Shared Protocol for Learning Disability & Mental Health Interface Working

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Revision/Amendment Information

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0		New Policy	L Nicholson
2.0			J Fitzpatrick

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1. Context

1.1. This Protocol details the interface arrangements between Specialist Learning Disability Services and Community Mental Health Services.

As defined by the Service Specification for Mental Health Service in the Community, Community Mental Health Services comprise Primary Care Mental Health Teams (PCMHT), Community Mental Health Teams (CMHT), and Specialist Community Mental Health Services (including the following; Forensic CMHTs (including the Forensic LD Team), Adult Autism, Adult Eating Disorder Service, Esteem, Psychotherapy, Perinatal and Psychological Trauma Service.)

Community Specialist Learning Disability Services are provided through Learning Disability Teams in each HSCP. The teams have a wide remit as defined by the Learning Disability NHS GG&C Strategy for the future framework, and health input is provided by Learning Disability Nursing, Occupational Therapy, Psychology, Learning Disability Psychiatry, Speech and Language Therapy and Physiotherapy. Referrals for mental health are discussed through a multidisciplinary team meeting and allocated to the appropriate professional. The majority of referrals to the team are not for mental health problems.

1.2. For most people using Mental Health Services, it is clear which service best meets their needs. This protocol should be used for the small number of people for whom it is less clear which service best meets their needs, and for people who would benefit from input from both Specialist Learning Disability Services and Community Mental Health Services.

1.3. NHS GG&C Specialist Learning Disability Services and the various Community Mental Health Services have Operational Policies in place. This protocol should be followed in conjunction with existing Operational Policies[i]. The protocol is about high level principles around interface arrangements; it is not intended as an operational policy and it has not given specific examples. Instead it provides the principles and a framework to support a needs-led model of mental health provision.

2. Principles

2.1. The overriding principle behind this Shared Protocol is that people should access whichever service best meets their needs as an individual. People without a learning disability should be able to access Specialist Learning Disability Services if they have additional relevant needs that are not able to be met by Community Mental Health Services and require specialist Learning Disability skills. People with a learning disability should be able to access Community Mental Health Services if this is more appropriate for their needs. If patients need to access aspects of both services then this should be facilitated by services. If a patient's needs change with time then they should be supported to change services as appropriate.

2.2. Whilst the term “learning disability” may be helpful in directing referrals to Specialist Learning Disability Services, it should not necessarily determine which service the person finally accesses.

2.3. Services should work together with the patient, professionals and their support network to identify which service is most appropriate. This should be done as quickly as possible in order for patients to receive the help and support that they need without delay.

3. Point of referral

3.1 The referral should be accepted by the receiving service and should undergo the usual screening process as described by the relevant operational policy. If the receiving service is able to meet the needs of the patient then they should provide a mental health service as per operational policy.

3.2 Where initial screening suggests that an alternative service would better meet the patient needs, the receiving service should contact the relevant service with the necessary supporting information to discuss the referral.

3.3 The referral remains with the receiving service until agreement is reached with an alternative mental health service. If immediate treatment is needed before an agreement can be reached, then the receiving service should provide treatment. Treatment should be provided according to existing agreed timescales. If emergency treatment (including Out Of Hours treatment) is required then the patient should accesses this as per current existing operational policy. If patients are unknown to services, emergency mental health assessments should be provided by the local CMHT. It is important that transfers between teams are not made during a crisis situation as this presents a risk as the receiving team will have no working knowledge of the client.

3.4 Whenever possible, agreement should be reached at a local level. Where an agreement between mental health services cannot be reached, this should be escalated as appropriate to the relevant Clinical Directors and Heads of Service.

3.5 If it is felt that a service out with Mental Health Services would better meet the patient’s mental health needs, then the referral should either be redirected as appropriate, and/or clear guidance should be given to the referrer/patient so that they can access alternative services. If referring to another service within NHS GG&C then relevant policy should be adhered to (e.g. Mental Health Addictions Interface protocols).

3.6 All discussions and decisions regarding redirection of referrals should be clearly documented in the receiving service paper/electronic patient notes. All referrals should be discussed and agreed before formally transferring to another service.

3.7 Once a decision has been reached, the referrer (and G.P. if he/she is not the referrer) and patient should be informed according to existing operational policy.

4. Ongoing care and review

4.1 Services may request advice or assessment from alternative services as appropriate. This would usually be a verbal request in the first instance, followed by a formal written request to allow services to track service activity.

4.2 Following further ongoing assessment, it may be apparent that the patient needs would be better met by an alternative service. In this case the service should contact the relevant service with supporting information to request transfer. Patients should only be transferred after consultation with the patient and relevant service, and if they are likely to actively benefit from the transfer. Patients should not be transferred purely on the grounds that they do or do not have a learning disability.

4.3 If a patient has autism and a learning disability, care and treatment would normally be provided through Specialist Learning Disability Services. Other patients are able to access the Adult Autism team for assessment and diagnosis of ASD specific issues.

4.4 In some instances, it may be in the patient's best interests to be open to both Community Mental Health and Specialist Learning Disability services. In this case, there needs to be clear agreement as to which team is responsible for managing which aspect of patient care including in-patient admission. There should be multidisciplinary reviews with input from both teams. A single Key Worker from one of the services must be identified as a point of contact for the patient, and to coordinate care between the teams. A Care Programme Approach (CPA) may be appropriate to help coordinate complex cases.

4.5 In some instances, a patient may benefit from a specific service that is available only through the other service (for example, access to One-Stop Clozapine Clinics). In this case, a cross-referral can be made to the appropriate service. Where a service has greater experience or expertise in a particular approach which may benefit a particular patient the service holding the case may wish to consult with that service for support in adapting their approach to better meet the patient's needs.

5. Interface with inpatient services

5.1. The same overriding principle applies to patients accessing inpatient services i.e. people should access whichever service best meets their needs as an individual.

5.2. A very small number of patients with very mild learning disability and who present with mental health problems that are not related to their learning disability may have their needs better met on a General Adult ward rather than through Specialist Learning Disability Services. If this is likely to be the case then prior agreement should be reached through discussion between the relevant admitting and community Consultant Psychiatrists. The General Adult consultant will act as RMO for the course of admission, but should have input from Specialist Learning Disability Services throughout the course of admission and in particular in relation to discharge planning.

5.3. If a patient open to Learning Disability Psychiatry requires admission to a specialist bed, but a bed is not available within Specialist Learning Disability Services then the patient should be admitted on an alternative ward until a bed becomes available. Learning disability services will continue to provide supportive input to the ward team during the inpatient admission and will arrange transfer when a specialist bed becomes available.

5.4. If a patient open to Learning Disability Services is admitted to a General Adult ward out of hours then the Bed Manager should contact the relevant Learning Disability Service the next working day. Most patients will already be open to Learning Disability Psychiatry; if this is not the case then a cross-referral should be made by the admitting Consultant Psychiatrist. Once the referral has been accepted, the Learning Disability Psychiatrist will be responsible for liaising with Learning Disability Services to provide specialist input, including transfer to a Specialist Learning Disability ward if appropriate.

5.5. Under ideal circumstances all admissions should be planned, discussed and agreed during working hours; if a patient with a learning disability presents and requires admission out of hours this may not be possible. Out of hours procedures should then be followed and the decision to admit should be based on clinical need. Further discussion with Specialist Learning Disability Services should take place at the earliest possible opportunity as described above.

5.6. If an inpatient is suspected of having a Learning Disability but is not known or open to Specialist Learning Disability Services and the diagnosis of Learning Disability has not been confirmed, a cross-referral to the appropriate community learning disability team may be made by the admitting Consultant Psychiatrist. Unless there are urgent clinical needs that cannot be met by General Adult inpatient services, this will be dealt with through the usual referral procedures as per operational policy.

5.7. All of these processes are documented in detail in the Greater Glasgow and Clyde Psychiatric Emergency Plan 2019 - 2020[ii].

6. Discharge

6.1. If patients are open to both Community Mental Health Services and Specialist Learning Disability Services, then both services must be in agreement around discharge arrangements. For example, it may be appropriate for all aspects of patient care to be transferred across from one service to another, and the patient formally discharged from one of the services. This should only take place after discussion and agreement between services.

6.2. Sometimes a patient will be accepted and treated by one service; but it is felt that subsequent episodes of mental illness would be better treated by an alternative service. This should be discussed with the patient, and agreement reached and documented with the alternative service prior to discharge.

7. Guidance to support using the protocol

Additional guidance has been appended to this protocol to support professionals with less experience of working with people with learning disabilities and Specialist Learning Disability Services.

7.1. Who should access Specialist Learning Disability Services?

This document is a high level protocol setting out the principles of how discussions around referrals should work. The overriding principle is that people should access services according to need. For most people with a learning disability, the most appropriate service to meet their individual need will be Specialist Learning Disability Services; but consideration of need should always take priority over diagnosis for people either with or without a learning disability.

The tables in section 7.1 and 7.2 provide guidance to help professionals have a better understanding of learning disabilities and learning disability services.
However, the tables should not be used either to include or exclude people from services; and clinical judgement should always be used.

More likely to benefit from Specialist LD Service	Less likely to benefit from Specialist LD Service
Moderate-profound LD	Very mild or "borderline" LD
Complex physical health problems related to LD e.g. treatment resistant epilepsy, PEG feeding, cerebral palsy	
Significant communication difficulties	Reasonable verbal communication skills
Challenging behaviour which requires a specialist LD multidisciplinary approach.	Very mild LD with primary problem of mental illness, addiction or offending

More likely to benefit from LD specialist service	Less likely to benefit from specialist LD service
In receipt of LD specialist social care services.	Not in receipt of any LD specialist social care services
Would require LD specialist in-patient treatment Significant difficulty accessing mainstream physical health services	Could reasonably access mainstream in-patient service Would not require specialist support to access mainstream physical health services
	Individuals who do not view themselves as needing a specialist LD health service

7.2. How to determine whether a person has a learning disability

A learning disability is defined as Global Cognitive Impairment (IQ<70) with onset before the age of 18 and associated with significant functional impairment in at least 2 areas. A full assessment of learning disability therefore requires formal cognitive and functional assessment supported by a developmental history. Most people accessing learning disability services have not had a full formal assessment. If the diagnosis is unclear, then Specialist Learning Disability Services would usually assess this through a face-to-face visit, supported by relevant history and, sometimes also supported by a structured information gathering tool. This approach to assessing which service may be appropriate will be taken in the first instance (and should be sufficient in the majority of cases) before considering the need to refer to psychology for psychometric assessment.

When a patient is referred to Community Mental Health Services or the Specialist Learning Disability Services and there is question as to whether an alternative service may be more appropriate, the referral should be reviewed through the usual multidisciplinary screening and information gathering process in order to establish whether the person is likely to have a learning disability. Depending on the nature of the referral this may include case note review, gathering information from Primary Care and Social Work records, telephone discussions with the referrer and other appropriate parties and a face to face meeting with the patient. Community Mental Health Teams are encouraged to liaise with Specialist Learning Disability Services for advice around assessment of suitability for referral to LD service as appropriate and referral would not usually depend on formal cognitive assessment.

The following table gives a range of indicators to help facilitate a clinical decision; clinical judgement should always be used.

More likely to have a learning disability	Unlikely to have a learning disability
Attended Special Education services (although caution must be applied as certain Special Education schools will accept pupils with other difficulties such as ADHD or behavioural problems.)	Attended mainstream school (unless with significant one-to-one support).
Have not achieved any mainstream qualifications including NVQ, HNC etc.	Achieved mainstream qualifications (even with support).
Unlikely to have a diagnosis of a specific developmental disorder such as dyslexia as this is more likely to have been subsumed by the diagnosis of "Global Developmental Delay" as a child.	Have a diagnosis of a specific developmental disorder such as dyslexia.
Have a diagnosis of "moderate learning difficulty	Have a diagnosis of "mild learning difficulty".

Unlikely to have a learning disability	More likely to have a learning disability
Literate - if a person has no difficulty in filling out forms and reads novels for pleasure they are unlikely to have a learning disability.	A large number of people in NHS GGC without a learning disability have poor literacy skills and this alone is not helpful in supporting a diagnosis.
Developmental milestones within normal range (although a precise history may be difficult to get, and people with a mild learning disability may have normal developmental milestones).	Developmental milestones outside normal range.
Educational problems not picked up until late primary school/High school.	Educational problems picked up at nursery or early in primary school.
Have maintained a full time job at any point in the past- especially any full time job where literacy skills are required.	Unable to maintain a full time job or in supported employment.
Manage household finances without support.	Receiving external support with household finances.
Manage day-to-day running of household without support.	Receiving external support with day-to-day management of household.
Able to cook a complex meal (e.g. making a hot meal from scratch which involves attending to several components) unsupported.	May be able to cook unsupported, but typically heating up prepared food or cooking food that requires little preparation.
Full independent travel.	May travel independently, but typically only uses a small number of fixed routes and unable to read timetables.
Does not identify as having a learning disability, and does not have peers from the wider community of people with learning disabilities.	Identifies as having a learning disability, and has peers from the wider community of people with learning disabilities.
Has not needed to access Specialist Learning Disability Services in the past (for any aspect of health or social care).	Has previously accessed and benefitted from Specialist Learning Disability Services.
No relevant history of brain injury before the age of 18.	History of relevant childhood brain injury (such as pre/perinatal problems, childhood infections such as meningitis, or significant head Additional physical health problems or known syndrome associated with learning disability.

Although face-to-face interview can support a decision, it can be extremely difficult on the basis of presentation alone to be confident that a person has a mild learning disability. Issues to bear in mind before reaching conclusions include:

- Some people with a learning disability may be reluctant to acknowledge problems and may not wish to be identified as having a learning disability.
- In Children's Services, the term "learning difficulty" is generally used in an educational context. Children with a "moderate learning difficulty" are likely to have a mild learning disability, and children with a "mild learning difficulty" usually function above the learning disability range as adults.
- In the context of health and social care for adults, the meanings of the terms learning disability and learning difficulties are less clear cut and can be used interchangeably. Some people with learning disabilities may prefer the term learning difficulties, whilst some people with learning difficulties may prefer to identify themselves as having a learning disability. Professionals are not always careful to identify what is meant by the terms, and may make transcriptions errors leading to further confusion.
- People with a mild learning disability may be experienced at compensating for, or attempting to mask any cognitive difficulties.
- People without a learning disability may have cognitive impairment for a range of other unrelated reasons (e.g. alcohol related brain damage; dementia). Factors such as severe social anxiety and cultural experiences may also affect presentation at interview.

A provisional diagnosis of mild learning disability should therefore not be purely based on presentation at interview, but should be supported by incorporating information from the person's history into a wider formulation of their difficulties.

7.3. Examples of when joint working may be of benefit to the patient

Specialist Learning Disability Services may wish to link in with Community Mental Health Services:

- For advice and support with the management of patients with conditions that are seen in Specialist Learning Disability Services less often (such as Emotionally Unstable Personality Disorder or Drug induced psychosis.)
- For advice and support with specific nursing issues around mental health (NB Learning Disability Nurses have a different training pathway to CPNs)
- For patients with a learning disability who are accessing Crisis services or Inpatient services on a frequent basis, to establish a joint management plan.
- For advice on how to access appropriate community supports for people with very mild learning disability who do not wish to link in with learning disability services.

Community Mental Health Services may wish to link in with Specialist Learning Disability Services:

- If a patient is presenting with “Challenging Behaviour” that might benefit from a Positive Behavioural Support approach.
- For advice and support from Learning Disability Nursing colleagues around supporting people with complex physical health needs.
- For advice and support for patients with significant cognitive impairment or communication difficulties.
- For complex issues around capacity relating to cognitive impairment.

[i] Mental Health Services Community and Specialist Services Review, Service Specification for Mental Health Services in the Community, NHS GGC, April 2016, v.10 150416

[iv] From Community Learning Disability Team Standards and Processes, Specialist Learning Disability Services NHSGGC, 2014, Appendix 2

[i] NHS Greater Glasgow and Clyde Community Mental Health Team Operational Policy (Draft April 2016), Glasgow City CHP Learning Disability Operations Manual February 2013, Community Learning Disability Team Standards and Processes, Specialist Learning Disability Services NHSGGC, 2014

[ii] Greater Glasgow & Clyde Psychiatric Emergency Plan (PEP) 2019 - 2020, Section 9 pp 55-59