the columns

correspondence

Mental health services for people with learning disabilities

Sir: The reconfiguration of mental health and learning disabilities NHS trusts has highlighted once more the lack of clarity for the provision of mental health services for people with learning disabilities. The prevailing view is that the mental health needs of people with learning disabilities should be provided by mental health trusts through specialist services (Hassiotis *et al*, 2000).

Psychiatrists for people with learning disabilities are not seen to have an extended medical responsibility for other health needs, i.e. primary care, epilepsy etc. (Doody & Neville, 2001). Primary care teams are now the principal providers of primary clinical care to people with learning disabilities (Lindsey, 1998). They act in cooperation with multi-disciplinary and often multi-agency community learning disability teams.

The role of the psychiatrist specialising in the care of people with learning disabilities should not be diluted and confused by these other service requirements. This is compatible with the practice of other psychiatric specialities; for instance child and adolescent mental health teams focus on mental health problems, while child development teams address developmental issues. Similarly, for elderly people there are the specialist multi-disciplinary teams and mental health teams.

The White Paper *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Department of Health, 2001) reiterates that people with learning disabilities should have access to mainstream mental health services and that the National Service Framework for Mental Health applies to people with learning disabilities and mental health problems. Although it proposes clear protocols for collaboration between specialist learning disability services and mental health services, it does not offer any clarification about the organisational and funding implications. It emphasises that alternatives to in-patient treatment should be sought whenever possible for people with learning disabilities and mental health problems. However, each local service should have access to an acute assessment and treatment resource for those who cannot appropriately be admitted to general psychiatric services, even with specialist support.

The consequences are that a distinct mental health service is needed for people with learning disabilities and that the general psychiatric services will have increasing responsibilities for this population in terms of admissions, forensic cases and for people with mild learning disabilities and borderline cognitive impairment.

We are interested to hear the views of our colleagues in general psychiatry on these issues.

We believe that the specialist mental health service for people with learning disabilities is a tertiary psychiatric service, which has a service interface with the developmental aspects of other learning disability services. It should predominately function as part of an overall mental health service including general psychiatry and the other psychiatric specialities. A consensus opinion should emerge as to what are the necessary components and responsibilities of the specialist mental health service for people with learning disabilities.

DEPARTMENT OF HEALTH (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century.* CM5086. London: Stationery Office.

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Assaults and threats on psychiatrists

Sir: Recent papers on psychiatrists' safety raise important issues. Davies reaffirms the view that psychiatrists are vulnerable to violence (*Psychiatric Bulletin*, March 2001, **25**, 89–91). Osborn and Tang demonstrate the ineffectiveness of audit in ensuring that interview rooms are safe (*Psychiatric Bulletin*, March 2001, **25**, 92–94).

While we welcome their emphasis on training and audit, we should be clear that NHS trusts, like all employers, have a duty under the Health and Safety at Work Act 1974 to ensure the health, safety and welfare of their employees (Health & Safety Executive, 1989). Responses should be dynamic but despite the fact that violence is common, monitoring systems are frequently lacking. Osborn and Tang describe mechanisms that may explain the poor response, concluding that clear action plans should be formulated with responsible individuals identified to oversee the process. Without regular review by those responsible, change is unlikely.

Royal College of Psychiatrists training approval visits provide opportunities to influence this process. The College has put junior doctor safety high on the agenda and has produced a clinical practice guideline (Royal College of Psychiatrists, 1998). Trusts take approval visits seriously – not least because of the impact of loss of training status. The response to these visits is often to deal hurriedly with problems, many of which have been unresolved for years. Unfortunately, if Osborn and Tang are correct, this activity will rapidly tail off, only to be reactivated prior to the next visit.

We propose that the Royal College of Psychiatrists should introduce mechanisms that increase the likelihood of safety issues remaining high on trust agendas. The College should develop an audit tool based on the clinical practice guideline. This would form the basis of review at approval visits. Between visits, the tutor could undertake an annual audit, with the results reported to the approval team convenor. Deterioration in performance would trigger an interim visit focusing on safety issues.

By taking a proactive role in assessing not only the quality of teaching, but also the safety of the environment, the College would ensure that trusts discharge their legal responsibilities effectively.

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