

Proposed model for the delivery of a mental health service to people with intellectual disability

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Executive summary

There have been great improvements in the quality of life of people with intellectual disabilities in Ireland over the past 20 years: education, housing, work and recreational opportunities have all been significantly developed. Although this progress must be acknowledged, many educational, work and health-related services for those with intellectual disabilities are still not good enough. In particular, mental health/psychiatric services for people with intellectual disabilities have not kept pace with these developments – they remain underresourced and grossly underdeveloped in many Health Board areas in Ireland. Some counties have no psychiatric service at all for people with intellectual disabilities.

Medicine and psychiatry have progressed over the years by specialisation, ensuring that the best care possible is delivered to patients. Psychiatry has developed specialties by age (child and adolescent psychiatry, old age psychiatry) and by need of special groups (intellectual disability psychiatry and forensic psychiatry). To meet the mental health needs of people with intellectual disabilities, a specialist mental health service is required by virtue of the following factors:

- Special expertise and experience is required for accurate diagnosis, because of the atypical presentation of mental disorders, communication difficulties and the absence of subjective complaints.
- Special expertise, experience and treatment is required in the management of chronic and persistent problem behaviours.
- Special expertise is needed in diagnosing autistic spectrum disorder and treating comorbid mental health problems in this group.
- Drug therapy may be complicated by a high frequency of side-effects and atypical responses.
- Co-existing epilepsy and medical conditions need to be taken into consideration.
- Ethical issues arise in relation to capacity and consent.

A number of countries allocate specific and significant resources to mental health services for people with intellectual disabilities, and promote training and research in this area. The National Association for Dually Diagnosed (NADD) in the USA and the European Association for Mental Health in Mental Retardation (MHMR) have been influential in promoting research and specialist psychiatric service development for this group. There is a lack of such research and development in Ireland.

We hope that this Occasional Paper will unleash a chain of events that will lead to the development of quality mental health services for people with intellectual disabilities and their families.

For the purpose of this strategy document the committee have decided to use the term 'intellectual disability' rather than 'learning disability', 'mental handicap' and 'mental retardation'. The Committee have also decided to use the terms 'psychiatric disorder' and 'mental ill health' interchangeably and view them as synonymous terms.

Recommendations

1. That significant reform of the mental health services in Ireland for the intellectual disability population should commence immediately.
2. That funding be ring-fenced and prioritised to develop quality mental health services in all Health Board areas. Management and funding of mental health services for people with intellectual disabilities should ideally come from the same source as generic mental health funding.
3. That the Department of Health and Children should be given prime responsibility for providing the resources necessary to implement, develop and monitor this reform.
4. The Mental Health Commission and the National Disability Authority should oversee the implementation.
5. The Mental Health Commission and the National Disability Authority should monitor the quality of mental health services provided to people with intellectual disabilities.
6. People with intellectual disabilities have the right to the same type of mental health service as any other citizen, taking account of their special needs. That all safeguards offered to the general population in respect of the Mental Health Act 2001 be extended to intellectual disability mental health services. That use of time-out and mechanical restraint be used within the Mental Health Act. Consultant psychiatrists in intellectual disability are currently working in a legal vacuum, with respect to the Mental Health Act. This must be addressed as soon as possible by the implementation in full of the Mental Health Act 2001.
7. All future appointments of consultant psychiatrists in intellectual disability should be catchment area-based with multidisciplinary mental health of intellectual disability teams – in close liaison with Health Board consultant psychiatrist colleagues in other specialties such as adult psychiatry, child and adolescent psychiatry and psychiatry of old age. This would integrate the psychiatry of intellectual disability with mainstream psychiatry and would involve partnership with the voluntary bodies.
8. That a consultant psychiatrist-led mental health multidisciplinary team for people with intellectual disabilities be established, and given priority, in each Health Board area, commencing in 2004. Two consultant psychiatrists are required – one in adult psychiatry and one in child and

adolescent psychiatry, in accordance with the Irish College of Psychiatrists' norms: i.e. one consultant adult psychiatrist per 100 000 population plus one consultant child and adolescent psychiatrist per 100 000 population. Current norms for consultant psychiatrist-led multidisciplinary teams of 1 per 100 000 population do not take into account the European Working Time Directive and recent requirements for doctors to engage in continuing professional development. Thus these norms will require upward revision.

9. Coordination of the mental health services to people with intellectual disabilities requires a clinical director and an administrator/manager.
10. It is recommended that all catchment areas have access to an in-patient mental health treatment unit specifically for people with intellectual disability and psychiatric disorder.
11. That the transfer of all patients with intellectual disabilities from psychiatric hospitals should not take place until a designated consultant psychiatrist-led mental health multidisciplinary team has been identified that will continue to provide psychiatric assessment, treatment and management, if and when required.
12. It is recommended that a joint working group within the Irish College of Psychiatrists, incorporating the Faculty of Adult Psychiatry and the Faculty of Learning Disability Psychiatry, be set up to examine how best to deliver a comprehensive mental health service to individuals functioning in the mild range of intellectual disabilities.
13. Adolescent mental health services need to be developed for people with intellectual disabilities.
14. Forensic mental health services need to be developed for people with intellectual disabilities.
15. A psychiatric service needs to be developed for people with intellectual disabilities and autistic spectrum disorder and mental health problems.
16. That the number of senior registrar posts in learning disability psychiatry be increased.
17. That representation from the Irish College of Psychiatrists' Faculty of Learning Disability Psychiatry be on all future Department of Health and Children mental health policy reviews, developments and initiatives.
18. That representation from the Irish College of Psychiatrists' Faculty of Learning Disability Psychiatry be on all future mental health policy reviews, developments and initiatives of any Health Board.
19. That substantial resources be directed towards research in this area, looking (for example) at the incidence and prevalence of psychiatric disorder to assist service development. To further this, a professor of psychiatry of intellectual disability needs to be appointed.
20. The Irish College of Psychiatrists' Faculty of Learning Disability Psychiatry should formally review this policy in 2009.

Definitions

Intellectual disability

Intellectual disability is the presence of a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development. This definition encompasses people with a broad range of disabilities. The presence of low intelligence, for example an IQ below 70, is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining need. Many people with intellectual disabilities also have physical and/or sensory impairments. The definition covers adults with autistic spectrum disorder who also have intellectual disabilities, but not those who are of average or even above average intelligence, such as some people with Asperger syndrome. Intellectual disability does not include all those who have a 'learning difficulty' which is more broadly defined in education legislation (Department of Health, 2001).

Psychiatric disorder

Psychiatric disorder is defined as abnormalities of thinking, perception, emotions and behaviour, which are developmentally inappropriate and of sufficient duration and severity to cause persisting suffering or hardship to the individual, disruption to interpersonal relationships and/or distress to the family or community (Rutter & Graham, 1968). Examples of such conditions include mood disorders, schizophrenia, autistic spectrum disorder, anxiety and personality disorders and problem behaviours.

Challenging behaviour

Challenging behaviour is now a frequently used term (not a diagnosis) to describe severe problem behaviour. It is an important component of psychiatric disorder and is defined as 'behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access or use of ordinary community facilities' (Emerson *et al*, 1987). Challenging behaviour may be caused by one or more of a number of factors: autistic spectrum disorder, psychiatric illness, personality disorder, environmental stressors, physical illnesses and behavioural phenotypes.

1 Introduction

According to the National Intellectual Disability Database Annual Report 2002, there are 25 448 persons with an intellectual disability in Ireland (Mulvany & Barron, 2003). Of these, 9412 are in the mild range of intellectual disability, 14 557 are in the moderate, severe or profound range of intellectual disability and 1479 individuals' disability was not verified.

There is a huge variation in the reported prevalence of psychiatric disorder and mental health problems among people with intellectual disabilities. Campbell & Malone (1991), for instance, reported prevalence rates between 14% and 67%. If aggressive and disruptive challenging behaviours are included as a form of psychiatric disorder, prevalence estimates tend to be high, with a large proportion of people receiving diagnoses of personality disorders. Reiss (1990) reported an overall prevalence of 39%, Menolascino (1989) 30% and Iverson & Fox (1989) 36%. Among hospital populations, figures as high as 60% have been reported (Leck *et al*, 1967; Craft, 1971; Primrose, 1971; Reid, 1972). However, if people who only show challenging behaviour are excluded, then the prevalence of psychosis and neurosis combined appears to be as low as 8–10% (Heaton-Ward, 1977). This discrepancy would tend to be lower in older groups, because older groups demonstrate a lower rate of behaviour problems than younger ones (Day, 1985; Kiernan & Fox, 1990). In a Welsh community-based population study by Deb *et al* (2001), the overall rate of functional psychiatric illness (point prevalence) was similar to that found in the general population (16%). However, the rates of schizophrenic illness and phobic disorder were significantly higher in the study cohort compared with those in the general population. Increasing age and the presence of physical disability were significantly associated with the occurrence of psychiatric illness. Intellectual disability is associated with a two and a half fold increase in the prevalence of health problems (particularly neurological, behavioural and sensory), compared with a general practice control population, in those with moderate, severe and profound intellectual disability (van Schroyenstein Lanteman-De Valk *et al*, 2000). Life expectancy is also markedly reduced (Hollins *et al*, 1998).

Intellectual disability is strongly associated with autistic spectrum disorder. For people with an IQ below 20 the prevalence of this disorder is 86%, for those with an IQ of 20–50 the prevalence is 42% and for those with an IQ of 51–70 the prevalence is 2% (Wing & Gould, 1979).

There can be no argument that mental health problems occur in the intellectual disability population at a much higher rate than in the normal population. It is hard to credit that as recently as the early 1980s, the question of whether people with intellectual disability could suffer from depression was a moot point in the literature. We should like to think we have all come a long way since then

(McBrien, 2003). However, despite millions of euros being reportedly spent on intellectual disability services over the past decade in Ireland, mental health services for this population fall well below acceptable standards. The deficiency in standards can partly be attributed to the lack of specific funding or ring-fencing for mental health services for those with an intellectual disability.

Access to mental health services for this population is unclear. Consultant psychiatrists do not have specific geographical catchment areas or sectors. From the service user's perspective, the establishment of geographical catchment areas is a prerequisite to an effective localised service. This idea was formally proposed in 1981 in *Planning Mental Handicap Services* (Eastern Health Board, 1981) and subsequently in *Mental Handicap Services – Proposals For Change* (Eastern Health Board, 1987), but never followed through. The Department of Health and Children's *Discussion Document on Mental Health Needs of Persons with Mental Handicap* (the Mulcahy Report; Department of Health and Children, 1996a) also proposed geographical catchment area services, as did the *Report on the Establishment of a Dual Diagnosis Service in the Eastern Regional Health Authority* (Eastern Health Board/Northern Area Health Board, 2000).

There is a lack of designated specialist in-patient beds for treatment of acute psychiatric disorder in people with intellectual disability in Ireland. Stewart's Hospital, Dublin (8 beds) and Belmont Park, Waterford (8 beds) are registered psychiatric hospitals and have in-patient beds, as has St Ita's Psychiatric Hospital, Portrane, Co. Dublin, i.e. St. Joseph's Intellectual Disability Services (251 beds), with 9 admissions in 2001 (Department of Health and Children, 2003). It is our understanding that currently Belmont Park is not operating as a psychiatric unit for people with an intellectual disability. In addition, as can be seen from the Inspector of Mental Hospitals report (Department of Health, 2003), the vast majority of psychiatric beds in both Stewart's Hospital and St Ita's Hospital are occupied by long-term patients. There is minimal movement of these long-term psychiatric patients who in addition have intellectual disabilities from these hospitals. Apart from these units, admissions must be made to the general psychiatric services and are dependent on local hospital guidelines with respect to admissions of people with intellectual disabilities and psychiatric disorder. There is no consistent admissions procedure, which adds to the difficulties being already endured by families and patients requiring urgent in-patient treatment. In most instances, when patients with an intellectual disability and psychiatric disorder are admitted to the general psychiatric services, they are then managed by consultant psychiatrists in general adult psychiatry. The absence of specialised mental health in-patient beds for patients with intellectual disability and psychiatric disorder is a national disgrace.

Intellectual disability organisations and centres providing mental health services are not investigated by the Inspector of Mental Hospitals; thus the safeguards and legal frameworks that protect patients who have a mental disorder are not applied to those with mental disorder and intellectual disability. The use

of time-out and mechanical restraints, within the intellectual disability services, for health and safety reasons do not have the same procedural safeguards as when used in the general population within the mental health context.

Neither consultant adult nor child psychiatrists in intellectual disability work with mental health multidisciplinary teams (with mental health-trained psychologists, social workers, nurses, occupational therapists, etc.) similar to those available to generic psychiatry services; thus, many consultant psychiatrists in intellectual disability work in isolation, without the skilled expertise and back-up that such teams would provide.

The assessment, treatment and management protocols of people with intellectual disability, autistic spectrum disorder and psychiatric disorder vary from Health Board to Health Board, with no clear policies or guidelines. The lack of designated mental health services for this group has led in many instances to costly *ad hoc* crisis intervention solutions, including out-of-state placements. Unpublished information provided by the Advisor on Intellectual Disability to the Department of Health and Children revealed that 56 persons with intellectual disability and psychiatric disorder/challenging behaviour were currently receiving treatment out of state. This is at an average cost of €100 000 per person. Surely this money would be more appropriately spent in developing and providing such services within Ireland? This in turn would reduce hardship for family members and carers in terms of travel, distance and separation.

In some Health Boards, consultant adult psychiatrists in intellectual disability are required to provide a mental health service to children and adolescents without being trained to do so. This is due to a shortage of resources, and is an unsatisfactory and inequitable situation which is not in keeping with the mental health services being provided to the general population.

The voluntary bodies have no onus or responsibility to provide a mental health service to people with intellectual disabilities. The Health Boards do have a statutory responsibility to provide such a service. Most consultant psychiatrists in intellectual disability are employed by the voluntary bodies and are curtailed in delivering a mental health service as they do not have admission rights, discharge rights, or staff who are trained and employed to deliver mental health care. Most staff in intellectual disability services do not have training in mental health and are generally employed to deliver an intellectual disability service incorporating housing (residential places) and employment (day places), as opposed to a mental health service.

The transfer of people with intellectual disabilities from inappropriate placement in psychiatric hospitals to community-type homes is welcome. However, many patients when transferred to intellectual disability services have no access to a mental health service. In many instances these patients have long-standing mental health or psychiatric disorders, which require continued monitoring and treatment by a consultant psychiatrist and a mental health multidisciplinary team. This deficit should be addressed in the planning of the

transfer of services or when services are being de-designated. In a recently discharged cohort (2001) of 36 patients transferred from St Joseph's Psychiatric Hospital in Limerick to the Daughters of Charity Intellectual Disability Services, Limerick, an overall prevalence rate of 42% (15 patients) for psychiatric illness and 58% (21 patients) for problem behaviours was encountered using the Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation (DC-LD; Royal College of Psychiatrists, 2001).

People with mild intellectual disabilities and psychiatric disorder currently present a difficulty for both general adult psychiatric services and psychiatric services for people with intellectual disability. Only a proportion of people (approximately a third) with mild intellectual disabilities will have their needs appropriately met within the current intellectual disability psychiatric services. Providing quality mental health services to people with mild intellectual disability at present requires close liaison, cooperation and flexibility between general adult psychiatric services and psychiatric services for people with intellectual disabilities. At present, both psychiatric services are needed to meet the psychiatric needs of this group. The decision as to which service is most appropriate should always be a clinical decision and not resource-driven. This policy document has deliberately not designated people with mild intellectual disability and psychiatric disorder to either the general adult psychiatric services or the intellectual disability psychiatric services. There is no capacity in the intellectual disability psychiatric services at present to cater for the needs of all people with a mild intellectual disability. However, there may be a willingness for the intellectual disability psychiatric services to take responsibility for this group of patients, if adequate additional resources required could be made available over the next few years.

2 Service provision and policy

This chapter provides a glimpse of the historical contextual setting for health-funded services to people with intellectual disabilities in Ireland, followed by an overview of the policy frameworks within which mental health services are delivered, with particular reference to people with intellectual disabilities.

Quality and Fairness – A Health System for You (Department of Health and Children, 2001) fails to mention mental health services for people with intellectual disabilities.

In 1879 Stewart's Hospital in Dublin began to provide care for people with intellectual disabilities and remained the only institution of its kind for over 50 years (Robins, 1986). In the main, care was provided for people with intellectual disabilities in mental hospitals, until the early part of the 20th century when the religious orders set up residential and day services. The nuns in most instances provided services for girls and women, and the brothers provided services for boys and men. At this time, mental health problems were not recognised as occurring in people with intellectual disabilities and any outward manifestation of these problems was assumed to be due to intellectual disabilities. It is only in the past 20 years or so that the mental health problems experienced by people with intellectual disabilities have begun to receive attention (Corbett, 1979).

Services for people with intellectual disabilities are currently moving towards a rights-based model (Department of Justice and Law Reform, 1998, 1999; Quinn, 1993). The report *Strategy for Equality* (Department of Health and Children, 1996b) notes that public attitudes towards disability are still based on charity rather than on rights. Recent international legislation and practice has adopted a civil rights perspective towards meeting the needs (including health care needs) of people with disabilities.

Despite numerous national reports on health service provision for people with intellectual disabilities (Department of Health and Children, 1965, 1980, 1990), there is no report on mental health provision. The most recent Department of Health and Children (1990) report *Needs and Abilities* does acknowledge that some people with intellectual disabilities might need to remain within the psychiatric services; however, no service plan for this group is outlined. This report also suggests that the frequency of problem behaviour should decrease as the quality and scope of services develop. In addition, disturbed behaviour receives mention as if it were a distinct, homogeneous identity. Current understanding of mental health issues would not concur with this. The report does acknowledge that a special multidisciplinary team including a psychiatrist would be required to deal with disturbed behaviour. This specialist multidisciplinary team, however, was not seen to be necessarily part of a mental health service for people with intellectual disabilities, which this group

recommends. This has resulted in a fragmented and *ad hoc* approach to managing problem behaviours, with the setting up of challenging behaviour units in some intellectual disability services without any consultant psychiatrist being involved.

Current mental health policy is set out in *The Psychiatric Services – Planning for the Future* (Department of Health and Children, 1984). This report omitted to include people with intellectual disabilities in the Needs of Special Groups section. However, two recommendations specific to people with intellectual disabilities are made:

- ‘Mentally handicapped persons in psychiatric hospitals should be segregated from the mentally ill and provided with programmes of care and activity to their needs. The intellectual disability service should take over responsibility for these persons when this has been achieved.’
- ‘Disturbed mentally handicapped persons should be catered for within the intellectual disability service’ (Department of Health and Children, 1984).

Unfortunately no service provision was made to provide mental health services for the ‘disturbed mentally handicapped persons’. Currently, mental health services for people with intellectual disabilities are provided, in the main, within generic child and adult services and the voluntary intellectual disability services. The former tend to provide services for people with mild intellectual disabilities whereas the latter care for people with moderate, severe and profound intellectual disabilities.

A management development strategy for the health and personal social services in Ireland (Dixon & Baker, 1996) commissioned by the Department of Health and Children noted that the most challenging aspect of the 1994 Health Strategy was the need to change ‘the culture of acceptance, deference and inertia...A dominant theme of the health strategy is that health service managers (and professional and clinical staff) will need to operate effectively in a more open and accountable manner’. The report goes on to note that ‘aspects of health strategy may require particularly urgent management development initiatives. For example...mental health’. A steering group, composed of managers within the health care system, endorsed this report. The need for quality management, including clinical management, within the health services was acknowledged, and the Office for Health Management was subsequently set up.

In 1996 the Department of Health and Children produced a discussion document, the Mulcahy Report, in relation to the mental health needs of persons with intellectual disabilities. The Mulcahy Report (Department of Health and Children, 1996a) was the first to focus specifically on the mental health needs of people with intellectual disabilities. The mental health service framework proposed in this seminal report consists of an area intellectual disability team operating at the primary health care level and a mental health team for people with intellectual disabilities operating at the secondary health care level, and appears to be a workable solution to a complex problem. The proposal for

catchment area-based mental health services was novel, as was the acknowledgement of the absence of a clearly identifiable (mental health) service which hinders the evolution of preventive and intervention strategies. The broad framework as set out in the Mulcahy Report is adopted in this policy document. It was also adopted by the first of two reports by the Eastern Health Board/Eastern Regional Health Authority (Eastern Health Board/Northern Area Health Board, 2000; Eastern Regional Health Authority, 2002). Unfortunately the Mulcahy Report never passed beyond the discussion phase.

The Department of Health and Children's document *Guidelines on Good Practice and Quality Assurance in Mental Health Services* outlines the many ingredients necessary for a quality mental health service. The report notes that 'the product (a quality mental health service) is the highest level of mental health care possible, delivered in a manner which is transparent and informed by clinical practice, audit and research to the highest possible level of communication between professionals, patient, family and community, having regard to the rights of all participants in this interaction' (Department of Health and Children, 1998).

In 1998 the Irish Division of the Royal College of Psychiatrists (Irish College of Psychiatrists) published *The Future of Psychiatry in Ireland*, a report that included mental health service provision for people with intellectual disabilities. This report, in keeping with best practice, advocated that a consultant psychiatrist trained in the area is necessary and that mental health services for people with intellectual disabilities should be catchment area-based with appropriate in-patient mental health admission facilities (Irish Division of the Royal College of Psychiatrists, 1998).

The Medical Council in its *Guide to Ethical Conduct and Behaviour* declares that 'doctors have an obligation to point out deficiencies to the appropriate authorities' (Medical Council, 1998). This echoes Council Report 51 published by the Royal College of Psychiatrists, *The Responsibilities of Consultant Psychiatrists*, which states that 'all consultants have a responsibility to draw attention to any deficiencies in service and the facilities provided' (Royal College of Psychiatrists, 1996). Another Council Report, *Good Psychiatric Practice*, notes that 'not striving for improved clinical standards' is an example of unacceptable practice. In relation to good practice in the psychiatry of intellectual disability it includes 'acting as an advocate for adequate and good-quality services for particularly neglected and undervalued members of our society' (Royal College of Psychiatrists, 2000).

In April 2000 the *Report on The Establishment of Dual Diagnosis Service in the Eastern Regional Health Authority* was produced. This report comprises the deliberations of a working group set up by the Eastern Health Board Programme Manager with responsibility for disability services. In the foreword it is noted that

'Services for people with mild intellectual disability are now largely delivered in the mainstream areas...Individuals in this group who have serious mental health problems are disadvantaged. Their needs may not always be appreciated – thus they may not receive the most appropriate psychiatric interventions in either the generic or intellectual disability services. The services for

people with moderate, severe and profound intellectual disability...the need for specialised psychiatric treatment for individuals in this category has been identified but not appropriately addressed' (Eastern Health Board/Northern Area Health Board, 2000).

The report goes on to suggest the setting up of an area intellectual disability team operating at primary health care level, a catchment area mental health service for people with moderate, severe and profound intellectual disabilities and a mental health service specifically for people with borderline/mild intellectual disability within the general adult psychiatric services at regional level. The report reflects the general thrust of the Mulcahy Report (Department of Health and Children, 1996a). Unfortunately, this report was 'lost' in the change from the Eastern Health Board to the Eastern Regional Health Authority.

A Proposed Specialist Service for Clients with Intellectual Disabilities Presenting with Severe Challenging Behaviour and/or Psychiatric Illness was produced in 2002 by a sub-committee of the Regional Planning Forum for Intellectual Disability Services (Eastern Regional Health Authority, 2002). It is unclear how this Planning Forum fits with the two committees recommended in *Enhancing the Partnership* (Department of Health and Children, 1997): the Intellectual Disability Services Consultative Committee and the Intellectual Disability Services Development Committee. The Intellectual Disability Services Consultative Committee is assigned to providing 'a broadly based forum for the exchange of information and ideas on all matters pertaining to intellectual disability in the region', whereas the Intellectual Disability Services Development Committee's role includes 'preparing a development plan for the region which will ensure the delivery of a comprehensive quality service' (Department of Health and Children, 1997). Unfortunately, the Regional Planning Forum's proposals tend to be ambiguous throughout, and this is a cause for concern. The document describes a regional specialist service to meet severe challenging behaviour and/or psychiatric illness among people with intellectual disabilities, only stating once in the body of the text that it is a mental health service. The aim of the service is to:

- improve the quality of life for the individuals concerned;
- remove a potential threat to themselves and the community;
- prevent the disruption that this behaviour causes to the current service.

However, in keeping with mental health services, surely the primary aim should be to assess, diagnose, treat and manage mental health problems so that the above three points are realised. A further cause of concern is the principle that 'the service user must return to and be accepted back by their own community and service agency at the end of their treatment or special care'. This will not be possible in a number of cases. What happens when the need of the service user is best met within the mental health service and their own community and service agency does not have either the expertise or the resources to meet the need? The right of people with intellectual disabilities and mental health problems to 'proper treatment and care' is welcome, as is the acknowledged need for 'proper staff training and development' (in mental health). This report recommends the setting

up of a dedicated outreach and assessment team, acute in-patient beds, day hospital and rehabilitation unit. Unfortunately, the service is not explicitly named as a mental health service, even though it is to operate under the Mental Treatment Act 1945. The proposed model of service is linked primarily with the intellectual disability services rather than the mental health services. This might not maximise its full potential. Why should the mental health service to people with intellectual disabilities be segregated from the general mental health services? Finally, the mixing of different patient groups proposed in this document would not necessarily be in keeping with best practice.

The omission of any explicit use of the term 'mental health service' perpetuates the ambiguity related to mental health service development for people with intellectual disabilities in Ireland.

3 Intellectual disability and mental health legislation

Reports from Amnesty International (2003) and the National Disability Authority (2003) criticise Irish mental health care policy and provision. Ireland is a signatory to a number of international conventions that both enshrine the rights of people with intellectual disabilities to equality of access to services (including health and social care services) and the rights of people with mental illness to appropriate care in pursuance of quality of life and opportunity (UN Principles for the Protection of Persons with Mental Illness, Principle 7(1), 9(1), Article 3, UN Declaration on the Rights of Disabled Persons).

‘Despite significant efforts, Irish mental health care policy and service provision remain out of step with international best practice and as such, fail to fully comply with international human rights law’ (Amnesty International, 2003).

There is a profound policy and service provision confusion both at national level (Department of Health and Children) and at local level (Health Boards and voluntary services) as to which of the services has lead responsibility for planning and/or delivering mental health services.

Despite the fact that people with intellectual disabilities represent one of the most vulnerable groups in our society, the vast majority of those who are receiving psychiatric treatment within the specialist services are outside the remit of protective mental health and other legislation. It is clear that this matter needs to be addressed as a matter of urgency.

The Mental Health Act 2001 represented a significant step towards affording increased protection of civil liberties to detained persons for treatment of mental illness while at the same time attempting to address the right to treatment of the mentally ill. However, the Act requires strengthening in relation to persons with intellectual disabilities. Issues of particular concern include consent to treatment, and detention.

Consent to treatment

There is concern regarding the capacity of people with intellectual disabilities to give informed consent to treatment and the protection of their rights. This concern needs to be addressed by the appropriate legislative authorities, such as the Law Reform Commission. In the interim, with particular reference to mental health services, guardianship *ad litem*, advocacy and the judicious use of the Mental Health Act 2001 should be utilised as appropriate.

Detention

Detention, seclusion and restraint are matters of concern for psychiatrists working with people with intellectual disabilities. Detention is taken very seriously in

law. Powers to detain are restricted to specific circumstances, and any organisation or individual going beyond these would be considered to be breaking the law. A person who is detained formally with a mental disorder under mental health legislation is offered important independent safeguards in law. In contrast, patients who are detained informally under the common doctrine of necessity are not adequately safeguarded and there is a danger that the right to liberty could be violated. The situation in the UK following the Bournemouth NHS Trust appeal (*R v. Bournemouth*, 1998) is that a patient without capacity who does not seem unwilling to be admitted can be admitted as an informal patient. However, the matter is still being debated and has been referred to the European Convention on Human Rights. In the UK, the case is being strongly argued for legislation under the Mental Health Act.

With the new Mental Health Act 2001, any detention, seclusion and restraint practised in an approved centre will operate within this law. All other detention, seclusion and restraint occurring within the intellectual disability services, currently widely practised in an unmonitored and unsafe fashion, needs urgent examination by the appropriate authorities.

4 Recommendations for a model mental health service

Existing mental health services for children, adolescents and adults with intellectual disabilities are poorly developed and resourced, with some Health Board areas and voluntary intellectual disability agencies having no consultant psychiatrist in intellectual disability. In addition, none of the Health Boards that do employ consultant psychiatrists in intellectual disability have adequately developed and resourced multidisciplinary mental health teams.

Comhairle na nOspidéal records consultant posts in intellectual disability (adult and child). Their January 2004 report recorded 31 posts approved, but only 24 were filled and of these some were filled in a part-time or sessional capacity. Approximately 20% (6.5) of posts were vacant, which represents a significant gap in service provision (Comhairle na nOspidéal, 2004).

Over 80% of consultant psychiatrists in intellectual disability work for voluntary intellectual disability agencies. Multidisciplinary professionals such as social workers and psychologists who are employed by the voluntary agencies are generally not specifically recruited to carry out mental health work; consequently, there is no dedicated multidisciplinary mental health team. Where professionals take on a mental health role, this has largely arisen from individual interest and goodwill. In order to develop a mental health service for persons with intellectual disabilities, it is necessary to clarify the roles and responsibilities of professionals and adequately resource a dedicated mental health service.

The development of separate intellectual disability teams and mental health of intellectual disability teams is required to provide a high-quality, comprehensive service to children, adolescents and adults with intellectual disabilities and mental health problems.

Mental health services for adults with intellectual disability and psychiatric disorder

Intellectual disability team for adults

The intellectual disability team for adults envisaged would be a multidisciplinary team with a catchment area, working at primary care level for people with all levels of intellectual disability. The Mulcahy Report (Department of Health and Children, 1996a) suggested that this team should include a medical doctor, social worker, community nurse, clinical psychologist, physiotherapist, speech therapist and occupational therapist. Everyone with an intellectual disability should come within the team's terms of reference. The team could fulfil some or all of the following functions:

- The team would be an essential point of contact in each area, for example working in close cooperation with general practitioners, early intervention teams and community health services. It would liaise with other related agencies such as educational, vocational, community welfare and mental health services.
- The team would ensure that all relevant persons are with their consent, entered on the National Intellectual Disability Database. It would monitor and update the database for all age groups.
- The team would regularly review the needs of clients on the waiting lists for residential and day care.
- The team would offer assessment and intervention at primary care level for a range of problems. This would enable families to deal with problems early and would be expected to reduce the number of emergency admissions to residential and respite care.
- In the case of mental health problems for which psychiatric intervention is required, the intellectual disability team could facilitate referral to the mental health of intellectual disability team through the family doctor, if the latter team is not already involved.

Mental health of intellectual disability team for adults

The mental health of intellectual disability team for adults would be a multidisciplinary team led by a consultant psychiatrist with appropriate training in adult psychiatry and learning disability psychiatry. The team would have a defined catchment area. Other members of the team would include psychologists, nurses, social workers, non-consultant hospital doctors, occupational therapists and speech and language therapists (see Box 1).

The cornerstone of the mental health of intellectual disability service is the multidisciplinary team. Its function is to provide a dedicated mental health service to persons with intellectual disabilities, including:

- multidisciplinary assessment and diagnosis;
- treatment offering a range of options including pharmacotherapy, behavioural interventions and psychotherapies – e.g. individual, group and family psychotherapy and cognitive-behavioural therapy;
- comprehensive after-care planning to include liaison with other services and follow-up by mental health of intellectual disability team if required;
- promotion of positive mental health.

Service delivery

The core feature of a mental health service is the multidisciplinary team, which offers treatment in a range of settings (Eastern Regional Health Authority, 2000). The strength of the service lies in the provision of a comprehensive range of

treatment options and settings which complement each other. There is a need for more health service research to assist with service planning in this area.

Out-patient service

The out-patient service would include out-patient clinics and domiciliary visits where clinically indicated, in addition to support from multidisciplinary team members, in particular the community mental health nurses (Department of Health and Children, 2002).

Psychiatric day hospital

The psychiatric day hospital would provide more intensive multidisciplinary treatment for those with severe mental health problems, as an alternative to in-patient treatment.

- Recommendation: 30 places per 500 000 population (Day, 1993).

In-patient service

In-patient services are an essential component of a dedicated mental health service. All treatment centres must be designated units under the Mental Health Act 2001, thereby offering the same degree of protection of civil liberties as offered to detained individuals in the general population with mental health problems. In the first instance, such a unit would offer assessment for people with the full range of psychiatric disorders or problem behaviour who cannot be managed in the community or day hospital – for example, individuals with severe depression or those with a psychotic illness such as schizophrenia or mania associated with problem behaviour. All admissions would be for short-term mental health assessment and treatment.

- Recommendation: we recommend 5 beds per 100 000 population.

Step-down facilities

In order for the acute in-patient unit to function effectively and remain accessible, a range of units offering different levels of rehabilitation are required to facilitate discharge from in-patient care; for example, in the case of an individual with moderate intellectual disability with schizophrenia who has recovered from the acute phase of illness but has not recovered sufficiently to return to a previous place in the community.

- Recommendation: 10 places per 500 000 population (Day, 1993).

Continuing care mental health treatment units

Long-standing and enduring mental health problems that are resistant to treatment require ongoing mental health intervention in appropriate settings, e.g. the young adult with autistic spectrum disorder and severe self-injurious behaviour and/or physical aggression to self and others.

- Recommendation: 30 places per 500 000 population (Day, 1993).

Respite beds

Respite beds are a necessary adjunct to support families and carers of individuals with mental illness.

Staffing requirements

The staffing requirements of a mental health of intellectual disability team for adults are shown in Box 1. Provision of a mental health of intellectual disability service for adults requires one multidisciplinary team, led by a whole-time

Box 1 Staffing requirements of a mental health intellectual disability team for adults

Recommended minimum to commence the development of a mental health service

1 consultant psychiatrist of intellectual disability with designated multidisciplinary team per 100 000 population

Multidisciplinary team members

1 consultant psychiatrist (dually trained in adult psychiatry and learning disability psychiatry)

2 psychologists:

1 senior grade

1 basic grade

2 community mental health nurses:

1 clinical nurse specialist

1 clinical nurse manager II

2 social workers:

1 principal

1 team leader

2 non-consultant hospital doctors:

1 senior registrar

1 registrar

1 occupational therapist

1 speech and language therapist (senior grade)

physiotherapist (sessional commitment)

2 administration officers:

1 grade IV

1 grade III

(clerical and administrative support is essential to the team)

Table 1 Staffing needed to provide a mental health of intellectual disability service for adults, compared with existing consultant numbers

Health Board	Population	WTE & MDT	Existing consultant numbers
ERHA East Coast	333 458	3	1
ERHA Northern	486 305	5	6
ERHA South-Western	581 551	6	5
Mid-Western	339 930	3	1
Midland	225 588	2	1
North-Eastern	344 966	3.5	2
North-Western	221 376	2	2
South-Eastern	423 540	4	1
Southern	580 605	6	1
Western	380 057	4	1
Total		38.5	21

ERHA, Eastern Regional Health Authority; MDT, multidisciplinary team; WTE, whole-time equivalents. These figures are taken from Comhairle na nOspidéal (2004). They do not take into account whether posts are vacant or filled either in a temporary, part-time or permanent capacity. Accordingly, the figures are an overestimate of actual WTEs.

equivalent (WTE) consultant psychiatrist, per 100 000 population. Nationally, this would require the staffing levels shown in Table 1.

Recognition should be given to the fact that several long-established voluntary bodies operated on a national catchment basis and therefore have distortedly high numbers of persons in residential care who are not representative of a local catchment population. These people came into care because of a higher prevalence of mental health difficulties, problem behaviour, autistic spectrum disorder and dementia, and as a consequence it must be recognised at a consultant staff planning level that specific problems exist within some voluntary services which necessitate exceptions being made to pure catchment area-based planning.

Mental health services for children and adolescents with intellectual disability and psychiatric disorders

Existing mental health services for children and adolescents with intellectual disabilities (age 0–15 years) are significantly underdeveloped and under-resourced. Comhairle na nOspidéal (2004) reported 10 approved consultant posts in psychiatry of intellectual disability for children and adolescents: most of the

posts (7) were filled on a part-time/sessional basis, also one post was vacant. Together this represents a gap in service provision.

Service provision is shared between consultants in child psychiatry and consultants in intellectual disability, with considerable differences throughout the country. The majority of consultants in intellectual disability psychiatry providing a mental health service to children and adolescents also have responsibility for adults: that is, they provide a service for the full age span, 'from cradle to grave'.

Consultants in child psychiatry with special interest in intellectual disability accept referrals of children and adolescents under 16 years (Irish College of Psychiatrists, 2002). Currently there is considerable concern regarding the lack of mental health services for young people aged 16–18 years with intellectual disabilities. The acuteness of the problems varies nationally depending on existing level of services. Future developments of mental health services for children and adolescents with intellectual disability and psychiatric disorder will require careful consideration of existing services and local needs in order to avoid the creation of additional gaps in service which would further disadvantage this vulnerable group.

Intellectual disability team for children and adolescents

Many organisations already have intellectual disability teams in place, in the form of early intervention teams and teams for children and adolescents attending school. Not all would have the range of professionals previously mentioned to constitute multidisciplinary teams. The team could fulfil some or all of the following functions:

- The team would be an essential point of contact in each area, e.g. working in close cooperation with general practitioners and community health services; it would liaise with other related agencies, such as educational, vocational, community welfare and mental health services.
- The team would ensure that all relevant persons are, with their consent, entered on the National Intellectual Disability Database. It would monitor and update the database for all age groups.
- The team would regularly review the needs of young people on the waiting lists for residential and day care.
- The team would offer assessment and intervention at primary care level for a range of problems. This would enable families to deal with problems early and would be expected to reduce the number of emergency admissions to residential and respite care.
- In the case of mental health problems for which psychiatric intervention is required, the intellectual disability team could facilitate referral to the mental health of intellectual disability team through the family doctor, if the latter team is not already involved.

Mental health of intellectual disability team for children and adolescents

The psychiatric assessment and treatment of children and adolescents with learning disabilities should be the responsibility of a consultant psychiatrist with appropriate training in child psychiatry and learning disability psychiatry with a fully resourced multidisciplinary team. The function of the mental health of intellectual disability team is to provide a dedicated mental health service to children and adolescents, which includes:

- multidisciplinary assessment and diagnosis;
- treatment offering a range of options including pharmacotherapy, behavioural interventions and psychotherapies;
- liaison and consultation to intellectual disability teams, mental health of intellectual disability teams (adults), schools and other agencies involved in care and welfare of children and adolescents;
- follow-up where ongoing psychiatric care is indicated;
- promotion of positive mental health.

Service delivery

The cornerstone of a child and adolescent mental health service is the multidisciplinary team. Multidisciplinary teams require specific

Table 2 Staffing needed to provide a mental health of intellectual disability service for children and adolescents, compared with existing consultant numbers

Health Board	Population	WTE & MDT	Existing consultant numbers
ERHA East Coast	333 458	3	0
ERHA Northern Area	486 305	5	1
ERHA South-Western	581 551	6	0
Mid-Western	339 930	3.5	2
Midland	225 588	2	1
North-Eastern	344 966	3.5	0
North-Western	221 376	2	0
South-Eastern	423 540	4	2
Southern	580 605	6	3
Western	380 057	4	1
Total		38.5	10

ERHA, Eastern Regional Health Authority; MDT, multidisciplinary team; WTE, whole-time equivalents. These figures are taken from Comhairle na nOspidéal (2004). They do not take into account whether posts are vacant or filled either in a temporary, part-time or permanent capacity. Accordingly, the figures are an overestimate of actual WTEs.

Box 2 Staffing requirements of a mental health of intellectual disability team for children and adolescents

Recommended minimum staffing requirements

1 consultant child psychiatrist plus multidisciplinary team per 100 000 population (Irish College of Psychiatrists, 2002)

Multidisciplinary team members

1 consultant child psychiatrist of intellectual disability

2 psychologists:

1 senior clinical

1 basic grade

2 social workers

1 principal

1 team leader

2 community mental health nurses:

1 community psychiatric nurse (grade CNMIII)

1 clinical nurse specialist dually trained in child psychiatry and learning disability

1 senior speech and language therapist

1 senior occupational therapist

2 non-consultant hospital doctors:

1 senior registrar

1 registrar

2 administrative staff:

1 Grade III

1 Grade IV

(clerical and administrative support is essential to the team)

psychotherapeutic skills, including psychotherapy, family therapy, cognitive-behavioural therapy and play therapy. Staffing requirements are summarised in Box 2.

It is important that treatment can be offered in a range of settings according to the complexity and severity of the mental illness: these include out-patient services, day hospital, in-patient services and respite care.

The service provision figures given in Table 2 reflect available information for the population aged 0–16 years. Additional research is needed for the 16–18 year age group. Further research is also required to predict accurately the numbers of day hospital places, in-patient beds and respite beds required, as information is very limited in this area.

Resources

The successful implementation of these proposals will depend critically on staffing and other resource issues. Mental health services will be effective only if they are delivered by appropriately trained and highly motivated staff and only in the context of high staffing ratios.

Team

In developing a multidisciplinary team attention is required to ensure an appropriate skill mix in order that a range of therapies can be offered. Attention also needs to be paid to team development and team functioning to maximise service delivery. Ongoing training is essential for all disciplines to ensure a high-quality service.

Accommodation

All in-patient units, day hospitals and out-patient services require high-quality, spacious accommodation constructed to suit the purpose. Cohesive and effective functioning of the mental health of intellectual disability team is enhanced by providing all the team members with their own offices and therapy rooms. This will maximise efficiency and output in regard to service delivery.

Equipment

A high-quality service requires the provision of adequate clinical equipment for professionals. Up-to-date information technology facilities are essential. Dedicated transport is required to enable patients to avail themselves of programmes at a distance from their home or residential centre.

Mental health services for young people aged 16–18 years

In the context of current practice and policy within mental health services there is significant potential for the development of a gap in services to older teenagers. To avoid disadvantage to an already marginalised group, it is recommended that mental health of intellectual disability services to older teenagers be adequately resourced. Consideration should be given to the development of day hospital and in-patient places that are appropriate for this age group.

5 Interface of the service

People with intellectual disabilities and mental health problems often present with complex social, medical and therapeutic problems. In order to develop a high-quality and dynamic mental health service for this group, each mental health service provider needs to strive constantly for optimal working relationships with other service providers.

The following describes potential areas of interface between the specialist mental health services for people with intellectual disabilities, and other allied agencies, services and administrative structures.

Interface between Health Boards and voluntary bodies

To provide the basis of equity and fairness in the distribution of mental health services to people with intellectual disabilities, it is essential for the Health Boards, in collaboration with the Department of Health and Children, to set out geographical areas of service, making up the catchment areas of population (similar to the distribution of services in adult mental health). It will be the responsibility of both the intellectual disability team and the mental health of intellectual disability team to provide services to the population in these areas. Consultation between the voluntary bodies, who are providing existing services, and the Health Boards will need to take place to determine the exact portions of the catchment areas to which the voluntary bodies will be contracted to provide services. Accountability and transparency are fundamental to all agreements.

Interface of mental health of intellectual disability team with administrative managers and clinical directors

It is envisaged that the proposed mental health of intellectual disability team will be headed by a consultant psychiatrist supported by an administrative manager. The administrative manager will be dedicated to the management and development of the resources of the team. The success of the team will depend on close collaboration between these two key individuals. Reflecting the structures in other services (e.g. Child and Adolescent Mental Health Services), and in order for high quality and cost-effective services to be developed, it will be necessary for regional Clinical Directors of Mental Health of Intellectual Disabilities to be developed. These clinical directors will be consultant psychiatrists appointed to provide overall clinical responsibility for a number of mental health of intellectual disability teams in a region.

Interface between the intellectual disability team and the mental health of intellectual disability team

The presence of severe mental health problems in people with intellectual disabilities is one of the leading reasons for either loss of community placements or retention in residential environments more restrictive than otherwise required. In order for people with intellectual disabilities and mental health problems to live successfully in the community, it is essential that the interface between the two teams previously described be structured to facilitate and develop communication and training.

Possible components of interface

Referral, assessment and treatment are all processes that will involve interaction between the teams. Individuals with mental health problems will be referred by their respective general practitioners to the consultant psychiatrist of the mental health of intellectual disability team for assessment and treatment if required.

- If the intellectual disability team is involved with the care of the referred individual, good practice suggests that the intellectual disability team should nominate a key staff member to work closely with the mental health of intellectual disability team, acting as a point of contact between the teams and also acting as an advocate for the individual concerned.
- Individuals successfully treated as in-patients will be discharged back to the care of the general practitioner, with appropriate community mental health follow-up if needed.
- For those individuals living in continued care mental health treatment units (or those requiring community mental health follow-up), their psychiatric care will be managed by the mental health of intellectual disability team.

Emergency cover

The mental health team must be structured and resourced to provide 24-hour emergency mental health cover to the catchment area, with access to adequately resourced emergency admission beds.

Training

The mental health of intellectual disability team would provide advice and training support to the intellectual disability team, as well as to front-line staff working in community residential settings. Of particular importance is the recognition that front-line staff working with people with intellectual disabilities and additional mental health problems need ongoing training and support in dealing with conditions such as schizophrenia, mood disorders, dementia and autistic

spectrum disorders. High-quality training requires adequate funding and support from management.

Mental health promotion

There is scope for the prevention of mental health problems in people with learning disabilities. The mental health of intellectual disability team should liaise with the intellectual disability team on issues such as early detection of mental ill-health and mental health service planning.

Interface with the generic mental health services

In general, urgent steps need to be taken by the mental health services for people with intellectual disabilities and the generic psychiatric services to facilitate a more flexible and adaptable approach to providing psychiatric care for this patient group. Consultants in intellectual disability psychiatry should be involved in local strategic mental health service planning, and there should be direct liaison between the mental health services for people with intellectual disabilities and the local generic mental health services to coordinate this interface. If any particular patient or group of patients is found to fall outside the locally operating service limits of adult psychiatry, child and adolescent psychiatry and the intellectual disability mental health services, a gap analysis should be made and followed by negotiation about future service provision. There should never be an assumption that either service will act as the 'default service'. This interface is most important for those individuals, both children and adults, with a mild intellectual disability and a psychiatric illness. Although a proportion of this group (those with high levels of adaptive functioning) will be looked after by the generic psychiatric services, people with a low level of adaptive functioning would in general be referred to the mental health of intellectual disability team for assessment and possible treatment.

General practitioner

The general practitioner remains the primary carer for people with intellectual disabilities. In most cases, the general practitioner should refer all appropriate mental health problems to the mental health of intellectual disability team. Priority should be given to the development of a close liaison between the general practitioner and the team regarding clinical issues, mutual education and training, in addition to developing referral and follow-up procedures.

Forensic services

Many people in prisons have intellectual disabilities, and a significant proportion of these people have a psychiatric illness or a substance misuse problem (Noble

& Conley, 1992; McGee & Menolascino, 1992). Currently there is no dedicated clinical service available to individuals who have both a forensic problem and an intellectual disability. There is an urgent need for the Department of Health and Children to set about examining possible service developments in this area. In order for a successful forensic mental health service for people with intellectual disabilities to develop, it must form close working and training links with mental health of intellectual disability teams as well as the generic psychiatric services. In addition, closer links need to be established between these mental health services and agencies such as the Gardai, and the Department of Justice and Law Reform, in order to improve legislative provision and custodial care for this group.

Specialist medical and dental services

People with intellectual disabilities who develop mental health problems often have concomitant medical, dental and/or sensory problems. Indeed, the complete assessment of problem behaviours or mental illness in this group often necessitates specialist medical input. However, significant barriers exist preventing easy access to these services. Closer links need to be forged with the general hospitals to facilitate access.

Social support agencies

People with intellectual disabilities frequently experience significant social problems, which almost always negatively affect mental health. Therefore there is an urgent need for the proposed mental health services described to forge close links with such agencies as the Health Boards, the Department of Education and Science, the Department of Social Welfare, the National Disability Authority, local authorities, youth services, community services, FÁS and the voluntary agencies, to achieve coordination of services.

Interface with academic departments in the universities

To advance research and teaching in the psychiatry of intellectual disability, closer links need to be developed between the voluntary bodies, the Health Boards and the universities. This will involve the development of joint appointments between the universities and service providers, similar to the developments in general adult psychiatry and in child and adolescent psychiatry. The initial aim would be the development of a professor/consultant psychiatrist post between a university and a service provider, with sessions working in both the university and the clinical setting. From this, other posts such as senior lecturer/consultant psychiatrist and lecturer could be developed, with the formation of an academic department. These developments, which reflect

international best practice, are essential for research on clinical and academic issues – examples include service development, epidemiological studies, psychiatric diagnosis and treatment, autistic spectrum disorder problem behaviours, evaluation of psychotherapies, child and adolescent intellectual disability psychiatry, old age intellectual disability psychiatry and genetics – as well as for taking part in international studies of relevance, and for collaboration with other departments such as general practice, psychology and nursing.

6 Role of the consultant psychiatrist in intellectual disabilities

The consultant psychiatrist has responsibility to develop and deliver mental health services to people with learning disabilities.

The context within which consultant psychiatrists work has undergone great change since the 1990s, with the publication of documents such as *The Psychiatric Services – Planning for the Future* (Department of Health and Children, 1984), the Health Strategy (Department of Health and Children, 2001) and the *Guidelines on Good Practice and Quality Assurance in Mental Health Services* (Department of Health and Children, 1998). The expectations of the public too have changed. They now expect a more transparent and accountable health service.

Some consultant psychiatrists in learning disability work with people of all ages, some work with adults only and others with children only. The competencies and values required by a psychiatrist specialising in learning disability are set out in *Good Psychiatric Practice*, published by the Royal College of Psychiatrists (2000). They include:

1. clinical competence;
2. understanding and acknowledgement of the role and status of the vulnerable patient;
3. bringing empathy, encouragement and hope to patients and their carers;
4. a critical self-awareness of emotional responses to clinical situations.

Clinical

- Consultant psychiatrists take responsibility for accepting referrals, assessing, diagnosing and treating the mental health problems of their patients, including monitoring of seclusion, restraint and usage of psychotropic medication in keeping with best practice.
- They give information about diagnosis and prognosis to patients, relatives and carers.
- They ensure that there is continuity of care plus cover for emergencies.
- Many consultant psychiatrists in learning disability also provide a neuropsychiatric service for people with epilepsy.

Management

- Consultant psychiatrists have a role in the development of mental health services and partaking in audit.

- Consultant psychiatrists have a responsibility for ensuring that the mental health service they deliver is in keeping with best practice, e.g. the availability of a mental health multidisciplinary team.
- Consultant psychiatrists have a responsibility for engaging in policy development relevant to mental health.

Education and training

- Consultant psychiatrists have a role in the education of medical, non-medical practitioners and the public.
- Consultant psychiatrists are expected to monitor their competence through a process of lifelong learning and to participate in continuing professional development.

Liaison

- Consultant psychiatrists have a responsibility to liaise with other professionals involved in health care.

Research and audit

- Consultant psychiatrists have a responsibility to engage in practice that is transparent and acceptable. Some consultant psychiatrists have an interest in research.

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