Advisory Paper to the Department of Health

Mental ill-health in people with Learning Disabilities: a coordinated and considered care approach

March 2012

The Judith Trust

Established in 1997, The Judith Trust works for all those with both learning disability and mental ill-health to identify and close the gaps that they experience in their lives (especially those of women and members of the Jewish community). The Trust seeks to ensure that the emotional, social, health and spiritual needs and concerns of this group of people are understood and met. The Trust works to enable their full integration and inclusion within society by developing new thinking, research and best practice.

Background

The Problem

Why are people with learning disabilities more likely to develop mental ill-health?

Mental ill-health is common, affecting one in six adults at any one time (ONS, 2000) and research suggests that adults with learning disabilities can be up to three times more likely to develop mental-ill health (Emerson, Hatton, Robertson et al 2010) This could be due to those with a learning disability being more vulnerable to various factors - social, psychological, emotional and physical that can predispose people to mental health problems. These factors are addressed individually in more detail on our website http://www.judithtrust.org.uk/learning-disability-and-mental-ill-health/social-psycological-emotional-and-physical-issues/

Incidence of particular mental ill-health in people with learning disabilities

- Schizophrenia has a prevalence of 3 per cent in people with a learning disability. This is three times higher than those without a learning disability (O'Hara and Sperlinger, 1997).
- Between 1.3 and 3.7 per cent of people with a learning disability will have depression at any one time. This is twice as high as for the general population (Deb et al., 2001).

- Generalised anxiety disorder is equally common, and according to some studies more common, among people with learning disabilities (Raghavan, 1997).
- The prevalence of dementia for people with Down's syndrome is significantly increased; with prevalence rates of 9 per cent for ages 40–49, 36 per cent for ages 50–59 and 55 per cent for people aged 60–69 (Alzheimer's Society, 2000).
- There are higher rates of bipolar disorder in people with a learning disability (Dosen and Day, 2001).

In order to better understand the importance and potential impact of these factors and incidences, the Judith Trust commissions research to address and understand some of these issues and in turn campaigns for change where appropriate to do so. Please see http://www.judithtrust.org.uk/our-work/research-projects/previous-research/ for further details of the Judith Trust's previous research. In November 2011 the Judith Trust held a roundtable to launch and discuss the implications of its most recent research; *Mental Health Services for Adults with Learning Disabilities*[1]. The main emphasis of this research was to answer the question 'What makes a good carer?'

In response to this event Bruce Calderwood, Director of Mental Health and Disability at the Department of Health, who addressed the roundtable, asked the Judith Trust to coordinate a paper that detailed the key recommendations and further work to be considered in this area.

The Current Climate

Last April the Government embarked on a process to 'pause, listen, reflect and improve' NHS reform plans. This has resulted in a variety of outcome-led measures to improve how the NHS operates and more importantly how it develops a programme of integrated care with adult social care, a modernised health and care system.

The purpose of this paper is not to examine these measures as a whole - the Judith Trust supports the report, 'Integrated care for patients and populations: Improving outcomes by working together', published by the Kings Fund and the Nuffield Trust (January 2012) - but to focus on its impact for those who have learning disabilities and mental ill-health, their families and carers. Central to this report is the important role gender plays to ensure effective service delivery.

We have entered a period where the commissioning and the delivery of care is facing fundamental reform, and thus presents a poignant time to reflect on changes that can be made which could have a positive impact on the lives of those with learning disabilities and mental ill-health.

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[1] Stenfert Kroese,B., Rose, J.L. (2011) Mental Health Services for Adults with Learning Disabilities

Case Study

Sally

Sally has mild learning disabilities. Throughout her life, Sally has been labelled as having 'challenging behaviour'. She has volatile relationships with her family and her peers. She can be destructive to the environment and has been known to self-harm. This has resulted in a number of unsuccessful placements in residential and supported living environments, and an inability to hold down a job, or to sustain relationships.

Sally turned 40. At this milestone in her life, she felt nothing but disappointment and failure. She compared her life to that of her sister, who is married and has children, a job she enjoys and a beautiful home. Sally realised she would never have any of these things and within a year, she tried twice to cut her wrists. This only resulted in superficial cuts and the Psychiatry team therefore labelled it as 'attention seeking' and discharged her.

Within the Local Authority's Learning Disability Team that supported her, they continued to work on Person-Centred Planning, supporting her to mix with peers with learning disabilities and to maintain relations with her family. She did voluntary work experience and eventually got a job for three hours a week, with support from a Job Coach. However, Sally still spoke about how worthless her life was and became increasingly angry with her family for being 'successful' and with herself for her 'failures'. She ended most of her friendships as she resented being friends with people with learning disabilities, whom she saw as 'failures' like herself. She continued to talk about killing herself.

Eventually, Sally was offered counselling from the local Learning Disabilities Team. Her support worker contacted a local voluntary organisation for people with mental ill-health, hoping to offer her some new opportunities for activities, friendships and support. As part of their acceptance criteria, they requested a letter from her GP to confirm she had mental ill-health. The GP said there was no such diagnosis on her records. Her counsellor also refused to write this letter, saying that she had learning disabilities and that it would not be helpful to give her additional labels. Sally was therefore not able to access this service.

Sally is now 44, and has recently been given anti-depressants. This decision came as a last resort, from professionals who felt they did not know what else to do for Sally, and through pressure from her family. Her relationship with her family is now more stable and she is starting to contact old friends with whom she lost touch. She is now working independently in her job, and looking for further employment.

Sally's case illustrates why people with learning disabilities are more vulnerable to mental ill-health. At the same time, it shows how an appropriate diagnosis of mental ill-health can be over-shadowed by a 'diagnosis' of learning disability, however mild. A lack of integrated working meant Sally was pigeon-holed into learning disability services and was unable to access the mental health services she needed.

Key Messages

As a result of the research and the roundtable event, some key messages have become particularly apparent relating to those specifically with both learning disabilities and mental ill-health which need to be considered by the Department of Health. These are:

- **Recruitment and Selection**
- **Training and Ongoing Support**
- **Interdisciplinary Working**
- **A Family Centred Approach**
- **Commissioning of Learning disabilities and Mental Health Services**

These will be explored in more detail below.

Key message

Recruitment and Selection

Ensure the recruitment, selection, training and ongoing support for staff reflects the need to retain a 'workforce which possesses the attributes, experience, knowledge and skills needed to work with this group of service users'.[2]

In January 2012 the NHS launched its Policy, 'Liberating the NHS: Developing the Healthcare Workforce *From Design to Delivery'* which sets out a new training and education system to ensure 'the needs of patients and the public' are 'served by a workforce that has the skills and knowledge to provide safe, effective and compassionate care at all times'.[3] With the vast changes about to be embarked on by the NHS, it is hoped that when the Department sets their education and training outcomes, these will be implemented effectively for those with learning disabilities and mental ill-health. Part of this **implementation must start at the recruitment and selection stage and must not just begin once a member of staff is appointed.**

As demonstrated in the Judith Trust's most recent research, it is crucial to include **'well-defined personal qualities in Person Specifications'.**[4] The case below supports the importance recruitment and selection processes play in successful choices and retention of staff, even and although operating in an environment of high staff turnover, and is one example of how organisations are undertaking this work.

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[2] Stenfert Kroese,B., Rose, J.L. (2011) Mental Health Services for Adults with Learning Disabilities, 21

[3] Department of Health (2012),Liberating the NHS: Developing the Healthcare Workforce From Design to Delivery, 7

[4] Stenfert Kroese,B., Rose, J.L. (2011) Mental Health Services for Adults with Learning Disabilities, 21

Case Study

MacIntyre Great Interactions

The MacIntyre Great Interactions staff selection and training programme is a combination of recruiting front line social care workers through the use of a bespoke personality profile and competency framework and specific training in facilitation skills - those soft skills that underpin warm, effective and person-centred interactions.

Many people believe that very good support workers are 'naturals' – i.e. people with intuitive ways of working that set them apart from others. Three years ago MacIntyre undertook some research into understanding the personal characteristics and behaviours of 'naturals' to gain a better understanding of how to improve success at the point of recruitment. Using a standard personality test (known as RPQ) which assesses five core personality types MacIntyre discovered something very striking expressed by MacIntyre's Chief Executive:
'Our so-called naturals (over 100 people assessed) were similar to the general population except for two important areas - benevolence (perhaps not surprising) and introversion (totally unexpected). From this an idealised personality profile was created (known as the MacIntyre Profile) and all new recruits are assessed against this. The selection interview is then structured by the use of a competency framework which was compiled following interviews and observations of high performing front line staff'.

With support from external HR specialists and with the full involvement of front line colleagues, combined with observation of work in practice, MacIntyre has created its own set of competency frameworks. These have been incorporated in job descriptions, supervision and appraisal and are used at interview. Examples include: "Listens to and checks their understanding of others' views, ideas and feelings" as opposed to: "Assumes they understand the views, ideas and feelings of others without listening or asking". Also "Expresses confidence and self-belief in the ability or success of others by providing encouragement and praise" rather than "Focuses on risks/ difficulties/problems/obstacles facing others during the task".

Since implementation of this method, evidence collated across the organisation has supported the belief that there are positive effects on core workforce performance indicators. There has been a marked improvement in workforce retention, less sickness and absence, a greater take up of formal learning opportunities and significantly fewer management issues of low level performance.

To find out more about Macintyre's 'Great Interactions' please following the link below http://www.macintyrecharity.org/Resources/?/Great+Interactions/45/

Gender Perspective to Recruitment

A dominant theme emerging from the Judith Trust's recent research **was the importance of the personal qualities of male and female staff. The latter were often described as better at listening and being more gentle and understanding whereas some male staff were viewed as having less empathy**. On the other hand, many female staff respondents noted how male staff often had more

authority and they emphasised the value of having male staff act as appropriate role models.[5] While these are stereotypical models, they clearly have dynamic effects. Professionals who attended the roundtable reinforced the emphasis in the report that there **are too few male workers available for these roles because the workforce is predominately female.**

The roundtable also particularly welcomed the gender perspective presented in a separate section of the report, and commented that having such a perspective and **the gendered analysis of care work was a vital contribution to understanding and to effective staff training.**

Involvement of service users in recruitment and selection process

In addition our research suggested it was important to '**appoint service users on interview panels in order to rate candidates according to those (personal) qualities'.**[6] Many organisations have endeavoured to **include service users in their recruitment and selection processes;** this has been done in diverse ways and with varying degrees of success. Meaningful involvement must include training for service users on recruitment, to enable them to understand and effectively fulfil the role.

The views and concerns of service users are reflected throughout the process, from setting person specifications, designing interview questions and in assessing candidates. It is vital, as part of the assessment process, to see how the candidate interacts with, and responds to, the service users. **Involvement also sends a clear message to prospective staff that service users are central to what an organisation does, that their voice is valued and their views are translated into action.** This can be reinforced through the co-delivery of induction training by managers and service users, setting a clear expectation for the new staff member as to the status of service users in an organisation.

Pay Scales of Support workers

Even before the cuts being made at the present time, **pay scales for support workers were too low and there is often no meaningful career structure in place**. Many staff do not have English as their first language; many are drawn from minority ethnic groups so that care staff are often minority ethnic women on minimum wage. Staff who work in community and residential settings should be rewarded for taking on more responsibility or knowledge; feeling valued and knowing there is an investment in them will hopefully attract high quality people to the work (including those whose first language is English) and improve staff retention. It would also reduce the potential costs of repeating the recruitment process and having to train staff from scratch. **Caring is a skilled role and working with people with mental ill-health and learning disabilities is an additional challenge. This work should be seen as a progression in their career, as it requires additional experience and skill and should therefore attract higher rates of pay.** At present rates of pay do not differ regardless of the problems of the service user with whom they are working**. When commissioning services this must be addressed.**

[5] Stenfert Kroese,B., Rose, J.L. (2011) Mental Health Services for Adults with Learning Disabilities, 45

[6] Stenfert Kroese,B., Rose, J.L. (2011) Mental Health Services for Adults with Learning Disabilities, 21

We understand that support workers, especially women, are not always willing to move up a career ladder to a management role. One such woman recently explained, 'I would get 50p an hour more so why would I want to be a manager with all that added responsibility and long hours and no overtime and no more 'real care work' – just getting other people's rotas straight?'[7] Others want less responsibility and closer contact with the people for whom they are caring both for its own sake and because it also offers them greater freedom to be with their own families and/or lead more fulfilling lives beyond the job. Offering additional development and pay through working with people with more challenging needs, offers an alternative career progression for such women; retaining their skills, knowledge and experience.

Key Message

Training and Ongoing Support

Whilst there has been some improvement in the last decade, training and continual support to support workers who work with people who have learning disabilities and mental ill-health **has not been embedded within organisational structures, which has a detrimental effect on service users whose mental health problems may not be recognised, and, as such, termed 'challenging behaviour'** (especially common for men)**.** One would rarely see this ignored if someone *without* a learning disability presented with equivalent behavioural problems. Furthermore, mental health problems which lead to a person's withdrawal or reduced functioning, as may occur for instance in depression, may fail to be recognised as a problem at all. These are especially prevalent issues for women.

Whilst there are various generic training courses / modules that address mental health, **they are not delivered in the context of understanding a person with a learning disability experiencing mental ill–health.** There are optional units on the Qualifications and Credit Framework (QCF) Health and Social Care Diploma (Levels 2+3) in supporting people with learning disabilities that look specifically at mental health. These address promoting mental well-being, risk factors for mental ill-health, classification of mental health conditions and the impact of mental ill-health. However, **they do not address the practical steps of what to do where mental ill-health is suspected or identified. This must change to ensure staff are fully knowledgeable in order to deal with this situation when it arises. This qualification is weak and should address intervention and not only recognition of the problem.** It is also important for QCF units to be developed for care managers at level 5

A core component of staff training for people with learning disabilities does deal with challenging behaviour, because such behaviour is relatively common for this group. Challenging behaviour is generally viewed as a form of communication and a response to factors external to the individual. As such, the solution to challenging behaviour is also to be found externally to the individual. Challenging behaviour training does recognise that when there is a 'medical problem' the cause of the challenging behaviour may lie within the person. However, the lack of awareness amongst care

[7] Personal communication, key worker, residential care home for the elderly, JT.

staff of mental ill-health in people with learning disabilities means that primarily this is taken to mean *physical* health needs. As a result, there are likely to be times when behavioural interventions are being pursued where the cause may be *mental* ill-health. Raising awareness of mental ill-health, and its effects on behaviour amongst learning disability care staff would empower them to identify mental health concerns and seek appropriate help to address these. **Guidance for care providers, trainers and commissioners of training for learning disability services, should ensure that all staff receives basic mental health awareness training and that the issue is also addressed in all challenging behaviour training.**

As discussed above, **it is important to investigate the effectiveness of training aimed at supporting both male and female staff** who work with adults with learning disabilities and mental-ill health in developing the interpersonal qualities (traditionally considered female although not necessarily an aspect of all women's personal qualities), relevant to listening skills and expressing empathy.[8] Training should also aim to affect underlying values as to what care work is about, which varies between genders and cultures. It is particularly common amongst ethnic minority cultures, and amongst women, for care work to be defined as "caring for…", rather than focusing on the empowerment and enablement agenda promoted in Valuing People. Moving from 'doing for…' to 'doing with…' is a cultural shift on which the move towards supported living and the employability of people with learning disabilities is dependent.

Key Message

Interdisciplinary Working

At the roundtable, a vast majority of those present spoke about the need for those working in both learning disability and mental health settings **to understand each other's work and to ensure there was good liaison between professionals.** One delegate said:

'I think that it is very hard to over-estimate how little people in one sector understand the other, and so getting together and sharing basic information is vital. I managed several learning disability social workers who didn't understand mental health services at all – the difference between a psychologist and psychiatrist, for example'.

This reiterated the statement in our report, '**regular reviews and good liaison between professionals was seen as an important determinant of service quality by both users and staff'.**[9] This can be realised by ensuring not only that **those with learning disabilities are provided with annual physical health checks, but that 'mental health is (also) included in the standard health checks and relevant primary care staff is trained in the symptomatology of mental health problems in people with learning disabilities'.**[10] Once a GP or other health care professional sees someone with learning disabilities they must continue to see them as an individual. This is to ensure

[8] Stenfert Kroese,B., Rose, J.L. (2011) Mental Health Services for Adults with Learning Disabilities, 46

[9] Ibid, 21

[10] ibid

mental ill-health can be recognised. They may, however, not know how best to communicate with a person with learning disabilities, or to interview a person with learning disabilities so as to assess whether there is also a mental health problem. However, there is work being undertaken at present to address these needs and to publish the training packs.

In fact, one good result of the Roundtable consultation **was to point to the many resources available to professional and support staff.** The Estia Centre at SLAM NHS Trust with whom the Judith Trust has worked for many years, for example, provides some excellent training courses to a wide range of professional staff. And there are some widely available tools, simple to use even by those without qualifications such as the PAS-ADD Checklist, developed by Dr Steve Moss, which can be used by family members and support staff (without training) to check whether a person might need formal assessment for a mental health problem. Moss has also developed the Mini PAS-ADD (for adults) and CHA-PAS (for children) for qualified nurses, occupational therapists, social workers and others to carry out a more detailed assessment, drawing on information from carers and where appropriate, the person themselves. Most recently, Pavilion has published the new PAS-ADD Clinical Interview which provides psychiatrists and psychologists with a complete assessment of a person's mental health functioning. All these tools, which have been translated into a range of languages so are useful for minorities without English, are based on the World Health Organisation and American psychiatric classification systems and training is available on how to use them.

The Mencap Campaign 'Death by Indifference', the subsequent 'Six Lives' Report by the Health Ombudsman and the Department of Health's response(http://www.mencap.org.uk/campaigns/take-action/death-indifference/six-lives-report) and Mencap's most recent report 'Death by Indifference: 74 deaths and counting'(http://www.mencap.org.uk/74deaths) highlight the fact that **hospitals are failing to provide proper healthcare to people with learning disabilities**. The issue of 'diagnostic overshadowing' was a key factor in this report, whereby the fact that the individual has a learning disability is then regarded as a cause for many symptoms, rather than investigating other underlying health factors. The same situation arises with mental ill-health.

Signs and symptoms of mental ill-health, which would result in appropriate mental health referral and diagnosis in the mainstream population, are attributed to the learning disability. Such signs and symptoms might include obsessive behaviours, self-harm, frequent tearfulness, disengagement from routines and other people, and the like. **For these symptoms to be effectively addressed there needs to be a greater awareness of the prevalence of mental ill-health in people with learning disabilities, inclusion of mental health in annual health checks, and clearly defined assessment methods for diagnosis as mentioned below**.

There also needs to be learning about the ways in which symptoms of mental ill-health are distributed differently in the population according to gender and other cultural differences including race and ethnicity. As people age, the 'normal' symptoms of ageing and dementia might again be seen as part of the learning disability rather than of growing older or of mental ill-health.

The interface between learning disabilities and mental health services can also be improved by '**carry(ing) out joint assessments when a service user falls in the 'borderline' of learning disabilities, mental health, substance abuse and or forensic eligibility criteria so that a joint care co-ordinating approach can be adopted by the relevant services.'**[11] Another way to improve a

[11] Ibid, 22

coordinated approach is to '**create 'virtual teams' around service users to allow professionals to cross service boundaries and work together by each providing their particular area of expertise, thus avoiding unnecessary and time-consuming 'battles' between the services which result in exclusion or delay.** Such changes in these types of coordinated approaches must be formalised in both NHS and adult social care outcomes. The concept of adult teams is very important more generally too. For example, someone with a learning disability who uses a wheelchair will be assigned to the Learning Disability Team and not Physical Disability Team; similarly with sensory impairment. **By splitting services this will create a need to identify individuals by one primary label, when in reality people with one identified disability are likely to have multiple areas of need.**

Alongside continual development for staff in both areas, regular **clinical supervision/mentoring for direct care staff is crucial**. Professional staff receives such input but less qualified staff rarely do. Yet they are often much in need of advice and a chance to reflect on their own practice.

Key Message

A Family Centred Approach

'Adopting a 'family centred approach'[12] by which the needs of the family as a whole are considered is an important factor in determining positive outcomes for an individual service user.[13]

Families should have equal access to systemic (family) therapy so that, if necessary, the needs of the family as a whole can be considered and the person with the learning disability is not seen as the sole 'problem' but that all family members consider their role and function in the problematic situation. Such therapy is provided by qualified specialist mental health workers, is available in most mental health services and should be open to families where one or more members have learning disabilities if such an intervention is deemed appropriate.

In addition, carers need to be provided with training to enable them to respond appropriately to family members and be aware where to 'signpost' them if they require social or psychological support. Family circumstances and home conditions should also be considered in the service user's Personal Care Plan (PCP). Family members are likely to know more about and to be most aware of the problems posed in caring for their relative with both learning disabilities and mental ill-health. Hence, without bypassing their relative, family members should, where appropriate, be involved in the development of the PCP and perceived as being able to play a 'consultant' role.

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[12]Rosenbaum,P., King,S., Law,G., and Evans,J. (1998) Family-centred service: a conceptual framework and research review. Physical and Occupational Therapy in Pediatrics, 8 (1), 1-20

[13] Stenfert Kroese,B., Rose, J.L. (2011) Mental Health Services for Adults with Learning Disabilities, 22

Key Message

Commissioning of Learning Disabilities and Mental Health Services

At the time of writing, before a formal consultation process is launched, The Department of Health has asked for feedback on its Draft Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy Guidance. This has described the JSNA as, 'a fundamental part of the planning and commissioning cycle at a local level.[14] Health and Wellbeing Boards must ensure joint outputs in how services are commissioned and delivered.

We believe that the **Health and Wellbeing Boards will require assistance from sector leaders to ensure services for those with learning disabilities and mental ill-health are commissioned and delivered appropriately.**

Examples of commissioning between these services could include **flexible or dual registration for service providers so people with learning disabilities** can access mainstream mental health services more easily. It would also mean that learning disability and mental health services could work more holistically together instead of being consumed with issues that relate to eligibility criteria and with questions about which is to provide the service.

Those services with dual registration **must also receive compulsory detailed training about both learning disability and mental ill-health**. **Their status should also be reflected in the fees paid and salaries of the staff**

Mental health services promote Cognitive Behavioural Therapy and other talking therapies to their service users. However, this is rarely offered to those with learning disabilities, who are often offered only medication and other such avenues are not explored. **Aligning these two services may help promote the use of talking therapies for those with learning disabilities and thus provide more options in their overall care package.** There is now a substantial body of evidence which suggests that people with learning disabilities benefit from talking therapies provided they are adapted to make the methods and materials accessible to people with limited comprehension and literacy. People with learning disabilities are often offered creative therapies (music, art, drama) but there needs to be clear demarcation of where this is therapy, where it is therapeutic and where it is for leisure only.

Further research must also be undertaken to explore **the benefits of same sex support groups for women and men with learning disabilities and mental ill-health**, 'particularly groups which adopt a community psychology approach'.[15] A women's group formed part of the outcome of an earlier study funded by the Judith Trust and carried out in Northern Ireland by Laurence Taggart; according to their own report members of the group found it to be empowering and useful.

[14] Draft guidance on Joint Strategic Needs Assessments and joint health and wellbeing strategies (2012) Department of Health, 5

[15] Stenfert Kroese,B., Rose, J.L. (2011) Mental Health Services for Adults with Learning Disabilities, 46

When commissioning services to those with learning disabilities and mental ill-health, joint commissioners must think further about **the care time dedicated to service users provided to people living in the community. This 'one size fits all' approach is inappropriate for this group of people**. Tasks such a brushing teeth, for example, may take a longer time than the minute or so listed within the 15 minutes allocated to personal care when provided in the home. Standard basic rates of pay are not enough – working with people who need more specific skills should be appropriately rewarded as discussed above.

Conclusions

When the Judith Trust was founded in 1997, it was already clear that a major problem affecting all those with both a learning disability and a mental heath problem was that they were falling between two services. Those in mental health were largely ignorant of learning disabilities and vice versa. The first report the Trust commissioned was published as *Joined Up Care*[16] and focussed on finding examples of good practice around the country (England). Now, more than a decade later, we find continuing problems of a dislocation between services for people who need both. The authors of our research did find examples of good practice and in this advisory paper we comment on some of them, including virtual teams. But we are a very long way short of an integrated service that actually serves the real needs of this group of people.

The usual answer is 'more training' and, alas, this remains the key to the ultimate delivery of a service to people with both these problems by carers including nurses. Nurses may be those who have either psychiatric training or learning disability training but not both; they need both. The care staff are, as we have pointed out, often very poorly trained, knowing very little about either issue, have poor career options and insufficient levels of pay. But these problems are symptomatic of a problem within the medical profession where clinicians across the board are poorly trained, or not exposed at all, to the necessary knowledge of each of these problems, especially when present in one person.

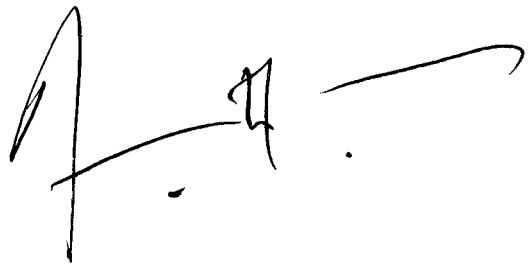
However, our key messages examine the process before anyone is in post through better recruitment and selection – and there is good practice, not only from the MacIntyre system, but we have highlighted it here. Clearly more can be done to get the most appropriate people in place and then training has to be continuous – even the best training and learning needs constant updating, discussion and further learning, besides which staff rotate, move, leave the service and new people enter.

The Judith Trust takes a gendered perspective on all it does and at every stage it is clear that thought needs to be given to the needs and challenges posed by women and men, the different approaches needed for each and the importance of the relationship of male and female carers to female and male clients.

Finally, in the dramatic changes within Adult Social Care and the NHS, commissioning has to take centre place and commissioners need to be fully aware of the challenges people with learning

[16] Zarrina Kurtz for the Judith Trust, *Joined Up Care: good practice in services for people with learning disabilities and mental health needs*, The Judith Trust, 1999

disabilities present to carers compared to those who have mental ill-health and **then** put together packages that suit women and men with both problems.



Annette Lawson

Chair, March 13 2012