opinion & debate

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P. K. CARPENTER

Should there be a Faculty of Learning Disability Psychiatry?

Does the completion of the closure of the old 'mental deficiency' hospitals in Great Britain mean that the relevance of learning disability as a major sub-speciality of psychiatry has been lost? In the past 10 or 20 years many non-psychiatrists, including service users, have blamed learning disability specialist psychiatrists for these hospitals and for many of the adverse social effects of being labelled as having a learning difficulty. With the new White Paper, *Valuing People* (Department of Health, 2001), is the role of the Faculty changing?

Britain is very unusual in having psychiatrists as the main medical group who are seen as specialists in the care of people with a learning disability. This has arisen owing to historical reasons. The 1913 Mental Deficiency Act set up colonies for 'mental defectives'. Like workhouses, these were to have a superintendent and a visiting medical officer, but there was no requirement, even by 1935, for the medical officer to be the superintendent or to be anything other than a medical practitioner (Mental Deficiency Regulations, 1935). At the time the visiting medical officers were usually general practitioners rather than psychiatrists, much as with the workhouses earlier. However, the central regulation of the colonies was given to the regulators of the lunatic asylums. Although they could instruct that the superintendent was a medical practitioner, this does not seem to have occurred to any significant extent prior to the NHS. However, there was a trend for superintendents to be medically qualified and the main training to be medical superintendent was in the mental asylums. Thus, although the colonies were operated by local authorities, the central regulation by the Board of Control encouraged the medical managers of the colonies to be trained in mental asylums. This central regulation by the Board of Control and the similarity of the powers of detention in mental deficiency colonies and mental asylums ensured that mental deficiency colonies joined the asylums in being taken from the local authorities to join the NHS. This event and the 1959 Mental Health Act cemented the role of the psychiatrist as the main medical regulator of the in-patients of the renamed mental subnormality hospitals. The role of a psychiatrist in 'mental handicap' was effectively defined by his or her role in the care of in-patients in a (re-named) mental handicap hospital. The need for a person living in a mental handicap hospital to be overseen by a psychiatrist was defined by residency in a hospital rather than by behaviour or mental needs.

Now the large hospitals that housed people with a learning disability have closed, we should ask if the needs of people with a learning disability are best met by a separate sub-speciality of the psychiatry of learning disability. We should also ask if the skills of a learning disability psychiatrist still match the psychiatric needs of only people with a learning disability.

In current times learning disability is not seen in itself as an illness. There is no unique medical characteristic that identifies it. It is a socially defined condition with an artificially determined cut-off of an IQ of 70. In practice it does not operate consistently in the community. Ninety per cent of people who could be identified as having a learning disability are not so identified, because they have a mild learning difficulty and can 'pass' as 'normal'. In England the operational definitions of learning difficulty that are used by education, social services and health all differ. In addition, the services provided by the community learning disability team (CLDT) reflect more the history of providing for a residential community than the specialist needs of people with a learning disability in the community. In the team, only the psychiatrist is trained in managing mental illness in people with a learning disability. A learning disability trained nurse receives minimal training in the features and care of mental illness in people with learning disability. The majority of such nurses now run residential care homes, reflecting their old role in providing for the custody of these with mental deficiencies. A few are now developing their skills in epilepsy, behavioural management and mental illness. The occupational therapist, speech therapist and physiotherapist for people with a learning disability in general use skills that are not exclusive to people with a learning disability. Some social service teams do not have learning disability teams but have disability teams that encompass other disabilities, or simply have generic teams. The integrity of some CLDTs is sometimes further compromised by different professions having different IQ cut-offs for the population that they serve. This only further emphasises the artificiality of the definition of the target population.

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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.

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

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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, 1997*a*) 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

†See pp. 86–87, this issue.

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