Service Framework for Mental Health implementation groups to ensure that people with learning disabilities benefit from the initiative.

6. Lead clinicians from learning disability and mental health services should be identified to have a coordinating role.
7. People with mild learning disabilities may need support to access some of the mainstream services. Each district should have a specialist learning disability team, whose members, in their role of health facilitators as outlined in *Valuing People* (Department of Health, 2001*a*), could provide this support. Principles of intensive case management could be used, as they have been shown to be effective for this group.

At strategic health authority level

8. The strategic commissioning group should be charged with ensuring the development of services for people with learning disability with severe complex needs.

Continuing professional development

9. Joint continuing professional development (CPD) and audit meetings with psychiatrists from other faculties and with academics will improve liaison with forensic, old age, child and rehabilitation psychiatrists to ensure a seamless service.
10. There should be opportunities for consultant psychiatrists to obtain competencies to look after the mental health needs of adults with a mild learning disability.

Training

11. There should be more opportunities for senior house officers and specialist registrars in psychiatric specialties to obtain experience in working with adults who have mild learning disabilities and a mental illness.
12. Staff in both learning disability and mental health services should have training in psychological approaches adapted for use with people with mild learning disabilities.

Introduction

In human populations, IQ approximates to a normal distribution except for an excess at the lowest end, representing brain damage and disorder, which mostly affects the prevalence of severe intellectual impairment defined by an IQ below 50. Mild intellectual impairment, or mild learning disability, is largely a product of the population distribution (Fryers, 1997). Two-and-a-half per cent of the population have an IQ below 70 and 0.05% have an IQ below 50. This equates to 98% of people with learning disabilities functioning in the mild learning disabilities range, as defined by the ICD–10 (World Health Organization, 1992).

It is generally recognised that people with learning disabilities have a higher rate of psychiatric disorders compared with the general population, with the prevalence estimated at 30–75% (Borthwick-Duffy, 1994). Richards *et al* (2001) found that learning disability was associated with a four-fold increase in the risk of affective disorder not accounted for by social and material disadvantage or by medical disorder.

Psychiatric disorders may be an important – even a primary – factor limiting the functioning of people with learning disabilities, their quality of life and their adaptation to life in the community (Reiss, 1994). People with a learning disability as well as a psychiatric disorder are most at risk of institutional admission (Emerson, 1995). Effective treatment and support services are crucial to reduce the dependency on institutions and to avoid the creation of new long-stay populations.

Background

Historically, institutions (both learning disability and mental health) have provided services for people with comorbid mild learning disabilities and mental illness. Frank Menolascino (1970) introduced the concept of 'dual diagnosis' to describe this group of people. In line with the principle of normalisation, the expectation has been that their needs could adequately be catered for within mainstream mental health services.

Similar arguments have taken place around the world, and it is useful to look for examples of good practice or otherwise.

American experience

In America, residential, social, vocational and recreational needs are met by 'mental retardation services', while mental health needs are met by mental health centres. Dorn & Prout (1993) surveyed directors of psychological services at mental health centres and found that, in general, adults with mild learning

disabilities were less likely to receive the full array of available services. They were not frequent consumers of community mental health services and received differential treatment at these centres.

On a positive note, Patterson *et al* (1995) described the success of an inter-agency consortium in Spokane County, Washington State, between 1990 and 1992. The consortium was established to promote coordination of services between the community mental health centre, the State Hospital, the County Human Resources Agency, the State Regional Developmental Disability Service Agency, the State Institution for the Developmentally Disabled and several community agencies serving people with 'developmental disabilities' (learning disabilities). As a result, between 1990 and 1992, admissions of people with learning disabilities to the state institution were more likely to be appropriate admissions of people suffering from mental illnesses. People with learning disabilities were more likely to be discharged more efficiently, and crisis respite services were used in place of hospitalisation. There were also anecdotal reports indicating a reduction of interagency tensions.

European experience

In Sweden, people with learning disabilities use generic services for their mental health needs, in the spirit of normalisation. Gustafsson (1997) compared the number of people with mild and severe learning disability admitted to in-patient psychiatric care, with the corresponding figures from the general population, and found a low frequency of psychiatric care utilisation. People with depression living on their own, and people with mild learning disability and psychiatric disorders, had longer hospital stays than those with other psychiatric diagnoses or those in supported living. The latter highlights the social networks available to this vulnerable group and the need for collaboration between agencies responsible for mental health and learning disability services.

Driessen *et al* (1997) examined the determinants of referral to psychiatric services and the amount of mental health care consumed by people with learning disability in a defined geographical area in The Netherlands. They found that being older, having mild learning disability and living alone predicted a higher probability of receiving psychiatric treatment. Living alone was also associated with a higher level of mental health service consumption.

UK experience

In 1973, Sir George Godber, the Chief Medical Officer, gave a clear message that psychiatrists working in the field of learning disability should use their specialist skills to treat the psychiatric disorders of their client group rather than assume total control of those resident in hospital. The Royal College of Psychiatrists and other professional bodies have addressed training issues in a systematic way, and Psychiatry of Learning Disability is now one of the Faculties of the College.

The expectation that mainstream mental health services could respond to the needs of people with learning disabilities often proved unrealistic in the UK. First, the complex behavioural problems of people with severe learning disabilities could not be managed by generic mental health services. Mainstream psychiatric services lack the expertise, training and skills necessary for the assessment and treatment of such a heterogeneous group of people. Second, no attempt was made to negotiate the associated service issues, and problems arising between mental health and learning disability service providers. There was a lack of clear operational policies or service agreements – only vague definitions of who was entitled to access which service. Professional rivalries were common, and budgets constrained. The funding implications for such a shift of service responsibility were never adequately addressed (Bouras *et al,* 1995).

Biological methods of treatment are likely to be employed with little adaptation and psychosocial approaches are well developed in the field of learning disability. However, psychological methods of treatment for people with learning disability are often limited to behavioural approaches with little psychotherapeutic input.

Current services

Services for people with a mild learning disability and mental illness in the UK may be:

- *Residential*: in-patient and out-patient services are centred around hospitals (if they have not closed). The advantages include the availability of a range of services, including those for offenders, good multi-disciplinary working and facilities, and maintaining skills and training. Some disadvantages are isolation from generic services and the removal of the individual a considerable distance from home, as these hospitals are few and far between.
- *Non-residential*: services are linked to learning disability services, and sometimes to both learning disability and mental health services.

Evidence base

Gravestock & Bouras (1995) conducted a survey in the South East Thames Regional Health Authority, which demonstrated concerns about the range, quality and quantity of mental health and social care provision for adults with a dual diagnosis. In their national multi-professional survey (Gravestock & Bouras, 1997), only 12% of the respondents had quantitative data on adults with learning disabilities and mental health needs. Learning disability services were more accessible, and were more likely to be part of specialist learning disability services than generic mental health services. Most localities had multiple unmet health and social care needs in spite of central initiatives such as *Building Bridges* (Department of Health, 1995) encouraging interdisciplinary and multi-agency care planning, delivery and monitoring for psychiatric patients, including adults with both learning disability and mental health needs. They also found that 77% of the respondents served people with borderline IQ (70–80). Bailey & Cooper (1997) also found a variation in the quantity of specialist learning disability services across the country, with some trusts providing comprehensive services and others having a shortage of resources.

The UK700 trial is a randomised controlled trial of case management. Hassiotis *et al* (2001) have reported that intensive case management was significantly more beneficial for patients with borderline IQ than for those with average IQ in terms of reduction in days spent in hospital, hospital admissions, total costs and needs, and increased satisfaction, compared with standard case management. With intensive case management, the case manager had a case-load of 10–15 people, was able to have a clinical role, could be proactive and could help clients do things for themselves instead of doing it for them. In the standard case management model, the case manager had 30–35 clients.

Bouras & Holt (2001) describe the community specialist mental health service in London, which has been in operation for the past 15 years. This service uses all the facilities of the generic mental health service, including acute and medium-stay in-patient beds and a variety of community resources. There is a strong multi-professional approach and treatments are carried out in a variety of settings. Forty-seven (11%) of 424 consecutive new referrals required admission to general psychiatric facilities, of whom 86% had mild learning disabilities. Limitations of this model include the effect of the pressures on beds within the generic services for acute admissions, which may make these facilities a hostile environment for this client group. These facilities are unsuitable for people with severe learning disabilities and those who need a long period of admission or secure accommodation. To address these issues, the community specialist mental health service has been strengthened by the development of a specialist in-patient admissions unit (as an extension of the adult mental health admission service), community houses with specialist support, and a centre providing training, research and development in dual diagnosis.

Shaun Gravestock (personal communication, 2003) described an innovative service for people with low social functioning, low IQ (60–85) and severe challenging behaviour who fall between the traditional service boundaries of learning disability and mental health. The 'Bridging the Gap' service was set up in the London boroughs of Bexley and Greenwich, and was funded by a grant from the Mental Health Partnership Fund. Evaluation of the service showed that:

- there needs to be a clear definition of the gap in services to be bridged, as the new service can meet only certain deficiencies
- there should be strict interpretation of the eligibility criteria and the service to be provided
- it should be a tertiary service, with good links with other teams and services working in conjunction to enable service users to move forward; the team would not offer ongoing non-specialist, non-intensive support care, but would transfer care of the service user to an existing team when appropriate
- all individuals receiving the service should have a detailed contract outlining the partnership arrangements by which services are to be provided, including crisis management, care management, the remit of the responsible medical officer (RMO), and how to deal with unmet need.

The problems of introducing such services are shown by the experience of setting up a specialist in-patient unit for people with a mild learning disability and mental health needs in a new in-patient mental health development in the Midlands. Both learning disability and mental health services were part of the same trust and there were good working relationships between all the professionals. The learning disability unit was part of the learning disability directorate, but staff had been recruited by the mental health directorate. When dealing with challenging in-patients, the unit's staff felt unsupported by their

colleagues from mental health and isolated from their learning disability colleagues. Workers began leaving to take up other posts, and it became difficult to staff the unit. After less than a year, the unit closed and the consultants were given admission rights to four beds on the site. There are some concerns about how people with a learning disability are treated in the generic wards.

Qualities of a good 'dual diagnosis' service

Bouras & Holt (2000) describe the qualities of a good service for people with a dual diagnosis of mild learning disability and mental illness; it should have:

- good inter-agency communication
- high levels of awareness of mental health issues by direct care staff
- multi-disciplinary working
- the ability to provide training, consultancy, assessment and treatment
- community-based interventions
- access to both generic and mental health care
- access to specialist in-patient assessment, treatment and rehabilitation
- resources to meet the residential, recreational and vocational needs of those with enduring needs.

Davidson *et al* (1999) examined models of community-based dual diagnosis services, nine from the USA and one each from the UK, Canada and Australia. They found conceptual and operational problems between mental health and learning disability services. Inter-agency communication was not well established and access to service across systems was limited. Barriers were:

- lack of community commitment to establishing special services, attributed to limited consumer advocacy
- dearth of momentum generating support from professional organisations
- lack of fiscal resources
- organisational resistance to change
- need for consensus among providers, consumers and purchasers to establish a comprehensive service network.

A number of models emphasised the need for consensus among providers, consumers and purchasers which could be facilitated by bringing all stakeholders together to sanction the need for and characteristics of the service before establishment.

Learning disability and mental ill-health dual diagnosis services in the UK and Ireland

Policy in England

Government policy in the 1990s was one of inclusion for people with learning disabilities and mental health needs. This is implicit in Department of Health publications such as *Needs and Responses* (Department of Health, 1989) and *Building Bridges* (Department of Health, 1995). The College Psychiatry of Learning Disability and General Psychiatry Sections jointly produced the Council Report *Meeting the Mental Health Needs of Adults with Mild Learning Disability* (Royal College of Psychiatrists, 1997), which made the following recommendations:

1. There is a need for specialisation to achieve high standards in services (including adherence to the legal and policy context, responsiveness to the views of carers and patients, and other factors to improve outcome).
2. Comprehensive coverage requires attention to potential gaps (arising from age and geography, diverse clinical needs and patterns of services).
3. Specialist multi-disciplinary mental health teams for people with learning disabilities are required (to enable people with mild learning disabilities and mental health problems to use ordinary health services wherever possible, and to provide help to meet needs that cannot be met through the ordinary range of services).
4. Joint working should be promoted (between specialists in psychiatry of learning disability and other specialists). A task for these specialists is to improve the ability of other, less specialised services to serve people with mild learning disabilities.

These recommendations have not been implemented in many areas.

The policy developments of the past 2 years have been more prescriptive. The two relevant ones are published as the *National Service Framework for Mental Health* (Department of Health, 1999) and *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Department of Health, 2001*a*).

National Service Framework for Mental Health: standards

1. Health and social services should promote mental health for all, working with individuals and communities, combating discrimination against groups with mental health problems and promoting their social inclusion.
2. Service users who contact their primary health care team with a common mental health problem should have their mental health needs identified

and assessed, and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

3. Individuals with a common mental health problem should be able to make contact around the clock with the local services necessary to meet their needs and receive adequate care, and be able to use NHS Direct as it develops for first-level advice and referral on to specialist helplines or to local services.
4. All mental health service users on the care programme approach (CPA) should receive care that optimises engagement, prevents or anticipates crises and reduces risk. They should also have a copy of a written care plan that includes the action to be taken in a crisis by service users, their carers and their care coordinators, advises general practitioners how to respond if the service user needs additional help, and is reviewed regularly by the care coordinator; and they should be able to access services 24 hours a day, 365 days a year.
5. All service users who are assessed as requiring a period of care away from home should have timely access to an appropriate hospital bed, or an alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public, and as close to home as possible. They should also have a copy of a written aftercare plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care coordinator and specifies the action to be taken in a crisis.
6. All individuals who provide regular and substantial care for a person on CPA should have an assessment of their own caring, physical and mental health needs, repeated at least annually, and have their own written care plan, which is given to them and implemented in discussion with them.
7. Local health and social care communities should prevent suicides by:
   - promoting mental health for all, working with individuals and communities
   - delivering high-quality primary mental health care
   - ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline and/or an accident and emergency department
   - ensuring that individuals with a severe and enduring mental illness have a care plan that meets their specific needs, including access to services around the clock
   - providing safe hospital accommodation for individuals who need it
   - enabling individuals caring for someone with severe mental illness to receive the support that they need to continue to care

   and in addition:

- supporting local prison staff in preventing suicides among prisoners
- ensuring that staff are competent to assess the risk of suicide among individuals at greatest risk
- developing local systems for suicide audit to learn lessons and take any necessary action.

Valuing People: A New Strategy for Learning Disability in the 21st Century

This White Paper states clearly that the National Service Framework (NSF) for Mental Health applies as much to people with learning disabilities as to other patients, that people with learning disabilities should benefit from the initiative, and that:

1. People with learning disabilities should be enabled to access general psychiatric services wherever possible. This will require mainstream mental health services to become more responsive and specialist learning disability services to provide facilitation and support.
2. The NSF for Mental Health applies to all adults of working age. A person with a learning disability who has a mental illness should therefore expect to be able to access services and be treated in the same way as anyone else. The NSF for Mental Health seeks to integrate the CPA with care management. This will lead to a seamless service for people with learning disabilities who have mental health needs.

The Government will take steps to ensure that:

1. Mental health promotion materials and information about services are provided in an accessible format for people with learning disabilities, including those from minority ethnic communities.
2. Strategies for improving access to education, housing and employment, which enhance and promote mental well-being, will include people with learning disabilities and mental health problems.
3. Clear local protocols are in place for collaboration between specialist learning disability services and specialist mental health services.
4. For people with learning disabilities and mental health problems, the health action plan will equate with the care plan. Care coordinators should have expertise in both mental health and learning disabilities. There will be close collaboration between psychiatrists in the relevant specialties.
5. Specialist staff from learning disability services will, if necessary, provide support to crisis resolution/home treatment services or other alternatives to in-patient care wherever possible.
6. Each local service has access to an acute assessment and treatment resource for the small number of individuals with significant learning disabilities and comorbid mental health problems who cannot appropriately be admitted to general psychiatric services, even with specialist support.

7. If admission to an assessment and treatment facility is unavoidable, specialist staff will help the patient understand and cooperate with treatment.

Tertiary specialist health services are for the small number of people with complex health needs that cannot be met locally. Development of services for this group is a priority for the use of the capital element of the Learning Disability Development Fund. Sufficient, good-quality, multi-disciplinary specialist services are key to the new policy and there is an expectation that the specialists would refocus their roles to help people access mainstream services.

The specialist services will offer short-term in-patient assessment and treatment facilities and some outreach provision to facilitate rehabilitation. The funding arrangement for all services for people with learning disabilities will remain with local commissioning arrangements. However, the Regional Specialised Commissioning Group (RSCG) will have the responsibility for the strategic planning of these services. Local partnership boards will be the key planning groups but the plans will need to be approved by the RSCG. The client group would include:

1. people with learning disabilities and severe challenging needs who present a major risk to themselves and/or to others
2. people with learning disabilities and severe mental health problems who cannot be addressed by general psychiatric services
3. people with learning disabilities and autistic spectrum disorders with severe challenging and/or mental health needs.

The guidelines *Treatment Choice in Psychological Therapies and Counselling* (Department of Health, 2001*b*) state that it should not be assumed that people with a learning disability fail to benefit from such treatments.

Policy in Scotland

Policy documents influencing services for people with learning disabilities include the *Mental Health Services Framework* (Scottish Office Social Work Services Group, 1998), *Modernising Community Care* (Scottish Office, 1998) and *Our National Health – A Plan for Activity, A Path for Change* (Scottish Executive Health Department, 2000*a*). However, the main document with influence on services for people with learning disabilities in Scotland has been *The Same as You? A Review of Services for People with Learning Disabilities* (Scottish Executive Health Department, 2000*b*). This document was written with both user and carer input, and reflects Government policies of social inclusion, equality and fairness, and opportunities for people to improve through continuous learning. It enshrines seven key principles, which include people with learning disabilities being valued in the same way and having the same rights as everyone else, and being able to use local services like everyone else wherever possible. It does, however, recognise the need for these people to 'have special services if they need them as well as and not instead of general services'. The main recommendations of the review included health boards

and local authorities drawing up 'partnership in practice agreements' (PIPs), appointing local area coordinators and closing all long-stay hospitals for people with learning disabilities by the year 2005. The document repeatedly emphasises rights to primary health care and mainstream services, an example being the right of older people with learning disabilities and dementia to access mainstream services for older people.

Regarding mental health needs, the policy document *The Same as You?* again emphasises the need to access mainstream services, and to offer appropriate support and training for this to happen. However, there is also recognition that additional specialist support needs to be provided for groups with severe mental problems, severe challenging behaviour and forensic problems. There is recognition that there will need to be a small number of in-patient facilities for people with learning disability and specialist health care needs. There is a recommendation that health boards should provide 4 beds per 100 000 population for assessment and treatment for people with learning disabilities. There is also recognition in the document of the need to provide beds for people on statutory orders under the Mental Health Act 1983.

The provision for mental health care for people with mild learning disabilities and psychiatric disorder varies across the country. Some parts of Scotland have specialist in-patient learning disability units, and most plan to have these. In some areas of Scotland, people with 'dual diagnosis' access beds in mainstream general adult psychiatry units, but usually these are beds where RMO responsibility is taken by a consultant who has a joint appointment in general psychiatry and learning disability psychiatry. Community working in learning disability teams is the norm throughout Scotland. Some are joint teams with social work and some are health teams only, but with the publication of *The Same as You?* it seems likely that everyone will move to joint teams. Although the Scottish Executive document supports the idea of people with learning disabilities accessing mainstream services, presumably including mainstream general adult psychiatry services, there is little support for this from general adult psychiatrists who do not feel they have either the skills or the space necessary to take on the additional workload. In some parts of the country, however, where learning disability psychiatrists are scarce, general adult psychiatrists do provide a service for dual diagnosis patients. However, many find it particularly difficult to help in dealing with learning disability patients who present with challenging behaviour rather than psychiatric disorder.

Policy in Wales

A learning disability advisory group produced a mental health strategy document and a report for the National Assembly for Wales entitled *Fulfilling the Promises: Proposals for a Framework for Services for People with Learning Disability* (Learning Disability Advisory Group, 2001). This document proposes that, as a service principle, people with learning disability of all ages have:

- a right to similar good health as other people, to have their general health needs met by primary health care services, and equity of access to secondary and specialised health provision as appropriate
- a right to expect treatment from health care workers who have received adequate training in the recognition and provision of appropriate care
- a right to skilled specialist help to diagnose and, if required, manage and provide appropriate support for particular conditions such as autistic spectrum disorders.

It further states that people with learning disability and mental health needs should be able to access local mental health services. It proposes that acute mental health services should provide the same level and quality of services for all, regardless of whether they have a learning disability, via:

- additional training for nurses and medical staff, to provide support for clients when admitted
- collaborative working between community learning disability teams and mental health colleagues with advice and support if and when admission is needed, but no decommissioning of existing specialist services before adequate and appropriate mental health services have been established
- particular provision for those with complex or challenging needs, and sub-regional intensive rehabilitation services.

The strategy document *Equity, Empowerment, Effectiveness, Efficiency* (National Assembly for Wales, 2000), laying down the strategy for mental health services in Wales, states that these services should be available to all and allocated according to individual needs, irrespective of place of residence, ethnic origin, gender, culture, religion, sexuality or 'any physical disability'. The only mention of people with learning disabilities is:

> 'A small but significant number of individuals suffer both from a learning disability and a mental illness. Optimum care for people in this position requires effective liaison with specialist learning disability professionals and adult mental health services. For the treatment of the mental health component of their problem they should have the right of access to the appropriate part of the adult mental health service.'

Policy in Northern Ireland

Traditionally, services for people with mild learning disability have been included as part of learning disability hospital and community services. Given the numbers who fall into this intellectual range a very significant number receive services through generic mental health services and a consultation service is provided to general psychiatry colleagues. Cases are transferred to learning disability services if the person's needs cannot be met in generic services. However, staff in learning disability services have little or no training in mental health issues. Service development in Northern Ireland continues to include hospital treatment for people with mild learning disability in specialist hospital services, but a

community-based treatment model and services have yet to be developed for mental health and forensic patients.

Policy in Ireland

There is an expectation that mainstream adult general psychiatry will provide the total service. About a third of people with a mild learning disability and additional needs such as epilepsy, behaviour disorder and physical disorder receive limited services. Some of this group are treated within the learning disability services. In Ireland, there is not historically a tradition of providing for people with a mild intellectual disability within learning disability services, but there is an agreement that their needs are not being met adequately by psychiatrists in general psychiatry or learning disability.

The Irish Division of the Royal College of Psychiatrists set up a committee to consider provision for people with a mild learning disability and a psychiatric disorder. Its recommendations (unpublished document 'Proposed model of service for adult people with a mild learning disability and psychiatric disorder'; available on request from the Irish College of Psychiatrists, 123 St Stephen's Green, Dublin 2, Ireland) include a defined catchment area and specialist services, including appropriate legislation, a specialist mental health team with a specialist consultant psychiatrist, and a range of treatment options including in-patient and respite facilities underpinned by education, training and research.

Summary of needs and policies

1. People with mild learning disability form 98% of the total number of people with learning disabilities.
2. People with learning disabilities have a higher prevalence of psychiatric disorder compared with the general population.
3. The principle of normalisation and Government policy state that wherever possible, people with learning disabilities should use mainstream mental health services.
4. Mainstream mental health services lack the resources, skills and expertise to manage this group of people.
5. Government policies and College documents have existed for the past decade encouraging multi-agency, multi-professional working.
6. There are not many examples of good practice from around the world and the UK. However, the outcome is positive with intensive case management. Collaborative systems of care are also beneficial.

Consultation and consensus

At the 2002 residential meeting of the Faculty of the Psychiatry of Learning Disability, there was consensus that the members would take responsibility for people with a learning disability, as defined in the ICD–10 and the White Paper *Valuing People* (Department of Health, 2001*a*). This would mean people with an IQ of less than 70 with onset before the age of 18 years. The IQ of below 70 could be interpreted flexibly to take into account people who have a wide scatter of abilities but globally fit into learning disability services, e.g. people with high-functioning autism. There is, however, recognition within the Faculty that at present there are not enough learning disability psychiatrists to meet this need. Similarly, there are not enough general adult psychiatrists.

The Royal College of Psychiatrists Working Party, looking at the interface between adult psychiatry and psychiatry of learning disability, supports the view that the IQ cut-off of 70 is a useful primary guide to the most appropriate service. There needs to be some flexibility around two important groups: first, people with early-onset schizophrenia (severe mental illness) and cognitive decline may need to access resources such as day activities, respite care, rehabilitation services and outreach teams. Although the primary responsibility would often remain with learning disability psychiatrists, adult psychiatrists should be open to the patients accessing this service. The second group consists of people with an IQ of 70 or above who globally fit into learning disability services, specifically people with high-functioning autism.

The Working Group recommends that learning disability psychiatrists should be involved in local strategic planning and local consultant peer groups, and that there should be direct liaison between lead clinicians from learning disability and local adult mental health services to coordinate the interface.

References

Bailey, N. M. & Cooper, S.-A. (1997) The provision of specialist health services to people with learning disabilities in England and Wales. *Journal of Intellectual Disability Research*, **41**, 52–59.

Borthwick-Duffy, S. A. (1994) Epidemiology and prevalence of psychopathology in people with mental retardation. *Journal of Consulting and Clinical Psychology*, **62**, 17–27.

Bouras, N. & Holt, G. (2000) Planning and provision of psychiatric services for people with mental retardation. In *The New Oxford Textbook of Psychiatry*, vol. 2 (eds M. G. Gelder, J. J. Lopez-Ibor & N. C. Andreasen), pp. 2007–2012. Oxford: Oxford University Press.

Bouras, N. & Holt, G. (2001) Community mental health services for adults with learning disabilities. In *Textbook of Community Psychiatry* (eds G. Thornicroft & G. Szmukler), pp. 397–407. Oxford: Oxford University Press.

Bouras, N., Holt, G. & Gravestock, S. (1995) Community care for people with learning disabilities: deficits and future plans. *Psychiatric Bulletin*, **19**, 134–137.

Davidson, P., Morris, D. & Cain, N. (1999) Community services for people with dual diagnosis and psychiatric or behaviour disorders. In *Developmental Disabilities and Mental Retardation* (ed. N. Bouras). Cambridge: Cambridge University Press.

Department of Health (1989) *Needs and Responses: Services for Adults with Mental Handicap who are Mentally Ill, who have Behaviour Problems or who Offend.* London: Department of Health.

Department of Health (1995) *Building Bridges: A Guide to Arrangements for Inter-agency Working for the Care and Protection of Severely Mentally Ill People.* London: Department of Health.

Department of Health (1999) *National Service Framework for Mental Health.* London: Stationery Office.

Department of Health (2001*a*) *Valuing People: A New Strategy for Learning Disability for the 21st Century.* London: Stationery Office.

Department of Health (2001*b*) *Treatment Choice in Psychological Therapies and Counselling.* London: Department of Health.

Dorn, T. A. & Prout, H. T. (1993) Service delivery patterns for adults with mild mental retardation at community mental health centres. *Mental Retardation*, **31**, 292–296

Driessen, G., Du Moulin, M., Haveman, M. J., *et al* (1997) Persons with intellectual disability receiving psychiatric treatment. *Journal of Intellectual Disability Research*, **41**, 512–518.

Emerson, E. (1995) *Challenging Behaviour: Analysis and Intervention in People with Learning Difficulties*, pp. 4–10. Cambridge: Cambridge University Press.

Fryers, T. (1997) Impairment, disability and handicap: categories and classifications. In *Seminars in the Psychiatry of Learning Disability* (ed. O. Russell), pp. 16–30. London: Gaskell.

Gravestock, S. & Bouras, N. (1995) Services for adults with learning disabilities and mental health needs. *Psychiatric Bulletin*, **19**, 288–290.

Gravestock, S. & Bouras, N. (1997) Survey of services for adults with learning disabilities. *Psychiatric Bulletin*, **21**, 197–199.

Gustafsson, C. (1997) The prevalence of people with intellectual disability admitted to general hospital psychiatric units: level of handicap, psychiatric diagnoses and care utilisation. *Journal of Intellectual Disability Research*, **41**, 519–526.

Hassiotis, A., Ukomunne, O. C., Byford, S., *et al* (2001) Intellectual functioning and outcome of patients with severe psychotic illness randomised to intensive case management. Report from the UK700 trial. *British Journal of Psychiatry*, **178**, 166–171.

Learning Disability Advisory Group (2001) *Fulfilling the Promises: Proposals for a Framework for Services for People with Learning Disability.* Cardiff: National Assembly for Wales.

Menolascino, F. J. (1970) *Psychiatric Approaches to Mental Retardation.* New York: Basic Books.

National Assembly for Wales (2000) *Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency.* Cardiff: National Assembly for Wales.
Patterson, T., Higgins, M. & Dyck, D. G. (1995) A collaborative approach to reduce hospitalisation of developmentally disabled clients with mental illness. *Psychiatric Services*, **46**, 243–247.
Reiss, S. (1994) *Handbook of Challenging Behaviour: Mental Health Aspects of Mental Retardation*, pp. 4–5. Worthington, OH: IDS Publishing.
Richards, M., Maughan, B., Hardy, R., *et al* (2001) Long-term affective disorder in people with mild learning disability. *British Journal of Psychiatry*, **179**, 523–527.
Royal College of Psychiatrists (1997) *Meeting the Mental Health Needs of People with Learning Disability* (Council Report CR56). London: Royal College of Psychiatrists.
Scottish Executive Health Department (2000*a*) *Our National Health – A Plan for Activity, A Path for Change.* Edinburgh: Stationery Office.
Scottish Executive Health Department (2000*b*) *The Same as You? A Review of Services for People with Learning Disabilities.* Edinburgh: Stationery Office.
Scottish Office (1998) *Modernising Community Care.* London: Stationery Office.
Scottish Office Social Work Services Group (1998) *Mental Health Services Framework. Modernising Community Care and Action Plan.* London: Stationery Office.
World Health Organization (1992) *ICD–10 Classification of Mental and Behavioural Disorders.* Geneva: WHO.