opinion
& debate

In these days of antidiscrimination legislation, we need to be certain that we are not further disadvantaging people by saying that their needs are determined by their learning disability. It should not be the label of learning disability that in itself enables us to do things to a person. It is the fact that the person, on assessment, is felt to be unable to give valid consent that enables us to treat him or her as incapable, not the fact that he or she has a learning disability. Identifying a separate team for people with learning disability carries the danger that the team will treat this group in a different way to others. For example, locally a director of social services insisted that the learning disability specialist health services could not be operated by a mental health trust, as 'learning difficulties is not a mental illness'. He did not appear to accept either that people with learning difficulty became mentally ill and when so ill needed a service from a mental health unit, or that the CLDT provided a specialist mental illness service. One of the problems of the current artificial identification of learning disability is that there is an assumption that, for example, the specialist training and skills appropriate to assessing and treating a person with autism and mild learning disability are more similar to those needed for a man with profound Down's syndrome than a person with autism who is of normal intelligence. Similarly a person with hyperactivity at present will receive a service that is determined by his or her IQ, from psychiatrists who have different training. A person with epilepsy and associated psychiatric illness has his or her team determined by his or her IQ. We are in danger that a person's needs are dominated by the fact he or she is labelled as having learning disability, rather than by an individual assessment of his or her needs.

If it is not appropriate to use learning disability as the term that most accurately describes the expertise of psychiatrists who are in the Faculty of Learning Disability Psychiatry, then what is the description that most closely reflects our expertise?

Psychiatrists dealing with people with learning disabilities appear to have three main groups of skills.

The biggest is a neurodevelopmental training, which develops a greater expertise than generic psychiatrists in dealing with epilepsy, other organic conditions and mental illness in the setting of mental immaturity. The second developing expertise is in psychotherapy, but this is arguably best regulated and trained through the faculty of psychotherapy. Similarly, the third group of a forensic service for people with learning disability can be said to have greater links in its training and service needs with the generic forensic service than with the generic CLDT.

The most effective way that the Faculty could help deal with the discrimination given to people with learning disability is to reform as a faculty of neurodevelopmental psychiatry, which does not use IQ as a cut-off in people provided with a service. This faculty might be the appropriate home of neuropsychiatrists and of mental health services for people with asperger syndrome or head injury who are of 'normal intelligence'.

There would be implications of any such change on the Certificate of Completion of Specialist Training. It would also force a clearer analysis of the roles of the CLDT and of the specialist health service. We are inevitably nervous of this as change may lead to a loss of service, but this is currently happening by stealth. Being clearer on the role of the psychiatrist can only help to clarify the supports and skills that people with a variety of disabilities need and how they are to be provided. Changing the title and boundaries of the Faculty could be the first step in this process.

References

DEPARTMENT OF HEALTH (2001) *Valuing People. A New Strategy for Learning Disability for the 21st Century.* A White Paper (Cm 5086). London: Stationery Office.

MENTAL DEFICIENCY REGULATIONS (1935) *Statutory Rules & Orders 1935, No. 524.*

P. K. Carpenter Consultant Psychiatrist, Bath and North East Somerset Primary Care Trust, Community Learning Difficulties Team, Hanham Road, Kingswood, Bristol BS15 8PQ

JOHN LOUDON AND DENISE COIA

The Scottish scene[†]

Health service provision now lies almost completely within the powers of the Scottish Parliament and accounts for 40% of the Executive's budget. There is a Minister and a Deputy Minister for Health. There are six key groups – the Scottish people, the Scottish Parliament, the Scottish Executive, the health service, the local authorities and the press, all with high expectations that things should get better.

Policy initiatives – the framework

Following criticism of the lack of formal policy objectives for mental health by the Scottish Grand Committee in 1995, the then Government committed itself to producing a strategic framework. An external and representative reference group was formed. The *Framework for Mental Health Services in Scotland* (Scottish Office, 1997a) was accepted by the incoming government after the election and was launched in September 1997. It contains a statement of service philosophy, direct guidance on how implementation should be achieved and a tabulated compilation of 22 necessary service elements. It is a template for those at every level in service provision. The central role of users and carers in planning, the necessity for the care provided to relate to individual need, by services jointly commissioned and provided by

84

organisations working in partnership, was emphasised. The Mental Health Development Fund provided £9 million spread over 4 years to facilitate implementation of the Framework. The Scottish Development Centre for Mental Health Services was set up with Government funding for 3 years, to act as a resource for any group implementing the Framework and to provide an independent source of advice about policy and practice.

The Care Programme Approach in Scotland pre-dated the Framework and has been official policy since 1993, but as a much more selective instrument than in England. Even so, its implementation has been patchy and clinicians remain uneasy about effectiveness and the additional workload. Those outside psychiatry wonder why a process designed to produce robust joined-up care arrangements is treated with such suspicion.

To review progress in implementing the Framework, the Minister and the Deputy Minister held a summit in January 2000 of over 30 organisations concerned in the provision of mental health services in Scotland. The Framework was confirmed in its central role, and was again in *Our National Health: A Plan for Action, a Plan for Change* (Scottish Executive, 2000). To support its implementation, a mental health and well being support group, chaired by a psychiatrist, was formed, to report on progress by local partners to the Health Department, and to foster the exchange of information about good practice.

Structures

Mental health is one of three national clinical priorities. The Scottish Health White Paper *Designed to Care* (Scottish Office, 1997*b*) reorganised trusts so that mental health services are brigaded with primary care in primary care trusts (PCT). There are no primary care groups as such, but the majority of general practices are grouped into local health care cooperatives, within the PCT. Scotland has not had a system of mandatory public inquiries about homicides by people with a history of mental health problems, nor does it have a system of coroners courts. A fatal accident inquiry, initiated by a procurator fiscal, is held by a sheriff (a legally qualified judge) and can be just as searching, but is used selectively. Mental health review tribunals have no exact equivalent in Scotland. Currently the legal testing of the appropriateness of detention is carried out by a sheriff. The Mental Welfare Commission for Scotland has a statutory role in the protection of the individual patient, informal or detained from deficiencies of care, and may discharge an individual from a liability to detention. It plays an active role in contributing to the development of mental health policy in Scotland and is well respected by clinicians, users of services and the public.

The Scottish Health Advisory Service continues to function as a directly funded organisation, now with a right of access to the First Minister. The Royal Colleges under the auspices of the Scottish Academy continue to have a key role in influencing service delivery. They have been joined in the mental health field in a partnership of users (Scottish Users Network), voluntary organisations (Scottish and Local Associations for Mental Health) and the Dementia Services Centre, Stirling University. All of these receive some Health Department funding. The Scottish Division of the College held a very successful joint meeting with users and carers, and a cross-party parliamentary interest group has been launched with close College involvement.

Quality

One signal achievement has been the national audit of electroconvulsive therapy services, funded through the Health Department over 4 years. All centres in Scotland participated, and the results would suggest practice is superior to that found elsewhere in the UK.

With the arrival of clinical governance the focus is on clinical effectiveness and the delivery of clinical care to an appropriate standard. To fill the gaps, the Clinical Standards Board for Scotland has been established to develop and review clinical standards that focus on a patient's journey of care through different NHS services for specific disorders. Standards for schizophrenia are now completed, and have been piloted successfully. A bottom up inclusive approach has been used in developing the standards, involving clinicians and users of services. Implementation in 2001 is by means of internal audit and external accreditation.

The Chief Scientists Office funded a project on outcome measurement in adult mental illness, due to be reported on shortly. The Mental Health and Well Being Support Group has produced reports on risk management (Mental Health Reference Group, 2000) and needs assessment (Mental Health Reference Group, 2001). The Clinical Effectiveness Programme for Scotland recently has allocated £200 000 per annum for 3 years to projects in child and adolescent, liaison and acute psychiatry. The Health Technology Board for Scotland has become operational, and will review the evidence on new drugs and technological advances that may be available to the NHS in Scotland to assess efficacy and the health gain they may bring to the population.

The work of these groups is backed by a continuing programme of activity by the Health Services Research Unit based in Aberdeen and the four academic departments. The National Institute for Clinical Excellence and Commission for Health Improvement do not have a remit in Scotland although there is an active cross border dialogue with their counterparts.

Issues

Legal challenges

The legal framework in which we deliver care to those with mental illness is changing radically. Scotland was first in the UK to incorporate the European Convention for Human Rights (ECHR) into legislation. The Millan Committee has reviewed the Mental Health (Scotland) Act 1984, and reported in January 2001 (Scottish

Executive, 2001). Clinicians and service users have been well-represented. In line with the ECHR and a theme of open accountability, it recommends 10 principles against which the operation of a new Act should be judged. The first Act to be passed by the Scottish Parliament was in response to the freeing of an individual from the state hospital, at Carstairs, by a sheriff court. This highlighted ambiguities around the management and treatment of those suffering from personality disorders in Scotland. The MacLean Committee has reported on its review of services for serious violent and sexual offenders (Criminal Justice, 2001).

An Act based on enlightened principles to develop a system of practice for adults with incapacity has recently been passed by the Scottish Parliament, and will be implemented from 2001.

Factors working against positive change

Although mental health services have been a priority for the NHS in Scotland for over 20 years, any change in the allocation by health boards on the proportion of resources devoted to them has been very slow. For child and adolescent services the expenditure per head of population served was found to vary threefold between boards. At health board level there has been a lack of intuitive understanding of mental health issues, no strategic approach to positive mental health and no tradition of collaboration with other service providers, or users of services. There is a poverty of intelligence available to boards on the mental health needs of the populations they serve, and the activities of the mental health services.

Since 1991, the lead role for the development of community care has lain with local authority social work departments. The difficulties besetting joint commissioning and resource transfer are not unique to Scotland. Different planning cycles and financial reporting systems or conflicting priorities compromise joint working. Some areas do better, and all involved need to learn how to learn from good practice, to adapt and apply the lessons locally.

Primary care has a well articulated view of the mental health needs of practice populations. As yet, the rebrigading into PCTs has not had time to develop the necessary meeting of minds between primary and secondary care. There is a need for mental health services to respond positively and flexibly to the development of integrated care plans and pathways.

Progress has been slow in fostering real involvement of users of services and those who care for them. 'Allies in Change', a consortium of voluntary and user groups with support from not-for-profit organisations, has obtained Health Department funding to set up training to assist users in representing themselves effectively in the planning and service monitoring processes and thus impact on the move to a user-led model. Although in operation for little more than a year, this project has found a way to draw in carers and staff as well. It has produced excellent good practice guidance.

Conclusions

This paper is not inclusive of all the changes in mental health services in Scotland but is an attempt to introduce some of the differences to a wider audience. If we wish, as doctors, to remain part of a UK-wide NHS family we must acknowledge and respect our different priorities and aspirations. There has to be space on our Royal Colleges' agendas and systems for matters peculiar to Scotland, Wales and Ireland to be dealt with in a way that is different from England, without a threat being perceived to the overall integrity of the organisation.

References

CRIMINAL JUSTICE (2001) *A Report of the Committee on Serious Violent and Sexual Offenders.* Edinburgh: Scottish Executive.

MENTAL HEALTH REFERENCE GROUP (2000) *Risk Management.* Edinburgh: Scottish Executive.

— (2001) *Needs Assessment for a Comprehensive Local Mental Health Service.* Edinburgh: Scottish Executive.

SCOTTISH OFFICE (1997a) *A Framework for Mental Health Services in Scotland.* Edinburgh: Scottish Office.

— (1997b) *Designed to Care.* Edinburgh: Scottish Office.

SCOTTISH EXECUTIVE (2000) *Our National Health: A Plan for Action, A Plan for Change.* Edinburgh: Scottish Executive.

— (2001) *New Directions. A Report on the Review of the Mental Health (Scotland) Act 1984.* Edinburgh: Scottish Executive.

John Loudon FRCPsych, Consultant Psychiatrist and Principal Medical Officer, Scottish Executive Health Department, St Andrew's House, Regent Road, Edinburgh EH1 3DG **Denise Coia** FRCPsych, Consultant Psychiatrist and Mental Health Advisor, Greater Glasgow Health Board

IAN PULLEN

Commentary: the Scottish scene[†]

Loudon and Coia (pp. 84–86, this issue) have provided an informative snapshot of the Scottish scene that is clear, succinct and objective. They set out the main organisational structures and framework within which we operate north of the border, and touch upon some of the factors working against positive change.

What they have not conveyed is the huge amount of time and energy that is being devoted to redesigning and developing mental health services, despite the impact of structural changes within the care systems, and the daunting size of the change management task.