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Psychiatry of learning disability – a future with mental health?†

AIMS AND METHOD

A postal survey was sent to all consultants in the psychiatry of learning disability from four English regions. Their views on job satisfaction, their core roles and the management re-structuring of services were elicited.

RESULTS

The proportion agreeing or strongly agreeing with each management option was 79% for integrated mental health–learning disability trusts, 61% for specialist learning disability trusts, 47% for care trusts, 10% for primary care trusts and 5% for social services. Only 34% felt consulted or able to influence the process of change and only 33% were satisfied with the current management changes within their trust but 67% were satisfied overall with their jobs.

CLINICAL IMPLICATIONS

Management from integrated mental health–learning disability trusts is the most preferred option for psychiatrists in learning disability. A large number of consultants, though otherwise satisfied with their jobs, feel excluded or unable to influence the current changes in management structures. A model of integrated service provision in line with the government's learning disability strategy is presented.

Traditionally, the care of those with learning disability and complex problems was based in hospitals and led by psychiatrists. The closure of these institutions and the move towards community care was accompanied by the creation of community learning disability teams (Aspray *et al*, 1999). These multi-disciplinary teams worked across the whole spectrum of learning disability and provided services for both physical and mental health problems (O'Hara, 2000). In this set up, the core rule of psychiatrists in learning disability was to provide a specialist service for those with dual diagnosis (learning disability and mental health problems). Up to 50% of those with learning disability may have significant mental health problems (Department of Health, 1998) and a large proportion contact specialist psychiatric services at some point in their life.

With the dawning of primary care trusts, single speciality mental health trusts and joint commissioning between health and social services, the debate over where learning disability services are best placed and their interface with mental health services has re-emerged (O'Hara, 2000). Different health districts have adopted different models, with the majority opting for merger with either specialist mental health services or primary care trusts. Other models, including that of management from either social services or care trusts (Department of Health, 2000), are slowly emerging. Very few NHS trusts in the UK remain as stand-alone specialist learning disability trusts.

There are currently 174 consultants in the psychiatry of learning disability in England. Although there is anecdotal evidence (O'Hara, 2000; O'Dwyer, 2000) that they are concerned about current changes, there has been no systematic attempt to elicit their views. This survey aimed to explore the views of consultants on the different management structures for psychiatric services in learning disability and their ideas on the core services that should be provided by them.

The study

A list of all consultants in learning disability from four regions in England (London, Trent, south-west England and the West Midlands) was obtained from the Royal College of Psychiatrists. A questionnaire was designed for the study, with wide consultation. This was piloted on a consultant sample of 10 and modified based on the feedback. The first part of the questionnaire covered personal details such as age, gender, experience and population covered. In the second part respondents were asked to rate each of the five possible management structures and 10 core roles for consultant psychiatrists in learning disability on a four-point Likert scale, from 'strongly agree' to 'strongly disagree'. Overall satisfaction with their job, satisfaction with the current direction of management changes and their sense of being consulted in that process were also rated on a similar four-point Likert scale.

The questionnaire was sent to all 95 consultants from the four regions mentioned above.

Findings

A total of 67 consultants responded, giving a response rate of 71%: 39 (58%) were male and 28 (42%) were female. The mean age of the sample was 46 years and the mean experience was 9 years. Excluding those who were part of national or regional services and those providing services exclusively for children or adolescents, the population covered by each consultant varied from 100 000 to 580 000 (mean=227 730).

A total of 45 (67%) consultants were satisfied or very satisfied with their jobs. In contrast to the figures for overall satisfaction, only 22 (33%) were satisfied or very satisfied with the current changes in management structures within their trust. Only 23 (34%) agreed or

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Table 1. Management structure proposed

Management structure suggested	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly disagree (%)
Integrated mental health–learning disability trust	24 (38)	26 (41)	10 (16)	4 (6)
Specialist learning disability trust	10 (16)	29 (45)	18 (28)	7 (11)
Care trust	4 (6)	26 (41)	20 (32)	13 (21)
Primary care trust	1 (2)	5 (8)	29 (45)	29 (45)
Social services	2 (3)	1 (2)	16 (24)	48 (72)

Table 2. Core roles

	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly disagree (%)
Assessment and treatment of mental illness	65 (97)	2 (3)	0 (0)	0 (0)
Assessment and treatment of behavioural problems	33 (49)	29 (43)	4 (6)	1 (2)
Assessment and treatment of epilepsy	28 (42)	30 (45)	7 (10)	2 (3)
Provision of in-patient services	44 (67)	20 (30)	1 (2)	1 (2)
Providing services for offenders with learning disability	30 (46)	32 (49)	2 (3)	2 (3)
Services for autistic spectrum disorder with IQ >70	6 (10)	27 (44)	23 (37)	6 (10)
Services for autistic spectrum disorder with IQ <70	50 (77)	14 (22)	0 (0)	1 (2)
Consultancy service for borderline learning disability	22 (33)	37 (55)	5 (8)	3 (5)
Services for cognitive impairment secondary to head injury	2 (3)	15 (23)	30 (47)	17 (27)
Joint on-call with general psychiatry	8 (13)	16 (25)	20 (32)	19 (30)

strongly agreed that they were consulted and were able to influence that process of change.

The responses to preferred management structures are summarised in Table 1: 79% of respondents either agreed or strongly agreed with the suggestion that the psychiatry of learning disability services should be managed by integrated mental health–learning disability trusts, and at the other end of the scale only 5% agreed or strongly agreed with management from social services.

Table 2 summarises respondents' views about the core roles and services that should be provided by consultants in the psychiatry of learning disability.

Discussion

This is the first survey of consultant opinion on management changes in the psychiatry of learning disability. The sample covered over 50% of NHS consultants in England. The response rate of 71% is high and indicates the level of interest that consultants have about this subject.

Often, the main debate about the future of learning disability services has focused on whether they should be managed by primary care trusts or specialist mental health trusts. As far as psychiatrists in learning disability are concerned, some have argued persuasively that a modern, comprehensive mental health service for people with learning disability and mental illness must keep its roots within mainstream mental health services (Hassiotis *et al*, 2000). Under this model, specialist mental health services for people with dual diagnosis would be within a mental health trust, whereas the rest of the team dealing with issues other than mental health problems would be within a primary care trust. However, one could argue that this model results in an unacceptable fragmentation of learning disability services, a fragmentation that could adversely affect service provision. Many practising psychiatrists in learning disability are worried that in a larger mental health trust the needs of those with learning disability would be marginalised in comparison with the high-profile demands of severe mental illness or personality disorders. This concern was heightened when the much heralded National Service Framework for Mental Health made no mention at all about the mental health needs of those with learning disability (Department of Health, 1999).

Despite these worries, the findings of this survey indicate that management from integrated mental health–learning disability trusts seems to be the most preferred option for psychiatrists in learning disability. One could speculate that this is because the model allows them to maintain their core identity as psychiatrists. Concern that their day-to-day functioning and the effective treatment of patients will be jeopardised by organisations that do not understand the nuances of mental health care in learning disability is probably making management from social services the least preferred option. Perhaps for the same reason, the preference for primary care trusts is almost on par with that for social services. With its joint health and social services management structure, the Government's preferred option for the future – care trusts – addresses this anxiety, albeit to a limited extent. This might explain the cautious welcome that it has received in this survey. The option of specialist learning disability trusts, which would keep all professionals in learning disability within the same organisation, thus avoiding any fragmentation, is also a popular choice. However, the financial viability of such organisations in the current

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climate of trying to drive down costs throughout trust mergers is debatable.

The survey reveals that the consultant workforce, by and large, remains satisfied or very satisfied with the job overall. However, on the issue of management changes, a large majority feel that they were either not consulted at all or were unable to influence that process. A similar proportion feel dissatisfied with those changes. This may not be entirely owing to local factors. The past two decades have seen enormous changes in the structure and organisation of services in learning disability and many of these have been driven centrally by the agenda of the government of the day. The current changes may well be perceived as a continuation of that process and it is not surprising if clinicians feel that these changes are pre-determined and will go ahead regardless of what they think.

Resource limitations mean that the criteria for accessing specialist psychiatric services in learning disability and the core roles of these specialists should be tightly defined. The survey confirms that the traditional roles of the specialist in this area, which included the assessment and treatment of mental illness, behavioural problems, epilepsy and autistic spectrum disorders, are seen as being of paramount importance. A very high proportion see the provision of services for offenders with learning disability and a consultancy service for those with borderline intellectual functioning as part of their core roles. The issue of who is best placed to provide services for those with an autistic spectrum disorder, in the absence of a learning disability, has been the subject of some interest. Over 50% of consultants in learning disability either agree or strongly agree with a view that providing services for this group is a core role of theirs.

The recently published national strategy on learning disability (Department of Health, 2001) emphasised the need to provide a seamless service with greater participation from all agencies. For people with learning disability and mental illness, this will mean greater access to general psychiatry services and, by implication, inclusion in the National Service Framework for Mental Health.

A preferred model would be for those with mild learning disability and mental health problems to access general psychiatric services with support from consultants and other professions allied to medicine in learning disability. At the same time application of National Service Framework principles to this dually diagnosed patient group will allow them to access support from assertive outreach, crisis resolution and first-episode psychosis teams in the same way as the general population. The importance of an appropriate skills mix in the composition of those professional teams cannot be overemphasised. Evolving clinical experience, supplemented by suitable training, will lead to better integration of the two services in the long run. Examples of this sort of collaborative arrangement already exist, particularly in the case of in-patient services in the psychiatry of learning disability (Alexander *et al*, 2001). Learning disability psychiatrists, besides providing support and consultancy for general adult psychiatry colleagues, will continue to provide secondary and tertiary mental health care for those with moderate to profound learning disability and also for those unable to access general psychiatric services for any other reasons. This approach will be in line with the national strategy on learning disability.

However, one must acknowledge the implications of such a move for general adult psychiatrists, many of whom are already overstretched in terms of their clinical commitments. Integrated service planning, clear definition of the roles of different professionals, protocols to ensure coordination of the two services and appropriate allocation of resources could help to address this issue. It is a time of extensive reorganisation in the management structure and functions of specialist services within mental health and learning disability. Perhaps uniquely in recent history, this desire of the policy-makers to restructure things is matched by a willingness to put extra resources into the system. This makes it even more important that we should get this process right, not just for the future of specialist learning disability and general mental health services, but also in the best interests of the patients we serve.

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Declaration of interest

None.

References

ALEXANDER, R. T., PIACHAUD, J. & SINGH, I. (2001) Two districts, two models: in-patient care in the psychiatry of learning disability. *British Journal of Developmental Disabilities*, **47**, 105–110.

ASPRAY, T. J., FRANCIS, R. M., TYRER, S. P., *et al* (1999) Patients with learning disability in the community. *BMJ*, **381**, 476–477.

DEPARTMENT OF HEALTH (1998) *Signposts for Success in Commissioning and Providing Health Services for People with Learning Disabilities*. London: HMSO.

— (1999) *Modern Standards and Service Models. Mental Health National Service Framework*. London: HMSO.

— (2000) *NHS Plan: A Plan for Investment, a Plan for Reform*. London: HMSO.

— (2001) *Valuing People, a New Strategy for Learning Disability for the 21st Century – A White Paper*. London: HMSO.

HASSIOTIS, A., BARRON, P. & O'HARA, H. (2000) Mental health services for people with learning disabilities. *BMJ*, **321**, 583–584.

O'DWYER, J. M. (2000) Learning disability psychiatry – the future of services. *Psychiatric Bulletin*, **24**, 247–250.

O'HARA, J. (2000) Learning disability services: primary care or mental health trust? *Psychiatric Bulletin*, **24**, 368–369.

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