



thoroughly modernised, radically redesigned health service. It is highly likely that this new service will require more trained psychiatrists, even with clever redesign of professional tasks and roles. Perhaps the National Director could expend some energy unblocking the expansion of senior house officer training posts in psychiatry.

Declaration of interest

None.

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What is the future of the psychiatry of learning disability?†

Two surveys about learning disability service organisation and psychiatric staffing appear in this issue. Smiley *et al* (2002, this issue) had a 100% response from Scottish service providers to their survey looking at the relationship between psychiatric staffing levels, other resources and catchment area sizes. They found that services that had completed their resettlement programmes had the highest staffing ratios. In a survey of consultants in four English regions, Alexander *et al* (2002, this issue) had 67 (71%) responses, the majority of whom were satisfied with their jobs, despite being dissatisfied about the limited extent to which they had been consulted about management-led service reconfigurations. These consultants had a large measure of agreement about the focus of their clinical work being with people with learning disabilities who also have mental illness or behavioural problems. In addition, more than half thought that learning disability services should include people with high-functioning autism, and a third thought that they should include people with cognitive impairment resulting from head injury. This is particularly interesting following Carpenter's opinion in the February *Bulletin* (2002) that psychiatry of learning disability should encompass these groups and evolve into a new speciality of neurodevelopmental psychiatry.

The future of the psychiatry of learning disability has been the subject of lively debate since Professor Joan Bicknell's appointment to St George's Hospital Medical School in 1980. The same fundamental challenge remains now as it did then – to be clinically relevant and not just concerned with service delivery models. Bicknell's brief from the South Thames Regional Health Authority was to redefine the contribution of doctors to the health care needs of people with learning disabilities. Her

appointment followed the conclusion of the Normansfield Inquiry (Department of Health, 1978) into appalling conditions in a mental handicap hospital that, nevertheless, had had a distinguished early history. The report of the inquiry heavily criticised the medical superintendent.

Specialists in mental handicap have always been members of the Royal College of Psychiatrists and have had a prominent position within the College, but at that time this was as a separate speciality from mental illness. The service model was primarily a custodial one. Joan Bicknell's vision of learning disability as a psychiatric speciality aroused considerable anxiety and mistrust at the College, and perhaps this was understandable given the slow pace of long-stay hospital closure and the prominent role of mental handicap consultants within them. However, during the 1980s a number of psychiatric specialities were delineated, the psychiatry of learning disability gradually clarified its own position as primarily a community-based psychiatric speciality and the move away from separate health care for people with learning disabilities began to gain momentum.

In the early 1990s the Mental Handicap Section had a ballot on a change of name and the majority voted for psychiatry of learning disability. I recall proposing psychiatry of disability as one option and 11 others voted with me. The name of the Academic Department at St George's Hospital Medical School had already been changed from Psychiatry of Mental Handicap to Psychiatry of Disability. Our idea had been to explore the similarities and differences in the phenomenology of mental illness for people with learning disabilities, deaf people and people with sensory disabilities, head injury or autism. We were interested in the clinical relevance of mental health issues for all disabled people. Our proximity

†See pp. 299–301 and pp. 302–304 this issue.



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to the deaf mental health services at Springfield and an agreement by the health authority to establish a joint post for a psychiatrist in learning disability and physical disability had added impetus to this move (Kadambari, 1990). Furthermore, our teaching role in the medical school has always encompassed more than learning disability, with learning disability frequently being used as an exemplar for understanding broader disability issues, including social models of disability (Oliver, 1991). On the research and clinical front, however, these links have so far failed to develop in any substantial way, instead being areas of interest that operate more in parallel than through acquiring real synergy.

The big questions facing the speciality now are whether we should retain our focus on learning disability and strive to provide comprehensive community mental health services as the last surviving generalist speciality within psychiatry, or whether we should develop further as a tertiary speciality. Whichever direction is chosen must be coherent with the clinical needs of people with learning disabilities, be achieved within the workforce available and remain in line with changing policy aspirations. With respect to workforce, we can be pleased by the fact that recruitment to the psychiatry of learning disability is marginally easier than to adult psychiatry. However, when we compare the catchment area sizes suggested by the College with the existing workloads of consultants, it is apparent that we would need to double the number of posts to achieve adequate community coverage.

Given the stated targets of *Valuing People*, the recent English White Paper (Department of Health, 2001), the access and use of mainstream mental health services by people with learning disabilities will need to be facilitated by members of specialist learning disability mental health teams, with the additional support for personal care and communication that is required by many patients who have a dual diagnosis. In reality, most people with severe or complex disorders will continue to need specialist services in which all the staff will have additional skills to work with people with learning disabilities. However, these services must also meet the standards set out in mainstream guidance.

There are implications in these policies for all other branches of psychiatry and for the training of psychiatrists. The requirement has now been established for all senior house officers to have experience of developmental psychiatry before admission to the Membership. This must be audited to ensure that approved developmental psychiatry posts are providing relevant learning disability experience to equip all future specialists in psychiatry to meet the policy and practice expectations outlined above.

So what effect will these changes in policy direction and in the competencies of the workforce have on the future direction of learning disability psychiatry and on the mental health of people with learning disabilities?

Carpenter (2002) questions whether it is appropriate to determine which service someone receives by his or her IQ, but also whether the skills of learning disability psychiatrists only match the psychiatric needs of people with learning disabilities. He suggests that both

psychotherapy and forensic services for people with learning disabilities would be better placed as special interests within the specialities of psychotherapy and forensic psychiatry. He argues that this would then pave the way for a new Faculty of Neurodevelopmental Psychiatry to be created, encompassing neuropsychiatry and the psychiatry of learning disability and autism. People with learning disability or cognitive impairment following head injury or high-functioning autism all have a similar range of mental health needs to the rest of the population and will require improved mainstream access to mental health services. But some will also need to access tertiary specialist skills. Forensic learning disability psychiatrists will no doubt comment on the appropriate future home for their skills. However, with respect to psychotherapy I disagree with Carpenter. The skills required at a tertiary level will not just be in neuro-psychiatry but also in psychotherapy. Mainstream psychotherapy services should indeed become allies in helping to meet the emotional needs of people with learning disabilities, people with other neurodevelopmental disorders and their families. In my view, learning disability psychiatrists and neurodevelopmental psychiatrists should be well-informed about the complex emotional needs of their patients and understand the dynamics of caring. There will be a need for some disability psychiatrists to have advanced psychotherapy skills and to be able to bridge both disability and psychotherapy services.

It is a time of change. As the stigma associated with learning disability diminishes and our public services become more inclusive, psychiatrists must beware of being the last to embrace those changes that are truly in the interests of our patients. The strength of our speciality will always be in its clinical relevance.

Declaration of interest

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