

Services for adults with learning disabilities and mental health needs

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A postal questionnaire assessing key professionals' and managers' views about local services achieved an overall 72% response rate. The results demonstrated concerns about the range, quantity and quality of mental health and social care provision for adults with learning disabilities and mental health needs in all 15 districts. Only eight (14%) respondents provided specific local service utilisation data, and confusions about care co-ordination responsibilities were evident. Improving future service provision should involve utilising needs assessments and quality assurance data to better inform multi-agency commissioning and purchasing strategies.

In line with community care policies (Department of Health, 1989), adults with learning disabilities (LD) are being resettled from long-stay hospitals and supported to remain living in the community. Specialist LD services are increasingly expected to liaise with primary care, generic physical and mental health services, local authorities, and private and voluntary agencies to meet the health and social care needs of adults with LD (Department of Health, 1992).

There is growing awareness of the complex health care needs of people with LD arising from epilepsy, sensory impairments and challenging behaviours (Mansell, 1993). However, the mental health needs (MHN) of adults with LD which arise from diagnosed psychiatric disorders are less often addressed beyond specialist psychiatry of LD services. Yet local research confirmed that over 40% of adults with LD referred to specialist LD services have MHN (Bouras & Drummond, 1992).

The study

The South East Thames Regional Health Authority (SETRHA) area comprises 15 London, Kent and Sussex health districts

whose total populations range from 160,000 to 330,000 people with a mean district population of 240,000 people. The SETRHA resettlement programme is almost completed with less than 200 adults remaining in five mental handicap hospital units (SETRHA, 1993). This study aimed to focus attention on service provision for adults (aged 19 to 65 years) with LD and MHN by surveying the views of key clinicians and managers about relevant local mental health and social care services in mid-1993.

A semi-structured questionnaire (Q1) was developed to gather mainly descriptive data and some quantitative service utilisation and planning data. The Q1 was sent to all consultant psychiatrists, senior psychologists, senior nurses and managers in the 15 health authority LD services and to the 16 corresponding local authority LD service managers.

Findings

The 55 Q1s returned represented an overall 72% response rate with at least three responses from 14 out of 15 districts. Using χ^2 tests, no statistically significant differences were found between data from different professional and managerial groups nor between grouped data from London, Kent and Sussex districts. Thus, selected data are summarised below for all 55 respondents.

Thirty-six (65%) respondents were aware of local care registers and 28(51%) supplied quantitative data on adults using various LD services. While 29(53%) reported the operation of care management systems for adults with LD, only 8(14%) could provide data on the number of adults with LD and MHN using or requiring local services.

Table 1. Availability, accessibility and adequacy

Q1 Items	Good (%)	Poor (%)	χ^2
Availability of:			
LD services	31 (56)	24 (44)	0.59
Generic mental health services	26 (47)	27 (49)	NS
Accessibility of:			
LD services	33 (60)	21 (38)	9.94
Generic mental health services	17 (31)	38 (69)	$P < 0.01$
Adequacy of:			
Psychiatry of LD clinics	38 (69)	7 (13)	
Community LD teams	35 (64)	15 (27)	
Staffed homes	31 (56)	17 (31)	
Respite care services	19 (35)	29 (53)	
Supported lodgings	18 (33)	22 (40)	
LD hospital units	16 (29)	9 (16)	
Generic psychiatric wards	15 (27)	28 (51)	
Specialist/generic community mental health teams	15 (27)	25 (45)	
Daycare services	14 (25)	37 (67)	
Secure units	5 (9)	17 (31)	

Comparing data supplied from different districts indicated a range of local estimates of adults with LD (487–1087) and a wider range of local estimates of adults with LD and MHN (24–300). The range of local estimates were only partially explained by varying total district populations.

Respondents reported providing services for adults with LD and MHN within a mixed economy of care. Table 1 shows their diverse views about whether the general availability (volume) accessibility and adequacy (volume and quality) of local services for adults with LD and MHN were good or poor. Missing data are accounted for by respondents without clear-cut views, often due to limited or no experience of the given service type locally.

More respondents (37;67%) described most local clinical provision for adults with LD and MHN as part of specialist LD services rather than integrated with generic mental health services (15;27%). Thirty-one(56%) said most adults with LD and MHN with non-urgent clinical or social needs were assessed within four weeks of referral, while 29(53%) reported that the local services also responded to crises. The range of respondents' views about which services should be responsible for care co-ordination for adults with LD and MHN were: 21(38%) favoured multi-agency care planning; 18(33%) wanted the LD health services to remain responsible; 10(18%) were keen on flexible arrangements depending on an individual's level of LD; four(7%) wanted the

generic mental health services but only two (4%) wanted local authorities to become responsible.

Comment

Given the SETRHA's advanced resettlement programmes, these results should interest the purchasers and providers of LD services in other regions. The response rate reflected continuing local and national multi-agency interest in planning comprehensive services for adults with LD. The data highlighted specific concerns shared by most local multi-disciplinary LD teams and managers in the SETRHA area about the inadequate range, varying quantity and quality of mental health and social care provision, particularly for adults with mild LD and MHN.

LD services were viewed as significantly more accessible than generic mental health services, but the availability and accessibility of both services for adults with LD and MHN could be improved. Employing more clinically trained staff and experienced managers would support adults with LD and MHN receiving services in a wider range of care settings. Some adequate out-patient, community LD team and staffed residential services have been developed in most districts. However, an adequate volume of high quality specialist daycare and respite places, assessment, treatment and secure hospital beds are still

needed to provide local 'back-up' clinical support for adults with LD and MHN using community LD services (Royal College of Psychiatrists, 1992).

Most respondents acknowledged that the additional clinical service and staff resources needed to support community care developments had not been agreed between local service planning data and the diverse views of respondents about responsibility for care coordination suggest continuing confusions about appropriate mental health and social care provision for adults with LD and MHN in several districts. The varying difficulties using local generic mental health services emphasise the essential clinical and advisory roles of existing specialist psychiatry of LD services. Such roles include supervision of psychiatric treatment and rehabilitative care, input to community LD teams, monitoring adults with LD and chronic MHN and crisis intervention support.

These findings broadly confirm similar concerns raised by a survey in the West Midlands Region (Roy & Cumella, 1993). They showed greater use of mental handicap hospital assessment and treatment beds for adults with LD and MHN rather than mainly admitting to generic psychiatric wards as in the SETRHA districts. Both surveys encouraged psychiatrists' involvement in developing co-ordinated multi-agency local purchasing strategies.

Central government has attempted to clarify the continuing responsibilities of local LD health services and other providers towards adults with LD and additional MHN, challenging behaviour, physical nursing needs and those who offend (Department of Health, 1992; Reed, 1992; Mansell, 1993). These data, a related report (SETRHA, 1993) and our current national survey also hope to encourage better informed future commissioning of local multidisciplinary and multi-agency hospital and community service provision, as advised by the Royal College of Psychiatrists (1992).

Local individual and population need assessments and care management systems

must include specific data on adults with LD and MHN. Otherwise their health and social care needs will not be adequately met within evolving complex economies of community care. Integrated quality assurance systems (Gravestock, 1994) should also provide local LD, mental health and local authority service providers with data to stimulate improvements in the health and social gains of adults with LD and MHN using finite hospital and community resources.

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