Learning Disability Service Model

Consultation Response Document

Personal details	
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Are you responding on behalf of an organisation?	**Yes**
Organisation **Royal College of Psychiatrists in Northern Ireland**	

Learning Disability Services provide care and support to individuals with unique and often complex support needs. The Learning Disability Service Model aims to enhance service delivery by ensuring that each person receives tailored, person-centred support, designed to enhance independence and maximise quality of life.

1. **Principles underpinning the Learning Disability Service Model - Do you agree with the ambitions underpinning the Learning Disability Service Model?**

Fully agree	Mostly agree	Neither agree or disagree	Mostly disagree	Fully disagree
	✓			

Please add any comments:

1.0 Introduction about RCPsych in NI:

The Royal College of Psychiatrists (RCPsych) is the statutory body responsible for the supervision of the training and accreditation of Psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care, and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those

with mental illness and to improve the mental health of individuals, families and communities.

The College has approximately 450 Members in Northern Ireland (including Doctors in training) who provide the backbone of the local Psychiatric service, offering acute and community treatment, as well as specialist care and consultation across a large range of settings.

2.0 General Comments & Context Setting

This response is reflective of the views of both the Intellectual Disability Faculty and the General Adult Faculty of the Royal College of Psychiatrists in Northern Ireland and is submitted in this context on behalf of the Devolved Council of the Royal College of Psychiatrists in Northern Ireland.

As well as facing many common and shared challenges, our Members in each Faculty face very different pressures and contexts in their Clinical work – and for this reason this response includes the views of each Faculty seriatim.

The detailed views of the Intellectual Disability Faculty are expressed in response to each question within this response template and the views of the General Adult Faculty are expressed in the Addendum at the end.

Where there is any difference of emphasis, it is important that the Department takes a holistic account of the diversity of views within existing service provision and staffing as reflected herein by our Membership.

Both Faculties within the Royal College of Psychiatrists in Northern Ireland would very much like to be involved in the further development/next steps of the service model.

Dated: 25th November 2025

Dr Julie Anderson Chair RCPsych in NI & Vice President RCPsych
- on behalf of RCPsych in NI

3.0 Substantive Response/Specific Comments of Intellectual Disability Psychiatry Faculty:

Some of the principles could be further developed to ensure they will drive meaningful and sustainable change. Many of the concepts/principles have been in common usage and nominally embedded in practice for years but have not led to improved quality of life for people with learning disability. The service model should endeavour to outline how such principles will be realised.

For example, equality of access must lead to equality of outcome. Simply enabling access to services does not always mean that people with learning disability get the same quality

of care: Despite them accessing a service, their needs might remain misunderstood and not fully met. In this sense, “equal is not the same” - and people with learning disability sometimes need a more specialist service to achieve the same outcome. Beyond equal access, we need to ensure **equity** of service provision and people with learning disability should enjoy the same quality of life and level of health and wellbeing as their peers.

The term “person-centred approach” in its fullest form is not dissimilar to “empowerment, choice and control”. These concepts are far from the lived experience of people with a learning disability. Practice remains out of date and misguided in respect of exercising capacity, ascertaining the wishes and assessing the needs of people with severe learning disabilities and co-production involving people with severe learning disabilities. This needs to be addressed across all aspects of the service model if we are to achieve meaningful change.

“Proportionality in managing risk” and “least restrictive approaches” are principles demanded by human rights legislation and make most sense when considered in the context of human rights. The Intellectual Disability Faculty respectfully suggest that a human rights foundation should be a principle of care. Our approach to the concept of risk should focus on promoting human rights, **comprehensively meeting a person’s needs** and achieving positive ‘real-life’ outcomes rather than the elimination of risk. A narrow focus on risk limits ambition.

Service delivery should also be based on a principle of high quality and **evidence-based** care, otherwise the service delivered will be ineffectual and unsafe. Services should be carefully evaluated and be able to demonstrate outcomes. To achieve this, our services need to be **data- and research-informed.**

2. **Current Services: What aspects of our current Services are working well?**

There are pockets of good practice across health, social care and the voluntary sector. Often these are driven by committed, innovative individuals and teams who have been informed by models of best practice. However, there is a high level of inconsistency across time and geography - and services are not sustainable. This needs to be addressed through clearer regional policy and direction, more effective commissioning, better workforce planning/renumeration, support for innovation and *sustainable* change, better use of data etc.

3. **Current Services: What aspects of our current Services are not working well or could be improved?**

- Access to specialist, multidisciplinary therapeutic teams who can assess and treat mental illness and/or behaviours of concern associated with high levels of distress/risk
- Timely access to appropriate inpatient mental health care and timely discharge when treatment is complete, with prevention of delayed discharges
- Better health outcomes and better data about health outcomes e.g. access to screening, identification and treatment of common conditions. The Intellectual Disability Faculty fully endorses and commends the concept of **learning disability physicians**
- Opportunities for employment - and social and recreational activity

- Wide range of housing options that are suited to people's needs across the lifespan including adaptation of people's family homes, supported living and residential care
- Co-production with people with learning disability, especially those with more severe learning disability
- Prevention of caregiver stress and burnout
- Elimination of over reliance on restrictive practices to contain/maintain situations that do not represent the best interests of the individual

4. **The Learning Disability Service Model outlines 6 Key Ambitions to improve services. Please rank order these Ambitions in order of priority (1 = most important; 6 = least important) and provide any comment(s) in relation to the Ambition** Please see response below the table.

Key Ambition	Priority ranking (1 - 6)	Comments
Life Changes		
Health and Wellbeing		
Carers and Families		
Meaningful Lives and Citizenship		
Home		
Mental Ill Health and Behaviours of concern or distress		

Additional Outcomes – Are there additional outcomes which you feel should be included as a Key Ambition? Please outline details

The Intellectual Disability Faculty considers the concept of ranking fundamental human rights and needs inappropriate – every individual might rank these differently, but all are essential for a basic quality of life that we should all enjoy. The hierarchy of needs is the same for people with learning disability as it is for all people and, in that sense, people are unlikely to thrive if they do not have a home where they are safe. A sense of security, autonomy/mastery in their own environment and stability/permanence is fundamental to the concept of 'home' and, without this, we cannot thrive. Too many people with a learning disability do not have a home in this sense. They are living in hospital or in residential facilities/family homes where those looking after them feel overwhelmed by the demands of looking after them (sometimes frightened), with people they do not have a close relationship with, where the environment does not meet their needs or where their situation is temporary. This is a fundamental failing.

Good health is also considered fundamental to meeting your potential and enjoying your life. The marked health inequalities experienced by people with learning disabilities needs

to be more comprehensively addressed by this service model so that it reaches the entire population of people with learning disabilities and not just those who come to the attention of health and social care.

We are aware of the challenges that people with learning disability +/- autism face, especially at times of transition and illness. They have a right to access services that they need and there should be an onus on the service to tailor what it offers to accommodate individual needs rather than the individual having to be the one that adapts. Support is essential when planning for transitions.

The Intellectual Disability Faculty notes that the first five ambitions are framed positively, whilst the sixth reads as if "mental ill health and behaviours of concern or distress" is an ambition. This should be framed positively, recognising that people with learning disability are much more likely to experience mental ill health or distress than their peers - and this should be tackled at all levels from prevention through to highly specialist and tertiary services.

5. **Service Delivery Plan – The Service Delivery Plan outlines a number of strategic actions designed to improve the delivery of services for adults with learning disabilities. What actions or innovative approaches do you believe should be made to make services better?**

Implementation would be improved by:

- **An understanding of what needs to happen in the immediate future to stabilise services and ensure they are safe**
- A plan for realistic and sustainable change
- A programme of **research and development** that helps solve some of the enduring inequalities experienced by people with learning disability e.g. higher use of restrictive practices, earlier death
- Outcomes which avoid "hitting the target and missing the point" e.g. (a) movement from day care to community-based programmes is only positive if the community programme leads to an improved quality of life e.g. employment, success/achievement, improved social networks (b) being offered a health check is meaningless if this is a 'tick box exercise'.
- **Wider and deeper data capture will be helpful**
- **Clinical leadership and governance** must be resourced, embedded and valued
- Addressing the workforce crisis

Northern Ireland should have an equivalent process to the "LeDeR: Learning from Lives and Deaths Review Programme". This is a review process aimed at understanding why people with a learning disability and autistic people die younger than the general population with a view to use this knowledge to improve services and reduce health inequalities.

Development and delivery of comprehensive CAMHS-Learning Disability services across Northern Ireland will improve outcomes for young adults with learning disability

6. **Do you have any additional suggestions or recommendations to help strengthen the Learning Disability Service Model and Delivery Plan? We welcome your ideas on how we can improve services and better meet the needs of adults with learning disabilities.**

The Intellectual Disability Faculty wholeheartedly welcomes the focus on mental health and emotional wellbeing - and particularly the Stepped Care Model. Provision at each step needs to be more fully defined *e.g.* team size and skill mix, care pathways. Positive Behaviour Support should inform care at all steps rather than being the domain of certain professionals/teams/steps.

People should receive treatment in the community when possible and in hospital when necessary.

People with learning disability need access to specialist, multidisciplinary therapeutic teams at step 3+. These teams need to provide comprehensive assessment and range of evidence-based interventions when people present with more significant mental health problems or significant/sustained behaviours of concern. There should be greater co-location with adult mental health services, in the same way that CAMHS-LD teams are integrated within CAMHS i.e. specialist 'mental health of learning disability teams' operating alongside adult mental health services, with the possibility for joint working when appropriate. The Intellectual Disability Faculty agrees with shared governance arrangements and joint leadership. Some people with the mildest forms of learning disability should be able to access mainstream mental health services with reasonable adjustments in place - and at other times joint working will be appropriate. Collaborative approaches to care should be informed by broader assessed need rather than I.Q. in isolation. Effective collaboration will depend on reasonable adjustments, increased resources, clear pathways and enhanced expertise.

Specialist mental health or learning disability teams should be able to provide:

- Clear & accessible care pathways
- Comprehensive assessment & diagnostic formulation
- Access to all NICE recommended evidence-based interventions
- Multi-component therapeutic plans (PBS, psychological & pharmacological)
- Risk management
- Stepped approach
- Clinical leadership and governance

Step 4 services should meet the needs of people with significant mental health problems or significant/sustained behaviours of concern and additional needs relating to:

- Need for crisis support and/or home treatment
- Forensic care
- Older age/dementia
- Complex/rare genetic or neurological disorders including epilepsy and tic disorders
- Management of neurodevelopmental disorders e.g. ADHD

Access to mainstream services should be possible if that is the best fit for the patient e.g. substance use or perinatal care. We need clear pathways to establish what needs to be done by clinicians working in specialist teams - and when those teams would be most effective by providing in-reach or consultation to mainstream services.

Services should be specialist but not segregated.

A focus on crisis prevention should not be to the detriment of earlier assessment and intervention to prevent people reaching crisis. Crisis teams must be competent to prevent admission to hospital *i.e.* multidisciplinary, able to manage high levels of risk, able to co-ordinate multiagency responses.

With regards to inpatient care, there needs to significant improved provision of specialist learning disability inpatient care across the region. If there is an intention to co-locate these with mainstream adult mental health wards, these will require substantial changes to

- the design and environment of buildings (including bed numbers)
- the therapeutic milieu on the wards
- the number and skill set of staff
- the range of treatments available.

The situation that has unfolded in recent years, where people with learning disability have been admitted to existing mainstream facilities, has placed patients and professionals at risk. When people with Learning Disability experience treatment in inappropriate environments by staff who do not fully understand their needs nor have the necessary skills, it could lead to an overuse of medication, excessive levels of restrictive practice and poor treatment outcomes. This impacts the patients, their carers/supporters and the staff team. There is also a potential negative impact on other patients in the units.

Inpatient services also need to accommodate people with learning disability and mental illness and additional forensic or rehabilitation care *i.e.* secure care or longer stays. This should be for a very small number of patients with highly complex mental health needs. Hospitals cannot become default long term accommodation options for people with autism and severe learning disability/challenging behaviour due to lack of suitable community support and treatment. Specific strategies to prevent delayed discharges or effective 'long term segregation' need to be prioritised as these situations are legally and ethically challenging and lead to very poor outcomes for people. In addition, there is a need for highly specialist community provision for people whose needs mirror those who have ended up living in hospital in the past.

People attending specialist learning disability services because of mental health problems or behaviours of concern often have a multitude of unmet physical health needs, with conditions being under-recognised and under-treated. This frustrates efforts to improve their mental health, as well as leading to poor outcomes including preventable deaths. There is a need for better prevention and primary care as well as better secondary/specialist care as an outpatient or in hospital. All trusts should have a dedicated learning disability physician who can work collaboratively with GPs, psychiatrists and other secondary/tertiary care doctors.

It is important to note that whilst the Intellectual Disability Faculty endorses the principles and ambitions of this document and wants to work together to improve the experience of services and outcomes for people with a learning disability, the Intellectual Disability Faculty is concerned about the gulf between the current reality on the ground and the ambitions set out in this document. Those concerns include:

- the rapidly escalating workforce crisis with vacancies in consultant psychiatrist and SAS psychiatrist posts being significantly higher than anywhere else in the UK
- significantly higher than recommended bed occupancy in adult mental health units and substantial retraction of adult learning disability beds, with lack of a plan to improve access to specialist inpatient care for people with a learning disability
- challenges with implementation of mental capacity legislation

The reality of this situation will need to be addressed if the ambitions of the service model are to be realised. There is a need for specialist learning disability psychiatrists to work across inpatient services, community-based assessment and treatment services, including newer models of home/intensive treatment - be integral to PBS services - and provide expertise in areas such as forensic and dementia services. NICE guidance is clear about the need to "Refer people with Learning Disabilities who have a suspected serious mental

illness or suspected dementia to a psychiatrist with expertise in assessing and treating mental health problems in people with Learning Disabilities". The Intellectual Disability Faculty is clear that work in multidisciplinary teams is desired.

Patients should expect to be treated by doctors with relevant training and expertise, who are adequately supported by a multidisciplinary team and working with safe case load levels etc. The current situation across services compromises this and needs to be addressed so that services can be considered safe in the first instance; the delivery plan then needs to set out how incremental reform and modernisation of services will allow realistic progress towards the ambitions of the model.

The Intellectual Disability Faculty draws attention to the Mental Health Strategy for Northern Ireland. It sought a renewed focus to ensure that mental health promotion meets the needs of those who would benefit from early intervention. This can include targeted approaches to groups more likely to be adversely affected by mental ill health, such as people with a physical or sensory disability and persons with a learning disability. As an outcome of promoting mental health, "increased access to specialist mental health provisions, including for those with underlying disabilities" is listed as an outcome. The model should address the need for significantly improved mental health prevention and early intervention for people with learning disability - and this should start before they reach adulthood.

The Intellectual Disability Faculty also commends a range of best practice documents such as:

- Various Royal College of Psychiatry Reports (CR226 Mental health services for adults with mild intellectual disability, CR230 Attention deficit hyperactivity disorder (ADHD) in adults with intellectual disability, CR203 Management of epilepsy in adults with intellectual disability)
- 'Challenging behaviour: a unified approach' which is being re-drafted in 2025
- NICE guidelines – already referenced in the service model (NG11 Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NG54 Mental health problems in people with learning disabilities: prevention, assessment and management, NG96 Care and support of people growing older with learning disabilities)
- QNLD standards
- STOMP and STAMP
- Learning Disability Professional Senate, "Delivering Effective Specialist Community Learning Disabilities Health Teams / Services for Adults with Learning Disabilities and their Families and Carers"

We are happy to provide copies of the College documents upon request.

ADDENDUM

4.0 Substantive Response/Specific Comments of General Adult Psychiatry Faculty:

The General Adult Faculty have significant concerns with regard to the vision for Key Ambition 6- Mental Ill Health and Behaviours or concern.

While the General Adult Faculty agrees in principle with the Key Ambition statement 6 that people with learning disabilities will achieve better mental health outcomes through integrated community and specialist hospital services that meet their needs, the vision for achieving this has not been well described. Furthermore, the practicalities and requirements for achieving this are not adequately outlined in the Strategic Development Plan (S.D.P.).

The General Adult Faculty very much does want to find a joint way forward to improve the services and experiences of people with a learning disability.

However, the background with regard to General Adult psychiatric services needs to be recognised and understood as a first step. This document does not address any of this. There is a serious workforce crisis for consultant and SAS psychiatrists in all specialties in Northern Ireland. Both Learning Disability and General Adult psychiatry posts have significant vacancy rates. Other mental health professional staff face similar issues. This has resulted in major limitations in what General Adult mental health services can provide both in the community and in hospital. The inpatient bed capacity rate is over 100% (RCPsych recommended level is 85%) and it makes it very difficult to admit patients in the current climate and many have extended stays in Emergency Departments. There is currently no sustained and funded plan to reverse this very fractured situation.

The document describes the aims of co-location between adult and learning disability services at a very high level with little reference to the deeper professional practicalities and no reference to the current workforce and service provision crisis. The document maintains a theoretical approach to developing this aspect of the learning disability service model, which is not squared with the reality on the ground.

Section 2.6.2 To meet Outcomes - What success looks like; This needs staff and resources, especially if the plan is to ensure that people with a mild learning disability and mental disorder are to be treated by General Adult mental health services. It will also require intense planning which needs to look at all professions involved and their professional competencies.

There are no detailed figures on current activity.

The outcomes as identified in the **Section 6 S.D.P**. are laudable but a base to start from is seriously lacking and they are over ambitious. They need to be reviewed in order to identify what is possible to be introduced.

In **Section 6.3 of the S.D.P.**, the three years of indicators seem not to reflect our current workforce and service provision crisis. They are too ambitious. There is a need to start with basics - and more importantly not raise hopes - or worse still, lead to a fragmented introduction with patients falling between the cracks in services.

Section 6.9 of the S.D.P. seems to suggest that patients with moderate and severe learning disability may be considered for both community and inpatient general adult services. This would need to be clarified that this is not the purpose.

In **Section 2.6.3 Key actions for Trusts and SPPG** - the first paragraph ignores the reality of what is currently happening in services and what would need to be done in order to achieve this.

Other comments from General Adult Faculty members:

- Currently patients with all ranges of learning disabilities are being treated in inpatient General Adult acute wards. Many admissions do not go to plan and patients do not receive the expertise that they need.
- Many General Adult psychiatrists do not have training in learning disability. They would not be able to act as Responsible Medical Officer.
- The RCPsych document CR226 states that patients with a mild learning disability could be treated in General Adult psychiatry wards, but that a Learning Disability psychiatrist should act as the responsible clinician.
- Mental illness presents differently in those with learning disability in comparison to the general population. That is why there is separate training and CCTs for psychiatrists who specialise in treating people with a learning disability.
- Patients with a learning disability need the expertise of many professional groups, but they need to be experienced in learning disability mental health.
- Each Trust needs their own inpatient learning disability beds to ensure their patients receive the expert treatment that they deserve.
- The Muckamore Abbey Hospital Inquiry makes clear that people with a learning disability are the most marginalised in society.
- There is no definition for mild learning disability.
- It is not stated what services people with a mild learning disability currently receive.
- There will be a significant impact on General mental health services if there are no new resources, planning or workforce initiatives.
- Expecting a psychiatrist trained in General Adult work and not trained in Learning Disability to work with a learning disability patient, potentially places both the psychiatrist at a professional risk and the patient at risk of not getting the treatment that their needs merit. This applies to other professional groups also.

Please send your completed questionnaires to us by post or email.

Post them to us at Learning Disability and Autism Unit, Department of Health, Room D2, Castle Buildings, Stormont, Belfast BT4 3SQ or email to: ldsm@health-ni.gov.uk

You must send us your answers by 5pm, 25 November 2025.